

**Statewide Summary Report Including Review of Statewide Leadership
and Overview of Major Services**

Report of the 2nd Court Appointed Expert

Lippert v. Godinez

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Prepared by the Medical Investigation Team

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Table of Contents

Background	2
Methodology.....	2
IDOC Prisons Overview	6
Key Findings	9
Statewide Medical Operations.....	12
Leadership, Staffing, and Custody Functions.....	12
Wexford Provider Staffing and Physician Credentialing.....	21
Statewide Use of University of Illinois	31
Statewide Overview of Major Services.....	32
Clinical Space and Equipment.....	32
Medical Records.....	37
Medical Reception	42
Intrasystem Transfer	45
Nursing Sick Call	48
Chronic Care.....	52
Urgent/Emergent Care.....	59
Specialty Consultations	62
Infirmity Care	69
Pharmacy and Medication Administration	77
Infection Control	84
Mortality Reviews	91
Dental Program	103
Internal Monitoring and Quality Improvement.....	118
Recommendations	121
Key Recommendations of Second Court Expert.....	121
Organizational Structure, Facility Leadership, and Custody Functions	122
Clinic Space and Equipment.....	124
Medical Records.....	126
Medical Reception	127
Intrasystem Transfer	129
Nursing Sick Call	129
Chronic Care.....	131
Urgent/Emergent Care.....	133
Specialty Consultations	135
Infirmity Care	137
Pharmacy and Medication Administration	138
Infection Control	140
Mortality Reviews	146
Dental Program	147
Internal Monitoring and Quality Improvement.....	150

Background

This report is produced for the United States District Court for the Northern District of Illinois Eastern Division with respect to the litigation Don Lippert, et al. v. John Baldwin, et al. No. 10-cv-4603. The Court has asked for the Expert to:

“Assist the Court in determining whether the Illinois Department of Corrections (“IDOC”) is providing health care services to the offenders in its custody that meet the minimum constitutional standards of adequacy.”¹

The Court gave further direction. The Court asked the Expert to determine primarily whether any of the systemic deficiencies identified by the First Court Expert as reported in December of 2014 currently exist. The Court asked the current Expert, in the course of the evaluation, to identify any additional systemic deficiencies. Finally, the Court asked for assistance in forming recommendations to correct identified deficiencies. The Court asked the current Expert to consider the solutions proposed by the First Court Expert or to suggest alternate solutions. For newly identified deficiencies, the Court asked for new recommendations.

In order to form our opinion to answer these questions, the Expert, Michael Puisis DO, formed an investigative team consisting of Jack Raba MD, nurse practitioner Madie LaMarre MN, FNP-BC, Catherine Knox MN, RN, CCHP-RN, and dentist Jay Shulman DMD, MSPH.

Methodology

The current Court Expert met with parties on December 18, 2017 to discuss his methodology and plan. The methodology explained to parties was one typically used by correctional experts in answering questions regarding adequacy of medical care in correctional settings. We interview staff and patients. We observe delivery of care as it occurs for selected processes. We review Administrative Directives, policies, and other documents such as budgets, staffing documents, quality improvement meeting minutes, and reports, etc. We tour facilities’ areas where care is provided and observe the setting of care to determine the adequacy of resources that support care. Lastly, we review a sample of health records, including death records. From these interviews, tours, document reviews, and record reviews, we form our opinions and recommendations.

During our five site visits we reviewed 362 medical records and 363 dental records.² In addition, we reviewed 33 death records. Dr. Puisis performed all mortality reviews. Findings in site visit record reviews corroborated findings in death reviews. Charts for urgent care, specialty care, and hospital care record review were chosen based on having an ambulatory care-sensitive

¹ Second Order Appointing Expert, United States District Court for the Northern District of Illinois Eastern Division, No. 10-cv-4603 filed 12/8/17.

² A table with details of record reviews is found at the end of this report as an appendix.

condition.³ For all other site visit medical record reviews, records were chosen of patients that had an actual or potential serious medical needs. In the case of chronic illness,⁴ records were chosen randomly by type of disease (e.g., diabetes, autoimmune, HIV, etc.) For nursing sick call, we selected records nursing sick call logs of patients with potentially serious medical needs such as shortness of breath or chest pain instead of persons complaining of athlete's foot or wanting a low bunk.

For mortality reviews, there were 174 deaths in 2016 and 2017. We asked for 89 records but only reviewed 33 records due to the truncated investigation. We excluded from selection nine suicide deaths, three overdose deaths, and one death from injury. Record selection was somewhat limited by the availability of records. We asked for death records when the Expert first met with the attorneys in December of 2017. We started receiving records on March 7, 2018. Initially we reviewed six records,⁵ as they were the only records we had available. Twenty-one records were then chosen from sites we were visiting.⁶ We then randomly chose two records from sites that the First Court Expert had visited.⁷ The remaining four records were chosen at random from sites that neither Expert visited. The only information available at the time of record selection was the name, date of death, age, facility, and cause of death. The cause of death was not provided for all patients; some patients had "natural causes," "cardiac arrest," or "unknown" listed as the cause of death. Autopsies were not available for all deaths; even when an autopsy was done it was not consistently available. We randomly chose more records from facilities we were visiting intending to allow for a comparison with observed care during site visits. We reviewed one to two years of documentation of care in these records.

Our mortality review consisted of describing episodes of care, and for each episode we identified errors using a classification of 18 different error types. This allowed us to identify common and systemic problems within the health program. Error types were summarized as an appendix in the mortality review document. We summarized the mortality reviews in a narrative summary, but also provided the spreadsheets used to document each individual episode of care reviewed so that reviewers can see the specific instances of care that formed our opinion in the narrative. The mortality reviews are integral to our opinion and should be reviewed. These documents are provided as an appendix.

For dental records, the chart selection methodology is described in each element of the dental program.

The IDOC, in their comments on our report, asserted that the report "relies primarily on a subjective review of the health record" and failed to use "objective clinical measurements such

³ Ambulatory care sensitive conditions (ACSC) are conditions that can be managed in an outpatient setting. HEDIS, the Agency for Healthcare Research and Quality (AHRQ) and quality improvement programs use ACSC to select records to review to assess whether hospitalization might be preventable or whether care reveals quality or systemic issues. For more information see the Prevention Quality Indicator Overview at https://www.qualityindicators.ahrq.gov/modules/pqi_overview.aspx.

⁴ We presume that all patients with chronic illness have a potential or actual serious medical illness.

⁵ Patients #1, 2, 3, 4, 5, and 6.

⁶ Patients #7 through 27 inclusive.

⁷ Patients #30 and 31; Pontiac had no deaths.

as those found with the Healthcare Effectiveness Data and Information Set (“HEDIS”⁸) guidelines or critical process assessments.”⁹ The IDOC does not participate in HEDIS measurement so there was no IDOC data to review with respect to HEDIS measures.¹⁰ Moreover, quality improvement reports did not include objective data measures similar to HEDIS that might have informed us. IDOC lacks useable data for analysis of clinical care, which is evident in their quality improvement efforts. The First Court Expert in his analysis of the quality improvement program also identified this problem.¹¹

In their comments on our reports, the IDOC asserted that we believed that prison health care systems should provide care “significantly in excess of what is available in the community” and that our report “takes the position that inmates are entitled to a perfect healthcare delivery system.” We do not agree with those assertions. The benchmarks we use are community and correctional standards of care,¹² not a hypothetical standard “in excess of what is available in the community.”

⁸ The Healthcare Effectiveness Data and Information Set (HEDIS) is a performance measurement system managed by the National Committee for Quality Assurance (NCQA). There are over 90 HEDIS measures over six domains including safety, effectiveness, patient-centered, timely, efficient, and equitable. Large health maintenance organizations and practices use HEDIS to measure their performance. Data submission used for HEDIS reporting is strictly controlled and defined. These measures are a useful comparator between managed care organizations and other health organizations. These measures do not address acute or emergency care, access to specialty services, access to hospital care, access to an appropriate provider, timely access to a professional opinion and evaluation, access to medication, or many other areas specific to the correctional setting. These performance measures are useful but are not designed for correctional health care programs

⁹ Letter via email from John Hayes and Michael Arnold, Office of the Attorney General to Dr. Puisis: Re: *Lippert v. Baldwin*, No. 10-cv-4603 – Defendants’ comments to the Draft Report of the 2nd Court Appointed Expert, dated September 10, 2018.

¹⁰ Although IDOC does not track HEDIS measures or participate in HEDIS, we made comments on and/or reviewed care in multiple areas that correspond to HEDIS measures. Our report documents record reviews or other investigations that identified quality of care and/or systemic issues in all of the following HEDIS measurement areas: Adult BMI assessment; Colorectal cancer screening; Care for older adults; Use of spirometry testing in the assessment and diagnosis of chronic obstructive pulmonary disease; Statin therapy for patients with cardiovascular disease and diabetes; Comprehensive diabetes care; Follow-up after emergency department visit for people with multiple high-risk chronic conditions; Medication management in the elderly; Fall risk management; Management of urinary incontinence in older adults; Influenza and pneumococcal vaccination status for older adults; Hospitalizations for potentially preventable complications; Acute hospitalization utilization; and Emergency Department utilization.

¹¹ On page 44 of the First Court Expert’s summary report he states, “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 performance.”

¹² As examples of references reflecting community standards of care, we utilized the U.S. Preventive Services Task Force Recommendations for Primary Care Practice; CDC Recommended Immunization Schedule for Adults Aged 19 Years or Older, United States, 2018; MMWR (2006) Prevention and Control of Tuberculosis in Correctional and Detention Facilities; Standards of Medical Care in Diabetes by the American Diabetes Association; 2013 American College of Cardiology/American Heart Association Guideline on the Treatment of Blood Cholesterol to Reduce Atherosclerotic Cardiovascular Risk in Adults; Global Initiative for Chronic Obstructive Lung Disease updated 2016; American College of Cardiology/American Heart Association Guidelines for the Management of Patients With Unstable Angina and Non-ST-Elevation Myocardial Infarction; Evidence-Based Guideline for the Management of High Blood Pressure in Adults, Report from the Panel Members Appointed to the Eighth Joint National Committee (JNC 8): Centers for Disease Control and Prevention; HIV Testing Implementation Guidance for Correctional Settings. 2009; National Commission on Correctional Health Care, 2014 Standards for Health Services in Prisons; HCV Guidance: Recommendations for Testing, Managing, and Treating Hepatitis C, Last Updated May 24, 2018; American Association for the Study of Liver Diseases and Infectious Diseases Society of America; Occupational Safety and Health Standards – Toxic and Hazardous substances. 29 CFR 1910.1096(e)(3)(i); Guidelines for Infection Control in Dental Health-Care Settings–2003. MMWR, December 19, 2003/52(RR17):1:16; Stefanac SJ. Information Gathering and Diagnosis Development; American Dental Hygiene Association Standards for Clinical Dental Hygiene Practice Revised 2016; Makrides, N. S., Costa, J. N., Hickey, D. J., Woods, P. D., & Bajusca, R. (2006); Correctional Dental Services. In M. Puisis (Ed.), *Clinical Practice in Correctional Medicine* (2nd edition); Dental Radiographic Examinations: Recommendations for Patient Selection and Limiting Radiation Exposure.

In addition to record reviews, we toured five facilities: Northern Reception Center (NRC), Stateville Correctional Center (SCC), Dixon Correctional Center (Dixon), Logan Correctional Center (LCC), and Menard Correctional Center (MCC). Four Experts visited each site; two doctors, a dentist, and a nurse. During each facility visit, we:

- Met with leadership of custody and medical
- Toured the medical services areas and housing units
- Talked with health care staff
- Reviewed health records and other documents
- Interviewed inmates

The First Court Expert mentioned in his report that the State provided comments that the Investigative Team should utilize standards from the National Commission on Correctional Health Care (NCCHC) or the American Correctional Association (ACA) as the basis for their investigation. We agree with the First Court Expert's response that NCCHC standards are useful as a basis to evaluate IDOC Administrative Directives and certain processes of care. We do use the NCCHC standards for that purpose and mention this in this report. However, the request of the Court is to determine adequacy of care for serious medical needs. In order to do that, one must do more than evaluate whether Administrative Directives meet NCCHC standards. Adherence to NCCHC standards does not verify that quality of clinical care is adequate, which is arguably the most important aspect of determining adequacy of care. The limitations of the NCCHC standards as a sole measure for constitutional adequacy require additional investigative measures to answer the Court's request. Observation of actual practices at the facilities form the basis for evaluation of actual care as it is delivered, and review of records forms the basis for evaluation of clinical care.

To facilitate comparison with the First Court Expert's report, we have utilized similar headings of major services reviewed. We agree with the First Court Expert's organization of topics of study as presented in his table of contents. One change we made was to combine laboratory functions and clinic space and sanitation, and to include other diagnostic testing available onsite. These items are all support functions and were combined for that reason. We have added a section in the summary document discussing the statewide operations of the IDOC, UIC, and Wexford, the medical vendor, including a section on credentialing of physicians on a statewide basis. We also included a brief summary describing the statewide monitoring effort of the current medical contract.

The Second Order Appointing Expert gave authority to perform tours of eight facilities that had been reviewed by the First Court Expert. The Court's Order gave the Expert discretion to decline visiting any of the facilities if determined to be unnecessary. The Court's Order required the Expert to meet parties after the first 120 days of the investigation to establish a plan and timeline for concluding the review in a timely and cost-effective manner.

American Dental Association and U.S. Food and Drug Administration, 2012. For items for which there is no standard of care, we utilized information as found in Up-To-Date, an online medical reference.

We started this project intending to review eight facilities. At the 120 day meeting, the Expert discussed preliminary findings and announced that it was his opinion that review of the eight facilities was not necessary. The findings were consistently similar facility to facility and confirmed by the First Court Expert's findings. Review of death records from 12 facilities demonstrated consistently poor care and the evidence was so overwhelming that the Expert found it unnecessary to continue visiting the full complement of eight facilities. The Expert strongly believes that further visits would not add to our opinions, except for site-specific recommendations. We terminated visits after five facilities were visited. These included: NRC, SCC, Dixon, LCC, and MCC. It is our opinion that this complement of facilities is adequate to form an opinion of statewide services. The sample includes the main male and female reception centers, the center used to house geriatric patients, two of the three maximum security prisons, the largest IDOC facility (Menard Correctional Center), and facilities from Northern, Central and Southern areas of the state. We are confident that review of this group of facilities gives a representative sample of the IDOC health care system.

With respect to this report, for each section in which the First Court Expert had findings, we summarize his findings in a paragraph and make a subsequent statement whether his findings were still present or have been resolved. We then present our own findings. With respect to recommendations, we do the same. We list, verbatim, the First Court Expert's Recommendations and document whether we agree or not. If we disagree or had additional comments we add those. When we comment on the First Court Expert's Recommendations we do so in italics so our comments can be distinguished from the First Court Expert's comments.

IDOC Prisons Overview

The Illinois Department of Corrections was established in 1970 to administer and operate state prisons, juvenile centers, and juvenile and adult parole services. In 2006, the Illinois Department of Juvenile Justice was formed, which separated the adult and juvenile correctional systems. In 1970, the IDOC operated seven adult prisons. Currently, the IDOC operates 25 adult prisons,¹³ a facility for housing the severely mentally ill (Joliet Treatment Center), and four transition centers.¹⁴ The population of Illinois prisons has increased from approximately 6000 inmates in 1974 to approximately 49,000 inmates in 2015,¹⁵ an eight-fold increase in population. The most recent information given to us by the IDOC is that the correctional center population as of November 30, 2017 is 41,376.¹⁶

Illinois prisons are overcrowded. The latest data from 2015 comparing prisons nationwide show that, based on design capacity, Illinois is the second most overcrowded prison system in the

¹³ NRC and SCC are considered one facility for custody purposes, but NRC and SCC now have separate medical programs. Therefore, for purposes of this report there are 26 facilities. When we refer to prisons with respect to the medical programs we will refer to 26 prisons.

¹⁴ Agency Overview on the IDOC website found on December 16, 2017 at <https://www.illinois.gov/idoc/aboutus/Pages/IDOCOverview.aspx>.

¹⁵ Illinois Prison Overview, Illinois State Commission on Criminal Justice and Sentencing Reform, 2015, as found at <http://www.icjia.org/cjreform2015/research/illinois-prison-overview.html>.

¹⁶ 180126 Presley Rated Capacity on November 30, 2017, provided to us by IDOC.

nation. Alabama is the most overcrowded.¹⁷ That 2015 data showed that Illinois had a population at 145% of capacity. Since 2015, the population has been reduced by several thousand. Still, as of November 30, 2017, the IDOC is at 131% of rated capacity. It houses 41,376 inmates in facilities rated to hold 31,525 inmates.¹⁸

Many IDOC facilities are old and hard to maintain. The state, on several occasions, has attempted to close some of these older facilities, including SCC, Pontiac, and Vandalia. In recent years parts of the Stateville Correctional Center, including the old Roundhouse building, have been closed. Of its 25 adult prisons, only four were opened in the 21st century, and two of these facilities (Decatur and Sheridan) were older facilities that were rehabilitated. Thirty-eight percent of inmates in IDOC reside in facilities built before 1981. Two of the facilities housing approximately 11% of the IDOC population were built in the 19th century (MCC 1878 and Pontiac 1871), and two facilities were built in the early 20th century (Vandalia 1921 and SCC 1925). All of the male maximum security beds in the IDOC are in structures built in the 19th century or early 20th century (MCC 1878, Pontiac 1871, and SCC 1925). Maximum security facilities house approximately 7500 inmates (approximately 17% of the IDOC population) who spend more in-cell time. These structures make delivery of medical care more difficult and less efficient, are difficult to maintain, and may negatively affect inmate health in a variety of ways. These health-related effects include heat exposure issues, particularly at the Menard facility, and potential for rodents and vermin. In addition, these facilities present challenges in health care delivery, including access to care, medication administration, and providing ordered medical care. As our reports show, we found some of these problems in the older facilities we visited. We did note an additional egregious issue at NRC, where inmates are locked down 24 hours a day except for four hours per week. In some cells, inmates had no functioning lights for weeks at a time, inhibiting nurses' ability to properly identify inmates when administering medications. These conditions are a serious obstacle to health care access.

With respect to IDOC health care costs, a 2017 study detailed costs of health care in state prison systems between 2010 and 2015.¹⁹ In 2015, the average per inmate per year health care spending for persons in state prisons in the U.S. was \$5,720. Illinois spent \$3,619. This was 37% below national average. Nationwide, per capita expenditures for health care for state prisoners ranged from a low of \$2,173 to a high of \$19,796. Illinois ranked seventh lowest in the U.S. in terms of per capita spending per inmate per year as noted in the table below.²⁰ We were given information from the IDOC Chief Financial Officer that for 2017 the annual spending per inmate increased to approximately \$4800 per inmate per year, but there is no comparable data for

¹⁷ Appendix Table 1, Prison facility capacity, custody population, and percent capacity, December 31, 2015, as found in Prisoners in 2015, Bureau of Justice Statistics, US Department of Justice, December 2016, NCJ 250229 located on the web at <https://www.bjs.gov/content/pub/pdf/p15.pdf>.

¹⁸ 180126 Presley Rated Capacity on November 30, 2017, as provided by IDOC.

¹⁹ Data from Prison Health Care: Costs and Quality; a report from the PEW Charitable Trust, October 2017, as found at <http://www.pewtrusts.org/en/research-and-analysis/reports/2017/10/prison-health-care-costs-and-quality>.

²⁰ We note that the Kaiser Family Foundation reported that Illinois civilians had per capita health care expenditures of \$8,262. This can be compared to the \$3,619 per capita health expenditures per inmate per year. Health Care Expenditures per Capita by State of Residence for 2014 for the Illinois civilian population is found at <https://www.kff.org/other/state-indicator/health-spending-per-capita/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D>.

other state prison systems nationwide.²¹ IDOC Spending in 2017 is still below the average 2015 spending of prisons nationwide.

Ten Lowest Per Capita Expenditures for Health Care in US State Prison Systems in 2015	
State	Per Capita Annual
Louisiana	\$2,173
Alabama	\$3,234
Indiana	\$3,246
Nevada	\$3,246
South Carolina	\$3,478
Arizona	\$3,529
Georgia	\$3,610
Illinois	\$3,619
Kentucky	\$3,763
Mississippi	\$3,770

For most state systems, the number of employees, age, and percent of female population were the largest drivers of cost of prison health programs. The Federal Bureau of Prisons assessed that institutions with the highest percentages of aging inmates spent five times more per inmate on medical care and 14 times more per inmate on medication than institutions with the lowest percentage of aging inmates. The National Institute of Corrections estimates that inmates over age 55 cost, on average, two to three times more than the expense for all other inmates.²² Based on this same 2017 report, Illinois has the seventh *lowest* rate of persons over age 55 (8.5%). As well, in 2015 IDOC had a female population of 5.8%, the ninth *lowest* rate of females incarcerated in state prison systems. These two factors should lower the costs of care somewhat, but are not so great as to account for the difference in IDOC cost from the mean health expenditure of state prison systems.²³

Staffing appears to be the biggest contributor to the low IDOC spending on health care. In fiscal year 2015, Illinois has the second lowest number of full-time equivalent (FTE) health care workers (19.3 per 1,000 inmates) of all 50 state prison systems. The range of FTEs per 1,000 in the 50 state systems range from 18.6 FTEs per 1,000 inmates to 86.8 FTEs per 1,000 inmates.²⁴

²¹ In his deposition, Mr. Brunk the Chief Financial Officer for the IDOC stated on pages 12-13 that the total expenditures on health care in the IDOC were approximately \$203 million. Using a population of approximately 42,000 the expenditures per inmate per year would be approximately \$4,800.

²² Prison Health Care: Costs and Quality; a report from the PEW Charitable Trust, October 2017 as found at <http://www.pewtrusts.org/en/research-and-analysis/reports/2017/10/prison-health-care-costs-and-quality>.

²³ Prison Health Care: Costs and Quality; a report from the PEW Charitable Trust, October 2017 as found at <http://www.pewtrusts.org/en/research-and-analysis/reports/2017/10/prison-health-care-costs-and-quality>.

²⁴ Prison Health Care: Costs and Quality; a report from the PEW Charitable Trust, October 2017 as found at <http://www.pewtrusts.org/en/research-and-analysis/reports/2017/10/prison-health-care-costs-and-quality>.

There is a direct correlation between the FTEs per 1,000 inmates and per-inmate annual spending. A low number of staff can reflect a more efficient system of care or understaffing with its attendant negative consequences for provision of health care. In our study, we found that in 2018 there were 25 employees per 1,000 inmates, which still places Illinois approximately in the lower 10% of state prison systems based on 2015 data. This will be discussed later in this report.

Key Findings

Overall, the health program is not significantly improved since the First Court Expert's report. Based on record reviews, we found that clinical care was extremely poor and resulted in preventable morbidity and mortality that appeared worse than that uncovered by the First Court Expert.

Governance of the IDOC medical program is subordinated to custody leadership on a statewide level and at the facility level. The subordination of health care to custody leadership has resulted in a medical program that is not managed on sound medical principles and one that is without medical leadership.

The existing IDOC system of care was established to have a more robust central office capable of monitoring vendor activity. The IDOC central office has been progressively diminished over the years to the point where it is incapable of effective monitoring.

The medical program does not have a separate budget. The IDOC could not provide to us a document that included expenditures for medical care. Authorization and responsibility for medical expenditures does not reside with the health authority.

IDOC Administrative Directives are inadequate policies for this state system. The IDOC medical policies need to be refreshed, augmented, and address all National Commission on Correctional Health Care (NCCHC) standards.

The IDOC does not have a staffing plan that is sufficient to implement IDOC policies and procedures. The staffing plan does not incorporate a staff relief factor.

Custody staffing has also not been analyzed relative to health care delivery to determine if there are sufficient custody staff to deliver adequate medical care.

Budgeted staffing was increased but vacancy rates were higher than noted in the First Court Expert's report. Staff vacancy rates are very high.

The vendor, Wexford, fails to hire properly credentialed and privileged physicians. This appears to be a major factor in preventable morbidity and mortality, and significantly increases risk of harm to patients within the IDOC. This results from ineffective governance.

Wexford and the IDOC fail to monitor physician care in a manner that protects patient safety. There is no meaningful monitoring of nurse quality of care. If care is provided it is presumed to be adequate, when in fact it may not be adequate.

The inability to obtain consultation reports and hospital reports appears to be a long-standing system wide problem. This is a significant patient safety issue.

The collegial review process of accessing specialty care is a patient safety hazard and should be abandoned until patient safety is ensured.

Specialty care is not tracked with respect to whether it is timely. The Wexford system of utilization management is ineffective and for many patients is a barrier to timely care. The use of free care at UIC appears to have resulted in unacceptable delays. Waiting for unacceptable time periods for free care when care needs to be performed timelier has harmed patients.

Patients are not consistently referred for specialty care when it is warranted. We view this as a problem of hiring unqualified physicians and as a problem of the utilization process itself.

The paper medical record system creates significant barriers to delivery of safe health care, including inaccessibility of prior reports and prior diagnostic tests. The current paper medication administration records (MARs) are inconsistently filled out, filed, or able to be viewed by clinicians. The paper record also makes monitoring health care processes exceedingly difficult. An electronic medical record is needed.

Sanitation, maintenance, and equipping health care units is not standardized. Many clinical areas are inadequately sanitized.

The reception process does not ensure a thorough initial medical evaluation that will correctly identify all of a patient's problems in order to develop an appropriate therapeutic plan. Provider medical histories are inadequate. Follow up of abnormal findings is inconsistent. Laboratory tests and other studies needed for an initial evaluation of a patient's chronic illnesses are inconsistently obtained. Tuberculosis (TB) screening is improperly performed due to custody rules at NRC.

The chronic disease system promotes fragmentation of care and fails to adequately address all of a patient's problems from the perspective of the patient. Patient problems are lost to follow up or are not addressed in the context of a patient's complement of diseases.

The chronic care disease guidelines need to be updated. Alternatively, contemporary existing guidelines by major specialty organizations should be used in lieu of IDOC-specific chronic care

guidelines. These specialty organization guidelines are periodically updated and are based on latest scientific evidence. For the Office of Health Services to attempt to duplicate these guidelines is unrealistic.

The Administrative Directive for periodic examination ²⁵ is inconsistent with current standards of preventive care.²⁶ Inmates are therefore not offered all preventive services that are typically offered to individuals in the community. The most important missed preventive care is colorectal cancer screening in individuals over 50 years of age.

Housing of the elderly and disabled is inadequate. The IDOC needs to perform an assessment of its geriatric and disabled population to determine housing needs for this population. It is likely that new or rehabilitated housing for this population is needed.

There is no active infection control program. Infection control practices lack guidance from a physician with expertise in infection control practices. This is evident in HIV testing, TB screening, and analysis of surveillance practices.

The quality improvement program operates on a legacy system of principles that no one any longer understands or effectively implements. No one in the IDOC has experience or knowledge of contemporary quality improvement methodology and practice. The quality improvement program is ineffective statewide.

The quality improvement program does not have a means to identify problems for study and does not associate identified problems with systemic processes.

Data for quality improvement is obtained by manually counting events. Logs tracking processes of care are either not maintained or maintained in a manner such that the data is not easily useable.

The methods of preparing and administering medications is not standardized across the system. There are pervasive and systemic issues with respect to medication administration that place inmates at risk of harm. When these occur, there is no system to identify or correct the systemic problem.

Overall, the dental program has not improved since the First Expert Report. Dental care continues to be below accepted professional standards and is not minimally adequate. Examinations are inadequate and routine care is provided without intraoral x-rays, a documented periodontal assessment, and a treatment plan. Periodontal disease is rarely diagnosed and treated.

²⁵ Offender Physical Examination; Illinois Department of Corrections Administrative Directive 04.03.101.

²⁶ As exemplified by the US Preventive Services Task Force Recommendations.

There is no systemwide capital replacement plan for dental equipment. As examples, the panoramic x-rays taken at the R&C centers are inadequate and the x-ray devices are outdated. IDOC has no dentist on the Medical Director's staff and the clinical oversight of the dental program is inadequate.

Dental staffing is insufficient to provide adequate and timely care.

Statewide Medical Operations

Leadership, Staffing, and Custody Functions

Methodology: We interviewed the Agency Medical Director, the Regional Coordinators, the Regional Medical Coordinator, Chief of Programs and Support Services, the Wexford Vice President of Operations, the Wexford Director of Operations, two Wexford Regional Managers, and two Wexford Regional Medical Directors. We reviewed the table of organization, and reviewed selected documents. We obtained and reviewed staffing documents. We reviewed peer review documents and credentialing documents provided by Wexford.

First Court Expert Findings

The First Court Expert found that leadership was a problem at all facilities visited. Many leadership positions were vacant. Some Wexford supervisory staff spent considerable time on Wexford corporate duties rather than on the operational assignments they were being paid for. Several physicians did not have primary care training and hiring of underqualified physicians was a problem. Clinical quality was variable and compounded by lack of clinical oversight, peer review, and access to electronic resources to access clinical information. Medical Directors spent little time in reviewing clinical practice of other providers or engaging in important administrative duties. Staffing deficiencies were present at several facilities but were facility specific. Nurses other than registered nurses (RNs) were performing independent assessments, which is not consistent with the State of Illinois Nurse Practice Act. The Office of Health Services was under-resourced and unable to provide clinical oversight. The First Court Expert was informed by State and vendor staff of problems [unspecified] with Wexford Regional Medical Directors. Professional performance review, mortality review, and quality improvement were described as extremely disappointing.

Current Findings

We agree with the findings of the First Court Expert and note that, with minor exceptions, findings are the same. There have been staffing increases, particularly at NRC and SCC, but vacancies are increased. Staffing is deficient, in our opinion, even if vacancies were filled. The IDOC does not know how many staff are necessary because a staffing analysis has not been performed, even for development of Schedule E staffing budgets for contract medical services. There are fewer HCUA position vacancies. The HCUA leadership staff at all five facilities was very good. Physician leadership, however, is worse. We had additional findings regarding the governance of the health program, monitoring of clinical services, credentialing of physicians, and policy concerns. There is no centralized medical health authority that develops the budget,

determines recommended staffing levels, monitors the contract, and provides oversight of clinical care. Because operational control of the medical program is under the authority of the Wardens of individual facilities, processes can be established that are not consistent with appropriate medical management practices.

Structure of Medical Services and IDOC Leadership

The organizational structure of the IDOC health program was established in the 1980s and early 1990s. The program was structured so that the IDOC staff would maintain administrative control over the health program and have a variety of vendors provide physician staff and other staff the state was unable to provide. Staffing of the facilities was provided by contract medical vendors with a considerable number of state employees. Currently, dialysis services are provided at three facilities by NaphCare. University of Illinois at Chicago provides laboratory services statewide and statewide management of HIV and hepatitis C patients with anti-viral medication via telemedicine. Wexford Health Sources provides the remaining medical, dental, vision, and pharmacy services under the guidance of the IDOC Agency Medical Director and in accordance with their contract.

Currently, the IDOC medical program table of organization is not organized on a medical model. Governance of the IDOC medical program is subordinated to custody leadership on a statewide level and at the facility level. The health authority²⁷ is the Chief of Programs and Support Services, and is an ex-warden. The IDOC medical program has no named responsible physician,²⁸ although in practice some aspects of this responsibility appear to reside with the Agency Medical Director, who appears to be primarily a consultant. The budget of the health program is not a separate budget. At a facility level, wardens are the Chief Administrative Officer and are responsible for operations of the health program.

The health authority is not responsible for operational management of the statewide medical program. Instead, authority and responsibility are diffuse. This results in gaps in management, oversight, and monitoring, and leads to poor performance. The Office of Health Services is not responsible for determining staffing levels, budget needs, equipment needs, or oversight of the medical program.

The responsible health authority is the Chief of Program and Support Services, who reports to the Director. This is a custody position. The current organizational structure does not require that the health authority have health care education and training commensurate with the requirements of the position. Requirements of the health authority position are not explicit in the Office of Health Services policies. This position is currently filled by a licensed clinical psychologist who was previously with the Department of Mental Health in Chester, Illinois and recently was the Warden at Southwestern Illinois Correctional Center. She has ultimate responsibility for oversight of medical care and ensuring that systems are in place to ensure

²⁷ A health authority is a person responsible for health care services. This person arranges for all levels of health care and ensures that all levels of service are provided, and that care is accessible, timely, and of good quality.

²⁸ A responsible physician is a physician who has final authority regarding clinical issues.

adequate care. We have concerns with the health authority being a custody person, particularly because it can be filled with non-health care personnel without experience in managing a clinical medical program. In an interview with the Chief of Program and Support Services, she had minimal knowledge of operational features of the medical program, was not intimately involved in the medical budget, was not responsible for the medical contract, and was not involved in developing or managing staffing levels.

Custody personnel have considerable responsibilities over health care. In addition to the Chief of Program and Support Services being the health authority, Wardens have authority over medical operations on a facility level. An Assistant Director is responsible for implementation of the electronic medical record. Another Deputy Director, who was previously a nurse, is occasionally asked to develop staffing analyses of selected facility medical programs. This level of custody authority and involvement over management of the health program is considerable. Because oversight authority of the medical program is not medical staff, there is the risk that medical autonomy will be lost and that clinical operational processes will be disadvantaged with respect to custody processes and that clinical and operational independence will be lost. This is contrary to two fundamental NCCHC standards which are critical to an adequate correctional health care medical program.²⁹ We did see evidence of this with respect to medication administration and health request processes at several facilities. We also noted at NRC that inmates were locked in their cells, except for brief periods, for 24 hours a day. This is similar to a super-maximum prison and is excessive. This practice impaired the ability of nurses to adequately pass medication, read TB skin tests, and to appropriately access medical care. Despite this ongoing barrier to medical care as a result of this custody practice, there was no evidence of medical advocating for ways to appropriately perform their work. Because the Warden supervised the medical program, it is our opinion that medical staff were unlikely to advocate for improved care.

The IDOC Agency Medical Director reports to the Chief of Program and Support Services. The Agency Medical Director has limited responsibility with respect to the health program. He is responsible for formulation of statewide health care policy and chronic care guidelines. Through subordinates, he monitors and reviews medical services, but he has insufficient physician staff to perform adequate monitoring, especially for physician care. *He has no authority to manage operations of the health program.* He has no responsibility for the budget except in a consultative role. He participates in scoring prospective vendors of the medical contract and in reviewing staffing recommendations in the contract. But this is mostly an advisory and consultative role. According to his job description and interview, he does not function as the authority in establishing budgets, staffing levels, or equipment purchases. Although he appears to be the final clinical medical decision maker, one has to infer this responsibility because it is nowhere stated in his job description.

²⁹ P-A-02 Responsible Health Authority and P-A-03 Medical Autonomy, Standards for Health Services in Prisons 2014; National Commission on Correctional Health Care.

Each facility is managed by a health care unit administrator (HCUA), which is a state position. However, most facilities have a mix of state and Wexford employees. Because of co-employment rules,³⁰ the mixed staff creates supervisory confusion between Wexford and IDOC supervisors working under the HCUA. This is most evident at the NRC and SCC. The Wexford staff are supervised by Wexford employees who are not under supervision of the HCUA.

Each HCUA reports to the assistant warden of programs of the facility. Each facility medical program is therefore under the operational management responsibility of the Warden of the facility, not the Agency Medical Director. This means that medication administration or access to sick call, as examples, are under ultimate control of the Warden through the supervision of the HCUA. Wardens have no knowledge of how to manage medical program operations. This arrangement reduces the Office of Health Services to a consultative role as opposed to operational control. The Office of Health Services needs to have final authority over health care policies, not merely a consultative role.

The Office of Health Services has a staff of four employees assisting the Agency Medical Director in his monitoring function: an Agency Medical Coordinator who is a nurse and three Regional Coordinators who are also nurses. There is no dentist on staff. These individuals act mostly as regional resources to facility staff with respect to interpretation and implementation of the Administrative Directives and clinical guidelines. They also provide a monitoring function. Because they do not have authority to change operational practices, their monitoring function lacks the authority to direct operational changes, even if they disagree with how practices are being managed.

The Agency Medical Director monitors and reviews care through contract monitoring reports³¹ and verbal reports of the Regional Coordinators. Contract monitoring reports are the responsibility of the HCUA. In the absence of the HCUA, the Assistant Warden of Programs at the facility is responsible for the contract monitoring report. The Agency Medical Director monitors the quality of doctors through review of credentials at annual CQI meeting, review of problematic peer reviews, and studies of the quality improvement meetings.³² However, the credential reviews are inadequate, as will be described later in this report. The peer reviews are performed by Wexford doctors on each other and are ineffective. And the quality improvement studies do not monitor clinical quality of care.

Two of three of the Regional Coordinator positions are currently vacant and filled on an acting basis by HCUAs who are still responsible for managing their facility. While an HCUA filling in as a Regional Coordinator on short-term basis is reasonable, longer than 60-90 days is likely to result in reduced effectiveness at the HCUA's home facility. The Agency Medical Coordinator fills in

³⁰ Co-employment is a relationship between two or more employers whereby each has legal responsibilities to the same employee. In this case, line staff may be Wexford but have an IDOC supervisor and IDOC employees may have a Wexford supervisor. This created problems at multiple facilities we visited. This is particularly problematic with respect to scheduling and disciplinary issues.

³¹ Page 26 Dr. Meeks 30(b)(6) deposition on July 25, 2017.

³² Page 33 Dr. Meeks 30(b)(6) deposition on July 25, 2017.

periodically for one of the HCUAs when she is performing as a Regional Coordinator. When Regional Coordinators visit sites, they monitor clinical care but do not issue reports on their work. Each Regional Coordinator has a monthly phone call with the Agency Medical Director, Agency Medical Coordinator, and HCUAs, Assistant Wardens, and other staff in their region to discuss any issues. The Regional Coordinators do not engage in direct review of nursing practice at individual facilities that results in reports. We were told they occasionally review records of nursing care. We found no evidence of formal reports of oversight over nursing practice on a regional level. This includes oversight of nursing independent evaluations and medication administration practices.

On a regional level, because Regional Coordinators and the Agency Medical Coordinator are nurses, they are unable to monitor or review physician care, leaving a large gap in oversight of the quality of medical care. The Regional Coordinators perform mortality reviews using a structured format which result in reports, which were not made available to us. A Regional Coordinator, who is a nurse, testified that he reviews deaths and complicated medical cases.³³ In these reviews, he has never found care to be inadequate. We found many preventable deaths and inadequate care on most death reviews we performed, even ones at the facility supervised by the Regional Coordinator, who never found inadequate care. This work needs to be done by a physician, not a nurse, but the only physician in the Office of Health Services is the Agency Medical Director. The Agency Medical Director cannot monitor or review physician care at 26 facilities. The Agency Medical Director does not perform any mortality reviews. It would be difficult to impossible for him to review every death. The time allowed in his job description for monitoring physicians is less than 15 hours a week, which is inadequate time to monitor all physicians statewide. This task is not apparently performed by Wexford either. The Agency Medical Director told us that he has not received any communications from Wexford Regional Medical Directors with respect to problems identified in mortality review or peer review. As a routine, the IDOC Agency Medical Director stated in deposition that he does not review Wexford peer reviews except for isolated peer reviews for problematic providers.³⁴ As a result, oversight of facility physicians, including Medical Directors, is virtually non-existent. As this program is currently staffed, the Agency Medical Director is unable to effectively act in accordance with his job description, specifically to monitor medical care, especially physician care. IDOC oversight is inadequate and has not identified physician practice problems largely because of lack of physician oversight.

The IDOC has contracted with Wexford Health Sources Inc. for approximately 20 years. When IDOC first contracted out its medical services in the 1980s, the IDOC managed the contract. Sometime in the mid-2000s, the Illinois Department of Healthcare and Family Services (HFS) became responsible for letting this contract, including monitoring and oversight of the contract. The latest contract with Wexford was completed in 2011. Sometime after that contract was awarded, responsibility for monitoring and managing the contract returned to IDOC. The contract expired April 30, 2016 and provided for renewals of one or more years for a period of

³³ Page 34 Joseph Ssenfuma deposition on September 28, 2017.

³⁴ Page 33 Dr. Meeks 30(b)(6) deposition on July 25, 2017.

five additional years through 2021. The latest renewal of this contract signed in April of 2016 was signed by IDOC. HFS is no longer involved in letting the contract, choosing the vendor, or in monitoring the contract. This responsibility returned to the IDOC, which is not prepared to monitor this contract.³⁵

With respect to monitoring medical care including physician care, there is a large gap. In the most recent contract with Wexford in 2011, the onsite Wexford Medical Director is assigned responsibility for monitoring the performance of medical personnel and is to report deficiencies to the HCUA.³⁶ However, the onsite Medical Director is a Wexford employee and therefore clinical monitoring is self-monitoring by the vendor, rather than independent monitoring by IDOC. Moreover, about half of the Medical Directors do not have primary care training and are unable to effectively give guidance on appropriate care. The IDOC is therefore depending on the vendor to monitor itself with respect to clinical physician care, but the vendor has hired persons who are not always trained sufficiently to understand what constitutes appropriate care.

The contract monitoring on the part of the state is inadequate. Formal contract monitoring is performed by HCUAs via the monthly contract monitoring reports.³⁷ The HCUA is the only IDOC staff that is specifically assigned for formal contract monitoring. HCUAs are provided a spreadsheet to use for this purpose. There are five performance targets that are assessed. The performance targets are:

- Whether all hours in the contract are fulfilled
- Whether all bills have been paid timely
- Whether there has been any Court finding of deliberate indifference
- Whether Administrative Directives have been complied with
- Whether Wexford met provisions of the contract.

We found no clinical quality of care items in contract monitoring reports of the five sites we visited, even when we noted significant clinical issues during our site visits. This is a major deficiency. No one is monitoring clinical care, particularly physician care. Even non-clinical deficiencies are not monitored adequately. Most sites had performance issues with respect to staffing and some Administrative Directive performance targets, yet the IDOC has never levied penalties against Wexford based on these performance targets.³⁸ Because of IDOC tardiness in invoice payments to Wexford, it has been difficult for IDOC to penalize Wexford for its infractions. While this has an element of fairness to the vendor, overall it contributes to lack of enforcement of the contract as a result of budgetary realities.

³⁵ 1299433 Deposition of Jared Brunk Chief Financial Officer of the IDOC. In this deposition in January of 2018, Mr. Brunk acknowledges that there was more than one person in the IDOC who thought that it would be useful to have additional contract monitoring on pages 80-83. This Chief Financial Officer could not describe how the contract is monitored.

³⁶ Item 2.2.2.21 Contract between Wexford Health Sources Inc. and IL Department of Healthcare & Family Services signed 5/6/11.

³⁷ 30(b)(6) deposition of Dr. Meeks on July 25, 2017 on page 26.

³⁸ Deposition of Jared Brunk, Chief Financial Officer of the IDOC conducted January 31, 2018.

The HCUA positions are filled by nurses. Nurses are not able to monitor clinical care of physicians, including appropriateness of referral, chronic care, and infirmity care. Several of the HCUAs remarked on their inability to monitor the clinical care of the Wexford physicians and were unaware of quality issues, even when they existed.³⁹ Because HCUAs cannot monitor physician care, the contract monitoring is ineffective and incomplete. The only monitoring of clinical performance of the physicians is Wexford peer review, in which Wexford physicians monitor other Wexford physicians. Many of these physicians are unqualified to practice primary care medicine. We found that these peer reviews are ineffective and fail to critically monitor physician performance. Peer reviews will be discussed later in this report.

Wexford has a regional management structure that contributes to the fractured organizational structure of the IDOC medical program. Administratively, there is a Wexford Director of Operations and five Regional Managers. Each Regional Manager is responsible for five facilities, with one Manager taking responsibility for six facilities. The clinical medical management structure includes two Regional Medical Directors, each being responsible for 13 facilities. The span of control of the two Wexford Regional Medical Directors is so large that it is very difficult to spend meaningful time on site at any facility, and in our opinion not possible to effectively supervise clinical care.

The Director of Operations and two of the five Regional Managers (50% of Wexford senior administrative management staff) are ex-wardens and have no training in provision of medical care. Because the IDOC HCUAs administratively manage operations at each facility, the Wexford administrative managers have no role in managing operations at any of the IDOC facilities. The Wexford view of duties and responsibilities⁴⁰ of the Regional Managers include:

- Oversee leadership of Health Services Administrators (HSA)⁴¹ in the operation of facility health care units.
- Provide HSAs with management guidance strategies for regional growth and operational assistance.
- Oversee HSAs' resolution of health care unit personnel issues.
- Supervise the performance of the HSA and department heads, conducting annual evaluations.
- Instill a sense of accountability among the HSA team members through fair and consistent oversight of individual and organization performance standards.

These duties and responsibilities appear inaccurate and not applicable to IDOC. The Regional Managers do not oversee or supervise the HCUAs. The Regional Managers do not oversee health care unit personnel issues except for Wexford employees. The Regional Managers

³⁹ For example, we spoke to the HCUA at Dixon about a death. We found the death preventable. She was unaware that there were problems with the death. No one from Wexford had brought up clinical issues with respect to this death with her even though in our opinion problems were significant.

⁴⁰ There is no job description for this position. There is a position summary listing duties and responsibilities on the Wexford website which was advertising for a Regional Manager. This was provided to us as representative of a job description for the Regional Manager. This is found at https://jobs.wexfordhealth.com/search/jobdetails/regional-manager/73d40fc0-c935-47d4-b51f-b8095ad79af0?s_cid=ssEmail.

⁴¹ We understood the term Health Service Administrator to be the same as Health Care Unit Administrator (HCUA).

appear to mainly act as intermediaries with respect to personnel issues, obtaining supplies and equipment, and other similar issues related to adjusted service requests (ASRs). They also act as customer relations functionaries. We were challenged in determining what they are actually responsible for. They do not participate in CQI, analysis of operational issues at the sites, resolution of operational issues, or other similar typical operational activity. They add little value to the operational effectiveness of the IDOC management structure with the exception of personnel issues of the Wexford staff.

The Regional Manager who was responsible for SCC, NRC, and Dixon Correctional Center told us that he knew of no consistent problems at these facilities; yet we found serious operational problems with medical records, medication administration, and evaluation of health requests. Physician care, follow up of specialty care, and intake evaluations were also inadequate. To not understand that there were problems is to be unengaged or indifferent to significant serious issues. At Menard Correctional Center, where there were also serious operational problems, the Regional Manager stated there were no problems and no areas of concern. These responses were not in line with problems identified by the HCUA. Neither Regional Manager we spoke with actively participates in quality improvement activities. One of the managers perceived his role as administering the contract. Despite significant operational issues at all sites we visited (e.g., lack of hospital and consultation reports, medication administration issues, staffing concerns, problems with medical records, and supply issues), these Regional Managers do not appear to be engaged in improving operations.

Based on interviews with HCUAs, neither the Regional Managers nor the Regional Medical Directors spend much time at the facilities, nor do they participate in solving significant problems. The most pressing problem of four of the five HCUAs was staffing and vacancies. HCUAs were universally unhappy with the effort of Wexford on these issues.

The Wexford Regional Medical Directors are responsible for ensuring that direct patient care is consistent with community standards and with contract requirements. They supervise the facility Medical Directors and are responsible for peer reviews of Medical Directors, and must ensure and/or conduct death reviews.⁴² Since there is inadequate oversight by the IDOC over physicians, the supervision of Wexford Regional Medical Directors is the only oversight of physicians. Wexford is thereby evaluating its own performance and does this extremely poorly.

Although the Wexford Regional Medical Directors have a clinical supervisory role over their physicians, based on their job descriptions we could not verify that they perform this adequately, as they perform no peer review, mortality review, or formal written review of clinical work. According to the Agency Medical Director, he receives no formal communication regarding clinical oversight of Wexford physicians, including Regional Medical Director initiated peer review, mortality review, or other review of clinical care. There is no evidence we could find that verifies their oversight of physicians except their statements that they review the work of the physicians. Neither Regional Medical Director stated that clinical care review is on their

⁴² Regional Medical Director's Responsibilities as provided by Wexford Health Sources.

list of major responsibilities or tasks, except for addressing questions of the physician staff. Because neither IDOC nor Wexford performs effective review of clinical care of physicians, poorly performing physicians continue to perform poorly without apparent oversight. We noted this on multiple chart reviews and mortality reviews.

Wexford Regional Medical Directors are also responsible for ensuring patient care is consistent with community standards.⁴³ Yet we found many examples of physicians providing care inconsistent with current standards of care that appear to be systemic practices. For example, IDOC does not provide colorectal cancer screening based on current standards of care and does not appear to routinely screen patients with cirrhosis for varices or hepatocellular carcinoma. Persons with chronic obstructive lung disease (COPD) are not provided pulmonary function testing, which is a cornerstone of management of COPD. The current management of lipid disorders is not in line with current standards or with the Office of Health Services treatment guideline. We will discuss these later in the Chronic Disease section of this report. These deficiencies need to be corrected because these deficiencies have caused morbidity and mortality. There is no evidence of participation of the Wexford Regional Medical Team in identifying these deficiencies to the IDOC or ensuring that their physicians are practicing based on contemporary standards of care.

With respect to facility leadership, administrative supervision by HCUAs at individual facilities has improved since the First Court Expert's visit. The IDOC HCUAs are responsible for administrative operational supervision of each facility. Of the 26 HCUA positions, all but one is now filled. However, two of the HCUAs also serve as acting Regional Coordinators, making them much less effective as HCUAs. Effectively, only 23 of 26 HCUA positions are filled. HCUAs were all competent and were engaged in solving administrative problems, even though some problems appeared unrecognized. This is one of the most significant and positive advances since the First Court Expert's report and is a strength that the program can build on.

Medical Directors are all Wexford positions. Of the 26 Medical Directors statewide, 8.5 (33%) are vacant.⁴⁴ This is an enormous vacancy rate for this key leadership position. Approximately only half of physicians have training in primary care, which will be discussed later in this report. This is a very small percentage of physicians trained in primary care. When a Medical Director is not trained in primary care it is very difficult to be responsible for monitoring performance of medical staff rendering direct patient care. An untrained physician is not likely to know how that care is supposed to be provided. We found that onsite monitoring of clinical care was very poor to nonexistent.

Director of Nursing (DON) positions can be either Wexford or IDOC. Fifteen (58%) of the DON positions are staffed by Wexford. Eleven (42%) are staffed by the IDOC. Seven (27%) of DON positions are vacant; four DON vacancies are Wexford positions and three DON vacancies are

⁴³ Regional Medical Director's Responsibilities as provided by Wexford Health Sources.

⁴⁴ Illinois Medical Vacancy Report with ASRs as of 6/18/18 provided by the Attorney General's Office from Wexford Health Sources. This report gives staffing at all facilities as of 6/18/18.

IDOC positions. Nursing staff can be either IDOC or Wexford, making it difficult, because of co-employment rules,⁴⁵ to properly supervise line staff.

Of the 78 leadership positions (Medical Director, DON, and HCUA) at the 26 facilities, 16.5 (21%) are vacant. The vacant positions are compounded by co-employment issues⁴⁶ and use of two HCUAs as Regional Coordinators. The leadership vacancies are significant on a statewide basis. The lack of Medical Directors is dramatic and is compounded by using physicians in these positions who are, in our opinion, unqualified by virtue of not having primary care training.

In summary, administrative supervision by HCUAs is adequate but clinical-medical supervision and management, particularly physician care, is inadequate and places patients at significant risk of harm. The clinical supervision at the facility level is inadequate based on Medical Director and DON vacancies, and poor qualifications of physicians.

IDOC Policy

The IDOC provides policy direction on clinical care through its Administrative Directives and chronic care guidelines. The medical Administrative Directives are a part of the larger IDOC Administrative Directives which include all custody policy. We will discuss the chronic disease guidelines in the section on Chronic Disease and dental guidelines in the Dental section. The Medical Administrative Directives are inadequate with respect to the breadth of guidance that is necessary for a correctional medical program. The IDOC has only 18 Administrative Directives. In comparison, the National Commission on Correctional Healthcare⁴⁷ has 68 standards, which is a minimum panel of policies for a large prison system. There are essential areas of service that are not governed by Administrative Directives and thereby are not guided by policy and not standardized statewide. Though each facility can have additional institutional policies and procedures, the lack of statewide guidance means that practices are not standardized. The Office of Health Services needs to be responsible for statewide policy guidance in all areas of service, with local policy following statewide policy. The 18 medical Administrative Directives are inadequate for this purpose. The National Commission on Correctional Health Care standards are a reasonable guideline to determine the scope of processes of care that should be governed by Administrative Directives.

Wexford Provider Staffing and Physician Credentialing

It is our opinion that the quality of physicians in the IDOC is the single most important variable in preventable morbidity and mortality, which is substantial. The first step in provision of quality of care is to ensure appropriately credentialed medical staff. In its response to the First

⁴⁵ Co-employment means that there are two employers (IDOC and Wexford), each of whom has some legal responsibility for the same employees.

⁴⁶ When a State employee HCUA is responsible for managing the health care unit but staff are Wexford, there are some limitations with respect to discipline and assignment as a result of union rules. When a DON is a Wexford employee and staff nurses are state employees, the same occurs. These co-employment issues affect multiple facilities we visited.

⁴⁷ The National Commission on Correctional Healthcare is the leading organization establishing standards for correctional health programs.

Court Expert's report,⁴⁸ on page 4 an attorney for the State states that, "More than 80% of WHS' [Wexford Health Services] physicians are either Board Certified in Family Practice or Internal Medicine, or have more than 10 years of Family/Internal Medicine practice experience or correctional medical experience." This is a misleading statement that gives an inaccurate representation of the credentials of physicians. Credentialing information provided by Wexford shows that only six (20%) of the physicians are board certified in a primary care field. Because physicians typically work alone in these facilities, experience alone is no guarantee that performance will improve to be consistent with current standards of care. We document multiple preventable deaths in the mortality review section of this report. It is our opinion that poorly credentialed physicians contribute significantly to those preventable deaths.

Currently, there are 30 Wexford physicians working in IDOC facilities. Of these, only 16 (53%) have completed training in primary care. Of the 16 that completed primary care training, only six (20% of the 30) are board certified in primary care. Two doctors are obstetricians who work at LCC doing women's care, for which they are appropriately credentialed and privileged; one of these is board certified. These doctors only provide obstetrical and gynecological care, not primary care. Five physicians have an internship or a year or two of primary care training but did not complete a residency.⁴⁹ The remaining seven include:

- One anesthesiologist
- One doctor with two years of occupational medicine
- One doctor with some training in pathology
- One doctor with a year of physical medicine
- One surgeon
- Two radiologists, one of whom did not complete residency training.

Credentialing is a process whereby a physician's qualifications are evaluated by reviewing their education, training, experience, licensure, malpractice history, and professional competence with respect to the work they will be expected to perform. Proper credentialing is the foundation of protecting patient safety. Credentialing must ensure that a physician is properly trained for the work they will be performing. Credentialing protects patient safety by preventing incompetent, *poorly trained*, or impaired physicians from engaging in patient care. In correctional facilities, the scope of practice required and the health care needs of patients are mostly primary care, which requires physicians who have residency training in a primary care field. However, the only requirement in the IDOC with respect to credentialing is to verify that a physician has a license. A Regional Coordinator testified that the only review of credentials is to verify that the doctor has a license, and that their training, board certification, or disciplinary history is not part of credentialing review.⁵⁰

⁴⁸ Letter via email to Dr. Shansky, First Court Expert from William Barnes, representing the IDOC dated 11/3/14.

⁴⁹ This information comes from items 42Z9081-42Z8845-Part 1; 42Z9082-42Z8845-Part 2; 42Z9085-42Z8845-Part 4; 42Z9088-42Z8845-Part 3; and 42Z9090-42Z8845-Part 5. This credentialing information was provided by Wexford Health Sources, Inc.

⁵⁰ Deposition of Joseph Ssenfuma, Regional Coordinator, on September 28, 2017.

Privileges are the services and procedures that a physician is qualified to perform based on training and experience. The credentials and training of a physician determine what privileges that physician should have. As an example, a doctor who is trained and credentialed in general surgery can obtain privileges to perform appendectomies and cholecystectomies. A physician trained and credentialed in obstetrics can obtain privileges to deliver babies. Physicians trained and credentialed in internal medicine or family practice can obtain privileges to practice primary care. Physicians trained and credentialed in internal medicine cannot obtain privileges to deliver babies or perform appendectomies. And physicians trained and credentialed in radiology or general surgery cannot obtain privileges to provide primary care. Because the scope of practice and needs of the patients in a correctional medical program are primary care, physicians should be credentialed and privileged in primary care. In IDOC, physicians are credentialed to perform primary care even when they have no training in primary care. This is a serious problem with the credentialing process. For this reason, we agree with the First Court Expert that Medical Directors be board certified in a primary care specialty. Given the size of the IDOC facilities, there is only one physician on staff at most facilities. When this physician is not trained in primary care, there is no other available physician to care for the patient.

Because there are so many physicians who have not completed a primary care residency, the level of supervision of their care should be at a higher level than for board certified physicians. This is not the case. There is no special monitoring for this group. All physicians receive the same type of peer review.

Peer review is a means to monitor the quality of physician and other provider care, and thereby protects patient safety. Peer review of physicians in the community is typically of two types. One type of peer review is done on a routine basis for all physicians and is done as a monitoring device to ensure quality of care. This type of peer review is often called performance evaluation program or PEP. A second type of peer review is done when a member of the medical staff may have committed a serious gross or flagrantly unacceptable error or exhibits a serious character or behavior problem and needs to be evaluated with respect to possible reduction of privileges or referral to a medical board. The latter type of peer review is generally a formal quasi-legal procedure that has significant implications for the physician's employment and professional status. We found that the first type of peer review is done for all physicians and mid-level providers in the IDOC, but the second type of peer review does not appear to occur in IDOC, based on information made available to us. As will be detailed later in the mortality review section of this report, there were numerous grossly and flagrantly unacceptable episodes of care that should have resulted in peer review but did not. Peer review in the IDOC is ineffective, as physicians who commit repeated egregious medical errors continue to practice and continue to harm patients.

The first type of peer review which is performed by Wexford is a structured questionnaire performed by one Wexford physician on another Wexford physician. We noted at one facility that a general surgeon performed the peer review of the primary care work of a nuclear radiologist. It is our opinion that this type of performance evaluation is defective and unlikely to

result in meaningful evaluation, as neither doctor is adequately trained to practice primary care and would not be able to know when care was adequate.

Also, the peer review that is done is so poor that it is unlikely to identify problems. The Wexford peer review consists of a review of 10 single episodes of care for five areas of service. For each of these areas of service there are a series of questions ranging from 10 to 15. Some of the questions are not relevant to clinical quality, such as:

- Is the handwriting legible?
- Is the signature with professional designation legible?
- Is the patient enrolled in all relevant clinics?
- Are all medications written on a script?
- Does the clinic include pertinent vital signs?

While it is important to write a legible note, legibility does not evidence clinical competence. Many questions require an interpretation. For example, the question “Was treatment appropriate for this visit” requires that a physician know the appropriate treatment. The problem is that when only 20% of doctors are board certified and 23% have no training in primary care, many doctors will not know the appropriate treatment. Doctors performing these evaluations need to be expected to know what the appropriate treatment is, otherwise the test will not perform as expected. Also, these episodes of care are picked at random and may not include patients that have serious illness. When someone does not have a serious illness, it is difficult to test the clinician, because it is very difficult to make an error if there is no decision to make with respect to the treatment. Additionally, it appears that these reviews are not taken seriously and appear to be done merely because these are requirements of the contract. For these reasons, it is not surprising that almost all peer reviews were scored 100% adequate. When we compare these results with death chart reviews we performed, there is dramatic discrepancy. Most chart reviews we performed contained many errors. We reviewed the care provided over two years prior to the death. Of 33 death charts we reviewed, there were over 1700 errors. Many had serious errors. Some had egregious errors that resulted in death. We noted the same level of medical error in chart reviews we performed on site visits. The Wexford methodology of peer review does not appear to accurately review physician practice, based on a comparison to our record review of clinical care. This process is not working as intended.

The First Court Expert opined that Wexford hired underqualified physicians, and recommended that facility Medical Directors be trained in primary care and be board certified. We agree with this finding, based on the credentialing information above, and we agree with his recommendation.

In reviewing the Defendants’ comments to the First Court Expert’s Draft Report,⁵¹ the Defendants challenged the assertion of the First Court Expert that Wexford Health Services has hired “underqualified clinicians.” In their attempt to refute that assertion, the Defendants

⁵¹ Re: Lippert v. Godinez – Defendants’ comments regarding Confidential Draft Report via email dated November 3, 2014, authored by William Barnes.

stated that, “The community standard, as espoused by the American Medical Association, requires physicians to possess only a license to practice medicine.” This is misleading and inaccurate. This statement implies that the current community standard of medicine is for physicians to only have a license to practice medicine, presumably in any field. We disagree. It is our opinion that the community standard in the U.S. is for physicians working in primary care to have residency training in a primary care field. One would never see a pathologist delivering babies. The Defendants’ statement also implies that the American Medical Association (AMA) endorses their position. This statement of Defendants is neither the community standard nor is it a standard we could identify as espoused by the AMA.

It is true that it is legal for a doctor without residency training to open a private practice in the community and practice primary care medicine without any training in primary care. However, it is becoming increasingly uncommon, and particularly in urban areas, it is now extremely uncommon to find doctors without residency training in primary care who work in general practice. The standard in the community is for physicians in organized medical practices to undergo credentialing and privileging, and to have residency training consistent with their scope of practice.

With respect to the recommendation to hire board certified physicians, the State’s response said,

“This recommendation, along with any recommendations dictating specific training or certification for licensed correctional physicians, lacks any justification or support in state law and community, ACA, AMA, and NCCHC standards. Accordingly, this recommendation *exceeds minimum constitutional standards of adequacy*” [my emphasis].⁵²

With respect to the assertion that use of board certified primary care physicians exceeds minimum constitutional standards of adequacy, we note as an example that there has been Federal Court intervention requiring use of primary care trained physicians when that training was necessary to protect inmate-patients. For years, the California Department of Corrections and Rehabilitation (CDCR) had poorly credentialed physicians, which resembled the current situation in the IDOC. In 2004, in the California prison system, many physicians were not trained in primary care; instead, they had training in surgery, radiology, gynecology, pathology, etc., similar to the IDOC situation in 2018. Many physicians had prior or current sanctions of their licenses and evidence of clinical incompetence by virtue of malpractice claims, which we were unable to evaluate for Wexford physicians. It was the opinion of the Court in California that the lack of qualified physicians resulted in increased morbidity and preventable death. We believe that the situation in California is similar to the situation in the IDOC. In California, as a result of that situation, the Federal Court issued an order⁵³ requiring the use of physicians who were

⁵² Letter via email to Dr. Shansky, First Court Expert from William Barnes, representing the IDOC dated 11/3/14.

⁵³ Proposed Stipulated Order Re: Quality of Patient Care and Staffing; Marciano Plata, et al., v. Arnold Schwarzenegger, et al.; United States District Court Northern District of California No. C-01-1351 T.E.H., originally filed 9/17/04. In that order, the Court stated: “As of January 15, 2005, defendants shall not hire independent contractor primary care physicians who are not board-eligible or board certified in internal medicine or family practice.” p. 3.

board certified or board eligible⁵⁴ in internal medicine or family practice.⁵⁵ We note that in the California prison system in 2007, there were 18 preventable and 48 potentially preventable deaths, and in 2017, when all physicians were required to be board certified, there were 0 preventable deaths and 18 potentially preventable deaths.⁵⁶ Although there were other systemic improvements that helped reduce the number of preventable deaths, improvements in physician credentialing played the major role. Improving credentials of physicians and removal of unqualified physicians has been shown to reduce mortality.⁵⁷

We have learned that in the mid-1980s, approximately 12 IDOC prison facilities were accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). At that time, the Agency Medical Director approved all facility Medical Directors and his requirement was that Medical Directors completed primary care training. Accreditation by JCAHO required privileging based on appropriate credentials. At that time, the IDOC placed into its Administrative Directives the requirement that all physicians have one-time primary source verification of their credentials, which was a requirement to verify training. The IDOC ended their accreditation with JCAHO but kept in the Administrative Directives the requirement of primary source verification. Over the years this practice was ignored and currently the HCUAs we interviewed do not even know what primary source verification is. The only credentialing review is to ensure at the annual CQI meeting that every physician has a license.

Physician Staffing

Physician staffing in IDOC is very poor. The Vice President of Operations for Wexford could not remember the last time there was a full physician staff. She thought in 2014 there was only one vacancy, but that was as close to full staffing as the program got. We noted earlier in this report that IDOC lacks adequately trained physicians. This is compounded by vacancies in physician positions. Persistent and ongoing vacancies in the Medical Director position title contribute significantly to physician staffing deficiencies. In addition to vacancies of Medical Directors, all five facilities we visited were missing a physician. Two facilities had replaced a physician position with a nurse practitioner because of the inability to fill physician positions. Statewide, the total days of missing Medical Directors totaled 22% of total days these positions were supposed to be filled,⁵⁸ an unacceptable vacancy rate.

Because of vacancies, physicians are moved from site to site as “Traveling Medical Directors.” One of the facilities we investigated, NRC, had a Traveling Medical Director. This individual did

⁵⁴ Board eligible is a term used to describe a physician who has completed a residency training in a field and is therefore qualified to take a board certification test for that specialty. For example, a board eligible internist is one who has completed a residency in internal medicine and is qualified to take the board certification test but has not yet done so.

⁵⁵ Since this order, the California Department of Corrections and Rehabilitation, through the Receiver’s office, requires board certification in family practice or internal medicine.

⁵⁶ Based on annual analyses of inmate deaths as reported by Dr. Imai, consultant to the medical receiver in California as found under the heading of Death Review at <https://cchcs.ca.gov/reports/>.

⁵⁷ Terry Hill, Peter Martello, Julie Kuo; A case for revisiting peer review: Implications for professional self-regulation and quality improvement. Plos One at <https://journals.plos.org/plosone/article/file?id=10.1371/journal.pone.0199961&type=printable>.

⁵⁸ Document 42P5621-IDOC Facilities lacking permanent medical directors 7-1-15 to 11-26-17 Bates number 550.

not participate meaningfully in quality improvement, did not show any evidence of oversight of the medical program, and had clinical issues.

The turnover of Wexford physicians is also very high. Of 33 physicians listed on a 9/19/14 report⁵⁹ by Wexford, only 18 (54%) are still working three and a half years later. The inability of Wexford to hire and *retain* qualified physicians is a serious problem and was mentioned as a significant problem by every HCUA we spoke with. There has been no formal analysis of this that we could find. The Vice President of Operations for Wexford told us that it was harder to recruit to corrections because of the impression that if you worked in corrections, you were a bad doctor. We disagree. In our opinion and from experience, recruitment in corrections depends on establishing conditions of work that are professional and foster a sense of providing a worthwhile service. When that occurs and when doctors are properly supported, qualified doctors can be found and retained in correctional environments and elsewhere.

At the five sites we visited, none had a long-tenured Medical Director. LCC had a Medical Director who had the longest tenure of the five facilities we inspected. She had been Medical Director since May of 2016. The Medical Director at Dixon started in October of 2017. The Medical Director at MCC has been in his position since June of 2017. One Medical Director was at Dixon for a short period of time before being moved to NRC. After several months at NRC, he was moved to SCC. About two months after being moved to SCC, he resigned. His position at NRC was filled in coverage by the ex-Medical Director at Hill, who the First Court Expert stated had identified clinical issues. This musical chairs rearrangement of Medical Director assignments is demonstration of the failure to create an environment likely to attract qualified physicians. The IDOC needs to determine why it is that their vendor cannot recruit and retain qualified physicians.

Physician leadership was not improved based on the First Court Expert's comment that,

“the Medical Directors were functioning in primarily clinical roles and spent little if any time reviewing the clinical practice of other providers or engaging in other important administrative duties.”⁶⁰

Several of the HCUAs spoke about poor physician quality as an issue. Two of the Medical Director positions were vacant. A coverage physician at one facility with a vacant Medical Director position did not participate meaningfully in quality work or in providing clinical leadership. In two of the remaining three facilities we visited, the HCUA spoke of having problems with the Medical Director. One was described as only doing chart reviews, not wanting to see patients, not reviewing deaths, and having to be urged to see patients. When leadership and quality of physicians is inadequate, patients are placed at risk because poor quality will not be identified or corrected.

⁵⁹ 40C0134- IL Physicians Report 9 19 14 Key Produced by Wexford Health Services.

⁶⁰ Final Report of the Court Appointed Expert, Lippert v. Godinez December 2014 p. 7.

Non-Physician Staffing

On a statewide basis, exclusive of dialysis and the HIV and hepatitis C telemedicine program, there are 1119.6 medical staff in the IDOC program, with an inmate population at mid-year 2017 of 43,075. This amounts to 26 staff per 1000 inmates, which places IDOC approximately in the lowest 10% of state prison systems in the country⁶¹ with respect to staffing numbers *based on 2015 data*. Of the 1119.6 staff, 401 (36%) are employed by IDOC and 718.6 (64%) are employed by Wexford Health Sources. Of the 1119.6 medical staff, there are 245.8 (22%) vacancies, not including leave of absences, which would increase this number a few points. Wexford has an 18% vacancy rate for its 718.6 employees and IDOC had a 29% vacancy rate for its 401 employees. These are very high vacancy rates and compound a very low staffing level, making staffing a critical problem statewide. This was confirmed by HCUAs at sites we visited.

We compared facility staffing for mutually visited facilities. In 2014, the First Court Expert determined that for the five facilities we visited there were 303.41 budgeted positions, an 18% vacancy rate, and 25 staff per 1000 inmates.

Positions, Vacancies, and Positions per 1000; First Court Expert's 2014 visit⁶²

Facility	Positions	Vacancies	% Vacancy	Population	Staff per 1000
SCC & NRC	73.90	23	31%	4078	18
LCC	62.21	4	6%	1997	31
Dixon	66.30	18	27%	2349	28
MCC	101	9	9%	3750	27
Total	303.41	54	18%	12174	25

For the same five sites we visited, there were 405.05 budgeted positions. There were 99 (23.5%) vacancies. This is a very large vacancy rate, which makes it difficult to effectively operate a health program.⁶³ Four of the five facilities we visited had unacceptable vacancy rates.⁶⁴ We note several key differences in the staffing differences between 2014 and 2018. The population in the five facilities we reviewed decreased by 2177 (18%). The number of positions

⁶¹ Prison Health Care: Costs and Quality, Pew Charitable Trusts, October 2017. We note that the staffing levels given in the Pew study reflect 2015 numbers. However, these 2018 IDOC staffing numbers still would rank Illinois in the lowest 10% of state prison systems comparing IDOC 2018 staffing to nationwide 2015 numbers.

⁶² This table is constructed from data taken from tables presented in the First Court Expert's report.

⁶³ In Defendants' comments on our report they noted that there is a national nursing shortage and cite a survey of readily available health care facilities in the United States in January 2018 by Nursing Solutions, Inc. a recruitment firm. Defendants note that over 25% of the hospitals in this country who responded to the survey have Registered Nurse (RN) vacancy rates of greater than 10%. This same study reported that the average vacancy rate for Registered Nurses is 8.2%. In either case, nursing vacancies in the IDOC facilities we visited exceeded the average from this survey and were much more than the maximum of 12.5% used in the study.

⁶⁴ Except for LCC, all IDOC facilities had vacancy rates of 20% or greater. These vacancy rates are much higher than Federal Bureau of Prisons policy that establishes that vacancy rates not exceed 10% during any 18-month period (Program Statement P3000.03: Human Resources Management Manual, Chapter 3, page 11 obtained at <https://www.bop.gov/PublicInfo/execute/policysearch#>). There are no published reports comparing vacancy rates amongst health care providers working in state prison settings.

increased by 101.64 (33%).⁶⁵ The staff per 1000 inmates increased by 16 (64%). But the vacancy rate increased from 18% to 23.5%, a 30% increase.

Positions, Vacancies, and Positions per 1000 Inmates; 2018 visits

Facility	Wexford and IDOC staff	Vacancies	% Vacancy	Population	Staff per 1000
SCC	98.00	24	24%	1183	83
NRC	69.00	29	42%	1681	41
LCC	53.15	1	2%	1806	29
Dixon	93.80	19	20%	2298	41
MCC	91.10	26	29%	3029	30
Total	405.05	99	23.5%	9997	41

While budgeted staffing increased at three of five facilities we visited, it decreased at two of five facilities. There are 44 additional staff working at these facilities than there were when the 2014 report was written.

Four of five facilities we visited had significant vacancy rates, as high as 42%, which are mostly nursing staff. Almost every HCUA told us that there were insufficient nursing staff. This was confirmed in the deposition of the Agency Medical Coordinator, who noted that over the past several years there have been nursing shortages at SCC, Pontiac, Decatur, Graham, Southwestern, and MCC.⁶⁶

Most HCUAs told us that if all their positions were filled they believed that there would be adequate staff. We do not agree. The IDOC has not performed a staffing analysis based on expectations of the Administrative Directives and special care needs, including infirmaries and geriatric care. Relief factors have not been included in staffing considerations and budgeted staffing numbers do not appear to be adequate. In our opinion, despite increased nurse budgeted staffing and even when vacancies are filled, there will still be nursing shortages. The IDOC, in their comments on our report, assert that the IDOC in the current fiscal year and Wexford in the past year spent a total of \$8,283,718 on overtime wages. We acknowledge that this is a significant expenditure. Based on our investigation, overtime is used to cover some but not all vacant shifts. However, reliance on overtime contributes to staff fatigue, increased errors, staff dissatisfaction and turnover as well as higher incidence of poor patient outcomes.⁶⁷ While we did not evaluate working conditions for staff, we did find ample evidence of error and

⁶⁵ Dixon appears to have had a significant increase in staffing, but as the HCUA related to us, this is artefactual, as 22 nurses were moved from the mental health program to the medical program but still had assignments in mental health. Their reassignments did not create increased staffing for the medical program, but gave the impression that there had been a large increase in staffing. If these 22 nurses are removed from the Dixon staffing, the actual increase in staffing would be 79.64 positions or a 26% increase, not a 33% increase.

⁶⁶ Deposition of Kim Hugo, Agency Medical Coordinator pp. 25-31, April 11, 2018.

⁶⁷ Institute of Medicine (2004) Keeping Patients Safe: Transforming the Work Environment of Nurses. National Academies Press, Washington, D.C., Stanton, M. (2004). Hospital nurse staffing and quality of care. Agency for Healthcare Research and Quality. Research in Action, Issue 14.

poor patient outcomes in our review of health care provided to IDOC prisoners. The use of overtime does not change our opinion that a staffing analysis is needed or that there is lack of adequate staffing.

The Wexford component of staffing is memorialized in a contract document called a Schedule E. Based on interviews with senior leadership of Wexford and IDOC, we could not determine who is responsible for developing staffing levels found in the Schedule E. The Wexford Vice President of Operations told us that the Schedule E staffing is the recommended staffing of the IDOC to which the vendor can make suggestions. Mr. Brunk, the Chief Financial Officer, told us that the Schedule E is developed by the Wexford Regional Manager and reviewed by the IDOC Office of Health Services. The Agency Medical Director told us that he had input into the Schedule E for new facilities but otherwise had no input into the Schedule E, and that Mr. Brunk or Wexford developed the Schedule E, which the Office of Health Services approved. The Chief of Programs and Support Services, who is the health authority, told us that the Agency Medical Director was responsible for development of the Schedule E. Development of the Schedule E is not in the job description of the Agency Medical Director. The lack of a central health authority, we believe, contributes to this confusion. Furthermore, the Schedule E as represented in the current contract does not include input from HCUAs, Regional Coordinators, or even the Agency Medical Director in addressing clinical needs in their facilities. Given these responses, it is our opinion that the Schedule E does not reflect actual staffing need, as it does not appear based on any staffing analysis we could identify after discussions with health leadership who we thought would be responsible for this document.

No one we spoke with has responsibility for determining if total staff (state and Wexford) is adequate. The IDOC Agency Medical Director and the Agency Medical Coordinator told us that an Assistant Warden of Programs (AWP) from Sheridan, who also was a nurse, was engaged in analyzing staffing at various sites, but the extent of this analysis was not known to the Agency Medical Director. The Illinois Nursing Association (INA) is the union for the registered nurses in the IDOC. The Agency Medical Coordinator participates on an INA standing committee that meets monthly to discuss INA related nursing issues. The INA has raised issues with respect to staffing at certain facilities. When this occurs, the AWP from Sheridan performs a staffing analysis, brings it to the standing committee, which then considers staffing recommendations, and forwards them the Agency Medical Director for review. Other than this effort, we could identify no analysis of staffing need state wide.

Based on conversations with senior IDOC leadership, staffing increases at NRC and SCC were a result of union negotiations. Senior IDOC Office of Health Services staff were not involved in this decision,⁶⁸ although a Regional Coordinator gave recommendations on how many nurses were needed. These increases were not based on a thorough staffing analysis, as relief factors were not used and because no positions other than RN positions were considered. At no facility has there been an analysis of staffing need based on adherence to the Administrative Directives. This creates a gap between clinical need and staffing levels that affects all facilities.

⁶⁸ See pages 14-16 of deposition of Kim Hugo, Agency Medical Coordinator, April 11, 2018.

Because we only visited a small number of facilities, the true staffing deficiency is unknown. The program should undertake a staffing analysis, considering all job classifications with relief factors. This was a recommendation of the First Court Expert and we agree with that recommendation. This analysis should not be performed by a custody person and probably should be performed by an outside expert.

We noted at four sites there were inadequate supervisory nurses. At MCC, SCC, Dixon, and LCC, we felt that budgeted supervisory nurse positions were inadequate. At Dixon, SCC, and LCC, the HCUA provides some nursing supervision due to vacancies.

Custody staffing was not addressed by the First Court Expert. At several facilities we visited, there were issues related to insufficient officer staffing to properly accompany nurses in medication administration or to escort patients for scheduled appointments. While we did not study this in depth and lack the ability to review officer staffing, the numbers of officers need to be sufficient to ensure that medical services can be timely and appropriately provided. For this reason, we believe that officer staffing with respect to medical services needs to be studied and additional officers hired as indicated.

Statewide Use of University of Illinois

Current Findings

The First Court Expert did not address services provided by University of Illinois at Chicago (UIC). UIC provides laboratory services statewide. We found no problems with laboratory services at any facility we visited. UIC also provides HIV and some hepatitis C services via telemedicine statewide. Everyone we spoke with commented on the high quality of these services. All patients with HIV are scheduled for care by UIC clinicians. The First Court Expert found that coordination of care between UIC and IDOC providers could be improved. We agree, but found that overall when patients are referred, care was of very good quality.

For hepatitis C, IDOC physicians evaluate patients with hepatitis C in a hepatitis C chronic clinic. We found that these clinics were not performing well. When patients reached a level of fibrosis that is equivalent to stage 3 fibrosis, the IDOC physician refers the patient to a Wexford internist, who evaluates whether the patient should be referred to UIC and whether any other testing needs to occur. In our opinion, this process only serves to delay access to hepatitis C care and we found multiple cases of delayed hepatitis C care that caused harm.

Furthermore, because IDOC physicians lack primary care training, they appear to not know how to manage cirrhosis. There is no evidence that patients with cirrhosis from hepatitis C obtain timely baseline esophagogastroduodenoscopy (EGD) to screen for varices or every six month ultrasound screening for hepatocellular carcinoma, which is a standard of care. We noted on death reviews a patient who died of bleeding varices who never had an EGD to screen for this condition.

As a result of these problems with referral for hepatitis C, it is our opinion that fewer people are treated than who should be treated based on barriers to referral for care. Once engaged at UIC, care appeared appropriate.

What was clear in reviewing the program at UIC was that credentialing of physicians is part of the hiring process at UIC and all physicians are qualified. Progress notes are reasonable and clinically adequate. Referrals are appropriate. There were no identified errors. The UIC medical school correctional program is a significant resource that has potential to provide qualified physicians to the IDOC correctional medical program. The UIC School of Medicine has a subsidiary school of medicine in Rockford which has a significant primary care program. The Southern Illinois School of Medicine is also a potential significant resource which is close to many of the southern Illinois prisons. As we will discuss later in the recommendations, we believe that the UIC program or some combination of state affiliated medical school programs can be the basis for improving physician quality in the IDOC system of care. This needs to be carefully explored. The UIC program also has potential to provide dialysis services. Telemedicine services can include specialty care some of which can reduce but not eliminate the need for transportation of inmates for offsite encounters. We believe that an affiliation with a university based program like UIC can reduce some costs by use of 340B pricing discounts.⁶⁹ The IDOC would be remiss in not exploring these options.

We note the UIC and SIU both have dental schools, which is a potential resource for oversight functions and possibly for direct service provision.

Statewide Overview of Major Services

Clinical Space and Equipment

First Court Expert Findings

In the final report, the First Court Expert noted that clinical space, sanitation, and equipment were problematic at virtually every facility. The report noted facilities that lacked designated space to conduct sick call in the housing units, did not have the clinical equipment needed to perform adequate examination and screening, and had examination areas that did not allow sufficient privacy or confidentiality during clinical encounters. There were nurse sick call and provider clinical spaces that did not have examination tables. In housing units without designated sick call rooms, nurses performed sick call duties at the cell doors without any potential for confidentiality and no opportunity to perform an adequate physical examination if so warranted.

System wide deficiencies in sanitation were identified. In many facilities, examination tables and stools, infirmary mattresses, and stretchers had cracked or torn impervious outer covers

⁶⁹ 340B pricing is a government sponsored price discount on pharmaceuticals that can be provided to disproportionate share hospitals that provide care to underserved populations. 340B pricing is currently used for the HIV/hepatitis C telemedicine program.

which did not allow proper cleaning and sanitation. Many facilities were not using paper barriers on exam tables which could be changed between patients nor, alternatively, was there evidence that the tables were cleaned with a sanitizing solution after each patient use. Some clinical examination rooms lacked handwashing sinks.

Current Findings

The experts inspected the physical plants and equipment in the medical care areas at the NRC, SCC, Dixon, LCC, and MCC. Overall, we found problems with nurse sick call rooms, infirmary spaces, and examination rooms in all facilities we visited. The dialysis unit at SCC is inadequate and needs renovation. These problems detracted from the ability to provide care.

Nurse Sick Call Rooms

The nurse sick call rooms in three of the five facilities have been situated in the housing units to increase access to care. In two facilities, the sick call rooms are located in a centralized health care building.

NRC has established nurse sick call rooms on the first floor of each of the three tiered cell houses. These rooms are also used by providers to perform intake physical examinations that were deferred during the intake process. Nurses commonly do sick call interviews cell by cell through closed doors, moving some patients to the sick call rooms, which have a few plastic chairs or four bolted metal chairs with shackles. The sick call rooms do not have examination tables or desks, and all clinical equipment is carried in the during sick call session. Not all rooms have sinks or soap and paper towels. The sinks were dirty and the floors poorly scrubbed. In this condition, these rooms are unacceptable for the performance of nurse sick call or provider intake physical examinations.

SCC established nurse sick call rooms in the all six housing units. The rooms are adequately sized and equipped, having examination tables with paper rolls. The oto-ophthalmoscopes in two of the six rooms were not functioning. These rooms were generally clean and organized. One room did not have a sink but sanitizing hand gel was available for hand cleaning.

Dixon primarily provides nurse sick call in two dedicated and two part-time rooms in the centralized health care unit (HCU). (There were two additional satellite sick call rooms in the distant disciplinary segregation building). One nurse sick call room in the HCU had two desks and two exam tables; this room lacked any auditory and visual privacy. The other three rooms did not have examination tables. Only two of the four rooms had sinks. Having two exam tables in one room and none in the other three is a barrier to the delivery of care and does not allow for adequate privacy and confidentiality.

LCC provides nurse sick call in the ambulatory care wing of centralized health care building. Two exam rooms and occasionally a third room were utilized for nurse sick call; all had sinks and were adequately equipped. The exam tables had small tears in the upholstery and one oto-ophthalmoscope was not functional. Due to the need to share the examination rooms with the

provider staff, there were times when there were not enough exam rooms to meet the nurse sick call needs of the women at LCC.

MCC has established seven clinical examination areas in the facility's cell houses that are used for daily nurse and intermittent provider sick call and chronic care. In cell houses with only a single examination room, nurse sick call and provider clinics cannot be provided simultaneously and have to be separately scheduled so as not to overlap. The condition of these satellite clinics varied from cell house to cell house. Some rooms were well maintained, others had cracked and peeling paint, uncovered electrical outlets and ceiling vents, boxes cluttering the exam area, and records and supplies stacked on exam tables during clinical sessions. One of the exam areas did not have a sink. Not all of the areas were properly equipped; some lacked otophthalmoscopes, oximeters, peak flow testing mouthpieces, blood sugar testing devices, automated external defibrillators, and other supplies. One of the exam rooms in the East cell house was cramped by the presence of correctional items, including three large file cabinets, water damaged cardboard boxes, and an ancient refrigerator with a totally rusted door. Unsealed emergency bags were found in a number of the clinical spaces.

Infirmiry Space

NRC opened a 12-bed medical infirmiry in 2016. The nursing station is in a converted storage closet with no sink, no electrical outlets, no phone, no computer, and only one desk for two to three nurses. The size and condition of this nurse station hampers the efficiency of the infirmiry nursing staff. There were functioning patient nurse call devices at each infirmiry bed. The monitoring panel in one of the two negative pressure isolation rooms was not operational. Even though the majority of the patients housed in the medical infirmiry were chronically ill, and had clinical issues including frailty, disability, ambulation deficits, inability to provide self-care, or bladder or bowel incontinence, there were no adjustable hospital beds with safety rails in the infirmiry. Many of the mattresses had torn covers and could not be properly sanitized. One patient with urinary incontinence had an uncovered porous foam egg crate cushion in lieu of a mattress that was odiferous, dirty, and could not be cleaned and sanitized. The weekly supply of clean linens was insufficient to meet the needs of the infirmiry patient population of incontinent, diapered patients who frequently soil their sheets. The medical infirmiry rooms were shabby and unacceptably dirty.

The SCC infirmiry's nursing station's design does not allow direct line of sight of any of the 32 patient beds. Functional nurse call devices were in all of the two-bed rooms but not in the single bed medical rooms. The HEPA filters and negative pressure units in both the isolation rooms were non-functional; its filters and vents were clogged with dust. Low, fixed position beds were not suitable to allow appropriate examination or to meet the clinical needs of the patients housed on the infirmiry. The head and leg sections could not be raised or lowered, beds had broken wire springs, and safety railings were broken. The condition of the infirmiry beds created a safety hazard for the staff and patients. The tub room had large cracks in the floor and no safety grab bars, rendering it unusable. The rooms were inadequately cleaned. The cleanliness of the room varied based on the ability of the individual patients to assist with cleaning their rooms. Elderly, physically and mentally impaired individuals who were unable to

assist with cleaning their rooms had unacceptably dirty rooms. Only a single room with two more physically fit patients was judged to be adequately clean. Flies, gnats, and cockroaches were noted in patient rooms and in the corridor.

Dixon's second and third floors contain the infirmary, ADA housing unit, and the geriatric housing unit. The building's two elevators were broken; one had been disabled for a long time and the other had become non-operational on the day before the expert's visit. The malfunctioning of elevators created a major potential safety threat to the expeditious evacuation of these floors, given the clinical condition (elderly, frail, bedridden, physically ambulation impaired, etc.) of the patients housed on the health care building's upper floors. Most of the infirmary beds were functional, second-hand hospital beds with intact mattresses and adjustable sections. However, one patient with dementia had a broken bed with a middle section that sagged nearly to the floor. The infirmary rooms had nurse call devices and the negative pressure unit in the isolation room was functional. The ADA and geriatric units have fixed metal frame beds without adjustable sections with metal wire mattress supports. The wire mattress supports were commonly broken and replaced with strips of sagging tied bed sheets. The fixed metal beds must be replaced with more suitable beds; these beds are inadequate and put the safety and health of the geriatric patients at risk. Peeling paint, cracked wall plaster, rusted, dusty vents, and poorly ventilated showers were noted on both floors. As throughout the entire health care building, floor tiles are cracked and loose; this is major safety hazard for staff and the at-high-risk-for-fall patient population.

LCC's infirmary occupies one wing of the health care building. Relatively new hospital beds in excellent condition with adjustable height and head and leg sections were in all of the single (non-crisis) and double bed rooms. There were nurse call devices next to all the medical beds. The unit was clean and well organized. Both of the negative pressure units and the monitor at the nurse station were not functional, even though the nursing logs had previously indicated that they were operational.

MCC's infirmary is located on the third floor of the centralized health care building and can be reached by stairs or a single elevator. Overall, the infirmary was clean and in good repair. The heavy doors to the patient rooms are kept locked with individual padlocks. This is a safety hazard because emergency evacuation of the infirmary would be significantly delayed due to correctional staff having to open each of the padlocks. These padlocked rooms are also a safety hazard because there are no nurse call devices in any of the infirmary rooms; patients who are able to ambulate have to bang on the doors to get medical attention. Patients unable to ambulate have to call for help. The nurse station is in an enclosed room that is not within sight or sound of the patient rooms. Twenty three of the 26 beds were low, fixed-position metal beds without safety railings or adjustable heights and head and leg sections. The low to the ground fixed position beds made it difficult and even unsafe for the staff to properly examine and transfer patients into and out of bed. One patient with risk for falls slept on a mattress on the floor because there were no available beds with safety railings. The negative pressure units were operational, but the anterooms in these isolation rooms were cluttered and had overflowing waste bins. The shower room used by the infirmary's chronically and acutely ill

patients did not have safety grab bars; the ceiling vent in the shower rooms was clogged with lint and dirt.

Health Care Unit Space

The NRC health care unit did not have a sufficient number of exam rooms to accommodate the facility's four providers and the monthly UIC telemedicine specialty team. There are sessions when one provider has to be shifted into a cluttered interview/storage room without an examination table or clinical equipment. This is inappropriate for the use by clinical providers. Two additional examination rooms are needed to assure that access to clinical care is not hampered by the lack of examination space. The three exam rooms have non-adjustable exam tables and none had paper rolls. Sinks in all the rooms were crusted with mineral deposits, and uncovered paper memos were taped on the walls, creating a fire safety hazard. The wall mounted oto-ophthalmoscopes were non-functional in every exam room and in the treatment room. One portable scope was shared by the providers. Even though many infirmity and general population patients have physical disabilities, there was not a single adjustable exam table or an electric table in the clinic.

SCC's health care unit was reasonably clean and organized. The unit had two provider exam rooms and a telehealth room; if needed, the adjacent treatment room was used as a third provider room. The four-chair hemodialysis suite was in deplorable condition, with peeling paint; dirty, unbuffed floors; standing water on the floor of the deionization room; and an uncovered waste container. The front of refrigerator door was totally rusted and impossible to sanitize. The suite, deionization room, and the storage areas were cluttered, creating a safety and fire hazard. The space of the suite did not allow for the required separation of the hepatitis B infected dialysis patients. A very few of these egregious deficiencies had been noted on Monthly Safety and Sanitation reports, but no action had been taken by IDOC, Wexford, or the dialysis vendor to expeditiously correct these problems. The Hemodialysis Unit does not meet the community standards of care or the CDC guidelines for prevention of the infections in dialysis units (Reference CDC, Recommendations for Preventing the Transmission of Infections among Chronic Dialysis Patients). The Hemodialysis Unit should be closed until all these deficiencies in the physical plants and practice have been corrected; these conditions would not be tolerated in community dialysis centers.

Dixon's health care unit on the first floor of the health care building had three adequately equipped provider examination rooms with an additional telehealth room. There were sufficient exam rooms to accommodate all three providers at the same time. One of the examination tables did not have a paper roll. The provider offices in an adjacent corridor were reportedly to allow access to electronic medical references. The HCU was generally clean and well maintained; however, as in the entire health building, there were cracked and missing floor tiles throughout the first floor. This is a safety, sanitation, and infection control concern for patients and staff.

LCC's ambulatory health care unit occupied one wing of the health care building. Provider chronic care clinics, provider sick call, and OB-gynecology specialist clinics, along with nurse sick

call, are co-located in this area. The five examination rooms are not adequate to accommodate the 7.5 budgeted full-time equivalent providers and nurses assigned to provider and nurse clinical sessions. All of the examination rooms are adequately equipped; one oto-ophthalmoscope was not operational. One room did not have a sink, two of the five rooms did not have a paper barrier on the exam table. Emergency jump bags are kept in the health care unit and in a car used to transport nurses to distant cell houses on this large campus; these bags were noted to be unsealed. The facility's failure to restock and reseal the emergency bag after every use jeopardizes the next response to an emergency on the campus.

MCC's health care building's first and second floor houses radiology services, telehealth room, nurse staffed treatment room, dental suite, optometry, physical therapy, and support and administration offices. Nurse and provider sick call and chronic care clinics formerly provided in the four exam rooms on the first floor have been relocated to the cell houses. With the exception of the telehealth room, the examination rooms are not well maintained; examination tables and chairs have torn upholstery, oto-ophthalmoscopes were not functional, one of the rooms was cluttered with supplies. These rooms are used intermittently for nurse sick call and treatment room overflow, and should be kept in operational condition.

Medical Records

Methodology: We toured medical record areas, interviewed medical records personnel, and reviewed medical records.

First Court Expert Findings

The First Court Expert found the quality of medical records poor at most facilities visited. This included problem lists not updated and cluttered with redundant, irrelevant information. MARs were incompletely filled out. "Drop filing" occurred mostly at NRC and LCC. The IDOC fails to file health requests in the medical record. Progress notes often contain no information with respect to history, examination, or clinical decision making. Illegible handwriting made many notes unreadable and unusable, except by the author.

Current Findings

LCC has corrected the problems with drop filing. With that exception, there has been no improvement. We found several additional significant problems. These include:

- With the exception of MCC, charts are so large that they frequently come apart, making the record extremely difficult to use. This promotes loss of documents.
- Record rooms are too small to accommodate all records. Therefore, additional storage space is necessary, making finding an older document extremely cumbersome.
- Record rooms are not secure and therefore violate Administrative Directives and fail to follow Illinois Department of Human Services guidelines on protection of the medical record.
- There is not a standardized tracking system in place to sign out a record.

- Any staff member can access the records room and pull and re-file records. This promotes loss of records and does not safeguard confidentiality or use by unauthorized persons.
- Access to a medical record for use during clinical encounters is not universal.
- Data for use in quality improvement is obtained manually. This makes measurement of health care processes extremely cumbersome.
- We noted inability of the IDOC to find all documents in mortality records sent to us.
- Records of on-site dialysis are maintained separately from the IDOC medical records and the medical record fails to contain updated information about what is occurring in dialysis.

At the time of the First Court Expert visits in 2014, the IDOC was in the process of implementing an electronic medical record. This effort started at LCC and Decatur, the only two female facilities. The record was incompletely implemented; the electronic MAR was not implemented. After part of the electronic record was implemented at LCC and Decatur, the electronic record project was aborted. We did note on our review at LCC that there were some serious problems with the electronic record. This record defaults vital signs from the last vital signs obtained. The record will automatically present vitals in a note from months previous if no more recent vital signs were done. This is dangerous and should be stopped, as it is a patient safety issue.

The IDOC is considering implementation of a different electronic record. The IDOC has placed a custody Deputy Director in charge of the project to implement an electronic medical record. It is our opinion that someone with medical expertise and medical record expertise should head this effort, not custody personnel. No funding has been provided for this project.

A correctional health program generates large volumes of paper. Infirmaries, mental health units, the health request process, and administration of medication are hospital-like with respect to the volume of paperwork that is generated. As a result, inmates who remain incarcerated for a long period of time generate massive paper medical records. Three problems ensue. One problem is that there is no place to store all the paper record volumes so that they are easily accessible. A second problem is that the paper record comes apart, making use of the documents contained therein extremely cumbersome. The third problem is that the current volume of documents often does not contain all of the documents necessary to provide care. This can result in physicians acting without complete information about the patient. This is particularly true because of the frequency of changes in physician staff.

Almost all inmates with chronic illness or with mental health problems have multiple volume files, easily in the thousands of pages per inmate. Record rooms in the prison facilities do not have the capacity to store all volumes of the record. As a result, most of the volumes of records are placed in storage someplace on the grounds of the facility, but not always close to the medical unit. The most current volume of a record often does not contain a key test result, consultation report, hospital summary, or diagnostic test result that is necessary to understand the progress of the patient. In our own review of records, we had to frequently ask for additional volumes of the record. When this occurs, clerks have to go to the storage unit to find

the document. This delay is not workable if a provider is with the patient. The entire patient record should be available for use, but this would be exceedingly impractical using a paper record.

Also, the paper medical records frequently come apart. All paper documents are two-hole punched and held together by a plastic binding clip. The plastic clip is glued to a pressboard binder that is used for covers of the record. These covers are expandable. The thinning process is standardized except for when to initiate the thinning process. By IDOC rules, certain documents are carried forward to the current volume. The carry-forward documents often do not include critical test reports, consultation reports, or other clinical information that is critical to understanding the patient's diagnosis or therapeutic plan. Other than MCC, the IDOC has no rule on when to thin the record. Several facilities allowed records to expand well beyond two inches. One facility told us they could not afford to purchase the pressboard covers, so charts were not thinned when they should have been.

There are major problems with this process. Medical record volumes that may contain important information are not easily accessible. A newly thinned record may have insufficient medical record documents to properly care for the patient. Medical record volumes that are not thinned come apart. The plastic clips come undone and the clinician is left with a pile of paper that can easily become misplaced in the medical record. This promotes poor care.

None of the facilities we visited had a completely secure record room. Medical records are considered confidential and must be secure. The Illinois Department of Human Services guidelines for providers in maintaining a medical record state that medical records must be maintained in accordance with accepted medical standards which require confidentiality, secured by lock when not in use, and safeguarded against loss or use by unauthorized personnel.⁷⁰ Typically, when paper records are used, staff maintaining the record must keep the records in a locked room to which no one except authorized medical record employees have access. Records are pulled by medical records staff only. When a record is pulled, a placeholder is inserted into the space where the record was, containing information on where the record is. After-hours record use is strictly managed so that only authorized persons are permitted in the records room. None of the facilities we visited ensured that this happened at all times and in all circumstances.

The NRC record room was the worst of all facilities. Everyone had access to the record room. Any staff member could pull and refile records they used. Paper documents were not in a pressboard folder and sometimes were merely stapled together or in piles. When a pile of record documents was removed from the room, there was no indication where the record was. In chart reviews we conducted, it appeared that many documents were missing.⁷¹ This arrangement is a patient safety hazard and needs to be corrected as soon as possible. We were

⁷⁰ Illinois Department of Human Services website as found at <http://www.dhs.state.il.us/page.aspx?item=40657>.

⁷¹ We noted on four mortality records that there were parts of the record that were missing that made it impossible to evaluate the death. These records included Mortality Review Patient #11 from SCC/NRC; Mortality Review Patient #12 SCC/NRC; Mortality Review Patient #16 SCC/NRC; and Mortality Review Patient #31 Illinois River.

told that the State had funded additional clerical positions for this unit. However, the room size is so small that we do not believe that the room can accommodate any additional employees. This process will require significant work to remedy.

Some patient encounters occur without a medical record; this mostly pertains to nursing sick call at MCC and NRC. All patients need to be seen with a medical record. When patients are seen without a medical record, nurses write their note on a blank progress note without benefit of review of the patient's current problems, medications, or other significant information. The progress notes are filed later. This is inappropriate medical care and is likely to lead to mistakes, placing patients at risk of harm. All nursing and provider evaluations must occur with a medical record.

Some of the First Court Expert's findings are a result of use of a paper medical record and some are staffing and practice issues as well as medical record issues. The First Court Expert found deficiencies with problem lists. Problem lists are easier to maintain in an electronic record than in a paper record. However, in both electronic and paper records, the quality of the problem list is directly related to medical staff participation in maintaining it. The failure to maintain the problem lists in IDOC is a failure on multiple levels. Leadership has not instituted standardized practices with respect to who can enter a problem on the problem list. When providers do not work to place accurate problems in a standardized methodology on the list, the list also becomes inaccurate. While this problem is easier to correct with an electronic record, it is a matter of leadership, supervision, and practice, and is related to personnel and practice issues rather than medical record issues.

Incomplete MARs can be a staffing or process problem. When there are insufficient nurses to administer medications, the records can be incompletely filled out. Also, the practice of recording medication administration hours after medication has actually been administered, which occurs at several sites we visited, will result in inaccurate entries. This appears to be a staffing issue and a process issue. We believe that the burden of using, filing, and reviewing paper MARs is so great that it alone is a compelling argument for implementation of an electronic medical record. If paper records are to be continued in the IDOC, significant root cause analysis and process work needs to be done to discover what the problems are so that they can be fixed.

Paper requests for health care contain the patient's written complaint that nurses address in the sick call process. In our opinion, these written complaints are health record documents, as they describe the patient's problem. The IDOC does not include these in the medical record and discards them. These documents need to be included in the paper record or scanned to the electronic medical record.

The issue brought up by the First Court Expert that many practitioners fail to document a history, physical examination, or therapeutic plan is not a medical record problem in our opinion. This is a problem of physician quality. As an example, we noted one physician at SCC who was a surgeon and not primary care trained who, for six months, was following an

infirmity patient who had dementia. His entire note for 19 consecutive patient evaluations consisted of the statement, "No specific complain, no change, dementia, continue same care."

The patient was ultimately hospitalized for a cardiopulmonary condition but because the doctor failed to evaluate the hospital record it wasn't clear why the patient was hospitalized. Ultimately, the patient developed metastatic colon cancer not diagnosed until the patient had advanced disease. For almost a year following hospitalization, the doctor wrote the following note repeatedly, "No specific complaint, no change, dementia, post colectomy for metastatic ca [cancer]. Continue same care."

This repeated note was written during a time when the patient experienced falling repeatedly, developed incontinence, developed pustular otitis, and severe malnutrition and dehydration. This was negligence and incompetence of the provider and not a result of the medical record. Many notes failed to contain adequate history, physical examination, assessments, or development of therapeutic plans. In review of 33 death records, we found 276 episodes of care with inadequate history; 249 episodes of inadequate examination; and 228 episodes in which a therapeutic plan was inadequate. In our opinion, this is not a problem with the medical record, but is a problem of physician quality.

Illegible handwriting is an individual problem which is extremely difficult to correct with a paper medical record system. We noted problems with legibility at all sites except at LCC, where an electronic record is used.

We also note that use of a paper record means that accessing data from the record for the purpose of measuring performance must be done manually. This is extremely cumbersome and discourages quality investigations. An electronic record can significantly improve data use.

Dialysis is provided by a vendor. Even though dialysis occurs onsite at IDOC facilities, the records of dialysis are not incorporated in the medical record. We noted at SCC that the nephrologist will occasionally write a few comments on a referral form but these are not thorough or fully inform the status of the patient's condition or treatment. These dialysis records should either be incorporated into the record or a reasonable complete summary of the patient's status and treatment should be provided on a regular basis to update the medical record.

In summary, there were many problems with use of the paper record that will be difficult to correct. These include storage of important information due to excessive chart size, documentation on the MAR, ensuring confidentiality of the record, legibility, and functionality. It is our recommendation to implement an electronic medical record statewide to include electronic medication administration functions. The system should be designed and acquired so that the IDOC has easily accessible data for use in measuring performance. Data analysts who are expert in obtaining data from the electronic record for quality purposes should be employed.

Medical Reception

The medical reception evaluation and treatment plan establishes a baseline for the patient's medical, mental health, and dental conditions, and serves as a blueprint for the patient's care following transfer to the patient's parent institution. Failure to identify and treat serious medical conditions at intake increases the risk of harm to patients and liability to IDOC. Our review showed that the medical reception process generally occurs timelier since the First Court Expert report; however, there are persistent issues related to the reliability of various processes (e.g., TB skin testing) and quality of medical reception evaluations. There are also issues related to the timeliness of follow-up of serious medical conditions. Our report confirmed findings of the previous report and identified previously undescribed problems.

First Court Expert Findings

The First Court Expert reviewed three reception centers, noting that the purpose of the medical reception process is to identify and treat acute and chronic medical and mental health problems, including communicable diseases, and to identify any special medical needs. The Court Expert found the following problems:

- IDOC forms do not elicit current symptoms (all facilities).
- Nurse screenings being performed in areas that were noisy and did not provide adequate privacy (LCC).
- Significant delays in performance of clinician history and physical examinations of newly arriving inmates, sometimes for more than a month (NRC).
- Lack of integration of TB and laboratory test results into the history and physical examination so that all medical conditions are timely diagnosed with an accompanying treatment plan for each condition and documentation on the problem list (NRC, Menard).
- Medical record disorganization that impeded clinicians' ability to identify and utilize clinical information to timely diagnose and treat patients appropriately (NRC).
- Delays in follow-up and treatment of chronic diseases and other medical conditions (NRC, MCC, LCC).

Current Findings

This review showed that improvements have taken place with respect to the timeliness of completion of the medical reception process at some facilities (NRC and LCC) but not uniformly across the system (MCC).

Record review showed that county jails forwarded medical transfer information that was available to health care staff at the time of arrival. However, NRC providers did not document that they reviewed the information and, in some cases, missed important medical diagnoses (e.g., prostate cancer, pancreatic cancer, pulmonic valve regurgitation) or medications for high blood pressure (e.g., hydrochlorothiazide). One such error resulted in death.

We noted two cases in mortality reviews that included significant problems with failing to review transfer information or to take an adequate history. In one case, a provider failed to

take an adequate history of a patient in the midst of getting valve replacement for a congenital anomaly.⁷² The provider made the wrong diagnosis, failed to contact the patient's civilian doctor, and even failed to read a letter in the IDOC medical record from the patient's civilian doctor. As a result of this failure, the patient's planned surgery was never done, his condition was unrecognized in IDOC for six months, and the patient died from complications of his heart condition without having obtained surgery. Another patient from LCC was at Cook County Jail and was sent to Stroger Hospital for a pancreatic mass. A biopsy was non-diagnostic but the mass was strongly suggestive of pancreatic cancer and follow up was recommended.⁷³ The doctor at LCC presumed that the patient had a benign pancreatic mass and no follow up was initiated for five months. Pain medication history was also not taken and the patient was placed on inadequate doses of pain medication and suffered in pain over the last five months of her life.

Medical reception was conducted in clinic examination rooms that were not standardized with respect to medical equipment and supplies. There was no microscope available at LCC to the provider to diagnose vaginal infections.

Clinic examination room furniture was often in disrepair (e.g., torn exam table covers) and needs to be repaired or replaced. Exam tables did not have paper to use as a barrier between patients and there was no schedule of sanitation and disinfection activities. Exam rooms were dirty, and in some cases filthy. At NRC, the lack of a water softening system at the facility (reportedly due to budget issues) results in mineral deposit buildup on sinks and faucets, making disinfection difficult, if not impossible. At LCC, the nurse and clinician conduct the medical reception process in rooms that are small and difficult to clean. These conditions present a risk of infection to patients.

On the day of patient arrival, nurses perform a medical history, TB symptom screen, height and weight, vital signs, visual acuity, and plant a tuberculin skin test. Phlebotomists draw labs including hepatitis C and HIV opt out testing. At NRC we found that the scales were not calibrated.⁷⁴ Nurses incorrectly measured visual acuity by having the patient sit in a chair to read the visual acuity chart approximately 10 feet away instead of having the patient stand 20 feet away and testing visual acuity for each eye separately. NRC nurses incorrectly read tuberculin skin tests by having the patient show his arm in the cell window rather than palpating the patient's arm for induration. Tuberculin skin test results were not consistently documented in the health record. At LCC, nurses did not document urine pregnancy testing on all patients of childbearing age upon arrival.

Lab tests performed as part of intake screening routinely include serum chemistry, syphilis, and opt-out hepatitis C and HIV testing. Although HIV is supposed to be opt-out,⁷⁵ the

⁷² Mortality Review Patient #2.

⁷³ Mortality Review Patient #20.

⁷⁴ One of the experts stepped on two scales which gave a 10 pound discrepancy between the scales.

⁷⁵ Opt-out testing means that testing will be performed unless the patient refuses the test. Opt-in testing means that the patient is offered testing and is performed only upon patient consent.

Administrative Directive (AD) requires that consent be obtained before drawing blood for HIV, which essentially renders the process as opt-in.⁷⁶ Opt-out testing is recommended by the Centers for Disease Control because it supports early identification and treatment. Data shows that significantly fewer inmates are being tested for HIV than hepatitis C infection.

A nurse performs the medical history. The IDOC Offender Medical History form is limited with respect to chronic diseases and does not include COPD, thyroid, kidney, liver, autoimmune diseases, or cancer. Importantly, as noted in the previous Court Expert report, the form also does not include a section for review of systems (e.g., chest pain, shortness of breath, abdominal pain, blood in stool, difficulty with urination, etc.) that are typically included in a comprehensive history and physical examination. This poses a risk that important medical diagnoses or symptoms of serious illness will be missed and not medically evaluated, increasing risk of harm to the patient.

The IDOC Offender Physical Examination form (DOC 0099, Rev. 11/20/12) includes a section for substance abuse, risk factors for blood borne infections (e.g., HIV and HCV), and TB symptoms, but does not include a section for chronic disease pertinent review of systems (e.g., chest pain, SOB, polyuria, polydipsia, neuropathy, etc.), which contributes to the assessment of disease control.

The timeliness of clinician history and physical examinations has generally improved. At NRC and LCC, a medical provider saw patients with acute or chronic diseases within 24 hours of arrival. At MCC, only 60% of examinations took place in seven days or less. Although timeliness of physical examinations has generally improved, clinicians did not consistently elaborate on positive findings noted by the nurse,⁷⁷ and the history and physical examinations were often cursory and lacking in quality. Because nurses complete the patient history, providers generally do not complete a thorough history leaving a gap of information about the patient's illnesses. In many cases, NRC clinicians simply noted the patient's diagnosis rather than perform a medical history, review of systems, and assess the patient's disease control. At LCC, record review shows a physician assistant was conscientious and did an excellent job.

Providers wrote orders to enroll patients into the chronic disease program in 30 days and assigned patients low bunk/gallery status as clinically indicated. At NRC, providers also ordered diagnostic tests (e.g., chest x-ray, EKG) and labs for some chronic diseases (e.g., thyroid, anticoagulation), but did not order HbA1C for any diabetics. At NRC, medical provider orders (EKG, chest x-ray, blood pressure monitoring, etc.) were not consistently implemented by nurses.

Clinicians usually ordered medications on the day of arrival; however, in some cases they did not provide continuity of care with respect to patients' chronic disease medications, either omitting or changing medications (e.g., insulin types) without documenting a clinical indication.

⁷⁶ Administrative Directive 04.03.11 Section 5 II. F. 5. D.

⁷⁷ MCC Medical Reception Patients #12, 13 & 14.

MARs did not consistently reflect that the patients received the medications. At NRC, nurses gave some patients blister-packed medications from stock supplies but did not create a MAR and document that it was given to the patient. In some cases, nurses documented giving medication to the patient on the physician order form, but in other cases there was no documentation that the patient received the medication.

A clinical concern is that at NRC, three patients were being treated for heroin withdrawal at the time of admission, but the provider did not order Clinical Opiate Withdrawal Scale (COWS) monitoring to assess whether the patients' symptoms were improving or worsening, and that may have required changes in medication withdrawal regimens.

We observed a NRC dentist perform dental screening examinations without changing gloves between patients (See Dental Section).

With respect to follow-up, medical providers did not timely address abnormal lab test results and did not complete the initial chronic disease form when seeing patients at the first follow-up visit.

There are no mechanisms in place to monitor timeliness of the intake process or to evaluate the quality of intake screening, the health history, or physical examination. There were no CQI studies provided that indicate the intake screening is monitored for quality or timeliness. This is a high volume, high-risk area of health care delivery in the correctional setting and should be regularly reviewed as part of the CQI program.⁷⁸

Intrasystem Transfer

Our report confirmed findings of the previous Court Expert report and identified previously undescribed problems. Overall, we find that the timeliness of medical screening following transfer has improved, but there continue to be problems with the completeness of the forms and continuity of care following transfer. We also found that the CQI program does not consistently address continuity of care provided following intrasystem transfer.

First Court Expert Findings

The previous Court Expert found problems with the intrasystem transfer process at almost every facility resulting in discontinuity of care (e.g., medications, chronic disease follow-up). At Dixon, the process was so broken that despite having a special medical mission, nurses did not perform the process for two to three weeks after patients' arrival, resulting in discontinuity of care. The Court Expert also found that continuity of care following intrasystem transfer is not studied to identify and correct problems.

Current Findings

⁷⁸ National Commission on Correctional Health Care. 2014. Standards for Health Services in Prisons. Pp. 13-14.

IDOC Administrative Directive 04.03.103, Offender Health Care Services, does not include a policy and procedure for how custody and health care staff are to conduct the intrasystem transfer process. SCC Operations Policies and Procedures includes a Transfer Screening policy that is consistent with NCCHC Standards for Health Care Services in Prisons (P-E-03). However, the policy is not site-specific with respect to how custody notifies health care staff of inmates who are transferring into and out of the facility, which health care staff performs medical screening, how patients are to be enrolled into the chronic disease program, and the procedure for providing continuity of medications.

We found that institutions did not use a tracking log to document completion of required services following transfer into the facility (e.g., enrollment into the chronic disease program, periodic health assessments, etc.).

NRC does not receive a large volume of patients transferring into the facility. Inmates who transfer into NRC are typically scheduled to go out to court or receive specialized medical services in the Cook County area. At the time of our review there were 29 inmates at the facility for greater than 90 days. Of this number, 12 were for medical reasons, 12 were for parole board hearings, two were boot campers, two were pending WRITS and one was for discharge. A review of five records showed that all patients were timely seen upon arrival, but one of three eligible patients was not timely enrolled into the chronic disease program.

Transfers to SCC average less than 50 per month. Inmates received on transfer are brought to urgent care in the health care area for nurse screening before placement in population. The nurse reviews the sending facility transfer form and inquires if the inmate is currently receiving treatment or has any other immediate need for medical attention. The nurse then schedules the inmate for subsequent health care (i.e., enrollment in a chronic care clinic, initiation of medications, etc.) as needed. The nurse also provides a verbal explanation and handout about how to access health care at the facility.

SCC does not keep a log, list, or other method to track inmates received on transfer. A sample of 12 records was obtained from other sources. Ten of these inmates had health care requirements that needed continuation at SCC. The transfer process was complete in seven of the 10 charts reviewed of inmates with ongoing health care needs. One transfer summary did not list psychotropic medications that were prescribed, but these were identified by the nurse upon review of the chart and continued.⁷⁹ In another, there was no transfer summary for an inmate with diabetes and hypertension. The nurse who reviewed the chart noted his medical history, enrolled him in chronic care and ensured that his medications were continued.⁸⁰ In another chart reviewed, an inmate on prescribed psychiatric medications was not scheduled to see a provider urgently and no other attempt was made to continue medication upon his arrival at SCC.⁸¹ Transfer screening at SCC has improved since 2014. However, record review revealed

⁷⁹ SCC Intrasystem Transfer Patient #11.

⁸⁰ SCC Intrasystem Transfer Patient #12.

⁸¹ SCC Intrasystem Transfer Patient #10.

that for 30% of the inmates requiring continuity of care, transfer information was incomplete or care was not provided as prescribed. Continuity of care upon transfer needs to be more reliable. At SCC, the First Court Expert recommended that the CQI program address the intrasystem transfer process with respect to continuity of care. However, CQI minutes and related material for the calendar year 2017 showed no reports monitoring the continuity of care following transfer.

At Dixon, the process has improved since the previous Court Expert's report. All transferred inmates are brought to the dispensary upon arrival at DCC. Registered nurses review the transfer summary, take vital signs, and conduct a brief screening interview to identify any immediate medical needs and reconcile prescribed medications so that treatment can be continued. Each inmate receives an individual explanation from the nurse about how to request health care attention for urgent and routine medical needs. The next day these inmates are seen again by nurses, who complete a lengthier interview using the intake screening questions and review the medical record. At this encounter, the nurse ensures the problem list is up to date, completes any screening not done at intake, and identifies any pending referrals or appointments. Inmates who have chronic diseases are enrolled in chronic care clinic, and medication, treatments, and labs are ordered. At this second encounter, the nurse answers any questions and confirms the inmates' understanding of how to request care, procedures to receive KOP and pill line medications, and obtain refills.

A review of eight records showed opportunities for improvement. In two cases, the transfer summary did not include the name of the sending facility and information on TB screening.⁸² In two cases, the inmate was not scheduled for a chronic care appointment within 30 days of arrival for an initial evaluation.⁸³ Five patients had medications which were provided without dose interruption when received at DCC.⁸⁴ However, one of these ran out two weeks after the transfer and was not reordered.⁸⁵ It was a KOP medication. It was not possible to ascertain if the discontinuity was because the inmate did not know how to request a refill, or the patient was lost to follow up. Two others were not taking medication at the time of transfer but were referred to a provider who ordered medication that was within 24 hours.⁸⁶

Our review showed that timeliness of intrasystem transfer has improved since the First Court Expert report. However, the completeness of these evaluations, as well as continuity of care following arrival, needs improvement. Given the number of errors and omissions found in the chart review that affect patient care, we recommend that health care leadership establish a process to monitor and provide feedback as part of the CQI program. When facilities send inaccurate or incomplete information on the intrasystem transfer form, the receiving facility should provide feedback to the sending facility. Errors and omissions should be subject to focused study to improve the accuracy of transfer information and continuity of patient care.

⁸² DCC Intrasystem Transfer Patients #1 & 2.

⁸³ DCC Intrasystem Transfer Patients #2 & 3.

⁸⁴ DCC Intrasystem Transfer Patients #1, 2, 5, 6, 7, & 8.

⁸⁵ DCC Intrasystem Transfer Patient #1.

⁸⁶ DCC Intrasystem Transfer Patients #3 & 4.

Nursing Sick Call

Our report confirmed findings of the previous Court Expert report and identified previously undescribed problems. Overall, we find that IDOC lacks an adequate system for access to care through nursing sick call, creating a systemic risk of harm to patients. The findings at NRC were particularly egregious, in part due to lockdown of the population 24 hours a day, and warrants immediate attention.

First Court Expert Findings

The previous Court Expert found that nursing sick call ranged 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:

- Sick call request forms are available to inmates.
- Completed requests are placed directly by the inmate into a locked box or handed directly to a health care staff member.
- Completed requests are collected by a health care staff member.
- There is identified clinic space.
- The clinic space is appropriately equipped.
- The space provides patient privacy and confidentiality.
- Sick call, including paper triage, is conducted by a licensed RN whose education, licensure, and scope of practice permit independent assessments.
- Sick call is conducted pursuant to IDOC policies and procedures with regard to the use of approved treatment protocols at each encounter, use of over-the-counter (OTC) medication dosages only, and referrals follow-up as needed.
- A sick call system must ensure confidentiality from request to treatment.
- A sick call system which addresses all a patient's complaints or, at a minimum, prioritizes the complaints.
- A sick call log and tracking system has been developed and maintained.

Particularly problematic was that the sick call process permitted non-registered nurses to conduct sick call at many facilities. The Illinois Nurse Practice Act does not permit LPNs to perform independent nursing assessments, which is being done in IDOC. Moreover, in segregation units, nurses did not conduct meaningful assessments but rather talked to the patient through a solid steel door. There was no immediate review by an RN or physician to ensure that the LPN conducted an appropriate assessment. At Stateville and Pontiac, there was frequent and arbitrary canceling of sick call by custody staff. At Dixon, inmates were permitted to raise only one complaint per sick call visit. At NRC and Dixon, there was no sick call log. Hill Correctional Center's sick call system did have many of the required elements.

Current Findings

IDOC Administrative Directive Offender Health Care Services 04.03.103 6. (a-c) addresses review of sick call requests. However, the policy provides insufficient operational guidance to staff regarding how to implement the sick call program. For example, the policy does not address what sick call request forms are to be used, how they are ordered, which staff is

responsible for ensuring that health care request forms are available to inmates, how inmates are to submit their requests to protect confidentiality, etc. The policy does not address where sick call is to be performed, by what level of staff, or the disposition of written health requests (i.e., scanning into the health record). Thus, the policy is inadequate. In addition, the policy is not consistent with NCCHC standards.

The previous Court Expert found standardization with respect to how inmates access nurse sick call; through submission of written health requests that nurses collected, triaged, and assigned a priority to be seen. We found lack of standardization in how inmates access health care in IDOC, with some institutions using a written health request process that is consistent with IDOC Administrative Directives and some institutions using a daily sign up system, which is not consistent with current Administrative Directives. The sign-up system (which does not include the nature of the patient's complaint), does not allow nurses to prioritize which patients should be seen first based upon the urgency of their complaint and does not result in scanning of the patient's complaint into the medical record. At LCC, staff retain sign-up sheets, which are the only record that the patient has requested to be seen; however, we found that multiple sign-up sheets were missing. This is a concern because then there is no medical-legal documentation that the patient requested health care.

In IDOC facilities, both RNs and LPNs perform sick call using Treatment Protocols. In the State of Illinois, LPNs are to practice "under the guidance of a registered professional nurse, or an advanced practice registered nurse, or as directed by a physician assistant, physician...to include conducting a focused nursing assessment and contributing to the ongoing assessment of the patient performed by the registered professional nurse." LPN's may also collaborate in the development and modifications of the RN or advanced practice registered nurse's (APRN) plan of care, implement aspects of the plan of care, participate in health teaching and counseling, and serve as an advocate for the patient by communicating and collaborating with other health service personnel.⁸⁷ However, Illinois scope of practice does not permit LPNs to perform assessments independent of an RN or higher level professional, as is currently being done in IDOC. Neither does the scope of practice permit LPNs to perform independent assessments according to protocols. LPNs do not have requisite education and training, including physical assessment skills, needed to perform independent assessments.⁸⁸ *Thus, some IDOC patients do not receive evaluations by health care staff licensed to perform independent assessments. This increases the risk of harm to patients.* In addition, we found that nurse to provider referrals are not made when clinically indicated, and when made are not timely performed.

Although we found some improvements in nursing sick call relative to the previous Court Experts report, these improvements were uneven across the system, with some facilities demonstrating significant improvement with access to care and others none at all.

⁸⁷ Illinois LPN Scope of Practice. Section 55-30.

⁸⁸ NCCHC defines Qualified Health Care Professionals to include nurses without distinguishing between registered and licensed practical nurses. However, RN and LPN practice must remain within their education, training, and scope of practice for their respective state.

The findings at NRC were the most egregious and warrant special mention. At NRC, there is no functional sick call system that provides timely access to care. Inmates are not provided approved health request forms to submit their requests; therefore, inmates write their requests on small scraps of paper or generic Offender Request forms. Inmates may or may not have pens or pencils to write their health requests. Staff reported that inmates could borrow a pen from another inmate, but an officer commented to a court expert: “Yes, but it will cost them a lunch tray.”

Inmates cannot submit their requests confidentially by placing them in a locked box accessible only by health care staff. Instead, they place the piece of paper in a crack in the door that could be picked up by anyone walking by, even inmate porters on the unit. Sometimes officers pick up the forms and place them in open folders to be picked up later by a nurse. *Even if there were sick call boxes on each unit, inmates cannot submit their forms because throughout NRC inmates are locked down 24 hours a day except for four hours per week.⁸⁹ Thus, the institutional practice to lock offenders down 24 hours per day is a serious obstacle to access to care.*

At NRC, health care staff does not collect health request forms on a daily basis. Staff does not date, time, and sign when health requests are received. Nurses do not triage patient health requests within 24 hours, nor do nurses document the urgency of the disposition (e.g. urgent, routine) on the request. The Director of Nurses reported that some nurses did not see patients and threw the health request away rather than file the request in the health record. For example, if a CMT/LPN triaging the request noted the patient had not yet had a physical examination, the request would be thrown away under the assumption that the complaint would be addressed at the time of the physical. Likewise, if the CMT/LPN noted that a provider saw the patient in the last day or two, the request would be thrown away under the assumption that the complaint had been addressed. Nurses do not assess patients with symptoms within 24 hours of triage according to IDOC administrative directives. Nurses are to have the health record available to them for a sick call encounter but during our tour, a nurse reported she was only able to locate three of 10 health records of patients she was scheduled to see. Nurses conduct sick call in inadequately equipped and supplied rooms in housing units without access to a sink for handwashing. This contributed to inadequate patient assessments. Nurses did not consistently refer patients to providers when clinically indicated and when made, referrals to providers did not timely take place.

At other facilities we found that some of the problems identified in the previous Court Expert’s report had been resolved but other problems persisted.

- At SCC, access to sick call is through a combination of a written health request and sign-up system. Problems related to the frequency of sick call clinics and custody’s failure to escort patients to clinic exam rooms have been resolved. Improvements were noted with the standardization of exam room equipment and supplies, and availability of the medical record at nursing encounters. However, issues persist with respect to LPNs conducting sick call; inadequate health assessments; inadequate privacy in segregation;

⁸⁹ This information was confirmed by correctional officers on the units and the Superintendent.

and failure of nurses to refer patients to providers in accordance with IDOC treatment protocols or to document the urgency of referrals (i.e., routine, urgent).

- At Dixon, access to nurse sick call is through a written health request. Problems related to confidentiality of sick call request forms have been resolved through installation of sick call boxes on the housing units. RNs are assigned to perform sick call, but LPNs are assigned when there are insufficient RNs available, exceeding their scope of practice. Dixon has implemented a sick call log that is used to monitor the timeliness and appropriateness of nursing decisions. Persistent problems from the previous report include health requests not being filed in the health record; inadequately equipped and supplied examination rooms; inadequate nurse assessments; lack of access to health records in X-house; nurses not triaging patients with dental pain; and patients not being timely seen by a provider or dentist in accordance with IDOC treatment protocols.
- At LCC, our review showed some improvement from the previous Court Expert's report but other issues persist. To access sick call, inmates sign up for sick call on a sheet of paper in the housing unit rather than submitting a written request with the nature of the complaint. Patients are supposed to be seen the following day; however, in a sample of records reviewed, 31% of patients were not seen due to no show, refusal, or lockdown. This is a concern because if nurses cannot see all patients within 24 hours, they need to be able to triage patients according to the urgency of their complaint. However, this is not possible because inmates do not document the nature of the complaint on the sign-up sheet. This is a serious disadvantage of the sign-up system versus the written request system, which also provides documentation in the medical record of the patient's complaint. Sick call tracking logs show extraordinarily high no-show or refusal rates, in some cases exceeding 50%. In X-building, where segregated inmates are housed, correctional officers do not escort inmates to a clinic area and nurses still perform cell-front assessments. An RN is assigned to perform sick call, but records also show that LPNs also performed sick call. Record review showed that some patients who require a medical diagnosis are assessed only by a nurse and not medically evaluated by a provider and/or do not receive ordered medical treatment.
- At MCC, our review found that some of the problems with sick call described in the previous Court Expert's report have been resolved while other problems persisted. Positively, the rooms used by nursing staff to conduct sick call are uniformly equipped and supplied. Many of the exam rooms have a Plexiglas door which ensures auditory privacy during the sick call encounter. However, we found that LPNs also performed independent assessments, nurses did not have the patient's record when performing patient assessments, assessments were inadequate, and referrals to providers were not timely.

Chronic Care

First Court Expert Findings

The First Court Expert found variable provider quality with respect to provision of medical care and that there was lack of oversight of the providers. He also found deficiencies in chronic care guidelines and policy. The First Court Expert's Report raised concerns about the organizational approach to the delivery of chronic care in the IDOC; patients were predominantly seen in single disease clinics that arbitrarily dictated that patients were seen only two to three times a year regardless of the their disease control. The First Court Expert found patients with poorly controlled chronic illnesses who went many months without active management of their disease as they awaited the next disease specific clinic that were only scheduled for two-three months out of the year. This process created a fragmented and inefficient system of care for patients with chronic illnesses. The report also found fault with the lack of involvement of the primary care providers with monitoring the condition of patients with human immunodeficiency virus (HIV) between their intermittent telehealth visits with UIC specialists, the failure to define whether diabetic patients had type I or II diabetes, and the failure to synchronize the delivery of insulin with meal times. The First Court Expert found that the IDOC guidelines did not clearly define when Pap smear screening could be discontinued, when mammograms should be performed more frequently, and the need for increased Pap smear screening in women with HIV infection. The First Court Expert also noted that chronic obstructive pulmonary disease (COPD) and asthma were treated identically which is inappropriate. There were no guidelines for treatment of COPD. He noted that they found discontinuity of medication without anyone noticing, compounded by physicians evaluating patients in clinic without having access to the MAR. He also noted that patients frequently missed their HIV medications without any chronic care monitoring.

Current Findings

We found that the IDOC now uses a UIC HIV chronic care guideline. Aside from this there have been no improvements based on the First Court Expert's findings.

The poor training and qualifications of physicians was the most important deficiency that resulted in significant morbidity and mortality with respect to managing chronic illness. The deficiencies of many providers based on record reviews included not understanding how to diagnose or manage certain chronic illnesses, failure to timely or appropriately manage patients whose disease was not well controlled, failure to monitor key tests or other variables with respect to disease management, failure to identify or properly manage red-flag or other critical abnormalities involving chronic illness, failure to consistently document the rationale for clinical decisions and diagnoses in the chronic care patient progress notes, failure to document adequate histories, physical examinations or therapeutic treatment plans, failure to incorporate specialty recommendations with respect to management of chronic illness into a unified therapeutic treatment plan, failure to refer for specialty care when indicated, and failure to monitor medication management in a safe manner. Chronic disease guidelines, chronic disease procedure, schedules, forms, or other processes appear to fail to overcome the deficiencies of provider quality with respect to managing chronic care conditions in the IDOC.

A chronic medical condition is an illness that typically lasts longer than three months and requires medical management on a continuous basis. Typically, a primary care physician will address all of a patient's chronic illnesses at each visit. In IDOC the primary care physician will only manage a single disease at each chronic care visit. Typically, when a primary care physician encounters a condition they are incapable of managing they refer that patient to a specialist who knows how to manage the condition. In IDOC this often does not occur and patients are frequently not referred for specialty care when it appears indicated. Typically, when a specialist evaluates a patient, a primary care doctor will integrate the specialist's recommendations and findings into the care plan of the patient. In IDOC, the primary care doctors often do not even obtain specialty care reports and do not appear to consistently review or integrate specialty findings or recommendations into the patient's therapeutic plan. In IDOC, primary care physicians are poorly trained and do not appear to know how to diagnose or manage many chronic illnesses. Many illnesses appear to not be followed in chronic clinics and some conditions are not managed. The result is fragmented care that fails to address all of a patient's problems.

Four years ago, the First Court Expert found that most of the IDOC chronic care clinics addressed only a single disease and were conducted every four to six months. We found chronic care clinic schedules were unchanged. With the exception of a few multiple illness clinics (MIC) for a select group of conditions at Dixon and MCC, patients with multiple chronic illnesses continue to have their illnesses addressed in single disease clinics spread over the course of a year. The non-baseline chronic care clinics (asthma, cardiac/hypertension, diabetes, hepatitis C, high risk/HIV, seizure) are silos in which only a single disease is managed. The schedule for these clinics is inflexible and not based on the degree of control of a patient's illness.⁹⁰

Failure to manage patients based on the degree of control of their illness has the potential to harm patients, as patients are evaluated on a fixed schedule irrespective of the degree of control of their illness. Therefore, persons who need greater attention because their disease is poorly controlled may not receive it. We view this as inefficient, wasteful, and potentially harmful. Patients should be evaluated as frequently as is necessary to establish disease control and not based on an inflexible schedule. Primary care doctors also need to coordinate care for the patient integrating treatment for all of the patient's conditions. When specialists manage a single illness, they typically list all of the patient's other medical conditions and medications, and consider the implication of all diseases on the condition being monitored. In the IDOC, every single disease is managed as if it is the only disease the patient has. Diseases are often interrelated, such as metabolic syndrome. Drug-drug interactions need to be considered in the

⁹⁰ IDOC's chronic care clinic annual schedule is generally, with some site variation, as follows: asthma (January and July,) diabetes (April, August, and December), cardiac/hypertension (A-L March and September; M-Z April and October), general medicine (May and November), hepatitis C (June and December), high risk/HIV (monthly), seizure (February and August), and TB (monthly, annual evaluation). LCC has combined two conditions, diabetes/lipids and diabetes/hypertension, for simultaneous evaluation in the initial baseline clinic but not in the follow-up chronic care clinic sessions. Dixon and Menard have created a limited number of multiple illness clinics that combine the treatment of diabetics with a few other chronic illnesses.

management of medications. Some illnesses have an effect on other illnesses. When IDOC providers evaluate patients in individual chronic care clinics, they do not list the patient's other illnesses and do not address any other conditions, even when a condition may not be in control or may have an impact on the condition being treated. There has been limited movement since the First Court Expert's Report to develop chronic care clinics that consolidate the evaluation of multiple illnesses in a single visit. Dixon and MCC have established a few combined illness clinics called MIC (multiple illness clinics); these clinics generally address diabetes and one or two other chronic illnesses. There was no evidence or communication during the site visits that combined illness clinics would continue to expand at Dixon or MCC or would be initiated at any other sites.

A single chronic disease clinic (General Medicine Clinic) is used as a vehicle to manage all diseases other than disease specific chronic illness clinics. But we found that there are many diseases that are not managed in IDOC chronic clinics and therefore are unmonitored. This included patients with cirrhosis, cancer, heart failure, substance abuse, and rheumatoid arthritis as examples. This is consistent with deficient problem lists. We found that problem lists were incomplete indicating that providers were unaware of all of the patient's problems. When patients were seen in either chronic clinics, routine provider clinics, or on an emergency basis, a complete list of problems was not documented and at no clinics did all of a patient's diseases receive monitoring.

Also, some diseases are monitored in a clinic that is inappropriate for their condition. As an example, COPD is a common respiratory condition affecting about five percent of the population and is the third-ranked cause of death in the United States.⁹¹ IDOC treats COPD in the asthma clinic and utilizes identical forms and nomenclature for control and management as if COPD were the same disease as asthma. They are not the same disease even though there can be an overlap syndrome. Diagnosis, staging, and management of these two conditions are different. Yet in IDOC they appear to be treated the same. The First Court Expert commented on this but there has been no modification to guidelines, forms, or management practices based on our findings.

Some illnesses are managed in specialty clinics. All individuals with HIV and eligible patients cleared for treatment with hepatitis C are managed via telehealth by the UIC infectious disease telehealth clinic. UIC HIV telehealth clinics are held monthly. A monthly telehealth renal clinic staffed by a consulting nephrologist is scheduled as needed. Dialysis patients are seen monthly by a NaphCare nephrologist even though the nephrologist does not document his notes in the medical record. Hepatitis C is managed in the hepatitis C chronic clinic. When IDOC physicians deem a patient is a candidate for treatment the patient is referred to a Wexford corporate doctor who makes a decision on referral to UIC. This system has become a barrier to access to care for hepatitis C.

⁹¹ UpToDate, Chronic obstructive pulmonary disease: Definition, clinical manifestations, diagnosis, and staging.

There are currently 2,500 active hepatitis C patients in the IDOC. Even though effective, short-course regimens of medications that result in a high percentage of cures have been developed and are in common use in the community, only 345 patients (3%) of the nearly 10,500 hepatitis C patients incarcerated in the IDOC between 2010 and 2016 were offered and received treatment.⁹² An additional 125 patients have completed treatment from 2017 through June 2018.⁹³ At the present time, only 10 hepatitis C patients are currently receiving treatment. The low rates of treatment are primarily due to a restrictive screening protocol that limits patients' eligibility for treatment which was developed, in no small part, to control the costs of the medications. These eligibility restrictions limit hepatitis C treatment to patients who have developed advanced stages of liver fibrosis (cirrhosis). The failure to aggressively treat hepatitis C in the IDOC has negative public health and health care cost impacts, both in the IDOC and ultimately in the non-incarcerated communities of the Illinois. We support more aggressive treatment of hepatitis C and elimination of barriers to access to the UIC program.

Patients with uncontrolled or partially controlled chronic illnesses were not consistently well managed. When medications for chronic conditions were modified in chronic care clinics there was no follow up on the impact of this treatment adjustment until the next chronic care clinic which could be four to six months later. We noted some patients who were not followed up appropriately after a modification in the treatment plan.⁹⁴ Some patients whose chronic illnesses were complicated and difficult to control were not appropriately or timely referred to medical specialists for consultation.⁹⁵ The care of many diabetics was found to be flawed and put patients at risk for hypo and hyperglycemia, and ultimately for end organ damage.⁹⁶ Patients on Vitamin K antagonist anticoagulation medication (warfarin) were rarely well controlled. The adjustment of anticoagulation medication to attain a therapeutic level of anticoagulation was often not aggressively pursued, leaving the patient at risk for repeated clot formation. The logistics of testing and adjusting warfarin dosages placed a number of patients at risk.⁹⁷ IDOC should consider placing patients requiring long term anticoagulation on direct factor Xa inhibitor anticoagulants that do not require ongoing testing and dose adjustment. The current prescribing of warfarin puts patients and the institution at risk and we noted one death in a patient on warfarin who was not being properly monitored.⁹⁸ Providers virtually never documented in the chronic care progress notes that they had reviewed patients' MARs or communicated with nursing staff to assess the frequency of medication administration and patient compliance.⁹⁹ The failure of the chronic care providers to routinely monitor patient compliance with prescribed medication put the patient at notable risk for overprescribing and needlessly increasing medications dosages. Weights of patients were recorded with vital signs

⁹² Email communication 12/28/2016 from DOC.

⁹³ UIC Liver Telemed Treatment Analytics.

⁹⁴ NRC Chronic Care Patients #1, 2, 10.

⁹⁵ NRC Chronic Care Patient #9; SCC Chronic Care Patients #7, 13; Dixon Chronic Care Patient #14; LCC Chronic Care Patients #4, 6; MCC Chronic Care Patient #2.

⁹⁶ Dixon Chronic Care Patient #13; LCC Chronic Care Patient #6; MCC Chronic Care Patient #9.

⁹⁷ SCC Chronic Care Patient #12; Dixon Chronic Care Patients #7, 10; MCC Chronic Care Patient #11.

⁹⁸ Patient #30 Death Review Records.

⁹⁹ NRC Chronic Care Patient #3; SCC Chronic Care Patients #6, 8; Dixon Chronic Care Patient #6; LCC Chronic Care Patient #10; MCC Chronic Care Patients #2, 8.

at most clinical encounters, but the chronic care providers seldom documented that they had reviewed weights for significant gains or losses. Weight loss in correctional settings is an ominous sign; patients with weight loss need to be aggressively evaluated for an underlying cause, which may include cancer, uncontrolled diabetes, hyperthyroidism, and other etiologies. The failure of chronic care, infirmary, and sick call clinical teams to monitor and address changes in patient weights can result in significant delays in the diagnosis of treatable medical conditions and illness in IDOC patients.¹⁰⁰

The First Court Expert had significant concerns about the care provided to diabetics in the IDOC. The system wide failure of the providers to differentiate treatment differences between type I or type II diabetes and the IDOC universal practice of treating all diabetics on insulin with the same regimen of medications is not consistent with the level of care provided in the community and, in some circumstances, puts the patient at risk for hypoglycemic episodes. Type 1 and type 2 diabetes are different metabolic diseases and require different management. Type 1 diabetes occurs in patients who fail to produce sufficient insulin. These patients have an insulin deficiency. Type 2 diabetes is a metabolic condition of excess weight causing insulin resistance. The body fails to respond appropriately to insulin causing glucose levels in the blood to increase. The IDOC does not appear to differentiate these conditions with respect to use of insulin therapy. Every patient taking insulin prior to incarceration is automatically placed on a twice daily regimen of an injectable long acting insulin (either NPH or Humulin 70/30 insulin which combines a long and short acting insulin in a single injection) and a sliding scale short acting insulin. The standard of care is not to use pre-mixed insulins (70/30) in the treatment of type 1 diabetes. Use of pre-mixed insulins in type 2 diabetics is also not preferable if normal blood sugars are desired.¹⁰¹ The sliding scale dosage is based on the results of capillary blood glucose (CBG) finger stick testing that is performed before every breakfast and dinner meal on all insulin using diabetics. This practice is inherently flawed.

Most type I diabetics will require three or four, not two, times per day CBG testing to determine the quantity of short acting insulin that is needed to be administered before meals. Most type II diabetics who cannot be adequately controlled on oral medication alone are typically placed a variety of long acting insulins, some of which are given once a day, others twice a day. Although some Type II diabetics will require the addition of pre-meal short acting insulin, most do not. Type II diabetics, even if they are on insulin, generally require intermittent but not twice a day CBG testing. Placing patients on unnecessary pre-meal CBG testing is not without risks. Short acting insulin alone or in combinations should be administered in close timing with meals to minimize the risk of a sudden drop in blood sugar. The timing of insulin administration and meal delivery in IDOC's large correctional facilities is consistently poorly coordinated and puts diabetics on short acting insulin at heightened risk of hypoglycemic attacks. IDOC exacerbates this risk by placing many insulin-using diabetics on 70/30 insulin, which contains a combination that is 70% long acting and 30% short acting. For example, a patient on 40 units of 70/30 insulin will receive 28 units of long acting and 12 units of short acting insulin with each injection.

¹⁰⁰ Dixon Chronic Care Patients #1, 10; Dixon Infirmary Patient #1; LCC Infirmary Patients #1, 4.

¹⁰¹ See UpToDate® section on premixed insulins in General Principles of Insulin Therapy in Diabetes Mellitus.

Adding an additional sliding scale-determined two to eight or more units of rapid acting regular insulin to the patient's dose because the pre-meal CBG is elevated further increases the risk of sudden drops in blood sugar. This practice endangers the health of IDOC diabetics and should be reevaluated. IDOC should consult with an endocrinologist/diabetologist to review its current prescribing of insulin and the frequency of CBG testing.

The experts also noted that there was varying provider compliance with national diabetes standards of care concerning testing of urine protein and microalbuminuria, and the prescribing of medications to diminish the risk or progression of chronic kidney disease; annual eye evaluations for diabetic retinopathy; examination for diabetics' feet to prevent foot ulcers; sensory testing of lower extremities; administration of pneumococcal 23 vaccination; and the appropriate initiation of HMG CoA reductase inhibitors (statin) to minimize a diabetic's risk of cardiovascular disease. The care of diabetes in the IDOC does not consistently meet the standard of care provided to diabetics in the community.

The IDOC annual or biannual examinations fail to provide a number of nationally recommended preventive and screening interventions that are designed to prevent certain chronic illnesses. All patients with chronic illnesses including diabetes, asthma, COPD, chronic kidney disease, congestive heart failure, HIV infection, and other chronic conditions are to be vaccinated with the pneumococcal-23 vaccine.¹⁰² A review of the medical records of 52 patients with chronic illnesses revealed that only eight (15.4%) had received the pneumococcal 23 vaccine. All adults 65 years of age and older are to be administered both the pneumococcal 23 and 13 vaccinations. Only three (14.3%) of 21 patients 65 years of age or older had been administered pneumococcal-23 and not a single one (0%) of these elderly individuals had been offered the pneumococcal 13 vaccine.¹⁰³ All HIV patients are also to receive the pneumococcal 13 and meningococcal disease vaccines. None (0%) of the 12 charts of patients with HIV had documentation that either pneumococcal 13 or meningococcal vaccines had been administered. The IDOC is putting its patients and staff at risk for preventable infections by not providing basic adult immunizations to its at-risk patients. This does not meet the community standard of care. IDOC is administratively negligent by not purchasing either pneumococcal 13 or meningococcal vaccines for use in its correctional facilities.

It is a national recommendation that all adults (men and women) 50 years of age or older are to be screened for colon cancer.¹⁰⁴ The charts of 50 IDOC patients with chronic illnesses who were 50 years of age or older were reviewed; none (0%) of these patients had been electively screened for colon cancer using any of the acceptable screening methodologies (colonoscopy, fecal immunochemical test, stool guaiac cards, flexible sigmoidoscopy with stool guaiac cards). IDOC is grossly negligent in not providing nationally recommended colon cancer screening to the incarcerated men and women 50 years of age or older in their facilities; this is resulting in preventable deaths and avoidable morbidity in the IDOC.

¹⁰² CDC, Recommended Vaccination Schedule Adults 18 Years or Older, United State 2018 and IDOC Office of Health Services, Chronic Illness treatment Guidelines, Diabetes, Asthma March 2016.

¹⁰³ CDC, Recommended Vaccination Schedule Adults 18 Years or Older, United State 2018.

¹⁰⁴United States Preventive Service Task Force, Colorectal Cancer Screening, June 2016.

Women at LCC are generally being appropriately screened for cervical and breast cancer on a regular basis. The medical charts of 14 (93%) of 15 women had received a cervical cancer screening (Pap smear) in the last three years as per IDOC policy. However, the IDOC practice guidelines failed to note that women with HIV are to have annual Pap smears until three consecutive annual negative smears have been documented, and thereafter cervical cancer screening can be performed at three year intervals. One HIV patient was found have only one negative Pap smear and, as of three years later, had not received a repeat test. HIV patients are at high risk for cervical cancer; this woman was not being properly screened for cervical cancer. Four (80%) of five women over 45 years of age had received a mammogram in the last two years in accord with IDOC protocols.

A large number of patients assigned to chronic care clinics are at risk for or already have had a stroke, heart attack, or peripheral vascular disease. National¹⁰⁵ and IDOC standards¹⁰⁶ recommend that all at-risk patients over a certain age and patients with diabetes, high blood pressure, hyperlipidemia, other selective conditions have their 10-year risk of arteriosclerotic cardiovascular (ASCVD) calculated. If their risk is 7.5% or higher or they already had suffered a cerebral-cardiovascular event, they are to be prescribed a high dosage of a high intensity HMG CoA reductase inhibitor (statin) medication. Forty-eight medical records of chronic clinic patients over 50 years of age and others with a history of arteriosclerotic disease, diabetes, hypertension, hyperlipidemia, etc., were reviewed. IDOC providers had not calculated the 10-year ASCVD risk on any of these 48 patients. We assessed the 10-year risk for these 48 patients and noted that 46 of the 48 patients' scores exceeded the percentage that indicated that a high dosage of a high intensity statin be prescribed; only one of those patients whose risk was 7.5% or higher had been prescribed a high intensity statin, but it was not at the recommended level of intensity dosage. IDOC is failing to meet the national and its own standard of care by not calculating at risk patient's ASCVD 10-year risk and not prescribing the appropriate HMG CoA reductase inhibitor (statin) medication to minimize patients' future risk of heart attack, stroke, and peripheral arterial vascular disease.

Chronic care, provider sick call, and infirmary progress notes frequently lacked useful clinical information about the patient's clinical status. Providers rarely listed an alternative diagnosis that was being considered as a reason for a change in the patient's conditions or symptoms. We noted earlier that lack of training affected the ability of IDOC physicians to diagnose and manage chronic illnesses. This is compounded by lack of access to current electronic medical reference services that might assist them with the care of routine and complex patients. IDOC providers failed to consistently or appropriately seek the assistance of specialists in many patients whose complexity warranted additional advice which resulted in delays in diagnosing or initiating appropriate testing and treatment. Providers whose primary care skills are limited

¹⁰⁵ Stone NJ, Robinson JG, Lichtenstein AH, et al; 2013 ACC/AHA Guideline on the Treatment of Blood Cholesterol to Reduce Atherosclerotic Cardiovascular Risk in Adults: A Report of the American College of Cardiology/American Heart Association Task Force on Practice Guidelines; Circulation Nov 2013, 129 S1-S45 as found at <https://www.ahajournals.org/doi/abs/10.1161/01.cir.0000437738.63853.7a>.

¹⁰⁶ Office of Health Services, Chronic Illness Treatment Guidelines, Hyperlipidemia Guidelines March 2016.

would be expected and should be encouraged to more readily request consultation with specialists when they are unsure of a patient's diagnosis or treatment.

Urgent/Emergent Care

The IDOC requires that all facilities be prepared and equipped to respond to medical emergencies in a timely and orderly fashion. This includes the ability to provide first aid and cardiopulmonary resuscitation by trained correctional staff until medical personnel arrive. Emergency response drills are to be conducted on each shift at least semi-annually, one of which must involve multiple casualties.¹⁰⁷ The IDOC-Wexford contract requires the vendor to provide emergency treatment procedures that include the provision of in-service training on first aid and emergency response, policies and procedures for emergency transfer and transport, 24-hour coverage by a physician and psychiatrist, immediate transfer capability, automatic external defibrillators (AED), and emergency response. The vendor is required to report all referrals for emergency services monthly.¹⁰⁸

First Court Expert Findings

Findings of the First Court Expert for this service were that nurses and clinicians failed to identify when patients required emergency room services and/or hospitalization. Other findings were that patients were not assessed by nurses upon return from the emergency department or hospital, and that the record of offsite care was not obtained. Finally, some patients were not appropriately followed up by a primary care clinician. Unscheduled services were not tracked, and performance was not monitored.

The key criteria for the adequacy of unscheduled services defined by the First Court Expert include:

1. A nurse performs an initial assessment of any patient with an urgent or emergent need for health care attention.
2. The nurse contacts the appropriate clinician to discuss the findings and obtain direction for subsequent care.
3. If the patient is sent offsite, they are brought back to the medical unit with a report from the offsite provider, and seen by a nurse.
4. The nurse reviews the recommendations from the offsite provider and obtains orders as necessary. If no report accompanies the patient's return, the nurse contacts the offsite provider to obtain the report and treatment recommendations.
5. The nurse also assesses the patient, including vital signs, and determines if the patient can be discharged to population or, if unstable, the patient is admitted to the infirmary or another location where the patient can be cared for appropriately.
6. The patient is seen by a primary care physician for follow-up within the next few days.
7. A log of all unscheduled services is kept, and used to monitor and improve performance.

¹⁰⁷ IDOC Administrative Directive 04.03.108 Response to Medical Emergencies dated 9/1/2017.

¹⁰⁸ IDOC Wexford Contract 2.2.3.12, 2.2.3.19.1, 2.9.3.2.1.3.

Current Findings

Our findings are unchanged from those of the First Court Expert. Among charts reviewed that were obtained from lists of patients sent to the ED, seen in sick call, chronic care clinics, specialty care, and hospitalizations, we found numerous instances of incomplete nursing assessments and failure to contact a higher-level clinician,¹⁰⁹ patients returning without records from the offsite provider,¹¹⁰ failure to assess patients upon their return from offsite care,¹¹¹ and lack of appropriate follow up by the primary care provider.¹¹² Here are a few recent examples:

- On 1/22/18, a 51-year-old woman with a history of asthma, hypertension, and chronic hepatitis C infection was seen urgently for burning in the center of her chest radiating to her throat, and vomiting.¹¹³ The chest pain protocol instructed the nurse to call the provider urgently for patients with a history of hypertension. The LPN did not refer the patient to a provider, but instead ordered Pepcid. On 2/17/18, an LPN responded to an emergency called on the same woman. The patient was found sitting on the floor stating that she was dizzy. The nurse did not perform any cardiovascular review of systems (e.g., chest pain, SOB). The patient's vital signs were normal. The nurse determined that the patient should rest in her cell and did not contact a provider. Two days later the woman had another episode of chest pain and dizziness. The LPN who saw her urgently performed no cardiovascular review of systems. Vital signs were normal, but the patient's last EKG showed nonspecific T-wave abnormality. The LPN did not contact a provider. On three occasions LPNs responded to this patient's complaints of chest pain and never contacted a provider. The independent decisions made by the LPNs in this case are well beyond their scope of practice. The use of unqualified personnel, failure to conform to written direction and the failure to consult a higher-level clinician placed this woman at risk of harm from a cardiovascular emergency that could be avoided with appropriate and responsive clinical care.
- A nurse saw a patient on 4/16/2018 for a boil on his buttocks that had been present for one and a half weeks. The nursing assessment was incomplete. The nurse referred the patient to see the provider the next day. However, he was not seen for five days, at which point an antibiotic was ordered. No labs or wound care was ordered. The provider did order a follow-up appointment in four to five days. The patient was not seen for eight days and at this encounter was sent to the ED because he was having lower abdominal pain. There is an outbound note, but it contains minimal information. Upon his return, the inbound note documents the medications and dressing change recommendations that were on the patient discharge summary from the ED visit. He did not see a provider for another two days. The nursing assessment of this patient's

¹⁰⁹ Dixon Urgent/Emergent Patients #1-3; MCC Urgent/Emergent Patient #1; Sick Call Patients #1-2; Specialty Consultations and Hospitalization Patient #6.

¹¹⁰ SCC Urgent/Emergent Patient #1; DCC Urgent/Emergent Patient #2; MCC Urgent/Emergent Patient #1; Specialty Consultations and Hospitalization Patients #6-9.

¹¹¹ SCC Urgent/Emergent Patients #1-3; DCC Urgent/Emergent Patients #2-3.

¹¹² SCC Urgent/Emergent Patients #1, 3, 5-7; Dixon Urgent/Emergent Patient #2; MCC Urgent/Emergent Patient #1; Sick Call Patient #4; Specialty Consultations and Hospitalization Patients #6-7.

¹¹³ LCC Urgent/Emergent Patient #3.

condition was incomplete, access to definitive care was delayed, and he was treated symptomatically with antibiotics without a thorough evaluation. Documentation of the ED visit was not obtained from the hospital and he was not seen promptly upon his return to the facility. This is a patient whose condition deteriorated because it was not managed in a timely and clinically appropriate manner by nurses and providers.

- A patient with shortness of breath, dehydration, renal failure, and anemia was hospitalized for nearly a month.¹¹⁴ When he returned to the facility on 11/19/17, the nurse who admitted him to the infirmary assessed his condition visually but did not examine him or take vital signs. The nurse also did not review the patient discharge instructions that accompanied him or contact the facility physician for orders. The patient was seen the next day by a physician. While much of the hospital record was available, the physician only listed diagnostic possibilities and was not clear about the plan of care. The treatment plan consisted of monitoring and comfort care only. There is no documentation that the patient was seen by a physician for the next seven days. In the meantime, nurses documented clear signs that the patient's condition was worsening, including bloody stools, diminished lung sounds, pitting edema of the legs, poor oxygenation, and low blood pressure (98/62). When the provider was contacted, the nurses were instructed to continue monitoring the patient and report if his condition worsens.

On 11/27/17 the physician documented in an encounter that the patient needed to be more compliant; the patient was demanding a change in his diet. Vital signs are described as stable; also, that he had better aeration and his lower legs seemed improved. The provider took no steps to definitively treat the patient; instead continued monitoring and comfort care. There is no documentation that the patient agreed to palliative or hospice care. The patient was not seen by a provider the next day, even though he was bleeding from the mouth and had petechia on his trunk and upper extremities. The following day, 11/29/17, the provider saw the patient and mused about whether the dose of anticoagulant medication was correct. Ultimately, he ordered the patient transferred to the local emergency room. There is an outbound note written by a nurse, but it does not contain all the information relevant to the patient's ongoing care and there is no specific statement of the reason higher level care was being sought. The patient was admitted to the hospital from the ED and died 20 days later.

The review of 33 deaths corroborates the findings from the review of records of patients seen for urgent or emergent conditions. Errors made in urgent/emergent services provided to patients who later died included the failure by nurses to refer to a higher-level clinician,¹¹⁵ failure to recognize patient instability and the need for hospitalization,¹¹⁶ patients who were returned to the facility for whom the record of offsite care was never obtained or reviewed,¹¹⁷

¹¹⁴ Dixon Urgent/Emergent Patient #1.

¹¹⁵ See Mortality Review Patients #1, 7, 14, 15, 18, 23, 25 and 30.

¹¹⁶ See Mortality Review Patients #7-9, 13, 17-19, 21-23, 25, 28-29, 32-33.

¹¹⁷ See Mortality Review Patients #6, 9, 17, 21, 28.

and patients who did not receive adequate follow up and implementation of recommendations.¹¹⁸

Emergency equipment and supplies vary greatly from site to site. There are no standardized expectations for the type and amount of emergency response equipment that is to be available at each facility. All facilities had emergency response bags that are taken by responding health care providers to the site of an emergency. At Dixon, the contents and their location in the emergency response bags were standardized and listed on the outside. These bags were sealed with a numbered, breakable seal to signify that the bag was ready to use. This was not the case at any of the other facilities. At MCC, the contents of the bags are standardized but they are not sealed to indicate readiness for use. At SCC and NRC, the contents of the emergency response bags are poorly organized, poorly kept, and unsealed. All facilities except NRC check that the emergency response equipment is available and functional. At NRC, the AED had expired electrodes; at the other facilities, emergency equipment was checked and found functional. Mass disaster bags were available at NRC and MCC, but in both cases were dusty, dirty, and contained outdated supplies. These bags are not checked by health care staff regularly. Facilities also have first aid kits available in the housing units and program areas. We found that these were not always current and stocked.

Facilities varied in compliance with the IDOC requirement for emergency response drills. NRC had not conducted a drill for the eight months prior to our visit in January 2018; all other facilities were doing drills, but not in the frequency required by the AD. Except for Dixon, critiques of these drills were brief, not very thorough, and seldom were areas of needed improvement noted. None of the facilities developed plans for performance improvement in emergency response. Emergency response drills as well as the list of emergency visits are reported to the institution CQI committee, but there is no discussion of the information or evaluation of quality or performance measurement. While we were provided with lists of emergency visits at all facilities except NRC, the tracking tool recommended by the First Court Expert has not been implemented. There is no review of clinical care the patient received prior to unscheduled urgent or emergent health care encounters to determine if it could have been avoided; nor is care provided afterwards reviewed to ensure that a provider reviewed and acted upon recommendations timely.

Specialty Consultations

Methodology: Interview personnel responsible for tracking/approval of specialty services. Review tracking logs. Perform record reviews of persons having specialty care needs.

First Court Expert Findings

The First Court Expert found that every area of the specialty care process showed problems. This included delays in perceiving a need for specialty care; delays in obtaining an appointment; delays in processing approvals; delays in following up on abnormal consultation findings; and

¹¹⁸ See Mortality Review Patients #20-21, 27, 32.

problems with follow up of the consultation by facility staff. The First Court Expert found that the rate of approval by Wexford corporate utilization physicians is variable and dependent on the physician reviewer. He also noted that at Dixon and SCC there were substantial delays in obtaining authorization for offsite specialty care, especially for care obtained at UIC. Consultation reports are often not obtained.

Current Findings

There was no improvement since the First Court Expert's report. Our opinion is that the specialty care process of collegial review is a patient safety hazard and should be abandoned until such time that patient safety is ensured.

Specialty care is needed when a patient requires a special service or consultation that is unavailable at the facility. This is managed by Wexford Health Sources Inc. in a process called collegial review. In this process, whenever a physician or mid-level provider believes that a special service is necessary, the provider refers the patient to the Medical Director of the facility. If the Medical Director believes that the service is necessary, then the patient is referred for collegial review. A significant problem with this aspect of the process is that only 20% of Medical Directors are board certified in primary care and only about half have finished residency training in primary care. Therefore, there are many Medical Directors who have not been trained on when to appropriately refer for consultation. We found this problem repeatedly in record reviews. In our opinion, these deficiencies are due to lack of training or to overly restrictive barriers to specialty care. These episodes of care would not be found on the specialty care tracking log as they were never referred.

The collegial review is a phone conference call attended by a utilization physician in Pittsburgh, the facility Medical Director, and the scheduling clerk from the facility. At these calls, the corporate utilization physician reviews the list of referrals from the facility over the prior week. The utilization physician either approves or denies the referral. If a service is approved, the facility scheduling clerk then schedules the patient for the service. If a service is denied, the utilization physician is to provide an alternate treatment plan for the facility. After the specialty consultation service occurs, a follow up by a facility provider is to occur within five days. This visit is to include evaluation of the consult report and any follow up concerns. Each of these steps (referral, collegial review approval or alternative treatment plan, appointment, and follow up) are to be documented in the medical record. Though it is not a requirement of the administrative directives, each of these steps is tracked in logs maintained by the scheduling clerks.

We listened in on one of these collegial review conference calls and spoke to staff about the calls at other sites. The calls are brief. One scheduling clerk said sometimes the calls are canceled because the utilization physician believes all referrals are appropriate. The same clerk said that typically the calls take 10 minutes. The call we witnessed had no clinical collegial discussion about individual cases but was more of an approval process in which the utilization physician states approval or recommends getting another test before the approval is made.

There is a lack of guidance in policy with respect to specialty care. The IDOC-Wexford contract has no specifications with respect to timeliness of specialty care. There is no administrative directive (AD) on specialty care, including timeliness of care. AD 04.03.103 Offender Health Care Services describes the requirements of obtaining specialty care. With the exception of a requirement that the vendor Utilization Management Unit will review all referrals within five working days, there are no timelines associated with obtaining specialty care. None of the facilities tracked timeliness of specialty consultations. Dixon did perform a one-time study of timeliness of UIC consultations, which showed significant delays.

Medical records we reviewed did not consistently contain documentation of all benchmark events including referral, collegial review, alternate treatment plans, appointment, or follow up, even though documentation in the medical record is either required or implied because these benchmarks are medical events that need to be documented in the medical record. This made verification of specialty care impossible.

Each site had a tracking log detailing the benchmark dates of specialty care. None of the tracking logs was complete and some were inaccurate. Tracking logs were similar but not standardized. These tracking logs were under Wexford management. The purpose of tracking logs is both to manage current referrals to ensure scheduling occurs and to review logs for the purpose of ensuring that all steps of the process are occurring as expected. We noted that tracking logs showed significant errors. At Dixon, 22% of consultations on the tracking log did not have a referral date. At MCC, 44% of referrals in 2017 did not have a referral date documented on the tracking log and only 53% had the date the appointment was completed documented. Because of lack of information on these tracking logs, we found them unreliable. Some were inaccurate. At SCC for a three month period on the log, 7% of collegial reviews were documented as occurring *before* the date of referral, which is not possible. Also, at SCC for a period in January of 2017, 60 consultations were documented as being completed before the referral was made. These impossible scenarios imply that the tracking log is not accurately maintained and make the log unreliable for validation of knowing whether referrals are timely.

The Administrative Directives require that the specialty care benchmarks are to be documented in the medical record. We did not find alternative treatment plans documented in the progress notes of the medical record. These are typically included in utilization doctor's approval sheet in the consultation section of the medical record, but it is never clear how the primary provider incorporates this into actual practice. At NRC, because we were not provided a tracking log, we attempted to verify all specialty care benchmarks in the medical record. Only 14 (63%) of 22 consultations had a referral. Only three (14%) had a collegial review documented. Only nine (41%) had an approval. Only 15 (65%) were seen within five days in follow up of the consultation. As a result, using the medical record, we were unable to verify that benchmarks for specialty care occur as expected.

A major but unmonitored problem with specialty care is underutilization. The First Court Expert found the same problem and described it as delays in perceiving a need for the service. This can occur when physicians are unaware that a specialty procedure or consultation is necessary or

when the utilization process is so restrictive that providers fail to refer because they believe that it will not be approved. We were unable to specifically identify the cause in the IDOC but have definitively identified that it occurs. On the 33 death records reviewed, we noted 95 instances when a procedure should have been requested but was not, and 81 instances where specialty consultations should have been requested but were not. This is a large number of unrecognized specialty care referral in just 33 patients and demonstrates significant underutilization. This does not include need for radiologic studies such as CT scans. We view this deficiency as a result of improperly trained physicians and a learned process of not requesting care. This lack of referral places patients at risk of harm and has caused preventable morbidity and mortality. This is a systemic problem that appears at all facilities we investigated. In multiple cases on record reviews, patients who needed referral were not referred. Some resulted in death. Others resulted in morbidity with delayed diagnosis. These cases are found in record reviews of individual sites and in mortality reviews.

Underutilization is incorporated into IDOC practice. For example, the IDOC has no formal policy on colorectal cancer screening. Community standards are to screen non-high risk patients for colon cancer beginning at age 50 with either highly sensitive fecal occult blood tests, colonoscopy, CT colonography, or flexible sigmoidoscopy. The IDOC does not provide this screening and has no written guideline. AD 04.03.101 Offender Physical Examination requires periodic examinations every five years until age 30, every three years between ages of 30 and 39, and every two years for persons 40 years and older. Policy requires an annual TB skin test and females are screened with Papanicolaou (PAP) test and a screening mammogram at appropriate ages. There are no other recommendations for screening tests, which is not consistent with current standards.¹¹⁹ Current IDOC practice for colorectal cancer screening, not clarified in policy, is to perform digital rectal examination at the annual or biannual examinations with fecal occult blood testing. Digital rectal examination with or without single office-based guaiac fecal occult blood testing is not adequate screening for colorectal cancer and is not recommended. At Danville, a patient who was only offered digital rectal examinations for colorectal cancer screening died from complications of advanced colorectal cancer.¹²⁰ We viewed this death as preventable. Another 56-year-old man who developed locally invasive rectal cancer described below is another example.

Current standard of care for all persons with COPD and asthma is to have spirometry or full pulmonary functions tests. Asthma and COPD are different diseases which have different monitoring objectives. Yet in IDOC they are treated the same, resulting in inappropriate care. Almost no patients we reviewed with either COPD or asthma have evidence of referral for spirometry or pulmonary function testing. This is inadequate management and inconsistent with contemporary standards of care.

¹¹⁹ Routine screening recommendations are provided by the US Preventive Services Task Force as found at <https://www.uspreventiveservicestaskforce.org/Page/Name/recommendations>.

¹²⁰ Mortality Review Patient #1.

It is recommended that persons with cirrhosis have screening upper endoscopy to evaluate for varices; treatment with beta-blocker medication if varices are identified; and referred for screening ultrasound every six months to screen for hepatocellular carcinoma. These screening tests are only occasionally completed in IDOC and this practice is not codified in policy or in clinical guidelines. It appears that many facility physicians do not understand how to care for persons with cirrhosis and do not order these tests when indicated.

We also noted that a significant number of consultations occur without evidence of a report.¹²¹ The IDOC refers patients to consultants and to hospitals, but when those consultations and hospitalizations are completed, the IDOC does not obtain a report of the consultation or hospitalization in a significant number of these referrals. This is a patient safety risk. When a report is not present, the providers will be unaware of other recommended testing or consultations, and will be unaware of the consultant or hospital findings that have a significant impact on therapeutic plans.

Even when consultation and hospital reports are obtained, they are not always reviewed. An example was at NRC. We reviewed 22 consultations; only eight consultation reports were present. On these eight reports there were 19 recommendations of consultants which were not carried out. This may have been due to the extremely dysfunctional medical record system at NRC.

At NRC, only eight (36%) of 22 specialty consultations included a report. At SCC, only 19 (35%) of 35 consultations included a report in the medical record. At LCC, five (63%) of eight consultations included a report. At MCC, the scheduling clerk told us that approximately 50% of consultations will not have a report. When reports are not present, the providers will not know the status of the patient and may fail to understand recommendations, placing the patient at risk of harm. A referral sheet is sent with patients on all offsite referrals. Consultants usually, but not always, will write brief comments on these forms to communicate key items to the primary doctor. However, this is an unreliable system and is incomplete, as it does not give the full consultant report.

The contract between Wexford and the IDOC requires that the vendor is to meet with hospital and other providers to coordinate referral of inmates, including the reporting of test results and medical records.¹²² The contract also requires that medical records are to contain hospital discharge summaries and reports of consultations.¹²³ Yet the IDOC has taken a position¹²⁴ that they have no control over consultants or outside hospitals, and therefore obtaining a report is beyond the IDOC's control. They were mainly speaking of hospital emergency room reports. We

¹²¹ As an example, on 33 mortality review records, there were 137 episodes when records were unavailable from offsite specialty care or hospital care. This included both specialty consultation reports and hospital discharge summaries.

¹²² Contract between Wexford Health Sources Inc. and State of Illinois Department of Healthcare & Family Services dated 5/6/11 and found at 2.2.3.11 on page 9.

¹²³ Contract between Wexford Health Sources Inc. and State of Illinois Department of Healthcare & Family Services dated 5/6/11 and found at 2.2.3.13.5 on page 10.

¹²⁴ Letter to First Court Expert regarding Defendants' comments regarding the confidential draft report of the First Court Expert dated 11/3/14 and signed by William Barnes on pages 22-23.

assumed that they hold the same position for consultation reports. They maintain that Wexford has implemented a system which provides the Medical Director with reliable and timely information so that appropriate care is provided. We did not find that this was accurate. There is no evidence in the five day follow up to consultations or in the follow up after hospitalizations that doctors consistently understood what occurred during the offsite event. If they did, they did not document it. At times, doctors would document that there was no report and made no changes to the therapeutic plan because information was still pending. This is a serious problem. In our experience managing contract medical services and a county-managed health program, we have always been able to negotiate with consultants and hospitals timely access to consultant and hospital reports. We view this as a failure of the vendor to perform and should be fixed via the oversight process.

A special situation exists with respect to use of UIC for consultant care. Years ago, UIC agreed to provide IDOC with a certain amount of free care. This amounted to 216 inpatient hospital admissions and 2160 outpatient visits per year. Only four facilities are permitted to participate: SCC, Dixon, Pontiac, and Sheridan. NRC and SCC are considered the same institution. Each facility is permitted to send approximately 520 patients a year for specialty consultations. For a variety of reasons, these specialty consultations are delayed. At Dixon, consultations to UIC average six months to complete and range from 100 days for a cardiology consultation to 239 days for a gastroenterology consultation. These delays have resulted in morbidity and mortality, and place the patients at significant risk of harm. There is no process to assess whether a patient's condition needs earlier attention. Because the cost of UIC is free and the cost of alternate care is borne by Wexford, there is significant incentive to send patients to UIC even if it results in delayed care.

An example of this was at SCC. The patient¹²⁵ was a 56-year-old who complained of blood in his stool on 11/8/16. A fecal occult blood test verified blood in his stool. The patient also had weight loss. The standard of care for a 56-year-old with weight loss and blood in the stool is prompt colonoscopy and possibly additional work up to exclude colon cancer. This man was not referred for colonoscopy; instead, he was referred for a gastroenterology appointment on 1/4/17, about two months later. The gastroenterology appointment did not occur until 7/7/17, about six months after the referral. The gastroenterologist recommended colonoscopy, which did not occur until 11/27/17, when a locally invasive rectal cancer was identified. This delay of over a year resulted in unnecessary spread of the cancer. Physicians were aware of the delay but there was no effort to schedule the patient to a local gastroenterologist for this procedure.

We reviewed aggregate specialty care visits for 2017. They are listed in the table below. Though the populations at SCC and MCC are similar in that they are both maximum security prisons without special medical missions, the referrals numbers and rates are quite different. We question whether the four times higher rate of referral at SCC is related to the free care provided at UIC. Dixon and SCC, which have free care at UIC, had the highest numbers and rates

¹²⁵ SCC Hospitalization Patient #6.

of referral. This implies that other sites may have suppressed referral rates because the cost of care is borne by the vendor.

Site	Population	Referrals ¹²⁶ per year	Referrals per 1000	Denials per year	Denials per 1000	% Denied
NRC	1681	242	144	8	5	3%
SCC	1183	1731	1463	87	74	5%
Dixon	2298	1666	724	109	47	7%
LCC	1806	753	417	71	39	9%
MCC	3029	994	328	237	78	24%

Dr. Meeks testified¹²⁷ that if the site Medical Director or HCUA feel that any request denied is necessary, it can be appealed directly to the Agency Medical Director. Dr. Meeks stated that over an eight-month period he thought he had received about 10-15 appeals on a statewide basis. It is our opinion based on record reviews that there are a substantial number of patients who are not referred for services who need them. We were unable to identify any data to show who appeals utilization decisions to the Agency Medical Director, but based on interviews it appears that the HCUA at the facility is the person who does this. But the HCUA is a nurse who is not trained to determine whether a referral is necessary. This manner of oversight is therefore flawed and will not adequately protect patient safety because this should be done by a physician, and needs to include review of care so that persons who never get referred but should be referred are identified.

Based on multiple record reviews, including mortality reviews, we have identified considerable morbidity and mortality associated with untimely or lack of referral for higher level of care. In review of 33 deaths, we found 93 episodes of care when a patient should have been referred to a hospital. Many of these delayed or failed hospital admissions contributed to patient death. While we believe that this occurs as a result of poorly qualified physicians, the utilization process appears to be a significant barrier to access to timely specialty and higher level of care. The defects in this cost containment mechanism effectively result in denial of necessary medical services that harm inmates. For that reason, we make a strong recommendation to abandon the collegial review process until patient safety can be ensured.

IDOC providers should be strongly encouraged to request specialty consultation when patients' clinical conditions are complicated, exceed the skills and training of the providers, or are not responding the initial treatment regimens. It would be in the best interest of the patient and the IDOC if there was a system wide specialty consultation plan that included contracts with specialty providers for face-to-face, telehealth, and e-consult consultation. IDOC should expand and build on the current telehealth program that provides ready access to HIV, hepatitis C, and renal consultation. The present relationship with the University of Illinois Chicago could be used

¹²⁶ Referral and denials were taken from the latest year's annual CQI reports provided to us by the IDOC.

¹²⁷ Page 23 30(b)(6) deposition of Dr. Meeks on July 25, 2017.

as a template to expand the number and type of specialty consultations that are readily available to IDOC providers.

Infirmary Care

First Court Expert Findings

The First Court Expert noted in the final report that there were deficiencies in infirmary policies, practices, and physical plants. The expert stated that IDOC policies failed to provide a detailed description of the scope of services that could be safely provided in the infirmary setting and did not provide guidelines that would assist the clinical staff in determining which patients should be referred to the hospital and not be admitted to the infirmary. The report criticized the 23-hour observation policy that allowed nurses to directly admit patients to the infirmary for short term observation without contacting the provider or to discharge patients without arranging for post-observation follow-up. They report that Dixon did not have 24 hour/7 days per week registered nurse presence in the infirmary, and that there was no or only partial nurse call systems in five facilities. It was also noted that in some infirmaries, bedding linens were of poor quality and in short supply.

Current Findings

All five of the correctional centers inspected had infirmaries including NRC, SCC, Dixon, LCC, and MCC. The NRC infirmary was opened in 2016, two years after the First Court Expert's site visit.

The physical plants of the infirmaries were described in the section on Clinical Space and Equipment, which noted serious problems with the level of cleanliness, lack of adjustable hospital beds, torn mattresses, non-functioning negative pressure units in isolation rooms, the absence or incomplete distribution of nurse call devices, and unsafe shower rooms in many of the infirmaries.

There was overall compliance with timeliness of nursing admission notes, which were consistently written at the time of admission, and the frequency of nursing progress notes. Nursing progress notes were consistently entered no less than daily even when the policy required only weekly notes. There was varying compliance with the timeliness of provider admission notes, which were to be written within 48 hours of admission.¹²⁸ A number of provider admission notes were not entered in accord with this standard.¹²⁹ As also directed by the Offender Infirmatory Services directive (see reference above), provider progress notes were to be written three times a week for "acute" admissions and weekly for "chronic" admissions. There was inconsistent compliance with this directive in the IDOC infirmaries.¹³⁰

The Offender Infirmatory Services Administrative Directive dated 9/1/2002 states that "the scope of infirmary services available on site shall be based upon the nature of offender population

¹²⁸ Offender Infirmatory Services 04.03.120.

¹²⁹ NRC Infirmatory Patients #1, 3, 4; Dixon Infirmatory Patient #1.

¹³⁰ NRC Infirmatory Patients #3, 4; Dixon Infirmatory Patients #3, 5; MCC Infirmatory Patient #2.

and the prevalence of disease entities or disabilities that might benefit from infirmatory services within the facility's population."¹³¹ It has not been modified since the First Court Expert's visit. There are still no written policies that provide guidance to the IDOC clinical staff on which conditions or level of instability exceed the capabilities of the infirmaries and should be promptly referred to a hospital. Moreover, based on record reviews, the current complement of Wexford physicians does not appear to appreciate when patients are unstable and require hospitalization. This places patients at significant risk of harm. The lack of a clear scope of service contributed to admission of patients to the infirmaries whose presenting or ongoing conditions warranted referral to a higher level of care, whether to a hospital or a skilled nursing facility. Many of these failures to refer to a higher level of care resulted in death.¹³² Two examples of failure to refer to higher level of care based on infirmatory record review during facility visits included the following.

A patient with recent assaultive head trauma and an episode of falling out of his bed presented with fluctuating altered mental status, disorientation, and confusion, and was admitted to the NRC infirmory.¹³³ The provider's admission note did not document a neurological exam, the bruises on the patient's head, the recent head trauma, and the past history of a cerebroventricle-peritoneal shunt. This patient's condition warranted direct referral to a hospital emergency room for brain imaging study (CT scan) and neurology evaluation to rule out an intracranial hemorrhage or increased intracranial pressure. This patient's clinical condition exceeded the capabilities of the infirmory and he should have been hospitalized. The care of this patient was negligent and did not reflect the standard of care in the community.

Another patient with a chronic draining leg ulcer was not able to be properly diagnosed and treated in the infirmory.¹³⁴ The indicated preliminary diagnostic testing and specialty consultation were not initiated. When the patient did not improve with the initial antibiotic regimen, she should have been hospitalized to have additional definitive diagnostic testing and the timely initiation of the proper intensive antibiotic treatment. Her complex non-healing leg ulcer, which most likely was due to chronic osteomyelitis, exceeded the scope of service that could be adequately diagnosed and managed in the IDOC infirmory setting.

At the time of the Experts' site visits, a high percentage of the patients in the infirmaries were physically and/or mentally impaired patients with dementia, traumatic brain injuries, advanced cardiovascular disease, and cerebrovascular disease. Many were incontinent of bladder and bowel and needed partial or full assistance with activities of daily living (ADLs), including toiletry, feeding, bathing, dressing, and transfers in and out of beds and chairs. This was especially true of the Dixon facility which includes a special mission of housing geriatric patients. Nine (50%) of the 18 patients in the Dixon infirmory were judged by the infirmory nursing staff as needing full or partial assistance with ADLs and would be better served in a

¹³¹ Offender Infirmory Services, Administrative Directive 04.03.120.

¹³² We noted in 33 mortality reviews that there were 93 episodes in 33 patients when the patient should have been referred to a higher level of care but was not. Many of these resulted in death.

¹³³ NRC Infirmory Patient #3.

¹³⁴ LCC Infirmory Patient #5.

skilled nursing facility.¹³⁵ Health care administrators, nursing leadership, and correctional staff leadership in a number of the facilities communicated their concerns about the increasing number of elderly mentally and physically disabled individuals in the IDOC and their concerns about the infirmaries' capability of caring for this complicated patient population. It was apparent that the IDOC is aware of the need for additional skilled nursing care facilities and geriatric care housing but has not taken action to address this problem.¹³⁶ In our opinion, the Dixon facility is inadequate as the principal housing placement for the geriatric and disabled population. There has been no evaluation to assess the number of persons needing geriatric care or skilled nursing placement within the IDOC and no apparent effort to correct existing inadequate housing for these individuals.

One example at NRC included a patient with diabetes, lymphoma on chemotherapy, deep vein thrombosis with an inferior vena cava filter, urinary incontinence, decubitus ulcer, and a hospitalization in 2017 for altered mental status, repeated falls, and cranial burr hole procedures who spent most of his day in bed.¹³⁷ He needed assistance with ADLs including straight catheterization to empty his bladder. He could not walk without assistance. He had a decubitus ulcer that appears to have developed while in the infirmary. His constant needs exceeded the capabilities of the NRC infirmary; he would be more appropriately housed in a skilled nursing facility.

An elderly, incontinent patient at SCC with dementia was noted having his diaper changed.¹³⁸ The staff stated that he required total care and constant observation. Later in the day, the patient was observed to be unattended and precariously laying half off the bed at significant risk for fall.

One long term patient in the Dixon infirmary with advanced dementia had developed contractures of his upper and lower extremities and deep, infected decubitus ulcers.¹³⁹ He required total care including gastric tube feeding, diapers, bathing, and dressing. The extreme contractures and recurrent pressure sores developed while he was in the infirmary. The manifestation of these findings indicated that the Dixon infirmary was incapable of providing the level of care that would be expected in a skilled nursing facility. Once the patient started to develop contractures, he should have been transferred to a skilled nursing facility in the community. These and other mentally and physically impaired patients have clinical and nursing care needs that cannot be adequately met in IDOC infirmaries. IDOC must either internally develop a certifiable skilled nursing facility that is properly designed, staffed, and equipped or transfer high risk chronic care patients to certified skilled nursing facilities in the community.

With the exception of LCC, the provider infirmary admission notes contained very limited history of the reason for admission, the diagnosis, any differential diagnoses, and only brief

¹³⁵ Verbal communication with Dixon infirmary nurse.

¹³⁶ Deposition of Kim Hugo, April 11, 2018 pp. 69-70.

¹³⁷ NRC Infirmary Patient #2.

¹³⁸ SCC Infirmary Patient was observed during rounds. His chart was not reviewed.

¹³⁹ Dixon Infirmary Patient #3.

diagnostic and treatment plans. With the exception of the infirmary at LCC which has an electronic medical record, the provider progress notes were commonly illegible. Provider progress notes commonly offered limited if any clinical information, did not include justification for modifications in treatment plan or medications, and were exceedingly brief with little clinical information. The assessment and plan in provider progress notes often repeatedly contained little more than phrases such as stable, no change in condition, or continue present management.¹⁴⁰ Other than limited notes about the illness that prompted the infirmary admission, there was virtually no documentation or clinical updates about any of the patients' other chronic illnesses including diabetes, hypertension, congestive heart failure, chronic kidney disease, etc. The provider progress notes during one SCC infirmary patient's seven month admission never commented, even once, on the status or control of his seizure disorder.¹⁴¹ It was extremely difficult for Experts and other providers to understand the course of the patient's condition and the rationale for any of the modifications in treatment. A provider recently assigned to the SCC infirmary stated that the notes of the previous infirmary provider were incomprehensible and made it extremely difficult for him to comprehend the status of the patient and the treatment plan.¹⁴² The lack of informative, comprehensive provider notes that legibly addressed both the acute and chronic needs and illnesses of each infirmary patient put the health and safety of infirmary patients at risk. The illegibility of the provider and some of the nursing notes provides strong justification for implementation of an electronic medical record in all IDOC facilities.

Some infirmary problem lists were missing, had erroneous entries, or failed to include key chronic illnesses.¹⁴³ Absent, inaccurate, or incomplete problems created a potential risk to the comprehensiveness and continuity of the care delivered to a patient housed in IDOC infirmaries.

The care provided to a number of infirmary patients, as identified during site visits, was found to be suboptimal and of poor quality. When the admitting diagnosis was not clear or the patient was not responding to the initial treatment, the providers failed to consider reasonable alternative diagnoses and order additional diagnostic tests to investigate the initial or other diagnoses. Patients were prescribed confusing regimens of antibiotics and other anti-infection agents. Chronic conditions were not aggressively managed, resulting in delays in attaining reasonable levels of control. This lack of clinical adequacy put the health of patients at risk. Examples of patients whose infirmary care was suboptimal are provided below.

¹⁴⁰ In Mortality Review Patient #9, over six months a doctor wrote an identical note 19 times despite fluctuating clinical condition of the patient. The note consisted of the sentence, "no specific complaint, no change, dementia, continue same care." After the patient had a cardiopulmonary event undocumented by the provider and colon cancer the provider over the course of approximately a year wrote the identical note repeatedly, "no specific complaint, no change, post colectomy for metastatic ca [cancer], continue same care." This was despite the patient having repeated falls and other clinical events described by nurses.

¹⁴¹ SCC Infirmary Patient #2.

¹⁴² Verbal communication from Dr. Roz Elazegui.

¹⁴³ SCC Infirmary Patients #1, 2, 3; LCC Infirmary Patient #5; MCC Infirmary Patient #1.

- A newly incarcerated diabetic patient entered NRC with a black toe and should have been immediately referred to a hospital emergency room.¹⁴⁴ However, he was placed in the general population and received no follow-up care until two weeks later, when he had to be emergently referred to the hospital. His hospital treatment included IV antibiotics for septicemia and surgical amputation of his infected gangrenous toe. Upon discharge from the hospital he was admitted to the NRC infirmary. After five weeks in the infirmary, the recommended follow-up appointments with vascular surgery and podiatry had not yet been scheduled. The infirmary provider notes were mostly illegible and contained limited clinical information about the post-hospital wound healing. Upon initial entry to NRC, this patient's syphilis test was found to be reactive with a high RPR titer of 1:124 treatment (active syphilis); he was not treated for syphilis prior to his hospitalization and was not identified as having active syphilis until 33 days after his admission to the SCC infirmary. The provider had not reviewed the intake laboratory testing when the patient was admitted to the infirmary. The delay in initiating the treatment of active syphilis was negligent and put the patient at risk for syphilitic complications.
- Another NRC infirmary patient with recent head trauma and a ventriculoperitoneal (VP) shunt that had been previously placed to treat hydrocephalus was admitted to the infirmary with altered mental status, confusion, and disorientation; he also had bruises and a hematoma on his head.¹⁴⁵ This patient should have been directly sent a hospital emergency room but was not. Ten days after admission to the infirmary, the provider had not performed a neurological exam and had not ordered a brain imaging study to rule out cerebral hemorrhage, subdural hematoma, and increased intracranial pressure. The care provided to this patient did not meet the standard of care in the community and was grossly and flagrantly unacceptable.
- Another NRC patient was an insulin using diabetic with a wired jaw on sliding scale insulin and a total liquid diet who had widely fluctuating blood sugars with episodes of marked hypoglycemia after injection of short acting regular insulin.¹⁴⁶ The provider did not comment on the possible impact of the patient's entirely liquid diet, which can result in extreme variations of blood sugar levels. The provider did not comment on whether this patient had type I or II diabetes. The continued use of sliding scale short acting insulin should have been discontinued in this patient. The lack of a clear plan about treating this diabetic who was temporarily unable to eat solid foods put this patient at risk. Consultation with a diabetic specialist was needed but had not been solicited. Treatment was also not ordered to address protein in the urine nor was the pneumococcal vaccine 23 administered; both these interventions are the standard of care for all diabetics. The care provided to this patient was substandard.

¹⁴⁴ NRC Infirmary Patient #1.

¹⁴⁵ NRC Infirmary Patient #2.

¹⁴⁶ NRC Infirmary Patient #4.

- A patient in the SCC infirmary had recurrent deep vein thromboses (DVT) and was prescribed chronic anticoagulation with warfarin.¹⁴⁷ After nine weeks of anticoagulation, the level of anticoagulation (INR testing) were still sub-therapeutic. The infirmary provider failed to more expeditiously increase warfarin dosage to achieve a therapeutic level. This patient was still at risk for a recurrent DVT after nine weeks at SCC. At one point, the UIC providers requested that the warfarin order be stopped and the anticoagulant be switched to injectable low molecular weight heparin in preparation for an upcoming surgical repair of the patient's post-operative abdominal wound. The infirmary provider discontinued the oral anticoagulant but failed to prescribe the injectable anticoagulant, leaving the patient without any blood thinning medication. The lack of aggressive management of his oral anticoagulation medication and the failure to immediately prescribe the temporary injectable anticoagulant put the patient at heightened risk for additional clot formation.
- Another SCC infirmary patient whose diagnoses included cardiovascular disease, diabetes, DVT, and seizure disorder had episodes of black outs and significant drops in blood pressure documented in the nursing notes.¹⁴⁸ The infirmary provider failed to document or address these occurrences of syncope in his progress notes. This patient should have been, but was not, assessed or tested for arrhythmia, atypical seizure, and orthostatic hypotension. The provider progress notes never once commented on the control of patient's seizure disorder. The patient also had a history a massive DVT but he had not been prescribed anticoagulant medication and the provider did not provide any rationale for not treating this potentially life threatening condition. The care provided to this infirmary patient was grossly and flagrantly unacceptable.
- Another SCC infirmary patient had a history of arteriosclerotic heart disease (ASHD), hypertension, and cerebral vascular accident (stroke).¹⁴⁹ For the last seven months he had multiple elevated blood pressure recordings documented in the infirmary record without any change being made in his antihypertension medication regimen. It was not until a new provider was assigned to the infirmary in 2018 and increased the blood pressure medication that the blood pressure finally become controlled. The management of this patient's hypertension was negligent and put the patient at increased risk for another stroke.
- A patient at LCC had repeatedly sought medical attention since late 2016 for abdominal pain, blood in her stool, mucous in her stool, change in her bowel patterns, and progressive weight loss.¹⁵⁰ She was seen repeatedly and had been presumptively started on antibiotics for diverticulitis; the nurses and providers consistently failed to comment on her steady loss of weight which was readily viewable in LCC's electronic medical record. Failing to note that the patient had already lost 29 pounds, one provider wrote

¹⁴⁷ SCC Infirmary Patient #1.

¹⁴⁸ SCC Infirmary Patient #2.

¹⁴⁹ SCC Infirmary Patient #4.

¹⁵⁰ LCC Infirmary Patient #1.

in July 2017 that this patient had no “red flags” for cancer. He was wrong; weight loss is a strong warning sign for cancer. Due to increased abdominal pain and blood in her stool, the patient was admitted to the infirmary in September 2018 and treatment for diverticulitis was continued. It was not until her twelfth day in the infirmary that a provider recognized that the patient had lost another 18 pounds during the infirmary admission and a total of 40 pounds since January 2017. Another 20 days passed before an abdominal CT scan revealed abnormalities consistent with colon cancer with metastases to abdominal lymph nodes and the liver. Biopsy at UIC Springfield verified the diagnosis of colon cancer and on 12/18/17, 73 days after her admission to LCC’s infirmary, the patient had a hemicolectomy with a colostomy performed and she was started on chemotherapy. The pre-infirmary and infirmary care of this patient failed to meet the standards of care in the community. The failure of the providers in the clinics to recognize the patient’s weight loss and symptoms as being suggestive of a malignancy was indifferent and grossly and flagrantly unacceptable. The slow scheduling of diagnostic tests and referrals while the patient was housed in the infirmary was inexcusable; the two and one-half month delay between infirmary admission and surgery potentially decreased the quality and duration of this patient’s life.

Patients admitted to the infirmaries with less complicated conditions (post-op, basic wound care, no assistance with ADL’s, etc.) were more likely to be adequately managed. However, patients with complicated conditions and multiple diagnoses that required close monitoring and diligent provider involvement were frequently noted to have received substandard levels of care. Some of these patients had clinical needs that exceeded the clinical experience and knowledge of the providers. IDOC providers do not have timely, if any, access to nationally respected, comprehensive, current electronic medical references when they need expedited answers to clinical questions. Most importantly, the negative impact of the provider’s knowledge gap would have been lessened if the infirmary providers readily requested specialty consultation concerning diagnostic testing and treatment. There were multiple instances when the infirmary (and sick call and chronic care) providers failed to consult specialists when there were clear indications that clinical advice and assistance was needed. The infirmary providers either lacked the knowledge and competence to recognize that they needed clinical assistance or they were reluctant to seek outside consultation due to institutional culture and practice. The Wexford “collegial” process that required providers to submit justification for offsite specialty consultations and offsite (and some onsite) diagnostic tests only serves an administrative “gate keeper” function and is an unnecessary barrier that delays or prevents the scheduling of needed consultation.

Examples of infirmary patients whose clinical conditions should have generated a request for specialty consultation but for whom the provider failed to submit requests for this clinically warranted specialty assistance follow.

- A insulin requiring diabetic patient in the NRC infirmary with a wired, fractured jaw on a total liquid diet had widely fluctuating blood sugar levels that were not able to be

controlled by the infirmiry provider.¹⁵¹ This is an unusual clinical situation and the advice of an endocrinology specialist was needed but not requested. The infirmiry provider's insulin orders put the patient at significant risk for hypoglycemia.

- Another patient in the SCC infirmiry with severe cardiovascular disease, peripheral artery disease, iliac artery stent, diabetes, seizure disorder, and a history of DVT had, over a seven month duration, episodes of black outs and significant drops in blood pressure recordings.¹⁵² The infirmiry provider ordered no interventions and failed to seek consultation with cardiac and vascular specialists. When a new infirmiry provider was assigned to the infirmiry, the patient was immediately referred to both cardiology and vascular surgery specialty clinics.
- A patient in LCC's infirmiry had multiple chronic conditions including congestive heart failure, atrial fibrillation, and mitral valve replacement.¹⁵³ She developed persistent dark colored, draining, and itching sores. The infirmiry provider's attempts to treat this skin problem were unsuccessful. The provider never considered that one of the patient's medications, known to cause itching and blistering skin lesions, could be the cause of her skin condition. Dermatology consultation should have been requested but was not. Over an eight month period in the infirmiry, the patient's vital signs documented eight episodes of bradycardia (slow heart rates less than 60 beats per minute) that were never addressed in the provider's progress notes. No consideration was given to the decreasing one of the patient's medications that commonly causes bradycardia. The patient's severe chronic cardiac illnesses and her eight documented episodes of bradycardia never resulted in a referral to cardiology specialists. The patient was urgently hospitalized when her pulse rate increased to 130 beats per minute and her oxygen saturation suddenly dropped. While hospitalized she was found to have sick sinus syndrome, which can cause intermittent bradycardia and tachycardia; a cardiac pacemaker was implanted. This patient's conditions were complicated, yet specialty consultation with cardiology and dermatology were not solicited prior to her emergency hospitalization. Her intermittent episodes of bradycardia went unnoticed by the provider; it appears that the provider was not reviewing the vital signs that were frequently recorded by the nursing staff. The care provided to this patient was negligent. The failure to adequately monitor this patient and to seek timely specialty consultation for complex dermatological and cardiac conditions did not meet the standard of care in the community.
- Another patient in the LCC infirmiry with blackened toes due to frost bite was treated with an array of antibiotics but was not immediately referred to a podiatrist as is the standard of care in the community.¹⁵⁴ Only after two months in the infirmiry, when her right large toe became gangrenous was she referred to a podiatrist. The podiatrist

¹⁵¹ NRC Infirmiry Patient #4.

¹⁵² SCC Infirmiry Patient #2.

¹⁵³ LCC Infirmiry Patient #2.

¹⁵⁴ LCC Infirmiry Patient #3.

arranged for the toe to be surgically amputated. Immediate referral for podiatric consultation when the patient was admitted to the infirmary could potentially have prevented the need for the amputation.

- Another patient in the LCC infirmary had a history of recurrent DVT with pulmonary emboli and a chronic draining lower extremity leg ulcer.¹⁵⁵ During her infirmary stay, the patient was treated with five different antibiotics in six different, confusing combinations. The working diagnosis appears to have been osteomyelitis but this was never noted in the provider's treatment plan. The provision of multiple antibiotics in varying combinations without a definite diagnosis was not in accord with national standards of care and put the patient at risk for drug resistance and severe gastrointestinal complications. A definite workup for osteomyelitis, including bone probing, bone biopsy, and specialized bone scans, was never ordered. Infectious disease, orthopedic, and possibly dermatology consultation to clarify the diagnosis was needed but was not requested. The provider's extremely belated requests for infectious disease consultation for assistance with the choice of antibiotics, not to establish a diagnosis, was inappropriately denied by Wexford's collegial referral process. If even the appropriate preliminary diagnostic tests and consultations had been performed at the infirmary, this patient should have been hospitalized for definite diagnostic tests and intensive treatment. The failure to solicit specialty consultation during this patient's six month stay in the LCC infirmary without resolution of her draining leg ulcer and the inexplicable combinations of antibiotics and antifungal agents reflected poor understanding of this patient's possible diagnoses, and was incompetent.

Pharmacy and Medication Administration

Prescription medication is a common form of medical treatment today. In the general community, 37% of adults aged 18-44 took a prescription drug in the last 30 days, 70% of adults aged 45-64 took a prescription drug in the last 30 days, and 91% of those aged 65 and older took a prescription drug in the last 30 days.¹⁵⁶ Persons incarcerated in correctional facilities are well known to have a greater disease burden than the general community.¹⁵⁷ A survey done by the Bureau of Justice Statistics of inmates in jails and prisons in 2011-2012 found that 66% of those in prison reported taking prescription medication for a chronic medical condition.¹⁵⁸

¹⁵⁵ LCC Infirmary Patient #5.

¹⁵⁶ National Center for Health Statistics. (2017) Health, United States, 2016 with Chartbook on Long-term Trends in Health. Hyattsville, MD. <https://www.cdc.gov/nchs/fastats/drug-use-therapeutic.htm>.

¹⁵⁷ Nowotny, K., Rogers, R. & Boardman, J. (2017) Racial disparities in health conditions among prisoners compared with the general population. *SSM-Population Health*. 3; 487-496. Elsevier. Macmadu, A. & Rich, J. (2015) Correctional Health is Community Health. *Issues in Science and Technology*. 31 (1). Binswanger, I., Krueger, P., Steiner, J. (2009) Prevalence of chronic conditions among jail and prison inmates in the USA compared with the general population. *Journal of Epidemiology and Community Health*. 63(11):912-919.

¹⁵⁸ Maruschak, L. (2015) Medical Problems of State and Federal Prisoners and Jail Inmates, 2011-2012. Bureau of Justice Statistics available at <https://www.bjs.gov/index.cfm?ty=pbdetail&iid=5219>.

The use of prescription medication in health care is governed by both state and federal regulations designed to provide protection for the patient, treating clinicians, and the general community. The safety of medications in the delivery of patient care has been a major area of emphasis since the 1990's, when the Institute of Medicine reported that medication errors were a significant contributor to morbidity and mortality.¹⁵⁹ Since then, numerous organizations, including the federal government and accreditation organizations, have studied the problem of medication safety and put forth guidelines that improve patient safety. These include computerized provider order entry, medication reconciliation, use of clinical pharmacists, patient-specific unit dose packaging, adherence to the "five-rights" of medication safety, bar code medication administration, and minimization of interruptions during all aspects of medication preparation and delivery.¹⁶⁰ The methods to deliver medication in correctional facilities are expected to be like those evident in the general community, including implementing changes to improve safety.

Availability and access to medications involves the cooperation of custody and other programs. Correctional officer support is essential to complete medication administration efficiently and safely. This includes providing escort, controlling movement, reducing distractions (e.g., television, noise levels, fights, etc.), accounting for missing inmates, and ensuring that inmates ingest medication that has been administered. Custody officer support needs to be guided by custody post orders or Administrative Directives that give standardized guidance to custody staff on how they are to cooperate with nurses when they administer medication. When this does not occur, nurses must individually negotiate with officers, resulting in varying levels of cooperation when nurses attempt to administer medication. This reduces standardization of practice, causes inefficiency and delay, and as a result increases risk of medication errors.

Medications may be only needed once a day, but a few medications may require as many as four to six doses in a 24-hour period. Correctional facilities may reduce some of the burden of medication administration by allowing inmates to keep and take their own medications as needed, but this is usually limited to groups of medications not likely to be misused and to inmates who are capable of self-administration. When inmates are unable or not allowed to take medication on their own, a nurse must administer each dose. There are also some patients who need closer monitoring of their clinical condition, such as when medications are first initiated, the patient is experiencing side effects, or the when the patient's condition is not improving. These patients should be scheduled for nurse administered medication.

Patient adherence with medication treatment is essential in achieving desired clinical outcomes. When patients do not receive medication as ordered, treatment is compromised. There are many reasons a patient in a correctional facility does not receive medications as prescribed. These can include the medication has not yet been received from the pharmacy, the nurse did not see that the medication was ready and available to administer, the officer

¹⁵⁹ Institute of Medicine. (1999) *To err is human: building a safer health system*. Washington DC: National Academy Press.

¹⁶⁰ Patient Safety Primer (2017) *Medication Errors* available at <https://psnet.ahrq.gov/primers/primer/23>. Agency for Healthcare Research and Quality, U.S. Department of Health and Human Services.

may not have released the inmate from his cell to obtain the medication, the inmate may be elsewhere (at court, in the visiting room, with an attorney, attending a program, working etc.), the inmate may have been transferred to another housing location or institution, or the inmate may not want to take the medication. Each of these reasons requires a different action by the nurse to ensure that the patient receives ordered treatment. For example, inmates may refuse medication, but if so, the nurse needs to refer the patient to a provider to discuss a change in the plan of care. If the inmate has been transferred, the nurse needs to locate the inmate and transfer his medication, or notify the new location that the inmate needs to receive medication, and so forth. Whenever an inmate is not present or refuses a prescribed dose of medication, the nurse must investigate further to determine what steps must be taken to continue the inmate's care. Each of these missed medications and the reason must also be documented on the MAR.

Nurses and correctional officers must work collaboratively to ensure that patients ingest medications, as medications that are diverted in the correctional setting become contraband and are a challenge to safety and security of operations. Correctional officers are responsible for preventing and eliminating contraband. A single pill or capsule is considered contraband when it is not being administered by a nurse or taken by an inmate as a keep on person (KOP) medication. It is important that policies and procedures clearly identify when it is not acceptable for medication to be in the possession of an inmate and that correctional staff are vigilant in monitoring for the presence of contraband and the potential for misuse or drug overdose.

First Court Expert Findings

The First Court Expert found no problems with the system to provide pharmacy/medication administration services. The Expert found discontinuity in medication treatment for individuals with chronic disease, which was unrecognized and not addressed by treating clinicians. This was because the MAR was not filed timely in the medical file and nurses did not notify providers when an inmate missed taking medication. The Expert also found at NRC that medication administration was significantly delayed because an officer was not assigned to escort the nurse, per policy.

Current Findings

We agree with the First Court Expert's findings. We have additional findings that evidenced a far worse situation from the First Court Expert's report. We found systemic medication administration practices that are unsafe and not consistent with community standards at every facility visited. We also found that some problems with medication are not recognized and those that are recognized are not addressed. The failure to rigorously monitor and address problems with medication treatment is a systemic issue that results in medication errors, resulting in adverse patient events and creating an ongoing risk of harm to patients.

Pharmacy Services

Most pharmaceuticals are provided by BosWell Pharmacy Services, an institutional pharmacy located in Pennsylvania. Orders are either faxed, or in the case of LCC, entered by computer.

Each order is verified by a pharmacist, the prescription filled, and the medication shipped to the institution, arriving the next day. Staff assigned to work in the medication storeroom at the institution track each medication that has been ordered, reconcile its receipt, and put it into the area used by nurses to prepare medication for administration. UIC provides medications to treat inmates with HIV and HCV via an interagency agreement. Each institution also has a “back-up” pharmacy in the local community which can fill prescriptions needed more urgently than can be delivered by BosWell. We did not find any significant issues with the availability or timeliness of prescribed medication supplied by either BosWell or UIC.

A consulting pharmacist visits each site regularly at least once a quarter to inspect the medication area and audit charts. The results of these reviews are included in the institution CQI meetings. We identified concerns when we inspected medication rooms. There was no schedule of sanitation and disinfection activities for the medication areas. At NRC and LCC, medication storage rooms were dirty and disorganized. At Dixon and LCC, we found multiple use containers (e.g., Lidocaine) that were open and not dated. We also found expired medication and testing material at these two facilities.

Policy and Procedure

IDOC provides minimal direction and guidance about how medications are ordered and administered. For example, it states that prescriptions must be signed by a physician or dentist; it does not state the elements of a complete order. Facilities have operational procedures for pharmacy services and medication administration. Procedures we reviewed were several years old and often not signed. While they do provide more specific directions about when and how medication will be accounted for and administered at the facility, they still are too general. For example, the operational procedure at LCC does not state the elements of a complete order. It also does not specify how the nurse administering medication is to identify that it is the correct inmate. Health care staff are therefore left to their own devices and there is no mechanism to insist upon legible, complete orders or instructions about how inmates are to be identified before receiving medication. This leads to variation and unsafe practices as described in the following paragraphs.

An example of how the absence of policy and procedure leads to poor practices is one we observed at MCC. Nurses used a list of inmates who are prescribed controlled substances to select and sign out medication from the cabinet where controlled substances are kept. All the medications were put into a collective cup. Once all the controlled substances were collected, the nurse took the cup to the medication room and, by visual identification only, selected which controlled substances each patient was to receive and put them into the respective patient envelope. Not only was the nurse dispensing; there was no accountability for the proper disposition of each medication and the potential for error magnified by not using the MAR to select medications. In another example, at LCC, unlicensed staff delivered KOP medications to inmates without the MAR present to verify the medication against the physician order and to document that the medication was administered. We found many MARs in which there was no documentation that the patient received ordered medication.

The IDOC has no Administrative Directives or post orders that provide guidance on how officers are to cooperate with nursing staff when nurses administer medication. At NRC, as an example, nurses individually negotiate for this cooperation when they administer medications. This practice at NRC resulted in the poor practices we observed at that facility. There needs to be a standardized procedure for officer cooperation with nurses during medication administration that ensures nurses are able to satisfactorily administer medication in accordance with accepted nursing practice.

Medication Orders

Dispensing and administration of medication must only be done under physician order. Illinois statute¹⁶¹ requires that a physician prescription contain the name of the patient; the date when the prescription was issued; the name and strength of the drug or device prescribed; the quantity; the directions for use; the prescriber's name, address, and signature; and the DEA number for controlled substances. We did not find evidence that the prescription process in IDOC conforms to state regulation. Providers do not always write orders on the order form; we found multiple examples among charts reviewed of orders written on the physical exam form or on the lab results or in the progress notes, but a corresponding order was not written on the physician order form. It is the order form that is used to inform the pharmacy that there is a prescription to be filled, otherwise care is not implemented. Providers write orders that at times were not legible to the experts or the nurses working with the provider who wrote the order. Some orders were incomplete and documentation in the chart did not indicate the reason or intended goal of treatment.

Nurses are responsible for transcribing orders onto the MAR. At all facilities, we found orders which had not been transcribed onto the MAR or that were transcribed late. At NRC, nursing staff give KOP medication to inmates at intake without consistently transcribing the order and documenting administration of medication onto the MAR. Therefore, there was no documentation that the patient received ordered medical care. We also found instances of nurses overwriting new orders over old orders on the MARS at every facility. This is alteration of a legal record and should be ceased immediately. Finally, we observed nursing staff transcribing orders onto the MAR using the label on the blister pack instead of the original order; this is a poor practice because it does not identify dispensing errors.

Medication Administration

At all the facilities we visited, the process for medication administration was fraught with problems. None of the methods used to administer medication at the five facilities we visited ensure that the *five rights* of medication administration are observed. These are the *right patient*, the *right medication*, the *right dose*, the *right route*, and the *right time*. Problems which were universal included:

¹⁶¹ Illinois Compiles Statutes; 225 ILCS 85/3 as found at <http://www.ilga.gov/legislation/ilcs/fulltext.asp?DocName=022500850K3>.

1. Failure to identify that it was the right inmate, using two-part identification (e.g. use of identification badge and verification of date of birth or institution number).
2. Failure to verify that the inmate received the right medication in the right dose at the time of administration.
3. Lack of hand hygiene, cross contamination of the envelopes, and occasionally the pills themselves.
4. Untimely or failure to document medication administration to include the reason why an inmate did not receive a medication that was due.
5. Not observing the inmate to ensure that medication has been ingested.
6. Not accounting for missing inmates or arranging to administer the dose later.
7. Not signing the MARs so that it was possible to identify from the initials who had documented on the MAR.

Most medications are taken orally, in tablet or capsule form. These are packaged in 30-day blister packs that are labeled specifically for each patient. This is patient-specific unit dose packaging. This type of packaging reduces medication errors made by nurses in preparing and administering medication. At every facility we visited, this safety feature is totally abandoned because nurses take the pills out of the pharmacy dispensed package and put them in improperly labeled envelopes, which are repeatedly used, or medicine cups. This practice is known as pre-pouring and is widely recognized as unsafe. Nurses essentially duplicate what has already been done by the pharmacy, introducing the possibility of putting the wrong medication into the wrong patient envelope or another type of error. It also wastes the cost of packaging, which is expensive compared to other forms of stock medication.

We were told that pre-pour is necessary because doing it correctly takes too much time and, in some facilities, the physical plant makes it impossible to use a medication cart. We note that two of three of the IDOC maximum security facilities (MCC and Pontiac Correctional Center) were built in the 19th century, and the remaining maximum security facility (SCC) was built in the early 20th century. These facilities are so old that they are an impediment to appropriate administration of medication. Some areas do not have elevators and nurses are not able to use medication carts when they administer medications in many areas of these facilities. At NRC, inmates are essentially locked down 24 hours a day (except four hours per week), resulting in nurses delivering all medications cell to cell. Physical plant and operational practices are common reasons given for reluctance to adopt safer practices that meet nursing practice standards. However, IDOC is not so unique that these problems have never been experienced elsewhere and not been resolved. Other correctional systems have implemented patient specific unit dose systems and were able to address these types of problems in the process.

Because of these conditions, nurses make an accommodation to custody in using medication administration procedures (e.g., pre-pouring, not opening doors to properly identify inmates, and not having the MAR with them when they administer medication) that are not in keeping with current standards of nursing practice. Instead, custody should develop with the medical program an acceptable and safe alternative, given the existing physical plant barriers. In every facility, the Warden is the Chief Administrative Officer and the HCUA of the facility reports to

the Warden. This appears to have resulted in procedures that accommodate custody needs even when it results in medication administration practices that violate nursing practice standards.

Further, we observed nurses floating medication well in advance of administration, which alters the medication's properties, and crushing medication that was put in the reused envelopes, which contaminates other medications put into the envelope. These practices put inmates at risk of receiving ineffective treatment and adverse drug reaction.

Medication Continuity

Chronic disease patients are not monitored to ensure continuity in treatment nor is their compliance with prescribed treatment assessed. Chronic disease medications are provided to patients either as "Keep on Person" (KOP) or each dose is administered by a nurse. We found many examples of patients whose ordered medications were never provided, were delayed starting, and were stopped because the patient had not been seen by a provider to renew medication. Record reviews indicated that appointments for chronic care are not scheduled to take place prior to expiration of chronic disease medication orders. As a result, providers often reorder medications without seeing the patient to conduct a clinical evaluation to determine whether the treatment plan should be continued or changed, based upon the how well the patient's chronic disease is controlled.

Facility policy and procedures¹⁶² direct that the MAR be available with the medical record at the time of a chronic care provider visit. However, we saw no evidence that current MARs were available at the time a patient saw a provider. We also saw no evidence that providers review the MAR and discuss the patient's adherence as part of chronic care appointments. Facility policy and procedures¹⁶³ also instruct nurses to refer patients to a provider for evaluation and possible change in treatment if they refuse to take prescribed medication. In the records we reviewed, there were multiple examples of patients not taking medication as prescribed who were not referred for provider evaluation.

Monitoring Performance

Pharmacy audits and inspections, which are done routinely, document the problems described above. These reports are reviewed and included in the institution CQI meetings. They document ongoing problems system wide with medication, including: use of the envelope rather than MAR to prepare medication; failure to document medication given on the MAR; failure to transcribe orders onto the MAR; administering medication for which there was no order, or when the inmate was not present at the facility; administering medications that differ from the order; documenting in advance that medication was administered; and the presence of open, undated, multi-use containers of medication. There has been some coaching and

¹⁶² LCC, SCC, and DCC Operations Policy and Procedure P. 107 Management of Chronic Disease and MCC Policy and Procedure V3-12 Medical management of offenders with a chronic condition. No policies and procedures were provided for NRC.

¹⁶³ LCC, SCC, and DCC Operations Policy and Procedure P. 128 Medication Services and MCC Policy and Procedure V 4-1 Pharmacy Services. No policies and procedures were provided for NRC.

counseling of individuals, but there has been no review or analysis done to identify root causes for these persistent failures, and no effort made to eliminate systemic causes of failure or improve performance through corrective action planning. In the meantime, inmates are subjected to delays and interruptions of treatment, unsanitary conditions, and medication errors.

We note that some of the root cause problems appear to be related to custody control of medical processes within the institution and the apparent reluctance of health staff to openly discuss with custody the need for their cooperation in the process of medication administration. The governing bodies of CQI committees at several facilities were mostly custody-trained staff. This is an impediment to effective monitoring of clinical processes, such as medication treatment. Participation and support of custody staff in CQI is very important; however, medical staff must direct and control the monitoring of health care and be able to drive necessary performance improvements.

Infection Control

Infection control is an essential element of an adequate health care system. The inmate population has a high prevalence of communicable and infectious diseases. Because of the high prevalence of communicable diseases, a highly functioning infection control program must be in place to identify, track, and assist in management of these illnesses.

Approximately 4-6% of TB cases reported in the United States occur among people incarcerated at the time of diagnosis. The incarcerated population contains a high proportion of people at greater risk of TB than the overall population.¹⁶⁴ In 2013, there were 36,064 persons with HIV infection in the civilian population of Illinois, with a population over 18 years old of 9.7 million or 0.4% of the population. In 2010-2015, IDOC had 686 inmates with HIV infection or 1.5% of its population.¹⁶⁵ The IDOC HIV prevalence was almost four times as high as the civilian HIV prevalence. It is estimated that approximately 160,000 persons in Illinois have hepatitis C or about 1.6% of the Illinois population, as opposed to 5.6% known cases in IDOC and an estimated 10% overall estimated prevalence. The IDOC had at least 3.5-6.25 times the rate of hepatitis C infection of the civilian population. The burden of sexually transmitted disease, MRSA, and scabies are also typically higher in prison systems.

Conditions of confinement promote the spread of disease because of environmental conditions within the prisons. Inmates are housed in close quarters. In our IDOC Prison Overview section we spoke about how crowded the IDOC prisons are. The overcrowded conditions, particularly in antiquated facilities, promote transmission of multiple types of infections and contagious diseases. Individuals have no control over the quality of air they breathe via the facility ventilation system; they live in cells or dormitories that have been occupied by others and are

¹⁶⁴ TB in Correctional Facilities in the United States, Centers for Disease Control and Prevention as found at <https://www.cdc.gov/tb/topic/populations/correctional/default.htm>.

¹⁶⁵ HIV in Prisons, 2015 – Statistical Tables, Laura Maruschak and Jennifer Bronson, Ph.D., BJS Statisticians; August 2017, NCJ 250641, US, Department of Justice *Bureau of Justice Statistics*.

expected to clean their living area with supplies that are available; they are provided food prepared by inmate workers to eat with silverware and plates cleaned by inmate workers; they are provided linens and clothing that are washed by inmate workers or wash linens themselves with laundry soap that is available; they use toilets, sinks, and showers that are used by many others. Every one of these activities of daily living carries multiple opportunities for communicable or infectious disease transmission and illness for both staff and inmates. Infection control programs in the correctional setting establish and monitor procedures to prevent exposure to diseases that can be transmitted in the correctional setting. Infection control programs also identify sources of infection through screening and take steps to prevent or mitigate infection of others, to treat persons with infectious diseases, and improve the health and safety of staff and inmates by providing information on prevention, education on self-care, and immunizations.¹⁶⁶ These efforts require surveillance of disease by accurate statistical means, both for required reporting purposes and so that the IDOC medical program can understand how to study, plan, and prepare for the care they will need to provide. The infection control program is usually coordinated by a registered nurse with consultation from a designated provider with expertise in infectious diseases,¹⁶⁷ and supported by data collection methods that can reasonably track diseases within the prison system.

First Court Expert Findings

The First Court Expert found IDOC's infection control program was a moving target across the system, with some facilities having well developed infection control programs and other facilities having programs described as being in their infancy. Facility health care staff had been provided with an exposure control manual, but IDOC provided no oversight of infection control. At some facilities, no one was clearly designated with responsibilities for infection control, and the duties were simply added to those of the HCUA or DON. Other facilities had identified a specific nurse responsible for infection control, but the duties of the position had not been defined. In addition, no training in how to operate an effective infection control program had been provided to those individuals who had been assigned responsibility for infection control.

Examples of systemic issues described by the First Court Expert which occurred as a result of the disarray in infection control monitoring and lack of oversight from IDOC included the failure to launder bed linens of infirmary patients in water temperatures hot enough to destroy pathogens transmitted by blood and body fluids; negative pressure rooms that were not functional and not monitored to ensure that negative pressure was maintained to prevent transmission of airborne illnesses; lack of proper sanitation of medical equipment; and lack of disinfection procedures to provide clean surfaces when examining patients.

Current Findings

The systemic issues described in the First Court Expert Report still occur today. While there has been some improvement in the use of paper barriers on examination tables, little else has

¹⁶⁶Bick, J. (2006) Infection Control in the Correctional Setting. In M. Puisis, (Ed.) *Clinical practice of Correctional Medicine*. (2nd ed.) Philadelphia: Mosby Elsevier. 230-231.

¹⁶⁷ Lane, M. (2006) The infection control program. In M. Puisis, (Ed.) *Clinical practice of Correctional Medicine*. (2nd ed.) Philadelphia: Mosby Elsevier. 460-461.

changed with regard to the infection control program. The following summary of our findings reinforces the findings of the First Court Expert. We had multiple additional findings that give us concern.

The IDOC has had numerous recent outbreaks of contagious and infectious diseases. Since 2008, there have been several outbreaks of scabies in Illinois prisons. The latest was in Taylorville in 2016, in which the prison was locked down and 214 inmates were treated.¹⁶⁸ In 2012, a norovirus outbreak sickened 140 inmates at SCC.¹⁶⁹ The numbers of inmates affected in these outbreaks reflects poorly on the surveillance and typical preventative measures enacted by infection control procedures to abort the contagion earlier and prevent the widespread infections that occurred at these facilities. An inmate at SCC also contracted Legionnaire's disease in 2015.¹⁷⁰ At the Danville Correctional Center, 78 persons were affected by histoplasmosis in 2013, likely from soil disruption. This outbreak was initially thought to be adenovirus, but required investigation by the federal Centers for Disease Control and Prevention and was found to be histoplasmosis.^{171, 172}

Typically, outbreaks such as these are monitored and sometimes managed by the infection control program. Yet in the IDOC, there was no designated individual responsible for infection control at four of five facilities we visited, including at SCC, where one of the outbreaks described above occurred, as well as the isolated case of Legionnaire's disease. At SCC, infection control duties were dispersed amongst several staff nurses, the DON, and the HCUA, and the program was not effective. The norovirus outbreak at SCC was large, and typically early infection control measures would be expected to reduce the size of such an outbreak. At the same four facilities there were no schedules for routine sanitation and disinfection of health care areas. Basic maintenance of rooms was lacking. MCC has an extensive collection of policies and procedures that detail cleaning and sanitation of every room in the health care building.

At MCC, responsibility for infection control resides with one of the nursing supervisors. Her responsibilities are managing TB surveillance, performing sanitation inspections, ensuring food handlers are cleared for work, monitoring skin infections, interface with the Illinois Department of Public Health, monitoring negative pressure rooms, and monitoring hygiene in clinical spaces. In addition, she manages HIV and hepatitis C clinics, coordinates follow-up of patients treated for TB infection, and provides supervision of inmate peer educators. It is our opinion that the infection control nurse is an essential component of the health care program at IDOC facilities and is a full-time position.

¹⁶⁸ Scabies Outbreak Causes Temporary Lockdown of Taylorville Prison, Doug Finke, The State Journal Register, September 19, 2016.

¹⁶⁹ Norovirus Outbreak Hits Illinois Prison; Food Safety News December 29, 2012.

¹⁷⁰ Stateville Inmate Diagnosed with Legionnaire's Disease, Dawn Rhodes, Chicago Tribune August 12, 2015.

¹⁷¹ New details regarding illness among inmates at Danville Correctional Center. Found at <https://www2.illinois.gov/idoc/news/2013/pages/danvilleccillness.aspx>.

¹⁷² Centers for Disease Control and Prevention website Outbreaks and Investigations lists Histoplasmosis in an Illinois Prison. Details given were that this occurred in August-September 2013 with 78 cases and likely related to disruption of soil containing bird droppings. Found at <https://www.cdc.gov/fungal/outbreaks/index.html>.

We observed significant challenges to safety and sanitation at every facility visited. For example, at SCC we observed cockroaches, gnats, and flies in the infirmary; the room used for hemodialysis (considered a sterile procedure) had peeling paint on the walls, there was standing water on the floor, and the garbage can was not covered. The kitchen/dining area was occupied by birds, and their droppings were evident on the walls and floors. At Dixon, all three floors of the medical building had missing floor tiles, which is a sanitation issue in an area dedicated to the delivery of health care.

NRC is the only facility among the five we visited that does not conduct monthly safety and sanitation inspections. At the other facilities, safety and sanitation inspections do not adequately identify problems requiring remediation. For example, we found faulty negative pressure isolation rooms and nonfunctional dental equipment that were not identified because they are not included in the safety and sanitation inspections. We also found furniture, equipment, and hard surfaces (floors, ceilings, sinks, cabinetry) were rusted, broken, or deteriorated in health care areas at all facilities, which had not been documented as issues needing repair on safety and sanitation rounds.

Moreover, review of safety and sanitation findings in the minutes of CQI meetings document the persistent failure or lengthy delay in remedying identified problems. Safety and sanitation inspections should inspect or monitor the condition, function, and annual certification of clinical equipment, functionality of the negative pressure rooms, integrity of bed and chair upholstery, completeness of medical cart and emergency response bag logs, the training of health care unit porters, and other health care issues.

The TB prevention and control program in IDOC is not effective. The hallmarks of an effective TB program in correctional facilities are: initial and periodic TB screening, successful treatment of TB disease and infection, appropriate use of airborne precautions, comprehensive discharge planning, and thorough and efficient contact investigation when a case of TB disease is identified.¹⁷³

At IDOC, TB screening is improperly performed, treatment of infection is delayed, and negative pressure rooms (an airborne precaution) often are not functional or monitored. We did not evaluate TB discharge planning or contact investigation, although in the absence of an individual assigned responsibility for infection control, these interventions are most likely sporadic and haphazard as well. At NRC, nurses do not read tuberculin skin tests properly and only document results in the health record when they have time. Instead of inmates being escorted to the medical clinic for nurses to read their tuberculin skin tests, nurses must go cell to cell. In addition, NRC officers do not open the food port for inmates to extend their arm for nurses to palpate and measure the results of the test. Instead, nurses read the test by looking through the glass window of the cell door, which is inappropriate technique.¹⁷⁴ There was

¹⁷³ TB in Correctional Facilities at <https://www.cdc.gov/tb/topic/populations/correctional/>, Epidemiology of Tuberculosis in Correctional Facilities 1993-2014 at <https://www.cdc.gov/tb/publications/slidesets/correctionalfacilities/default.htm>.

¹⁷⁴ A tuberculin skin test is read by manually palpating the size of induration of the test site with good overhead lighting. To read a tuberculin skin test through a glass window is inappropriate.

evidence in the review of records that other sites distrust TB screening performed at reception centers and rescreen inmates upon arrival at their parent facility. We also observed that nurses at Dixon merely look at the skin test site through the cell door rather than palpating and measuring induration in a well-lit area. We did not observe nurses reading tuberculin skin tests at all facilities, but based upon the two sites where we observed poor practices, we conclude that TB screening at IDOC is not adequate.

We reviewed the records of four patients who had completed treatment for latent TB infection. In three cases, the patient was subjected to multiple skin tests (which were positive) and multiple chest radiographs, which were unnecessary, before treatment was finally initiated. In the other case, treatment was initiated even though skin testing was ordered but never completed, based upon a history of a positive skin test reported by the inmate when he requested treatment initiation. Initiation of treatment for latent infection was haphazard and delayed.

Negative pressure isolation rooms were either not functional or the monitor was not working at three of the five sites we visited. At NRC, the monitor in one room was not working and in the other room the vent was taped shut, disabling the negative pressure. At SCC, neither room was functional and the equipment had not been serviced for years. At LCC, two of three rooms were not functional. Negative pressure rooms need to be maintained and ready for use; this is not the case in the IDOC, and places patients and staff at risk of airborne infection.

The UIC provides treatment of inmates with HIV and hepatitis C via telemedicine. For hepatitis C, UIC has no role in managing hepatitis C patients before referral and after antiviral treatment and has no role in screening for these diseases. UIC provides no assistance in managing other complications of hepatitis C including cirrhosis, varices, or ascites as examples. IDOC facility providers are responsible for that care but do not appear to know how to provide it. One or more nurses are designated at each site to coordinate these clinics and the care of these patients. The quality is highly dependent upon the interest and capability of each nurse assigned these responsibilities. There is no one identified to monitor or oversee the work of the clinic coordinators, who must negotiate with all the other users of the telemedicine space to schedule clinics timely. Coordination between the UIC infectious disease specialists and primary care providers is problematic, as evidenced in the example of one patient with HIV; the specialist recommended lowering the patient's dose of metformin (a medication used to treat diabetes) because of an interaction with one of the HIV medications prescribed.¹⁷⁵ The primary care provider at the facility responsible for the patient's diabetic care never acted on the recommendation. The HIV specialist reduced the dose of metformin at the next visit. The patient was at risk of clinical deterioration because of the primary care provider's omission for five months.

IDOC has adopted what it describes as opt-out HIV testing at intake, but policy and practice are not consistent with the use of this term. Opt-out testing is recommended by the Centers for

¹⁷⁵ Dixon Infection Control Patient #3.

Disease Control because it supports early identification and treatment.¹⁷⁶ The IDOC Administrative Directive still requires that consent be obtained before drawing blood for HIV, and in practice this consent is still obtained.¹⁷⁷ The practical effect is that fewer newly arriving inmates are screened for HIV as compared to hepatitis C. The IDOC should revise the Administrative Directive to eliminate the requirement for written consent and initiate opt-out HIV testing.

We also question the effectiveness of periodic screening programs for HIV and hepatitis C infections. We noted on one death review¹⁷⁸ a man who was not known to be HIV infected and was not offered HIV screening at two annual health evaluations we reviewed, despite having a history of multiple sexual partners, prior blood transfusions, and a history of sexually transmitted disease all of which were risk factors for HIV infection. He ultimately developed severe HIV disease, which was unrecognized for several years until he was finally admitted to a hospital, where he died of severe complications of his undiagnosed and untreated HIV disease. Sentinel cases such as these should prompt an investigation into why the system failed to timely screen, diagnose, and treat this patient, whose death was preventable. The infection control nurse should monitor results of HIV and HCV screening to verify that policies to screen for communicable diseases are effective.

All five of the facilities visited report cases of culture positive *Methicillin-resistant Staphylococcus Aureus* (MRSA) as is required by IDOC. However, only MCC tracks all skin and soft tissue infections (independent of whether a culture is performed) as recommended by the First Court Expert. In addition, tracking should include culture and sensitivity results to ensure correct antibiotic selection and housing location of the patient. Infection control nurses should review tracking results to identify clusters of infections by housing unit, perform additional case-finding, and identify environmental factors that may be promoting infection. Factors in correctional settings found to contribute to skin and soft tissue infections include sharing towels and soap, ineffective laundry practices, poor sanitation of exercise equipment and showering facilities, poor hygiene practices, unnoticed infections that leak pus, and poor access to medical care.¹⁷⁹ Tracking enables sources of infection to be identified and steps taken to eliminate factors associated with disease transmission. For example, at MCC one of two cases of skin infection reviewed was a patient who developed infection six days after hernia surgery and having been returned immediately to general population at the facility.¹⁸⁰ This case of soft tissue skin infection raises questions about the ability of the patient to adhere to wound care instructions and suggests consideration of a policy of admitting inmates to the infirmary only after it is determined that the patient is stable and able to adhere to wound care instructions.

¹⁷⁶ Opt-out testing means that testing will be performed unless the patient refuses the test. Opt-in testing means that the patient is offered testing and it is performed only upon patient consent. The IDOC has large rates of refusal of HIV testing, unlike other similar correctional centers that offer opt-out testing. Opt-out testing generally raises the rates of screening.

¹⁷⁷ Administrative Directive 04.03.11 Section 5 II. F. 5. d.

¹⁷⁸ Mortality Review Patient #22.

¹⁷⁹ Smith, S. (2013) Infectious Diseases. In L. Schoenly and C. Knox (Eds.) *Essentials of Correctional Nursing*. New York: Springer. P. 189.

¹⁸⁰ MCC Infection Control Patient #7.

The IDOC requires a monthly report of communicable diseases and infection control data. This report includes items such as the number of MRSA cases, HIV and HCV tests performed, the number of tuberculin skin tests administered, the use of negative pressure rooms, etc. We found that these reports are submitted to the Quality Improvement Committee (QIC) and included in the monthly minutes. However, there is no trending or analysis of infection control data. There is no discussion in the infection control report or CQI minutes of, for example, why only half of incoming inmates are tested for HIV, given the statewide opt-out policy. A more notable example of the lack of introspection about communicable and infectious disease are three needle stick injuries which occurred in 2017 at Dixon, and the fact that there has been no focused review of these injuries to determine what measures would increase worker safety.

We found numerous examples of poor infection control practices on the part of health care professionals. At all facilities, inmates are not routinely provided eye protection during dental procedures. At NRC, the dentist examined patients without changing gloves between patients and reached into a bag of sterile mirrors to select one for use, contaminating all the other mirrors which were then used on subsequent patients. At SCC, the hemodialysis unit does not have a dedicated chair and technician for dialysis of patients who have hepatitis B, thereby exposing other dialysis patients to this blood borne infection. At NRC and SCC, paper barriers are not available to use on any of the examination tables and they are not cleaned between patients. Finally, the order in which instruments were sterilized was incorrect in four of five facilities we visited. The placement of sterilization equipment and procedures should proceed from dirty to sterilized. At four of five facilities we visited, the placement of the ultrasonic cleaner required clean instruments to pass over the dirty area, thus contaminating their sterilization. At SCC, sterilized instruments were removed from their packages and put in an open bin in the trauma room, making them clean, rather than sterile, instruments. The nursing supervisor could not explain why these instruments were clean rather than sterile.

Inmate porters are assigned to work in the health care areas of each of the five facilities we visited. At only two of the facilities had the inmate porters received training in how to clean and sanitize patient care areas, and how to take personal protective measures before working in the health care area. Only two facilities had vaccinated the inmate porters for viral hepatitis. The assignment of untrained and unvaccinated inmates to clean and sanitize health care areas exposes these inmates as well as patients receiving care to several infectious diseases with potentially serious health consequences, and is deliberately reckless.

Infirmery linens are still laundered in residential style washers and dryers at all the facilities we visited, except NRC. At NRC, a log provided by the institution showed water temperatures were less than the 165°F required by AD 05.02.180 about 30% of the days reviewed. Water temperatures were not hot enough to effectively sanitize laundry from the infirmery at any facility we visited. We also observed furniture and equipment throughout each of the health care areas at every facility we visited that was torn, frayed, rusted, and corroded. These objects, including stretchers, exam tables, stools, cabinets, and work surfaces cannot be properly sanitized and are sources of communicable disease in a setting that treats and cares for patients who are ill, medically fragile, and immunocompromised. While some have been

identified as needing repair or replacement, the safety and sanitation rounds do not often include these health care areas and there is no effective tracking of the repair or replacement of these items. It is understood that it takes time to repair or replace worn equipment, but in IDOC the volume of items needing repair and the length of time that unacceptable conditions linger indicate pervasive and systemic problems with environmental controls to prevent communicable disease.

The First Court Expert noted that the Communicable and Infectious Diseases Coordinator in the Office of Health Services retired some time ago and that the position was never filled. That is true today as well. There is no one in the Office of Health Services who has responsibility statewide to direct and oversee infection control in the IDOC. The IDOC also does not have an infectious disease physician responsible for directing infection control activity within the department. The Infection Control Manual was last updated in 2012, and many of the resources in the manual are out of date or more current material is available. The facility health care programs have some policies and procedures for infection control, but we found these also not up to date. Nursing Treatment Protocols are also provided by the IDOC for possible infections such as scabies, rash, urinary infection, pediculosis, chicken pox, and skin infections. These were last updated in March 2017 and are adequate, but stand-alone rather than as part of a comprehensive infectious disease program. The need for statewide oversight is evident to resolve issues, such as the conflict between the IDOC practice of HIV opt-out testing and the AD, to eliminate the continued insufficient laundering of infirmary linens, to address the problem of needle stick injuries, to provide meaningful analysis of communicable disease surveillance, and to provide guidance to facility health care programs on infection control performance expectations.

Mortality Reviews

Methodology: We interviewed the Agency Medical Director and senior leadership of Wexford, reviewed death summaries, and reviewed death records.

First Court Expert Findings

The First Court Expert and his team evaluated a total of 63 deaths records. There were one or more significant lapses of care in 38 (60%) of cases. Of cases with significant lapses, 34 (89%) had more than one lapse. The internal IDOC mortality review process was seriously flawed. Reviews are performed by the doctor most closely involved in care of the patient. Twenty (52%) of death summaries were reviewed. In none were any lapses of care identified. Only a few deaths were reviewed by the Office of Health Services, but these were selected based on lapses identified by local review. The First Court Expert found that for many patients who were chronically ill with terminal conditions there were no resources in place to assist health care staff with management of end of life symptoms. As well, the First Court Expert found that once a patient signed a do-not-resuscitate order, they were no longer treated even for simple reversible illness.

Current Findings

We confirmed all the First Court Expert's findings and found additional evidence of clinical lapses of care with respect to deaths. We added a perspective of preventable deaths because preventable deaths reflect the degree of harm to patients.

The U.S. Department of Justice (USDOJ) tracks inmate deaths.¹⁸¹ For 2014, the latest year of available statistics, The IDOC had the sixth lowest mortality rate (182/100,000 inmates) of the 50 state systems. The average mortality rate of state correctional systems was 275 per 100,000 inmates. The IDOC, in their comments on our report, assert that "the low IDOC mortality rate would be representative of a health system functioning at or above the norm of its comparators."¹⁸² However, these data are not adjusted¹⁸³ for any risk or variable. According to the Department of Justice authors, "overall mortality rates and mortality rates by state and by cause of death may not be directly compared between states due to differences in age, sex, race or Hispanic origin, and other decedent characteristics."¹⁸⁴ It is misleading to use crude mortality rates alone to compare quality of health care of different prison systems without any adjustment for these multiple variables.¹⁸⁵ As the IDOC states later in their comments on our report, specifically about use of hepatitis C and age as they relate to mortality, "One would have to conduct an adjusted multivariable statistical analysis with complete and comparable data from all other state DOCs to examine the independent contributions of age and hepatitis C to the variation in mortality rates across systems." We agree with that statement and note that to the best of our knowledge, reliable risk, age, and sex adjusted mortality rates are not available, allowing for use of crude mortality data to compare medical care between state prison systems.

The Court has asked the Expert to "assist the Court in determining whether the Illinois Department of Corrections (IDOC) is providing health care services to the offenders in its custody that meet the minimum constitutional standard of adequacy." We have used mortality review to identify quality of care and systemic issues that can provide definitive information in

¹⁸¹ Mortality in State Prisons, 2001-2014 – Statistical Tables; Margaret Noonan, US Department of Justice, Bureau of Justice Statistics, December 2016, NCJ250150.

¹⁸² Letter via email from John Hayes and Michael Arnold, Office of the Attorney General to Dr. Puisis: Re: *Lippert v. Baldwin*, No. 10-cv-4603 – Defendants' comments to the Draft Report of the 2nd Court Appointed Expert dated September 10, 2018.

¹⁸³ Adjusting allows for comparison of different populations by reducing variations and to standardize populations. Adjustment is a statistical technique to reduce variability between populations when multiple variables affect the outcome. This allows for different populations to be compared.

¹⁸⁴ Page 2, bullet on Deaths reported by state in Mortality in State Prisons, 2001-2014 – Statistical Tables; Margaret Noonan, US Department of Justice, Bureau of Justice Statistics, December 2016, NCJ250150.

¹⁸⁵ To support the assertion that the IDOC mortality rate indicates above average medical care, the State references a study from Centers for Medicare & Medicaid Services (CMS). This study was a study of hospitalized patients. CMS used a "risk-standardized rate of mortality within 30 days of hospital admission" for their study and studied only patients over 65 years of age. According to the CMS report (Hospital-Side All-Condition, All-Procedure Risk-Standardized Mortality Measure: Draft Measure Methodology for Interim Public Comment prepared by Centers for Medicare & Medicaid Services (CMS) October 2016 as found at <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/MMS/Downloads/Hospital-Wide-All-Condition-All-Procedure-Risk-Standardized-Mortality-Measure-Public-Comment.pdf>) they adjusted for case mix, types of conditions, and procedures of patients; did not include patients if 30-day mortality could not be reasonably considered a signal of quality; and did not include patients under 65 years of age. This methodology does not make the case that use of crude prison mortality can be used as a measure of quality of medical care, as the crude mortality rates did not adjust for any variables affecting prison populations.

answering the Court's question. We performed in-depth evaluations of 33 deaths. These mortality reviews identified numerous quality of care issues that are systemic and are important in answering the question required by the Court. These reviews demonstrate significant systemic and quality of care issues that were confirmed in site-visit record reviews, on-site observations, and interviews.

Of the deaths that occur, it is critical to understand whether mortality is preventable or demonstrates correctable errors. For this purpose, correctional programs typically perform organized mortality review. Organized mortality review should be performed for every death. Participants in this review should be senior physicians, administrative and nursing staff, and other senior leaders of relevant disciplines whose services may have had an impact on the death (e.g., pharmacy, mental health, etc.). Generally, most correctional centers include a custody representative in mortality review meetings. Persons directly responsible for care of the patient are interviewed for their perspective on the care they rendered. However, persons who cared for the patient should never be placed in positions of reviewing the death, as they could not be expected to give an unbiased review.

Mortality reviews typically review care as far back as necessary to understand the evolution of the patient's illness and can be six months to a year or more. Mortality reviews should be constituted as to identify errors and problems with care. These errors and problems need to be addressed in a follow-up manner (typically through quality improvement corrective actions or investigations) so as to prevent the error or problem from occurring again.

There were 174 deaths in the IDOC in 2016 and 2017.¹⁸⁶ We intended to review 89 death records but because of time limitations we were only able to review 33 (19%) deaths from 12 facilities, which is a sample of 46% of the IDOC facilities. Eleven of 33 deaths were preventable. Eight of 33 were possibly preventable. Nineteen (58%) of the 33 deaths reviewed were either preventable or possibly preventable. This is an extraordinary number of preventable or possibly preventable deaths and speaks to the ongoing serious harm to patients from care in the IDOC. We do not assert that this sample can be extrapolated to the entire population. However, even if there were only 19 preventable or possibly preventable deaths out of the 174 deaths, that would be 11% of the deaths, which is still a very high number. Our findings confirmed the First Court Expert's report that none of the Wexford death summaries identified any problems. All of the Wexford death summaries that we were provided were performed by physicians who were responsible for care of the patient and failed to identify any problems, even when grossly and flagrantly unacceptable care was provided.

We reviewed two years of care as documented in the health record for most of the 33 deaths. The reviews were detailed reviews of individual episodes of care. We have provided the spreadsheets which give detail on every episode of care reviewed as well as detailed narrative

¹⁸⁶ Defendants stated in their comments that we requested 174 death records, but this was inaccurate. There were a total of 174 deaths in 2016 and 2017. Of these deaths we chose 89 records to review. We asked to receive death records in December 2017, but did not receive records until March 2018 and received almost all records by April of 2018, well into our investigation.

summaries for each death.¹⁸⁷ We identified 1757 errors in care. Many of these were common errors, but many were serious. These errors reflect poor primary care knowledge and training. Most were related to primary care functions, such as taking adequate history, examining the patient, and developing a treatment plan, which accounted for almost half of errors. In our opinion, this demonstrates the lack of primary care training of the medical staff. About 8% of errors were nursing errors related to nurses not referring or consulting a physician for serious problems such as abnormal vital signs, red-flag symptoms or signs, or other serious abnormalities. Approximately 10% of errors were related to not referring a patient to a specialist or for special testing. This verifies our finding that significant underutilization occurs in the IDOC. About 5% of errors were related to not timely sending patients to a hospital for evaluation. Many of these errors contributed significantly to the deaths.

The 33 death record reviews contained 73 episodes of grossly and flagrantly unacceptable care. For a few record reviews, there was a repetitive pattern of inappropriate care that in aggregate constituted grossly and flagrantly unacceptable care. This type of care is so egregious that it would typically result in a peer review for possible reduction of privileges or referral to licensing boards for evaluation or sanction of their license. These are serious errors. A sampling of these included the following:

- A 30-year-old man was in the process of valve replacement surgery for a congenital heart condition when he was incarcerated.¹⁸⁸ IDOC physicians failed to contact his cardiologist and his planned surgery was never recognized, even though a letter from his civilian cardiologist recommending surgery was in the IDOC medical record. He was routinely referred to UIC cardiology, who requested an echocardiogram and old records because the history was uncertain. The echocardiogram report documented that valve surgery was indicated. This report was never obtained or reviewed. When the patient developed arrhythmia, hypotension, and near syncope, a doctor failed to take action. The patient's diagnosis was unknown for six months of incarceration and he died of complications of his congenital heart problem without IDOC physicians ever knowing what his diagnosis was.
- A patient had diabetes, decompensated cirrhosis, and an unknown skin condition.¹⁸⁹ She developed fever (101.8°F), hypotension (88/50), and periorbital swelling. Her condition indicated sepsis and warranted hospitalization, yet the patient was treated without a diagnosis with oral Bactrim, pushing fluids, and Tylenol with infirmary admission by phone consultation. The doctor stated he would consider laboratory tests and a chest x-ray in the morning. The next day, the doctor noted right upper quadrant pain with a distended abdomen. The doctor ordered routine labs and diagnosed fever. Two days after infirmary admission, the doctor referred the patient to a hospital when the blood pressure was 60/palpable. When the patient returned from the hospital there

¹⁸⁷ The spreadsheet detailing episodes of care is included as an appendix to this report. Also, a table of the breakdown of the 1757 errors is also listed as an appendix to the mortality narrative summary.

¹⁸⁸ Mortality Review Patient #2.

¹⁸⁹ Mortality Review Patient #6.

was no report and it was not clear that staff knew what occurred. The day the patient returned from the hospital, she vomited dark red emesis and was hypotensive (75/48). The only order was to “continue present management.” The patient had repeated episodes (four) of bloody emesis during the night. The doctor was called at home but took no action. In the morning and when the patient was in shock, the doctor obtained a “do not resuscitate” (DNR) order from the patient. Her barely legible signature did not match her typical signature and the signature appeared to have been obtained under duress. After obtaining a DNR, the doctor sent the patient to the hospital, where no intervention was taken because of the DNR order. The patient expired of bleeding varices.

- A 51-year-old had headache, complaint of fever, and vomiting.¹⁹⁰ Treatment for this condition was infirmary admission, IV fluid, and intravenous antibiotics for presumed pharyngitis. These signs were inconsistent with pharyngitis. The patient continued to vomit, yet continued to be managed for pharyngitis. The provider ordered labs on the second infirmary day that were not done. Later, on the second day on the infirmary, the patient developed altered mental status and hypothermia, and was not responding. These are red-flag signs. The patient was not sent to a hospital despite signs of acute sepsis. No laboratory tests had yet been done after two days of infirmary housing. On the third infirmary day, the patient was found on the floor and would open his eyes only to severe stimulus. He was not sent to a hospital until he was found unresponsive and in shock (BP 68/palpable). The patient died in the hospital; there was no autopsy.
- A 45-year-old mentally ill man developed a firm neck mass.¹⁹¹ He was initially diagnosed with parotitis, even though the parotid gland is on the face, not the neck, and the parotid gland demonstrated no evidence of infection. There was therefore a two month delay in diagnosing his neck cancer. After four months, the patient was still awaiting treatment when he passed out and had hypotension (60/40). This warranted hospitalization. The doctor diagnosed loss of consciousness; the plan was to place the patient on the infirmary for observation without ordering any diagnostic testing. Radiation therapy was started. About a month after radiation started, the patient was hospitalized for chemotherapy. A day after return from the hospital, the patient was found on the floor and was lethargic and unresponsive. A nurse called a doctor who ordered “neuro checks,” but did not send the patient to a hospital. The following day, the patient had a single dilated pupil consistent with brain damage, a red-flag sign that should have resulted in immediate hospitalization. The doctor ordered morphine for unclear reasons. Later that day a doctor evaluated the patient and noted that the patient had a fall the day before. The doctor did not examine the patient and apparently failed to note the dilated pupil. The doctor took no action except to increase morphine. The following day the patient was found unresponsive and was sent to a hospital, where

¹⁹⁰ Mortality Review Patient #7.

¹⁹¹ Mortality Review Patient #8.

he died. A hospital EKG showed that the patient was in atrial fibrillation. One of the side effects of atrial fibrillation is stroke, which may have accounted for the dilated pupil.

- A 24-year-old with mental illness swallowed two plastic sporks (combination spoon and fork) that was witnessed by a correctional officer.¹⁹² A doctor did not evaluate the patient but ordered an x-ray, which would not likely show the ingested plastic item. The x-rays were normal. About two and a half months later, a nurse practitioner evaluated the patient. The NP failed to recognize a 33-pound weight loss, but the patient did tell the NP that he had swallowed a spork a long time ago and needed it removed. The NP made an assessment that the patient had an ingested spork but took no action. The patient remained untreated and eventually lost 54 pounds and had repeated episodes of abdominal pain with an inability to eat without pain, nausea, and diarrhea. Eventually the patient was found unresponsive, was sent to a hospital, and died. On autopsy, the two swallowed sporks were found having caused esophageal perforation, which was the cause of death.
- A 70-year-old man with atrial fibrillation and severe bradycardia needed and received a pacemaker.¹⁹³ Two years after the pacemaker was inserted, the patient experienced leg edema, weight gain, and had signs of heart failure (BNP 712; shortness of breath, orthopnea, and edema). Although the doctor noted a heart rate of 44 and questioned whether the pacemaker was functioning, the doctor took no action with respect to the pacemaker. An EKG showed aberrant ventricular conduction with ventricular escape, indicating pacemaker malfunction. The patient needed immediate hospital admission, but the doctor only admitted the patient to the infirmary and treated for heart failure on the infirmary. The patient continued to have low heart rate and began complaining of chest pain. If the pacemaker was functioning, the heart rate would not be expected to fall below the set point of the pacemaker, so it was clear the pacemaker was not functioning. Yet the doctor took no action. Two days later, the patient was found dead.
- A 75-year-old man experienced weight loss and anemia, yet was never offered colonoscopy.¹⁹⁴ He had pancytopenia, which corrected to anemia; and thrombocytopenia, low albumin, and weight loss, but was not evaluated for these problems. He had a prosthetic leg from prior amputation from osteomyelitis and the prosthesis was causing an ulcer. Wexford initially denied repair of the prosthesis but then authorized a limited repair, which failed to correct the problem. The patient began using a wheelchair because of the problem with the prosthesis. After using the wheelchair, the patient developed a pressure ulcer on his buttock which was inadequately monitored. The patient was kept in general population. The ulcer began draining pus and a sedimentation rate of 60 indicated possible osteomyelitis (infection of bone), yet no evaluation occurred. The pressure ulcer worsened, yet providers failed

¹⁹² Mortality Review Patient #15.

¹⁹³ Mortality Review Patient #18.

¹⁹⁴ Mortality Review Patient #19.

to manage the pressure ulcer in accordance with contemporary standards, and appeared not to know how to manage the patient. Instead of referring to a skilled nursing unit, the patient was still housed for a long period of time in general population. Nurses described a tunneling wound draining pus and at one point even showing bone, yet providers failed to document a thorough examination of the wound and even described the wound as “healthy,” without ordering any diagnostic studies to eliminate osteomyelitis. The patient lost 42 pounds. Despite these abnormal findings, the patient was kept in general population, where eventually a cell mate reported that the patient had not eaten in two days. A nurse placed the patient on the infirmary and called a doctor, who ordered IV antibiotics by phone without diagnosis. Later that day, the patient was found unresponsive and was sent to a hospital, where he died. He had overwhelming sepsis, with both bacteria and fungus growing in blood cultures, likely from his infected pressure ulcers.

- Another 72-year-old patient was inadequately evaluated over an eight-month period for abdominal pain, but eventually was sent to an emergency room, where a CT scan showed a large retroperitoneal mass consistent with cancer.¹⁹⁵ The patient was sent back to the prison with a recommendation for outpatient work up. One would expect this to be worked up within weeks. This did not occur. The patient had lost 50 pounds. Over three subsequent months a work up did not take place, although referrals were made. The patient was not monitored well. Eventually, while in general population, the patient developed pressure ulcers and had significant weight loss, yet he was not housed on the infirmary. Three months after the diagnosis of the mass, the patient was admitted to the infirmary only because *security* complained that he could not be managed in general population. He was admitted as a chronic care patient. The day following admission to the infirmary, a doctor noted that the patient was confused, which was a red-flag sign, but undertook no evaluation. This was a new diagnosis and the patient should have been hospitalized. Two days later, the patient remained confused and was incontinent but was still not evaluated or sent to a hospital. That day the patient became delirious and was talking to people in his cell who weren’t there. A nurse referred the patient to mental health. Two days later, the patient still had no evaluation and was noted to be lethargic, confused, mumbling unintelligibly. A doctor took no action. Later that day the patient was sent to a hospital for lethargy and uneven respirations. The patient died in the hospital never having a diagnosis of his retroperitoneal mass found over three months ago.
- Another 46-year-old man had neutropenia¹⁹⁶ for over three years without appropriate evaluation.¹⁹⁷ The patient had intermittent fevers and altered mental status for over a year without appropriate evaluation. The patient had confusion and was incontinent without recognizing that it was inappropriate, yet evaluation for serious central nervous

¹⁹⁵ Mortality Review Patient #21.

¹⁹⁶ Neutropenia is a low white count. In this case the patient had low lymphocytes, one of the white blood cell types. This element, when low, is consistent with HIV infection and should have prompted that test.

¹⁹⁷ Mortality Review Patient #22.

system disorder was not done. The doctor, who was a surgeon, inappropriately believed that the patient had lupus, a collagen vascular disorder, which was an incompetent diagnosis and unquestionably related to his lack of primary care training. A rheumatologist initially refused to see the patient because the patient did not have serologic evidence of lupus. A rheumatologist eventually saw the patient almost a year later and again confirmed that the patient was unlikely to have lupus. Despite the confusion, the patient was kept in general population. Eventually, the doctor provided the patient with an assistive device without attempting diagnosis of his difficulty ambulating. The doctor took virtually no history and performed virtually no examinations for extended periods of time. The patient was mistakenly given methotrexate, a medication that can lower white counts. Eventually the patient was unable to walk and was given a wheelchair. When he developed severe hypoxemia (70%), hypotension (90/66) and tachycardia (128), he was sent to a hospital, where septic shock and HIV infection were diagnosed. He died in the hospital with an AIDS-related central nervous system disorder and disseminated systemic infection, never having been appropriately evaluated at the prison for his problem. The patient was described as having multiple pustular lesions on his left leg, right foot, right hip, penis, and abrasions on the hip and shoulder, none of which were recognized at the prison. The patient also had severe unrecognized malnutrition. We incidentally note that this patient was evaluated at least twice on annual examinations and had risk factors for HIV infection (blood transfusions, multiple sexual partners, and a sexually transmitted disease), and yet was never offered HIV testing.

- Another patient had hepatitis C and cirrhosis evident as early as June of 2012, yet facility providers failed to list cirrhosis as a problem and did not monitor the patient for this condition.¹⁹⁸ Doctors did not initially order tests typically ordered for cirrhosis (EGD to screen for varices and ultrasound to screen for hepatocellular carcinoma) and the patient was not monitored for ascites. In May of 2015, the patient eventually received an ultrasound, which showed a liver mass. A CT scan later that month confirmed a liver mass. The patient was referred for interventional radiology for a biopsy in August 2015, but this was denied by Wexford UM and instead an MRI was recommended. The reason was unclear, as a biopsy was indicated. An MRI was done in October but a biopsy was never done. The patient developed hypoxemia (oxygen saturation of 79%) with hypotension (96/64) and the patient was admitted to the infirmary, but should have been admitted to a hospital. The day following admission to the infirmary the patient developed fever, but no action was taken. The patient had massive ascites, fever, hypotension, and hypoxemia, yet was kept on the infirmary. The following day the patient again developed hypotension (88/60) and hypoxemia (84%) on four liters of oxygen and was sent to a hospital, where he died. The delay in transfer to a hospital contributed to his death. He also never had a biopsy of his liver mass and therefore never had a diagnosis.

¹⁹⁸ Mortality Review Patient #23.

- Another patient was being treated for a lymphoma but treatment was delayed four months.¹⁹⁹ The chemotherapy treatment resulted in low white counts, for which medication was prescribed (Granix) to be administered after chemotherapy to raise the white count. After one of the chemotherapy sessions, the patient failed to receive the Granix. After this error, the patient developed fever and inability to stand independently. This was a red-flag sign indicating infection and warranting hospitalization, but instead the patient was placed on a medical housing unit without any diagnostic intervention. Two days later the patient had nausea and diarrhea and fever of 101°F. This was a life-threatening status and red-flag warning, and the patient should have been admitted to a hospital; instead, a doctor started oral antibiotics without ordering laboratory tests (WBC, platelets, blood cultures, or other diagnostic tests for infection). The following day the patient was hypotensive (90/60) and felt sick, but no action was taken. On the third day on the medical housing unit the patient developed pus draining from his ear, a red-flag sign in a potentially neutropenic patient, yet the doctor only ordered a blood count and metabolic panel, tests which were never done. The following day the doctor again noted pus coming from the ear and ordered intravenous Levaquin for otitis externa, which is not a typical plan for otitis externa. This patient needed admission to the hospital, as he had life threatening status. He was not seen for three days when he was found unresponsive, bleeding from his mouth and penis, with a 101°F fever and in shock. He was finally hospitalized. The bleeding and fever were most likely due to complications of his chemotherapy, after which the patient failed to receive necessary medication. The patient apparently expired in the hospital.
- Another patient, a 66-year-old African American man with history of hypertension, high blood lipids, diabetes, asthma, and chronic kidney disease was only being monitored for hypertension, diabetes, asthma, and high blood lipids.²⁰⁰ He had poorly controlled diabetes, was a smoker, and had hypertension yielding a 46% 10-year risk of heart disease or stroke, yet was only on a low-intensity statin. His diabetes was poorly controlled for two years. The patient had repeated episodes of shortness of breath with exertion yet was not evaluated with appropriate testing (EKG, echocardiogram, stress test, or pulmonary function test), even though the diagnosis was uncertain. Shortness of breath can be a sign of angina. On 1/28/16, a doctor saw the patient for chest pain with elevated blood pressure (169/94). The EKG was equivocal, showing non-specific STT wave changes, which can be consistent with angina. The doctor, however, noted no acute changes on the EKG and told the patient he would need a cardiac treadmill *after* he paroled. The doctor increased Norvasc for the blood pressure. This was indifferent, as work-up of the angina should not be delayed until the patient paroled. Ten weeks later, the patient experienced shortness of breath and oxygen saturation of 85%. A doctor started Lasix by phone, but the oxygen saturation decreased to the 60s. The

¹⁹⁹ Mortality Review Patient #25.

²⁰⁰ Mortality Review Patient #28.

patient was sent to the hospital, but expired. Autopsy showed an active plaque rupture consistent with myocardial infarction.

- Another patient had prior traumatic injury resulting in a VP²⁰¹ shunt in his brain.²⁰² He also had seizure disorder and history of deep vein thrombosis. The patient also had an IVC filter,²⁰³ but this was unrecognized at IDOC facilities. He was also treated with Coumadin, an anticoagulant, and aspirin. The reason for being on aspirin was not documented, but this placed the patient at risk for life-threatening bleeding. There was no indication for aspirin. IVC filters are typically used when there is a contraindication to anticoagulation, such as the repeated seizures the patient had. When an IVC filter is used in conjunction with anticoagulation medication, a specialist should be consulted. Typically, when an IVC filter is used, the patient is not treated with anticoagulation. The patient had repeated seizures but was nevertheless not sent to a neurologist, although doctors could not manage the seizures. The patient was transferred to the Hill facility; after transferring he experienced repeated seizures and was hospitalized. The patient was found to have pseudoseizures.²⁰⁴ After hospitalization, the patient was admitted to the infirmary. On admission, a NP noted that the patient had ataxia and unequal pupils, which are red-flag signs of central nervous system disease. The patient had a recent normal CT scan in the hospital. Nevertheless, unequal pupils and ataxia, particularly in a patient with a VP shunt, are serious signs which warranted immediate re-hospitalization or confirmation with the hospital regarding the prior diagnoses. The patient was unsteady, and instead of hospitalizing the patient, the NP placed his mattress on the floor. The patient remained on the infirmary for three weeks. The patient experienced progressively deteriorating altered mental status. He was noted by nurses to be unable to stand, incontinent, and not responsive for several weeks. Yet during this time there was no adequate neurologic examination of the patient, despite his ataxia and unequal pupils. The patient also developed bruising over elbows, then buttock, back, arms, and legs. Yet despite being on Coumadin and aspirin, the doctor did not order an INR a test to measure whether the patient was over anticoagulated. The grossly and flagrantly unacceptable care continued for weeks until the patient began urinating blood. Still, the doctor only incompetently treated for a presumed UTI. The doctor still did not check an INR. The patient had gross bleeding for several days with bleeding from urine, from bruises on his back, from a nasal laceration, and in his stool. He developed bleeding around his eyes spontaneously. Still no action was taken. Finally, a nurse found the

²⁰¹ Normally, cerebrospinal fluid circulates in the ventricles of the brain. Due to injury or congenital abnormalities, there may be defects which cause the cerebrospinal fluid to accumulate, causing excess pressure on the brain. In order to resolve this, a drainage system is created to drain cerebrospinal fluid from the brain to the peritoneal cavity. This ventriculo-peritoneal (VP) shunt is subject to blockage and when a person has a VP shunt, any alteration of mental status should prompt evaluation of the shunt by brain imaging to ensure that excess fluid is not accumulating in the brain.

²⁰² Mortality Review Patient #30.

²⁰³ An IVC filter is a filter placed in the inferior vena cava to block thromboses from the legs. Typically, when IVC filters are used, anticoagulation is not necessary. This patient probably had the IVC filter because of history of repeated seizures which placed the patient at risk for intracranial bleeding. Yet this IVC filter was unrecognized throughout his incarceration.

²⁰⁴ This is seizure-like activity without corresponding EEG abnormalities of brainwaves, indicating that the episode is psychogenic.

patient unresponsive, with new bruises on his hip and head, and fixed pupils bilaterally. The patient was finally sent to a hospital. At the hospital, the INR was 10 and the patient had a massive subdural bleed causing a brain shift and herniation. The diagnosis was hypercoagulable state from Coumadin causing brain hematoma and herniation.

- Another patient was a 58-year-old man who was transferred to Robinson from Graham.²⁰⁵ He had high blood pressure for at least seven months, but it was not treated. He also had elevated risk for heart disease for at least seven months, but was not treated with a statin. The patient was bleeding from his rectum, but never received a colonoscopy and was continued on non-steroidal medication. After being at Robinson for about six months, the patient experienced chest pain with nausea and dyspnea, with blood pressure 200/118 and pulse of 129. An EKG showed new onset atrial fibrillation with marked ST depression in lateral leads. This is consistent with acute coronary syndrome and warrants immediate hospitalization and cardiac catheterization. Even the automated reading said, “immediate clinical assessment of this individual is strongly recommended.” Instead, a nurse called a doctor, who gave an order by phone for single doses of Inderal and clonidine. The patient was having acute coronary syndrome and should have been hospitalized for immediate catheterization. The following day, the doctor took a history of typical chest angina with exertional squeezing, chest pain associated with nausea, and shortness of breath. Another EKG was done, and the atrial fibrillation was no longer present. Instead of immediately obtaining cardiac catheterization or cardiology evaluation, the doctor started a statin and aspirin but no anti-angina medication. Weeks later, a family member called with concern that the patient was having chest pain when walking to the dining hall. An administrator scheduled a routine referral to a physician, who instead of admitting the patient for catheterization ordered the patient a wheelchair. The doctor added Norvasc for elevated blood pressure. This potentially could have increased the risk for myocardial infarction. The patient had another episode of exertional chest pain with shortness of breath diagnosed as chest wall pain. After another episode of chest pain, a nurse obtained an EKG that again showed ST segment depression consistent with acute ischemia, warranting immediate hospitalization and catheterization. Instead, a doctor ordered 23-hour observation without any intervention. The nurse told the patient to change his job assignment so he wouldn’t have to work in a job that precipitated chest pain. Four days after this episode, the doctor referred the patient for a routine stress test. Instead of a stress test, the Wexford UM program had the patient referred for a routine cardiology appointment, which would ultimately delay the cardiac intervention. This appointment occurred a month later. The cardiologist recommended cardiac catheterization “in the near future.” About two weeks later, the patient again developed chest pain. A nurse obtained an EKG that showed atrial fibrillation, which the nurse described as “A fib same as previous.” This should have resulted in immediate hospitalization. Instead, a doctor ordered 23-hour observation without intervention. About six hours later, the patient was found on the floor with a forehead laceration and

²⁰⁵ Mortality Review Patient #33.

surrounded by vomit. He had no pulse or respirations and was transferred to a hospital, where he was pronounced dead.

At least nine of 19 of preventable or possibly preventable deaths were cared for by poorly trained physicians. One preventable death involved care by a nuclear radiologist. Two involved care by a surgeon. Three preventable and two possibly preventable deaths involved care by another surgeon. Another death involved care by a doctor who had a year of training in pathology. The remaining doctors either had illegible signatures or we were unable to determine their training because we did not have credentials for them. It is our firm opinion that the lack of primary care physicians in the IDOC health care system is resulting in preventable deaths, which shows a gross departure from normal standards of care.

The IDOC leadership is unaware that they have preventable deaths. Both Dr. Meeks and a Regional Coordinator testified that the Regional Coordinators perform mortality review.²⁰⁶ We have asked for but have not received these Regional Coordinator mortality reviews. The Agency Medical Director does not independently conduct mortality review. Dr. Meeks stated that Wexford performs a mortality summary, but there is no formal Wexford mortality review that we were provided. The Regional Coordinators are nurses and would not be able to effectively review physician care or identify if it was adequate or inadequate. These reviews, if done, are insufficient as mortality review. One of the Regional Coordinators, who is responsible for a region where we found preventable death, testified that none of the death reviews he performed indicated inadequate care.²⁰⁷ Wexford does not perform mortality review; instead, it completes a death summary, which is a non-critical summary of the death. This is done by the Medical Director of the site who is often the same doctor who cared for the patient and who often was responsible for the incompetent care. The 2011 contract with Wexford has no requirement for mortality review; its only requirement is that there shall be documentation of deaths.²⁰⁸ Wexford has no process to critically review deaths and therefore any critical clinical deficiencies are unnoticed and unmonitored, resulting in ongoing harm to patients in the IDOC.

Identification of errors can be perceived by the vendor as well as the IDOC as a liability concern. This possibility may result in failure to identify errors or to hide errors to reduce their liability and protect their reputation. If this occurs, significant errors remain unaddressed. The needs of the jurisdiction and vendor, however, should not be contraposed to the needs to protect patient safety. The system of mortality review should be constructed to protect patient safety. For these reasons, when vendors provide medical care, the hiring authority should lead or participate in mortality review to ensure that patients are protected and/or an independent evaluator should perform this review. In this respect, we agree with the First Court Expert on his recommendation to have an independent reviewer of all deaths.

²⁰⁶ Page 34 deposition of Joseph Ssenfuma, Regional Coordinator, on September 28, 2017 and page 34, 30(b)(6) deposition of Dr. Meeks on July 25, 2017.

²⁰⁷ Page 35 deposition of Joseph Ssenfuma, Regional Coordinator, on September 28, 2017.

²⁰⁸ Item 7.1.2.1.2 Contract between Wexford Health Sources Inc. and Illinois Department of Healthcare and Family Services signed on 5/6/11.

Dental Program

Dental: Executive Summary

While aspects of the dental programs at some prisons we visited have improved and others have declined, the net result is a worsening of the dental programs since the First Court Expert's Report. Our visits confirmed most of the First Court Expert's findings and identified issues the First Court Expert did not mention. Based on the prisons we visited, IDOC dental care remains not minimally adequate; and it is substantially below accepted professional standards despite the four years the IDOC and Wexford had to remedy the previously identified program deficiencies.

Dental: Staffing and Credentialing

Methodology: Reviewed staffing documents, interviewed dental staff, reviewed the Dental Sick Call Logs, and other documents.

First Court Expert Findings

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

Current Findings

Staffing has deteriorated since the First Court Expert's Report. We concur with the First Court Expert's finding that dental hygienists are essential members of the dental team and should be on staff at all IDOC facilities.²⁰⁹ Notwithstanding the finding that staffing followed Administrative Directive 04.03.102, we found staffing (primarily dentist) shortages at several facilities due to IDOC's and Wexford's inability or unwillingness to fill vacancies timely.²¹⁰

Adequate staffing requires the appropriate number and mix of dental personnel positions and that these positions be filled. While NRC and SCC appear to have adequate dental staffing to address patient treatment timely, this is not true for Dixon and MCC. In fact, in 2017 MCC prisoners had to wait more than 15 months for fillings and for dentures. Dixon staffing is particularly problematic, since there is no dental hygienist and staffing shortages have resulted in the clinic being closed Mondays for more than a year. It is noteworthy that the Dixon dental hygienist position has not been established despite the First Expert's finding that it is essential.

Among the dental program's systemic inadequacies we identified are under diagnosis and under treatment of dental disease. Consequently, when diagnosis and treatment become minimally adequate, the prevalence of diagnosed dental disease will be higher and necessitate

²⁰⁹ Makrides, N. S., Costa, J. N., Hickey, D. J., Woods, P. D., & Bajuscak, R. (2006). Correctional Dental Services. In M. Puisis (Ed.), Clinical Practice in Correctional Medicine (2nd ed., pp. 556-564). Philadelphia, PA: Mosby Elsevier, p. 557 ("In prisons where routine dental care will be provided, the basic dental team should consist of a dentist, dental assistant, and dental hygienist")

²¹⁰ For example, MCC has two dentist vacancies. One vacancy is an IDOC position that has been unfilled for approximately two years. We were told that IDOC has asked Wexford to fill it.

increased dental staffing. We do not consider this in our assessment of dental staffing but recognize that this will have to be addressed as part of remediation.

Dental: Facility and Equipment

Methodology: Toured dental clinics, radiology areas, and dental intake areas to assess cleanliness, infection control procedures, and equipment functionality. Reviewed the quality of x-rays and compliance with radiologic health regulations.

First Court Expert Findings

Much of the equipment was old, corroded, and badly worn. Cabinetry and countertops were generally badly worn, corroded, or rusted, broken, and not up to contemporary standards for disinfection.

Current Findings

Overall, facilities and equipment have deteriorated since the First Court Expert's Report. We concur that most of the equipment in the clinics is old and worn, with many chair and counter surfaces cracked and difficult to decontaminate. Four years have passed since that assessment, and while some equipment has been replaced, for the most part, equipment has deteriorated. In addition, we found that the most problematic deficiency to be the inadequate panoramic x-ray units and processor at NRC, which will be discussed in a later section. Not only are many panoramic x-rays clinically inadequate but the NRC clinic intraoral film processor been inoperative for three years and dentists at Dixon have not been able to take intraoral x-rays for several months. Similarly, the x-ray film processor in the MCC North clinic has been inoperative and exposed film must be carried to the radiology clinic for processing.

Dental: Sanitation, Safety, and Sterilization/Autoclave Log

Methodology: Reviewed Administrative Directive 04.03.102. Toured dental clinics and dental intake examination areas. Observed dental treatment room disinfection. Interviewed dental staff. Observed intake dental examinations and patient treatment. Reviewed last two years of entries in autoclave log.

First Court Expert Findings

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 open, large cardboard boxes on pallets in the dental clinic. In none of the clinics were the sterilization area²¹¹ and the radiology area posted with proper hazard warning signs.²¹² Safety glasses were seldom worn by patients.

²¹¹ CFR 1901.145(e)(4). ("The biological hazard warning shall be used to signify the actual or potential presence of a biohazard and to identify equipment, containers, rooms, materials, experimental animals, or combinations thereof, which contain, or are contaminated with, viable hazardous agents.")

²¹² Occupational Safety and Health Standards – Toxic and Hazardous substances. 29 CFR 1910.1096(e)(3)(i). "Each radiation area shall be conspicuously posted with a sign or signs bearing the radiation caution symbol and the words, 'CAUTION RADIATION AREA'". Emphasis in original.

Current Findings

Overall, sanitation, sterilization, and, safety have deteriorated since the First Expert's Report, primarily due to inadequate hand sanitation at NRC and MCC. However, autoclave log maintenance has improved at SCC and MCC. We concur with the First Court Expert's finding of lack of appropriate warning signs, patient protective eyewear and lead aprons with thyroid collars not used routinely,^{213,214,215} and inadequate sterilization flow at several facilities. However, while the instrument flow was less than ideal, instruments could still be sterilized and stored adequately.

In addition, we found that surface decontamination was adequate but made challenging by the cracked and inadequate dental chair surfaces and countertops in many clinics. The most problematic issue (not found by the First Court Expert) was the inadequate infection control practices between intake exam patients at NRC, in which the patients were examined by a dentist who typically did not change gloves (or wipe them with alcohol between exams) and MCC (where the dentist did not wash his hands or disinfect them with alcohol wipes between changing gloves).²¹⁶ That this egregious breach of infection control could occur suggests inadequate monitoring by Wexford and the IDOC.

Dental: Comprehensive Care/Removable Dental Prosthetics

Comprehensive or routine care (to include removable dental prosthetics) is non-urgent treatment that should be based on a health history, a thorough intraoral and extraoral examination, a periodontal assessment, and a visual and radiographic examination. A sequenced plan (treatment plan) should be generated that maps out the patient's treatment.

Methodology: Interviewed dental staff, reviewed dental charts of inmates who received non-urgent care to include removable prosthetics, observed dental treatment. Selected charts for

²¹³ Guidelines for Infection Control in Dental Health-Care Settings ---2003. MMWR, December 19, 2003/ 52(RR17):1:16; pp. 17-18. ("PPE [personal protective equipment] is designed to protect the skin and the mucous membranes of the eyes, nose, and mouth of DHCP [dental health care provider] from exposure to blood or OPIM [other potentially infectious materials]. Use of rotary dental and surgical instruments (e.g., handpieces or ultrasonic scalers) and air-water syringes creates a visible spray that contains primarily large-particle droplets of water, saliva, blood, microorganisms, and other debris. This spatter travels only a short distance and settles out quickly, landing on the floor, nearby operator surfaces, DHCP, **or the patient**. The spray also might contain certain aerosols (i.e., particles of respirable size, <10 µm). Aerosols can remain airborne for extended periods and can be inhaled" and "Primary PPE used in oral health-care settings includes gloves, surgical masks, **protective eyewear**, face shields, and protective clothing (e.g., gowns and jackets). All PPE should be removed before DHCP leave patient-care areas (13). Reusable PPE (e.g., clinician **or patient protective eyewear** and face shields) [...]"). Emphasis added. Moreover, eyewear protects eyes from objects or liquids accidentally dropped during the course of treatment.

²¹⁴ Why we Take Infection Control Seriously. UIC College of Dentistry. Viewed at <https://dentistry.uic.edu/patients/dental-infection-control>, viewed February 2, 2018 ("We use personal protective equipment [...] **as well as provide eye protection to patients for all dental procedures.**") Emphasis added.

²¹⁵ While radiation exposure from dental radiographs is low, dentists should follow the ALARA Principle (As Low as Reasonably Achievable) to minimize the patient's exposure. Dentists should follow good radiologic practice and (*inter alia*), **use protective aprons and thyroid collars**. Dental Radiographic Examinations: Recommendations for Patient Selection and Limiting Radiation Exposure. ADA and FDA (2012), 14. Emphasis added.

²¹⁶ Centers for Disease Control and Prevention. *Summary of Infection Prevention Practices in Dental Settings: Basic Expectations for Safe Care*. Atlanta, GA: Centers for Disease Control and Prevention, US Dept of Health and Human Services; October 2016, p.7.

review randomly from Prosthetics List (patients with two partial dentures) and Daily Dental Reports (patients who received fillings and biennial examinations).

First Court Expert Findings

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.

There was seldom a dental prophylaxis or oral health instructions provided prior to routine restorative care to include removable prosthetics. 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.

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 prosthetic impressions.

Blood pressures were not being taken on inmates with a history of hypertension.

Current Findings

Overall, comprehensive care is unchanged since the First Court Expert's Report. We concur that routine care (to include removable prosthetics) is inadequate and is provided without adequate x-rays, periodontal assessment, and documented oral hygiene instruction and a sequenced treatment plan.^{217,218} Moreover, we agree that the biennial examination, as currently performed, is of little clinical value.

Rather than relying on intraoral x-rays, the accepted professional standard for routine examinations,²¹⁹ dentists base their charting for caries on the panoramic x-ray in conjunction with a visual exam. Not only is this insufficient to diagnose interproximal (between the teeth) decay but it ignores the existence of periodontal disease. Moreover, even when periodontal disease is occasionally categorized per Administrative Directive 04.03.102 (Dental Care for Offenders), there is no documented periodontal probing²²⁰ and the location of the disease is

²¹⁷ Stefanac SJ. Information Gathering and Diagnosis Development. In Treatment Planning in Dentistry [electronic resource]. Stefanac SJ and Nesbit SP, eds. Edinburgh; Elsevier Mosby, 2nd Ed. 2007; pp. 11-21, *passim*.

²¹⁸ IDOC agreed that "[r]outine comprehensive care should be provided for through a comprehensive exam and treatment plans. The exam [should include] radiographs diagnostic for caries, a periodontal assessment, a soft tissue exam, and accurate charting of the teeth," and "hygiene care and oral health instructions be provided as part of the treatment process." IDOC Response, ¶XIII (5).

²¹⁹ Dentate or partially dentate adults who are new patients should receive an "[i]ndividualized radiographic exam consisting of posterior bitewings with panoramic exam or posterior bitewings and selected periapical images." Furthermore, recall patients [i.e., biennial exam patients] should receive posterior bite wing x-rays every 12 to 36 months based on individualized risk for dental caries. With respect to periodontal disease, "[i]maging may consist of, but is not limited to, selected bitewing and/or periapical images of areas where periodontal disease (other than nonspecific gingivitis) can be demonstrated clinically." Dental Radiographic Examinations: Recommendations for Patient Selection and Limiting Radiation Exposure. American Dental Association and U.S. Food and Drug Administration, 2012. Table 1, pp. 5-6.

²²⁰ Stefanac SJ. (A panoramic radiograph has insufficient resolution for diagnosing caries and periodontal disease. Intraoral radiographs (e.g., bite wings) and periodontal probing are necessary), p. 17. Also, (Periodontal Screening and Recording (PSR), an early detection system for periodontal disease, advocated by the ADA and the American Academy of Periodontology since

not noted.²²¹ As with most of the other patients who received comprehensive care including removable prosthetics, sequenced treatment plans and periodontal assessments that included documented probing were absent.

Biennial exams were scanty and of minimal clinical value since they were informed by neither bite wing x-rays nor documented periodontal probing. Documented oral cancer screening and sequenced treatment plans were rare.

Absent a sequenced treatment plan informed by intraoral x-rays²²² and periodontal probing, the dentist does not have sufficient information to make an informed decision. In the community, what is called a biennial exam is analogous to a periodic exam.²²³ The biennial exam is cursory, and not substantially different from the inadequate exam performed at intake.

Not only is periodontal disease underdiagnosed but it is undertreated. In none of the dental charts reviewed was there a treatment plan that identified specific non-surgical periodontal procedures such as scaling and root planing. Moreover, the Daily Treatment Report that lists the treatment provided to each patient has no section for periodontal treatment.²²⁴ The IDOC and Wexford dentists and dental hygienists we interviewed who were in private practice were familiar with the industry-standard dental procedure codes. However, there is no column for scaling and root planing (SRP)²²⁵ and no way of knowing if it is performed. Similarly, dentists and dental hygienists knew what periodontal screening and recording (PSR) was but did not use it in IDOC, although many acknowledged using it in private practice.

The Wexford contract specifies that “[v]endor shall provide dental checkups to offenders every two years, or more often if clinically indicated, and evaluations must be provided within 14 days after the offender's request for routine care treatment.” However, it is mute on the more critical issue, the maximum waiting time for **treatment**. So, under current dentist staffing, a prisoner who needs (for example) three fillings that require three appointments could conceivably wait more than three years for the last tooth to be filled. It is more likely than not that the teeth awaiting filling will become more difficult to fill or become non-restorable and require extraction and cause preventable pain.

1992, is an accepted professional standard.), pp. 12-14. See American Dental Hygiene Association. Standards for Clinical Dental Hygiene Practice Revised 2016, pp. 6-9. (Periodontal probing is also a standard of practice for dental hygiene).

²²¹ The only categories related to specifically periodontal disease are Ib (“acute periodontal abscess”), Ic (“acute periodontitis”), Ie (“acute gingivitis”), IIb (“localized gingival involvement”), and Vb (“lack of visible gingival irritation”). *Id.* Attachment A.

²²² See NCCHC P-E-06 (Oral Care), ¶8 ([r]adiographs are used in the development of the treatment plan”).

²²³ The ‘uniform record system’ sponsored by the American Dental Association is the Code on Dental Procedures and Nomenclature. “In August 2000 the CDT Code was designated by the federal government as the national terminology for reporting dental services on claims submitted to third-party payers. The industry standard code for a periodic exam is D0120. It is defined as “[a]n evaluation performed on a patient of record to determine any changes dental and medical health status since a previous comprehensive or periodic examination. This includes an oral cancer evaluation, and periodontal screening where indicated, [...]”. American Dental Association Dental Procedure Codes, 2015, pp. 1, 5.

²²⁴ The categories are “scale and prophylaxis,” “gingivitis,” and “periodontal.” While “scale and prophylaxis” is mappable to ADA treatment code D1110 that has a standard profession-wide definition, “gingivitis” and “periodontal” are not directly mappable to an ADA code. The IDOC and Wexford dentists and dental hygienists we interviewed who were in private practice were familiar with the industry-standard dental procedure codes.

²²⁵ ADA codes D4341 and D4342.

Wait times are most problematic at MCC, with April 2018 backlogs for fillings and dentures more than 15 months. While Wexford does not report periodontal treatment wait times, dental hygienist caseload (in number of patients) is reported in the monthly April 2018 CQI minutes. We imputed dental hygienist wait time to be approximately 16 months.²²⁶ While a cleaning or prophylaxis is not a periodontal procedure, it is often a precursor to periodontal treatment (if periodontal treatment has been prescribed by a dentist on the treatment plan). A wait of more than a year before periodontal treatment can begin, even if it is diagnosed, is unreasonable and such a treatment delay can result in preventable disease progression with concomitant bone loss.

While patients planned for removable prosthetics are not treated by outside specialists but rather onsite dentists, approval for dental prosthetics must be obtained from Wexford through a process referred to as “collegial review.” The reviewer is Dr. Karanbir Sandhu, who serves on a part-time basis as a Wexford Prosthetic Advisory Dentist. Dr. Sandhu is not specialist in prosthodontics, or for that matter any other aspect of dentistry.

Dental: Intake (Initial) Examination²²⁷

Methodology: Reviewed dental records and panoramic x-rays of inmates who have received recent intake (initial) examinations. Reviewed Administrative Directive 04.03.102.

First Court Expert Findings

Although a review of records revealed that the IDOC followed its screening examination policy, oral health instructions are omitted as part of the process. 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 the screening exam, the panoramic radiograph, and the charting as a treatment plan from which to deliver routine care.

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.

Current Findings

Overall, the initial examination is unchanged since the First Court Expert’s Report. We concur that the initial examination is inadequate and fails to include appropriate head, neck, and soft

²²⁶ The April 2018 CQI minutes (based on March data) reported a dental hygienist caseload of 1018 patients and the March 2018 Dental Report noted that the hygienist performed 61 cleanings/prophylaxes. This equates to a more than 16-month backlog.

²²⁷ The First Court Expert Report describes the examination performed at intake screening as a “Screening Examination;” however, Administrative Directive 04.03.102 describes it as a “complete dental examination.” We use the terminology of the Administrative Directive and refer to the intake or initial dental examination as a complete dental examination.

tissue assessments. While the First Court Expert found that area disinfection was poor²²⁸, there was no mention of the breaches of infection control by the NRC and MCC dentists described in previous reports. In addition, we found as follows.

The initial examination is governed by Administrative Directive 04.03.102 which states (*inter alia*) that

Within ten working days after admission to a reception and classification center or to a facility designated by the Director to accept offenders with disabilities for a reception and classification center, each offender shall receive a **complete dental examination by a dentist**.²²⁹

While “complete dental examination” is not defined in Administrative Directive 04.03.102, the examination performed at the three R&C centers we visited is by no means “complete” because it is too brief and not informed by intraoral x-rays, a documented periodontal probing, and a consistently performed oral cancer screening.^{230, 231} The deficiencies of this examination are particularly problematic, since it is used to classify treatment needs and determine treatment priority.

Notwithstanding the plain text of Administrative Directive 04.03.102, it is apparently IDOC’s position that the dental examination performed at intake is a screening examination (citing NCCHC Oral Care Standard P-E-06) is cursory and need not be performed by a dentist.²³² However, compliance with Oral Care Standard P-E-06 (assuming IDOC adopts it as its standard) requires that in addition to an oral screening, an oral examination should be performed by a dentist within 30 days of admission.^{233, 234, 235}

²²⁸ Which we found at NRC.

²²⁹ Administrative Directive 04.03.102 (¶II F 2) (emphasis added). Furthermore, the exam should include, “[c]harting of the oral cavity and categorization of status or treatment needs in accordance with the American Public Health Association’s priorities delineated in Attachment A.” *Id.* at (¶II F 2a).

²³⁰ This is generally done by holding the anterior portion of the tongue with 2x2 gauze and reflecting the tongue with a mouth mirror. This is a professional standard for an oral examination. See, for example, National Institutes of Health. National Institute of Dental and Craniofacial Research. Detecting Oral cancer. A Guide for Professionals. Viewed 6/4/2018 at <https://www.nidcr.nih.gov/sites/default/files/2017-09/detecting-oral-cancer-poster.pdf>.

²³¹ Stefanac SJ. (“Evaluation of head and neck structures for evidence of tissue abnormalities or lesions constitutes an important part of a comprehensive examination.”), p. 12. See also Shulman JD, Gonzales CK. Epidemiology/Biology of Oral Cancer. In Cappelli DP, Mosley C, eds. Prevention in Clinical Oral Health Care. Elsevier (2008) (“Regular, thorough intraoral and extraoral examination by a dental professional is the most effective technique for early detection and prevention of most oral cancers. [...]”) p. 41.

²³² IDOC Response to First Expert Report, pp. 32-33.

²³³ 2014 NCCHC Oral Care Standard P-E-06, p. 81 and 2018 NCCHC Oral Care Standard P-E-06, pp. 96-97.

²³⁴ IDOC’s selective invocation of the NCCHC Standard is inappropriate. If (as the IDOC Response maintains), initial dental examination is a screening and not a “complete dental examination” as set forth in the Dental AD, when does an IDOC prisoner receive an oral examination (that per NCCHC P-E-06 should be performed within 30 days of admission)?

²³⁵ IDOC Response to First Expert Report, p. 33. (“Initial dental contacts between clinicians and offenders at IDOC reception centers constitute dental screenings, as defined by the NCCHC. Accordingly, the reception center dentist performs a “visual observation” and notes “obvious or gross abnormalities requiring immediate referral to a dentist.” Subsequent referrals result in a dental examination, which comports with the NCCHC definition of “examination.” Because its procedures meet NCCHC standards, IDOC believes they meet the minimum constitutional standard of adequacy.) They do not.

However, IDOC's assertion that since subsequent referrals result in a dental examination IDOC complies with the NCCHC Oral Care Standard ignores the plain text of P-E-06, since under IDOC's idiosyncratic interpretation, the only prisoners who would receive a dental examination would be those who were referred based on a screening that could be performed by a non-dentist or even the current inadequate intake examination performed by a dentist.

While IDOC does not define "complete dental examination," the definition of a comprehensive or complete dental examination is set forth by the American Dental Association (ADA) and the NCCHC.²³⁶ The ADA defines a Comprehensive Oral Examination (Procedure Code D0150).²³⁷ Similarly, a comprehensive clinical examination includes an intraoral and extraoral soft tissue examination (primarily screening for oral cancer); a periodontal examination using, at a minimum, Periodontal Screening and Recording (PSR); an examination of the teeth; and a radiographic examination using panoramic **and** intraoral x-rays.²³⁸ Furthermore, as mentioned earlier, the ADA and Food and Drug Administration (FDA) recommend that intraoral x-rays should be part of a dental examination.

At two prisons (NRC and LCC), the dentists did not document a thorough soft tissue examination. For example, they did not visualize the lateral and posterior regions of the tongue, potential sites of squamous cell carcinoma. Performing a thorough soft tissue examination is critical for a new inmate, since unless the prisoner requests care within two years, the next exam will be biennial under current policy.²³⁹

We visited three prisons that performed intake screening; NRC, LCC, and MCC. The NRC has the largest volume, processing 15,942 prisoners in 2017. All inmates have a panoramic x-ray taken and receive a cursory direct-view oral examination that includes a scanty health history. Not only is the exam uniformly deficient, but the quality of the panoramic x-rays used is poor and documentation was deficient.²⁴⁰ Furthermore, infection control was inadequate at two

²³⁶ "Oral examination by a dentist includes taking or reviewing the patient's oral history, an **extraoral head and neck examination**, charting of teeth, and examination of the hard and soft tissue of the oral cavity with a mouth mirror, explorer, and adequate illumination." NCCHC Oral Care Standard P-E-06, 2018, p. 96. Emphasis added.

²³⁷ "[This code is] [u]sed by a general dentist and/or a specialist when evaluating a patient comprehensively. This applies to new patients; established patients who have had a significant change in health conditions or other unusual circumstances, by report, or established patients who have been absent from active treatment for three or more years. It is a thorough evaluation and recording of the extraoral and intraoral hard and soft tissues. It may require interpretation of information acquired through additional diagnostic procedures. [...] This includes an evaluation for oral cancer where indicated, the evaluation and recording of the patient's dental and medical history and a general health assessment. It may include the evaluation and recording of dental caries, missing or unerupted teeth, restorations, existing prostheses, occlusal relationships, periodontal conditions (including periodontal screening and/or charting), hard and soft tissue anomalies, etc." American Dental Association Code on Dental Procedures and Nomenclature, 2015; p. 6.

²³⁸ Stefanac SJ, pp. 12-15, *passim*. Emphasis added.

²³⁹ This deficiency is compounded by the fact that dentists do not document soft tissue examinations at biennial exams (see *infra*).

²⁴⁰ Of 20 panoramic x-rays from screening exams performed January 23, 2018, nine (45%) were clinically inadequate; characterized by poor contrast (washed out) or the presence of artifacts that interfered with interpretation. Our findings were confirmed by an SCC Quality Improvement Study in which intake screening charting was compared with the results of clinical examinations performed on the same patients. Of the 21 NRC charts, 62% had no charting of pathology (e.g., "abscessed teeth, teeth that needed extraction, [and] periodontal disease, (+3) mobility in teeth, grossly decayed teeth, impacted wisdom teeth in the maxillary sinus, and numerous visible dental caries"), with the remainder having only a partial charting.

facilities.^{241,242}

The oral hygiene instructions (OHI) were inadequate at all prisons we visited. For example, at MCC, they consisted of saying, “make sure you brush and floss,” and took no more than a minute.²⁴³ This is not adequate oral hygiene instruction. Furthermore, while spooled dental floss is deemed contraband at MCC, the dentist did not mention the existence of (not to mention how to use) floss alternatives.

Dental: Extractions

Methodology: Reviewed records of inmates who had extractions, randomly selected from Daily Dental Reports October 2017 through January 2018 and Dental Sick Call Logs. Interviewed dental staff.

First Court Expert Findings

Antibiotics were provided routinely after dental extractions at some institutions.

A proper diagnostic reason for extraction was seldom part of the dental record. Documentation was, overall, very poor.

Current Findings

Our finding that extraction care is adequate diverges from that of the First Court Expert which suggests that many of the previously identified deficiencies have been remedied. Moreover, we identified current and additional findings as follows.

With few exceptions, extractions were informed by adequate preoperative x-rays and were accompanied by signed consent forms. However, while the tooth to be extracted was identified, the reason for the extraction was rarely noted. On the other hand, most of the health history forms were not updated. Generally, patients with dental infections who were prescribed antibiotics had the tooth extracted timely,²⁴⁴ that is within the therapeutic window of the antibiotic²⁴⁵ (i.e., within 10 days – the duration of most of the antibiotic prescriptions).²⁴⁶

²⁴¹ The most egregious example was at NRC which we discuss in the NRC Report. “The dentist donned gloves, selected mouth mirrors from a bag of sterile mirrors that he opened and placed on a bracket table before the first exam. A standard dental light illuminated the patient’s mouth. He reviewed the panoramic x-ray and took a cursory health history. He used one or two mirrors to reflect the cheeks and adjusted the light for optimal illumination. While his gloved hands did not always touch the patient, in approximately half the exams we observed, they touched the patient’s face, lips, or mouth. He did not change gloves between patients consistently. In fact, there were several instances where he examined a patient wearing the gloves he used to touch a previous patient’s mouth or face. He did not wash hands between patients because the exam room had no sink.” Centers for Disease Control and Prevention.

²⁴² *Summary of Infection Prevention Practices in Dental Settings: Basic Expectations for Safe Care*. Atlanta, GA: Centers for Disease Control and Prevention, US Dept. of Health and Human Services; October 2016, p.7.

²⁴³ Oral Hygiene Instructions (ADA Code D1330) “may include instructions for home care. Examples include tooth brushing technique, flossing, and the use of special oral hygiene aids.” ADA Procedure Codes.

²⁴⁴ MCC was particularly problematic. “Of the 11 who were prescribed antibiotics, all but one (91%) waited more than 10 days.” MCC Report. See sick Call discussion *supra*.

²⁴⁵ Shulman JD, Sauter DT. Treatment of odontogenic pain in a correctional setting. *Journal of Correctional Health Care* (2012) 18:1, 58 – 69; p. 68.

Dental: Sick Call/Urgent Care / Treatment Provision

Methodology: Interviewed dental staff. Reviewed Dental Sick Call Logs and Daily Dental Reports. Reviewed randomly selected records of inmates who were seen on sick call. Reviewed recent intake examination records.

First Court Expert Findings

The SOAP format was not being used to document urgent care encounters.

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.

Current Findings

Overall, urgent care has not changed materially since the First Court Expert's Report and remains inadequate. We concur with the First Court Expert that urgent care was generally untimely. In addition, we identified current and additional findings as follows.

Prisoners access dental care via submitting a written request, going on nurse sick call, or communicating their problem with staff. There is substantial variation in the wait time for prisoners with a painful dental condition who submit a sick call request or sign up for nurse sick call, with several prisons (e.g., MCC, SCC, and Dixon) having median times to be seen by a provider for dental pain of more than two days. Some prisons have a nurse sick call process where prisoners who state dental pain are assessed timely by a nurse using a "dental pain" protocol and are palliated and referred to the dental service.²⁴⁷ At some prisons, requests for dental urgent care that are sent directly to the dental service are delayed due to an intervening weekend or when the dentist is not available (e.g., NRC, Dixon), or a staff shortage (e.g., MCC).

When a patient with an urgent care complaint is seen by the dentist, the SOAP format is not consistently used for dental sick call progress notes (e.g., NRC, SCC) nor is the health history updated – a system wide problem.

Dental: Orientation Handbook

Method: Reviewed the Orientation Handbook and other orientation documents.

First Court Expert Findings

²⁴⁶ Makrides, N. S. et al. ("[d]elayed dental treatment of the original focus of the [tooth-related] infection may turn a minor problem into a serious condition. Although infection is usually self-limiting and spatially-confined, it may spread because of a highly virulent organism. Complications could include Ludwig's angina, mediastinitis, cerebral abscess, maxillary sinusitis, chronic fistulous tracts, and infective endocarditis." (p. 559).

²⁴⁷ At NRC, there is no process for nurses, when the dentist is not available, to perform a face-to-face examination on dental patients who state they have pain to identify pain and infection and provide analgesics and referral to a mid-level or advanced level provider if immediate treatment is necessary.

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

Current Findings

Overall, inmate orientation to dental care has improved since the First Court Expert's Report. While we concur with the First Court Expert that the orientation handbook could benefit from additional information about access to dental care, there was sufficient information provided about sick call in general for inmates to access dental care. Furthermore, dentists provided relevant information during the NRC, LCC, and MCC intake exams.

Dental: Policies, Procedures, and Program Management

Methodology: Reviewed Administrative Directives that deal with the dental program. Interviewed dental staff. Reviewed dental charts. Toured dental clinical areas. Reviewed organizational charts.

First Court Expert Findings

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 guidance for developing and managing a successful dental program.

The Administrative Directives do not address quality of care issues, clinic management, record management, or staff oversight and responsibilities. Dentists are provided no orientation to the IDOC dental program or training on how to manage their institution's programs. This, in conjunction with inadequate quality assurance and peer review, suggests a lack of oversight on the part of the IDOC and Wexford. Moreover, there is no 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 considering the dental staffing guidelines.

Current Findings

Overall, policies, procedures, and program management have not improved materially, and we concur that they are inadequate. In addition, we identified current and additional findings as follows.

Administrative Directive 04.03.102 is flawed and should be rewritten. The components of the initial examination should be specified. Is it a "complete examination" per ¶ II F (2) or a "screening examination?" To remove ambiguity, all procedures should be defined to be consistent with the federally recognized ADA Procedure Codes.²⁴⁸ So, for example, a complete

²⁴⁸ The uniform record system sponsored by the American Dental Association is the Code on Dental Procedures and Nomenclature. "In August 2000 the CDT Code was designated by the federal government as the national terminology for

oral examination for a new patient (D0150) has a profession-wide definition, as does periodic oral examination for an established patient (D0120) that is analogous to a biennial examination.

As noted by the First Experts, Administrative Directives, and dental program guidance from IDOC are lacking.

The IDOC Medical Director stated that while he is responsible for the dental program, he relies on a Wexford dentist for oversight. He acknowledged that this was not a good arrangement and prefers a Chief of Dentistry who is a state employee as part of his regional team.²⁴⁹

In a response to a recommendation made in the First Expert Report, IDOC stated that it has committed to creating and filling a 0.25 FTE Statewide Dental Director position.^{250, 251} After almost four years, no such position has been established.

Dental: Failed Appointments

Methodology: Reviewed Dental Sick Call Logs. Interviewed dental staff. Reviewed Daily Dental Reports.

First Court Expert Findings

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

Current Findings

Overall, failed dental appointments have not improved materially since the First Court Expert's Report.²⁵² While the failed appointment rate appears to have improved compared to the First Expert Report, it could not be determined for NRC and Dixon. However, a scan of Dixon daily and monthly dental logs suggests that failed appointments may be a problem.

Dental: Medically Compromised Patients

Methodology: Reviewed health history form and records from recent intake exams. Compared the health history in the dental chart to the medical problem list. Reviewed randomly selected charts of patients on Chronic Care Lists for diabetes and anticoagulant therapy.

First Court Expert Findings

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

reporting dental services on claims submitted to third-party payers." American Dental Association Dental Procedure Codes, 2015, p. 1.

²⁴⁹ Meeks Interview, ¶135.

²⁵⁰ IDOC Response pp. 9, 31.

²⁵¹ IDOC should have at a minimum a 0.5 FTE position for a Statewide Dental Director to oversee the Wexford contract as it relates to dental care. Leaving dental oversight to the vendor is inviting the fox to guard the hen house.

²⁵² A facility that does not track and routinely report the failed appointment rate is deemed inadequate.

dental record was inadequate. Blood pressures were not being taken on inmates with a history of hypertension.

Current Findings

Documenting the health history of medically compromised patients has not changed materially and remains inadequate since the First Court Expert's Report. We concur with the First Court Expert's findings. In addition, we identified current and additional findings as follows.

The health history form is too limited and omits conditions relevant to dental care, for example, anticoagulant therapy. Moreover, there is insufficient room on the form for adding information. Health histories were not filled out or updated at the last visit in most charts. In addition, there was no documented periodontal assessment and request for follow-up for diabetics, which is particularly problematic given the relationship between periodontal disease and diabetes.²⁵³

Dental: Specialists

Methodology: Interviewed dental staff, reviewed CQI documents, and reviewed dental charts of all inmates who were seen by an oral surgeon.

First Court Expert Findings: None.

Current Findings

Dental specialty referral has not changed materially since the First Court Expert's Report and remains adequate. We concur with the First Court Expert's findings. In addition, we identified current and additional findings as follows.

Approval for onsite or offsite oral surgery consultations requires the consent of the Wexford Regional Medical Director through a process referred to as "collegial review." The reviewer for oral surgery consultations is Dr. Karanbir Sandhu, who serves on a part-time basis as a Prosthetic Advisory Dentist. Dr. Sandhu is neither an oral surgeon nor a specialist in any other aspect of dentistry.

Several prisons have arrangements for local oral surgeons to provide care on site for less complex procedures and transport prisoners to the oral surgeon's practice for complex procedures. Other prisons send all prisoners who require oral surgery care off site. Oral surgery consultations we reviewed were appropriate, and appointments were made timely.

Dental: CQI

Methodology: Reviewed CQI minutes and reports. Interviewed dental staff.

²⁵³ See, for example, Herring ME and Shah SK. Periodontal Disease and Control of Diabetes Mellitus. *J Am Osteopath Assoc*. 2006; 106:416-421; Patel MH, Kumar JV, Moss ME. Diabetes and Tooth Loss. *JADA* 2013;144(5):478-485 (adults with diabetes are at higher risk of experiencing tooth loss and edentulism than are adults without diabetes); and Teeuw WJ, Gerdes VE, and Loos BG. Effect of Periodontal Treatment on Glycemic Control of Diabetic Patients. *Diabetes Care* 3 (3) :421-427, 2010 (periodontal treatment leads to an improvement of glycemic control in type 2 diabetic patients).

First Court Expert Findings

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 ensure that proper policies and protocols are in place and followed, and that dental standards of care are practiced.

Current Findings

The dental CQI program has improved marginally since the First Court Expert's Report but remains inadequate. We concur with the First Court Expert. In addition, we identified current and additional findings as follows.

CQI studies were limited in scope and follow up with corrective action plans was lacking.²⁵⁴ For example, the 2016-2017 SCC CQI Report described study of compliance with the charting at the initial examinations at NRC. Among the findings from the NRC charts were that 62% had no charting of pathology, with the remainder having only a partial charting; for example, visible heavy tartar [calculus], and periodontal needs were never charted or indicated. Moreover, the panoramic radiographs from NRC varied in diagnostic quality. However, we were not provided with any corrective action plans.

The LCC 2017 Annual Governing Body Report described a quality improvement study on "[t]he time frames for dentures start to finish including healing. Is it within 3 months?" There were neither recommendations nor a planned follow up. The study was, at best, trivial. Given the inadequacy of the clinical aspects of the dental program described in this report, a 'study' of how long it takes to fabricate a denture ignores far more relevant issues, such as inadequate health histories, inadequate diagnosis of periodontal disease, and failure to use intraoral x-rays.

We were provided with a summary of two MCC studies. A study of 50 patients who were on the restoration (filling) list May 2015 to December 2015, with treatment dates ranging from August 2016 until September 2016, found that 94% had successful restorations without need of extraction. However, the actual study was not provided, just a five-line summary, so its validity cannot be assessed. Another MCC study summary, "Effects of lockdowns and dental coverage on filling numbers and backlog numbers," had no analysis, just a recitation of findings.

Peer Review

We asked to see all peer reviews of dentists working at the eight facilities on our site visit schedule and were informed that dentists (unlike other practitioners) are not routinely peer reviewed. According to Attorney Ramage, speaking for Wexford,²⁵⁵ neither the IDOC contract²⁵⁶

²⁵⁴ While a study of the quality of SCC onsite oral surgery consultations and one follow-up was performed, the Root Cause Analysis recommended by Dr. Meeks was not performed. Furthermore, Dr. Meeks recommended that Dr. Funk and Mr. Mote monitor the oral surgeon's performance at other institutions. We requested the Root Cause Analysis and other follow-up material; however, they were not provided,

²⁵⁵ Email from Andrew Ramage to Michael Puisis 3/29/2018.

nor Wexford policy requires that dentists be peer reviewed.²⁵⁷ He further stated that “[r]outine peer reviews of dentists are not a mandatory standard of NCCHC,”²⁵⁸ however, he is confuted by the NCCHC, which specifically includes dentist peer reviews in its Clinical Performance Enhancement Standard P-C-02.²⁵⁹

Moreover, “Wexford Health has never found a true dentist ‘peer review’ to be a productive means to determine clinical quality.”²⁶⁰ Finally, it is Wexford’s position that the dentist peer reviews are not a part of the community standard.²⁶¹ While clinical peer review is not the community standard for dental care in a private practice environment, it is the community standard for organized dental practices such as the military, Department of Veterans Affairs, and Departments of Corrections that have recently emerged from federal monitoring (e.g., California and Ohio.)²⁶²

We were provided with peer reviews of Drs. Crisham (performed 12/30/15) and O’Brien (performed 1/16/17) who practiced at Dixon, and we were able to locate five of the 20 charts on which the peer review was based. Our findings were consistent with those of the reviewer; however, several critical elements were absent from the checklist, and were not evaluated. Consequently, many of the fundamental flaws we found in the dental care provided at Dixon, such as inadequate treatment plans, failure to use bite wing x-rays to inform caries diagnosis, and failure to diagnose and treat periodontal disease, were undiscovered. Dental peer review **as implemented by Wexford** is poorly designed and does not therefore determine clinical quality.

²⁵⁶ The contract addresses “physician peer review,” which applies to the onsite Medical Director, staff physicians, nurse practitioners, physician assistants, and psychiatrists; however, dentists and psychologists are excluded. Wexford Contract, ¶2.2.2.19 and ¶7.1.5.

²⁵⁷ However, Wexford Clinical Performance Enhancement Policy P-403 states, “[a] minimum of one annual “peer review” [will be performed] whereby a practitioner’s clinical performance is evaluated by a senior or supervising practitioner, and, when necessary, senior practitioners are evaluated by regional/corporate staff. [...]” ¶III A3; and “[t]he senior dentist will complete a peer review for each dentist and ensure the completion of the biennial external review for those qualified. The Regional Medical Director will assign a peer reviewer for small contract locations having single or part-time dentists.” Wexford Resp. RTP#5, Question 2, p. 0405.

²⁵⁸ Ramage email, *id.*

²⁵⁹ “In contrast [to an annual performance review], a clinical performance enhancement review focuses only on the quality of the clinical care that is provided. This type of review should be conducted only by another professional of at least equal training in the same general discipline. For example, an RN should evaluate other RNs and LPNs, a physician should review the work of a physician, and **a dentist should review the work of a dentist;**” and “[Clinical Performance the standard requires that the facility’s direct patient care clinicians and RNs and LPNs are reviewed annually. Direct patient care clinicians are all licensed practitioners who provide medical, dental, and mental health care in the facility. This includes physicians, dentists, midlevel practitioners, and qualified mental health professionals (psychiatrists, psychologists, psychiatric social workers, psychiatric nurses, and others who by virtue of their education, credentials, and experience are permitted by law to evaluate and care for mental health needs of patients). NCCHC recognizes that there are many other professions that have licensed practitioners (e.g., dental hygienists) who may be considered direct patient care clinicians. While it is good practice to include these professionals in the clinical performance enhancement process, technically it is not required by the standard.” National Commission on Correctional Health Care, Clinical Performance Enhancement (<https://www.ncchc.org/clinical-performance-enhancement-1>) viewed 3/30/18 (emphasis added).

²⁶⁰ Ramage e-mail, *id.*

²⁶¹ *Id.*

²⁶² California Department of Corrections Inmate Dental Services Program. September 2014, ¶ 4.3; Ohio Department of Corrections Policy 68-MED-12, ¶ VI B 3.

Internal Monitoring and Quality Improvement

Methodology: Interview facility health care leadership and staff involved in quality improvement activities. Review the quality improvement meeting minutes and annual CQI reports.

First Court Expert Findings

The First Court Expert found that the IDOC does not have the ability to monitor itself in part because it lacks data on key processes of care. For that reason, he recommended use of tracking logs to facilitate efficient review and data collection of quality performance measures. He found that data sources, including tracking logs, are not consistently used. He found that some facilities performed no quality improvement activity and other facilities collected data but did not measure the quality of performance against a standard. He was unable to find any facility they investigated that measured quality of performance against a standard. He also failed to find any facility that initiated any effort to improve the quality of the program. None of the quality improvement coordinators had any formal training in quality improvement methodology. He also noted that although his team found a high rate of lapses of care in mortality review, internal mortality review identified no lapses in care.

Current Findings

We found there were some improvements since the First Court Expert's report. We did not confirm the finding that some of the facilities performed no quality improvement activity. Every facility we investigated had quality improvement meetings, produced quarterly and annual reports, and performed studies. We found, however, that annual reports and quality improvement studies were ineffective. We also did not find that facilities were not measuring quality against a standard. Some studies were undertaken that measured against Administrative Directive requirements as a standard. The First Court Expert failed to find any facility that initiated any effort to improve quality. We found that all facilities we investigated initiated effort, but these efforts were ineffective. The lack of experienced or knowledgeable CQI staff and the failure to integrate quality into the fabric of operations was significant and made the CQI programs ineffective. There was also an absence of evaluation of *clinical* quality, which contributes to preventable morbidity and mortality. The ineffectiveness of the CQI program, in our opinion, was a result of the following.

None of the facilities investigated had anyone who had expertise or knowledge of CQI methodology or implementation. CQI coordinators at NRC, SCC, and MCC are medical records personnel. None had any experience or training in CQI and had no knowledge of how to implement a CQI program. They were named CQI coordinators apparently because they could manage the paperwork requirements with respect to producing monthly minutes and annual reports. At two facilities, Dixon and MCC, the HCUAs were acting CQI coordinators by default because there was no one else available for this task. These individuals had no experience or training in CQI methodology. It did not appear that facilities understood how to design or implement an outcome study, and process studies failed to include any discussion or analysis of

variables involved in the process of care being studied. Outcome and process studies are required elements of the IDOC Administrative Directive on quality improvement.

None of the facilities had a reasonable CQI plan. An annual CQI plan needs to identify the major areas of investigation that the CQI committee is working on in the upcoming year. These plans should be based on the most important identified problems at the facility. Instead, the annual CQI plans at all facilities were generic and gave no formulation of the plan for the upcoming year's CQI work. The SCC and NRC plans were identical and copied one from the other, even though each site had separate types of problems. Problems were not identified and CQI studies did not match problems that existed at the facilities we visited.

None of the facilities had a Medical Director who participated meaningfully in CQI work. The absence of clinical medical leadership in quality improvement work is significant, as studies lack a clinical perspective necessary for medical CQI work.

Quality of physician care was not included in any CQI studies. The lack of physician quality reviews was significant. Mortality review is not performed. Peer review, as has been discussed, was ineffective and, in our opinion, did not accurately reflect the quality of provider care at the facilities we investigated. CQI studies evaluate mostly whether an intervention such as sick call or chronic illness clinic happened. But there is no evaluation as to whether it was adequately performed from a clinical basis.

All facilities had difficulty in identification of their key problems, indicating that a critical analysis of their processes of care was lacking. We view this as a lack of knowledge of how to implement CQI. When facilities were able to identify problems, they failed to thoroughly evaluate the problems. One facility, NRC, did identify medication errors as a problem, which we agreed with. However, there was no analysis of why the problem was occurring and no attempt to establish corrective action plans to correct the problem, so the problem persisted and was repeatedly reported in CQI meeting minutes. SCC identified that referral from nurse sick call to providers was not timely. This study was repeatedly performed without any evaluation as to why this was occurring with an attempt to fix the problem. The problem persisted.

We noted pervasive and systemic problems with preparing and administering medications. This process is not standardized across the system. Problems with administration of medication place inmates at risk of harm. We noted problems with failure to complete parts of the intake process. There is a problem with timely scheduling of specialty care and chronic care. There were problems with surveillance and tracking of infectious and contagious disease. There were problems with standardization of maintaining equipment and supplies. There was no standardized sanitation program. There is no system to monitor sentinel events or adverse clinical events. The IDOC lacks both a process to identify problems and lacks the ability to correct these systemic problems. In systems under Court supervision that we have monitored, a fundamental element of the exit strategy is the ability of the system to self-monitor by identifying problems and taking corrective action to fix the problem. The ability to self-monitor

is essential for a correctional health program but the IDOC currently does not demonstrate capacity to self-monitor.

Access to data useful for quality improvement purposes was poor at all facilities. The First Court Expert recommended that facilities utilize logs for various services as data sources to evaluate processes of care. This is still not in evidence at any facility. Data that is available is not useful for the purposes of quality improvement. The annual CQI reports give statistical data without any analysis that identifies problems or gives evidence that the system is performing as expected. The IDOC does not use data to measure adequacy of the program. Data is presented without analysis. The type of data provided give no indication of whether the program is in control.

Many “studies” were in areas that would be expected to yield good results. These were meaningless studies, as there was no effort to improve the program; instead, a study was designed so that it yielded a good result.

Review of primary source credentials of physicians at the annual meeting is not done. Instead, the site only verifies that the physician has a license. This affects the quality of physicians.

The Governing Body at SCC and NRC have three members, two of whom are custody trained staff; the Warden and the Regional Manager of Wexford. Half of the Governing Body at MCC are also custody staff. The Governing Body of the CQI program should be predominantly medical staff, as it is a medical program.

Recommendations

We have listed below key recommendations from the Second Court Expert. These are followed by the verbatim First Court Expert recommendations with our comments on each placed in *italics* after the First Court Expert recommendation. We include our additional recommendations following the First Court Expert recommendations.

Key Recommendations of Second Court Expert

Current Recommendations

1. Governance of the medical program must change. The medical program needs to be under medical control, not custody control. This would entail a restructuring of the medical program and Office of Health Services such that custody leadership are not responsible for medical operational control of the medical program. This will require an augmentation of the Office of Health Services so that it is capable of managing and monitoring clinical care. The health authority and responsible physician, if they are not the same person, need to be members of the Office of Health Services. The Office of Health Services needs regional physicians to monitor physician quality; an Infection Control physician and coordinator; a quality improvement coordinator; and sufficient data analysts to maintain data and statistical information necessary for operational management.
2. The medical program should have a budget that is managed by the health authority. Any vendor contracts should be under control and direction of the health authority.
3. IDOC should conduct a staffing analysis under the direction of medical, **not custody**, leadership that determines systemic staffing needs necessary to adhere to Administrative Directives and acceptable standards of medical and nursing care. This analysis needs to consider all levels of staffing and must include relief factors.
4. Physician staff must be properly trained, credentialed, and privileged. In order for this to happen, we strongly recommend that the IDOC negotiate with the state universities that have medical school programs to provide physician and possibly comprehensive care in the IDOC.²⁶³ Physicians should be required to be credentialed similar to state university medical school requirements. Such a program should have an enhanced telemedicine component, including for specialty care.
5. The collegial review process should be immediately abandoned as a patient safety hazard. If a utilization program is re-instituted, the Office of Health Services should hire an additional board certified physician to perform prospective review.
6. The medical policies of the IDOC need to be augmented and refreshed and be made consistent with standards of the National Commission on Correctional Health Care. These policies should cover all aspects of a medical program and must be maintained by the IDOC, not the vendor.

²⁶³ These universities might include University of Illinois Chicago; Southern Illinois University; and the Rockford School of Medicine.

7. The IDOC should negotiate with the Illinois Department of Public Health for IDOC to fund and maintain an infectious disease-trained physician and infection control coordinator who would jointly work with IDPH and IDOC and would coordinate, advise, and lead the infection control program in the IDOC. This can be pursued as an interagency agreement. The infection control coordinator should be a person with a master's training in public health nursing.
8. An analysis of geriatric and disabled patient needs in the IDOC needs to be done. The purpose would be to determine the numbers of individuals who require skilled nursing, supportive nursing, and infirmary levels of care. The IDOC needs to build or rehabilitate facilities to accommodate the current needs of these types of patients, with facilities that are appropriate for the level of need. Alternatively, if this cannot be done, the IDOC needs to find placement for the geriatric population in community facilities appropriate for their needs and properly licensed and managed in accordance with community standards.
9. The IDOC needs to have a statewide electronic medical record that includes physician order entry and electronic MARs. The implementation would include a device survey to determine the number of devices that need to be in place; a wiring survey to assess the capacity of existing communication wiring; access to an electronic medical reference system paired with the electronic record such as UpToDate®; and consideration to augment the current communication wiring to accommodate a more robust telemedicine program.
10. The IDOC needs to hire a statewide dental director, establish standardized statewide dental policies, and establish a monitoring system to ensure adequate dental services are provided.
11. The IDOC medical program needs to be able to effectively self-monitor all aspects of the medical care program. This will require knowledge of quality improvement methodology, data systems to obtain the necessary information to analyze and monitor care, and capable staff who can provide leadership.
12. The IDOC should develop combined medical and custody Administrative Directives that specify the participation of custody in ensuring that patients attend all scheduled medical appointments in the desired location and ensuring that custody collaborates with nurses so that nurses are able to properly administer medications.

Organizational Structure, Facility Leadership, and Custody Functions

First Court Expert 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 becoming 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 outcome. *We generally agree with this recommendation. All physicians practicing primary care need to be trained in primary care. We believe that this recommendation will not be accomplished using the current contract process. See Key Recommendation #4 above.*

2. All clinicians should have access to electronic medical references at the point of care. *We agree with this recommendation.*
3. Every special medical mission facility must have its own Health Care Administrator. *We agree with this recommendation.*
4. The Director of Nursing position in all facilities is a full-time position whose time should not be taken away by corporate responsibilities. *We agree with this recommendation.*
5. Establish approved budgeted positions for SCC and the NRC which allow for each facility to function independently. *We agree with this recommendation.*
6. Provide a full-time Health Care Unit Administrator as well as a full-time Quality Improvement Coordinator/Infection Control Nurse for both SCC and NRC. *We agree that a full time HCUA should be budgeted at SCC and NRC. However, we recommend that every site have a full time CQI coordinator. The infection control nurse FTE equivalent should be determined based on the expected activities at that facility. For intake facilities the infection control nurse should be full time. For large facilities with any medical mission, infection control positions should also be full time.*
7. Each facility is to develop and implement a plan to insure registered nurse staff is conducting sick call. *We agree with this recommendation.*
8. Medical vendor health care staff assigned leadership positions, such as the director of nursing, supervisory nurse, or medical records director, will not be assigned corporate duties such as time keeping, payroll, or human resource activities. *This is similar to recommendation #4 above and we agree with this recommendation.*
9. IDOC [is] 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. *We agree with this recommendation but note that this should be part of the staffing analysis recommended above in Key Recommendation #3.*

First Court Expert's IDOC Office of Health Services Staffing Recommendations

1. Immediately seek approval, interview, and fill the Infection Control Coordinator position. *We agree with this recommendation but add that the infection Control Coordinator can be a nurse consistent with Key Recommendation #7. This nurse needs to work collaboratively with an infectious disease trained physician. The Infection Control Coordinator should have a master's degree in public health nursing.*
2. Establish and fill the position for a trained Quality Improvement Coordinator who will be responsible for directing the system wide CQI program. *We agree with this recommendation. The required training for this position can be a systems engineer, nurse, or other person trained in CQI methodology (e.g. six sigma). Persons considered*

for this position need to have CQI training prior to hiring. They should not learn on the job.

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. *We agree with this recommendation.*

Additional Recommendations

1. IDOC custody should perform a staffing analysis to ensure that they have sufficient officer staff to ensure that medical programs can appropriately and effectively function. This is particularly true with respect to medication administration and ensuring that patients show up in required clinic spaces for appointments that are ordered. This study should include a survey of available transport van to ensure that IDOC has sufficient transportation vehicles to transport inmates for their scheduled appointments.
2. Contract monitoring needs to be improved to include meaningful operational metrics and must include quality of care for physicians, mid-level providers, and nurses.
3. Privileges for physicians should only be granted to doctors who have residency training in the service for which they are seeking privileges.
4. The physician performance evaluation component of peer review needs to be performed by persons trained in primary care and needs to be augmented to adequately reflect quality of care.
5. The sanctioning component of peer review needs to be started. Any physician committing grossly and flagrantly unacceptable care needs to undergo peer review for possible reduction of privileges.

Use of University of Illinois

The First Court Expert had no recommendations related to UIC.

Current Recommendations

1. In addition to Key Recommendation #4 above, we strongly suggest that IDOC explore the possibility of utilizing the university programs to assist with respect to comprehensive medical care, dialysis, dental, nursing, and pharmacy programs.

Clinic Space and Equipment

First Court Expert 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. *We agree with this recommendation. The existing spaces and conditions at NRC, Dixon, and some of the rooms at MCC are unacceptable for the performance of*

sick call services, and to protect patient privacy and confidentiality. Non-functional or missing equipment and supplies were noted in clinical areas at almost all of the five facilities inspected. These deficiencies present barriers to the delivery of care and create an unprofessional work environment for both clinical and correctional staff.

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. *We agree with this recommendation. Torn mattress coverings and/or uncovered foam cushions were noted at NRC, SCC, and MCC. Varying degrees of torn examination table upholstery were noted at SCC, LCC, and MCC. Frayed and ripped upholsteries on staff chairs in the clinical areas were noted at SCC and MCC. These deficiencies make it impossible to properly clean and sanitize the beds and examination tables, creating infection control risks and an unprofessional work environment for clinical staff.*
3. A paper barrier which can be replaced between patients should be used on all examination tables. *We agree with this recommendation. Varying degrees of absent changeable paper barriers on examination tables and no evidence of a suitable alternate method to sanitize examination tables between patients were identified at all of the facilities, with the exception of MCC. This deficiency creates an infection control risk for patients and staff.*
4. Handwashing and sanitizing must be provided in all treatment areas. *We agree with this recommendation. Sinks were lacking in all nurse sick call areas and one provider backup exam room at NRC, one nurse sick call room at SCC, three nurse sick call rooms at Dixon, one provider room at LCC, and one clinical exam room at MCC. Hand sanitizing gel was not consistently identified as available in treatment rooms lacking sinks.*

Additional Recommendations

5. All of the infirmaries must have sufficient numbers of hospital beds with adjustable heights, heads, and legs, and safety railings to meet the clinical and safety needs of the high-risk infirmatory patient population. The infirmaries at NRC, SCC, and MCC lacked an adequate quantity of hospital beds.
6. Nurse call devices must be installed in all infirmaries. The infirmatory at MCC was the only infirmatory found to be lacking nurse call devices.
7. All facilities must have a sufficient number of examination rooms to accommodate all the nurses and providers who are simultaneously assigned to see patients. NRC, Dixon, and LCC do not have an adequate number of properly equipped examination rooms to accommodate all of their treating nurses and providers. This is a barrier to access to care at these facilities.
8. The showers in the infirmaries and other special housing units (geriatric, ADA, etc.) must have intact, non-slip floors, safety grab bars, shower chairs, and proper ventilation to assure the safety and health of the high-risk population assigned to these special housing units. Showers in special housing units in all of the facilities inspected had notable structural and safety deficiencies that put the health and safety of this compromised population at risk.

9. The physical condition of the hemodialysis unit at SCC must be immediately addressed by the contracted vendor, IDOC, and Wexford.
10. The flooring on all three floors of the health care building at Dixon must be immediately replaced. The vast number of cracked, missing, and loose floor tiles throughout the three-story health care building puts patients, medical staff, and correctional staff at risk for injury.

Medical Records

First Court Expert's Recommendations

1. Problem lists should be kept up to date. *We agree with this recommendation but believe it is a physician practice issue not a medical record issue.*
2. Only providers should have privileges to make entries on the problem list. *We agree with this recommendation.*
3. The system of "drop filing" should be abandoned. *We agree with this recommendation.*
4. Medical records staff should track receipt of all outside reports and ensure that they are filed timely in the health record. *We agree with this recommendation. See also First Court Expert's recommendation #8 in specialty care below.*
5. Charts should be thinned regularly and MARs filed timely. *We agree with this recommendation.*
6. Consideration should be given to scanning specific important records into the new electronic system if possible. *It is our opinion that all medical record documents that are not electronic need to be scanned to the electronic record. This should not occur just "if possible;" it is required.*

Additional Recommendations

7. See Key Recommendation #9 above.
8. If paper records are continued, *all records* need to be located near by the medical records office so that any volume of the record can be easily obtained for clinical care.
9. The medical record must include dialysis records or summaries of dialysis records so that clinical staff understand the status of the patient's dialysis.
10. Medical records rooms need to be secured. Only medical record staff should pull or re-file medical records. Only authorized personnel should be permitted in a medical record room.
11. Records should be maintained in accordance with guidance from the Illinois Department of Human Services.
12. When records are pulled for use, an outguide should be used to identify that the record has been pulled and where the record is.
13. Policy for medical records needs to be revised to include the electronic medical record currently in use and should also address security and confidentiality of the medical record paper or electronic.

Medical Reception

First Court Expert Recommendations

We agree with the First Court Experts recommendations which include:

1. Sufficient nursing and clinician staff to complete the reception evaluation in one week.
2. A process that ensures that 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.
3. Forms to identify acute symptoms (i.e., a review of systems).
4. A requirement that clinicians, during the history, elaborate on all positives from the nurse screen.
5. A system of placing patients on hold in the midst of appointments or incomplete treatment.
6. A policy that requires the medical record to be well organized and the staff to ensure this is accomplished.
7. A quality improvement process that monitors completeness, timeliness, and professional performance, and is able to intervene in order to implement improvements.
8. A Medical Director trained in primary care.
9. A HCUA dedicated to NRC and appropriate supervisory resources.
10. A well-trained Quality Improvement Coordinator at each reception center and each facility dedicated to ensuring the timeliness, completeness, and appropriateness of clinical decisions.

We disagree with the First Court Expert's recommendation to have a system that ensures relevant electronic data arrives with patients from Cook County Jail. While access to the electronic medical record is desirable, we find that provision of a paper medical transfer summary is adequate.

Additional Recommendations

11. IDOC health care leadership should develop and implement an electronic medical reception tracking log that documents the timeliness of completion of all required medical reception transfer activities.
12. IDOC should amend medical reception forms to include a comprehensive review of systems (ROS) to identify serious medical conditions.
13. Providers need to take and document a medical history and not rely only on the nurse history.
14. At medical reception, medical records staff should initiate a green jacketed medical record for each patient, with documents filed under the correct tab, eliminating drop filing.
15. Examination rooms should be adequately equipped and supplied, including paper for examination tables to provide infection control barriers between patients. Furniture that is torn or in disrepair should be replaced.

16. At LCC, a microscope should be purchased for medical reception evaluations to diagnose vaginal infections.
17. Staff should change gloves and wash their hands between patients.
18. The IDOC Administrative Directive 04.03.101 should be revised to eliminate obtaining written consent for HIV testing given the opt-out policy that has been established.
19. Weight scales should be periodically calibrated (e.g., weekly).
20. At LCC, nurses should perform and document urine pregnancy testing on all women of child-bearing age.
21. Nurses should measure uncorrected and corrected visual acuity in each eye and document results in the medical record. If large Snellen charts are used, the nurse should ensure the patient stands the correct distance away from the chart. Consider smaller hand-held Snellen charts.
22. Use QuantiFERON testing to detect TB infection rather than tuberculin skin testing.
23. As long as TST is being performed, nurses should correctly read tuberculin skin tests via palpation and measurement of induration. This should be done in a medical setting, not through the food port.
24. Nurses should timely document tuberculin skin test results in the medical record (e.g., within 24 hours).
25. Providers should document review of medical transfer information sent by county jails.
26. Providers should perform a history to include pertinent review of systems for each chronic disease and/or significant illness.
27. Providers should order CIWA and/or COWS monitoring in accordance with current guidelines for patients withdrawing from alcohol, opiates, or other drugs.
28. Providers should provide continuity of medications unless there is a clinical indication for changing medication regimens (e.g., glargine to NPH insulin, etc.).
29. Providers should document all significant medical conditions onto the patient's problem list.
30. Nurses should transcribe all medication orders (i.e., KOP and nurse administered) onto a MAR at medical reception and document administration of KOP medications at the time they are administered to the patient.
31. Health care leadership should develop systems to ensure that all physician orders are timely implemented (e.g., EKG, blood pressure monitoring, etc.).
32. Providers should timely follow-up on all abnormal labs.
33. Providers should use a chronic disease form or document that they are evaluating the patient for chronic care when seeing patients for the first chronic disease appointment within 30 days.
34. Health care leadership should revise medical reception policies and procedures to provide sufficient operational detail to staff to adequately complete each step of the process.
35. Health care leadership should develop and monitor quality indicators related to each step of the medical reception process.

Intrasystem Transfer

First Court Expert 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 ensure 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.

We agree with these recommendations.

Additional Recommendations

7. IDOC should develop an intrasystem transfer policy and procedure consistent with NCCHC standards, and that provides sufficient operational guidance to staff regarding each step of the process.
8. IDOC/Wexford should train staff regarding the revised policy.
9. Nurses should complete each element on the intrasystem transfer form and address all aspects of health care requiring continuity.
10. A system should be developed and implemented that provides sending facilities feedback when there are errors on the intrasystem transfer form.

Nursing Sick Call

First Court Expert Recommendations

1. Each facility is to develop and implement a plan to ensure:
 - a. Sick call is conducted in a defined space that is appropriately equipped and provides patient privacy and confidentiality.
 - b. Sick call requests are confidential and viewed only by health care staff.
 - c. The review/triage of sick call requests and conducting of sick call is performed by a licensed RN.
 - 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 policy and procedure.
 - g. Complete documentation.
 - h. Implementation of a sick call log.
 - i. Administration must ensure health care activities such as sick call are not routinely cancelled, as this results in unacceptable delay in health assessment.

We agree with these recommendations.

Additional Recommendations

2. IDOC should revise its Administrative Directives on nursing sick call to provide adequate policy, operational, and procedural guidance regarding how to implement the policy.²⁶⁴

The policy should include:

- a. Designating what IDOC forms are used for inmates to submit written health requests and which staff are responsible for ensuring that they are available to inmates on a daily basis.
 - b. Developing a standardized paper or electronic Nursing Sick Call Tracking Log.
 - c. Installation of lockable Health Request form boxes that are accessed only by health care staff in each inmate housing unit.
 - d. Inmates must be permitted out of their cells on a daily basis to confidentially submit their health requests into health request boxes, except in restricted housing units where nurses collect health request forms.
 - e. Health care staff should collect health care request forms seven days per week.
 - f. Health care staff should legibly date and time receipt of health requests.
 - g. An RN should triage health requests and document a disposition on the form (e.g. urgent, routine). Nurses should legibly date, time, and sign the form, including credentials.
 - h. Each health request should be entered onto the Sick Call Log, including the urgency of the disposition.
 - i. A nurse should schedule patients to be seen in accordance with the urgency of their complaint.
 - j. Nursing sick call should be conducted in adequately lighted, equipped, and supplied rooms with access to a sink for handwashing. This includes a desk and chairs so the nurse and patient can be seated, and an examination table, otoscope, scale, etc. Consider installing lockable cabinets to store supplies (e.g., nurse protocol forms, gauze, tape, tongue blades, etc.).
 - k. Nurses should have the medical record available at the time of the sick call encounter.
 - l. An RN nurse should perform and document an assessment of each patient in accordance with treatment protocol forms and/or sound nursing judgement.
 - m. Nurses should refer patients to providers in accordance with the treatment protocol and in accordance with sound nursing judgment.
 - n. Health requests should be filed chronologically in the medical record.
 - o. At the regional and institutional level, health care leadership should develop and monitor quality indicators associated with each step of the sick call process.
3. IDOC should standardize the nursing sick call process to all institutions.²⁶⁵

²⁶⁵ Variances to the policy should only be granted to institutions that have demonstrated that access to care is timely and appropriate.

Chronic Care

First Court Expert 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. *We agree with this recommendation.*
2. Chronic care forms and flow sheets should be updated and designed so that all chronic diseases are addressed at each visit. *We agree with this recommendation. We add that use of an electronic medical record can eliminate the problem of inadequate forms and the time wasted completing multiple forms for persons with multiple chronic illnesses.*
3. HIV patients should be followed regularly by IDOC providers in the chronic care program to monitor for medication compliance, side effects of therapy, and overall health status. *We agree that IDOC physicians should monitor patients between UIC telemedicine visits to address problems that occur.*
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.²⁶⁶ *We agree in part. It is our opinion that it is not efficient or productive for the IDOC to write chronic clinic guidelines, as they will not have the expertise or time to do this. Their guidelines should be confined to the timeliness and frequency of clinics, the required laboratory and other testing for inmates with chronic illness, and the conditions under which patients are referred for specialty management of a chronic illness. It is our opinion that the IDOC should refer providers to national standards of medical care in lieu of chronic disease guidelines. These should include at a minimum:*
 - *Standards of Medical Care in Diabetes, American Diabetes Association as found at http://care.diabetesjournals.org/content/38/Supplement_1/S1.full.*
 - *2014 Evidence-Based Guideline for the Management of High Blood Pressure in Adults, Report from the Panel Members Appointed to the Eighth Joint National Committee (JNC 8). As found at <http://jama.jamanetwork.com/article.aspx?articleid=1791497>.*
 - *Guidelines for the Diagnosis and Management of Asthma (EPR-3), National Heart, Lung, and Blood Institute as found at <http://www.nhlbi.nih.gov/health-pro/guidelines/current/asthma-guidelines>.*
 - *2013 American College of Cardiology/American Heart Association Guideline on the Treatment of Blood Cholesterol to Reduce Atherosclerotic Cardiovascular Risk in Adults as found at <https://circ.ahajournals.org/content/early/2013/11/11/01.cir.0000437738.63853.7a.full.pdf>.*
 - *Prevention and Control of Tuberculosis in Correctional and Detention Facilities: Recommendations from CDC found at <http://www.cdc.gov/mmwr/PDF/rr/rr5509.pdf>*

²⁶⁶ National Heart Lung and Blood Institute; Guidelines for the Diagnosis and Management of Asthma (EPR-3) published August 2007 as found at <https://www.nhlbi.nih.gov/health-topics/guidelines-for-diagnosis-management-of-asthma>.

- *Global Initiative for Chronic Obstructive Lung Disease updated 2016 as found at [http://www.goldcopd.org/uploads/users/files/WatermarkedGlobal%20Strategy%202016\(1\).pdf](http://www.goldcopd.org/uploads/users/files/WatermarkedGlobal%20Strategy%202016(1).pdf).*
- *HIV/AIDS guidelines sponsored by National Institutes of Health found at <https://aidsinfo.nih.gov/guidelines>.*
- *The Management of Sickle Cell Disease, National Institute of Health/National Heart, Lung, and Blood Institute as found at http://www.nhlbi.nih.gov/files/docs/guidelines/sc_mnqt.pdf.*

When a patient has a disease other than one supported by a referenced guideline, the IDOC should require that provider refer to UpToDate® as a reference.

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. We agree with this, but note that IDOC has Administrative Directive guidance on initial and subsequent cervical and breast cancer screening. Even though there is an obstetrician available for pregnancy care, access of females to care for female care issues could be improved.*
6. *The TB guideline should be updated to provide basic information regarding interferon gamma testing, including appropriate uses of this test. It is our opinion as stated in Infection Control Recommendation 1.d. that interferon gamma testing should replace Mantoux skin testing for tuberculosis screening of all individuals.*
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. We agree with this recommendation.*
8. *Copies of the current MAR should be available for the provider's review during chronic care clinic. We agree with this recommendation.*

Additional Recommendations

9. *All chronic illnesses should be monitored at every chronic disease clinic.*
10. *Consult with an endocrinologist or diabetes specialist to perform a comprehensive review, recommendations and training concerning the management of diabetes, and in particular, insulin-prescribed diabetes in the IDOC.*
11. *Implement and utilize current Center for Disease Control (CDC) age-based and disease-based standards for the administration of adult immunizations.*
12. *Implement and utilize current United State Preventive Services Task Force (USPSTF) guidelines for screening adults for cancer and other conditions. The IDOC should adopt the A and B recommendations of the USPSTF.*
13. *Calculate and document the ten year cardiovascular risk score on all appropriate adults to assist with the decision and timing to initiate HMG-CoA reductase inhibitors (statins).*
14. *Revise the current restrictive criteria and lengthy screening and approval process utilized to determine in order to expand the number of active hepatitis C patients are eligible for treatment and when treatment is initiated.*

15. Particularly given the current configuration of physicians, when a physician has not been trained in residency training to manage an illness, the physician should refer that patient to a physician who is trained in managing that condition.
16. Increase access to specialty care throughout the IDOC by increasing the number of onsite specialty consultants, expanding the existing telehealth specialty program to include additional medical specialists to assist facility providers with the management of complex and common medical conditions including diabetes, hypertension, cardiology, dermatology, neurology, and non-HIV, non-hepatitis C infectious diseases, and establishing an e-consult program that would allow providers to readily consult with specialists about diagnostic and treatment questions.
17. Develop a plan to shift anticoagulation treatment from vitamin K antagonists (warfarin) to new types of anticoagulants that do not require frequent ongoing lab testing and frequent dose modifications to achieve an adequate state of anticoagulation.

Urgent/Emergent Care

First Court Expert 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. *We agree with this recommendation. All facilities, except NRC, provided a list of patients sent to the ED, but did not provide a log that contains a list of all unscheduled urgent/emergent encounters. Patients seen urgently, but not sent to the ED, are not consistently tracked on a log. The current list does not include the location the patient was seen (cell front, sick call area, trauma room, yard etc.), whether a report was returned with the patient, and the date the patient was seen by a provider for follow up after receiving offsite services. Existing logs should be modified to include this data.*
2. Assessments must be performed by staff appropriately licensed to be responsible for that service. *We agree with this recommendation. The use of CMT and LPNs to respond to medical emergencies is not within their scope of practice. Only registered nurses have a scope of practice that allows them to make independent decisions about whether to contact a clinician. There should be sufficient registered nurse staffing so that an RN is assigned to respond to evaluate patients with urgent/emergent complaints.*
3. Guidelines should be developed for nursing staff with regard to vital signs reflecting instability that require contacting a clinician. *We agree with this recommendation. We note that the IDOC issued a revised set of nursing treatment protocols in March 2017. The document does provide guidance to nurses on vital sign results among the determinants in contacting a provider. Ongoing review of urgent/emergent clinical performance using the criteria in the protocols would aid in improving nursing performance and is also useful in identifying revisions or additions that should be made to the protocols.*

4. When patients are sent offsite, work with hospitals to ensure that the emergency room report is given to the officer to return to nursing with the patient. *We agree with this recommendation. We found many examples of patient discharge instructions but few actual records from emergency room visits or hospitalizations. This was particularly true of hospitals in the local community. The First Court Expert recommended developing an understanding that payment for services included receiving at least the discharge summary from a hospital. We agree that this is one way to accomplish this.*
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. *We agree with this recommendation. The follow up by an advanced level clinician needs to be within three days (see recommendation #7 below). We found many instances of patients returning from offsite services who were not seen promptly upon return or not seen at all. We also found instances of patients returning from offsite services who should have been put in the infirmary, but instead were housed in general population.*
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. *We agree with this recommendation.*
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. *We agree with this recommendation. However, given the number of hospital visits where the patient is never seen, we suggest IDOC consider requiring patients sent off site in an emergency be admitted to the infirmary upon return to the facility until evaluated by a provider and a plan for ongoing care established.*
8. The QI program should monitor timeliness and appropriateness of professional responses. *We agree with this recommendation. All unscheduled urgent/emergent encounters should be reviewed by a nurse manager as soon as possible after the encounter but no longer than the next business day. The review by the nurse manager should include review of the nursing assessment for compliance with the relevant treatment protocol as well as timeliness of the response. These reviews should be documented, and an analysis given to the QI committee monthly, including recommended areas of improvement. The QI committee should direct corrective action or performance improvement plans and monitor implementation. In addition, a sample of patients sent to the ED should be reviewed at least quarterly to evaluate whether the care of the patients in the months preceding the offsite could have better addressed the clinical reason the patient required unscheduled urgent/emergent care. Examples of conditions which should be considered for review are seizures, hypoglycemia, ketoacidosis, infection, etc. The results of chart review should be analyzed to identify individual clinicians who would benefit from coaching or other performance improvement measures as well as systemic factors that would improve care. The analysis should be presented to the QI committee and the systemic factors discussed to identify corrective action to be taken.*
9. As an aspect of the QI program, review nursing and clinician performance to improve it. *We agree with this recommendation. See discussion of #8 above.*

Additional Recommendations

10. The Office of Health Services should standardize the equipment and supplies that are at the facilities for emergency response. This should include specifying the contents of the emergency bag, identifying the minimum number and location of AEDs and other equipment (oxygen tanks, suction, cervical collars, etc.) for each site, and whether one or more trauma or disaster bags are kept in addition to the emergency bags. The contents of the emergency bag (and if kept on-site, trauma and disaster bags) should be listed on the outside of the bag and include the expiration date of any medicine or other supplies. Every opening on the emergency bag (and trauma or disaster bags) should be sealed with a numbered, plastic seal or lock to indicate that the contents are undisturbed.
11. Emergency equipment and supplies should be checked each shift and documented on a standardized log. The log should list what specifically is to be checked (i.e., the expiration date of the electrodes on the AED, the pressure in the oxygen tank, etc.) and include the numbers of the tags on the sealed emergency bag. If the locks are intact, the bag does not have to be opened and checked. If the bag has been opened, it is removed from service until it has been replenished and a new seal applied. The log is checked daily by a nurse manager to ensure that equipment is being checked and is functional.
12. The Office of Health Services should monitor to ensure compliance with expectations for emergency response equipment and that drills are conducted per the AD. The Office of Health Services should also develop a template with criteria to be considered in the review and analysis of emergency response and mass disaster drills, and monitor the reporting and corrective action pursued through the facility CQI committees.
13. The Office of Health Services needs to incorporate in its quality improvement program review of sentinel events.²⁶⁷ These should be reviewed consistent with methodology used for mortality review in an attempt to discover correctable process errors or other errors.

Specialty Consultations

First Court Expert 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. *We agree that offsite specialty care needs to be tracked and this system of tracking should continue if a prospective review process is continued. This tracking should be standardized across all IDOC facilities and directed and/or managed by IDOC.*
2. Presentation to collegial review by the Medical Director must occur within one week. *See Key Recommendation #5 above. We believe the collegial process should be abandoned as a patient safety hazard. Doing so makes this recommendation mute.*

²⁶⁷ Sentinel events are unexpected events involving death or serious physical harm or risk of harm.

3. When a verbal approval is given, the authorization number must be provided within one business day to the onsite scheduler. *See Key Recommendation #5 above. We believe the collegial process should be abandoned as a patient safety hazard. Doing so makes this recommendation mute.*
4. When a scheduled routine appointment cannot be obtained within 30 days, a local resource must be utilized. *We generally agree with this recommendation. But we note that some referrals are meant to be longer than 30 days out. This recommendation relates to UIC referrals presumably and we agree that for routine appointments that are meant to occur as soon as can be reasonably scheduled local resources should be used when UIC cannot provide a timely appointment.*
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. *We agree with this recommendation. But we note that some referrals are meant to be longer than 30 days out (e.g., a patient is referred by a cardiologist to be seen in follow up in six months)*
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. *We agree with this recommendation.*
7. When the patient returns without a report, a staff member should be assigned to contact offsite services and obtain a report. *We agree in principle with this recommendation. However, it is our opinion that the root cause of this problem is a failure of the vendor to negotiate with contract hospitals and consultants in order to obtain reports. To force line staff to attempt to obtain reports is misplaced and is unlikely to succeed. The vendor must correct this problem systemically.*
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. *We agree in principle with this recommendation. However, it is our opinion that the root cause of this problem is a failure of the vendor to negotiate with contract hospitals and consultants in order to obtain reports. To force line staff to attempt to obtain reports is misplaced and unlikely to correct the problem. The vendor must correct this problem.*
9. Nurses should contact clinicians for any orders. *We agree with this recommendation.*
10. When patients are scheduled for appointments, they should be put on hold for as long as clinically necessary to complete the appointment before being transferred. *We agree with this recommendation.*
11. When the paperwork is obtained, an appointment with the ordering clinician or Medical Director must be scheduled within one week. *We agree with this recommendation.*
12. That encounter between the patient and the clinician must contain documentation of a discussion of the findings and plan. *We agree with this recommendation.*

Additional Recommendations

13. See Key Recommendation #5 above.
14. We recommend that IDOC investigate and negotiate for expanded specialty coverage via telemedicine with UIC or SIU. Given the degree of underutilization, additional

specialty care resources will be indicated. To the extent possible (onsite providers, onsite radiography, etc.) IDOC will need to increase specialty care resources to attain adequacy. The extent to which unqualified doctors continue to be used, the expansion of specialty care necessary to attain adequacy will be considerable.

Infirmary Care

First Court Expert Recommendations

1. It is our opinion a registered nurse should be readily available to address infirmary patient issues as needed. *We agree with this recommendation.*
2. In the large facilities, such as SCC, Pontiac, and MCC, where medical staff is assigned to work in multiple buildings/cell houses outside the main health unit where infirmary is located, it is recommended that at least one registered nurse is assigned at all times to the building where the infirmary is located. *We agree with this recommendation provided the analysis called for in Key Recommendations #3 and #8 are completed and this level of coverage is sufficient to ensure the safety and meet the needs of patients in the infirmary. We also have concerns that nurses in the building but not on the infirmary will not hear the alarm unless they are present on the infirmary unit.*
3. At all other facilities, it is recommended at least one registered nurse is assigned to each shift. *We agree with this recommendation.*
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. *We agree with this recommendation.*
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. *We agree with this recommendation.*
6. Develop and implement a plan to open and operate the NRC infirmary. *The NRC infirmary was opened in 2016 and this recommendation is no longer necessary.*
7. Develop and implement a plan to insure a constant security presence in the infirmary. *We agree with this recommendation. Security staff are stationed at desks outside the SCC and Dixon infirmaries. During the day shifts, correctional officers were observed inside both of these infirmaries.*
8. Develop and implement a plan to insure each infirmary patient is provided a nurse call device. *We agree with this recommendation. Nurse call devices are in place in all patient rooms at the NRC and LCC infirmaries and in some infirmary rooms at SCC and Dixon. MCC's infirmary has not placed nurse call devices in any infirmary patient rooms.*
9. Develop and implement a plan of teaching/continuing education for nursing staff which addresses accurate and informative documentation. *We agree with this recommendation.*
10. The inconsistencies between IDOC and Wexford Infirmary policies should be rectified, specifically regarding the issue of 23-hour admissions/temporary placements. *We agree with the recommendation. Wexford policies were no longer in use at the time of our visits*

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. *It is our opinion that if a nurse believes that a patient needs to be placed on the infirmary for observation, a physician should examine the patient the following day. The rationale is that if a nurse judges a patient to have an urgent medical condition requiring infirmary admission, a physician should see the patient.*
12. Ensure that institutions with infirmaries have at least one registered nurse available onsite 24 hours a day. *We agree with this recommendation. See also recommendation #2 above.*
13. The infirmary policy should require follow up after discharge from the infirmary. *We agree with this recommendation.*
14. Develop and implement a plan to insure sufficient quality and quantities of infirmary bedding and linens. *We agree with this recommendation. We note that with the exception of NRC, a sufficient quantity of bedding and linens in reasonably good condition were available in the infirmaries inspected. This does not address the laundering of linens which is addressed in the Infection Control Recommendations below.*

Additional Recommendations

15. Health care leadership and the quality improvement committee should develop, monitor, and report quality indicators that measure and track provider and nurse adherence to the infirmary policy and the quality of the acute and chronic care provided to infirmary patients.
16. Problem lists in the infirmary charts must be complete and accurate.
17. Provider infirmary notes must be legible, communicate the rationale for modifications in treatment, list reasonable differential diagnoses, document pertinent physical findings and symptoms, record clear treatment plans, and include regular comprehensive progress notes that update the status of each and every acute and chronic illness.
18. Provider infirmary admission notes and progress notes should be performed in accord with the timeframes detailed in IDOC policy 04.03.120, Offender Infirmary Services.
19. Physical therapy services must be provided in the infirmary for those patients who cannot be readily moved to the physical therapy treatment rooms.
20. Patients whose clinical needs and support for their activities of daily living exceed the capability of the infirmaries must be transferred to a licensed skilled nursing facility in the community or to an infirmary in the IDOC that meets all the State of Illinois standards for licensure at a skilled nursing facility. See Key Recommendation #8.
21. Educate, encourage, and direct infirmary providers to expeditiously consult with surgical and medical specialists to address the care of complex infirmary patients.

Pharmacy and Medication Administration

First Court Expert Recommendations

1. Following patient ingestion of medication, security staff should be responsible to check the mouth for contraband. *We agree with this recommendation. Some officers we observed do check for ingestion, but it was sporadic. See also Key Recommendation #12*

which recommends that the IDOC develop, in collaboration with the Office of Health Services, an Administrative Directive that provides standardized guidance to custody staff on the expectations for safe delivery of medications. The IDOC should translate this into post orders at each site that explicitly detail correctional officers' responsibilities during medication administration. This should ensure that nurses are safe and can administer medication in accordance with established nursing standards.

2. A security staff member must be assigned to accompany the nurse who performs medication administration. *We agree with this recommendation. See Key Recommendation #12. Correctional officer support is essential to complete medication administration swiftly and safely. This includes not just escort but also controlling movement and distractions in the environment (television, fights, etc.), accounting for missing inmates, and ensuring that inmates ingest medication that has been administered. Many facilities identify these duties in the officers' post orders as discussed in the recommendation above.*

Additional Recommendations

We provide detailed recommendations in the facility reports for improvements needed in pharmacy and medications services. They are so numerous and basic that they are not restated here. The five recommendations below are overarching and require the concerted and immediate attention of IDOC.

3. Pharmacy and medication services need to be completely redone to bring practices into conformance with standards of care. This should be accomplished by leadership from the Office of Health Services and managed as a comprehensive plan of change with clear targets, steps to proceed, timeframes, and outcomes.
4. IDOC Office of Health Services needs to establish more detailed operational guidance (See Key Recommendation #6) that specifies how medication is prescribed, how and by when treatment is initiated, how medication is to be administered safely and timely, including support to be provided by the facility, and establish how and by when documentation of medication administration takes place. At a minimum this should include:
 - a. Nurses should timely transcribe medication orders onto a MAR;
 - b. Nurses should have the MAR present at all times medication is administered to patients;
 - c. Nurses should administer medications to patients directly from pharmacy-dispensed containers and contemporaneously document administration on the MAR.
5. Computerized provider order entry should be implemented at all facilities. This will resolve problems with legibility and, if a template is created, assist providers to write complete orders. The MAR should also be automated. Automation of the MAR will make information on medication orders and treatment available to providers, who can use this information to guide decisions about subsequent care. Automation will provide detailed and accurate statistical measures of medication administration and of compliance of medication by individual inmates. Automation will also provide staff and

managers with information which directs work and identifies outliers, which can be immediately resolved. See also Key Recommendation #9 above.

6. Facility operations need to provide sufficient access to inmates so that medications are administered safely. This may mean that schedules need to be renegotiated or additional personnel or equipment must be obtained. The compromise of widely accepted practices to administer medication is unacceptable. See Key Recommendation #12 above.
7. Health care programs at each facility should be expected to monitor the extent practices comply with the expectations of the Office of Health Services (as described in recommendation #4) and to report these results to the CQI committee. CQI committee meetings should document the analysis of root causes of systemic problems, develop corrective action plans, and monitor the results of corrective action. The Office of Health Services needs to monitor facility compliance with the comprehensive plan of change as well as performance criteria outlined in the operational guidelines.

Infection Control

First Court Expert 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.

We agree, but would modify the recommendation as follows: The IDOC should develop the position description for an infection control nurse that includes the duties listed by the First Court Expert on page 35 of his report as well as responsibility for coordination of clinics and care for patients with HIV and HCV; the initiation and follow up of treatment for patients with tuberculosis; monitoring and managing vaccination programs for inmates and staff; managing and providing surveillance of infectious and contagious disease screening programs; monitoring and resolving problems with conditions of confinement that are known risks for communicable disease transmission; monitoring and managing Occupational Safety and Health Administration (OSHA) requirements to provide protection from infectious disease by delivering training, overseeing the availability and use of PPEs, and screening with vaccination of staff and inmates; and conduct surveillance, manage and report on resolution of communicable disease outbreaks in collaboration with the Illinois Department of Public Health. Each facility should be expected to fill this position and operate an infection control program consistent with the position description adopted by IDOC. This model is in place at MCC and should be used as a model for other facilities. It needs to be a dedicated position but does not have to be a nursing supervisor. We note that the First Court Expert recommends combining the infection control and quality improvement responsibilities. It is our recommendation that

each of the infection control positions be a dedicated full time position and not combined with quality improvement responsibilities.

In addition, the IC-RN should report to the statewide Communicable and Infectious Diseases Coordinator for clinical performance.

- 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 healthcare unit, infirmary, and dietary department, with monthly reporting to the Quality Improvement Committee (QIC).

We agree with this recommendation and would amplify it as follows: Safety and sanitation inspections should monitor the condition, function, and annual certification of clinical equipment, the cleanliness and sanitation of clinical rooms, the integrity of all flat surfaces for sanitation, functionality of the negative pressure rooms, integrity of bed and chair upholstery including on infirmaries and ADA units, completion of medical cart and emergency response bag logs and ensuring proper sealing of these bags, the safety of shower areas used by special needs populations, the training of health care unit porters, and other health care issues. Reporting should include request and completion dates of all repair or replacement requests. Delays longer than 30 days should be reported to IDOC Office of Health Services for further efforts at resolution.

- c. Develop and implement a plan for the IC/QI-RN to monitor food handler examinations and clearance for staff and inmates.

We do not agree with this recommendation. A medical examination of persons to work as a food handler is not necessary because it only represents that individual's condition on the day of the exam and is not predictive of future illness or disease that would contradict working as a food handler. Instead, we recommend that staff and inmates working in food service be trained and pass an examination on proper food handling techniques, sanitation procedures, and what health conditions need to be reported to the food services supervisor. This training should be approved by the IDOC Communicable and Infectious Diseases Coordinator. In addition, food service supervisors should be trained and certified by IDOC or the IDPH in supervision of food handlers and prevention of food borne illnesses. The food services supervisor's job description should include responsibility to prevent food borne illnesses by monitoring workers' compliance with policy and procedures for food safety, and vigilance for health conditions that should exclude workers from food preparation and serving.

- d. Develop and implement a plan for the IC/QI-RN to monitor compliance with initial and annual TB screening, with monthly reporting to the QIC and facility administration as needed.

We agree with this recommendation and would amplify it to include the following: Monitoring shall include observation of TB screening practices as well as chart review. In addition, we recommend that IDOC replace skin testing with interferon gamma testing to screen for TB. We also recommend that each facility IC-RN complete training in TB control offered through the Southeastern National TB Center or online at the Centers for Disease Control.²⁶⁸ The statewide Communicable and Infectious Diseases Coordinator should work with the Tuberculosis Control Section of the IDPH to determine rates of TB infection in the state correctional centers and establish parameters to monitor the quality and efficacy of TB screening, prevention and treatment.

- 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.

We agree with this recommendation. Only one of the facilities we visited had implemented this recommendation. Given the poor conditions of the physical plant, particularly the showers and sinks, as well as the sanitation issues we observed with water temperatures and poor surface cleanliness, skin infection should be a major area of focus for infection control. Detailed records of each case should be kept on a log that identifies the housing and work assignments and places frequented by the inmate for programming. The log should be surveilled by the infection control nurse to identify cells and other locations to receive targeted deep cleaning. Finally, vigilance for skin infection referral needs to be broadly disseminated throughout the institution. Identification of possible skin and soft tissue infection needs to originate from sick call visits, provider visits, and use of urgent care, not just from the lab (culture) or pharmacy (antibiotics). Referrals from correctional officers to infection control of inmates with possible skin infection should be supported by the facility and health care program.

We also recommend that this tracking and monitoring include scabies and lice, two types of skin infection readily transmissible in correctional facilities and easily contained with astute and early intervention.

- 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.

²⁶⁸ <https://www.cdc.gov/tb/education/professional-resources.htm>, specifically the online course "TB 101 for Health Care Workers" and the Self Study Modules 1-9 as well as <https://sntc.medicine.ufl.edu/home/index#/catalog>, which provides a course "Arresting TB: Best Practices for Controlling TB in Corrections" and other seminars.

We agree with this recommendation and would amplify it to include the following: Negative pressure rooms or alarm systems that are not functional after five days shall be reported to the Office of Health Services and a plan for correction established with the approval of the Office of Health Services. In addition, the statewide Communicable and Infectious Diseases Coordinator should establish, in consultation with the TB Control Section of the IPHD, the number of negative pressure isolation rooms that are needed and the location for each of these rooms based upon the population served.

- g. Develop and implement a training program for healthcare 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.

We agree with this recommendation and would supplement it with the following: Inmates shall not be assigned to work in the health care area until such training has been documented as received in the inmate's institution record. We would add that inmates will not be assigned work in the health care area until vaccinated for hepatitis A and B, a record of such vaccines has been documented in the inmate's record, and clearance for assignment to the health care area provided by health services is placed in the inmate's institution file.

In addition to the training, each facility should have procedures for the cleaning and sanitation of each area in the health care area to include proper use of PPEs. The policies and procedures at MCC should be considered an example once they have been updated.

- 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.

We agree with this recommendation but would expand it to include all health care areas.

- 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.

We agree with this recommendation and would supplement it with the following: Such monitoring shall include the condition, function, and annual certification of clinical equipment, the integrity of all flat surfaces for sanitation, integrity of bed,

chair, and other upholstery. Additionally, a record of each item found in disrepair, the date taken out of service, and the date repaired or replaced should be documented on a log. We would also recommend that IDOC establish the practice of recording the expected useable life and replacement date for each piece of patient care equipment with a replacement cost greater than \$50 on a capital repair and replacement log. This log should be used to plan and requisition replacement equipment and furniture.

- j. Interface with the County Department of Health and Illinois Department of Health, and provide reporting as required by each.

See our Key Recommendation #7 above. We agree with this requirement and found that an individual at each facility had been designated with this responsibility. We did not evaluate if reportable conditions were being reported as required to the county and state health departments. There was evidence of collaboration between IDOC facilities and the county/state health departments.

However, this interface should be for more than just reportable conditions, as it is now. The relationship with county health departments and the state should include establishing prevalence rates for certain communicable diseases, validation of communicable disease screening processes and results, access to the state vaccine registry and to vaccines, assistance with monitoring environmental safety and sanitation, and so forth. The statewide Communicable and Infectious Diseases Coordinator should be principally involved in establishing these relationships and developing organizational relationships that translate Illinois' interests and goals for the health and safety of its citizens into the state prisons.

- k. Develop and implement a plan for the proper sanitizing of healthcare unit linens.

We agree with this recommendation. IDOC has known that linens are not adequately sanitized since at the least the First Expert's report and has not corrected it. This is an example of how pervasive and systemic the conditions for transmission of infection with communicable disease are in IDOC. The same could be said for the lack of protection provided during dialysis of patients with chronic hepatitis B. The fact that at SCC birds still fly through the kitchen and roost over the dining area today, after an outbreak of histoplasmosis at the Danville facility in 2013, is unfathomable except as a reflection of deliberate indifference to the health and safety of inmates.

These are problems that require the attention of infection control personnel who are trained and qualified in measures to prevent and control transmission of communicable disease in the prison setting. In addition to training and qualifications, the infection control nurse must have the authority to drive change in both institution and health care practices, with accountability to the Office of Health Services. In addition, a schedule for sanitation and disinfection for each area of the

institution should be established. The IC-RN should monitor compliance with the schedule as part of Safety and Sanitation rounds.

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

We agree with this recommendation. See Key Recommendation #7. There are obvious areas of infection control that should be dealt with at a statewide level. The first and most obvious is that the Administrative Directive related to communicable disease screening is not current with articulated policy, the Infection Control Manual is out of date, and the facility policies and procedures vary widely and are not up to date. Other areas of primary responsibility include establishing the job expectations and performance criteria for infection control at each of the state facilities, ensuring vaccination rates are compatible with age and disease related expectations, implementing policy for robust communicable disease screening, the standardization of policy and procedures for infection control practices, monitoring surveillance activities, acting as a point person with IDPH on contagious disease outbreaks, and analyzing statistics to identify and address areas of disease progression and infection control that are problems.

A problem cited at every facility was that the infection control reports made to the CQI committee did not contain any analysis of disease prevalence or trends in disease identification. In addition, we found at one facility that a TB conversion was not identified as such in the monthly report. The statewide Communicable and Infectious Diseases Coordinator must be responsible for establishing the methods and means for IC-RNs to analyze and trend infectious disease data correctly and meaningfully. This information needs to be reviewed and further analyzed at a statewide level by the Communicable and Infectious Diseases Coordinator. It should be used as a basis for decision making by the IDOC Medical Director on policy and program direction.

The statewide Communicable and Infectious Diseases Coordinator should be a masters prepared public health nurse and should be guided and supported by a part-time infectious disease physician specialist to advise on policy and updated recommendations for prevention and control of communicable disease. For example, while the IDOC does inconsistently offer pneumococcal 23 vaccine to a few individuals with high-risk conditions, it does not offer the pneumococcal vaccine 13 in accord with the CDC's aged and illness-based adult vaccination guidelines. IDOC also fails to provide meningococcal vaccine to individuals with immunodeficiency (e.g., HIV, etc.).²⁶⁹ The infectious disease specialist would also design and carry out prevalence studies to monitor disease rates,

269



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train and monitor quality of the work performed by the IC-RNs, evaluate the performance of disease monitoring clinics provided by UIC, and consult in treatment and prevention of communicable disease. We suggest that IDOC consider establishing this position within the IDPH. This would provide access to resources of the IDPH and support collaboration with the IDOC.

Mortality Reviews

First Court Expert Recommendations

1. All mortality review 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. *We do not completely agree with this recommendation. It is our opinion that under current circumstances an independent physician should review all deaths. Under circumstances of adequate IDOC central office staff (when and if that occurs), it is our opinion central office IDOC physicians and nurses can perform this review. We do not believe that regional nurses should be responsible for reviewing physician clinical care with respect to mortality review. That is currently what is occurring and as we note, regional nurses find no problems when significant problems exist. Physicians should review physician care in mortality review and nurses should review nursing care. Nurses should not review physician care. We agree that IDOC physicians, not vendor physicians should conduct mortality review.*
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. *We agree that that an end-of-life policy needs to be developed. This policy needs to ensure that **informed** consent is specifically given and that when a person is not competent to provide informed consent that reasonable legal options are taken. This policy also needs to address the current practice of palliative sedation to ensure that it is not used merely to hasten death or engage in euthanasia. Palliative sedation also needs to follow strict guidelines with respect to informed consent. The policy should also address end of life pain management as this appears to be an area of deficiency in the medical program.*

Additional Recommendations

3. Morality review should be completed for all deaths. We recommend that this be done at a central office level when the central office is adequately staffed.
4. We recommend that the Office of Health Services (OHS) make a determination of preventability and track preventable, possibly preventable, and non-preventable deaths.
5. Mortality review should be structured and include:
 - a. A brief summary of the care of the patient;
 - b. A list of all of the patient’s medical conditions;
 - c. A list of all the patient’s most current medications;
 - d. The age, date of incarceration, current housing unit, and the location of death;

- e. The preliminary cause of death;
 - f. The coroner's cause of death;
 - g. A psychological autopsy in the event of a suicide;
 - h. Inclusion of any administrative or custody reports of the death;
 - i. A list of all problems identified on review of the death; and
 - j. A summary of any corrective actions or referrals taken with respect to identified problems.
6. All deaths should include an autopsy.
 7. All deaths should be tracked by the OHS and a summary report made at the end of the year. This report should be forwarded to the Director of the IDOC and reviewed at the statewide medical meeting. This should include reporting on the numbers of preventable deaths. Analysis of recommendations based on deaths should be provided at an annual statewide meeting.

Dental Program

First Court Expert Recommendations

1. Screening [initial] examinations at the reception center should include a thorough, documented, intra and extra-oral soft tissue examination. *We note that per Administrative Directive 04.03.102, the examination performed at the R&C center should be a complete examination; however, it is not complete at all.*
2. The screening [initial] exam should not be used to develop treatment plans.
3. The examination should include radiographs diagnostic for caries, a periodontal assessment, a soft tissue exam, and accurate charting of the teeth.
4. Appropriate medical conditions should be red-flagged, and medical consultations and precautions should be documented in the dental record.
5. The health history should be more comprehensive, and appropriate conditions red-flagged. *We note that the health history form should be expanded in scope and reside on a separate page.*
6. Proper area disinfection and clinician hygiene should be implemented.
7. Proper radiology hygiene should be put in place. *We note that this includes, at a minimum, using a lead apron with a thyroid collar,²⁷⁰ and posting radiological hazard signs in the areas where x-rays are taken.*
8. Routine comprehensive care should be provided from a thorough, comprehensive examination and treatment plan.²⁷¹
9. Hygiene care and oral health instructions should be provided as part of the treatment process.

²⁷⁰ While radiation exposure from dental radiographs is low, it is F to follow the ALARA Principle (As Low as Reasonably Achievable) to minimize the patient's exposure. Dentists should follow good radiologic practice and (*inter alia*), **use protective aprons and thyroid collars**. Dental Radiographic Examinations: Recommendations for Patient Selection and Limiting Radiation Exposure. ADA and FDA (2012), 14. Emphasis added.

²⁷¹ IDOC agreed that "[r]outine comprehensive care should be provided for through a comprehensive exam and treatment plans." The exam [should include] radiographs diagnostic for caries, a periodontal assessment, a soft tissue exam, and accurate charting of the teeth," and "hygiene care and oral health instructions be provided as part of the treatment process. IDOC Response, ¶XIII (5).

10. Removable partial dentures should be provided as the last step in the comprehensive care process.
11. All teeth should be restored, and the periodontium should be stable before partial denture impressions are taken.
12. A proper diagnosis should be part of the treatment process. *We note that except for NRC, the diagnoses were appropriate in most of the charts we reviewed.*
13. Inmates with urgent care needs should be provided care within 24-48 hours.
14. The SOAP format should be used to document emergency and urgent care contacts. *We note that the SOAP format was used consistently, except for NRC and SCC.*²⁷²
15. A proper diagnosis should be part of the treatment process. *We note that except for NRC, the diagnoses were appropriate in most of the charts we reviewed.*
16. The IDOC should develop a policy to ensure that each institution has a meaningful orientation manual to instruct inmates how to access acute and routine care.
17. The IDOC should insure that all institution dental programs have well-developed and thorough policy and protocol manuals that address all areas of the dental program.
18. All dental staff should be familiar with these policies and protocols.
19. Policies should be reviewed annually and amended as necessary.
20. An administrative dentist should be available to oversee the IDOC dental program. This person could remain in the field as a part-time practicing dentist.²⁷³ *We feel the position should be 0.5 FTE. See Key Recommendation #10.*
21. The IDOC should insure that all dental programs follow current infection control guidelines as well-defined by the Centers for Disease Control, to include documented weekly spore testing of autoclaves.
22. Bulk biohazardous waste be properly stored outside the dental clinic.
23. Biohazard and radiology warning signs should be in place.
24. Patients should wear protective eyewear during treatment.
25. Every dental program should develop a robust and meaningful CQI program to include ongoing studies and corrective measures that address identified program weaknesses.
26. The IDOC should develop a clinically oriented peer review system and dentists should be available to provide these reviews, such that deficiencies in treatment quality or appropriateness can be corrected.
27. A systemwide evaluation of existing equipment should be performed and old, badly worn, rusted, corroded, and non-functional units, equipment, and cabinetry/countertops should be replaced. We agree and note that this should be part of a systemwide capital equipment replacement plan.

²⁷² IDOC agreed with the First Court Expert that “the SOAP format be used to document emergency and urgent care contacts.” IDOC Response to First Expert Report, ¶ XIII (2).

²⁷³ We note that Dr. Meeks, the IDOC Medical Director, opined that while he is responsible for oversight of the dental program, he relies on the Wexford Dental Director, which is not a good arrangement. He prefers a Chief of Dentistry, who is a state employee and part of his management team. Meeks Interview ¶¶35-36. Note that IDOC stated (in 2014) that it is committed to filling the statewide position of Dental Director, who would spend 25 percent of his time on statewide administrative duties and 75 percent of his time on facility dental practice. IDOC Response, p. 31.

28. Dental hygienists be hired ASAP at Henry Hill²⁷⁴ and Dixon Correctional Centers. *While we did not visit Henry Hill Correctional Center, we note that all prisons should have dental hygienists on staff.*

We agree with these recommendations.

Additional Recommendations

29. Valid oral hygiene instructions should be provided, and if they are not, the dental chart should not record that they have been provided.
30. All inmates should have a comprehensive examination within 30 days of intake. This exam should use the criteria of the ADA Procedure Code D0150 (Comprehensive Oral Examination—New or Established Patient) and biennial exams should use the criteria of Procedure Code D0120 (Periodic Oral Examination).
31. Treatment performed should be reported using standard (ADA) definitions and procedure codes, or entries that can be mapped to the treatment codes. Similarly, dental statistics reported to the CQI Committee should use profession-standard definitions.
32. The health history should be updated at every examination and treatment.
33. The consent form should specify the tooth to be extracted and the reason for the extraction (i.e., the diagnosis).
34. When an antibiotic is prescribed for a tooth-related infection, the tooth should be extracted within the therapeutic window of the antibiotic. A follow-up appointment for the extraction should be made so that the tooth is extracted within 10 days.
35. When an antibiotic is prescribed, the reason for the prescription (i.e., the diagnosis) should be recorded.
36. The panoramic x-ray units and film processor at NRC should be replaced immediately. It is strongly recommended that all dental x-ray units be digital.
37. The dental CQI program (as well as all other components of the dental program) lacks guidance from a dentist with experience in corrections. This expertise should reside centrally at IDOC and not from a Wexford employee or contractor. IDOC should retain a 0.5 FTE dental director. See Key Recommendation #10.
38. IDOC should develop protocols for periodontal diagnosis that include the use of periodontal screening and recording, and appropriate intraoral radiographs.
39. All routine dental examinations should include a sequenced treatment plan.
40. All dental assistants should be capable of taking intraoral x-rays.
41. Nurses should triage all requests for dental care. Non-urgent requests (cleaning, routine exams, fillings, etc.) should be sent to the dental clinic for scheduling. All other dental complaints should be assessed at nursing sick call, treated for pain as needed, and referred to the dentist based upon clinical urgency.
42. Diabetics should be referred for a periodontal assessment that includes periodontal probing every six months, and those diagnosed with periodontal disease should be offered an oral prophylaxis every six months and non-surgical periodontal treatment

²⁷⁴ Since we did not visit Henry Hill Correctional Center, we express no opinion about its staffing. However, as a general principle, all IDOC prisons should have a dental hygienist assigned.

(i.e., scaling and root planing) if clinically indicated. This should be part of the chronic care program.

Internal Monitoring and Quality Improvement

First Court Expert Recommendations

1. A trained Quality Improvement Coordinator must be assigned to each facility. *We agree with this recommendation. This should be a dedicated position.*
2. Training for members of the line staff should also be provided. *We agree with this recommendation.*
3. Each facility's program should develop a calendar in which every major service is reviewed at least once a year. *This strategy is reasonable but it is more important that high priority problems be identified and resolved. See Key Recommendation #11. Instead of annual review of each area of service the program should develop standardized metrics that measure major areas of service on an ongoing basis. These should be regular reports to the QIC. We note that these metrics are difficult to attain with a paper medical record. Examples of these types of metrics could include:*
 - a. *Percent of new medication orders that the patient receives within 24 hours.*
 - b. *Percent of medications that are received by the patient. We note that this item is only possible if there were an electronic medical record.*
 - c. *Percent of preventable hospitalizations.*
 - d. *Percent of patients who fail to show up for a scheduled appointment.*
 - e. *Percent of patients transferring from an intake facility who do not have a thorough therapeutic plan based on a list of all patient problems.*
 - f. *Number and percent of nursing and physician clinical care episodes that are of poor quality- based on professional performance evaluations.*
 - g. *Number of items remaining uncorrected on sanitation and safety inspection.*
 - h. *Number of unfilled positions.*
 - i. *Intake opt-out screening results.*
 - j. *Emergency bags which are not in compliance.*
 - k. *The number of examination rooms that are out of compliance with respect to space, equipment, supplies or sanitation as evidenced on monthly environmental inspections.*
4. When reviews are performed, they must utilize one or more of the eight quality performance measures.²⁷⁵ *We agree that these measures are important and can form the basis of reviews. However, it is more important that the program focus on high priority deficiencies whether or not they include one of these eight 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. *We agree with this recommendation.*

²⁷⁵ These Joint Commission on Accreditation of Healthcare Organizations include Accountability, Availability, Effectiveness, Efficiency, Quality of Providers, Safety of Environment, Continuity and Timeliness.

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. *Under current circumstances, we agree with this recommendation. Ultimately, mortality review can be conducted by IDOC OHS as described in recommendations 3-7 under Mortality Review above.*
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. *We agree with this recommendation.*

Additional Recommendations

8. The IDOC needs to develop a system of identifying key problems. Mortality review and sentinel event reviews should be included in that system. See Key Recommendation #11.
9. The IDOC should hire a statewide CQI leader who has training qualifications in quality improvement (e.g., systems engineer, six-sigma blackbelt, etc.). See Key Recommendation #1.

Chart Review Details

Area of Record Review	Dixon	LCC	MCC	NRC	SCC	Totals	Totals
Medical Reception/ Intrasystem Transfer	8	10	15	26	12	71	
Nursing Sick Call	29	22	15	11	27	104	
Chronic Care	14	14	14	3	13	58	
Urgent Care	5	4	5		8	22	
Hospitalization and Specialty care	7	9	11	7	9	43	
Infirmary Care	7	8	7		6	28	
Medication Administration	12		11		6	29	
Infection Control			7			7	
Totals						362	362
Death Reviews (12 Facilities)	33						33
Total Medical Records Reviewed							395
Dental Records Reviewed	Dixon	LCC	MCC	NRC	SCC	Total	
Dental Comprehensive Care	12	10	16	1	10	49	
Dental Biennial Exams	10	10	8			28	
Dental Outside Oral Surgery	2		5		4	11	
Dental Medically Compromised Patients	12	8	8		10	38	
Dental Extractions	11	10	11	5	9	46	
Dental Scheduled Extractions			15			15	
Dental Prosthetics	8	6	4		6	24	
Dental Sick Call	10	32	5	5	10	62	
Dental Nurse Sick Call			7		7	14	
Dental Peer Reviews	5					5	
Dental Intake (initial examination)	11	20	10	20	10	71	
Total Dental Records Reviewed						363	363

Dixon Correctional Center
2nd Court Appointed Expert Report
Lippert v. Godinez

Visit Date: April 2, 2018 – April 5, 2018

Prepared by the Medical Investigation Team

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Table of Contents

Overview.....	2
Executive Summary	2
Findings.....	6
Leadership, Staffing, and Custody Functions.....	6
Clinic Space	10
Sanitation	16
Medical Records.....	18
Reception Processing and Intrasystem Transfer	20
Nursing Sick Call	22
Chronic Care.....	26
Urgent/Emergent Care.....	46
Specialty Consultations.....	58
Infirmity Care	65
Pharmacy and Medication Administration	72
Infection Control	77
Radiology Service	80
Dental Program	82
Internal Monitoring and Quality Improvement.....	95
Recommendations	100
Leadership, Staffing, and Custody Functions.....	100
Clinic Space	100
Sanitation	101
Medical Records.....	101
Reception Processing and Intrasystem Transfer	102
Nursing Sick Call	102
Chronic Care.....	104
Urgent/Emergent Care.....	106
Specialty Consultations.....	107
Infirmity Care	107
Pharmacy and Medication Administration	108
Infection Control	110
Radiology Service	111
Dental Program	111
Internal Monitoring and Quality Improvement.....	116
Appendix A.....	118

Overview

From April 2, 2018 through April 5, 2018, the Medical Investigation team visited the Dixon Correctional Center (DCC) in Dixon, Illinois.

DCC has a capacity for 2529 inmates. On the day of our visit there were 2298 inmates, with an occupancy of 90.4%. DCC is a low security prison. Only 5.5% of inmates are maximum security inmates, with 39% minimum security and 55% medium security. Sixty-seven percent of inmates have a sentence of five years or less. Thirty-one percent of inmates have a sentence of less than a year. DCC has a significant mental health mission and a significant elderly population. There are 761 (33%) inmates with a severe mental illness.

The nationwide average of inmates over 50 years of age in state and federal prisons is 19.2%.¹ In the IDOC, the percent of inmates over the age of 50 is 17.6%. At DCC, 26% of inmates are over 50 years of age. DCC has a 23-bed American Disabilities Act (ADA) unit, an 84-bed geriatric unit, and a 28-bed infirmary. Most of the ADA, geriatric, and infirmary units (135 beds) are filled with elderly. The remainder of the elderly population (472) is housed in general population. The health program at DCC is served by two local hospitals and one remote hospital. Katherine Bethea Hospital is within three miles and CGH Medical Center is in Sterling Illinois, about 14 miles away. University of Illinois Chicago (UIC) is used for the majority of hospitalizations and is over 100 miles away.

This report describes our findings and recommendations. During this visit, we:

- Met with custody and medical leadership
- Toured the medical services area
- Talked with health care staff
- Reviewed health records and other documents.

We thank Warden Varga and staff for their assistance and cooperation in conducting the review.

Executive Summary

Based on a comparison of findings as identified in the First Court Expert's report, we find that the intrasystem transfer and sick call processes have improved since the First Court Expert Report but clinic space, medication administration, and the infirmary processes are worse, and the remainder are the same. Access to specialty care and physician quality of care were so poor that overall, we find that Dixon Correctional Center (DCC) is not providing adequate medical care to patients, and that there are systemic issues that present ongoing serious risk of harm to patients and result in preventable morbidity and mortality. The deficiencies that form the basis of this opinion are provided below.

¹ Prisoners in 2015, Bureau of Justice Statistics, US Department of Corrections.

Although a competent Health Care Unit Administrator (HCUA) is now in place, the remainder of the leadership team is either new or not in place. Leadership staff is still deficient. The Director of Nursing (DON) position is vacant but is to be filled by a State supervisory nurse. When that happens, two of three nurse supervisor positions will be vacant. The remaining nurse supervisor is deemed ineffective and spends considerable time on managing the onsite personnel matters for Wexford as opposed to actual nursing supervision. The Medical Director position is recently filled but the staff physician position is vacant. The HCUA acts as the HCUA, CQI Coordinator, supervisor of medical records, infection control coordinator, and as a supervisory nurse, including taking call. The new DON will also act as a supervisory nurse. Even if all positions were filled, it is our opinion that additional nursing staff is needed on the infirmary to provide the necessary level of care. Three supervisory nursing positions are inadequate given the population size and mission of this facility. Given the complexity of clinical care at this facility, it is our opinion that an additional physician is needed. Also, our opinion is that the lack of consistently filled physician positions over the years and lack of physicians with primary care training has contributed to preventable morbidity and mortality.

The physical plant is not well maintained. On the initial day of our visit both elevators in the three-floor medical unit were not functioning, and patients needed to be evacuated for safety reasons. Nursing examination rooms do not all have a standardized set of equipment, including examination tables. Privacy and confidentiality is not yet ensured for all nursing examination rooms. The ADA unit needs to be remodeled and refurbished, and beds need replacement. Equipment for the disabled needs to be present in shower areas. Infirmary beds are not all in acceptable condition. The infirmary needs to be refurbished by replacing cracked tiles, repairing missing and cracked plaster, removing peeling paint, and repainting. The geriatric unit needs refurbishing. Cracked and missing tile needs replacement to prevent falls in the elderly. Vents need to be cleaned. Showers need refurbishing to improve ventilation and remove mold. Otherwise, clinical areas were generally clean. The negative pressure room unit was functional and regularly inspected. Medical equipment is mostly regularly inspected.

Problem lists are not up to date in medical records. The medical record jackets are still too large to be effectively used; they come undone. Thinning records has been problematic due to lack of availability of funds to purchase medical record folders. Hospital and consultant reports are obtained for only about 10-15% of offsite visits. This adversely affects clinical care.

All inmates transferring into DCC are now brought to the dispensary for evaluation, which was not occurring during the First Court Expert's visit. Nurses are identifying new needs, taking vital signs, updating problems, and reconciling medications. The establishment of this process resolved a finding of the First Court Expert. However, chart reviews indicate that performance could be improved but is not being monitored effectively through the quality improvement program.

With respect to nursing sick call and access to care, we found that some of the problems identified by the First Court Expert have been resolved. Boxes have been put in place to receive health care requests and these are picked up daily. A log has been established. We found that

sick call requests were timely triaged. Because licensed practical nurses (LPNs) work in close proximity and under supervision of an RN, nursing sick call now conforms to the Illinois Nurse Practice Act requirements. Sick call is no longer done in the hall. Rooms are designated for this function, but rooms are not all equipped adequately. Other problems identified by the First Court Expert remain and there are new problems. Sick call requests are still not filed in the medical record. Nurse documentation is inconsistent or absent, and did not consistently give an indication of the assessment or plan of care. Quality review of nurse performance is not done. Medical records are not available in X house; patients there are seen without a medical record. Provider follow up on nurse referrals was not timely. Segregation inmates only have access to sick call once a week. We noted that care of dental patients with pain have their pain addressed inconsistently by medical staff until a dentist can evaluate the patient. This process should be standardized so that pain is timely addressed.

Emergency response equipment and supplies were available, properly sealed, and maintained. Equipment is regularly checked. Mass casualty drills are performed and are thorough, although critiques of the drills seldom find any problems. No strengths or weaknesses are found, and the quality improvement minutes do not reflect any discussion of these drills. Two of five patients sent out on an emergency basis had problematic care as described in the report.

Our review of records of persons hospitalized identified preventable hospitalization and preventable morbidity. It is our view that this is a result of systemic issues, including the inadequate physician staffing and inadequate credentialing of physicians.

There has been no improvement in management of specialty care. The tracking log does not accurately record the date of referral. Referrals, collegial reviews, and approvals are not consistently documented in the medical record. Providers do not update the status of the patient after consultations. There are significant and unacceptable delays in getting patients scheduled at UIC, which accounts for approximately 80% of specialty consultations. Delays to gastroenterology average 239 days and all UIC consultations average about six months. When significant delays occur, alternate consultants are not used. This results in harm to patients. Consultation reports were frequently unavailable, making it difficult to determine the clinical status of the patient. Record reviews identified that doctors did not document knowledge of the patient's status or condition after consultation visits. Care of patients before and after consultations was poor, as described in the specialty care section, and placed patients at significant risk of harm and possibly caused harm for several patients.

Medication rooms were clean, secured, and uncluttered. Medication refrigerators were well maintained. Narcotic counts were accurate. However, medication administration practices are unsafe and outdated. Medication orders are incomplete, and providers do not consistently document the decision to order medications or the rationale. There were problems with handwritten transcription of orders to medication administration records (MAR). Only 37% of MARs reviewed had complete documentation. Only 70% of new medication orders had the first dose administered within 24 hours. Nurses pre-pour medications. On the STC, mental health unit nurses use unsanitary envelopes to administer medication and do not have the MAR when

they administer medication. Medication administration is inconsistently documented at the time medication was actually provided. Continuity of medication for persons with chronic disease is not ensured and compliance with medication in chronic illness patients is not assessed. Reported medication errors are not analyzed to identify systemic causes or subjected to corrective action in order to improve care.

There have been no improvements in the infection control program since the First Court Expert's visit. There is no person with leadership and responsibility to effectively manage infection control. Safety and sanitation inspections are performed monthly, but deficiencies reported since September of 2017 have not yet been corrected. Infirmarary porters were not offered hepatitis A vaccination and only one of two porters completed vaccination for hepatitis B. Communicable disease data collected for continuous quality improvement (CQI) is not analyzed or discussed. We noted, for example, four occupational exposures to blood borne pathogens in 2017. Three of these were needle stick injuries. There was no discussion of this in the CQI minutes. We were told that Wexford has not responded to address this issue. Not addressing this issue is an OSHA violation, as an employer must evaluate environmental and engineering controls to reduce exposure to blood borne pathogens.

Radiology services are inspected and current. Access to plain film x-rays is acceptable and turnaround time is good. The x-ray technician does not wear a dosimeter to measure radiation exposure, which may not be in accord with State regulations.

We found infirmarary services worse than in the First Court Expert's report. Patients housed on this unit have needs that exceed the capacity of the program to manage. There are insufficient nurses and equipment to manage the population of patients requiring total or partial assistance with activity of daily living care or to manage those with skilled nursing care needs. There is no physical therapy on the unit. Provider notes contain limited clinical information or rationale for treatment plans and fail to document key history, physical findings, or treatment plan components. Provider admission notes and progress note timeliness and frequency do not meet IDOC policy standards.

Dental staffing is inadequate. A dental hygienist and an additional dentist should be hired immediately. The clinic is closed on Mondays due to inadequate dentist scheduling and should be open five days a week. Routine treatment is inadequate since it is not informed by a comprehensive oral examination (i.e., intraoral x-rays, a periodontal assessment, and a treatment plan). The failures of the dental program documented in this report place patients at risk of preventable pain and tooth loss by fostering widescale underdiagnosis and treatment of dental disease. Dentists consistently fail to update health histories, which is particularly problematic since the dental chart is separate from the medical record. The dental program has not changed materially since the First Court Expert Report, and the treatment provided to IDOC inmates remains substantially below accepted professional standards and is not minimally adequate.

The First Court Expert found an inactive CQI program. We found that the CQI program was in place but had not yet become effective. There is no CQI coordinator. The program does not have a CQI plan specific for DCC. The CQI program is not performing all IDOC required studies. Monthly meeting minutes are brief and lack discussion about existing problems. Most studies measure only that care was provided, not whether it was effective, of good quality, or whether it could be improved. Peer review was ineffective. Mortality review does not occur. There were 26 deaths over a two-year period of 2016-2017. We asked for charts for 13 deaths and reviewed six of these deaths. Of the six deaths reviewed, four were preventable in our opinion, and two were possibly preventable. We found systemic failures and grossly and flagrantly unacceptable clinical practice resulting in preventable death. This is an extraordinary number of preventable and possibly preventable deaths.

Findings

Leadership, Staffing, and Custody Functions

Methodology: We interviewed medical and custody leadership, reviewed staffing documents, and other pertinent documents.

First Court Expert Findings

At the time of the First Court Expert's visit to DCC, the HCUA, DON, and Medical Director positions were all vacant. The Medical Director position was filled by a traveling Medical Director, but this person was not performing all duties typical of a Medical Director. The lack of a Medical Director dedicated to the program resulted in no continuity of medical authority. Both supervisory nurses were new to their positions, so there was a significant leadership gap. Because of the lack of leadership, there was a lack of monitoring of program effectiveness. The First Court Expert recommended prioritizing filling the Medical Director, HCUA, DON, nurse practitioner (NP), and seven RN positions. The First Court Expert also recommended reevaluation of total nursing positions to determine whether additional RNs should be added. He made this recommendation because non-RN nurses were involved in conducting sick call, which was outside the scope of their license.

Current Findings

There have been changes since the First Court Expert's report, but the net result is only a minimal change in overall staffing and leadership. Currently, the HCUA position has been filled since 2015. The DON position is vacant. One of the current state nurse supervisors will fill this position beginning on 4/16/18. In 2014 the DON was vacant, but two of three nursing supervisor positions were filled. Now the DON will be filled but two of three nursing supervisor positions are vacant. In 2014 the Medical Director position was vacant, but the staff physician was filled. Currently, the Medical Director is filled, and the staff physician is vacant. The net effect of all these changes is not much change except for the HCUA, which will be discussed below. In comparison to the First Court Expert's report, there have been some improvements, but these are insufficient to create an adequate program. We agree with the First Court Expert's recommendations to reevaluate nursing positions.

We identified additional findings or confirm First Court Expert findings, including:

- There has been no effective change in budgeted staffing since 2014 with the exception of three additional staff assistants for medical records.
- The effective vacancy rate (long-term leave of absence and vacancies) is 23%, which is an improvement from the 28% vacancy rate in 2014. However, a 23% vacancy rate is an unacceptably high vacancy rate.
- There is a deficiency of nurse supervisory positions. The existing nurse supervisory positions are not filled, resulting in the DON and HCUA undertaking nurse supervision roles that detract from their ability to manage the program.
- The only consistent elements in physician staffing have been continual change of physicians and moving of physicians to other facilities. Quality of physician care has been poor. Insufficient time has passed to evaluate clinical quality of the new physician. Care we reviewed showed preventable morbidity and mortality.
- There are insufficient nursing staff managing patients on the infirmary unit.
- Given the population and numbers of complex geriatric patients, there needs to be an additional physician.

We provide a staffing table in Appendix A. What appears to be an increase in staffing as compared to the 2014 Court Expert's report is not really a staffing increase. There were always two state nursing supervisors and one Wexford nurse supervisor, but only one State nurse supervisor and one Wexford nurse supervisor were documented in the First Court Expert's report. There has been no increase in nurse supervisor positions since 2014. Also, we list 48 RN staff. This appears to be a significant increase in nurses compared to the 26 RNs in the 2014 report. But the total complement of RN staff has not changed. Twenty-two mental health nurses were moved to the medical program, making it appear as an increase when there was no increase. These 22 nurses were responsible for mental health programming and administration of medication to mental health inmates and will still be responsible for those tasks. This change was done to allow the DON to be more flexible in using nurses for various assignments. Thus, mental health nurses can work on medical units and medical nurses can pass medication on mental health units. Whether this will adversely affect nurse staffing for medical tasks is uncertain. The only increase in staffing from 2014 to 2018 is a permanent increase of a 0.5 FTE phlebotomy position and an increase of three staff assistants who assist in the medical records department.

One significant change is that the State has filled the HCUA position with a very capable person. She appears to have led changes that have resulted in improvements noted in this report. The HCUA has been in her position since 2015. This person has provided leadership, but she lacks nursing supervisors and a consistent Medical Director, and therefore the program still does not have adequate medical leadership. Also, because of staffing shortages, the HCUA serves as the CQI coordinator, supervisor of medical records, infection control coordinator, and acts as a supervisory nurse, including taking call. One person is incapable of effectively performing all of these roles.

Supervisory nursing positions are deficient. It is our opinion that three nurse supervisory positions (two state and one Wexford) are inadequate given the large population and mission to care for the elderly. There is one Wexford supervisory nurse who is also the Wexford Site Manager and supervises 10 LPNs and six CNAs. The HCUA and the Assistant Warden of Programs believe this individual is ineffective and is not performing at a level expected of a supervisory nurse. Wexford will not replace this person. Because this person is ineffective and because only one of three State supervisory nurse positions (DON and two nurse supervisors) are filled, the DON will be the only effective supervisory nurse responsible for the performance of 48 registered nurses. Therefore, the HCUA, who is a nurse, acts as a supervisory nurse, including taking call, and this detracts from her effectiveness as a HCUA. Because the DON has to act as a supervisory nurse, she too will be less effective in her role as DON, which includes establishing policy and procedure, response to grievances, monitoring of nursing practice, and implementing program improvement. Given the sizeable population of vulnerable patients in the mental health program, infirmary, ADA unit, and geriatric unit, additional nursing supervision is needed. It is our opinion that there should be a daytime inpatient and swing shift supervisor for the infirmary, ADA, and geriatric units; an outpatient daytime nursing supervisor; and an evening outpatient nursing supervisor. Given the large mental health population, it is our opinion that daytime and swing shift mental health nursing supervisors are needed. The lack of nursing supervision is significant and negatively affects the program.

The Medical Director position was not filled from the time of the First Court Expert's review in February of 2014 until July of 2015. It was then filled from July of 2015 until May of 2017. The position was unfilled from May of 2017 until a traveling Medical Director filled the position from July to October of 2017. Since October 2017, a new Medical Director has been in place. The new Medical Director works four 10-hour days. Because there is no staff physician, there is no onsite physician on Fridays. The Medical Director covers the infirmary and has administrative duties, leaving most of chronic care management to the nurse practitioners (NP). Also, the second physician position has not been consistently filled over the past four years. When this second physician position has been filled, according to the HCUA, it has been filled by less than qualified doctors. On multiple occasions Wexford was asked to replace these doctors on the basis of quality of care.

The infirmary and geriatric units in combination require more than a full-time physician, particularly if the Medical Director covers these units in addition to the other Medical Director duties. Currently, all medical care outside of the infirmary is managed by the two NPs. While it is uncertain what the situation would be like if all four medical provider positions (Medical Director, physician, two mid-level providers) were filled, it is our opinion that for a population of 2300 with a significant elderly population, an additional budgeted physician is indicated.

The frequent changes and lack of primary care trained physicians appears to have continued since the First Court Expert's report. We note that the new Medical Director has primary care training but has not been in place long enough to determine if quality will improve. The past lack of qualified physicians has resulted in a significant absence of quality of medical leadership and physician coverage. Based on chart reviews and death reviews we performed, we identified

preventable morbidity and mortality, which will be described later in this report. The lack of adequate and qualified physician coverage is causing harm and is the single most important factor in preventable morbidity and mortality in our opinion.

There are 93.8 health care employees.² There are 19 (20%) vacancies. Three staff are on long-term leave of absence. If these are added to the vacancies, the effective vacancy rate is 23%. This is a significant vacancy rate and contributes to an inadequate program. More than half of the state vacancies (52%) are RN positions. There are more RN vacancies now than there were in 2014, although it is uncertain what the effect has been with respect to combining mental health and medical nursing staff. There are 57 state employees and 36.8 Wexford employees in the medical program. The vacancy rates for state employees is 28% and for Wexford employees 17%. However, because the Wexford employees include physicians, the Wexford vacancies in the Medical Director and physician positions, over recent years, impact the program significantly more than any other position.

It is our opinion that there are insufficient numbers of budgeted positions in the nursing categories even if vacancies were filled. The infirmary unit is understaffed with nurses and nursing assistants. The geriatric unit on the third floor has people who should be on the infirmary and require a higher level of nursing care than is now being provided. These units attract elderly patients from all IDOC facilities, yet these units have insufficient staff to provide care at a necessary level based on our review of services on that unit. Inmates provide considerable assistance on these units. Services that require health trained personnel are either not provided or are provided at a level inadequate for the designed purpose of these units.

During this visit we were also able to interview the Wexford Regional Manager. This individual manages seven facilities. He has a background in criminal justice and has no formal training in any aspect of health care. He worked for the IDOC beginning in the 1990s and left IDOC in 2004, when he was a warden at Pontiac Correctional Center. He said that though he had no training in health care or health care management, he felt his administrative experience with the IDOC as a warden was sufficient to warrant his being a manager of a health care program. We disagree. Criminal justice training is not a sufficient background to obtain a high-level health care management position.

The Wexford Regional Manager said that he was not aware of any persistent problems at any of the sites we had visited. The problems at the three sites that he manages and that we visited are considerable. Failure to be aware of these ongoing problems demonstrates a level of disinterest or failure to understand how to manage a health care program. Both the Assistant Warden of Programs and the HCUA detailed year-long problems that they had brought to his attention, mostly involving the performance of physicians, filling positions, and performance of the Wexford supervisory nurse. The Wexford Regional Manager perceived his role as only administrative, which was difficult to understand. He stated that he referred any clinical issues to other clinical staff. However, as a manager of a health program he must be involved in

² See Appendix A.

clinical issues, as the program is a clinical medical program. He also has not meaningfully participated in quality improvement efforts at any of the facilities he manages. His lack of knowledge of ongoing problems at the facilities he manages and his lack of involvement in attempts to improve the program are demonstration of why a person with a criminal justice background should not be involved in managing a health care program.

Clinic Space

Methodology: Accompanied by a correctional officer, the acting Director of Nursing, and the Wexford site administrator, we inspected the three-story medical building. Accompanied by the HCUA and the Assistant Warden, we separately visited the nurse sick call rooms and medication rooms in the X-building (Segregation Unit).

First Court Expert Findings

The First Court Expert found the clinical areas at DCC reasonably clean and well maintained. The expert raised concerns about the metal beds on the third floor being taken apart to make weapons, contributing to musculoskeletal problems for the third floor's geriatric population, and being difficult to clean and sanitize.

Current Findings

- The three provider exam rooms in the medical building are insufficient to accommodate the four budgeted clinical providers.
- The telehealth room used for UIC HIV and hepatitis C care, renal specialty consultation, and telepsychiatry is clean and adequately sized. The telehealth room is not shared with the clinical providers and thus there is no competition for this space.
- Nurse sick call rooms are not all properly equipped, and all do not provide for patient privacy and confidentiality.
- One of the two dedicated nurse sick call rooms on the first floor of the medical building has two exam tables; the other only a desk and chairs. Having two exam tables in one room and none in the other is a barrier to the delivery of care and does not allow for adequate patient privacy and confidentiality.
- When not in use, the optometry and telehealth rooms are used as backup nurse sick call rooms; neither of these backup rooms have an exam table.
- The location of a satellite nurse sick call room in a housing unit of the X building maximizes the segregated patient-inmates' access to sick call.
- The infirmary beds, ADA unit beds, and the geriatric beds were not all in acceptable condition. Broken beds need to be properly repaired or replaced.
- The low height and limited mattress support of the metal beds in the geriatric unit make it difficult for this aging patient population to effectively and safely utilize them.
- The negative pressure unit in the infirmary is regularly inspected. The unit was fully functional. The unit has documented inspections on a weekly basis. The unit should be regularly checked during the environmental rounds and the condition noted in the monthly Medical Safety and Sanitation Report.

- Both elevators in the three-floor medical building were non-functional on the first day of the site visit.
- Most but not all of the medical equipment and devices in the medical building had documentation of annual inspection by biomedical engineering.
- Multiple air vent covers were missing. Many air vents and air vent covers were rusted and cannot be fully sanitized.
- All three floors of the medical building had cracked and missing floor tiles. This is a safety, sanitation, and infection control concern for patient-inmates and staff who use these areas. This is a special concern for the high-risk-for-fall population that is housed on the second and third floor.
- All the showers in the medical building were poorly ventilated, had peeling ceilings, had musty odors, and evidence of mold. There were an insufficient number of shower chairs; the existing shower upholstery needs to be repaired or the chair replaced.

The medical unit contains three floors. The first floor outpatient clinical unit houses medical exam rooms, nurse sick call rooms, an urgent care center, physical therapy, dental clinic, telehealth rooms, x-ray suite, optometry clinic, mental health interview rooms, nurse medication preparation room, the pill call/KOP medication pick up window, medical records department, storeroom, health care administrative offices, provider and nurse work areas, and a conference room. The second floor houses the infirmary, the ADA housing unit, and mental health offices. The third floor houses the geriatric housing units.

With the exception of the nurse sick call held in the X building (segregation unit), all medical health care is provided on the first and second floors in the three-story medical building that is located in the central area of the expansive DCC campus. There are two elevators in the medical building. One has not been functional for a long time. On the day before the experts' site visit, the only operational elevator broke down. Patients housed on the second and third floor who were ambulatory were moved to backup housing in outlying buildings on the DCC campus. Non-ambulatory patients in the ADA unit and the infirmary were not moved. One elevator was fixed and operational by the end of the first day of the experts' visit. The second elevator remained non-operational during the entire visit and there was not a repair team working this elevator. Both elevators need to be operational, assuring that all patients residing on the second and third floors of the medical building can be safely and readily relocated in the case of environmental and medical emergencies. This is a significant life-safety and fire-safety issue.

The first floor of the medical building is the hub of the health care delivery services provided at DCC. It is separated into two sections, with the patient-inmate entrance to the building in the middle of the two sections. Inmates walk approximately 200-1000 feet to the medical building from multiple housing units located on two divided sides (general population and mental health) of the campus to pick up keep-on-person (KOP) medications and nurse administered medications just inside the entrance, and to receive ambulatory reception, medical, dental, limited specialty, diagnostic, and urgent care services. Mental health patients have their medication administered dose-by-dose in their housing units.

The west side of the first floor houses the medication preparation and medication storage areas, and the pill call window and medical supplies.

The east end of the first floor has three interconnected corridors. The main/central corridor houses the urgent care and procedure room, two centralized nurse desks, three provider exam rooms, a three-chair dental suite, three observation bays, physical therapy unit, medical records, conference room/backup telehealth room, and a waste disposal room. The north corridor has the plain film x-ray suite, an optometry suite, a telehealth room, and two nurse sick call rooms. When not in use, the optometry and telehealth rooms are also used by the sick call nurses. The north corridor houses the health administrative and provider offices, medical supply storeroom, and a conference/breakroom.

Although generally clean, there were cracked and missing floor tiles in all three corridors on the first floor of the medical building. This is a safety, sanitation, and infection control concern for patient-inmates and staff who use these areas.

The treatment and procedure room has one adjustable table with an intact mattress and paper barrier, a new ECG machine, oxygen tanks in racks, an AED with a current inspection sticker and pads that do not expire until 2019, a Gomco suction machine, nebulizers, three backboards, medical supplies, and an emergency response bag. The handwashing sink in the room is clean. The space is adequately sized to provide treatment and urgent care. The counters in this treatment room are congested with supplies, and the two alcoves used for storage are cluttered, with 10-15 wooden crutches leaning against one wall, and staff bags and coats. The slop sink in one alcove is crusted and not able to be fully sanitized.

Two desks in the main corridor serve as a nursing station where pre-visit interviews and vital signs are performed, and reception screening and transfer forms are completed by nursing personnel. This layout does not allow optimal audiovisual privacy for patient interviews.

Despite having four budgeted providers, there are only three provider exam rooms in proximity to the nursing desks. All three are clean, adequately sized, and similarly outfitted with exam tables with intact upholstery, a desk, two chairs, functional oto-ophthalmoscopes, medical supply cabinets, a handwashing sink, gloves, and paper towels. One exam table did not have a paper barrier, one sink was crusted with mineral deposits, a few paper memos without protective sleeves were taped on the walls, and a single box of fecal occult blood testing cards had expired in October 2017. A 23-year-old Physician Desk Reference (PDR) was found in one room; however, it was reported to the experts that the three providers had access to UpToDate® electronic medical reference on the computers in their offices in the adjacent administrative corridor.

Three curtained observation bays with flat beds are located in the main corridor. They are used for short term observation and nebulization treatments when the treatment room is occupied. There is no equipment or supplies kept in these bays. The bays are a few steps away from the nursing desks and in voice range but not in line of sight of the nurses. A large conference room

in the main corridor is used as the chronic care nurse office/computer workstation and serves as a backup telehealth room on the occasion when overlapping tele-specialists are scheduled. The telehealth unit in the conference room does not have an electronic stethoscope.

A three-chair dental suite is situated off the main corridor and will be described in the dental section of this report.

The physical therapy (PT) room with multiple stations, mats, and equipment is located at the west end of this corridor. Visual inspection did not identify any notable deficiencies. Every bit of space in the PT room is utilized; although crowded with equipment and mats, it is well organized.

On the north side of the central patient-inmate entrance is the T-shaped north corridor. The top section of this T houses four clinical rooms. Two rooms are designated exclusively for nurse sick call service. One nurse sick call room has two exam tables and two desks; the other has a desk and two chairs but no exam table or sink. The other two rooms house the telehealth room and the optometry service. The telehealth unit is located in a large room with the telehealth unit along one wall with a desk and a chair facing the monitor. The unit has an electronic stethoscope. Three part-time services (HIV/hepatitis C, renal, and psychiatry) use the telehealth room. The fourth room is the generously sized optometry clinic with storage cabinets, a variety of optometry instruments (none of which had inspection labels), a sink, a desk, and a chair. The optometry clinic is only in session eight hours per week. When the optometry and telehealth rooms are not in use, the rooms are used as additional nurse sick call rooms. Since only one of the four dedicated or part-time nurse sick call rooms has an exam table, nurses interview patients and bring them over to the room with two exam tables if further physical evaluation is required. This could result in a breach of privacy if two patients are examined in the same room at the same time. Two of the other rooms could readily accommodate an exam table and this should be done. Handwashing gel was noted in the rooms without a sink, or if not is brought in by the nurses when they use these rooms.

The x-ray suite is in the long arm of the north corridor. During the expert's visit, the existing and aging plain film radiology unit was removed and a used but updated non-digital unit was being installed. The interior space was adequate but could not be walked through due to the construction. The radiology technician has a work space at the entrance to the suite that is separated from the corridor by a floor-to-ceiling metal screen. There is limited foot traffic on this corridor.

The second floor of the medical building has three separate units: mental health staff offices, the medical infirmary, and an ADA housing unit for inmates with ambulatory deficits, including those requiring wheel chairs. There is a security station staffed by a correctional officer in front of the entrances to these three units on the second floor.

The mental health staff offices are used almost exclusively for administrative duties and functions. Only on a rare occasion are selective patients interviewed in this area.

The ADA housing unit is a 23-bed housing unit for patient-inmates with significant difficulties with ambulation. Many of the men on this unit use ambulation aides, including wheel chairs. On the day that this unit was toured, there were only eight men on the unit; 15 had been temporarily relocated to buildings 31 and 41 until the elevator was repaired. The men housed on this unit must be able to provide for all their activities of daily living. Some get intermittent limited assistance from inmate health aides. There are no nursing personnel assigned to this unit and clinical providers do not make rounds on the ADA area. Individuals seeking medical attention must submit a sick call request sheet to access non-urgent care. The ADA unit is a housing unit located with good proximity to 24-hour medical services in the building, but it is not a medical treatment unit. The beds are almost universally metal bed frames with metal wire mattress supports. Some of the wire supports have been separated from the metal legs and struts and held together with strands of ripped sheets. The separated metal wires had sharp ends and constitute a potential safety hazard. These beds are less than optimal for individuals with heightened risk for decubitus ulcers. Unoccupied metal beds were turned on end and this presented a notable safety risk. There are three showers on the ADA unit. Only two of the showers are functional; the ceiling paint in all three showers is peeling, and the ceiling light in front of the showers is not functioning. The single shower chair has ripped upholstery and needs to be sealed or replaced. The showers cannot accommodate wheelchairs; we were advised that some men are moved to the infirmary to bathe and shower. There are cracked and missing tiles in the patient rooms, the hallway, and in front of the showers; this is a significant safety hazard for this high-risk population and for staff. Many of the ceiling air vents are dirty and/or missing covers. The slop sink in the janitorial closet was dirty, rusty, and had constant running watering that could not be turned off. The floor in this closet was dirty. A correctional officer was on the unit at the time of the inspection.

The 28-bed U-shaped infirmary is located across from the ADA unit. The patient rooms have two to three beds per room. Most rooms appeared to have two beds per room. There were a few individuals who were housed alone. At the time of the expert visit 18 beds were occupied. Most of the beds were hospital beds with intact mattresses and adjustable heads. There were no electrical beds in the infirmary. Most of the hospital beds have been acquired from local hospitals as they upgraded their beds.

A central nursing station with glass on both sides has doors to each of the two side corridors. A shower and tub room also can be accessed from both sides of the unit. A dayroom with a TV is situated in the middle of each side of the infirmary; this room is also used for meals for some of the patient-inmates. A biohazard room is located on the unit; waste material is removed one to two times per day. There is a restraint room with a single impervious covered, cushioned four-point restraint bed; the room was clean, and the bed was intact. Call buttons were available in the patient rooms. Four were tested and the warning monitor in the nursing station appropriately lit up.

The restraint room (room 35) also serves as the negative pressure room; the exhaust was turned on and the tissue paper test demonstrated a high level of negative pressure. The negative pressure monitor in the nursing station has been non-functional for a long time; the

monitor is old, and it was reported that replacement parts are no longer available. The negative pressure log in the nursing station verified that the room was tested weekly for functionality. It was reported that the negative pressure had recently failed due to a blown fuse; the problem was corrected that day by the engineering team. The restraint room is directly across from the nursing station, allowing a moderate degree of direct observation.

The infirmiry nursing staff checks and logs the results for the three glucometers on a daily basis and the negative pressure room functionality (tissue paper method) and the emergency response bag on a weekly basis. Inspection of the infirmiry logs verified that these devices and equipment were being monitored as described. Oxygen tanks were full and kept in safety racks. Review of the equipment in the storage room or the nursing station identified that one of the three oxygen concentrators, one of three nebulizers, two of two IVAC pumps, two of two Gomco suction units, and the AED had a current bioengineering stickers. No explanation was provided on why some of the devices had not been inspected within the last year.

There are cracked and/or missing floor tiles throughout the infirmiry, including the nursing station, the hallways, the patient rooms, the biohazard room, and the patient bathrooms. This creates a safety hazard for this very high-risk-for-fall patient population. A patient with dementia was occupying a broken bed in Room 33. Unrepaired cracks and missing plaster were noted in some of the patient rooms. Peeling paint was noted on the ceiling of the shared shower room. Room 29 had a dirty sink and a cracked electrical outlet cover with exposed live electrical connections. A number of ceiling vents were missing and/or rusty. The ceiling in the nursing station had rust stained tiles.

The third floor of the medical building is divided into two wings and serves as an 84-bed geriatric housing unit. Seventy-six patients were assigned to the third floor on the day of the inspection, but 26 had been temporarily relocated to building 41 due to the non-functional elevators. Patient rooms have two to three beds and a toilet with a sink. Similar to the ADA unit, the vast majority of the beds on the geriatric housing unit had non-adjustable fixed metal frames with an intertwined wire mattress support. The wires provide limited mattress support for this geriatric population. The wires on some beds were separated from the metal and were tied with ripped sheets to the frame. Unoccupied beds are flipped on end in the rooms, creating a risk for injury. The men must be able to independently manage their activities of daily living. Each room has a call buzzer next to the door. Inmates in three separate rooms were knowledgeable about the use of the call buzzer and demonstrated competency in its use. Many patients have their own TV sets at their bedside. There are dayrooms that are also used to eat meals and these have a TV.

Each side of the third floor had a shared five-cubicle shower room. One shower cubicle on each side was not functional. The showers emanated a musky odor, mold was noted in some of the showers, ceilings in both showers were peeling, the vents were rusty, and the shower space was humid and steamy when in use. The showers were poorly ventilated. Only one shower chair was noted in each of these two shower rooms. Cracked and missing floor tiles were noted throughout all areas of the third floor. This creates a safety risk for this aging population and is

a barrier to the effective cleaning and sanitation of the units. Missing and/or rusted ceiling vent covers were noted throughout the third floor. Some of the vents were blocked with medical chucks, others were clogged with dust.

There are no nurses assigned to the geriatric unit. Patients place a request in locked boxes on the floor to seek medical attention. Patients reported that their requests are screened by a nurse within 24 hours and, if needed, they are seen in two to three days in nurse sick call on the first floor.

There is a staging kitchen area on the west end of the third floor; food is served by inmate workers. Dirty trays are placed in different carts than those used to bring food to the floor. The temperature in the food refrigerator is checked and logged on the day and evening shifts; the recorded temperature was always less than or equal to 41°F.

In summary, the medical building was generally clean and organized; the exceptions are the infirmary, ADA, and geriatric units, which need refurbishing, including providing functional shower equipment, installing ventilation in the showers, fixing broken tiles, and fixing plaster and painting. This can be a safety issue for elderly and disabled patients. There are insufficient provider examination rooms. A number of physical plant and maintenance deficiencies were identified that have created safety, sanitation, and infection control risks. The metal beds used in the geriatric unit are not appropriate for use in this population. The nurse sick call rooms are not all adequately equipped nor do these rooms allow for patient privacy and confidentiality. All of the beds in the infirmary must be hospital-quality beds with adjustable sections.

We agree with the recommendations of the First Court Expert. We have additional recommendations found at the end of this report.

Sanitation

Methodology: We inspected the infirmary rooms, the ADA unit, the geriatric floor, the first-floor health care unit, and the sick call rooms in the medical building and the X building. We interviewed nurses, correctional officers, infirmary patient-inmates, health care leadership, and inmate porters. The Safety and Sanitation reports for the months of September 2017 to February 2018 were reviewed.

First Court Expert Findings

The First Court Expert reported that the clinical spaces were generally well-maintained and made no specific recommendations about sanitation.

Current Findings

- Monthly safety and sanitation inspections and reports are being done by the health care team at DCC.

- The safety and sanitation reports fail to address the condition of the patient beds in the infirmary, ADA unit, and geriatric floor; the compliance with annual inspections of all clinical equipment and devices; and the lack of exam tables in all nurse sick call rooms.
- The clinical areas in the medical building and in the X building and the patient rooms in the infirmary, ADA unit, and the geriatric floor were generally clean.
- It is not possible to fully sanitize areas with rusted vents, broken or missing floor tiles, and cracked walls and peeling paint.

Safety and sanitation inspections (environmental rounds) are performed by the health care team on a monthly basis and reported by the HCUA to the Assistant Warden. September 2017 to February 2018 reports were reviewed by the experts. These rounds identified concerns, some of which appear to have been corrected or are being addressed. However, the inspection reports repeatedly noted a number of deficiencies, including cracked and missing tiles, mold in the showers, non-functional ceiling light fixtures, peeling paint, rusty ceilings, and non-functional showers that have not been corrected. During this site visit, the experts noted the same not yet addressed defective conditions throughout the entire medical building and in all the housing areas in the medical building. In addition, the experts identified missing and rusty vent covers and vents, a few sinks crusted with mineral deposits, 10-15 crutches leaning the treatment room wall, the shower chair in the ADA unit had torn upholstery, a broken bed being used by a demented patient in the infirmary, and oxygen concentrators and nebulizers that had not been inspected in the last year.

Sharps boxes, gloves, handwashing sinks, or sanitizing gel was found in all clinical areas. Inmate porters sweep and mop the floors of the infirmary rooms two to three times a week. They report that they spray and clean the toilets, sinks, and showers on a regular basis. They reported that they clean and spray beds of discharged patients prior to another patient being placed in that bed. Two infirmary porters were interviewed.³ The first floor medical unit was generally clean. The rusty vents and vent covers noted in almost all areas of the medical building cannot be fully sanitized. As previously noted, the shower rooms on the second and third floor were poorly ventilated, and subsequently, musky odors and mold were noted in all the shower rooms, and the ceilings in the shower rooms had peeling paint. Although most sinks were clean, at least one sink on each floor was found be dirty or crusted with mineral deposits. We noted the broken and missing tiles on multiple areas in the Clinic Space section of this report. Broken and missing tiles make proper sanitation difficult.

In summary, although the First Court Expert had no findings with respect to sanitation, we noted several problems as described above. Overall, the cleanliness of the health care unit and patient housing areas is generally good except for the infirmary, ADA, and geriatric units. Monthly safety and sanitation inspections are being done in the health care areas. The rounds have appropriately identified problems with the maintenance of the physical plant but these problems are not consistently corrected. These inspections also must focus more attention on the beds and clinical equipment.

³ Infirmary Patients #6 & 7.

Medical Records

Methodology: Interview medical records staff, inspect the medical records room and filing system, and by way of record review, identify any problems.

First Court Expert Findings

The First Court Expert noted that medical records were “overstuffed and in dire need of thinning.” Because the paper records were so large, they were difficult to use and were deemed an obstacle to efficient delivery of care. Medication Administration Records (MARs) were often missing, making it difficult to determine if patients were receiving ordered medication. There were large backlogs of MAR documents that had not been filed. Also, the infirmity charts were on clipboards even when infirmity patients were permanently housed on that unit. This would make it difficult to follow the care of the patient because the paperwork was not organized.

The First Court Expert recommended that charts should be thinned regularly, MARs should be promptly filed, and problem lists should be kept up to date. He also recommended timely filing of all offsite medical reports.

Current Findings

Since the First Court Expert’s report, MARs appear now to be timely filed in the medical record. Three additional medical record staff have been added since the First Court Expert’s visit in 2014, which has helped in this regard. However, the remaining problems identified by the First Court Expert have not been resolved. Our key findings include the following, which confirm problems identified by the First Court Expert and include an additional finding.

- We confirmed that problem lists are not up to date. This is a pervasive problem and has not been fixed.
- The infirmity use of clipboards as the medical record makes it harder to track paper documents relevant to each patient.
- The paper medical charts are too large to be effectively used. They come undone frequently. Chart thinning sometimes results in critical documents to be missing from active records.
- Consultant and hospital reports are obtained for only approximately 10-15% of offsite visits. In most cases, it is not clear what the status of the patient is from the perspective of the consultant. This makes it extremely difficult to impossible to provide adequate continuity of care.

Medical records are stored in a single room that connects the main and the administrative corridors. The medical record system is entirely paper. The records are stored on multi-tiered shelves in two double sided aisles with a central counter. The space is extremely cramped but well organized. The experts received every chart that was requested during the four-day visit.

A medical record director position and health information assistant position are vacant. The medical record director position has been vacant since 2005 and the HCUA serves as the

supervisor. There are now three additional staff assistant positions for medical record filing. The filing backlog, including for MARs, was negligible and total backlog of filing was less than a few inches. However, there are backlogs in copying records for legal purposes and when inmates request a copy of their medical record. This has been an improvement since the last visit.

However, the remaining findings of the First Court Expert are the same. Clipboards holding medical documents are still used on the infirmary. These clipboards contain documents that are periodically moved to the formal paper medical record binder. Documents in the clipboard are not in any sorted order. This makes it more difficult to manage patients.

Charts at DCC tend to be large. Thirty-three percent of the inmates at DCC have serious mental health conditions and 26% of inmates are over 50 years of age. This results in a large number of medical documents, as these populations are more frequent users of the medical program and have increased medical or mental health documents to file. Recent changes in the mental health program have resulted in a large increase in mental health documents to maintain. Patients at DCC, therefore, have large charts consisting of many medical record documents.

Chart folders consist of an accordion-like pressboard folder with a fixed plastic binder. The binder consists of two flexible plastic tubes of about an eighth of an inch in diameter that fit into a forked clip. The paper record documents have two holes punched that fit over the flexible plastic tubing. The plastic tubing can easily become dislodged from the plastic fork and papers can come loose from the binder. The accordion pressboard folder is approximately one and three quarters of an inch wide. But the volume of paperwork in most charts far exceeds this amount, so the charts become distended and put pressure on the plastic tubing, and it comes undone frequently when staff leaf through the record and when progress notes are written. Charts we reviewed were difficult to use without dislodging the plastic tubing from the paper documents. The program has not been able to adequately thin excessively large records because they are short of funds to purchase additional pressboard folders.

A chart is thinned when a nurse notifies medical records to thin the chart or when a medical record clerk believes the chart is too large for use. Chart thinning is also dependent on the availability of medical record folder stock. When a chart is thinned, the forward volume is required to contain the following information from the previous chart:

- One year of AIMS testing
- Any psychosexual evaluations
- All problem lists
- All intake and yearly physical evaluations
- Two years of documents in the "Lab" section
- Approximately a year of progress notes
- At least six months of mental health documentation
- Chronic illness flow sheets
- The general medical consent sheet if the inmate is under 18 years old

- Any existing living will
- A month of medication refusals
- One year of other refusals

Critical consultant reports and specialized tests (EEGs, pulmonary function tests, CT scans, etc.) are not required to be moved forward, but are often critical in understanding the clinical status of the patient. Without these documents, clinicians have a much more difficult time determining the existing problems of the patient, particularly since physicians change so frequently. In our own chart reviews, we frequently had to ask for a prior volume to obtain necessary information about the patient. Not having critical information readily available may be a reason for some of the problems with following clinical care that we identified on chart review. Also, this carry forward volume of documents can be substantial and newly thinned records therefore start with a fair-sized volume. Most patients have multiple chart volumes. Any clinician attempting to understand the clinical course of care would need to go back and review multiple old volumes to obtain necessary information about the existing problems of a patient, particularly since problem lists are so out of date. This lack of maintaining critical information in the existing volume in use and the difficulty in using the paper record make the paper record system a significant barrier to adequate care. An electronic medical record should be used.

Nurses in X house see patients without a medical record. When this occurs, they write their note on separate documents and present these documents later to medical records for filing. This is inappropriate and supports the implementation of a fully electronic medical record.

Unlike most IDOC facilities, DCC maintains its dental charts in the dental clinic, and not as a component of the health record.⁴ While there are some advantages to this practice, it makes documenting a patient's health history in the dental chart critical, since the medical problem list will not be available unless it is requested.

Reception Processing and Intrasystem Transfer

Methodology: To evaluate the medical screening of inmates received at DCC as transfers from other Illinois DOC facilities we interviewed health care staff, toured the dispensary where transfer screening takes place, reviewed the IDOC health status form, DCC Admission Checklist, the Health Care Unit (HCU) Operations Policy and Procedure P-118 Transfer Screening, and health records of inmates received at DCC.

First Court Expert Findings

The previous Court Expert found that transfer screening was either not done at all or was significantly delayed, and when done was completed incorrectly. Inmates were not brought to medical for transfer screening; instead, nurses interviewed inmates on the housing unit (without the medical record or transfer summary) and attempted to address any critical

⁴ DCC received a variance from AD 04.03.102 10/21/16.

medication needs they learned about from the interviews. Nurses were not familiar with the requirements for intrasystem transfer screening. There was no process in place to log and track intrasystem transfers so that the timeliness and appropriateness of this health care encounter could be monitored, and feedback provided to improve performance.⁵

Current Findings

The previous Court Expert's recommendation has been achieved. All transferred inmates are brought to the dispensary upon arrival at DCC. Nursing staff (RNs) review the transfer summary, take vital signs, and conduct a brief screening interview to identify any immediate medical needs and reconcile prescribed medications so that treatment can be continued. Each inmate receives an individual explanation from the nurse about how to request health care attention for urgent and routine medical needs. The next day these inmates are seen again by nurses who complete a lengthier interview using the intake screening questions and review the medical record. At this encounter the nurse checks to make sure the problem list is up to date, completes any screening not done at intake, and identifies any pending referrals or appointments. Inmates who have chronic diseases are enrolled in chronic care clinic, and medication, treatments, and labs are ordered. At this second encounter, the nurse answers any questions and confirms the inmates' understanding of how to request care, procedures to receive KOP and pill line medications, and obtain refills.

We reviewed eight charts of inmates arriving as an intrasystem transfer between May 19, 2017 and April 4, 2018. These eight charts were selected from lists of patients prescribed medications that cannot be missed. The transfer summary and documentation of continuing care (medication administration, enrollment in chronic care clinic, pending appointments, etc.) was reviewed. In two cases, the transfer summary did not include the name of the sending facility and information on tuberculosis screening.⁶ In two cases the inmate was not scheduled for a chronic care appointment within 30 days of arrival for an initial evaluation.⁷ Five patients had medications which were provided without dose interruption when received at DCC.⁸ However, one of these ran out two weeks after the transfer and was not re-ordered.⁹ It was a KOP medication. It was not possible to ascertain if the discontinuity was because the inmate did not know how to request a renewal, or the patient was lost to follow up. Two others were not taking medication at the time of transfer but were referred, and medication was ordered and administered within 24 hours.¹⁰

It appears that problems with intrasystem transfer at DCC that were identified by the First Court Expert have been resolved. However, the quality of these evaluations is not uniformly good quality. Given the number of errors and omissions in the information found in the chart review of intrasystem transfers that affect patient care, we recommend that health care

⁵ Lippert Report DCC pp. 7-9.

⁶ Intrasystem Transfer Patients #1 & 2.

⁷ Intrasystem Transfer Patients #2 & 3.

⁸ Intrasystem Transfer Patients #1, 2, 5, 6, 7, & 8.

⁹ Intrasystem Transfer Patient #1.

¹⁰ Intrasystem Transfer Patients #3 & 4.

leadership establish a process to monitor and provide feedback as part of the CQI program. When facilities send inaccurate or incomplete information on the intrasystem transfer form they should hear about the mistake from the receiving facility. Errors and omissions should be subject to focused study to improve the accuracy of transfer information and continuity of patient care.

Nursing Sick Call

Methodology: Nursing sick call was evaluated by reviewing DCC Institutional Directive 04.03.103K Offender Health Care Services, HCU Operations Policies and Procedure P 103 Non-Emergency Health Care Requests and Services, and IDOC Treatment Protocols. We observed the boxes on the housing units where inmates put their health care requests, and observed nurses conducting sick call. We inspected the rooms used for sick call in the dispensary and X-house. We also reviewed tracking logs and used them to select records to review. Twenty-nine sick call requests were reviewed. Fifteen were selected from sick call logs from July 2017 through March 2018, with complaints of potentially serious conditions (chest pain, acute infection, shortness of breath, seizures, etc.), and their charts reviewed; three were observed at sick call on Tuesday April 3, 2018, and charting was reviewed. Eleven requests were selected for review because of complaints of dental pain; six were obtained from the dental clinic and five were selected from sick call logs for February 2018.¹¹

First Court Expert Findings

The previous Court Expert found that original sick call requests were discarded after triage and that no log was maintained to evaluate timeliness or responsiveness of nursing sick call. There also were significant breaches of medical confidentiality because sick call requests were handled through the general mail system. Unqualified personnel (LPNs) were assigned responsibility for sick call triage in the X-House and because these encounters took place “cell-side,” an adequate examination of the inmate’s complaint was impossible. In other parts of the facility the areas used for sick call were not adequately equipped, lacking an exam table; sometimes a hallway or other open area was used, with insufficient privacy. Also, inmates were limited to only one complaint per sick call request, which limits access. Nursing documentation was absent (times, dates, etc.) or not in SOAP format. Nursing treatment protocols were not used consistently. In segregation, nurses did not have access to the inmates’ medical record and so left progress notes made during sick call encounters in the segregation log until they were released from segregation. Referrals to providers often did not take place, were not timely, were not documented, or the problem for which the patient was referred was not addressed at the provider appointment.¹²

Current Findings

Our review found that some of the problems with sick call described in the previous Court Expert’s report have been resolved. DCC has put specific boxes on each of the housing units

¹¹ Sick Call Patients #1-26.

¹² Lippert Report DCC pp. 9-15.

designated for inmates to put their sick call requests into. These requests are picked up by nursing staff seven days a week and triaged, so problems with confidentiality and delay have been resolved. DCC has also implemented a sick call log, so it is possible to monitor the timeliness and appropriateness of nursing triage and referral decisions. Documentation of timeliness in responding to sick call requests was evident from review of the sick call logs. Of 15 medical sick call requests, all were triaged within 24 hours and all were seen within 48 hours of receipt. Four urgent requests were seen the same day the request was received.¹³ DCC nursing staff are assigned to monitor that the log is filled out. Undoubtedly, this helps to ensure that the log is current and timelines are being met.

For the month of March 2018, staffing assignments for nursing sick call were in accordance with the Illinois Nurse Practice Act. An LPN was assigned to do sick call along with an RN on two of the four Fridays in the month. The minimum number of staff assigned to sick call is two. Some days, three or four RNs are assigned to sick call. Practices at DCC are to assign an LPN to sick call only when it cannot be staffed with two or more RNs. When an LPN is assigned sick call, he or she works under the direction of the RN assigned to sick call. This information was verified by nursing staff who were interviewed while observing sick call. However, the use of LPNs to assist in conducting sick call risks patient harm and is an example of how RN vacancies (23%) affect quality of patient care.

Sick call assessment is no longer done in the hallway, cell side, or in rooms without access to an exam table. Rooms have been designated and equipped in the dispensary and in X-House to see patients requesting sick call attention. See the description of these areas in the previous section on Clinic Space. These rooms are not adequately equipped, lacking exam tables and examination equipment.

Four rooms in the dispensary area are used to perform nursing sick call. These are adjacent to each other or across a small hallway. One of the rooms has an exam table with paper. There also are two alcoves down the hall with beds and curtains that were also used for unclothed examination. The nurses share an otoscope and two weight scales. Each room has hand washing capacity and equipment to take vital signs. Forms and treatment supplies are kept in a locked medication cart in one of the rooms, which all of the nurses performing sick call can access. Nurses share the examination table and otoscope, which promotes lack of confidentiality and is disruptive of nursing services. Our opinion is that the sharing of examination tables is inappropriate and unreasonable. We do not endorse that practice for physicians and likewise do not endorse that practice for nurses. Each nurse should be afforded the equipment and supplies necessary to conduct their work.

The day sick call was observed (4/4/2018), an officer was stationed at a table in the hallway and managed inmate movement from the cell blocks to the waiting area and to the sick call nurses. The nurses had the inmate's sick call request and their health record at the time of the encounter. Nurses used the IDOC treatment protocols; assessments were appropriate to the

¹³ Sick Call Patients #4, 7, 10, 12.

complaint and responsive to the patients' medical issues. Inmates were not limited to one complaint in the encounters we observed, or the records reviewed. Four registered nurses saw 29 patients from general population and four from the Special Treatment Center (STC).

In X-House, sick call requests are picked up daily and triaged by registered nurses. Registered nurses see patients for sick call Monday through Friday. Patients are seen for sick call in an examination room located at the front of the segregation unit. The room has an examination table with paper, a desk, chairs, scale, and examination light. Examination equipment and hand wash is brought to the room when sick call is conducted. This room is also used when the provider sees patients housed in this building.

Problems with sick call identified in the initial Lippert report that were still evident include:

- Original sick call requests are not filed in the inmate's medical record. It is an improvement that the nurse has the actual request at the time the patient is seen. However, there is no record of the patient's actual request for health care attention. Documentation of the patient's complaint on the nursing note is not verbatim; it is often shortened and interpreted by the nurse. This is not an accurate reflection of the patient's request for medical attention. Sick call requests should be filed in the patient's medical record.
- Nursing documentation was absent (times, dates, etc.) or not in SOAP format, and nursing treatment protocols were not used consistently to guide the assessment and plan of care. In the charts of 15 medical requests reviewed, there were 12 that resulted in a face-to-face nursing assessment. Of these, only six (50%) were adequately assessed and an appropriate plan of care developed. Either the assessment was incomplete,¹⁴ the nursing protocol was not used,¹⁵ the nurse did not address the complaint,¹⁶ or did not follow up on significant symptoms.¹⁷ A rate of 50% inaccuracy in the nursing assessment and follow-up of medical requests for potentially serious complaints (unexplained weight loss, numbness, chest pain, infection, etc.) puts patients at significant risk of harm.
- A quality improvement study of the use of nursing treatment protocols was included in the 2016 CQI Annual Review.¹⁸ This QI tool only monitors whether nurses used a protocol, identified their credentials, and documented the date and time the patient was seen. There is no evaluation of the quality or completeness of the nursing assessment or the appropriateness of clinical decision making. In addition, the DCC Medical Director reviews two records of every nurse assigned sick call each month and reports these findings at the monthly CQI meeting. Performance of less than 80% on criteria used to evaluate sick call was reported month after month in CQI minutes reviewed.¹⁹ The only corrective action was counseling and progressive discipline. No

¹⁴ Sick Call Patient #14 complained of "bladder issues," and a urine dipstick was not done per the IDOC Nursing Treatment Protocol for Urinary Tract Symptoms.

¹⁵ Sick Call Patients #4, 13.

¹⁶ Sick Call Patients #4, 10, 11.

¹⁷ Sick Call Patients #10, 11, 15.

¹⁸ Dixon Correctional Center Annual Governing Body Report, September 21, 2016 p. 19.

¹⁹ Criteria include whether a full set of vital signs were taken, was the assessment thorough, was a treatment protocol used, etc. DCC CQI Minutes May 2016, July 2016, August 2016, January 2017, March 2017.

attempt has been made to trend problem areas or to analyze systemic factors that contribute to poor performance; instead, individuals are blamed.

- Medical records are not available in X-House. The IDOC Nursing Treatment Protocols state that “sick call evaluation using these protocols should be performed with a medical record.”²⁰ Patients with medical complaints are evaluated without consideration of their problem list or medical history, which contributes to inadequate assessments and plans of care. Nurses document the sick call encounter on IDOC medical record forms which are kept in the nurses’ office. This loose filing is incorporated into the inmate’s medical file eventually.
- Inmates who were referred from nurse sick call were not seen or not seen timely by providers. Providers failed to follow up at intended intervals and treatment orders were not completed.
- In the charts of 15 medical requests reviewed, nine were referred to a provider. Two additional patients should have been referred by the nurse and were not.²¹ Of those referred, three were referred urgently and all were seen within 24 hours (100%). Of the other six patients referred to a provider non-urgently,²² only one was seen in less than 72 hours for higher level medical attention (16%).²³
- Health Care Unit Policy and Procedure P-103 states that provider sick call for general population and the special treatment program takes place Monday through Friday from 8 a.m. to 4 p.m. However, in segregation, provider sick call only takes place once a week. The frequency of provider sick call and scheduling practices results in patients not being seen timely. Patients’ medical conditions are at risk of deterioration when medical attention is untimely, and can result in harm.

A new problem identified by the Court Appointed Experts is a practice variation in how complaints of dental pain are handled. Sometimes nurses forward complaints about dental pain directly to the dental department and other times the patient is seen by nursing staff in sick call and then referred to the dentist. The problem with forwarding complaints about dental pain directly to the dental program is that it may be several days before the patient is seen. In the meantime, the patient’s pain is untreated. The pain may also mask other more serious conditions, such as infection, that needs to be attended to immediately to prevent more serious consequences.

We were told by both nursing and dental staff that requests for dental care are routed to the dental program for triage and appointment. We used six sick call requests found in the dental clinic from patients who complained of having dental pain and looked at their medical records to see if the request had been triaged and assessed by nursing staff.²⁴ None of these patients had their complaint of dental pain triaged or assessed by nursing staff; instead, the request was routed directly to the dental program.

²⁰ IDOC Nursing Treatment Protocols p. 6.

²¹ Sick Call Patients #4 and 11.

²² Sick Call Patients #1, 8, 10, 13, 14, 15.

²³ Sick Call Patient #1.

²⁴ Sick Call Patients #24-D through 29-D.

The IDOC Nursing Treatment Protocols provide instruction to nurses in the assessment and treatment of dental complaints.²⁵ A toothache without fever or swelling is to be referred to the physician or dentist for evaluation within 24 hours. Using the nursing sick call log, we found five patients who had dental complaints in February 2018. Each of these patients had been triaged by nursing and a progress note written in the chart. Three patients agreed to be seen at nursing sick call and the nursing protocol was used to guide the assessment, urgency of referral, and to provide care in the interim until seen by the dentist.²⁶ In two of the three referrals, the patient was not seen for evaluation by a dentist or physician within 24 hours as specified in the protocol.²⁷

We brought this practice variation to the attention of the IDOC Nursing Supervisor and did not receive any clarification about what nurses were expected to do when triaging complaints of dental pain. We recommend that an expectation be established that complaints of dental pain are assessed in nursing sick call, then referred to the dentist based upon urgency, and interim treatment options considered (use of OTCs or obtain a provider order).

The nursing treatment protocol for toothache/dental complaints should be revised by the IDOC. Separate protocols for dental decay, infection, and trauma to the oral cavity should be developed. Expectations for the assessment, directions on determining the urgency of referral provided, and the timeframe in which the dentist or physician is to see the patient should be specified. A review and revision of the treatment protocol can also delineate options for nurses to treat pain while the patient awaits appointment.

In summary, some of the problems with sick call identified in the previous Court Expert's reports have been corrected. Problems with sick call currently include:

- Sick call requests are not filed in the patient's medical record.
- Nursing assessments and documentation of sick call encounters are not adequate.
- Rooms used by nurses for sick call are not adequately equipped or supplied.
- Patient medical records are not used for evaluations in the X-House and cannot be used to reference the problem list, medical history, or orders when seeing patients.
- Patients referred to providers from sick call are not seen timely.
- Complaints of dental pain are not consistently triaged and assessed by nursing staff.

Chronic Care

Methodology: The Chronic Care Nurse was interviewed about the chronic clinic processes and scheduling. The 2016-2017 and 2017-2018 chronic care clinic statistics, the current chronic care clinic annual schedule, and the chronic care patient lists were reviewed. The medical records of 14 patients with chronic medical illnesses and conditions were reviewed. The Office of Health Services Chronic Illness Treatment Guidelines dated March 2016 were reviewed as needed.

²⁵ IDOC Nursing Treatment Protocols p. 80.

²⁶ Sick Call Patients #20-D through 22-D.

²⁷ Sick Call Patients #21-D and 22-D.

First Court Expert Findings

The previous court expert noted that it was difficult to determine how many patients were enrolled in chronic care clinics, that the chronic care tracking system was inadequate, that patients with chronic illnesses were not all enrolled in a chronic care clinic, and some without chronic illnesses were erroneously registered in chronic care clinics. The expert stated that the chronic care clinic process was fragmented and disjointed. The absence of a single chronic care nurse to coordinate the chronic care clinics was a prominent contributing factor to the lack of an effective chronic care program. It was noted that DCC has established multiple illness clinics (MIC) that allows patients to have more than one chronic illness assessed and managed in a single visit.

Current Findings

DCC now has a single dedicated nurse coordinating chronic care. Patient are assigned and seen in chronic care clinics and patients are tracked and reported. The remaining problems identified by the First Court Expert have not been corrected. In addition, we identified additional findings and confirmed some of the First Court Expert's findings as follows:

- DCC now has a single, designated nurse to staff and coordinate the chronic care clinic program.
- Patients assigned to chronic care clinics are regularly seen in these disease specific clinic sessions. Chronic care patient lists identify the next scheduled appointments of the patients.
- Chronic care clinic statistics are tracked and reported.
- The names of patients enrolled in one chronic care (HIV) clinic list was compared to the HIV medication list. With the exception of four patients who had recently been transferred and one patient who had not yet been started on HIV medications, the two lists were in accordance.
- DCC has established biannual MIC clinics (two non-diabetes chronic illnesses) and MIC diabetes clinics (diabetes and at least one other chronic illness). This allows patients with more than one chronic illness to have their multiple chronic conditions managed in a single comprehensive clinic visit.
- The handwritten notes in the chronic care visits are generally legible; this is a notable improvement from the previous site visits.
- The current practice of not rescheduling chronic care patients who refuse to attend their scheduled appointment until the next chronic care clinic, which may be as long as six months later, is not in the best interest of the patient or the institution.
- Providers are primarily documenting changes in warfarin anticoagulation dosages on the INR lab report sheet but not in the progress notes. This important, even life affecting, information is inappropriately filed in the wrong section of the medical chart where it is likely to be undiscoverable.
- The chronic care clinic notes inconsistently contained needed clinical information, did not always indicate that needed examinations had been performed, did not universally document the rationale for clinical decisions and therapy modifications, and did not clearly outline the patient's treatment plan.

- The care of chronic illnesses (diabetes, hepatitis C, seizure, asthma, hyperlipidemia) and the provision of age-based routine health maintenance screenings are not in full accord with both the Office of Health Services Chronic Illness Treatment Guidelines and national standards of care.
- Asthmatic and COPD patients do not have documentation in their medical record that they have been educated and have demonstrated competency in the use of metered dose inhalers (MDI). Poor technique in the use of MDIs contributes to poor control of asthma/emphysema and increased morbidity.
- Asthmatic and COPD patients who present with respiratory symptoms to nurse sick call do not routinely have their peak expiratory flow rates (PEFR) measured. This is not in compliance with IDOC Asthma Treatment Guidelines.
- Diabetics at DCC were seen regularly, had HbA1C and urine microalbumin creatinine ratio testing performed at reasonable intervals, and received annual optometric screening for diabetic retinopathy. However, detailed foot exams, preventive pneumococcal vaccinations, and evaluation of 10-year heart disease and stroke risk scores that are recommended in the IDOC diabetes treatment guidelines and in national standards of diabetes care fail to be performed.
- The one chart of a patient 65 years of age or older whose chart documented a past history of tobacco use had no documentation in his record that he was offered one-time screening for aortic abdominal aneurysm as recommended by national standards of care.²⁸ DCC failed to screen all patients over 50 for colon cancer and repeat the screening at intervals based on the results and the methodology of screening utilized. The charts of seven patients 50 years of age or older were reviewed; six (86%) of the seven eligible patients had not been screened for colon cancer.²⁹ The one patient credited for being screened was not routinely screened for colon cancer but had a colonoscopy performed when he was 49-year-old to evaluate bloody stools.
- Nationally recommended vaccinations for adults are not consistently administered. Pneumococcal and meningococcal vaccinations were not offered or given as recommended by national age and disease-based guidelines.³⁰
- Warfarin is the anticoagulation therapy provided at DCC. The monitoring of this modality of anticoagulation is staff intensive and logistically complicated, which makes it extremely difficult to maintain a safe level of anticoagulation. Patients are not adequately anticoagulated for a significant percentage of the time that they are on treatment.
- Uncontrolled chronic illnesses with problems that appear to be beyond the expertise of the DCC providers are not referred for specialty consultation.

²⁸ USPSTF AAA 2014.

²⁹ Chronic Care Patients #2,4,5,8,9,12,13.

³⁰ In references, CDC Recommended Immunization Schedule for Adults 19 Years or Older by Medical Conditions or Other Indications, 2018).

- The chronic care providers did not document any review of the MAR, the CBGs, the nursing and provider sick call notes and blood pressure readings when they saw patients in the disease-specific chronic care clinics or in the intervals between chronic care visits.
- The Medical Director reported that the providers have access provided by Wexford on their administrative office computers, but not in the infirmary or clinic exam rooms. Nurses do not have access to electronic medical references in the sick call exam rooms. This lack of ready access to current clinical diagnostic and therapeutic information is a barrier to the delivery of comprehensive, quality care at DCC.
- Chronic care scheduling in separate clinics for each individual disease is wasteful, without basis in contemporary medical primary care practice, and may be harmful to patients. On the basis of patient safety we recommend this practice be discontinued.

Two advanced practice nurses are assigned to staff the chronic care clinics. The single physician at DCC provides care to the infirmary patients and does administrative duties, but does not staff chronic care clinics.

Chronic care clinics at DCC are scheduled to be seen at specific monthly intervals that are inflexible.³¹ These schedules are not based on the degree of control of the patient's illness. Patients need to be seen as frequently as is necessary to obtain control for their illness, not based on an inflexible schedule. The practice of seeing patients in disease specific chronic illness clinics encourages providers to ignore the implications of any one disease on another disease and to ignore the multitude of drug-drug interactions that exist in the practice of medicine. Many chronic illness are clinically interrelated. Metabolic syndrome, for example, is a condition that consists of obesity, diabetes, high blood lipids, and hypertension. Yet in the IDOC, each of these diseases (diabetes, high blood lipids, and hypertension) may be evaluated in a separate chronic clinic. In the IDOC, these disease specific clinics also do not include documentation that the provider evaluating the patient is aware of the patient's other clinical conditions. Each individual illness is documented on a separate medical record document, which makes it impossible to obtain a unified perspective with respect to therapeutic treatment planning. This redundant documentation is wasteful of time, unnecessary, and is clinically inappropriate. Unless a specialist is managing an individual disease, there is no legitimate clinical basis for this practice, which we believe should be discontinued on the basis of patient safety and elimination of waste.

For these reasons, patients with chronic medical conditions should be seen for all of their chronic medical conditions each time they are evaluated unless a specialist is managing their care. A patient in a primary care practice with six chronic conditions might be seen four times a year or more frequently if clinically indicated. In the IDOC, a patient with six chronic illnesses

³¹ At DCC, asthma chronic clinic is scheduled in January and July. Diabetes chronic clinic is scheduled in April, August, and December. MIC/DM is scheduled in April, August, and December. Hepatitis C clinic is scheduled in June and December. High risk/HIV clinic is scheduled monthly. Hypertension/Cardiac clinic is scheduled in March and September. Seizure clinic is scheduled for February and August. Tuberculosis clinic is scheduled monthly. General Medicine clinic is scheduled May and November. Renal clinic is scheduled monthly via telehealth by a consulting nephrologist.

can have up to 24 chronic care documents in the medical record each having been developed in a separate clinic session.

The chronic care clinic enrollment and scheduling processes were reported as follows:

1. Within 24 hours of admission, the admitting RN documents names of patients and their chronic illnesses in the clinic log.
2. The chronic care nurse reviews the clinic log on a daily basis, adds patients to the appropriate chronic care list, arranges for the next chronic clinic visit based on the due date and the date of the previous visit, and arranges lab testing if the patient is to be seen within the next 30 days.
3. Within one week, an advanced practice nurse (APN) reviews the charts of all newly admitted individuals, identifies missed chronic illnesses, orders any needed labs, and if needed, sees patient within 30 days if a chronic illness baseline is required.
4. During the interval before the first chronic care visit at DCC, APNs will renew expiring medications.
5. The chronic care nurse reviews all patients to be seen in the upcoming month's chronic clinic, and arranges required lab tests to be drawn in advance.
6. Medical record staff generate the passes no less than the day before the clinic and a movement list/clinic schedule is printed and sent to the correctional staff. The chronic care nurse arranges the passes/list for the telehealth specialties (HIV, hepatitis C, renal).
7. Refusals for chronic care appointments (and treatments, dressings, nebulizer treatments, insulin injections) must be documented in person in the health care unit.

Medications will be renewed if needed for patients who refuse a chronic clinic appointment. But the patients who refuse an appointment will then be rescheduled at the next chronic illness clinic, which could be as long as six months later. This places the patient at risk for having a sustained period of lack of control without any clinical intervention unless their condition deteriorates to the level of causing clinical symptoms. We view this as indifferent. Patients at DCC include the mentally ill and many geriatric patients who have mental challenges. Refusals of care, particularly in this group of patients, must be viewed with the perspective that this group may have cognitive challenges. IDOC must therefore establish procedures that ensure that high-risk, non-cooperative, or non-compliant patients who refuse visits are rescheduled promptly based on their existing clinical need. In all other respects, monitoring of these patients must continue as ordered. On the other hand, as opposed to refusals, all no shows due to lockdowns, NP call-ins, offsite site writs, and hospitalizations are currently automatically rescheduled and seen shortly after the missed appointments.

There were 2,560 chronic care visits at DCC from July 2016 through June 2017. In the first eight months of FY 2017-18 (July 2017 to February 2018), 1,781 chronic care clinic visits were provided; this projects to a slightly higher annualized volume than the previous year.

Chronic Care Clinic Statistics

July 2017 – June 2018

Table 1

Clinic	HTN	DM	Sz	Asth/COPD	Gen Med	Hep C	HIV	INH	MIC*	MICDM	Total
Average Pt. Roster	307	28	59	173	238	129	27	1	96	128	1185
Annual Visits	605	85	113	356	501	256	80	12	196	368	2560
Visits per patient/year	2	3	1.9	2.1	2.1	2.0	3.0	2	2	2.9	
% of DCC Population	13.4%	1.2%	2.6%	7.6%	10.4%	5.7%	1.2%	0	4.2%	5.6%	

*MIC includes patients with ≥ 2 conditions: hypertension, seizures, asthma/COPD, gen med. MIC DM includes patient with diabetes **and** ≥ 1 of these conditions: hypertension, seizures, asthma/COPD, or gen med.

Over 50% of all the patients at DCC have a chronic illness. Based on the data noted in Table One and the review of the medical records of 14 chronic care patients, most patients with chronic illnesses at DCC are seen by a provider approximately twice a year.

At the time of the site visit to DCC, 11 patients were receiving chronic anticoagulation using warfarin (Coumadin or Jantoven). Patients receiving warfarin treatment must have frequent International Normalized Ratio (INR) testing to assure that the level of anticoagulation is within a recommended therapeutic range. Lower than therapeutic range results predispose the patient to recurrent clots and possible pulmonary emboli; elevated levels create risks of serious bleeding. The experts had difficulty evaluating the care provided to this patient population who were at high risk for serious complications. The progress notes and chronic care clinic notes had limited if any documentation of INR results and clinical decisions to modify warfarin doses. Ultimately, the experts identified, albeit inconsistently, scribbled annotations at the bottom of lab reports buried amidst multiple lab results noting a change in warfarin dosage. This vital clinical decision and the rationale for dose modification must be documented in progress notes which providers and nurses commonly use to comprehend and verify the care provided to a patient. This must be expeditiously addressed by IDOC and DCC medical leadership. The utilization of INR testing was tracked on two patients receiving warfarin for chronic anticoagulation. One patient had 24 INRs in 16 months; nine (38%) were in the recommended therapeutic range, 11 (46%) above this range, and four (17%) below the therapeutic range.³² The other had 43 INRs over 41 months; 31 (72%) in the therapeutic range, three (7%) above this range, and nine (21%) below the therapeutic range.³³ The varying levels of anticoagulation in these two patients resulted in multiple increases and decreases in the dosage of warfarin. Given the logistical difficulty in maintaining therapeutic levels of anticoagulation in the correctional setting, IDOC must strongly consider switching to the use of newer anticoagulants that do not require INR testing and the subsequent frequent adjustments of the anticoagulant dosages.

³² Chronic Care Patient #7.

³³ Chronic Care Patient #10.

The documentation in the chronic care clinic notes does not consistently contain sufficient, pertinent clinical information needed to clarify and understand the status of a patient's chronic illness or justify a change in the treatment plan. This lack of consistent clinical documentation creates a barrier to the continuity and quality of care delivered to the DCC patient population. The experts found limited documentation that the chronic care providers had reviewed the MAR (refusals, compliance with prescribed medications), the CBGs, the previous nurse and provider sick call notes, and the blood pressure readings taken in the previous sick call visits when they assessed patients in the disease specific chronic care clinic visits. This failure to review and document the data and information that had been gathered between chronic care visits contributes to inappropriate clinical decisions for DCC's patient population.

The chronic care clinic notes are handwritten but were, for the most part, legible. The legibility of the chronic care handwritten notes was a notable improvement from the Experts' site visits to the previous two correctional facilities.

It was reported that the providers have access to the UpToDate® electronic medical reference on their administrative office computers, but this important access to current diagnostic, treatment, and clinical information is not available to providers or nurses in their clinical work areas (infirmary, nursing stations, exam rooms), making access to this information not available when it is needed.

Most of the chronic care patients had completed problem lists. However, four (29%) of the 14 charts reviewed had important diagnoses missing from the problem list and one had diagnoses that were either incorrect or no longer active problems.

The care provided to diabetics and patients on chronic anticoagulation, antihypertensive, and asthma/emphysema medications had deficiencies. The Office of Health Services Chronic Illness Treatment Guidelines were not fully adhered to: diabetics did not receive pneumococcal vaccines or have documented detailed foot examinations. Asthmatics did not receive pneumococcal vaccination and did not have pulmonary function tests performed when there was uncertainty about their diagnosis. Seizure patients did not have documentation of the occurrence of their most recent seizure. Hepatitis C patients did not have a baseline HCV RNA measured. Some diabetics, hypertensives, and patients on warfarin anticoagulation remained uncontrolled for lengthy periods of time, and detailed foot and lower extremity sensory exams are not documented in the diabetes chronic care notes. Recommended vaccines are not universally provided to patients whose age or disease warrant such vaccination. Compliance with prescribed medication is important for all chronic illnesses and the impact of not taking or receiving diabetic, hypertension, anticoagulation, and seizure medications can result in rapid deterioration and morbidity. There was no documentation in the chronic care provider notes that they were reviewing the MAR's or nursing notes to assess compliance with medication and initiating appropriate interventions as needed.

All 14 (100%) of the patient records had some degree of problems identified in the provision of care. The following patient summaries highlight the concerns and the findings noted above.

Chronic Care Patient Summaries

- This patient is a 49-year-old male with diabetes, hypertension, obesity, ETOH abuse, and paranoid schizophrenia, whose medications included glipizide 5mg, metformin 1000mg BID, fenofibrate 54mg/d, metoprolol 50mg BID, hydrochlorothiazide 25mg/d, and aspirin EC.³⁴ There was no documentation in the database of pneumococcal vaccination, which is recommended for all diabetics. He was followed in DCC's combined chronic (MIC DM) clinic. Lab testing in 2013 revealed cholesterol 206, LDL 95, TG 343 (45-150), and HbA1C 8.6%. In 2015, simvastatin was discontinued and fenofibrate was started due to an elevated TG (343). This is a questionable clinical choice, with only a mildly elevated TG. The national guidelines recommend statins for patients with high risk of cardiovascular disease. This patient's 10-year cardiovascular risk score was not assessed by the DCC providers, but we calculated his risk to be 20.5%, which warranted prescription of a statin.³⁵ His diabetic control improved and his HbA1C was maintained between 5.4 and 5.7%. He has chronic kidney disease (creatinine 1.77) but his urine microalbumin was within normal range. The optometry visit in March 2017 identified no findings of diabetic retinopathy. His blood pressure was controlled; however, in 2016 a prescription for lisinopril, an antihypertensive that is strongly indicated in diabetics with early kidney disease, was discontinued. The rationale for this decision was not noted. At none of his chronic care visits was there documentation that a detailed foot exam had been performed. At the 8/6/17 annual exam, his cognition was felt to be somewhat impaired, but the provider did not list any reasons or possible etiologies for the assessment of mild cognitive impairment. The patient lost 51 pounds over six years (311 lbs. in 2011 and 260 lbs. in October 2017). This may be due to exercise and better food choices, but there was no documentation by the provider that a wider differential (hyperthyroidism, cancer, malabsorption, etc.) was considered. This patient will be 50 years old later this year and consideration should be given to additional age-based screening (e.g., colon cancer screening). A review of recent MARs showed good administration and compliance with medications.

In summary, for the most part, this patient's diabetes (HbA1C's consistently in the 5 range) and hypertension have been well controlled for the last two years. The improvement in his diabetes may be due to his weight loss. Although the repeated HbA1C's in the 5 range put the patient at risk for hypoglycemia, the provider did not reassess the diabetes medications and did not consider discontinuing at least one of the two anti-glycemic medications (for example glipizide). His 10-year risk of heart disease and stroke was greater than 7.5%. Based on current standards and on the IDOC Chronic Illness Guidelines, this patient should have been prescribed a statin to lower his risk of cardiovascular events. Also, the providers failed to comply with the IDOC guidelines by not documenting a foot examination, and not ordering a pneumococcal 23 vaccination. The providers failed to identify, monitor, and evaluate the reason for the patient's

³⁴ Infirmity Patient #1.

³⁵ ACC/AHA Heart Risk Calculator.

notable 51-pound weight loss during his incarceration. This puts the patient at risk from potentially preventable morbidity and even mortality.

- This patient is a 53-year-old male with HIV infection, hyperlipidemia, hypertension, asthma, substance use disorder, and a past history of positive TB skin test.³⁶ His medications included lisinopril 20mg, QVAR MDI, albuterol MDI, pravastatin, Genvoya, and darunavir. The patient was transferred in September 2017 from Northern Reception Center (NRC) to DCC. He was followed in the UIC HIV telehealth clinic and the MIC chronic care clinic. In the past 21 months he has been seen three times in the UIC HIV clinic while at NRC and DCC, three times in the hypertension chronic clinic at NRC, and two times at the MIC clinic at DCC. His HIV has been stable on Stribild/darunavir and then Genvoya/darunavir, with viral loads <20 and CD4s ranging between 680 and 838. His HIV medications included protease inhibitors. The patient was on simvastatin from June 2016 to March 2017. Simvastatin is contraindicated in persons on protease inhibitors, which this patient was on, yet this contraindication was not recognized for 10 months. He had been seen three times in the NRC hypertension chronic care clinic before this contraindicated medication was discontinued. There is no documentation in the chart that he was offered or administered the pneumococcal 13 or 23 or the meningococcal vaccinations. His asthma was well controlled with no exacerbations noted in the medical record, and his PEFs ranged between 600 and 750 L/min. His blood pressure was controlled over the last 21 months. On 3/21/17, when simvastatin was discontinued at SCC, gemfibrozil was ordered without a rationale documented in the medical record. Gemfibrozil is not recommended for lipid lowering in the absence of high triglycerides. An elevated triglyceride level was not identified in the medical record. A different statin drug other than simvastatin should have been chosen. Labs on 7/20/17 showed a cholesterol of 251, LDL 173, TG 156. The patient transferred to DCC in late 2017. In March 2018, gemfibrozil was discontinued and an appropriate statin (pravastatin) was finally initiated. The decision to appropriately start statin medication was delayed by the providers' failure to calculate the patient's 10-year ASCVD risk score as is mandated in the IDOC diabetes treatment guidelines.³⁷ This patient's estimated 10-year cardiovascular risk was 9.7%; the national and IDOC guidelines recommend starting a statin when the 10-year risk is >7.5%.³⁸ This 53-year-old has not yet been screened for colon cancer; all individuals should be screened for colon cancer beginning at the age of 50.³⁹

In summary, this patient was continually seen in HIV and chronic care clinics. His HIV, asthma, and hypertension were adequately controlled. Even though this patient was seen three times in an NRC/SCC chronic care clinic, for seven months he was left on a type of statin that has serious drug interactions with HIV medications before this contraindicated statin was recognized and discontinued. This delay put the patient at

³⁶ Chronic Care Patient #2.

³⁷ IDOC Chronic Illness Treatment Guidelines, Diabetes 2016.

³⁸ ACC/AHA Heart Risk Calculator.

³⁹ USPHS Taskforce.

risk and supports a recommendation that chronic care clinic providers need to be engaged and knowledgeable about the care provided in other chronic care and specialty clinics and in sick calls. There was no rationale documented in the medical record for starting gemfibrozil after the contraindicated statin was stopped; triglycerides were never more than mildly elevated. The providers failed to comply with the IDOC and national guidelines by not calculating the 10-year ASCVD risk and delaying the ordering of another statin that was not contraindicated for use with HIV medications. The providers failed to comply with national guidelines to offer screening for colon cancer to all individuals at the age of 50 years and to offer pneumococcal and meningococcal vaccination to this patient with HIV.

- This patient is a 29-year-old male with asthma. His only medication is levalbuterol MDI.⁴⁰ His database noted a negative PPD and hepatitis B vaccination series being administered in 2017. There was no documentation of pneumococcal or flu vaccines. In 2016, he was seen three times in nurse sick calls for upper respiratory infections and asthma exacerbations. The nurses did not measure peak expiratory flow rates (PEFR) but did measure oxygen saturations. The patient improved with increased use of the levalbuterol inhaler. The patient was seen in asthma chronic care clinics four times between July 2016 and January 2018. In the asthma clinic his peak flows ranged from 450 to 500 L/min. The providers did appropriately document the frequency of levalbuterol usage as one to three times per week when the weather was cold. There was no documentation in the medical record by nurses or providers that the patient's inhaler technique was reviewed and found to be appropriate. MARs reviewed in 9/2017 and 11/2017 documented the distribution of the KOP inhalers to this patient.

In summary, the patient had very stable asthma that only required intermittent use of his rescue inhaler. He was seen regularly in the asthma chronic care clinic. There was no evidence in the medical record that he had been offered pneumococcal vaccination, as is nationally recommended for all asthmatics. The nurses did not measure PEFRs when the patient was seen in nurse sick calls for breathing issues. Nurses should measure and record PEFRs before and after treatment on all asthmatics who are evaluated in sick call or in the urgent care treatment rooms. Oxygen saturation testing has a place in the evaluation of symptomatic patients in respiratory distress or those not responsive to treatment, but does not replace the measurement of PEFRs. Asthmatic and COPD patients should have documented ongoing training and documented observation of their inhaler technique. This is not being done at DCC and should be incorporated into the standard care provided to all users of inhalers. Failure to do this puts the patient's health at risk.

- This patient is a 81-year-old male housed on the geriatric floor with diabetes, hypertension, hyperlipidemia, and decreased vision.⁴¹ His medications include

⁴⁰ Chronic Care Patient #3.

⁴¹ Chronic Care Patient #4.

simvastatin, metoprolol, furosemide, aspirin, lisinopril, and metformin. The patient was seen regularly in the diabetes/hypertension MIC chronic care clinic. His HbA1Cs have ranged from 5.4 to 5.7 for the last 2¾ years. His blood pressure was 178/90 on 1/12/16 and furosemide was added to this anti-hypertensive regimen. His blood pressure was also elevated (158/80) in December 2017, but no treatment modifications were made at this visit. There was no documentation in the medical record that this patient received the pneumococcal vaccines, which are indicated for all diabetics and every patient 65 years of age or older. He also was not screened for colon cancer, which is indicated for all patients 50 years of age or older.

Since 2015, this patient has been followed by the DCC optometrist for failing vision, worse in the right eye. He was referred to the UIC cataract clinic in February 2017. On 3/8/17, the optometrist documented that the patient could only count fingers at five feet with his right eye and had visual acuity of 30/40 on the left. On 4/26/17, the optometrist noted that he was still looking into the request to get approval for cataract surgery. On 5/4/17, the optometrist found that the patient's vision deteriorated to a visual acuity of 20/100 on the left, and only finger counting on the right at five feet. The optometrist submitted another request for referral to UIC. On 10/11/17, eight months after the initial referral, the patient was seen at UIC, where retinal swelling was noted and drops in both eyes continued for glaucoma. A two week follow up was recommended. On 11/8/17, the optometrist found the patient's vision to be only finger counting at two feet in both eyes. The optometrist added a second eye solution and wrote "need to get back to retina specialist...will refer again." On 12/13/17, the intraocular pressure of both eyes was normal. The optometrist noted that the patient had a history of retinal swelling due to diabetic retinopathy and advised that the patient keep the eye appointment with the retinal specialist. No further visits to the UIC eye specialists were located in the medical record. The patient's MAR indicated compliance with all medications.

In summary, the patient was seen regularly in the chronic clinics and his diabetes appeared to be over treated because his HbA1C level was significantly below goal. The risk of hypoglycemia should have prompted reevaluating the need for metformin in this elderly patient. Failure to offer and administer pneumococcal 13 and 23 vaccines is not in compliance with community practice nor with IDOC diabetes treatment guidelines. Failure to screen this patient for colon cancer is also not in accord with national standards. The patient's vision was rapidly deteriorating. It took eight months before the visit to the UIC eye specialist was arranged. The optometrist had to submit a second request three months after his initial request. The patient was seen in October 2017 at UIC and was to return in two weeks; the optometrist wrote on 11/8/17 that the patient needed to see the retina specialist and re-submitted a referral request. As of 12/13/17, the patient had not yet been seen back at UIC. The patient's vision has notably deteriorated. There have been delays with the initial and follow-up appointments at UIC that may have contributed to his failing vision. The delays in obtaining specialty

ophthalmology consultation at UIC should have prompted DCC to consult with a local ophthalmologist. These delays place the patient at risk of loss of vision.

- This a 53-year-old male with hepatitis C, asthma, hyperlipidemia, and a psychiatric disorder.⁴² His database noted PPD negative in 2017 and hepatitis A and B vaccination series in 2013-14. He was followed in the asthma and hepatitis C chronic clinics. His medications were levalbuterol and ciclesonide MDIs. There was no evidence in the medical record that he received the pneumococcal vaccine as is recommended for persons with asthma or emphysema. His last asthma attack was documented as occurring in 2013. Given he had infrequent asthma exacerbations, he had questionable need for inhaled steroid medication. His PEFs ranged from 325 to 520 L/min, but the PEF was not always recorded when he was seen at his chronic care visits. There was no evidence in the medical record of pulmonary function testing. This testing was needed to identify if this patient had asthma as opposed to emphysema. His lipid profile in September 2015 noted cholesterol 263, HDL 61, and LDL 159. His 10-year ACC/AHA cardiac risk was not assessed by the DCC providers, but we calculated this risk to be 10.8%. In spite of this elevated risk, his statin medication was discontinued without a clinical explanation in 2016. The patient was followed for hepatitis C infection since at least 2013. His liver enzymes were slightly elevated, and his platelet counts were within normal ranges. He was treated for oral thrush with Diflucan (fluconazole). There was no rationale given for why this patient developed an oral candida infection. Although the cause might have been the use of an inhaled steroid, oral thrush is rarely seen in patients who do not have AIDS or diabetes. He was not tested for HIV. His APRI was calculated to be 0.418, which is below the IDOC criteria for treatment. We were not able to identify lab testing for HCV quantitative RNA testing as is required in the IDOC Hepatitis C Guidelines 2017.⁴³ There was no documentation in the medical record that this over 50-year-old patient has been screened for colon cancer.

In summary, this patient was seen four times over 31 months in the asthma clinic. His respiratory condition was stable. He failed to receive necessary pulmonary function testing. There was no clinical justification in the medical record indicating that this patient needed to continue to use inhaled steroids. There was no documentation in the medical record that this patient was trained on the use of the MDI or successfully demonstrated proper technique during any of this asthma clinic visits. There was no evidence in the medical record that hepatitis C virus (HCV) RNA testing had been ordered as directed in the hepatitis C guidelines. The cause of oral thrush was not identified; HIV testing was clearly needed but was not ordered. This poses a significant risk to this patient. This patient was over 50 years old, yet has not received colon rectal screening, which is indicated by both national and community standards of care.

⁴² Chronic Care Patient #5.

⁴³ Hepatitis C Guideline, December 2017.

- This patient is a 38-year-old male with hepatitis C infection, seizure disorder, and depression.⁴⁴ His database noted that he had received hepatitis A and B vaccination series in 2016-17. His medications included valproic acid 500mg BID. He was followed in the hepatitis C and seizure clinics. He was admitted to IDOC in July 2016 and was seen three times in the hepatitis C clinic. His liver enzymes were slightly elevated, his platelets were normal, and his APRI scores was less than 0.46, which meant that the patient could have significant fibrosis but was unlikely to have cirrhosis. There was no documentation in the medical record that he had been tested for HCV RNA as directed in the hepatitis C guidelines.⁴⁵ Based on current institutional criteria, he was not a candidate for hepatitis C treatment. In the 5/15/17 seizure clinic, it appeared that he had stopped or had not received his seizure medications and valproic acid was re-started. On 2/27/18, he was examined in the seizure clinic. His valproic acid level was low 27.4 (50-100) and the ALT test result was 53. There was no mention about when he had his last seizure. Review of the MAR documented that he had received his KOP monthly supply of valproic acid from September 2017 to December 2017, but there is no documentation that he received valproic acid in January and February 2018. There is no indication or documentation that the provider in the seizure chronic care clinic reviewed the MAR and documented the most recent failure to receive his valproic acid. None of the seizure clinic notes document when the patient had his last seizure.

In summary, there is no evidence in the medical record that this patient has ever had HCV RNA testing; this is not in accord with the system's hepatitis C guidelines. If the test showed that there was no active infection, the patient would no longer need to be followed and repeatedly examined and tested with respect to treatment of hepatitis C. The seizure clinic notes fail to document if the patient had any epileptic seizures since the previous visit. The failure to record this key clinical information poses a health risk for this patient. There was a question about the patient's ability or willingness to take his seizure medications, but he continued to be allowed to self-medicate his seizure treatment instead of placing him on nurse administered medication.

- This patient is a 44-year-old male whose problem list includes DVT since 2016 on chronic warfarin anticoagulant treatment, seizure disorder, NIDDM, congestive heart failure, and migraine headaches.⁴⁶ His medications include warfarin, levetiracetam, phenytoin, haloperidol, and levalbuterol and ipratropium MDIs. The problem list included no documentation that the patient had a mental health disorder yet, he was noted as receiving haloperidol, a psychotropic medication. The patient was receiving a rescue bronchodilator, but neither asthma nor COPD were noted on the problem list. Heart failure and diabetes were on his problem list, but he was not prescribed any medications for the treatment of either condition. During the past two years, the patient had no asthma attacks or emphysema exacerbations. Based on the inhalers

⁴⁴ Chronic Care Patient #6.

⁴⁵ Hepatitis C Guidelines.

⁴⁶ Chronic Care Patient #7.

being prescribed, it appears likely that this patient was being treated for emphysema, yet pulmonary function testing was never performed to verify the patient's actual diagnosis. His PEFs ranged between 270 and 400. He attested to using his inhalers two to three times per week. There is no documentation in the record that this asthma/emphysema patient was offered pneumococcal vaccination in accord with national guidelines. While housed at Pontiac Correctional Center, his carbamazepine level was 2.6 (4-12) and his phenytoin level was 9.4 (10-20) both of which were below therapeutic levels. There was no comment in the clinical notes made about recent seizure activity nor about these low drug levels. The patient's history and physical exam notes were extremely limited to the point of being non-contributory. The patient was transferred to DCC and was seen in the asthma/seizure clinic on 6/2/16. A more thorough history noted that his last seizure was in May 2016 and that he was using his rescue MDI two to three times per week. His carbamazepine and phenytoin levels were now within therapeutic range; carbamazepine was discontinued and levetiracetam was started. At the 12/15/16 MIC clinic, he reported having a seizure one week ago; he was reported to have been noncompliant with his anti-seizure medication. At the 1/17/18 asthma/seizure clinic, the provider documented that there had been no seizures since the last visit and his phenytoin level was found in the therapeutic range. The management of this patient's chronic anticoagulation was complicated by the failure of the NPs providing chronic care to clarify in the medical record why this patient had to be prescribed long-term anticoagulation with warfarin or any other anticoagulant. From 8/14/15 through 12/21/16 (16 months), 24 INR tests were performed. Only nine (38%) were in the recommended therapeutic range; 11(46%) were high and put the patient at risk for serious hemorrhage; and four (17%) were low, creating the potential of new clot formation. Due to these varying levels of anticoagulation, the warfarin dosage had to be changed at least eight separate times. Warfarin was eventually discontinued because of the patient's propensity to self-mutilate. At one point, the patient developed anemia from bleeding from self-inflicted lacerations. At two clinical visits (7/30/17, 1/17/18), the provider's plans were "see orders" and "see RX." These short cut plans are an impediment to the effective communication to nurses and other providers about the treatment of this patient.

In summary, this patient's likely diagnosis was COPD, but the patient failed to have pulmonary function testing to make that determination. The patient was never offered or administered the pneumococcal vaccines; this is not compliant with the standard of care in the community. The patient's anticoagulation treatment was in the therapeutic range only 38% of the time in 2015-2016. The provider's documentation at the 7/30/17 and 1/17/18 chronic care clinics to "see orders or RX" instead of documenting a therapeutic plan of care has the potential to disrupt the continuity of care for this patient and put the patient's health at risk.

- This patient is a 51-year-old male with hyperlipidemia.⁴⁷ He was followed in the general medicine chronic clinic. He was not on medication; simvastatin was discontinued in 2012 due to non-compliance. In 1/8/2007, initial labs showed cholesterol 280, HDL 33, LDL indeterminate and TG 461. One month later on 2/19/2007, repeat lipid testing revealed cholesterol 196, HDL 23, LDL 128, and TG 224. We were not aware whether the patient was on statin medication when this test was taken. At the general medicine clinic on 6/10/15, the patient's dyslipidemia was controlled with diet. There was no documentation in the record why and when the statin had been discontinued. The patient was subsequently seen four times in the general medicine clinic between November 2015 and November 2017. His weight decreased from 230 in 2014 to 219 on 11/12/17. He continued to be advised by the providers to exercise, increase dietary fiber, and eat a healthy diet. There was no documentation in his chart, as recommended in the IDOC Hyperlipidemia Guidelines 2016, that his 10-year risk for heart disease or stroke was calculated.⁴⁸ Using his most recent lipid profile, we calculated his 10-year ASCVD Risk to be 4.7% which does not meet the criteria for treatment with a statin medication. In 2015, the patient had an episode of bright red blood per rectum (BRBPR). He was evaluated twice by DCC providers and the bleeding was thought to be caused by an external hemorrhoid. He had a colonoscopy done at UIC on 9/2/15; a sessile polyp was removed. The patient is to have a repeat colonoscopy in 2020. He was not told about the colonoscopy results until eight months later, when he asked for this information.

In summary, this patient was followed regularly in the general medicine chronic care clinic. He has had six chronic care clinic visits in the last 29 months. Although the 10-year ASCVD risk score was below the threshold to initiate anti-cholesterol medication, the providers failed to follow the IDOC hyperlipidemia guidelines by not regularly calculating this risk. The colonoscopy performed in 2015 to evaluate BRBPR fulfilled the age-based screening for colon cancer in this over 50-year-old patient.

- This patient is a 70-year-old male with COPD and a previous 50-year history of smoking tobacco.⁴⁹ His database noted a flu shot on 9/20/17 and a pneumococcal 23 vaccine. His medications included fluticasone and vilanterol inhaler, levalbuterol inhaler and ipratropium, and albuterol inhaler. He was seen seven to eight times in the asthma chronic care clinic from July 2015 through January 2018. His medications were modified on a number of occasions to address his respiratory status. His PEFs were consistently low, 110-130 L/min, and his oxygen saturations ranged from 95 to 97%. He was admitted to the infirmary on two occasions (1/8-22/2016, 4/4-20/16) for exacerbations of his COPD. The patient was referred to UIC pulmonary clinic on 1/20/17, but there was no evidence in the medical record that this has been accomplished. His weight dropped from 125 on 7/17/15 to 116 on 2/21/17, but has remained stable through 1/17/18 at

⁴⁷ Chronic Care Patient #8.

⁴⁸ IDOC Treatment Guidelines Hyperlipidemia.

⁴⁹ Chronic Care Patient #9.

115 lbs. He initially refused cancer screening and lab screening on 2/21/17. A lipid profile performed in October 2017 showed cholesterol 179, HDL 59, LDL 103. We calculated the patient's 10-year ASCVD risk as 16.3% which warrants treatment with a statin. There is no documentation in the medical record that he has been offered or received pneumococcal 13 vaccine. Though the patient had COPD, a pulmonary function test was not evident in the medical record. Though the patient was a 70 year old ex-smoker, abdominal aortic ultrasound testing was not done to screen for an aortic aneurysm.⁵⁰ It is unclear which cancer screening he refused on 2/21/17. Given that the patient was recently allowing lab testing again, colon cancer screening should be revisited. There is no documentation in the medical record that colon cancer screening has been offered in the last 12 months.

In summary, this patient has been seen regularly in the COPD clinic and his medications have been adequately modified to include a corticosteroid, short-acting beta agonist, long-acting beta agonist, and an anticholinergic bronchodilator. He has never had a pulmonary function test to fully verify the clinical diagnosis of emphysema. His COPD is quite severe, and it is in his best interest that the pulmonary specialty appointment requested in January 2017 be resubmitted. Per IDOC hyperlipidemia guidelines, the providers should have (but have not been) calculating his 10-year ASCVD risk. His 16.3% 10-year risk indicates that he should have been offered a statin medication. This patient is not being offered nationally recommended age and risk-based tests to screen for abdominal aortic aneurysm and colon cancer. He also has not been offered and administered the pneumococcal 13 vaccine. The failure to offer these preventive and early detection screenings puts this patient's health at risk.

- This patient is a 43-year-old male with asthma, DVT on chronic anticoagulation with coumadin, psychiatric disorder, past history of seizure disorder (no longer on antiepileptic medications), traumatic brain injury (TBI) in 1999 due to MVA, and blindness in one eye.⁵¹ His database noted a flu shot and HIV Ab negative test in 2017. His medications included levalbuterol and ciclesonide inhalers, and warfarin. He was followed semi-annually in the asthma chronic care clinic, with eight chronic care visits in the last 40 months. His PEFs have ranged been 300 and 650 L/min, with a mean of 380-400. He has had no urgent care or ED visits for asthma attacks. The patient was prescribed warfarin for the past treatment of DVT. We could not find a comprehensive note in the medical record explaining why he is receiving chronic anticoagulation. On 8/13/17, the lead physician wrote that the NP primary care provider needed to determine if there was clinical justification to continue anticoagulation; the NP then only noted in the 10/16/17 progress note that a history of multiple DVTs was the reason for the ongoing warfarin treatment. Forty-three INR tests were done in the last 41 months: 31 (72%) were in the therapeutic range, nine (21%) below, three (7%) above this range. Warfarin doses were modified six times during this timeframe. The patient's

⁵⁰ USPSTF AAA 2014.

⁵¹ Chronic Care Patient #10.

weights were recorded as 301 lbs. on 2/6/15, 291 on 8/11/15, 281 on 12/8/16, and 228 on 1/29/18. He lost 73 lbs. in 36 months. On 5/13/17, lab tests revealed a normal HbA1C and TSH, ruling out diabetes and hyperthyroidism. There is no documentation in the chart that discusses this notable weight loss. This patient needs to be fully evaluated to determine that the weight loss is not caused by an underlying medical condition.

In summary, the patient was seen regularly in the asthma chronic care clinic; he has not had any exacerbations and his PEFs are stable. There was no evidence in the chart that he has been trained about the use of an inhaler and his technique verified to be competent. The patient continually received INR testing to assess the adequacy of anticoagulation for his past history of DVT(s). The patient was therapeutically anticoagulated only 72% of the time. The providers need to thoroughly review this patient's history of DVTs to ensure that anticoagulation was still necessary, as an adverse side effect of warfarin is serious risk of bleeding. The frequent lab testing and medication adjustments needed when warfarin is prescribed are logistically complicated and put patient-inmates at risk for poor outcomes. Utilizing newer anticoagulation medications that do not require frequent ongoing measurement of the level of anticoagulation should be strongly considered by the IDOC. The patient's significant weight loss has not been fully and comprehensively evaluated. The providers have not taken a careful history, performed a thorough physical exam, and ordered additional laboratory and diagnostic tests to evaluate the unexplained weight loss. This must be initiated immediately.

- This patient is a 40-year-old male with hypertension and a history of anemia.⁵² His database noted a diphtheria/tetanus vaccine in 2013. His medications included diltiazem 240mg ER, metoprolol 50mg bid, losartan, and hydrochlorothiazide 12.5mg/d. He has been followed in the hypertension and general medicine chronic care clinic at Danville and DCC. From September 2016 through April 2018, he was seen seven times in the hypertension and general medicine clinics. His blood pressure was controlled until 10/2/17, when he ran out of his medications and his blood pressure was noted to be 165/109; his BP medications were renewed. On 10/20/17, he was transferred to DCC. His blood pressure at the 11/3/17 hypertension clinic was 150/100. At the 3/20/18 hypertension clinic, even though his blood pressure was 126/80, lisinopril was added to his blood pressure regimen. At the next hypertension clinic on 3/28/18, his blood pressure was 142/88. The lisinopril was stopped because of the development of a cough, and losartan was substituted. Over the next week, blood pressures ranged from 122/74 to 158/98. At the 4/4/18 hypertension clinic, the blood pressure was 130/90, with a follow-up pressure in two weeks.

On 7/10/17, while housed at Danville CC, the patient presented with a history of rectal bleeds, and he was found to be significantly anemic, with a hematocrit of 22.4%, hemoglobin of 6.3g/dl, and an MCV of 57. This was suggestive of an iron deficiency

⁵² Chronic Care Patient #11.

anemia. A rectal exam was not performed. No additional workup was ordered or initiated. He was placed on iron tablets. At a follow-up visit on 7/27/17, his hemoglobin level had improved to 8.6g/dl, his bleeding had ceased, a rectal exam was deferred but hemorrhoids were noted as the cause of the blood loss. By 10/2/17, the blood counts had returned to normal ranges. The patient has voiced complaints of constipation. This serious bleed should have been but was not fully investigated. It would have been fully justified to have initially admitted the patient to the hospital to stabilize, monitor, and evaluate the etiology. The patient's investigations should have included additional blood tests and upper and lower endoscopies.

In summary, the patient has been prescribed four hypertensive medications and his BP control was not yet stabilized. The exchange of lisinopril for losartan was not fully explainable; both can cause dry cough and the patient's cough was under control on the day of the change. The use of four medications at less than optimal dosing is questionable. The Danville CC providers put this patient at risk by not hospitalizing and fully investigating his profound blood loss. The patient's health and life could have been in jeopardy if he had suffered further bleeding episodes at the prison. Upon transfer to DCC three months after the anemia had first been detected, the DCC providers should have initiated the warranted evaluations. They failed to do this even though they had received transfer information noting that one of his problems included anemia.

- This patient is a 76-year-old male with hypothyroidism, atrial fibrillation, type 2 diabetes, prostatic hypertrophy (BPH), glaucoma, and cataracts.⁵³ His medications included metformin, levothyroxine, metoprolol, aspirin, and terazosin. He had been in IDOC for at least seven years. He was not offered pneumococcal vaccination. He was followed in the diabetes/hypertension chronic care clinic. He had 10 visits to the chronic care clinic between March 2015 and December 2017. Without any reason being documented, his statin medication was stopped on 3/20/15. The patient was taking 250mg of metformin for his diabetes and multiple HbA1C's were between 5.1 and 5.5, all reflecting totally normalized blood sugars. This indicated that the patient may be too tightly controlled or might not even require any diabetic medications. Multiple thyroid stimulating hormone (TSH) tests were documented to be between 1.65 and 3.85 over the last two years. All of these thyroid tests are so close to normal and the dose of levothyroxine so low that it would in the best interest of the patient to further lower or discontinue this medication. Unneeded thyroid supplementation in this elderly patient's very mild underactive thyroid disease could stimulate an exacerbation of his atrial fibrillation. The patient's blood pressure was usually in the low normal range. He was taking two medications for reasons other than hypertension that could lower blood pressure: terazosin (BPH) and metoprolol (likely for heart rate control of atrial fibrillation). On 12/2/16, his blood pressure dropped to 90/62; the metoprolol and terazosin were appropriately discontinued. His levothyroxine was decreased to 25

⁵³ Chronic Care Patient #12.

mcg/d. Even though this is a very low dose of thyroid medication, the use of this medication puts the patient at risk of a possible exacerbation of atrial fibrillation.

In summary, this elderly patient should not be taking levothyroxine, metoprolol, and metformin. This is in accord with the standards of care in the community. His hypothyroidism does not require treatment, he no longer requires treatment for diabetes, and the discontinued low dose of metoprolol had very limited benefit for this patient. The patient's 10-year risk of cardiovascular disease is extremely high (>30%) and warrants consideration for the reinstitution of a statin and the continuation of aspirin. The preventive health maintenance of this patient has been ignored; he had not received either pneumococcal vaccination, and there is no evidence in his medical record that he has been screened for colon cancer.

- This patient is a 60-year-old male with diabetes, hypertension, hepatitis C, and bipolar disorder.⁵⁴ His medications included 70/30 insulin, metformin, nifedipine xl, and losartan. He was followed in the hepatitis C and the MIC diabetes/hypertension clinics. At NRC his blood pressure was elevated at 174/115, and his antihypertensive medications were switched to nifedipine xl and losartan. There was no rationale for these changes documented in the medical record. His initial diabetes medications were 70/30 insulin 40U BID, metformin 1000mg/d, and sliding scale regular insulin before breakfast and dinner. This insulin regimen contains two short acting insulins. One component of 70/30 insulin is regular insulin. The patient was also on a sliding scale insulin, which is regular insulin. There is a risk of hypoglycemia when simultaneously administering two short acting insulins. He was seen three times in the MIC diabetes/hypertension chronic care clinic between October 2017 and March 2018. His blood pressure control was never at goal of 130/80 and his HbA1C results have only modestly improved (9.85 to 8.8%). Even though his diabetes was not controlled, the 70/30 insulin dosages were lowered in October and December 2017. The reason for decreasing the insulin doses was not documented in the medical record, which would have been especially important to document, since the HbA1Cs indicated poor control. There were no documented instances of hypoglycemia and his capillary blood sugars in November and early December 2017 ranged between 80 and 354, with a mean in the mid-100s. The optometrist identified no evidence of diabetic retinopathy and the patient's urine microalbumin was normal. The March MAR noted "missed no insulin injections."

The patient was seen twice at the hepatitis C clinic in 2017. His liver enzymes, platelet counts, and coagulation studies were within normal limits. His APRI score was less than 0.3 and did not qualify him for treatment. There was no documentation in the medical record of HCV RNA testing. If this test were normal, this patient would not have active hepatitis C infection and would no longer need to be followed in the hepatitis C chronic

⁵⁴ Chronic Care Patient #13.

care clinic for purposes of treatment for hepatitis C. The failure to order HCV RNA is not in compliance with the IDOC hepatitis C guidelines.⁵⁵

This elderly diabetic patient has not been offered pneumococcal vaccination or colon cancer screening as recommended in national age and disease-based prevention and screening guidelines. His 10-year ASCVD risk score has not been assessed by DCC providers, and was calculated to be 27.1%; but he has not been offered a high intensity statin medication.

In summary, after six months this patient's diabetes and hypertension are not yet adequately controlled. The decision to order two diabetic injections that can rapidly lower blood sugars puts the patient at increased risk for hypoglycemic episodes. HCV RNA viral load has not been drawn. If this test was negative, there would be no need for this patient to be followed in the hepatitis C clinic for hepatitis C treatment. DCC providers are not adhering to national standards of providing pneumococcal vaccines to all diabetics and those over 65 years old, and of offering colon cancer screening to individuals 50 years of age or older. The failure to assess the patient's 10-year risk of cardiovascular disease and to administer a statin is not in line with the practice of medicine in the community.

- This patient is a 49-year-old male with insulin requiring diabetes, hepatitis C, and psychiatric disorder.⁵⁶ His database noted flu shot on 9/27/17 and completion of hepatitis A and B vaccines, but not the administration of pneumococcal 23 vaccination. His medications include NPH insulin and sliding scale regular insulin. The patient's blood pressure was not elevated during his incarceration at DCC. Since March 2016, he was seen four times in the hepatitis C clinic; his liver enzymes were normal or minimally elevated, his APRI scores ranged between 0.258 and 0.519. HC RNA viral load levels had not been drawn. Per IDOC guidelines, the patient is currently not a candidate for hepatitis C treatment. He has been seen six times in the diabetes chronic care clinic. His HbA1Cs have been 9.1, 9.7, 9.2, 8.7, and 8.9%, and have not yet reached adequate control during his two-year incarceration. Due to early morning episodes of near hypoglycemic symptoms, his NPH insulin has been decreased from 28U/am and 26U/pm to 19U/am and 17U/pm. The optometrist visit on 3/2/17 identified trace diabetic background retinal changes; his creatinine is minimally abnormal (1.6) with a normal urinary microalbumin. The patient's morning and evening CBGs widely range from the 50s to 400. The MARs indicate that the patient is compliant with his prescribed regimen. Pneumococcal 23 vaccination has not been offered or provided to this diabetic as is nationally recommended.

In summary, after two years of incarceration, this patient's diabetes is not yet controlled. His insulin dosages have been decreased in spite of this lack of control. The

⁵⁵ Hepatitis C Guidelines.

⁵⁶ Chronic Care Patient #14.

episodes of near hypoglycemia occurred in the early morning hours and the provider efforts should have focused on correcting this issue rather than lowering both the morning and the evening doses. The ongoing difficulty of fully controlling this patient's diabetes warrants consultation with an endocrinology/diabetes specialist. Pneumococcal 23 vaccination should be offered to this diabetic patient. The failure to perform HCV RNA testing is not in accord with IDOC Hepatitis C Guidelines.

Urgent/Emergent Care

Methodology: We interviewed the Nursing Supervisor (IDOC), toured the medical clinic, and assessed the availability and functionality of emergency equipment and supplies. We also reviewed emergency drills, CQI reports, written directives, and medical records. Medical records were selected from the list provided by DCC of emergency room visits beginning in January 2017. This list includes the reason for the ED visit. Records selected for review were those conditions sensitive to ambulatory care, such as seizure, withdrawal, infection, diabetic complications, abdominal pain, chest pain, etc. A total of five records were reviewed. We also reviewed six records of patients who were admitted to a hospital for conditions sensitive to ambulatory care to assess clinical quality of care.

First Court Expert Findings

Emergency room reports or hospital records were absent in all the medical records reviewed. The emergency care of patients at DCC was inadequate, usually lacking a thorough assessment and failing to involve advanced level clinicians. Patients referred to a provider either were not seen or the problem was not addressed at the next provider appointment. No records of emergency response or transports to the emergency department were kept and there was no self-monitoring.⁵⁷

Current Findings

DCC does not have a crash cart. The institution performs basic CPR, applies the AED, and calls 911 for cardiac arrests. This is an acceptable option for responding to codes/cardiac arrests. DCC also provides first aid. There are two emergency response bags kept in the dispensary nursing office that contain first aid supplies, personal protective equipment (PPEs), stethoscope, blood pressure cuff, equipment and supplies to start an IV, and a few medications (i.e., glucagon, an EpiPen, aspirin). The contents of the bags are standardized,⁵⁸ and they are sealed with a lock to indicate that the bag is fully supplied and ready for use. An automatic external defibrillator (AED), stretcher with backboard and cervical splint, ambu bag, portable oxygen, EKG machine, suction, nebulizer, and oto-ophthalmoscopes are available in the urgent care room adjacent to the nursing office. AEDs and emergency equipment are also available in

⁵⁷ Lippert Report DCC pp. 22-23.

⁵⁸ Contents of emergency response bags



DCC list of
emergency supplies.

the infirmary and in X-House. The Nursing Supervisor (IDOC) said that there was no trauma bag as described in DCC's ID #04.03.108. Instead, a staff member is posted in the urgent care area to collect additional equipment and supplies if radioed from the scene that they are necessary.

The presence and functionality of the first aid equipment is checked each shift and documented on a log. We recommended to the Nursing Supervisor (IDOC) that the expiration date for each medication in the bag be added to the log so that it was apparent when it needed to be replaced. We checked the AED and other emergency equipment listed above and found all were functional. DCC ID #04.03.108 lists the contents and location of first aid kits available in housing units, program areas and vehicles, but we did not evaluate the accuracy of this information.

The DCC ID #04.03.108 and DCC Health Care Unit Policy and Procedure P-112 differ in the requirements for drills. The ID requires drills twice a year on each shift. One of these is to be a mass casualty drill involving multiple people with injuries. One is to be an emergency response drill and an actual emergency can be substituted. The Health Care Unit Policy and Procedure P-112 requires only one mass casualty drill annually and one emergency response drill on each shift annually. Actual practice appears to conform to P-112 rather than ID #04.03.108, in that one mass casualty drill is completed annually. We recommend revising the ID to conform to actual practice; it has not been updated since 2011. The mass casualty drills for 2016 and 2017 were reviewed and found to be thorough, with good multidisciplinary participation, and candid critique of strengths and weaknesses. However, no corrective action or plans to improve were developed as a result of these critiques. An incident report is written each time there is an emergency response and sometimes these are reviewed and critiqued. The report and critique are kept in binders available for review. We reviewed all emergency response reports and critiques in these binders from January 2017 to the present. Critiques are very complimentary and seldom identify needed improvement. Of the five medical emergencies selected for chart review, two were critiqued by DCC Health Care; no strengths or weakness in the response to either were identified. Emergency response is an item regularly on the agenda of the Quality Improvement Meetings. The minutes of these meetings do not reflect any discussion, analysis of issues, or plans for improvement in emergency response.

We reviewed the medical records of five patients sent to the ED in 2017 and found that the ED visit could have been prevented in two of the cases if the patients' care had been different in the preceding months. Information and recommendations from the ED were not obtained, or if they were, not incorporated into the patients' subsequent treatment plan. These findings are detailed in the following paragraphs.

- The first patient is also discussed in the hospital section below; his death was possibly preventable if care in the preceding months had been better.⁵⁹ This patient had returned to DCC on 11/19/17 after nearly a month of hospitalization. A physician described his discharge problems as COPD exacerbation, hypercalcemia, pleural

⁵⁹ Urgent/Emergent Patient #1 and Hospitalization and Specialty Care Patient #7.

effusion, post-chest tube, pneumonia, anemia, renal failure and DVT. However, what the doctor failed to acknowledge was that the patient had a large retroperitoneal mass, likely a malignant lymphoma, which was not addressed in the plan of care. The diagnosis was pending. While much of the hospital record was available, the physician only listed diagnostic possibilities and was not clear about the plan of care. The treatment plan consists of monitoring and comfort care only. The inbound note written by a nurse describes the patient's condition based upon a visual assessment only. The nurse did not document a review of the discharge instructions or contact the facility physician for orders as required by Health Care Unit Policy and Procedure P-104.⁶⁰

There was no plan of care in place in the nine days immediately before his last hospitalization on 11/29/2017. In the meantime, nurses documented clear signs that the patient's condition was worsening, including bloody stools, diminished lung sounds, pitting edema of the legs, poor oxygenation, and low blood pressure (98/62). When the provider was contacted, the nurses were instructed to continue monitoring the patient and report if his condition worsens.

On 11/27/17, the physician documented an encounter and that the patient needed to be more compliant; the patient was demanding a change in his diet. Vital signs are described as stable and that he had better aeration and his lower legs seemed improved. The provider took no steps to definitively treat the patient and made no effort to uncover the diagnosis of the retroperitoneal mass. Instead, the doctor continued monitoring and comfort care. There is no documentation that the patient agreed to palliative or hospice care. The patient was not seen by a provider the next day even though he was bleeding from the mouth and had petechia on his trunk and upper extremities. This should have prompted immediate concern, since the patient was on anticoagulation. No action was taken until the following day, 11/29/17, when the provider saw the patient and mused about whether the dose of anticoagulant medication was correct. Ultimately, he ordered the patient transferred to the local emergency room. There is an outbound note written by a nurse on the intrasystem transfer form, but it does not contain all of the information relevant to the patient's ongoing care, and there is no specific statement of the reason higher level care was being sought. The patient was admitted to the hospital from the ED and died 20 days later.

Problems with the medical care of this patient post-hospitalization include: an inaccurate problem list (not updated since 1/2017); the nurse did not adequately examine and document her findings and did not summarize the discharge recommendations or contact the Medical Director for orders when he returned from hospitalization on 11/19/17; the physician did not incorporate information obtained from the hospital discharge records into the patient's plan of care; the physician did not see the patient as frequently as required by DCC Health Care Unit Policy and Procedure

⁶⁰ Continuity of Care During Incarceration pg. 6, II. G and III. A.

P-113⁶¹ or as indicated by his deteriorating condition; and the note written to accompany his transfer to the emergency room on 11/29/17 did not contain all of the information relevant to the patient's ongoing immediate care.

- The next patient was hospitalized emergently on 5/31/17 because he was having signs of a stroke including slurred speech, inability to move or grasp with right arm, tongue deviated to the right side, and delayed thought processing.⁶² He was 61 years old at the time. His problem list dated 6/23/16 included dyslipidemia, insulin dependent diabetes, CVA (2012), gunshot wound to the head, and degenerative disorder of the thoracic spine.

There is no nursing treatment protocol for stroke; the nursing assessment included vital signs and blood glucose and the symptoms described above. The provider was contacted and ordered a transport to the emergency department. No orders were given to start O2 or an IV while awaiting transport, and there is no documentation of subsequent assessment of the patient while awaiting transport. No transfer note was written.

There is no note summarizing recommendations from the hospital after he was returned to DCC on 6/14/17 with a diagnosis of cerebral vascular accident (CVA). The provider admitted the patient to the infirmary as an acute patient, ordered regular medications, and a physical therapy evaluation. No comment was made about discharge recommendations from the hospital and there was no documentation of the rationale for not implementing the recommendations.

This patient's medical care in the months prior to the emergency room visit was problematic. First, he was transferred from Big Muddy Correctional Center 18 months earlier because of increasing blood glucose levels. He was received at DCC on 4/14/16. The receiving nurse noted that he also was followed in the hypertension clinic (HTN is not on his problem list), he had a diagnosis of sleep apnea and used a CPAP machine. Sleep apnea is not on the problem list and neither the diagnosis of sleep apnea nor the need for a CPAP machine are listed on the transfer summary. The CPAP machine was not in his property when transferred. The problem of sleep apnea was not identified or treated, and he never received a CPAP machine in the 18 months after being received at DCC. This may have been a factor contributing to the stroke this patient had in May 2017.

He was seen in chronic care clinic for diabetes in August 2016, December 2016, and May 2017. HbA1C was elevated in December (9.9), so the provider ordered a nighttime dose of Lantus in addition to Metformin, with follow up in two weeks. The follow-up appointment did not take place. His HbA1C was still elevated when next seen in clinic on

⁶¹ Infirmary Care III. 1. A. p. 25.

⁶² Urgent/Emergent Patient #3.

5/4/17 (9.5) and 70/30 insulin twice a day was ordered; the Lantus and metformin were discontinued. Aspirin 81 mg. was also ordered at this visit. Medication for HTN and dyslipidemia were continued.

This patient was also being treated for wounds on his buttocks from August through October 2016. A note written by a provider on 8/9/16 indicates that this is related to the patient's paralysis, but the extent of his paralysis is never described. Another episode of skin breakdown on his left hip was being treated in May 2017. Undoubtedly his skin wounds affected his diabetes and vice versa, and yet this was never considered by providers who were treating him. This patient's diabetes was not managed to obtain good control and changes in the plan of care were slow and inadequate.

- Another patient was a 61-year-old man seen in the emergency room on 2/11/17 for chest pain.⁶³ His problem list contains diagnoses of insulin dependent diabetes with neuropathic pain in his feet, which is inaccurate given that the problems listed on the outbound transfer summary include hypertension, chronic obstructive pulmonary disease, asthma, and hepatitis C. The problem list also does not identify that he has a pacemaker.

The patient was brought to the health care unit. The nurse used the chest pain protocol to assess the patient, but did not describe precipitating factors or do an EKG. The provider was contacted and ordered transport to the ED. Oxygen and an IV were started before transport. A transfer note was written to give to the ED upon arrival. The patient was admitted and treated for congestive heart failure and thrombocytopenia until discharge on 2/14/17.

The hospital summary was reviewed by a physician the day after he was released from the hospital, 2/15/17. He does comment on the discharge recommendations. He put lisinopril and Aldactone on hold until the nephrologist approved resumption. There was no note that the nephrologist was contacted to make this decision. The Lisinopril was never restarted. He also held the patient's Lasix for four days. This was a KOP medication and there was no note that the patient was instructed to do this. He also ordered labs, which were drawn, but the results were never commented on. At the next chronic care appointment in April 2017, the provider did not comment on the patient's hospitalization in February.

While the emergency response was adequate, the fact that the problem list is grossly out of date makes treatment of the patient a guessing game. Even after the patient returned from hospitalization, the problem list was not updated to ensure its accuracy. There were several aspects of care ordered after the patient's return to DCC that were not followed up on, including the medications to be held and restarted, consultation with the nephrologist, and lab results. The failure to comment on the patient's recent

⁶³ Urgent/Emergent Patient #2.

hospitalization at the next chronic care visit is emblematic of episodic treatment rather than managed chronic care.

A 24-year-old man with no history of health problems was treated in the ED for chest pain on 7/19/17.⁶⁴ The emergency response was good, including use of the chest pain protocol and documentation. However, the patient returned from the emergency room with no treatment records and was not seen by a provider. While this man appears to be in good condition, he had been seen in January for chest pain and had an abnormal EKG at the time of the ED visit in July. Knowing what diagnostic and clinical work was done at the ED is essential for the provider to ensure that clinically appropriate care is continued after return to the prison. Not only is a provider visit required by the Health Care Unit Policy and Procedure P-104, it was clinically indicated.⁶⁵

In summary, we concur with the First Court Expert's findings that ED reports were often absent in the medical records reviewed and the care of patients was problematic before the ED visit and after the patient's return to SCC. We agree with the First Court Expert's recommendations and make additional recommendations found at the end of this report.

We reviewed six patients who were hospitalized to assess for quality of care at the facility before and after admission to the hospital. We noted that hospital reports were inconsistently present in the medical record. We agree with the First Court Expert's recommendation in the Emergency Services section that after all offsite emergencies, a provider should see the patient to document a discussion of findings and a discussion of any changes to therapeutic plans. We found that while physicians generally evaluated patients after hospitalization, discussion of findings and a change of therapeutic plan were not well documented. We suspect that this was because providers do not appear to have the hospital report. Lacking the hospital report, clinicians do not know what occurred at the hospital and often appeared to be unaware of the status of the patient's clinical condition. This makes establishment of a therapeutic plan difficult to develop.

We found in the review of records of persons hospitalized that clinical care preceding hospitalization was poor and often resulted in a problem deteriorating and needing to be addressed on an emergency basis. There were preventable hospitalizations, preventable morbidity, and preventable mortality. These findings on record reviews are summarized below.

- One example was a patient with severe coronary artery disease that resulted in prior bypass surgery and multiple cardiac stents.⁶⁶ The patient also had peripheral artery disease, hypertension, high blood lipids, and diabetes, which were all risk factors for coronary artery disease. The patient had no problems documented on the problem list until March of 2017. The patient saw a provider on 6/29/16. The provider took no

⁶⁴ Urgent/Emergent Patient #5.

⁶⁵ Continuity of Care During Incarceration II. F and III. A. pp. 6-7.

⁶⁶ Hospitalization and Specialty Care Patient #4.

history with respect to angina but did note that the patient was to see the cardiologist soon. The patient saw a cardiologist at UIC on 7/6/16. There was no report. Brief comments on the referral form noted increased angina over the past two months. The cardiologist recommended titrating up nitrate medication (Imdur) for angina and noted that the patient needed “aggressive” medical management.

The patient did not see a physician timely after this appointment. On 7/22/16, a nurse saw the patient for chest pain and used an “Indigestion/Heartburn” protocol despite the patient complaining of three months of chest pain, “like getting stabbed in the chest [after] eating + when walking.” This description is typical of angina. The nurse should have used a chest pain protocol. The nurse should also have obtained an EKG and should have immediately referred to a physician. Instead, the nurse noted that the patient had been on Pepcid and switched to Zantac, both of which are for acid reflux disease and neither of which were working. The nurse initially referred the patient to a physician urgently, but this was scratched out and a routine appointment was made. This was a serious error. This patient had significant angina, but a nurse assumed his complaint was for acid reflux disease. The patient was not properly referred, which placed him at significant risk of harm.

On 7/25/16, a nurse again evaluated the patient for chest pain, this time using the chest pain protocol. The nurse noted pressure-like chest pain and referred the patient to a doctor. An EKG was done. This EKG did not include an automated reading but showed ST elevation in lead III consistent with acute ischemia. Dr. Meeks, the Agency Medical Director, was at DCC on the day we were reviewing this record. He is an emergency medicine physician. He reviewed the record and agreed that this was an ST elevation consistent with ischemia. This should have resulted in immediate transfer to a hospital. Instead, the physician ordered Prilosec, a medication for acid reflux, and a follow up on 8/10/16. This was grossly and flagrantly unacceptable practice that placed the patient at risk of death.

On 7/28/16, a doctor saw the patient for the five-day follow up from the 7/6/17 cardiologist visit. The doctor noted that the cardiologist recommended increasing the Imdur, but the doctor took no history and failed to note the evaluation by the nurse four days earlier for what appeared to be typical angina, and more importantly failed to note the evaluation three days earlier with the EKG showing acute ischemia with typical symptoms of angina. The doctor documented referral to cardiology and ophthalmology but took no other action and did not update the status of the patient’s therapeutic care. Since referrals to cardiology at UIC take on average 100 days, the patient should probably have been sent to a local cardiologist.

On 8/1/16, a doctor saw the patient because Zantac was not working for his presumed gastric reflux disease. The doctor took no history of the patient’s pain and advised the patient to elevate the head of his bed without realizing that the patient’s symptoms might be from his angina. The doctor failed to recognize the prior abnormal EKG. The

therapeutic plan was not evaluated or refreshed. This lack of knowledge about how to manage angina was significant.

On 9/16/16, the patient had an episode of chest pain walking up stairs which was relieved by nitroglycerin. The doctor recommended a "medical movement" pass and increased Prilosec, but did not increase anti-anginal drugs or order cardiac testing (EKG, stress testing, or cardiac catheterization). The doctor failed to properly treat angina and may have failed to recognize that the patient's symptoms were angina. The episode of care failed to follow generally accepted guidelines or usual practice.

On 10/27/16, a doctor saw the patient and noted that the patient had chest pain, but the doctor was not sure if the pain was related to "gas" or to angina. The doctor thought that the patient had lactose intolerance and prescribed a gas relieving medication and documented that he would "consider" increasing Imdur (the anti-anginal medication) if there was no improvement. This was a judgment error, in our opinion. Gastro-esophageal reflux disease (GERD) is not life-threatening. His angina was life threatening. The doctor was placing greater significance on a condition that was much less likely to cause harm. This was incomprehensible practice.

On 11/30/16, a practitioner noted that his chest pain "resolved" since eliminating dairy and assessed likely lactose intolerance and discussed elimination of lactose from his diet.

On 3/22/17, an NP saw the patient in chronic care clinic but took no history and noted that the patient offered no complaints. The NP did not address the chest pain, evaluate the prior EKG, and did not address the angina. Notably, the patient had peripheral vascular disease that was not being monitored.

On 3/24/17, a doctor noted that the patient complained of chest pain lying flat that was relieved by nitroglycerin. The patient also described chest pain when walking accompanied by calf pain when he walked. This description is consistent with angina and claudication, a condition of atherosclerosis of leg arteries. Although the patient's description of pain was consistent with angina and peripheral artery disease, the doctor prescribed Tums antacid and increased the dose of reflux medication. There was no examination of the pulses to assess the peripheral artery disease. The doctor noted that a cardiology appointment was pending and ordered a three-week follow up. The doctor did not increase anti-anginal medication. This was not generally accepted practice for treating angina.

On 4/17/17, an NP saw the patient and documented that the patient was waking up in the middle of the night with chest pain and difficulty breathing. The NP did not order an EKG and made an assessment of "chest pain/? GERD," and advised the patient to take Tums first when he got this pain, and if the pain was not resolved to take his nitroglycerin. The NP did not adjust the anti-anginal medication. This patient needed to

be diagnostically evaluated for ongoing unstable angina, but providers appeared ignorant of what should be done.

On 4/20/17, a nurse evaluated the patient for chest pain at 1:05 a.m. The patient had steady pressure in his chest with dyspnea. The nurse called a doctor and the patient was referred to a hospital where NSTEMI [myocardial infarction] was diagnosed. The patient had two stents placed.

The care for this patient was grossly and flagrantly unacceptable. The patient had multiple risk factors for heart disease and had established severe heart disease. A cardiologist recommended titrating up the anti-anginal medication for angina. Despite this, the providers at DCC treated his symptoms of angina with antacids on multiple occasions and never increased anti-anginal medication. On one occasion, the patient had evidence on EKG of acute coronary syndrome that was not addressed and unrecognized by a physician reviewing the EKG. The patient should have been referred much earlier for cardiac diagnostic assessment, including nuclear stress testing and/or cardiac catheterization, but this was not done until the patient had a heart attack. The hospitalization and heart attack may have been prevented if earlier diagnostic evaluation (cardiac catheterization) occurred. This is another case of underutilization, which will be discussed in the specialty care section.

- Another patient had HIV infection, high blood cholesterol, and prostate cancer.⁶⁷ He was 66 years old. On 8/25/16, the patient was evaluated in chronic clinic for high blood lipids. Although the doctor mentioned the patient's HIV infection and prostate cancer, the doctor did not address these conditions. A prior abnormal laboratory result (abnormal renal function) was not addressed. On 11/22/16, a doctor saw the patient again for chronic disease clinic. The patient asked the doctor about radiation treatment for his prostate cancer, but the doctor did not document a response. The kidney function was still abnormal (creatinine 1.78), but not addressed.

On 5/21/17, a doctor saw the patient for chronic disease clinic, but except for high blood lipids, none of the patient's other problems were addressed. The patient reported right flank pain, but the doctor took no further history of this and ordered no laboratory tests. We believe that all problems should be address at each chronic disease clinic visit. Under the current system, many chronic illnesses are never monitored.

On 6/7/17, a doctor saw the patient for abdominal pain with episodes of vomiting since the night before. The patient had anemia, but this was not addressed. The doctor admitted the patient to the infirmary for intravenous fluid but ordered no laboratory testing. Abdominal pain with vomiting warranted laboratory testing and possibly radiologic testing (CT scan or ultrasound), yet these were not done.

⁶⁷ Hospitalization and Specialty Care Patient #2.

The patient was evaluated on 6/8/17 by a doctor and still had abdominal pain, but the physician still ordered no diagnostic work up, instead diagnosing abdominal pain of unknown etiology, and prescribed Toradol. Prescribing pain medication for abdominal pain of unknown etiology was a failure to follow accepted standards of care, as the doctor did not know what the source of the pain was. The doctor should have initiated a work up of the abdominal pain.

On 6/9/17, a doctor ordered that the patient be given a regular diet the following day and then be discharged to general population. The following day, the patient complained to a nurse that he was weak and in a lot of pain. The nurse described the patient as "looks like he is in pain, squinting, and not moving, breathing slowly." The nurse documented that she would talk to the doctor about not discharging the patient. The patient was nevertheless discharged.

On 6/14/17, a doctor saw the patient, who had constant abdominal pain, weakness, and diarrhea. The patient had lost 11 pounds over approximately three months. The abdomen was tender, and the doctor noted an enlarged liver. The doctor admitted the patient to the infirmary and ordered laboratory tests but no diagnostic radiologic studies (ultrasound or CT scan). The patient exhibited dehydration (BUN 26), abnormal kidney function (creatinine 1.75), possible malnutrition (albumin 2.5), and altered liver function (AST 385 and ALT 368). Despite these significantly abnormal blood tests, no diagnostic radiologic testing was ordered. The patient should have had a CT scan or ultrasound of the abdomen on an immediate basis.

There was no infirmary note on 6/15/17, but the patient was sent offsite for an ultrasound. The patient should have been sent to an emergency room for this study. Instead, it was ordered as a consultation. The patient returned to the prison after the ultrasound, and on 6/16/17, the ultrasound report was unavailable. The doctor noted abdominal pain of unknown etiology and made no other effort to diagnose the patient's condition. This placed the patient at significant risk of harm. There were no physician notes on the infirmary from 6/16/17 through 6/21/17, even though the patient had an acute illness.

The ultrasound report, dated 6/15/17, appeared to have been faxed to the facility on 6/19/17. The report documented a perforated viscus with fluid around the dome of the liver. Cirrhosis was also present. These are life threatening findings, yet no one reviewed the report for two more days, when an NP noted the findings and described the patient as having severe abdominal pain with nausea. The patient was sent to a hospital, where he remained after surgery for a perforated viscus. Care for this patient was grossly and flagrantly unacceptable and placed him at risk of death. Earlier diagnostic intervention was indicated. Serious, potentially life-threatening symptoms were treated as a routine. There was a lack of physician follow up. Notably this was during a time when there was no physician on staff at the facility.

- Another patient had an annual physical examination on 2/15/16 and weighed 345 lbs.⁶⁸ The patient had anemia for over four years without a work up, which fails to follow generally accepted guidelines. This patient had high blood lipids, COPD/asthma, prior hip replacements, and GERD. In February of 2016, the patient was found to have carcinoma in situ of a rectal condyloma, a wart like condition. The patient had seven colorectal follow-up visits and one dermatology visit for his rectal lesion. Only two of the seven visits included a report, so the therapeutic plan was unclear. At a dermatology visit on 1/11/17, biopsies were done and follow up was requested pending biopsy results, but the biopsy results were never obtained or followed up by DCC physicians. It was not clear what the patient's clinical status was, as the doctors at DCC failed to review reports. On 1/18/17, a liver biopsy, EGD, and colonoscopy were approved in collegial review. It was not clear why these tests were recommended, as there was no progress note documenting the rationale. The consultation reports were almost all missing and the status of the patient was unclear. The patient refused a 4/5/17 colorectal appointment, but it was not clear why. The patient was not seen after this for over five months. The biopsies taken by dermatology on 1/11/17 were never checked on. The liver biopsy, EGD, and colonoscopy were never approved or completed. A physician never followed up with the patient about his rectal squamous cell cancer or on the failed appointment back to colorectal service.

On 7/11/17, blood tests done for unclear reasons showed persistent anemia and elevated alkaline phosphatase, a liver enzyme, but these were never followed up by a physician at the facility.

On 9/8/17, the patient developed difficulty breathing and was unable to get up off a chair. An NP admitted the patient to the infirmary and ordered tapering prednisone, antibiotics, a chest x-ray, CBC, and CMP.

A doctor covering at the facility discharged the patient from the infirmary on 9/11/17. The doctor documented reviewing the x-ray, which he perceived as normal. The x-ray report actually showed an elevated left diaphragm and left pleural effusion with left lower lobe atelectasis abnormalities that should have resulted in immediate physician examination and further radiological diagnostic studies (CT scan). The elevated diaphragm suggested something was pushing up on the diaphragm and this needed to be diagnostically resolved, but was not.

The radiologist x-ray report was not reviewed until 9/13/17. The doctor reviewing the report did not examine the patient, but documented that the patient was doing well and planned to repeat the x-ray in three weeks. This was unacceptable. The patient should have been examined and a CT scan should have been done promptly.

⁶⁸ Hospitalization and Specialty Care Patient #7.

The chest x-ray was repeated on 9/20/17 and showed a density in the left base, a possible combination of pleural effusion and infiltrate. A doctor again did not examine the patient, but wrote a note that he would schedule the patient and would *consider* repeating the x-ray. This was grossly and flagrantly unacceptable. The patient had an abnormal x-ray indicating a serious infection or other serious disease and to not examine the patient is unacceptable practice.

By 10/5/17, the patient told a nurse that he had not been able to walk for six weeks. The patient had come to the infirmary in a wheelchair from general population to take a shower. The patient was dizzy and was not able to independently transfer. The nurse noticed that he was wheezing. The nurse referred to a doctor for possible infirmary placement. The patient should have been evaluated promptly, yet was not seen for three days. This patient's serious medical condition was being neglected.

On 10/10/17, a doctor noted the prior abnormal chest x-ray and expiratory wheezing, and assessed COPD; a chest x-ray, prednisone, nebulizer treatment, and oxygen were ordered. No laboratory tests were ordered. The patient was ordered to the infirmary but was not admitted to the infirmary until 10/14/17, four days later. On admission to the infirmary the patient weighed 300 lbs. The patient had a 45-pound weight loss over 20 months, which was unrecognized. This is either a serious systemic deficiency or indifferent medical care or both. The infirmary admission note failed to acknowledge the abnormal chest x-ray or develop a plan for that. The doctor noted that the patient had COPD and a self-care problem. No other history was taken. The prior history of squamous cell carcinoma of the rectum was not recognized. The doctor ordered no diagnostic studies; a CT scan was indicated. No laboratory tests were ordered but should have been done. The patient should have been admitted to a hospital, but no diagnostic studies were done. Care was grossly and flagrantly unacceptable.

Even though the patient was admitted to the infirmary for COPD, the patient was not seen regularly. After the 10/14/17 infirmary admission note, a doctor did not see the patient until 10/27/17, almost two weeks later. The patient was not eating or drinking, and the doctor documented abdominal pain, decreased appetite, and that the patient appeared dehydrated. The patient should have been admitted to a hospital. Instead, the doctor documented that he would consider permanent placement and ordered a CBC and CMP. The failure to recognize acute and serious problems was grossly and flagrantly unacceptable medical practice.

The blood work reported 10/27/17 showed significant dehydration (BUN 69), renal failure (creatinine 2.46), a life-threatening serum calcium (16), and anemia (hemoglobin 11.9). *These life-threatening laboratory results were not reviewed for three days*, when the doctor next saw the patient. This was grossly and flagrantly unacceptable practice. The patient was sent to a hospital.

The patient was discharged from the hospital almost a month later, on 11/19/17. He had been diagnosed with hypercalcemia, pleural effusion requiring a chest tube, pneumonia, anemia, renal failure, bilateral deep vein thromboses, and an undiagnosed retroperitoneal mass thought to be lymphoma. His last two weeks at DCC are described above in the Urgent Care patient #1 record review. The patient died after a second hospitalization about a month later.

A coroner's report listed multi-organ failure and sepsis as the causes of death, but noted that the patient had lymphoma which had not been previously diagnosed. Remarkably, the autopsy documented that the retroperitoneum was "unremarkable" and the regional lymph nodes were "unremarkable," yet during hospitalization at UIC, a CT scan showed a large retroperitoneal mass and multiple lymph nodes. The coroner did document that the patient had lymphoma, and it was not clear if the coroner had the lymph node biopsy result, which the facility never obtained.

This patient's death was possibly preventable. Follow up of the patient's rectal cancer was poor and the patient was lost to follow up. A biopsy in January of 2017 was never followed up. Liver biopsy, EGD, and colonoscopy approved in collegial review in January of 2017 were never done. The patient had anemia that was not worked up for four years. Once the patient developed a pleural effusion in September, he was incompetently managed for almost two months, at which time his disease was so advanced that he could not be treated. Earlier diagnosis and treatment may have prevented his death.

Specialty Consultations

Methodology: Review specialty tracking logs. Interview the scheduling clerk. Perform record reviews of persons who have had specialty consultation.

First Court Expert Findings

The First Court Expert found lengthy delays in obtaining an appointment at UIC. The date of the order for consultation and the date of the appointment are not included on the DCC offsite tracking log. This made it very inefficient to track the timeliness of the appointment based on the order. On occasion, appointments are delayed so long that new referrals have to be made. The First Court Expert's opinion was that if a system wants to efficiently track whether offsite specialty consultations are timely, they must track the date of order, date of authorization, date of appointment, and date of primary care follow up for discussion of the consultation with the patient.

The First Court Expert recommended that delays in scheduled offsite appointments must be eliminated. He recommended that DCC obtain authorization from the UIC scheduling coordinator within seven days after approval of the consultation. When UIC cannot provide the service within 30 days, a local service needs to be used. He also recommended that immediately after the patient returns from the offsite service, a nurse review the paperwork

reports related to the consultation and, if unavailable, take steps to obtain these reports. After paperwork is obtained, a primary care appointment needs to be scheduled so the primary care clinician can review the report and discuss findings and recommendations with the patient. This discussion needs to be documented in the medical record.

Current Findings

The findings of the First Court Expert were confirmed by our review as still in existence. We agree with the First Court Expert's recommendations. We confirmed the First Court Expert's findings and identified additional problems as listed below.

- The scheduling log is not standardized from facility to facility and does not appear to be used to monitor timeliness of offsite consultations.
- At DCC, 22% of consultations on the scheduling log do not have a referral date. The collegial review appears to be the milestone used to establish the onset of a referral for care.
- Milestones, especially the referral and collegial review, are not consistently memorialized in the medical record.
- The five-day "writ return" visit occurs without a consultation report. Providers do not typically update the clinical status of the patient. The only information conveyed on the five-day writ return provider note is to document the recommendations of the consultant, if they are known. The diagnoses of the consultant are not included on the problem list or followed as part of the chronic illness program, and are not consistently documented as part of the five-day writ return review. In this respect, the provider is merely acting as a second scheduling clerk and not as a medical provider following the clinical status of the patient.
- Care before and after consultations was poor and resulted in preventable adverse events.
- There remain significant delays in getting patients scheduled at UIC. Yet even though delays are significant, alternate sources of consultation are not used. This results in delays of care that can be harmful.

Studying scheduled offsite events has been difficult at all IDOC facilities.⁶⁹ The referral process at DCC requires the doctor to write a referral on a form that is received by the scheduling clerk and discussed at the next collegial review.⁷⁰ The scheduling clerk transmits this information to the corporate UM doctors. After the collegial review, referrals that have been approved and are for local services are promptly scheduled. Referrals that are to go to UIC are placed in folders

⁶⁹ At NRC, we never received the scheduling tracking log we requested, even though the document we requested is apparently used by the scheduling clerk. We were not able to talk to her until after the visit. At SCC, we did not receive the scheduling tracking log we requested until after the visit. Before the visit, we received a tracking log nonresponsive to our request. At DCC, we received a tracking log, but it did not contain information for a year as we had asked and was again nonresponsive to our request. We asked again for this information after the visit. We were then told that prior to August 2017, a tracking log for specialty care was not being used, which we verified as accurate.

⁷⁰ A collegial review is a Wexford utilization management process. Doctors from each correctional facility have a conference call with a Wexford corporate physician and every consultation referral is discussed. During this process, the Wexford corporate utilization physician either approves or denies the consultation request. These conference call meetings ostensibly occur weekly.

for the corresponding specialty service. The scheduling clerk has 21 folders for UIC referrals. The specialty services with the largest volume include cardiology, neurology, ophthalmology, orthopedic surgery, urology, rheumatology, and radiology. On the day of our visit there were 75 requests for service that had not yet received an appointment.

The scheduling clerk faxes the requests to a UIC scheduler, who arranges for appointments. The UIC scheduler permits 10 scheduled appointments a week. This amounts to 520 appointments a year. The arrangement with UIC is that IDOC is allowed 2160 outpatient visits a year at no cost. IDOC facilities allowed to participate in this arrangement include Stateville, Pontiac, Sheridan, and DCC. The 520 permitted visits a year at DCC approximates the average number of allowable visits for each of these four facilities (2160 divided by four). It appears therefore that consultation timeliness is predicated on the availability of free care and not on the need of the patient. By contract, Wexford is responsible for the cost of offsite medical care and should they choose to have the patient seen elsewhere, they would be responsible for the cost.⁷¹ We were told that approximately 90% of offsite medical care goes to UIC, which is 100 miles away, as opposed to the 3-15 miles for local hospital providers. By design, IDOC has placed the geriatric unit with many of the sickest patients at DCC. Yet, it has dramatically reduced access of this population to specialty services. This has caused predictable morbidity and mortality.⁷²

A quality improvement study in April 2017 showed that appointments were delayed for many services. The *average* time to see a consultant was as follows:

- 239 days for gastroenterology
- 225 days for rheumatology
- 187 days for urology
- 179 days for neurology
- 175 days for orthopedic surgery
- 172 days for radiology
- 147 days for oncology
- 137 days for pain clinic
- 134 days for endocrinology
- 133 days for infectious disease
- 100 days for cardiology

The criteria used by IDOC in this study was that urgent consults were to occur in a week and non-urgent consults were to occur within eight weeks based on the Wexford-IDOC contract. None of these averages meet contract requirements and probably most patients require an earlier appointment. These data show that the specialty care to UIC is significantly delayed and thereby fails to protect patients from harm.

⁷¹ Exhibit 1, Schedule E, page 1 Non-Hospital Services states that Wexford is responsible for all professional services that are NOT in a hospital setting. Contract between State of Illinois, Department of Healthcare and Family Services and Wexford Health Services dated 5/6/11.

⁷² We note in the mortality review section that there were six death records from DCC reviewed and all six were preventable. Many were related to lack of access to timely specialty care or other higher level services.

We were told by the Wexford attorney that prior to August 2017 there was no scheduling log at DCC. It appears that the scheduling log is a convenience log for the scheduler to coordinate scheduling with offsite consultants. It is not used as a log to determine if patients receive timely care. The only consistent item tracked on the offsite log is the collegial review date. It is present on all entries. Referral dates appear to be less important events. 172 of 785 (22%) appointments in the specialty tracking log do not have a referral date. It therefore appears that the key variable in a referral is when the referral is approved, not when it is referred.

The First Court Expert found that appointments to UIC are not consistently timely and that these appointments are not tracked. We found that 142 (18%) of referrals on the log (excluding refusals and denied referrals) do not have an appointment date and are therefore pending. Of 142 pending referrals, 32 (23%) have been waiting longer than three months. Of the 32 appointments pending longer than three months, seven (22%) do not have a referral date, so the length of time from referral to appointment cannot be tracked.

According to the HCUA, for a period of time when there was no physician at the site, collegial reviews were not done. The HCUA discovered piles of requests for offsite referrals, apparently from mid-level providers, that were not being evaluated in collegial review. The HCUA started demanding that selected referrals be immediately scheduled based on her clinical sense of the need and the scheduling clerk began scheduling patients at the direction of the HCUA.

With respect to documentation of specialty care which is required by IDOC Administrative Directives, we could not find evidence in progress notes of consistent documentation of referrals or collegial reviews. We could also not find evidence that doctors seeing the patients after consultation understood what had occurred at the consultation. This resulted in fragmented care, lack of continuity of care, and in some instances, preventable adverse events. Due to lack of funds, the number of transportation vans has been reduced over the years. In the past, the facility had as many as 42 cars for transportation and this has been reduced to 13. There is one functioning wheelchair van for use for the disabled. This van is borrowed by other facilities regularly, including from Illinois River, Stateville, Hill, and Sheridan. It was not possible to verify whether the lack of adequate transportation vehicles is a barrier to timely attendance for offsite consultation care, but it should be studied. Many patients, including those with significant disabilities, complained as documented in medical records about a black box. One inmate was injured when being transported while in a black box. The inmate did not appear to be secured with a seat belt. We were unable to review this during our visit and noticed this episode of injury on a chart review. But transportation for appointments should be evaluated by IDOC to ensure patient safety.

We confirmed the First Court Expert's finding that consultant reports were frequently unavailable. This had an adverse effect on patient care.

We reviewed four records that verified our findings and demonstrated poor clinical care. A summary of these is provided below.

- One patient had acute myeloid leukemia and was receiving chemotherapy and oncology care at UIC.⁷³ The patient went to chemotherapy five times from 2/27/17 to 3/28/17. There were no reports from UIC. For the five oncology visits there was only one five-day post writ follow up by a provider. That note did not document the problems of the patient or include a therapeutic plan update. The patient was apparently losing weight, but it was not being documented. On 3/9/17, the patient had a potassium of 6, which is a critical value, yet it was unnoticed at the facility. This level of potassium requires immediate attention, especially in someone with kidney disease, which this patient had. About a week after this critical value, UIC called about a treatment for elevated potassium noticed on one of their labs, but the nurse appeared to transcribe their directions inaccurately. The nurse documented that UIC recommended lactulose for an elevated potassium, which is not recommended therapy.

Doctors at DCC failed to document all of the patient's problems in their notes and failed to document a therapeutic plan for the patient throughout the course of care we reviewed. The therapeutic plan of the oncologist was only known in its general terms and the only communication with the oncologist was by way of very brief recommendations on the referral form. The DCC physicians were not following laboratory values during chemotherapy, even though chemotherapy can cause significant deterioration of blood counts. About a week after a series of chemotherapy sessions, a DCC doctor saw the patient, but did not monitor laboratory values, did not document knowledge of the therapeutic plan, and did not document all problems. The patient was documented as having no complaints. The following day, the patient was emergently hospitalized for multi-lobe pneumonia with a critically low neutropenia (0.5), low platelets (9), and hypotension. The low white blood count was likely due to chemotherapy, and this was unrecognized and unmonitored by providers at DCC. This patient was basically unmonitored throughout this series of specialty consults, which placed him at risk of significant harm and may have resulted in a preventable hospitalization.

- Another example was a 48-year-old man who was transferred to DCC in February of 2015 with a diagnosis of metastatic colon cancer.⁷⁴ The thinned chart volume we reviewed was labeled volume three of three volumes, but we actually discovered that there were six volumes of medical records for this individual.⁷⁵ When the patient transferred to DCC, he was being followed by oncology and was on chemotherapy. The patient was to be scheduled for chemotherapy at the infusion center and also with the oncologist for clinic follow-up visits. We started review of this patient for a 1/3/17 chemotherapy visit. The patient was scheduled for nine chemotherapy visits, which appeared to occur timely. Only three of the nine visits included a report. There were recommendations for oncology clinic follow up on two occasions, but we could not

⁷³ Hospitalization and Specialty Care Patient #3.

⁷⁴ Hospitalization and Specialty Care Patient #1.

⁷⁵ This is yet another example of why an electronic medical record is necessary.

verify that these occurred. A recommended CT scan was done a month late and there was no report of the CT scan in the record. A recommended Doppler test was done two months late and there was no report of this test in the medical record. The five-day post-consultation physician visits seldom occurred. Moreover, it was not possible reviewing the progress notes of the DCC medical staff to understand the progress, status, or problems of the patient. The chemotherapeutic agents being used were not identified. A complication of chemotherapy (hand foot syndrome and response or non-response to chemotherapy) was not documented as known to DCC physicians and was not being monitored. It appeared that the scheduling clerk was managing this patient's care. This care was indifferent.

- Another patient had Crohn's disease, an inflammatory bowel disease.⁷⁶ The patient transferred to DCC from SCC. He was being followed at UIC for infusions of vedolizumab, a monoclonal antibody medication that is used as an alternative to tissue necrosis factor medication for moderate to severe Crohn's disease. On 1/31/17, while at SCC, the patient weighed 235 lbs. Crohn's disease is an intestinal disorder characterized by inflammation of the colon or small intestines causing pain, diarrhea, bloody stool, and weight loss. Between 2/8/17 and 4/24/17, the patient was treated with vedolizumab three times in the infusion clinic at UIC. Reports were not available for these visits. Doctors saw the patient after each of these visits, but we could not verify that a report was returned or was reviewed. The doctors did not take a history after these visits or note the status of the patient. The doctors would merely reschedule infusion therapy without monitoring the progress of the patient. At a five-day post-consultation visit on 3/28/17, a doctor documented that the patient complained of weight loss, but the doctor took no history, failed to verify the amount of weight loss, and merely stated, "doing well per GI and pt." This was despite the patient complaining of weight loss. On a nurse visit on 4/24/17, a nurse documented that the patient had abdominal discomfort. The patient weighed 190 lbs., which was a 45-pound weight loss since transferring from SCC on 2/2/17. This weight loss was unrecognized. The patient's disease was not being monitored. Reports from UIC were unavailable. UIC and DCC were not coordinating care. The patient may have been deteriorating and was apparently losing weight without being monitored. The DCC providers were indifferent to this patient's serious medical condition.
- Another patient had severe mental illness and hypertension.⁷⁷ He had persistent hyponatremia (low serum sodium) for more than three years, probably due to his psychotropic medication or mental illness, yet this was not documented as a problem and not documented as being monitored by medical staff. The patient had an inguinal hernia that progressively enlarged and was not treated for two and a half years, when it had enlarged into the scrotum. This patient also developed a pressure ulcer on his left hip on 6/14/17, which continues to affect the patient as of 4/4/18. The only staging of

⁷⁶ Hospitalization and Specialty Care Patient #5.

⁷⁷ Hospitalization and Specialty Care Patient #6.

the wound was on 7/26/17, when an NP diagnosed a stage II ulcer. An NP documented ordering DuoDERM on 7/26/17. When we asked the current physician at the site about this wound, he replied that the patient picks at the wound and is mentally ill. Neither of these explanations is documented in the medical record as an etiology of the persistence of the wound. The patient has had this wound for over eight months and should have evaluation for a chronic non-healing ulcer, which includes evaluation for osteomyelitis. Wound care was not well documented. This type of wound can result in systemic infection and should be managed more carefully. On 7/31/17, without explanation, the patient became disoriented, drinking shampoo, and vomiting. He was initially placed on mental health crisis watch but subsequently became disoriented and was talking to himself. He was referred to mental health and was then sent to a hospital. There were no medical notes prior to his transfer to the hospital.

Upon return to DCC, there were only limited notes from the hospital and no hospital discharge summary. The patient had four of four blood cultures in the hospital growing gram positive bacteria and the patient had rhabdomyolysis (breakdown of muscle) and bilateral hydronephrosis (enlarged kidneys typically from inability to drain urine). How this patient developed such a serious systemic infection at DCC is unknown because of the paucity of medical evaluations prior to hospitalization. It may very well have been due to his pressure ulcer. His care appeared neglectful. The patient was discharged from the hospital on 8/8/17. The DCC doctor noted that the patient had bilateral hydronephrosis and needed an ultrasound. The DCC doctor also noted that an infectious disease doctor requested weekly CBC and CMP with an infectious disease follow up in four weeks. The patient had a Foley catheter. The doctor at DCC did not document the diagnosis or the reason for the blood infection or the reason for the Foley catheter. Blood cultures were ordered for 10/1/17 and 10/2/17, after completion of antibiotics. An ultrasound was completed on 8/25/17, but the report was not obtained. The patient saw the infectious disease doctor on 9/8/17, but there was no report. The patient still had the Foley catheter and the infectious disease doctor recommended consulting the urologist about discontinuing the catheter. A doctor discontinued the Foley catheter without consultation with an urologist. An urologist saw the patient on 10/2/17. There was no report. The referral form had brief comments by the urologist recommending urine culture, ultrasound of the kidneys, continuing Flomax, and return in two to four weeks. When the intravenous antibiotics were completed the patient was sent to general population. An ultrasound was completed on 10/18/17, and showed bilateral hydronephrosis with distended urinary bladder, and large post void residual. This condition can cause permanent kidney damage if untreated. On 10/19/17, the patient was referred to urology. This referral was approved on 12/12/17 and approved again on 2/1/18. As of 4/4/18, the patient had still not seen a urologist. Uncorrected hydronephrosis can result in end-stage renal disease. This patient has been waiting over six months for a follow-up urology visit. We note that the average wait to see urology is 187 days. This person needed a more timely consultation, as he may sustain permanent kidney damage. The lack of reports was significant and made it impossible to

understand the status of the patient. It appeared that the lack of reports also made it difficult for DCC providers to understand how to manage this patient.

Infirmary Care

Methodology: The clinic space and equipment in the infirmary was inspected, nursing staff were questioned, clinical charts audited, nurse logs reviewed, porters questioned, and patient-inmates interviewed. There was only limited contact with the infirmary physician.

First Court Expert Findings

The First Court Expert noted that infirmary LPNs were working outside the scope of practice, patients were not seen by the provider at the minimum required intervals, an RN was not assigned to the infirmary on all shifts, the provider charting was limited in format and content, call buttons were not available in all rooms, there was insufficient equipment in the infirmary, and there were defective and/or insufficient sheets and pillows.

Current Findings

With the exception of the finding that LPNs were working outside of their scope of practice, we agree with the findings of the First Court Expert's findings and we identified the following additional findings:

- Fifty percent of the patient-inmates housed in the infirmary were classified as requiring total or partial care with their activities of daily living.
- One long-term patient had developed contractures of all his limbs and stage 4 decubitus ulcers while housed in the infirmary.
- At least half of the infirmary patient population requires skilled nursing care; however, the infirmary is neither staffed nor equipped to provide this level of care.
- Physical therapy services are not provided in the infirmary.
- Provider admission and progress notes were brief and contained limited clinical information or rationale for treatment plans.
- Provider admission and progress notes did not meet the frequency and timeliness standards established by the IDOC.
- Admission RN notes are written in accord with the established timelines. Nurse notes are written daily and provide useful information on the clinical status of a patient.
- The quality of provider notes was inconsistent and failed to reflect key components of the patients' histories, physical findings, and the treatment plan.
- In spite of the high level of physical and mental impairment of the patients housed on the infirmary, there were no electric beds in the infirmary. This is a barrier to the delivery of needed care and put the staff at risk for injuries.

The infirmary is located on the second floor of the medical building across from the ADA housing unit. The infirmary has 28 beds; the census was 18 on the day of the inspection. The physical plant and layout is unchanged since the First Court Expert's report. Nurses reported that the provider is expected to write progress notes within 48 hours of admission and three

times a week for “acute” admissions, twice a week for “chronic” patients, and once a week for “permanent” patients. The provider concurred that acute admissions are to have thrice weekly notes, but chronic and permanent patients were only required to have weekly progress notes. IDOC Policy 04.03.120 Offender Infirmary Services⁷⁸ directed providers to write admission notes with 48 hours and progress notes no less than three times a week for acute patients and once a week for chronic patients. Review of five infirmary records verified that four of five provider admission notes were written within 48 hours or on the next working day. One record of an “acute” did not yet have a provider admission note or a progress note as of the sixth day of admission. The frequency of the provider progress notes for these five patients were: no note to date as of day six of stay,⁷⁹ one progress note five days after admission and then none for the next two weeks,⁸⁰ six progress notes in 21 days,⁸¹ one note in 20 days,⁸² and one note in nine days.⁸³ The timeliness of the progress notes was not found to be fully in compliance with this policy; four of the five infirmary records did not comply with this established policy. Nursing notes were consistently entered no less than daily and commonly on every shift.

It was reported that an RN is assigned to the infirmary on all shifts seven days a week. LPNs and CNAs provide added staffing in the infirmary. A number of inmate hospice workers supervised by the nursing staff assist with a variety of tasks.

Nine of the individuals in the infirmary were designated as requiring assistance with activities of daily living (seven partial assistance, two with total care); thus 50% of the infirmary patient population were unable to fully care for themselves. Included in this non-independent group were individuals with metastatic cancer, dementia with contracted limbs, post CVA, advanced multiple sclerosis, and dementia. The RN on duty stated that all nine would be permanently housed in a skilled nursing facility if they were not incarcerated.

We note that the IDOC acknowledges a lack of appropriate housing for the infirm and disabled elderly prisoners. In her deposition, the IDOC Agency Medical Coordinator⁸⁴ answered questions on this issue.

“Q. What were you proposing in this e-mail of August 2nd, 2016?

A. For them to consider an assisted living environment at Kewanee or in another facility or changes to a current facility.

Q. And in this you say that you’re writing to bring attention to the effect our aging population has on the facility infirmaries, right?

A. Correct.

⁷⁸ Reference Offender Infirmary Services.

⁷⁹ Infirmary Patient #1.

⁸⁰ Infirmary Patient #2.

⁸¹ Infirmary Patient #4.

⁸² Infirmary Patient #3.

⁸³ Infirmary Patient #5.

⁸⁴ This nursing position reports to the Agency Medical Director and supervises the Regional Nurse Coordinators.

Q. And we are having problems placing offenders due to our infirmaries being full and this is only going to continue to get worse as the baby boomer population ages, right?

A. That's what I wrote, yes.

Q. Do you know if anything has come of this suggestion?

A. I do not know.

Q. Getting tired of having to figure out where to put aging and elderly prisoners?

A. I want to appropriately place them for care, for appropriate care, and meet the operational needs of our department."⁸⁵

Although approximately half of the infirmary rooms had nurse call buttons, many of the patients were unable to utilize them due to their advanced mental and physical conditions. Only the restraint/negative pressure room has direct line of sight from the glass window in the nurse station.

We identified a number of concerns and deficiencies in the care provided to infirmary patients as noted below.

- This patient was admitted to the DCC infirmary on 3/30/18 upon transfer from Schwab Rehabilitation Center in Chicago.⁸⁶ The nurse admission note written on Thursday morning/early afternoon of 3/30/18 listed the diagnoses as neurogenic bladder, seizure disorder, and low back pain, and noted that the patient used a seizure helmet, wore a diaper due to urinary incontinence, was confused and disoriented, and walked with a cane. The admission nursing note failed to note that the patient had advanced multiple sclerosis. The patient was assigned to the "Acute" status. Nursing notes were written on every shift. As of 4/3/18, five days after admission, there was not a provider admission note or a progress note in the infirmary record. Five days after infirmary admission, this patient had not been seen by a provider. This is not in accord with IDOC policy.⁸⁷ One of the other DCC providers should have been scheduled to cover infirmary admissions during the vacation of the assigned provider.
- The next patient is a 35-year-old patient who was admitted to the infirmary on 11/22/17 with abdominal pain and weight loss.⁸⁸ Prior to admission to the infirmary he had been in nurse sick call on 10/25/17 for abdominal pain and constipation, and his weight was 165 lbs. He was seen again in five nurse sick calls in October and November 2017 for similar symptoms. His abdominal pain worsened with meals, he had nausea and vomiting, and was provided a variety of over the counter medications. On 11/8/17, his weight had dropped to 154 lbs.

On 11/22/17, nursing referred him to the NP because of knife-like abdominal pain for two weeks and a pulse of 120. The NP noted that the patient's weight was 144, a drop

⁸⁵ Deposition of Kim Hugo, April 11, 2018 pp. 69-70.

⁸⁶ Infirmary Patient #1.

⁸⁷ Reference #IDOC Policy 04.03.120 Offender Infirmary Services.

⁸⁸ Infirmary Patient #2.

of 21 pounds within one month. The NP admitted him to the infirmary for observation and a battery of stat tests (CBC, CMP, amylase, lipase, thyroid studies). The lab results showed urine ketones, mildly elevated total bilirubin (1.5), and mild electrolyte abnormalities. The infirmary nurse spoke with the physician, who advised continuation of the current management. On the same day, the patient voiced having pain near/behind his umbilicus. For the next few days he continued to have abdominal pain with poor appetite, and the hard marble sized spot above his umbilicus continued to cause pain. On 11/27 and 11/28/17, the physician examined the patient and felt that he had a non-reducible umbilical hernia. The physician sent the patient to the KSB Emergency Room on 11/28/17. An abdominal CT Scan at KSB showed no evidence of a hernia but showed terminal ileum inflammation. KSB recommended follow-up with a surgeon for a possible inflamed umbilical stump due to inflammatory bowel disease. At the patient's request he was discharged on 11/29/17 from the infirmary, and referrals for gastroenterology and general surgery consultations were submitted. Only an admission weight had been recorded during his eight day stay in the infirmary. No order was placed to repeat the abnormal comprehensive metabolic panel (total bilirubin) or to schedule an EGD and a colonoscopy.

The patient was seen by the NP 12/24/17 and had a weight of 141 lbs. Nurses saw the patient in nurse sick call on 12/24/17, 1/4/18, 1/8/18, 1/9/18 (141 lbs.) for abdominal pain. An NP saw the patient again on 1/12/18 for abdominal pain and a mass of unknown origin near the umbilicus. Nurses saw the patient again at nurse sick call on 1/14/18, 1/16/18 (130 lbs.), and 1/18/18 (130 lbs.) for abdomen pain and tenderness, left testes pain, and abdominal bloating. On 1/23/18 (123.7 lbs.), a nurse noted that the patient was jaundiced/icteric, and his abdomen was tender to the touch. On 1/25/18, the patient was sent to Town Square General Surgery for the consultation requested on 11/29/17. The patient returned with a diagnosis of significant jaundice. Stat labs drawn at the surgeon's office showed elevated total bilirubin of 14.9, alkaline phosphatase 509, ALT 327, and AST 136 with normal amylase and lipase levels.

On 1/26/18, the patient was transported to the UIC ED and admitted to the hospital. His 3/7/18 UIC discharge summary noted the diagnosis of mucinous producing adenocarcinoma/cholangiocarcinoma, biliary stents insertion, and s/p excision of an umbilical nodule. The patient was readmitted from the infirmary to UIC on 3/13/18 for weight loss and malnutrition. He was started on Gemcitabine chemotherapy and returned to DCC on 3/16/18 with the diagnosis of Metastatic Cholangiocarcinoma.

The patient was readmitted to the DCC infirmary on 3/16/18. The patient was transported to receive chemotherapy infusion at UIC on 3/20/18 and 3/27/18, and went to an oncology appointment on 3/24/18. Nursing notes were written on nearly every shift from 3/19/18 to 4/2/18. The patient's condition is determined to be terminal and chemotherapy is palliative. The patient's weight has decreased from 111 lbs. on 3/21/18 to 104 lbs. on 3/28/18.

Although the patient had multiple encounters with the DCC health care team between 10/25/17 and 1/25/18, including one admission to the infirmary and a referral to KSB emergency, they missed opportunities to more expeditiously and thoroughly evaluate this patient's symptoms and condition.

Following a month of unexplained abdominal pain, when the patient was noted on 11/22/17 to have lost 21 pounds and laboratory tests and a CT scan at KSB failed to identify a cause, he should have been admitted for additional diagnostic workup. EGD, colonoscopy and contrast CT were indicated. The general surgery consultation requested on 11/29/17 was not scheduled until 1/25/18, at which time the patient was already overtly jaundiced. This two-month delay for a surgical consultation in a continuously symptomatic patient was unacceptable. Although the total bilirubin performed on 11/22/17 was only mildly elevated, the comprehensive metabolic panel should have been repeated after his infirmary discharge on 11/29/17, especially since the patient continued to have abdominal pain and lost another 20 pounds over the next two months. All of these missed administrative and clinical opportunities to intervene and appropriately manage this patient's care resulted in avoidable delays that have negatively impacted on his care and his health.

- The next patient is an elderly patient with long standing dementia, history of pica,⁸⁹ hypertension, upper and lower extremity contractures, and deep decubiti ulcers.⁹⁰ He was thought to have Picks Disease (frontotemporal dementia). He has been housed in the infirmary for a number of years. The infirmary record reveals daily vital signs and nursing notes. He requires total care (feeding via gastric tube, bathing, diapers). His limbs are fully contracted, he remains in a fixed fetal position. He was observed being transferred to a tub by the CNA and a hospice worker. He has chronic decubitus ulcers (pressure sores) over his coccyx and left gluteus. These ulcers have required antibiotic treatment on at least two occasions in the past year (September 2017 and October 2017). The wounds are now emitting a foul-smelling discharge and one was noted as deeply tunneling toward bone. The nurses write no less than daily progress notes. On 3/15/18, the nurses noted that the coccyx ulcer was foul smelling and on 3/20/18 the nurse wrote that one of the ulcers had a putrid smell and was tunneling. She requested a consult from the infirmary provider. On 3/21/18, the provider saw the patient, advised continued local wound care, and submitted a referral request to the wound care clinic at CGH Hospital in Sterling, IL. This was the only note written by the provider between 3/15/18 through 4/3/18. A single provider note in nearly three weeks for this permanent resident of the infirmary with an infective decubitus ulcer is not in compliance with the IDOC Offender Infirmary Services guidelines.⁹¹ The extreme contractures and the recurrent pressure sores in this patient are strong indications that the past and current level of care in the DCC infirmary does not meet the community

⁸⁹ Pica is an eating disorder typically defined as persistent eating of nonnutritive substances.

⁹⁰ Infirmary Patient #3.

⁹¹ Reference IDOC Policy 04.03.120 Offender Infirmary Services.

standard of care. Contractures are preventable with ongoing physical therapy; decubitus ulcers are preventable with frequent repositioning of the patient in beds or wheel chair. The manifestation of these findings in this long-term patient indicates that the DCC infirmary is not able to provide a level of care that is expected to be provided in skilled nursing facilities. Once the patient started to develop contractures, he should have been transferred to a facility in the IDOC or in the community that could have provided the needed preventive care.

- The next patient is a 46-year-old who was admitted on 3/14/18 to the infirmary.⁹² Nurse and provider admission notes were completed on the day of admission. His admitting diagnosis was right foot ulcer/cellulitis with a purulent discharge. Intravenous fluids and antibiotics were started. The patient also has a history of depression, schizophrenia, and cardiac murmur. There were nursing notes written at least once on every shift; dressing changes were performed multiple times a day. There were six provider notes from 3/14/18 through 4/2/18 (19 days). On 3/19/18, wound cultures grew MRSA, which is sensitive to the antibiotics being administered. The patient was placed in contact isolation, where he remained until isolation was discontinued on 4/1/18. Progress notes on 3/19/18 (improved), 3/20/18 (no drainage), 3/21/18 (granulating), 3/22/18 (healing), 3/27/18 (slow healing), and 4/1/18 (sanguineous discharge) documented the status of the infection. The care provided to this patient was deficient and did not meet the community standard of care. The failure of the provider to initiate investigations to identify an underlying, potentially correctable, etiology of this chronic foot ulcer of six-month duration was unacceptable.

During this infirmary admission there was no reference to the previous treatment in September to December 2017 for an infection at the same site. This important clinical information would have raised the possibility that there was some underlying cause for this recurrent infection. A recurrent infection would have warranted further lab studies including blood glucose, HbA1C, CBCs and a careful examination for the adequacy of arterial circulation (pulse, arterial blood flow) and sensation in the involved foot. None of these indicated tests and examinations were performed. There was also no documentation that the patient's history of a cardiac murmur resulted in an examination of his heart. The cause of this recurrent infection was never evaluated nor explained, minimizing the opportunity to implement prevention measures and putting the patient at risk for another reoccurrence of this serious infection.

- The next patient is a 61-year-old with a history of hypertension, hyperlipidemia, BPH, psychiatric disorder, and atrial fibrillation.⁹³ He was admitted to the infirmary on 3/27/18 with dizziness. His medications on admission included Atorvastatin, aspirin, Flomax (Tamsulosin), Zoloft (sertraline), Cogentin, Haldol, and possibly Norvasc (amlodipine). A nurse admission note was recorded on 3/27/18. The nursing note on

⁹² Infirmary Patient #4.

⁹³ Infirmary Patient #5.

3/28/18 documented orthostatic drops in blood pressure and the patient was placed on fall precautions. On 3/29/18, the first and only provider note stated that the patient was now off Norvasc (a medication for blood pressure) and that Midodrine was being administered TID. The provider note made no mention of the recent past history of atrial fibrillation, the recent history of admission to Karen Shaw Berea (KSB) hospital for similar symptoms and did not include a cardiac examination. Nursing notes were written almost on every shift with orthostatic blood pressure measurements performed twice daily. The patient was asymptomatic but had orthostatic drops in blood pressure of 20mmHg.

The patient had been admitted to KSB approximately 10 days prior with orthostatic hypotension with syncope. He was also found to have paroxysmal (intermittent) atrial fibrillation with a low-moderate CHADS-VASc⁹⁴ score for which anti-platelet treatment (aspirin) was initiated at this time. His hematocrit was 40 and hemoglobin 13.5; his echocardiogram revealed an ejection fraction of 60-65% with a moderately dilated left atrium and trace mitral valve regurgitation. None of this pertinent information was recorded on any of the progress notes during this infirmity admission.

There was only a single very limited provider note recorded from 3/27/18 to 4/3/18 (eight days) for this acute admission. This is not in accord with IDOC Policy,⁹⁵ which directed that acute admissions have three provider notes per week. The failure to even succinctly summarize the recent KSB admission and testing put the patient at risk for being inappropriately managed in the infirmity. The patient should have had a basic metabolic panel (glucose, BUN, electrolytes), CBC, and an ECG performed. The provider note did not indicate the cause of this patient's dizziness and persistent orthostatic hypotension nor document possible alternative etiologies. Consideration should have been given to a cardiac arrhythmia or side effects of some of the patient's other medications (Tamsulosin, sertraline) and to seeking specialty consultation for this patient's unexplained orthostatic hypotension.

In summary, a number of the patients admitted to the DCC infirmity require a higher level of care than can be delivered in the DCC infirmity. These high-risk patients need to be transferred to a skilled nursing facility in the community until this higher level of care can be provided in an IDOC facility. The provider notes in the infirmity failed to meet the IDOC standard for timeliness and do not adequately address the acute and chronic needs and illnesses of the each infirmity patient.

With the exception that since RN's are assigned to all shifts in the infirmity, we did not find that LPNs are working outside their scope of services, we agree with the recommendations of the First Court Expert and have additional recommendations that are found at the end of this report.

⁹⁴ The CHAD score determines whether a patient requires anticoagulation for atrial fibrillation.

⁹⁵ Reference #IDOC 02.04,120 Offender Infirmity Services.

Pharmacy and Medication Administration

Methodology: We reviewed medication services by touring the medication room with the Nursing Supervisor (Wexford) who is also the vendor's Site Manager. We observed nurses as they prepared, administered, and documented medication administration. We reviewed medication administration records and corresponding medical records of 12 patients selected from lists of patients on medications that cannot be missed. We also reviewed medication room inspection reports, pharmacy reports, the Wexford-IDOC contract, Administrative Directives, and DCC operational policies and procedures.

First Court Expert Findings

The system used and policies and practices described in the First Court Expert's report are unchanged today. Medications are provided by BosWell, a subcontractor to Wexford, using a "fax and fill" system. Pharmacy assistants are responsible for sending orders and requisitions for stock medication to be dispensed by BosWell. These same personnel receive shipments and verify medications received against those ordered. Once this is completed, the medications are moved to the medication room where they are prepared by nurses for administration. Medications were either administered by nursing staff to a line of patients waiting in line at the health care unit or were taken to the living units and administered through the food port at the cell door. A security officer escorted the nurse while administering medication cell side. Documentation of medication administered, refused, or not available is done on a paper Medication Administration Record (MAR) that is kept in a binder in the medication room for the current month and filed in the medical record the month after.⁹⁶ The First Court Expert had no adverse findings with respect to medication administration.

Current Findings

Medication administration has apparently deteriorated since the First Court Expert report. Medication administration at DCC is problematic and relies on outdated practices that are no longer considered safe from patient harm. These problem areas include:

- Handwritten and incomplete orders
- Inconsistent documentation by providers in the progress notes about the decision to order medication and clinical rationale
- Handwritten transcription of orders to the MAR
- Late transcription of orders
- Pre-pouring medication
- Use of unsanitary envelopes to administer medications in the Special Treatment Center⁹⁷ (STC)
- Not having the MAR available during medication administration in STC
- Not documenting administration of medication at the time it is given.

⁹⁶ Lippert Report DCC p. 21.

⁹⁷ This is a mental health unit at the DCC.

Chronic disease patients are not monitored to ensure continuity in treatment. Their compliance with prescribed treatment is not assessed. Prescription end dates do not coincide with chronic clinic appointments and require patients to request renewals via sick call.

In addition, we found that medication errors are documented and reported, but not analyzed to determine root causes or trended to identify problems and improve patient safety. Persistent problems with medication practices are not subject to corrective action or systematic quality improvement.

Orders and Delivery of Medication

Medications are obtained from BosWell Pharmacy Services, via subcontract with Wexford. Prescriptions are faxed to BosWell and filled in 30-day “blister packs” and then delivered to DCC. A pharmacy assistant at DCC receives and inventories the medications and then puts them into the medication room nurses use to prepare medication to give to patients. The lead pharmacy assistant reported that prescriptions faxed to BosWell by mid-afternoon are received the next day. Prescriptions faxed after that take another day to arrive. If medications are urgently needed, they can be obtained from a local pharmacy.

We toured the room used to administer medications to inmates housed in general population, the medication storage room where nurses work, and the area where the pharmacy assistants send and receive medication supply. These rooms were clean, uncluttered, well-lighted, and kept secure. There is a refrigerator with a thermometer and temperature log that was up to date. All other refrigerators used to store medications had thermometers and documentation of daily temperature checks. Of the logs inspected, temperatures were within the correct range. There was an opened bottle of lemon juice in the refrigerator that was undated. Multiple dose containers should always be dated when opened and not used for more than 30 days after opening. We also found four undated insulin vials of the 10 being used by nurses in the dispensary on Monday April 2, 2018 to give insulin to diabetic patients. Multidose vials should also be dated when opened. No outdated medication was found in the pharmacy/medication administration areas. We did find expired HIV rapid test material in the refrigerator in the dispensary, occult blood testing material, and eye wash solution in the nurses’ room in X-House.

Issues with accountability of controlled substances were identified by facility audits of Institutional Directive (ID) #04.03.110 in the spring of 2016.⁹⁸ Accountability of controlled medications was also found in pharmacy inspections during that same time.⁹⁹ Corrective action was implemented and substantial compliance with ID #04.03.110 was found in performance by the fourth quarter of the year and was sustained in 2017.¹⁰⁰ On Monday April 2, 2018, we observed the count between day and evening shift, and verified that it was accurate. Other issues identified in the pharmacy inspection reports were pre-signing for medication

⁹⁸ Facility Review Report, April-June 2016, July-September 2016.

⁹⁹ Dixon Correctional Center Annual Governing Body Report, September 21, 2016 pp. 142-143.

¹⁰⁰ Facility Review Report, October 2016-December 2016, January-March 2017.

administered, outdated medications still being administered, patient specific blister cards used for stock, medication not stored correctly, and failure to document medication administered. The only corrective actions taken were education and counseling. There is no systemic analysis to determine root cause and develop solutions that support performance improvement or prevent human error.

Orders for prescription medication were often barely legible. The lead pharmacy assistant reported that BosWell seldom returns orders because they are unreadable. However, a nurse could not decipher a provider's handwriting when asked by the Expert during chart review. Only 73% of the orders reviewed were complete (signed, dated, and timed). Only 64% of the orders had a corresponding progress note. Sometimes there was a comment written on a lab or diagnostic study report indicating intent to order medication; however, there was no progress note. The providers need to document their decisions and rationale about treatment in the progress note, but at DCC this is not done consistently.

Nurses transcribe provider medication orders onto the patient's MAR. We did not find any transcription errors among the 12 charts reviewed. We did find that sometimes nurses handwrite the new order over an old order.¹⁰¹ This is an alteration of the record and should be prohibited. We also found a consistent pattern of transcribing orders more than a day after the order was written.¹⁰² This causes a delay in the initiation of treatment. In fact, only 70% of the medications ordered had the first dose administered within 24 hours of the start date.

Transcription errors are by far the most common type of medication error reported to the DCC CQI committee.¹⁰³ These errors are evaluated to document whether there was harm to the patient. There is no other documentation or other report that medication errors are trended or analyzed to identify systemic sources of error, nor has it been identified as a problem for possible improvement by the CQI committee.¹⁰⁴

Medication errors have long been recognized as a substantial area of focus in improving the safety of patient care.¹⁰⁵ Handwritten orders and transcription have been eliminated in many correctional health care programs. An obvious solution is to install computerized provider order entry (CPOE). This eliminates transcription by hand. Labels generated from the computerized order after it has been reviewed by a pharmacist are affixed to the MAR.¹⁰⁶ Automated dispensing cabinets are also being used more often now to record the withdrawal of controlled substances and eliminate manual inventory control systems like that implemented at DCC because of non-compliance on the audit at DCC. Upgrading pharmacy services in this way

¹⁰¹ Pharmacy/Medication Administration Patients #3 & 7.

¹⁰² In four of 11 charts (36%), the order was transcribed more than eight hours later.

¹⁰³ DCC Annual Governing Body Report, September 21, 2016 p. 144.

¹⁰⁴ HCU Policies and Procedures P-129 p. 68 only requires analysis of individual events but does not analyze error trends. See also the DCC Annual Governing Body Report, September 21, 2016 p. 144. The report of medication errors made to the CQI committee does not include root cause analysis nor is there any discussion of change.

¹⁰⁵ Institute of Medicine (2000), To Err is Human: Building a Safer Health System. Washington DC: The Academies Press.

¹⁰⁶ Patient Safety Network. (2017) Medication Errors, Agency for Healthcare Research and Quality available at <https://psnet.ahrq.gov/primers/primer/23/medication-errors>.

requires capital expenditure and would only likely happen as a statewide decision made by IDOC. But if these pervasive problems are not identified, discussed, studied, or reported at the facility level, IDOC is without notice that there is a systemic issue that must be addressed statewide.

When the medication arrives from BosWell, a pharmacy assistant verifies the medication received against the order, which serves to identify dispensing errors. Once verified, the medication is put in the nurses' medication work room into boxes designated by the housing location of the inmate.

Medication Administration

There are two ways medications are administered at DCC. Inmates in general population come to the HCU and stand in line to receive their medication. In the STC, a mental health treatment program, medications are brought to the inmate by a nurse and administered cell-side. Practices of staff are problematic with both methods.

Nurses pre-pour all medication administered to inmates in general population. The only exception is "as needed" (PRN) medications. Pre-pouring entails multiple steps: looking at the MAR; selecting the right medication for the patient; and popping the pill out of the blister pack into a soufflé cup. The soufflé cups are placed in a tray with a card with the patient's name on it. If it is a medication that must be crushed, the nurse will crush it in advance as part of the pre-pour. If the patient had a pattern of not taking the medication, the nurse waits until the inmate appears at the window and indicates he will take it. Then the nurse obtains it from the blister pack, crushes it and administers it to the patient. We were told by the Nursing Supervisor (Wexford) that all controlled medications are crushed; any others are only crushed as a result of an order to do so. Blanket crushing policies such as this are not recommended. Any medication to be crushed should only be as a result of a provider order. We did not observe medication being floated. Documentation that medication was given takes place after all medications have been administered to the general population. The only exception to this practice is "as needed" medications, which are documented as given at the time administered.

Correctional officers supervise inmates waiting in line for medication. Inmates are called over by housing unit, so the line does not become too long. There is also an officer near the medication window who monitors the inmate's behavior during and immediately after medication is administered. Nurses use the name and photo on the inmate's identification card to verify that it is the right patient. When asked if they had ever had an inmate exchange identification cards, the nurses said no and were surprised to hear that it occurs with some regularity at other correctional facilities. Because of the window between the nurse and the patient, there is very little interaction that takes place. This barrier diminishes the opportunity for inmates to ask questions or voice concerns about the medication, side effects, or other symptoms they may experience. Nurses are also unable to observe more than the inmate's face and so cannot identify changes in the inmate's condition at these encounters.

Problems with this method of medication administration are:

- Pre-pouring defeats the purpose of patient specific packaging. As soon as the medication is taken out of the blister pack, verification that it is the correct medication, for the right patient, at the right time, and the right dose is not possible. This is a patient safety risk and unnecessarily exposes the patient to errors in administration (receiving the wrong drug). It is also a wasteful use of the cost of blister packaging.
- Nurses do not have a way to verify medication that is not taken. Visual identification of remaining medication is not accurate.
- Medication is not documented at the time it is given. This practice is a source of errors and omissions in documentation of patient care.

Medications administered to inmates in the STC are also pre-poured. Adjustments have been made in times when medication is administered to accommodate expectations for inmate treatment programming and the time available for any one medication pass is limited.

We accompanied a nurse escorted by a correctional officer during the midday medication pass in STC. The medications to be administered were in small envelopes with each inmates' name. The officer approached the cell door and the nurse called out the inmate's name as it was opened. Each cell had one or two inmates. The inmate stood in the doorway. The nurse asked to see the inmate's identification card but did not use a second identifier. The nurse poured the medication into the inmate's hand or, if the medication was "floated," into a glass of water that the inmate had. The nurse and the officer observed the inmate swallow the medication and checked his mouth afterward. If the inmate did not want to take a particular medication the nurse put it back in the envelope. One inmate questioned the identity of one of the medications he was to receive. Because the medication was not in its original container the nurse could not identify it. Instead, the inmate returned the medication to the nurse. She said that she would check and tell him what the medication was at the next medication pass. The interaction between the nurse, officer, and inmates was professional.

The MAR is not taken when the nurse administers medication in the STC and so the nurse did not document administration at the time the medication was given. The nurse is instead expected to document after returning to the nurses' medication work room.

Problems with medication administration in the STC are the same as those listed for the method used in general population and in addition include:

- Repeated use of the same envelopes is a source of transmission for infectious disease because they are handled multiple times.
- Crushed medications in the envelope contaminate other medication in the envelope and may cause an adverse interaction.
- The MAR is not available to the nurse at the time medication is administered and therefore is not used as a reference when there is a concern or question at the point of patient care.

Only 37% of the MARs selected for review were complete.¹⁰⁷ Documentation of doses given, refused, or not available was missing from five of eight charts reviewed. This is extremely poor performance and calls into question the accuracy of the MARs. Contemporaneous charting on the MAR at the time of administration is considered the nursing standard of practice. DCC does not meet this standard of professional performance.

KOP medications are delivered to inmates in general population once a day at a line designated for this purpose. There are no KOP medications in the STC.

When we shared feedback about our findings with the HCUA, we were told that the programming requirements of STC are such that the only way medications can be delivered is the method being used now. Similarly, she explained that they tried to administer directly from the patient specific blister packs in general population but that it took too much time, so they reverted to pre-pour. It is true that pre-pour reduces the amount of time the nurse is with the patient, but it significantly increases the risk of medication error and patient harm. Both arguments are another way of saying that facility operations are impeding nurse's ability to provide patient care safely and in accordance with contemporary standards of practice. This is dangerous and needs to be fixed.

Renewal of Chronic Disease Medications

Chronic disease medications are provided to patients monthly either as KOP or each dose is administered by a nurse. The scheduled appointments for chronic disease clinic do not coincide with the end date on medications ordered for chronic disease. Providers are to be notified of impending expiration dates.¹⁰⁸

DCC HCU Policies and Procedures for Chronic Disease require providers to review current medications and ensure continuity of prescription medicines.¹⁰⁹ During our record review we identified several patients prescribed medication that required continuity who had lapses on their care.¹¹⁰ Chronic disease patients are not monitored to ensure continuity in treatment nor is their compliance with prescribed treatment assessed.

In summary, DCC medication services do not meet the standard of practice, they employ outdated methods that compromise patient safety, and they are not reviewed and analyzed to make improvements that prevent human error.

Infection Control

Methodology: We interviewed the medical lab technician assigned to track and report on infection control. We also interviewed inmate-porters, reviewed the Infection Control Manual,

¹⁰⁷ Pharmacy/Medication Administration Patients #6, 7, 8, 9 & 12.

¹⁰⁸ HCU Policies and Procedures P-128 Medication Services p. 61.

¹⁰⁹ HCU Policies and Procedures P-107 p. 11.

¹¹⁰ Intrasystem Transfer Patient #1, Pharmacy/Medication Administration Patients #1, 2 & 4, Infection Control Patient #1.

CQI minutes, and other documents related to communicable diseases and infection control. We also reviewed the charts of two patients who completed a course of TB prophylaxis.

First Court Expert Findings

The First Court Expert Report noted that there was no named infection control nurse at DCC. Two nursing supervisors shared responsibility for compliance with IDOC policy concerning communicable diseases, blood borne pathogens, and compliance with Illinois Department of Public Health reporting requirements. Inspection of the health care areas and inquiry about infection control practices revealed that personal protective equipment was available, and that infectious waste was properly disposed. He was unable to confirm that inmate porters assigned to work in the infirmary had received any training in cleaning and sanitation; the Nursing Supervisors had not addressed the issue with the porters.¹¹¹

Current Findings

We agree with the findings of the First Court Expert's report. In addition, we identified additional findings and confirmed some of the findings of the First Court Expert's findings as follows:

- Paper barriers were noted to be used on most but not all examination tables.
- The floors and surfaces in the health care building, particularly the second and third floor, are dirty or have deteriorated to the extent that they are a medium for transmission of infectious disease.
- Inmate porters are allowed to work in the infirmary without being trained in proper cleaning procedures and personal protection.

When we asked the Nursing Supervisor (IDOC) to speak with the person responsible for infection control, we were directed to the medical lab technician (Wexford). The lab technician did not see herself as having responsibility for infection control. She does submit reports of infectious conditions as required to the state Health Department. She also tabulates the monthly infection control report that is presented at the CQI meeting. This report lists the number of patients placed in isolation, compliance with testing the room for negative pressure, cases reportable to Public Health, MRSA cases, and patients screened for, monitored, and treated for HIV, and HCV. She was knowledgeable of the facility's infection control manual, including control of infectious disease outbreak, and has assisted in several investigations including norovirus, chicken pox, and MRSA. She also has experience with the facility's approach to controlling influenza transmission. The chronic care nurse manages the HIV and HCV clinics. The HCUA stated that she has overall responsibility for infection control only because of the number of vacancies in her supervisory staff. There is no single person with leadership and responsibility for infection control. The lab technician has insufficient training to be responsible for the infection control program.

CQI Minutes and the 2016 Annual Report show that communicable disease data is collected and reported monthly. There is minimal to no discussion of the meaningfulness of the data

¹¹¹ Lippert Report DCC p. 33.

reported. CQI Minutes also report statistics regarding skin infections due to MRSA. Data does not include tracking of skin infections due to other pathogens. Equipment and instructions for prevention, response, and reporting of occupational exposures were readily available at the facility.

The IDOC Infection Control Manual was reviewed. It was last updated in 2012. While the material in the manual is thoughtful and many resources are provided, some of them are out of date. The manual should be updated at least every two years. An up to date and accurate infection control manual is critically important in guiding the work of staff assigned these duties in the absence of dedicated positions for trained infection control staff, as is the case at DCC. The IDOC Nursing Treatment Protocols, revised March 2017, were reviewed, and provide guidance to nurses in the care of common infectious diseases and infections such as scabies, urinary infection, rash, pediculosis, chicken pox, and skin infections.

We note in the Clinic Space and Sanitation sections of this report many infection control challenges and hazards that were observed during our site visit at the facility that need to be remedied to prevent spread of infection or safety hazards to patients, including elderly inmates at risk of falls.

The CQI minutes report four occupational exposures to blood borne pathogens in 2017.¹¹² The HCUA reported that three of these were needlestick injuries. She requested Wexford provide a different type of re-sheathing needle to help prevent additional injury. To date, Wexford has not responded to her request. At a minimum, Wexford should conduct an evaluation of the effectiveness of existing hypodermic needles and review of feasibility of instituting more advanced engineering controls as required by Occupational Safety and Health Administration (OSHA).¹¹³ Further, the CQI committee should conduct a focused review of these injuries and determine what measures to implement in order to increase employee safety.

One porter had documentation in his medical record that he had received formal training on blood borne pathogens and had been vaccinated against hepatitis B. The other porter had not yet been trained concerning his duties in sanitizing patient rooms, showers, tub rooms, and showers, and had received only the first of the three required hepatitis B vaccination shots. He is reportedly scheduled to receive the required training. Neither porter had been offered hepatitis A vaccination, even though there is a higher risk of exposure to pathogens, and a more frequent and higher degree of sanitation is needed in the infirmary.

Tuberculosis screening is completed annually. We did not evaluate actual practices for TB screening. We reviewed the charts of two patients who completed prophylaxis. In one case, the

¹¹² DCC Infection Control Minutes August, September, and October 2017.

¹¹³



osha3161
preventing needlestick

inmate gave a history of a positive skin test and there was a record of a normal chest x-ray in 2006. In April 2017, a physician ordered the skin test and x-ray repeated. The x-ray was normal but no results for the skin test were recorded. Six months later at a chronic care clinic, the inmate requested TB prophylaxis. The NP documented that he was asymptomatic and had a normal chest x-ray and initiated treatment. Once initiated, the inmate was seen in TB clinic monthly for review of medication compliance and symptom review. Labs were drawn as ordered.¹¹⁴

The other patient received three TB skin tests in July and August 2017, all recorded as 20mm, which is considered positive. A chest x-ray was normal, and he was asymptomatic. TB prophylaxis was initiated shortly thereafter. He was seen by the nurse monthly in TB clinic for review of medication compliance and symptom review. Labs were drawn as ordered.

In both cases, initial tuberculosis skin testing and follow up was haphazard. Once treatment was initiated and the patient seen by the TB control nurse, monthly care was timely and appropriate.¹¹⁵

If tuberculosis prevention were managed by specifically designated nurses according to standardized protocol with provider consultation, the initiation of preventive treatment would be more timely and precise. We note as described in the Clinic Space section of this report that the negative pressure unit in Room 35 of the infirmary is tested, with results documented in a nursing log on a weekly basis.

Inmates may request HIV testing at any time and it is also offered to inmates just before release from incarceration. Inmates who are infected with HIV are managed as part of the chronic clinic program with oversight from UIC. Hepatitis C (HCV) disease is also managed via the chronic care clinic, with their work up and treatment directed by UIC.

Radiology Service

First Court Expert Findings

The First Court Expert's report did not include any findings about the radiology equipment or services.

Current Findings

- The Illinois Emergency Management Agency (IEMA) radiation safety inspections and reports for the radiology units at DCC are current. The active x-ray equipment at DCC was found to be in compliance with the Radiation Protection Act of 1990.
- The access to plain film x-rays at DCC is acceptable.
- The turnaround time for radiologist readings and return of the reports is good.

¹¹⁴ Infection Control Patient #1.

¹¹⁵ Infection Control Patient #2.

- The system decision not to have the x-ray technician wear radiation exposure dosimeters may not be in accord with State of Illinois regulations and is definitely not in accord with community practice.

Plain film and fluoroscopy x-ray services are provided Monday-Friday during the daytime hours. A single radiology technician staffs and manages the unit. This technician also assists the management of the optometry clinic, which is located 20 feet from the radiology suite. Studies not provided at DCC are referred to UIC or two local hospitals. Patients requiring emergency x-rays are generally referred to the nearby Katherine Shaw Bethea Hospital (KSB) emergency room.

It was reported that there is not a waiting list for non-urgent onsite x-rays. Most x-rays are reported to be taken within one to two days after receiving the order. Weekend and holiday requests are completed on the next working day. The requests and the radiology log for four patients were reviewed. All four had films taken within one to three days of the request. All of the films were read within 24 hours, with a report faxed to DCC on the day after the reading. The films are read by a local contracted radiologist.

During the Expert's visit the existing and aging plain film radiology unit was removed, and a used but updated non-digital unit was being installed. The radiology technician has a work space inside the entrance to the radiology suite that has a locked door.

Although the Illinois Emergency Management Agency (IEMA) Division of Nuclear Safety, Certificate of X-ray Registration was not posted in the radiology suite, the x-ray technician produced the certificate, the IEMA list of active equipment, and a April 25, 2017 letter from IEMA stating that during the April 18, 2017 radiation safety inspection, that the DCC "radiation producing equipment and operative procedures reviewed by the inspector were in compliance with applicable Illinois radiation protection regulations."¹¹⁶ The x-ray technician produced her current license that is valid through July 31, 2018.

The x-ray technician was noted not to be wearing a radiation exposure dosimeter badge. She stated she had been told by Wexford that the State of Illinois does not require the use of dosimeters. She communicated that she is required to wear separate dosimeters at two different medical facilities in the Rockford area where she works in her off hours.

In summary, the radiology services at DCC have reasonable access and turnaround time of reading and reports. The decision of the system to not provided radiation exposure dosimeter badges is not in accord with community standards and needs to be further reviewed by the IEMA.

The First Court Expert's report did not have any recommendations about the radiology services. We have noted recommendations that are noted at the end of the report.

¹¹⁶ Reference IEMA Division of Nuclear Safety Certificate and Letter.

Dental Program

Dental: Staffing and Credentialing

Methodology: Reviewed staffing documents, interviewed dental and other staff, reviewed the Dental Sick Call Log and other documents.

First Court Expert Findings

- DCC has one full-time dentist, one 14-hour part-time dentist, two full-time assistants, and no dental hygienist, a serious omission. To expect the dentists to provide hygiene and periodontal care to 2300 inmates in addition to their expected dental workload is unrealistic and, in our opinion, cannot be done. It is also a poor use of a dentist's time and resources.
- CPR training is current on all staff, all necessary licensing is on file, and DEA numbers are on file for the dentists.

Current Findings

Dental staffing has not changed materially since the First Court Expert's Report. We agree with the First Court Expert that dental staffing is inadequate and the lack of a dental hygienist is a serious omission.¹¹⁷ Moreover, we identified current and additional findings as follows.

Most dental personnel work 10-hour days (from 6 a.m. to 4 p.m.); however, patients are not treated until count ends, typically after 8 a.m.¹¹⁸ Dentists are paid for two hours (6 a.m. to 8 a.m.) when patients are not available. The clinic has been closed Mondays for about a year, since Dr. O'Brien reduced his time by 10 hours, and Wexford has been unable or unwilling to find a dentist to work Mondays. The dental assistant is present on Mondays, the day there are no dentists present. This is a foolish waste of patient treatment time resources and should be corrected immediately.¹¹⁹

We were told that an IDOC dental assistant position vacated by a retirement two years ago has finally been advertised.¹²⁰ In addition, there is one dental assistant vacancy. The current (Wexford) dental assistant has not had formal dental assisting training and does not take x-rays,

¹¹⁷ Makrides, N. S., Costa, J. N., Hickey, D. J., Woods, P. D., & Bajuscak, R. (2006). Correctional dental services. In M. Puisis (Ed.), Clinical Practice in Correctional Medicine (2nd ed., pp. 556-564). Philadelphia, PA: Mosby Elsevier, p. 557 ("In prisons where routine dental care will be provided, the basic dental team should consist of a dentist, dental assistant, and dental hygienist").

¹¹⁸ Dr. Crisham: Wednesday 6 a.m. to 4 p.m. & Friday 6 a.m. to 10:30 a.m.; Dr. O'Brien: Tuesday, Wednesday & Friday 6 a.m. to 4 p.m.; and Dr. Schmidt: Friday: 6 a.m. to 4 p.m. There are 54.5 hours of dentist coverage Tuesday through Friday, or 1.36 full-time dentist equivalents (FTE). Of the 54.5 dentist hours, 12 (21%) are between 6 a.m. and 8 a.m., a period when patients are not available. This 'dead time' comprises 0.3 FTE, reducing the dentist FTEs available for treatment to 1.06 FTEs

¹¹⁹ While a case can be made for one dental assistant arriving shortly before patient treatment begins to prepare the clinic for patients' arrival, two hours is too much time. Moreover, since the dental assistant leaves at 3:30 p.m., it is unlikely the dentists (whose day ends at 4 p.m.) are treating patients.

¹²⁰ "In need of a dental assistant. It has been vacant since 2016 and it is starting to effect productivity. Backlog numbers are starting to go up again." Dixon Correctional Center Quality Improvement Committee, August QI Meeting Minutes, September 2017, p. 1 (emphasis in original). That the position had not been filled at the time of our visit (April 2018) illustrates the indifference IDOC has shown to the Dixon dental program.

a critical deficiency. CPR is current on all dental staff. Licensure and DEA registration is current for all dentists.

Dental: Facility and Equipment

Methodology: Toured the dental clinic and radiology area to assess cleanliness, infection control procedures, and equipment functionality. Reviewed the quality of x-rays taken at DCC and the reception centers. Reviewed compliance with radiologic health regulations. Observed clinical care.

First Court Expert Findings

- The clinic consists of three chairs and units with adequate free movement around them. Two dental units are two years old and in good repair. The third chair is old, worn, and does not work. There are no plans to repair this chair.
- There is a panoramic unit in the health services x-ray department in a dedicated room. It is old but functions adequately. The x-ray unit in the clinic works well. The autoclave is old but functions well. The compressor is in the basement and works well. The instrumentation is adequate in quantity and quality. The handpieces are old but well-maintained and repaired when necessary.
- The cabinetry is old and showing wear and corrosion and staining on work surfaces, but is functional, although this makes disinfection of surfaces more difficult. The ultrasonic works well.
- There was a separate sterilization area of adequate size and surface workspace. The staff office is large with a single desk. The dental records are maintained in this room. It also houses the dental laboratory with its equipment and workspace. There is adequate room for all. The clinic is adequate in size and function to meet the needs of the inmate population.

Current Findings

Dental facilities and equipment have not changed materially since the First Court Expert's Report and are adequate. While we concur with the First Court Expert, we identified current and additional findings as follows.

The clinic comprises three chairs and units, with adequate free movement around them. Dentists and assistants have adequate room to work unimpeded. Two dental units are in good repair. The third chair is old and has not worked for at least four years.¹²¹ There are no plans to repair this chair. There is no ultrasonic scaler.

The foot pedal controls on three sinks are non-functional and are secured with clear packing tape. According to the dental assistant, a work order was placed approximately one year ago, and she was told that the parts are not available.

¹²¹ The chair will have to be repaired or replaced to accommodate a dental hygienist, who should be hired immediately.

There is an old but functioning panoramic x-ray unit in the health services x-ray department. X-rays are taken by the x-ray technician. The intraoral x-ray unit, autoclave, compressor, and ultrasonic cleaner work well. The instrumentation is adequate in quantity and quality. The handpieces (drills) are old but well-maintained and repaired when necessary. The x-ray units have recently passed inspection by a health physicist.

The dental assistant said that they have not taken bitewing x-rays in months and dentists order panoramic x-rays for biennial exams if they feel the panoramic x-ray taken at the reception center is dated or clinically inadequate.¹²²

Dental: Sanitation, Safety, and Sterilization

Methodology: Reviewed Administrative Directive 04.03.102. Toured the dental clinic and observed dental treatment room disinfection. Interviewed dental staff and observed patient treatment.

First Court Expert Findings

- Adequate surface disinfection using proper disinfectants was performed between patients. Protective covers were used on some surfaces.
- Instruments were properly bagged and sterilized, with handpieces sterilized and in bags.
- The sterilization procedure was flawed because instrument flow was improper, since it did not go from dirty to sterile in a linear fashion.
- The ultrasonic was on the opposite side of the autoclave from the sink. It should flow from ultrasonic to sink to work area to autoclave without crossing its path.
- A biohazard label was not posted in the sterilization area and there was no warning sign where x-rays were being taken to warn of radiation hazards.
- Safety glasses were not always worn by patients.
- The clinic was neat and orderly.

Current Findings

Dental sterilization, safety, and disinfection has not changed materially since the First Court Expert's Report and are adequate. While we concur with the First Court Expert's findings, we identified current and additional findings as follows.

The clinic was neat and clean. Surface disinfection between patients was adequate and instruments were bagged and stored properly. The sterilization procedure was flawed because instrument flow did not go from dirty to sterile in a linear fashion. The ultrasonic cleaner was on the opposite side of the autoclave from the sink. Instruments should flow from ultrasonic to sink to work area to autoclave without crossing the ultrasonic cleaner's path.

A biohazard label was not posted in the sterilization area¹²³ and there was no warning sign where x-rays were being taken to warn of radiation hazards.¹²⁴

¹²² This is highly problematic and will be addressed in the section on comprehensive care.

Neither a stethoscope nor a sphygmomanometer was present. According to the dental assistant, dentists borrow them from nursing when they feel that patients have a problem, and often nurses will come to the clinic to take the blood pressure.

According to the dental assistant, patient eye protection is not used routinely;^{125,126} however, we noted that the dentist suggested a patient wear his own glasses for protection.

Dental: Review Autoclave Log

Methodology: Reviewed the last two years of entries in autoclave log, interviewed dental staff, and toured the sterilization area.

First Court Expert Findings

- Spore testing was performed weekly and was documented, and no negative results were recorded.
- The past three years were reviewed and showed that autoclaving was accomplished weekly and documented.
- They utilize the Maxitest system through Henry Schein. A single negative result was documented, but corrected immediately with a retest, which was negative.

Current Findings

Autoclave log maintenance is unchanged since the First Court Expert's Report and is adequate. We agree with the First Court Expert's findings and note that the sterilization log for the past two years was in order. Testing was performed weekly and documented. No negative results were recorded.

Dental: Comprehensive Care

¹²³ 29 CFR 1901.145(e)(4). "The biological hazard warning shall be used to signify the actual or potential presence of a biohazard and to identify equipment, containers, rooms, materials, experimental animals, or combinations thereof, which contain, or are contaminated with, viable hazardous agents.")

¹²⁴ Occupational Safety and Health Standards – Toxic and Hazardous substances. 29 CFR 1910.1096(e)(3)(i). Each radiation area shall be conspicuously posted with a sign or signs bearing the radiation caution symbol and the words, "CAUTION RADIATION AREA." Emphasis in original.

¹²⁵ Guidelines for Infection Control in Dental Health-Care Settings ---2003. MMWR, December 19, 2003/ 52(RR17):1:16; pp. 17-18. ("PPE [personal protective equipment] is designed to protect the skin and the mucous membranes of the eyes, nose, and mouth of DHCP [dental health care provider] from exposure to blood or OPIM [other potentially infectious materials]. Use of rotary dental and surgical instruments (e.g., handpieces or ultrasonic scalers) and air-water syringes creates a visible spray that contains primarily large-particle droplets of water, saliva, blood, microorganisms, and other debris. This spatter travels only a short distance and settles out quickly, landing on the floor, nearby operatory surfaces, DHCP, or the patient. The spray also might contain certain aerosols (i.e., particles of respirable size, <10 µm). Aerosols can remain airborne for extended periods and can be inhaled" and "Primary PPE used in oral health-care settings includes gloves, surgical masks, **protective eyewear**, face shields, and protective clothing (e.g., gowns and jackets). All PPE should be removed before DHCP leave patient-care areas (13). Reusable PPE (e.g., clinician **or patient protective eyewear** and face shields) [...]"). Emphasis added. Moreover, protective eyewear prevents injury from objects or liquids accidentally dropped by providers.

¹²⁶ Why We Take Infection Control Seriously. UIC College of Dentistry. Viewed at <https://dentistry.uic.edu/patients/dental-infection-control>, viewed February 2, 2018 ("We use personal protective equipment [...] **as well as provide eye protection to patients for all dental procedures.**") Emphasis added.

Comprehensive, or routine care¹²⁷ is non-urgent treatment that should be based on a health history, a thorough intraoral and extraoral examination, a periodontal examination, and a visual and radiographic examination.¹²⁸ A sequenced plan (treatment plan) should be generated that maps out the patient's treatment.

Methodology: Interviewed dental staff, reviewed randomly selected dental charts of an inmates who received non-urgent care based on Dental Reports.

First Court Expert Findings

- A review of 10 records revealed that no comprehensive examination was ever performed, and no treatment plans were developed.
- A periodontal assessment was not done in any of the records and no examination of soft tissues or periodontal assessment was part of the treatment process.
- Hygiene care and prophylaxis were never provided, and oral hygiene instructions were never documented.
- Bitewing or periapical x-rays were never taken to diagnose caries. Restorations were provided from the information from the panoramic radiograph. This radiograph is not diagnostic for caries.
- None of the record entries were time documented.

Current Findings

Comprehensive care has not improved materially since the First Court Expert's Report and remains inadequate. We concur with the First Court Expert's findings; however, we identified current and additional findings as follows.

Of 12 records reviewed, none had a periodontal assessment documented. All but one¹²⁹ had the treatment plan that consisted only of charting dental problems (primarily decay) with no mention of periodontal disease. In fact, the standard instrument pack for an examination contains a mirror and an explorer but lacks a periodontal probe.¹³⁰ Moreover, none of the treatment plans were informed by bitewing x-rays. Of 10 records of patients who received biennial exams, none was informed by a periodontal assessment or bitewing x-rays.^{131,132} None had signed and updated health histories.

¹²⁷ Category III as defined in Administrative Directive 04.03.102.

¹²⁸ Stefanac SJ. Information Gathering and Diagnosis Development. pp. 11-15, *passim*.

¹²⁹ Comprehensive Care patient #9.

¹³⁰ This is consistent with the dental program's indifference to periodontal disease.

¹³¹ While all had panoramic x-rays, it is below accepted professional standards to diagnose caries and periodontal disease with a panoramic x-ray alone. Furthermore, many of the x-rays were inadequate (Biennial Exam Patients #2, 5, 6, 8, 9, and 10).

¹³² Dentate or partially dentate adults who are new patients receive an "[i]ndividualized radiographic exam consisting of posterior bitewings with panoramic exam or posterior bitewings and selected periapical images." Furthermore, recall patients should receive posterior bitewing x-rays every 12 to 36 months based on individualized risk for dental caries. With respect to periodontal disease, "[i]maging may consist of, but is not limited to, selected bitewing and/or periapical images of areas where periodontal disease (other than nonspecific gingivitis) can be demonstrated clinically." Dental Radiographic Examinations: Recommendations for Patient Selection and Limiting Radiation Exposure. American Dental Association and U.S. Food and Drug Administration, 2012. Table 1, pp. 5-6.

Per the dental assistant, the dentists review charts of newly arrived prisoners using the panoramic x-ray taken at the reception center and decide whether to place the prisoner on a treatment list.¹³³ It takes approximately 90 days to be seen for routine care; however, once treatment commences, subsequent appointments are said to occur within a few weeks. Co-pay is not charged when the appointment is generated by the clinic (as opposed to a patient request).

Diagnosis and treatment of periodontal disease is nonexistent. Not only are comprehensive and biennial examinations not informed by periodontal probing and appropriate intraoral x-rays, but oral prophylaxis is not included in the exiguous treatment plans when present.^{134,135} To illustrate the dental program's turning a blind eye to periodontal disease, the daily and monthly treatment logs do not have a category for oral prophylaxis and scaling and root planning, procedures that are essential to prevention and early non-surgical treatment of periodontal disease.¹³⁶

Wait times for extractions, fillings, and dentures were four, eight, and 12 weeks, respectively.¹³⁷ However, since the dental program neither diagnoses nor treats periodontal disease and provides inadequate examinations for caries that are not informed by intraoral x-rays, the amount of dental disease that should be treated is understated substantially, and the wait times and backlogs are artificially deflated.¹³⁸

Dental: Intake (Initial) Examination¹³⁹

Methodology: Reviewed 11 dental records of inmates that have received recent intake (initial) dental examinations and Administrative Directive 04.03.102 (Dental Care for Offenders).

First Court Expert Findings

- Reviewed 10 inmate dental records that were received from the reception centers within the past 60 days to determine if: 1) screening was performed at the reception center and 2) a panoramic x-ray was taken, to insure the reception and classification

¹³³ However, most of the panoramic x-rays taken at the NRC are clinically inadequate and even an adequate x-ray is insufficient to diagnose caries and periodontal disease.

¹³⁴ Stefanac SJ. Information Gathering and Diagnosis Development. A panoramic radiograph has insufficient resolution for diagnosing caries and periodontal disease. Intraoral radiographs (e.g., bitewings) and periodontal probing are necessary (p. 17). Also, Periodontal Screening and Recording (PSR), an early detection system for periodontal disease, advocated by the American Dental Association and the American Academy of Periodontology since 1992, is an accepted professional standard. *Id.*, pp. 12-14. See American Dental Hygiene Association. Standards for Clinical Dental Hygiene Practice Revised 2016. Periodontal probing is also a standard of practice for dental hygiene.

¹³⁵ Makrides et al., p. 560 (Early diagnosis of periodontal disease is important since the disease is often painless and the prevalence of moderate to severe periodontal disease in correctional populations is high and often not associated with pain).

¹³⁶ These procedures can be performed by a dentist or dental hygienist, and a dental practice that does not provide these treatments is operating substantially below accepted professional standards.

¹³⁷ Dixon Correctional Center Quality Improvement Committee Minutes, October 12, 2017, p. 1.

¹³⁸ Providing x-rays for caries, and periodontal diagnosis and treatment consistent with accepted professional standards would require more treatment capacity or the waiting times would increase markedly.

¹³⁹ The First Expert Report describes the examination performed at intake screening as a "Screening Examination;" however, Administrative Directive 04.03.102 describes it as a "complete dental examination." We use the terminology of the Administrative Directive and refer to the intake or Initial Dental Examination as a complete dental examination.

policies as stated in Administrative Directive 04.03.102, section F. 2, are being met for the IDOC.

Current Findings

Dental intake examinations have not changed materially since the First Court Expert's Report and remain inadequate. The First Court Expert focused on the initial examination *process* (i.e., whether the clinic complied with the Directive 04.03.102), while we focused on the *clinical domain* (e.g., quality of the panoramic radiographs). We believe since the Directive 04.03.102 is inadequate, measuring DCC's compliance with it would be unproductive.

Of 11 charts recently received from reception centers, only one panoramic x-ray¹⁴⁰ was of diagnostic quality. Most were washed out, some contained artifacts, and others were improperly aligned. Two were classified IIa for oral surgery.¹⁴¹

Dental: Extractions¹⁴²

Methodology: Interviewed dental personnel and reviewed 11 dental and medical records randomly selected from Daily Dental Reports. In none of the 11 records reviewed was the medical history updated. While some medical history forms had markings (e.g., a vertical line suggesting no medical issues), none had the date last reviewed and the dentist's signature.

All the extractions relied on panoramic x-rays; several¹⁴³ were more than three years old.¹⁴⁴ Consequently, only five x-rays were clinically adequate.¹⁴⁵ Signed consent forms were present in all charts; however, they did not list the reason the tooth was to be extracted. Furthermore, the clinical progress note in one record did not document the reason for the extraction.¹⁴⁶

First Court Expert Findings

- All dental treatment should proceed from a well-documented diagnosis. In none of the 10 records examined was a diagnosis or reason for extraction included as part of the dental record entry.
- In none of the records was a consent form available. When asked, I was told that it was just not a part of the treatment process for surgery at DCC. This is a serious omission and a major violation of a well-established standard of care.

Current Findings

¹⁴⁰ Dental: Intake (Initial) Examination Patient #2.

¹⁴¹ Dental: Intake (Initial) Examination Patient #7: Teeth #3, 13, and 18 were charted IIa for oral surgery but the referral disposition box not marked. Patient #9: Tooth #17 was charted IIa for oral surgery, but referral disposition box not marked. Patient #10: Tooth #19 was charted IIa for oral surgery, but referral disposition box not marked.

¹⁴² The dental assistant said that she requests the medical charts for all scheduled extraction patients.

¹⁴³ Extraction Patients #3, 4, 6, and 7.

¹⁴⁴ The only x-ray that shows the roots of #14 is a panoramic x-ray that has no date or other patient information on the label.

¹⁴⁵ Extraction Patients #1, 2, 9, and 11.

¹⁴⁶ Extraction Patient #5.

We concur with the First Court Expert's findings Expert and note that documentation associated with extractions has improved; however, it remains inadequate. Moreover, we identified current and additional findings as follows.

While the First Court Expert found that the diagnosis of the tooth that was extracted was not documented, and consent forms were not present, we found that all 11 records had signed consent forms and all but one chart¹⁴⁷ documented the reason for the extraction.

In none of the 11 records reviewed was the medical history updated. While some medical history forms had markings (e.g., a vertical line suggesting no medical issues), none had the date of last review and the dentist's signature.

All the extractions relied on panoramic x-rays; several¹⁴⁸ were more than three years old.¹⁴⁹ Consequently, only five x-rays were clinically adequate.¹⁵⁰

Dental: Removable Prosthetics

Methodology: Reviewed eight charts of patients who received partial dentures in the past year selected randomly from the Prosthetics List and interviewed dental staff.

First Court Expert Findings

- In only two of the five records reviewed on patients receiving removable partial dentures were oral hygiene instructions provided.
- Periodontal assessment was not documented in any of the records. In two of the five records a prophylaxis and/or a scaling debridement was provided.
- Because comprehensive examinations and treatment plans were not documented in any of the records, it is almost impossible to ascertain if all necessary care, including operative and/or oral surgery treatment, is completed prior to fabrication of removable partial dentures.

Current Findings

We concur with the First Court Expert and note that removable prosthetics care has not changed materially and remains inadequate. Moreover, we identified current and additional findings as follows.

Of eight patients who received partial dentures, none had a sequenced treatment plan. While the Treatment Needed portion of the chart was marked, there was no date or signature, nor was a treatment sequence indicated. Moreover, none of the treatment was informed by bitewing or periapical x-rays, or periodontal probing. This is not an adequate treatment plan. None had documented oral prophylaxis or oral hygiene instruction.

¹⁴⁷ Extraction Patient #5.

¹⁴⁸ Extraction Patients #3, 4, 6, and 7.

¹⁴⁹ The only x-ray that shows the roots of #14 is a panoramic x-ray that has no date or other patient information on the label.

¹⁵⁰ Extraction Patients #1, 2, 9, and 11.

Dental: Sick Call/Treatment Provision

Methodology: Interviewed dental staff; reviewed Dental Sick Call Logs, Daily Dental Reports, and reviewed records of 10 inmates who were seen on sick call for dental problems randomly selected from Daily Dental Reports and Sick Call Logs.

First Court Expert Findings

- Inmates access dental sick call through either a sick call sign-up process or via the inmate request form. The sick call sign-up takes place in the health services unit every morning. They sign up one day and are seen and evaluated the next day by an RN. The RN then refers the complaint to the dental program and the inmate is scheduled within four to five days.
- Request forms are received from the institution mail, evaluated by the dentist, and scheduled for an examination and evaluation within four to five days.
- No system was in place to attempt to see inmates with urgent care complaints within 24 to 48 hours from the date of the request form. Emergency call-ins from staff are seen the same day.
- In none of the records was the SOAP format used.
- Minimal diagnosis was available for any delivered care. Routine care was not being provided at sick call appointments. The chief complaint, as well as could be determined, was being addressed at sick call.

Current Findings

The dental clinic is now closed on Monday, reducing access to care markedly. We concur with the First Court Expert; however, we note that sick call treatment documentation has improved since the SOAP format is now used consistently. Moreover, we identified current and additional findings as follows.

Inmates seeking dental care place a request in a box in the housing unit, send it through prison mail, or communicate directly with staff. Written requests are screened by nursing and referred to the dental clinic for scheduling, and typically staff communicate directly with dental personnel. Since the clinic is closed on Mondays, patients with urgent care issues may have to wait four or five days to be seen by a dentist.

The SOAP format was used for all sick call entries; however, in none of the 10 charts reviewed was the health history updated. There were several instances where treatment was performed without adequate x-rays or a treatment plan.¹⁵¹

According to the dental assistant, the dentist reviews charts of newly arrived prisoners and, using the panoramic x-ray that is typically taken at the reception and classification center,

¹⁵¹ Sick Call Patient #4: fillings (teeth #18, 19) done without intraoral x-rays or treatment plan. Patient #5 complained of pain in the right side. The dentist concluded there was no decay and treatment was not indicated. However, intraoral x-rays were not taken, and the most recent x-rays were almost three years old. This is insufficient data to base a diagnosis. Patient #7 had a fractured tooth that was scheduled to be filled without recent intraoral x-rays. The most recent x-rays were dated 4/30/10.

decides whether to place the prisoner on a treatment list. It takes approximately 90 days to be seen; however, once treatment commences, subsequent appointments are within a few weeks. Co-pay is not charged when the appointment is generated by the clinic (as opposed to a patient request).

Dental: Orientation Handbook

Methodology: Reviewed Orientation Manual and related documents.

First Court Expert Findings

The Orientation Manual only mentions dental care in relation to co-pays. It describes medical sick call procedures, but no mention is made of dental sick call.

Current Findings

Inmate orientation to dental care has improved since the First Court Expert's Report. The First Court Expert found that the orientation manual did not describe how to access dental care. While there are now two orientation manuals for DCC, one for the General Population and for the Special Treatment Center, neither manual addresses access to dental care. There is, however, an adequate description of how to access health care via sick call.

Dental: Policies and Procedures

Methodology: Reviewed Administrative Directives that deal with the dental program. Interviewed dental staff. Reviewed dental charts. Toured dental clinical areas. Reviewed DCC organizational chart.

First Court Expert Findings

The Policy and Procedures Manual and statements for DCC only paraphrase the Administrative Directives. It includes nothing specific for DCC and the running of the dental program. When asked, the dental director knew little of its existence and had never reviewed it.

Current Findings

Dixon policies and procedures have not changed materially since the First Court Expert's Report. We concur with the findings in the First Court Expert's Report that the Policy and Procedures Manual is inadequate and should be revised. We were provided with institutional directives covering several domains; however, none addressed dental care. There is a binder in the clinic that contains (inter alia) Administrative Directive 04.03.102 (Dental Care for Offenders), blank forms used by the dental program, and an outdated version of the *Illinois Dental Practice Act*. There was an untitled, undated, unsigned policy relating to dentures of uncertain provenance.

Dental: Failed Appointments

Methodology: Reviewed Dental Sick Call log. Interviewed dental staff. Reviewed Daily Dental Reports.

First Court Expert Findings

A review of monthly reports and daily work sheets revealed a failed appointment rate of about 10.4%. All failed appointment inmates are required to sign a refusal form. They are all located and brought to the dental clinic to do so.

Current Findings

Failed appointments have remained unchanged since the First Court Expert's report. We concur with the findings in the First Court Expert's Report and note that failed appointments are not an area of concern at Dixon. Moreover, we identified current and additional findings as follows.

As noted in the First Expert report, inmates who fail to appear for a dental appointment are located and made to sign a refusal form. This is an excellent practice and should be employed by all IDOC dental programs.

Since the failed appointments are not reported to the CQI Committee or noted in the Daily and Monthly Dental Logs, it is difficult to determine retrospectively; however, it appears not to be a substantial problem.

Dental: Medically Compromised Patients

Methodology: Reviewed health history form and records from recent intake exams. Compared the health history in the dental chart to the medical problem list.

First Court Expert Findings

- Because the dental record is maintained in the dental clinic separate from the medical record, identification of medically compromised patients relies on assessment by the clinician and on the history section on the cover of the dental record.
- Of the 10 records reviewed of inmates on anticoagulant therapy, only one was adequately red-flagged to catch the immediate attention of the provider. Four of the records did not indicate that the inmate was on anticoagulant therapy. Five of the records indicated anticoagulant therapy, but they were not sufficiently red-flagged. On one record, treatment was provided and was managed properly.
- When asked, the clinicians indicated that they do not routinely take blood pressures on patients with a history of hypertension.

Current Findings

Health history documentation for medically compromised patients is unchanged from the First Court Expert's Report and we concur that it is inadequate. Moreover, we identified current and additional findings as follows.

Of the 12 records randomly selected of prisoners who were taking insulin or anticoagulant medication who appeared on the Chronic Care Program Report, the relevant medical condition was not noted in the health history in the dental charts of two patients.¹⁵² There was no

¹⁵² Medically Compromised Patients #1 and 11.

documented periodontal assessment and request for follow-up for the diabetics, which is particularly problematic given the relationship between periodontal disease and diabetes.^{153,154} Of the patients on anticoagulant therapy,¹⁵⁵ all but one on anticoagulant therapy had it noted on the health history.¹⁵⁶ Health histories were not filled out or updated at last visit in most charts.¹⁵⁷

Dental: Specialists

Methodology: Interviewed dental staff, reviewed CQI documents, and reviewed dental charts of inmates who were seen by an oral surgeon.

First Court Expert Findings

The dental program utilizes the Joliet Oral and Maxillo-facial Surgery group. This case was the only one sent out in the past nine months. It was a large cyst of the body and ramus of the mandible, a very extensive surgery. All other surgeries, including impactions that require removal, surgical extractions, and lesion removals, are done by the dentists at DCC.

Current Findings

Oral surgery consultations have not changed materially since the First Court Expert's Report. We agree that oral surgery consultations appear to be adequate. We reviewed the charts of two inmates who were referred to the Joliet Oral and Maxillo-facial Surgery group within the past year. Both cases were extensive, and the referral and treatment provided appeared to be appropriate.

Dental: CQI

Methodology: Reviewed CQI minutes and reports. Interviewed dental staff.

First Court Expert Findings

- The dental program contributes monthly statistics to the CQI committee.
- The waiting list for extractions and fillings is eight weeks and for dentures is 12 weeks. These are very reasonable lengths of time. No concern was expressed.
- The dental program recently completed a CQI study that evaluated percentage of required denture adjustments at the time of insertion. The study is under evaluation to see if any changes can be made in the construction or delivery process.
- No other studies are ongoing at the time of this report.

¹⁵³ Patients #1, 2, 3, 4, 5, 10, and 12. None of the records documented that an oral prophylaxis (prophy) was performed.

¹⁵⁴ See, for example, Herring ME and Shah SK. Periodontal Disease and Control of Diabetes Mellitus. *J Am Osteopath Assoc.* 2006; 106:416–421; Patel MH, Kumar JV, Moss ME. Diabetes and Tooth Loss. *JADA* 2013;144(5):478-485 (adults with diabetes are at higher risk of experiencing tooth loss and edentulism than are adults without diabetes); and Teeuw WJ, Gerdes VE, and Loos BG. Effect of Periodontal Treatment on Glycemic Control of Diabetic Patients. *Diabetes Care* 33 :421-427, 2010 (periodontal treatment leads to an improvement of glycemic control in type 2 diabetic patients).

¹⁵⁵ Patient #6, 7, 8, 9, and 11.

¹⁵⁶ Medically Compromised Patient #11.

¹⁵⁷ Medically Compromised Patients #1, 2, 3, 4, 5, 6, 7, 8, 9, and 10.

Current Findings

The Dental CQI program has not improved since the First Court Expert's Report. Since dental peer review records and facility reviews were not available to the First Court Expert, it is difficult to compare our findings except with respect to the number of CQI reports.

Peer Review

We asked to see all peer reviews of dentists working at the eight facilities on our site visit schedule and were informed that dentists (unlike other practitioners) are not routinely peer reviewed. According to Attorney Ramage, speaking for Wexford,¹⁵⁸ neither the IDOC contract¹⁵⁹ nor Wexford policy requires that dentists be peer reviewed.¹⁶⁰ He further stated that "[r]outine peer reviews of dentists are not a mandatory standard of NCCHC,"¹⁶¹ however, he is confuted by the NCCHC, which specifically includes dentist peer reviews in its Clinical Performance Enhancement Standard P-C-02.¹⁶²

Moreover, "Wexford Health has never found a true dentist 'peer review' to be a productive means to determine clinical quality."¹⁶³ Finally, it is Wexford's position that the dentist peer reviews are not a part of the community standard.¹⁶⁴ While clinical peer review is not the community standard for dental care in a private practice environment, it is the community standard for institutional care; that is in the military and Department of Veterans Affairs, and Departments of Corrections that have recently emerged from federal monitoring, for example, California and Ohio.¹⁶⁵

¹⁵⁸ Email from Andrew Ramage to Michael Puisis 3/29/2018.

¹⁵⁹ The contract addresses "physician peer review," which applies to the on-site medical director, staff physicians, nurse practitioners, physician assistants, and psychiatrists; however, dentists and psychologists are excluded. Wexford Contract, ¶2.2.2.19 and ¶7.1.5.

¹⁶⁰ However, Wexford Clinical Performance Enhancement Policy P-403 states, "[a] minimum of one annual 'peer review' [will be performed] whereby a practitioner's clinical performance is evaluated by a senior or supervising practitioner, and, when necessary, senior practitioners are evaluated by regional/corporate staff. [...]" ¶III A3; and "[t]he senior dentist will complete a peer review for each dentist and ensure the completion of the biennial external review for those qualified. The Regional Medical Director will assign a peer reviewer for small contract locations having single or part-time dentists." Wexford Resp. RTP#5, Question 2, p. 0405.

¹⁶¹ Ramage email, *id.*

¹⁶² "In contrast [to an annual performance review], a clinical performance enhancement review focuses only on the quality of the clinical care that is provided. This type of review should be conducted only by another professional of at least equal training in the same general discipline. For example, an RN should evaluate other RNs and LPNs, a physician should review the work of a physician, and **a dentist should review the work of a dentist**; and "[Clinical Performance the standard requires that the facility's direct patient care clinicians and RNs and LPNs are reviewed annually. Direct patient care clinicians are all licensed practitioners who provide medical, dental, and mental health care in the facility. This includes physicians, dentists, midlevel practitioners, and qualified mental health professionals (psychiatrists, psychologists, psychiatric social workers, psychiatric nurses, and others who by virtue of their education, credentials, and experience are permitted by law to evaluate and care for mental health needs of patients). NCCHC recognizes that there are many other professions that have licensed practitioners (e.g., dental hygienists) who may be considered direct patient care clinicians. While it is good practice to include these professionals in the clinical performance enhancement process, technically it is not required by the standard. National Commission on Correctional Health Care, Clinical Performance Enhancement (<https://www.ncchc.org/clinical-performance-enhancement-1>) viewed 3/30/18 (emphasis added).

¹⁶³ Ramage e-mail, *id.*

¹⁶⁴ *Id.*

¹⁶⁵ California Department of Corrections Inmate Dental Services Program. September 2014, ¶ 4.3; Ohio Department of Corrections Policy 68-MED-12, ¶ VI B 3.

We were provided with peer reviews of Drs. Crisham (performed 12/30/15) and O'Brien (performed 1/16/17) and were able to locate five of the 20 charts on which the peer review was based. Our findings were consistent with those of the reviewer; however, several critical elements were absent from the checklist, and were not evaluated. Consequently, many of the fundamental flaws we found in the dental care provided at DCC, such as inadequate treatment plans, failure to use bitewing x-rays to inform caries diagnosis, and failure to diagnose and treat periodontal disease, were undiscovered. Dental peer review ***as implemented by Wexford and countenanced by IDOC*** is poorly designed and is not therefore determinative of clinical quality.

Facility Reviews

We were provided with several facility in which the dental program was deemed to be compliant with the Administrative Directive 04.03.102.¹⁶⁶ However, the Administrative Directive does not address clinical adequacy; so while the findings of the reviews may be useful, they omit the most important domain and provide a false sense of security considering the myriad clinical deficiencies reported by the First Court Expert and confirmed by our inspection.

Internal Monitoring and Quality Improvement

Methodology: Interview facility leadership and staff involved in quality improvement activities. Review CQI Committee meeting minutes, including the Annual Meeting minutes.

First Court Expert Findings

The First Court Expert found that the only data used for purposes of quality improvement were statistics that served no purpose with respect to quality improvement. There was no documented effort to investigate processes of care or professional performance with an intention of improving the program. The Acting CQI Coordinator had no experience in CQI. The First Court Expert described the CQI program as inactive. He also commented that there was a lack of data (specifically tracking logs) that could be used to determine the timeliness of scheduled services.

The First Court Expert recommended that the program needs CQI leadership that has training in quality improvement philosophy and methodology. He recommended that operational processes and professional performance must be studied. Studying grievances in a meaningful way was recommended. The First Court Expert recommended that this program be used to improve every operational process in the medical program. He recommended use of logbooks to track information for use in studying these processes. He recommended retraining the CQI leadership regarding quality improvement philosophy and methodology as well as study design and data collection. He recommended studying outliers in order to develop targeted improvement strategies.

Current Findings

¹⁶⁶ December 2015 to May 2016, and June 2016 to November 2016. While these purport to be semi-annual reviews, we were not provided with reviews for 2017 and do not know whether the dental program was reviewed since November 2016.

While the First Court Expert described the quality improvement program as inactive, we would describe it as nascent. There has been an effort to initiate quality studies and the HCUA has a desire to improve the program. However, because she acts as the HCUA, CQI Coordinator, supervisory nurse, and director of medical records, she is spread thin and has less than necessary time to devote to this task. While there have been some small improvements, the quality improvement program has a considerable way to go.

There is no CQI coordinator. The HCUA has not had any training in CQI. No one at the site had experience in CQI methodology or implementation. The HCUA did have the IDOC CQI manual. This is the first facility to have this document, which is required in the AD on quality improvement.¹⁶⁷ This document was produced in 1992 and has not been modified since then. Despite its age, this document has some valuable information and gives reasonable instruction on how to set up and maintain a quality improvement program. Because this manual is already available it should be used in the CQI effort, but it is not. This manual should be updated. The apparent effort to train staff on CQI methodology appears nonexistent.

The CQI program is not performing all required studies as stipulated in the ADs. Primary source verification is not done except to verify an existing state license. Offsite services are not reviewed with respect to quality or appropriateness as required by the AD. There is no evidence of 100% review of denials of specialty care in CQI minutes.

Monthly CQI meeting minutes contain very little information. Most of the statistical data provided has no bearing on quality improvement. For example, while listing the number of persons seen in NP, physician, and nursing sick call is useful administratively, it gives no measure of the quality of those visits and gives no information as to whether there is a problem with these processes. The same could be said of most of the statistical information provided in this report. We noted in the Infection Control section of this report that needle sticks and blood borne pathogen data is provided but not analyzed. This misses an opportunity to protect employees and reduce unnecessary needle stick injuries.

As with the prior two IDOC facilities we have reviewed, the CQI plan is a generic plan that gives no specific information on the work that the CQI committee will be engaged in for the upcoming year. The short-range goals for the year were to fill vacancies and to develop an orientation program. Long-term goals were generic goals that did not include identification of problem prone areas of service. The CQI plan needs to be a site-specific plan on what the quality improvement program will be engaged in during the upcoming year with respect to improving care.

The 2016 annual CQI report provided to us contained nine medical studies. One study on diabetes care in mental health patients had no methodology and it was not clear what the

¹⁶⁷ AD 04.03.125 Quality Improvement Program page 2 of 10: II.F.1. "The Agency Medical Director shall develop, maintain, and distribute to the facility Health Care Unit Administrators a Quality Improvement Manual. The Health Care Unit Administrators shall maintain the Quality Improvement Manual locally."

study was measuring. Another study that studied 100 patients referred urgently for specialty care was intended to study how many had consultations completed within two weeks. The data was not included, and the results were therefore not provided.

Of the remaining seven studies, five were outcome studies and two were process studies. Four of the five outcome studies were:

- Two studies of whether x-rays were received back timely from the radiologist.
- A study of whether inmates who received education after evaluation for injury then re-injured themselves.
- A study of whether nurse referrals to providers were seen timely.
- A study of whether inmates with poorly controlled hypertension were improved after a year of routine management.

Two of these were true outcome studies; the other two were not outcome studies. Clinical outcomes are end point measures of health status; for example mortality, hospitalization, an HbA1C level of 7 or less, or normal blood pressure. An outcome study measures the effectiveness of interventions based on the ultimate outcome measure. An example would be to study the effect of colorectal cancer screening on colon cancer mortality or the effect of increasing the interval of chronic clinic visits on obtaining a normal blood pressure.

One of the studies at DCC that was an outcome study assessed whether education had an effect on the outcome of re-injury. This study showed that two of 13 individuals re-injured themselves after education. However, the study did not make any analysis of whether the education had an effect or not. The study drew no conclusions, so it was not clear what the purpose of the study was. Also, we question why this topic was chosen when there are so many other important problems at this facility. The second outcome study looked at 10 individuals who were in poor hypertension control. The study looked at their status after a year of typical management to assess whether their degree of control had improved with typical management. Four patients were improved. Four patients were discharged and two patients refused. There was no comment on this study. The sample was so small that its value is questionable. The remaining “outcome” studies were not outcome studies but were performance measures.

DCC studies were mostly measurements of performance. Performance measurement of typical processes are reasonable ways to study job performance, but these are not CQI outcome or process studies. More important, almost none of these studies looked at clinical outcomes or clinical performance, which remains unstudied.

The CQI program appears to make no effort to evaluate the clinical quality of care. We heard complaints from IDOC custody and IDOC health care leadership about the poor quality of physician care. We agree that physician quality is poor, based on mortality reviews and chart reviews. Yet there was no evidence of the CQI program monitoring for this.

The Wexford peer review program is supposed to be a method of evaluating for clinical quality of care. This program is an episode-of-care based system using a single episode of care to

answer up to 10 or 11 discrete questions to determine whether care was adequately provided. These episodes of care are randomly selected. There was one prior peer review of the former Medical Director and two peer reviews of NPs. Virtually all episodes of care were 100% adequate, which given our chart reviews does not accurately reflect what we would consider the status of quality of provider care at this facility.

The medical record documents that are used for these peer reviews are typically not provided. Also, it is not possible to know the context of care when evaluating a single episode of care. In death records that we have reviewed, we noted multiple patients who had considerable weight loss that was not identified, laboratory tests that were recently done that were not reviewed, medical conditions that were not identified or followed up, etc. These problems will not be identified by looking at a single episode of care because the prior orders and problems will not be available for review. We find that using single episodes of care does not work well for this system. Also, because so many physicians have inadequate primary care training, they will not be able to review primary care with a level of expertise that is equivalent to a typical community standard of care. Doctors not trained in primary care are often reviewing other doctors also not trained in primary care. It is not unexpected that few problems are identified.

There is no mortality review at DCC. Monthly and annual CQI minutes list the deaths. A Wexford physician, typically the doctor who cared for the patient, writes a death summary. This is a non-critical summary of events from the perspective of the Medical Director. There is no evidence that anyone is examining deaths to understand if there were quality issues or identified problems that should be addressed to prevent further deaths. Although no one is reviewing deaths in an attempt to prevent further death, we found that of six deaths we reviewed, four were preventable and two were possibly preventable. Details of these deaths are found in the mortality review section of the summary report. The high number of preventable deaths at DCC justifies a robust mortality review process performed by persons not associated with care of the patient.

We found serious problems with clinical medical care at DCC in these reviews, including:

- Multiple episodes of care that failed to follow generally accepted guidelines and multiple episodes of grossly and flagrantly unacceptable care.
- In multiple deaths, each patient lost significant amounts of weight without anyone recognizing that the patient was losing weight. In one of these cases the patient had lost 60 pounds.
- In several patients, significant life-threatening laboratory values were not timely addressed.
- Care for patients with mental health issues was not well coordinated with the mental health staff.
- On multiple occasions, patients who should have been hospitalized or sent to a specialist were not. This underutilization contributed to or resulted in death.

In most cases, these deficiencies related to physician quality; some might have been systemic deficiencies. Untimely specialty care and delayed hospitalization may be a result of inadequate

physician training or barriers to use of these services by the vendor. The doctors who cared for the patient should not be documenting a death summary. Because they cared for the patient, they have a conflict in reviewing their own care and may be unlikely to find problems when problems exist. For that reason and under these circumstances, mortality review should be conducted by either the Office of Health Services or an external reviewer. The vendor should not be permitted to perform the only mortality review on their own services.

Recommendations

Leadership, Staffing, and Custody Functions

First Court Expert Recommendations

1. The First Court Expert recommended to make a priority of filling the vacant Medical Director, Health Care Unit Administrator, Director of Nursing, Nurse Practitioner, and seven Correctional Nurse I (RN) positions. *We agree with this. The Medical Director and Health Care Unit Administrator, Director of Nursing, and Nurse Practitioner positions have been filled. However, two nurse supervisor positions, the Director of Medical Records, staff physician, and multiple nursing positions are now vacant. All positions need to be filled. It is critical to fill supervisory positions, but that does not mean that staff positions can remain vacant. A vacancy rate of 23% is unacceptable.*
2. The First Court Expert's recommendation was as follows. Due to concerns regarding non-registered nurses conducting sick call and working outside of their educational preparation and licensed scope of practice, and when all the Correctional Nurse I positions are filled, total registered nursing positions should be evaluated as to the need for additional positions or a reconfiguring of current positions in order to provide an "all RN" conducted sick call process. *We agree with this recommendation, but believe that the nurse staffing, particularly on the infirmary and geriatric units, and the physician budgeted staffing are deficient. For this reason, it is our recommendation to perform a staffing analysis based on the existing service requirements of the program. Staffing should be augmented based on that analysis. The analysis should be based on policy requirements and clinical care requirements of the program.*

Additional Recommendations

3. Physicians receiving privileges to practice primary care at this facility must have completed residency in a primary care program. This needs to be inserted in the contract obligations of the vendor.
4. The IDOC contract needs to require that vendor health care managers have training in a health discipline appropriate for their management responsibilities.
5. The current vendor is unable to provide physicians of sufficient training and in sufficient numbers. The IDOC needs to explore alternate avenues to fill physician spots with qualified physicians.
6. This facility needs infection control and quality improvement positions.

Clinic Space

First Court Expert Recommendations

1. Develop and implement a plan to replace the style of beds being used for geriatric patients on the third floor of the medical building.
2. Properly equip designated sick call rooms in the health care unit and X-house.

We agree with these recommendations.

Additional Recommendations

3. All medical equipment must be inspected, calibrated, and tagged no less than annually by a qualified bioengineering team.
4. Each room used for nurse sick call should be on the first floor of the medical building.
5. Each room must have its own exam table and be properly equipped. The use of two exam tables in the same open room is to be discontinued.
6. Both elevators must be operational at all times.
7. All the beds in the infirmary must be hospital beds with adjustable heights and sections.
8. At least one electrically adjustable hospital bed should be available in the infirmary.
9. The metal beds in the geriatric unit need to be replaced with beds that are safe, can be readily sanitized, and meet the needs of the geriatric population.
10. Additional shower chairs need to be provided in the patient housing areas of the medical building. Existing shower chairs with torn upholstery need to be repaired or replaced.
11. The cracked and missing floor tiles noted throughout the entire medical building are safety hazards for both patient-inmates and medical and correctional staff, and should be expeditiously repaired, replaced, and maintained.
12. The environmental rounds and the deficiencies noted in the monthly Medical Safety and Sanitation Report should be expanded to include the condition of the patient beds, the functionality of the negative pressure infirmary room, the compliance with annual inspection of medical devices, and other clinical space and equipment findings.

Sanitation

First Court Expert Recommendations

The First Court Expert had no recommendations

Additional Recommendations

1. Safety and sanitation inspections need to include all areas of clinical space including infirmary beds, ADA units, the geriatric floor, annual inspection of clinical equipment and devices, and all other clinical areas.
2. Maintenance needs to be done to replace missing tiles, rusted vents, cracked walls, and peeling paint.

Medical Records

First Court Expert Recommendations

1. Medical records staff should track receipt of all outside reports and ensure that they are filed timely in the health record. *We agree with this recommendation. This presumes that outside reports are all obtained. We strongly recommend that all outside reports be obtained timely and filed within timeframes required by the IDOC Administrative Directive.*

2. Charts should be thinned regularly, and MARs filed timely. *We agree with this recommendation if a paper record continues to be used.*
3. Problem lists should be kept up to date. *We agree with this recommendation.*

Additional Recommendations

4. An electronic medical record needs to be implemented in the IDOC. The difficulty in maintaining and finding paper documents in this system is a systemic barrier to care.
5. If a paper record continues to be used, thinning charts should include carrying forward key diagnostic studies and consultant reports that are important to track the status of the patient's conditions.

Reception Processing and Intrasystem Transfer

The previous Court Expert's recommendation has been achieved. All newly transferred inmates are brought to the dispensary and screened upon arrival to identify immediate medical needs and reconcile prescribed medications so that treatment can be continued. The next day, these inmates are seen again by nurses who complete an in-depth interview, review the medical record, and initiate the plan of care.¹⁶⁸

Current Recommendations

1. We recommend that health care leadership establish a process to monitor and provide feedback as part of the CQI program. Errors and omissions should be subject to focused study to improve the accuracy of transfer information and continuity of patient care.
2. Written directives of IDOC and Wexford be revised to add responsibility for the sending IDOC facility to accurately complete the Health Status Summary in advance of inmate transfer.¹⁶⁹
3. When facilities send inaccurate or incomplete information on the intrasystem transfer form they should hear about the mistake from the receiving facility.

Nursing Sick Call

First Court Expert Recommendations

1. Develop and implement a procedure for one style of sick call. *This recommendation has been implemented at DCC.*
2. Develop and implement a plan for an "all RN" sick call process. *We agree with this recommendation.*
3. Develop and implement a plan to assure non-medical personnel do not have access to inmate sick call requests. *This recommendation has been implemented at DCC.*
4. Develop and implement a plan to maintain inmate sick call requests on file. *We agree with this recommendation.*

¹⁶⁸ Lippert Report DCC p. 42.

¹⁶⁹ Documents to be revised include the IDOC-Wexford contract, Wexford Policy and Procedure P-118 Transfer Screening, and DCC HCU Policies and Procedure P-118 Transfer Screening.

5. Develop and implement a plan to initiate and maintain a sick call log. *This recommendation has been implemented at DCC.*
6. In the X-House, develop and implement a plan to conduct a legitimate sick call encounter, including listening to the patient complaint, collecting a history and objective data, performing a physical examination when required, making an assessment, and formulating a plan of treatment, rather than the current practice of talking to the patient through a solid steel door and basing treatment on the conversation only. *This recommendation has been implemented at DCC, but the medical record is still not available to the nurse to refer to during the sick call encounter. This must be corrected.*
7. Per Office of Health Service policy, assure sick call encounters are documented in the medical record in the Subjective-Objective-Assessment-Plan (SOAP) style. *We agree with this recommendation and found practices more consistent with this recommendation.*
8. Develop and implement a plan to assure the Office of Health Services' approved, preprinted treatment protocol forms are used at each sick call encounter. *We agree with this recommendation and found practices more consistent with this recommendation.*
9. Develop and implement a plan to ensure each of a patient's complaints are addressed during a sick call encounter, or a prioritization of needs to address future encounters is developed, rather than the current practice of allowing only one complaint per visit. *We agree with this recommendation and did not find any instances of patients being limited to only one complaint per encounter.*
10. Develop and implement a plan of education for all nursing staff which will be conducted by the Medical Director and addresses the following issues:
 - a. Assure the patient's complaint is addressed at the time of the sick call encounter.
 - b. Assure documentation is complete and, at a minimum, addresses the complaint, duration, history, pain level if applicable, location of pain, location of injury, etc., and collection of complete vital signs including weight, an examination if applicable, and an assessment and plan.
 - c. Use of the Office of Health Services approved treatment protocols at each sick call encounter.
 - d. When using the protocol, staff must comply with the OTC dosages, as increasing the strength or frequency may take the OTC dosage to an unauthorized prescription dosage.

*We found that there is still significant room for improvement in the quality of nursing sick call. We agree that sick call encounters should include elements a–d above. We do not agree that training conducted by the Medical Director is necessary to accomplish this level of performance. We recommend instead a trended analysis of specific areas that are problematic and a system review of process to identify structural or other barriers to desired performance.*¹⁷⁰

¹⁷⁰ For example, are nurses distracted or rushed during sick call encounters? Do they have all of the equipment and supplies necessary to perform the work? Are the Treatment Protocols clear in guiding the nursing assessment and treatment plan?

11. The nursing department must implement a sick call logbook with fields including date, patient name, patient number, reason for visit, date of clinician appointment, and if cancelled, reason for cancellation and date for the rescheduled appointment. *A sick call log has been implemented. However, the problem of providers seeing patients timely when referred from nursing sick call still exists. Providers also failed to follow up at intended intervals and treatment orders were not carried out. We recommend filling vacant provider positions with qualified practitioners and adding physician positions as described in the recommendations under the heading Leadership, Staffing and Custody Functions.*

Additional Recommendations

12. The quality of nursing assessments and the plan of care should be monitored by nursing service as part of the peer review or quality improvement. This should replace Medical Director review.
13. Rooms used for nursing sick call should each have an exam table, equipment, and supplies to conduct a thorough physical assessment without having to move the patient or share equipment.
14. Medical records must be available when the nurse sees patients housed in X-House. This is one example of the benefit of having an electronic health record.
15. The sick call documentation forms should be revised to indicate if the referral is emergent, urgent, or routine. The indicated urgency should be used to schedule provider appointments.
16. Providers should see patients timely according to the urgency of the referral.¹⁷¹
17. Revise HCU Policy and Procedure P-103 so that patients in segregation are seen by providers according to the urgency of the referral rather than holding clinic on a single day of the week.
18. Require nurses to assess patients who request sick call for dental pain according to an IDOC Nursing Treatment Protocol.
19. Revise the IDOC Nursing Treatment Protocol for Toothache/Dental Complaints to clarify expectations regarding dental pain, particularly the assessment, factors in determining the urgency of referral, the timeframe to see the dentist, and options to treat pain until seen by a dentist. We suggest accomplishing this by developing separate protocols for dental infection, dental trauma, and dental pain.

Chronic Care

First Court Expert Recommendations

1. There should be a single nurse assigned to the chronic care program to identify, enroll, monitor, and track patients in an organized and comprehensive way.

¹⁷¹ Emergent referrals should be seen immediately, urgent referrals should be seen the same day, and routine referrals seen within 72 hours.

2. Patients with HIV should be enrolled and monitored in the chronic disease program. There should be a system in place to identify medication noncompliance (or other missed doses) and refer those patients to a provider timely.

We agree with these recommendations.

Additional Recommendations

3. Problem lists in the medical record must be complete and accurate.
4. The care of chronic illnesses must be in accord with national standards of care and the Office of Health Services Chronic Illness Treatment Guidelines.
5. Age-based routine health maintenance, including cancer screening and immunizations for patients with and without medical conditions, must be provided in accord with the United States Preventive Services Task Force (USPSTF) guidelines and other national standards of care.
6. Chronic care visits must address *at every visit* all interrelated medical conditions that impact on the treatment, control, and outcomes of that clinic's specific disease. Strictly focusing on a single specific disease and not addressing other associated clinical problems is not in the best interest of the patient and delays needed interventions.
7. The chronic care providers must regularly document the review of the MAR, the CBGs, nursing and provider sick call notes, and blood pressure readings when they see patients in the disease-specific chronic care clinics.
8. Nursing or quality improvement staff should do monthly medication compliance audits on all patient with HIV, diabetes, chronic anticoagulation, seizure disorders, and other chronic illnesses as needed. The results should be communicated to the providers and to the QIC.
9. The IDOC should develop a plan to shift anticoagulation treatments from Vitamin K antagonists (warfarin) to newer types of anticoagulants that do not require frequent ongoing lab testing to determine the adequacy of anticoagulation. The frequent lab testing and medication adjustments are logistically complicated and put patient-inmates at risk for poor outcomes. Utilizing newer anticoagulation medications that do not require frequent ongoing measurement of the level of anticoagulation should be strongly considered by the IDOC.
10. Patients with selected chronic illnesses including diabetes, hypertension, and hyperlipidemia should have the 10-year cardiovascular risk calculated to determine if they require a HMG CoA-reductase inhibitor (statin drug) at a proper dosage to minimize the risk of myocardial infarction, stroke, and other cardiovascular diseases.
11. Providers should be provided with access to electronic medical references and/or cell phones with internet capability that would allow clinical staff to readily access updated clinical information in their offices and in all clinical service areas. This is the standard of care in the community.
12. DCC and IDOC must establish a process to monitor the status of high-risk patients who refuse chronic clinic appointments during the interval between chronic care clinics. The current practice of not rescheduling chronic care patients who refuse to attend their scheduled appointment until the next chronic care clinic, which may be as long as six

months later, is not in the best interests of the patient or the institution. These patients should be promptly rescheduled based on the urgency of their medical condition.

13. Providers must document any modification of warfarin dosage and the INR result in the patient's progress notes, chronic care notes, or a warfarin log. The current practice of documenting changes in warfarin doses on the INR lab form is a barrier to continuity of care and the communication of this vital clinical decision.
14. Providers must consistently document key clinical information, the performance of indicated examinations, the rationale for clinical decisions and therapy modifications, and any modifications of the treatment plan in the chronic care progress notes.
15. DCC must develop a process to ensure that all patients 50 years of age or older are screened for colon cancer and men 65 years of age or older with a history of tobacco use are screened for abdominal aortic aneurysm (AAA).
16. Uncontrolled Chronic illnesses with problems that appear to be beyond the expertise of the DCC providers are to be referred for specialty consultation.

Urgent/Emergent Care

First Court Expert Recommendations

1. A log book be maintained that contains fields for date, time, patient name, patient number, presenting symptom, where the assessment was performed, and the disposition, including if the patient was returned to the cellhouse or sent offsite. *We agree with the previous Court Expert and found that such a log is maintained when inmates are sent to the Emergency Department. All onsite emergency response incident reports and critiques are maintained in a binder kept on site and reviewed in the monthly CQI meetings.*
2. When patients are sent offsite, a staff person be assigned responsibility to obtain either the emergency room report or, if the patient was admitted to the hospital, the discharge summary. *We agree with this recommendation.*
3. All patients sent offsite should be brought to the clinic for a nurse to review the relevant documents and ensure the required documents, if not available, are obtained (see recommendation #2) and the patient is scheduled for a follow-up visit with a primary care clinician. *We agree with this recommendation and recommend, in addition, that the follow-up visit be scheduled the next working day.*
4. At the primary care clinician visit, the clinician must document a discussion of the findings and plan. *We agree with this recommendation.*

Additional Recommendations

5. Determine if the Health Care Unit is to maintain a trauma bag for mass casualty disaster as specified in DCC ID #04.03.108.
6. Add the expiration dates of medications and solutions kept in the emergency response bags to the equipment checklist to identify products nearing expiration so that they can be replaced.
7. Revise DCC ID #04.03.108 to reduce the number of mass casualty drills required. It should conform to the HCU Policy and Procedure P-112.

8. A corrective action or improvement plan should be developed based upon the critique of the annual mass casualty drill. Implementation of the plan should be monitored by the CQI Program.
9. The process or persons assigned to critique emergency responses should be revised to provide meaningful feedback on strengths and weaknesses. This feedback should be reviewed by CQI for trends and areas identified for correction or improvement.
10. All emergency room visits should be reviewed with regard to timeliness, appropriateness of preceding care, accuracy of information in the health record, and continuity of care upon release back to the facility. This should be done by clinical leadership and the QI program.
11. Sentinel events resulting in hospitalization should be monitored by the Office of Health Services to ensure that quality of care is practiced and that the sentinel event was not preventable.¹⁷²
12. Potentially preventable hospitalizations should be monitored by the Office of Health Services to ensure that quality of care is practiced.

Specialty Consultations

First Court Expert Recommendations

1. The delays in obtaining scheduled offsite services must be eliminated. Wexford must be required, within seven days after verbal approval, to have provided authorization to the UIC coordinator. If the UIC is assigning an appointment date greater than 30 days in the future, an effort must be made to obtain the service locally. After the service has been provided, the patient should be returned through the medical clinic and a nurse should review the paperwork or take steps to obtain it. After the paperwork is obtained, the patient must be scheduled for a follow-up visit with the primary care clinician, who must document the discussion of findings and plan. *We agree with this recommendation. However, certain adjustments should be made for those follow-up appointments that are requested for periods longer than 30 days (for example, when a consultant recommends a six month follow up).*

Additional Recommendations

2. Given the existing problems with the Wexford system of obtaining offsite care, it should be abandoned. Patients are being harmed. Until a system is put in place that protects patients, all referrals by providers should be scheduled without utilization review.
3. Senior management from Wexford or IDOC needs to obtain medical records from consultants and hospitals on a timely basis.

Infirmiry Care

First Court Expert Recommendations

¹⁷² A sentinel event is any unanticipated event in a health care setting resulting in death or serious physical injury to a patient not related to the natural course of the patient's disease.

1. Staff the infirmary with a registered nurse 24 hours a day, seven days a week.
2. Educate nursing staff on the need for complete charting, which includes providing a thorough description of a patient's medical condition.
3. Develop and implement a plan to provide an accessible nurse call system for patients who are physically unable to access the current call system and provide for a credible system for those patient rooms with no nurse call system.
4. Establish minimum inventory levels for bedding, linens, and pillows and provide acceptable items which are not torn, threadbare, or frayed.
5. Provide a permanent manned security post within the infirmary.
6. Develop and implement a plan to obtain needed additional equipment as determined by the Medical Director, Health Care Unit Administrator, Director of Nursing, and a nursing staff representative who is routinely assigned to the infirmary.
7. Develop and implement a plan to provide additional institutional radios to the infirmary nursing staff.

We agree with these recommendations.

Additional Recommendations

8. Provider infirmary admission notes and progress notes should be performed in accord with the timeframes detailed in IDOC policy 04.03.120, Offender Infirmary Services.
9. Provider notes must communicate the rationale for modifications in treatment; list reasonable differential diagnoses; document pertinent histories, physical findings, and symptoms; record clear treatment plans; and write regular comprehensive progress notes that update the status of each and every acute and chronic illness.
10. All Infirmary beds must be functional hospital beds with the capability to adjust the height, head, and foot of the bed, and have operational safety railings. Non-functional infirmary beds put the safety of patient-inmates and staff at risk. At least one electrical bed should be available for use in the infirmary.
11. Physical therapy services must be provided in the infirmary for those patients who cannot be readily moved to the physical therapy treatment room on the first floor of the medical building.
12. Patients whose clinical needs and support of their activities of daily living exceed the capability of the DCC infirmary must be transferred to a licensed skilled nursing facility either in the IDOC or in the community.
13. Given the numbers of elderly patients and the skilled nursing needs that are not now provided, the IDOC should perform a statewide analysis of its geriatric needs and develop a plan that ensures safe housing in an appropriate level of care for this population. Based on a review of this facility it appears that IDOC needs a new skilled nursing unit. But this effort should not be undertaken before an analysis of the need is completed.

Pharmacy and Medication Administration

The First Court Appointed Expert made no recommendations concerning pharmacy and medication administration.

Current Recommendations

1. Adopt a computerized provider order entry (CPOE) program to eliminate handwritten orders. Replace handwritten transcription of orders to the MAR with printed labels after the pharmacy has reviewed and verified the order. Medications which must be started urgently may be transcribed in handwriting onto the MAR. When the label arrives, it should be affixed to a new line on the MAR and documentation continued on the new line.
2. Evaluate continuity of care with respect to prescription medication for chronic illness.¹⁷³ Included in this review should be whether there is a progress note written to correspond with the order describing rationale and plan of care regarding prescription medication. The results of these reviews should be reported and analyzed in CQI. The Regional Medical Directors need to review these CQI efforts and provide coaching and feedback to the providers.
3. Order implementation should take place within 24 hours. Adopting CPOE eliminates delays in treatment resulting from not transcribing orders timely.
4. Medication should be administered in patient specific, unit dose packaging. The practice of pre-pouring should be eliminated in GP and STC, as well as the multiuse envelopes in STC.
5. The MAR should be used by the nurse to verify that the medication, dose, and route of administration is correct immediately before giving the medication to the patient. The nurse should have the MAR available to answer any questions or concerns the patient has about the medication.
6. Medication should be documented on the MAR at the time it is administered.
7. Printed labels should be provided to place on the MAR when a new order is dispensed. Orders should not be handwritten on the MAR unless it is a medication to be given immediately.
8. A system for timely renewal of chronic disease and other essential medications should be developed.
9. Nurses should refer any patient who does not receive three consecutive doses of medication critical in managing a chronic disease (insulin, Plavix, factor H, HIV medication, antirejection medications, etc.) to the treating provider. The treating provider should meet with the patient and determine if treatment can be modified to improve adherence.
10. Patient adherence with KOP medications prescribed to treat chronic disease should be monitored at regular intervals (monthly by nursing and by the provider at each chronic disease visit).
11. Revise the policy and procedure for medication administration to provide sufficient operational guidance to administer medications in accordance with accepted standards of nursing practice.
12. The CQI program should develop, implement, and monitor quality indicators related to pharmacy services and medication administration.

¹⁷³ National Commission on Correctional Health Care (2014) Standards for Health Services in Prisons. E-12 Continuity and Coordination of Care During Incarceration. p. 93.

13. Root cause analysis and corrective action plans should be used to target the causes of performance that is below expectations. Corrective action should consider system improvements such as computerized provider order entry, use of bar coding, patient specific unit dose packaging, EMAR, etc., to support desired performance.

Infection Control

First Court Expert Recommendations

1. Develop a position description and name an Infection Control Registered Nurse (IC-RN). *We agree with this recommendation.*
2. Develop and implement a plan for the IC-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). *We agree with this recommendation.*
3. Develop and implement a plan for the IC-RN to monitor food handler examinations and clearance for staff and inmates. *We do not agree with this recommendation. A medical examination of persons to work as a food handler is not necessary because it only represents that individual's condition on the day of the exam and is not predictive of future illness or disease that would contradict working as a food handler. Instead, we recommend that staff and inmates working in food service be trained and pass an examination on proper food handling techniques, sanitation procedures, and what health conditions need to be reported to the food services supervisor.*
4. Develop and implement a plan for the IC-RN to monitor compliance with initial and annual tuberculosis screening, with monthly reporting to the QIC and facility administration as needed. *We agree with this recommendation.*
5. Develop and implement a plan to aggressively monitor skin infections and boils, and work jointly with security and maintenance staff regarding cellhouse cleaning practices, with monthly reporting to the QIC and facility administration as needed. *This recommendation has been accomplished with regard to MRSA infection. Reporting and surveillance should be expanded to include skin infections in addition to MRSA.*
6. Develop and implement a plan to daily monitor and document negative air pressure readings when the room(s) are occupied for respiratory isolation, and weekly when not occupied. *This recommendation has been accomplished. However, the room air exchange monitor does not work, and parts are no longer available. Staff use the tissue test to monitor air flow. An HVAC expert should evaluate negative airflow in the room annually.*
7. Develop and implement a training program for healthcare unit porters which includes training on blood-borne pathogens; infectious and communicable diseases; bodily fluid clean-up; and proper cleaning and sanitizing of infirmary rooms, beds, furniture, toilets, and showers. *This recommendation has been partially accomplished. Apparently, training has been developed, but porters are assigned work before this training is completed. We agree that porters should be trained and vaccinated before being assigned work in the infirmary.*

8. Monitor all sick call areas to assure 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. *We agree with this recommendation.*
9. Develop and implement a plan to monthly monitor all patient care associated furniture, including infirmiry mattresses, to assure the integrity of the protective outer surface, with the ability to take the furniture out of service and have repaired or replaced as needed. *We agree with this recommendation. Safety and sanitation inspections take place monthly, but items that need to be repaired or replaced are not taken out of service.*
10. Interface with the County Department of Health and Illinois Department of Health and provide reporting as required by each department. *This recommendation has been accomplished.*

Additional Recommendations

11. Infections and communicable disease data should be analyzed and discussed as part of the monthly and the annual CQI meetings. This should include discussion of trends, updates from the CDC, and review of practices. For example, employee exposures to blood borne pathogens, such as the needlestick injuries in 2017, should be analyzed by CQI with consideration of alternate systems, products, and methods to reduce potential injury.
12. Track and report skin infections due to all pathogens, not just MRSA, including infestations with scabies or body lice.
13. Update the IDOC Infection Control Manual now and at least every two years.
14. Airborne Infection Isolation (AII) rooms need to be regularly serviced, inspected by knowledgeable individuals, and monitored regularly. The maintenance of adequate air changes and pressure should be documented on a log specifically as part of the infection control program.
15. The cracked and missing floor tiles noted throughout the entire medical building interfere with the proper cleaning and sanitation and create infection control hazards for both patient-inmates and medical and correctional staff and should be expeditiously repaired, replaced, and maintained.

Radiology Service

No recommendations.

Dental Program

Dental: Staffing and Credentialing

First Court Expert Recommendations

1. Hire a dental hygienist immediately. We agree with this and specify that the dental hygienist should be full-time. *We agree with this recommendation.*

Additional Recommendations

2. Dentist staffing should be increased to 2.0 FTEs.
3. Dental assistant staffing should be increased to 2.5 FTEs.
4. All dental assistants should be qualified to take intraoral x-rays.
5. The clinic should be open for patient treatment five days per week.
6. Dentists' hours should coincide with patient availability.
7. Dentist and dental assistant schedules should be coordinated so that dentists are not treating patients when an assistant is not available.

Dental: Facility and Equipment

First Court Expert Recommendations

1. Repair or replace the chair and unit that is not working. *We agree with this recommendation.*

Additional Recommendations

2. Purchase an ultrasonic scaler.
3. Repair the faulty foot pedal controls on all sinks. If repair is not feasible, the sinks should be replaced.

Dental: Sanitation, Safety, and Sterilization

First Court Expert Recommendations

1. Sterilization flow to the autoclave should be from dirty to sterile in a linear fashion; from ultrasonic to sink to work area to autoclave.
2. Safety glasses should be provided to patients while they are being treated.
3. That a biohazard warning sign be posted in the sterilization area.
4. A warning sign should be posted in the x-ray area to warn pregnant females of radiation hazards.

We agree with these recommendations.

Additional Recommendations

5. The clinic should obtain a stethoscope and a sphygmomanometer.

Dental: Review Autoclave Log

First Court Expert Recommendations: None.

Additional Recommendations: None.

Dental: Comprehensive Care

First Court Expert Recommendations

1. Comprehensive “routine” care should be provided only from a well-developed and documented treatment plan.
2. The treatment plan should be developed from a thorough, well documented intra and extra-oral examination, to include a periodontal assessment and detailed examination of all soft tissues.
3. In all cases, that appropriate bitewing or periapical x-rays be taken to diagnose caries.
4. Hygiene care should be provided and documented as part of the treatment process.
5. Care should be provided sequentially, beginning with hygiene services and dental prophylaxis.
6. All record entries should include date and time.

We agree with these recommendations.

Additional Recommendations

7. The health history should be updated and signed at all biennial exams.
8. A periodontal probe should be added to a mirror and explorer in all examination packs.
9. All prisoners who arrive from a reception center should receive a comprehensive exam within 30 days.
10. The daily and monthly log forms should be amended to include oral prophylaxis and scaling and root planing.

Dental: Intake (Initial) Examination

First Court Expert Recommendations

Although no recommendations were made, the First Court Experts did not review the quality of the panoramic x-rays or the disposition of potential urgent care issues noted at intake.

Additional Recommendations: None.¹⁷⁴

Dental: Extractions

First Court Expert Recommendations

1. A diagnosis or a reason for the extraction be included as part of the record entry. This is best accomplished through the use of the SOAP note format, especially for sick call entries. It would provide much detail that is lacking in most dental entries observed.
2. A consent form be developed and signed by the patient and the dentist. That the procedure and any potential complications be well explained to the patient. While all records contained signed consent forms, we recommend that the consent forms specify the reason for the extraction.

We agree with these recommendations.

Additional Recommendations:

3. The health history should be updated before a tooth is extracted.
4. Teeth should not be extracted without clinically adequate x-rays.

¹⁷⁴ We address the inadequacy of the panoramic x-rays in the NRC report.

Dental: Removable Prosthetics

First Court Expert Recommendations

1. A comprehensive examination and well-developed and documented treatment plan, including bitewing and/or periapical radiographs and periodontal assessment, precede all comprehensive dental care, including removable prosthodontics.
2. Periodontal assessment and treatment should be part of the treatment process and that the periodontium should be stable before proceeding with impressions.
3. That all operative dentistry and oral surgery as documented in the treatment plan be completed before proceeding with impressions.

We agree with these recommendations.

Additional Recommendations: None.

Dental: Sick Call/Treatment Provision

First Court Expert Recommendations.

1. Implement the use of the SOAP format for sick call entries. It will assure that the inmate's chief complaint is recorded and addressed, and a thorough focused examination and diagnosis precedes all treatment. *We note that all the sick call records we reviewed used the SOAP format.*
2. Daily dental sick call should be seen and evaluated by the dentist, rather than through the medical program. *We do not agree with this recommendation. Instead, we recommend that nurses triage all requests for dental care. Non-urgent requests (cleaning, routine exams, fillings, etc.) should be sent to the dental clinic for scheduling. All other dental complaints should be assessed at nursing sick call, treated for pain as needed, and referred to the dentist based upon clinician urgency.*
3. Requests from inmates with urgent care complaints should be scheduled for the next work day from receipt of the nursing referral from sick call. *We agree with this recommendation.*
4. Efforts should be made to see urgent care complaints via the request form in a timelier manner. They could easily be scheduled for the next day. Sick call sign-ups are seen the following day by RNs who have pain medication protocols available. Dental sick call signups should be scheduled directly by dental for the following day, rather than by the RN who then refers them to dental. *We do not agree that urgent complaints should be scheduled directly by the dental service. Only requests for routine (non-urgent) care should be scheduled by the dental service.*

Additional Recommendations

5. RNs should perform face-to-face examinations on patients with complaints that suggest pain or infection and refer or palliate per protocol. Nurses should refer patients to the dentist according to criteria for urgency established in the treatment protocol.
6. The health history should be updated at each clinical encounter.

Dental: Orientation Handbook

First Court Expert Recommendations

1. Amend the orientation manual to include dental sick call procedures and instructions on how to access routine, urgent and emergency care. *The recommendation is moot since recent revisions adequately address sick call procedures and access to health care.*

Additional Recommendations: None.

Dental: Policies and Procedures

First Court Expert Recommendations

1. The dental program should develop a current detailed, thorough, and accurate policy and procedures manual that define show all aspects of the dental program are to be run, to include access to care, care provision, clinic management, infection control, etc. Once developed, it should be reviewed and updated on a regular basis and as needed for new policies and procedures. *We agree with this recommendation.*

Additional Recommendations

2. The Dental Program Binder should be reviewed and updated.

Dental: Failed Appointments

First Court Expert Recommendations

1. Failed appointment percentages are slightly high and should be watched. We agree with this recommendation.

Additional Recommendations

2. Failed appointment percentages should appear on the Monthly Dental Logs and be reported to the Quality Improvement Committee.

Dental: Medically Compromised Patients

First Court Expert Recommendations

1. The medical history section of the dental record should be kept up to date and that medical conditions that require special precautions be red flagged to catch the immediate attention of the provider. These would include medication allergies, anticoagulants, interferon therapy, pre-medicated cardiac conditions and any other health condition that would require medical intervention prior to dental treatment.
2. That blood pressure readings be routinely taken of patients with a history of hypertension, especially prior to any surgical procedure.

We agree with these recommendations.

Additional Recommendations

3. Diabetics diagnosed with periodontal disease should be offered an oral prophylaxis every six months and non-surgical periodontal treatment (i.e., scaling and root planing) if clinically indicated as part of the chronic care program.

Dental: Specialists

First Court Expert Recommendations

None. Specialists are available and utilized.

Additional Recommendations: None.

Dental: CQI

First Court Expert Recommendations

1. The CQI process should be used extensively to address the program deficiencies outlined in the body of this report. Policies and procedures should be developed from this process to ensure that measures are in place to maintain program continuity and improvement. *We agree with this recommendation.*

Additional Recommendations

2. Annual dentist peer reviews should be implemented immediately.
3. The dentist peer review form should be modified to focus on substantive aspects of clinical care such as diagnosis, treatment planning, the appropriate use of periodontal probing and x-rays, and the treatment of periodontal disease.
4. Facility reviews of the dental program should be performed semi-annually. They should encompass clinical aspects of the dental program and be reviewed by a disinterested dentist.

Internal Monitoring and Quality Improvement

First Court Expert Recommendations

1. This program must be recreated and provided the leadership that has had training in quality improvement philosophy and methodology. The program should focus on both process improvement and professional performance improvement as well as grievance responses. The program must be used to improve intrasystem transfers, both nurse and provider sick call, the chronic care program, infirmary care, unscheduled services care, scheduled offsite services care, medication administration, grievances, infection control, dental services, and mental health services. This program requires the use of logbooks for tracking capabilities for both intrasystem transfers, sick call, infirmary care, chronic care, unscheduled services care, scheduled offsite services, and grievances.
2. The leadership of the continuous quality improvement program must be retrained regarding quality improvement philosophy and methodology, along with study design and data collection.
3. This training should include how to study outliers in order to develop targeted improvement strategies.

We agree with these recommendations.

Additional Recommendations

4. We recommend that the current peer review program of Wexford be revised. The Office of Health Services or outside reviewers should monitor physician performance for sentinel event reviews and mortality reviews. Standardized professional performance evaluations by Wexford should focus on whether the patient's care over a span of time was adequate and resulted in an expected outcome. The professional performance evaluation should be related to privileges granted at re-credentialing.

Appendix A

DCC Staffing as of 4/5/18

Position	Budgeted positions	Vacancies	LOA long-term	Effective vacancies	State or Wexford
Health Care Administrator	1	0	0	0	State
Director of Nursing	1	1	0	1	State
Medical Director	1	0	0	0	Wexford
Medical Record Director	1	1	0	1	State
Physician	1	1	0	1	Wexford
Nurse Practitioner	2	0	0	0	Wexford
Nursing Supervisor	2	1	0	1	State
Nursing Supervisor	1	0	0	0	Wexford
RN	48	10	1	11	State
LPN	10	2	1	3	Wexford
Certified Nurse Assistant	6	1	1	2	Wexford
Pharmacy Tech	1	0	0	0	State
Medication Room Assistants	3	0	0	0	Wexford
Chief Dentist	1	0	0	0	Wexford
Dentist	0.4	0	0	0	Wexford
Dental Assistant	1	1	0	1	State
Dental Assistant	1	0	0	0	Wexford
Office Coordinator	1	0	0	0	State
Health Information Assistant	1	1	0	1	State
Staff Assistants	7	0	0	0	Wexford
Phlebotomist	1	0	0	0	Wexford
Optometrist	0.2	0	0	0	Wexford

Physical Therapist	0.2	0	0	0	Wexford
Physical Therapy Assistant	1	0	0	0	Wexford
Radiology Technician	1	0	0	0	Wexford
	93.8	19	3	22	

*The Director of Nursing will be filled on 4/16/18.

**One of the filled nursing supervisor positions will be vacant beginning 4/16/18.

Logan Correctional Center
2nd Court Appointed Expert Report
Lippert v. Godinez

Visit Date: April 23, 2018 – April 26, 2018

Prepared by the Medical Investigation Team

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Table of Contents

Overview.....	2
Executive Summary	2
Findings.....	6
Leadership, Staffing, and Custody Functions.....	6
Clinic Space, Sanitation, and Support Services	8
Sanitation	15
Medical Reception	16
Nursing Sick Call	18
Medical Records.....	21
Urgent/Emergent Care.....	23
Specialty Consultations.....	29
Pharmacy and Medication Administration	38
Infection Control	42
Radiology Services	45
Infirmiry Care	46
Chronic Care.....	53
Women’s Health	66
Dental Program	70
Internal Monitoring and Quality Improvement Activities	83
Recommendations	87
Leadership, Staffing, and Custody Functions.....	87
Clinic Space, Sanitation, and Support Services	87
Medical Reception	88
Nursing Sick Call	88
Medical Records.....	89
Urgent/Emergent Care.....	90
Specialty Consultations.....	90
Pharmacy and Medication Administration	91
Infection Control	92
Radiology Services	93
Infirmiry Care	93
Chronic Care.....	94
Women’s Health	95
Dental Program	96
Internal Monitoring and Quality Improvement.....	100
Appendix A.....	102
Appendix B.....	103
Appendix C.....	104

Overview

From April 23 through April 26, 2018, the Court Expert team visited the Logan Correctional Center (LCC). This report describes our findings and recommendations. During this visit, we:

- Met with leadership of custody and medical
- Toured the medical services area
- Talked with health care staff
- Reviewed health records and other documents
- Interviewed inmates

We thank the Warden and staff for their assistance and cooperation in conducting the review.

LCC is the woman's reception center for the State of Illinois. This facility was opened in 1978. LCC was meant to hold 1,106 individuals but now holds 1806 females and is at 163% of rated capacity. In 2013, Logan became a female-only facility.

Executive Summary

Based on a comparison of findings as identified in the First Court Expert's report, we find that dental care is improved and there were improvements in access to care, but all other areas were either the same or worse than the First Court Expert's findings. Clinical care in all areas of record reviews appeared worse, and in some cases resulted in harm. Medication management was much worse than described in the previous report. Although there is an electronic medical record, it is incompletely implemented. We find that overall, the Logan Correctional Center (LCC) is not providing adequate medical care to patients and there are systemic issues that present ongoing risk of harm to patients and result in preventable morbidity. The deficiencies that form the basis of this opinion are provided below.

The Wexford supervisory nurse is dedicated to business duties related to the Wexford contract instead of being responsive to her role as supervisory nurse. This problem has been ongoing since the First Court Expert's report. The HCUA has too many responsibilities. Her responsibilities include HCUA at LCC, acting Regional Coordinator for the central region, infection control nurse, Continuous Quality Improvement coordinator, and nurse supervisor. LCC has only one supervisory nurse, making nurse supervision ineffective. This is compounded by lack of collaboration between IDOC leadership and Wexford leadership at this site. A physician position has been vacant for so long that it is now filled with a nurse practitioner position and the responsibilities of the Medical Director are such that she completes her notes at home after normal work hours. There have been five doctors at LCC over the past four years. Though there is only a 2% vacancy rate for the 53.15 positions, LCC had the lowest staffing rate per thousand inmates of all the facilities we visited. LCC had 30% less staffing per thousand inmates than NRC, the IDOC male intake facility, even though females require more testing evaluations than males.

Clinic space was inadequate. LCC used to be a medium security male facility and was not built with the intention of serving as the main female intake center and main female facility. As a result, there are inadequate numbers of examination rooms. There is insufficient equipment, including a lack of microscopes for analyzing specimens for yeast and trichomonas infections, a safe and functioning medical vehicle, a functioning colposcope, automated external defibrillators (AED), and physical therapy equipment. The health units were generally clean and well organized. Emergency response bags need to be inventoried and sealed. Negative pressure rooms need to be monitored and logs for this purpose need to be maintained. Safety and sanitation rounds need to include inspection of medical equipment, medical rooms including negative pressure rooms, emergency response bags, and the training of porters. This is not currently part of the sanitation rounds.

Intake evaluations do not include a thorough review of systems. The clinic where intake evaluations occur does not have a microscope, which limits the ability to perform a thorough examination related to vaginal infections. Because of the process of documenting medication administration, it is not clear whether medication ordered in the intake area is actually provided to the patient. Despite having identified these deficiencies, we found that the physician assistant working in this area performed very well. He was thorough and conscientious, and we were impressed with his work.

Access to care had some improvements, but some deficiencies identified by the First Court Expert remained. Many, but not all, patients had timely access to care; there are a high percentage of no shows and refusals to nurse sick call, without effort to determine the reason. Providers do not consistently evaluate patients with medical conditions identified by nurses. Instead, providers treat patients by remote orders without examining the patient. This is inappropriate.

LCC uses an electronic medical record, but this record was only partly implemented and is therefore ineffective in supporting the clinical program. Medication administration is not electronically recorded. Obstetrical records are maintained on paper and not integrated into the electronic record. Problem lists are improperly maintained. Problem lists include symptoms or undiagnosed findings, which are not diagnosed problems. Because of this, there is no official problem list we could identify used with this electronic medical record. There are insufficient computer terminals to log onto the medical record, particularly on the infirmary, and providers have to write their notes in an area where they are not examining the patient. This promotes bad practice. We also noted that the electronic medical record has a feature that transfers week-old vital sign information into a later note. This feature should be disabled, as all clinical encounters need *current* vital signs. The data in the electronic record has not been able to be used in obtaining data for quality improvement purposes. We also note that the electronic

medical record appears to have encouraged cut and pasted notes,¹ which is improper documentation.

Unscheduled nursing evaluations are now tracked on a nursing sick call log. We found that licensed practical nurses (LPN) and registered nurses (RN) were independently managing patient medical conditions when they should have referred to a physician. This included providing medications to patients and evaluating serious medical conditions that needed to be evaluated by a licensed provider.

We found in four of six hospitalized patients that there were delays in diagnosis because of untimely referral for higher level care. Two of these delays were extended (10.5 and 11 months). One likely resulted in dissemination of colon cancer. Four of six hospitalized patients did not have hospital records, so it was not possible to determine what occurred at the hospital.

We found that specialty care fails to protect patients and the current system of obtaining specialty care should be abandoned, based on patient safety concerns. Tracking of specialty consultations is not based on requirements of the IDOC. Referral dates are not tracked unless a consultation is completed. We noted multiple denials of referral, even when physicians did not appear to know how to manage the patient's problem. We noted one patient who appeared to not have rheumatoid arthritis, yet was being treated for several years with high dose steroid for presumed rheumatoid arthritis, medication that was causing harm. When the patient finally went to a rheumatologist, the rheumatologist noted no findings consistent with rheumatoid arthritis and recommended decreasing the steroid medication. This was not done and follow up with the rheumatologist stopped. We noted several other patients who sustained harm as a result of lack of follow up or referral to appropriate specialty care.

We found systemic issues related to pharmacy and medication administration. The medication room was dirty and there were opened yet undated vials of medications as well as expired medication. Medication assistants working in the pharmacy are unlicensed and were only provided on-the-job training, but deliver hundreds of keep-on-person (KOP) medications to patients on a daily basis, often without documenting onto a medication administration record (MAR). Observation of medication administration showed it was unhygienic. Similar to other facilities, nurses pre-pour medications into improperly labeled envelopes and administer medications without simultaneously recording administration. Patients are not positively identified by the nurse prior to administration of the medication. Keep-on-person (KOP) medications are delivered to patients without consistent documentation in the medical record. Some medication administration records (MAR) were absent in 10 of 10 records reviewed and several of these patients had MARs showing that they did not receive ordered medication. MARs are not timely scanned into the EMR. We found other deficiencies, including orders not

¹ Cut and pasted notes in an electronic medical record consist of copying a section or entire record of a prior note and pasting that copied section into a more current evaluation document. Every episode of care should be documented with information obtained during that episode of care.

being transcribed to the MAR, nurses documenting continuation of medication after it had been discontinued, and improper documentation on MARs.

LCC has no budgeted infection control staff. We noted that deficiencies identified on safety and sanitation reports are sometimes not addressed, repeatedly. Inmate porters have not received training and have no evidence of being vaccinated for hepatitis A or B. Negative pressure rooms were not functional on the first day of our visit, suggesting that they are not being routinely monitored. Paper barriers are not in evidence in all examination areas. The washer used to launder infirmery linen still operates with water below acceptable temperature.

Radiology services are timely and there is no backlog. Access to this service is good. Equipment appears to be in compliance with state regulations. We had concerns about the safety of the radiology technician with respect to panorex films, as this unit does not have typical shielding, and we question whether the technician is receiving unnecessary radiation exposure.

The infirmery was clean and organized. The infirmery lacked sufficient electronic devices for entering information into the electronic medical record. This forced some staff to write their notes at a later time or in other locations. The physician wrote some infirmery notes on a routine basis well after hours and in one case over a week after the clinical event. This is inappropriate and will lead to errors. Not all shifts on the infirmery were covered by an RN. Weights are not tracked well at LCC, resulting in delays in initiating diagnostic testing. Patients on the infirmery in need of specialty care often do not receive it. The use of antibiotics appears excessive and not in line with typical standards of care, and appear guided by presumptive diagnoses rather than an accurate diagnosis supported by diagnostic testing. We view this as a lack of ordering appropriate diagnostic testing and referral. We could not consistently find consultation reports for infirmery patients.

Chronic care patients are seen in a separate clinic encounter for each of their chronic illnesses. For primary care this is inefficient, results in duplicative documentation, promotes lack of attention to interactions between various diseases, and drug-drug interactions. Patients should be evaluated for all of their conditions at one time and based on the degree of control of their illness, not on an inflexible schedule. For hepatitis C, viral load testing is not performed in accordance with IDOC hepatitis C guidelines. As with other facilities, LCC does not adhere to contemporary standards of lipid management, immunization, or colorectal cancer screening. Providers lack access, at the point of care, to electronic references. We noted problems in record reviews related to chronic disease management.

There are insufficient providers to provide female specific care. Care of the pregnant females was generally of good quality. Of 11 records of pregnant females, only one had not been timely evaluated. However, we note that pregnancy has such high risk potential that all patients must be timely evaluated. Referral to a high-risk OB center was in place and appeared to function well. Screening Pap smears and mammograms were mostly done, but rates could be improved. We note that Pap smears for HIV infected women do not occur at the recommended frequency. We attribute lower than desired screening rates to insufficient staffing and monitoring.

Microscopy is not used in diagnosis of vaginal infections (trichomonas, yeast, and bacterial vaginosis). Presumably, this is done presumptively, which is not the standard of care.

The dental program has improved marginally since the First Expert Report due to the introduction of the electronic health record. Routine treatment is timely but inadequate, since it is not informed by a comprehensive oral examination (i.e., intraoral x-rays, a periodontal assessment, and a treatment plan). Adequate soft tissue oral cancer examinations are not performed at the reception screening and are not documented at biennial examinations. The failures of the dental program documented in this report place patients at risk of tooth loss by fostering widescale underdiagnosis and under-treatment of caries and periodontal dental disease. The program remains below accepted professional standards and is not minimally adequate.

The quality improvement program has no one who is trained in quality improvement methodology and no one specifically assigned to perform quality improvement work. The Quality Improvement Plan was inadequate. There was a lack of understanding of the difference between outcome and process studies. There was no critical evaluation of data obtained for the program. Mortality reviews did not include critical analysis and failed to identify correctable problems with care.

Findings

Leadership, Staffing, and Custody Functions

Methodology: We interviewed medical and custody leadership, reviewed staffing documents, and other pertinent documents.

First Court Expert Findings

The Director of Nursing (DON) position was vacant, significantly impacting the workload of the Health Care Unit Administrator (HCUA). The HCUA and Medical Director positions were filled with capable persons. The First Court Expert found that there was a strong leadership team in place and the Warden was supportive. The Assistant Warden of Programs was a nurse. The Medical Director was conscientious. There were 62.21 positions, with a 6% vacancy rate. The HCUA was also acting DON and acted as the infection control nurse.

Current Findings

There was no significant change compared to the findings of the First Court Expert. LCC now has a HCUA, Medical Director, and DON. The HCUA has been in her position since the time of the First Court Expert's visit. She is experienced, but similar to the First Court Expert findings, has too many responsibilities. She is the HCUA at LCC, is filling in as the IDOC Central Regional Coordinator, is the LCC Continuous Quality Improvement Coordinator, covers as the infection control nurse at LCC, and also provides some nurse supervision. It is not possible to effectively manage all those responsibilities.

Nursing supervision is inadequate. The Schedule E has no DON position, but recently a DON position was created and has been recently filled. Prior to this position being filled, the Wexford supervisory nurse was the only nurse supervisor. However, the supervisory nurse, according to the HCUA, spends much of her time performing business duties as the Wexford site manager and is not supervising nurses. For this reason, a DON position was created. The Schedule E nursing supervisor positions will apparently continue to perform business duties. The lack of participation in nursing supervision by the Wexford supervisory nurse has increased the work of the HCUA. This is made worse because the HCUA cannot schedule or discipline nurses, who are all Wexford staff. The HCUA told me that whichever nurse is assigned to respond to emergencies (referred to as the desk nurse) is the effective nurse supervisor. This is not effective supervision. The new Wexford DON and nursing supervisor were both ill and not present during our visit; therefore, we were unable to speak with them.

We were impressed by the enthusiasm and dedication to improvement of the HCUA and the direction she has provided to the program. However, her work has not yet been complemented by coordination with Wexford leadership staff. The reasons for this are unclear, but do appear to affect the program. The absence of apparent collaboration between the HCUA at this facility and Wexford management is a lost opportunity in making improvements.

There are two physician positions at LCC, the Medical Director, and a staff physician. The Medical Director has been in her position since May of 2016. The staff physician position has not been filled for some time. Because of the extended length of vacancy, the program has filled the vacant physician position with another nurse practitioner. The failure to fill the physician position with a qualified physician overburdens the Medical Director, who needs to see all infirmity patients and all complicated patients. Nurse practitioners manage all patients with chronic illness. The Medical Director cannot complete her work during daytime hours. In particular, admission and discharge notes for the infirmity have been a problem significant enough to study this issue as a CQI study. The Medical Director will see patients during the day and often completes her notes at night while at home. We found some notes written as late as midnight two days after the patient was apparently evaluated and one note written over a week after the episode of care. This is not a good practice and can lead to errors. The overwhelming clinical burden for the Medical Director also results in less available time to work with the HCUA in improving systemic problems at the facility.

As we will describe in the section of Women's Health later in this report, there are insufficient providers to handle the volume of female specific health needs. This should be addressed.

There has been considerable physician turnover at the LCC. Since 2014, there have been five doctors at LCC. The inability to consistently fill physician positions with qualified physicians has been an ongoing problem at this facility. The failure of Wexford to fill physician positions significantly impacts the program. We do not agree with the substitution of the staff physician with a nurse practitioner. The inability to recruit and retain physicians has resulted in the program reducing its physician coverage.

This facility has all Wexford staff except for the HCUA, who is a state employee. The Schedule E provided prior to our visit is not entirely accurate. The vacant staff physician position has been changed to a nurse practitioner position, and a DON position has been created. Given these changes, there are 53.15 positions in the medical program, of which only one is vacant.² This is a 2% vacancy rate, which is very good. Based on a population of 1806, there are 29.4 staff positions per 1000 inmates, which is the lowest staffing rate of all facilities we visited. NRC, the male intake facility, had 41 staff per 1000 inmates; LCC has 30% less staffing than NRC, even though female intake requires more work because of the additional examinations and testing needed. In our opinion, there are insufficient RN positions. LPNs perform independent evaluations, which they should not be doing. Vital signs are not obtained consistently for all clinical encounters and monitoring of infirmary patients could be more thorough. We do not agree with having a single physician at this facility, and the lack of ability to recruit physicians negatively affects clinical care of patients.

The LCC operational policies were last reviewed on September 15, 2016. However, the actual policies appear dated and are not completely pertinent to the current facility. The receiving screening policy gives no specific direction with respect to how reception screening at LCC is to occur. This policy is a generic policy which does not even list the requirements of testing or evaluations that are required by the Administrative Directives (AD). The medical records policy is still similar to generic IDOC policy with respect to the paper record, even though LCC now has a partial electronic medical record (EMR). The policy does not address down-time procedures for the electronic record, does not address how medication administration records (MARs) are placed into the electronic record or how offsite consultation reports are placed into the electronic record. This is important because, as we learned, medical record documents can be dated in the electronic record based on the date of scanning into the record or based on the date of service. This process should be established by policy so that it is clear to clinical staff when a clinical event occurred.

Clinic Space, Sanitation, and Support Services

Methodology: Accompanied by a Wexford staff assistant, the experts inspected the single-story health care building, which housed the main medical care clinical unit, with medical exams rooms, nurse sick call rooms, one exam room/treatment room, dental clinic, telehealth rooms, x-ray suite, optometry clinic, medication storage room, nurse medication preparation rooms, injectable medication (enoxaparin, insulin, etc.) administration windows, medical records department, infirmary, supply storeroom, health care administrative and clinician offices, and a conference room. Accompanied by the HCUA, we separately visited the housing unit #6, commonly referred to as the Americans with Disability Act (ADA) unit, and inspected patient rooms, showers and toilets, day room, and the physical therapy room. We also toured the clinical space in building X Reception and intake screening unit. We reviewed the Safety and Sanitation reports for the months of July, August, November, December 2017, and February 2018.

² See Appendix A for a staffing table for this facility.

First Court Expert Findings

The First Court Expert found the clinical areas at LCC reasonably clean and well maintained. The First Court Expert raised concerns that the noise level in the medical reception building made it difficult to properly interview and communicate with new admissions during the intake history and evaluations.

Current Findings

- The infirmary beds were all hospital beds in good condition with adjustable heights, heads, and legs. The three crisis room beds were elevated concrete slabs with mattresses.
- The battery powered nurse call devices located in the infirmary patient rooms were functional. The crisis rooms were located in direct line of sight from the infirmary nursing stations and did not have call devices.
- Only one of the infirmary's three negative pressure rooms was adequately functioning. The engineering staff corrected this problem during the site visit. The nursing staff had not noted nor reported this malfunction in their daily log.
- The five exam rooms in the medical building were not sufficient to accommodate the number of anticipated users. There is a Medical Director, four nurse practitioner positions, a part time obstetrician, and two sick call nurses. Each should have an open and fully equipped examination room. Based on the budget there is need for 7.5 examination rooms. It is our opinion that an additional physician is needed. The planned conversion of one nursing office in the outpatient clinic into an additional provider room will still not provide sufficient space for the number of anticipated users.
- The telehealth room used for monthly UIC HIV and hepatitis C care and infrequently scheduled renal specialty consultation, is also utilized by the OB-GYN specialist for obstetrical Doppler ultrasound evaluation and by a contracted general US technician for general ultrasonography exams. The room is clean and modestly, but adequately, sized. The telehealth room schedule is arranged so that there is no competition for this space.
- Most but not all of the medical equipment and devices in the medical building had documentation of annual inspection by biomedical engineering. However, the obstetrical Doppler ultrasound, the capillary blood glucose testing units, one oxygen concentrator, one Gomco suction machine, and one IVAC unit did not have current inspection labels.
- The colposcope has exceeded its functional life span, has broken parts that are not able to be repaired, and needs to be replaced.
- There was only one operational AED at LCC during the time of the site visit. A single AED at a correctional facility with the population and geographic size of LCC is not adequate to enable a timely and effective emergency response.
- The medical vehicle used to move emergency staff throughout the expansive campus needs to be replaced. Its doors were difficult to open.
- The two emergency response bags on the campus (one in the medical vehicle, the other in the outpatient clinic equipment room) were both unsealed.

- Monthly safety and sanitation inspections and reports are being done by the health care team at LCC. The current inspections focus on physical plant issues (toilets, infestations, mold/mildew, etc.) that must be addressed and corrected by the correctional leadership.
- The safety and sanitation reports do not include documentation of the condition, functionality, and certification of clinical equipment or adequacy of clinical space.

The vast majority of the inmate population is housed in multiple residential buildings, each of which are divided into small dormitories. There is a separate reception building (X-building) where all new admissions are housed until intake screening is fully completed. All medical health care for patient-inmates who have completed the intake screening and have been assigned to a sentenced housing unit is provided in the single story medical building that is located in the central area of the LCC campus. This medical unit is approximately 300 to 1000 feet from inmate housing. Inmates who cannot walk are pushed in wheelchairs by inmate workers or transported in a correctional van to the medical building for all of their care needs.

The single floor linear medical building is the hub of the health care delivery services provided at LCC; it is separated into two sections, with the patient-inmate entrance in the middle of the two sections. Ambulatory care services are located in one wing and the other wing houses the infirmary, biohazardous waste room, medication storage and preparation room, injectable and KOP medication delivery area, medical records, health care administration, optometry room, and dental services.

A correctional staff station is situated at the entrance in the medical building. At this security station there is a video monitor that receives live feed from the infirmary rooms. Correctional officers were at this station during the entire four-day visit of the Experts. Officers stated that they also do visual checks of the infirmary rooms at 30-minute intervals, but the experts seldom saw correctional staff in either wing of the medical building. Directly across from the security station was a patient-inmate waiting area with bench seating that could accommodate approximately 15 women.

The ambulatory care wing of the medical building has a centralized nurse station and five private exam rooms, a telehealth room, an equipment storeroom, a phlebotomy room, and two nurse offices. There is a centralized nursing station in the outpatient clinic area with an open counter, two chairs, computer monitors, and supply cabinets. The station was clean and organized.

Two of the exam rooms are used for nurse sick call; one of these rooms is shared with the OB-GYN specialist, who is onsite two to three days per week. The other three exam rooms are used by the physician and three nurse practitioners; one additional nurse practitioner position is vacant. There is an insufficient number of exam rooms. There are 5.5 budgeted providers and two sick call nurses. It is our opinion that an additional physician is needed. The five examination rooms are insufficient to accommodate the 7.5 budgeted staff who have need of an examination room.

Each exam room has an exam table, computer monitor, desk, two chairs, wall mounted oto-ophthalmoscope unit, liquid soap or sanitizer solution, paper hand towels, mounted sharps container, and a supply cabinet. Four of the five exam rooms had a sink with hot and cold water; the chronic care nurse practitioner room had hand sanitizer in the room without a sink. Three of the five exam tables had a paper barrier in place. The oto-ophthalmoscope was fully operational in four of five rooms; the ophthalmoscope head was not functional in one room. The exam tables were in good condition, but a few had unsealed minor tears that made the tables difficult to fully sanitize. Only one sink had a small amount of mineral deposit. Oxygen tanks were stored in the two exam rooms, but the tanks were only stored in safety racks in one of the rooms. The OB-GYN room had a gooseneck lamp and a cryosurgery unit with three cryosurgery/liquid nitrogen tanks; only one of the tanks were secured in a safety rack. Only one of the provider rooms has a functional microscope with slides, cover slips, and normal saline, but the microscope was dusty and appears to be infrequently used. A new nurse practitioner stated that she had not yet been trained to perform vaginal wet mounts³. This same room has disposable gynecology specula with a functional attachable light source and a supply of thin prep solution containers. The physician's exam room had a sealed medication cart that had documented daily inspections noted on a log. The exam rooms were generally clean and adequately organized.

The telehealth room has a chair, an exam table, and a telemonitor with a stethoscope attachment. UIC infectious disease specialists schedule monthly half-day sessions for the management of HIV and hepatitis C patients, and a Wexford contracted nephrologist provides teleconsultation on an infrequent "as needed" basis. LCC's contracted OB-GYN specialist uses this room to perform obstetrical Doppler ultrasonography on a weekly basis. Once a month a contracted ultrasound technician also does general ultrasonography studies in this room. The schedule for the utilization of this room accommodates the part-time needs of these four services. There is no sink or hand sanitizer in this room which should be present as clinical evaluations are performed.

The phlebotomy room is staffed by two phlebotomists who split their time between the reception center and the medical building. The lab room has a phlebotomy chair, a refrigerator, a sink with hot and cold water, soap and paper towels, a sharps box, a centrifuge, and a computer monitor. The refrigerator was empty and the freezer compartment needed to be defrosted. Lab specimens are sent to the UIC laboratory and result turnaround time was reported to be 24-48 hours. The room was clean and organized.

The radiology suite has chest x-ray and plain film units and a mammography machine in a shielded room. A panorex unit is located in an internal corridor that leads into the radiology technician work area. The suite is staffed by a radiology technician on Monday, Wednesday,

³ Typically, female examination rooms in female centers, particularly intake centers, have microscopes in the examination rooms. These are used to examine vaginal specimens to identify yeast and trichomonas infections. A vaginal smear is applied to a microscope slide and examined under the microscope. Alternatives to this are to perform yeast culture or nucleic acid amplification tests (NAAT), which are expensive to perform. When microscopes are unavailable, there is greater propensity to guess regarding diagnoses, which is not appropriate.

and Friday. A contract mammography technician performs mammography studies on Tuesday and Thursday. (Further findings about the radiology services are detailed in the Radiology Services section.)

There were two nurse offices adjacent to the nursing stations. The chronic care nurse occupies one these rooms to arrange chronic care schedules and statistics. The other room was used by two nurses but will soon be converted into a sixth exam room.

An equipment room contained a back board, a tool control rack, and an emergency response bag. There was a log that tracked the tool count on each shift. The emergency response bag was unsealed and contained a very limited amount of medical supplies. It was communicated that this emergency response bag was the backup bag for the medical team. Injectable glucagon and EpiPen in the backup bag were current but will expire within the next few weeks. It is unacceptable to have an unsealed emergency response bag in the medical building. This bag would be of limited use in the case of an emergency at LCC. An automated external defibrillator (AED) used to be stored in this room but the unit was reported to be out for repairs. The only AED and fully stocked emergency response bag for the entire 1,700-bed institution is kept in the medical vehicle that is parked at the back door of the medical building. LCC does not have a crash cart. The institution performs basic CPR, applies the AED, and calls 911 for cardiac arrests. This is an acceptable option for responding to codes/cardiac arrests.

An ambulatory clinic nurse escorted the expert to inspect the medical vehicle, an aging four door Jeep-like vehicle. This vehicle is only used to transport clinical staff to the injured or ill patient-inmate. This vehicle is never used to transport patients. The rusted rear side and the trunk doors were extremely difficult to open. The emergency bag was stocked with supplies and equipment including a stethoscope, oral airways, ambu bag, bandage material, neck braces, glucagon, EpiPen, and a blood glucose monitor. A full oxygen tank, an operational AED, and current AED pads were in different sections of the vehicle. The emergency response bag was not sealed. The emergency response bag, equipment, and supplies were not stored in an organized, easily retrievable way in the vehicle. It was obvious that the bag was not easily accessible. A review of the inspection logs for February and March 2018 (April's log was missing) documented no deficiencies concerning the van's emergency response bag. However, the inspections were not done on 17 (28%) of the 59 days in these months. The unsealed, unchecked emergency response bag may not contain all the supplies, medications, and equipment needed to effectively respond to an emergency. The emergency response bag must be checked and sealed; the emergency equipment must be organized in the vehicle so that it can be readily accessed. The aging vehicle's doors must be repaired, or the vehicle must be replaced.

A single AED at a correctional facility the size of LCC is not adequate to enable a timely and potentially effective emergency response to a patient-inmate or a correctional or medical staff member who has a cardiac arrest. An AED must always be kept in the medical building to be able to expeditiously respond to emergencies in the high-risk infirmary and to the large number of acute and chronic patients being treated in the ambulatory clinic. Additional AEDs should be

placed in various locations on the LCC campus to minimize emergency response times. The HCUA advised the experts that a request has been or will be made for six additional AEDs.

A correctional transportation van was inspected. The van had two rows of seats; all the seats had seat belts. There was room in the first row to accommodate a wheel chair. A patient-inmate in building #6 who has had multiple offsite specialty visits communicated that vans had seat belts that she always used.

A few dated medical and pharmaceutical references were found in exam rooms. Providers stated that *they believe* that there was a way to access UpToDate electronic medical reference via the EMR, but they did not know how to do this. One nurse practitioner communicated that she uses the physician assistant's private purchase access codes to access UpToDate. The physician stated that she uses Google to access clinical information as needed. All medical and nursing staff at LCC should have ready access to current online medical reference systems such as UpToDate.

A two-chair dental suite is situated behind the correctional office station at the entrance to the medical building. (The physical space and the dental equipment will be addressed in the Dental Services section).

Building #6 is a single-floor structure that houses 131 women, many of whom have difficulty with ambulation or require ambulatory assistive devices (cane, crutches, wheel chairs, walkers). The entrance of the building opens into a large common dayroom with tables, chairs, and two flat screen televisions; the security desk is situated in the day room. Patient-inmates sign a sick call list, noting only their names, not their health care concern, when they seek non-urgent care. The list is kept at the security desk, picked up in the evening, and brought to the medical building. Four women were interviewed; they all stated that they are generally seen by a nurse on the next work day after they submit a sick call request. Women are housed in two wings that open into the dayroom in rooms with two, four, and six-bed rooms. Women have keys to their rooms. All the beds are bunk beds; women with disabilities or at risk for fall are assigned to the lower bunk. Each wing has a common shower and toilet area. The showers are handicap accessible with safety grab bars and shower chairs. At least one toilet in each shower/bathroom was wheelchair accessible. There was a large patch of tile missing in one of the bathrooms that would be difficult to adequately sanitize. It was reported to the Expert that a work order had been placed to replace the missing tile. That same bathroom had a section of frayed insulation of undetermined material wrapped around a pipe at about shoulder level height; this was communicated to the facility engineer, who said that he would correct this concern.

The physical therapy (PT) room is located in building #6 at the back of the dayroom. The PT room is moderately sized and is equipped with two exercise bicycles, one treadmill, a set of parallel bars, and two exercise tables. Locating the PT room in building #6 is quite appropriate and enhances access for the physically challenged population who are housed in this building. However, the PT room is sparsely equipped, even obviously underequipped, when compared to the physical therapy units serving the male populations at SCC and DCC. The physical therapist

also goes to the infirmary and building #14 (mental health) to provide physical therapy services as needed.

Because a partial electronic medical record is used, the medical record area consists of a single room used to manage MAR documents and other paper documents such as outside consultant reports. This room connects the dental, optometry, and supply storage areas with health care administrative offices, conference room, and staff locker room/breakroom.

The 15-bed infirmary is located at the opposite end of the medical building from the ambulatory care wing. The nursing station with an adjacent medication/supply/equipment room is located at the beginning of the infirmary corridor. Four patient rooms had two beds per room with a toilet in each two-person room. There were seven single-bed rooms; three of these single person rooms were crisis/negative pressure rooms located directly in front of the nursing station. Relatively new, excellent condition hospital beds with adjustable heights and head and lower extremity sections were in all the single (non-crisis) and two-person rooms. Nurse call devices were mounted on the walls next to each bed in the non-crisis rooms; four were tested and found to be functioning. The infirmary nurse quickly responded to an unannounced activated device. The three crisis/negative pressure rooms had concrete beds with a mattress. There were no nurse call devices in the crisis rooms. All patient rooms in the infirmary were clean, neat, and organized. The negative pressure monitor at the nursing station was turned on and indicated that at least one of the negative pressure units was not operational. Utilizing the tissue paper test used by the infirmary nursing staff, it was identified that two of the negative pressure units were not functioning properly. A review of the April 2018 infirmary logs noted that the negative pressure was not checked regularly but no deficiencies had been documented. The facility's engineer adjusted the control unit and all three negative pressure units were fully operational before the end of the Experts' visit.

A central infirmary nursing station had an open counter, computer monitor, and supply cabinets. An adequately sized medication preparation, medical supply, and equipment room was located immediately behind the nurse station. There were two Gomco suction machines, two IVAC units, and one oxygen concentrator in the storeroom. One Gomco, one IVAC, and the oxygen concentrator did not have current annual inspection labels. A single person shower room that could accommodate a wheelchair was situated near the nursing station. A biohazard room was located on the unit; the room was clean, waste material bagged, and sharps containers locked. It was reported that a biohazard waste vendor removes the material one to two times per week.

Monthly safety and sanitation inspections are being done in the health care areas, dietary, and housing units. The rounds have appropriately identified problems with the maintenance of the physical plant that could have a negative impact on the safety and health of the patient-inmates and the correctional and medical staff. However, these environmental rounds do not inspect or monitor the condition, function, and annual certification of clinical equipment, functionality of the negative pressure rooms, integrity of bed and chair upholstery, completion of medical cart and emergency response bag logs, the training of health care unit porters, and

other health care issues. The safety and sanitation inspection should be expanded to focus more attention on the beds, clinical equipment, and the training of the infirmary and health care unit porters. Alternatively, separate healthcare-specific environmental rounds should be initiated. The findings of environmental rounds and the safety and sanitation inspections should be reported to the Quality Improvement Committee.

In summary, with the exception of the medication room, the medical building was generally clean and organized. The clinical space was generally adequate to address the needs of the LCC patient population with the exception of the five existing exam rooms which are not sufficient to accommodate the facility's 7.5 FTE clinical staff assigned to nurse and provider sick call, specialty care, and chronic care clinic. The facility has an inadequate number of AEDs to provide timely emergency response in the all clinical and housing units on the expansive LCC campus. The medical vehicle is defective and needs to be repaired and/or replaced. All medical equipment did not have evidence of current annual inspection. The emergency response bags were not sealed and not checked on a daily basis. The infirmary negative pressure room logs did not note that two of the negative pressure rooms were not functional and that the monitoring panel at the nurse station was not accurately indicating the lack of adequate negative pressure.

We agree with the recommendations of the First Court Expert. We have additional recommendations found at the end of this report.

Sanitation

Methodology: The medical building, the physical therapy room in building #6, and the reception center in the X-building were inspected. Nurses, infirmary patient-inmates, and inmate porters were interviewed.

First Court Expert Findings

The First Court Expert reported that the infirmary porters were provided with orientation to the health care unit that included proper cleaning and sanitation procedures.

Current Findings

- The clinical areas in the medical building, building #6, and building X's reception center were generally clean. One exception was the medication room. Floor and countertops were dirty. The medication refrigerator was in need of cleaning. The staff food refrigerator was very dirty, with liquid spills and food debris. The room was notably cluttered and disorganized.
- One sink in the outpatient clinic and in the reception center has crusted mineral deposits.
- The shower on one wing of building #6 ADA housing unit had a large section of tile missing from the wall and a frayed insulation sleeve around an accessible water pipe. This deficiency makes it impossible to fully sanitize this area.

- There was no documentation that the three infirmary porters had been fully trained in the duties and risks of working on a health care unit with potential exposure to body fluids or had received hepatitis B vaccination.

Overall, the clinical areas at LCC were clean, organized and well maintained. A few exceptions were noted. One was the medication room used to store pharmaceuticals (see Pharmacy and Medication Administration Section). Another area was the common showers/bathrooms in building #6 had a large patch of missing tile on a wall. Although most sinks were clean, one sink in an exam room in the medical building and another in the reception center were crusted with mineral deposits. The shower wall and the crusted sinks are not able to be properly cleaned and sanitized.

Inmate porters clean, sweep, and sanitize all clinical areas at LCC. Three porters in the infirmary were interviewed. One had been the infirmary porter for a long period of time, the other two were recently assigned to the infirmary. In addition to cleaning the infirmary, they wash patient linens in the non-industrial washer and dryer in the infirmary and occasionally assist nurses with patient transfers in and out of beds/chairs. The experienced porter remembered having received some training in the past; the other two stated that they had only received some on-the-job-training. None were sure if they had been vaccinated against hepatitis B (or A). The EMRs of the three porters were reviewed; we found no evidence that they had received blood borne disease education or formal job duty training. There was no documentation in their medical records that they were immune to hepatitis B (or A) or if they had been vaccinated against hepatitis B (or A). The Wexford staff assistant who is responsible for the training of infirmary porters also was unable to provide documentation that the three porters had been trained or vaccinated.⁴

In summary, the sanitation of the health care units was adequate overall, but we identified problems as noted above.

The First Court Expert made no specific recommendations concerning sanitation. We have recommendations that are found at the end of this report.

Medical Reception

Methodology: To assess medical evaluation of newly arriving inmates, we toured the medical reception area, interviewed health care staff, reviewed IDOC health record forms, and reviewed 10 health records.

First Court Expert Findings

The previous Court Expert found that the medical reception process timely took place following the patient's arrival, but there were opportunities for improvement. The initial nurse intake screen took place in a noisy area that interfered with the nurse's ability to hear the patient.

⁴ Infirmary Patients #5, 6, 7.

Patients arrived without medical transfer information from the jail. There were deficiencies in the quality of patient medical histories, problems with follow-up of medical conditions, and untimely follow up of patients with chronic diseases.

Current Findings

We found that the medical reception process has improved from the First Court Expert's report and we also found areas needing improvement.

Medical reception is performed in the B-Wing of X-building. The room where nurses perform intake screening has been moved from the main medical unit to B-Wing. The room is not optimal. It is small and has no sink, but did have hand sanitizer. The examination room used by the medical provider is larger and has an exam table and sink. The exam table cover is torn, preventing inadequate infection prevention, and should be repaired or replaced. The ophthalmoscope head is missing. The provider reported that he did not have a large blood pressure cuff. There is no microscope for the provider to use to diagnose vaginal infections. Both rooms had gloves, sharps, and biohazardous waste containers.

Medical records show that medical transfer information was sent with the patient and available for nurse and provider review. Medications were usually ordered on the day of arrival, but medication administration records (MARs) do not reflect that medications were received within 24 hours and in some cases, not at all. Nurses ordered intake labs according to protocols that were typically performed within a day or two of arrival. Lab reports were generally available at the time of the physical examination. A concern is that nurses do not consistently perform and document urine pregnancy testing in the medical record, which may lead to missed pregnancy.

A provider performed a physical examination in seven days or less in eight (80%) of 10 records reviewed (range=1-12 days). The provider generally addressed the patient's medical history but did not consistently perform a review of systems (ROS) to assess disease control at the time of arrival. The medical provider performed thorough physical examinations including pelvic exam and Pap smear. The provider tests patients with vaginal discharge for chlamydia and gonorrhea, but did not have a microscope to diagnose patients with other common infections, such as trichomonas, yeast, and bacterial vaginosis, and treated these infections empirically. However, due to problems related to inconsistent transcription of medication orders onto a MAR, nurses did not consistently document administration of medications for treatment of vaginal infections onto a MAR.

The provider developed an appropriate treatment plan for each medical condition and followed up on abnormal labs. Mammograms were ordered and completed in accordance with recommended guidelines. The provider referred patients to the chronic disease program and initial visits usually took place within 30 days. The medical provider initiated the problem list, but did not consistently include all pertinent medical diagnoses, including TB infection. Although there are opportunities for improvement, we were impressed with the physician assistant who performs physical examinations. His medical care is very thorough and conscientious.

Nursing Sick Call

Methodology: We evaluated nursing sick call by reviewing IDOC Administrative Directive Offender Health Care Services, (04.03.103K), Wexford Non-Emergency Health Care Requests and Services (P-103), IDOC Treatment Protocols, and the Logan Offender Handbook. We also interviewed health care leadership, staff, and inmates, inspected areas where sick call is conducted, and reviewed tracking logs and health records.

First Court Expert Findings

The previous Court Expert found that nursing sick call was conducted seven days per week. Inmates accessed sick call by submitting a health services request form that nurses triaged, and then the patient was scheduled to be seen by a nurse. In X-house where segregation, maximum security and reception inmates were housed, nurses conducted sick call cell-side, without privacy or performing an examination, despite there being an examination room where sick call could be performed. Licensed practical nurses (LPNs) performed independent nursing assessments, which is beyond the scope of practice for an LPN in the State of Illinois.

Current Findings

Our review showed some improvements with respect to access to care and confirmed that certain conditions found by the First Court Expert remain. The system does not yet ensure timely access to care.

Sick call is still conducted seven days per week. The process for inmates to access sick call has changed since the previous Expert's report. To access sick call, inmates sign up for sick call on a sheet of paper in the housing unit rather than submitting a written request with the nature of the complaint. The exception is segregation, where the officer maintains control of the sign-up sheet and writes the inmate's name on the sheet. Health care staff pick up the sign-up sheets each evening, but the replacement sign-up sheets are not delivered until the next morning. Therefore, there is an approximately 12-hour gap where inmates are unable to sign up for sick call. The Logan Offender Handbook has not been changed to reflect the new process.

Health care leadership reported that all inmates are supposed to be seen the day after signing up; however, our record review showed that in some cases, inmates were not seen for two days after they signed up. This is a concern because if health care staff cannot see all patients within 24 hours, they need to be able to triage patients according to the urgency of their complaint. However, this is not possible because inmates do not document the nature of the complaint on the sign-up sheet.

We reviewed inmate sign-up sheets and noted that there were missing sign-up sheets each month. For example, according to notes on the stacks of sign-up sheets, there were sign-up sheets missing for 2/21, 2/23, 2/25, 2/26, 2/27, 2/28, 3/1, 2/2, 3/3, and 3/4/18. This is significant because the sign-up sheet is the only documentation that the patient submitted a health request. If sign-up sheets are missing, there is no record that the patient requested care.

Review of available sign-up sheets show that on some days there were very high numbers of no shows or refusals. For example:

- On 1/5/18, 56 inmates signed up for sick call and there were 22 (39%) no shows or refusals;
- On 1/7/18, 62 inmates signed up and there were 35 (56%) no shows or refusals;
- On 1/26/18, 61 inmates signed up and there were 20 (33%) no shows or refusals; and
- On 3/6/18, 46 inmates signed up and there were 19 (41%) no shows or refusals.

These are extremely high no shows/refusal rates; however, these high no show/refusal rates have not been studied under the auspices of the CQI program to determine whether barriers to access to care exist. We interviewed staff and inmates as to why inmates no show for sick call. One reason given is that inmates sign up to meet other inmates for social reasons, and then do not come to sick call. Another reason given is that inmates wait long periods of time for their appointments. Staff and inmate interviews indicate that the sick call nurse responds to emergencies on the compound, and when this occurs, inmates waiting to be seen do not know how long the nurse will be unavailable and therefore return to their housing unit. At least on one occasion, a lockdown was a barrier to care. On 1/8/18, four patients were noted not to be seen due a lockdown. We reviewed each of these records and found that patients were not rescheduled for sick call and were not seen.

The HCUA reported that all inmates are escorted to an examination room to be assessed by a nurse, either in the main medical unit or housing units. However, in X-building where segregated inmates are housed, correctional officers do not escort inmates to a clinic area and nurses still perform cell-front assessments which does not permit an adequate assessment.

We reviewed 26 health requests in 22 records, which included four patients noted above not seen due to a lockdown (15%).⁵ Of the remaining 22 health requests, we found that in 14 (54%) cases patients were seen the next day,⁶ four (15%) patients were seen in two days,⁷ and four (15%) patients were not seen due to no show, refusal, or unknown reason.⁸ Thus, 69% of patients were seen in one to two days, but 31% were not seen due to lockdown, no show or refusal. Two of the patients seen by a nurse in two days were housed in segregation.

At LCC, both RNs and LPNs perform sick call using treatment protocols. In the State of Illinois, LPNs are to practice “under the guidance of a registered professional nurse, or an advanced practice registered nurse, or as directed by a physician assistant, physician...to include “conducting a focused nursing assessment and contributing to the ongoing assessment of the patient performed by the registered professional nurse.” LPNs may also collaborate in the development and modifications of the RN or APRN’s plan of care, implement aspects of the plan of care, participate in health teaching and counseling, and serve as an advocate for the

⁵ Sick Call Patients #5, 6, 7, and 8.

⁶ Sick Call Patients #1, 2, 3, 4, 9, 12, 14 (four separate requests), 15 (two separate requests), 16, and #21.

⁷ Sick Call Patients #11, 19, 20, and 22.

⁸ Sick Call Patients #10, 13, 17 and 18.

patient by communicating and collaborating with other health service personnel.⁹ However, Illinois scope of practice does not permit LPN's to perform assessments independent of a registered professional nurse or higher level professional, as is currently being done at LCC. Neither does the scope of practice permit LPNs to perform independent assessments according to protocols. LPNs do not have requisite education and training, including physical assessment skills needed to perform independent assessments.¹⁰ *Thus, some LCC patients do not receive evaluations by health care staff licensed to perform independent assessments. This increases the risk of harm to patients.*

Record review showed that some patients who require a medical diagnosis are assessed only by a nurse and not medically evaluated by a provider and/or do not receive ordered medical treatment. The following examples are illustrative:

- A 28-year-old presented to a nurse on 1/16/18 for urinary frequency with foul-smelling urine.¹¹ The patient reported a history of urinary tract infections and that the nurse practitioner told her at intake she might have a yeast infection. A urine dipstick was normal. The nurse contacted a provider, who did not examine the patient but ordered Flagyl (which is not used to treat yeast infections). On 1/30/18, a registered nurse saw the patient again for the exact same complaint. The RN notified a provider, who did not see the patient but again ordered Flagyl. This patient did not receive a medical diagnosis for her condition.
- A 48-year-old woman with a history of left eye trauma and artificial eye was seen by an LPN, who noted the patient had swelling of the upper and lower eyelids for the artificial eye.¹² There is no documentation that the LPN contacted a provider, and a provider did not examine the patient. There was an order for topical and oral antibiotics, artificial tears, and referral to an eye doctor. On 1/18/18, an optometrist saw the patient and ordered another five days of oral antibiotics. There is no January 2018 medication administration record (MAR) in the record to show the patient received the medications. A provider has not seen the patient for follow-up for her eye infection.
- A 42-year-old woman signed up for sick call on 1/14/18 and a LPN saw her on 1/16/18. The patient complained of a herpes infection. The LPN did not perform an examination but called a provider, who ordered acyclovir. The medication order was not transcribed onto a medication administration record and there is no documentation the patient received the medication.¹³

⁹ Illinois LPN Scope of Practice. Section 55-30.

¹⁰ NCCHC defines Qualified Health Care Professionals to include nurses without distinguishing between registered and licensed practical nurses. However, RN and LPN practice must remain within their education, training and scope of practice for their respective state.

¹¹ Nursing Sick Call Patient #15.

¹² Nursing Sick Call Patient #12.

¹³ Nursing Sick Call Patient #11.

- A 54-year-old woman signed up for sick call on 1/20/18, but not seen due to No Show. On 1/25/18, a nurse saw the patient, who stated that on 1/20/18 she fell on her left wrist and heard a “pop.” It hurt to move her fingers and wrist. The nurse noted swelling to her wrist and hand. The nurse contacted a nurse practitioner, who did not see the patient but ordered ice, an Ace wrap and x-ray that was performed on 1/31/18 and showed no fracture. The patient had no follow-up for her wrist.¹⁴
- A 36-year-old woman signed up for sick call on 2/19/18 and a registered nurse saw the patient on 2/21/18. The patient complained of herpes simplex and the nurse contacted a provider, who did not see the patient but ordered acyclovir. There is no February 2018 MAR that shows whether the patient received the medication.¹⁵

These cases show a pattern of patients not being examined by a medical provider to establish a medical diagnosis or see the patient for follow-up to determine whether the patient’s condition had improved. Several records show that there is no documentation that ordered medications were received.

In summary, while many patients have timely access to a nurse, not all patients are seen the following day, and there are a high percentage of no shows and refusals. In addition, patients requiring a medical diagnosis are not timely seen by a medical provider. Instead, providers treat patients remotely and do not schedule patients for follow up to assess whether their conditions have improved. This is a particular concern in light of the lack of documentation that patients receive ordered medications.

Medical Records

Methodology: We reviewed multiple medical records and interviewed staff.

First Court Expert Findings

The First Court Expert had no findings with respect to medical records. The First Court Expert did have three recommendations. The first was that medical records staff should track receipt of all outside reports and ensure that they are filed timely in the health record. The second recommendation was that charts should be thinned regularly, and MARs filed timely. The third was that problem lists should be kept up to date.

Current Findings

This facility partially implemented the Pearl® EMR in 2014. The electronic record is an improvement, but the partial implementation of the record has created other problems and makes the electronic record ineffective in supporting the clinical program.

¹⁴ Nursing Sick Call Patient #13.

¹⁵ Nursing Sick Call Patient #19.

The electronic medication administration component has not been implemented. As a result, medication administration records are on paper. The First Court Expert's second recommendation that charts be regularly thinned is no longer pertinent. Many reports of outside consultants are still unavailable in the medical record. This is not a problem of the electronic record but is related to effort of Wexford management in obtaining these reports. The First Court Expert's recommendation to keep problem lists up to date has not been effectively addressed.

The EMR has interfaces with the pharmacy and with the laboratory vendor. Doctors write prescription orders electronically and these are received by BosWell, the pharmacy used by Wexford. These orders appear in the record. The current list of medications appears in progress notes. Laboratory results can be reviewed electronically and can be viewed in a flow sheet format. The same is not true of problems. Although problems can be entered into the database, these are not updated. Also, the list of problems includes items that are symptoms or undiagnosed findings, which are not problems. For example, "weakness" can be listed as a problem. Problems are medical diagnoses and weakness is not a diagnosis. Progress notes, including for chronic illness visits, do not include updated problem lists. It is not clear whether the software lacks this ability or whether it is not used. Also, the previously used paper problem list is no longer in use. Therefore, there is no official problem list that we could identify. Regardless, the electronic record system fails to include one of the major advantages of electronic records, which is to track all of a patient's problems and make those available to clinical staff when they evaluate patients. Because the problem list in the EMR is not maintained accurately, it is unusable for purposes of tracking or monitoring care. Clinicians do not use problem lists when evaluating patients even though a patient's problems can presumably be entered as data elements in the electronic record. Policy should guide who is to enter problems into the problem list and when they are to be entered and updated.

Because the problem lists are ineffective, the list of patients with chronic illness is not obtained from the electronic record. Instead, patients in chronic illness clinics have their chronic illness information manually entered into a security database. This security database is used by the chronic illness nurse to track chronic illness. This is duplicative, risks loss of data by manual entry operations, fails to make the patient's updated problems readily available, and potentially exposes health information to custody personnel. The electronic record should be utilized to track chronic illness.

There are insufficient devices, specifically terminals for use of the record, in some clinical areas, particularly on the infirmary. The providers go to their office to write their records. A device survey needs to be done to ensure that there are sufficient devices for the number of simultaneous users. The electronic record also includes a feature which is dangerous. This record defaults vital signs to the last vital signs obtained. If a patient has vital signs performed on January 1, 2018 and is evaluated on January 5, 2018, the vital signs from January 1, 2018 will present on the January 5, 2018 note unless new vital signs are obtained. Vital signs should be used only for the date and time for which they were obtained.

Remarkably, the program has been unable to obtain data out of the medical record to support the quality improvement effort. Visits, problems lists, laboratory data, and prescription data are all present in the database of the electronic record. Yet, the program does not have the ability to use these data in ways to measure performance. Implementation of an electronic record reduces the need for medical record clerks. Four to five staff are still assigned to medical records and involved with a variety of health information duties including offsite scheduling, obtaining hospital and specialty consultation reports, and providing court ordered records and release of information requests. However, to make the record effective, the program needs to have information technology staff capable of using appropriate data queries of the electronic record in order to obtain useful information on an ongoing basis for the purpose of measuring quality and for tracking clinical data.

We noted extreme difficulty in obtaining information regarding patient immunization. One of the advantages of an electronic record is to present immunization status so that preventive measures can be easily taken. It was not clear whether this feature is unavailable or unused in the current system. Nevertheless, it was easier for us to find immunization status in the paper record at other IDOC facilities than it was in the electronic record at LCC.

The electronic record is only used at the female facilities and is only partially implemented. Yet IDOC administrative directives do not address the electronic record or give guidance on its use or what to do in the event of outages. Adequate policy needs to be developed to guide use of this product.

Lastly, we note that the electronic record makes it easier to cut sections of a progress note from a prior note and copy the cut piece to another note as a way to produce a note without much writing. The problem is that every note must represent exactly the evaluation during the episode of care being documented. When cut and pasted notes are used, it appears that the doctor is using documentation from a prior episode of care to describe a current episode of care. This is inaccurate and unprofessional documentation. We noted cut and pasted notes for some patients on the infirmary that made it impossible to determine if they were an accurate representation of the patient's actual condition at the time of evaluation. We strongly recommend against cut and pasted notes, as they appear inaccurate and appear to misrepresent the actual condition of the patient.

Urgent/Emergent Care

Methodology: We reviewed records of four patients who nurses evaluated for urgent care complaints. We also reviewed six patients who were hospitalized to assess whether the hospitalizations may have been preventable with timelier or improved primary care.

First Court Expert Findings

The First Court Expert found that there was no log to track urgent calls from housing units or to track patient send outs on an emergency basis.

Current Findings

We found that nurses now track unscheduled evaluations on the nurse sick call log. We found that LPNs and RNs independently managed patients with urgent medical symptoms and did not notify a medical provider, increasing risk of harm to patients. LPNs exceed their scope of practice by performing independent nursing assessments. Even when notified, medical providers did not examine and evaluate patients with potentially serious medication conditions. The following cases are illustrative.

- A 51-year-old woman with a history of asthma, hypertension, and chronic hepatitis C infection was a code 3 on 1/22/18.¹⁶ The patient reported burning in the center of her chest radiating to her throat and vomiting x 1. The chest pain protocol instructed the nurse to call the provider urgently for patients with a history of hypertension. The LPN did not refer the patient to a provider but instead ordered Pepcid. On 2/17/18, an LPN responded to a code 3. The patient was found sitting on the floor stating that she was dizzy. The nurse did not perform any cardiovascular review of systems (e.g., chest pain, SOB). The patient's vital signs were normal. The LPN determined that the patient should rest in her cell and did not contact a provider. On 2/19/18, an LPN responded to a code 3. The patient reported chest pain and dizziness. Again, the nurse performed no cardiovascular review of systems. Vital signs were normal. The patient's last EKG showed nonspecific T-wave abnormality. The LPN did not contact a provider. These LPNs independently managed this patient with dizziness and chest pain, which is well beyond their scope of practice. We discussed this case with the HCUA.
- This 53-year-old woman had a history of six hospitalizations for asthma as well as diabetes, hypertension, hyperlipidemia, and hypothyroidism.¹⁷ On 12/6/17, the patient presented to the HCU stating, "I need a breathing treatment." A LPN evaluated the patient whose vital signs were blood pressure 140/90mm Hg and pulse=90/minute. The nurse did not ask about the frequency of symptoms. The patient had right lower lobe wheezing. The LPN did not measure peak flow expiratory rates (PEFR) or oxygen saturation. Apparently the LPN administered a nebulizer treatment and documented "no wheezing after treatment." On 12/9/17, a RN assessed the patient for shortness of breath. The patient told the nurse, "At home I use steroid, here I am not on one." The patient's PEFR's showed her asthma was poorly controlled (Before treatment PEFR=150/200/225). The patient had scattered faint wheezing throughout posterior bases. The treatment protocol indicates provider referral "if peak flow less than 300 does not improve with Albuterol." However, the nurse did not measure PEFR's after treatment and did not contact a physician for steroid inhaler or referral back to chronic disease program. On 12/10/17, the patient presented again with SOB. The nurse did not measure vital signs or PEFR. The oxygen saturation was 95% with wheezing upon expiration. It is unclear from the note if the nurse treated and if so, there was no post treatment assessment. On 12/19/17, a physician saw the patient and added prednisone,

¹⁶ Urgent/Emergent Patient #3.

¹⁷ Urgent/Emergent Patient #4.

inhaled steroid and Xopenex. On 1/22/18, an LPN assessed the patient as a code 3 with SOB. "I am having trouble breathing." The patient had wheezing auscultated in all lobes with oxygen saturation of 95%. No vital signs or PEFr were obtained. The LPN gave the patient a breathing treatment and did not assess the patient afterwards, documenting that the patient was to return to the clinic as needed. On 1/25/18, the patient presented with a two-week history of a cold. The temperature was 99.5°F and blood pressure was 158/100mm Hg. On 1/30/18, the NP saw the patient for chronic disease management; patient noting that she used her steroid inhaler (Alvesco) three to four times, and that the patient's asthma was in fair control. The NP scheduled her for follow up in six months. In this case, both LPNs and RNs performed inadequate assessments of a patient with asthma and exceeded their scope of practice by independently treating the patient and/or not timely referring the patient to a provider. The NP did not schedule the patient for follow-up in accordance with her disease control.

- A 45-year-old woman with a history of hypertension presented with chest pain on 1/3/18.¹⁸ An LPN saw the patient, whose vital signs were normal. The LPN performed an EKG that was read by a nurse practitioner, who did not examine the patient or medically evaluate the patient. On 2/6/18, the physician saw the patient and addressed her hypertension and chest pain. This was not timely care.
- A 23-year-old woman was seen by an LPN on Wednesday, 12/20/17 for sore throat, body aches, and nasal congestion.¹⁹ The patient had a fever of 101.4°F with no other vital signs measured. The patient's throat was red with enlarged lymph nodes. The LPN planned to refer the patient to a provider but a medical provider did not examine the patient. An OB/GYN wrote an order for azithromycin the same day. It is unclear whether and when the patient received the medication. On Saturday 12/23/17, the patient presented urgently with sore throat and inability to swallow. A RN saw the patient and noted a swollen soft palate that was deviated to the left. The patient was unable to speak or able to swallow. The temperature was 100.5° F, the pulse was 125/minute, and the blood pressure was 130/83. A registered nurse contacted a NP, who ordered the patient sent to the hospital, where the patient underwent incision and drainage of a peritonsillar abscess. On 12/23/17, the patient was sent back to the facility on Augmentin and admitted to the infirmary for 24-hour observation. On 12/25/17, the physician reviewed the note from the hospital, but did not see the patient until 1/13/18, three weeks after she was hospitalized. A provider should have examined the patient on 12/20/17 and timely seen the patient following hospitalization.

In the six hospital records we evaluated, we noted delayed diagnosis in four of the six patients. These delays included:

- A three-month delay in evaluation of pancreatic cancer
- A 10.5-month delay in treatment of a sigmoid-vaginal fistula

¹⁸ Urgent/Emergent Patient #2.

¹⁹ Urgent/Emergent Patient #1.

- A two-day delay in hospitalization for a life-threatening drug overdose
- An 11-month delay in identification of colon cancer which likely resulted in dissemination of the cancer.

In four of six hospitalizations there were incomplete or no hospital records. The delays in treatment include systemic deficiencies, including:

- Failure to obtain records from transferring jails related to diagnoses of the patient and failure to act on information obtained in transfer documents
- Failure to timely obtain diagnostic studies for serious illness
- Failure to establish an appropriate and timely treatment plan for abnormal findings
- Failure to appropriately assess or act on laboratory findings.

We note some of these problems in cases below. We also note that several of these cases are discussed in the section on specialty care below.

- The first patient was incarcerated at LCC on 1/11/17.²⁰ The patient had a prior positive tuberculosis skin test and therefore received a screening chest x-ray. This x-ray showed a 6 mm nodule with streaking from the nodule and a small pleural effusion. The radiologist recommended obtaining a CT scan, as this was suspicious for cancer. A PA consulted a doctor, who told the PA instead of obtaining a CT scan to obtain a repeat chest x-ray in three months. This was not appropriate care as the nodule was suspicious for cancer. In three months, a repeat chest x-ray was done and showed a large right pleural effusion with a large consolidation on the right lung. The effusion was compressing the lung. The radiologist again recommended a CT scan. This patient should have been admitted to a hospital for diagnosis and evaluation of the large pleural effusion. Instead of admitting the patient to a hospital for a diagnosis, the doctor admitted the patient to the infirmary and ordered routine blood tests, antibiotics, presumably for pneumonia, and another chest x-ray. The radiologist had recommended a CT scan on the second x-ray report, but this was not done.

Within four days of being on the infirmary the patient was short of breath, had unilateral leg edema, and was wheezing. The unilateral leg edema was suggestive of a deep vein thrombosis. This in combination with a large lung consolidation and pleural effusion, should have prompted immediate hospitalization to evaluate for pulmonary embolism and to perform thoracentesis for diagnosis of the pleural effusion. Instead, the doctor initiated treatment for deep vein thrombosis (Lovenox), treated for presumptive pneumonia, and ordered an urgent Doppler test and routine CT scan of the chest. This was dangerous for the patient, as the doctor did not have a diagnosis for a potentially life-threatening condition. Three days later, the urgent Doppler test had not yet been done and the doctor ordered another chest x-ray, which was unchanged. This resulted in the doctor finally admitting the patient to a hospital.

²⁰ Patient #1 Hospitalization and Specialty Care.

The patient had deep vein thrombosis, pulmonary embolism, adenocarcinoma of unknown primary, and disseminated cancer to pleura and peritoneum. The patient received the first cycle of palliative chemotherapy with a recommendation for follow-up chemotherapy. It was somewhat difficult to follow the course of care, as the doctor was writing notes not on the date of evaluation but at home from memory. The doctor was also using cut and pasted notes, which created an impression of identical notes being repeated, which may or may not have represented the actual condition of the patient or evaluation of the provider. The doctor at LCC also did not prescribe pain medication consistent with recommendations of the oncologist. Based on equivalency dosing, the patient was receiving less pain medication than recommended by the oncologist.

In summary, this patient's cancer diagnosis was delayed by about five months. It may not have made a significant difference in ultimate outcome. However, the patient did have a life-threatening presentation (pleural effusion, leg swelling, shortness of breath, and wheezing) and was not admitted to a hospital for four days. This placed the patient at significant risk of harm and is inconsistent with generally accepted guidelines for a pleural effusion.

- Another patient was a 43-year-old woman who had a history of HTN, COPD, and prior gastric surgery in the past for unstated reasons.²¹ The intake history and physical examination on 7/5/17 failed to identify the reason for the gastric surgery. Intake laboratory results showed anemia and low white blood count. There was no follow up of these significant abnormal laboratory results.

The patient had a mental health condition and within a month of incarceration, a mental health staff member documented that the patient was not eating. The patient then began complaining about her stomach hurting and not wanting to eat because of this problem.

On 8/16/17, the patient was admitted to the infirmary by mental health for "failure to thrive, R/O medical vs. psychosis." Initial laboratory results showed pancytopenia.²² The white count was low, and the absolute neutrophil count was 492, which is severe neutropenia and a critical level. The laboratory tests also showed a critical value of valproic acid at 154 (normal 50-100). This drug was being used to manage the patient's mental health conditions. The elevated valproic acid can be associated with pancytopenia. Valproic acid toxicity is also known to result in central nervous system dysfunction, low blood pressure, and liver dysfunction. The patient was not eating or drinking fluid and a doctor ordered intravenous fluid, but the intravenous line was not working well, and the IV fluid was not flowing. A doctor examined the patient on 8/17/17, and the patient had hypotension (94/81), which was unnoticed by the doctor.

²¹ Patient #2 Hospital and Specialty Care.

²² Pancytopenia is a low level of white blood cells, red blood cells and platelets. This is a serious problem that typically in all cases requires prompt referral to a hematologist for consideration of a bone marrow biopsy.

Hypotension can be caused by valproic acid toxicity and should have resulted in hospitalization, as it was unsafe to keep a patient with critical, severe neutropenia and hypotension on an infirmary unit. The patient was nevertheless kept on the infirmary for two days despite the critical valproic acid level and pancytopenia. The patient eventually began vomiting and developed altered mental status. She was lethargic, unable to answer questions, and was speaking unintelligibly. The patient was eventually sent to a hospital on 8/19/17, several days after critical blood pressure and pancytopenia in the context of valproic acid toxicity were identified. There was no hospital report and it was not clear what occurred at the hospital. Partial records documented elevated ammonia, pancytopenia, encephalopathy, and valproic acid toxicity as initial problems. There was no discharge summary, so the discharge plan was not available.

On return to LCC, a repeat blood count showed persistent pancytopenia. A doctor noted that because the absolute neutrophil count was 1.2 the patient was “stable.” Pancytopenia is a serious condition, and because the etiology of the pancytopenia was uncertain, the patient should have been referred to a hematologist. There was no documentation of why the patient was hospitalized or what occurred in the hospital. The doctor did not address the pancytopenia in her assessment or plan. The weight was not monitored. There was not a plan for the patient’s weight loss or pancytopenia.

The LCC Medical Director discharged the patient from the infirmary (when the doctor was at home) at midnight without documenting the discharge diagnosis from the hospital and without documenting a discharge plan to evaluate the pancytopenia. The discharge date was 8/31/17, but the note was written on 9/7/17. The doctor’s note at midnight appeared to be a cut and pasted note taken from a prior mental health note. The only diagnosis was schizoaffective disorder. This is unacceptable documentation and care.

The patient had two subsequent blood counts, the latest of which was on 10/2/17. This test continued to show low white count, anemia, and absolute neutrophils of 760, which is moderate neutropenia. This continued problem in light of correction of the valproic acid toxicity warranted hematology consultation, but it was not addressed. The doctor noted that the patient was “stable” and could “come to sick call if problem.” This was indifferent to the patient’s serious medical condition. Low white count with anemia can reflect a serious problem including cancers, immune disorders, or other serious conditions.

- Another patient transferred from Cook County Jail with information that the patient had a pending appointment with colorectal surgery.²³ The intake history failed to identify why the patient had a pending colorectal surgery appointment. The patient gave a history of significant weight loss, but the weight loss was not included in the intake problem list and there was no diagnostic effort to evaluate for weight loss. This weight

²³ Patient #3 Hospital and Specialty Care.

loss could be verified because the patient had a prior incarceration in the IDOC, and in prior IDOC notes weighed 245 pound in 2014; the weight on admission on 5/18/16 was 189. The failure to address a verified 56-pound weight loss was unacceptable.

About three weeks later, on 6/6/16, a nurse practitioner took a history that the patient had prior tumors identified during a cystoscopy performed earlier that year. The patient also gave a history of a prior colonoscopy in December of 2015. The nurse practitioner did request old records, which showed that the patient had a CT scan in December of 2015 showing a posterior bladder wall mass of 3.4 cm. The patient was sent to an urologist and eventually that patient had a cystoscopy on 8/23/16, two months after intake. This procedure was normal.

In the meantime, on 7/8/16, the patient began complaining of stool coming out of her vagina. A doctor evaluated the patient on 7/25/16 and wrote that she would "consider" a CT scan. Lacking the prior CT scan, a new diagnostic study should have been done, as the patient had considerable weight loss, history of an abdominal mass, and stool coming out of her vagina. Instead, the doctor waited for the cystoscopy. This procedure was done on 8/23/16, but there was no report. There was also no report of a follow-up visit on 9/7/16 to the urologist except the urologist wrote on the referral form, "no malignancy in bladder... F/U prn [recommend] gyne eval."

A doctor saw the patient on 9/7/16 and obtained a history that the patient had stool coming out of her vagina for three months. On 9/15/16, a doctor referred the patient to a gynecologist, who saw the patient on 9/23/16 and recommended an ultrasound to rule out a recto-vaginal fistula. The ultrasound was done 10/3/16 and the radiologist recommended a CT scan. The CT scan was done on 10/25/16 and showed a suspected fistula between the sigmoid colon and the vagina. A doctor referred the patient to a colorectal surgeon on 11/3/16. Notably, when the patient transferred from Cook County Jail, the patient had a pending appointment to colo-rectal surgery which was ignored. The colorectal surgeon saw the patient on 11/28/16, but again there was no report in the medical record. The surgeon recommended an MRI and surgical exploration. On 12/12/16, the MRI was done, but there was no report. The patient had a colonoscopy on 12/30/16, but there was no report and it was not clear what happened. The patient went to colorectal surgery on 1/19/17 for follow up, but again there was no report. This patient eventually obtained surgery to repair a sigmoid colon-vaginal fistula on 3/28/17, but the failure to take an adequate history at intake regarding weight loss and to address the pending colorectal surgery appointment at the Cook County Jail resulted in a 10-month delay in treatment of the patient. The failure to obtain consultation reports impaired the ability of the providers to understand the status of the patient.

Specialty Consultations

Methodology: We reviewed specialty care tracking logs, interviewed the scheduling clerk and performed record reviews of persons who received specialty care.

First Court Expert Findings

The First Court Expert found that when patients return from scheduled consultations, they are not brought to the health care unit. Review of paperwork, including recommendations, and scheduling of follow-up visits did not consistently occur, resulting in failed follow up. Also, the process of offsite scheduling begins with the collegial review, and the referral date by the clinician is not tracked. Record reviews showed that consultation reports were unavailable in the medical record. In a review of records, the First Court Expert found that in three of five records there was no follow up of the consultation by the primary care provider. Also, the First Court Expert reviewed care of 13 patients referred by an outside attorney. Of these 13 patients, six (46%) consisted of delayed or denied necessary specialty care.

Current Findings

Specialty care referrals are initiated via the electronic record. The scheduling clerk collects the referrals electronically on the Tuesday before collegial reviews from an inbox in the electronic record. The supporting data is obtained by the clerk and emailed to the Wexford UM reviewers. The referral is placed on the tracking log only when the referral is approved by the utilization reviewer. Referrals need to be placed into the medical record whether they are approved or not.

Review of specialty care continues to be difficult.²⁴ We examined the first month of specialty referrals for 2017. There were 62 referrals for care. Collegial reviews occurred within five days for 60 (97%) of referrals. However, we noted in a separate review of multiple consultations for a single patient that referrals in seven of eight consultations occurred close to a day before the approval, even when it appeared that the actual referral²⁵ occurred weeks before the approval indicating that the log is not accurately maintained. Fifty-five of these 62 (92%) referrals occurred within a month of the referral. The log used by the scheduling clerk and presented to us for our investigation does not contain all specialty referrals. In our interview with the scheduling clerk, we were told that only completed consultations are maintained on this log. Denials are not placed on the log. Though we were told that there are five or less denials in a year, there were 31 denials provided to us over an eight-month period or approximately 46 denials pro-rated over the past year.

We evaluated a series of consultations in the medical record of one patient to assess whether medical care was timely and appropriate.

²⁴ It has been very difficult to investigate this area of service. We asked for the tracking log as used by the scheduling clerk at the site in a spreadsheet format to include the name, Illinois Department of Corrections number, date of referral for specialty care, date of collegial review, date of approval, date of service, and the service referred for. We again did not receive what we asked for. We were sent a PDF file which could not be sorted. There were 39 pages of appointments not in chronologic order for any of the items. This made it very difficult to use. After receiving this list, we asked again for the spreadsheet used by the scheduling clerks at the site. I received an email on April 20, 2018 that the Wexford site team used the PDF file for tracking and did not use a spreadsheet. This PDF was too disorganized to effectively use. Once at the site, we discovered that the site did use a spreadsheet and asked for and received this document before we left. This delayed our ability to review this process.

²⁵ When a consultant recommends a follow up or specialized test, we view that recommendation as a date of referral. Many consultant recommendations do not appear to be evaluated timely and thus their new referrals for care may not be addressed for weeks. LCC apparently uses the collegial review episodes to coordinate referrals rather than the physician review of offsite consultation. This makes care appear more timely than it actually is.

- We examined a patient who had multiple consultations.²⁶ This patient had multiple sclerosis (MS). We examined eight of his consultations on the tracking log from 12/1/15 to 1/18/18, and three consultations occurring before the tracking log started. There were two denials for referrals to neurologists in late 2014 (8/14/14 and 12/29/14). The alternative treatment plan recommended was “conservative” therapy without any explanation of what this might be for someone with MS. The doctor appeared unsure of how to manage the patient. These denials prevented neurology consultation for MS, which is generally accepted medical care.

Of the eight consultations on the tracking log, there were only five consultation reports in the medical record. One of the reports was filed two months late. Six of eight referrals were timely based on the tracking log. However, one referral was to UIC with a recommendation for a four month follow up. This never occurred; instead the patient was sent to a local neurologist, even though the local neurologist recommended that the patient see a neurologist at a major medical center. Two of the eight referrals were late. One was one month late and the second was five months late. Two of the eight visits were for MRI tests. In neither was there documented evidence that a doctor had reviewed the results. For two of the six neurology consultations there was no evidence that a provider reviewed the consultation findings with the patient or reviewed what occurred at the consult. After another consultation visit, the findings were not reviewed for about six weeks after the consultation. After another consultation, a doctor saw the patient but did not document review or understanding of what occurred at the neurology consultation. After only two of the eight consultations was there evidence of understanding of what occurred at the consultations. Referrals were documented on the log on average about three weeks after the actual consultation was referred by the consultant or LCC provider. The actual log documents six of eight approvals as occurring the day following the referral, making it appear that the tracking log is maintained based on collegial review events rather than based on the clinical referral itself.

Doctors at LCC did not document understanding of what occurred at neurology visits or understanding of the MRI results. This lack of understanding of what occurred at the consultations was important because the patient’s chronic condition was not being monitored well in chronic clinics. This patient was being followed in chronic clinic every six months, but providers were not consistently seeing the patient after neurology consultations or documenting understanding of the consultant’s findings and recommendations. The providers did not perform adequate history or assessment of the patient’s MS. Providers inconsistently documented the therapeutic plan of the neurologist and did not independently perform adequate assessments. Because it did not appear that physicians at LCC knew how to manage this disease, the patient needed to be followed by a neurologist. Indeed, physicians at LCC attempted to refer to neurologists on four occasions because the patient was not getting better on prescribed care. Yet, on four occasions when LCC physicians wanted to refer to a neurologist, the

²⁶ Patient #4 Hospital and Specialty Care.

Wexford utilization physician denied their referral. On two occasions the UM physician asked that the LCC physicians use “conservative” management without advising what this meant for this complex disease. On two other occasions, a neurologist wanted the patient to be sent to a tertiary care neurologist for management. These requests were also denied. These denials were not all tracked on the tracking log. The facility HCUA had to intervene to get the Agency Medical Director to overrule this UM decision.

When the patient was sent to the neurologist at the major medical center (UIC), the consultation took eight months to occur. The neurologist at UIC could only perform a limited examination because correctional officers kept the patient in restraints during the evaluation. The neurologist had no information available. MRI tests and ophthalmology reports, requested to be sent, were not sent with the patient. The neurologist stated that the patient might need a second line disease modifying agent. The consultant recommended an MRI, different disease modifying agents, and a follow up in four months, but this follow up never occurred and the patient was sent back to the local neurologist. This specialized consultation was ineffective due to lack of information and inability of the neurologist to perform an adequate examination.

The ineffective and inconsistent monitoring of the patient at the facility was compounded by an unprofessional attitude of one of the physicians. After the UIC neurology consultation, the LCC doctor believed that the patient was faking and failed to undertake the recommendations of the UIC neurologist. The LCC doctor wrote, “In my opinion voluntarily exhibits purposeful resistance to exam for secondary gain I see no neurological finding.”

This patient appeared to deteriorate clinically over four years and had inconsistent neurology management. There were four denials of care when doctors at LCC deemed the level of care to be beyond their expertise. Wexford utilization physicians denied care without providing LCC physicians appropriate alternative therapeutic plans. A cynical and unprofessional attitude by one of the LCC physicians appeared indifferent to the patient’s real and inconsistently treated disease.

We noted multiple episodes of care, which based on contemporary standards of care, should have resulted in diagnostic testing or consultations, which were not referred. In at least two cases, harm resulted to the patient. It is our opinion that this aversion to timely and appropriate referral is related to the utilization process. We had an opportunity to observe a “collegial review” process at LCC. The “collegial review” took only about five minutes and consisted of the utilization doctor reciting the offsite referrals and giving approval or asking for more information. There was little “collegial” discussion about the cases. This process appears to be an approval meeting as opposed to a collegial discussion about cases. Staff told us that this “collegial review” typically only takes a few minutes to conduct. Collegial review is a misnomer, as there is no meaningful collegial discussion of cases. It is an approval process and, in our opinion, does not contribute to patient safety. We continue to believe that this process should be abandoned to protect patient safety. In our limited chart reviews, we identified four

denials²⁷ in a single patient for necessary care for multiple sclerosis without any documented collegial discussion of alternative plans, a delayed diagnosis of colon cancer that likely resulted in unnecessary spread of the colon cancer,²⁸ failure to send a patient²⁹ with necrotic foot lesions to a podiatrist or to thoroughly evaluate for osteomyelitis, failure to evaluate a diabetic patient³⁰ with a draining ulcer over the tibia for MRI, bone biopsy, or infectious disease consultation to evaluate for osteomyelitis, and a failure to obtain pulmonary function testing in a patient³¹ with COPD.

- Another patient was 50 years old.³² Earlier in her incarceration, on 8/15/13, she weighed 250 pounds. On 12/1/16, the patient complained at an annual health evaluation of abdominal pain and bloody stool. The only diagnostic screening that was done was a rectal examination noting a guaiac negative stool.³³ The patient should have had a colonoscopy on the basis of symptoms and age.

Subsequent blood counts showed that the patient had anemia. When a doctor saw the patient and took a history of bloody diarrhea for three months, the doctor ordered metronidazole, apparently treating the patient for colitis on a presumptive basis. The doctor failed to notice the weight loss. Also, bloody diarrhea warrants a CT scan of the abdomen and colonoscopy, which were not done.

More than a month later, on 2/27/17, the doctor noted continued diarrhea and the stool was positive for blood. This warranted colonoscopy. But the doctor diagnosed hemorrhoids and prescribed hemorrhoidal cream. While the patient may have had hemorrhoids, the more serious potential diagnosis (colon cancer) should have been excluded with a colonoscopy. This was not done. The patient was not seen for over four months, when a different doctor saw the patient for an annual physical examination. The doctor performed a rectal examination but did not test stool for blood. The patient now weighed 215 pounds (35-pound weight loss) and the weight loss was noted by the doctor who wrote, "hemorrhoids, historically is a long-term problem without any red flags to indicate a more significant condition." This statement was grossly and flagrantly unacceptable. A 50-year-old person with 35-pound weight loss and blood per rectum with anemia needs to have a colonoscopy and possibly a CT scan of the abdomen. Instead nothing was done. The patient had red flags unrecognized by this physician.

Two months later, the patient continued to lose weight and weighed 204 pounds. The patient had abdominal pain with blood in her stool. The doctor diagnosed non-specific pain and took no action. This also was grossly and flagrantly unacceptable practice.

²⁷ Patient #4 Hospitalization and Specialty Care as discussed above.

²⁸ Patient #5 Hospitalization and Specialty Care as discussed below.

²⁹ Patient #6 Hospitalization and Specialty Care as discussed below.

³⁰ Patient #7 Hospitalization and Specialty Care.

³¹ Patient #8 Hospitalization and Specialty Care as discussed below.

³² Patient #5 Hospitalization and Specialty Care.

³³ Digital rectal examination even with guaiac testing will miss 90% of colon cancers. A colonoscopy was indicated.

On 9/20/17, a nurse practitioner noted ongoing abdominal pain for the past seven months. The nurse practitioner ordered a pelvic ultrasound and blood count. A colonoscopy or abdominal CT scan were indicated, not a pelvic ultrasound.

On 9/26/17, the Medical Director saw the patient, who was complaining of abdominal pain, nausea, vomiting, and diarrhea. The patient had 48-pound weight loss. The doctor ordered blood tests and a plain abdominal x-ray, which is not a useful test when evaluating anemia, weight loss, and bloody stool. It appeared that there was either ignorance of an appropriate work-up or a reluctance to refer appropriately. We asked the Medical Director what she would do for someone in her private practice for colorectal cancer screening and she indicated that she would typically order colonoscopy. She had no answer to why this was not being done at LCC. This patient should have had prompt colonoscopy, but it was not done. Presumably the utilization process is a barrier to adequate care.

The ultrasound was done 9/29/17 and only showed stool. A pelvic ultrasound is not an appropriate diagnostic test to exclude colon cancer. Finally, on 10/7/17, the Medical Director ordered a CT scan of the abdomen. On 10/16/17, the CT scan showed a large circumferential thickening of the sigmoid and descending colon consistent with cancer. MRI and colonoscopy were recommended. On 11/10/17, a colonoscopy showed a large ulcerated rectosigmoid lesion suspicious for cancer. The scope could not be passed beyond the mass. The patient was referred to an oncologist and had surgery on 11/28/17, where stage IV disseminated colon cancer was diagnosed. The patient saw the oncologist on 12/28/17.

This patient had an 11-month delay in diagnosing colon cancer, likely resulting in unnecessary dissemination of the disease, which harmed the patient. The patient had symptoms consistent with colon cancer (weight loss, blood per rectum, abdominal pain, and anemia) on 12/1/16, yet did not have a colonoscopy until 11/10/17. Providers saw the patient seven times during that time interval and presumed a more innocent diagnosis, even though the patient's symptoms and findings were consistent with colon cancer.

- Another patient with diabetes, asthma, deep vein thrombosis, and hypertension was incarcerated at LCC on 8/10/17.³⁴ An intake nurse noted that the patient had recent surgery on her leg for an infection. The wound was open and draining. The intake physician assistant documented that the patient had repeated episodes of deep vein thrombosis and required life-long anticoagulation.

At a subsequent evaluation, a doctor noted that the patient had the leg wound for over two years and was told she had a bone infection by staff at Stroger Hospital in Chicago.

³⁴ Patient #7 Hospitalization and Specialty Care.

Osteomyelitis generally requires intravenous antibiotics. The prior record from Stroger Hospital was not obtained. An initial sedimentation rate was slightly elevated at 27 (nl < 20) and an x-ray of the leg was normal. This patient should have had osteomyelitis excluded unless prior records demonstrated that the patient was adequately treated.

Over the course of eight months the patient continued to have drainage from an ulcer on her tibia. This indicated that the osteomyelitis was likely still present. A draining ulcer over a bone in a person with diabetes must include exclusion of osteomyelitis. This did not occur for this patient. The patient was treated with multiple different antibiotics simultaneously, including, for example, Bactrim, Levaquin, metronidazole, and fluconazole. Fluconazole is an antifungal therapy. We could not determine for what reason this drug was being used. Treatment of osteomyelitis is typically intravenous antibiotics for an extended period. There was not a reasonable effort to evaluate for osteomyelitis.

The patient was hospitalized in late December of 2017 for a MRSA cellulitis of the leg, but the hospital record was unavailable, and it was unclear if the patient received evaluation for osteomyelitis. The patient continues to have drainage from the leg ulcer with brawny skin changes. The patient has never had a thorough evaluation (MRI of the leg, CRP, bone biopsy) for osteomyelitis. A doctor referred the patient to an infectious disease doctor, but this referral was denied. The alternate treatment plan was to perform another wound culture, which was unlikely to be useful in the contaminated wound. The patient needed MRI, bone biopsy, ankle brachial index, and CRP.

- Another patient was transferred to LCC from Jackson County Jail on 1/6/17 with a history of mitral valve heart disease.³⁵ The patient had a prior history of clusters of blisters on her feet during a prior incarceration in 2015. The patient experienced episodes of what sounded like a fugue state. A doctor saw the patient on 2/15/17 for an episode of “temporary amnesia.” Without taking an adequate history and performing a neurological examination, the doctor documented the patient as “neuro normal,” diagnosed epilepsy, and enrolled the patient in seizure clinic and started Depakote, an anti-epileptic drug. A nurse practitioner changed the Depakote to Keppra, another anti-epileptic drug, at a later date. The patient remains on anti-epileptic drugs without ever having a witnessed seizure and without having had an EEG, or CT scan. The latter tests are typically required diagnostic studies for all new onset seizures. In this case, there was little evidence that the patient had a seizure and no diagnostic evaluations to diagnose this condition. The patient should have been sent to a neurologist, as the facility providers did not appear to know how to evaluate a new onset seizure disorder and the patient may not have epilepsy.

In addition, this patient again developed blisters on her feet on 1/11/18. Initially, a doctor ordered Diflucan, an antifungal agent, and metronidazole by phone order,

³⁵ Patient #9 Hospitalization and Specialty Care.

without evaluation. The blisters worsened and eventually on 2/8/18 a doctor diagnosed “foot rot” between the toes. Vinegar soaks, metronidazole, Keflex, and fluconazole were ordered. None of these antibiotics or antifungal agents is typically used for initial treatment of skin and soft tissue infections which, in a prison, need to cover for MRSA.

A doctor continued to treat the patient with multiple antibiotics and Diflucan, an anti-fungal agent, for over three months. During our tour we evaluated the patient, who had necrotic black tissue covering the webs between all the toes of her foot. We were told that the HCUA pressured the Medical Director to obtain an infectious disease consultation, which is scheduled for 5/1/18. The providers have not debrided the necrotic tissue, which needs to be removed until healthy tissue is present. The depth of the ulcerations on the feet has not been determined. If, after debridement, the wound probes to bone, then evaluation for osteomyelitis needs to be initiated. The patient should be treated with antibiotics appropriate for the type of infection and we agree with the infectious disease consultation, which should have been initiated earlier in the course of the infection and was only initiated at the urging of the HCUA.

- Another patient was a 49-year-old with a history of diabetes, hypertension, prior deep vein thrombosis, and presumed rheumatoid arthritis with long-term oral steroid use to treat her presumed rheumatoid arthritis.³⁶ This patient was incarcerated at LCC prior to initiation of the EMR and her old record volume was inaccessible and could not be reviewed. The patient had apparently been evaluated by a Wexford telemedicine rheumatologist, although there were no documented notes of these encounters in the medical record. The first documented chronic clinic visit was on 5/23/14, and the doctor noted that the patient had been on prednisone for years and had not seen a rheumatologist since 2008. It was unclear when the patient was incarcerated. The patient was on 20 mg of prednisone a day, which is an extremely atypical therapy and is not currently recommended.³⁷ On 9/15/14, a doctor on the infirmary documented that the Wexford rheumatologist recommended decreasing the prednisone dose from 20 mg to 15 mg. This is still an exceedingly high dosage, likely to cause adverse effects.

On 5/14/15, the patient was finally referred to a rheumatologist. The rheumatologist noted that the patient had no evidence for synovitis, yet had diabetes and Cushingoid presentation. This was likely from excessive prednisone use. The rheumatologist recommended stopping the non-steroidal medication and tapering the patient off prednisone. The rheumatologist recommended blood tests to monitor the use of methotrexate. The patient returned to the rheumatologist once more on 10/9/15. This was two months later than recommended. The rheumatologist noted that the facility physician had increased the dose of prednisone and again noted that there was no

³⁶ Patient #6 Hospitalization and Specialty Care.

³⁷ While short courses of oral steroids are used for rheumatoid arthritis, long-term steroid use is not recommended. Use of disease-modifying anti-rheumatic drugs (DMARDs) are recommended. Use of glucocorticoids are recommended only as adjunct therapy. Chronic use of steroids can cause increased risk of adverse events including osteoporosis, fractures, gastrointestinal bleeding, diabetes, infections, cataracts, and impaired adrenal function.

synovitis.³⁸ Synovitis is a key feature of rheumatoid arthritis and not having synovitis suggested that the patient might not have rheumatoid arthritis. The patient was still on the non-steroidal medication and the rheumatologist recommended again to stop the non-steroidal medication and to decrease the prednisone dose to 10 mg. The rheumatologist recommended a six month follow up, with an accurate list of the patient's medications. There were no further rheumatology visits.

The patient was not referred back to a rheumatologist and yet was continued on relatively high doses of prednisone, contrary to recommendations of the rheumatologist. On 3/1/17, a nurse practitioner saw the patient in general medicine chronic clinic for her rheumatoid arthritis. The nurse practitioner referred the patient to a rheumatologist but sent the request via the Medical Director. This referral was never made by the Medical Director. The Medical Director subsequently obtained x-rays of the hands and ordered a sedimentation rate. The x-rays showed no evidence for rheumatoid arthritis, and the sedimentation rate was normal. There were no erosions and no evidence for rheumatoid arthritis. Thus, the patient had no evidence of rheumatoid arthritis, as the patient had no evidence of inflammatory arthritis of any joint and no residual bony defects (erosions) consistent with rheumatoid arthritis. Also, a rheumatologist previously stated that the patient had no evidence of synovitis in any joint.

Nevertheless, LCC physicians failed to refer this patient to a rheumatologist and continued to treat the patient as if she had rheumatoid arthritis, with prednisone, methotrexate, and eventually hydroxychloroquine, all of which had significant potential adverse reactions. The Federal Drug Administration has assigned multiple black box warnings³⁹ for methotrexate and describes a multitude of adverse actions related to prednisone. Hydroxychloroquine also has multiple potential adverse actions, especially retinal toxicity that can result in irreversible retinopathy. While it was unlikely that the patient had rheumatoid arthritis, the patient was experiencing multiple adverse consequences of the treatment for presumed rheumatoid arthritis including diabetes, elevated high triglycerides, and fatty liver; all consequences of prolonged high dose prednisone use. The fatty liver was unrecognized as a problem. The elevated triglycerides were initially treated with fenofibrate, which is not a first or second-line therapy for elevated triglycerides. This drug should be used with caution in persons with liver disease, but the fatty liver was unrecognized by the facility providers. Fenofibrate was started apparently in December of 2016 and was eventually stopped in April of 2017. The diabetes, likely caused by the unwarranted use of prednisone, caused additional problems.

³⁸ This suggested that the patient had no active manifestations of rheumatoid arthritis and probably did not have rheumatoid arthritis.

³⁹ According to the FDA, a black box warning is a warning designated to call attention to serious or life-threatening risks that can cause disability, be potentially life-threatening, and can result in hospitalization or death. As found at <https://www.fda.gov/downloads/forconsumers/consumerupdates/ucm107976.pdf>.

The patient also had diabetes with HbA1C levels demonstrating poor control as of April of 2018 (HbA1C 8.3). The poorly controlled diabetes likely caused the fatty liver and elevated triglycerides, which are a risk factor for heart disease. The patient also developed a diabetic foot ulcer, first noticed on 11/30/15. The diabetic foot ulcer was improperly treated, as the patient was allowed and even encouraged to walk on the foot, when recommended therapy is to not have the patient walk on the affected foot. The patient did have an evaluation for vascular insufficiency (ankle-brachial index) but did not have an evaluation for osteomyelitis despite having the ulcer for at least 15 months. We stopped review of this record in April of 2017 and were unsure whether the ulcer was present after this. A diabetic foot ulcer for 15 months needs evaluation for osteomyelitis, which was not done.

This patient appears to be treated with multiple drugs for a condition it does not appear that the patient has. If the patient has seronegative rheumatoid arthritis, there certainly does not appear to be any adverse outcome (joint disease or erosions). Given that, this patient should not be treated with high dose prednisone for years. The prednisone is causing harm to the patient. The harm being caused is likely to cascade and cause other problems. This patient needs to be evaluated by a rheumatologist to determine if indeed the patient has rheumatoid arthritis, which appears unlikely, as there is no evidence for this disease. If the patient still has a foot ulcer, the patient needs evaluation for osteomyelitis.

- Another patient is a 72-year-old woman who had a 10-year risk of heart disease or stroke of 29% and should have been on a moderate-intensity statin, but was on a low-intensity statin.⁴⁰ The patient had hypertension and an LDL cholesterol of 179, but instead of placing the patient on a moderate to high-intensity statin, the doctor added cholestyramine, a second line cholesterol medication, to a low-intensity statin dose. Later, the patient was also treated with fish oil, a marginal anti-lipid drug. The patient was never placed on standard treatment for her lipid disease. The patient had a diagnosis of chronic obstructive lung disease (COPD), but was monitored as if she had asthma. The First Court Expert made a recommendation that IDOC develop a guideline for COPD as opposed to asthma, but this has not been done. In this patient's case, monitoring in chronic clinic was for asthma but the patient had COPD. There was no evidence of the patient ever having a pulmonary function test, which is the cornerstone of diagnosis for COPD. Every patient with COPD should have a pulmonary function test, but this test is seldom done in IDOC for patients with COPD.

Pharmacy and Medication Administration

Methodology: We conducted a comprehensive review of pharmacy and medication services from the time a medication order is written until medication is delivered to the patient. We met with health care leadership and staff involved in pharmacy and medication services, toured

⁴⁰ Patient #8 Hospitalization and Specialty Care.

pharmacy and medication administration areas, observed medication administration, and reviewed medication administration records.

First Court Expert Findings

The First Court Expert Report did not include findings or recommendations related to pharmacy practices or medication administration. The review did not appear to include a review of medication administration records.

Current Findings

This review showed systemic issues related to pharmacy and medication administration systems.

BosWell Pharmacy Services provides medication services at LCC through a “fax and fill” process. Providers enter medication orders directly into the EMR and the order is electronically transmitted to an offsite pharmacy. BosWell dispenses and ships prescriptions six days per week (not on Sundays). Medications are either patient-specific or for stock supply. When new medications arrive, medication assistants check medications received against a packing list of what was shipped.

The medication room is of adequate size for its purpose. The floors and countertops were dirty. The refrigerator used to store staff food was unlabeled (i.e., staff food) and filthy. The medication refrigerator required cleaning. We found an injectable medication that expired in January 2018 and two open insulin vials that were not labeled with the date of opening and expiration dates. In a nearby cabinet we also found two opened Lidocaine vials that were not labeled with the date of opening or expiration. A random check of sharps and controlled medications showed that counts were accurate.

According to the HCUA, the area is staffed by unlicensed and uncertified medication room assistants, not licensed pharmacy technicians or nurses. There is no formal training curriculum and staff are provided on-the-job (OJT) training. This raises safety concerns, as these staff deliver hundreds of KOP medications to patients on a daily basis. A major concern is that medication assistants deliver medications to patients and do not consistently document administration on the MAR. This is further described below.

Nurses administer medications to general population inmates in the chow hall, which is a centralized location near the medical building. Nurses prepare medications by transferring medications from pharmacy-dispensed, properly labeled containers into small white envelopes that do not contain the same information as on the blister-pack label. Nurses then place medication envelopes into small transport containers and carry them to the chow hall. Nurses do not bring MARs with them to document medication administration at the time medications are given.

We observed three nurses administer medications in the chow hall. Inmates arrived based upon work or housing status. Nurses stood behind a metal rail and inmates approached a nurse

based upon last name. Although inmates had identification badges, nurses did not positively identify each patient by looking at the badge or having the patient state her name and a second identifier (e.g., inmate number or DOB). Nurses did not use medication cups to administer medications. Instead, nurses took the medication envelopes and poured the medication into the patient's hand. One nurse was observed to touch an inmate's hands in multiple instances to steady it as she poured the medication. This was unhygienic and neither this nurse nor the other two nurses were observed to use hand sanitizer during any time in the course of administering medications. One nurse got Milk of Magnesia on her hands and wiped her hand on her pants.

As noted above, nurses did not bring MARs with them and did not document administration of medications at the time they were administered. This increases the risk of error in documenting medications.

In segregation, the nurse prepared medications in the same manner as in general population and did not bring MARs with her. We observed this nurse make a medication error by giving medication to the wrong patient. We interviewed the nurse, who reported that as she came into segregation, an officer was escorting an inmate back to the unit who was due for medication (Patient X). As this took place, another inmate approached her to receive her medication (Patient Y). The nurse did not positively identify the patient and stated that she was thinking of Patient X and retrieved and poured her medications into the hand of Patient Y. Patient Y stated, "These are not my medications," and gave them back to the nurse, who then gave Patient Y her scheduled medications. It is unclear what the nurse did with Patient X's medications, as they had already been poured into another patient's hand. This was a "near miss" medication error, in that the nurse gave the patient the wrong medication and it was only because of the patient's refusal that the medication error was not committed. It is clear that in both general population and segregation nurses do not positively identify patients prior to administering medications. These findings were discussed with the HCUA during the site visit.

Medication Administration Records

As noted above, review of MARs showed lack of documentation that patients received KOP chronic disease and other medications, sometimes for several months. Our interview with the HCUA revealed that medication room assistants deliver KOP medications to patients without consistently documenting administration onto the MAR. Instead, medication assistants note on the BosWell pharmacy inventory list that the medication was given to the patient; however, this is not part of the medical record. Therefore, in multiple records there is no documentation that the patient received ordered chronic disease and other essential medications. In addition, in many records previous months' MARs had not been scanned into the record, including July and August 2017 MARs.

For example, in 10 of 10 health records reviewed to assess the medical reception process, all records were missing some MARs, including January and February 2018. In addition, several patient MAR's showed that they did not receive chronic disease medications, sometimes for months. In addition, there were other documentation errors. The following cases are examples:

- An HIV patient who arrived in 10/18/17.⁴¹ That patient's December 2017 MAR showed that she did not receive HIV medications. There was no January 2018 MAR in the record.
- A patient with hypertension and hyperlipidemia arrived on 1/5/18.⁴² There is no documentation on her January and February 2018 MAR that she received Norvasc, metoprolol, and gemfibrozil. In addition, on 2/5/18, the medication order for her chronic disease medications expired and was not renewed until 2/20/18. As of 4/23/18, there was no March 2018 MAR scanned into the record.
- A patient with glaucoma and hypertension arrived on 11/21/17.⁴³ A November 2017 MAR does not show the patient received her chronic disease medications. On 12/7/17, a new order was written for glaucoma medication (Latanoprost), but there is no documentation that the patient received the medication in December 2017.
- A patient with hypothyroidism and hypertension arrived on 2/2/18.⁴⁴ On 2/3/18, a provider ordered the patient's medications. Her February 2018 MAR does not show that the patient received levothyroxine or Lisinopril. As of 4/23/18, there was no March 2018 MAR scanned into the record.
- A patient with a history of hypertension and two heart attacks arrived on 2/27/18.⁴⁵ She was taking the blood-thinner Plavix, metoprolol, isosorbide dinitrate, and atorvastatin. There is no February 2018 MAR to show that the patient received her medication. A March 2018 MAR shows that on 3/1/18 she received isosorbide dinitrate and on 3/3/18 she received her other chronic disease medications. In addition, although the patient was given metoprolol via KOP on 3/3/18, a nurse documented giving the patient the medication on 3/4/18 and 3/5/18 via nurse administration. Another nurse wrote on the MAR that the patient received the medication via KOP and not dose by dose, after which nurses stopped documenting they were giving her the medication daily.
- A patient with hypertension and mental health disorder arrived on 10/17/17.⁴⁶ A provider ordered her medications on 10/18/17. On 10/30/17, chronic disease medications were received. The November 2017 MAR does not show the patient received hydrochlorothiazide. The patient's January 2018 MAR does not show that the patient received hydrochlorothiazide and amlodipine. As of 4/23/18, a March 2018 MAR had not been scanned into the record.

⁴¹ Medical Reception Patient #1.

⁴² Medical Reception Patient #3.

⁴³ Medical Reception Patient #4.

⁴⁴ Medical Reception Patient #6.

⁴⁵ Medical Reception Patient #7.

⁴⁶ Medical Reception Patient #9.

- Another patient with diabetes and hypertension arrived on 7/19/17.⁴⁷ There is no July or August 2017 MAR scanned into the record. The patient's September 2017 MAR shows the patient did not receive glipizide or Lisinopril. The January 2018 MAR shows the patient did not receive any chronic disease medications, except inhalers.

We also found that not all medication orders were transcribed onto a MAR; therefore, except for the original order, there was no documentation that the patient was due to receive or had received the medication.

We found blank spaces indicating that nurses did not document the status (administered, refused, etc.) of medication administration for that dose, including for patients taking insulin. We found medication errors, in that nurses continued administering medications after a provider discontinued the order.

Review of MARs also shows inconsistency with how nurses document discontinuation of previous orders and new medication orders. When providers change or discontinue medication orders, standards of nursing practice are for nurses to draw a line on the date of discontinuation and write "Discontinued" or "D/C" after the line. If there is a new order for the medication, it should be transcribed onto a separate line on the MAR with new start and stop dates. However, we found that in some cases, nurses overwrite dates of a previous medication order with the date of the new order. This defaces the MAR, making the dates of the previous medication order illegible. It also increases the risk of medication error, as the provider may have changed the dose or frequency of administration of the medication, and not simply renewed the order.

In summary, our review showed systemic issues with medication administration that failed to ensure that the right patient received the right medication, at the right dose, by the right route at the right time. These issues included administration of KOP medications by unlicensed and untrained staff, failure to document administration of medications onto MARs, failure to timely scan MARs into the EMR, failure of nurses to document administration of medications at the time of administration, failure of nurses to document each scheduled dose of medication, and failure to properly discontinue and transcribe new medication orders.

Infection Control

Methodology: We inspected the clinical areas in the medical building, building #6's physical therapy room and patient common showers/bathrooms, and the #15/X-building's reception center. We interviewed nursing personnel, HCUA, facility engineer, Wexford staff assistant, and infirmary porters. We reviewed the safety and sanitation reports for the months of July, August, November, December 2017, and February 2018.

First Court Expert Findings

⁴⁷ Medical Reception Patient #10.

Our findings are consistent with the First Court Expert's findings. There is not a budgeted infection control position and infection control duties have not been formally assigned, although individual health care staff may perform duties such as completing public health forms for reportable diseases. The First Court Expert raised significant concerns about the water temperature in the infirmary's non-industrial washer. The expert noted that the health care unit laundry machines did not reach the required minimum temperature of 140 degrees with bleach or 160 degrees without bleach, and thus could not adequately sanitize infirmary linens. He noted that the infirmary porters are provided orientation to the health care unit which includes proper cleaning and sanitation procedures, blood-borne pathogen training, and communicable disease training.

Current Findings

We agree with the findings of the First Court Expert's report. In addition, we identified additional findings and confirmed some of the findings of the First Court Expert's findings as follows:

- Regular safety and sanitation inspections and reports are being done by the health care team at LCC.
- A number of the safety and sanitation deficiencies in the physical plant at LCC that have been reported, some repeatedly, since July 2017, including mold/mildew on ceilings and walls, failure to change ice machine filters, missing cold and hot water showers knobs, sinks that do not drain, infestations, and non-functional toilets in the housing areas. These problems constitute patient and staff safety, and infection control risks for patient-inmates and correctional and medical staff.
- There is no one formally assigned at LCC to the tasks of infection control.
- The three infirmary porters who were interviewed and whose medical records were reviewed had no documentation that they received the hepatitis B vaccination series or had been trained about blood borne pathogens prior to starting to provide sanitation services.
- The infirmary porters at LCC are not offered hepatitis A vaccination even though they will be cleaning the patient rooms and bathing areas where they will have a probability of the contact with fecal waste.
- Two of the three negative pressure rooms in infirmary were not fully operational on the first day of the site visit. The facility engineer had corrected this problem by the last day of the site visit.
- Paper barriers were noted to be used on most but not all examination tables.
- The temperature of the washer in the infirmary laundry room was found to be insufficient (120 F) to sanitize the infirmary patient linens.

Safety and sanitation inspections (environmental rounds) are performed by the health care team on a monthly basis and reported by the HCUA. A number of reports from July 2017 through February 2018 were reviewed by the experts. These rounds identified concerns, some of which appear to have been corrected or are being addressed. However, the inspection reports repeatedly noted a number of deficiencies, including mold/mildew on walls and

ceilings, missing cold and hot water knobs in common patient showers, and non-functional toilets that do not appear to have resulted in correcting the deficiency.

Sharps boxes, gloves, handwashing sinks, or sanitizing gel was found in all clinical areas. Paper barriers were being used on only three of the five examination tables in the outpatient clinic exam rooms. Small tears in exam tables and crusted mineral deposits in two sinks in health care areas make it difficult to fully sanitize these items.

Two of the three negative pressure rooms in the infirmary were not functional on the initial day of the site visit. The facility engineer was summoned, and all three negative pressure units were operational by the last day of the site visit.

Inmate porters perform sanitation duties. There is no schedule of routine clinic sanitation, and disinfection activities are not consistently performed in clinical areas. During this site visit, the pharmacy floors and countertops were dirty. The September 2017 CQI minutes include a Safety and Sanitation report that focused primarily on whether housing unit showers, sinks, and toilets are broken, but not on sanitation of clinical areas or housing units. We described the duties of the porters earlier in the Sanitation section of this report. We note, however, that there was no documentation in their medical records that they were immune to hepatitis B (or A) or if they had been vaccinated against hepatitis B (or A). The Wexford staff assistant who is responsible for the training of infirmary porters also was unable to provide documentation that the three porters had been trained or vaccinated. All infirmary porters must be trained and fully vaccinated prior to being assigned to duties in the infirmary, where there is higher risk of exposure to pathogens and a more frequent and higher degree of sanitation is needed.⁴⁸

CQI meeting minutes contain reportable disease statistics, but no analysis of prevalence or incidence of new infections. As an example, there is no analysis of Methicillin-Resistant *Staphylococcus Aureus* (MRSA) infections to determine whether infections are clustered in certain housing units that might require further screening and intervention. LCC does not have an effective infection control program.

In summary, LCC does not have an infection control nurse, the function of the negative pressure rooms was not adequately monitored, the training of the infirmary porters about their job duties and exposure and prevention of blood-borne infections was not documented, there is no evidence that the infirmary porters had received hepatitis B (or A) vaccination or had immunity to hepatitis B (or A), some deficiencies noted on safety and sanitation rounds do not appear to be corrected, there are health care unit sinks with crusted mineral deposits, and exam tables with torn upholstery, and CQI minutes lack analysis of infection control data.

We concur with the recommendations of the First Court Expert on Infection Control. We have additional recommendations that are included at the end of the report.

⁴⁸ Infirmary Patients #5, 6, 7.

Radiology Services

Methodology: We inspected the radiology unit and reviewed x-ray logs.

First Court Expert Findings

The First Court Expert's report did not include any findings about the radiology equipment or services

Current Findings

- The Illinois Emergency Management Agency (IEMA) radiation safety inspections and reports for the radiology units at LCC are current. The active x-ray equipment at LCC was found to be in compliance with the Radiation Protection Act of 1990.
- The access to plain film x-rays at LCC is good.
- The turnaround time for radiologist readings and return of the reports is good.
- The lack of a shielded post to take panorex films has the potential for radiation exposure to the radiology technician.
- The system decision not to have the x-ray technician wear radiation exposure dosimeters may not be in accord with State of Illinois regulations and is definitely not in accord with community practice.

IEMA inspected and certified the LCC radiology units in September 2017; this certification is valid through September 2019. The x-ray technician produced his current license, which is valid through July 31, 2018.

Plain film non-digital x-ray services and panorex studies are provided Monday, Wednesday, and Friday during the daytime hours by a single radiology technician who staffs and manages the unit. The technician estimated that 50 patients generating about 90 plain films receive x-rays on a weekly basis. Mammography studies are performed on Tuesday and Thursday by a contracted mammography technician. An intact lead apron to shield patients was inspected. Patients requiring advanced or emergency studies are referred to local hospitals in Springfield or occasionally to UIC Medical Center.

It was reported that there is not a waiting list for non-urgent onsite x-rays. Most x-rays are reported to be taken within one to two days after receiving the order. Weekend and holiday requests are completed on the next working day. The requests and the radiology log for 18 patients were reviewed. All 18 had films taken within one to four days of the request. Audits of films taken on April 13 and April 18, 2018 revealed that all of the films were read and returned to LCC in two to three days. Abnormal results are called in by the reading radiologist; most results are faxed on the day of or after the reading is completed. The films are read by a local contracted radiologist in Bloomington, Illinois.

The chest x-ray unit and the plain film table are in a room that has a shielded post for the technician to stand behind while the film is being taken. The radiology technician has a dark room and a work space immediately adjacent to the plain film suite. The panorex was added to

the LCC radiology services after the radiology room had been constructed. It was located in an interior hallway that connects to the other side of the technician's work space. There is not a shielded post that can be used when panorex films are taken; the technician has to stretch the trigger cord as far as he can and then stand behind a cabinet in the work space to minimize his risk of radiation exposure. He is not aware if IEMA or the IDOC has ever measured the radiation exposure generated when panorex films are taken.

The x-ray technician was noted not to be wearing a radiation exposure dosimeter badge. They stated they had been told by Wexford that the State of Illinois does not require the use of dosimeters. They communicated that they are required to wear a dosimeters at their other work site.

In summary, the radiology services at LCC have reasonable access to x-ray services and reasonable turnaround time of radiologist readings and reports. The location of the panorex and the absence of a shielded post to take panorex films raises concerns about the risk of radiation exposure. The decision of the system to not provide radiation exposure dosimeter badges is not in accord with community standards and needs to be further reviewed by the State of Illinois IEMA and possibly OSHA.

The First Court Expert's report did not have any recommendations about the radiology services. We have noted recommendations that are noted at the end of the report.

Infirmary Care

Methodology: Accompanied by either the HCUA or the Wexford staff assistant, the Expert toured the infirmary, inspected the clinical space and equipment, and audited infirmary charts. Nursing staff, porters, and patients-inmates were interviewed.

First Court Expert Findings

The First Court Expert noted significant concerns about the condition of the paper medical record in the infirmary. Information was kept in two files, reports and notes were loosely dropped in the chart binder, forms were not in chronological order, admission orders could not be found, consultation reports could not be located, and the SOAP charting method was not utilized. The expert also reported that there was not a nurse call system, nurse admission notes were inconsistently completed, and vital signs were not consistently performed. The expert reported that the provider notes were thorough and written at least daily.

Current Findings

Since the visit of the First Court Expert, LCC has implemented an EMR system that addressed most of the deficiencies related to the poor organization of the former paper medical record and the inability to find clinical information. A nurse call system has been installed adjacent to all the non-crisis infirmary beds. Vital signs are regularly taken. We identified the following confirmatory and additional findings.

- The infirmary was clean and organized.

- An EMR has been implemented since the First Court Expert's visit but there are an insufficient number of devices to enter information into the EMR on the infirmity unit. There needs to be as many devices as the number of potential simultaneous users. This reflects on a poor EMR implementation process.
- A nurse call device was mounted next to each non-crisis infirmity bed. The system was verified as being operational. Patients demonstrated competency in activating the system.
- Nurse and provider admission and progress notes were written in accord with established timelines. We did note, however, on record reviews that the provider occasionally but routinely writes notes at home after work hours. Notes should be written at the time service is provided.
- There is a nurse assigned to the infirmity on every shift, seven days a week; however, not all of the infirmity shifts were covered by an RN.
- Vital signs in the infirmity were regularly taken and recorded.
- The failure of the health care system and the providers at LCC to monitor and track weights contributed to delays in initiating needed diagnostic testing.
- The failure of the infirmity provider to timely consult with medical and surgical specialists put infirmity patients at risk for disease progression and increased morbidity. The collegial referral system added little value and contributed to delays in accessing specialty consultation.
- The provider's use of antibiotics and antifungal agents was excessive and not in alignment with current practice of care, and put patients at risk for complications of antibiotics, superinfections, and resistance to antibiotics.
- Offsite specialty consultation reports were not consistently retrievable in the EMR.
- The utilization of warfarin for anticoagulation is logistically complicated and puts patients at risk for serious medical complications due to failure to consistently obtain therapeutic levels of coagulation. It is our opinion that the IDOC should consider newer alternatives to warfarin for anti-coagulation.

The infirmity is located at one end of the medical building. The unit consists of single and double bed rooms. There were three crisis/negative pressure rooms with large glass viewing panels situated directly in front of the nursing station. The physical plant appears to be unchanged since the First Court Expert's site visit in 2014. With the exception of the crisis rooms, hospital beds with adjustable heights and sections in good condition were universally deployed in all infirmity rooms. The crisis rooms had concrete beds with intact mattresses.

Nurse call devices were mounted on walls adjacent to each infirmity bed. The system was verified as being operational. Patients demonstrated full understanding of how to activate the nurse call device. There were no nurse call devices in the crisis rooms, but the rooms were in the line of sight and/or sound of the nursing station.

At the time of the visit, all of the patients housed in the infirmity were able to independently perform their personal activities of daily living (ADL). This was in marked contrast to the

infirmaries at previously inspected male IDOC facilities, where up to fifty percent (50%) required total or partial care with their ADLs.

IDOC Policy 04.03.120 Offender Infirmary Services⁴⁹ directed nurses to write admission notes at the time of admission and progress notes no less than daily for acute patients and weekly for chronic patients. Providers are to write admission notes within 48 hours and progress notes no less than three times a week for acute patients and once a week for chronic patients. Review of five current infirmary records with six infirmary admissions verified that each of these patients had nurse admission notes on the day of admission and no less than daily progress notes; most records had notes on each shift, on all patients. Provider admission notes were written on the six admissions within 48 hours and the five chronic patients had progress notes no less than weekly. The one acute admission was discharged on the day after admission. We did note on record reviews, however, that provider notes are sometimes entered late at night; sometimes around midnight. We were told that the provider will routinely write infirmary notes after hours. For one episode, a provider wrote a discharge note from home for a discharge that occurred 8 days earlier.⁵⁰ We found several examples of this and were told that it is a routine practice. As we noted in the medical record section, there are an inadequate number of devices on the infirmary to access the electronic medical record and this is one contributing factor. We also believe that there is inadequate physician staffing as this physician does not appear to have time to write all her notes at the time care is administered.

One nurse is assigned to the infirmary on every shift, seven days a week. Although RNs covered most shifts, LPNs were sometimes assigned to infirmary shifts. If the infirmary is near full occupancy or the patients' acuity level of care is higher, additional nursing personnel (LPN, CNA) would be needed to address patient care needs.

Although the frequency of provider progress notes and quantity of documentation was reasonable, we had a number of concerns about the quality of the provider's clinical judgement, accuracy of clinical diagnoses, rationale for therapeutic clinical decisions, and understanding of when to consult outside specialists or refer patients whose conditions warranted inpatient care. The provider ordered antibiotics or antifungal agents when there was no justification for their use. These medications were continued for durations of time that were not warranted by the patient's condition. The provider prescribed confusing combinations of antibiotics and antifungal agents that were not clinically justified which put the patient at danger of serious gastrointestinal infections and antibiotic resistance. Patients whose conditions warranted the early and ongoing involvement of specialists were treated in the infirmary by the primary care provider in lieu of referral. Doctors utilized presumptive diagnoses without obtaining diagnostic testing or consultative referral necessary to make a diagnosis. The diagnostic testing or consultation necessary for a definitive diagnosis were either

⁴⁹ Offender Infirmary Services.

⁵⁰ Patient #2 Hospitalization and Specialty Care. In this case, the doctor wrote a discharge note on 9/7/17 for a discharge that occurred on 8/31/17. This patient also had episodes in which the physician wrote notes at a later time for events that happened the day before. In this 9/7/17 episode, the doctor also appeared to have cut and pasted a portion of a mental health note to her note which made the note appear nonsensical.

not timely done or not done at all. We had a number of concerns about the care provided to infirmity patients which are provided below.

- The first example is a patient who had complaints of persistent lower abdominal pain, intermittent episodes of passing bright red blood from her rectum, and progressive weight loss for almost a year without timely work up.⁵¹ She was noted as having anemia as early as January of 2017. The providers failed to note her weight loss; she was initially treated in January of 2017 for presumed diverticulitis without benefit of diagnostic studies (CT scan, ultrasound or follow up colonoscopy). A CT scan should have been done for a diagnosis of diverticulitis and colonoscopy should have been done for symptoms of abdominal pain, passing blood, anemia, and weight loss and for follow up screening for cancer if diverticulitis were diagnosed. From January to September of 2017 we noted 11 documented weights all showing progressive declining weight. Yet, only one provider note mentioned weight loss, and this was recorded seven months prior to her admission to the infirmity. In July of 2017 a provider noted that the patient had no “red flags” when at that visit the patient had a 28 pound weight loss. Eventually, on 9/26/17 the patient was admitted to the infirmity with nausea, vomiting, and abdominal pain. No diagnostic testing or consultation were ordered in the outpatient clinics.

The initial therapeutic plan on the infirmity was to add ciprofloxacin to an ongoing prescription of metronidazole. The infirmity provider’s plan was to continue antibiotics without ordering diagnostic testing (CT scan and white count), which is typically necessary to make a diagnosis of diverticulitis. Only after another 12 days in the infirmity did a provider note that the patient had lost a significant amount of weight and diagnostic testing was initiated. At this point the patient had lost 40 pounds. A CT scan was not done for about three weeks for what was an urgent medical problem. The CT scan showed a colon mass, likely cancer with metastases to lymph nodes and liver. Biopsy was done electively. Over two months after admission to the infirmity the patient was finally admitted to a hospital for surgery. Chemotherapy started a month later. This patient’s complaints were not timely identified or evaluated, and resulted in late diagnosis and treatment of cancer that likely significantly harmed the patient. The metastases to the liver increased the probability of early death from this condition. The failure to link the weight loss to her symptoms indicated either incompetence, indifference, or negligence by the providers.

- Another patient had clinical history of transient ischemic attack, mitral valve replacement in 2006, severe tricuspid valve regurgitation, chronic atrial fibrillation, chronic kidney disease, COPD, left atrial appendage thrombus, chronic anticoagulation on warfarin, and chronic congestive heart failure (CHF), NYHA Class IV.⁵² This patient was noted to have repeated episodes of bradycardia (slow heart rate) and multiple

⁵¹ Infirmity Patient #1.

⁵² Infirmity Patient #2.

itchy, draining skin lesions. The patient was admitted to the infirmary in September 2016 after hospitalization for heart failure and severe non-operable tricuspid regurgitation.

From October 2016 through April of 2018, the patient's level of anticoagulation was not therapeutic 29% of the time. Since July 2017, the patient had chronic itching with excoriated draining skin lesions which failed to resolve. Yet despite being unable to develop an adequate therapeutic plan or diagnosis, the patient was not referred to a dermatologist. We noted that the patient was on a medication (torsemide) which can cause a similar rash, yet this was unnoticed by providers. From July 2017 through March 2018, the patient had at least eight episodes of bradycardia. The slow heart rate was not noticed based on provider notes and there was no history or evaluation for associated symptoms of bradycardia. The patient was taking a medication (metoprolol) with a known side effect of causing bradycardia, but this medicine was not stopped nor was the dosage decreased. The provider did not document that any other heart condition was considered as the etiology of the slow heart beats, nor was consultation with a cardiologist requested.

In April of 2018, the patient was admitted to a hospital for tachycardia (130) and hypoxemia (oxygen saturation 88%). At the hospital, bradycardia (pulse in the 40s) was noted. Sick sinus syndrome⁵³ was identified and a pacemaker was inserted. On return from the hospital, the medication likely causing the rash was discontinued and the metoprolol dose was decreased. Doctors at LCC failed to adequately evaluate the patient's skin rash, failed to identify potential medication adverse reactions, failed to adequately identify or evaluate the slow heart rate with diagnostic testing, and failed to timely refer the patient to a cardiologist for slow heart rate in a patient with atrial fibrillation. These failures placed the patient at risk for harm.

- Another patient, newly incarcerated at LCC, was admitted to the infirmary with severe damage to her toes from frostbite.⁵⁴ The patient was incarcerated on 1/30/18 and was noted to have a one month history of black, swollen toes. She was admitted to the infirmary and started on an antibiotic without documentation of the reason for initiating the antibiotic. A progress note on 2/20/18 documented gangrene and another antibiotic (cephalexin) was added to the metronidazole. On 3/6/18, fluconazole was added to metronidazole and cephalexin. The reason for this was not given and there was no apparent indication for adding an antifungal agent to the therapeutic plan, and the doctor did not document the infection resulting in the decision to start metronidazole or cephalexin. The 3/9/18 progress noted stated that right distal large phalanx was hard, dry, and black. On 3/12/18, 42 days after admission to LCC and 27 days after admission to the infirmary, the patient was seen by a general surgery consultant, who

⁵³ Sick sinus syndrome is a cardiac arrhythmia that results in a slow heartbeat. This arrhythmia typically requires a pacemaker. Notably this patient had a slow heartbeat for months which was not appropriately evaluated until emergency hospitalization occurred.

⁵⁴ Infirmary Patient #3.

recommended that the patient be referred to a podiatrist. This referral was not timely. Referral to surgical consultants with experience in managing frostbite needs to be prompt to prevent unnecessary amputation. The LCC doctor continued antibiotics without clear documentation of why they were being used. Cephalexin was discontinued on 3/12/18 and metronidazole stopped on 3/16/18, but fluconazole was ordered to be continued for another three weeks. On 3/23/18, metronidazole was reordered. A podiatry consultation appears to have been scheduled on 3/27/18, but may not have taken place (no consultation report, no provider progress note). On 4/14/18, the provider noted "no signs of infection," but cephalexin was added to metronidazole. The patient was seen by podiatry at Taylorville Podiatry on 4/19/18. The podiatrist recommended elective amputation. The podiatry consultation report was not located in the EMR. The doctor treated the patient with a changing and inexplicable array of antibiotics, including an oral anti-fungal agent for which there was no documented indication. The patient had black gangrenous toes and should have been either hospitalized or promptly referred to a foot specialist experienced in managing frostbite injury for early consultation to maximize the potential viability of her damaged toes. The first documented podiatry appointment occurred 66 days after her admission to the infirmary; the podiatrist immediately made arrangements to amputate one of her large toes. The excessive use of combinations of antibiotics and antifungal agents was unwarranted and exposed the patient to the risk of medication side effects. We note that the consultation reports were not found in the EMR. We also noted several late-night after-hours notes were written for this patient.

- Another patient is a 42-year-old patient had a history of total abdominal hysterectomy/ovarian cyst in 2010, and obesity.⁵⁵ She was admitted to the infirmary for observation on 9/7/17 for abdominal pain and a complaint of an enlarged abdomen, but was discharged the following day. She again complained of abdominal pain on 10/5/17 and was found to have mild anemia, for which iron was started without any other diagnostic testing except a normal plain abdominal x-ray, which has little utility in evaluation of abdominal pain. By January 2018, the patient still had abdominal pain and was admitted to the infirmary. For the five month period from September through January, we noted four evaluations for abdominal pain during which the weight loss of the patient was not noted. We noted a 13.5 pound weight loss since August 2017. A doctor initiated treatment for diverticulitis with ciprofloxacin and metronidazole, ordered an elective abdominal ultrasound, but discharged the patient the same day back to general population. This is an inappropriate therapeutic plan, as diverticulitis is an urgent problem. The patient should have remained on the infirmary until the conclusion of the diagnosis and the evaluation should have been promptly conducted. Instead, the ultrasound was not done for almost a month and showed a large pelvic mass. A subsequent CT scan showed an ovarian mass, possibly carcinoma. Approximately six weeks passed before the patient was hospitalized on 4/3/18 for exploratory surgery. This was a significant delay to diagnose and initiate treatment of

⁵⁵ Infirmary Patient #4.

the patient's condition. After return to the infirmary post-hospitalization, a final pathology report was not available in the medical record; a preliminary report indicated a benign condition. We remain concerned about the lack of attention to weight loss. This appears to be a systemic problem in the IDOC, as we have seen this on multiple record reviews at multiple sites, including on multiple death records. Whether this is due to indifference, lack of primary care training of providers, or some other reason is unclear, but the IDOC needs to address this issue.

- Another infirmary patient is a 28-year-old who had a history of four episodes of recurrent deep vein thrombosis (DVT) and pulmonary emboli since 2012 requiring continuous anti-coagulation therapy.⁵⁶ Since 2015, the patient had a right lower extremity ulcer. She had been on the infirmary for the past eight months for the non-healing, draining leg ulcer. The doctor ordered a confusing and changing combination of antibiotics without apparent indication. These included levofloxacin (9/20/17-10/25/17), doxycycline (12/18/17-1/23/18), trim-sulfamethoxazole (1/23/18 to 4/23/18), levofloxacin plus trim-sulfamethoxazole (2/28/18 to 4/23/18), fluconazole once weekly off and on, and metronidazole off and on for a number of courses. Over an eight month period, the provider failed to evaluate the patient for osteomyelitis despite the patient having a chronic draining ulcer over a bone. The doctor should have considered or ordered bone scan, bone biopsy, MRI, and blood tests (white count, blood cultures, CRP, or sedimentation rate). In March and April 2018, the provider submitted several referrals to an infectious disease doctor which were denied by Wexford utilization, even though it appeared that the doctor was uncertain how to manage this condition. This patient clearly needed specialty consultation due to the doctor being unable to diagnose the patient's serious medical condition, but these requests were denied without appropriate alternatives. With respect to anticoagulation for this patient, the INR levels were in the therapeutic range only 47% of the time. Her anticoagulant was modified 13 times in response to the high or low INRs. Given the inability of physicians to maintain therapeutic control and the logistics of warfarin anticoagulation in a correctional setting, newer alternative anticoagulants that are less complicated and safer to administer should be used. The lack of timely evaluation for osteomyelitis was a significant problem, as the patient has had the leg ulcer for over eight months. This places the patient at significant risk of harm.

In summary, with the exceptions noted in the first paragraph of the current findings section that the EMR had addressed many of the deficiencies in the medical record and nurse call devices had been installed in most infirmary rooms, we agree with the recommendations of the First Court Expert and have additional recommendations that are found at the end of this report.

⁵⁶ Infirmary Patient #5.

Chronic Care

Methodology: The chronic care nurse was interviewed about the chronic care scheduling and tracking processes. The current chronic care annual schedule, the chronic care patient lists, and chronic illness medication lists were reviewed. The chronic care nurse practitioner was interviewed. The records of 15 patients with chronic care illnesses and conditions were reviewed. The Office of Health Services Chronic Illness Treatment Guidelines dated March 2016 and the IDOC Hepatitis C Guidelines December 2017 were reviewed as needed.

First Court Expert Findings

The First Court Expert noted that the chronic care program at LCC lacked oversight and organization. The chronic care nurses' duty to compile lists of patients' degree of control was not being done. There was a very large backlog in scheduling patients for chronic care appointments. The part-time provider staffing the chronic care clinics only saw chronic care patients one day a week. This provider's notes were completely illegible. The Medical Director was seeing the majority of the chronic care patients in sick call sessions; this was decreasing patients' access to sick call and urgent care services. The expert noted that it was impossible to determine how many patients were enrolled in LCC's chronic care program.

Current Findings

The First Court Expert's finding of not having an assigned nurse for chronic care has been resolved. Also, patients are now assigned to clinics and regularly seen. We identified current and additional findings as follows:

- An EMR has been implemented at LCC. This addressed the First Court Expert's strong concerns about the legibility of provider notes.
- LCC now has assigned a single, dedicated nurse to coordinate the chronic care program.
- Patients assigned to chronic care clinics are regularly seen in these disease specific clinics.
- The nurses pull the MAR's for patients' chronic care visits, but there is no documentation that the providers review this important clinic data about medication compliance and CBGs.
- The MAR is still completed manually by the nursing staff. Blank days, non-approved codes, and illegibility were noted for dose-by dose medications and varying methods of documentation were utilized for KOP medication delivery. The lack of accuracy of the MAR's is a barrier to verifying a patient's compliance with medications and determining the efficacy of the treatment.
- LCC does not reschedule chronic care appointments of patients who refuse a chronic care visit until four to six months later, when the next disease specific chronic clinic is held and does not have a process to monitor and track the status of these patients during the intervening months.
- LCC primary care providers and nurse do not have access to current, comprehensive, electronic medical references such as UpToDate in all clinical exam rooms and offices.
- LCC does not screen patients over 50 years of age or patients with high-risk clinical conditions for colon cancer as is recommended by national guidelines. None of the four

patients over 50 years of age whose records were reviewed had been screened for colon cancer.

- LCC does not calculate 10-year cardiovascular risks for adult patients as directed by the ACC/AHA and IDOC treatment guidelines.
- LCC does not administer age-based and disease-based adult preventive vaccinations, including pneumococcal 13 and 23, diphtheria, tetanus, and pertussis, meningococcal as recommended by the Center for Disease Control (CDC),⁵⁷ or routine health maintenance screening tests as recommended by the USPSTF.
- Only one (9%) of 11 patients with chronic illnesses, including asthma, CHF, COPD, HIV, diabetes, and cancer on chemotherapy had received pneumococcal 23 vaccination. The only patient over 65 years of age whose chart was reviewed had not received pneumococcal 13 or 23 vaccinations. Only one (33%) of three HIV patients had documentation of having received pneumococcal 23 vaccination; none of the three had received pneumococcal 13 or meningococcal vaccinations.
- The current disease specific chronic care schedule contributes to delays in achieving control of chronic illnesses.
- Providers at LCC inconsistently document the rationale for clinical decisions and diagnoses in the chronic care progress notes.
- HIV patient with active hepatitis C are not timely advanced toward the evaluation and initiation of hepatitis C treatment.
- The process to determine eligibility for hepatitis C treatment is excessively lengthy and a barrier to the initiation of treatment. It is not consistent with processes in other correctional facilities and public health systems.

With the exception of the general medicine clinic, the non-baseline chronic care clinics (asthma, cardiac/hypertension, diabetes, hepatitis C, high risk/HIV, seizure) are silos in which only a single disease is managed. The schedule for these clinics is inflexible and not based on the degree of control of a patient's illness.⁵⁸ This has the potential to harm patients, as patients are evaluated on this schedule irrespective of the degree of control of their illness. Therefore, persons who need greater attention because their disease is poorly controlled may not receive it.

We view this as inefficient, wasteful, and potentially harmful. Patients should be evaluated as frequently as is necessary to establish disease control and not based on an inflexible schedule. Primary care doctors need to coordinate care for the patient, integrating treatment for all of the patient's conditions. When specialists manage a single illness, they typically list all of the

⁵⁷ CDC Recommended Immunization Schedule Adults 19 Years of Older, United States, 2018.

⁵⁸ LCC's chronic care clinic annual schedule is as follows: asthma (January and July,) diabetes (April, August, and December), cardiac/hypertension (A-L March and September; M-Z April and October), general medicine (May and November), hepatitis C (June and December), high risk/HIV (monthly), seizure (February and August), and TB (monthly, annual education). LCC has combined two conditions, diabetes/lipids and diabetes/hypertension, for simultaneous evaluation in the initial baseline clinic but not in the follow-up chronic care clinic session. Hepatitis C patients who have not yet met the IDOC criteria for treatment are seen in the June and December hepatitis C chronic care clinics. Other chronic illnesses (hyperlipidemia, anemia, cancers, multiple sclerosis, sickle cell disease, neurological disorders, etc.) are treated and monitored in the general medicine chronic care clinics.

patient's other medical conditions and medications, and consider the implication of all diseases on the condition being monitored. In the IDOC, every single disease is managed as if it is the only disease the patient has. Diseases are often interrelated such as metabolic syndrome.⁵⁹ Drug-drug interactions need to be considered in management of medications. Some illnesses have an effect on other illnesses. When IDOC providers evaluate patients in individual chronic care clinics, they do not list the patient's other illnesses and do not address any other conditions, even when a condition may not be in control or may have an impact on the condition being treated.

Some illnesses are managed in specialty clinics. All individuals with HIV and eligible patients cleared for treatment with hepatitis C are managed via telehealth by the UIC infectious disease telehealth clinic. UIC HIV telehealth clinics are held monthly. A monthly telehealth renal clinic staffed by a consulting nephrologist is scheduled as needed. This kidney specialist also provides telehealth consultation to other IDOC facilities.

The high risk/HIV chronic care roster was compared to the medication list to assess the accuracy of the chronic care roster. Five patients were not on the chronic care roster who were receiving HIV meds. Four of these five patients had recently been transferred to DCC; the other patient had only recently been started on HIV medications. It appears that the roster is accurate.

On April 6, 2018, the census of LCC was 1,617, with an additional 230 patients housed in Reception & Classification (R&C) and Segregation. The March 2018 Chronic Care Clinic Roster was as follows:

Clinic	Patients	Percentage of ADC (1,617)
Asthma	183	11.3%
Cardiac/Hypertension	362	22.4%
Diabetes	91	5.6%
General Medicine	195	12.1%
Hepatitis C	174	10.8%
High Risk/HIV	16	1.0%
TB	30	1.9%
Chronic Care roster	1,141*	

*Individual patients with more than one chronic illness are enrolled in a number of chronic care clinics.

These percentages reflect the prevalence of each chronic illness in the LCC population. The chronic roster of 1,141 patients was not further analyzed to determine how many unique women were on this roster. The percentage of individual women with chronic illnesses would be significantly less than 1,141.

⁵⁹ Metabolic syndrome is a combination of diabetes, hypertension, and high blood lipids. These inter-related conditions must be treated as a single disease. When kidney disease, retinopathy, or neuropathy exist with diabetes, they are also treated as diseases related to diabetes.

The chronic care clinic scheduling processes were reported as follows:

1. Providers and nurses enter chronic illnesses into the EMR.
2. EMR generates the baseline chronic care list, nurses review the list, order lab panels, and verify that labs are completed.
3. EMR sends a reminder for baseline appointments that are to be scheduled within 30 days, nurses manually enter the appointment in 360 (an IDOC program).
4. Chronic care clinic rosters are maintained by clinic in 360 (an IDOC program).
5. Nurse coordinator downloads and prints the next month's follow-up chronic care patient list from 360 and searches EMR to verify or order labs.
6. Once lab results are in EMR, nurse enters an appointment in the EMR.
7. A nurse schedules 13-15 patients per day for the chronic care provider (12-13 patients in the morning and 1-3 patients in the afternoon).
8. Appointment schedules are printed, and administrative staff fill out movement passes that are given to corrections 24 hours in advance.
9. IDOC transports patients to the clinic.
10. Nurses manually enter into 360 all no shows and patients seen; EMR also maintains and tracks patients seen, no shows, and refusals.

Patients who choose to refuse to be seen in a chronic care clinic are to be transported to the clinic to sign a refusal form; in practice, corrections is reluctant to force a patient to walk to the health care building to sign the refusal. When a patient does not arrive for a chronic care clinic session, nurses staffing the chronic care clinic call the officers in the housing units to remind them to move the patient. If the officer informs the nurse that the patient is refusing, no further action is taken. Providers are informed when a patient has refused a chronic care clinic visit. The provider reviews the new lab reports in the EMR and reorders or adjusts any ongoing medications for chronic clinic refusals. Even if the patient's chronic condition is not controlled, patients who refuse a visit will not be rescheduled until the next scheduled chronic care session, which is as long as six months later. We were informed that this is done to instill responsibility and accountability into the patient. The staff related that no focused review of vital signs or capillary blood sugars or medication compliance are done during the many month interim before the next disease-specific chronic care clinic to minimize the risk of clinical deterioration for patients who have refused the chronic care visit. Patients who refuse chronic care visits tend to fall into high-risk categories; many have mental health conditions. This current practice puts patients at risk. LCC must develop and implement a process to intermittently monitor patients who refuse chronic care appointments. Patients not brought to clinic because of lockdowns or correctional or weather issues are rescheduled to be seen within a week or two.

The chronic care clinics at LCC are primarily staffed by a full-time nurse practitioner, but the physician provider also sees a number of complicated or special interest chronic care patients. The nurse practitioner reported that her chronic care clinics run six hours per day and with up to 20 patient appointments scheduled per day. Two nurses support the chronic care clinics; scheduling patients, ordering labs, pulling medication administration records (MAR) mainly for CBG results, and doing vital signs. Although it was reported that MAR's are pulled for review at

chronic care visits, the experts did not find any documentation in the visit notes that this valuable information about medication compliance and CBG's on the MAR's were ever reviewed. It was reported that the physician annually reviews and makes clinical suggestions on all of the nurse practitioner's chronic care charts. The provider mentioned that there is a need for onsite podiatric consultation for foot and nail conditions that cannot be readily addressed by LCC's primary care staff. The physician stated that she did not have access to Up-to-Date but occasionally accesses some of the other online, less comprehensive medical references. One nurse practitioner and one physician assistant had access to personally purchased, comprehensive, current (UpToDate®) electronic medical references. Another nurse practitioner stated she did not have access to comprehensive electronic medical references.

In March 2018, 157 follow-up chronic care and 100 chronic care baseline visits were performed. Based on a review of chronic care medical records, most patients with chronic illnesses at LCC are seen by providers in the chronic care clinics approximately twice a year. Diabetic patients were found to have HbA1C testing on a regular basis, documented foot exams, urine microalbumin-creatinine ratio testing, and annual eye evaluations by an optometrist.

Providers were generally critical of the utilization management program that served as a barrier to timely care. One provider questioned the need for collegial requests/approvals for specialty consultation and to order onsite ultrasonography studies and non-formulary labs, in particular certain tests to monitor cancers that have been requested by specialists. This process delays access to these and other diagnostic studies and specialty consultations. We agree. One provider reported that, with the exception of breast and cervical cancer screening, no one does age-based routine health maintenance screening or age and disease-based vaccinations at LCC.⁶⁰ One provider stated that the current IDOC policy to perform rectal exams and a single fecal blood test is not a valid screening test for colon cancer. The provider also communicated that colon cancer screening using the three separate fecal occult blood cards methodology could be used but is not because of the institution's practice to make patients come to the health care unit to defecate to obtain the specimen was too cumbersome. This practice was reported to have been established because the women might tamper with the test if allowed to gather the specimen in the housing unit. The provider was not aware of the new fecal immunochemical test (FIT) that is available to screen for colon cancer. The failure of LCC to screen for colon cancer does not meet the national and community standards of care.

The care provided to a number of patients with chronic illnesses had deficiencies. The providers did not consistently document the rationale for clinical decisions, including the selection of medications, changes in medications, and modification of medication dosages. It was difficult to understand the reasoning for the treatment regimens that were being provided to some patients. Some patients needed specialty consultation but did not receive it. Consultants recommended additional diagnostic studies for a patient but there was no documentation in the medical record that these tests were ordered and there was no documented clinical rationale for not proceeding with the recommendations. Some patients were treated with

⁶⁰ CDC Adult immunization schedule 2018, reference # USPSTF Colorectal Cancer Screening June 2016.

medications without appropriate indication. Fenofibrate was used to treat mild elevations of triglycerides in three patients, including two uncontrolled diabetics, when treatment was not indicated. Some patients had uncontrolled disease but the intervals of scheduled appointments were not appropriately shortened. Two patients with HIV and hepatitis C were not approved to begin evaluation for hepatitis C treatment until four and eight months respectively after admission to LCC. This is an excessive delay for HIV patients, who are considered at risk for accelerated deterioration and listed as priorities for treatment of hepatitis C. Patients with hepatitis C also do not receive HCV viral load testing as recommended in the IDOC Hepatitis C guidelines.⁶¹ As recommended in the IDOC hyperlipidemia treatment guidelines,⁶² LCC providers are not calculating the 10-year cardiovascular risk on older patients, diabetics, hypertensives, and those with hyperlipidemia. This has resulted in the failure to initiate statins, the proper dose of statins, or the proper intensity of statins on patients with a high risk of having a stroke or heart attack in the next 10 years. Diabetics, asthmatics, HIV patients, and patients over 65 years of age are not being offered protective pneumococcal vaccinations as is the national standard in the USA. Patients over 50 years of age or otherwise at high risk are not being screened for colon-rectal cancer; this is also not in accord with national standards of care. Many of these are systemic problems found at all facilities we have visited.

The following patient summaries highlight the concerns and the findings noted above.

Chronic Care Patient Summaries

- This patient is a 36-year-old with a history of HIV and hepatitis C who was admitted to LCC in July 2017 and followed in the UIC HIV telehealth clinic and the (LCC) hepatitis C clinic.⁶³ Her HIV viral load has been fully controlled and CD4 counts have ranged between 692 and 805. She had immunity to hepatitis A and B. Her HCV RNA was 639,892 IU/ml. Her last APRI was 0.89 in April 2017 and it was noted that she could now be worked up for hepatitis C treatment. This patient has not received pneumococcal 23, 13 or meningococcal vaccinations which are indicated for all patients with HIV. Her discharge date is March 2019. It took eight months before she was deemed eligible for the hepatitis C treatment process to begin. This delay put the patient at risk for complications of hepatitis C. In the United States, patients with hepatitis C and HIV are moved more expeditiously into hepatitis C treatment due to the more rapid progression of hepatitis C in patients co-infected with HIV.
- This 40-year-old patient has a history of HIV and hepatitis C.⁶⁴ She was admitted to LCC on 9/7/17; she did not agree to start HAART until 10/10/17. By 1/10/18, the viral load was <20 and the CD4 improved to 443. She was given pneumococcal-23 vaccine but not the meningococcal or pneumococcal 13 vaccines. At her first hepatitis C clinic visit on 9/28/17, vaccinations for Hep A and B were initiated. The HCV RNA was elevated, 7,727,120 IU/ml. In December 2017 the APRI score was 1.2 and at the 1/10/18 UIC HIV

⁶¹ Hepatitis C Guidelines December 2017.

⁶² Offender Health Services, Treatment Guidelines, Hyperlipidemia.

⁶³ Chronic Care Patient #1.

⁶⁴ Chronic Care Patient #2.

clinic, the provider recommended that she be evaluated for hepatitis C treatment as per IDOC protocol. As of 4/19/18, the patient has not started on hepatitis C treatment. In summary, the patient is seen regularly in the UIC HIV and the hepatitis C clinic. Her HIV is well controlled. She has not yet been offered meningococcal or pneumococcal 13 vaccinations. It took four months before she was deemed eligible for the hepatitis C treatment process to begin and another three months have passed and she has not yet started treatment. However, in many US medical centers, patients with hepatitis C and HIV have liver fibroscans ordered quickly and are moved more expeditiously into hepatitis C treatment due to the more rapid progression of hepatitis C in patients co-infected with HIV. Given that this patient did not start HIV treatment until October 2017, some time lag before initiating the evaluation for hepatitis C treatment was justifiable, but the delay to initiating treatment is excessive.

- This patient is a 35-year-old female with HIV.⁶⁵ Since 5/12/17, she was seen four times in the UIC HIV clinic. On 6/29/17, she agreed to start a new regimen of HIV meds. As of 12/18/17, she was still taking the meds; the viral load was undetectable and the CD4 817. There was no documentation in the UIC HIV notes reviewed that this patient had been offered or vaccinated with pneumococcal 13, pneumococcal 23, or meningococcal immunizations. She has not had a documented Pap smear since 7/28/15. In summary, this HIV patient is now fully controlled with an undetectable viral load and an excellent CD4 (817). She has not received pneumococcal 13, pneumococcal 23, or meningococcal vaccines. She has not received a Pap smear since 2015. The IDOC protocol states that women between 30-39 years of age are to have a Pap smear with HPV testing every three years. However, US guidelines state that HIV positive women must have three consecutive normal annual Pap smears before the testing interval is increased to three years. There was no documentation identified in the medical record that this patient previously had three normal annual Pap smears.
- This patient is a 38-year-old female with seizure disorder, chronic hepatitis C, and substance abuse.⁶⁶ She entered LCC on no medications. Her intake history was done on 11/21/17 and the physical exam on 11/22/17. She reported that she has had seizures occasionally accompanied by urinary incontinence since age 21. The seizures were treated in the community with Xanax (alprazolam). She reported that her most recent seizure occurred on 10/20/17. At that time the seizure was felt to have been precipitated by Xanax withdrawal or possibly opioid withdrawal (patient reported that she had stopped her methadone maintenance medications). LCC started the anticonvulsant Keppra (levetiracetam) 500mg BID at the time of the provider intake exam on 11/22/17. No additional workup was initiated to evaluate this history of seizure disorder. She was followed in the hepatitis C and seizure chronic care clinics. At the 12/22/17 hepatitis C chronic care clinic, lab results were noted as: hepatitis C antibody reactive, hepatitis A and B antibody positive (protective), liver enzymes elevated (AST

⁶⁵ Chronic Care Patient #3.

⁶⁶ Chronic Care Patient #4.

41, ALT 48), INR 1.1, and APRI 0.5. There was no record that the HCV RNA was performed as recommended in the system's hepatitis C guidelines.⁶⁷ She was deemed not eligible for treatment at this time. She has been seen twice in the seizure chronic care clinic. In summary, this patient has been seen in the hepatitis C and seizure clinics. To date, her HCV RNA level has not been performed as directed by the Hepatitis C Guidelines. If this test is negative, her hepatitis C has resolved, and she would no longer need to be followed in the hepatitis C clinic. This test must be performed as per protocol. This patient's seizure disorder has not been appropriately evaluated. Based on the patient's history, her seizures have a high possibility of being caused by withdrawal from benzodiazepines (or possible opioid withdrawal) such as Xanax (alprazolam), not by underlying epilepsy. The decision to start an anticonvulsant is reasonable pending further investigation into her seizure history, obtaining past medical records, and consultation with a neurologist. However, consultation with a neurologist has not been requested and there is no documentation that additional tests (electroencephalogram or CT scan of the brain) or outside medical records were requested. Anticonvulsant medications have multiple serious side effects. It is in the patient's best interests to determine if she really requires taking an anticonvulsant. LCC has not adequately evaluated this patient's seizure disorder; the level of care for this patient does not meet the community standard of care.

- This patient is a 66-year-old whose problem list includes seizures, diabetes, and hypertension.⁶⁸ Her medications included aspirin, metformin 500mg/d, simvastatin 5mg/d, and lisinopril 10mg/d. Although seizures are listed on her problem list, this patient is not taking an anti-convulsive medication and there is no mention of seizures or epilepsy in her medical record. This erroneous problem list entry must be corrected or clarified. Pneumococcal 23 vaccine was administered in 2014. Her diabetes is very mild and is controlled (median HbA1C 6.2). Her blood pressure has been adequately controlled; so well controlled that she may not require the anti-hypertensive that she is currently being prescribed. The LCC providers have not done this patient's 10-year cardiovascular risk scores as recommended in the IDOC's hyperlipidemia treatment guidelines,⁶⁹ but it computes to 17.7%. She has been prescribed a very low dose (5mg) of simvastatin, a moderate intensity statin. Based on national standards and the IDOC hyperlipidemia treatment guidelines, a diabetic with high 10-year cardiac risk should be prescribed a high intensity drug such as atorvastatin 40-80mg. This 66-year-old patient has not been offered nor received age-based screening for colorectal cancer or preventive vaccination against pneumococcal 13.

In summary, this patient has been seen regularly in the diabetes and hypertension clinics. Both of these chronic illnesses are controlled with low doses of medication. Her problem list erroneously listed "seizures;" this inaccuracy must be corrected. The LCC

⁶⁷ Hepatitis C Guideline, December 2017.

⁶⁸ Chronic Care Patient #5.

⁶⁹ Office of Health Services, Chronic Illness Treatment Guidelines, Hyperlipidemia, March 2016.

providers are not adhering to IDOC and national guidelines by failing to calculate this patient's 10-year cardiovascular risk score. This failure has resulted in this patient not receiving the recommended high intensity statin medication that has the potential to minimize her future risk of heart attack and stroke. This patient has not been screened for colorectal cancer; national standards recommend that all patients 50 years of age or older should be regularly screened for this potentially preventable cancer. IDOC policy advises rectal exams for patients over age 40 as part of their periodic physical exams. Rectal examination (with or without a single fecal occult blood test) is not a recommended screening test for colon cancer. This patient had not received pneumococcal 13 vaccination as recommended for all patients 65 years of age or older.

- This patient is a 50-year-old female with diabetes and hypertension.⁷⁰ Her medications include 70/30 insulin 56U/am and 54U/pm, sliding scale regular insulin BID, metformin 1000mg BID, fenofibrate 54mg/d, amlodipine 10mg/d, glipizide 30mg/d, aspirin, lisinopril 40mg/d, and triamterene/hydrochlorothiazide. She is followed in the diabetes and hypertension clinics. Fourteen HbA1C tests have been done in the last four years; not a single one has reflected adequate control. The HbA1Cs have ranged from 8.8 to 12.5 with a median of 10.2. The dose of 70/30 insulin has been steadily increased and is currently 56U/am and 54U/pm. The patient is also prescribed a sliding scale dose of regular (short acting) insulin before breakfast and dinner; this is in addition to the 17U/am and 16U/pm regular insulin that is being injected in the 70/30 combination. Adding additional regular insulin to the 70/30 insulin is potentially dangerous and poses a heightened risk of hypoglycemia. The patient is also receiving a high dose (30mg) of the oral diabetic agent, glipizide, which has little practical value in this patient who is already injecting very high doses of 70/30 insulin twice a day. Review of the 2018 MARs indicates good compliance with the medication regimen. Capillary blood glucoses (CBG) in 2018 have been consistently over 200. This patient's diabetes has not been controlled for the past four years. Consultation with an endocrinologist is needed but has not been requested. The patient is receiving four anti-hypertensive medications but 50% of the blood pressures recorded at the diabetes and hypertension clinic visits were not controlled. The LCC providers have not calculated this diabetic, hypertensive patient's 10-year cardiovascular risk scores as recommended in the IDOC's hyperlipidemia treatment guidelines,⁷¹ but it computes to 15.4%. The only anti-hyperlipidemia medication (fenofibrate) that she has been prescribed has limited if any cardio-protective value. Based on national standards and the IDOC hyperlipidemia treatment guidelines, a diabetic with high 10-year cardiac risk should be prescribed a high intensity statin. This has not been done and there is no documentation in the progress notes that this patient has any contraindications to the use of a statin. This 50-year-old patient has not been offered or received age-based screening for colon cancer or preventive vaccination against pneumococcal 23; vaccination that is recommended for all diabetics. In summary, for the last four years this patient's diabetes and hypertension have been

⁷⁰ Chronic Care Patient #6.

⁷¹ Office of Health Services, Chronic Illness Treatment Guidelines, Hyperlipidemia, March 2016.

uncontrolled. She is taking very high doses of injectable 70/30 insulin and a high dose of glipizide (oral agent) which has not been able to control her blood sugars. Her HbA1Cs persistently are in the 9-11 range. The use of a sliding scale in a patient injecting 70/30 is potentially dangerous, creates a significant risk of hypoglycemia, and should be stopped. Adding high dose glipizide to this patient's diabetic regimen increases the risk of hypoglycemia and has limited if any added value to the treatment of this patient's diabetes. An endocrinologist should be consulted to assist with the management of this complex and uncontrolled diabetic patient. The patient should be prescribed a high dose statin to minimize her risk of heart attack and stroke. This patient's blood pressure is not controlled; consultation with the telehealth nephrologist should be solicited. This patient is not receiving a level of care consistent to what is provided in the community.

- This patient is a 38-year-old female whose problem list includes diabetes and elevated triglycerides.⁷² Her current medications include 70/30 insulin 20U/am and pm, sliding scale regular insulin, metformin 500mg BID, and fenofibrate. She is followed in the diabetes and general medicine chronic care clinics. Since 2014 she has been seen 13 times in the diabetes clinic and five times in the general medicine clinic since 2016. The concomitant prescribing of 70/30⁷³ insulin and sliding scale regular insulin before breakfast and dinner puts the patient at risk for hypoglycemia. Metformin in varying doses has been started, stopped, and restarted. Glipizide was started and stopped. The 70/30 insulin dose of 20U/am and pm has not been increased since 2016 even though the four HbA1Cs in 2017-2018 have been 7.3 to 8.3. The provider's rationale for these changes or renewals were not documented in the progress notes. Her triglyceride level was 326 in 2014 when the HbA1C was 9.7 and 10.2. Her cholesterol was 226, HDL47, and LDL 152. Pneumococcal 23 vaccine has not been administered to this diabetic patient.⁷⁴ In summary, this diabetic patient has been seen regularly in the diabetes and general clinic. There is no reason why her very straightforward lipid concern could not be simultaneously managed in the diabetes clinic. The provider's chronic care notes give limited if any history about the patient's status, symptoms, and CBG's since the last visit. This patient's diabetes is only moderately controlled. The provider should have modestly increased the 70/30 insulin dose at the 4/19/18 diabetes clinic; there was no documentation in the progress note if this was considered or why this was not done. There also was no written rationale for the changing doses and the prescription/discontinuation of the diabetic oral agents. The continued use of fenofibrate has limited indication. There is limited justification to have started and continued fenofibrate for a moderately elevated triglyceride level in a diabetes patient who was not adequately controlled at the time of the initial testing as out of control diabetes raises the triglyceride level. Treatment should have been considered when the

⁷² Chronic Care Patient #7.

⁷³ 70/30 insulin is a combination of 70% isophane insulin and 30% regular insulin. When 70/30 insulin is used in combination with regular insulin, the dosage of regular insulin thereby increases. This combination can unknowingly result in higher doses of regular insulin than are realized.

⁷⁴ Office of Health Services, Chronic Illness Treatment Guidelines, Diabetes.

diabetes was under control. LCC providers have failed to administer pneumococcal 23 vaccine to this diabetic patient as is directed in the policies.

- This is a 50-year-old patient with non-insulin requiring diabetes and hypertension.⁷⁵ Her current medications include glipizide 20mg BID, metformin, lisinopril 10mg/d, metoprolol, simvastatin 40mg, and ferrous sulfate. She is followed in the diabetes and hypertension chronic care clinics. Since August 2016 she has been seen five times in the diabetes clinic and four times in the hypertension clinic. In 2016 and most of 2017, HbA1Cs were not at goal and ranged from 7.7 to 9.3. In December 2017, the HbA1C result was 6.9, which now reflected good diabetic control. Over the last two years the provider did increase, albeit belatedly, the doses of the oral diabetic medications. Seventy-five percent of the eight blood pressures recorded in the chronic care clinics in 2016-2018 were at goal. The provider's rationale to add a second BP medication, metoprolol, on 3/3/17 when this patient's BP was well controlled (123/83), was not documented in the progress notes. The use of metoprolol, a beta blocker that can mask the symptoms of hypoglycemia, is generally avoided in diabetics and no rationale for this decision was documented. Pneumococcal 23 vaccine has not been administered to this diabetic patient as recommended in the IDOC diabetes guidelines.⁷⁶ On 1/15/16, the patient (then 48 years old) was seen by the OB-GYN provider for heavy menses; the gynecologic exam was normal. An ultrasound on 5/14/16 reported the presence of uterine fibroids. The patient's hematocrit (red blood cell level) on 6/1/16 was 43.4%, hemoglobin 14.4, both normal levels. In November 2017, the now 50-year-old patient's blood counts (hematocrit/hemoglobin) had notably dropped to 24.5/7.0 and 24.3/6.9. Her MCV was microcytic consistent with iron deficiency anemia thought to be due to her menorrhagia (heavy menses). Iron supplementation was started, and the blood counts returned to normal (43.0/13.6) by 4/3/18. Although it is likely that the cause of the blood loss was heavy menses, this 50-year-old patient should have been investigated for other causes of blood loss, including gastrointestinal bleeding due to peptic ulcers or colon cancer. The failure to investigate alternate causes of blood loss was below standard of care. To date, this patient in her fifty-first year of age still has not been investigated or screened for colon cancer as is nationally recommend for all patient 50 years of age or older.

In summary, this patient was regularly seen in the diabetes and hypertensive clinics; there was no reason why these two conditions could not have been readily addressed in a single chronic care clinic. It should not have taken the chronic provider two years to get the patient's diabetes under control. The chronic care provider should have shortened the interval between visits and monitored CBGs in order to achieve control more quickly. The delay in advancing medications and doses was not justifiable. The LCC providers should have administered pneumococcal 23 vaccination to this diabetic as is recommended by national and IDOC guidelines. The failure of the providers in 2017 to

⁷⁵ Chronic Care Patient #8.

⁷⁶ Office of Health Services, Chronic Illness Treatment Guidelines, Diabetes.

consider alternate causes, such as gastrointestinal bleeding, for the patient's severe anemia put the patient's health and life at risk. All persons 50 years of age or older patients, should be screened for colon cancer. This has not yet been ordered.

- This patient is a 39-year-old female asthmatic.⁷⁷ Her current medications include levalbuterol inhaler and ciclesonide. Since early 2016 she has been seen five times in the asthma chronic care clinic. Her PEFs (peak expiratory flow rate) have been between 340 and 450 L/min. Her asthma did not require any urgent care visits, emergency department visits or hospitalizations. Wheezes were never detected at any of her asthma clinic visits. At the 1/25/17 asthma clinic, she reported that she was having two asthma attacks per week and the provider added ciclesonide to her asthma regimen. On 7/25/17, the patient reported that when the weather was hot she would use the inhaler three to four times per night and that one inhaler only lasted for one month. The provider noted that the patient should continue levalbuterol and ciclesonide inhalers. However, the MARs for September 2017 through February 2018 do not list ciclesonide as one of this patient's medications. At her most recent asthma clinic visit on 1/25/18, she reported that she was still using about one inhaler canister per month. The review of the MARs (September 2017 – February 2018) indicated that the patient had not requested any refills of the inhaler during this five-month period. There is no documentation in the progress notes that the provider had reviewed the medication administration records (MAR). If the MARs had been reviewed, the provider would have been aware that the patient was not using one inhaler per month as reported on 7/25/17 and 1/25/18, but was more likely refilling her inhaler every six months. This asthmatic has not received the pneumococcal 23 vaccine as is recommended for all asthmatics.

In summary, this asthmatic patient is relatively stable. Her PEFs were consistently between 340 and 450. An additional asthma medicine was added when the patient reported that she was having two attacks per week. The patient reported periods when she increased her use of metered dose inhaler from one canister every six months to one every month. The provider was not regularly reviewing the MARs. This resulted in the provider not knowing that the patient was actually using up her inhaler less frequently (every six months not every month) than she reported. This important clinical information would have allowed the provider to delve more carefully into the patient's history of asthma attacks and self-treatment, and possibly might have resulted in a decision to stop the use of one of her medications (ciclesonide). It is a national recommendation that asthmatics receive the pneumococcal 23 vaccine; this vaccine has not been offered to this patient.

- This patient is a 49-year-old female with multiple sclerosis and hypertension.⁷⁸ Her current medications include monthly injectable Copaxone (glatiramer), vitamin B12,

⁷⁷ Chronic Care Patient #10.

⁷⁸ Chronic Care Patient #15.

baclofen, oxybutynin, gabapentin, lisinopril, and fenofibrate. She has an unsteady gait, experiences urinary incontinence and blurry vision, and uses a walker. She is followed in the general medicine chronic care clinic mostly by the LCC physician and has had nine general medicine clinic visits in the last four years. The chronic care provider generally writes comprehensive notes commenting on the patient's condition, the neurologist consultations, and imaging reports. The LCC optometrist has seen the patient no less than yearly since 2014. Physical therapy has been provided to the patient at LCC since 2014. The patient has had six or seven neurology consultations since April 2014. The neurology specialist is managing the patient's multiple sclerosis treatment regimen. There have been possible MS flares in 2015 and 2017 that prompted the neurologist to order repeat MRI studies, which showed evidence of demyelinating disease with no active changes and cervical cord demyelinating plaques with a new lesion in the left pons, no active demyelination, and cervical spondylosis with severe left foraminal stenosis. Left C6 and C7 radiculopathy workup was advised but there is no documentation that this evaluation was ordered. Almost all of the neurology consultations were found in the EMR. The patient also saw a urology specialist for urinary incontinence on 8/19/15. The urology specialist initiated medication to treat the patient's sudden losses of urine and advised cystoscopy, renal US, and urodynamic studies. There is no evidence in the medical record that the urology procedures and tests had ever been done. The patient has developed mild hypertension for which she has recently been started on lisinopril, and she was given an appointment to the hypertension chronic care clinic. Fenofibrate was initiated at the 3/16/18 general medicine chronic care clinic; the rationale for this added medication was not documented. The patient's 10-year cardiovascular risk score was not done but calculated 10-year cardiovascular risk was determined to be 3.0%, below the threshold to initiate lipid therapy. The provider did not document why it had been determined that the patient warranted treatment, but the choice of medications would have been a statin, not a fibrate medication.

In summary, this multiple sclerosis patient has been seen regularly in the General Medicine chronic care clinic at LCC and by a St. John's SIU neurology specialist who manages the treatment of the patient's multiple sclerosis. MRIs have been done and medications provided as ordered by the neurologist. The neurologist ordered tests to evaluate cervical radiculopathy, but these tests were not done. A urology specialist was consulted to evaluate the patient's urinary incontinence. In 2015, the urologist recommended a variety of additional procedures including cystoscopy, urodynamic studies, and renal ultrasound; there is no evidence in the EMR that these tests/procedures were ever performed. When the patient developed hypertension, there was no reason that this additional chronic illness could not have been easily co-managed at the time of general medicine clinic appointments.

Women's Health

Methodology: Nurse practitioners were interviewed about the women's health screening practices. The Guidelines for Inmate (Female) Periodic Physical Exams were reviewed. The list of current pregnant patients and the records of pregnant women were reviewed. The records of patient-inmates were audited for PAP and mammogram screening records.

First Court Expert Findings

The First Court Expert noted that patients with or at high risk for women's health issues were not tracked in an organized way. Cervical cancer screening was not performed in a timely manner, high-risk patients were not screened as frequently as warranted, and abnormal Pap smears were not adequately followed up. The expert noted that the current staff (24 hours per week OB-GYN) assigned to the provision of women's health care was not adequate to meet the needs of the LCC population and the addition of a women's health nurse practitioner was justified.

Current Findings

We agree with the findings in the First Court Expert's report. We had additional findings that are as follows:

- At the time of the site visit there were 11 pregnant women at LCC.
- One pregnant woman has been in LCC for 64 days and has not yet been seen by the OB-GYN provider and her prenatal record has not been started. Prenatal labs, vital signs, Pap, and fetal ultrasound have been done. Prenatal vitamins and iron supplementation have been prescribed.
- Fourteen of 15 (93%) charts audited had a Pap smear that was done in the last three years as per IDOC protocol.
- Four of five (80%) charts audited of women over 45 years of age had a mammogram performed in the last two years as per IDOC protocol. In another record sample, 12 of 13 patients above age 50 were offered a mammogram.
- Two of the three (66%) HIV patient charts reviewed had a Pap in the last year or evidence of three consecutive negative annual Paps in medical record.
- The existing needs for female-specific care have not been adequately addressed in the past. Newly hired nurse practitioners are being assigned to women's health responsibilities. It was reported that the nurse practitioners will be soon be oriented by the OB-GYN provider to the provision of prenatal care. This would enhance the coverage of the prenatal clinic services. Additional provider staffing may be needed to cover the services needed by this large and high-risk female population, which also has a reception & classification center that requires gynecological screening of all patients.
- All providers do not have access to comprehensive online medical references at all clinical and administrative work areas.
- The nurse practitioners have not been trained to evaluate wet mounts of vaginal discharges and vaginal infections are treated presumptively. The single microscope is seldom, if ever, used.

The LCC women's health periodic physical exam guidelines recommend Pap smears every three years, without human papilloma virus (HPV) testing for women less than 30 years of age and with HPV testing for women over 30 years old. Pap smears can be stopped after age 65. Mammograms are to be done every two years beginning at 45 years of age through age 70. Pap smears are performed on all new admissions over 21 years of age as part of the reception and screening process and are updated per protocol at the annual physical exams. Mammograms are scheduled as indicated for patients over 45 years of age along with the annual physical appointment. The process to schedule annual physicals is as follows:

1. The Offender 360 IDOC program generates a list of all patients with birth dates in an upcoming month.
2. Nurse practitioners review the patients' medical records.
3. Women's health "to do" list is created.
4. Based on the "to do" list, appointments are scheduled with the two nurse practitioners.

Audits of 15 women's charts revealed that 14 (93%) have had Pap smears in the past three years. One patient had not had a Pap smear in over four years. Three women were found to have abnormal Pap smears with low grade squamous intraepithelial lesions (LGSIL) and human papilloma virus positivity. One had a colposcopy with a biopsy in November 2017 and is scheduled for repeat colposcopy in May 2018. Another had colposcopy and biopsy in 2014, with improvement to atypical squamous cells of undetermined significance (ASCUS) smears in 2016 and 2017. A third was found to have LGSIL in March 2018 and will have repeat studies done after the delivery of her child in late May 2018.

Charts reviews showed that three of four (75%) women over 45 years of age had a mammogram in the last two years. One additional patient under 45 years of age also had a mammogram when she was 38 years old. One 49-year-old woman had not yet had this screening test performed four years after she was eligible for a screening mammogram.

In a separate sample of 13 records randomly selected from a list of patients above age 50, in 12 of 13 cases women were offered mammograms. In the lone woman who was not offered mammogram screening, the patient was admitted to LCC in early April 2018 and the mammogram was not ordered at intake. In 11 of 12 cases in which mammogram was offered, they were either completed or refused. In the remaining case there was an equipment failure and the mammogram needed to be rescheduled. We reported this to the HCAU.

All of the prenatal care is provided by the OB-GYN specialist (approximately 50% FTE) who provides onsite service and consultation. The OB-GYN provider uses a paper antepartum/postpartum record to record patients' progress, tests reports, vital signs, fetal heart tones, uterine measurements, etc. This patient form is maintained in a binder in the ambulatory clinic. A copy of the record is sent to the delivering hospital. This record is not incorporated into the electronic medical record but should be. The OB-GYN provider was soon to be temporarily away from LCC; a nurse practitioner reported that the OB-GYN provider will soon be orienting the nurse practitioners to the provision of prenatal care to allow coverage during the specialist's absence. Colposcopy and cervical biopsy, cervical cryosurgery, obstetrical

Doppler ultrasonography, pelvic ultrasound (contracted service), and mammography are provided onsite.

There were 10 pregnant women at LCC at the time of the Experts' visit. The charts of four currently pregnant women were reviewed. Two have very high-risk pregnancies (recurrent deep vein thrombosis with pregnancy, gestational diabetes); both have been appropriately referred to and jointly managed with St. John's SIU Medical Center's maternal and fetal medicine (MFM) specialists. No MFM consultation reports were found in the antepartum record or the EMR on one of these patients. Another pregnant woman has had two previous c-sections and has been appropriately monitored. The fourth pregnant patient was admitted to LCC on 2/22/18. Prenatal tests, Pap smear, fetal ultrasound, and vital signs have been done. Prenatal vitamins and iron supplementation was prescribed. The first appointment with the OB provider was scheduled for 4/6/18, but was cancelled due to provider absence. As of 4/26/18, 64 days after admission to LCC, this patient has not seen the OB provider and the antepartum record has not been started. If additional providers (nurse practitioners) were trained to provide basic prenatal care, this patient would have been fully evaluated by this time.

There is a functional microscope, but it was dusty and appeared not to be in use. It was reported that the nurse practitioners had not been trained to perform wet mounts to identify yeast, bacterial vaginosis, and trichomonas vaginal infections and thus were not using the microscope. Not all providers at LCC have access to a comprehensive electronic medical references such as UpToDate.

In summary, the provider staffing is not adequate to provide the volume of clinical work at this large women's facility and reception center. In the absence of the OB-GYN provider, there are no providers trained to provide prenatal care. At least one of the nurse practitioners should be trained and regularly assigned to prenatal clinic. Not all offsite specialty consultation reports are being returned with the patient or retrieved by the LCC support staff; this should be addressed. Women with HIV are not being screened for cervical cancer as frequently as is nationally recommended. Most women are receiving Pap smears and mammograms in accord with IDOC and national guidelines. It appears that a few women are not consistently being screened as directed in the IDOC guidelines. The following chart summaries highlight the concerns and findings noted above.

Women's Health Charts

- This patient is a 35-year-old female with HIV and genital HSV.⁷⁹ Her last Pap smear was done on 7/28/15; the result was negative. No repeat or previous Pap tests were identified in the record. In summary, this HIV patient should be having annual Pap smears until three consecutive annual tests have been performed; then the interval can be increased to three years. LCC is not following national guidelines concerning the frequency of cervical cancer screening in this higher risk HIV patient.

⁷⁹ Chronic Care Patient #3.

- This patient is a 66-year-old whose problem list includes seizures, diabetes, and hypertension.⁸⁰ Mammograms done in 2014 and 2016 were both reported to be Breast Imaging Reporting and Data System (BIRAD) II. A Pap smear in 2014 was negative and ASCUS/HPV negative in 2016. In summary, this patient has, to date, had mammograms at intervals recommended in national and IDOC protocols. Even though she is older than 65 years of age, she should have another negative Pap smear before cervical cancer screening is no longer recommended.
- This patient is a 34-year-old pregnant female with history of DVT during previous pregnancies, pre-eclampsia in the past, diet-controlled diabetes in the past, tobacco use, and substance use.⁸¹ Her expected due date is 5/27/18. This patient was admitted to LCC on 3/9/18. The patient was pregnant seven times in the past and had DVTS with her pregnancies in 2010, 2012, and 2013, and at least one pulmonary embolus. She was listed as a high-risk pregnancy. She was treated with Lovenox (enoxaparin, subcutaneous blood thinner) during her prior pregnancies. Her intake Pap was read as LGSIL/HPV+; this abnormality had also been previously identified at some time in the past. The prenatal flow forms showed that the patient had seven visits with the LCC OB provider between 3/14 and 4/24/18. Prior to admission to LCC, ultrasounds at Northwestern Medical Center and Stroger Cook County Hospital revealed a single umbilical artery. Post entry to LCC, two additional ultrasounds (St. John's SIU Medical Center and LCC) revealed a normal fetus. The patient was referred to Maternal Fetal Medicine (MFM) at St. John's SIU Medical Center where she has had two, possibly three, visits to date, with two more visits prescheduled in May 2018. The visits are commented on in the prenatal flow forms, but consultation reports from St. John's MFM were not located in the EMR. The patient is scheduled for induction of labor on 5/21/18 at St. John's SIU Medical Center. In summary, this high-risk pregnancy has been closely monitored by the OB provider/team at LCC. Ongoing consultation with the MFM OB specialists at St. John's SIU Medical Center was initiated within two weeks of the patient's admission to LCC. Consultation reports from the specialist are not in the LCC EMR; this deficiency must be addressed and corrected.
- This patient is a 29-year-old pregnant female with diabetes who had taken insulin during previous pregnancies, and a psychiatric disorder.⁸² An ultrasound on 3/19/18 showed FHT 140 and a fetal age of 26 weeks +/- 4 days. The prenatal tracking form documented OB provider/team encounters on 3/9, 3/19, 3/23/18. The patient was seen at the St. John's SIU Maternal Fetal Medicine (MFM) by specialists on 4/2/18; insulin was changed to NPH 15U/am, 5U/pm and Lispro insulin 5U-6U-8U with the three meals. St. John's requested that capillary blood glucoses (CBG) be sent weekly for their review. On 4/6/18, the patient was admitted to the LCC infirmary for closer monitoring due to CBGs above 300. On 4/20/18, the infirmary provider noted that CBG's were still in the 200s

⁸⁰ Chronic Care Patient #5.

⁸¹ Chronic Care Patient #11.

⁸² Chronic Care Patient #13.

and increased the NPH insulin dosage to 20U/am and 10U/pm. Some improvement of CBG's were reported on 4/13/18. On 4/17/18, it was noted that CBG results were sent to St. John's SIU MFM service. The patient was again seen at St. John's MFM on 4/18/18; ultrasound showed FHT 148 and a fetal age of 31 weeks +/- 4 days. The MFM providers recommended that the glucose treatment goals were fasting blood glucose (FBS) <90 and post prandial <120. In summary, this pregnant patient with gestational diabetes was quickly placed under the care of the LCC OB provider and St. John's SIU MFM specialists. She is being appropriately tested and monitored to date. CBG results have been communicated at least once to the MFM specialists.

- This patient is a pregnant 21-year-old female with a history of tobacco use and possible mental health disorder.⁸³ Labs were ordered, blood pressure was normal, and prenatal vitamins and ferrous sulfate prescribed. From 2/28/18 to 3/13/18, the patient was placed on mental health crisis watch. On 3/6/18, onsite ultrasound revealed FHT 168 and a fetal age of 10 weeks +/-2 days. The OB provider appointment on 4/6/18 had to be rescheduled by the provider, but a Pap smear was done on this date. As of 4/26/18, the patient has not yet been seen by the LCC OB provider. Sixty-four days after intake, the prenatal tracking form has not yet been initiated and the OB provider has not examined this first trimester/early second trimester patient. In summary, this first/early second trimester pregnant patient has had prenatal labs and tests performed, fetal ultrasound done, prenatal vitamins and ferrous sulfate prescribed, and blood pressure monitored. However, 64 days after admission to LCC, this patient has yet to be evaluated by the OB provider who had to cancel one scheduled appointment. LCC now has three advanced practice nurse practitioners (NP); it would be in the best interest of patient care if at least one of the NPs was assigned to staff the prenatal clinic with the OB provider and acquire skills and experience in managing OB patients in the absence of the OB specialist.
- This patient is a 49-year-old female with multiple sclerosis and hypertension.⁸⁴ She has been incarcerated since at least 2004 and transferred to LCC when it opened in 2013-14. She had a normal Pap in 2014 but there have been no Paps in last four years. No mammograms have yet been done even though the patient is over the age (45 years old) when IDOC recommends starting mammography screening. In summary, LCC is not following the IDOC Pap and mammography screening recommendations, which recommend Pap smears every three years and mammography starting at 45 years of age.

Dental Program

Dental: Staffing and Credentialing

⁸³ Chronic Care Patient #14.

⁸⁴ Chronic Care Patient #15.

Methodology: Reviewed staffing documents, interviewed dental and other staff, reviewed the Dental Sick Call Log and other documents.

First Court Expert Findings

- LCC has two full-time dentists, two full-time assistants, and one full-time hygienist. This should be adequate to provide meaningful dental services for LCC's 2000 inmates.
- CPR training is current on all staff, all necessary licensing is on file, and DEA numbers are on file for the dentists.

Current Findings

We concur with the First Court Expert's findings that staffing is adequate. LCC has 2.0 dentist FTEs,⁸⁵ one full-time dental hygienist and three full-time dental assistants; an increase of one dental assistant.

Dental: Facility and Equipment

Methodology: Toured the dental clinic to assess cleanliness, infection control procedures, and equipment functionality. Observed intake screening and clinical care. Evaluated the quality of x-rays taken at intake. Reviewed compliance with radiologic health regulations.

First Court Expert Findings

- The clinic is small, with equipment that is more than 20 years old. Provider and assistant had very little room to work. If both chairs were in use, the providers could interfere with each other.
- Loose wires were strewn on the floor and plugged into a loose metal junction box, upright on the floor next to the unit. It interfered with movement and was a real safety hazard.
- Several areas of rusted metal were evident, and the cabinetry is worn. The chairs have torn fabric and are not up to contemporary infection control standards.
- Metallic surfaces were rusty and stained, and corners were worn and frayed, which impeded adequate surface decontamination and disinfection.
- The intraoral x-ray unit was inoperative, a deficiency that interfered with the provision of dental care.
- The Panelipse [panoramic] radiographic unit was old and faded and the quality of x-rays was poor.
- An EMR is in the early testing phase at LCC.
- The handpieces and instruments were adequate.
- There was a separate sterilization and laboratory room of adequate size with a large work surface and a large sink to accommodate proper infection control and sterilization.
- Laboratory equipment was in a separate corner of the room. The staff had an office with two desks.

⁸⁵ Two dentists work four eight-hour days and one dentist works two eight-hour days.

- At the time of the visit, two additional units were being installed in another room adjacent to the clinic area to be used for hygiene and prosthetics and has an extra chair to accommodate patient overflow, e.g., emergencies and examinations.

Current Findings

Dental facilities and equipment have improved since the First Court Expert's Report and are adequate. We concur with the First Court Expert and note that that since then, the loose wires have been secured, the EMR has been implemented, and the dental hygiene area has been completed. We identified current and additional findings as follows.

There are two dental units in the main clinic and two in the dental hygiene area. The dental hygienist's unit is not in the dental clinic but rather in a small room in a corridor that is not contiguous with the dental clinic, isolating the hygienist from clinic activity.

The two chairs in the main clinic are old, and one has torn upholstery which interferes with surface disinfection. The light stanchion of the other unit was salvaged from another facility and is mounted askew. In addition, the bracket table is unstable and cannot be maintained in place, posing a hazard to patients and staff.

There are only four functioning high-speed handpieces (drills). Since two dentists are working most of the time and handpieces must be sterilized between patients, this is insufficient, since there are always some handpieces in various stages of sterilization that are unavailable for use.

There is one functioning intraoral x-ray unit mounted near one of the dental units. The dental hygienist's operatory does not have an x-ray unit. As a result, the hygienist, who is accustomed to taking bitewing x-rays on her patients, cannot do so feasibly.

There is no stethoscope and sphygmomanometer in the clinic and when dentists want to measure blood pressure, they borrow them from Nursing.

Dental: Sanitation, Safety, and Sterilization

Methodology: Reviewed Administrative Directive 04.03.102. Toured the dental clinic and observed dental treatment room disinfection. Interviewed dental staff and observed patient treatment.

First Court Expert Findings

- The surface disinfection was performed between patients and was adequate. Protective covers were utilized on some surfaces.
- Instruments properly bagged, sterilized, and stored. Handpieces were sterilized and in bags.
- The sterilization procedures were adequate, and flow from dirty to clean was acceptable.
- Safety glasses were not always worn by patients.

Current Findings

Dental sanitation, safety, and sterilization are unchanged since the First Court Expert's Report and are adequate. However, we identified current and additional findings as follows. Surface disinfection performed between patients in the clinic was appropriate and protective covers were used on surfaces. Sterilization procedures and instrument flow were adequate. Instruments were properly bagged, sterilized, and stored. Patients did not always wear safety glasses^{86,87}. Sanitation at the intake dental examination was inadequate and will be discussed in the Initial Examination section, *infra*.

Dental: Review Autoclave Log

Methodology: Reviewed the last two years of entries in autoclave log, interviewed dental staff, and toured the sterilization area.

First Court Expert Findings

- A review of the past two year's sterilization logs showed that autoclaving was accomplished weekly and documented. They utilize a service from Henry Schein called Crostex that does the testing and maintains the results. A spread sheet of the results is available and provided annually. A biohazard warning sign was not posted in the sterilization area.

Current Findings

Autoclave Log maintenance is unchanged since the First Court Expert's Report and remains adequate. We agree with the First Expert's findings. The sterilization log was in order.

Dental: Comprehensive Care

Comprehensive, or routine care⁸⁸ is non-urgent treatment that should be based on a health history, a thorough intraoral and extraoral examination, a periodontal examination, and a visual and radiographic examination.⁸⁹ A sequenced plan (treatment plan) should be generated that maps out the patient's treatment. This plan should be updated after each treatment or examination.

⁸⁶ Why We Take Infection Control Seriously. UIC College of Dentistry. Viewed at <https://dentistry.uic.edu/patients/dental-infection-control>, viewed February 2, 2018 "We use personal protective equipment [...] **as well as provide eye protection to patients for all dental procedures.**" (emphasis added).

⁸⁷ Guidelines for Infection Control in Dental Health-Care Settings ---2003. MMWR, December 19, 2003/ 52(RR17):1:16; pp. 17-18. ("PPE [personal protective equipment] is designed to protect the skin and the mucous membranes of the eyes, nose, and mouth of DHCP [dental health care provider] from exposure to blood or OPIM [other potentially infectious materials]. Use of rotary dental and surgical instruments (e.g., handpieces or ultrasonic scalers) and air-water syringes creates a visible spray that contains primarily large-particle droplets of water, saliva, blood, microorganisms, and other debris. This spatter travels only a short distance and settles out quickly, landing on the floor, nearby operatory surfaces, DHCP, **or the patient**. The spray also might contain certain aerosols (i.e., particles of respirable size, <10 µm). Aerosols can remain airborne for extended periods and can be inhaled" and "Primary PPE used in oral health-care settings includes gloves, surgical masks, **protective eyewear**, face shields, and protective clothing (e.g., gowns and jackets). All PPE should be removed before DHCP leave patient-care areas (13). Reusable PPE (e.g., clinician **or patient protective eyewear** and face shields) [...]"). Emphasis added. Moreover, protective eyewear prevents injury from objects dropped by the provider.

⁸⁸ Category III as defined in Administrative Directive 04.03.102.

⁸⁹ Stefanac SJ. Information Gathering and Diagnosis Development. In Treatment Planning in Dentistry [electronic resource]. Stefanac SJ and Nesbit SP, eds. Edinburgh; Elsevier Mosby, 2nd Ed. 2007, pp. 11-15, *passim*.

Methodology: Interviewed dental staff, reviewed dental charts of inmates who received non-urgent care randomly selected from Daily Dental Reports.

First Court Expert Findings

- A basic and essential standard of care in dentistry is that all routine care proceeds from a thorough, well-documented intra and extra-oral examination and a well-developed treatment plan, to include diagnostic x-rays. In none of the 10 records reviewed was any of this present.
- No comprehensive examination was performed, no treatment plans developed, and no hygiene care performed before routine care.
- No diagnostic x-rays for caries were available. Restorations were provided from the information from the panoramic radiograph and an inadequate screening exam. This radiograph is not diagnostic for caries.
- A periodontal assessment was not done, and oral hygiene instructions were not documented in the dental record as part of the treatment process.

Current Findings

Comprehensive care is materially unchanged since the First Court Expert's Report and we concur with the First Court Expert that it is inadequate. Moreover, we identified current and additional findings as follows.

Dr. Zielinski said that while he "likes to take bitewing x-rays every year" in private practice, he does not do so at LCC. The hygienist said that she would normally take bitewing x-rays; however, she does not have an intraoral x-ray unit in her operatory. To take x-rays, she would have to bring the patient to one of the dentist's chairs; however, this is not feasible since 1) typically, a dentist is seeing a patient and, 2) the dental hygiene operatory is separate from the dental clinic.

Biennial exams are scanty and of minimal clinical value. Neither x-rays nor periodontal probing are performed, and a sequenced treatment plan that involves periodontal treatment is not produced. Moreover, there is no documentation that a soft tissue examination for oral cancer is performed.⁹⁰

The dental hygienist completes Dental Hygienist Progress Notes after treatment. The form is organized in the SOAP format; however, it does not document Periodontal Screening and Recording, a standard of care for dentistry and dental hygiene.⁹¹ Furthermore, the assessment

⁹⁰ Appendix B shows the biennial examination form of Biennial Exam Patient #7 is typical of biennial exam entries. Other than a box indicating that treatment has not been requested, the examination is of little clinical value.

⁹¹ Stefanac SJ. (A panoramic radiograph has insufficient resolution for diagnosing caries and periodontal disease. Intraoral radiographs (e.g., bitewings) and periodontal probing are necessary), p. 17. Also, (Periodontal Screening and Recording (PSR), an early detection system for periodontal disease, advocated by the American Dental Association and the American Academy of Periodontology since 1992, is an accepted professional standard.), pp. 12-14. See American Dental Hygiene Association. Standards for Clinical Dental Hygiene Practice Revised 2016, pp. 6-9. (Periodontal probing is also a standard of practice for dental hygiene).

is general and does not indicate the location and severity of the periodontal problem. Consequently, there is no way to monitor disease progression or reversal.

Of 10 inmates who received comprehensive (routine) care, all had treatment plans; however, the treatment plans were below accepted professional standards, since the sequence of the prescribed care was not specified, and they were informed by neither bitewing x-rays nor periodontal probing. As a result, caries and periodontal disease were underdiagnosed.

Oral hygiene instruction (OHI) was documented only in conjunction with treatment by a dental hygienist and the two patients who were not treated by the dental hygienist had no documented oral hygiene instruction. The Dental Hygiene Progress Note in the electronic health record⁹² has several boxes corresponding to procedures that the hygienist can check: Scaling and Root Planing, Prophylaxis, Perio-Prophylaxis, Full Mouth Debridement, and Oral Hygiene Instruction.⁹³

The dentists were unable to provide the definitions the clinic uses for these procedures and referred me to the dental hygienist.⁹⁴ The hygienist said that when she records “scaling and root planing” it means that she removed some calculus with either hand instruments or an ultrasonic scaler and a “perio-prophylaxis” is a deeper scaling for patients who have periodontal disease. These are idiosyncratic definitions that do not comport with standard dental terminology.

Dental: Intake (Initial) Examination⁹⁵

Methodology: Observed intake screening process. Reviewed dental records of inmates that have been screened recently. Reviewed Administrative Directive 04.03.102.

First Court Expert Findings

- The screening examination was performed within 10 days of arrival, and the intra and extra-oral examinations were adequate. Panoramic x-rays were taken at the dental clinic and APHA priorities were designated.
- In none of the records were oral hygiene instructions included. The examiner explained orally and had written instructions available on how to access dental care.

⁹² Dental Hygiene Progress Note for Biennial Examination Patient #7 (Appendix C).

⁹³ American Dental Association procedure codes show that the definitions of scaling and root planing (D4341 and D4342) are clear and specify the scope of the procedure. This is not the definition used by the dental hygienist. In fact, her description more closely resembles the definition of an adult prophylaxis (D1110).

⁹⁴ This is problematic, since per the Illinois Dental Practice Act, dentists supervise dental hygienists and prescribe the treatments the dental hygienists provide. “General supervision means supervision of a dental hygienist requiring that the patient be a patient of record, that the dentist examine the patient in accordance with Section 18 prior to treatment by the dental hygienist, and *that the dentist authorize the procedures which are being carried out by a notation in the patient's record* [a treatment plan satisfies this requirement], but not requiring that a dentist be present when the authorized procedures are being performed.” Illinois Dental Practice Act 225 ILCS 25/4). Viewed at <http://www.ilga.gov/legislation/ilcs/ilcs3.asp?ActID=1296&ChapterID=24> 8/6/2018. Emphasis added.

⁹⁵ The First Court Expert Report describes the examination performed at intake screening as a “Screening Examination;” however, Administrative Directive 04.03.102 describes it as a “complete dental examination.” We use the terminology of the Administrative Directive and refer to the intake or initial dental examination as a complete dental examination.

- The room where the panoramic x-ray was taken did not provide sufficient warning to pregnant females that the area was potentially hazardous. Additionally, no consent form was developed that explained the potential hazards and gave permission for the x-rays to be taken on female inmates who might be pregnant.

Current Findings

The dental intake examination has not changed materially since the First Court Expert's Report. We agree with the First Court Expert that the intake exams were timely, oral hygiene instructions were not documented, and that warning signs were not posted in the panoramic x-ray area. However, we find the most important problem (not addressed by the First Court Expert) to be the overall inadequacy of the initial examination. We identified current and additional findings as follows.

The dental intake examination is performed in a small room that has a dental chair and light. A dental assistant asks health history questions and records responses. The dentist is gloved; however, he does not wash hands or use alcohol wipes between changing gloves. No disposable barriers were used on dental lights. Exams employ adequate light, a mirror, and an explorer. A dental assistant records the charting. Oral hygiene instructions are not provided, although a handout and oral instructions are provided relating to how to access dental care at LCC.

The dentist does not perform a thorough soft tissue examination.⁹⁶ For example, he does not visualize the lateral and posterior regions of the tongue,⁹⁷ a site of squamous cell carcinoma. This is especially important at LCC, since "[s]uspect lesions in females younger than the age of 50 years, with no history of alcohol or tobacco use, have a greater risk of malignant potential and often behave more aggressively. Lesions in this population of patients must be treated [and *a fortiori*, diagnosed] very quickly and aggressively."⁹⁸ Performing a thorough soft tissue examination is critical at the initial examination, since unless the inmate requests care within two years, her next exam will be biennial.⁹⁹

A dentist reviews the charting and panoramic x-ray later and records a treatment plan. This is inadequate because it is not informed by bitewing x-rays and a periodontal assessment. Twenty charts and panoramic x-rays of inmates who received oral screening examinations in the past month were reviewed. All the chartings were adequate; however, four x-rays (20%) were clinically inadequate.

⁹⁶ Stefanac SJ. ("Evaluation of head and neck structures for evidence of tissue abnormalities or lesions constitutes an important part of a comprehensive examination."), p. 12. See also Shulman JD, Gonzales CK. Epidemiology / Biology of Oral Cancer. In Cappelli DP, Mosley C, eds. *Prevention in Clinical Oral Health Care*. Elsevier (2008) ("Regular, thorough intraoral and extraoral examination by a dental professional is the most effective technique for early detection and prevention of most oral cancers. [...]") p. 41.

⁹⁷ Shulman and Gonzales, p. 31, Figure 3.7. This is generally done by holding the anterior portion of the tongue with 2x2 gauze and reflecting the tongue with a mouth mirror. This is a professional standard for an oral examination.

⁹⁸ Shulman and Gonzales, p. 41.

⁹⁹ This deficiency is compounded by the fact that dentists do not document soft tissue examinations at biennial exams. See section on Comprehensive Care, *supra*.

None of the 10 biennial examinations reviewed were informed by bitewing x-rays or periodontal probing. While seven patients¹⁰⁰ did not request treatment, there was no documentation of their treatment needs – if only to note that that no treatment was warranted. None of the patients who requested treatment had an updated treatment plan. There was no documented periodontal assessment or soft tissue exam for oral cancer. In short, the examinations are substantially below accepted professional standards.

Dental: Extractions

Methodology: Interviewed dental personnel and reviewed 11 dental and medical records.

First Court Expert Findings

- A tenet of dentistry is that all treatment proceeds from a well-documented diagnosis. In none of the 10 records examined was a diagnosis or reason for extraction included as part of the entry. Too often, the dental record includes only the treatment provided with no evidence as to why that treatment was provided.

Current Findings

Dental extraction care has improved since the First Court Expert's Report and is adequate. We concur with the First Court Expert's findings but note that unlike those findings, of 10 records of inmates who had extractions, all extractions were informed by adequate panoramic x-rays. This aspect of the program has improved substantially since the First Expert's Report. All progress notes documented the reason for the extraction. We did, however, find that none of the charts documented that the health history had been updated. All extractions were accompanied by signed consent forms.

Dental: Removable Prosthetics

Methodology: Reviewed eight charts of patients who received partial dentures in the past year that were randomly selected from the Prosthetics List and interviewed dental staff.

First Court Expert Findings

Removable partial denture prosthetics should proceed only after all other treatment recorded on the treatment plan is completed. The periodontal, operative [fillings], and oral surgery needs all should be addressed first.

- In none of the five records reviewed on patients receiving removable partial dentures were oral hygiene instructions provided.
- Periodontal assessment is never included, but in three of five records a prophylaxis and/or a scaling debridement was provided.
- Because there is no comprehensive examination, or any treatment plans documented in any of the records, it is almost impossible to ascertain that operative or oral surgery treatment is complete prior to fabrication of removable partial dentures.

¹⁰⁰ Biennial exam patients #1, 2, 3, 4, 5, 7, and 9.

Current Findings

Removable prosthetics care has not changed materially since the First Court Expert's Report. We agree with the First Court Expert's findings with respect to the inadequacy of the provision of removable prosthetics. We identified current and additional findings as follows.

Of six inmates who received partial dentures, all but one¹⁰¹ received oral hygiene instruction.¹⁰² All had extractions and fillings completed before the denture was fabricated. All but one inmate¹⁰³ had a periodontal assessment and received some treatment by a dental hygienist; however, the assessment was inadequate since it omitted periodontal probing (specifically, the PSR), a professional standard for dentistry and dental hygiene. Moreover, as discussed in the Comprehensive Care section *supra*, the putative procedures documented do not correspond to standard dental terminology; consequently, it is difficult to know what was done.

All had documented treatment plans; however, the Treatment Needed – Completed Restorations form produced by the EHR does not indicate the need for periodontal treatment, nor does it distinguish between the procedures that were planned and those that were completed.

Dental: Sick Call/Treatment Provision

Methodology: We interviewed dental staff, reviewed dental sick call logs, daily dental reports, and reviewed records of 10 inmates who were seen on sick call.

First Court Expert Findings

- Inmates access sick call through an inmate request form or via a direct call from a staff member if it is perceived to be an emergency. The dental hygienist reviews all request forms the following day from the collection of the forms, triages the complaints, and schedules per the dentists' direction or as soon as possible.
- By policy, all inmates who submit a request form are to be seen by dental staff within 14 days. LCC was not compliant with this policy. Toothaches or infections can be called in from anywhere in the institution and the inmate will be seen that same day.
- In none of the dental records reviewed was the SOAP format used; as a result, treatment was usually provided with little information or detail preceding it.
- Routine care was often provided at these appointments, always without a comprehensive examination or treatment plan.
- The LCC dental department does not keep request forms; consequently, it was difficult to review sick call records from more than a month ago.

Current Findings

¹⁰¹ Prosthetics Patient #4 did not receive documented oral hygiene instruction.

¹⁰² The only documented oral hygiene instruction in the charts I reviewed was at the dental hygiene appointment. Dentists do not document the provision of oral hygiene instruction.

¹⁰³ Prosthetics Patient #4.

The dental sick call process has changed since the First Court Expert's Report and is adequate. Consequently, our findings diverge from those of the First Court Expert. Moreover, we found that the SOAP format was used consistently, which represents an improvement in documentation.

Inmates access dental care by checking the 'Dental' column on the nurse sick call signup form. Since the form does not indicate the nature of the dental issue (e.g., the existence of pain), dental staff pick up the forms daily and interview the inmates. Those with urgent care issues are seen by a dentist, typically, the next business day, and the others are scheduled for a routine visit, typically, within three weeks.

Inmates may also submit sick call requests (sick slips) which they place in locked boxes in the housing areas. These forms are collected daily by nursing personnel. Since the forms state the problem, dental staff call in those with urgent care issues and schedule the others for a routine appointment as they do for referrals from nursing sick call.

Of 10 records of inmates who were seen on dental sick call, all had a diagnosis documented in the chart; however, none had the health history reviewed or updated at the visit. The nursing sick call lists from April 1 thru April 8 had 32 inmates requesting dental care, of which 10 (31%) were either no-shows or refusals.

Dental: Orientation Handbook

Methodology: Reviewed the Orientation Handbook.

First Court Expert Findings

Dental care is not addressed in the Offender Handbook and Orientation Manual. This omission should be addressed immediately. I was told that inmates were informed about the dental program and how to access care at the reception intake screening examination. This is inadequate.

Current Findings

Inmate orientation to dental care has not changed materially since the First Court Expert's Report. We concur with the First Court Expert with respect to the inadequacy of the Orientation Handbook. We identified current and additional findings as follows.

The Offender Handbook's only mentions of dental care are that dental care is available (p. 7) and that there is \$5.00 co-pay for non-emergency dental services for non-indigent inmates (p. 70). While the dentist provides an orientation to accessing dental care at the intake screening, the information should appear in the Orientation Manual.

Dental: Policies and Procedures

Methodology: Reviewed Administrative Directives that deal with the dental program. Interviewed dental staff. Reviewed dental charts. Toured dental clinical areas. Reviewed LCC organizational chart.

First Court Expert Findings

- The existing policy and procedure manual is old and outdated and does not address the current state of how the clinic is managed, nor does it fully address the areas concerned with managing a successful clinic.
- The policy addresses treatment plans, scheduling treatment, medications, dental care for inmates (directly out of the Dental Administrative Directive), copay, security of medication and needles, instruments, etc., infection control (from 1993), job description for dentists and dental assistants.
- It does a poor job of defining and directing the management and running of the dental program.

Current Findings

The Operations Policies and Procedures were last updated in 2016—after the First Court Expert report; however, we concur with the First Court Expert that the clinic management guidance is inadequate.

Oral Care Policy P-108, modeled on NCCHC Oral Care Policy P-E-06, specifies that newly admitted inmates will “will receive an oral screening during the Receiving Screening process and will include a visual observation of the teeth and gums noting any obvious abnormalities requiring immediate referral to the dentist.”¹⁰⁴ Furthermore, “[...] a complete dental examination will be conducted within 30 days of admission (which will normally be provided while the inmate-patient is at the intake center) and will include: 1) [a] review of the patient's oral history, 2) [v]isual assessment of intra and extra oral condition, 3) [x]-rays when deemed necessary by the dentist, 4) [p]atients ability to or limitations of mastication, 5) [c]harting of presence/absence and condition of teeth, 6) [s]pecified priorities for treatment, [and] 7) [t]he results of the dental examination will be recorded on a specific uniform dental record system approved by the American Dental Association.”¹⁰⁵

LCC is noncompliant with Policy P-108. First, while an oral screening is performed, a **complete** examination is not performed within 30 days of admission, **or for that matter, at any time**. The examination is far from being complete for reasons addressed earlier in this section; that is, inadequate oral soft tissue and periodontal examination, the absence of intraoral x-rays, and the absence of a sequenced treatment plan. Furthermore, the American Dental Association procedure codes are not used.

¹⁰⁴ *Id.* at ¶ II B.

¹⁰⁵ *Id.* at ¶ II D. The ‘uniform record system’ sponsored by the American Dental Association is the Code on Dental Procedures and Nomenclature. “In August 2000 the CDT Code was designated by the federal government as the national terminology for reporting dental services on claims submitted to third-party payers.” American Dental Association Dental Procedure Codes, 2015, p. 1.

Dental: Failed Appointments

Methodology: Reviewed dental sick call log. Interviewed dental staff. Reviewed daily dental reports.

First Court Expert Findings

- A review of monthly reports and daily work sheets revealed a failed appointment rate of about 17.5%. This is high and should be addressed. When asked, the staff related that it is often difficult for inmates to be released from the housing units to come to their appointment or there may be other program activities to prevent them from coming to the appointment. The staff did not feel it was a purposeful no-show on the inmates' part. A refusal form is signed if the inmate does not want to keep the appointment.

Current Findings

Failed appointments have not improved materially since the First Court Expert's Report. We concur with the First Court Expert that the failed appointment rate is too high. We identified current and additional findings as follows.

The nursing sick call lists from April 1 thru April 8 had 33 inmates requesting dental care, of which 10 (30%) were either no-shows or refusals.

Dental: Medically Compromised Patients

Methodology: Reviewed health history form and records from recent intake exams. Compared the health history in the dental chart to the medical problem list. Reviewed randomly selected charts of patients on the Chronic Care list for diabetes and anticonvulsant therapy.

First Court Expert Findings

- The dental record is maintained with the medical file, so all medical information is available to the dental staff from the medical record. The health history on the dental chart is updated at the time of what is called an "initial examination" at this institution. This is a modified comprehensive examination from which a treatment plan is developed.
- This health history is inadequate and does not directly address all the compromised medical conditions that may affect how dental care is provided. There is no system in place to "red flag" patients with medical conditions that can affect dental care. The health history in the dental chart is poorly developed and not very thorough.
- When asked, the clinicians indicated that they do not routinely take blood pressures on patients with a history of hypertension.

Current Findings

Documentation of the health history on medically compromised patients has not improved materially since the First Court Expert's Report. We concur with the First Court Expert that documentation of the health history of medically compromised patients is inadequate. We identified current and additional findings as follows.

Of eight patients with diabetes or receiving anticoagulant therapy, four¹⁰⁶ (50%) had dental treatment without an update of the health history. Of the six¹⁰⁷ diabetic patients, none had documented periodontal probing. Dentists neither properly assess periodontal disease nor develop an **explicit** treatment plan to address it.¹⁰⁸ Dentists are inconsistent in updating the health history at clinical encounters.¹⁰⁹

Dental: Specialists

Methodology: Interviewed dental staff, reviewed CQI documents, and reviewed dental charts of inmates who were seen by an oral surgeon.

First Court Expert Findings

Dr. Frederick Craig, an oral surgeon, is available on an as needed basis, usually once a month. He was scheduled for the near future to see a group of patients. A review of these consultation requests revealed that they were all referred to the oral surgeon for appropriate reasons. All were for difficult extractions and removal of wisdom teeth that were beyond the scope of the dentists' practice. Dr. Craig is used by several other IDOC institutions. Pathology services will be the same as for medical pathology. They will give the specimen to the appropriate medical person for processing.

Current Findings

We concur with the First Court Expert that oral surgery consultations are adequate. Unlike the finding by the First Court Expert, an oral surgeon does not provide care at LCC; rather, patients requiring oral surgery services that cannot be provided by the dental department are referred to a local oral surgery practice. This requires the approval of the Wexford Regional Medical Director through a process referred to as "collegial review." The reviewer for oral surgery consultations is Dr. Karanbir Sandhu, who serves on a part-time basis as a Prosthetic Advisory Dentist. Dr. Sandhu is neither an oral surgeon, a specialist in prosthodontics, or any other dental specialty.

Dental: CQI

Methodology: Reviewed CQI minutes and reports. Interviewed dental staff.

First Court Expert Findings

The dental program only contributes monthly dental statistics to the CQI Committee. No CQI study was in place at the time of this review. A recent mission change at LCC allowed only two months of minutes to be reviewed.

Current Findings

¹⁰⁶ Medically Comprised patients #1 (anticoagulant), #2 (diabetes), #3 (diabetes), and #8 (diabetes).

¹⁰⁷ Medically Compromised patients #2, 3,4, 5, 6, and 7.

¹⁰⁸ It appears that dentists refer patients to the hygienist without an appropriate diagnosis and prescribed treatment plan and the dental hygienist determines the treatment *sua sponte*. See footnote 95 *supra*.

¹⁰⁹ For example, Medically Compromised Patient #1 (10/30/17); Patient #2 (7/14/16); Patient #8 (3/23/17 biennial exam).

We concur with the First Court Expert that the dental CQI program is inadequate. Moreover, it has not improved materially. We identified current and additional findings as follows.

As noted by the First Court Expert, there were no CQI studies ongoing. The 2017 Annual Governing Body Report reported a quality improvement study on “[t]he time frames for dentures start to finish including healing. Is it within 3 months?”¹¹⁰ There were neither recommendations nor a planned follow-up. The study was, at best, trivial. Given the inadequacy of the clinical aspects of the dental program described in this report, a ‘study’ of how long it takes to fabricate a denture ignores far more relevant issues such as inadequate health histories, inadequate diagnosis of periodontal disease, and failure to use intraoral x-rays.

The dental service reports the total patients seen, the total procedures, backlogs and wait times, and number of referrals to an oral surgeon.¹¹¹ In addition, the monthly and annual total treatments.¹¹² The number of failed appointments was not reported.

Internal Monitoring and Quality Improvement Activities

Methodology: Interview facility leadership and staff involved in quality improvement activities. Review CQI Committee meeting minutes, including the Annual Meeting minutes.

First Court Expert Findings

The First Court Expert found that the minutes showed no effort to engage in quality improvement activity. The minutes consisted only of data collected on a variety of services. There was no documented discussion, analysis, or effort to improve quality.

Current Findings

We do not completely agree with the First Court Expert’s finding that the LCC CQI minutes showed no effort to engage in quality improvement activity. While the minutes mostly consisted of data collection on a variety of services, there were attempts on a few studies to evaluate for quality of services. However, these efforts fall short of demonstrating an effective CQI program. Largely, we view this as not having staff dedicated to quality, not understanding methodologies of performing quality studies, and not making quality improvement a system-wide program goal.

LCC does not have a CQI coordinator; the HCUA acts as the CQI coordinator. But her responsibilities are so wide ranging (HCUA, regional coordinator, CQI coordinator, infection control nurse, and nurse supervisor) that she is not effective in this role. LCC does not have a CQI plan specific to LCC. It merely paraphrases or repeats verbatim sections of the AD on CQI. This gives no indication of the CQI plan for LCC the upcoming year and is not a plan.

¹¹⁰ Annual Governing Body, Logan Correctional Center. July 19, 2017, p. 25.

¹¹¹ Annual Governing Body, Logan Correctional Center, July 19, 2017, p. 299. (Annual governing 2017-2.pdf).

¹¹² For example, fillings, extractions, dentures, biennial exams, intake screenings, panoramic x-rays. Id. p. 301.

The First Court Expert was critical of the CQI program and found that there was no effort to engage in quality improvement activity. We found that there was an effort to engage in quality improvement, but the studies that were done either lacked understanding of how to perform a quality study or used the quality study as a proxy for supervision as opposed to an effort to create a systemic improvement. There were eight CQI studies pertaining to the medical program.

Like other facilities, there was a misunderstanding of what outcome studies are. Five studies were listed as being outcome studies. Clinical outcomes are end point measures of health status such as mortality, hospitalization, an HbA1C level of 7 or less, or normal blood pressure. An outcome study measures interventions based on the ultimate outcome measure. An example would be to study the effect of colorectal cancer screening on colorectal cancer mortality or the effect of increasing the interval of chronic clinic visits on obtaining a normal blood pressure. The studies listed as outcome studies were:

1. Whether ordered injections were given.
2. Are glasses received within six weeks?
3. Whether patients discharged from the infirmary were evaluated within 14 days.
4. Did a provider see a patient within five days after a medical furlough?
5. Does the Medical Director sign off on injury reports?
6. Whether nurse referrals to providers were medically indicated.

None of these includes a clinical outcome. These are all performance measures which assessed whether staff were performing their jobs. These are measures that are useful to analyze with respect to whether operations are performing as expected. However, they are not outcome studies. One study, signing off on injury reports, was listed once as a process study and once as an outcome study.

One study, listed as a process study, was actually an outcome study. This study asked a question; did HbA1C values improve at the next clinic after education was provided? An intervention was studied as to whether it could affect an outcome – the HbA1C level. This study was a credible study and posed a valid hypothesis. It attempted to evaluate the value of current educational efforts to improve diabetic control. Over two months of study, the finding was that 11 patients had the same HbA1C level after education, 49 patients had an improved HbA1C, and 43 patients had worse HbA1C values. These findings appear to demonstrate that education had no effect on HbA1C values. However, there was no investigation of the reasons for the results associated with this finding. Only the data was given. This was an interesting finding but there was no study to determine why this result occurred. Was the study flawed? Does education have no value? Was the education flawed? This study can have value, but it was not thoroughly executed, apparently due to a lack of ability to conduct the analysis.

The remainder of the 2016-17 annual CQI report mostly gives statistics that have no inherent value with respect to quality improvement. This is consistent with comments of the First Court Expert, who stated that minutes consisted only of data collected on a variety of services. The monthly meeting minutes consist only of data without any analysis or study.

We also note that this facility does not perform some required studies as required by the IDOC AD, including:

- There is no evidence of primary source verification of physician credentials.
- There is no evidence of evaluation of quality or appropriateness of 100% of offsite referrals.
- Hospitalizations are listed but not reviewed with respect to quality.

We also note that there is no mortality review. The facility Medical Director writes a brief summary of the death but there is no analysis of death with a perspective of attempting to identify correctable problems in order to reduce preventable deaths or reduce problems that place patients at risk of harm.

We evaluated one death from LCC.¹¹³ This is discussed in greater length in the mortality review section of this report. However, this patient had several problems. The patient had known pancreatic mass identified at Cook County Jail that was thought to be due to pancreatic cancer. The patient had significant abdominal pain and on transfer was on approximately 90 mg of morphine for pain control. On transfer to LCC, the patient had a pending follow up with the gastroenterologist at Stroger Hospital. Instead of following up with a gastroenterology consultation and obtaining or repeating a CT scan, LCC treated the pancreatic mass as a benign lesion and took no diagnostic action. Also, the patient was treated with only one Tylenol #3 tablet three times a day, a pain medication reduction of approximately 80%.

About a month after arrival to LCC a doctor obtained a tumor marker test that indicated a high probability that the patient had pancreatic cancer, a diagnosis suspected at Cook County Jail. The doctor ordered a CT of the abdomen and a routine GI consultation. The GI consultation did not occur until 3/21/17, four months after transfer from Cook County Jail. The biopsy was not done until 4/14/17, five months after transfer from Cook County Jail. The diagnosis was delayed for five months and should have been accomplished within a month of transfer.

The patient was undertreated for her increasing abdominal pain from the metastatic pancreatic cancer throughout her incarceration at LCC, but especially over the last two months of life. Despite being undertreated for pain throughout her five months at LCC, during the last two days of life the patient was treated with palliative sedation without a documented discussion in the medical record with the patient of what palliative sedation is or a consent for this process. The patient, given only the equivalent of 15 mg of morphine during the prior months, was given 120 mg morphine a day and 2 mg of a benzodiazepine every two hours by intravenous infusion during the last two days of life. This was a huge increase of dosage and was apparently unrelated to existing pain symptoms of the patient. Palliative sedation is a last resort measure at the end of life to relieve severe and refractory symptoms. However, treatment in excess of symptoms can be problematic, especially if the patient does not agree to the excess treatment. There can be ethical concerns using palliative sedation, including that it hastens death or is a

¹¹³ Patient #21 Mortality Reviews.

form of euthanasia.¹¹⁴ For this patient, the lack of adequate pain control with the sudden apparent excessive use of morphine with a sedative drug raises ethical concerns about the purpose of this prescription. Despite this, there was no documented discussion with the patient or consent of the patient that we could find.

These issues bring up three concerns with care of this patient that should have been identified in the mortality review and should have resulted in a quality investigation as to why the problem occurred with a goal of fixing the problem.

- There was a significant delay in continuation of the work up of a significant illness. It took five months to make a diagnosis that should have taken much less time. There should be a review as to why this occurred.
- There was a deficiency of pain management over the five months of incarceration. The patient complained repeatedly of pain and endured pain unnecessarily over several months despite having a likely untreatable cancer. The program should evaluate why pain management was inadequate and review how pain is managed.
- The patient was treated with palliative sedation without documented informed consent, which gives the impression of hastening death or engaging in euthanasia. The program should review their end-of-life procedures to ensure that patients are treated with respect and dignity.

The death summary documented that the patient “wish of DNR and the more recent wish of palliative care” could not be found in the medical record. The Mortality Review Worksheet found that there was no way to improve care. We disagree.

¹¹⁴ From section on Palliative Sedation from UpToDate an online electronic medical text.

Recommendations

Leadership, Staffing, and Custody Functions

First Court Expert Recommendations

1. Seek approval and fill the Director of Nursing position as soon as possible. *We agree with this recommendation.*

Additional Recommendations

2. LCC needs to fill its physician positions instead of converting them to nurse practitioner positions.
3. A staffing analysis should be done to determine whether staffing is adequate for this facility.
4. Nursing supervision needs to increase so that there are always supervisory nurses present.
5. The IDOC needs to fill its central region nurse coordinator position so that the HCUA can function full time at LCC.
6. LPNs should perform within the scope of their licenses.
7. Policies should be reviewed and revised as needed.

Clinic Space, Sanitation, and Support Services

First Court Expert Recommendations

1. Implement a nurse call system for each infirmary patient. *This recommendation has been addressed with the installation of battery powered nurse call devices in all infirmary patient rooms with the exception of the crisis beds that are within sight and/or sound of the nursing station.*

Additional Recommendations

2. Develop and implement a plan to daily monitor and document negative air pressure readings when the infirmary's negative pressure room(s) is occupied for respiratory isolation and otherwise on a weekly basis.
3. Create at least one additional provider exam room(s) in the ambulatory clinic in order to accommodate all of the current (and future providers) at the same time.
4. Implement a plan to assure that all medical equipment and devices have documented annual safety inspections.
5. Replace the existing colposcope.
6. Purchase sufficient quantity of additional automated external defibrillators (AED) in order to place AEDs in the infirmary, ambulatory clinic, reception and screening, ADA housing unit, emergency response bag(s) and other high-risk areas on the LCC campus.
7. Replace the deteriorating vehicle that is used to transport clinical staff and equipment to emergencies on the LCC campus.

8. Enforce and monitor the existing policy to keep all emergency bags sealed and inspect and restock emergency bags that have been unsealed.
9. Expand the scope of the current safety and sanitation rounds or create separate rounds to include focused inspections of clinical areas including clinical equipment, exam tables, negative pressure, expired supplies, and medications, etc. and report the findings to the Quality Improvement committee.

Medical Reception

First Court Expert Recommendations

1. There should be a space on the intake physical form to document the breast examination.
2. There must be a more appropriate space where a nurse can interview a patient for the nurse screen or a nurse practitioner for the history and physical in which there is no auditory disturbance.
3. A system must be set up to insure that appropriate and timely follow-up from the reception process does occur.

We agree with these recommendations.

Additional Recommendations

4. Repair or replace equipment in disrepair (e.g., examination table) and purchase needed medical equipment (e.g., microscope, large blood pressure cuff).
5. Providers should order chronic disease and other essential medications on the day of the patient's arrival. Ensure that patients receive the first dose within 24 hours or sooner as clinically indicated (e.g., insulin for diabetics).
6. Nurses should perform and document urine pregnancy screening on all newly arriving inmates except those who are menopausal and/or documented tubal ligation or hysterectomy.
7. In addition to performing a past medical history, providers should perform a review of systems (ROS) for chronic diseases to determine urgency of referral to the chronic disease program.
8. Providers should document the patient's medical conditions onto the problem list, including a history of TB infection and previous surgeries.

Nursing Sick Call

First Court Expert Recommendations

1. Develop a plan to implement an all "RN" sick call process.
2. In the X-house, develop and implement a plan to conduct a legitimate sick call encounter, including listening to the patient complaint, collecting a history and objective data, performing a physical examination when required, making an assessment, and formulating a plan of treatment, rather than the current practice of talking to the patient through a solid steel door and basing any treatment on the conversation only.

3. Per Office of Health Services policy, assure all sick call encounters are documented in the Subjective-Objective-Assessment-Plan (SOAP) style.
4. Develop and implement a plan to assure Office of Health Services approved, pre-printed treatment protocols are used at each sick call encounter.
5. Develop and implement a plan of education for all nursing staff to address negative attitudes towards inmates.
6. Develop and maintain logs for sick call.
7. Develop and implement a plan to ensure that daily wellness checks and the weekly nurse practitioner rounds are documented in the segregation log and in the inmate specific medical record if any treatment is provided.
8. Develop and implement a plan to conduct the daily segregation wellness checks between the hours of 0700 and 2300.

We agree with these recommendations.

Additional Recommendations

9. Staff collecting sick call sign-up sheets at night should leave a new sheet, so inmates are able to sign-up 24 hours per day.
10. Inmates in segregation should be able to sign-up for sick call in the same manner as in non-segregation and not require the officer to enter the inmate's name.
11. Officers must escort all inmates being evaluated for sick call to an adequately equipped examination room that provides privacy and access to handwashing.
12. Nurses should document notification to medical providers and the provider's response to the notification.
13. Medical providers should examine patients requiring a medical diagnosis and document the examination in the medical record. Providers should schedule patients for follow-up as clinically indicated.
14. Health care leadership should perform CQI studies regarding the high rates of no shows, or failure of correctional officers to escort inmates to medical appointments.
15. If health care staff are unable to see all sick call patients within one day, consider returning to a written health request system that enables staff to triage and see patients with urgent requests.
16. Revise the Offender Orientation Manual to reflect actual access to care practices.
17. Health care leadership should develop and monitor quality indicators associated with each step of the sick call process.

Medical Records

First Court Expert Recommendations

1. There should be no loose filing inside the health records. Medical records staff should adopt a "touch it once" philosophy when it comes to filing loose documents.
2. Health service request forms should be filed in the health records.

These recommendations are no longer pertinent because of the partial implementation of an electronic medical record.

Additional Recommendations

3. An electronic medical record should be fully implemented.
4. The record should be unified to include prenatal care documents in the electronic medical record.
5. Sufficient devices need to be provided in all clinical areas that accommodate the possible number of simultaneous users.
6. The practice of using default aged vital signs should be stopped.
7. Providers should be responsible for entering problems into the problem list. Every patient should have an updated problem list that is accurate.
8. All hospital discharge summaries, specialty test reports, and consultation reports need to be available in the medical record.
9. The program needs to be able to track immunizations in the electronic record.
10. The program needs to have the capacity to obtain data from the electronic record for the purposes of quality review.

Urgent/Emergent Care

First Court Expert Recommendations

1. A system of nursing supervision with feedback must occur so that errors with regard to the adequacy of the assessment or the appropriateness of the clinical decision making are reduced substantially.
2. The administrator should develop a log that can be used to track unscheduled offsite services. The log should have the time and date, patient identifiers, the presenting complaint, what the disposition was in terms of being sent offsite and whether the reports from the offsite service are retrieved.
3. There should be a method to track the follow-up visits with the primary care clinician and whether they documented the discussion with the patient of the findings and plan based on the offsite service report.

We agree with these recommendations. The second recommendation has been resolved.

Additional Recommendations

4. The program needs to develop a means of reviewing the quality of clinical care with an aim to preventing unnecessary hospitalization and preventable clinical errors.

Specialty Consultations

First Court Expert's Recommendations

1. The policy should require that patients returning from scheduled offsite services are brought through the clinic area where a nurse receives the paperwork, interviews the patient, and ultimately insures that a timely follow-up visit with the primary care clinician does occur. *We agree with this recommendation.*

Additional Recommendations

2. The current system of “collegial review” should be abandoned on the basis of patient safety.
3. The program needs to monitor underutilization. All patients in need of specialty care need to receive it. We noted so many cases of patients who were either not referred or denied referral that underutilization was systemic and widespread. A root cause analysis needs to be completed regarding this and it needs to be corrected.
4. The IDOC should establish a tracking system to be used for monitoring the timeliness of specialty care. This should not be maintained by the vendor.
5. Quality of care for those needing offsite care needs to be monitored. The current system of monitoring fails to identify existing morbidity that results from the specialty care process.

Pharmacy and Medication Administration

First Court Expert Recommendations

The First Court Expert’s report contained no recommendations regarding the pharmacy and medication administration. *We do not agree with this assessment, as this review demonstrated systemic issues regarding pharmacy and medication management.*

Current Recommendations

1. A sanitation/disinfection schedule should be established for the medication room and staff assigned to monitor completion of sanitation activities, including scheduled cleaning of refrigerators.
2. Pharmacy inspections should be more accurately performed to identify expired medications and unlabeled open vials.
3. Eliminate the process of transferring medications from properly dispensed medication blister packs into white envelopes that are improperly labeled. Nurses should administer medications from pharmacy-labeled blister packs maintained in medication carts that are transported to the chow hall.
4. Medication administration records should be brought to medication administration.
5. Medication carts should contain supplies such as small medication cups and hand-sanitizer.
6. The medication administration process should be modified. Nurses should:
 - a. Wash their hands prior to medication administration and use hand sanitizer during medication administration (e.g., after every fifth patient or if they contaminate their hands in any way);
 - b. Positively identify patients with two identifiers, including the patient’s ID badge and one other (e.g., date of birth). Have the patient state their name as they approach the nurse;
 - c. Compare the MAR against medication blister packs to ensure the orders match.
 - d. Pour medications into a cup and give it to the patient without touching the patient. Have the patient dispose of the cup in the presence of a nurse or officer;
 - e. With the assistance of officers, perform oral cavity checks to ensure ingestion, preferably using a penlight;

- f. Document administration or refusal of medication onto the MAR at the time medication is offered to the patient.
 - g. For medication administration in segregation, consider establishing a secure medication room for storage of a medication cart and MARs. Nurses would transport the medication cart and MARs into segregation/reception and inmates line up to receive medications.¹¹⁵
- 7. All medication orders should be transcribed onto a MAR, including medications ordered by a dentist.
 - 8. Nurses or medical providers should document administration of all medications at the time they are administered to the patient.
 - 9. All medications, including KOP medications, should be administered or delivered by licensed and trained personnel.
 - 10. Healthcare leadership should retrain nurses regarding the procedure for transcribing and discontinuing medication orders.
 - 11. Nurses should refrain from defacing previous medication orders on the MAR as a short cut for transcribing new orders.
 - 12. Nurses should document discontinuation of previous orders and write new orders on a separate entry on the MAR.
 - 13. Nurses should document administration status for each scheduled dose of medication at the time of administration.
 - 14. Medical records personnel should timely scan patient MARs into the EMR within five business days of the end of each month.

Infection Control

First Court Expert Recommendations

Develop and implement a post-description for an infection control nurse.

- 1. Assign a specific RN to the responsibilities of infection control.
- 2. Develop, implement, and maintain a plan to assure the proper laundering of infirmary bedding and linens.

We agree with these recommendations.

Additional Recommendations

- 3. Health care leadership should establish, implement, and monitor a schedule for sanitation and disinfection activities in all areas where health care is delivered.
- 4. All torn and cracked outer protective coverings of infirmary beds, wheelchairs, examination tables and gurneys should be repaired or replaced to permit adequate infection control.
- 5. An analysis should be performed of infectious/communicable disease statistics, including prevalence of TB, HIV and HCV infection among newly arriving inmates.

¹¹⁵ When we went into segregation, several inmates were out of cell and congregating at tables, versus a policy that prohibits inmates from interacting with others.

6. Track and report skin infections due to all pathogens, not just MRSA, including infestations with scabies or body lice.
7. Infection control and CQI meeting minutes should analyze communicable diseases (e.g., MRSA) to determine whether there are clusters of infections occurring in certain housing units.
8. Fully train porters about blood borne pathogens, the proper methods of cleaning and sanitizing clinical areas, and initiate appropriate vaccinations before they are assigned to clean and sanitize patient rooms in the infirmary. The training should be documented and maintained in the porters' medical record.
9. Consider adding hepatitis A vaccination to the currently recommended Hepatitis B vaccination for all porters.
10. Monitor all sick call areas to assure 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
11. Develop and implement a plan to monthly monitor all patient care associated furniture, including infirmary mattresses and exam tables, to assure the integrity of the protective outer surface with the ability to take out of service and have repaired or replaced as needed
12. Replace the cracked wall tiles in the ADA housing unit's shared shower room that interfere with proper cleaning and sanitation and create infection control hazards for both patient-inmates and medical and correctional staff.
13. The current tuberculosis skin test should be replaced with interferon gamma testing methodology.

Radiology Services

First Court Expert Recommendations

The First Court Expert had no recommendations concerning the radiology services

Current Recommendations

1. IDOC and the health care vendor must jointly contact the Illinois Emergency Management Agency (IEMA) and Occupational Safety and Health Administration (OSHA) to review the reported decision that IDOC x-ray technicians do not need to use radiation exposure monitoring devices (dosimeters) while working in the IDOC radiology suites as outlined in Illinois Administrative Code 32 -340 510 and 520. This current practice is not in alignment with the radiation safety practices in the community.
2. Contract with a radiation safety expert to assess the safety for the panorex unit's current location in an unleaded interior corridor adjacent to the radiology suite without a shielded area for the technician to stand when panorex films are being taken.

Infirmary Care

First Court Expert Recommendations

1. More bed space is needed in the infirmary.
2. Rethinking the physical plant to create a more therapeutic, less chaotic environment would be beneficial.
3. Develop and implement a plan to insure 24/7 RN staffing.
4. Implement a nurse call system for all infirmary patients.
5. Develop, implement, and maintain a plan for organization of infirmary medical records including but not limited to:
 - a. the use of the infirmary record.
 - b. permanent filing of all documents in the record.
 - c. chronological filing of all documentation.
6. Develop and implement a plan of education for staff including but not limited to:
 - a. Per IDOC Office of Health Services policy, documentation to be provided in the Subjective-Objective-Assessment-Plan (SOAP) format.
 - b. all documentation to be provided chronologically as to date and time.
 - c. documentation of vital signs as ordered by the physician
 - d. physician and nursing admission and discharge documentation required for all infirmary patients.

Since the First Court Expert's visit, the majority of the medical record related recommendations have been addressed by the implementation of an EMR in all clinical areas of LCC including the infirmary. We note that there are insufficient devices on the infirmary so the number of staff in the infirmary do not have access to a device on the infirmary resulting in having to go off the unit to write a note or review a record. This is addressed in the medical records sections. We also note that the use of dated vital signs needs to be stopped. All episodes of clinical care need current vital signs. This is also addressed in the medical records section. Nurse call devices have been installed in all infirmary patient rooms with the exception of the crisis beds which are within sight and sound of the nursing station and the infirmary bed space was now adequate. However, an occasional infirmary shift is still cover by LPNs.

Additional Recommendations

7. Develop a plan to shift anticoagulation treatments from Vitamin K Antagonists (warfarin) to newer types of anticoagulants that do not require frequent ongoing lab testing to determine the adequacy of anticoagulation.

Chronic Care

First Court Expert Recommendations

1. Consider assigning the Medical Director to the poorly controlled chronic disease patients, as this is clearly one of his strengths.
2. There should be a comprehensive tracking tool to monitor important indicators for this at-risk population. This tool should be used to identify areas of poor performance in the program to target interventions to improve quality.

3. The chronic disease nurse should rarely if ever be pulled to other duties. This position should be filled with a carefully chosen individual to actively track this at-risk population.
4. Patients should be seen according to their degree of disease control rather than the calendar month and all chronic diseases should be addressed at each chronic care clinic visit. These are statewide policy issues.
5. Patients with active women's health issues should be tracked in an organized manner, perhaps in a chronic disease program.
6. Patients with HIV infection should have yearly cervical cancer screening.

We agree with these recommendations. Some of these recommendations have been addressed by the fulltime assignment of a nurse to coordinate and manage the scheduling of the chronic care patient appointments and the implementation of the IDOC 360 program and the EMR to assist with scheduling, tracking, and statistical reporting of chronic care clinics and annual physical exam clinics.

Additional Recommendations

7. Providers seeing patients with chronic diseases need to be trained in primary care. When care needs exceed the training of the primary care provider, patients need to be referred to a higher level of care.
8. Initiate a process to manage all chronic care diagnoses in a single chronic care appointment. This should be done for all conditions unless the patient is being managed in a specialty clinic, e.g. HIV clinic, hepatitis C treatment clinic, pre-natal clinic, etc.
9. Revise the current practice of not rescheduling chronic care patients who refuse a chronic care visit until the next disease-specific chronic care clinic (four to six months later), reschedule these individuals based the status of their clinical problem, and implement a process to monitor and track the status of these patients during the many months before their next appointment.
10. Implement and utilize current Center for Disease Control (CDC) age-based and disease-based standards for the administration of adult immunizations.
11. Implement and utilize current United States Preventive Services Task Force (USPSTF) guidelines for screening adults for cancer and other conditions (abdominal aortic aneurysm, etc.).
12. Calculate and document the 10-year cardiovascular risk score on all appropriate adults to assist with the decision and timing to initiate preventive HMG-CoA reductase inhibitors (statins).

Women's Health

First Court Expert Recommendations

The First Court Expert had no recommendations.

Current Recommendations

1. Improve provider staffing.

2. Ensure that at least one onsite full-time providers is trained and can substitute for prenatal care when the obstetrician is unavailable.

Dental Program

Dental: Staffing and Credentialing

First Court Expert Recommendations: None.

Current Recommendations

1. Dental staffing should be reviewed after dentists incorporate intraoral x-rays and periodontal probing into their practice.

Dental: Facility and Equipment

First Court Expert Recommendations

1. The space that is used for the clinic proper and houses the two main dental units is too small to allow efficient care flow and any sense of privacy. Enlargement of this space should be considered for efficient care delivery and safety considerations. *We agree with this recommendation; however, we acknowledge that this is not feasible given the physical constraints of the clinic.*
2. All electric outlets should be wall-mounted or protected by the cover for the junction box at the foot of the chair. Loose wires should be neatly arranged and out of traffic flow. *This has been done; consequently, the recommendation is moot.*
3. All the units, chairs, and cabinetry should be replaced, and surface areas should be better able to accommodate disinfection. *We agree with this recommendation.*
4. Replace the radiograph unit in the clinic immediately with a wall-mounted unit capable of digital radiography. *We agree that the wall-mounted unit should be replaced; however, the replacement should be mounted **between** the dental chairs so it can be used by both dentists.*
5. The Panelipse radiograph unit should be replaced. This is critical for a reception center. *We agree with this recommendation.*

Additional Recommendations

6. An intraoral x-ray unit should be installed in the dental hygienist's operatory immediately.
7. The dental clinic should purchase four high-speed handpieces to supplement the four currently in use.
8. All new dental x-ray units should be digital.

Dental: Sanitation, Safety, and Sterilization

First Court Expert Recommendations

1. The loose metal junction box on the floor should be wall-mounted where it does not interfere with traffic flow. Electric cords should be neatly arranged. *This problem has been resolved; consequently, the recommendation is moot.*

2. Patients should always wear eye protection during treatment. This is important for patient safety. *We agree with this recommendation.*
3. A biohazard warning sign should be posted in the sterilization area. *We agree with this recommendation.*

Additional Recommendations: None

Dental: Review Autoclave Log

First Court Expert Recommendations: None.

Additional Recommendations: None.

Dental: Comprehensive Care

First Court Expert Recommendations

1. Comprehensive 'routine' care should be provided only from a well-developed and documented treatment plan.
2. The treatment plan should be developed from a thorough, well-documented intra and extra-oral examination, to include a periodontal assessment and detailed examination of all soft tissues.
3. Appropriate bitewing or periapical x-rays should be taken to diagnose caries.
4. Hygiene care should be provided as part of the treatment process.
5. Care should be provided sequentially, beginning with hygiene services and dental prophylaxis.
6. Oral hygiene instructions should be provided and documented as part of the treatment process.

We agree with these recommendations.

Additional Recommendations

7. All inmates should have a comprehensive examination within 30 days of intake. This exam should use the criteria of the American Dental Association Procedure Code D0150 (Comprehensive Oral Evaluation).¹¹⁶
8. Oral prophylaxis and non-surgical procedures such as scaling, and root planing should comport with the definitions set forth in the American Dental Association Procedure Codes.
9. Biennial examinations should be informed by intraoral x-rays, a periodontal assessment that includes a PSR, and a soft tissue examination for oral cancer and use the criteria of Procedure Code D0120 (Periodic Oral Examination).

¹¹⁶ "It is a thorough evaluation and recording of the extraoral and intraoral hard and soft tissues. [...] This includes an evaluation for oral cancer where indicated, the evaluation and recording of the patient's dental and medical history and a general health assessment. It may include the evaluation and recording of dental caries, missing or unerupted teeth, restorations, existing prostheses, occlusal relationships, periodontal conditions (including periodontal screening and/or charting), hard and soft tissue anomalies, etc."

Dental: Intake (Initial) Examination

First Court Expert Recommendations

1. Oral hygiene instructions should be provided at the time of the screening [intake] examination.
2. The area where x-rays are taken should have warning signs posted that clearly warn of potential radiation hazards to pregnant females.
3. Consent form should be developed and used for pregnant females that explains radiation hazards and gives the examiner permission to take the x-ray.

We agree with these recommendations.

Additional Recommendations

4. Dentists should wash their hands or use an alcohol wipe between changing gloves.
5. Disposable infection control barriers should be used on the examination light and be changed between patients (as is done in the dental clinic).
6. The dentist should perform a soft tissue exam for oral cancer that includes holding the anterior portion of the tongue with 2x2 gauze and reflecting the tongue with a mouth mirror to visualize the posterior portion and lateral borders of the tongue.

Dental: Extractions

First Court Expert Recommendations

1. A diagnosis or a reason for the extraction should be included as part of the record entry using the SOAP note format, especially for sick call entries. *This deficiency has been corrected since the EHR used at LCC forces dental providers to use the SOAP format.*

Additional Recommendations: None

Dental: Removable Prosthetics

First Court Expert Recommendations

1. A comprehensive examination and well-developed and documented treatment plan, including bitewing and/or periapical radiographs, should precede all comprehensive dental care, including removable prosthodontics.
2. Periodontal assessment and treatment should be part of the treatment process and that the periodontium should be stable before proceeding with impressions.
3. Oral hygiene instructions should be provided as a precursor to removable prosthodontic impressions.
4. All operative dentistry and oral surgery should be completed before proceeding with impressions.

We agree with these recommendations.

Additional Recommendations: None.

Dental: Sick Call/Treatment Provision

First Court Expert Recommendations

1. Use the SOAP format for sick call entries. It will insure that the inmate's chief complaint is recorded and addressed, and a thorough focused examination and diagnosis precedes all treatment. *The EMR forces dental providers to use the SOAP format; consequently, the recommendation is moot.*
2. Inmate request forms should be retained in the dental record.
3. Provide only immediate or palliative care on sick call appointments. Do not use these appointments for routine care. Provide a dedicated schedule for these inmates.

We agree with these recommendations.

Additional Recommendations

4. The sick call failed appointment rate should be monitored and reported monthly.
5. The reasons for the high failed appointment rate should be studied by the Quality Improvement Committee.

Dental: Orientation Handbook

First Court Expert Recommendations

1. Insure that information about the dental program and how to access dental care is included in the Offender Handbook and Orientation Manual. *We agree with this recommendation.*

Additional Recommendations: None.

Dental: Policies and Procedures

First Court Expert Recommendations

1. The dental program should develop a detailed, accurate policy and procedure manual that defines how all aspects of the program are to be run and managed. Once developed, it should be updated on a regular basis and as needed for new policies and procedures. *We agree with this recommendation.*

Additional Recommendations

2. The "complete" examination should comport with the American Dental Association Code D0150 (Comprehensive Oral Examination – New or Established Patient). Revised policies should incorporate ADA procedure definitions.
3. The initial examination should comprise a complete oral cancer examination that includes an inspection of the lateral border and ventral surface of the tongue.

Dental: Failed Appointments

First Court Expert Recommendations

1. The dental staff should investigate the reasons for failed appointments and then put in place corrective action to lower the rate.
2. A continuing quality improvement study would be a good methodological technique.

We agree with these recommendations.

Additional Recommendations: None.

Dental: Medically Compromised Patients

First Court Expert Recommendations

1. The medical history section of the dental record be kept up to date and that medical conditions that require special precautions be red flagged to catch the immediate attention of the provider.
2. Blood pressure readings should be routinely taken of patients with a history of hypertension, especially prior to any surgical procedure.¹¹⁷

We agree with these recommendations.

Additional Recommendations

3. Diabetic patients should receive thorough periodontal assessments by a dentist annually **as part of the chronic disease program** and those with periodontal disease should have a sequenced treatment plan with six-month follow-ups.

Dental: Specialists

First Court Expert Recommendations

1. Thoroughly document in the dental record all findings and reasons that led to a referral to the specialist required. Provide all information pertinent to the condition being referred. *We agree with this recommendation and note that the dental referral requests we reviewed had all pertinent information.*

Additional Recommendations

2. The dental program should maintain an oral surgery log to include the date of the request for approval, the results of the collegial review (that is, approval or disapproval) the date of the appointment/treatment, the condition to be treated, and any post-surgical complications.

Dental: CQI

First Court Expert Recommendations

1. Evaluate program deficiencies and needs as outlined in this report through ongoing continuous quality improvement studies that address these deficient areas. Develop corrective actions and procedures to improve those areas.

We agree with this recommendation.

Additional Recommendations: None.

Internal Monitoring and Quality Improvement

First Court Expert Recommendations

¹¹⁷ The dental clinic does not have a stethoscope and sphygmomanometer.

1. The staff should be trained in CQI methodology, specifically with regard to how to perform studies, how to identify subthreshold performance, how to analyze the data in order to determine the causes of subthreshold performance, and then how to develop improvement strategies based on the identified causes and finally how to restudy to determine whether the improvement strategy had the required effect.
2. The leadership of the continuous quality improvement program must be retrained regarding quality improvement philosophy and methodology, along with study design and data collection.
3. This training should include how to study outliers in order to develop targeted improvement strategies.

We agree with these recommendations.

Appendix A

Logan Staffing

Position	Budgeted	Filled	Vacant
Health Care Unit Administrator	1	1	0
Medical Director	1	1	0
Director of Nursing	1	1	0
Medical Records Director	1	0	1
Registered Nurse Supervisor	1	1	0
Obstetrician	0.5	0.5	0
Nurse Practitioner/Physician Assistant	4	4	0
Registered Nurse	5	5	0
Licensed Practical Nurse	18	18	0
Medication Room Assistant	3	3	0
Dentist	2	2	0
Dental Assistant	3	3	0
Dental Hygienist	1	1	0
Licensed Physical Therapist	0.25	0.25	0
Certified Mammography Technician	0.4	0.4	0
Optometrist	0.2	0.2	0
Office Coordinator	1	1	0
Staff Assistants	8	8	0
Phlebotomists	1.2	1.2	0
Radiology Technician	0.6	0.6	0
	53.15	52.15	

Appendix B

ILLINOIS DEPARTMENT OF CORRECTIONS Offender Outpatient Progress Note LOGAN CORRECTIONAL CTR Center			
Date: 03/23/2017			
Offender Information		ID#: 14112	
Last Name	First Name	M	MI
Race:	Gender: female	Date of Birth: 03/23/1965	
Dental Note			
Current Vitals: T: 98.4 (Oral) P: 80 (Sitting) R: 16 / min B/P: 114 / 78 (Sitting)			
Height: In. Weight: Lbs.			
Current Vitals Date: 4/19/2016			
Allergies:	NO KNOWN ALLERGIES		
Problems:			
Dental:	Dental Caries First Observed 6/1/2015 08:55AM		
Not Specified:	Well Woman Examination First Observed 10/15/2014 10:23AM		
Medications:			
SUBJECTIVE:			
OBJECTIVE:			
2 Yr. Exam <input checked="" type="checkbox"/>			
Tx. Requested <input type="checkbox"/>			
No Tx. Requested <input checked="" type="checkbox"/>			
ASSESSMENT:			
PLAN:			
EDUCATION:			
CO-PAY:			
<input type="checkbox"/> \$5.00 Co-pay			
Electronically Signed by MCCALL, WILLIE D.D.S. on 03/23/2017. ##And No Others##			
DOC 0084			

Appendix C

ILLINOIS DEPARTMENT OF CORRECTIONS
Dental Hygienist Progress Note
LOGAN CORRECTIONAL CTR Center

Date: 02/27/2017 11:19

Offender Information			
Last Name	First Name	M MI	ID#:
Race:	Gender: female	Date of Birth:	

Current Vitals: T: 98.4 (Oral) P: 80 (Sitting) R: 16 / min B/P: 114 / 78 (Sitting)
Height: 63 in. Weight: 176 Lbs.

Allergies: NO KNOWN ALLERGIES


Problems:

Dental: Dental Caries First Observed 6/1/2015 08:55AM

Not Specified: Well Woman Examination First Observed 10/15/2014 10:23AM

Medications:

SUBJECTIVE:	
<input type="checkbox"/> Patient presents per request slip for prophylaxis	
OBJECTIVE:	
<input checked="" type="checkbox"/> Signed copyay <input type="checkbox"/> Signed consent <input checked="" type="checkbox"/> Inflamed tissue	
<input checked="" type="checkbox"/> Calculus <input type="checkbox"/> Light <input checked="" type="checkbox"/> Moderate <input type="checkbox"/> Heavy	<input checked="" type="checkbox"/> Bleeding <input checked="" type="checkbox"/> Light <input type="checkbox"/> Moderate <input type="checkbox"/> Heavy
<input checked="" type="checkbox"/> Plaque <input checked="" type="checkbox"/> Light <input type="checkbox"/> Moderate <input type="checkbox"/> Heavy	
ASSESSMENT:	
<input type="checkbox"/> Gingivitis <input checked="" type="checkbox"/> Periodontal disease	
PLAN:	



DOC 0084

Menard Correctional Center
2nd Court Appointed Expert Report
Lippert v. Godinez

Visit Date: May 21-24, 2018

Prepared by the Medical Investigation Team

Mike Puisis, DO
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Table of Contents

Overview.....	3
Executive Summary	3
Findings.....	7
Leadership, Staffing, and Custody Functions.....	7
Clinic Space	9
Sanitation	16
Radiology Service	17
Medical Records.....	18
Medical Reception and Intrasystem Transfer.....	20
Nursing Sick Call	22
Chronic Disease Management	25
Urgent/Emergent Care.....	39
Specialty Consultations.....	51
Infirmarary Care	62
Pharmacy/Medication Administration	66
Infection Control	71
Dental Program	75
Internal Monitoring and Quality Improvement Activities	90
Recommendations	93
Leadership, Staffing, and Custody Functions.....	93
Clinical Space.....	93
Sanitation	94
Radiology Services	94
Medical Records.....	94
Medical Reception and Intrasystem Transfer.....	95
Nursing Sick Call	95
Chronic Disease Management	96
Urgent/Emergent Care.....	97
Specialty Consultations.....	98
Infirmarary Care	99
Pharmacy and Medication Administration	100
Infection Control	101
Dental Program	102
Internal Monitoring and Quality Improvement.....	107
Appendix A.....	108

Overview

From May 21 to May 25, 2018, the Medical Investigation team visited the Menard Correctional Center (MCC) in Chester, Illinois. MCC is a maximum security prison. MCC houses 3029 inmates. The capacity of the prison is 3812 and the prison is at 79% of capacity. Eighty-one percent of inmates are classified as maximum security. Approximately 10% of inmates are medium security and approximately 9% are minimum security. Only 49 (1.6%) inmates were in the reception housing unit on the day of our visit. MCC had an infirmary unit, which on the day of our visit housed eight patients.

This report describes our findings and recommendations. During this visit, we:

- Met with leadership of custody and medical
- Toured the medical services area
- Talked with health care staff
- Reviewed health records and other documents
- Interviewed inmates

We thank Warden and staff for their assistance and cooperation in conducting the review.

Executive Summary

Based on a comparison of findings as identified in the First Court Expert's report, we find that except for minor improvements in nursing sick call and infection control, all areas were either the same or worse than the First Court Expert's findings. Clinical care in all areas of record reviews appeared worse and, in some cases, resulted in harm. Mortality review identified preventable and possibly preventable death. We find that overall, the Menard Correctional Center (MCC) is not providing adequate medical care to patients, and there are systemic issues that present ongoing risk of harm to patients and result in preventable morbidity and mortality. The deficiencies that form the basis of this opinion are provided below.

There are an extraordinary number of vacancies (33%) at this facility. This includes two physician positions, nurse practitioner positions, Director of Nursing, medical records director, Dental Director and 39% of nursing positions. It takes approximately 10 months to fill a state position, and the IDOC needs to reduce that timeframe or it will be unable to timely fill positions. The Medical Director does not provide clinical leadership at the facility. The Wexford regional team does not appear to participate in identification or resolution of operational problems. A staffing plan needs to be done, as it is unclear how many staff are necessary to provide services.

In order to accommodate custody, sick call and provider visits are conducted in housing units. But these housing unit examination rooms are not all appropriately equipped, were not well maintained, and were cluttered, making them inappropriate for clinical care. Some examinations occur with the patient in a chair. The panorex unit in intake is not shielded, which increases risk of radiation exposure to staff and other inmates. The infirmary has no examination room and

patient rooms have no nurse call devices. Equipment is not maintained or routinely inspected. Showers in the infirmary and in American for Disability (ADA) units were not well maintained and are in need of repair. There was a lack of automated external defibrillators. There was a lack of maintenance and repairs throughout all clinical areas, which we were told was a result of funding.

Most but not all examination tables had paper barriers. Sharps, gloves, sinks, and paper towels were available. Maintenance of equipment and physical plant was not being done. Sanitation rounds were being done but findings were not corrected. Environmental rounds need to include clinical equipment, electrical safety, emergency bags, negative pressure rooms, and clinical areas.

Radiology equipment, inspections, and safety were adequate except for the panorex in the reception area, which lacked shielding, making it a potential safety risk. Access to radiological services was adequate. The need for dosimeters should be reviewed with the State of Illinois Emergency Management Agency.

Medical records are properly thinned but the number of volumes of medical records is so large that additional storage space is needed to accommodate excess volumes. This makes access to a complete medical record extremely difficult. An electronic medical record is needed. Medical records are not available for nurses performing sick call in housing units. They write their notes on blank progress notes without access to review medical record information. Their notes are filed at a later date. All staff need to have access to a medical record for every clinical encounter. Any staff is authorized to pull or re-file medical records, which violates confidentiality and promotes loss of medical documents. Hospital and consultation reports are only available 50% of the time. This adversely affects clinical care.

Intake physical examinations are not timely; only 60% of new inmates have their intake physical examination within a week. As with NRC, although HIV testing is supposed to be opt-out, it still requires consent and may account for only 50% of incoming inmates being screened.¹ This is not trivial. We found on death reviews a man from MCC who was never screened for HIV despite having multiple risk factors. He died of unrecognized advanced AIDS and his death was preventable if he had been screened.² Although there were additional problems with the care of this patient, the lack of HIV screening was significant. The Center for Disease Control recommends opt-out screening as the optimal testing method for HIV in correctional centers and this should be put into place in the IDOC.³ Follow up of tuberculin skin testing was not always done and occasionally is not administered. Follow up of abnormal findings was inconsistent. There is no system to monitor these deficiencies.

¹ In our experience, opt-out testing typically results in rates greater than 95% acceptance. This is borne out by the experience in Rhode Island Department of Corrections, which had a rate of acceptance of testing of 98%. This is found in the following article. Beckwith CG, Bazerman L, Cornwall AH, Patry E, Poshkus M, Fu J, and Nunn A: An Evaluation of a Routine Opt-Out Rapid HIV Testing Program in a Rhode Island Jail. AIDS Educ Prev June 23, 2011 23(30): 96-109 and found at: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3734962/>.

² Patient #22 Mortality Review.

³ HIV Testing Implementation Guidance for Correctional Settings; Centers for Disease Control and Prevention, January 2009 as found at <https://www.cdc.gov/hiv/pdf/group/cdc-hiv-correctional-settings-guidelines.pdf>.

Since the First Court Expert's visit, MCC now has properly equipped rooms used to conduct nursing sick call evaluations. All sick requests we reviewed were seen timely, including urgent sick call requests. We verified this in interviews of inmates. Nurses failed to appropriately assess and examine patients in 20% of sick call requests we reviewed. We also found that licensed practical nurses independently perform sick call even though it is not within the scope of their license. This places inmates at risk of harm. Nurses also evaluate inmates for their requests without having the medical record with them during the evaluation. This violates IDOC protocols and MCC's policy. Only 20% of nurse referrals to providers occurred timely

About half of chronic illness patients are still managed in one-disease-only clinics. We examined hepatitis C chronic clinics at MCC and found that patients are unmonitored for ongoing harm of hepatitis C, including complications of cirrhosis and hepatocellular carcinoma. These failures have caused death.⁴ The insertion of a Wexford corporate hepatitis C physician into the process of referral to UIC is an additional barrier that serves to delay treatment of patients with antiviral medication. Facility physicians are not adhering to IDOC hepatitis C guidelines and fail to obtain required testing necessary to evaluate patients for treatment. Physicians seeing patients in chronic care clinics failed to consistently document rationale for their treatment decisions, failed to document review of the medication records, failed to review blood glucose levels in diabetics, failed to refer diabetic patients for annual retinopathy screening, failed to prescribe statins based on current IDOC guidelines, failed to screen for colon cancer, and failed to vaccinate patients in accordance with current recommendations. We found many deficiencies on record reviews.

Emergency supplies and equipment are standardized but bags are not sealed. Emergency bags are routinely checked but we did find some outdated supplies in these bags. All automated defibrillators were routinely checked and were found functional. Emergency response drills are performed as required. Although critiques of these drills were adequate, there was no discussion of analysis or plans for improvements in CQI meetings. Tracking of emergency evaluations ceased in 2017. In records reviewed of nursing evaluation of urgent episodes of care and in physician care of persons hospitalized, there were numerous deficiencies of clinical care.

Specialty care was not tracked, so it was not possible to evaluate timeliness of care. MCC had the second lowest rate of referral of all facilities we reviewed but the highest rate of denials. We found that many denials were inappropriate. In record reviews we noted delayed specialty care, lack of follow up after consultations, including noting the status of the patients and failure to describe the therapeutic plan developed by the consultant, failure to timely schedule specialty care, and failure to obtain specialty care reports. Access to care appeared so poor that we recommend abandoning the collegial review program.

We found that some patients on the infirmary had conditions that required a higher level of care, such as a skilled nursing unit. Provider notes on the infirmary failed to include adequate history, examination, or plans, and had limited clinical information or rationale for treatment plans. Infirmary beds are inadequate for the type of patients housed on this unit. The infirmary had no

⁴ Mortality Review Patient #23.

examination room. The fixed infirmary beds are so close to the ground that it was difficult to imagine how an adequate examination could be accomplished. There are no call devices on the infirmary and rooms had padlocks on them, creating an evacuation-safety hazard and making it impossible for bedridden patients to gain the attention of a nurse in an emergency.

We noted that medication rooms were clean and orderly, and that storage of medication was appropriate. Medication administration, however, is not safe and medication services do not meet standards of practice. We found that morning medication administration starts at three in the morning, which we find unwarranted. There are numerous transcription errors on medication records that can result in errors in providing medication. Pre-pouring of medication, including crushed and floated medication, is inconsistent with good nursing practice. There were numerous other problems with administration of medication that make this practice unsafe. The use of a list to prepare controlled substances and the placement of doses for multiple patients into a collective container is dangerous and should be stopped immediately. The MAR is not available during medication administration and therefore medication is not documented as given when the medication is actually administered. Instead, nurses document medication administration as given when they pre-pour the medication. We noted lapses of medication continuity in several patients and noted that chronic disease patients are not monitored to ensure continuity of prescribed medication.

There is a dedicated full-time nurse assigned to infection control, and important improvements have been made to the program. MCC tracks infectious disease and has the most advanced tracking of persons with infectious disease of all the facilities we have visited. This nurse could provide a better service if she worked in coordination with an infectious disease doctor so that her work could be guided by current infection control practices. Analysis of surveillance data needs attention, and repair and maintenance of clinical areas needs to improve.

Dental staffing is grossly inadequate; consequently, wait times for fillings and dentures is greater than 15 months. Patients who were prescribed antibiotics for dental infections do not have the teeth extracted timely. Two dentist positions should be filled immediately, and an additional 0.5 FTE dental hygienist position should be established. Routine dental treatment is inadequate since it is not informed by a comprehensive oral examination (i.e., intraoral x-rays, a periodontal assessment using probing, and a sequenced treatment plan). The failures of the dental program documented in this report place patients at risk of preventable pain and tooth loss by fostering widescale underdiagnosis and under-treatment of dental disease. The program has deteriorated markedly since the First Court Expert Report, and the treatment provided to IDOC inmates remains substantially below accepted professional standards, and is not minimally adequate.

The quality improvement program coordinator has no training in quality improvement and no knowledge of current quality improvement methodology. Half of the Governing Body of the quality improvement program consists of custody trained staff. This body needs to be predominantly medically trained. Staff performing studies did not appear to know the difference between outcome and process studies. CQI activities did not address major problems of the facility. Mortality review is not performed and there is currently no critical analysis of deaths,

even though we found that four of seven death records reviewed had preventable or possibly preventable mortality.

Findings

Leadership, Staffing, and Custody Functions

Methodology: We reviewed the Schedule E. We interviewed leadership staff and custody leadership.

First Court Expert Findings

There were no primary care physicians on staff. The Medical Director was a surgeon and the two staff physicians included another surgeon and an ophthalmologist. The Health Care Unit Administrator (HCUA) also served as the Director of Nursing. One of the supervising nurse positions was vacant. This left a lack of supervisory nurse staff. The vacancy rate was approximately 9%.

Current Findings

The medical leadership team is still incomplete. Currently, the Medical Director position is filled with a board-certified internist and the HCUA position has been filled by the same person since 2014. The Director of Nursing (DON) position, however, is vacant. There is no medical records director; a medical records technologist acts as the medical records director. The three supervisory nurse positions are all filled but two of these positions have been recently filled. The Dental Director position is vacant.

The HCUA position is filled by a nurse who is competent and well qualified for her position. Her effectiveness is diminished by not having a DON, an effective Medical Director, or a reliable quality improvement resource person knowledgeable in continuous quality improvement (CQI) methodology. There was no evidence of support by the vendor in improving programmatic deficiencies.

The Medical Director is not providing administrative clinical leadership. This position is filled by an internist who has been Medical Director since June of 2017. He sees patients on the infirmary and in the clinic, performs peer reviews for the nurse practitioners, addresses grievances, and attends the collegial review conference calls. There is no evidence of any participation in other administrative medical functions, particularly related to quality improvement or solving medical clinical problems. He was unaware of the plan for quality improvement and told us that the facility had no ongoing quality problems. He seemed unaware of any programmatic issues of the facility and saw his role with respect to quality improvement as providing good care. As an example, when asked if getting consultation reports was a problem he answered yes. His solution to this was to tell the scheduler about the lack of reports. He presumed that the Regional

Manager and Regional Medical Director knew of the problem but was unaware and not involved in any effort to correct this deficiency.

The IDOC Regional Nurse Coordinator was present for our visit. She does spend time at the facility and was aware of problems that the facility faced. However, she also serves as the full-time HCUA at Vandalia and does not spend full-time as the Regional Coordinator. She did indicate that she has trained staff at Vandalia to assume most of her functions at Vandalia; however, we were unable to verify the extent of time she spends in each of her positions.

The Wexford Regional Manager was present for our visit. She has been with Wexford for three years. She has no medical training or medical administration training. She previously worked as a warden in the IDOC. When asked what the top five problems were at MCC, she said that there were no problems at the facility and no areas of concern from her perspective as Regional Manager. She does not participate in quality improvement activity and has no role in mortality review. She said that no one has brought to her attention any problems with respect to mortality. She knew of no clinical issues with respect to the previous Medical Director, who was a surgeon. With respect to the current Medical Director, she knew that he needed additional training in order to be able to perform suturing of lacerations. From her perspective, operations worked well and were without problems. In our opinion, custody-trained personnel should not be hired to manage the medical program, as they have no experience or training in the provision of medical care.

The Wexford Regional Medical Director was not present for our visit. According to the HCUA, he rarely is present at the facility. He comes for annual Continuous Quality Improvement (CQI) meetings and rarely comes when there is a coverage issue. There was no evidence of his participation in clinical oversight at the facility based on documents we reviewed. He is available to the Medical Director by phone.

There are 91.1 staff positions at MCC. Sixty-six are state staff and 25.1 are Wexford staff. A table of staffing is present as an appendix to this report. There are 29 vacant positions and one long-term leave of absence, yielding approximately a 33% effective vacancy rate. This is a deterioration and a significantly higher vacancy rate than the 9% rate cited in the First Court Expert's report. This vacancy rate is extremely high and makes it impossible to effectively manage the program. State positions have a 33% (22 of 66) vacancy rate, most of which are nursing positions. Wexford has a 28% (7 of 25.1) vacancy rate. Both of these vacancy rates are extremely high. The vacancies for Wexford included the Dental Director, a dentist, and two physician positions, which are critical clinical positions. We were told that there have been applicants for many of the state vacant positions but that the state hiring process is so cumbersome that prospective employees take other positions before the state hiring process is completed. We were told that for a recent hire it took 10 months from the time of application to the time the employee started work.

Wexford has been unable to provide adequate physician coverage for this facility. The First Court Expert reported that all three positions were filled by non-primary care trained physicians and the Medical Director was a surgeon. This was deemed inadequate, which we agree with. The

current Medical Director is board certified in internal medicine, but the other two physician positions are vacant. We received a contract monitoring report covering seven months from June 2017 to December of 2017. This report documents that the physician position has been vacant since September of 2014. We were told that one of the two vacant physician positions was downgraded to a nurse practitioner position because it also could not be filled; this change is not evident in the Schedule E provided to us. That nurse practitioner position is currently vacant as well. The contract monitoring report for MCC shows that the Medical Director hours have mostly been filled. Only approximately 50% of the staff physician hours have been filled and only approximately 50% of nurse practitioner hours have been filled. Downgrading the physician position to the nurse practitioner position has apparently not resulted in additional provider staffing as expected. The current vacant physician position is partly covered by a coverage physician who received one year of a rotating internship and one year of a pathology residency in 1976. This facility still lacks adequate physician coverage and one of the coverage physicians has no primary care training. In terms of hours filled, physician coverage is worse than in 2014 but is slightly better with respect to coverage with primary care trained physicians. The lack of primary care physicians is evident in problems found in record reviews and mortality reviews, and this results, in our opinion, in preventable morbidity and mortality.

Nurse supervisory budgeted staffing is deficient. There are three nurse supervisory staff but there is no weekend or evening coverage. On-call nurses act as proxy evening and weekend supervisory staff. Nurse staffing is also deficient. Though 21 (39%) of 54 nurse positions are vacant, we believe that there remains a deficiency of budgeted nurse staff. The HCUA was unaware of any staffing plan developed for this facility. In addition to nursing positions, clerical positions also appear to be deficient. The number of medical appointments is large at this facility due to its size, and the one scheduling clerk is insufficient to adequately manage the paperwork and scheduling duties. As with other facilities, a staffing plan based on the expectations of the administrative directives with relief factor adjustments needs to be done to accurately determine staffing levels.

We did not review officer staffing. As with other facilities, we believe an officer staffing assessment needs to be done to ensure that all appointments timely occur, and officers assist nurses in a standardized manner when nurses administer medications.

Clinic Space

Methodology: Accompanied by a correctional officer, a nurse manager, and occasionally the HCUA, the experts inspected the nurse and provider sick call rooms on the housing units, the three-story health care unit which housed medical exams rooms, telehealth room, treatment room, physical therapy, nurse medication preparation room, phlebotomy room, dental clinic, sterilization room, medical records department, health care administrative offices, and the infirmary, optometry room, and radiology suite.

First Court Expert Findings

The First Court Expert found that the then 30-year-old health care unit was well maintained but aging, the nurse and physician sick rooms in the cell houses lacked privacy and were not

adequately equipped, and the Reception and Classification Unit was small but appropriately equipped. He noted that all of the clinical areas in the cell houses should be renovated to provide clean, private clinical settings.

Current Findings

- The location of the nurse and provider sick calls in the housing units maximizes the patient-inmates' access to sick call and chronic care services.
- The provider and nurse sick call rooms in the cell houses are generally small; some were not well organized and not in good physical condition.
- The only two exam tables (one is actually a gurney) in one cell house (North) were cluttered with supplies and medical charts, and were not usable for patient examination. Exams, if needed, were performed while the patient was in a chair.
- All of the clinical rooms, including the nurse and provider exam rooms, in the cell houses were wired for computers, but none had computers.
- Some exam rooms in the cell houses had been recently painted but others had cracked paint and walls, frayed wall paper, an electrical outlet without a cover plate, and a missing ceiling vent cover.
- Torn upholstery was noted on three exam tables on the campus.
- Missing or non-functional oto-ophthalmoscopes were noted in four exam rooms on the campus.
- Only three of the 26 beds in the infirmary had adjustable head and leg sections. One was an aged metal bed and the other two were hospital beds.
- There are an inadequate number of adjustable hospital beds to meet the needs of the complicated patient-inmates admitted to the infirmary.
- There is not an exam room in the infirmary.
- The low level of the beds makes it difficult and unsafe for the clinical team to properly examine and transfer patients.
- There were no nurse call devices in the infirmary patients' rooms. The HCUA stated that consideration is being given to installing wall-mounted bedside audible alarms that are currently in use at LCC.
- Not all medical equipment had documentation of annual electrical safety inspections.
- Out-of-date medical references were found in a number of clinical areas.
- The group shower in South Lower used by older men, some with physical impairments, was in poor repair that created safety and sanitation concerns.
- The infirmary shower was poorly ventilated, had a clogged ceiling vent, a non-functional shower head, a rusted grab bar near the tub, and no safety grab bars near the functioning shower.
- The anterooms in both infirmary isolation rooms were dirty and cluttered.
- The negative pressure units in the infirmary isolation rooms were functional and had regular documented inspections.
- The layout of the radiology room in the Reception & Classification building predisposes the staff and patients to the potential risk of radiation exposure.

- There are no automated external defibrillators (AEDs) in the Reception & Classification building or in every cell house.

At the time of the site visit, MCC housed 2,580 maximum security male inmates on the main campus and an additional 440 men at its Medium Security Unit located a few miles from the main facility. MCC serves as the Reception and Classification Center for a number of detention centers and jails in southern Illinois, receiving 90-150 new admissions per month. It also accepts transfers from all of the IDOC facilities and directly from the North Reception Center (NRC) near Chicago.

The Reception and Classification Center is located in a separate building with an adjacent housing wing that temporarily houses 30-50 new admissions until their intake screenings have been completed. The clinical screening is provided in four rooms (medical, TASC, mental health, and dental) along a single corridor. The medical exam room has an exam table with torn upholstery, paper barrier for the exam table, a desk, two chairs, a scale, sink with eye washing attachment, and paper towels. The wall mounted oto-ophthalmoscope was not functional. Unprotected paper directives were taped on the wall; this is a fire safety hazard. Vital signs and clinical histories and exams are performed in this room. Dental screening is provided one day per month. Panorex x-rays are taken in an unshielded, unleaded room. Prior to taking an x-ray, the radiology technician has to stop foot traffic in the corridor and pull the trigger cord into the corridor to minimize the risk of radiation exposure. The radiology technician does not wear a radiation exposure dosimeter badge. An automated external defibrillator (AED) is not kept in the R&C building.

Men are housed in two long, multi-story housing structures that have been subdivided into seven cell houses. One structure houses North 2, North Lower, North Upper, South Lower, and South Upper cell houses; the other has the East and West cell houses. Each of cell houses has two galleys on each side, each galley had two tiers that are not connected. The cell houses hold from 250-400 patient-inmates. Each cell has a toilet, a sink, and a bunk bed with two men; some inmates are housed alone. The doors are barred. Large open showers are located on each floor. There are steep stairs to each of the upper levels, but there is also an elevator for those who are unable to navigate the stairs. Men are allowed access to the shower three times per week. The group shower in South Lower that is used by an older population, including some individuals with physical disabilities, was inspected. The shower room had five shower chairs, safety grab bars, and ramps to access the showering area. The area was poorly ventilated, the ceilings were peeling, the concrete floor had large cracks, and metal doors, fans, and vent covers were completely rusted. The cracked floors pose a safety risk to this aged patient-inmate population and to staff. The rusted metal fixtures and the peeling ceiling are not able to be fully sanitized and create a risk for mold and the growth of bacteria and fungi. The correctional staff stated that the state funding has been inadequate to perform routine maintenance and repair of this shower and other service areas on the campus.

Each of cell houses has a clinical space where nurse and provider sick call and chronic care clinics are held; these clinic spaces vary from cell house to cell house in size, privacy, equipment, and upkeep.

North 2 medical area is located on an upper floor and serves the cell house's segregation unit, a general population unit, and an older patient, some with disabilities, unit. The area has a 10-person waiting room. The space is relatively tight but has two medical exam spaces, a tele-psych room, a single chair dental suite, and three mental health interview rooms. This is the most expansive clinical space in the cell houses. A provider uses one of the medical rooms one to two days per week. This room has a gurney covered with medical charts that serves as the exam table, a desk, two chairs, no computer, a sink with soap and paper towels, and a blood pressure unit. This exam room did not have an oto-ophthalmoscope; it was reported that it was broken. There was 13-year-old Physician Desk Reference (PDR) in the room. When questioned about the availability of electronic medical references, the physician stated that he can access online clinical references from the computer in his office in the health care unit, but he was unable to list even one comprehensive online resource that he uses. The gurney that reportedly serves as the exam table was so completely covered with medical charts that it was unlikely that it would or could be used during this session. Nurse sick call is performed in an adjacent exam room with an exam table which has tears in the upholstery and is covered with medical supplies; this exam table could not be readily, if at all, used for patient examination. The room had paper barriers, scale, BP unit, peak expiratory flow rate (PERF) meter, pulse oximeter, sink, desk, two chairs, phone, sharps box, and a stair chair. There was a functioning otoscope. An unsealed emergency bag with an ambu bag, EpiPen, glucose gel, expired glucagon, Accu-Chek machine (no safety inspection label) was inspected. There was no AED in the bag; it was reported to be broken. The nurse reported that the bag is checked every shift, but a log could not be identified. There were 18 and 19-year-old PDR's on the nurse's desk; she stated she does not have access to online medical references. The nurse holds daily sick call and sees most patients within one to three days after a request is submitted.

The medical area in North 1 Upper (population 350-370) had a small waiting room and two small, clean, recently painted, similarly equipped exam rooms. Each had exam tables with intact upholstery, paper barriers, two fixed chairs, and no computer. There was not a sink in the rooms. In the atrium just outside the exam rooms was a scale, and a sink with soap and paper towels, and a locked medical cabinet with a functional oto-ophthalmoscope, PERF meter, stethoscope, digital thermometer, and medical supplies.

North 1 Lower (population 247) sends its general population patients to North 1 Upper for sick call and chronic care clinics and its second floor medical area serves the protective custody patients (62 individuals) housed in this cell house. This clinic has only a single exam room with an exam table with intact upholstery, paper barrier on the table, desk, two chairs, phone, hand sanitizer, paper towels, a functional oto-ophthalmoscope, scale, BP unit, a stethoscope, and no computer. There was no PERF meter or mouthpieces or a pulse oximeter or Accu-Chek unit in this clinical area. The paint was cracked on the wall and an electrical plate was missing just above the exam table.

South Lower (population 316) has two clinics. A clinic on the first floor serves an older population, some with physical disabilities, housed on the adjoined lower levels of this cell house. The clinic has a single exam room with an exam table with intact upholstery, a sink with soap, scale, BP

unit, stethoscope, pulse oximeter, gloves, desk, two chairs, phone, and no computer. Wallpaper in the clinic was frayed, preventing the walls being properly cleaned. South Lower also has a clinic on the second floor that serves a general population and a worker/porter housing unit. This clinic has a single exam room with an exam table with intact upholstery, paper barrier on the table, scale, eye chart, functional otoscope, BP unit, pulse oximeter, two PEFR meters, desk, two chairs, phone, and no computer.

West Cell House (406 population) has a second floor clinic with one small exam room with an exam table with intact upholstery, paper barrier on the table, functional otoscope, PEFR meter with mouthpieces, pulse oximeter, desk, two chairs, and hand sanitizer. The space was cluttered, unprotected paper directives were taped on the walls, paint was cracked, the ceiling vent did not have a cover, and cardboard boxes filled with toothpaste nearly touching the ceiling were piled on top of a file cabinet. The accompanying West Cell House correctional officer stated that he would have the boxes and the paper directives removed immediately. He stated that the state funding has slowed down the completion of non-urgent repairs throughout the campus. The boxes and paper taped on the walls posed a fire safety hazard. The cracked paint made it impossible to properly sanitize this clinic space and creates an unprofessional work environment for the clinical staff.

East Cell House (310 population) has a second floor clinic with a tele-psych room with a counter and one chair, and an additional exam room that is shared by medical and mental health staff. The exam room has an exam table, a desk, and two chairs. The exam room is cramped and cluttered due to the presence of three large correctional metal file cabinets, water damaged cardboard boxes stacked on top of these cabinets, and an ancient refrigerator used by correctional staff with a totally rusted front. These items should not be located in a clinical exam area. The East Cell House Major who joined our inspection stated that he will have the file cabinets, cardboard boxes, and refrigerator removed from the exam room.

Patient-inmates interviewed in the cell houses were all knowledgeable about the sick call request procedure. Most stated that they are seen by a nurse within a few days after they place a request in the locked box. If they were referred by the nurse to see a provider, it will take three to four days up to a few weeks before they were seen in a provider sick call.

The health care unit is a three-story building located in the central section of the MCC campus. The first floor has four exam rooms, one of which is used for HIV, hepatitis C, and renal telehealth consultation. Only the telehealth room is now actively used for the delivery of medical care. The other three exam rooms are primarily used as mental health interview rooms and by at least one LPN as a storage and staging area. Since the provider sick call and chronic care clinics were moved into the cell houses, three of these exam rooms are only occasionally, if ever, used by nurses for the delivery of sick call and after-hours care. All the exam rooms have desks, chairs, sinks, soap, paper towels, exam tables, and oto-ophthalmoscopes. A scale was identified in one exam room. The exam tables in two of the rooms had torn upholstery. Only two of the four oto-ophthalmoscopes were functional, and one lacked a currently safety inspection label. Some of

chairs had torn and frayed upholstery. Only the telehealth room appeared to be organized and optimally clean. Nineteen and 13-year-old PDR's were noted in one of the exam rooms.

The first floor also has a sterilization room that also stores trauma bags, crutches, transport cots, a backboard, two autoclaves with current safety inspection labels, a dental suite that will be reviewed in the dental care section, medication storage and preparation room, medication records, a lab room with a current CLIA certificate, a phlebotomy chair, four centrifuges with current safety inspection labels, and a treatment room. The treatment room serves as the urgent care center for the MCC campus. It has an adjustable gurney, three oxygen tanks, a Gomco suction machine, pulse oximeters, digital thermometer, Accu-Chek machines, ambu bag, AED, an ECG machine, a functional oto-ophthalmoscope, and a variety of medical supplies. An emergency bag with emergency supplies, medications, and equipment, and an AED with pads were kept in the treatment room. None of the medications inspected had expired. Two new stair chairs and a backboard are stored in this area, cluttering an already tight space. An oxygen storage room within the treatment care area was packed with large and small tanks; only the small tanks were held in safety racks. The unracked large tanks pose a safety risk to patient-inmates and staff. It was reported that the Accu-Cheks are calibrated daily, but this activity was not logged. The ECG machine did not have an electrical inspection tag. Two additional gurneys and one additional stair chair were kept in an alcove in an adjacent corridor. There was no crash cart in the treatment room. MCC does not have a crash cart; the institution performs basic CPR, applies the AED, and calls 911 for cardiac arrests. This is an acceptable option for responding to codes/cardiac arrests. The second floor of the health care unit houses physical therapy, optometry, radiology suite, and clinical administrative and provider offices. The physical therapy room is small and has two matted tables, a cold/hot pack unit, steps, exercise balls, door mounted pulleys, a desk, chairs, and a storage cabinet. The radiology suite performs non-digital plain film x-ray examinations and panorex studies (see radiology section for further information). The clinical administrative and provider offices have computers that have access to the internet.

The third floor of the health care unit houses the 26-bed infirmary. The infirmary offices and patient rooms were generally clean. Room 304 emitted a smell of urine. This room houses the only restraint bed in the infirmary. The porters were directed to buff the floor. Twenty-three of the 26 beds were low fixed-position metal beds. The infirmary beds are low to the floor and cannot be raised. The head of the beds cannot be elevated. There were only three adjustable beds; one was an aged metal bed and the other two were relatively new hospital beds. This is an insufficient number of hospital beds to meet the needs of the complicated patients that are admitted to the infirmary. There is no exam room in the infirmary; patients are examined in their beds. The low to the ground fixed-position metal beds make it difficult and even unsafe for the staff to properly examine and transfer patients into and out of the bed. The bed mattresses were relatively thin and covered with an intact cleanable covers. Because of a lack of appropriate beds, one patient, with fall risk, had his mattress placed on the floor. His mattress had an uncovered, deteriorating foam head rest that was impossible to sanitize. This patient should be assigned to an adjustable hospital bed with safety railings. There were two negative pressure/isolation rooms. The negative pressure units were turned on and demonstrated to be operational using both the pressure gauge and the tissue paper test. The negative pressure units are checked and

logged daily. There were no patients in the negative pressure rooms. Both negative pressure room anterooms were dirty and cluttered with gloves, chucks, and paper forms. Both rooms had full red waste bins. These anterooms had not been used in quite a long time and need to be cleaned and kept ready for use.

The floor of the shower and tub room was clean. One shower head was not functional. There were no safety grab bars in the shower; the grab bar near the tub was totally rusted. The ceiling ventilation covers were rusted and the return vent near the tub was densely clogged with debris. The staff directed the porter to clean the vent. It was reported that the more frail patients in the infirmary have live-in inmate aides who assist them with bathing and other activities of daily living.

The clean and soiled utility rooms and an equipment room were organized and clean. Only one of the two IVAC units in the equipment room had a current safety inspection label; it was reported that the other one was new. A scale that could accommodate a wheel chair was demonstrated to be functional. The laundry room has a non-boosted washer and a dryer. Bleach is added to all laundry loads; significantly soiled sheets are sent to the main laundry, which washes clothes at a higher temperature. Cleaned sheets in the laundry room were noted to be in good condition.

There is a linear nursing station that connects into the two long corridors of the rectangular shaped infirmary. The doors at each end of the nursing station are kept closed. The patient rooms have solid metal doors with a small viewing window. There are no rooms that are in the direct line of sight to the nursing station and only a few are possibly within sound of the nursing station. Correctional officers are housed in the corner of one of the corridors. The officers also do not have direct line of sight into patient rooms from their desk. The nurse station has a long counter with two work areas, a medication cart, an operational AED with non-expired pads, oxygen tanks, ambu bag, functional Gomco suction machine, and a number of out of date nursing textbooks. An office at the entrance to the infirmary was soon to be assigned to a nurse manager who provides oversight of the infirmary. This room has a computer with access to the internet.

In summary, the relocation of all nurse sick calls, provider sick calls, and chronic care clinics to the cell house allows for improved access to primary care services. The physical condition of some of these exam rooms is deficient and needing repair of cracked paint and wallpaper, and replacement of missing and rusty vents, and missing electrical plates. The correctional staff repeatedly commented that repairs of the clinical areas had been requested but were not readily done because of inadequate State of Illinois funding. The types of medical equipment and supplies varied between cell house clinics; all of the cell house clinical areas need to be equally equipped and stocked. The staff do not have ready access to current clinical references while they are providing care in the cell houses or in the health care unit; decades old textbooks and PDRs were noted in many clinical areas. This could be readily corrected by installing computers in the already wired exam rooms in the cell houses and health care unit. Two showers were inspected (South Lower and infirmary); both needed repairs and improved ventilation, and both create safety and sanitation risks for patient-inmates and staff.

Sanitation

Methodology: The sick call and chronic care rooms on the housing units, the infirmary rooms, the health care unit, and the showers were inspected. Nurses, correctional officers, infirmary patient-inmates, and inmate porters were interviewed. Monthly Safety and Sanitation reports from January through April 2018 were reviewed.

First Court Expert Findings

The First Court Expert reported that the facility was generally well maintained.

Current Findings

We did not find that the facility was well maintained. We noted additional findings.

- The infirmary is generally clean with the exception of the anterooms in both isolation rooms, which were dirty and cluttered.
- Paper barriers were consistently used on most but not all examination tables throughout the facility.
- The upholstery on a number of exam tables in clinical areas had tears in their protective outer surfaces and could not be adequately sanitized.
- An uncovered foam head rest in one infirmary room could not be adequately sanitized.
- Physical plant deficiencies including peeling paint, cracked paint and walls, rusty and missing vents, frayed wall paper, missing electrical outlet cover plate, torn upholstery, rusted cabinets, and missing ceiling vent cover were noted in the clinical areas in the cell houses and the HCU. These deficiencies create a non-professional work environment for the clinical staff and make it impossible to adequately sanitize the clinical areas.
- Monthly Safety and Sanitation rounds and reports were being completed. Many of the same findings were noted and went unaddressed from January through April 2018.
- There are no environmental rounds that focus on the inspection and documentation of non-functional clinical equipment, the presence of current electrical safety inspections, and the completion of logs of inspections of clinical concerns, including emergency bags and equipment, negative pressure units, organization of clinical areas, etc.

The nurse and provider sick call and chronic care areas in the cell houses were generally clean, but the physical plant had a number of deficiencies (also noted in the Clinical Space section) that interfered with the ability to fully sanitize these areas. The reception and Classification clinical area had torn upholstery on an exam table. North 2 clinical area needed to be repainted. North 1 Lower had cracked paint and walls, and a missing electrical outlet cover plate just above the exam table. South Lower had frayed wall paper. West had cracked paint, no cover on the ceiling vent, and boxes stacked on top of file cabinets. East had the clinical space cramped with correctional file cabinets, deteriorating boxes with correctional logs and papers, and a totally rusted correctional staff refrigerator. The HCU was generally clean, with some missing ceiling tiles and uncleaned infirmary isolation anterooms. The showers in South Lower had peeling paint, cracked floors, rusted vents and metal doors, and poor ventilation. The infirmary had no safety hand grab bars, clogged ceiling vent, and poor ventilation. These physical plant deficiencies pose safety and infection control risks.

Inmate porters sweep, mop, and buff the floors of the infirmary rooms two to three times a week or more frequently as needed. They report that they spray with cleaning agent and bleach mixture. They clean the toilets, sinks, and showers on a regular basis.

In summary, the First Court Expert made a number of specific recommendations concerning sanitation and infection control. We have added recommendations that are found at the end of this report.

Radiology Service

Methodology: We reviewed the radiology unit.

First Court Expert Findings

The First Court Expert's report did not include any findings about the radiology equipment or services.

Current Findings

- The Illinois Emergency Management Agency (IEMA) radiation safety inspections and reports for the radiology units at MCC are current. The active x-ray equipment at MCC was found to be compliance with the Radiation Protection Act of 1990.
- The access to plain film x-rays at MCC is acceptable.
- The turnaround time for radiologist readings and return of the reports is acceptable.
- The lack of a shielded post to take panorex films in the Reception and Classification area has the potential for radiation exposure to the radiology technician and other staff.
- The system decision not to have the x-ray technician wear radiation exposure dosimeters may not be in accord with State of Illinois regulations and is definitely not in accord with community practice.

The radiology equipment had current IEMA inspection and certification. Plain film non-digital x-ray services and panorex studies are provided Monday through Friday during the daytime hours by a single full-time radiology technician who staffs and manages the unit. Patients requiring advanced or emergency studies are referred to the nearby Chester Memorial Hospital or to other health care systems, including Southern Illinois Health Care (SIHC).

It was reported that there is a three to five day waiting list for non-urgent onsite x-rays. The five x-rays ordered on 5/17/18 were being taken on 5/22/18, three working days after being ordered. Most x-rays are reported to be taken within one to two days after receiving the order. Weekend and holiday requests are completed on the next working day. The requests and the radiology log for eight patients who had films taken on 5/21/18 were reviewed. The waiting time for this small sample, between x-ray ordering and being taken, was 7.6 days, with a range of four to 10 days. Films are sent to a contracted radiologist in Bloomington, Illinois for reading. Reports are initially faxed back to MCC on the same or next day, with the hard copies sent within two to three days. Audits of films taken verified that the reading turnaround time was one to two days.

Onsite ultrasound exams are provided once a month by a contracted vendor. Ultrasound examinations must be reviewed and approved by the Wexford collegial review process. On the day of the inspection there were four patients on the ultrasound schedule. Some were awaiting Wexford approval.

The chest x-ray unit and the plain film table are in a second floor HCU room that has a shielded post for the technician to stand behind while the film is being taken. The radiology technician has a dark room and a work space immediately adjacent to the plain film suite. An additional panorex is located in an exam room in the Reception and Classification building. This room does not have a shielded post that can be used when panorex films are taken; the technician has to stretch the trigger cord as far as she can out the exam room door and into the main clinical hallway to minimize her risk of radiation exposure.

The x-ray technician was noted not to be wearing a radiation exposure dosimeter badge. She stated she had been told that the State of Illinois does not require the use of dosimeters as long as she was more than five to seven feet away from the unit. This radiology technician does not work at an outside medical center.

In summary, the radiology services at MCC have reasonable access to x-ray services and reasonable turnaround time of radiologist readings and reports. The location of the second panorex in a clinical exam room in the Reception and Classification building, which does not have a shielded post to take panorex films, raises concerns about the risk of radiation exposure. The decision of the system to not provide radiation exposure dosimeter badges is not in accord with community standards and needs to be further reviewed by the State of Illinois IEMA and possibly OSHA.

The First Court Expert's report did not have any recommendations about the radiology services. We have recommendations that are noted at the end of the report.

Medical Records

Methodology: We inspected the medical records room, interviewed medical records staff, and reviewed multiple medical records.

First Court Expert Findings

Charts were thinned so that the size of the medical record was manageable. Problem lists were cluttered with redundant information and with items that were not medical problems. The facility rarely received consultant reports or hospital reports. Sick call slips were not maintained in the medical record.

Current Findings

All of the findings of the First Court Expert are still present. Paper medical records are used and were thinned to a reasonable size. The problem lists were still incomplete and filled with

unnecessary, redundant information. Hospital and consultant reports are still not consistently obtained and sick call requests are still not filed in the medical record.

MCC does not have a medical records director position in their budget, but a health information technologist is a licensed medical records professional and serves in that capacity. The medical records room is insufficiently sized to accommodate all volumes of records and only the most current volume of a record is kept in the medical records room. Additional warehouse storage spaces are used for additional volumes of the current records and for death records. During record reviews, when we wanted a particular consultant report or other document, we had to ask for the additional volume, which took some time to obtain. The delay would be significant for clinical interactions with active patients. The inability to easily obtain all volumes of a record during every clinical encounter was a problem and is a reason why an electronic medical record should be installed statewide.

We confirmed the First Court Expert's finding that medical record volumes are thinned. Whenever a volume reaches two inches in depth, medical record staff thin the volume, and for all charts we reviewed, volumes were thinned to two inches or less. Charts we used for medical record reviews came apart much less frequently than occurred at other sites, but this still occurred.

There was minimal filing backlog. For most record documents there was only approximately a half inch of back filing. For medication administration records (MAR), there was two to three inches. This is not a significant volume of backlog filing.

With respect to access to the record, medical records staff pulls medical records for provider scheduled appointments. Nursing sick call evaluations occur without the availability of a medical record, which is inappropriate and subjects the patient to risk. When nurses perform health request evaluations in remote sites, they need to know the conditions of the patient, recent problems, and medications. For health request evaluations, nurses write notes on a single progress note and bring these at a later time to the medical records office. Some nurses will file the progress note in the patient's chart and some nurses will give the documents to records staff to file. Any staff is authorized to pull or re-file a medical record. This violates medical record confidentiality and promotes loss of medical information. All clinical encounters should occur with the availability of the medical record.

The First Court Expert found that the facility rarely received consultation or hospital reports. Obtaining these is the responsibility of the scheduling clerk, who indicated that approximately 50% of reports were obtained. In our record reviews, consultation and hospital reports were not consistently present and providers did not consistently document the status of the patient after consultation. Based on record reviews, the lack of consultation and hospital reports appeared to significantly and adversely affect clinical care.

Sick call requests are not filed in the medical record. In our opinion, the patient requests for care have clinical information and are therefore a medical record document and need to be filed in the medical record.

The lack of timely access to medical record documents for clinical encounters and lack of timely access to a complete medical record support the need for an electronic medical record. Lack of timely and accurate documentation in the MAR, which will be described in the medication section of this report, also supports use of an electronic medical record with an eMAR function.

Medical Reception and Intrasystem Transfer

Methodology: To assess medical evaluation of newly arriving inmates we toured the medical reception area, interviewed health care staff, reviewed IDOC health record forms, and reviewed 15 health records. Records were selected from a log documenting referral from the reception nurse to the provider due to a history of chronic disease, since October 2017.

First Court Expert Findings

The previous Court Appointed Expert found problems with the quality of the intake process, particularly the recognition and work up of abnormal findings.⁵

Current Findings

Our review showed that the quality of the intake process is still hampered by omissions in screening and failure to follow up on the information obtained. We also found that intake physical examinations were not completed timely. Finally, IDOC has adopted a policy of opt-out HIV testing, but the procedure still requires written consent for testing.

MCC receives an average of 86 inmates a month.⁶ Intakes arrive generally Monday through Friday from county jails or directly from the community as parole violators. According to staff interviewed, usually they have several hours' notice of inmates who will arrive as new admissions. Parole violators may arrive without notice.

Intake screening takes place in three rooms on a corridor adjacent to the booking and holding cells. There is a dental examination room, a medical examination room, and a room to complete the mental health evaluation. Other offices in the corridor include classification, and alcohol and drug screening. The medical examination room is used by nurses to conduct receiving screening and collect lab samples. It is also used by a provider to complete physical examinations. This room was clean, well-lighted, properly equipped, and maintained.

Intake screening includes a medical history, tuberculosis symptom screen, height and weight, vital signs, visual acuity, and planting a tuberculin skin test (TST). According to a recent nursing schedule provided to the Court Appointed Expert, about half the time this responsibility is

⁵ Lippert Report Menard pp. 8-9.

⁶ Data provided in advance of the site visit to Menard for the time period April 2017 through April 2018.

assigned to an LPN and half the time it is assigned to an RN.⁷ Nurses consistently contacted a provider to obtain telephone or verbal orders in order to continue medications inmates reported taking or those which were listed on the transfer summary from jail. Medication was provided as ordered the next time medications were due.⁸ Patients were not always followed up to have the tuberculin skin test read, and in one case, the skin test was not administered.⁹ These omissions were identified a few days later by the nurse completing the review of record prior to the physical exam; the test was administered again, and results obtained timely.

Lab tests performed as part of intake screening at MCC routinely include serum chemistry, syphilis, and opt-out HIV testing. Although HIV is supposed to be opt-out, the administrative directive (AD) requires that consent be obtained before drawing blood for HIV.^{10,11} Opt-out testing is recommended by the Centers for Disease Control because it supports early identification and treatment. The AD should be revised to eliminate explicit written consent to be consistent with an opt-out policy.¹² Data reported to the CQI committee shows that on average only half the incoming inmates are tested for HIV, which is consistent with an opt-in rather than opt-out testing policy.

A medical history and physical examination are to be completed within seven working days of intake.¹³ The medical history and physical examination by a physician, nurse practitioner, or physician's assistant took place within the first seven working days after admission in only 60% of the charts reviewed. Untimely physical exams were between nine to as many as 18 days after admission. As noted in the previous Court Expert report, the recognition and work up of abnormal findings was sometimes problematic. Providers did not consistently elaborate on positive findings noted by the nurse, and the history and physical examination were cursory and lacking in quality.¹⁴ Enrollment of patients in the chronic care program has improved since the previous Court Expert's review. Inmates with chronic diseases were usually seen for their first chronic care appointment at the time of the intake physical exam. This initial visit includes a review of relevant lab results, amplification of the disease history, assessment of disease control, and initiation of a treatment plan.

There are no mechanisms in place to monitor timeliness of the intake process or to evaluate the quality of intake screening, the health history, or physical examination. There were no CQI studies provided that indicate intake screening is monitored for quality or timeliness. This is a high

⁷ Nursing schedule 4-16-2018 through 4-28-2018.

⁸ Medical Reception Patients #5, 6, 10, 11, 13.

⁹ Medical Reception Patients #3 & 4.

¹⁰ Opt-out testing means that testing will be performed unless the patient refuses the test. Opt-in testing means that the patient is offered testing and is performed only upon patient consent.

¹¹ Administrative Directive 04.03.11 Section 5 II. F. 5. d.

¹² Centers for Disease Control and Prevention. HIV Testing Implementation Guidance for Correctional Settings. 2009: p. 8.



cdc-hiv-correctional
-settings-guidelines.

¹³ Administrative Directive 04.03.101, Section II. G. 2. a.

¹⁴ Medical Reception Patients #12, 13 & 14.

volume, high-risk area of health care delivery in the correctional setting and should be regularly reviewed as part of the CQI program.¹⁵

We found errors in tuberculosis screening, and the intake physical examinations are not timely or sufficiently thorough to ensure continuity of care. The procedural direction to obtain consent or HIV testing in IDOC Administrative Directive 04.03.11 conflicts with the policy of opt-out HIV testing and needs to be corrected.

Nursing Sick Call

Methodology: Nursing sick call was evaluated by:

- Reviewing Menard Institutional Directive 04.03.103 Offender Health Care Services, Health Services Policy and Procedure-Health Care Screening (Sick Call), and IDOC Treatment Protocols.
- Interviewing nursing and supervisory staff.
- Observing the boxes in each building where inmates put their health care requests.
- Inspecting the rooms used for sick call in each of the buildings, except MSU.
- Reviewing tracking logs, which were used to select records for chart review.
- Reviewing documentation of 15 sick call encounters. These were selected from Sick Call Logs from February 25, 2018 through May 9, 2018, with complaints of potentially serious conditions (chest pain, acute infection, shortness of breath, seizures etc.) and their charts reviewed.
- Reviewing the triage of 16 sick call requests that were picked up Thursday morning May 24, 2018 from the sick call box in North 1.

First Court Expert Findings

The previous Court Expert described the sick call system as one that relies on the inmate to submit a written request. These requests are picked up each morning and triaged by nursing staff. Each inmate was scheduled to be seen either that day if the problem was urgent or within the next 24 to 72 hours if the problem was routine. Inmates were seen by either LPNs or RNs who had been trained initially by a physician. Each month the charting of nursing sick call was reviewed by the facility Medical Director and the results discussed with individual nurses. The chart review results were also reported in the monthly CQI meeting. Most of the rooms used to conduct nursing sick call were inadequate, lacking privacy and appropriate equipment. Notable exceptions were North 2 and the renovations in East Cell House. The medical record was available to nursing staff conducting sick call, but the original requests were discarded after the sick call encounter had taken place. Chart review indicated that there were omissions in data collected during the assessment (incomplete vital signs, failure to indicate duration of the complaint, not documenting the precise location of injury).¹⁶

Current Findings

¹⁵ National Commission on Correctional Health Care. 2014. Standards for Health Services in Prisons pp. 13-14.

¹⁶ Lippert Report Menard pp. 10-11.

Our review found that some of the problems with sick call described in the previous Court Expert's report have been resolved. Most notably, the rooms used by nursing staff to conduct sick call are uniformly equipped with accurate weight scales, an otoscope, blood pressure cuff and stethoscope, peak flow monitor, pulse oximeter, and exam table with paper. Most have sinks to wash hands and those that do not had hand sanitizer available (in two rooms the hand sanitizer was empty). Each exam room had a flyer mounted on the wall reminding nurses to change paper between patients. Wall mounted oto-ophthalmoscopes did not work in most rooms but there were hand-held ophthalmoscopes in all the rooms. Many of the rooms have a plexiglass door which ensures auditory privacy during the sick call encounter.

Sick call requests may be written on any piece of paper and put into the designated sick call boxes in each building. Inmates may also give their request directly to nursing staff whenever they are on the gallery. The nurse then triages each request and determines whether the inmate needs to be seen at all, and if so, whether they should be seen that day because it is a problem of urgent nature or should be scheduled and seen the following day. Documentation of timeliness in responding to sick call requests was evident from review of the sick call logs. Of 15 medical sick call requests, all were triaged within 24 hours and all were seen within 48 hours of receipt. Eight urgent requests were seen the same day the request was received.¹⁷ We also interviewed several inmates in the North and South buildings about access to care. They consistently reported that they were seen for sick call within two days after putting in a written request and saw a provider in about a week, if referred by the nurse. The Health Care Unit studied timeliness in responding to sick call requests, which demonstrated compliance with the Administrative Directive in 2016. There have been no more recent studies of timeliness in responding to sick call requests. Timeliness of nursing sick call should be monitored at least annually.¹⁸

We interviewed an LPN who had picked up 16 sick call requests from inmates in the North 1 building Thursday morning May 24, 2018. Of these, 15 were requests to refill keep-on-person (KOP) medications. There was one request for attention to a problem of blood in the urine with clots. The nurse was not familiar with the inmate and had not reviewed the inmate's medical file. The nurse's triage decision was that the complaint was not urgent, and he would be scheduled to be seen the next day. We disagree with the nurse's triage decision and would have seen the inmate that day.

IDOC Nursing Treatment Protocols guide the nurse's assessment of inmates' sick call complaints. Nurses appropriately assessed and examined the inmate in 12 of 15 sick call encounters reviewed (80%).¹⁹ In one encounter, the nurse did not follow up on an inmate's elevated blood pressure and did not complete an opiate withdrawal screening (COWS).²⁰ In another encounter, the inmate complained of diverticulitis and gave a recent history of treatment for this disease. The nurse did not use the nursing treatment protocol for abdominal pain, choosing instead to use the

¹⁷ Sick Call Patients #1-8.

¹⁸ National Commission on Correctional Health Care. 2014. Standards for Health Services in Prisons. P. 14.

¹⁹ Sick Call Patients #3, 6-11, 13-15.

²⁰ Sick Call Patient #12.

one for non-specific complaints.²¹ In another encounter, there is no nursing assessment of the patient's urgent complaint, but only an outbound note that he was sent to the ED.²²

LPNs are assigned to perform triage and sick call approximately half of the time.²³ Sick call is conducted in the housing unit and thus each sick call nurse acts independently and autonomously from any other health care staff. This assignment is outside the Illinois scope of practice for LPNs. LPNs are to practice "under the guidance of a registered professional nurse, or an advanced practice registered nurse, or as directed by a physician assistant, physician...to include *conducting a focused nursing assessment and contributing to the ongoing assessment of the patient performed by the registered professional nurse.*"²⁴ The Illinois nurse practice act does not permit LPN's to perform assessments independent of a registered professional nurse or higher level professional, as is currently being done at MCC. Neither does the scope of practice permit LPNs to perform independent assessments according to protocols. We agree with the First Court Expert's finding that LPNs do not have the educational preparation or scope of practice to examine patients, make an assessment, and formulate a treatment plan.²⁵ *Thus, some patients at MCC do not receive evaluations by health care staff licensed to perform independent assessments. This increases the risk of harm to patients.*

Nursing sick call documentation is monitored by the facility Medical Director monthly. The results of these reviews are documented in the CQI minutes. The April 2018 CQI minutes include a table with results of these chart reviews for 11 months. This internal review appears to monitor important aspects of nursing sick call (complete vital signs taken, documentation of subjective complaint, observation of signs and symptoms, appropriateness and thoroughness of the assessment, appropriateness of referral, etc.). The results suggest that issues are seldom identified, especially the observation of signs and symptoms or appropriateness and thoroughness of the assessment. These findings differ from our chart review and suggest that the internal review is not objective or self-critical. This is an audit function that would be more appropriately done by expert clinical nurses employed by IDOC.

Two nurses, responsible for completing nursing sick call in the housing units, were interviewed. Neither reported having the patient's medical record with them when seeing patients. One said that it would be too cumbersome to carry the records to the nursing sick call room. However, there were several examples among the charts reviewed where the patient's previous medical history was relevant to the current sick call complaint.²⁶ The IDOC Nursing Treatment Protocols state that "sick call evaluation using these protocols *should be performed with a medical record.*"²⁷ MCC's Health Services Policy and Procedure also states that the patient's medical record will be pulled the day prior and taken to medical area in the unit to document the findings

²¹ Sick Call Patient #3.

²² Sick Call Patient #4.

²³ Scheduled nursing assignments 4/16/2018 – 4/28/2018.

²⁴ Illinois LPN Scope of Practice. Section 55-30.

²⁵ Lippert Report Menard p. 43.

²⁶ Sick Call Patients #3, 4, 8, 12, 13.

²⁷ IDOC Nursing Treatment Protocols p. 6; *emphasis added*.

and treatment provided during the sick call encounter.²⁸ Practices at MCC do not comply with IDOC guidelines or their own policy and procedure for sick call. We discussed with the HCUA various ways it would be possible for nurses to have the record when seeing the patient.

An improvement since the First Court Appointed Expert's report is that the sick call request written by the inmate is filed chronologically in the Miscellaneous section of the Medical Record. Apparently other HCUAs have complained about this practice but the HCUA at MCC has persisted. The previous Court Expert recommended that the inmate's written request be filed in the health care record and we agree. The practice at MCC should be adopted at all the IDOC facility health care units.

Inmates who were referred from nurse sick call were not seen timely by providers. Referrals to providers were appropriately generated for each of the 15 sick call encounters reviewed, but only three were seen within 48 hours.²⁹ One patient was referred after being seen for smoke inhalation; he was not seen by a provider for 11 days.³⁰ Another was seen by the nurse for epigastric pain. The provider was called and ordered medication and follow up in the chronic care clinic. His next chronic care appointment was five months in the future.³¹ Another patient was seen by a nurse after having a seizure. The nurse practitioner was contacted and directed that the patient be seen the next day. The expected appointment did not take place and was never re-scheduled.³² One patient complained of a possible ankle fracture. The nurse contacted a provider by telephone, who ordered x-rays of the ankle, a splint, and a lay-in. The patient had a severe sprain and was not seen by a provider for two weeks.³³ Patients such as these are at risk of deterioration when medical attention is untimely, and the result can cause harm.

In summary, some of the problems with sick call identified in the previous Court Expert's reports have been corrected. Problems with sick call currently include:

- LPNs are assigned responsibility to perform sick call, which is outside the scope of practice in Illinois.
- Nursing assessments and examinations are inadequate.
- Nurses do not use the patient's medical record during the sick call encounter.
- Patients referred to providers from sick call are not seen timely.

Chronic Disease Management

Methodology: The HCUA was interviewed about the chronic care scheduling processes. The current chronic care schedule, the chronic care patient lists, and the chronic illness medication lists were reviewed. The telemedicine nurse manager, the Wexford hepatitis C physician coordinator, and the UIC Telehealth (HIV and hepatitis) lead physician were interviewed. A

²⁸ V3-9 Health Care Screening (Sick Call).

²⁹ Sick Call Patients #5, 13, 14.

³⁰ Sick Call Patient #2.

³¹ Sick Call Patient #3.

³² Sick Call Patient #6.

³³ Sick Call Patient #7.

chronic care provider was briefly interviewed. The records of 17 patients with chronic care illnesses were reviewed. The Office of Health Services Chronic Illness Treatment Guidelines dated March 2016 and the IDOC Hepatitis C Guidelines December 2015 and 2017 were reviewed as needed.

First Court Expert Findings

The First Court Expert noted that there wasn't a scheduling backlog of chronic care patients. Combination clinics had been started in which all conditions can be addressed at the same visit. One of the two current providers assigned to the chronic care clinics was providing a high quality of care although overall care was not good. The report stated that the providers were not consistently assessing the degree of control accurately. Thirty-four percent of the 66 patients in the hypertension clinic who were not in good control had no change in their plan of care. Only 59% of 70 patients in less than adequate diabetes control had a change in their plan of care. Regardless of the type of insulin patients used as civilians they were all changed to NPH and regular insulin upon arriving at Menard which was described as inappropriate. Three of four patients on anticoagulation had therapeutic anticoagulation levels. Even though 15% of patients in pulmonary clinic had persistent symptoms, all were noted to be in good control which is contradictory as persistent symptoms is inconsistent with good asthma control. Five records of patients in asthma clinic had a degree of control that was overestimated or medications were not adjusted appropriately. Of six patients in seizure clinic who reported seizures since the last clinic only two had a change in therapy. There were delays in care of four of six seizure cases reviewed. Four of eight patients on latent tuberculosis treatment had converted their tuberculosis skin test while at Menard.³⁴ The HCUA presumed that this was a result of inaccurate tuberculosis skin testing and not conversions. This is inappropriate infection control. It was also noted that MCC was using a database that could be used to generate a variety of reports.

Current Findings

We had similar findings to the First Court Expert's findings. However, we identified current and additional findings as follows:

- Patients assigned to chronic care clinics are regularly seen in these clinics.
- MCC continues to utilize combination chronic care clinics, which allows some but not all chronic illnesses to be managed in a single clinic session.
- Problem lists occasionally are incomplete or inaccurate.
- Some providers' chronic care notes were illegible or partially legible; these difficult-to-interpret notes created barriers to the delivery of continuous, comprehensive care.
- Providers at MCC inconsistently document the rationale for clinical decisions and diagnoses in the chronic care progress notes.
- The MCC chronic care providers and nurses do not have access to current, comprehensive electronic medical references, such as UpToDate, in all clinical exam rooms. A few

³⁴ This implies that the patients acquired the disease while at Menard and that there was someone at Menard with active tuberculosis or that the skin tests were inappropriately done. While it may be true that the skin tests were inappropriately done, an tuberculosis outbreak investigation should have been done.

administrative offices distant from the chronic care clinical locations have access to the internet.

- Uncontrolled chronic illnesses with problems that appear to be beyond the expertise of the MCC providers are not referred for specialty consultation.
- There was no documentation that the providers reviewed the MARs at the time of chronic care visits for important data about medication compliance and capillary blood glucoses (CBG).
- A hospitalized patient returned with a prescription for a direct factor Xa inhibitor anti-coagulation medication; the MCC providers immediately stopped this medication and started warfarin. MCC providers were unable to obtain therapeutic anticoagulation in patients we reviewed. This places patients at risk of harm. Newer direct factor Xa inhibitor drugs should be used.
- The practice of treating diabetics on 70/30 insulin (70% long acting and 30% short acting insulin) concomitantly with a sliding scale administration of another short acting insulin puts patients at risk for hypoglycemia.
- The MAR is still completed manually by the nursing staff. Blank months for KOP medication delivery were noted on some patients' MARs. The lack of accuracy of the MARs is a barrier to verifying a patient's compliance with medications and determining the efficacy of the treatment.
- MCC did not screen patients over 50 years of age or individuals with certain high risk clinical conditions for colon cancer as is recommended by all national guidelines. Not one of the 14 MCC patients 50 years of age or older whose records were reviewed had been screened for colon cancer.
- MCC did not calculate 10-year cardiovascular risks for adult patients as directed by the ACC/AHA and IDOC treatment guidelines. Patients with high risk for cardiovascular events were not administered the statin medications and dosages recommended by IDOC Treatment Guidelines and by the American College of Cardiology.
- MCC did not administer age-based and disease-based pneumococcal 13 and 23 and meningococcal adult preventive vaccinations as recommended by the CDC.
- Two (14.3%) of 14 at-risk patients had received pneumococcal 23 vaccination, zero (0%) of the eight at-risk patients had received pneumococcal 13 vaccination, and zero (0%) of the two patients had been administered meningococcal vaccination.
- None (0%) of the five diabetic charts reviewed had documentation that optometry screening for diabetic retinopathy had been performed within the previous year.
- The process to determine eligibility for hepatitis C treatment is excessively lengthy and a barrier to the initiation of treatment. It is not consistent with processes in other correctional facilities and public health systems.
- Only 1 (0.7%) of the 134 patients at MCC with hepatitis C has been treated.

MCC has 1,037 individual patients, or 34% of the prison's population, enrolled in chronic care clinics.³⁵ Forty-one percent of patients at MCC are seen in chronic illness clinics for a single disease. However, wherever possible, multiple chronic illnesses are combined into a single session at the next available chronic care clinic. The MCC Clinic Count report dated May 21, 2018, indicated that 59% of patients with chronic diseases have at least some of their visits in combination clinics. The chronic conditions of a number of patients continue to be managed in single disease chronic care sessions. As discussed in other reports, we find single disease chronic clinic visits inefficient, wasteful, and potentially harmful. This is also consistent with the opinion of the First Court Expert. Patients are seen based on an inflexible schedule as opposed to the degree of control of their illness and do not have their various diseases coordinated into a unified therapeutic plan.

During the week of the experts' visit, the MCC census was 3,036, including 440 patients housed in the nearby Medium Security Unit. The May 2018 Chronic Care roster was as follows:

Chronic Care Clinic	Patients	Prevalence in ADC (3,036)
Asthma	275	9.1%
Cardiac/Hypertension	431	14.3%
Diabetes	136	4.5%
General Medicine	403	13.3%
Hepatitis C	134	4.4%
High Risk/HIV	22	0.7%
Seizure	68	2.2%
Total non-unique patients	1,333	

During the time of the First Court Expert's visit, the chronic care clinics were primarily conducted in the exam rooms on the first floor of the health care building. With the creation of air-conditioned satellite clinics in all of the cell houses, all of the chronic care clinics have been relocated to the cell houses. The only exception are three telehealth specialty clinics: UIC High/Risk, UIC Liver Clinic, and Renal Clinic that continue to be held in the telemedicine exam room on the first floor of the health care building. Chronic care patients in the satellite clinics are seen intermixed with provider sick call and walk-in patients.

Two nurse practitioners and two providers (one is part-time) staff chronic care clinics. The charts of chronic care patients indicate that patients with chronic illnesses are seen regularly at MCC. None of the clinical areas at MCC have access to electronic medical references, although it was reported that a few of the administrative offices in the distant health care building have internet access. When one provider was asked which current electronic medical references he could access, he could not list a single online medical reference that he utilized. This partially explains

³⁵ MCC's chronic care clinic schedule was listed as follows: asthma (January and July), seizure (February and August), cardiac 1 (A-L) (March and September), cardiac 2 (M-Z) (April and October), diabetes/combo (April, August, and December), general medicine (May and November), and hepatitis C (June and December).

some of the clinical decisions and medications prescribed that were not in accord with current national and community standards of care.

The chronic care nurse maintains spread sheets on patients being followed in each of the chronic care clinics, listing the last clinic date and the most recent laboratory test date. The spread sheets also rate the clinic status of each condition as good, fair, poor, and stable. This method of rating degree of control is very limited; it would be more useful if objective criteria were used.

Onsite specialty consultation is limited. Optometry examinations are provided in the health care building for 20 hours per week. UIC HIV infection, UIC liver (hepatitis B and C), and renal consultation and management are provided to MCC patients via the telehealth program. All other specialty consultations are provided at outside private practices and medical centers in southern Illinois and a few in St. Louis, Missouri.

A dedicated nurse manager is assigned to assist and coordinate the telehealth clinics. This nurse is present in the exam rooms during all the UIC High Risk/HIV clinic, UIC telemedicine liver clinic, and the renal telehealth clinic appointments. She coordinates the appointments for these three specialty clinics, manages the completion of hepatitis C pre-treatment database, and tracks the clinical status and lab results of the referrals to UIC liver clinic. This telehealth nurse manager maintains clinically useful spread sheets on patients being followed in the High Risk/HIV clinic that tracks the status of the preliminary workup and approval process for hepatitis C patients.

We examined care of hepatitis C patients at MCC. Patients with hepatitis C are followed in a hepatitis C chronic clinic. When a patient tests positive for hepatitis C, they are followed by facility providers and tested every six months for an APRI level.³⁶ When treatment of hepatitis C is deferred and when there is active virus present, there is a risk of ongoing harm to the patient and ongoing monitoring of liver disease is recommended.³⁷ Yet, except for continuing to obtain an APRI level, providers in hepatitis C clinic do not monitor for cirrhosis or its complications or other possible complications of hepatitis C infection. When patients develop cirrhosis, it is recommended that they receive a baseline EGD to screen for varices and every-six-month ultrasound or CT scan screening to evaluate for hepatocellular cirrhosis. This is seldom done, even when patients have significantly elevated APRI levels. We note that in four death reviews of patients at various facilities who died of complications of hepatitis C, the patients were not monitored with EGD, ultrasound or for their ascites.³⁸ One example at MCC was a patient who had APRI levels indicative of cirrhosis as early as 2012, but the patient failed to receive endoscopy until August of 2015.³⁹ The patient did not have screening for hepatocellular carcinoma until May of 2015. At that time, a liver mass was found on a CT scan but was not timely worked up. Edema

³⁶ An APRI test is the AST to Platelet Ratio Index. The AST is a liver enzyme and platelets are a blood element that are decreased in advanced liver disease. The ratio between the AST and platelets yield a number that correlates with the degree of liver fibrosis. When the APRI reaches > 0.7 there is a greater than 70% chance that there is significant fibrosis.

³⁷ HCV Guidance: Recommendations for Testing, Managing, and Treating Hepatitis C; Last Updated May 24, 2018, American Association for the Study of Liver Diseases and Infectious Diseases Society of America as found at https://www.hcvguidelines.org/sites/default/files/full-guidance-pdf/HCVGuidance_May_24_2018a.pdf.

³⁸ Patients #6, 12, 23, and 28 in Mortality Reviews.

³⁹ Patient #23 Mortality Reviews.

and ascites are complications of cirrhosis. The patient had edema as early as 2012 and ascites was noted on the CT scan in May of 2015, yet the patient was not treated with a diuretic until he had massive ascites over a year later, in June of 2016. The patient ultimately died of complications of his cirrhosis (hepatocellular carcinoma) without ever having a diagnosis of the liver mass known for over a year and without being appropriately treated for the complications of his cirrhosis. It does not appear that physicians knew how to monitor for ongoing liver disease and the hepatitis C clinic does not include monitoring for ongoing liver damage. The purpose of this clinic appears to be to monitor the APRI until the provider refers the patient for treatment. This is inconsistent with IDOC hepatitis C guidelines and places patients at risk of harm, and has resulted in preventable or possibly preventable deaths.

The IDOC hepatitis C guideline states that workup of all hepatitis C positive patients, including the decision to refer to the UIC Liver Telemedicine Clinic, will be the sole responsibility of the IDOC providers at each individual IDOC facility.⁴⁰ This does not occur, as Wexford has inserted an additional utilization barrier into this process. When the APRI is elevated above 1.0 or above 0.7 with low platelet counts or albumin, facility physicians are to refer patients to a Wexford corporate internist who makes the decision on whether to refer the patient to UIC.

After the facility physician refers the patient to the Wexford corporate hepatitis C internist, a pre-approval packet is also forwarded to the Wexford corporate internist, who reviews the database and orders pre-treatment tests. This Wexford corporate hepatitis C internist must approve all requests for diagnostic workups including EGD, ultrasound, fibroscan, additional lab tests, and the referral to the UIC Telemedicine Liver Clinic.⁴¹ This physician stated that she only is involved with patients who are referred to her for approval to start the process for hepatitis C treatment; she does not track or receive any data on patients at MCC with hepatitis C who have not been referred to her office.

Based on mortality records and on case reviews we performed, it appears that referral to the Wexford corporate hepatitis C internist is significantly delayed. Because these referrals are not tracked through the normal utilization process and because facility providers do not always document when they are referring to the Wexford corporate hepatitis C internist, it is not clear when patients are referred based on the medical record. Because the Wexford corporate hepatitis C internist does not write notes to the medical record, it is also unclear what her therapeutic plan is for the patient. At MCC, a chronic care nurse maintains a spreadsheet tracking patients who have hepatitis C, including those with referrals to the Wexford corporate hepatitis C internist. Review of three hepatitis C referrals indicated that once the referral was received by the Wexford corporate hepatitis C internist, the required diagnostic testing was quickly approved. The Wexford corporate hepatitis C internist did state that she was aware that the current IDOC policy does not prioritize patients co-infected with hepatitis C and HIV for expedited treatment. She also stated that she was aware that co-infected patients in the community who

⁴⁰ Hepatitis C Guidelines, December 2017.

⁴¹ The Wexford corporate hepatitis C internist does not have to go through the Wexford collegial process to obtain approval but is authorized to approve these tests directly.

have F2 fibroscans are advanced to treatment as opposed to IDOC's practice of treating only those with F3 and F4.

In April 2018, 134 men were on the Hepatitis Report maintained by the chronic care nurse. Only one (0.7%) had completed hepatitis C treatment. This is consistent with statewide data that shows that approximately 2.9 patients are treated per facility per year.⁴² Another 12 (9.0%) were in the process of being worked up. Even though IDOC guidelines⁴³ mandate testing of HCV viral load on all patients, 17 (12%) of the 134 hepatitis C patients have not yet had their HCV RNA viral load tested. 87.3% of the hepatitis C patients have not yet had a fibroscan performed, even though the IDOC Hepatitis C Guidelines mandate that all patients have fibroscans done as part of their initial evaluation. IDOC restricts HCV treatment to patients with APRI score greater than or equal to 1.0 or with APRI scores between 0.7 and 0.99 with additional abnormal labs and high risk conditions, or advanced liver disease. This threshold limits the number of patients who are eligible for treatment. The process of accessing UIC also has considerable barriers. These barriers limit the numbers of patients treated and cause unnecessary delays in treatment that harm patients.

MCC Hepatitis C Report April 2018

Category	Number	% of MCC Population
Total Hepatitis C Patients	134	4.4%
Total HCV Patients with HIV infection	0	0%
Total HCV Patients currently on treatment	0	0%
Total Completed HCV treatment	1	0.7%
Total with HCV RNA viral load	117	87.3%
Total without HCV RNA viral load	17	12.7%
Total with a Fibroscan	24	17.9%
Total without a Fibroscan	110	82.1%
Total with APRI ≥ 1.0	10	7.5%
Total with APRI ≥ 1.0 in workup	7	70% 3 release dates ≤ 12 mos.
Total APRI ≥ 1.0 with Fibroscans	5	50%
Total with APRI ≥ 0.7 and ≤ 1.0	16	11.9%
Total with APRI ≥ 0.7 and ≤ 1.0 in workup	3	19% 1 F3 with release date ≤ 12 mos.
Total APRI ≥ 0.7 and ≤ 1.0 with Fibroscans	8	50%
Total in Workup	10	7.5%

A patient with new onset atrial fibrillation was started on a direct factor Xa inhibitor anticoagulant by the hospital. The MCC providers immediately changed the anticoagulant medication to warfarin, medication that requires frequent testing and dose modification. There was no justification written in the provider note about this change. Over the next 150 days, 92% of the patient's anticoagulation tests (INR) were either above or below the therapeutic range,

⁴² Data we received from UIC is that for the three years 2015 through 2017 inclusive, 227 patients were treated for hepatitis C. This is approximately 2.9 patients per facility per year.

⁴³ Hepatitis C Guidelines December 2017.

resulting in nine dosage adjustments. At the time of the Experts' site visit, five patients were taking direct factor Xa inhibitors and 12 were prescribed warfarin. It was reported that direct factor Xa inhibitors are non-formulary and require a collegial approval. It is in the best interest of the patient and the institution that the preferred choice of oral anticoagulation be a medication in the direct factor Xa inhibitor class, especially in light of the inability of MCC providers to obtain therapeutic anticoagulation levels.

The clinical care provided to a number of patients at MCC with chronic illnesses had deficiencies and were not in accord with national standards of care. The providers did not consistently document the rationale for the selection of medications, changes in the dosages, and types of medications. The MCC provider progress notes are occasionally illegible; these difficult-to-interpret notes complicate the facility's ability to provide safe and quality care to its patient population. There was no documentation in any of the charts audited that the providers had reviewed the MAR for compliance of the prescribed medications or for the results of capillary blood glucose testing; clinical decisions were made without this important clinical data. In the charts of the five diabetics we reviewed, not a single one of these five patients have been screened by the facility's optometrist on an annual basis as mandated by the IDOC's diabetes treatment guidelines. This is the only one of the five IDOC facilities visited by the experts that was not meeting this IDOC diabetic retinopathy screening guidelines.

The primary and secondary prevention of arteriosclerotic cardiovascular disease (ASCVD) provided was not in alignment with current national and IDOC standards. The providers did not even once calculate patients' 10-year ASCVD risk score, which would have assisted them in determining the proper preventive medication and dosage. Patients were prescribed low intensity HMG-CoA reductase medications (statins) when high-intensity statins at higher dosages were indicated. Non-statin anti-hyperlipidemia (niacin, gemfibrozil) were prescribed without any documented clinical justification; these categories of medication have limited impact on the prevention or progression of cardiovascular disease. The providers concomitantly order 70/30 insulin and sliding scale short acting insulin before meals. The simultaneous use of these two types of short acting insulin puts diabetic patients at risk for hypoglycemic attacks. Fifty years of age and older patients are not regularly screened for colon cancer, putting patients at risk for the development of preventable cancer and delayed identification of potentially treatable colon cancer. Not one (0%) of 14 patients 50 years and older had been screened for colon cancer. The providers do not adhere to the CDC's recommendations for the vaccination of adults. MCC providers do not order pneumococcal 13 vaccinations for patients 65 years of age or older and immunocompromised individuals, or meningococcal vaccinations for HIV patients; or consistently order pneumococcal 23 vaccination for patients with chronic illnesses, patients 65 years of age or older, and those with immunocompromised conditions.

Many of the records of patients with chronic illnesses were found to have concerns about the clinical care provided. The following patient summaries highlight the concerns and the findings noted above.

- This patient is 73-year-old male whose diagnoses included hypertension, dyslipidemia, hepatitis C, and schizophrenia.⁴⁴ Due to the system's failure to order a HCV RNA viral load, which was found to be negative in 2018, he was erroneously diagnosed with ongoing hepatitis C infection for many years, resulting in multiple unnecessary lab tests and provider visits. His hypertension was adequately controlled but he inexplicably was not seen in the hypertension chronic care clinic for an 11 month period from September 2016 until August 2017. Based on his medication, it is likely that this patient was being treated for coronary artery disease and angina. He has had four episodes of chest pain in the last four months and he was prescribed nitroglycerin tabs. However, there was not a single mention of the etiology of his chest pain in the medical chart nor is angina listed on the patient's problem list. The progress notes about the chest pain were brief and did not adequately assess the clinical characteristics of the chest pain. His 10-year ASCVD risk score was not calculated by the MCC providers. (The score was determined to be an extremely high 21%). The providers have failed to prescribe a high-intensity statin as clearly indicated by his extremely high cardiac risk score and the presumptive diagnosis of angina. This patient is not receiving the same standard of care as would be received in the community. This 73-year-old has not been screened for colon cancer and has not been offered or administered nationally recommended adult immunizations (pneumococcal 13 and 23 vaccines). The failure of the providers to follow national preventive, treatment, and screening standards puts the health of this patient at risk.
- This 23-year-old with a history of seizure disorder had not initially provided IDOC providers with a complete history of his medical problems.⁴⁵ Once the patient told the MCC providers that he had previously taken anti-epileptic medications, even though he had not had a seizure in six to eight months; his seizure medications were restarted. Although drug levels were in the therapeutic range, the patient reported at the 2/3/18 chronic care visit that he was having one to two unverified seizures per month. This patient's history was complicated; additional past clinical history and treatment was needed to assure that this patient needs to be taking seizure medications and that the currently prescribed medication is appropriate. The MCC provider did not document that clinical records of the patient's care in the community were requested. The provider did not request consultation with a neurologist. The MARs document that the patient is taking only 30-50% of his seizure medication; yet the provider did not comment on this lack of compliance and likely did not even review this important clinical information during the chronic care clinic visits, nor comment on the presence of therapeutic carbamazepine drug levels in a non-compliant patient. The failure to monitor this patient's compliance with medication and seek neurology consultation jeopardizes the health of this complex individual.

⁴⁴ Chronic Care Patient #1.

⁴⁵ Chronic Care Patient #2.

- This patient is a 52-year-old male with a history of HIV infection, seizure disorder, and intravenous drug use.⁴⁶ His problem list also noted hypertension, but he was not on anti-hypertensive medications and his blood pressures were within acceptable range. MCC consulted with a neurologist when the patient's seizures were uncontrolled. The reports from two return visits to the neurologist in 2017 were not in the medical record. The latest visit to the clinic suggested the seizures were not fully controlled. The provider should have, but did not, order immediate drug levels of the anti-seizure medications. The patient's HIV was moderately well controlled; however, he has not been administered the nationally recommended pneumococcal 13 and 23, and meningococcal vaccinations. This 50-year-old patient has not been screened for colon cancer; this is not in accord with national standards of care. This patient has had lacunar infarcts of his brain, a sign of arteriosclerotic cerebrovascular disease. He should have been prescribed a high-intensity statin.
- This 69-year-old male with hypertension also had a Left Bundle Branch Block (LBBB) that was not noted on his problem list.⁴⁷ He had a number of biannual physicals but has never been screened for colon cancer, had never had his 10-year ASCVD risk calculated (it was extremely high 21.6%), and he had never been administered pneumococcal vaccinations. In spite of his elevated cardiac risk and LBBB, he has not been started on a high-intensity statin. This patient has not received a level of care that approaches that available in the community.
- This patient is a 43-year-old male with diabetes type II, hypertension, hyperlipidemia, and asthma.⁴⁸ He has been seen regularly in a combined chronic care clinic. His diabetes was not optimally controlled but the providers have appropriately initiated and increased the dosage of an additional medication (glipizide). There was no documentation that the patient's feet had been examined for sensory neuropathy. This diabetic patient has been housed at MCC for six months and has not yet been seen by an optometrist. This is an unacceptable delay for a patient at risk for diabetic retinopathy. Although recommended by the IDOC Treatment Guidelines, the providers did not calculate this patient's 10-year ASCVD risk score (it was determined to be 12.6 %). As recommended for diabetics with a high 10-year risk of a cardiovascular event, this patient should have been started on a high-intensity statin. The patient has not been administered the pneumococcal 23 vaccine, which is nationally recommended for all diabetics and asthmatics.
- This 33-year-old asthmatic who failed to tell IDOC that he had asthma was appropriately treated until he presented with an acute asthma attack.⁴⁹ The type of nebulization administered (two drugs) is generally used for COPD patients. A short burst course of prednisone and an inhaled corticosteroid inhaler in addition to albuterol should have been provided to this patient, who was at heightened risk for another exacerbation in the

⁴⁶ Chronic Care Patient #3.

⁴⁷ Chronic Care Patient #4.

⁴⁸ Chronic Care Patient #5.

⁴⁹ Chronic Care Patient #6.

near future. Montelukast is not recommended to be used in a patient whose asthma is not stabilized. The patient was not administered the pneumococcal 23 vaccine that is nationally recommended for all asthmatics.

- This 43-year-old patient had diabetes type II and two gunshot wounds (GSW).⁵⁰ The GSWs were not noted on his problem list. He had a HbA1C of 6.8% in June of 2015. Patients with HbA1C \geq 6.5% are diagnosed as having diabetes. The providers failed to acknowledge this abnormal test and did not counsel the patient about lifestyle changes that might impact on the progression of diabetes, and did not initiate medication to address this newly diagnosed type II diabetes. Two year later, the HbA1C was repeated, again was found to elevated, and a diabetic oral agent was prescribed. The two-year delay was unacceptable and put the patient at risk for diabetic morbidity. The patient had an optometry visit on 6/15/17, but funduscopy exam of the retina for signs of diabetic retinopathy was not performed. National adult immunization guidelines recommend that all diabetics receive a pneumococcal 23 vaccine; this has not been done. The patient's 10-year ASCVD risk score should have been assessed, but it was not calculated. The 2018 MARs revealed that the patient was taking only one half of his KOP diabetic medication. The misunderstanding or non-compliance with this prescribed diabetic medication should have been noted in the February and April 2018 diabetes clinic. The chronic care providers are not routinely reviewing the MARs.
- This patient is a 48-year-old with diabetes and hypertension.⁵¹ Diabetic medications were incrementally increased until an acceptable level of control was reached. However, there was a period of nine months (3/23/17 to 12/21/17) when his HbA1C's were 9.2% and 8.3% before the indicated increase in medications was ordered. Control would have been reached more quickly if medication adjustment had been made more expeditiously. Diabetics are to be screened annually for the diabetic retinopathy; inexplicably, this diabetic has not been screened for the last four years. In February 2018, the MAR indicated that the patient had not received his KOP diabetic and hypertensive medications; however, there was no comment on this potential lack of compliance or failure to deliver his medications in the progress notes. The failure to review this important clinical information in the MAR put the patient's health at risk. The MCC providers are not following national recommendations to administer a second pneumococcal 23 vaccine five years after the first vaccination.⁵² The providers are not adhering to IDOC treatment guidelines and national recommendations to calculate the 10-year risk of ASCVD for adult patients with diabetes and, if the risk is greater than or equal to 7.5%, to initiate a high-intensity statin. His risk was determined to be greater than 20%, yet a high-intensity statin was not prescribed.⁵³ This patient's health care is not being properly protected.

⁵⁰ Chronic Care Patient #7.

⁵¹ Chronic Care Patient #8.

⁵² CDC Recommended immunization Schedule for Adults 2018.

⁵³ IDOC Office of Health Services Treatment Guidelines Hyperlipidemia March 2016.

- This patient is a 60-year-old with insulin-requiring diabetes and coronary artery disease who had only been at MCC for a few weeks.⁵⁴ The intake HbA1C of 6.7% suggests that the patient's diabetes had been adequately treated prior to his incarceration. The decision to add additional short acting regular insulin (on a sliding scale) to this patient who was already receiving short acting insulin 19.5 units before breakfast and 18 units before dinner (30% of his 70/30 insulin, 65U/am and 60U pm, is short acting regular insulin) put the patient at increased risk of hypoglycemic episodes. The providers did not adhere to IDOC treatment guidelines by failing to prescribe a high-intensity statin in this diabetic with a documented history of coronary artery disease. They also failed to calculate his 10-year ASCVD risk (determined to be 19.1%), which should have led them to prescribe a high-intensity statin.⁵⁵ The providers missed an opportunity to administer the pneumococcal 23 vaccine to this diabetic as is recommended by both national adult immunization guidelines⁵⁶ and by IDOC treatment guidelines.⁵⁷
- This patient is a 59-year-old with hypertension, hyperlipidemia, HIV infection, and a history of tobacco abuse.⁵⁸ His hypertension was only moderately controlled, but his medication had been increased. His HIV infection was well controlled; his medications have been thoughtfully modified. The patient was not given pneumococcal 13 and 23 and meningococcal immunizations. This is contrary to national guidelines.⁵⁹ The MCC providers did not calculate the patient's 10-year ASCVD risk score (determined to be 14.4%); this is not in accord with IDOC treatment guidelines.⁶⁰ There was no documented justification for the use of gemfibrozil; this patient should have been prescribed a high-intensity statin. The patient has received four biannual physicals since he was 50 years old yet he was not offered screening for colon-rectal cancer. National guidelines recommend that individuals aged 50 to 75 years should be screened for colon cancer.⁶¹
- This patient is a 57-year-old male with a history of coronary artery disease (CAD) with stent placements, paroxysmal atrial fibrillation on chronic oral anticoagulation, degenerative joint disease, fatty liver, and tobacco use.⁶² The placement of coronary artery stents, fatty liver, and chronic anticoagulation were not noted on the problem list. Upon return from the hospital where he been prescribed apixaban anticoagulant on 11/6/17, the Graham providers switched the anticoagulation to warfarin 5mg/day. On 11/21/17, the patient was transferred to MCC. His anticoagulation treatment was poorly controlled on warfarin: 92% of his 13 INRs over the last five months (11/10/17 to 4/23/18) were non-therapeutic. On nine occasions, the warfarin medication was stopped or the dose changed. The providers' notes did not always document the reason for the dosage

⁵⁴ Chronic Care patient #9.

⁵⁵ IDOC Office of Health Services Treatment Guidelines Hyperlipidemia March 2016.

⁵⁶ CDC Recommended immunization Schedule for Adults 2018.

⁵⁷ IDOC Office of Health Services Treatment Guidelines Diabetes March 2016.

⁵⁸ Chronic Care Patient #10.

⁵⁹ CDC Recommended immunization Schedule for Adults 2018.

⁶⁰ IDOC Office of Health Services Treatment Guidelines Hyperlipidemia March 2016.

⁶¹ USPSTF Colorectal Cancer Screening June 2016.

⁶² Chronic Care Patient #11.

adjustments or why/when anticoagulation was temporarily stopped or held. The lack of comprehensive progress notes made it extremely difficult to track the care that was being provided to this patient. It is risky to continue to treat this patient with warfarin. It would be in the best interest of the patient and the institution if he was prescribed a direct factor Xa inhibitor that does not require frequent testing and dose adjustment, especially since providers at MCC were unable to obtain therapeutic control. This patient should have been administered pneumococcal 23 vaccine⁶³ and should have been screened for colon cancer;⁶⁴ neither one of these were performed. The provider notes were rarely adequately informative and were occasionally illegible. This jeopardizes MCC's ability to provide continuity of care to this complex patient. There was no rationale in the progress notes documenting the clinical reason that this patient was receiving fenofibrate. He was also prescribed a high-intensity statin, but at a dose that is less than recommended for a patient with arteriosclerotic coronary health disease.⁶⁵

- This is a 54-year-old patient with hypertension, diabetes-type II, hyperlipidemia, and an EKG suggestive of a previous myocardial infarction.⁶⁶ His diabetes and hypertension were adequately controlled. This was the only patient that we reviewed at five IDOC facilities that was appropriately administered two pneumococcal 23 vaccines. The MCC staff failed to calculate the patient's 10-year ASCVD risk score (determined to be 19.6%) or take into account his past history of a previous inferior wall MI when they prescribed a moderate-intensity rather than a high-intensity statin, as was recommended in the IDOC treatment guidelines.⁶⁷ The patient was prescribed niacin, presumably as part of the treatment of his hyperlipidemia, but there was no justification documented in the chart for the usage of this medication. The patient did not have an eye exam in the last two and a half years; diabetics are recommended to have annual exams for diabetic retinopathy.⁶⁸ This over 50-year-old patient was not screened for colorectal cancer.⁶⁹
- This patient is a 55-year-old with a complicated to treat and difficult to control seizure disorder.⁷⁰ His medications were changed a number of times, with the phenytoin dose changing from 400mg/day to 500mg/day to 200mg BID, and his levetiracetam starting at 500mg BID and then increasing to 1000mg BID, then back to 500mg BID. His phenytoin levels were tested nine separate times; five exceeded the therapeutic range, one was below the therapeutic level, and three were at the recommended levels. Providers had difficulty in maintaining the phenytoin level in the therapeutic range. Consultation with a neurologist was clearly needed but was never requested. The provider and chronic care progress notes did not document or justify the reason for the medication adjustments. The lack of comprehensive provider notes made it difficult to understand the course of

⁶³ CDC Recommended immunization Schedule for Adults 2018.

⁶⁴ USPSTF Colorectal Cancer Screening June 2016.

⁶⁵ IDOC Office of Health Services Treatment Guidelines Hyperlipidemia March 2016.

⁶⁶ Chronic Care Patient #12.

⁶⁷ IDOC Office of Health Services Treatment Guidelines Hyperlipidemia March 2016.

⁶⁸ IDOC Office of Health Services Treatment Guidelines Diabetes March 2016.

⁶⁹ USPSTF Colorectal Cancer Screening June 2016.

⁷⁰ Chronic Care Patient #13.

care. A new provider would struggle to comprehend the care being provided to this patient. The MCC providers must request specialty consultation for patients with conditions that do not readily respond to initial treatment. National standards recommend that all patients over 50 years of age be screened for colon cancer using a validated screening methodology,⁷¹ but this patient has never been screened. His 10-year ASCVD risk score has not been calculated by the MCC providers.⁷²

- This patient is a 65-year-old with diabetes, hypertension, hyperlipidemia, obesity, and hypothyroidism.⁷³ His problem list did not note obesity and hypothyroidism. This recently incarcerated (1/28/18 admission) patient's diabetes and hypertension were moderately well controlled. To date, the patient was not evaluated for diabetic retinopathy. His statin was changed from atorvastatin 10mg/d to simvastatin 10mg/d, a low-intensity statin. The providers, in violation of the IDOC treatment guidelines, failed to calculate his 10-year ASCVD risk score (determined to be extremely high, 28.4%).⁷⁴ If they had done this, perhaps they would have prescribed a high-intensity statin to minimize his risk of stroke and heart attack. Contrary to national standards, this patient has not been administered pneumococcal 13 and 23 immunizations.⁷⁵ The patient has not been screened for colorectal cancer; this is not in accord with national guidelines that recommend that screening begin at 50 years of age.⁷⁶
- This patient is a 58-year-old with hepatitis C who was unsuccessfully treated with interferon and ribavirin in 2009-2010.⁷⁷ Liver biopsy in 2009 revealed extensive periportal fibrosis and moderate bridging (stage 2). On 9/19/16, the hepatitis C clinic deemed this patient eligible for treatment; 20 months later, treatment had not yet been initiated. On 3/29/18, a fibroscan was read as F4 (advanced liver scarring, cirrhosis). Eighteen of the months of delay appear to have been due to internal delays at MCC. At least two months of the delay were due to the workup that is required by the UIC Hepatitis C clinic, which includes psychiatric evaluation and EGD. Psychiatric evaluation and EGD are not recommended evaluations prior to treatment with the newer anti-hepatitis C medications.⁷⁸ The HCV RNA viral load was not located in the medical record but was eventually located on the Hepatitis Report that is maintained by the telemedicine nurse manager. The lengthy wait to retreat this patient with advanced hepatitis C is unacceptable and puts the patient's health at risk. There is no documentation in the

⁷¹ USPSTF Colorectal Cancer Screening June 2016.

⁷² ACC/AHA ASCVD Risk Score.

⁷³ Chronic Care Patient #14.

⁷⁴ IDOC Office of Health Services Treatment Guidelines Hyperlipidemia March 2016.

⁷⁵ CDC Recommended immunization Schedule for Adults 2018.

⁷⁶ USPSTF Colorectal Cancer Screening June 2016.

⁷⁷ Chronic Care Patient #14.

⁷⁸ Recommended Assessments Prior to Starting Antiviral Therapy as found in HCV Guidance: Recommendations for Testing, Managing, and Treating Hepatitis C, last updated May 24, 2018: The American Association for the Study of Liver Diseases and the Infectious Diseases Society of America as found at: https://www.hcvguidelines.org/sites/default/files/full-guidance-pdf/HCVGuidance_May_24_2018a.pdf.

medical record that this patient was administered the pneumococcal 23 vaccination.⁷⁹ The patient was over 50 years old but had not been screened for colon cancer.⁸⁰

- This patient is a 66-year-old with hepatitis C infection.⁸¹ Sixteen months after having been deemed eligible for hepatitis C treatment, the patient's workup was still not completed. Twelve months of this delay was due to the internal processes at MCC. His liver fibroscan on 2/19/18 was read as F4 (advanced liver scarring, cirrhosis). The UIC Telemedicine Liver Clinic requested additional labs, EGD, liver ultrasound, and dermatology consultation, which also contributed to the long processing time. The EGD and liver US was pending collegial approval by Wexford, although the experts were informed that Wexford's Hepatitis C coordinator could directly approve these tests. Most institutions do not require such extensive pre-treatment diagnostic testing prior to treatment with the newer anti-hepatitis C medications. The lengthy wait to initiate treatment for hepatitis C puts this patient's health at risk. Colon cancer screening was not provided to this patient, who is over 50 years old.⁸²
- This patient is a 50-year-old male with hepatitis C.⁸³ Twelve months after having been deemed eligible for hepatitis C treatment, the patient's workup was still not completed. His liver fibroscan on 3/29/18 was reported as F4 (advanced liver scarring, cirrhosis). The UIC Telemedicine Liver Clinic's request for a psychiatric consultation has prolonged the waiting time. Most institutions do not require such extensive pre-treatment diagnostic testing including psychiatric consultation prior to treatment with the newer anti-hepatitis C medications. Colon cancer screening has not been performed on this patient, who is over 50 years old.⁸⁴

Urgent/Emergent Care

Methodology: We interviewed the Nursing Supervisor (IDOC), toured the medical clinic, and assessed the availability and functionality of emergency equipment and supplies. We also reviewed emergency drills, CQI reports, written directives, and medical records. Medical records were selected from the list provided by MCC of emergency room visits beginning in January 2017. This list includes the reason for the ED visit. Records selected for review were those conditions sensitive to ambulatory care, such as seizure, withdrawal, infection, diabetic complications, abdominal pain, chest pain, etc. These were used to evaluate nursing response to emergencies. A total of five records were reviewed. We also reviewed records of five patients who were hospitalized for ambulatory sensitive conditions to assess whether their pre and post hospital physician care was adequate.

⁷⁹ CDC Recommended immunization Schedule for Adults 2018.

⁸⁰ USPSTF Colorectal Cancer Screening June 2016.

⁸¹ Chronic Care Patient #16.

⁸² USPSTF Colorectal Cancer Screening June 2016.

⁸³ Chronic Care Patient #17.

⁸⁴ USPSTF Colorectal Cancer Screening June 2016.

First Court Expert Findings

The records of nine patients were reviewed, and more than half demonstrated significant deficiencies in patient care. These deficiencies included absence of important information from the hospital, inadequate assessments by nursing staff, untimely physician follow up, and failure to monitor or intervene.⁸⁵

Current Findings

MCC provides basic CPR and first aid. Emergency response bags are kept in the first aid room in the main clinic, the armory between north and south buildings, and at the medium security unit. These bags can be transported by responding nursing staff to the site. This equipment and supplies are used to conduct an initial triage, provide first aid, and CPR. The first aid room, North II Medical Clinic, and MSU are equipped to provide space and equipment to treat medical emergencies. The nursing staff must make a clinical decision to transport a patient in a medical emergency to the first aid room in the main clinic, which has the most extensive emergency equipment, or to the use an outlying room.

The emergency bags contain first aid supplies, personal protective equipment, stethoscope, blood pressure cuff, cervical collar, equipment and supplies to start an IV, and a few medications (i.e., glucagon, an epi pen, aspirin). The contents of the bags are standardized but not sealed. We checked the contents of several of these bags and found them to be adequately supplied. We discussed with the nursing supervisor who accompanied us the advantages of using plastic numbered locks to indicate a bag that was fully stocked and ready for use. The first aid room has, in addition to the emergency bags, two transport chairs, an automatic external defibrillator (AED), crash cart, stretcher with backboard, portable ambu-bag, portable oxygen, EKG machine, suction, nebulizer, and oto-ophthalmoscopes. A mobile crash cart with AED is also available in the infirmary and in the MSU clinic. Disaster trunks which contain triage tags and more first aid supplies are located in the first aid room, the armory between north and south housing units, in the MSU clinic, and in the North II clinic area.

The presence and functionality of the emergency response equipment is checked each shift and documented on a daily equipment log. No outdated supplies were found in the emergency bags we checked, but we did find outdated material in the disaster trunk in the armory. We checked the AED and other emergency equipment and found all were functional. Menard Health Services Policy V1-25 lists the contents and location of first aid kits available in housing units, program areas, and vehicles, but we did not evaluate the accuracy of this information.

The Menard ID #04.03.108 and Menard Health Services Policy and Procedure V1-26 P-112 are consistent with one another. Both require emergency response drills twice a year on each shift. In addition, one mass casualty or disaster drill must be conducted annually. Actual practice appears to conform to these directives. The mass casualty drill for 2017 was reviewed and found to be thorough, with good multidisciplinary participation and candid critique of strengths and weaknesses. The results were presented to the CQI committee; however, there was no specific

⁸⁵ Lippert Report Menard pp. 23-24.

plan to improve areas that were considered weaknesses. We also reviewed the emergency response drills for 2017 and 2018. They are sufficient in number and there is some critique, although not very thorough. These are also presented to the CQI committee. The minutes of the CQI meetings do not reflect any presentation of trends, discussion, analysis of issues, or plans for improvement in emergency response.

Emergency responses are documented in a log that includes the date, time, inmate name and number, location, and diagnosis. Only two emergencies were listed for 2017. When we inquired about this, the HCUA said that the nurses had stopped documenting in the log. She discovered this when she asked for the urgent care log in February. Entries since then are much more numerous than those recorded for 2017. We selected five patient charts to review from the list provided by MCC of emergency room visits beginning in January 2017.

Incomplete or inadequate nursing assessments were discussed in the earlier section on Nursing Sick Call. Two of these patients were seen by nurses for urgent complaints. One was seen for abdominal pain and the nurse assessed the patient using the protocol for non-specific complaints.⁸⁶ The assessment of his condition would have been more thorough if the protocol for abdominal pain were used. This patient had been seen in the ED three days earlier and diagnosed with diverticulitis. The nurse contacted the provider and was given a verbal order for a liquid diet. The provider did not see the patient for six days after his return from the ED. The other patient was seen urgently for priapism and the only documentation is the outbound note that he was sent to the ED.⁸⁷ The nurse conducted no assessment and did not even take the patient's vital signs.

- The first patient was seen in nursing sick call on 4/16/2018 for a boil on his buttocks that had been present for one and a half weeks.⁸⁸ The nursing assessment was incomplete. He was referred to see the provider the next day. However, he was not seen for five days, at which point an antibiotic was ordered. No labs or wound care was ordered. The provider did order a follow-up appointment in four to five days. The patient was not seen for eight days and at this encounter was sent to the ED because he was having lower abdominal pain. There is an outbound note, but it contains minimal information. Upon his return, the inbound note documents the medications and dressing change recommendations that were on the patient discharge summary from the ED visit. He did not see a provider for another two days. The nursing assessment of this patient's condition was incomplete, access to definitive care was delayed, and he was treated symptomatically with antibiotics without a thorough work up. Documentation of the ED visit was not obtained from the hospital and he was not seen promptly upon his return to MCC. This is a patient whose condition deteriorated because it was not managed in a timely and clinically appropriate manner by providers at MCC.

⁸⁶ Sick Call Patient #4.

⁸⁷ Sick Call Patient #5.

⁸⁸ Urgent/Emergent Care Patient #1.

- Another patient whose ED visit could have been avoided on 4/23/2018 had been seen in the emergency room on 11/1/2017 because of acute urinary retention.⁸⁹ He was diagnosed with septicemia resulting from bladder infection. He returned to MCC three days later with an indwelling catheter and a recommendation to see a urologist in two to three weeks. The provider tried to remove the catheter twice only to have another one reinserted because the patient could not urinate. He was discharged to general population and returned three weeks later because the catheter was not draining and had clots of blood in the tubing. A new catheter was inserted. He saw the urologist the next day, or five weeks after it was recommended, rather than two to three weeks later. The urologist recommended cystography, dilatation, and bladder biopsy for a chronic urinary tract infection. None of these procedures were completed and he continued with an indwelling urinary catheter until 1/18/2018, when it was removed at his request. On 4/23/2018, he was unable to urinate and was sent to the ED. He was hospitalized, and a prostatectomy was done. His discharge diagnosis was sepsis secondary to urinary tract infection with underlying severe BPH and possible nephritis. A cardiology consult was recommended four weeks post discharge, but has not been done per direction from the facility Medical Director. There is no note documenting the rationale for not having a cardiology consult on the patient. This patient would have benefited from prostate surgery that was worked up and done as a planned procedure. The delay in scheduling urology consults and diagnostic procedures resulted in an avoidable emergency and unplanned surgery. The prolonged reliance on an indwelling catheter to relieve urinary retention harmed the patient because of the increased risk of infection.⁹⁰

We also reviewed five patients who were hospitalized, in order to assess whether the hospitalization might have been prevented and whether follow-up care was appropriate. We, indeed, found preventable hospitalization and poor care in general. We found problems with all records reviewed.

- One patient had hypertension and elevated cholesterol as early as 2008.⁹¹ However, due to his age (46), his 10-year heart disease risk did not warrant use of a statin in 2008. In 2008, the patient did have EKG findings (T wave abnormalities suggesting lateral ischemia), but these abnormal findings did not appear to result in follow-up investigation. On 10/21/17, the patient sustained a myocardial infarction with cardiac arrest, for which he was hospitalized. He was resuscitated and was found to have stenosis of his left main coronary artery, for which he received a stent. The patient was discharged on a high-intensity statin, Brilinta, a beta blocker, Lisinopril, and aspirin, all of which he received upon return to the facility. The Brilinta was changed to a formulary medication (Plavix),

⁸⁹ Urgent/Emergent Care Patient #5.

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Retention in Men - P



⁹¹ Patient #1 Specialty Consultation and Hospitalization.

which is a reasonable substitution. A cardiologist saw the patient on 11/14/17 after the hospitalization. The cardiologist recommended follow up in three months, which did not occur. The specialty care tracking log documented the 11/14/17 visit, but no other referrals were documented. We could not find any documentation that the patient's heart condition was being monitored in chronic care visits. We could not locate the patient on the chronic illness roster provided to us by IDOC in preparation for our visit. A doctor did see the patient in follow up of the cardiology visit, but there were no further provider visits until 3/30/18. On that day, the doctor noted that the patient had a prior myocardial infarction. The doctor ordered no laboratory tests and did not enroll the patient in chronic care clinic. His coronary artery disease was not being monitored. We brought this to the attention of the HCUA, so he could be enrolled.

- Another inmate had problems listed as diabetes, hypertension, and asthma.⁹² However, the patient actually had chronic obstructive lung disease (COPD). Asthma and COPD are different diseases and not managed in the same manner. The patient was described in multiple chronic care visits as having various stages of asthma (mild persistent, moderate persistent, etc.) when he actually had COPD based on radiologic examinations. These descriptions for asthma were not pertinent to his actual diagnosis. There was no evidence in the medical record that the patient had a pulmonary function test, the cornerstone of diagnosis and management for COPD and asthma.

We reviewed the record for this patient for a two-year period. Over those two years the patient was seen on seven occasions for chronic care. The patient was diagnosed on all those occasions as having asthma, even though a chest x-ray on 10/26/17 showed hyperinflation and fibrotic changes consistent with COPD, and even though a CT scan of the abdomen incidentally showed fibrosis of the lung with emphysema consistent with COPD. The patient had wheezing on several occasions that were treated with steroids. Pulmonary function testing should have been ordered to clarify his diagnosis. Also, the wheezing may have been due to other conditions, including heart failure. Additional testing was indicated, specifically an echocardiogram. The patient should have been referred to a pulmonologist for clarification of his diagnosis so appropriate therapy could be provided, or MCC providers should have ordered a pulmonary function test. The patient was not on an anti-cholinergic inhaler, never had a pulmonary function test, had no assessment of exercise capacity, did not have an evaluation for the need for oxygen therapy (even though having an oxygen saturation of 85% on 1/9/17), and had no consideration for pulmonary rehabilitation.⁹³ This patient should also have been considered for evaluation of heart failure.

The patient was 82 years old in 2015. In 2015, he had a 43% 10-year risk of heart disease and should have been on a moderate or high-intensity statin and aspirin. Additionally, the

⁹² Patient #6 Specialty Consultation and Hospitalizations.

⁹³ Generally, persons with a room air oxygen saturation of less than 88% should be started on oxygen therapy. This person should at least have been tested to determine if oxygen supplementation was necessary. If the facility physicians were untrained in how to do this, referral to a pulmonologist was indicated.

patient had an EKG in 2013 that showed T wave abnormalities consistent with possible ischemia. Despite this, the patient was not on a statin or aspirin until 11/17/17, when he was started on a low-intensity statin. This placed the patient at risk of harm.

The patient weighed 208 pounds in a chronic clinic visit on 5/5/15. On 12/14/15 in chronic clinic, the patient weighed 182 pounds. This 26-pound weight loss was unrecognized. On 1/4/16, a doctor documented a 40-pound weight loss. The patient complained of abdominal pain, loss of appetite, diarrhea, and emesis. The doctor's only diagnostic evaluation was to order a blood count and abdominal x-ray. Despite having diabetes, the doctor did not check blood sugar values. The CBC showed anemia (hemoglobin 12.2) but no action was taken. GI symptoms with anemia and weight loss need to result in colonoscopy and other testing to determine if a serious medical condition is present. On 1/21/16, a doctor referred the patient for an abdominal CT scan. A plain abdominal CT scan is not adequate screening for colorectal cancer, but may be useful for other purposes. Specialized CT scanning for colorectal screening is called CT colonography. However, CT colonography was not ordered. This patient's CT scan showed emphysema, aortic atherosclerosis, hepatic cysts, renal cysts, infra-renal ectasia (abdominal aortic aneurysm), bilateral common iliac aneurysms, and compression fracture of the L1 vertebra. None of these problems were added to the problem list or monitored. The identification of aneurysms was of concern and should be monitored and referred, if indicated. The identification of aortic atherosclerosis in combination with diabetes, hypertension, and a greater than 40% risk of cardiovascular events should have prompted use of a statin drug, but this was not done at this time. There was no follow up of the CT scan or the problems identified on the CT scan. There was no follow up of the weight loss or anemia. The patient did not have a follow-up blood count until two years later on 1/19/18, and the hemoglobin was 9.9, a significant deterioration. At that time, the doctor ordered iron studies and gave the patient cards for fecal occult blood testing. Colonoscopy was not done.

On 11/4/16, the creatinine was 1.66, indicating chronic kidney disease. This was not added to the problem list and was not followed as a problem. Specifically, on 12/19/16, the patient was evaluated in diabetic and hypertension chronic clinics. The blood pressure was 142/84. For persons with chronic kidney disease and diabetes, the blood pressure should be controlled to less than 130/80, yet this was not done, and the chronic kidney disease was unrecognized as a problem. On several other occasions (9/10/15, 12/14/15, 5/3/16, 12/19/16, 11/17/17, 1/8/18), providers saw the patient with either a systolic pressure above 130 or a diastolic pressure above 80 without intervention or comment on why intervention was unnecessary.

On 1/9/17, a nurse evaluated the patient for shortness of breath and obtained an oxygen saturation of 85%, which improved with treatment with a beta agonist inhaler. Because of the patient's myriad problems, a physician examination was indicated; instead, a doctor presumed the etiology was asthma and ordered prednisone by phone. If the diagnosis was asthma, an oxygen saturation at this level would have been life-threatening

and the patient should have been admitted to a hospital. Even if COPD was the presumed diagnosis, an oxygen saturation of 85% should have prompted consideration of hospitalization for diagnostic evaluation. Treatment over the phone with prednisone without knowing the diagnosis or reason for the new hypoxemia was inappropriate.

HbA1C levels from 2015 through 2017 indicated good diabetic control. However, capillary blood glucose checks being done every other week started to show a rise in blood sugar values. These were not monitored. On 11/14/17, the blood sugar was 256. On 11/22/17, the blood sugar was 446. On 11/28/17, the blood sugar was 414. On 12/5/17, the blood sugar was 423. On 12/12/17, the blood sugar was 411. On 12/18/17, the blood sugar was 471. There were no interventions after any of these blood sugars which indicated out of control diabetes. On 12/19/17, a doctor saw the patient and noted that the most recent HbA1C value was 6.1, but that a recent blood sugar value was 460. The blood sugar had been significantly out of control for over a month. The doctor did not adjust medications; instead, they ordered that the patient be seen in the diabetic clinic in two weeks with an HbA1C test. On 12/23/17, a nurse practitioner saw the patient and documented that the patient had vomiting, agitation, and was not feeling well. The nurse practitioner did not check a blood sugar even though vomiting in an out of control diabetic can be caused by ketoacidosis. The nurse practitioner ordered a month follow up despite this being an acute problem. This patient should have had emergent blood testing and evaluation to determine if an acute medical problem was present. Instead, the patient was not seen again until the patient was sent to a local emergency room on 1/2/18, presumably for evaluation for possible diabetic ketoacidosis. There were no progress notes from MCC before the hospitalization, so it could not be determined why the patient was hospitalized. There was no hospital report, so it could not be determined what occurred at the hospital. When the patient returned to the prison, a nurse documented that the patient was to follow up with a provider in five days. The hospital patient instructions listed diabetes, vomiting, hyperglycemia, and abdominal aortic aneurysm as problems, but the patient instruction sheet had little information. If the admission was for diabetes, it was preventable. Poor management of the patient's out of control diabetes resulted in harm (hospitalization) to the patient. The problem of aneurysm was never addressed despite potentially being life threatening.

The patient was not seen in five days as ordered. On 1/8/18, a nurse saw the patient for chest pain. The pulse was 110 and blood pressure 140/88. A doctor did not write an independent note but wrote an annotation to the nursing note stating that the patient had numbness of his fingers for 10 years and had no chest pain. He documented that the EKG showed no acute changes. He diagnosed COPD and chronic numbness and took no action. He did not check a blood sugar or review the hospital record. The EKG showed non-specific STT changes with V2-6 T wave inversions that can be associated with ischemia.

On 1/9/18, a nurse notified a doctor about a blood sugar over 500. The doctor ordered regular insulin and increased metformin to 1-gram BID and ordered blood tests. The

doctor did not examine the patient. The patient was not evaluated after hospitalization until 1/13/18, 11 days after hospitalization. The doctor noted that the blood sugar control was poor but did not review the hospitalization or findings during hospitalization. A HbA1C on 1/19/18 was 11.4, indicating very poor diabetic control.

On 2/13/18, the patient was seen for his diabetes, hypertension and "asthma." The doctor took little history but did note that the patient was short of breath. The patient was started on an antibiotic without explanation of why. The patient was noted to be on Lantus insulin, but the recent hospitalization was not discussed. Many of the patient's problems were not addressed or even listed as medical problems, including anemia, prior weight loss, prior abdominal pain with vomiting, recent chest pain, abdominal aortic aneurysm, chronic kidney disease, renal and hepatic cysts, and atherosclerosis. The patient's COPD was still being managed as if it were asthma.

In summary, this patient had multiple chronic medical conditions, many of which were not being managed at all and some of which were managed inappropriately. It did not appear that clinicians knew how to manage this patient's medical problems. He was hospitalized, and it was not even clear, based on the medical record, that providers understood why he was hospitalized. Follow up of serious medical conditions (abdominal aortic aneurysm, anemia, renal and hepatic cysts, chronic kidney disease, atherosclerosis, and COPD) was non-existent. For most of these problems physicians appeared unaware that the patient even had the problem. This placed this patient at significant risk of harm.

- Another patient had a problem list that documented hypertension and asthma.⁹⁴ However, the patient also had hepatitis C, chronic kidney disease, and first-degree heart block, which were not being monitored.

Although the patient's chronic kidney disease was not listed as a problem and was not being followed in chronic clinic visits, the patient saw a nephrologist for this on 6/1/17. The specialty care tracking log documented that the patient was again seen in nephrology clinic on 10/5/17, but there was no report of the 10/5/17 visit or documentation in the medical record that this appointment occurred, or what occurred at that appointment. On the 6/1/17 visit, the nephrologist had recommended a vitamin D level, PTH level, urine protein/creatinine ratio, and a four-month follow up.

Based on a 12/23/17 chronic clinic visit, the patient had a 14% risk of heart disease and should have been on a moderate to high-intensity statin, but was not. He also should have been considered for aspirin therapy as primary prevention of cardiovascular disease. These were not provided to the patient and were not discussed with the patient.

On 12/25/17, the patient was admitted to a local emergency room for fever and diarrhea. He was diagnosed with acute kidney injury secondary to dehydration and diarrhea. There

⁹⁴ Patient #7 Specialty Consultation and Hospitalizations.

was no documentation of a follow up of this hospitalization and it was not entirely clear what occurred at the hospital, due to a lack of a complete report. The next physician visit was not until 2/24/18, when the patient was seen in asthma and hypertension chronic clinics. The blood pressure was documented as 120/18, but this clearly was a data entry error and was unnoticed and uncorrected.

A doctor saw the patient in chronic clinic on 3/6/18, and noted that the patient was recently hospitalized, but did not document what occurred at the hospital. The doctor did note that the patient for hospitalized for fever, dehydration, and chronic kidney injury, but there was no other history.

Several of this patient's problems were not even identified or monitored as problems. The patient did not have reports of a consultation visit and a hospitalization. Doctors did not acknowledge what had occurred at the hospitalization and at one of the nephrology visits. Lack of review of consultation and hospital reports meant that the patient's clinical status was unknown to medical staff. The patient should have been on a statin and possibly aspirin, but doctors appeared unaware of this need.

- Another 28-year-old patient had a medical reception screening at MCC on 8/18/17.⁹⁵ The nurse took a history of congenital heart disease, but the specific details were not documented. The patient's actual condition was not identified. A doctor did note that the patient had a venous stasis ulcer on his right leg, but the type of heart disease was not identified. On the day following medical reception, 8/19/17, a CMT evaluated the patient for chest pain, shortness of breath, oxygen saturation of 82%, and atrial flutter. The patient was sent to a local hospital.

The hospitalization log provided to us by Defendants in preparation for our visit showed that the patient went to Chester Memorial Hospital on 8/19/17, and from there was transferred to Carbondale Memorial Hospital on 8/22/17. A discharge summary from Carbondale was not available, but an echocardiogram showed tricuspid atresia with a possible small clot in the right ventricle. The patient was started on Lovenox, an anticoagulant. A report from the local hospital noted that the patient had atrial fibrillation, a stage II stasis ulcer, prior ablation procedures for atrial fibrillation, and had tricuspid atresia⁹⁶ with surgical correction at age five. The lack of the hospital record was significant, as it was not clear from the medical record what the opinion of the cardiologist was regarding the patient's serious heart condition.

⁹⁵ Patient #8 Specialty Consultations and Hospitalizations.

⁹⁶ Tricuspid atresia is a congenital absence of the heart valve between the right atrium and right ventricle, impairing flow of blood to the lungs and preventing oxygenation of blood. This is typically corrected by a Fontan procedure which diverts blood appropriately to the lungs from the inferior vena cava. When this procedure is done, patients require lifelong follow-up with a cardiologist experienced with complex congenital heart disease. Annual evaluation is recommended at a minimum, as additional interventions may be needed. These patients can acquire a number of complications which require intervention, including venous stasis ulcers and venous insufficiency, protein losing enteropathy, cirrhosis, thromboembolic events, arrhythmias, heart failure, and restrictive lung disease.

The patient was sent to Barnes Jewish Hospital in St. Louis the following day on 8/25/17, but there was no discharge summary and it was not clear what the therapeutic plan was for the patient, except that the patient was on metoprolol, diltiazem, and Lovenox. Barnes Jewish Hospital recommended a two to three week follow up.

On return from the hospital, the patient was admitted to the infirmary. The admitting physician did not document a therapeutic plan or acknowledge what had been recommended at Barnes Hospital. The doctor noted problems as atrial fibrillation, tricuspid atresia, and hypoplastic right ventricle. The doctor prescribed metoprolol, diltiazem, and Lovenox, but it was not clear what the therapeutic plan was.

Between 8/25/17 and 9/27/17, the patient was evaluated by providers six times. On none of those occasions was an accurate description of the patient's problems documented. None of these notes documented a therapeutic plan for the patient's serious medical conditions. At several clinic appointments, the only assessment was "cardiac." When we asked the physician who wrote this assessment what he meant, he stated that the patient had some type of cardiac issue. On one note, a doctor ordered a benzodiazepine and referred to mental health for palpitations, when the patient actually had atrial fibrillation which was possibly the cause of the palpitations.

According to the hospital log provided to us, the patient was sent to Memorial Hospital of Carbondale on 9/27/17. It was not clear why the patient was sent to a hospital based on progress notes before the admission. There was no hospital report, so it was not clear what occurred. On 9/28/17, the patient developed abdominal pain with an oxygen saturation of 79%, and the patient was sent to Barnes Jewish Hospital. There was no hospital report for this admission. On 9/29/17, a nurse practitioner documented that the patient "apparently had scan of G bladder, CT of chest, labs, EKG, US of abd [with] a note 'fit for confinement.'" The therapeutic plan was not documented. This uninformed note failed to document the results of any of these tests.

On 10/4/17, a cardiologist at Barnes Jewish Hospital saw the patient on a consultation and documented that the patient had pulmonary and tricuspid atresia with atrial septal defect and had multiple complications of his surgery, including atrial arrhythmia with prior cardioversion and ablation, iliac vein obstruction with venous stasis ulcers, and atrial thrombus. The cardiologist recommended stopping Lovenox, starting Eliquis, a liver ultrasound, and referral to an electrophysiologist for possible ablation therapy.

On return from the cardiologist, the patient was seen twice by a doctor. On both occasions, the doctor did not document review of the report. The recommendations for referral for ultrasound and for electrophysiology were not documented as recognized and do not appear to have occurred.

Progress notes document that the patient went offsite for a medical furlough on 11/4/17, but the specialty consultation log documents this as occurring on 12/4/17. Progress notes

do not document what the patient went offsite for. There was no report. On 12/4/17, a scheduling clerk documented that the patient was discussed in collegial review and approved for follow up. The clerk did not specify what the referral was for. On 12/15/17, Wexford utilization approved a six-month follow up with cardiology. Progress notes document that on 12/22/17 the patient went to Prairie Cardiology, but the reason for this appointment was not clear. The specialty care tracking log does not have this appointment in the log. The medical record remarkably did not detail the ongoing care of the patient.

On 1/10/18, a doctor documented that the patient had been to a cardiologist but did not document what occurred. The only diagnosis was "cardiac." There was no therapeutic plan.

Between 1/10/18 and 5/11/18, the patient was evaluated on three occasions. One of these was a chronic clinic visit. On none of these visits did physicians document review of prior consultations. On 2/9/18, a doctor wrote, "He is planned to have a procedure? At SLUH." The doctor did not appear to know what the therapeutic plan was or what procedure the patient was scheduled for. The other notes, including the chronic clinic visit, do not document understanding of what occurred at consultation visits or what the therapeutic plan was.

On 5/11/18, the patient went offsite for a medical furlough. There was no report. The specialty care tracking log did not document a visit for this patient on this date. A nurse practitioner saw the patient on 5/17/18 and documented that the patient had been offsite but that there was no report and no action was taken.

Care for this patient was grossly and flagrantly unacceptable as providers at MCC, despite three consultations, did not identify all of the patient's conditions, did not document a therapeutic plan for the patient, and were not monitoring all of the patient's medical conditions in chronic care clinics. No one documented what had occurred at the consultations, including status of the patient or recommendations for further care. One doctor diagnosed the patient repeatedly as "cardiac," and did not appear to understand what the patient's conditions were. It appeared that at least two recommendations of the cardiologist (ultrasound of the liver and referral to an electrophysiologist) did not occur. Two of the consultations had no report and it was not clear what the patient was seen for. The patient had multiple abnormalities that were not documented as being monitored including:

- Transformation of the EKG to first degree AV block with left atrial enlargement and STT wave changes
- Thrombocytopenia of 79,000 and white count of 3.8 on 9/11/17
- Bilirubin 1.3 on 2/5/18
- The venous stasis ulcer

The tracking log failed to accurately document specialty care appointments. Post consultation visits failed to include documentation of understanding of what occurred at the consultation or hospitalization. Three of five hospitalizations did not include a report. Two offsite consultations did not include a report. It was not possible, reading the medical record of this patient, to understand what the patient's status was or what the therapeutic plan of the cardiologist was. The patient's serious medical condition was so poorly managed that he is placed at serious risk of ongoing harm.

- Another patient was 66 years old with a history of hypertension.⁹⁷ This patient's medical conditions were mismanaged over a two-year period. The patient had wheezing on 10 separate occasions from late 2016 until April of 2018 without a diagnosis being made. Although presumably treated for asthma, the patient was not diagnosed with asthma and was not in chronic clinic for this condition. The patient's wheezing occurred with cardiomegaly and a chest x-ray showing an enlarged heart. These are consistent with heart failure, yet when providers referred the patient to a pulmonologist and cardiologist, the Wexford utilization doctor denied the referrals without recommending an adequate plan of action. Echocardiogram and pulmonary function tests should have been done. The referrals to cardiology and pulmonary were appropriate but not permitted. A second cardiology referral was again denied without an adequate alternative treatment plan. A nurse practitioner again referred the patient for CT scan and a pulmonary consult, but the CT scan was denied, and although the pulmonary consult was approved, there was no evidence it ever occurred.

In early 2018, the patient developed shortness of breath, wheezing, and tachycardia, and was seen on three occasions (4/21/18 and twice on 4/22/18) by nurses who did not even refer the patient to a doctor. The patient should have been immediately referred and this placed the patient at life-threatening risk, as there was no diagnosis yet. When a nurse practitioner finally saw the patient on 4/23/18, the nurse practitioner treated the patient for an infection and apparently for asthma, even though this diagnosis had never been made and was not made at this evaluation. A chest x-ray was ordered and was consistent with heart failure. But when a nurse practitioner saw the patient on 4/27/18, the chest x-ray was not documented as being evaluated. On 5/4/18, the patient was admitted to the hospital for a supraventricular arrhythmia and was diagnosed with atrial fibrillation. An echocardiogram was consistent with heart failure. When the patient returned to the facility on 5/8/18, the patient did not receive two ordered medications (Lopressor and diltiazem) for two days. The patient was never documented as having heart failure and his wheezing remained undiagnosed, although it appears he was treated as having asthma.

Also, we noted that this patient had elevated alkaline phosphatase as high as 217 on 12/15/17 and had an elevation of this test dating from 12/18/15, yet it was never evaluated. He may have undiagnosed serious liver or bone disease. Also, the patient had

⁹⁷ Patient #9 Specialty Consultations and Hospitalization.

an elevated 10-year risk of heart disease dating from at least 2/24/16, yet was not treated with a moderate or high-intensity statin, which is recommended; or considered for aspirin treatment, which is also recommended, but was not done. The care placed the patient at continual risk of ongoing harm. The care of this patient was grossly and flagrantly unacceptable, particularly the denial for cardiology and pulmonary referral when the patient had undiagnosed symptoms of pulmonary disease or heart failure that were not diagnosed or monitored.

In summary, the deficiencies in Urgent/Emergent Care were similar in frequency and type to those reported by the First Court Appointed Expert. These include absence of important information from the hospital, inadequate assessments by nursing staff, untimely physician follow up, and failure to monitor or intervene. We found many additional deficiencies, including inappropriate denials of care by the Wexford utilization physician, failure to review or complete recommendations of consultants, ignorance of the status or therapeutic plan recommended by consultants, and failure to follow up on abnormal test results. Several episodes of care were grossly and flagrantly unacceptable, sufficient to typically result in peer review of the clinician caring for the patient. We agree with the First Court Appointed Expert's recommendations and make additional recommendations found at the end of this report.

Specialty Consultations

Methodology: We reviewed 12 specialty consultations in four patients and reviewed other records. We spoke with the clerk who schedules specialty care. We reviewed the specialty care log and other documents.

First Court Expert Findings

Providers do not explain alternate treatment plans to patients. Follow up was inconsistent and problematic. Consultant reports were frequently unavailable, making follow up difficult.

Current Findings

We found that all of the First Court Expert's findings were still present. There was no documentation of a discussion by the primary care provider with the patient following consultation visits of the consultant's recommendations or after an alternative treatment plan was initiated. We found that the alternative treatment plans were occasionally described by the scheduling clerk in progress notes. However, alternative treatment plans were not being documented by the primary care provider. According to the scheduling clerk, consultation reports are present for only about half of the consultations. We also found that follow up of recommendations was inconsistent.

The process of obtaining specialty care was similar to all other facilities. The expectation is that there is to be a written referral for specialty care, an approval of the referral in a collegial conference call, a scheduled appointment, and a follow up of the appointment with the primary care provider. All of these events are to be documented in the medical record.

Specialty care referrals at MCC are not tracked on a log in a manner that accurately documents all steps of the referral process. Three hundred ninety-nine (44%) of 892 referrals in 2017 did not have a referral date documented in the specialty clinic tracking log. Of the 892 appointments, 877 (98%) had an approval date documented on the log, but only 469 (53%) had the date of the completed appointment documented on the log.

It was not possible, using the specialty care tracking log, to determine whether patients were timely receiving care. In chart reviews, the referral, approval, appointment, and follow up were not consistently documented in the medical record. This made it impossible to verify the timeliness or completeness of specialty care benchmarks using either the tracking log or the medical record. As with other facilities, the approval date was the most frequently documented item on the specialty care log, making it appear that approval of care is the most important tracked item.

There were a low number of referrals for specialty care and an extraordinary number of denials of care at MCC. The 2018 annual CQI report lists 994 referrals for care in fiscal year 2018.⁹⁸ This is the second lowest number of referrals per 1000 population of all five sites we have visited.⁹⁹ Despite having a very low rate of referrals, MCC also has the highest number and rate of denials of care of the five facilities we have visited.¹⁰⁰ The CQI report documents 237 (24%) denials of care. The five facilities we visited averaged 9.5% denials of referred cases. The CQI report did not analyze the reason for the high number of denials. We were told that the Medical Director was asked by patients for certain services which the Medical Director did not feel comfortable telling the patients were unnecessary. So, the Medical Director would refer the patient for a service knowing that the utilization physician would deny it. If this is accurate, this is a cynical misuse of a referral process, disrespectful of patients, and violates effective communication of the treating physician and the patient. We were told that this practice is no longer occurring. This practice does not explain the very low rate of referral. We were told that the Medical Director is also now taking referrals more seriously and preparing a rationale prior to the collegial reviews so that a greater number of referrals are approved. It is our opinion that, based on record reviews in this report, many persons who need specialty services are not referred. The lack of primary care physicians and the Wexford utilization process itself are likely the cause of this phenomena.

The program had a concern about the number of denials and initiated a CQI study on denials. The title of this study was Re-education in Amount of Medical Specialty Service Denials. The plan of the study was to decrease denials of specialty care by 30%. The hypothesis of the CQI study was that if a doctor reviewed documents being sent to the utilization physician prior to the collegial review conference call to ensure that all treatments and steps that should have been taken before referral were done and that all clinical information was available to the utilization physician, that the number of denials would decrease. The CQI study compared the usual referral process to a process with additional Medical Director preparation of referral documents. The

⁹⁸ The fiscal year in Illinois is July 1 through June 30.

⁹⁹ NRC was the lowest, at 144 referrals per 1000 population. MCC had 994 referrals a year or 328 referrals per 1000 inmates.

¹⁰⁰ We include a table of referrals and denials in the Specialty Care section of our Summary Report. Please refer to that section to review these data.

number of referrals for consultations was 578 in a six-month period prior to the Medical Director review of referral documentation material and 189 over a three-month period of study when the Medical Director reviewed documents in advance. There were 153 denials over the six-month period prior to the study and 55 denials in the three-month study period. This revised practice resulted in a decrease in both referrals and in denials.

Although the intention was to reduce denials, the most important result, in our opinion, was to reduce referral. Given that MCC has one of the lowest rates of referral for specialty care, we were concerned that this process will place inmates at greater risk of harm by further reduction of necessary referral.¹⁰¹ Based on record reviews, including mortality reviews, we found that far fewer patients were referred for consultations than should have been. It is our opinion that under referral is a more important problem than over referral. It is also our opinion that if the collegial review process worked as designed, unnecessary denials should be eliminated in the collegial discussion. What can the Medical Director prepare the day in advance that could not be discussed the day of the “collegial” review discussion? We view the collegial review process as a barrier to specialty care and believe it should be eliminated as it currently exists.

The program does not track whether clinical staff document benchmark events of specialty care (referral, collegial review, appointment date, and five-day follow up) in the medical record. The tracking log is so poorly maintained that it was not possible to use it for this purpose. As discussed above, 44% of referrals and 53% of appointments listed on the log did not have a date associated with them. Based on record review, we found that these specialty care benchmarks are not consistently documented in the medical record. There was therefore no means to verify whether care was timely or was being followed up.

The attorney for Wexford communicated by email to us that we would need to review individual records to obtain the alternative treatment plan information, as it was not centrally maintained. On chart reviews we performed we were unable to locate alternative treatment plans for all denials. The scheduling clerk, but not the doctor, would sometimes document the alternate treatment plan, based presumably on information obtained on the collegial review calls.

For specialty consultations that were completed, we noted multiple problems. These included:

- Delayed specialty care due to the collegial process
- Lack of follow up of recommendations of the consultant
- Failure to timely schedule follow-up appointments
- Failure to obtain reports of consultation care
- Failure to appreciate the status of the patient as reported by the consultant
- Failure to monitor the clinical care of the patient as recommended by the consultant and
- Failure to refer patients for specialty care when it was clinically indicated.

¹⁰¹ Referrals per 1000 inmates was 328 at MCC, which was the second lowest number of the five sites we visited. This information is available in a table in the Summary Report section of the overall report.

We reviewed four records of patients who had multiple specialty visits. All four had significant problems. The following record reviews illustrate these problems.

- The first patient had hypertension, epilepsy, and asthma.¹⁰² On three occasions in 2016, EKGs had T wave tracings consistent with possible ischemia. In April of 2016, he had over a 10% risk of heart disease but was not on a statin or on aspirin, both of which the patient should have been on. Eventually, in August of 2016 the patient was hospitalized for chest pain, and a cardiac catheterization showed 60% stenosis of the circumflex coronary artery and 15-20% stenosis of the left main coronary artery. It was recommended that he be aggressively medically managed, including with a high-intensity statin, and Brilinta, an anticoagulant.

On return to the facility from the hospital, medication was started as recommended. In November of 2017, the patient experienced chest pain and was again hospitalized. He had a myocardial infarction. A stent was inserted. The patient was documented as receiving two doses of medication at MCC during the times when he was hospitalized, indicating problems with documentation and medication administration. When discharged from the hospital, a cardiology consultation was recommended. This appointment occurred in December of 2017. The cardiologist recommended a follow-up cardiology consultation, but that referral never took place and there was no explanation in the record as to why the patient was not sent back to the cardiologist. The patient was on Brilinta, likely because of the myocardial infarction and because he had a stent. Some stents require use of a medication like Brilinta to prevent clotting in the stent. Yet in February of 2018, a doctor at MCC stopped the Brilinta without explanation and without substitution with a similar drug. This placed the patient at significant risk of stent clotting and further myocardial infarction. Based on documentation, it did not appear that the physician evaluating the patient reviewed the cardiology consult or understood the reason for being on Brilinta.

Problems with this patient's care included not being started on a statin drug or aspirin early in his disease, which placed the patient at higher risk for myocardial infarction. The patient was documented as receiving medication at MCC when he was hospitalized, which is a problem with documentation of medication administration. A recommended follow-up cardiology appointment never occurred and there was no explanation why. The post-cardiology physician visit at MCC was two months after the consultation and the doctor did not review the cardiology consultation report. Effectively, there was no follow-up medical appointment to determine the status of the patient's condition after the cardiology consultation. The doctor stopped the anticoagulant despite the patient having had a cardiac event and a recent stent. There was no explanation given for discontinuation of the medication. This placed the patient at significant risk of stent clotting and myocardial infarction.

¹⁰² Patient #2 Specialty Consultations and Hospitalization.

- Another patient initially complained to a nurse of neck pain in March of 2016, and the nurse did not refer to a provider, but gave the patient ibuprofen by protocol.¹⁰³ In December of 2016, the patient again complained of a sore throat and swelling on the left side of his neck. The nurse evaluating the patient used an upper respiratory protocol, which was not an appropriate protocol to use. The nurse noted an enlarged lymph node on the left which was tender. No referral was made. This was inappropriate; the nurse should have referred to a provider.

A CMT evaluated the patient again for sore throat on 1/6/17. The CMT noted an “enlarged lymph node” and gave the patient acetaminophen by protocol. A nurse practitioner saw the patient on 1/11/17 and noted that the left neck was swollen and “hard.” The nurse practitioner diagnosed pharyngitis and ordered an x-ray and an antibiotic. No follow up was ordered. A hard neck swelling is not consistent with pharyngitis. Other work up (CT scan and lab tests) were indicated but not done.

An LPN evaluated the patient on 2/7/17 for neck pain, which the patient described as having since December. The LPN noted a “large swollen lump under L side jaw.” Presumably, the LPN referred the patient to a physician. On 2/15/17, a clerk documented that a doctor presented the patient at collegial review for a CT scan, which was denied by a Wexford utilization physician. The CT scan was appropriate and should have been approved, in our opinion.

On 3/3/17, a CMT evaluated the patient again for neck pain and noted a large lump on the left side of the neck. The CMT described the lump as getting bigger and harder. On 3/8/17, a doctor again referred the patient for a CT scan, which was discussed in collegial review on 3/8/17 and again denied. The Wexford UM physician recommended a neck ultrasound as an alternative plan. Ultrasounds are useful tests to evaluate thyroid conditions, but hard neck masses are best evaluated with CT scan. Getting an ultrasound would only serve to delay the diagnostic effort.

An ultrasound was done on 4/4/17 and showed a mass. The radiologist recommended a CT scan. The doctor at MCC referred the patient for CT scan on 4/12/17 and it was approved on 4/17/17. The CT scan was not done until 5/22/17 and showed a complex mass suspicious for malignancy.

On 6/8/17, a doctor referred the patient to a general surgeon for biopsy, but in collegial review on 6/22/17, the Wexford utilization physician changed the referral to an Ear Nose and Throat (ENT) surgeon. The consultation with the ENT occurred on 7/31/17 and the surgeon recommended a biopsy. The biopsy was approved on 8/4/17 and done on 8/18/17. The biopsy showed squamous cell carcinoma of the tongue. This significant delay (eight months) in diagnosis of a head and neck cancer appeared to be caused by the collegial review process and inability of primary care doctors to timely evaluate a hard neck mass.

¹⁰³ Patient #3 Specialty Consultations and Hospitalization.

On 9/13/17, a doctor at MCC saw the patient but there was no report yet of the biopsy. A doctor saw the patient again on 9/27/17 and again there was no report. Apparently, the ENT surgeon working through the scheduler had multiple pre-operative appointments made at Barnes Jewish Hospital in St. Louis. The patient ultimately had surgery on 10/4/17 to remove an advanced disease tumor with metastases to lymph nodes. The patient was discharged with recommendation for speech therapy, a swallow study, and ENT and oncology follow up.

On 10/17/17, the patient went for an offsite appointment, but it was not clear what the patient was seen for. On 10/18/17, a doctor at MCC documented that the patient had a swallow study, but did not document what the therapeutic plan was for the patient regarding eating or follow up. A report of the swallow study noted that the patient could start eating with nutritional supplements and could upgrade the diet. Swallowing exercises were recommended during radiation therapy. These recommendations were not documented by MCC physicians as incorporated into the patient's therapeutic plan and it was not clear that they occurred. On 10/26/17, the patient was discharged from the infirmary without a documented therapeutic plan except that the patient was to start radiation therapy. Documentation was poor, and it was not clear whether the patient kept the ENT, oncology, or initial radiation therapy appointments.

Problems with this patient's care included a delay of eight months from the time the patient complained of a lump in his neck until the squamous cell carcinoma was definitively diagnosed and an additional two months until resection of the tumor occurred. The patient had advanced cancer and the delay may have contributed to its spread. The Wexford utilization physician made an improper decision in twice denying a CT scan for a hard neck mass. Consultant reports after surgery were not available in the medical record and doctors did not document understanding of the therapeutic plan except that the patient was to receive radiation therapy. There is no evidence in the records that some of the recommendations for follow up with consultants occurred or whether a recommendation for swallowing exercises was discussed with the patient. Also, there was no evidence we could find of a comprehensive dental examination, including of the oral cavity, that may have identified the oral cancer earlier. This speaks to the lack of comprehensive dental evaluations.

- Another patient had long standing hip pain.¹⁰⁴ On 8/22/08, an x-ray showed marked reduction of the left hip joint with sclerosis of the joint. The impression was severe osteoarthritis with no change since the last study. X-rays were taken again in 2009, 2011, 2013, and 2014, all showing continued deterioration. A 2015 x-ray showed "near obliteration of the joint space with prominent juxta-articular bone spurs and subcondylar cysts." Indications for hip replacement are failure of conservative management, debilitating pain, and significant decrease in activities of daily living. This patient appeared to have indications for hip replacement surgery as early as 2008.

¹⁰⁴ Patient #4 Specialty Consultations and Hospitalization.

On 3/8/16, a nurse saw the patient. Indications for hip replacement were present. The nurse documented that a physician requested a collegial review because the hip “comes out of joint when walking. Painful movements noted, appearance of possible foot drop.” We could not find the collegial review for this patient around March of 2016 in the record. So, it is not clear if the collegial review happened or if it was denied or just not documented.

On 6/5/16, a nurse saw the patient and noted pain in the hip, unsteady gait, and difficulty in standing up, and requested a low bunk for that reason. There were a lack of physician evaluations documenting a thorough history and physical examination during this time period. However, the nurse sent the patient to a nurse practitioner, who saw the patient on 6/8/16 and referred the patient to the Medical Director for a consultation referral for the hip.

On 6/10/16, a doctor referred the patient to an orthopedic surgeon. On 6/15/16, a clerk documented that the patient was discussed in collegial review, but a final decision was pending. On 6/29/16, a clerk documented that the referral was denied. The clerk did not document the alternative treatment plan. There were no physician notes documenting the plan of care for the patient. However, it appears that the alternate treatment plan was to refer to a physical therapist.

On 7/22/16, the patient went to a physical therapist in Carbondale. The therapist noted that the patient had a hard time walking and was unstable when standing and had crepitation of the left hip. The therapist gave the patient exercises but noted that the patient probably needed hip replacement.

No action was taken based on the 7/22/16 therapy consultation until 11/11/16, when an MCC physician referred the patient to an orthopedic surgeon again. This referral was an appeal of the prior decision. Because it was an appeal, the IDOC was involved. The referral was approved on 11/22/16.

An orthopedic consultant saw the patient on 12/20/16. The consultant noted that the patient could not put weight on the joint and struggled to walk, and pain medication was no longer effective in relieving pain. The consultant recommended total hip replacement. The patient was now on tramadol for pain relief. Tramadol is an opioid pain medication.

The MCC doctor referred the patient for total hip replacement on 12/23/16. The procedure was approved by Wexford on 1/6/17. Despite the approval for hip replacement, the pre-operative evaluation was not approved until 2/20/17. The hip replacement was not performed until 3/20/17. The hospital's procedure for hip replacement was to start an anticoagulant and perform a Doppler study of the legs to rule out DVT in four weeks. During the entire post-operative period when the patient was on anticoagulation, the INR was not checked once even though it is standard practice to do so.

On 4/4/17, an orthopedic surgeon saw the patient and again recommended obtaining a venous Doppler study and, if negative, to stop the anticoagulation. However, when a doctor at MCC saw the patient on 4/13/17, about nine days after the consultation, the doctor ignored the recommendation for a Doppler study and just stopped the anticoagulant. The doctor did not document review of the orthopedic consultant note. The patient was not referred for physical therapy until July 2017.

Problems with this patient's care included a significant delay in hip replacement surgery. There was x-ray evidence of severe degeneration of the joint since 2008. Physician notes failed to document a thorough history or physical examination in any notes of the current volume. However, a nurse noted that the patient could not walk due to the joint problem. Even after a doctor referred the patient to an orthopedic consultant, it was initially denied. Referral to a physical therapist resulted in an opinion that hip replacement was needed. The patient ultimately went to an orthopedic consultant. But after a recommendation for hip replacement, the surgery was delayed for another three months. A recommendation by the orthopedic consultant to obtain a Doppler study to assess for thrombosis was ignored by MCC staff. It was not even clear that they reviewed the consultant report. Physical therapy was not initiated for four months after the surgery. While hip replacement is an elective procedure, the surgery was delayed apparently for years, resulting in pain and disability endured by the patient for an extended period of time.

- Another patient did not have appropriate management of his goiter or appropriate follow up of his rheumatoid arthritis.¹⁰⁵ On 10/23/15, a dentist told a CMT to refer the patient to a doctor for a goiter first noticed by the dentist. The goiter had been unrecognized previously by medical staff. The dentist ordered a thyroid panel and an antinuclear antibody test. The antinuclear antibody test is a test for autoimmune disease and is not a test typically ordered to evaluate a goiter. A doctor, not a dentist, should have been initiating care for the patient. A doctor did not initially evaluate the patient's goiter by taking a history or performing a physical examination of the goiter. Goiters should be evaluated to assess whether they are so large that they are obstructive and impinge on the trachea. The reason for the goiter should also be determined; some multi-nodular goiters are cancerous. The TSH ordered by the dentist was reviewed by a doctor and was elevated, indicating hypothyroidism. A doctor ordered Synthroid but did not document a discussion of this medication with the patient, did not perform an evaluation of the etiology of the goiter, did not evaluate for obstruction, and did not appear to see the patient.

About two months after the dentist referred the patient, a doctor apparently saw the patient on 12/15/15. The doctor did not take a history of the patient's condition or perform a physical examination, so it was not clear from the note whether the doctor evaluated the patient in person. Goiters may be caused by a variety of conditions or may

¹⁰⁵ Patient #5 Specialty Consultations and Hospitalization.

be large and cause obstruction of the trachea. The doctor failed to evaluate for the cause of the goiter, did not evaluate for obstruction, and merely noted that the patient was not taking the Synthroid. The doctor did not document a discussion with the patient about why the Synthroid was necessary. The doctor did not document a diagnosis. The doctor was treating the elevated TSH without establishing a diagnosis. The doctor was a surgeon and may not have understood how to properly evaluate a goiter. The patient, therefore, should have been referred to an endocrinologist.

The TSH remained elevated. On 1/21/16, a physician saw the patient. Again, there was no history or physical examination. The doctor noted that the rheumatoid factor test was elevated (348) and that the Synthroid was recently increased. No action was taken with respect to the elevated rheumatoid factor. A year earlier the patient had complained to a nurse about multiple joint pains, but this had not resulted in a physician evaluation of the joint pains. Also, no evaluation was initiated to evaluate the cause of the goiter. It appeared that the doctor did not know how to evaluate the patient's conditions and the patient should have been referred to someone who knew how to manage these problems.

Two months later, on 3/15/16, without explanation, the doctor referred the patient for an ultrasound of the thyroid gland. This test was an appropriate test for the goiter but should have been ordered four months earlier, when the goiter was first identified. The doctor's only history was that the patient still had polyarticular pain. The doctor, knowing that the rheumatoid factor was significantly elevated, took no other history of the joint pains and performed no examination of the patient's joints. The doctor took no history of symptoms of obstruction of the trachea and performed no examination of the goiter. The only actions taken were to refer for an ultrasound, to order a TSH, and to increase the Synthroid. The doctor did not appear to know how to manage this patient's polyarticular arthritis or goiter.

On 5/20/16, an ultrasound of the goiter showed an enlarged thyroid gland with multiple nodules. Multinodular goiter can be caused by multiple different conditions, which had yet to be determined.

On 5/25/16, a doctor saw the patient for joint pains and ordered x-rays of the elbows and wrists. Another rheumatoid factor test was ordered and was again elevated.

On 6/13/16, a different doctor noted the positive rheumatoid factor and that the patient had an enlarged thyroid gland with multiple nodules. This doctor, who was an internist, referred the patient back to the primary doctor, who was a surgeon, to consider referral for a thyroid nuclear scan. A thyroid nuclear scan would be indicated if the patient was hyperthyroid, but this patient was hypothyroid. A thyroid scan would not typically be recommended. What was necessary was to determine the cause of the multinodular goiter and to determine if the goiter was causing obstruction.

On 6/16/16, a doctor saw the patient and noted painful wrists, but did not document a thorough examination of the joints.

On 7/7/16, a doctor saw the patient and noted that the patient had multinodular goiter and that the TSH was still elevated, and increased the Synthroid. The doctor initiated no further evaluation to determine the cause of the multinodular goiter. The doctor did not evaluate the size of the goiter and did not determine if it was causing obstructive symptoms. The doctor did finally refer the patient to a rheumatologist.

A rheumatologist saw the patient on 12/16/16. The rheumatologist diagnosed likely rheumatoid arthritis and recommended a tapering steroid dose. He requested hepatitis tests and, if negative, would start methotrexate. A six to eight week follow up was recommended.

A nurse practitioner saw the patient on 12/16/16, the day of the rheumatology consultation. The patient had not been evaluated at MCC for his arthritis or goiter since July. Apparently, he was not enrolled in chronic clinics for these conditions. The nurse practitioner noted that the rheumatologist had recommended a tapering steroid dose for the arthritis and that a surgery consultation was also recommended. The reason for the surgery consultation was not stated. The nurse practitioner did not document review of the rheumatology note; apparently this had not yet been provided. A doctor saw the patient post-rheumatology visit on 12/22/16, but did not document review of the consultation except to note that the patient was on a tapering steroid dose. The doctor took no history, performed no physical examination, and did not make any assessment of any of the patient's conditions.

Although the rheumatologist recommended a six to eight week follow up, the patient did not return to the rheumatologist until 3/28/17, over three months later. A report of this visit was in the medical record. The rheumatologist diagnosed seropositive erosive rheumatoid arthritis and recommended methotrexate titrated up to a dose of 20 mg weekly. He recommended monthly CBC and CMP to monitor for methotrexate toxicity and a six to eight week follow up.

There was no follow up by an MCC physician after the rheumatology visit. Rheumatoid arthritis was not added as a problem and was not being followed in chronic illness clinic. A CBC and CMP were done on 4/6/17, but monthly follow-up tests were not documented as reviewed by physicians.

The follow up with the rheumatologist occurred in about three months, on 6/16/17, later than recommended. The rheumatologist noted that the requested CBC and CMP tests were unavailable and that requested x-rays of the hands and a TB skin test result were also not sent as requested. The rheumatologist tried to contact the MCC Medical Director but could not contact him. The rheumatologist added sulfasalazine and was considering adding hydroxychloroquine for the arthritis, but wanted an ophthalmology evaluation

before adding hydroxychloroquine. The consultant recommended a CBC, CMP every 30 days along with ESR and CRP tests, an ophthalmology evaluation, and return in six to eight weeks.

The patient was not evaluated by a physician post-rheumatology consultation. On 8/24/17, more than two months after the rheumatology visit, a doctor documented that the patient was recently seen by a rheumatologist and that the patient was on methotrexate and folate. There was no history, physical examination, or update on the patient's status. The doctor did not document review of the rheumatology note and appeared unaware that the rheumatologist had recommended sulfasalazine. There was no evidence in the medical record or on the specialty tracking log that an ophthalmology referral was made. The doctor did not document review of the CBC and CMP for methotrexate toxicity.

On 9/22/17, a doctor documented that the patient had seen a rheumatologist but that there was no report. The tracking log documented that the patient was seen by a rheumatologist on 9/22/17, but there was no report in the medical record and no evidence in the medical record that an appointment had occurred. The doctor at MCC did document prescribing sulfasalazine on 9/22/17. There was no history, physical examination, or updates on the status of the patient's conditions. The multinodular goiter was not addressed. The patient was not monitored with CBC or CMP for methotrexate toxicity and neither the multinodular goiter nor rheumatoid arthritis were not being followed in chronic clinics. Since there was no report, it was not clear if a follow up rheumatology consultation was recommended.

The patient was not seen again for these problems by a physician until 12/30/17, when a coverage doctor saw the patient. There was no history or physical examination. The rheumatology note was still not present. The doctor wrote, "Pt wants [treatment] for Crohn's prescribed by consultant." The doctor prescribed sulfasalazine. The sulfasalazine had expired without notice. Also, the doctor presumed that the patient was taking the sulfasalazine for Crohn's disease, when he was taking it for rheumatoid arthritis. The doctor took no history, performed no physical examination, did not review the rheumatology report, did not monitor the patient for methotrexate toxicity, did not document or understand the therapeutic plan for the patient, and did not even know what conditions the patient had. There was a complete absence of management or monitoring of this patient's serious medical conditions.

There were multiple problems with the care of this patient. The goiter was not appropriately evaluated, and a diagnosis was not made as to the etiology of the goiter. There was no evidence of a history or physical examination determining whether or not there were obstructive symptoms. Physicians did not document whether the ultrasound indicated that a biopsy was needed. Because the physicians appeared unable to appropriately evaluate this condition, the patient should have been referred to an endocrinologist. Also, the patient had long-standing pain in multiple joints. The patient

never had an adequate evaluation for this condition at MCC over two years. The patient was sent to a rheumatologist but return appointments were late. Recommended testing was not done or not provided to the rheumatologist. A recommendation by the rheumatologist for ophthalmology evaluation was unnoticed or ignored by MCC physicians. Consulting reports were not all available, and doctors and MCC did not document knowledge of the status of the patient's condition. Recommended medication was not timely prescribed. One doctor appeared unaware of the patient's actual diagnosis. Doctors appeared unaware of the treatment plan of the rheumatologist and were not monitoring the patient as recommended. The patient's rheumatoid arthritis and goiter were not identified as problems and were not being monitored in chronic illness clinic. The doctors at MCC did not appear to know how to manage the rheumatoid arthritis. Even though the patient was sent to a rheumatologist, the follow up was non-existent and placed the patient at risk of harm.

- Another patient was incarcerated on 3/3/17 at MCC.¹⁰⁶ The patient had a history of hepatitis C. The platelets were not initially done, but by 7/18/17 the platelets were 147 and AST was 141, which yielded an APRI score of 2.4, indicating likely cirrhosis. The patient was released on parole and re-incarcerated on 5/4/18. Despite having likely cirrhosis on APRI in March of 2017, the patient did not have an evaluation for cirrhosis, did not receive an upper endoscopy to screen for varices, and did not receive semi-annual ultrasound tests to screen for hepatocellular carcinoma. Patients in IDOC are not typically screened for cirrhosis, do not typically receive endoscopy when they have likely cirrhosis, and do not consistently receive screening for hepatocellular carcinoma. We have seen this repeatedly in IDOC. We note that the IDOC hepatitis C guidelines require a fibroscan for patients with an elevated APRI. This was not done for this patient. A fibroscan would have provided additional information as to whether the patient had cirrhosis.
- Another patient had an APRI score of 1.14 from at least 5/1/17, yet a year later, as of 5/16/18, the patient was still not referred to UIC for treatment of his hepatitis C.¹⁰⁷ The patient was evaluated in hepatitis C clinic twice. Yet when seen in this clinic, there was no evaluation for cirrhosis, no endoscopy to screen for varices, and no ultrasound to screen for hepatocellular carcinoma. This is significant underutilization that places the patient at risk of harm. We discuss deficiencies in hepatitis C care in the Chronic Care section of this report.

Infirmiry Care

Methodology: The clinic space and equipment in the infirmiry was inspected, nursing staff were questioned, clinical charts audited, nurse logs reviewed, porters questioned, and patient-inmates interviewed. The infirmiry physician was not interviewed.

¹⁰⁶ Patient #11 Specialty Consultations and Hospitalizations.

¹⁰⁷ Patient #10 Specialty Consultations and Hospitalizations.

First Court Expert Findings

The First Court Expert noted that the infirmary was staffed 24 hours a day and seven days per week with RN's. The infirmary patient rooms were padlocked and did not have nurse call devices. He commented that padlocked rooms created a serious barrier to the expedited evacuation of patient-inmates in the case of fire or other emergencies. The First Court Expert reported that the porters had not been trained about blood borne pathogens, infectious and communicable diseases, body fluid cleanups, the proper sanitation of the patient-inmate areas, and the confidentiality of patient information. Only four of the 26 infirmary beds were hospital beds and only one of these four hospital beds had functional safety rails. The infirmary bed linen was torn and ragged. The First Court Expert also noted that the infirmary linens were being cleaned in a residential level washing machine that did not achieve the temperature required to sanitize contaminated linen.

Current Findings

With the exception of the finding that the porters now had received documented training and the linens were generally good condition, we agree with the findings of the First Court Expert and we identified the following additional findings:

- Nearly half of the patient-inmates were permanently assigned to the infirmary.
- Two of the patients primarily require skilled nursing care that the infirmary is neither staffed nor equipped to provide.
- Provider admission and progress notes met the frequency and timeliness standards established by the IDOC.
- Admission RN notes are written in accord with the established timelines. Nurse notes are written daily and provide useful information on the clinical status of a patient.
- The quality of provider notes was inconsistent and failed to reflect key components of the patients' histories, physical findings, and the treatment plan.
- Provider admission and progress notes were brief and contained limited clinical information or rationale for treatment plans.
- The infirmary provider does not write intermittent comprehensive progress notes that summarize and update the patient's current condition and treatment plan.
- Only three of the 26 infirmary beds were hospital beds with adjustable heights and head and leg sections. In spite of the high level of physical and mental impairment of the patients housed on the infirmary, there were an insufficient number of adjustable hospital beds in the infirmary. The low level fixed metal beds make it difficult to examine and transfer patients. This is a barrier to the delivery of needed care and put the staff at risk for injuries.
- There is no exam room in the infirmary.
- None of the infirmary patient rooms have nurse call devices.
- The padlocked patient room doors are an obvious barrier to the infirmary's ability to safely evacuate patient-inmates in emergency situations.
- The level of nursing staffing, the type and quality of the beds, and the diligence of the infirmary provider are not adequate to provide the level of care needed by patients who require skilled nursing services and monitoring of complicated conditions.

The infirmary is located on the third floor of the health care unit. The infirmary has 26 beds; the census was six on the day of the inspection. The physical plant and layout is unchanged since the First Court Expert's report. Nurses reported that the provider generally makes rounds once a week and that most patients have a weekly provider note. A review of the charts revealed that nurse admission notes and vital signs were recorded on the day of admission. This is in accord with IDOC policy 04.03.120.¹⁰⁸ In-depth review of four infirmary records verified that all four had provider admission notes written within 48 hours of admission and, with one exception, there were at least weekly provider progress notes. Nursing notes were consistently entered no less than daily and commonly on every shift.

It was reported that an RN is assigned to the infirmary on all shifts seven days a week and that there are generally two nursing personnel on each shift. Patients who need additional assistance with activities of daily living (ADL) may have an inmate assistant who is assigned to a bed in the same room as the patient. At the time of the inspection, one of the six patients had a live-in inmate assistant. Three porters also live in a separate room in infirmary.

Three of the individuals in the infirmary were designated or soon to be designated as requiring assistance with some activities of daily living. Included in this non-independent group were two individuals with metastatic cancer, one of whom refused all further treatment and had signed a Do Not Resuscitate form (DNR). Another individual has severe spinal arthritis; the risk for fall was so high that his mattress was placed on the floor. This individual should have been assigned to the hospital bed that had functional safety railings.

None of the infirmary rooms had nurse call devices. The HCUA is aware of this problem and is working to purchase the same type of nurse call device that has been installed at LCC. None of the patient rooms at MCC's infirmary was in the direct line of sight from the nurse station or the correctional officer desk. Since the infirmary rooms are padlocked, patients stated that they would have to bang on their padlocked door and yell if they had an urgent condition. The condition of at least two of the patients precludes their capability to stand up, walk to the door, and bang for assistance. As noted during the First Court Expert's report, the patient rooms continue to be padlocked at all hours; this creates a significant safety risk if the floor needs to be evacuated during a fire.

A number of concerns and deficiencies in the care provided to infirmary patients was noted. We describe these concerns and deficiencies below.

- A 63-year-old patient's problem list failed to note that this patient had a stroke, deep vein thrombosis on chronic anti-coagulation medication, an inferior vena cava filter, and urinary incontinence.¹⁰⁹ This creates a barrier to the delivery of continuous care to this very complicated patient. The infirmary provider notes were generally extremely brief,

¹⁰⁸Reference Offender Infirmary Services.

¹⁰⁹ Infirmary Patient #1.

with “no change” being the entire note. Providers did not write an intermittent comprehensive provider note that addressed all of the patient’s clinical conditions with the current treatment plan. There were no formal consultant reports from the interventional radiologist in the medical record. There was a seven-month period of time during which the patient’s anticoagulation level was subtherapeutic on five of seven (71%) lab tests before the provider finally increased the dosage of warfarin. The patient had an expressive aphasia that interfered with his ability to communicate, yet there was no documentation in the chart that he had ever received speech therapy or if the aphasia had worsened or improved. This patient with documented stroke and hypertension was at risk for a recurrent cerebrovascular accident (stroke) and a myocardial infarction, yet had not been prescribed a high-intensity statin. This is not in accord with national and IDOC guidelines.¹¹⁰ The patient had a ASCVD risk of >15% which warranted therapy.

- Prior to his recent return from the hospital and admission to the infirmary, another patient, a 58-year-old with hyperlipidemia on a moderate intensity statin, was seen three times in nurse sick calls during the month of March 2018 for mid-abdominal and chest pain and pressure, neck and shoulder pain with vomiting, and for EKG review.¹¹¹ An EKG with new ST elevation was inaccurately interpreted as having no changes from an EKG in 2017. There is no documentation that the provider compared these two EKGs. The only notes were written by nurses. The patient saw the provider on 3/30/18 with exercise-related shortness of breath and chest discomfort; he was sent to the hospital, where he underwent a coronary artery bypass after being diagnosed with a heart attack. He was returned to MCC with a LifeVest due to increased risk of ventricular arrhythmia resulting from decreased LVEF (24%) and ischemic cardiomyopathy. Based on his symptoms and his abnormal EKG, he should have hospitalized at least 12-24 days prior to his heart attack. His pre-heart attack ASCVD risk score was elevated (>7.5%) but the MCC clinical team did not calculate this risk and did not prescribe a high-intensity statin. He was seen twice by the infirmary provider during the first week, but then was not seen for next 21 days. This high-risk patient (post-op, congestive heart failure, high-risk for ventricular arrhythmia) should be followed and monitored more closely by the infirmary provider. To date, MCC providers have failed to screen this over 50-year-old patient for colon cancer¹¹² and to vaccinate this patient against pneumococcal 23 as indicated by national adult immunization standards.¹¹³
- A 48-year-old patient with an abdominal cancer that has progressed while on treatment is being followed by medical oncology, radiation oncology, and urology specialists.¹¹⁴ He had been in the infirmary for over a year. Although the chart had weekly provider notes, these notes are extremely brief and contain very little clinical information about the

¹¹⁰ Office of Health Services, Treatment Guidelines, Hyperlipidemia, March 2016, and ACC/AHA Arteriosclerosis Cardiovascular Risk Estimator.

¹¹¹ Infirmary Patient #2.

¹¹² USPSTF Colon Cancer Screening 2016.

¹¹³ CDC 2018 Vaccines for Adults.

¹¹⁴ Infirmary Patient #3.

patient's status and treatment. There were no intermittent comprehensive progress notes that summarize the current status and treatment plan for this complicated patient. Reading only the provider notes, it was difficult to follow the care that is being provided to this complicated cancer patient. If another provider had to assume responsibility for the care of the infirmary patients, it would be extremely difficult to comprehend the status of this patient's cancer and the plan of treatment. This puts the health of the patient at risk for errors. There is also no documentation that the patient has received pneumococcal 13 and 23 vaccinations.¹¹⁵

- The next patient is a 79-year-old with metastatic prostate cancer on heavy analgesia who was intermittently confused and had difficulty ambulating, who suffered a torn urethral meatus that was reported to have occurred when the patient (or another person) stepped on the tubing of the catheter that was dangling and laid on the floor.¹¹⁶ This could have been prevented with proper nursing management of the tube and bag. This patient is dying; there is no documentation that he has been considered for compassionate release from the IDOC. There is no documentation that this patient had ever been previously screened for colon cancer¹¹⁷ during times prior to his metastatic cancer or administered the age recommended pneumococcal vaccines.¹¹⁸ The patient has never been treated for hepatitis C, but based on his current condition, he is not a candidate for treatment.

With the exception of the previous recommendations that have been addressed, we agree with the recommendations of the First Court Expert and have additional recommendations that are found at the end of the report.

Pharmacy/Medication Administration

Methodology: We reviewed medication services by touring the medication room with the Nursing Supervisor (IDOC) and interviewed four of five nurses preparing medication for delivery the afternoon of Wednesday, May 23, 2018. They were documenting medication as having been given as it was prepared and put into envelopes or pill cups to be administered later. We observed the count of controlled substances in the trauma area between shifts on Monday May 21, 2018. We also observed a nurse count out controlled substances to administer that evening. We also toured the medication storage area and interviewed one of the pharmacy assistants. Medication administration was not observed. We reviewed medication administration records and corresponding medical records of 11 patients selected from lists of patients on medications that cannot be missed.

First Court Expert Findings

The system used, and policies and practices described in the previous Court Expert's report, are mostly unchanged today. Medications are provided by BosWell, a subcontractor to Wexford,

¹¹⁵ CDC 2018 Vaccines for Adults.

¹¹⁶ Infirmary Patient #4.

¹¹⁷ USPSTF Colon Cancer Screening 2016.

¹¹⁸ CDC 2018 Vaccines for Adults.

using a “fax and fill” system. Pharmacy assistants are responsible for sending orders and requisitions for stock medication to be dispensed by BosWell. These same personnel receive shipments and verify medications received against those ordered. Once this is completed, the medications are moved to the medication room where they are prepared by nurses for administration. Medications are administered by nursing staff at the cell door. Documentation of medication administered, refused, or not available is done on a paper Medication Administration Record (MAR) that is kept in binders in the medication room for the current month and filed in the medical record the month after.¹¹⁹

Current Findings

Medication administration at MCC is problematic and relies on outdated practices that are no longer considered safe from patient harm. These problem areas include:

- Handwritten orders and transcription of orders to the MAR
- Late transcription of orders
- Pre-pouring medication, including medications that are crushed and floated
- Use of unsanitary envelopes to administer medications
- Not having the MAR available during medication administration
- Not documenting administration of medication at the time it is given.

Chronic disease patients are not monitored to ensure continuity in treatment nor is their compliance with prescribed treatment assessed. Prescription end dates do not coincide with chronic clinic appointments and require patients to request renewals via sick call.¹²⁰

In addition, we found that medication errors are not identified and/or not reported. One of the charts reviewed was a patient who had been hospitalized for several days and yet the MAR documents that nurses at MCC administered medication to him.¹²¹ This is a significant documentation error that was not recognized or reported. Also, there is no accountability for the medications that were prepared but not administered to this patient.

In 23 months of CQI minutes provided for review, medication errors were reported only in four of those months.¹²² Only once was there an attempt to categorize the types of errors reported. Pharmacy inspection reports are also not discussed at CQI meetings. There was no discussion or analysis to determine root causes of medication errors or trending to identify problems with the system to provide medications, or improve patient safety. Persistent problems with medication practices are not subject to corrective action or systematic quality improvement.

Medication errors have long been recognized as a substantial area of focus in improving the safety of patient care.¹²³ Handwritten orders and transcription have been eliminated in many correctional health care programs because of error and inefficiency. An obvious solution is to

¹¹⁹ Lippert Report Menard pp. 21-22.

¹²⁰ Pharmacy/Medication Administration Patients #8-11.

¹²¹ Patient #2 Specialty Consultation and Hospitalization

¹²² MCC CQI agenda and minutes June 2016 – April 2018.

¹²³ Institute of Medicine (2000), To Err is Human: Building a Safer Health System. Washington DC: The Academies Press.

install computerized provider order entry (CPOE). This eliminates transcription by hand. Labels generated from the computerized order after it has been reviewed by a pharmacist are affixed to the MAR.¹²⁴ Automated dispensing cabinets are also being used more often now to record the withdrawal of controlled substances and eliminate manual inventory control systems like that implemented at DCC because of non-compliance on the audit at DCC. Upgrading pharmacy services in this way requires capital expenditure and would only likely happen as a statewide decision made by IDOC. But if these pervasive problems are not identified, discussed, studied, or reported at the facility level, IDOC is without notice that there is a systemic issue that must be addressed statewide.

Orders and Delivery of Medication

Medications are obtained from BosWell Pharmacy Services, via subcontract with Wexford. Prescriptions are faxed to BosWell and filled in 30-day “blister packs,” and then delivered to MCC. A pharmacy assistant receives and inventories the medications in the medication storage area and then puts them into the room nurses use to prepare medication to give to patients. The pharmacy assistant we interviewed reported that prescriptions faxed to BosWell generally are received the next day. Delays in receiving medications were because the order needed clarification, a drug-drug interaction had to be addressed, or they required higher level approval (nonformulary). If medications are urgently needed, they can be obtained from a local pharmacy. The pharmacy technician stated that there is communication with the hospital before patients are discharged and if they are on medications that are not on formulary or will require time to obtain, the Medical Director will ask the hospital to keep the patient until the medication can be obtained from BosWell. Rarely is the back-up community pharmacy used.

We toured the medication storage room where the pharmacy assistants send and receive medication supply and the medication room where the nurses prepare medication for administration. These rooms were clean, uncluttered, well lighted, and kept secure. There is a refrigerator with a thermometer and temperature log that was up to date. All other refrigerators used to store medications had thermometers and documentation of daily temperature checks. Of the logs inspected, temperatures were within the correct range. No outdated medication was found in the medication storage or preparation rooms. On Monday May 21, 2018, we observed the count of controlled substances and instruments between day and evening shift, and verified that it was accurate.

Medication orders in the charts reviewed were complete and there was an accompanying progress note that indicated the reason for the order. Transcription of the order by a nurse to the MAR was delayed in two of the charts reviewed (82%); therefore, the delivery of either antiviral or anticoagulation medication to the patient was delayed. We also noted that one of the charts reviewed for sick call had an order that was not transcribed for five days after the patient was seen by the provider for constipation.¹²⁵ We also found an instance of a nurse who wrote

¹²⁴ Patient Safety Network. (2017) Medication Errors, Agency for Healthcare Research and Quality available at <https://psnet.ahrq.gov/primers/primer/23/medication-errors>.

¹²⁵ Pharmacy/Medication Administration Patient #1, 4 and Sick Call Patient #14.

the date of the new order over the old order, rather than writing the new order on a new line on the MAR.¹²⁶ This is an alteration of the record and should be prohibited.

When the medication arrives from BosWell, a pharmacy assistant verifies the medication received against the order, which serves to identify dispensing errors. Once verified, the medication is put in the nurses' medication work room into boxes designated by the housing location of the inmate.

Medication Administration

The morning medication pass is scheduled to take place between 3:00 a.m. and 5:00 a.m. and the evening medications are administered between 6:00 p.m. and 8:00 p.m.¹²⁷ Nurses pre-pour all medications administered to patients at MCC. We observed the preparation of medications, which is done in a large room in the health care unit that contains shelves with boxes for patients in each housing unit and three ring binders of MARs for the current month. Pre-pouring entails looking at the MAR, selecting the right medication for the patient, popping the pill out of the blister pack, and putting it into an envelope labeled with the patient's name and medication. The envelopes are re-used for the same patient.

We also observed a nurse prepare controlled substances for administration. Controlled substances are stored in a double locked cabinet in the trauma room. A list of inmates with orders for controlled substances is used to guide the nurse in removing individual doses for each inmate on the list. Once removed from the blister card and signed out on the controlled substances log, the medication is put into a collective cup. The nurse takes the cup to the medication room. The nurse then selects the correct medication for each patient from the collective medications in the cup and puts it into the envelope for the individual patient.

Once all the medications the patient is scheduled to receive are in the envelope, it is placed in a tray and into a bag that the nurse transports to the housing unit. If it is a medication that must be crushed, the nurse will crush it in advance as part of the pre-pour. We also observed a nurse prepare a medication that was crushed and then floated in liquid. This is kept in a medicine cup with a lid until it is delivered to the patient sometime in the next several hours.

We interviewed a nurse preparing medications in the medication room. She requests that the patient provide identification only when she does not recognize or know the inmate. We also asked what happened when a pill fell onto the floor when being given to a patient. She said that the patient can choose to pick it up and take it or give it to her and she will waste it. She did not offer to obtain another pill to replace the one that was wasted. This is consistent with what one of the chronic care patients complained about during our visit.¹²⁸

¹²⁶ Pharmacy/Medication Administration Patient #3.

¹²⁷ Email communication dated May 17, 2018 from Nicholas Staley, AAG to Michael Puisis.

¹²⁸ Pharmacy/Medication Administration Patient #11.

Documentation that medication was given takes place at the time it is prepared rather than at the time it is given to the patient. If a patient refuses the medication or is not on the unit, the nurse will circle their initial on the MAR to indicate that the medication was not given after returning to the medication room in the clinic. Only 9% of the MARs selected for review were complete.¹²⁹ Documentation of doses given, refused, or not available was missing from 10 of 11 charts reviewed. This is extremely poor performance and calls into question the accuracy of the MARs.

Contemporaneous charting on the MAR at the time of administration is considered the nursing standard of practice. MCC does not meet this standard of professional practice.

None of the MARs reviewed contained the signatures and initials of nurses who administered medication. This practice violates MCC's own policy and procedure and demonstrates lack of supervision and oversight failure.¹³⁰ We asked the HCUA if a signature sheet was maintained and were told that at one time a signature sheet was kept but that it was not up to date. Therefore, it was not possible to identify any of the nurses who administered medication in the health record of a patient.

Problems with medication administration practices at MCC are:

- Pre-pouring defeats the purpose of patient specific packaging. As soon as the medication is taken out of the blister pack, verification that it is the correct medication, for the right patient, at the right time and the right dose is not possible. This is a patient safety risk and unnecessarily exposes the patient to errors in administration (receiving the wrong drug). It is also a wasteful use of the cost of blister packaging.
- Reuse of individual envelopes to hold medication is unsanitary.
- Use of a list rather than the MAR to select controlled substances for administration increases risk of medication error.
- Combining controlled substances for multiple patients into a single container and then selecting the right medication, in the right dose for the right patient by sight is an extremely risky practice and exposes patients to unnecessary harm from medication error.
- Crushing and floating medication in advance of administration is time consuming, but also dangerous because it changes the nature of the drug and can cause problems with absorption or irritation of the GI tract. The medication should instead be provided in another form (liquid or injectable).
- Two-part identification is not used to identify inmates before administration, greatly increasing the risk of giving the wrong medication to the wrong patient.
- When medication is dropped during administration, patients are not given replacement medication. It is cruel for nurses to make a patient choose between missing a dose or ingesting medication that has been dropped and unsanitary.

¹²⁹ The only MAR that was complete was Pharmacy/Medication Administration Patient #3.

¹³⁰ V4-1. Pharmacy Services p. 5.

- Nurses do not have a way to verify medication that is not taken. Visual identification of medication remaining after administration is not accurate.
- Medication is not documented at the time it is given. This practice is a source of errors and numerous omissions in documentation of patient care.

Renewal of Chronic Disease Medications

Chronic disease medications are provided to patients monthly either as “Keep on Person” (KOP) or each dose is administered by a nurse. The scheduled appointments for chronic disease clinic do not coincide with the end date on medications ordered for chronic disease.¹³¹ Providers often order medications for patients with chronic conditions without seeing the patient.¹³²

MCC’s policy on provider visits is that the MAR is available with the medical record at the time of a provider visit.¹³³ We saw no evidence that current MARs were available at the time a patient saw a provider. If filing is up to date, the MAR from the previous month will be in the chart for the provider to review. However, MCC’s policy and procedure on care of patients with chronic conditions makes no suggestion that the MAR be reviewed to evaluate patient adherence to prescribed treatment.¹³⁴ Further, MCC’s policy is that if an inmate refuses medication twice in two days they are referred to a provider for evaluation and possible change in treatment.¹³⁵ There were multiple examples of patients not taking medication as prescribed in the charts we reviewed which were not referred for provider evaluation. The record review also identified several patients prescribed medication that required continuity who had lapses in their care.¹³⁶ Chronic disease patients are not monitored to ensure continuity in treatment nor is their compliance with prescribed treatment assessed.

In summary, medication services at MCC do not meet the standard of practice, they employ outdated methods that compromise patient safety, and are not reviewed and analyzed to make improvements that prevent human error and harm to patients.

Infection Control

Methodology: We interviewed the nursing supervisor responsible for infection control, reviewed the infection control procedures, CQI Minutes, tracking logs, and other documents related to communicable diseases and infection control. Infirmary porter training agenda and training materials were reviewed. We also reviewed the charts of patients treated for tuberculosis infection (two), HIV disease (three), and skin infection (two).

First Court Expert Findings

¹³¹ Pharmacy/Medication Administration Patients #1,9.

¹³² Pharmacy/ Medication Administration Patients #9, Sick Call Patients #1, 3, 8, 12.

¹³³ V3-11 Assisting Physician Call Lines page 1.

¹³⁴ V3-12 Medical Management of Offenders with Chronic Conditions.

¹³⁵ V4-1. Pharmacy Services p. 5.

¹³⁶ Pharmacy/Medication Administration Patients #6, #9; Sick Call Patient #1.

The First Court Appointed Expert Report found that MCC had a named infection control nurse (IC-RN). This individual was responsible for reporting infection to the Illinois Department of Public Health. The facility also had an aggressive program to monitor and treat skin infections. Monthly safety and sanitation inspections were conducted by the IC-RN, as well as food handler screening, tuberculosis monitoring, and hepatitis vaccination for staff and inmate workers. The IC-RN also supervised the inmate peer education program.

Tours of the health care areas at the prison verified the availability of personal protective equipment (PPE). Puncture proof containers were available for disposal of needles, syringes, and other sharps in all areas where patient care took place. Problems identified with the infection control program were that there were no alarms on the negative air pressure rooms to indicate loss of pressure, porters had received no training and the water temperature used in the washing machine in the infirmary was too low to sanitize soiled linens, impervious vinyl on exam stools, tables and infirmary mattresses was torn or cracked, a paper barrier was not used between patients on the exam table, and there was no policy to clean the table between patients. Finally, one of the sick call rooms did not have a sink for handwashing.¹³⁷

Current Findings

MCC continues to dedicate one FTE to infection control. One of the Nursing Supervisors is responsible for infection control. Her responsibilities include all those described by the First Court Appointed Expert. In addition, she manages the HIV and HCV clinics. She was very knowledgeable of the facility's policies and procedures for infection control.

The IC-RN also tabulates the monthly infection control report that is reviewed at the CQI meeting. This report lists the number of patients placed in isolation, status of the negative pressure room, occupational exposures to blood borne pathogens, cases reportable to Public Health, skin infections treated, patients screened for, monitored, and treated for HIV and HCV, and results of tuberculosis skin testing. Review of CQI minutes from June 2016 through April 2018 reflect minimal analysis of the data reported. We also found an instance of incorrect data reporting on the monthly infection control report. This was a patient we reviewed who was positive on the annual tuberculin skin test (PPD) given in October 2017.¹³⁸ He should have been reported as a converter, since there were three prior PPDs that were documented as 0 millimeters, which is considered negative.¹³⁹ Neither the October 2017 or November 2017 infection control reports identify any TB converters.

The IDOC Infection Control Manual was reviewed. It was last updated in 2012. While the material in the manual is thoughtful and many resources are provided, some of them are out of date. The manual should be updated at least every two years. The IDOC Nursing Treatment Protocols, revised March 2017, were reviewed and provide guidance to nurses in the care of common

¹³⁷ Lippert Report Menard pp. 28-29.

¹³⁸ Infection Control Patient #4.

¹³⁹ Persons who have a previous negative skin test that becomes positive are labeled TB converters. These are red-flag type infection control issues as they mean that the incarcerated person has acquired TB within the prison. These need to be tracked and investigated.

infectious diseases and infections such as scabies, urinary infection, rash, pediculosis, chicken pox, and skin infections. In addition, the Menard Health Services Policies and Procedures provide detailed instructions for infection control, sanitation, and patient education material for several common communicable diseases (syphilis, herpes, HIV, tuberculosis infection, etc.). The Health Services Policies and Procedures were last reviewed in 2015 and need to be brought up to date.

Puncture proof containers were available for disposal of needles, syringes, and other sharps in all areas where patient care took place. Menard Health Services Policies and Procedures include detailed instructions for sanitation in the health care areas.¹⁴⁰ Paper was present on all the exam tables and there were sinks in all but one exam room. Hand sanitizer containers were in all patient care areas, but two were empty.¹⁴¹ Two of the infirmiry porters were interviewed and the records of these two and one other infirmiry porter were reviewed.¹⁴² The porters were knowledgeable about their duties and stated that they had received formal training about their duties. Their records revealed that all three had received training in 2017 or 2018. All three had completed or initiated hepatitis B (and A for two) vaccination series. The infection control nurse manager provided copies of their training curriculum.

As noted by the First Court Expert, the infirmiry washing machine does not attain a high enough temperature to adequately sanitize body fluid-contaminated linens. The infirmiry has attempted to address this deficiency by directing the porters to place bleach in all loads of linens being washed and having a practice to separately bag and send obviously contaminated patient linen to the facility's industrial level laundry. This does not fully address the sanitation level required to fully sanitize all patient linen for this high-risk patient population, who have bladder catheters and issues with fecal and urine continence. We did not find among the Menard Health Services any policy and procedure for laundering patient linens in the infirmiry. There are policies and procedures to clean, but nothing was found on laundry. We recommended to the HCUA that testing the water temperature be done periodically and that a booster on the hot water inlet could be used to increase temperature.

The IC-RN conducts Safety and Sanitation rounds monthly. The results of these inspections are reported to the CQI committee monthly. We reviewed these reports and note that action taken to correct identified problems is slow.¹⁴³ We suggested revisions to the items looked for during Safety and Sanitation rounds to incorporate items we were looking for during our site visit (vents, chipped paint, paper posted on walls, torn upholstery, working examination equipment, availability of hand wash, etc.).

¹⁴⁰ V4-64 through V4-69.

¹⁴¹ North 1 Lower, South Lower.

¹⁴² Infirmiry patients #5, 6, 7.

¹⁴³



Menard Safety and
Sanitation Inspection

Tuberculosis screening is completed annually. We did not evaluate actual performance of TB screening. We reviewed the charts of two patients who completed prophylaxis.

- In one case, at intake at NRC on 3/25/2018, the patient had a PPD of 10 millimeters, which is considered positive for tuberculosis infection.¹⁴⁴ The chest radiograph done on 3/26/2018 was normal. The health appraisal done at NRC on 4/6/2018 does not comment or elaborate on the patient's tuberculosis screening results and it is not noted on transfer screening. The screening results should have been documented on both the health appraisal and transfer summary. When the patient was received at MCC on 4/11/2018, tuberculosis screening was done again with a 12-millimeter induration and a second chest radiograph was done. He was seen promptly by the IC-RN and started on prophylaxis. He was also screened for HIV and syphilis. He had baseline labs done and has received medication as ordered. The secondary screening done when he transferred to MCC was unnecessary and could have been avoided if the results of screening at NRC had been apparent at the time of transfer.
- The other chart reviewed was the patient who was a tuberculosis test converter which was discussed earlier.¹⁴⁵ We suggested that the IC-RN consider calculating the rate of new conversions at MCC to assess risk on an annual or biannual basis per the CDC recommendations for prevention and control of tuberculosis in correctional facilities.¹⁴⁶

Inmates may request HIV testing at any time and it is also offered to inmates just before release from incarceration. See the comments and suggestion regarding HIV opt-out testing made in the earlier section of this report on Medical Reception and Intrasystem Transfer. Inmates who are infected with HIV are managed by UIC. Three charts of patients seen by the UIC HIV clinic were reviewed. In all three records reviewed, medication was initiated timely and each patient was seen at scheduled intervals with labs done in advance. One patient did not receive medication daily as prescribed and there is no documentation on the MAR as to the reason.¹⁴⁷ See comments about incomplete charting of medication administration in the section of this report on Pharmacy and Medication Administration.

- Another patient was seen in the HIV clinic on 11/17/2017 and the specialist recommended that his dose of Metformin be reduced below 500 mg. because of an interaction with one of the HIV medications.¹⁴⁸ His primary care providers at MCC did not act on this recommendation. When the patient was next seen by the HIV specialist on 4/10/2018, he was still on the same dose of Metformin. This time the HIV provider noted the drug interaction and wrote the order to reduce the dose of Metformin. The patient went for five months taking Metformin at a dose that was contraindicated. The HIV specialist reduced the dose when his primary care provider failed to act on the

¹⁴⁴ Infection Control Patient #5.

¹⁴⁵ Infection Control Patient #4.

¹⁴⁶ <https://www.cdc.gov/mmwr/preview/mmwrhtml/rr5509a1.htm>.

¹⁴⁷ Infection Control Patient #1.

¹⁴⁸ Infection Control Patient #3.

recommendation. This is an example of uncoordinated and contradictory care of a patient with multiple chronic conditions.

We also reviewed the charts of two patients with skin infection.

- The first was seen in nurse sick call for a complaint of having a boil for about a week.¹⁴⁹ The nursing documentation does not indicate what the nurse's action were to treat the complaint, but there is documentation by a nurse practitioner later that day. The nurse practitioner ordered an antibiotic (Bactrim) for 10 days. He saw the nurse practitioner 15 days later, who documented that the patient did not take the Bactrim because he did not know what it was. This patient's treatment was delayed because he misunderstood the treatment plan and none of the nurse's explained it to him.
- The second patient had surgery to repair a hernia on 4/4/2018.¹⁵⁰ Upon his return, he was cleared for general population, with a follow up with a provider in five days. On 4/10/2018, the provider saw the patient for follow up. He ordered daily dressing changes and an antibiotic (Levaquin) for 10 days. There is no documentation about the surgical site and whether it is infected. We suggested to the IC-RN that a review of post-surgical infections might result in a suggestion to use infirmary placement for a day or two after return to the institution to ensure the patient was capable of their own wound care.

Hepatitis C (HCV) disease is also managed via the chronic care clinic, with the work up and treatment of these patients directed by UIC.

The infection control program at MCC is managed by a dedicated nursing supervisor. Important improvements have been made in the sanitation and safety of health care delivery at MCC since the report of the First Court Appointed Expert. However, there are still areas that need attention, including the analysis of clinical information to prevent infection and improve patient care, updating of written directives, and the repair and maintenance of patient care areas and equipment. We also found examples of patient care that were delayed, unneeded repetition of screening and testing, and incomplete documentation that are consistent with systemic problems in the delivery of health care at MCC that are discussed earlier in this report.

Dental Program

Dental: Staffing and Credentialing

Methodology: Reviewed staffing documents, interviewed dental and other staff, reviewed the Dental Sick Call Log and other documents.

First Court Expert Findings

¹⁴⁹ Infection Control Patient #6.

¹⁵⁰ Infection Control Patient #7.

- MCC has a dental staff of three full-time dentists, one dental hygienist, and three full-time dental assistants. All are Wexford employees except one of the dentists. In addition, one PRN dentist and three PRN assistants are available if needed. This meets the Administrative Directive staffing guidelines and is adequate for MCC's 3700 inmates.
- All providers have current credentials on file and all the staff are current with their CPR certification.

Current Findings

While we agree with the First Court Expert that the number of authorized dental personnel positions is adequate, staffing has deteriorated materially since the First Expert's Report. When all positions are filled, the clinic is staffed by three dentists, three dental assistants, one dental hygienist, and one clerk. Currently, two dentist positions are unfilled¹⁵¹ and wait times for routine care are approximately 15 months (see Figure 1 *infra*).

State positions are filled by a dental hygienist, a dental assistant, and a dental office associate. Per the HCUA, the state dentist position had been open for more than two years. It had been advertised several times, and there were applicants; however, the position expired (and had to be reposted). Due to the inability of IDOC to fill the position, it asked Wexford to fill it.

Dental: Facility and Equipment

Methodology: Toured the dental clinic to assess cleanliness, infection control procedures, and equipment functionality. Observed intake screening and evaluated the quality of x-rays taken at intake. Reviewed compliance with radiologic health regulations.

First Court Expert Findings

- There are three clinics: a single chair clinic at North 2 that serves the segregation inmates and a general population housed in that unit. A single chair unit is in the Receiving and Classification clinic and is used for reception screening examinations. It contains a Panorex x-ray and developer. The third is a four-chair clinic located in the HSU and serves the rest of the institution. There is a 400-bed medium security satellite institution that does not have a dental clinic. This population is served by the clinic in the Health Service Unit. Both North 2 and R&C clinics have old and worn equipment.
- The chairs/units in the HSU clinic are only two years old and in excellent repair. There is a single x-ray unit for this entire clinic and it is very old, faded, and worn. There is a Panorex unit on the second floor of this building, above the dental clinic. The metal cabinetry is old, rusting, and has several areas of chipping paint. Proper disinfection is difficult.
- The x-ray developers in the North 2 clinic and the R & C clinic do not work and radiographs must be brought to the HSU clinic for developing. This is unacceptable, in that x-rays are often needed immediately, especially as a diagnostic tool in urgent care situations.
- The four chairs/units in the HSU are in small individual spaces. This space is barely adequate. The single chair clinics at North 2 and R&C are small but adequate. The lab and

¹⁵¹ A Wexford dentist recently retired, leaving a vacancy.

sterilization area are large. The existing facility is adequate to meet the needs of the institution. The x-ray developers need to be replaced or repaired immediately.

Current Findings

We concur with the First Court Expert's findings with respect to the inadequacy of the dental facilities and equipment. Moreover, they have not improved materially. We identified current and additional findings as follows.

The panoramic x-ray unit in the R&C clinic does not have shielding between the unit and the door. Before an x-ray is taken, people in the corridor are asked to move away from the door. There is no x-ray processor in the North clinic because an inoperative unit was not replaced. Exposed film is processed in the radiology clinic. There is an area in the MSU health clinic designated for a dental clinic.

Dental: Sanitation, Safety, and Sterilization

Methodology: Reviewed Administrative Directive 04.03.102. Toured the dental clinics and observed dental treatment room disinfection. Interviewed dental staff and observed patient treatment.

First Court Expert Findings

- Surface disinfection was performed between each patient and was thorough and adequate, and protective covers were utilized on most unit surfaces. Instruments were properly bagged and sterilized. All handpieces were sterilized and in bags.
- The sterilization procedures themselves at the Health Service Unit clinic were improper. Flow did not proceed from dirty to clean. The ultrasonic was on the wrong side of the sink, and a dental lathe and protective covers were situated between the sink and the autoclave.
- The R&C clinic used disposable instruments.
- The clinic at North 2 had a proper flow of sterilization from dirty to clean. Surface disinfection was adequate. Protective covers were used appropriately. No biohazard warning signs were posted in the sterilization areas.¹⁵²
- Safety glasses were not always worn by patients. Eye protection is always necessary, for patient and provider. No warning signs were posted where x-rays were taken to warn of radiation hazard.

Current Findings

Sanitation, safety, and sterilization have deteriorated since the First Court Expert's Report. We concur with the findings and we observed inadequate hand sanitation by the dentist between initial examination patients (see Initial Examination section *infra*). We observed initial exams at the R&C clinic, and treatment at the North 2 and HSU clinics. Surfaces were disinfected

¹⁵² CFR 1901.145(e)(4). "The biological hazard warning shall be used to signify the actual or potential presence of a biohazard and to identify equipment, containers, rooms, materials, experimental animals, or combinations thereof, which contain, or are contaminated with, viable hazardous agents.")

appropriately between patients and instruments were disinfected, bagged, and stored appropriately. The HSU and North 2 clinics have protective glasses for patients; however, we did not see them worn when we observed treatment at the HSU clinic¹⁵³.

Dental: Review Autoclave Log

Methodology: Reviewed the last two years of entries in autoclave log, interviewed dental staff, and toured the sterilization area.

First Court Expert Findings

- Spore testing of the steam autoclaves was being accomplished only once a month. This is highly irregular and violates OSHA guidelines calling for weekly spore testing of autoclaves. The dry heat sterilizer is tested on an irregular, somewhat quarterly basis. These are egregious deficiencies that should be corrected immediately. Steam autoclaves and dry heat sterilizers should be tested weekly.

Current Findings

Autoclave log management has improved since the First Court Expert's Report and is adequate. We identified current and additional findings as follows.

The dry heat sterilizer in the HSU clinic has not been used for two years and is not subject to spore tests. Weekly spore tests for the steam sterilizers were documented, and the deficiencies noted by the First Experts have been remedied.

Dental: Comprehensive Care

Comprehensive, or routine care¹⁵⁴ is non-urgent treatment that should be based on a health history, a thorough intraoral and extraoral examination, a periodontal examination, and a visual and radiographic examination.¹⁵⁵ A sequenced plan (treatment plan) should be generated that maps out the patient's treatment.

Methodology: Interviewed dental staff, reviewed dental charts of an inmates who received non-urgent care that were randomly selected from the Daily Dental Reports. Reviewed Daily and Monthly Dental Reports.

First Court Expert Findings

- A review of 10 records revealed that a comprehensive examination was not performed, and sequenced treatment plans were not developed. Examination of soft tissues for oral cancer was rarely documented and periodontal assessments employing probing was not part of the treatment process.

¹⁵³ Why We Take Infection Control Seriously. UIC College of Dentistry. Viewed at <https://dentistry.uic.edu/patients/dental-infection-control>, viewed February 2, 2018. "We use personal protective equipment [...] *as well as provide eye protection to patients for all dental procedures.*". Emphasis added.

¹⁵⁴ Category III as defined in Administrative Directive 04.03.102.

¹⁵⁵ Stefanac SJ. Information Gathering and Diagnosis Development. In Treatment Planning in Dentistry [electronic resource]. Stefanac SJ and Nesbit SP, eds. Edinburgh; Elsevier Mosby, 2nd Ed. 2007, pp. 12-15, *passim*.

- Hygiene care and prophylaxis were never part of comprehensive care. Restorations were, in five of the charts, provided without appropriate diagnostic x-rays for caries. No hygiene treatment was part of any of the routine care provided.
- Oral hygiene instructions were never documented in the dental record as part of treatment.

Current Findings

We concur with the First Court Expert's finding that comprehensive care is inadequate. Moreover, it has not improved materially. We identified current and additional findings as follows.

Routine care is provided without adequate x-rays and periodontal assessment. Rather than relying on intraoral x-rays, the accepted professional standard, the dentist bases his charting for caries on the panoramic x-ray in conjunction with a visual exam.¹⁵⁶ Not only is this insufficient to diagnose interproximal (between the teeth) decay but it ignores periodontal disease. In fact, even when periodontal disease is occasionally categorized per Administrative Directive 04.03.102 (Dental Care for Offenders), there is no documented periodontal probing^{157,158} and the location of the disease is not noted.¹⁵⁹ Dr. Assemeier stated that he occasionally does periodontal probing but does not record PSR; however, none of the records reviewed had documented probing. He said that he routinely did PSR on his military patients when he was in private practice and occasionally on his other patients, but not at MCC.¹⁶⁰

Of 16 inmates who received comprehensive (routine) care, none had documented periodontal probing or a sequenced treatment plan. While 10 (56%) had a recent Treatment Needed form

¹⁵⁶ Dental Radiographic Examinations: Recommendations for Patient Selection and Limiting Radiation Exposure. American Dental Association and U.S. Food and Drug Administration, 2012. Table 1, pp. 5-6. (Dentate or partially dentate adults who are new patients receive an "[i]ndividualized radiographic exam consisting of posterior bitewings with panoramic exam or posterior bitewings and selected periapical images." Furthermore, recall patients [i.e., biennial exam patients] should receive posterior bite wing x-rays every 12 to 36 months based on individualized risk for dental caries. With respect to periodontal disease, "[i]maging may consist of, but is not limited to, selected bitewing and/or periapical images of areas where periodontal disease (other than nonspecific gingivitis) can be demonstrated clinically.")

¹⁵⁷ Stefanac SJ. Information Gathering and Diagnosis Development. In Treatment Planning in Dentistry [electronic resource]. Stefanac SJ and Nesbit SP, eds. Edinburgh; Elsevier Mosby, 2nd Ed. 2007. A panoramic radiograph has insufficient resolution for diagnosing caries and periodontal disease. Intraoral radiographs (e.g., bite wings) and periodontal probing are necessary (p. 17). Also, Periodontal Screening and Recording (PSR), an early detection system for periodontal disease, advocated by the American Dental Association and the American Academy of Periodontology since 1992, is an accepted professional standard. *Id.*, pp. 12-14. See American Dental Hygiene Association. Standards for Clinical Dental Hygiene Practice Revised 2016. Periodontal probing is also a standard of practice for dental hygiene.

¹⁵⁸ Makrides, N. S., Costa, J. N., Hickey, D. J., Woods, P. D., & Bajuscak, R. (2006). Correctional dental services. In M. Puisis (Ed.), Clinical Practice in Correctional Medicine (2nd ed., pp. 556-564). Philadelphia, PA: Mosby Elsevier, p.560 (Early diagnosis of periodontal disease is important since the disease is often painless and the prevalence of moderate to severe periodontal disease in correctional populations is high and often not associated with pain).

¹⁵⁹ The only categories related to specifically periodontal disease are Ib ("acute periodontal abscess"), Ic ("acute periodontitis"), Ie ("acute gingivitis"), IIb ("localized gingival involvement"), and Vb ("lack of visible gingival irritation"). *Id.* Attachment A.

¹⁶⁰ None of the dental charts reviewed at MCC documented periodontal probing.

completed,¹⁶¹ five (31%) had the Treatment Needed assessment informed by bite wing x-rays,¹⁶² and (38%)¹⁶³ had a cleaning (prophy or oral prophylaxis) that preceded treatment.¹⁶⁴

Biennial exams are scanty and of minimal clinical value. Of eight patients who received biennial exams, none of the exams were informed by bite wing x-rays or documented periodontal probing, none had a sequenced treatment plan, and two had no documented oral cancer screening.¹⁶⁵

While the dental examinations performed by the dentist did not document a periodontal assessment, the dental hygienist documented a periodontal assessment when she saw a patient. However, she did not document periodontal probing, a standard of care for dentistry and dental hygiene.

Absent a sequenced treatment plan informed by intraoral x-rays and periodontal probing, the dentist does not have enough information to make an informed decision. In the community, what is called a biennial exam is analogous to a periodic exam.¹⁶⁶ To summarize, what is called a biennial exam is cursory, and not substantially different from the inadequate “complete” examination performed at intake.

Not only is periodontal disease underdiagnosed but it is undertreated. In none of the MCC dental charts reviewed was there a treatment plan that identified specific non-surgical periodontal procedures such as scaling and root planing. Moreover, the Daily Treatment Report that lists the treatment provided to each patient has no section for periodontal treatment.¹⁶⁷ Both the dentist and dental hygienist stated that they were in private practice and were familiar with the standard procedure codes which are required for billing third parties and are industry standard. However, there is no column for SRP and no way of knowing if it is performed.^{168, 169} The hygienist said that she classifies SRP as “periodontal;” however, she does not record the number of quadrants, nor are there details of the treatment (e.g., that a SRP procedure was performed, and which

¹⁶¹ Comprehensive Care Patients #2, 6, 8, 9, 10, 11, 12, 13, 14, and 16.

¹⁶² Comprehensive Care Patients #7, 10, 12, 14, and 15.

¹⁶³ Comprehensive Care Patient #1, 4, 11, 12, 14, and 16.

¹⁶⁴ Dr. Assemeier said that while he does not do a sequenced treatment plan, he often includes a treatment plan in his clinical progress notes.

¹⁶⁵ Biennial Exam Patients #1 and 8.

¹⁶⁶ The profession standard code for a periodic exam is D0120. It is defined as “[a]n evaluation performed on a patient of record to determine any changes dental and medical health status since a previous comprehensive or periodic examination. This includes an oral cancer evaluation, and periodontal screening where indicated, [...]”. Dental Procedure Codes. American Dental Association, 2015.

¹⁶⁷ The categories on the form are “scale and prophylaxis,” “gingivitis,” and “periodontal.” While the procedure “scale and prophylaxis” corresponds to American Dental Association treatment code D1110 that has a profession-wide definition and treatment, “gingivitis” and “periodontal” do not have a standard treatment. ADA Treatment Codes, 2015.

¹⁶⁸ The ‘uniform record system’ sponsored by the American Dental Association is the Code on Dental Procedures and Nomenclature. “In August 2000 the CDT Code was designated by the federal government as the national terminology for reporting dental services on claims submitted to third-party payers.” American Dental Association Dental Procedure Codes, 2015, p. 1.

¹⁶⁹ ADA Treatment Codes D4341 and D4342.

teeth were treated). The hygienist also said that she does not document PSR, although she did so in some of the private practices where she worked.

Dental: Intake (Initial) Examination¹⁷⁰

Methodology: Observed intake examination process. Reviewed dental records of inmates that have been examined recently. Reviewed Administrative Directive 04.03.102.

First Court Expert Findings

- All records reviewed revealed that the exam was performed timely, a panoramic x-ray was taken, and the APHA categorization was completed.
- Screening was not observed; however, based on its description, it appeared to be procedurally adequate.
- Four panoramic x-rays were processed improperly and presented as an opaque negative. These radiographs are not acceptable for diagnostic use. This problem did not occur in later record reviews. I was told the developer in the reception clinic was not functioning properly. The radiographs were being developed in the main clinic.

Current Findings

The “Initial Examination” is governed by Administrative Directive 04.03.102 (¶II F 2), which states (*inter alia*) that

Within ten working days after admission to a reception and classification center or to a facility designated by the Director to accept offenders with disabilities for a reception and classification center, each offender shall receive a **complete dental examination by a dentist**.¹⁷¹

The initial examination process has not changed materially since the First Court Expert’s Report and remains inadequate. While we agree that the initial examination was performed timely and the APHA categorization was completed, we find it to be inadequate nonetheless. We cannot compare our findings to those of the First Court Expert since the First Court Expert did not observe the exam.

MCC receives approximately 100 prisoners each month. The dentist (standing) examined a patient seated in a dental chair with a dental light. He performed a cursory oral exam using a mouth mirror, which lasted approximately five minutes, with a dental assistant acting as recorder. He used a mouth mirror to illuminate the lateral border, and the tongue and floor of the mouth. The dentist wore gloves and changed them between patients; however, he did not wash his hands (or disinfect them using alcohol wipes) between donning new gloves. This is a breach of infection control protocol.

¹⁷⁰ The First Expert Report describes the examination performed at intake as a “Screening Examination;” however, Administrative Directive 04.03.102 describes it as a “complete dental examination.” We use the terminology of the Administrative Directive and refer to the intake or initial dental examination as a complete dental examination.

¹⁷¹ Administrative Directive 04.03.102 (¶II F 2). Emphasis added. Furthermore, the exam should include, “[c]harting of the oral cavity and categorization of status or treatment needs in accordance with the American Public Health Association’s priorities delineated in Attachment A. *Id.* at (¶II F 2a). Emphasis added.

In addition to the charting of existing and needed dental treatment, the record noted that OHI (oral hygiene instruction) was provided, and that an oral cancer screening (OCS) was performed and the results were negative or WNL (within normal limits). The “OHI” consisted of saying, “make sure you brush and floss” – and took no more than a minute.¹⁷² This is not adequate oral hygiene instruction. Furthermore, while spooled dental floss is deemed contraband at MCC, he did not mention the existence of (not to mention how to use) floss alternatives.

Of 10 charts of inmates who had recent intake examinations, nine (90%) panoramic x-rays were clinically adequate. Since the panoramic x-rays are not available to inform the charting, the dentist completes the charting when the x-ray is available. Oral cancer screening was documented in all charts; however, no chart documented periodontal probing.

Dental: Extractions

Methodology: Interviewed dental personnel and reviewed 11 dental records of patients who had teeth extracted selected from the Daily Dental Report and 14 charts of patients who were scheduled to have extractions.

First Court Expert Findings

- A review of 10 records of inmates who had dental extractions revealed that nine of the 10 were in full compliance with the aspects reviewed. The radiograph was over three years old in one of the records and the reason for extraction was not included in another. This does not rise to a level of concern. A quick scan of several other records of inmates who had teeth extracted did not reveal a repeat of these issues.
- In two of the records, non-restorable was provided as a diagnosis for pain. This problem was seen in other records reviewed in other areas.

Current Findings

Our findings diverge from those of the First Court Expert and suggest that the treatment of dental extractions has deteriorated since the First Court Expert Report. While the First Court Expert found documentation to be generally adequate, we found that while of 11 patients who had extractions, all were informed by adequate preoperative x-rays and were accompanied by signed consent forms, nine (82%) forms¹⁷³ listed the tooth number but not the reason the tooth was to be extracted, and nine (82%)¹⁷⁴ did not document an updated health history.

Of 12 patients who were scheduled for extractions, the wait time ranged from seven to 41 days, with a median of 26 days (see Figure 2 *infra*).¹⁷⁵ Of the 11 who were prescribed antibiotics, all but one (91%) waited more than 10 days.¹⁷⁶ This is problematic, since the tooth should be

¹⁷² Oral Hygiene Instructions (D1330) “may include instructions for home care. Examples include tooth brushing technique, flossing, and the use of special oral hygiene aids.” American Dental Association Codes extract.

¹⁷³ Extractions Patients #1, 2, 4, 6, 7, 8, 9, 10, and 11.

¹⁷⁴ Extractions Patients #1, 2, 3, 4, 5, 8, 9, 10, and 11.

¹⁷⁵ The patient was seen with a complaint of pain, palliated, and scheduled for an extraction appointment. Scheduled Extractions Patients #1, 3, 4, 5, 8, 9, 10, 11, 12, 13, 14, and 15.

¹⁷⁶ Scheduled Extractions Patients #1, 2, 3, 6, 8, 9, 10, 11, 12, 13, 14, and 15.

extracted within the therapeutic window of the antibiotic,¹⁷⁷ which for these patients was 10 days.¹⁷⁸

Dental: Removable Prosthetics

Methodology. Reviewed four charts of patients who received partial dentures (selected from the Prosthetics List) in the past year and interviewed dental staff.

First Court Expert Findings

- Removable partial denture prosthetics should proceed only after all other treatment recorded on the treatment plan is completed. The periodontal, operative, and oral surgery needs all should be addressed first. In none of the records reviewed was a comprehensive examination and treatment plan developed prior to impressions for removable partial dentures.
- In none were oral hygiene care or oral hygiene instructions provided.
- Periodontal assessment and treatment were not provided in any of the records.
- Because there was no comprehensive examination, nor any treatment plans developed, it was impossible to ascertain if all necessary care, including operative and/or oral surgery treatment, was completed prior to fabrication of removable partial dentures.

Current Findings

We concur with the First Court Expert that removable prosthetics treatment is inadequate. Moreover, it has deteriorated since the First Court Expert's Report, as wait times have increased (see Figure 1 *infra*). As with most of the other patients who received comprehensive care, none had a sequenced treatment plan or a periodontal assessment that included documented probing. Three (75%) had no documented oral hygiene instruction.

Dental: Sick Call/Treatment Provision

Methodology: Interviewed dental staff, reviewed Dental Sick Call Logs, Daily Dental Reports, and reviewed records of 12 inmates who were seen on sick call.

First Court Expert Findings

- Sick call is accessed via the inmate request form or from staff referral if the perceived need is immediate. It takes five to 10 days for urgent care complaints to be seen. This is unacceptable; they should be seen within 24-48 hours.
- In all 10 records reviewed the SOAP format was used and the patient's complaint was addressed.

¹⁷⁷ Shulman JD, Sauter DT. Treatment of odontogenic pain in a correctional setting. *Journal of Correctional Health Care* (2012) 18:1, 58 – 69; p. 68.

¹⁷⁸ Makrides et al. ("[d]elayed dental treatment of the original focus of the [tooth-related] infection may turn a minor problem into a serious condition. Although infection is usually self-limiting, and spatially-confined, it may spread because of a highly virulent organism. Complications could include Ludwig's angina, mediastinitis, cerebral abscess, maxillary sinusitis, chronic fistulous tracts, and infective endocarditis." (p. 559).

- The sick call appointment was not used for routine care. Treatment proceeded with a diagnosis in only two cases and an improper diagnosis in another. This lack of a proper diagnosis was seen in records reviewed in other areas that included sick call entries.
- An inadequate triage system is in place that prioritizes treatment needs. Inmate request forms are evaluated by the dental program by the following day and their treatment needs, based upon the request form, are prioritized. Urgent care needs are identified from the request form and seen ASAP, often taking five to 10 days. Others are scheduled accordingly or placed on the hygiene list if requested. All request forms are seen within 14 days.
- Inmates seek urgent care via the inmate request form or, if they feel they need to be seen immediately, by contacting staff, who can then call the dental clinic with the inmate's complaint. These inmates are seen at the dentists' discretion.
- Inmates with urgent care complaints (pain or swelling) from the request form often take five to 10 days to be seen. They should be seen with 24-48 hours from the date of the request. Mid-level practitioners at the units do not routinely see the inmate face-to-face to evaluate urgent care needs as indicated on the request form. If an inmate complains of a toothache, swelling, or pain to the nurse making rounds, the nurse can call the dental clinic with this information. They can provide over-the-counter pain medication.
- Some inmates are seen immediately if correctional staff can get the inmate to the dental clinic. There is no system in place to provide a face-to-face evaluation with medical/dental staff or inmates that complain of pain or swelling. This should be provided within 24-48 hours from the date of the request.
- Request forms from inmates seeking routine care are evaluated the next working day and the inmate given an appointment to be evaluated within 14 days. Inmates requesting to have their teeth cleaned are placed on a waiting list. Inmates for routine care are placed on a waiting list in sequential order. This list is approximately nine months long.

Current Findings

Dental sick call has deteriorated since the First Court Expert's Report. We concur with the findings of First Court Expert that dental sick call for urgent care issues is often untimely and the sick call triage system for dental problems is inadequate. We also identified current and additional findings as follows.

Sick Call

Prisoners access sick call by placing written requests (kites) in boxes in the cellhouses or by signing up for nurse sick call. Of five patients who submitted kites for dental sick call, the wait time ranged from five to 14 days, with a median of nine days. All progress notes were in the SOAP format.

Of seven entries in the nurse sick call log that suggested dental pain, all were referred to the dental service and five (71%) received face-to-face assessments by nursing. All those assessed received analgesics. Of six patients whose records document treatment, wait time to see a

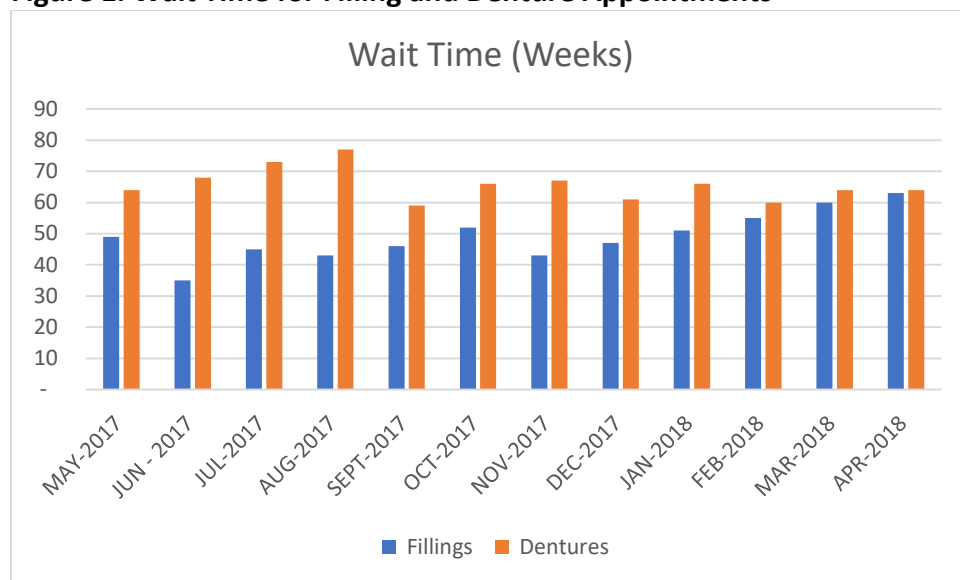
dentist ranged from five to 14 days, with a median of six days.¹⁷⁹ Patients who signed up for nurse sick call were generally seen by nursing staff the next day.

Timeliness of Care

Figure 1 is a summary of patient wait times based on monthly dental reports from May 2017 to April 2018. The wait time for fillings is more than 60 weeks (15 months),¹⁸⁰ higher than it has been since May 2017. Moreover, with only one dentist available, the backlog will continue to grow. According to the April dental report, 45 extractions and 18 fillings were performed; a 2.5:1 ratio, which suggests that MCC has insufficient dentist staffing to provide needed routine care and instead must focus on urgent care needs.

Wait time for dentures seems to have stabilized at around 15 months as well. However, since the standard of care is to complete the needed fillings and periodontal treatment before the denture impressions are done, there may be an additional delay of several years before denture fabrication can begin.

Figure 1. Wait Time for Filling and Denture Appointments



The kite log from January through April 2018 comprises 413 entries, listed by service requested.¹⁸¹ Before a prisoner may have a filling appointment, he must first have a “filling evaluation,” to determine if a filling is an appropriate treatment. If a filling is deemed to be the

¹⁷⁹ Nurse Sick Call Patient #6 has no documented treatment for this episode.

¹⁸⁰ The First Court Expert reported that the routine care wait list was approximately nine months long (see *supra*), which shows that the MCC dental program has deteriorated markedly since then.

¹⁸¹ Per memo from Colleen Runge to Gail Walls, HCUA, dated 5/21/18, the Dental Codes are O1 (written request), O2S (filling evaluation), O3S (filling evaluation), O4S (denture adjustment), O1x1 (extraction), O2x1 (filling), O3x1 (impressions), O6 (oral prophylaxis), O6x1 (dentist-referred prophylaxis), and O6D (Dilantin prophylaxis).

appropriate treatment, the patient is placed on the filling list.¹⁸² Of the 39 entries for fillings on the kite log, 28 were for filling evaluations and 11 were for fillings.

The Wexford contract specifies that “[v]endor shall provide dental checkups to offenders every two years, or more often if clinically indicated, and evaluations must be provided within 14 days after the offender's request for routine care treatment.”¹⁸³ However, it is mute on the more critical issue, the maximum waiting time for **treatment**.¹⁸⁴ So, under current dentist staffing, a prisoner who needs (for example) three fillings that require three appointments may wait more than three years for the last tooth to be filled. It is more likely than not that the teeth awaiting filling will become more difficult to fill and cause preventable pain.

While Wexford does not report periodontal treatment backlogs, dental hygienist caseload is reported in the in the monthly CQI minutes. The April CQI minutes (based on March data) reported a dental hygienist caseload of 1018 patients and the March 2018 Dental Report noted that the hygienist performed 61 cleanings/prophylaxes. This equates to a more than 16-month backlog. While a cleaning or prophylaxis is not a periodontal procedure,¹⁸⁵ it is often a precursor to periodontal treatment (if periodontal treatment has been prescribed by a dentist on the treatment plan).¹⁸⁶ A wait of more than a year before periodontal treatment can begin, even if it is diagnosed, is unreasonable and a such a treatment delay can result in preventable disease progression with concomitant bone loss.

Figure 2 shows that while the wait time for extractions has decreased from its high of 12 weeks in August 2017, it is currently at an unacceptable level for reasons explained in the extraction section, *supra*.

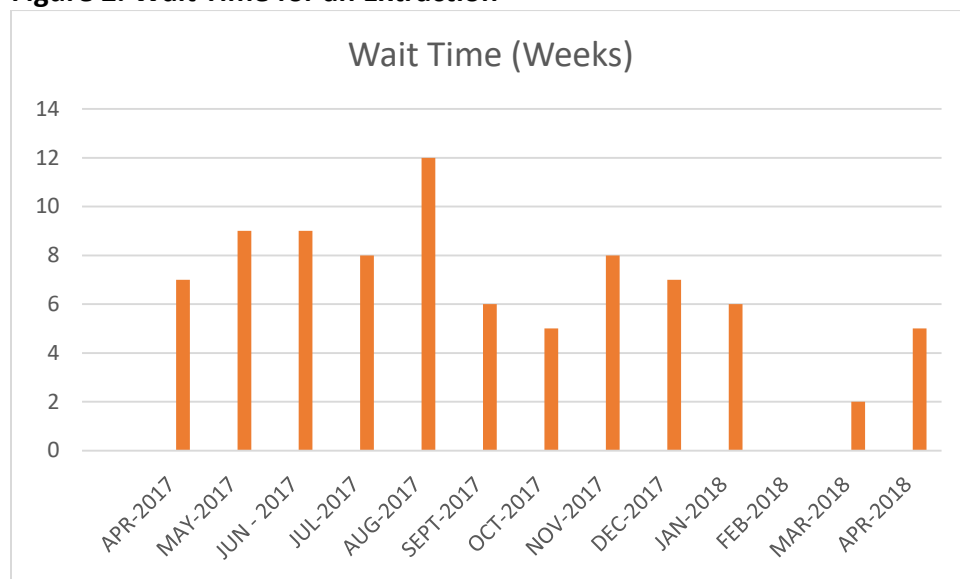
¹⁸² X-rays may be taken then, rather than at the biennial or initial exam. However, by delaying taking x-rays until the filling evaluation, valuable time may be wasted, and undiagnosed decay may progress to a point where the tooth becomes more difficult (or impossible) to fill.

¹⁸³ HFS# 2010-05-008, ¶ 2.2.6.1

¹⁸⁴ If the filling evaluations occur within 14 days, Wexford is deemed to be complying with the contract even if the queue for fillings is infinite. Similarly, if prisoners receive timely biennial examinations, Wexford is deemed to be in compliance even if the exams are incomplete and below accepted professional standards.

¹⁸⁵ The American Dental Association Classifies it as a preventive procedure (Code D1110).

¹⁸⁶ Treatment plans rarely prescribe periodontal treatment.

Figure 2. Wait Time for an Extraction¹⁸⁷**Dental: Orientation Handbook**

Methodology: Reviewed orientation manual and related documents.

First Court Expert Findings

The orientation manual is minimally but adequately developed for dental services and addresses types of care, access to care, and how treatment is scheduled.

Current Findings

We were not provided with an inmate orientation manual.

Dental: Policies and Procedures

Methodology: Reviewed Administrative Directives that deal with the dental program. Interviewed dental staff. Reviewed dental charts. Toured dental clinical areas. Reviewed DCC organizational chart.

First Court Expert Findings

The Dental Director was not aware of a policy and procedures manual. A review of the MCC Policy and Procedures Manual revealed a large section devoted to the policies and procedures for dental care. It was dated 1995, with no indication that it has been updated since then. This is not an adequate document from which to run the dental program.

Current Findings

¹⁸⁷ Wait time was not reported for February 2018.

The First Court Expert found that MCC dental policies and procedures were outdated and should be rewritten. This was done in 2015. However, the intake examination is still not consistent with the plain text of Administrative Directive 04.03.102.

The dental program is governed by Administrative Directive 04.03.102, amended 1/1/2012. It specifies that within 10 working days after admission to a reception and classification center, offenders shall receive “**a complete dental examination by a dentist**” (¶F2; emphasis added). The initial examination done at intake was not a complete examination by any reckoning and was in violation of IDOC policy.¹⁸⁸

We reviewed three MCC policies that relate to dental care: V1-15 (dental reporting and statistics), V1-16 (dental radiography), and V1-17 (handling instruments). All were revised January 2015. The policies suffer from several problems. First, the versions we were provided were unsigned. Second, the previous Medical Director’s signature block is present and there is no evidence that the current Medical Director is aware of (and approves of) these policies. Finally, there is no signature block for the Dental Director – the individual directly responsible for implementing the policies.

Dental: Failed Appointments

Methodology: Reviewed dental sick call log. Interviewed dental staff. Reviewed daily dental reports.

First Court Expert Findings

- The failed appointment rate of about 40% is very high. Reasons included refusals, lockdowns, and “other.” When asked, the dentists related that “other” usually meant security precedence and unavailability of escort staff.
- The percentage was very high for the month of April, when 362 appointments were missed because of a lockdown.
- When only failed appointments (inmate chose not to come to appointment) are included, the percentage drops to about 12%. In an older high security institution with multiple missions and security concerns such as MCC, movement of inmates is a challenge. That does not excuse the problem. Every effort should be made to work with administrative and correctional staff to correct this issue.

Current Findings

We concur with the findings of First Court Expert that failed appointments are a problem, despite apparent improvement. However, the April 2018 failed appointment rate (15.2%) is the lowest it has been this year.¹⁸⁹ On the other hand, there were 31 refusals, almost a yearly high.

Dental: Medically Compromised Patients

¹⁸⁸ See section on Comprehensive Care, *supra*.

¹⁸⁹ Source: Monthly Dental Reports.

Methodology: Reviewed health history form and randomly selected records of eight patients who were on Chronic Care Lists with diabetes or on anticoagulant therapy and had a dental encounter within the past two years.

First Court Expert Findings

- A review of the dental records of the four inmates on anticoagulant therapy revealed that two records made no mention of this in the health history section of the dental chart. It was indicated but not “red flagged” in the other two. No treatment was provided to any of these inmates.
- When asked, the clinicians indicated that they do not routinely take blood pressures on patients with a history of hypertension.

Current Findings

Documentation of the health record of medically compromised prisoners has not improved materially since the First Court Expert Report and we concur that documentation of the health record of medically compromised patients is inadequate. However, we identified current and additional findings as follows.

Of eight charts reviewed, five (63 %) did not document an updated health history at the last encounter.¹⁹⁰ There was no documented periodontal assessment and request for follow-up for the diabetics,¹⁹¹ which is particularly problematic given the relationship between periodontal disease and diabetes.¹⁹²

Dental: Specialists

Methodology: Interviewed dental staff, reviewed CQI documents, and reviewed dental charts of inmates who were seen by an oral surgeon.

First Court Expert Findings

- A local oral surgeon, Dr. Jay Swanson, is available and used for dental conditions such as trauma, removal of difficult wisdom teeth, and evaluation and removal of oral pathology. He has offices in Effingham and Mt. Vernon, Illinois. General anesthesia cases use the Effingham office.
- All records reviewed revealed proper case selection and good patient management, and good record documentation.

¹⁹⁰ Medically Compromised Patients #2 (anticoagulant therapy), #3 (diabetes), #5 (diabetes), #6 (anticoagulant therapy), and #7 (anticoagulant therapy).

¹⁹¹ Medically Compromised Patients #3 (generalized bone loss noted but periodontal probing was not documented, and treatment plan was not revised to include non-surgical treatment), and #5 (dental hygienist performed a prophylaxis; however, periodontal probing was not documented).

¹⁹² See, for example, Herring ME and Shah SK. Periodontal Disease and Control of Diabetes Mellitus. *J Am Osteopath Assoc*. 2006; 106:416–421; Patel MH, Kumar JV, Moss ME. Diabetes and Tooth Loss. *JADA* 2013;144(5):478-485 (adults with diabetes are at higher risk of experiencing tooth loss and edentulism than are adults without diabetes); and Teeuw WJ, Gerdes VE, and Loos BG. Effect of Periodontal Treatment on Glycemic Control of Diabetic Patients. *Diabetes Care* 33:421-427, 2010 (periodontal treatment leads to an improvement of glycemic control in type 2 diabetic patients).

Current Findings

Oral surgery consultations have not changed materially since the First Court Expert's Report and remain adequate and we concur with the First Court Expert's findings. Of five dental charts of patients sent to an offsite oral surgeon, all patients appear to have received appropriate treatment.

Dental: CQI

Methodology: Reviewed CQI minutes and reports. Interviewed dental staff.

First Court Expert Findings

- The dental program contributes monthly statistics to the CQI committee. The dental program conducted two studies, one in 2013 and another in 2014. One involved the effects of the medications Dilantin and Norvasc on the incidence of gingival hyperplasia. The other was a study of grievances as related to the different cellhouses within the institution. The results of each was presented and steps taken to address the findings.
- No studies were in place to address program weaknesses and problem areas.

Current Findings

The dental CQI program, has improved since the First Court Expert's Report and is adequate. We were provided with a summary of two studies.¹⁹³ We concur with the First Court Expert's findings that there is an ongoing dental CQI program. Moreover, current and additional findings follow.

A study of 50 patients who were on the restoration (filling) list May 2015 to December 2015, with treatment dates ranging from August 2016 until September 2016, found that 94% had successful restorations without need of extraction. However, the actual study was not provided – just a five-line summary, so its validity cannot be assessed.

Another study summary, "Effects of lockdowns and dental coverage on filling numbers and backlog numbers" had no analysis – just a recitation of findings.

Internal Monitoring and Quality Improvement Activities

Methodology: We reviewed annual and monthly CQI meeting minutes. We interviewed the CQI coordinator. We reviewed multiple death summaries and death records.

First Court Expert Findings

There was no relationship between CQI activity and improvements in the quality of services provided.

Current Findings

We agree with the First Court Expert's finding. We were told in interviews that a medical records technologist is the CQI Coordinator. She has no training in CQI. Although she told us that she

¹⁹³ Since we were not provided with the actual studies, we have no basis to assess their validity.

spends half of her working hours on CQI work, this work is mostly paperwork and organizing data collection and combining that into the CQI report. There is no one at the facility with any expertise or training in CQI. No one with CQI experience or knowledge of CQI methodology is involved in developing the CQI studies.

Three of six persons on the CQI Governing Body are custody-trained personnel (The Warden, Assistant Warden of Programs and the Wexford Regional Manager who is an ex-warden). Our opinion is that a Governing Body for a medical CQI program should not be directed by custody personnel. The medical CQI program should have a majority of medical personnel. The three persons on the Governing Body who are health personnel are the Agency Medical Director, the HCUA who is a nurse, and the Wexford site Medical Director.

The CQI plan is a generic plan that is not specific to issues at MCC. The CQI plan lists administrative directive requirements of the CQI program but does not indicate what the specific plan for CQI is at MCC.

There were 10 CQI medical studies. There were six outcome studies and four process studies. The six outcome studies were:

- Whether medication renewal for chronic illness was renewed prior to expiration.
- Whether a viral load was performed for persons with a positive hepatitis C antibody test.
- The percent of x-ray appointments which actually were completed when scheduled.
- The percent of inmates referred to the health unit for injuries who needed to be sent to a higher level of care.
- Whether inmates were seen within five days of discharge from the infirmary.
- Whether inmates with diabetes had medications renewed prior to expiration.

None of these were outcome studies. Two of these studies were poorly defined and we did not understand what the study was meant to measure. One was a study of viral load testing for hepatitis C. The study purpose was not defined. Another outcome study consisted of measuring the number of persons requiring treatment outside of the facility after being evaluated for injury. We could not figure out the purpose of this study or what clinical outcome it was meant to measure. The remaining four studies were performance measures, not outcome studies. As with other sites, none of these outcome studies included a clinical outcome. While some of these performance measurement were useful, none appeared to be amongst the most serious clinical problems at this facility.

We have comments on two of the process studies. One study had a declared intention of reducing denials by 30%. The study did not study variables of the referral process with an intention of improving the quality of referrals, but there was an intervention. The study resulted in a reduction of 389 referrals and a reduction of 98 denials. The intervention resulted in a reduction of referrals of 33 per month and a reduction of denials of 18 per month. Our concern is that it appears that patients who need referral are not receiving it. The study did not evaluate whether the reduced referrals were necessary or not. It's only intent was to reduce denials. Improvement

of quality was not the intent of the study. Reduction of referrals and denials only improves quality if the referrals and denials are unnecessary, which was not evaluated.

One study reviewed 1637 inmates with chronic illness with an intent apparently of studying whether their chronic illness appointment was timely. This study identified every staffing deficiency or lockdown situation with the resulting backlog in chronic illness clinic appointments. However, the study did not map the process and did not draw conclusions, so it was not clear what was learned or what actions could be taken to improve chronic illness appointments.

The HCUA identified staffing, scheduling appointments, and utilization management as the top three problems at the institution. There was only one study reasonably related to these three highest priority problems. This was a study of specialty care denials. This study was described in the specialty care section of this report. The study was initiated as an attempt to reduce denials without an analysis of whether denials were appropriate. The outcome of the study intervention was a greater reduction in referrals than a reduction of denials. In our opinion, the major problems related to specialty care referral are the lack of qualified primary care physicians who understand when to refer patients for consultation care, and the specialty care process itself, which we view as a barrier to care. The collegial review process and the impact of primary care training on referrals was not evaluated. Our opinion is that patients are not referred for necessary specialty care, but the CQI process had no mechanism to evaluate that question.

Deaths were listed in the CQI 2018 Annual Report. Death summaries were included in the report, but the death summaries had no critical analysis of the deaths. There was no mortality review and no problems were identified in the death summaries. Performing critical mortality review is a way to identify systemic problems so that future deaths can be prevented. This is not currently done. We reviewed seven deaths from MCC. Of those seven deaths, two were preventable and two were possibly preventable. This is an extraordinary large number of preventable deaths. We identified problems on all of the death reviews we performed. Summaries of these death reviews are present in the mortality review appendix of this report.

Recommendations

Leadership, Staffing, and Custody Functions

First Court Expert Recommendations

1. Place a priority on filling the Director of Nursing and Supervising Nurse positions. *We agree with this but believe that a priority should be placed on all supervisory positions and include physician and dental positions.*

Additional Recommendations

2. All budgeted positions should be filled.
3. A staffing plan should be developed that ensures sufficient staff to adequately provide care and to ensure administrative directives are adequately accomplished. This plan should include appropriate relief factors and include budgeted staff for infection control and CQI activities.
4. Vendor regional leadership positions should be filled with persons trained in a health care field.
5. IDOC Regional Coordinator positions should be filled by full-time persons without other IDOC responsibilities.

Clinical Space

First Court Expert Recommendations

1. Renovations in all the cell house sick call areas be completed.
2. All sick call areas be appropriately equipped.

We agree with these recommendations.

Additional Recommendations

3. Repairs (cracked walls, chipped and peeling paint, clogged vents, missing electrical outlet plates, etc.) and ongoing maintenance of the exam rooms in the cell houses and the medical building must be done to allow effective cleaning and create a safe patient care and professional environment.
4. Exam rooms and exam tables are not be used as storage spaces.
5. Replace all the non-adjustable infirmary beds with hospital beds with safety railings that have the capability to adjust the height, the head section, and the lower extremity sections. One of these beds should be an electrically adjustable bed.
6. Nurse call devices must be installed next to all infirmary beds.
7. Showers in the infirmary and geriatric housing units must be repaired and maintained to minimize the risk of falls.
8. Each cell house and the medical building must have an automated external defibrillator.
9. All clinical devices must have documented annual electric safety inspections.

Sanitation

First Court Expert Recommendations

1. Critically monitor cell house sick call areas for cleanliness and the use of paper barrier between patients on examination tables, or assure that table tops are sanitized between patients and appropriate hand washing/sanitizing is occurring between patients. *We agree with this recommendation.*

Additional Recommendations

2. Expand environmental rounds and the monthly Medical Safety and Sanitation Report to include the condition of the infirmary beds and exam tables, the functionality of the infirmary's negative pressure rooms, the compliance with annual inspection of medical devices, and other clinical space and equipment findings. The findings should be presented to the Quality Improvement Committee.

Radiology Services

First Court Expert Recommendations

The First Court Expert did not have any recommendations regarding radiology services.

Current Recommendations

1. IDOC needs to contact the Illinois Emergency Management Agency (IEMA) and Occupational Safety and Health Administration (OSHA) to review the reported decision that IDOC x-ray technicians do not need to wear radiation exposure devices (dosimeter badges) while working in IDOC radiology suites as outlined in Illinois Administrative Code 32-340 510 and 520. This current practice is not in alignment with the radiation safety practices in the community.
2. Contract with a radiation safety expert to assess the safety of the panorex (mandible films) unit's current location in an unleaded exam room in the MCC Reception and Classification building without a shielded area for the technician to stand when panorex films are being taken.

Medical Records

First Court Expert Recommendations

There were no recommendations of the First Court Expert for Medical Records.

Current Recommendations

1. An electronic medical record should be initiated statewide. This record should include electronic medication administration capability.
2. When charts are thinned, carry forward documents should include critical consultation reports, hospital reports, and specialized test reports that have significant impact on patient care.

3. Only medical records staff should file documents in medical records and only medical records staff should refile medical records.
4. Sick call requests by inmates should be filed in the medical record, as they are medical record documents.

Medical Reception and Intrasystem Transfer

First Court Expert Recommendation

1. The quality improvement program must utilize a clinician to review the records of patients who have recently gone through the reception process and for whom abnormalities have been identified in order to ensure that appropriate follow up occurs. This should be an ongoing part of the quality improvement program.¹⁹⁴ *We agree with this recommendation.*

Additional Recommendations

2. We recommend that the steps in the intake screening and reception process be monitored by adding data fields to the intake logs that indicate the timeliness of each step, including the physical examination, tuberculosis screening, etc.
3. The IDOC Administrative Directive 04.03.101 should be revised to eliminate obtaining written consent for HIV testing given the opt-out policy that has been established. HIV testing should be opt-out testing.

Nursing Sick Call

First Court Expert Recommendation

1. Transition to an all Registered Nurse triage and sick call system. Licensed Practical Nursing (LPN) staff is triaging sick call requests and may or may not perform an examination, make an assessment and then formulate a plan, which could be no treatment or treatment from approved treatment protocols or to refer to a provider. All of these actions are beyond the educational preparation and scope of practice for an LPN.¹⁹⁵ *We agree with this recommendation.*

Additional Recommendations

2. Timeliness of nursing sick call should be monitored by CQI at least annually.¹⁹⁶
3. The quality of nursing assessments and the plan of care should be monitored by nursing service as part of the peer review or quality improvement. This should replace Medical Director review.
4. Medical records must be taken to sick call and used by nurses when seeing patients. This is one example of the benefit of having an electronic health record.

¹⁹⁴ Lippert Report Menard p. 43.

¹⁹⁵ Lippert Report Menard p. 43.

¹⁹⁶ National Commission on Correctional Health Care. 2014. Standards for Health Services in Prisons. P. 14.

5. Providers should see patients timely according to the urgency of the referral.¹⁹⁷

Chronic Disease Management

First Court Expert Recommendation

1. Physicians should be trained and certified in a primary care field. Only primary care trained providers should be managing chronic illnesses.
2. The chronic disease database should be used as a tool to identify areas in which the program is underperforming so that interventions can be targeted to improve.
3. Providers should be implementing a change to the care plan when patients have suboptimal control of their disease.
4. All providers need access to electronic references at the point of care.
5. There were issues with the accuracy of evaluating the degree of disease control for patients enrolled in the pulmonary clinic. This is partly due to the language of the policy, which should be revised to be more consistent with the NHLBI guidelines.
6. Providers should be familiar with alternative methods of TB testing, i.e., the interferon gamma assays and their appropriate use. Efforts should be made to confirm patient's reports of previous treatment for LTBI prior to committing them to treatment.
7. The cell block clinics should be adequately equipped and present a professional clinical environment. Safety concerns among the providers need to be addressed.

We agree with these recommendations.

Additional Recommendations

8. Update problem lists so that they include all current and significant past clinical conditions and procedures. Failure to develop a complete and accurate problem list puts patients' continuity of care at significant risk.
9. Monitor the providers' documentation in the chronic care progress notes for the rationale for clinical decisions, diagnoses, and treatments.
10. Expand the existing telehealth and/or establish an e-consult specialty program to include additional medical specialists to assist primary care providers with the management of complex and common medical conditions including diabetes, hypertension, cardiology, dermatology, neurology, and infectious diseases.
11. Perform hepatitis C RNA viral loads and fibroscans on all patients with hepatitis C as required by IDOC policy.
12. Revise the hepatitis C Guidelines to increase the number of the patients who are eligible to receive treatment. It is the best interest of the patient-population, the institution, and the non-incarcerated community to treat all patients with hepatitis C. It is impossible to clinically and legally justify waiting for patients to develop cirrhosis before initiating treatment.

¹⁹⁷ Emergent referrals should be seen immediately, urgent referrals should be seen the same day and routine referrals seen within 72 hours.

13. Streamline the prerequisite testing required prior to initiating hepatitis C treatment to match the processes utilized in the community. The current lengthy pre-treatment testing and evaluation contributes to the unacceptably prolonged delays in hepatitis C treatment.
14. Implement and utilize current United States Preventive Services Task Force (USPSTF) guidelines for screening adults for cancer and other conditions (abdominal aortic aneurysm, etc.).
15. Implement and utilize CDC age-based and disease-based standards for the administration of adult immunizations.
16. Calculate and document the 10-year cardiovascular risk score on all appropriate adults to assist with the decision, timing, and medication selection for the prevention of cardiovascular disease.
17. Consult with endocrinologists/diabetologists to provide a comprehensive review and recommendations concerning the medical management and the frequency of CBG testing of type 1 and type 2 insulin-prescribed diabetics at MCC and in the IDOC system.
18. Develop a plan to change anticoagulation treatment from Vitamin K antagonists (warfarin) to newer types of anticoagulants that do not require frequent ongoing lab testing to determine the adequacy of anticoagulation. This should especially be considered when physicians are unable to obtain a therapeutic anti-coagulation level.
19. Provide all chronic care providers and nurses with access to current, comprehensive electronic medical reference services such as "UpToDate" in all clinical areas and clinical offices.

Urgent/Emergent Care

First Court Expert Recommendations

1. Nursing staff must be retrained with regard to an appropriate assessment for a patient who has been sent to the hospital and returned to the infirmary. Specifically, the training should include what subjective and objective information to collect in relationship to the problems that were addressed at the hospital. *We agree with this recommendation.*
2. A clinically trained person should insure that all of the relevant offsite service reports for unscheduled offsite services are available within a few days, including discharge summaries, emergency room reports, operative reports, and catheterization reports, so that they can be discussed by the primary care clinician with the patient and a plan can also be discussed. *We agree with this recommendation.*
3. When a procedure or a visit is interrupted due to a lockdown, the Medical Director should be notified and must determine whether, despite the lockdown, it must occur or can wait and occur the following day¹⁹⁸. *We agree with this recommendation. There were no instances of a procedure or visit being interrupted because of a lockdown among the charts we reviewed.*

Additional Recommendations

¹⁹⁸ Lippert Report Menard p. 44.

4. Each of the openings in the emergency response bag should be sealed with a numbered plastic tag. The integrity of the seal should be checked and documented on the emergency equipment log at the beginning of each shift.
5. A corrective action or improvement plan should be developed based upon the critique of the annual mass casualty drill. Implementation of the plan should be monitored by the QI program.
6. The critique of emergency responses should be reviewed by CQI for trends and areas identified for correction or improvement.
7. All emergency room visits should be reviewed with regard to timeliness, appropriateness of preceding care, accuracy of information in the health record, and continuity of care upon release back to the facility. This should be done by clinical leadership and the QI program.
8. IDOC medical supervisors should conduct reviews of sentinel events, including preventable hospitalizations. These reviews need to identify deficiencies and develop corrective actions. Providers who commit grossly and flagrantly egregious infractions should be referred to peer review and these actions should be reviewed with respect to their privilege renewal.

Specialty Consultations

First Court Expert Recommendations

1. A clinically trained staff person should be responsible for ensuring that all relevant offsite service reports are available for the clinician to review with the patient within a week of the offsite service having been provided. *We agree with this recommendation but add that the responsibility for this rests on the vendor that establishes the contract with the consultant and hospital. They must be held accountable for this deficiency. A clinically trained staff at the facility can be responsible for getting reports but responsibility for the process resides with the vendor.*
2. When the scheduled offsite service reports are available, the physician must document a visit with the patient in which the findings and a plan are discussed. *We agree with this recommendation but add that the physician must review the offsite service report and key findings and recommendations, and discuss all of these with the patient in an effective manner so that the patient understands the therapeutic plan resulting from the consultation. A rationale for not accepting recommendations needs to be documented and discussed with the patient. This must be done timely. A week timeframe is acceptable.*
3. Services that cannot be scheduled for more than a month must be addressed by the Medical Director with the State Medical Director. *We agree with this recommendation.*

Additional Recommendations

4. The collegial review process should be abandoned because it is, in our opinion, a patient safety hazard.
5. Referral for hepatitis C to UIC should not be required to go through Wexford utilization review. IDOC physician should refer patients directly.

6. Referral to the Wexford infectious disease doctor for approval for ultrasound and EGD for persons with cirrhosis should be abandoned on the basis of patient safety. If a Wexford doctor is not primary care trained (board certified or board eligible in a primary care field), then all patients with APRI > 0.7 should be used as a benchmark to begin diagnostic screening for cirrhosis (upper endoscopy for varices and biannual ultrasounds to screen for hepatocellular carcinoma). Primary care trained doctors should document cirrhosis as a problem when it is identified and begin appropriate screening as recommended for cirrhosis (screening EGD as baseline and ultrasounds biannually for hepatocellular carcinoma).
7. Tracking specialty care should be standardized and under control of IDOC, not Wexford. IDOC should track whether hospital reports and all types of specialty care reports are received within five working days of the service date. Summary statistics on reports received later than five days after the service date need to be reported in CQI monthly and annual reports. This should be included in the contract as a monitored item associated with penalties for poor performance (e.g., <95% of reports available within five days).

Infirmiry Care

First Court Expert's Recommendations

1. Address life/safety concerns with infirmiry patients padlocked in their rooms.
2. Train inmate health care unit porters in blood borne pathogens; infectious and communicable diseases; bodily fluid clean-up; the proper cleaning and sanitation of infirmiry beds, furniture, and linens; and confidentiality of medical information.
3. Replace torn and ragged linens. Maintain an adequate supply of bedding and linens.
4. Sanitize infirmiry bedding and linens through appropriate laundering methods.
5. Properly document in the patient medical record a medical acuity level, i.e., acute, chronic, housing, administrative placement.
6. Properly document in the patient medical record a medical assessment rather than a housing designation in the "assessment" portion of an infirmiry patient SOAP notes.

The First Court Expert's recommendations to train the infirmiry porters and to maintain an adequate supply of linens have been addressed. We concur with the remaining recommendations of the First Court Expert.

Additional Recommendations

7. Adjust the level of nurse staffing to assure that patient-inmates with significant physical and mental disabilities have their medical, physical, and safety needs met.
8. The IDOC needs to perform an assessment of housing for disabled, and elderly inmates who need skilled nursing care. IDOC needs to build or otherwise find acceptable housing for these inmates.
9. Transfer patients whose clinical needs exceed the capability of the MCC infirmiry to a licensed clinical skilled-nursing facility either within IDOC or in the community.
10. Educate, monitor, and track the comprehensiveness of the provider infirmiry notes to assure that progress notes adequately document the clinical status of the patient and the

current treatment plan. Failure to document this information puts the health of the patient at risk.

11. Educate, monitor, and track provider notes to assure that the clinical justifications and reasons for clinical decisions and treatments are documented. Failure to document this information puts the health of the patient at risk.

Pharmacy and Medication Administration

First Court Expert Recommendations

The First Court Appointed Expert made no recommendations concerning pharmacy and medication administration.

Current Recommendations

1. Adopt a computerized provider order entry (CPOE) program to eliminate handwritten orders. Replace handwritten transcription of orders to the MAR with printed labels after the pharmacy has reviewed and verified the order. Medications which must be started urgently may be transcribed in handwriting onto the MAR. When the label arrives, it should be affixed to a new line on the MAR and documentation continued there.
2. Order implementation should take place within 24 hours. Adopting CPOE eliminates delays in treatment resulting from not transcribing orders timely.
3. Medication should be administered in patient specific, unit dose packaging. The practice of pre-pouring and the use of multiuse envelopes should be stopped.
4. The use of a list to prepare controlled substances and the placement of doses for multiple patients into a collective container should be stopped *immediately*.
5. Alternative forms of medication should be used rather than crushing and floating (liquid or injectable).
6. The MAR should be used by the nurse to verify the medication, dose, and route of administration is correct immediately before giving the medication to the patient. The nurse should have the MAR available to answer any questions or concerns the patient has about the medication.
7. When medication is dropped on the floor, the patient should be offered a replacement and not be forced to choose between going without or ingesting a medication that is unsanitary.
8. Medication should be documented on the MAR at the time it is administered. When medication is not given, the reason must be documented on the MAR.
9. Every MAR should have the signature and initials of every nurse who has administered medication to that patient. An electronic MAR would document the identity and credentials of any person administering medication automatically.
10. Printed labels should be provided to place on the MAR when a new order is dispensed. Orders should not be handwritten on the MAR unless it is a medication to be given immediately.
11. A system for timely renewal of chronic disease and other essential medications should be developed.

12. Nurses should refer any patient who does not receive three consecutive doses of medication critical in managing a chronic disease (insulin, Plavix, factor H, HIV medication, antirejection medications, etc.) to the treating provider. The treating provider should meet with the patient and determine if treatment can be modified to improve adherence.
13. Patient adherence with KOP medications prescribed to treat chronic disease should be monitored at regular intervals (monthly by nursing and by the provider at each chronic disease visit).
14. Revise the policy and procedure for medication administration to provide sufficient operational guidance to administer medications in accordance with accepted standards of nursing practice.
15. The CQI program should develop, implement, and monitor quality indicators related to pharmacy services and medication administration.
16. Root cause analysis and corrective action plans should be used to target the causes of performance that is below expectations. Corrective action should consider system improvements such as computerized provider order entry, use of bar coding, patient specific unit dose packaging, EMAR, etc., to support desired performance.

Infection Control

First Court Expert Recommendations

1. Continue to aggressively monitor skin infections and boils. *We agree with this recommendation.*
2. Assure a practice of appropriately laundering and sanitizing infirmary bedding and linens either in the healthcare unit or institutional laundry. If laundering in the healthcare unit, water temperatures should be monitored and recorded daily to assure a 160°F or 140°F reading. *We agree with this recommendation and further recommend that a policy and procedure be written on how patient linens are laundered to include instruction to send linens soiled with body fluid to the institution laundry, that water temperature be tested and logged periodically, and that a booster be added to the hot water inlet on the washing machine.*
3. Train all healthcare unit porters in blood-borne pathogens, infectious and communicable diseases, and the proper cleaning and sanitizing of infirmary rooms, beds, furniture, toilets, and showers. *This recommendation has been accomplished.*
4. Since there are no visual or audible alarms for the infirmary negative pressure respiratory isolation rooms, when a patient is isolated due to respiratory infection, gauge readings should be monitored and recorded each shift. When the rooms are empty or being used for purposes other than respiratory infection, gauge readings should be monitored and recorded weekly. *Pressure is monitored and recorded consistent with this recommendation.*
5. Install, at a minimum, an audible alarm to immediately notify infirmary staff of the loss of negative pressure in respiratory isolation rooms. *Audible alarms are in place for the isolation rooms; therefore, this recommendation has been accomplished.*
6. Critically monitor cellhouse sick call areas for cleanliness, the use of a paper barrier between patients on examination tables or assure table tops are sanitized between

patients, and appropriate hand washing/sanitizing is occurring between patients. *This recommendation has been accomplished.*

7. Each month, critically inspect upholstered equipment and mattresses for any tears or holes in the outer cover and assure the items are taken out of service until repaired. *We agree with this recommendation and suggest that it be added to the Safety and Sanitation Rounds. We found numerous upholstered items which need to be removed and repaired.*

Additional Recommendations

8. Infections and communicable disease data should be analyzed and discussed as part of the monthly and the annual CQI meetings. This should include discussion of trends, updates from the CDC, and review of practices.
9. Update the IDOC Infection Control Manual now and at least every two years.
10. Update the Health Services policies and procedures that relate to sanitation and infection control now and at least every two years.

Dental Program

Dental: Staffing and Credentialing

First Court Expert Recommendations: None.

Current Recommendations

1. Hire two dentists immediately.
2. Until three full-time dentists are hired, and the backlogs are reduced, Wexford should provide one or more full-time PRN dentists.
3. An additional 0.5 FTE dental hygienist should be hired.
4. Dentist staffing should be revisited after dentists incorporate bite wing x-rays and periodontal probing into their examinations, since it is likely that additional pathology will be identified when examinations and treatment comport accepted professional standards.

Dental: Facility and Equipment

First Court Expert Recommendations

Replace or repair the x-ray developers in the North 2 and R&C clinics immediately.

1. The space in the HSU clinic that houses the two main dental units is too small to allow efficient care flow and any sense of privacy, and enlargement should be considered for efficient care delivery and safety considerations.
2. All electric outlets should be wall-mounted or protected by the cover for the junction box at the foot of the chair. Loose wires should be neatly arranged and out of traffic flow. We note that this issue has been addressed.
3. All the units, chairs, and cabinetry should be replaced, and surface areas should be better able to accommodate disinfection.
4. Replace the radiograph unit in the clinic immediately with a wall-mounted unit capable of digital radiography.

5. The Panelipse [panoramic] radiograph unit should be replaced. This is critical for a reception center.

We agree with these recommendations.

Additional Recommendations

6. While the quality of the radiographs is adequate, given the age of the panoramic x-ray unit and the R&C mission of MCC, a replacement should be high in the capital equipment replacement list. Moreover, the replacement should be digital.

Dental: Sanitation, Safety, and Sterilization

First Court Expert Recommendations

1. Sterilization at the HSU clinic is improper. MCC should develop a sterilization system that implements a proper flow from dirty to sterile. *We agree, but note that notwithstanding the inadequate design, the instruments were sterilized appropriately.*

Additional Recommendations: None.

Dental: Review Autoclave Log

First Court Expert Recommendations

1. Spore test the autoclaves, and sterilizers should be tested on a weekly basis and proper logs should be maintained. We note that the previously identified deficiencies have been corrected.
2. Safety glasses should be provided to all patients receiving dental care.
3. Biohazard warning signs should be posted in the sterilization areas in the dental clinics.
4. Warning signs should be posted in the area where x-rays are taken to warn pregnant females of potential radiation hazards.

We agree with these recommendations.

Additional Recommendations

5. The dry heat sterilizer in the HCU clinic has been out of service for approximately two years and should be removed.

Dental: Comprehensive Care

First Court Expert Recommendations

1. Comprehensive "routine" treatment should be provided only from a well-developed and documented treatment plan.
2. The treatment plan should be developed from a thorough, well documented intra and extra-oral examination, to include a periodontal assessment and thorough examination of all soft tissues.
3. In all cases, appropriate bite wing or periapical x-rays should be taken to diagnose caries.
4. Hygiene and periodontal care should be provided as part of the treatment process.
5. Care should be provided sequentially, beginning with hygiene services and dental prophylaxis.

6. Oral hygiene instructions should be provided and documented.

We agree with these recommendations and emphasize that current MCC practice falls well below accepted professional standards.

Additional Recommendations

7. Treatment performed should be reported using standard (American Dental Association) definitions and procedure codes or entries that can be mapped to the treatment codes.
8. Biennial exams should include a documented oral cancer examination.

Dental: Intake (Initial) Examination

First Court Expert Recommendations

1. Oral hygiene instructions should be provided at the time of the initial examination.
We agree. However, the OHI provided at the intake screening was inadequate.
2. The area where x-rays are taken should have warning signs posted that clearly warn of potential radiation hazards to pregnant females. *We agree with this recommendation.*
3. A consent form should be developed and used for pregnant females that explains radiation hazards and gives the examiner permission to take the x-ray. *This is moot since MCC is a male facility.*

Additional Recommendations

4. The oral hygiene instructions provided by the dentist should be more thorough, or in the alternative, they should be provided by other dental personnel.
5. The dentist should view the panoramic x-ray while the patient is being examined.
6. The dentist should wash hands before re-gloving or, in the alternative, use alcohol wipes.¹⁹⁹
7. The initial exam should document Periodontal Screening and Recording (PSR), which is a professional standard.

Dental: Extractions

First Court Expert Recommendations

1. A proper diagnosis should be part of the treatment process. *We agree with this recommendation; however, we note that the diagnoses were appropriate in the charts we reviewed.*

Additional Recommendations

2. When an antibiotic is prescribed for a tooth-related infection, the tooth should be extracted within the therapeutic window of the antibiotic. A follow-up appointment for the extraction should be made so that the tooth is extracted within 10 days.
3. The health history should be updated before a tooth is extracted.

¹⁹⁹ Centers for Disease Control and Prevention. *Summary of Infection Prevention Practices in Dental Settings: Basic Expectations for Safe Care*. Atlanta, GA: Centers for Disease Control and Prevention, US Dept of Health and Human Services; October 2016, p.7.

4. The consent form should specify the tooth to be extracted and the reason for the extraction (i.e., the diagnosis).

Dental: Removable Prosthetics

First Court Expert Recommendations

1. A comprehensive examination and well developed and documented treatment plan, including bitewing and/or periapical radiographs and periodontal assessment, precede all comprehensive dental care, including removable prosthodontics.
2. Periodontal assessment and treatment should be part of the treatment process and that the periodontium should be stable before proceeding with impressions.
3. All operative dentistry and oral surgery as documented in the treatment plan be completed before proceeding with impressions.

*We agree with these recommendations and note that **current** practice is substantially below accepted professional standards.*

Additional Recommendations: None.

Dental: Sick Call/Treatment Provision

First Court Expert Recommendations

1. All treatment should proceed from a proper diagnosis.
2. A system should be implemented immediately that insures that inmates with urgent care complaints (pain and swelling) are seen and evaluated by medical/dental staff within 24-48 hours from the date on the request form. It is from this face-to-face evaluation that scheduling, and treatment should proceed. The appropriate medical staff in the units should be utilized in this effort. We note that patients who sign up for nurse sick call with complaints of dental pain or swelling are seen within 48 hours by a nurse and are offered non-narcotic analgesics. Furthermore, patients who sign up for nurse sick call generally have timely face-to-face assessments and receive analgesics when appropriate.

We agree with these recommendations.

Additional Recommendations

3. Nurses should triage all requests for dental care. Non-urgent requests (cleaning, routine exams, fillings, etc.) should be sent to the dental clinic for scheduling. All other dental complaints should be assessed at nursing sick call, treated for pain as needed, and referred to the dentist based upon clinician urgency.
4. The Wexford contract should be amended to specify a maximum wait time for a routine care appointment to 90 days.

Dental: Orientation Handbook

First Court Expert Recommendations: None.

Additional Recommendations: None.

Dental: Policies and Procedures

First Court Expert Recommendations

1. The dental program should develop a current, detailed, thorough, and accurate policy and procedure manual that defines how all aspects of the program are to be managed. Once developed, it should be reviewed and updated on a regular basis and as needed for new policies and procedures. *We agree with this recommendation.*

Additional Recommendations

2. The Dental Director should sign the policies. Moreover, all dental personnel should sign a memo acknowledging having read the policies.

Dental: Failed Appointments

First Court Expert Recommendations

1. Develop a comprehensive CQI study to evaluate reasons for missed appointments and seek remedies to correct the problem and improve getting inmates to their appointments. *We agree. Although the failed appointment rate has fallen to a yearly low, it is still worthwhile to see if there remains room for improvement. Furthermore, the refusal rate is worth studying.*

Additional Recommendations: None.

Dental: Medically Compromised Patients

First Court Expert Recommendations

1. The medical history section of the dental record should be kept up to date and that medical conditions that require special precautions should be red-flagged to catch the immediate attention of the provider.
2. Blood pressure readings be routinely taken of patients with a history of hypertension, especially prior to surgical procedures.

We agree with these recommendations.

Additional Recommendations

3. Diabetics should be referred for a periodontal assessment that includes periodontal probing every six months.
4. Diabetic patients diagnosed with periodontal disease should be offered an oral prophylaxis and non-surgical periodontal treatment (i.e., scaling and root planing) every six months if clinically indicated. This should be part of the chronic care program.

Dental: Specialists

First Court Expert Recommendations: None.

Additional Recommendations: None.

Dental: CQI

First Court Expert Recommendations

1. Develop vigorous CQI studies that address the weaknesses presented in this report and put in place steps to correct the problems. *We agree with this recommendation.*

Additional Recommendations

2. IDOC should hire an individual experienced in health services research to guide the local CQI studies effort.

Internal Monitoring and Quality Improvement

First Court Expert Recommendations

1. The QI policy and the training connected to it must be redone in order to facilitate quality improvement effectively occurring at each institution. This will entail a lengthy discussion. *We agree with this recommendation.*

Additional Recommendations

2. The paperwork requirements of putting together information for the annual CQI report need to be separated from the role of leading CQI efforts in improving care.
3. The Governing Body of the health care program needs to be predominantly medical personnel.
4. CQI plans need to be specific to the facility and address major concerns or problems at that facility.
5. A mortality review process needs to be initiated. This process should be managed and performed by non-vendor personnel under direction of the Office of Health Services. This group should review all deaths and sentinel events to identify problems and offer solutions that the facility CQI program addresses and responds to.

Appendix A

Staffing for Menard Correctional Center					
Position	State or Wexford	Filled	Vacant	LOA	Positions
HCUA	State	1	0		1
DON	State	0	1		1
Nursing Supervisor	State	3	0		3
Office Coordinator	State	2	0		2
Office Assistant	State	1	3		4
Staff Assistant	Wexford	1	0		1
Office Associate	State	2	0		2
Clerk II	State	1	0		1
Health Info Assoc	State	2	0		2
RN	State	18	10	1	28
LPN	State	12	8		20
LPN	Wexford	4	2		6
Dental Director	Wexford	0	1		1
Dentist	Wexford	1	1		2
Dental Assistant	Wexford	2	0		2
Dental Assistant	State	1	0		1
Dental Hygienist	State	1	0		1
Medical Director	Wexford	1	0		1
Physician	Wexford	0	2		2
NP	Wexford	2	1		3
Wexford Site Manager	Wexford	1	0		1
Med Room Asst	Wexford	2	0		2
Radiology Tech	Wexford	1	0		1
Phlebotomist	Wexford	1	0		1
Optometrist	Wexford	1	0		1
PT aide	Wexford	1	0		1
Physical Therapist	Wexford	0.1	0		0.1
Total		62.1	29	1	91.1

Northern Reception and Classification Center
2nd Court Appointed Expert Report
Lippert v Godinez

Visit Date: January 29-February 1, 2018

Prepared by the Medical Investigation Team

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Table of Contents

Overview	2
Executive Summary	3
Findings	7
Leadership, Staffing, and Custody Functions.....	7
Clinic Space, Sanitation, Laboratory, and Support Services	15
Medical Records.....	22
Medical Reception	27
Intrasystem Transfer	34
Nursing Sick Call	35
Chronic Care.....	40
Urgent/Emergent Care.....	50
Specialty Consultations	51
Infirmity Care	56
Pharmacy and Medication Administration	62
Infection Control	67
Dental Program	68
Internal Monitoring and Quality Improvement.....	84
Recommendations	94
Leadership, Staffing, and Custody Functions.....	94
Clinic Space, Sanitation, Laboratory, and Support Services	95
Medical Records.....	95
Medical Reception	96
Intrasystem Transfer	98
Nursing Sick Call	98
Chronic Care.....	99
Urgent/Emergent Care.....	100
Specialty Consultations	101
Infirmity Care	102
Pharmacy and Medication Administration	102
Infection Control	104
Dental Program	104
Internal Monitoring and Quality Improvement.....	110
Appendix A	111
Appendix B	112
Appendix C	115

Overview

From January 29, 2018 through February 1, 2018, the Medical Investigation Team visited the Northern Reception and Classification Center in Joliet, Illinois. This report describes our findings and recommendations. During this visit, we:

- Met with leadership of custody and medical
- Toured medical services areas and housing units
- Talked with health care staff
- Reviewed health records and other documents
- Interviewed inmates

We thank Warden Randy Pfister and his staff for their assistance and cooperation in conducting the review. We had complete cooperation from the Illinois Department of Corrections (IDOC).¹

The Stateville Northern Reception Center's (NRC) primary mission is a reception center where staff performs intake processing of new inmates before they are sent to other IDOC facilities within the state. It was built in 2004 and is the largest reception center in the state of Illinois. On 1/29/18, the first day of our visit, the NRC census was 1,493 inmates, with an additional 188 inmates housed in the minimum security unit (MSU), for a total of 1,681 inmates. The NRC population includes 53 inmates in segregation, and 15 inmates in boot camp.

In 2017, the NRC received 15,942 inmates or approximately 307 inmates a week. NRC has a 20-bed infirmary; 12 beds are assigned to medical and eight beds are assigned to mental health.

NRC is part of a two-facility complex that includes Stateville Correctional Center (SCC). SCC is the parent facility of this complex and a single Warden manages both facilities. Each of these facilities is a stand-alone facility; they are not physically connected. They are separated by security perimeters and one must drive a short distance and reenter a second security gate to enter the other facility.

The population design capacity for NRC is not calculated separately from SCC. For SCC and NRC combined, the population is currently 89% of design capacity. Twenty-nine inmates were housed at the facility greater than 90 days. We note that this is significantly fewer than the 587 individuals who remained at the facility greater than 60 days at the time of the First Court Expert's NRC report.² This implies that intake evaluations and transfers are occurring at a faster rate than previously. The 29 inmates who remain at NRC greater than 90 days include 12 inmates who remain at the facility for medical reasons. Of these, six have disabilities and are

¹ We did not experience complete cooperation from Wexford Health Sources. Their attorney required that he be present for interviews with Wexford staff but was unable to attend our tour, prohibiting some interviews with the Medical Director, physician assistant, offsite scheduler, and follow-up questions with the Director of Medical Records. We are in discussions about how to improve the cooperation with Wexford so that it does not impair our ability to conduct interviews with staff.

² Northern Reception Center (NRC) Report, January 21-23, 2014 prepared by the Medical Investigation Team.

awaiting ADA placement at other facilities. The remaining six individuals are on hold for medical reasons, mostly for continuing specialty medical treatment. NRC has a consistent mental health caseload of approximately 450 inmates and eight rooms designed for mental health watches. Inmates attending Court in the northern district are housed at both SCC and NRC. These are called WRITS. The combined population of WRITS at SCC and NRC is 55.

Executive Summary

Based on a comparison of conditions as identified in the First Court Expert's report, we find that conditions appear to have deteriorated. We find that NRC is not providing adequate medical care to patients. There are systemic issues that present ongoing serious risk of harm to patients and result in preventable morbidity that could also result in mortality. The deficiencies that form the basis of this opinion are provided below.

Though NRC is a large facility with over 1400 inmates, it is still treated as part of SCC. NRC and SCC share a Warden, Assistant Warden of Programs, and medical staff. These facilities are unique facilities, each with a different mission; they need separate medical staff and need to operate independently due to their separate and unique missions.

While the leadership staff is now in place, they are all recently hired. The Medical Director is a nuclear radiologist and performs inadequately in primary care, and provides little to no clinical leadership. He has been with Wexford for years and has continued to perform poorly, and yet has been assigned to be a Medical Director. There is no evidence that Wexford performs any credentialing or privilege assessment except to ascertain that the provider has a license. This is below community standard of practice. Wexford has hired an ex-warden without formal medical training as Regional Manager, which in our opinion is unacceptable.

NRC has inadequate staffing. There is a 42% vacancy rate, which is extraordinarily high. The mixed staff of Wexford and IDOC employees creates confusion regarding supervisory lines of authority. The IDOC has not performed a staffing needs assessment. Some areas of service are understaffed or not staffed at all (e.g., infection control, quality improvement and clerical staff). Relief factors are not incorporated into projecting staffing needs. The numbers of custody staff appears inadequate to support the medical requirements of providing security to nurses as they administer medication and to transport inmates for clinical appointments.

We found that the conditions of confinement are a major impediment to the delivery of health care. At NRC, inmates are locked down 24 hours a day except for four hours per week. We have not observed the conditions of confinement found at NRC at any other correctional facility in the country except supermax prisons, where even these inmates are granted one hour out-of-cell time per day.

As a result, NRC inmates are unable to confidentially submit their health requests into locked boxes accessed only by health care staff because they are not allowed out of their cells. Nurses

do not adhere to standards of nursing practice with respect to medication administration due to the conditions of confinement. This has resulted in systemic medication errors and ongoing risk of harm to patients. (See Pharmacy and Medication Management).

NRC has a number of clinical space and sanitation problems. Inmates in the housing units are not brought to the health care unit for nursing sick call and these evaluations are performed in housing unit rooms unacceptable for clinical evaluations. The number of providers exceeds the number of examination rooms in the health care clinic, which results in prioritization of work schedules and promotes missed evaluations. In almost every clinical area, sanitation and maintenance of the physical plant was not at an acceptable level for provision of health care. Some equipment was non-operable, negative pressure rooms were not functioning, patient examination tables lacked paper barriers, examination tables and infirmary beds were nonadjustable, and sinks and faucets all had mineral deposits, making them harder to sanitize. Adequate clean linens were not in supply on the infirmary for incapacitated patients who frequently soil themselves. These deficiencies are typically addressed by a regular sanitation schedule and performance of environmental rounds, which do not happen at this facility.

Medical records are inadequate and promote poor clinical care. Because of the lack of staffing, NRC does not maintain the medical records in accordance with its own administrative directives. It also does not maintain medical records in accordance with guidelines from the Illinois Department of Human Services. Documents are not present in the medical record in an organized manner, making the record difficult to use. Laboratory and consultation reports are often not present in the medical record, making it difficult to provide adequate clinical care. The medical record room is undersized, cluttered, and not secure. There is no medical records tracking system to provide accountability for the location of medical records.

Although the timeliness of reception screening has improved since the First Court Expert's report, there are still numerous deficiencies. Equipment is not maintained or calibrated. Visual acuity testing is inaccurately performed and yields inaccurate results. Staff incorrectly read Tuberculin skin tests and inconsistently record results in the health record. HIV opt-out testing is inconsistently performed. Intake evaluations uniformly lack adequate history, and physical examinations are cursory. Providers do not consistently perform adequate assessments or order labs tests necessary to determine the patient's disease control. Providers often omit or change a patient's medications upon arrival without clinical indication. Nurses do not consistently initiate a medication administration record when giving patients stock medication in the reception area. Provider medical reception orders are inconsistently carried out. Provider follow up of abnormal reception laboratory tests is not consistently and timely performed.

Inmates are not provided access to approved health request forms and do not have a secure location to place these requests, which creates a barrier to access to care. Staff do not collect health requests daily and do not date-stamp requests when they receive them. Requests are not triaged within 24 hours and nurses do not indicate the urgency of follow up evaluations. Requests are evaluated without the patient's medical record. Nurses conduct health request evaluations in rooms that are inadequately equipped and supplied. Health requests are

inconsistently filed in the medical record. Correctional Medical Technicians/Licensed Practical Nurses perform assessments but are not licensed to perform independent assessments. A recently established sick call log does not adequately track the status of each patient request. The IDOC Administrative Directives provide insufficient operational guidance regarding nursing sick call.

NRC does not track persons with chronic disease because the nurse assigned to perform this task is typically pulled for other assignments. Because patients with chronic illness are not tracked, many are not followed for their chronic illness even when they remain at the facility for extended periods of time. The provider notes for patients with chronic illness are deficient. They lack adequate history, reasons for modifying treatment plans, and have inadequate physical examinations. Diabetes care, in particular, is not provided consistent with contemporary standards of care. There were significant gaps on medication records, making it appear that inmates do not receive ordered medications for their chronic illnesses. Patients with problems beyond the expertise of NRC providers were not referred for appropriate consultation.

The emergency response bags and equipment were disorganized and not sanitized. Emergency response drills were conducted but the critique was limited. When deficiencies were identified there was no corrective action plan. NRC does not track emergency response on a log so it is not possible for the program to evaluate its performance through the CQI program.

Planned staffing for the infirmary is appropriate but actual staffing shows lack of staffing and no RN coverage for some shifts. Provider notes are generally written on a weekly basis, even when patients had need for more frequent notes. The quality of physician care on this unit was inconsistent and often inadequate. Progress notes lack documentation of the rationale for therapeutic plan changes and fail to identify a differential diagnosis or clear treatment plan. There was no documentation that pertinent physical examinations were being performed. We noted that care of persons with diabetes was especially problematic. The level of provider care placed patients on this unit at risk of harm.

Medication administration is impaired because of lack of sufficient cooperation by security staff, which appears to be due to insufficient custody staff. Nurses do not administer medication consistent with accepted nursing practice. Administration is not hygienic. Nurses do not appropriately confirm the identity of the patient receiving medication. Doors are not opened for medication administration and nurses pass medication through cracks in the door and do not adequately visualize patients to confirm their identity. Nurses do not document on the medication administration records at the time they administer the medication to the patient. When inmates do not take medication there is no process to refer the patient to a provider for counseling. The nursing medication room is dirty, cluttered and disorganized. Process issues with the contract pharmacy result in nurses having to transcribe large numbers of medication orders onto new medication administration records (MARs) at the end of each month instead of the pharmacy providing preprinted MARs. This creates an enormous work load for nurses and results in documentation errors. CQI reports indicate that staff repeatedly

commit errors in medication administration, yet an effective correction action plan has not been developed.

NRC has no infection control program, and no one assigned for this work. Sanitation, disinfection, and environmental inspections are not done or are poorly performed. No one evaluates the effectiveness of infection control issues, including: TB skin test reading, effectiveness of intake infection control screening, or surveillance for contagious or infectious disease.

The dental clinic is small, with capital equipment approaching the end of its useful life cycle, and there is no replacement plan. While critical equipment has been repaired, recent history suggests that there are systemic problems in obtaining repairs. There is no documentation that the dental x-ray units have been inspected by a therapeutic radiological physicist per Illinois Administrative Code. Clinic disinfection and infection control are adequate; however, infection control at the intake screening exams is unacceptable and must be addressed immediately. Routine dental treatment occurs without a comprehensive oral examination (i.e., intraoral x-rays, a periodontal assessment, and a treatment plan), placing patients at risk of preventable pain and tooth loss. Clinical notes are inadequate. Antibiotics and analgesics are often dispensed without a diagnosis having been recorded, and the patient's chief complaint is rarely recorded. The dental sick call process is disorganized, and it is not possible to determine how long patients wait to be treated, or the failed appointment rate. There is no process for mid-level providers to triage and palliate patients whose sick call request states or suggests pain or infection when the dentist is not available. The dental program has not changed materially since the First Expert's Report. It represents a substantial departure from accepted professional treatment standards and is not minimally adequate.

Quality improvement is a critical form of self-monitoring and is necessary to identify and correct defective systemic issues. NRC did not have its own Continuous Quality Improvement (CQI) program until recently. It has not yet become effective. The Traveling Medical Director is an ineffective leader and ineffective in promoting quality improvement. No one at NRC has experience, training, or dedicated time to perform or lead the CQI effort. The NRC CQI plan is identical to the SCC CQI plan, even though these are different institutions. The CQI coordinator has no training in CQI, does not understand what CQI consists of, and has a full-time assignment that restricts her CQI to a few hours a month, which are mainly occupied in secretarial functions. The CQI program does not monitor for quality of clinical care. Peer review is ineffective and does not reflect the current status of clinical care. Mortality review and sentinel event reviews are not done. Data support for the CQI program is insufficient.

Findings

Leadership, Staffing, and Custody Functions

Methodology: We interviewed leadership of the health care program, the Warden and some of the Warden's staff. We evaluated staffing documents and discussed these with the leadership. We reviewed other selected documents.

First Court Expert Findings

The First Court Expert found that leadership provided by the Medical Director and Health Care Unit Administrator (HCUA) was deficient and resulted in a program ill-organized to provide quality services. The HCUA was on leave and her absence left the facility bereft of administrative leadership. The lack of leadership resulted in the absence of performance review, lack of data provided by tracking logs, and disorganized medical records, which were ascribed to the lack of leadership. The HCUA was a position shared with SCC. Staff was shared between SCC and NRC, which made it difficult to know how many staff work at each of these facilities.

Current Findings

Our review showed one improvement. NRC now has its own budgeted leadership team, including its own HCUA, Director of Nursing (DON), and Medical Director, even though these positions are not all filled.

The remainder of the problems cited in the First Court Expert's report persist. We identified additional findings, including:

- None of the leadership staff at NRC, including the Warden, was aware of or had read the 2014 First Court Expert's Lippert report. The leadership at NRC was not aware of the First Court Expert's recommendations or findings even when the IDOC agreed with the First Court Expert's findings or recommendations in their response to that report.
- The Medical Director position is vacant and filled by a "Traveling Medical Director" who does not adequately fill those responsibilities and who is poorly qualified to provide the type of medical care needed at this facility.
- The practical implementation of "Traveling Medical Directors" does not address the responsibilities required of a Medical Director.
- The Wexford Regional Manager for this facility is an ex-warden and has no formal training in health management.
- All leadership positions (HCUA, DON, Medical Director, and Director of Medical Records) are only recently filled. The HCUA is the longest tenured leadership position and this was filled nine months ago.
- NRC is understaffed, yet the program does not have a staffing plan that matches the medical needs at the facility.

- NRC still shares staff with SCC. There are not clear lines of authority in the table of organization with respect to assignment and supervision of staff that move between facilities. The hours shared-employees work at each facility are ineffectively tracked.
- A relief factor has not been used for staffing at NRC, which will result in understaffing.
- The budgeted staffing does not include clerical positions, quality improvement nursing hours, or infection control nursing hours.
- Budgeted positions do not appear to have been developed with respect to current workloads for many categories of employees, including physicians and mid-level providers, nurses, medical record clerks.
- There is no current document reflecting actual staffing at this facility.
- None of the senior staff at NRC participated in the development of the schedule E for this facility, indicating the lack of participation of local leadership in developing a needs assessment for the facility.
- There is a lack of custody staffing to timely assist nurses during medication administration. Inmates are not all brought timely for their medical appointments.

NRC no longer shares medical leadership with SCC, which is an improvement. This is consistent with one of the First Court Expert's recommendations. The HCUA, DON, and Director of Medical Records positions are all filled. The Medical Director position is now vacant, but this position was filled during the time of the First Court Expert's report. An NRC staff physician was recently promoted and is currently serving as the "Traveling Medical Director" at NRC, which is equivalent to a coverage position. The IDOC and Wexford both perform regional oversight of the medical program. The Northern Regional Coordinator, a nurse position for the IDOC, is filled. The Regional Manager and the Regional Medical Director for Wexford Health Services are both filled.

The Wexford Regional Manager was unable to be present for our tour. We learned from Wexford Vice President of Special Projects that the Wexford Regional Manager is an ex-warden by training.³ We have concerns that a person with criminal justice training will not have the skills necessary to manage a clinical medical program. This was confirmed in our discussion with the HCUA, who thought that the Wexford Regional Manager did not always understand medical issues as presented in the quality improvement meetings and, as an example, did not understand that using drop files in medical records is inappropriate.

The Regional Coordinator for the northern district of the IDOC is an RN and has an additional Bachelor of Science in nursing. This well-qualified individual has been in his position for two years. He covers 10 facilities for the IDOC, which is a large span of supervision. He does participate in quality improvement meetings and appears to be an active participant in issues at NRC and was present and engaged during our tour.

NRC leadership positions have only recently been filled. The HCUA is an IDOC employee and started at NRC in April of 2017. She is a RN and was previously a nurse at the Sheridan facility

³ Interview with Cheri Laurent 1/25/18.

and transferred as the HCUA at Pontiac before transferring to NRC as the HCUA. The HCUA told us that she inherited a facility that had not been properly managed for years. The DON, also an IDOC employee, started in September of 2017, only four months before our tour. The Medical Record Director, a Wexford employee, started two months ago in her position. The Medical Director position had been vacant for an extended time period. The physician assistant at NRC told us that over the past five years there have been seven Medical Directors. During the same five year period there was no Medical Director for a period of about 24 months. According to the HCUA, several months ago a physician moved from Dixon to serve as the NRC Medical Director. A few weeks ago, this physician, after being at NRC as Medical Director for only approximately three months, was moved to be Medical Director at SCC when its Medical Director died.

The NRC Medical Director position is now vacant but is filled by a “Traveling Medical Director.” The HCUA was not pleased with the current Traveling Medical Director’s lack of participation in leadership functions. The HCUA told us that she needed a strong medical leader in the Medical Director position and attempted to have the newly appointed SCC Medical Director remain at NRC but was unsuccessful.

The title of “Traveling Medical Director” is a misnomer, in our opinion. At NRC, the current Traveling Medical Director does not provide typical duties of a Medical Director based on our discussion with the HCUA. A full-time Medical Director knowledgeable in primary care medicine is needed. Furthermore, it appears from staffing documents provided to us from Wexford that physicians and Medical Directors are frequently moved from facility to facility.⁴ The lack of coverage by a consistent Medical Director detracts from having effective guidance from a reliable physician with respect to clinical issues at the facility. The lack of a permanent Medical Director at NRC significantly impairs the ability of the leadership team to improve the program through active participation of a physician in quality improvement and other activities.

The newly appointed Traveling Medical Director at NRC was the Medical Director at the Hill facility during the last First Court Expert visit to that facility and was described in that report as not performing some administrative responsibilities, having “clinical concerns,” and having interpersonal deficiencies. Also, a Wexford discipline report of 11/26/17 lists this physician as having been given a final warning on 2/16/16 for performance.⁵ We also noted, in record reviews, our own clinical concerns for this physician. Given his history and lack of clinical proficiency, we have concerns that he will be successful in this new role.

The NRC is grossly understaffed. The lack of staffing is reinforced by NRC management in several comments in quality improvement meeting minutes, including:

⁴ 40C0134-IL Physicians Report 9-19-14 key; 42P5643-IDOC Position History 7-1-2015 to 11-22-17 Bates #520-548; and 4253412-IDOC Physicians as of 1-25-18 Bates #124.

⁵ Bates document #549, 42P5751 Discipline Report – Employees Disciplined between 7-1-15 to 11-26-17 for Misconduct or Performance.

- “Not enough nurses or staff assistants. [The IDOC Regional Coordinator] wants some numbers. [The Wexford Regional Manager] said to let him know and he’ll get them. Breakdown of how many of each for every shift. Do staffing plan and review.”⁶
- “Mandates causing mistakes because nurses are working a lot but they are getting good pay and can still lose their license for their actions.”⁷
- “AWP says we are doing good with lack of staff...[Regional Coordinator] says things fall through because no nursing/staff or tracking issue.”⁸
- “[Director of Nursing] was supposed to assign a nurse for 30-day assignment to be held accountable. There is not enough staff for accountability.”⁹

Every individual we spoke with told us that staffing shortages were the most significant problem at this facility. However, an adequate and thorough staffing analysis based on need has not been done.

Staff is still shared between NRC and SCC. We were told that between September and October of 2017, the IDOC negotiated a labor agreement with the Illinois Nurses Association (INA) to have all registered nurse (RN) staff at five facilities (Menard, Pontiac, Dixon, Graham, and NRC) become state employees under the INA union contract and that all licensed practical nurses (LPNs) would be Wexford employees. For NRC this was intended to be part of a plan for NRC to function independently from SCC. The Vice President of Special Projects for Wexford, the Northern Regional Coordinator for the IDOC and the HCUA of NRC all told us that this arrangement was in planning stages but that there was no written agreement that they had seen.

Related to that negotiation, on October 6, 2017, only three months before our visit, the Regional Coordinator for the northern region estimated, for purposes of these negotiations, that NRC needed 33 nurses.¹⁰ This analysis was given to us as a staffing needs assessment at the facility. This analysis did not take supervisory nurses into account and did not address special functions, such as chronic disease nursing, quality improvement, or infection control. The negotiation was with the nursing union and only nursing staff was addressed in the staffing analysis. More importantly, this analysis did not include a relief factor, which means that the number of necessary nurses may be 1.4 to 1.7 times (46-56 nursing positions) as high as the 33 nurses given in this analysis.¹¹ An adequate staffing analysis needs to be done to determine adequate staffing levels for all staffing categories required to accomplish tasks. Also, because many tasks are not now being performed, it will be difficult to perform this analysis until

⁶ September 19, 2017 Quality Improvement Meeting minutes.

⁷ September 19, 2017 Quality Improvement Meeting minutes.

⁸ November 21, 2017 Quality Improvement Meeting minutes.

⁹ August 15, 2017 Quality Improvement Meeting minutes.

¹⁰ Email from Joseph Ssenfuma to Edward Jackson, Natalie Norther, Robin Best, Kim Hugo, and Steven Meeks on 10/6/17.

¹¹ A relief factor analysis determines how many hours of staffing does one post require for a year. The total coverage hours required for each position is divided by the number of hours each full-time employee is available to work. The number of hours each employee is available to work is calculated by the paid hours minus the hours off for vacation, holidays, weekends, sick leave, and training. In my management experience, each full-time post requires approximately 1.7 to 1.9 FTE employees.

leadership includes all tasks required by the administrative directives (AD) into a staffing analysis.

Because staff is shared between SCC and NRC, three different managers supervise NRC nursing staff: the NRC HCUA, the SCC Wexford DON, and the SCC HCUA. This results in supervisory conflicts that arise due to union contract rules. Wexford staff must be given assignments and have personnel actions given by Wexford supervisors. State employees must be given assignments and have personnel actions given by state supervisors. This means that when a Wexford employed staff works at NRC where there is no Wexford nursing supervisor, the staff at NRC does not have the ability to discipline or technically to make an assignment. The current table of organization does not provide clear lines of management authority and does not reflect this confusing supervisory structure. This makes managing NRC complicated, difficult, and can result in confusion.

SCC is the parent facility in its relationship to NRC. Since SCC and NRC are sharing staff, someone has to be responsible for making decisions on who is to get greater staffing, especially during times when staff is off sick or on vacation. This responsibility has not yet been assigned. We were told that the HCUAs of SCC and NRC are trying to work out a staffing schedule of shared staff and for assignment of nursing staff from SCC who will assist at NRC. Shared-staffing assignments appear to be an extemporaneous negotiation. When the SCC Wexford staff provides service at NRC, their hours are tracked by the Wexford management. The HCUA has complained to the Regional Manager of Wexford that the hours provided at NRC by the Wexford nursing staff from SCC are inaccurate. This shared staffing arrangement creates a "nightmare" as described by the HCUA.

The current schedule E provided to us by the IDOC is not accurate, as it does not reflect the recently negotiated changes in nursing staff at NRC and does not represent the portion of shared staff from SCC that can regularly be counted on to work at NRC. The HCUA could not provide me an official document that describes state medical employees and Wexford medical staffing at NRC. A table in Appendix 1 was based on the HCUA and the IDOC Regional Coordinator giving me the current configuration of staffing at NRC, which is not yet memorialized in a document. Shared staffing between NRC and SCC is not definitively apportioned in budget documents.

Our staffing table shows a total vacancy rate of 42%, although this reflects a large number of newly allocated positions. Still, this is an extraordinary vacancy rate. We note that this staffing level has not been developed with respect to staff needs at all levels. At best, it is a reflection of a recent analysis of nursing need without relief factor.

NRC provider staffing consists of two physician assistants, one staff physician, and a Medical Director. There are four budgeted providers but only three providers positions filled at NRC. We were told that all three providers work in the morning in the clinic, seeing patients for physical examinations, physician sick call, chronic care visits, and infirmary visits. At about noon, we

were told that all three providers go to intake to perform physical examinations. In the 2016-17 annual CQI the following statistics were provided:

Intake evaluations	17847
PA sick call	3062
MD sick call	2369
MD urgent care	616
MD encounters	6190
Referred to MD	1088
Total	31172

This amounts to 599 provider encounters per week or 119 encounters per day in a five-day work week. If there are four providers, each provider must see 29 patients per day. If there are three providers, each provider must evaluate 39 patients per day. At 29 patients per day, this is approximately four patients per hour if no lunch is taken. At 39 patients a day this is approximately five patients per hour if no lunch is taken. This does not include infirmary patients or review of labs, x-rays, collegial reviews, review of consultant reports, hospital reports, and quality improvement activity. This is consistent with the First Court Expert's report, which noted that providers may perform 25 or more physical examinations in three to four hours.¹² These are unrealistic patient loads not likely to promote quality care. This staffing pattern does not include a relief factor. This patient load is made worse given the lack of adequate support services, particularly poorly maintained medical records and failure to provide consultant reports to providers. This may account for an almost complete absence of adequate history taking and incomplete evaluations of many patients identified on record reviews.

An important aspect of physician staffing is physician credentialing. Administrative Directive 04.03.125 Quality Improvement Program requires one-time primary source verification be conducted by the vendor and presumably reviewed by the IDOC. Primary source verification is defined as verification from the original source of a specific credential to determine the accuracy of the qualification of an individual health care practitioner. Credentials include completion of medical school, training, licensure, and board certification if applicable. This would mean, for example, that one-time primary source verification would include:

- Query of the AMA Physician Masterfile for verification of US medical school graduation and postgraduate education completion. Alternatively, a letter from the medical school verifying graduation.
- Query of the Education Commission for Foreign Medical Graduates (ECFMG) for verification of a physician's graduation from a foreign medical school.
- A letter from a residency training program or hospital internship program regarding completion of internship or residency in part or in full.

¹² Northern Reception Center (NRC) Report, January 21-23, 2014, p. 9.

- The American Osteopathic Association (AOA) Physician Database for pre-doctoral education accredited by the AOA.
- The Federation of State Medical Boards for all actions against a physician's license or the National Practitioner Data Bank full report.
- A letter from fellowship programs for any fellowships completed.
- Query of the American Board of Medical Specialties (ABMS) for verification of a physician's board certification.

We agree with the requirement of the AD and believe this information should be available to the IDOC Agency Medical Director and Regional Coordinators so they can know whether the assignment of physicians by Wexford is appropriate from a clinical perspective.

Currently, in the IDOC, primary source verification is currently interpreted as including verification of only the physician's current medical license and DEA license. The HCUA and Regional Coordinator were unaware of the meaning of primary source verification in typical physician credentialing. The Medical Director at NRC told us that he completed three years of training in radiation oncology but did not finish the program. He then completed two years of nuclear medicine training and said he finished the program but never practiced in nuclear medicine. After finishing nuclear medicine training, this physician began working in the IDOC as a primary care physician. It is our opinion that this credential does not make this physician qualified to serve as a Medical Director or to obtain privileges to practice primary care medicine. When we spoke with the Agency Medical Director on January 19, 2018, we asked whether he would seek care from a nuclear radiologist if he had diabetes. He answered no and stated that using nuclear radiologists as primary care physicians is inconsistent with community standards. With respect to his prior emergency medicine business, he stated that he had never hired a nuclear radiologist and agreed that most Illinois residents seeking primary care would see a primary care trained physician.

There is no clerical support staff at NRC. The need for clerical staff needs to be taken into account in development of a staffing plan.

The schedule E is the staffing requirements of the existing vendor contract. Remarkably, none of the senior supervisory staff involved in the medical program we talked to are involved in the development of staffing needs that ultimately become incorporated into the schedule E. We understand that the last contract was developed well before any of the current leadership was in place. Nevertheless, current staffing needs are not reflected in the current schedule E. We asked the recent Vice President of Operations for Wexford, the Agency Medical Director, the IDOC Regional Coordinator, and the HCUA if any of them had input or created the schedule E staffing pattern. None of them had final authority or significant input into the schedule E. This means that the staffing needs of the facility are not brought to the attention of whoever is in charge of contracting for medical services or who is in charge of approving positions for the IDOC.

Though we did not review custody staffing, we heard complaints from supervisory staff that there are insufficient custody staff to escort patients to their appointments and to ensure that nurses have a custody escort when nurses administer medications to inmates. Because of lack of ability to bring segregation inmates for their appointments, doctors often go up to the segregation unit and see patients in a room not equipped for examinations and which only has a chair.

The Warden told us that there are no post orders for how officers are to assist nurses when they pass medications and no post orders or procedures for how inmates are to be scheduled and brought for their medical appointments. The health care program does not track how many people do not show up for appointments and there is no tracking of how often nurses encounter difficulties with respect to administration of medication. The Warden agreed that officers may monitor more than one housing unit due to staffing and that this was not their desired staffing arrangement. Medical staff told us that when that occurs, nurses have to wait for a custody escort, which delays medication administration. We were told that this is particularly problematic on the evening shift.

The CQI program should track the number of patients who fail to show up for all categories of appointments to determine if there is a problem with custody escorts. A custody staffing analysis should be done to determine if there is sufficient custody staff to ensure that patients are timely medicated and brought for ordered medical care.

With respect to a comparison of our findings with the findings and recommendations of the First Expert report, NRC now has its own leadership team, allocated in the budget, which was a recommendation of that report. There was a Medical Director in place at the time of the First Expert report. However, the Medical Director position is now vacant and is temporarily filled by an individual who is ineffective in that role and who has a history of clinical deficiencies and who Wexford has given a final warning with respect to clinical care. The First Expert report recommended a separate staffing grid for NRC. We agree with that recommendation but a staffing needs assessment and staffing allocation specific for NRC is still not in place. Staffing is still a combination of state and Wexford positions, which causes confusion and supervision problems.

The First Expert report found that the majority of problems could be traced to the lack of leadership at the facility. The condition does not appear to have improved, because the leadership team is only recently been formed and because the Traveling Medical Director does not provide clinical or administrative leadership in his role. Tracking logs and other data sources are still not reliable and therefore ineffective in analyzing processes of care. The leadership team also has not yet developed a plan of action, evidenced in their CQI plan, to correct systemic problems at the facility.

Clinic Space, Sanitation, Laboratory, and Support Services

Methodology: Accompanied by a nurse supervisor, we inspected the intake reception area, housing units, mental health crisis unit, medical infirmary, and the outpatient clinic (exam rooms, interview room, treatment room, storage closets, and x-ray suite). Staff in these areas were interviewed.

First Court Expert Findings

The First Court Expert found the reception space adequate and well maintained. At the time of the First Court Expert visit, the infirmary was not being used at NRC. The medical unit clinic had three examination rooms and an emergency care/urgent care/procedure room. The First Court Expert found the medical unit clinic clean and well maintained. The First Court Expert noted that there were no clinical spaces in the housing units to adequately perform sick call or physical examinations.

Current Findings

We agree with the First Court Expert's finding that there are no adequately equipped and supplied clinical examination rooms in which to perform sick call within the housing units. We identified additional findings and confirmed some of the First Court Expert's findings as follows:

- Since the First Court Expert's report, the 12-bed medical infirmary has been opened.
- There are functional patient-activated call assistance devices on the wall next to each medical infirmary bed.
- Overall, the reception area is adequate in size and is acceptably maintained except for the provider examination rooms, which are unsanitary, cluttered, and have poorly maintained furnishings.
- There are two negative pressure rooms in the medical infirmary. The negative pressure monitor was not working at the time of the current visit. The vent in one of the two negative pressure rooms was taped shut, disabling the negative pressure capability of that room.
- The recently relocated nurse office/work station in the medical infirmary is cramped and does not have a sink, phone, computer, or electrical outlets.
- The designated clinical spaces in the housing units are unsuitable for the provision of sick call and physical examinations, lacking exam tables, appropriate chairs, desks, paper towels, and in some rooms, sinks for hand washing.
- The three exams rooms in the clinic are insufficient to accommodate all four providers, nursing staff, and the UIC telemedicine physician, who may need to see patients at the same time.
- The interview room used as an overflow exam room lacked an examination table and clinical equipment.
- The wall mounted oto-ophthalmoscopes were non-functional in all the exam rooms.
- There was broken equipment (scale and refrigerator) in the clinical area.
- The providers' desks in the health care unit examination rooms were poorly maintained.

- The exam tables were flat and nonadjustable. The head could not be raised. There was not an electric exam table in the clinic that could be used by non-ambulatory and disabled patients.
- All the health care unit and infirmary clinical and patient spaces were poorly maintained and inadequately sanitized.
- There were a number of infection control violations and safety hazards noted in the clinical areas.
- None of the examination tables in the clinic had paper barriers that could be changed after use by a patient. The gurneys in the treatment room did have paper barriers.
- The nurse sick call rooms in the housing units, the clinic examination rooms, storage spaces, the treatment room, and the infirmary beds and patient rooms are not properly cleaned, are poorly maintained, and disorganized, creating unprofessional and unacceptable work and patient care areas. Environmental and infection control rounds must be immediately instituted, and corrective actions aggressively pursued as indicated. There is no sanitation schedule for cleaning and sanitizing clinical medical areas.
- Sinks in multiple areas have mineral deposits in the sink bowl and on faucets.
- The quantity of linens was inadequate to meet the needs of the medical infirmary patient population.
- The lockdown practices of this facility force health care staff to conduct clinical interactions on the housing units (medication administration, reading TB skin tests, nurse sick call, and provider examinations) in conditions that are inappropriate for the clinical interaction and do not permit adequate care to occur.

The intake reception area is essentially the same as was described in the First Court Expert's report. The reception area is designed to perform a production line screening of all new admissions to the NRC. Once the security team has completed its intake process, new admissions are guided through a step-by-step clinical screening process including phlebotomy, dental, nurse history, and provider physical examinations. The phlebotomy area and nurse screening areas were clean and orderly. The examination rooms where providers perform examinations were dirty and furniture was in disrepair. Examination tables did not have paper to provide infection control between patients. There is accumulation of mineral deposits on faucets and in sinks, impeding sanitation and infection control.¹³ There is no schedule of sanitation and disinfection practices to be carried out in these rooms.

The Minimum Security Unit (MSU) at NRC is a dormitory setting with a capacity of 272 beds housing inmate workers. The main NRC prison housing consists of 24 housing units A through X. A, B, and C are segregation units; the remainder are general population housing units. All the housing units at NRC are structurally the same. Each unit has three tiers with cells housing one or two individuals. The cells have a vertical glass slot and a chuck hole. We were told that the inmates on these units were allowed out of their cells for three showers a week and for two 2-

¹³ NRC has "hard" water (i.e., high mineral content) which causes build-up of mineral deposits in pipes, faucets, and sinks. The institution needs a water-softening system; however, according to custody leadership, there is no funding for it.

hour yard sessions per week. During inclement weather, the yard sessions are cancelled, resulting in men not leaving their cells except for showers and medical care. There are no pill call lines. Nurses pass medications, read tuberculosis skin tests, and not uncommonly do sick call interviews cell by cell with the cell door locked. There is a correctional room/office on the first level of each unit with a sink/phone/desk and a cut-down tool and a first aid kit. Next to the security office, there is an approximately 8' x 10' room that is used by the nurses to do sick call when the inmates cannot be moved to the first level. None of the nurse rooms inspected had an exam table or a desk. Not all the rooms had a sink. There were two chairs in one of the rooms and four bolted metal chairs with shackles in another. The room on housing A had a sink with hot water but no soap or paper towels. There is no equipment in these rooms. We were told that nurses bring equipment with them when they use these rooms for sick calls. Providers also use these rooms for the completion of intake physical exams that were deferred during the reception process. We were also told that these rooms are occasionally used for chronic care clinic visits. Sanitation of these rooms was poor. Floors and sinks were dirty. Although these rooms are well situated to increase access of the inmates to sick call services and minimize inmate movement to the clinic, in their current condition they are unacceptable for the performance of sick call or provider clinical examinations.

The infirmary has a separate entrance from the main corridor and a short internal connecting hallway that links the infirmary with the clinic. Although the mental health crisis beds have been utilized for some time, the medical section was only opened in 2016. The medical infirmary was not opened during the First Court Expert's visit in 2014 and resulted in a recommendation to open and staff this unit. There is a wing with eight single cell mental health crisis beds and an adjoining corridor with 12 medical beds (six rooms, each with two beds). The nursing office was recently moved away from the mental health wing due to environmental concerns when mental health patient-inmates would flood their cells or MACE was used. The new office was previously a closet and has one desk, a dressing cart, a medication cart, a file cabinet, and a medical record holder in a very cramped space. There is no sink, no phone, no electrical outlets, and no computer. There were two unmounted sharps boxes in the room. It was reported that work orders have been submitted to address these deficiencies, which currently hamper the efficiency of the nursing staff. Unprotected paper memos and directives were taped on the walls, creating a fire safety issue.

The medical infirmary was inspected. Eleven of the 12 medical beds were occupied. There is a call buzzer at each bed. The buzzers were found to be operational in all rooms that were tested, and the patient-inmates understood how to use this system. There were two negative airflow rooms (A-105-106), but the monitoring panel was not operational; the maintenance team was contacted and was working on this problem on the final day of our visit. The ceiling vent in A-106 was also taped over, interfering with the operation of the negative airflow system. Porters (inmate workers) were directed by a nurse supervisor to remove the tape.

The medical infirmary rooms were shabby. The beds are fixed in a flat position without the capability to raise the head or raise/lower the height of the bed. Most of the mattresses had open cracks and thus could not be adequately sanitized. One patient bed lacked a mattress and

had an uncovered porous foam egg crate full bed cushion that was dirty and absolutely could not be cleaned and sanitized. Even though two-thirds of the 11 individuals housed in the medical infirmary were chronically ill with issues of fragility, ambulation, self-care, disability, or continence, there were no adjustable hospital beds in the infirmary.

The mental health infirmary is generally for short-term crisis management. Three men were housed in the eight-bed mental health unit during the site visit. One of the individuals was smearing feces on the walls of his room.

The health care unit has administrative offices, a medical record room, a pharmacy/medication prep room, three examination rooms, one interview room, a single chair dental suite, a treatment room, a plain film x-ray room, a Panorex unit, and a central nursing station. Four providers are budgeted for doctor/provider sick call visits and chronic care clinics on Monday-Friday. A single provider also staffs a Saturday sick call. In the evening, nurse sick call is done. The clinic treats all urgent referrals in the treatment room. Each of the three exam rooms have non-adjustable upholstered tables without paper rolls, a sink, a wall mounted sphygmomanometer, and a desk. All of the desks no longer have veneer on the edges. Uncovered paper memos/directives/guidelines are taped on the walls. The mounted oto-ophthalmoscopes were missing electric cords and were non-functional in all the exam rooms. One room had a functional backup oto-ophthalmoscope placed on the exam table. There was not a single adjustable exam table or electric table in the clinic, making it extremely difficult to impossible to examine certain types of disabled patients. The sinks in the exam rooms were crusted with mineral deposits. One room lacked hand drying paper. A broken scale was in one room. Three crutches were stacked in the corner of one examination room for the entire site visit. There is an interview room with a desk and sink but without an examination table that is used by a provider when all four providers are on duty or one of the exam rooms is in use by the UIC Telemedicine specialty clinic. There were boxes on the floor and a broken desk-top refrigerator on a counter next to the desk. There were two closets in the interview room. One was stacked from the floor to almost the ceiling in violation of infection control and fire safety standards. The other closet was completely filled with oxygen tanks. Most were appropriately in security racks but six to seven were not; this is a safety hazard.

This clinic has an insufficient number of examination rooms. There are only four examination rooms and there are four providers. However, during morning sessions when all providers work in the health care unit, all rooms are occupied. There is then no space for a nurse to evaluate patients or for the UIC HIV/Hep C telemedicine clinic sessions. This lack of space results in prioritization and promotes failed appointments.

The treatment room had a suction unit, four secured oxygen tanks, two AEDS (one had an expired pad), crash cart, an EKG machine, two wall mounted oto-ophthalmoscopes without electric cords, and nebulization units. The crash cart is inspected on every shift; this was verified on the crash cart log. An emergency bag was inspected and was noted to have a variety of appropriate equipment (ambu bag, BP unit, stethoscope, dressings, ammonia capsules,

glucagon, thermometer, FSBG testing materials but not naloxone (Narcan). The treatment room was somewhat cluttered but operational.

In summary, we had additional findings as compared to the First Court Expert. We agree with the single recommendation of the First Court Expert that there should be a designated examination room in each housing unit appropriately equipped to conduct sick call. We have additional recommendations found at the end of this report.

Sanitation Schedule

Methodology: The reception screening area, the sick call rooms on housing units, the mental health crisis unit, the medical infirmary, and the clinic were inspected. Nurses, nurse supervisor, correctional officers, a sanitation sergeant, porters, and patients in the medical infirmary were interviewed.

First Court Expert Findings

The previous Court Expert reported that the clinical spaces were well maintained.

Current Findings

Although the First Court Expert had no findings with respect to sanitation, we noted multiple problems including:

- The level of sanitation in almost all the clinical areas has deteriorated since the visit of the First Court Expert.
- The cleanliness of the designated clinical spaces in the housing units, the mental health crisis unit, the medical infirmary, and the clinic was notably deficient, creating an unsanitary and non-professional clinical environment.
- The cleanliness of the reception screening was overall acceptable.
- Although requested, no documentation of training provided to the porters who sweep, mop, and sanitize the clinic and the infirmary beds was provided. The porters stated that they had received no environmental training and had learned their duties on-the-job. This may violate OSHA rules that govern exposures to blood borne pathogens.
- The porters wore surgical gloves that they did not change as they cleaned infirmary rooms/sinks/toilets and the clinical areas.
- Mattresses in the medical infirmary and the treatment room's gurneys' upholstery were torn and cracked.
- There was no documentation in the medical infirmary correctional log that beds and mattresses were sanitized before a new admission was assigned to a bed.
- There are no regular/monthly environmental or infection control rounds being performed at NRC.

NRC had posted a sanitation schedule in the clinic nursing station, but it does not specifically list the clinic and infirmary on the schedule. Interviews with a sanitation sergeant and two porters (inmate workers) related that the clinic and the infirmary are swept and mopped one to two times per week and as needed. The floors in both of these clinical areas are clearly not routinely

buffed. There is no record in the infirmary correctional log about the routine disinfection of occupied mattresses or after a bed has been vacated and before a new patient is assigned to that bed. The porters were noted not changing surgical gloves while they moved between infirmary rooms after cleaning sinks, toilets, and showers. They related that they had not received any training about their cleaning duties and the use of protective gear.

The porters are also responsible for the cleaning and disinfection of mental health crisis rooms that had been smeared with fecal material. They reported that there are Hazmat kits (gowns, face shields, gloves, booties) that they are to wear while cleaning body fluid on exposed floors/walls. However, the Hazmat kits are not always in stock. (Three Hazmat kits were found in the nursing supply area.) The sanitation sergeant stated that he did not know if there was any documented record/log about the sanitation training provided to the porters. The general uncleanliness of the infirmary and clinic is indicative of poorly trained and supervised workers.

The reception screening area was generally clean and in good condition except for the provider rooms. As noted in the Reception Screening section of this report, nursing staff sanitize their own work stations, but this service should be provided by porter staff in an organized manner for all areas, including provider examination rooms.

The overall cleanliness of the medical infirmary and mental health crisis unit was extremely poor. The sinks, toilets, and showers were functional but crusty and poorly cleaned. The floors in some of the infirmary rooms were painted, some were tiled. The painted floors were faded, and the blue color was discoloring the socks of the occupants. The edges of all the rooms had a rim of smudge and dirt. The wall in one medical room was splashed with some dried liquid material. Only one room (A-O6) was judged to be acceptably clean; this room was occupied by two more physically able patient-inmates who regularly clean their own space. The tile floor was shiny, the sink and toilet were not crusty, and the shower was clean. One vacant room in the mental health crisis unit was inspected; a section of the wall had a missing chunk of plaster, the floor was dirty and not been swept, the toilet had not been cleaned, the borders of the floor were dirty. The hallway in the mental health unit had missing and cracked tiles.

The edges of the clinic floors were smudged and dirty. The veneer on the sides of the providers' desks was missing, making it difficult to clean and sanitize. The supply cabinets in the clinic's exam rooms were cluttered and disorganized. Beverages/coffee were on the desks in two of the rooms. A provider's lunch was found in one of the cabinets.

The two gurneys in the treatment room had tears and cracks in the upholstery. The treatment room was disorganized and cluttered.

The infirmary and institutional sheets and bedding are washed in the central laundry. The plumbing staff maintains a log of the temperature of the hot water provided to these washing machines. The temperature logs from 10/1/17 to 1/29/18 noted 10 of the 121 days when the temperature was less than the 165 degrees (range 160-164 degrees) recommended in IDOC Administrative Directive 05.02.140.

In summary: The cleanliness and sanitation of nearly all of the clinical and patient care areas in NRC is notably deficient. There is an urgent need for the institution of vigilant, regular sanitation, and environmental and infection control rounds. The training of the inmate porters is nonexistent. Additional recommendations are noted at the end of this report in the Clinic and Sanitation and the Infection Control sections.

Environmental Rounds

Methodology: The HCUA, a nurse supervisor, nurses, and a sanitation sergeant were interviewed.

First Court Expert Findings

The First Court Expert did not address environmental rounds.

Current Findings

The NRC clinical leadership stated that routine environmental are not being done at NRC. Accordingly, there is no available documentation of such rounds. If the rounds were regularly performed, many of the deficiencies noted in the Clinic Space and Sanitation section would have been identified and corrective actions initiated. HCUA and nurse supervisors communicated that work orders are submitted for the repair or removal of broken equipment and furniture.

Radiology

Methodology: We toured the radiology unit and the radiology technician was interviewed.

First Court Expert Findings

The previous Court Expert did not comment on the radiology suite.

Current Findings

- There is no waiting list or backlog for plain x-ray studies at NRC.
- The turnaround time for the radiologist's reading and report is one to three days.
- During the upcoming visit to SCC, additional requests will be made to obtain any radiation physicist's reviews and certifications for NRC radiology units and discuss whether IDOC x-ray technicians are candidates for the use of monitoring devices as outlined in Illinois Administrative Code 32 -340 510 and 520.

NRC has a radiology suite in the clinic area that does non-contrast plain films. X-rays are performed Monday-Friday. A radiologist is onsite on Tuesday, Wednesday, Friday, Saturday, and Sunday to read films and write handwritten reports. The turnaround for receiving the radiologist's readings is one to three days. Six x-ray reports of films taken on 1/30/18 were audited; five were read within one day, and one was read in two days. There is no backlog and no waiting list for x-rays. Six patients were scheduled for studies on 1/31/18. Four had been x-rayed before noon; the arrival of other two men was awaited. It was reported that "no shows" are always rescheduled on the next working day.

It was not clear whether a Nuclear Radiation Physicist inspects the radiology unit in the clinic. There was not a certification posted in the suite. The administrative personnel who might have the certification was off duty during the four-day inspection. The x-ray technician stated that repairs are quickly done if so needed. The x-ray technician was not wearing a radiation exposure dosimetry monitoring device (badge); she was advised that this was not necessary at NRC.

In summary: Additional investigation is needed to verify whether the NRC Radiology unit is in compliance with the State of Illinois Radiation Safety regulations.

Medical Records

Methodology: We interviewed medical records staff, toured the medical record room, and performed record reviews from which we determined the state of the medical records.

First Court Expert Findings

The First Court Expert and his team had enormous difficulty in reviewing medical records because of “drop filing.” The First Court Expert found that drop filing creates “chaos for clinicians” and that important information will not be located. The First Court Expert found that stapling intake documents together was not unreasonable. The First Court Expert also found that there was no system of logging and tracking medical records. The First Court Expert recommended drop filing should not be done for patients with significant problems and all patients at NRC for more than 30 days.

Current Findings

We agree with all of the findings of the First Court Expert with one exception. We disagree with the practice of stapling intake medical documents together as a substitute for creating a medical record folder. We add the following additional findings:

- The medical records room is too small to accommodate the number of staff.
- Medical records are not maintained in accordance with IDOC requirements or in accordance with guidelines from the Illinois Department of Human Services.
- The medical record room is not secure. Unauthorized medical record staff can access the room at will. NRC fails to maintain privacy and confidentiality of the medical record.
- There is no tracking and accountability system for medical records. Because there is no sign-out process for medical records, it is not possible to know who has the medical record.
- Any staff member can pull and re-file medical records. This promotes loss of medical record documents and does not safeguard confidentiality or use by unauthorized persons.
- The intake packets of medical record documents include separate documents for dental, medical, and mental health. These are unified at a later date. There needs to be a unified medical record at the time a medical record is initiated.

The medical record at NRC is a paper record maintained in a green pressboard binder. There is a small medical record office in the health care unit to maintain and process the documents contained in the medical record. This office is too small for the number of staff. There are currently four medical record clerks and the room appears too small for this number of employees. Due to the inability to file records, five additional clerks have been added to this group. The space appears too small to accommodate nine employees and the volume of medical records. One wall of the records room is lined by file cabinets containing green medical record binders and manila folders containing individual inmate medical record documents. Opposite the file cabinets are a series of several desks used by medical records clerks to conduct their work. The space is extremely cramped and cluttered.

Medical records are not maintained in accordance with requirements of the IDOC Administrative Directives¹⁴ or with the Illinois Department of Human Services requirements¹⁵ for maintaining medical records. Medical records are so poorly maintained that the poorly maintained records are likely to adversely affect clinical care. This is similar to the finding in the First Expert report.

The Administrative Directive 04.03.100 Offender Medical Records gives requirements for how medical records are to be maintained. It states:

“A medical record for each offender shall be established by the appropriate reception and classification center.”

The AD describes the manner of maintaining a medical record, including:

- The tabbed sections of the medical record
- The tabbed section of the medical record that documents are kept in
- That medical records are confidential
- That every entry is legible
- That progress notes are filed within one day
- That reports from community health providers are filed within 14 days
- That consultation reports are filed within three days.

The IDOC AD on medical records requires use of a green binder for all inmates. This binder is a thick hard-backed pressboard folder with a medical record number. Each binder has nine tabs corresponding to the major types of documents including:

- Database
- Medical progress notes
- Consultations
- Mental Health Reports
- Dental/Vision
- Chronic clinic sheets/Flow sheets

¹⁴ Illinois Department of Corrections Administrative Directive 04.03.100 Offender Medical Records.

¹⁵ Illinois Department of Human Services website as found at <http://www.dhs.state.il.us/page.aspx?item=40657>.

- Medications
- Laboratory and X-ray reports
- Miscellaneous

The medical records at NRC are not maintained in accordance with the IDOC's AD on medical records. Many inmates housed at NRC do not have a green binder medical record. Those inmates at NRC who do have a green backed medical record have a record that is not maintained in accordance with AD requirements. Most files are loose paperwork in a manila folder or are loose paperwork placed in no particular order in a green binder. A significant number of files are merely an intake packet and any other medical record documents stapled together without any binder. The filing that occurs consists of placing medical record documents in a binder or stapling to a packet in no particular order. Documents are not separated into the pertinent section of a green binder. This situation has gone on for so long that this irregular and unacceptable medical record practice is institutionalized and accepted as normal.

For persons housed at NRC for extended periods and frequently seen for repeated treatments at UIC or John Stroger Hospital, their records become so disorganized that it is extremely difficult to find documents in the record. We noted on mortality reviews that two records of inmates who had been housed at NRC were missing medical record documents. We note that the IDOC response to the First Court Expert's report stated that, "The IDOC disagrees that recommendations voicing preference for the manner in which record-keeping and administrative duties are performed rise to the level of constitutional obligations."¹⁶ We disagree with this assertion. Not only does the manner of maintaining medical records violate the IDOC AD, but it also violates existing guidelines of the Illinois Department of Human Services. Also, significant risk of harm can arise when a medical record file is disorganized and fails to include all documents, as clinical staff may be unable to locate important documents. We note some problems in the specialty care section of this report whereby recommendations of consultants were not noted, possibly due to disorganized medical records and failure to provide consultation reports to clinical staff. We evaluated several patients who had large charts. These charts are unacceptable for routine use for clinical care. That clinical medical leadership has not objected to the state of these records reflects negatively on medical leadership.

The records process begins at intake. On each day of intake, a medical record clerk obtains the list of the number of arriving inmates and staples together a medical record packet for every inmate expected to arrive at NRC. Mental health and dental each have their own packets. The medical packets contain the sheets that are used in the intake process, including:

- A medical history form filled out by nursing
- A physical examination form filled out by a provider
- A problem list
- A progress note

¹⁶ Pages 13-14; email letter to Dr. Shansky on 11/3/14 sent by William Barnes representing the IDOC.

- A transfer summary form
- An HIV counseling form
- An influenza vaccination form

A packet is made for each incoming inmate. Inmates who arrive from the Cook County Jail arrive with a packet of limited medical information from the jail that includes their medication. This information is attached to the packet for the corresponding inmate. Mental health and dental documents are not initially included with medical documents and are added to the record at a later date. All documents need to be maintained as a unified medical record. After conclusion of intake the packets are brought to medical records and maintained in vertical desk sorters by date. Each sorter contains all the packets for each day after intake. The sorters are kept on top of a file cabinet. The packets are kept in the vertical sorters until a physical examination is done. When the physical examination is done, the packet is placed in a basket. The packet is kept in a basket until the Mantoux skin test for TB is read. Once the Mantoux skin test is read, the intake packet is complete, the staple is removed and the documents are placed loosely in a green binder, not in chronologic order. Patients who are technical parole violators or are on Court Writs have their documents placed in a manila file folder in no chronologic or consistent order. Any subsequent medical record document is merely placed into the green binder in no particular order. Documents are not sorted into the nine types of tabbed document separators and filed into the corresponding tab section. Documents need to be sorted into the nine types of document tab section and within each tab filed in chronologic order. This does not occur until the medical record arrives at the destination IDOC facility. The reason for this was reported as lack of staffing.

The medical records room promotes non-confidential practices and promotes loss of medical record documents. This room is unlocked and the medical records are unattended by official medical record clerks for most of the day. Numerous staff wander into the room at will and take medical record documents without any documentation of what record they are taking or where they are taking it. Charts are not signed out when removed from the file room. Non-medical records staff also re-file medical records. There is no accountability for records removed from the medical records room. Medical record clerks work daytime hours. For the remainder of the day the room is open and staff walks in to obtain records as needed. This violates medical record practices, as unauthorized persons are to be excluded from the medical records storage area on the basis of confidentiality of the medical record. It is the practice at NRC that charts for all clinics (nurse sick call, PA sick call, MD sick call, and nurse treatment call) are pulled by nurses. Mental health staff pulls their own charts. Typically, non-medical record staff are considered unauthorized personnel and are not allowed to take or re-file a medical record without signing out a record. Given these practices, it would not be surprising that there would be a high volume of lost documents and records. While we were not able to investigate the number of lost documents and records, on the last day of our tour we listened to a senior staff in health care searching for a chart of a patient who was transferring, but the chart was lost.

The practices in this medical record program also fail to conform to Illinois Department of Human Services medical record guidelines, which require:

- Medical records are confidential and must be safeguarded against loss or use by unauthorized persons.
- Medical records rooms will be locked after regular work hours.
- The agency must have policies in place regarding the retention and destruction of medical records. For advice on record destruction, public agencies are to contact the Illinois Secretary of State's Illinois State Archives.
- Medical records must be maintained in accordance with accepted medical standards, including:
 - Readily accessible
 - Systematically organized and in chronological order
 - Confidential
 - Safeguarded against loss or use by unauthorized persons
 - Secured by lock when not in use.

We had an initial interview with medical record staff, including the Medical Record Director. We reviewed multiple records. All larger records were disorganized and were not in chronological order. These documents were so difficult to use that use of such a record would significantly prolong patient encounters unless providers failed to review the record appropriately. We believe the latter happens, based on record reviews. On record reviews, labs were often not reviewed during follow-up patient evaluations, consultation reports were not documented as reviewed at subsequent clinical encounters, and prior adverse clinical events were not noted. For several record reviews, we noted missing labs or notes which the records' department brought to us on the following day. These items were not timely filed.

We also noted that consultation reports and hospital discharge summaries are mostly not present in the medical record. Of a sample of 22 consultations and one hospitalization, only 36% of medical records included a report of those consultations. A physician assistant told us that consultation and hospital reports frequently did not make it into the medical record. In the IDOC response to the First Court Expert's report, the IDOC states that they have no control over hospitals and consultants and cannot be responsible for obtaining those reports.¹⁷ Obtaining hospital and consultant reports is sometimes difficult. The IDOC is ultimately responsible to ensure that the reports are obtained. In our own experience in managing correctional programs, we sometimes have had to negotiate with hospitals and consultants but have always been able to obtain a hospital discharge summary and consultation reports of offsite services. The inability to do this is a reflection of the quality of management of Wexford. We note that the Regional Manager for Wexford is an ex-warden and lack of knowledge of how to do this may be an issue.

This medical record system is broken and unacceptable from a clinical medical perspective and violates Illinois Department of Human Services standards and the IDOC AD requirements. To fix

¹⁷ Pages 21-23; email letter to Dr. Shansky on 11/3/14 sent by William Barnes representing the IDOC.

this system would require a complete overhaul. In the case of NRC, obtaining an electronic record would be an easier solution than attempting to fix the existing broken system. In any case, the current arrangement is unacceptable.

We confirmed all of the findings in the First Court Expert's report and had additional findings with respect to confidentiality and lack of adherence to the IDOC AD and state regulations. We disagree with the First Court Expert's recommendation that medical records should be maintained in the same manner as in permanent institutions but only for persons who remain in the MSU for greater than two weeks. All patients should have a properly maintained record beginning as soon as they arrive. It is our opinion also that NRC should conform to the IDOC AD on medical records and the Illinois Department of Human Services' requirements for maintaining clinical medical records. This would require that a green backed medical record file be initiated upon arrival at the facility and maintained throughout the stay at NRC. An easier fix to this problem would be to institute an electronic medical record. The First Court Expert also recommended that medical record staffing be sufficient to ensure that medical records are adequately maintained, and we agree with that recommendation. While additional staff has been budgeted, they have not yet been hired. The question as to whether the additional staff will resolve medical record problems identified in this report is not answerable at this time.

Medical Reception

Methodology: To evaluate medical evaluation of newly arriving inmates we toured the medical reception area, observed the medical reception process, interviewed health care staff, reviewed IDOC health record forms, and reviewed 20 health records. Of the 20 records, 10 were selected from a log documenting referrals from the reception nurse to the provider. Ten records were selected from nursing sick call logs and from the list of inmates at NRC greater than 90 days.

First Court Expert Findings

The previous Court Expert found substantial delays in medical processing of newly arriving inmates. Medical records were disorganized and inhibited the provision of adequate health care. IDOC forms used by nurses and medical providers did not include questions designed to elicit current symptoms (e.g., chest pain, shortness of breath, abdominal pain, etc.) that may indicate serious disease. Approximately 30% of records reviewed found lack of timely follow-up of abnormal labs and chronic diseases. Providers did not document significant medical diagnoses on the problem list.

Current Findings

NRC's primary mission is to process and classify newly arriving inmates before transfer to other state institutions. In 2017, NRC received 15,942 inmates or approximately 307 a week.¹⁸ Newly arriving inmates transfer from county jails and also arrive as parole violators. On Wednesdays, NRC receives inmate transfers from around the state who are on a writ to appear in Cook

¹⁸ When the previous court expert evaluated the institution in 2014, the volume was approximately 500 inmates per week.

County court or inmates requiring medical services in the Northern Illinois area. These inmates are managed as intrasystem transfers and not medical reception inmates.

Our review showed that improvements have taken place with respect to the timeliness of completion of the medical reception process, including labs and provider physical examinations. Nurse and phlebotomy stations are clean and well organized. Medical providers document medical conditions on patient problem lists.

However, we found persistence of problems noted in the previous Court Expert's report as well as identified new problems. These include:

- Medical records are universally poorly organized with loose filing.
- Weight scales are not calibrated and are inaccurate.
- Nurses do not correctly measure visual acuity and do not consistently record results in the medical record.
- Nurses do not consistently record tuberculin skin test results in the medical record.
- Nurses do not change gloves or wash hands between patients.
- HIV opt-out testing is not being consistently performed.
- There is no schedule of sanitation and disinfection activities performed in medical reception. Instead of a system for routine sanitation and disinfection, the level of sanitation at each station is determined by the conscientiousness of individual staff.
- Provider examination rooms were filthy and furniture was in disrepair.
- Examination tables had no paper to provide an infection control barrier between patients.
- The dentist did not change gloves, wash hands, or change light-fixtured infection control barriers between patient intake dental screening examinations.
- IDOC medical reception forms do not contain an adequate past medical history section and review of systems (e.g., chest pain, shortness of breath, abdominal pain, blood in stools, etc.) to detect recent or current symptoms of potentially serious medical conditions.
- Medical provider physical examinations are cursory and do not adequately explore the patient's medical history, including a pertinent review of systems, to determine whether a patient's chronic diseases are well or poorly controlled.
- Medical providers do not provide continuity of care with respect to patients' chronic disease medications, either omitting or changing medications (e.g., insulin types) without a clinical indication.
- Nurses transcribing provider medication orders do not initiate a medication administration record (MAR) when they have given the patient medications from stock supply.
- Medical providers do not consistently order chronic disease labs to be available at the initial visit (e.g., HbA1C).
- Medical provider orders (EKG, chest x-ray, blood pressure monitoring, etc.) are not consistently implemented by nurses.
- Medical providers do not timely address abnormal lab tests results.

- Medical providers do not complete the initial chronic disease form when seeing patients for follow-up.

Observation of Medical Reception

Medical reception is conducted in a large room, with inmates moving from station to station to complete each step of the process. The stations where nurses and phlebotomists work are clean and well-organized.¹⁹ Staff had access to gloves and sharps containers.

As inmates begin the process, a phlebotomist collects blood for labs that include serum chemistry, syphilis, and opt-out HIV and hepatitis C antibody testing. Although HIV and hepatitis C testing are supposed to be opt-out, nurses consent inmates for HIV testing, which is an opt-in methodology.²⁰ Record review showed that HIV testing was not consistently performed even when patients requested HIV testing.²¹ January 2018 CQI minutes showed that more than 1500 lab draws were performed that included 1300 hepatitis C tests, but only 278 HIV tests. This suggests that opt-out testing is not working as intended.

After phlebotomy, an RN performs a medical history, tuberculosis symptom screen, height and weight, vital signs, visual acuity, and tuberculin skin test (TST). Typically, there are two to four nurses assigned to this component of medical reception, depending on patient volume and/or nurse availability. Observation showed that the medical reception process went smoothly; however, we noted issues with the accuracy of clinical information. One of the court experts stepped on two different scales and found a 10-pound discrepancy in weight, indicating that the scales are not calibrated. Snellen charts to measure visual acuity are posted on the wall behind each nursing station with a piece of tape placed on the floor at approximately 20 feet away. However, nurses had patients read the Snellen chart sitting in a chair which was approximately 10 feet from the chart and at angle. Nurses also did not measure visual acuity in each eye by having the patient cover one eye at a time. Record review showed that nurses documented visual acuity in only 50% of the records, in most cases documenting 20/20 vision in both eyes which, given our observations, are likely not accurate. We observed that nursing staff did not consistently change gloves or wash hands between each patient.

Staff reads patient tuberculin skin tests (TST) 48-72 hours after administration by going cell to cell in the housing units. We interviewed staff, who reported that sometimes the officer opens up the food port slot to have the inmate stick out his arm for staff to read the TST and other times the inmate holds up his arm in the cell window and staff reads the TST through the window. The correct method of reading TSTs is to palpate the TST site for induration, which cannot be done by looking through a window. Thus, the current practice likely results in inaccurate reading of tuberculin skin tests and missed cases of TB infection. We also found that staff does not consistently document tuberculin skin tests in the health record. We interviewed

¹⁹ There is no schedule of disinfection activities for the medical reception area. Nurses we spoke with made it their personal practice to organize and disinfect their work stations prior to seeing patients during medical reception.

²⁰ Opt-out testing means that testing will be performed unless the patient refuses the test. Opt-in testing means that the patient is offered testing and is performed only upon patient consent.

²¹ Medical Reception Patients #1, 5, 19.

a staff person responsible for documenting test results who reported that she does it “if she has time.” In several records we found that staff inexplicably documented planting the TST in January 2018 but reading the TST on 12/31/17.²²

We note that the TST is a labor intensive and human error prone methodology to identify individuals who have tuberculosis infection or disease. Many correctional systems are switching to drawing blood for interferon-gamma release assays (IGRAs), which is more reliable and less error prone. Use of IGRA testing will free up a significant amount of nursing time that can be devoted to other clinical duties. This test would be especially useful at this facility, where officers do not open cell doors, so that nurses can appropriately read the Mantoux skin test.

Following the medical history, nurses immediately refer patients with acute conditions and/or chronic diseases to a medical provider. Staff reported that typically three medical providers are assigned to perform patient physical examinations and develop a treatment plan, including ordering medications. As noted in the previous Court Expert report, on days in which the volume of intakes is high, providers may perform 25 or more physical examinations in three to four hours, which was “unlikely to reflect an appropriate quality standard.”²³

The examination rooms where providers perform examinations were dirty and furniture was in disrepair. Examination tables did not have paper to provide barriers between patients. There is accumulation of mineral deposits on faucets and in sinks, impeding sanitation and infection control.²⁴ There is no schedule of sanitation and disinfection practices to be carried out in these rooms.

Depending on volume, one or two dentists perform oral screening at reception. We observed one dentist who did not change his gloves or wash his hands between patients, even when he incidentally touched the patient’s lips while examining teeth and oral cavity.

IDOC Medical Reception Forms

We note that the IDOC Offender Medical History Past Medical History section of the form is limited with respect to chronic diseases and does not include chronic obstructive pulmonary disease (COPD), thyroid, kidney, liver, or autoimmune diseases, or cancer. The form also does not include a section for review of systems (e.g., chest pain, shortness of breath, abdominal pain, blood in stool, difficulty with urination, etc.) that are typically included in a comprehensive history and physical examination. *This poses a risk that important medical diagnoses or symptoms of serious illness will not be medically evaluated and missed, increasing risk of harm to the patient.* The IDOC Offender Physical Examination form (DOC 0099, Rev. 11/20/12) includes a section for substance abuse, risk factors for blood borne infections (e.g., HIV and HCV), and TB symptoms, but does not include a section for chronic disease review of systems

²² Medical Reception Patients #5, 8.

²³ Lippert Report, p. 9.

²⁴ NRC has “hard” water (i.e., high mineral content) which causes build-up of mineral deposits in pipes, faucets, and sinks. The institution needs a water-softening system, however, according to custody leadership, there is no funding for it.

(e.g., chest pain, SOB, polyuria, polydipsia, neuropathy, etc.), which contributes to the assessment of disease control.

Medical Provider Examinations

With respect to provider history and physical examinations, we found them to be cursory and lacking in quality. Providers did not consistently elaborate on positive findings noted by the nurse. Providers took no additional medical history of the patient's chronic diseases, including a review of systems (ROS) to assess disease control at the time of admission. In many cases, a medical transfer summary was received by the sending institution, but providers did not document that they reviewed the information and, in some cases, missed important medical diagnoses (e.g., prostate cancer) or medications for high blood pressure (e.g., hydrochlorothiazide).

Providers wrote orders to enroll patients into the chronic disease program in 30 days and assigned patients low bunk/gallery status as clinically indicated. Providers also ordered diagnostic tests (e.g., chest x-ray, EKG) and labs for some chronic diseases (e.g., thyroid, anticoagulation), but did not order HbA1C for any diabetics. Providers usually ordered continuation of each chronic disease medication; however, in some cases they did not continue medications without documenting the clinical rationale for not providing continuity of care. In other cases, ordered medications were not timely received.

A clinical concern is that three patients were being treated for heroin withdrawal at the time of admission, but the provider did not order Clinical Opiate Withdrawal Scale (COWS) monitoring to assess whether the patients' symptoms were improving or worsening, and that may have required changes in medication withdrawal regimens.

Following provider physical examinations, nurses review and note provider orders, including medications. A concern is inconsistency among nurses with how medication orders are noted. Some reception nurses transcribe medication orders onto a medication administration record (MAR) and some do not. Thus, many patients receive medications for which there is no corresponding MAR documenting that they have received the medication. (See Pharmacy and Medication Management).

The following cases are illustrative of concerns noted above.

- This 58-year-old man arrived at NRC on 1/12/18.²⁵ His medical history includes diabetes, hypertension, asthma, seizures, BPH, prostate cancer, s/p total prostatectomy in 2008, latent TB infection, chronic alcohol abuse, depression, bipolar disorder, and PTSD. The provider did not elaborate on all positives noted on the nurses' medical history form or on the medical transfer form, including asthma, hypertension, alcohol abuse, or prostate cancer. The provider documented that the patient had a total prostatectomy but not prostate cancer. He did not order a HbA1c to assess diabetes control or PSA to assess for possible recurrence of prostate cancer.

²⁵ Medical Reception Patient #4.

- A 43-year-old man arrived at NRC on 1/8/18.²⁶ His medical history includes hypothyroidism, substance abuse, depression, and right ear surgery with tube placement in 2016. The provider did not document whether the patient still had a right ear tube. The physician ordered levothyroxine for the patient's hypothyroidism but there is no medication administration record that shows the patient received levothyroxine. Thyroid labs showed the patient's hypothyroidism was in poor control (TSH=19.1, normal=0.5-4.5). The physician reviewed the report, but as of 2/1/18 had not increased the patient's thyroid medication.
- A 56-year-old man arrived at NRC on 1/10/18.²⁷ His medical history includes diabetes, hypertension, hyperlipidemia, mitral valve replacement (MVR) and venous stasis. His medications included coumadin, metformin, metoprolol, losartan, and Pravachol. On the day of arrival, labs showed the patient's INR was therapeutic (INR=2.2, goal=2-3). On 1/18/18, eight days after arrival, a provider performed a physical examination. The provider ordered medications and an EKG. The provider did not order a HbA1C or enroll the patient into the chronic disease program. The EKG was not performed. On 1/25/18, a provider saw the patient for follow-up of MVR and venous stasis. He did not take a history of the patient's diabetes or MVR. He ordered an INR, EKG, and chest x-ray. As of 1/31/18, neither the EKG or chest x-ray had been performed.
- A 69-year-old man arrived at NRC on 1/19/18 following discharge from a hospital for pulmonary embolism.²⁸ His medical history also included hypertension, atrial fibrillation, hypothyroidism, COPD/asthma, and trigeminal neuralgia. The provider did not elaborate on the patient's recent medical history of atrial fibrillation and pulmonary embolism. The patient's hospital discharge medications included Pradaxa, but the provider changed it to Coumadin without documenting the clinical rationale. On 1/19/18, the patient's INR was subtherapeutic (INR=1.5, goal=2-3). On 1/24/18, a provider reviewed the report but did not increase the patient's Coumadin dosage. Labs also showed the patient was hyponatremic (Na=128, normal=135-146), most likely due to treatment with Trileptal, but as of 1/30/18 a medical provider had not addressed the abnormal lab report. We referred this record to the Nursing Director.
- A 56-year-old man arrived at NRC on 1/16/18.²⁹ The patient's medical history included diabetes and hypertension. Transfer information from Cook County Jail showed that he was prescribed Glargine Insulin 100 units every night and rapid-acting Insulin Aspart before meals. The physician changed the patient's insulin from long-acting glargine insulin to intermediate acting NPH insulin without documenting a clinical rationale for the change. The patient's blood sugar was 337 upon arrival but the provider did not note this high glucose level or order insulin coverage at that time. Reception labs showed the patient's syphilis test was positive with a titer of 1:2. On 1/27/18, the

²⁶ Medical Reception Patient #8.

²⁷ Medical Reception Patient #14.

²⁸ Medical Reception Patient #9.

²⁹ Medical Reception Patient #6.

physician saw the patient but took no syphilis history, except that the patient denied a history of syphilis. The physician did not stage the patient's syphilis (primary, secondary, latent, or late latent) and treated him with one dose of Bicillin, which would not be adequate treatment for late syphilis.

- This 46-year-old man arrived at NRC on 1/18/18.³⁰ His medical history includes diabetes and psychiatric history. The provider did not perform a history of the patient's diabetes or perform a diabetes or cardiovascular review of systems (ROS). The provider ordered Metformin, but his MAR showed the patient did not receive Metformin until 1/22/18.
- This 48-year-old man arrived at NRC on 1/11/18.³¹ His medical history includes diabetes, myocardial infarction s/p stents in 2015, and high cholesterol. The provider did not perform a diabetes or cardiovascular ROS. The provider ordered medications including metformin, glipizide, Plavix, carvedilol, and gabapentin. There is no MAR showing the patient received keep on person (KOP) medications. Gabapentin was ordered on 1/12/18 but not received until 1/17/18. The provider ordered an EKG that was not performed. The patient consented to an HIV test, but it was not done. The patient's tuberculin skin test result was not documented in the health record.
- This 37-year-old man arrived at NRC on 12/22/17.³² His medical history includes obesity, hypertension, opioid dependence, and sleep apnea with C-PAP machine. The patient accepted HIV testing, but it was not done. A physician saw the patient and ordered lisinopril, hydrochlorothiazide, and aspirin. There are no MARs in the record showing that he received these medications. On 1/19/18, the physician saw the patient for blood pressure follow-up. He did not complete a chronic disease form. The patient's hypertension was poorly controlled (BP=153/113 mm Hg.) The provider ordered one dose of clonidine 0.2 mg, increased Lisinopril to 20 mg twice daily and ordered blood pressure checks for seven days. The physician did not renew the patient's hydrochlorothiazide. On an unknown date, the patient wrote a health request that he was "supposed to have his blood pressure checked for 7 days....my pressure has been high plus I haven't been called to get it checked."
- This 37-year-old man who arrived at NRC on 12/28/17.³³ His medical history includes heroin use, seizure disorder, asthma, hypertension, multiple injuries secondary to suicide, s/p splenectomy 2004, and left hand infection. His medications included Dilantin, hydrochlorothiazide, enalapril, QVAR inhaler, Neurontin, and doxycycline. There is no documentation that the patient was given medications at medical reception. Five days later, on 1/3/18, the patient received Dilantin, ibuprofen and Robaxin. The provider did not document hypertension on the problem list. At intake, his Dilantin level was subtherapeutic (6.3, normal=10-20), but a provider did not follow-up on this

³⁰ Medical Reception Patient #3.

³¹ Medical Reception Patient #1

³² Medical Reception Patient #19.

³³ Medical Reception Patient #20.

abnormal report. On 1/24/18, the physician saw the patient and renewed Lisinopril, not hydrochlorothiazide. There are no physician order forms containing medication orders in the record. All medication orders were transcribed from provider progress notes, not physician order forms. On 1/30/18, a provider ordered Dilantin, Lisinopril, and Neurontin, but not hydrochlorothiazide.

- This 36-year-old man arrived at NRC on 1/19/18.³⁴ His medical history includes injection drug use, HIV infection, anxiety, and depression. The provider did not perform a HIV review of systems or order HIV labs in advance of the patient's chronic disease visit. Although HIV patients are treated by an outside provider, NRC providers should perform an evaluation to determine if the patient has any symptoms or lab test results warranting urgent referral.

In summary, although improvements have been made with respect to timeliness of the medical reception process, there are multiple systemic issues that create an ongoing risk of harm to patients.

Intrasystem Transfer

First Court Expert Findings

The previous Court Expert reviewed 10 records of patients detained at NRC for >60 days and found that five patients with chronic diseases had not been enrolled into the chronic disease program.

Current Findings

Due to its mission as a reception center, NRC does not have a large volume of intrasystem transfer to NRC. Some inmates transfer to NRC to go out to court or to receive medical services in Cook County. Upon arrival, transferring inmates are subject to a process similar to medical reception. We reviewed medical records of five inmates who transferred to NRC and/or had been at the facility for greater than 90 days. Two of five inmates had no medical conditions requiring follow up. One patient with COPD transferred to NRC on 10/19/17 and received a history and physical examination on 10/24/17.³⁵ The patient was not enrolled into the chronic disease clinic and a provider did not see the patient until 2/1/18. In another record, the patient was timely processed in October 2017. In December 2017, a provider saw the patient for chronic disease management. The provider treated the patient for an exacerbation of asthma, for which the provider ordered prednisone 10 mg for three days; however, a nurse transcribed the order to be given for five days and the patient actually was given the medication for nine days due to a nurse's failure to properly transcribe the order. The provider did not timely see the patient for follow-up.

³⁴ Medical Reception Patient #10.

³⁵ Intrasystem Transfer Patient #23.

Nursing Sick Call

Methodology: We evaluated nursing sick call by reviewing IDOC Administrative Directive Offender Health Care Services, (04.03.103K), Wexford Non-Emergency Health Care Requests and Services (P-103), IDOC Treatment Protocols, and the NRC Offender Handbook. We also interviewed health care leadership, staff, and inmates; inspected areas where sick call is conducted; and reviewed tracking logs and health records.

First Court Expert Findings

The previous Court Expert Report found that there are no logs to track each health request and the corresponding staff response; inmates do not have the ability to confidentially submit health requests; health requests are not filed in the medical record; and there were problems with the quality of health assessments.

Current Findings

Our review concurred with the findings of the previous Court Expert. We also found that the basic components of a nursing sick call program are not in place. At NRC, patients do not receive timely and adequate access to health care, creating a systemic risk of harm to the NRC population. These problems include:

1. Inmates are not provided approved health request forms to submit health requests; therefore, inmates submit requests on scraps of paper or generic Offender Request forms.
2. Inmates are not provided the opportunity to confidentially submit their health requests on a daily basis.
3. Health care staff does not collect health request forms on a daily basis.
4. Staff does not date, time, and sign when health requests are received.
5. Nurses do not triage patient health requests within 24 hours.
6. Nurses do not document the urgency of the disposition (e.g., urgent, routine).
7. Nurses do not assess patients with symptoms within 24 hours of triage.
8. Nurses do not have medical records available to them when seeing patients.
9. Nurses conduct sick call in inadequately equipped and supplied rooms in housing units without access to a sink for handwashing.
10. Health requests are not consistently filed in the medical record.
11. Correctional Medical Technicians/Licensed Practical Nurses perform sick call, exceeding their scope of practice that prohibits them from performing independent nursing assessments.
12. Nurses do not timely refer patients to providers in accordance with IDOC Treatment Protocols.
13. A Nursing Sick Call Log has been recently implemented and does not track the status of each patient request.
14. IDOC Administrative Directives provide insufficient guidance regarding implementation of Nursing Sick Call.

Information supporting these findings is described below.

Access to Care

Upon arrival to NRC, inmates are provided an orientation manual that states that “inmates are educated regarding the sick call process and provided with a nurse sick call slip (Offender Sick Call/Medical Services Request. STA 0202 Rev 4/2013) they can use to access care. Additional nurse sick call slips are available to offenders from nursing and security staff upon request.” The slips are to be picked up twice daily during the morning and evening medication pass.³⁶ Health requests are to be triaged and seen within 24 hours of receipt and provider referrals in 72 hours or at the next scheduled physician clinic.³⁷

However, actual practice shows that inmates are provided two generic Offender Request forms (DOC 0286, Rev. 4/2010) at intake and thereafter are not provided routine access to Medical Services or Offender Request forms. Instead, our review showed that inmates submit their health requests on scraps of paper they have in their possession or borrow from other inmates. Inmates may or may not have pens or pencils to write their health requests. Staff reported that inmates could borrow a pen from another inmate, but an officer commented to a court expert: “Yes, but it will cost them a lunch tray.” We interviewed staff who confirmed that inmates are not provided Medical Request forms.

The previous Court Expert Report indicated that inmates were to submit their health requests in locked boxes accessed only by health care staff; however, we did not find that these boxes had been installed in the housing units.³⁸ Moreover, NRC inmates are locked down 24 hours a day except for four hours per week, and therefore do not have the ability to leave their cells to submit their requests on a daily basis.³⁹ Thus, the institutional practice to lock offenders down 24 hours per day is a serious obstacle to access to care.

Instead, inmates submit their health requests by placing slips of paper through the cracks of their cell door. These slips are typically picked up by officers or health care staff; however, anyone walking by a cell door could pick up these health requests, including other inmates (e.g., inmate porters). When officers pick up the forms, some place them in an unsecured, open folder in the housing unit or deliver them to health care staff.⁴⁰ It is also possible that officers misplace health requests or otherwise fail to deliver them to health care staff. Nurses also collect health requests during medication pass, but if an inmate is not receiving medication, it is unclear that the inmate would be able to notify a nurse to request a health request form or deliver a completed form to a nurse.

³⁶ Offender Sick Call/Medical Services Request. STA 0202 Rev 4/2013.

³⁷ The IDOC administrative directive regarding sick call states that “Health care staff shall review offender sick call requests within 24 hours of receipt;” that “When appropriate health care staff will schedule an evaluation within 24 hours of receipt, 72 hours on weekends, or sooner, as clinically indicated;” and when a request results in a referral to a provider, the evaluation will “Take place within 72 hours or upon the next scheduled visit by a primary care physician.”

³⁸ Although the IDOC Regional Medical Coordinator testified that these boxes had been installed in his region, this is not the case at NRC.

³⁹ We received conflicting information about how much out of cell time NRC inmates were provided. An officer and a nurse stated that they were allowed out of cell once a week for four hours at a time. A Superintendent said they were allowed out of cell twice a week for a total of four to five hours.

⁴⁰ However, an officer and nurse reported that not all officers will pick up the forms, as they do not see it as part of their duties.

Once collected, inmate health requests are transported to the medical clinic and placed in an open bin in the main medical clinic. We observed that it is possible for any person walking through the clinic to pick up these health requests, including officers and possibly inmates in the clinic area. Either a registered nurse or CMT/LPN is to triage the health requests within 24 hours to determine the urgency of the request (e.g. emergent, urgent, routine, etc.). *However, nurses/CMTs do not document when the health requests are received or when they are triaged.*

Once triaged, the nurse is to enter each request onto the nurse sick call log which is to be used to schedule patients the next day.⁴¹ However, staff reported that until recently, not all of inmate written requests were retained, addressed, and filed in the medical record. Staff reported that some of the requests were thrown away. For example, staff reported that if a CMT/LPN triaging the request noted the patient had not yet had a physical examination, the request would be thrown away under the assumption that the complaint would be addressed at the time of the physical. Likewise, if the CMT/LPN noted that a provider saw the patient in the last day or two, the request would be thrown away under the assumption that the complaint had been addressed. We were informed that this practice was recently stopped and now all health requests are addressed and filed in the medical record. However, while this practice was in effect, some inmates did not have timely access to care. This was supported by our finding that inmates submitted forms in which they wrote that they had submitted multiple requests to have their health need addressed.

Either a registered nurse or CMT/LPN performs sick call. Nurses are to have the health record available to them for a sick call encounter, but during our tour, a nurse reported she was only able to locate three of 10 health records of patients she was scheduled to see. Staff performs sick call in housing unit cells that are not adequately equipped and supplied. The rooms do not have an examination table, exam table paper, chairs and desk for the nurse and patient to sit, or access to a sink for handwashing. Nurses bring some equipment and supplies with them to these rooms, including blood pressure cuff, stethoscope, thermometer, scale, alcohol wipes and some over-the-counter (OTC) medications. However, nurses do not have otoscopes available to examine ears, throat and oral cavity. We inspected a cart used to transport this equipment that was dirty, with tape residue stuck to the cart. *Thus, nurses do not have medical equipment and supplies to perform adequate patient assessments.*

At NRC, both RNs and LPNs perform sick call using Treatment Protocols. In the State of Illinois, LPNs are to practice “under the guidance of a registered professional nurse, or an advanced practice registered nurse, or as directed by a physician assistant, physician...to include *“conducting a focused nursing assessment and contributing to the ongoing assessment of the patient performed by the registered professional nurse.”* LPNs may also collaborate in the development and modifications of the RN or APRN’s plan of care, implement aspects of the plan of care, participate in health teaching and counseling, and serve as an advocate for the patient by communicating and collaborating with other health service personnel.⁴² However,

⁴¹ We were informed that the log was started in November or December 2017.

⁴² Illinois LPN Scope of Practice. Section 55-30.

Illinois scope of practice does not permit LPN's to perform assessments independent of a registered professional nurse or higher level professional, as is currently being done at NRC. Neither does the scope of practice permit LPNs to perform independent assessments according to protocols. LPNs do not have the requisite education and training, including physical assessment skills, needed to perform independent assessments.⁴³ *Thus, some NRC patients do not receive evaluations by health care staff licensed to perform independent assessments. This increases the risk of harm to NRC patients.*

We reviewed the Nursing Sick Call Log for the Month of January 2018.⁴⁴ Staff does not completely fill the log out, including the date the request was received and including whether or not a nurse saw the patient. From 1/1/18 to 1/30/18, 282 requests were received, averaging approximately 10 per day. This is an extremely low number given the population of approximately 1400 inmates. On four days, no health service requests were noted as collected, and on seven days, less than five requests were collected. *This is consistent with inmates not having forms to fill out and/or staff not collecting health requests on a daily basis.*

We selected and reviewed 10 health records from entries on the Nursing Sick Call Log for the month of January 2018. In addition, we reviewed health requests found in medical reception records. The following cases are illustrative of problems noted above.

- This 31-year-old man arrived at NRC on 1/3/18.⁴⁵ His medical history includes seizure, asthma and bipolar disorder. On 1/25/18, the patient submitted an Offender Request (OR) form for back pain stating "this is the 10th time I have put in. I am almost out of my seizure medications." On 1/26/18, an RN saw the patient and did not assess his back pain, only that he was running out of seizure medications.
- This 20-year-old man arrived at NRC on 12/13/17.⁴⁶ His medical history included drug use. On 1/9/18, he submitted an OR form for chest pain with deep breathing, laughing or coughing. "I have put in several slips but haven't gotten a response." On 1/25/18, he was listed on the nursing sick call log. On 1/26/18, an RN assessed the patient using the chest pain protocol. He complained of chest pain seven of 10 in severity. His vital signs were normal. The nurse did not notify a provider in accordance with the IDOC chest pain protocol, but referred the patient to a PA for 2/7/18, approximately 10 days later. This referral time frame is also not consistent with IDOC Administrative Directives for referral to take place in 72 hours.

⁴³ NCHC defines Qualified Health Care Professionals to include nurses without distinguishing between registered and licensed practical nurses. However, RN and LPN practice must remain within their education, training, and scope of practice for their respective state.

⁴⁴ The log has undergone several revisions. At the beginning of 2018 the log included the name and ID number of the patient, complaint, date the request was written, date received, and date seen, treatment protocol used, whether the patient was referred to a provider, and a co-pay assessed. Later the log was changed so that the date the inmate submitted the request was not included, just the date the request was received and the date the patient was seen.

⁴⁵ Sick Call Patient #1.

⁴⁶ Sick Call Patient #2.

- This 56-year-old man arrived at NRC on 1/10/18.⁴⁷ He had a history of diabetes, hypertension, mitral valve replacement, and lower extremity venous stasis. On 1/23/18, the patient was listed on the sick call log for leg wounds. There is no health request form or nursing sick call visit in the health record. On 1/25/18, a provider saw the patient for follow-up of MVR and venous stasis.
- This 37-year-old man arrived at NRC on 11/30/17.⁴⁸ His medical history included seizures and anxiety. His medication was gabapentin. On 12/14/17, an RN saw the patient for complaint of not receiving gabapentin for neuropathy after two weeks. BP=145/85 mm hg. The nurse advised the patient that the provider would address his issues. On 12/18/17, the patient submitted a scrap of paper stating, "I was called to sick call yesterday morning but sent back due to crowding. I was told to come back but was never summoned. Please advise as my medication has still not been verified." An unsigned note documented "already seen," without documenting resolution of the complaint. On 1/17/18, he was listed on the sick call log for a rash and on 1/23/18, for possible urinary tract infection (UTI). On 1/23/18, a nurse saw the patient for the rash but did not address the UTI complaint.
- This 38-year-old man arrived at NRC on 1/4/18.⁴⁹ His medical history included pulmonary embolism. He was prescribed a blood thinner (Eliquis) since 2016. On 1/14/18, the patient signed a nursing sick call refusal form but there is no health request form in the record. On 1/19/18, the patient submitted a request complaining of having "blood clot cramps." There is no documentation on the form of when it was received or triaged by a nurse. On 1/26/18, a nurse completed a refusal form, stating that the patient refused to sign. On 1/27/18, the patient was scheduled to see the physician, but as of 1/31/18, there is no documentation in the record that the encounter took place.
- This 42-year-old man arrived at NRC on 11/9/17.⁵⁰ His medical history includes hepatitis C infection. On 12/13/17, a nurse saw the patient for back pain using the back-pain protocol.⁵¹ The nurse documented no physical examination of any kind, only vital signs. The nurse treated the patient with ibuprofen. On 1/9/18, the patient was listed on the sick call log for dental pain. On 1/10/18, an RN saw the patient using the toothache protocol. The patient complained of exposed nerve pain for four to five months that was 10 of 10 in severity. The patient was afebrile. The exam showed bleeding and swelling. The nurse noted that the patient met the referral criteria for 24-hour referral; however, the nurse did not contact the dentist. The nurse gave the patient ibuprofen 200 mg 1-2 tablets three times daily.

⁴⁷ Sick Call Patient #4.

⁴⁸ Sick Call Patient #6.

⁴⁹ Sick Call Patient #7.

⁵⁰ Sick Call Patient #8.

⁵¹ The credentials of the staff who assessed the patient are illegible.

- This 37-year-old man arrived at NRC on 12/22/17.⁵² His medical history includes obesity, sleep apnea, hypertension, and opioid dependence. The patient submitted an undated piece of paper that said, "Blood in stools, please help." An unknown person wrote "refused" without date, signature and credentials. On 1/17/18, an RN saw the patient for constipation. The patient reported that on 1/16/18 that his stools were dark red and soft. The problem started in November 2017. The RN noted that he was being seen by GI and was previously scheduled for colonoscopy. The patient's pulse was rapid (pulse=114/minute). The nurse documented a plan to refer the patient to the doctor if symptoms persisted for three days. On 1/19/18, a physician saw the patient for follow-up of his blood pressure (BP=153/113 mm Hg). The physician did not address the patient's complaint of blood in his stools. We referred this record to the Director of Nurses for follow-up with the provider.

In summary, at NRC the basic components of a system to access health care are not in place and patients do not have timely access to care for their serious medical needs. The practice of 24 hour lockdown is a serious obstacle to access to care. Inmates do not have the means to timely and confidentially submit their health requests. When submitted, staff does not timely respond. Patients are seen by CMT/LPNs who are not licensed to perform independent assessments, and therefore exceed their scope of practice whenever they perform independent assessments. Patients are not examined in a clinical setting with adequate lighting, equipment, supplies, and access to handwashing. Finally, nurse to provider referrals are not made when clinically indicated, and when made, they are not timely.

Chronic Care

Methodology: The medical records of 13 patients with chronic medical illnesses and conditions were reviewed. There was limited opportunity to interview NRC providers due to restrictions imposed by Wexford. The Office of Health Services Chronic Illness Treatment Guidelines dated March 2016 was reviewed as needed.

First Court Expert Findings

The previous monitor noted that a lower number than expected of individuals were enrolled in chronic care clinics, the chronic care form had not been revised for 12 years, and that not all eligible individuals had their first visit to a chronic care clinic within 30 days of admission to NRC. He noted concern that COPD was not included on the list of chronic care diseases and advised that asthma, COPD, and chronic bronchitis be cared for under a pulmonary disease clinic.

Current Findings

We agree with all of the findings in the First Court Expert's report. In addition, we found the following problems:

⁵² Sick Call Patient #9.

- Not all individuals with chronic illnesses are being evaluated in a chronic care clinic within 30 days of admission.
- Provider notes about the status of the chronic conditions, the reasons for modification of treatments, and the pertinent physical examinations are deficient. Quality of care, overall, was poor.
- The diabetic care at NRC fails to provide basic screening tests and vaccines that are recommended in the IDOC Diabetes guidelines (HbA1C, microalbumin-creatinine ratio, pneumococcal vaccination, foot exams). In addition, the guidelines should be revised to include routine screening for diabetic retinopathy and intake testing for HbA1C.
- Problem lists should be universally and accurately completed during the reception screening. Failure to complete the problem list puts the patient at risk for a disruption of care.
- The MARs demonstrated gaps (blanks spaces) in documentation of insulin administration. Insulin refusals are not regularly reported to the providers.
- There are unacceptable delays in obtaining specialty consultations and diagnostic tests.
- Patients with problems which appeared to be beyond the expertise of NRC providers were not referred for specialty care.

NRC has chronic care clinics for asthma, diabetes, hypertension, multiple sclerosis, seizure disorder, sickle cell disease, and tuberculosis. Individuals with human immunodeficiency virus (HIV) and hepatitis C are referred to the UIC infectious disease telemedicine consultation clinic. All other diseases are managed in a general medicine chronic clinic. The admission packets containing clinical information and medications from Cook County Jail or other correctional facilities in Illinois are rapidly reviewed by the NRC providers so that those new admissions with acute or chronic conditions are prioritized and seen more expeditiously during the reception screening.

During intake, a TB skin test is placed, and blood is drawn for HIV, hepatitis C, syphilis, and a basic metabolic panel (glucose, BUN, creatinine, electrolytes), and liver profile. These tests are meant to screen all inmates for potential infectious and certain chronic illnesses. However, if an inmate has a known chronic illness, there is no routine screening testing performed to ascertain the current status of the patient's chronic condition. Providers can ask the phlebotomists to add additional testing for some patients (e.g., HIV viral loads and immunodeficiency panels for HIV patients or International Normalized Ratio (INR) testing for those on anticoagulation). The lack of obtaining routine blood tests useful for determining the status of a patient's chronic illness is a major deficiency, as it delays identification of out-of-control status and delays initiation of a fully informed therapeutic plan. We noted this problem particularly for persons with diabetes, few of whom have a HbA1C test or microalbumin test obtained during the reception process. In part, it is our opinion that this deficiency is related to the order of reception steps. Phlebotomy is the first step of the medical process. The provider examination is typically the last step. If phlebotomy were the last step, then all tests necessary to determine the chronic disease status could be ordered by the examining provider and drawn before the inmate leaves the reception area in addition to the routine screening tests that are performed

on all persons coming through reception. In addition to blood screening, peak expiratory flow rates (PEFR) are measured on asthmatics, capillary blood glucose (CBG) point-of-care testing is done on diabetics, and viral load and immunodeficiency panels drawn for patients with HIV.

All new admissions with any chronic condition are to be seen no less than 30 days after admission to NRC. We were told that nurses performing reception screening record all individuals with chronic illnesses. At the conclusion of intake, a clinic nurse takes all intake paperwork and develops a list of all patients who have chronic illness and inserts newly identified patients onto a chronic illness roster. Because this nurse is so frequently pulled for other assignments, this task is mostly not done, resulting in extremely low numbers of patients enrolled in the chronic care program. Providers evaluating persons with chronic illness can also refer patients for a chronic care follow up. But this system is ineffective. Only nine of the 13 medical records reviewed documented that a chronic care visit had been scheduled or completed in <30 days and one within 60 days. Three of the 13 did not have a chronic care referral or a chronic care visit documented in the medical record.

We could only estimate the number of persons with chronic illness who are not tracked, but it appears to be more than the majority of patients. At NRC, there were 1493 inmates and 188 inmates at MSU, for a total of 1681 inmates on the NRC campus. There were only a total of 60 (4%) inmates on the chronic disease roster. We estimate the number of persons with chronic disease to be approximately 30%. This would mean that an estimated 504 (1681×0.3) inmates at NRC can be expected to have a chronic illness. Yet only 60 (12%) of inmates with chronic illness are on the chronic care list. A National Commission on Correctional Health Care study estimated chronic disease prevalence in state prison populations as 3.2% for heart disease, 16.7% for high blood pressure, 2.1% for diabetes, and 7.2% for asthma.⁵³ These are only for the more common conditions. This also excludes hepatitis C, which is estimated at above 10%. While some patients have multiple chronic illnesses, the rate of all unique individuals with any chronic illness is clearly higher than 4% of the NRC population.

As an example, there were 11 men on the diabetes chronic care list compared to 35 individuals on the list of patient-inmates being administered injectable insulin. This does not even include the many persons on oral diabetic agents. The diabetes chronic care list significantly underestimates the number of diabetics. This is consistent with the findings of the First Court Expert, who identified that not all individuals with chronic illnesses were being enrolled in chronic care clinics. This raises concerns that individuals with significant chronic illnesses could be delayed from receiving needed care or, at worst, could be lost to follow-up while at NRC.

The provider's documentation in the medical record is extremely brief and rarely contains clinical information needed to clarify the state of a patient's chronic illness or justify a change in the treatment plan. The only possible way to try to understand if a chronic condition was uncontrolled or over-controlled is to speculate. This lack of clinical documentation is a

⁵³ The Health Status of Soon-To-Be-Released Inmates, A Report to Congress, Volume 2, National Commission on Correctional Health Care, April 2002 as found as a PDF at https://www.ncchc.org/filebin/Health_Status_vol_2.pdf.

significant barrier to the continuity and quality of care. Because multiple providers see patients, the comprehensiveness of the previous clinical note is key to assuring that care delivered to a patient-inmate is coordinated and seamless.

Many of the charts reviewed had completed problem lists; however, records were reviewed that did not have a problem list and others had a serious chronic illness that was not noted on the problem list. Eight the 12 medical records reviewed had completed problem lists, two problem lists had not been completed, and two were incomplete (serious chronic illness not noted).

The care of diabetics was uniquely problematic. Without regard to the level of control or other needs of the patient, all insulin-requiring diabetics have their community or previous facility insulin types and dosages changed to twice a day NPH dosing accompanied by twice a day capillary blood glucose (CBG) testing.⁵⁴ Because patients have individual needs, this one-size-fits-all protocol has risks of deterioration of diabetes control and disrupts the continuity of care. Microalbumin-creatinine ratio, lipid profile, and HbA1C are not consistently drawn at the first provider visit as directed in the IDOC Office of Health Services Diabetes Treatment Guidelines (March 2016). Only one of the five diabetic charts reviewed had a HbA1C lab done, one had an order for this test, and three did not have an order or results in the chart. Pneumococcal vaccine was not being ordered. One of the five diabetics already had been vaccinated but four did not have a history of previously being vaccinated, nor was it ordered by NRC. The providers' notes do not detail their inspection and examination of the feet of the diabetics. On routine diabetic clinic visits, the providers check a box that lower extremity exam was done. Detailed notes about sensation, callouses, or the presence or absence of ulcers or other foot abnormalities are not documented in the medical record. None of the diabetic records reviewed had evidence that a retinal screening for diabetic retinopathy had been recently performed or had been ordered by NRC providers. The IDOC Office of Health Service's Offenders Diabetes Guidelines we received does not include a recommendation for routine retinal screening for diabetics; this is not in alignment with national USA standards of care. We believed that the IDOC Diabetic Chronic Care guideline was missing pages and we asked for but did not receive any further copies.

The medications for some new admissions were not ordered at intake, putting at risk the control of the chronic illness that is being treated. Lab reports are not always in the medical record. Medication administration records (MARs) and specialty consultation reports were not consistently found in the medical record. MARs have blanks where the nursing staff failed to note whether they administered insulin doses or refusals. The provider and nursing notes do not document that insulin refusals are regularly reported to the provider. Intake physical exams are not always done within seven days of admission.⁵⁵

⁵⁴ These are point of care finger stick blood glucose tests that civilian diabetics perform themselves but in correctional facilities are often performed by nurses.

⁵⁵ IDOC Administrative Directive 04.03.101 Offender Physical Examination.

Eleven of 13 (85%) patient records reviewed had problems demonstrating quality of care issues. The following patient care summaries illustrate some of the concerns noted above.

- This patient was admitted to NRC on 1/4/18.⁵⁶ Medical and mental health screenings were done on 1/4/18 and dental screening was done on 1/5/18. The medical history included tobacco use, hypertension, and aortic valve replacement. A problem list was completed. Medications included amlodipine, hydrochlorothiazide, and warfarin. During the 26 days he was at NRC, three INRs had been performed. All were in the therapeutic range. His problem list was complete. He was scheduled for a chronic care clinic on 2/3/18. As of 1/29/18, almost a month after reception, his admission physical exam had not yet been performed.
- Another patient was admitted to NRC on 11/17/17.⁵⁷ Medical history, physical exam, mental health screening, and dental screening were done on 1/17/18. The patient had diagnoses of pituitary tumor, type 1 diabetes, hypertension, hypercholesterolemia, hypothyroidism, sleep apnea, and a urological problem (note illegible). The problem list was completed. Medications included metoprolol, amlodipine, aspirin, Lisinopril, metformin, insulin, and levothyroxine. A low TSH resulted in his thyroid medication being held. On 11/21/17, he passed out and suffered a forehead contusion which required four sutures; a finger stick CBG test was not done, an electrocardiogram (EKG) was not immediately done, and the provider did not comment on the cause of the syncope. At a chronic care clinic visit on 12/16/17, the provider noted that the patient was missing some medications and his EKG was normal. The same dose of insulin was continued. Depo Testosterone, which has a single FDA indication for hypogonadism, was initiated on 12/29/17 with no explanatory note by a provider. It was not clear what was wrong with the patient. He was next seen by a provider on 1/16/18. His CBG tests in the first two weeks of January 2018 ranged from 200-300 (poor control) and the provider increased the insulin dosage. His CBG tests from 1/17 to 1/30/18 continued to range from 200-300 but there were no further intervention/visit/notes as of 1/30/18.

In summary, pneumococcal vaccine was not offered, HbA1C was not ordered, detailed foot exam was not done, retinal screening was not ordered. The response to the syncope and the ordering of additional testing were deficient. Although the insulin dosage was increased on 1/16/18, the CBG tests continued to be elevated (200-300) for the next two weeks with no further intervention and adjustment of insulin dosage. The patient was placed on testosterone without a documented indication.

- Another patient was admitted to NRC on 11/17/17.⁵⁸ A nurse identified a history of type 2 diabetes. A physical examination was done. His medications were insulin, metformin, atorvastatin, aspirin, and Lisinopril. The admission glucose was 240, which is

⁵⁶ Chronic Care Patient #1.

⁵⁷ Chronic Care Patient #2.

⁵⁸ Chronic Care Patient #3.

elevated, yet a HbA1C test was not ordered on admission. CBG tests from 11/17/17 to 12/2/17 ranged from 130-339 (mean >200). This indicates poor control of his diabetes. The MAR for insulin administration during these dates had 11 blanks, indicating that the patient did not receive insulin, or the nurse did not document administration of insulin. At a chronic care visit on 12/2/17, the insulin dosage was not increased despite the poor control of his diabetes over the preceding month. The provider ordered a HbA1C and a follow-up clinic in eight weeks. CBG tests from 12/3/17 to 1/30/18 ranged from 126-236 (mean >150), and during this period the MAR for insulin had two blanks and 25 refusals. There was no intervention concerning the insulin refusals or elevated CBG tests. There was no provider visit from 12/2/17 until 1/30/18, the day of our visit.

In summary, there was no problem list, pneumococcal vaccine was not offered/administered, there was no detailed foot exam, retinal screening was not ordered, there was no HbA1C ordered on admission, and there was no referral to a physician for failure to take insulin.

- Another patient came into NRC on 1/19/18.⁵⁹ Medical history, physical, and dental screening were done on intake. The diagnoses included: type 2 diabetes, hypertension, asthma, BPH, seizures (not on anti-epileptic medication and no seizure since 2002). There was no problem list in the medical record. The medication list that transferred with the patient from Cook County Jail included glargine and regular insulin, metformin, albuterol/QVAR, atorvastatin, metoprolol, Tamsulosin, amlodipine, enalapril, and pneumococcal 23 vaccine given. A NRC provider switched the patient's insulin to NPH BID with sliding scale regular insulin, and metformin. Laboratory tests included a CBG test of 212, a hepatitis C test reactive, and serum glucose 234. The blood pressure was 136/57. A provider requested a chronic care clinic appointment for 2/17/18. The MAR for insulin from 1/19 to 1/30/18 had two blanks/two refusals, with CBG values ranging from 76-235 (mean>140).

In summary, there was no detailed foot exam, no microalbumin-creatinine ratio, retinal screening was not ordered, and no HbA1C was done on intake. The hepatitis C antibody positive status was not added to the problem list.

- Another patient was admitted to NRC on 11/20/17.⁶⁰ The patient was a 58-year-old man. The medical history, physical examination, and mental health screening were done on intake. The diagnoses included: type 2 diabetes, hypertension, asthma, chronic obstructive lung disease (COPD), and carotid stenosis. Carotid stenosis was not on the problem list. Medications included: insulin, Lisinopril, metoprolol, aspirin, and amlodipine; influenza vaccine was given at the Cook County Jail. The admission laboratory tests included: glucose 111. The blood pressure was 161/80, the peak expiratory flow rate (PEFR) was 330. A doctor saw the patient on 12/1/17. The blood

⁵⁹ Chronic Care Patient #5.

⁶⁰ Chronic Care Patient #6.

pressure was 159/78, which is high for a person with diabetes, and the CBG test was 200, which is high. The provider ordered amlodipine as it was not ordered at intake. On 12/5/17, the HbA1C was 7.0. On 12/14/17, at an RN visit the patient was “dizzy” with a blood pressure of 130/84 and a CBG value of 131. On 12/25/17, an RN evaluated the patient who was “dizzy” with blood pressure of 163/94 (elevated) and pulse was 82. On 12/16/17, a provider saw the patient and documented left carotid bruit. An ultrasound had been done at Weiss Hospital and the record from Weiss was requested. The provider started atorvastatin. At the 1/18/18 provider visit, the blood pressure was still elevated at 167/114. The provider administered an immediate single dose of blood pressure medication and increased routine blood pressure medications. On 1/20/18, the patient had “chest discomfort.” The blood pressure was 177/105, which is very high. The EKG was negative. A provider only gave a once-only dose of clonidine, which is not an acceptable standard of treating elevated blood pressure. On 1/22/18, the medical record documented that the patient was “Not taking BP meds.” On 1/28/18, the blood pressure was 161/88 (which is elevated), but was not addressed. The MAR for insulin 1/1/18 to 1/30/18 had seven blanks and two refusals, with CBG tests ranging from 95-227 (mean >150).

In summary, there was no pneumococcal vaccine offered/administered, blood pressure medication was not started at intake, there was no detailed foot exam, and retinal screening was not ordered. Additional evaluation for dizziness/syncope should have included a thorough history and neurologic examination, and depending on findings, further testing (Holter monitor) might have been indicated. The blood pressure was not controlled and yet providers did not appropriately adjust anti-hypertension medications. This was particularly important since the patient had diabetes and history of carotid artery diseases and was therefore at risk of stroke and other cardiovascular diseases. The carotid ultrasound report from Weiss Hospital requested on 12/16/17 was not yet received as of 1/30/18.

- Another patient was admitted to NRC on 1/23/18.⁶¹ He was a 33-year-old. A medical history and physical examination were done on intake. Diagnoses included: type 2 diabetes, hypertension, and hepatitis C. Hepatitis C was not noted on the problem list. The medication list from Cook County Jail included: Lisinopril, metformin, and glipizide. The CBG was 153, which is high. The blood pressure was 177/94, which is also elevated. The TST was negative. A provider noted that the blood pressure was not controlled and referred the patient to chronic care clinic on 2/13/18. There were no lab reports in the chart.

In summary, there was no pneumococcal vaccine offered/administered, there was no definitive foot exam, no retinal exam ordered/done, and no HbA1C done on intake. The doctor evaluating the patient at intake should have evaluated whether the patient had

⁶¹ Chronic Care Patient #7.

taken his blood pressure medication that day and considered adjusting the blood pressure medication.

- Another patient was admitted to NRC on 6/20/17.⁶² He was a 29-year-old. Medical history, physical, dental, and mental health screening were done at intake. The diagnoses identified included: ankylosing spondylitis (HBL-27 reactive). A problem list was completed. A follow-up in medicine clinic was ordered. Medications included: prednisone and sulfasalazine. The laboratory tests ordered at intake included: BMP, CMP, liver profile, all of which were normal. Laboratory tests were repeated on 8/8/17, 11/13/17, and 12/27/17, and all tests were normal. At a six-month chronic care clinic visit, a doctor noted that prednisone was decreased to 10mg/d with a follow-up in six months.

In summary, there was no documentation about presence/absence of symptoms or assessment of functional status with respect to ankylosing spondylitis. Pneumococcal vaccine was not offered/administered even though patient is on prednisone, a chronic immunosuppressive medication. Sulfasalazine does not have an FDA indication for ankylosing spondylitis and prednisone is not recommended for long-term use in ankylosing spondylitis, yet a thorough medication history was not obtained to understand why the patient was taking these medications; it did not appear that the providers understood how to manage ankylosing spondylitis and yet did not refer the patient to a specialist who typically manages this disease. We note that patients with ankylosing spondylitis typically are managed with tumor necrosis factor alpha antagonist medications, which was not offered to this patient.

- Another patient was admitted to NRC on 8/18/17.⁶³ He was a 49-year-old. Medical history, physical, mental health, and dental screening were done at intake. Diagnoses included: right ankle deformity secondary to a fracture in 2016 and motor vehicle accident in 2017, use of crutches to walk, left total knee replacement, hypertension, and asthma. A problem list was completed. PEFr tests were 200 and 290 and the blood pressure was 154/115, which is elevated. Medications included: amlodipine and albuterol. Intake laboratory tests were normal. On 8/21/17, an x-ray showed a severely fragmented ankle joint with a suggestion of osteomyelitis or Charcot joint. On 8/25/17, a blood count was normal. On 10/14/17 at a chronic care clinic visit, the blood pressure was 157/92 and 136/92, and the amlodipine was increased. The PEFr was 350-400. A repeat blood pressure was ordered in 30 days. On 11/2/17, an orthopedic consult apparently occurred after about two months at NRC, but there was no consultant report in the medical record. On 11/16/17, a CT scan was ordered and approved. There was no evidence that this CT scan was done as there was no return transfer note in chart upon return to NRC. On 12/12/17, a CT/MRI of the ankle was approved. On 12/29/17, the CT/MRI results were noted to be pending. On 1/2/18, an x-ray report showed right ankle

⁶² Chronic Care Patient #9.

⁶³ Chronic Care Patient #10.

Charcot joint. Orthopedic recommendations included a fasting blood sugar, HbA1C and testing for lead/heavy metals and a podiatry referral. On 1/3/18, tests recommended by the orthopedic consultant were ordered. On 1/30/18, lead, copper, and heavy metal levels were not done due to cancellation. The patient's uncontrolled blood pressure was appropriately treated on 10/14/17 by increasing anti-hypertensive dose, but an order for repeat blood pressures ordered for mid-November was not done. There were no blood pressure values in the chart for the last three months.

In summary, this patient with severe ankle deformity was not seen by UIC Ortho until more than two months after NRC admission. The CT/MRI as recommended by the orthopedic consultant was not done for two months, and the results were not in the medical record. It is not documented why/who cancelled orthopedics' recommendation to do lead/copper/heavy metal levels to evaluate possible Charcot's joint. Patient has been in NRC for five months without completion of the evaluation of his damaged ankle. The patient had an elevated blood pressure at intake, yet blood pressure medications were not adjusted for about two months.

- Another patient was admitted to NRC on 7/3/17.⁶⁴ The patient was a 28-year-old. Medical history, physical, mental health, and dental screening were done at intake. Intake labs were normal. Diagnoses included: spastic paraplegia due to a prior gunshot wound, using crutches to walk, depression, and neurogenic bladder with use of catheters. The problem list was completed. Medications included; pain medication and medications for spasm. On 7/17/17, a urine culture and sensitivity was negative and a blood count was normal. On 8/11/17, the patient had abdominal discomfort. A rectal examination showed soft stool with a negative guaiac test. An abdominal x-ray was negative but suggested a possible ileus. On 8/16/17, a physician assistant note documented a normal white count and BUN test. The physician assistant ordered antacid. On 8/29/17, Imodium was ordered for diarrhea. On 8/31/17, a muscle relaxant and gabapentin were ordered. On 9/14/17, a urinalysis showed 6 WBC's and large leukocyte esterase which suggested infection; an antibiotic (ciprofloxacin) was started for UTI. On 10/21/17, a urine dipstick showed leukocyte esterase 70+. On 1/8/18, the patient fell out of bed and landed on his elbow with development of a new left wrist drop. An x-ray of the spine/elbow was negative for fracture and a support was provided (sling) and a urinalysis was ordered. On 1/10/18, the urine culture showed Klebsiella pneumonia >100,000. On 1/23/18, sensitivities were reviewed by the provider and Bactrim was ordered.

In summary, a provider completed an appropriate evaluation of patient's abdominal discomfort in August 2017. The patient had repeated colonization of his urine but for persons with neurogenic bladder, treatment is generally reserved for those who are symptomatic (fever, foul-smelling urine, incontinence, frequency, or dysuria). Initial management of left elbow trauma/l wrist drop was reasonable but there has been

⁶⁴ Chronic Care Patient #11.

unacceptably no follow-up as of 22 days post injury/wrist drop and no referral to Neuro/Ortho generated.

- Another patient was admitted to NRC on 12/12/17.⁶⁵ Medical history and physical examination were done at intake. Diagnoses included: HIV infection/high CD4, blindness in his right eye, and seizures (not on anti-epileptic meds; providers did not comment/address this serious history). The problem list was complete. Medications included: Genvoya. A viral load showed undetectable HIV, a CD4 716, and hematocrit of 43. On 1/23/18, a UIC Telehealth HIV consultant continued Genvoya, offered an influenza vaccine and scheduled a four month follow up. A MAR from December was not in chart as of 1/30/18, but on 1/11/18 KOP Genvoya was given; the quantity of pills was not listed.

In summary, the intake provider should have commented on the status of the patient's history/etiology of seizures and determined whether anti-epileptic meds were indicated or not. The HIV care was reasonable. The UIC HIV specialty appointment six weeks post admission was acceptable given the level of viral control documented on intake labs. The MAR should definitely document, as per established practice, the number of HIV pills given to the patient for KOP administration.

- Another patient was admitted to NRC on 11/30/17, and a medical history was done in reception.⁶⁶ Diagnoses included: HIV infection and asthma. There was no documentation in the 11/30/17 intake forms about whether the patient was on HIV meds. On 12/1/17, a provider performed a physical examination and ordered daily Bactrim x 30 days. Laboratory results included: VL 95462, CD4 88. No HIV medication was ordered nor was there any documentation about whether the patient was prescribed or taking HIV medication. On 12/6/17, the patient was given Bactrim six tabs KOP even though 30 days of medication was ordered. There was no justification in the chart for this discrepancy. On 1/5/18, a UIC Telehealth HIV consultant noted that the patient stopped HIV meds in October 2017. The HIV consultant ordered Genvoya and TMP/SX (Bactrim)/day. The consultant recommended repeat HIV labs in four weeks/UIC follow-up consult in six weeks. On 1/5/18, the MAR noted that Genvoya #30 KOP and Bactrim #15 KOP were given to the patient.

In summary, the intake medical history and physical should have clearly documented that the patient had not been taking his HIV meds prior to NRC admission. Laboratory tests reviewed in the 12/1/17 provider note revealed a severely uncontrolled and immunocompromised state, yet the UIC HIV consultation was not obtained until five weeks post admission. This was an unacceptable delay in access to much needed specialty consultation.

⁶⁵ Chronic Care Patient #12.

⁶⁶ Chronic Care Patient #13.

Urgent/Emergent Care

Methodology: We interviewed health care leadership and staff involved in emergency response, toured the medical clinic, assessed the availability and functionality of emergency equipment and supplies, reviewed actual or emergency drills, and CQI reports.

First Court Expert Findings

The First Court Expert Report noted that NRC had no useful logs to select records of patients being sent out for urgent or emergent conditions. A Nursing Telephone Urgent Care Log tracked only patients that were seen and not all notifications of patients reporting urgent complaints. The Court Expert recommended that NRC conscientiously use paper or electronic log books to document urgent/emergent care.

Current Findings

We requested but were not provided an urgent care tracking log. We inspected emergency response equipment and found that it was poorly organized and maintained. Health care leadership has not implemented the SCC-NRC Machine/Equipment Check Log Sheet that requires daily checks of the medical unit for sanitation and equipment such as suction, oxygen tanks, automatic external defibrillator (AED), EKG machine, EKG electrodes and paper, backboards, stretchers, biohazardous waste, sharps containers, and trauma bags, etc.

The treatment room where patients with urgent conditions are assessed was dirty and disorganized. Stretchers in the treatment room were torn. Several oxygen tanks were placed into a corner; the one closest to the stretcher was empty.

Two AEDs and emergency response bags were not kept in the same location in the clinic. We inspected the AEDs and found that they were operational, but electrodes had expired in 2016 and in August 2017. Two emergency response bags were found open in the main clinic area on a countertop. We asked staff whether equipment and medications in the response bag were standardized, locked, and routinely inspected and we were informed they were not. A CMT stated that one of the bags was for her personal use and she kept glucagon and a thermometer in her lab coat pocket and not in the bag.

A mass disaster response bag covered in dust was located on top of cabinets in the medication room. The bag was not included on the equipment check log sheet as one of the items that needed to be checked daily.

Emergency events or drills were conducted and critiqued on 11/21/16, 4/11/17, and 5/3/17. A mass casualty drill was conducted on 5/19/17. The critique of the events was extremely limited. The mass casualty drill identified a number of weaknesses for which no corrective action plan was developed or implemented.

No emergency response drills have been conducted in the past eight months, which is not compliant with NCCHC standards.

In summary, we concur with the First Court Experts findings regarding urgent care. In addition, we found that NRC has not developed an adequate emergency response system through the proper maintenance and checking of emergency equipment. Emergency response drills have not been performed timely and they have not meaningfully identified areas for improvement.

Specialty Consultations

Methodology: Interview HCUA. Review offsite tracking logs. Review selected medical records of persons having offsite consultations.

First Court Expert Findings

The First Court Expert found that specialty care for long-term NRC inmates is delayed. He also identified “problematic” clinical care in several patients who had specialty care. The First Court Expert recommended that NRC institute a tracking system for all scheduled offsite services and begin using logs for this purpose. The First Court Expert recommended that high-level security inmates be held at NRC until their specialty care has concluded.

Current Findings

We noted that of the seven patients we reviewed, several were being held at NRC while their specialty care was in progress. This was a recommendation of the First Court Expert. However, the lack of a tracking log made it impossible to verify this for a larger sample. There has been no improvement with respect to the other First Court Expert’s findings. We identified the following additional findings:

- Medical record documents (referrals, verifications of collegial review, approvals, and consultation reports) were mostly not found in the medical record.
- Only 36% of consultations included a formal report.
- The HCUA who is a nurse evaluated denials of specialty care. This evaluation needs to be by a physician.
- The collegial review process fails to ensure that patients receive timely consultative specialty care.

IDOC policy requirements regarding specialty care are in two separate ADs.⁶⁷ The ADs require that all referrals for specialty care are sent to the Facility Medical Director. It is our opinion that these are medical record documents (physician orders) and they should be filed in the medical record. The Facility Medical Director is to make a determination regarding approval or denial of all referrals. If the Facility Medical Director approves the request, it is to be referred to Wexford’s utilization management unit in writing or verbally. According to requirements in the ADs, verbal referrals must be documented in the medical record. A Wexford written response is to be made within five days and this response, according to the AD, is to be placed in the medical record. If the referral is denied by the corporate UM reviewer, the denial is to be referred to the HCUA. The HCUA is to “independently” review all denials and decide if the denial is medically appropriate. At NRC, the HCUA is a nurse. A nurse has insufficient training to

⁶⁷ 04.03.103 Offender Health Care Services and 04.03.125 Quality Improvement Program.

evaluate whether the consultation is medically necessary; a physician should be making this judgment. When the HCUA decides that a referral denied by the Wexford UM reviewer should be approved, the denial is referred to the Agency Medical Director. In this arrangement, the HCUA might agree with Wexford that some denied consults are appropriately denied when the Agency Medical Director might decide otherwise. A physician should review all of the denials. If the patient writes a grievance about a denial, the HCUA is also required to refer to the Agency Medical Director. The Wexford Regional Medical Director for the northern region told us that after a specialty consult it is a requirement that the patient is to be seen in follow up in five days. In the IDOC response to the First Court Expert report, the IDOC stated that when a patient returns to the prison after an offsite visit, the practice in IDOC is to have a physician evaluate the patient within three to five days.⁶⁸ In that response, the attorney for the IDOC stated that a three to five day follow up meets constitutional adequacy.

Tracking specialty care is useful to monitor the effectiveness of the specialty care process and to ensure that specialty care consultations are carried out timely. The IDOC agreed⁶⁹ with the First Court Expert's recommendation that:

"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."⁷⁰

We agree with the First Court Expert that this manner of tracking specialty care is needed. The IDOC stated, in their response to the First Court Expert's report, that there was a logbook currently in place for offsite services matching the requirements of the First Court Expert. We asked for but did not receive a logbook and were not given a logbook during our tour. In preparation for this visit we asked for a tracking log of onsite and offsite specialty care including the date of referral, date of collegial review, date of service, and the service the patient was referred for.⁷¹ Our visit started Monday 1/29/18. On 1/25/18, we received by email a list of onsite appointments. This list did not contain the date of referral, the date of collegial review, and reason for referral. An offsite specialty list was sent to us by email on 2/1/18, the last day of our tour. We had no internet capability in the facility and were not able to see this document until after we left the facility. We were able to obtain the same list from the IDOC on the second day of our visit. However, the list that Wexford sent and also provided by IDOC only contains the patient name, IDOC number, the destination consultant, the reason for consultation and the date of service. We learned during the SCC visit that the NRC offsite scheduler maintains the type of log we had asked for but had not received. We also asked for but did not receive a list of denials of specialty care.

⁶⁸ Page 22, email letter to Dr. Shansky on 11/3/14 sent by William Barnes representing the IDOC.

⁶⁹ Page 24, email letter to Dr. Shansky on 11/3/14 sent by William Barnes representing the IDOC.

⁷⁰ Final Report of the Court Appointed Expert Lippert v. Godinez page 31 of main report.

⁷¹ January 8, 2018 email to the Attorney General's representative.

When we visited SCC we had an opportunity to talk to the scheduling clerk from NRC. She indicated that she used the same spreadsheet as used at SCC. This SCC spreadsheet did not always have an accurate referral date but did contain the collegial date and date of the consultation. Some collegial reviews were documented as occurring before the referral was documented as having occurred. These tracking logs should be standardized so that the information can be used to measure adherence to administrative directive timelines. As well, referrals should be treated as physician orders and should be filed in the medical record as they occur, not after the consultation is completed.

Also, a key component of consultant care is that providers review the consultation report, review the findings of consultants, and evaluate all consultant recommendations including medications changes, further referrals for specialty care, and further recommendations for additional testing. The findings of these reports should be discussed with the patient. At NRC, review of consultation reports is ineffectively done and many consultant recommendations are either not reviewed or not carried out.

We reviewed a number of consultations to determine if the referral, collegial review, and approval were filed in the medical record. We also looked at specialty care follow-up to assess whether providers are carrying out the consultant's recommendations or documenting why they did not follow the recommendation. We found that specialty care is poorly documented in the medical record despite being required by the IDOC ADs. We reviewed seven patients who had 22 consultations and one hospitalization. Of the 22 consultations we found only 14 (63%) referral forms, only three (14%) collegial reviews, and only nine (41%) approvals in the medical record. Of the 22 consultations that occurred, only eight (36%) included a formal consultant report. Some consultations had a few brief lines written on the referral form giving recommendations, but these did not include information about the status of the patient and did not include a report of the evaluation. Particularly problematic was that 19 recommendations of consultants were not reviewed or carried out. Given that there were 19 recommendations not carried out in seven patients, there is a serious problem with clinical follow up of specialty appointments that represents a significant risk of harm to patients. These represent underutilization or not conducting necessary specialty care. The IDOC and Wexford have no current process to study underutilization even though it is a significant problem and patient safety issue. The Wexford collegial review process is so defective that, in our opinion, it is a patient safety issue and is likely causing harm to patients and therefore should be eliminated.

We looked for further evidence that Wexford or IDOC performed any audit or review of specialty care. We noted in the annual CQI report of September 26, 2017 documentation indicating that there were 273 collegial reviews and that 100% of patients who went offsite were seen within five days of the return to the facility. This was the only review of specialty care that we could find in the quality improvement documents provided to us.

Though the quality improvement report documented that 100% of persons were seen within five days of a specialty visit, our findings were different. Of 23 patients (22 consultations and

one hospitalization) we reviewed, only 15 (65%) were seen within five days after the consultation or hospitalization. We found that NRC providers failed to review or act on 19 consultant recommendations. This places patients at significant risk of harm. The report that 100% of patients who went off site being seen in five days misrepresents, in our opinion, the quality of offsite specialty care and fails to identify significant existing deficiencies in this service. In our opinion offsite specialty care is inadequately managed and places the patients at significant risk of harm.

In addition to these findings we noted poor care for six of seven patient records reviewed for specialty care, which is a similar finding of the First Court Expert. These reviews are as follows.

- One patient had lupus nephritis, hypertension, and history of pulmonary embolism.⁷² In patients with lupus nephritis and significant amounts of protein in the urine, which this patient had, the blood pressure should be controlled to a level of 130/80. This patient saw providers 11 times when the blood pressure was elevated. On only one occasion did a provider adjust long-term anti-hypertension medication and on two occasions a one-time only dose of medication was given. One-time only doses of medication are not considered appropriate therapy. The lack of blood pressure control was likely to damage the patient's kidney function. Consultants recommended that this patient have laboratory tests monitored, but this was not effectively done. During clinic visits, laboratory tests that were done were not consistently reviewed. The patient had significantly low albumin (1.7) and anemia (HGB 11.7), but these problems were not addressed. These deficiencies placed the patient at risk of harm and may have harmed the patient.
- Another patient had primary sclerosing cholangitis, a condition of uncertain etiology which can lead to severe liver disease, including cirrhosis and hepatocellular carcinoma.⁷³ Although the patient had abnormal liver function tests and although a consultant recommended a hepatology consultation, the abnormal tests were not reviewed or noted and the referral to hepatology did not occur. This placed the patient at risk of harm. The patient had a cytology examination during a specialized procedure (ERCP) but the results were never checked.
- Another patient had prostate cancer.⁷⁴ Providers at NRC never documented the staging and status of the patient's condition. The patient had testicular and groin pain that a consultant felt was due to a vascular condition as opposed to the patient's cancer; consultants also documented peripheral vascular disease as a problem. A recommendation to refer the patient to a vascular specialist was not noticed or referred. The patient's peripheral vascular disease was never identified by NRC providers as a problem.

⁷² Specialty Care Patient #1.

⁷³ Specialty Care Patient #2.

⁷⁴ Specialty Care Patient #3.

- Another patient had pancreatic cancer and was undergoing chemotherapy.⁷⁵ An oncologist noted that the patient had elevated liver function tests and should have an abdominal ultrasound to evaluate potential reasons for this abnormality. Indeed, abnormal liver function tests were available in the NRC record, and though signed as reviewed, nothing was done to evaluate for the abnormality. This patient never had an evaluation of the liver function abnormalities, even though the reason for the abnormal labs may have been related to the patient's cancer. This patient also experienced an episode of loss of consciousness and fell to the floor. The patient had an abnormal pulse (116) and low blood pressure (102/66). The nurse evaluating the patient did not consult a provider and did not refer the patient to a higher level of care for evaluation. This placed the patient at significant risk of harm.
- Another patient had keratoconus, a disabling condition of the cornea which results in a malformed cornea and can result in visual disturbances.⁷⁶ At intake, nurses recorded 20/20 visual acuity in both eyes. Several weeks later an optometrist identified 20/200⁷⁷ vision in one eye and did not record the visual acuity in the second eye. We noted problems with intake screening of visual acuity and this example demonstrates this problem. The patient was also on Plavix and aspirin, two drugs that can cause serious bleeding as a side effect of the medication. However, the reason for being on these medications was never determined and there was no corresponding problem listed as a reason for being on these medications. The patient had diabetes, hypertension, and high blood lipids but was seen in only one chronic clinic visit over a nine-month period. The patient had abnormal laboratory results (BUN 33; sodium minimally low at 134; WBC 12.5 and hemoglobin 11 indicating anemia). These abnormal laboratory results were not repeated, and providers did not attempt to determine the reason for the abnormalities. Though the patient was diabetic, the patient never received an HbA1C test even though this is required by chronic care guidelines for persons with diabetes. The patient's chronic illnesses were not being monitored or managed.
- Another patient had a history of pancreas and kidney transplants but the reason for these transplants was never identified or documented in the medical record.⁷⁸ History of the patient's illness was substandard. This patient had several consultations but because the reports were not available in the medical records, the providers at NRC failed to understand what the patient's clinical condition was and also failed to understand the status of the patient's conditions. We also could not determine the status of this patient because of lack of consultant reports. This places the patient at risk of harm. Because consultant reports are not filed in the medical record, when this patient transfers, subsequent providers will not understand how to care for this patient, who will be at risk of harm. The patient also had a hemoglobin of 12.7 on 10/5/17, which dropped to 8.9 on 12/21/17. This significant drop in hemoglobin was unnoticed

⁷⁵ Specialty Care Patient #4.

⁷⁶ Specialty Care Patient #5.

⁷⁷ 20/200 visual acuity is legal blindness.

⁷⁸ Specialty Care Patient #7.

and was not being monitored; it indicated a significant risk to the patient yet was unnoticed. The patient also was being treated for high blood lipids but was not being monitored for this condition.

We also note that in review of these records, the organization of the medical records was so poor that it was extremely difficult to discover what was happening to the patient. This was similar to the finding of the First Court Expert. Papers were merely placed in a folder, not sorted by type of document or placed in chronologic order. For larger records, examination of the record was so difficult that use of the record for routine care in a busy clinic would not be possible.

We were unable to evaluate the First Court Expert's recommendation that persons who require specialty care have that specialty care before they leave NRC because of a lack of tracking logs. We agree with this recommendation in principle, particularly when higher level care at UIC is needed, in that it ensures continuity of care.

With respect to findings of the First Expert, we agreed with the findings and recommendations regarding lack of tracking of specialty appointments. Specialty care needs to be tracked. The IDOC agrees with this recommendation as well. Yet the IDOC has not been able to provide evidence that this is done at this facility. The First Expert found two of three charts reviewed showed problems with care. We identified problems with care in six of seven records reviewed. Our review of medical records found similar findings to the First Expert report, including delays in perceiving the need for services, delays in following up abnormal results and problems with follow up. We had an additional finding that the IDOC has no current way to monitor the effectiveness of access to specialty care. In particular, underutilization or the lack of recognition of a necessary referral appears significant. For seven patients reviewed, there were 19 recommendations by consultants that were not carried out or determined to be unnecessary. This should be examined using a root cause analysis to determine why this is happening.

Infirmiry Care

Methodology: The clinical space and equipment was inspected, nursing staff schedules reviewed, clinical charts audited, nursing staff interviewed, correctional staff and porters questioned, and patient-inmates interviewed. There was only limited contact with the infirmiry physician.

First Court Expert Findings

The medical infirmiry was not operational at the time of the First Court Expert's site inspection. Individuals requiring infirmiry level services were housed in the nearby SCC infirmiry. The infirmiry charts of three of the four NRC patients in the SCC infirmiry were found to be inadequate. The provider's notes were consistently illegible to the experts.

Current Findings

The First Court Expert recommended opening the medical infirmary, which has since been done. We had several new findings, including:

- As recommended in the First Court Expert report, NRC opened the medical infirmary in 2016 and has assigned 24/7 coverage with nurses and correctional staff. However, nurse staffing plans show inconsistent coverage by a RN.
- Provider notes are generally written on at least a weekly basis.
- Infirmary admission notes are not always written by providers within 48 hours of admission.
- There continue to be problems with NRC providing the needed quantity of bed linens to the infirmary. This was also noted in the First Court Expert's report.
- The quality of care provided by the clinicians assigned to the infirmary is inconsistent and often inadequate.
- The provider progress notes lack documentation of the rationale for changes in treatment and fail to develop clear treatment plans and differential diagnoses.
- There is virtually no documentation of the status of patient's chronic illnesses.
- There was no documentation that any pertinent physical examinations were being performed.
- The care of diabetics is deficient.
- In its current state, the level of provider care in the NRC infirmary puts patients at risk.

The medical infirmary has been operational since December 16, 2016. Eleven of the 12 medical beds were occupied at the time of the site visit. Two-thirds of the patients were chronically ill individuals whose fragility, incontinence, and difficulty with ambulation and self-care precluded their assignment to regular housing units. The infirmary was reported to be staffed 24/7 by RNs with assistance of CNAs on most shifts. At the time of our exit from NRC, two nurse schedules for 1/29/18 to 2/4/18 were provided. One schedule had one to two RNs on all shifts assisted by CNAs on almost every shift; the second schedule had one to two RNs on the day shift with CNA coverage on six shifts, one RN on six of seven 3 p.m. to 11 p.m. shifts, and only one RN covering three 11 p.m. to 7 a.m. shifts without any CNA assistance. This lack of staffing is consistent with the lack of staffing at NRC and with the shared staffing between SCC and NRC. It was reported that there is a correctional officer assigned to the infirmary on each shift. During the site visit, one to two correctional officers were stationed in the medical infirmary and the adjoining mental health crisis beds.

There is a nurse call device/buzzer mounted on the wall next to each bed. The buzzers were found to be operational in all rooms that were tested, and the patient-inmates understood how to use this system. There were two negative airflow rooms (A-105-106) but, as noted in the Clinical Space section, the monitoring panel was not operational at the time of the inspection.

There are multiple deficiencies concerning sanitation and infection control in the infirmary and mental health crisis unit. The beds are fixed in a flat position without the capability to raise the head or raise/lower the height of the bed. Even though two-thirds of the 11 individuals housed in the medical infirmary were chronically ill with varying degrees of disability, there were no

adjustable hospital beds in the infirmary. The laundry was providing the infirmary with only 12 clean linen changes per week. The nursing staff reported that this quantity was insufficient to meet the needs of the infirmary patient population (incontinent, diapered elderly patients-inmates frequently soil their sheets) and the nursing staff's repeated requests for an ongoing additional stock of sheets had not been granted. We walked to the laundry and the nursing supervisor asked the laundry correctional officer for doubling of the weekly allotment, and this was verbally approved. This is a patient safety and sanitation issue.

All forms, notes, and reports generated after admission to the infirmary are kept in individual divided binders, with the clinical information placed in tabbed sections. This facilitates the review of the care provided in the infirmary. All care provided at NRC prior to the infirmary admission are in the same drop-filed loose paper arrangement as described in the medical records section of this report. This makes it difficult to assess the care provided prior to infirmary admission. The drop-file records are not all kept in the infirmary. The entire record of the patient needs to be available when the patient is evaluated.

IDOC Administrative Directive 04.03.120 Offender Infirmary Services has several requirements, including: admission to the medical infirmary must be authorized by a provider; nurses must complete admitting notes with vital signs upon admission; and admission notes by the providers are to be documented within 48 hours of admission. A review of four infirmary admissions found that nurse admission notes and vital signs were performed on the day of infirmary admission for all four individuals. Two of the four had provider admission notes written in less than 48 hours and the other two did not meet the timeliness standard, with provider admission notes written 11 days and 10 days post admission.

Acute care patients (rapid onset of symptoms, under treatment for acute illnesses, and post-operative status) are to be seen by a provider no less than three times per week and have daily provider notes. Patients with non-acute illnesses are to have a provider note no less than weekly. There were two patients (one post-operative and one with fluctuating mental status) who should have been initially given acute status, but they only had provider notes once a week.

There was a chronic disease patient who developed an acute serious eye problem and received an appropriately heightened amount of provider attention, including 14 provider notes in a 39-day period. However, the patient's diabetes status, with elevated CBG values, was not commented on once and did not include an adjustment of the patient's insulin. Most of the provider notes contained little, if any, clinical content, limited, if any, rationale for modifying treatment plans, a paucity of differential diagnoses about any set of symptoms, no notes about the control of patient's chronic illnesses, and only very brief, if any, comments about new or changing problems. Usually the only indication of a new concern was a new or changed order unaccompanied by an explanatory provider note. The paucity of the clinical content in the provider's notes would make it virtually impossible for a different NRC provider who was asked to cover the infirmary to understand the treatment plan or status of the patient. This puts the patient at risk. In addition, the provider's notes were very difficult to read and were mostly

illegible. These concerns were also raised in the First Court Expert's report. The nurse progress notes were generally more legible and contained more pertinent information of the condition of the patients.

The following summaries of the infirmiry patients' records highlight the concerns noted above.

- This patient was admitted to NRC on 11/30/17.⁷⁹ Physical exam on admission noted, "c/o pain in right great toe with discoloration." MD note: Right big toe ulcer with foul smell, surrounding erythema. The problem list noted: Diabetic R big toe ulcer, dime size, black x two months. Diagnoses: Diabetes, HTN, hyperlipidemia, renal insufficiency. MD ordered daily dressing changes, Rocephin 500mg/D. Intake lab: Syphilis/RPR 1:128. No dressing change log was found in medical. There is documentation that this patient's black toe was not evaluated or dressed as ordered until 12/5/17, when RN noted "in pain" and sent the patient to MD for evaluation. The right big toe was black with foul smell and erythema. He was sent to St. Joseph Hospital, was diagnosed as having right toe gangrene with abscess, his toe was amputated, he received treatment for sepsis, and he was discharged to NRC on 12/22/17 on IV antibiotics. On 12/22/17, he was admitted to the infirmiry. The RN admission noted: IV antibiotics, UIC podiatry and vascular clinic referrals in one to two weeks. The MD infirmiry admission note was written on 1/2/18, 11 days after admission. Post-hospitalization: Right big toe abscess/gangrene with sepsis, PICC line on IV antibiotics, angiography showed PVD, Meds Glipizide, Metformin, Lisinopril. On 12/5/17, RN note, "seen by MD, CPM." On 1/7/18, RN: red, swelling bottom of foot. 1/10/18, MD noted CPM [continue present management], but there was no physical exam. On 1/22/18, laboratory tests showed WBC 6.4, creatinine 0.87, RPR 1:64. On 1/27/18, five weeks after returning from a complicated hospitalization, the surgical (probably vascular) consultation was still pending and the podiatry appointment had not been scheduled. On 1/29/18, treatment for latent syphilis was finally ordered.

The pre-hospitalization care at NRC was deficient. The intake provider should have directly sent this diabetic with a black, foul smelling ulcer on his toe to the ED for emergency consultation and assessment for gangrene and osteomyelitis. NRC's failure to change dressings and re-evaluate the ulcer for seven days after reception minimized any opportunity to prevent amputation. The delay in transferring this patient to the ED contributed to the development of sepsis and jeopardized his life. The intake lab test identified syphilis; treatment should have been started during the seven days prior to hospitalization. Upon return to NRC, his abnormal syphilis test was not flagged for treatment and he was not treated until 1/29/18 (five weeks after his return from the hospital). The abnormal lab should have been quickly identified and treatment initiated immediately after his admission to the infirmiry on 12/22/17. The infirmiry physician clearly neglected to review the patient's previous test results upon admission to the infirmiry. During his infirmiry stay, the provider never once commented on the status

⁷⁹ Infirmiry Patient #1.

of the amputation wound site nor documented an examination of his feet. As a post-hospital return, the physician should have been initially writing progress notes at least three times a week. Provider notes were only written weekly. His post-hospital course was neglectful. Five-and-a half weeks after his return to NRC, he still had not been seen by a podiatrist and a vascular surgeon as recommended on 12/22/17. During his infirmary stay, the provider never commented on the control of the patient's diabetes. HbA1C, microalbumin-creatinine ratio, retinal screening, and an examination of the other foot was not documented in the progress notes. Pneumococcal vaccination was not offered or administered. At every stage of this patient's care the standards of care in the community were not followed.

- This patient was hospitalized from 11/2 to 11/8/17 for altered mental status, falls, and post-procedure for burr holes.^{80, 81} On 11/8/17, he returned to NRC and was admitted to the infirmary. MD admission note on 11/9/17. Diagnoses included type 2 diabetes, incontinence, decubitus ulcer, lymphoma on chemotherapy, and history of DVT, with IVC filter. On 11/28/17, lymphoma chemotherapy was completed. On 12/5/17, retinal vein occlusion was noted, urgent eye referral requested. On 12/7/17, MD called the eye consultant and had the patient's eye appointment moved up. On 12/11/17, the eye consultant recommended anti-VEGF injection, but the patient refused. On 12/15/17, anticoagulation was restarted. On 12/19/17, INR was 1.8, warfarin dose was increased. On 12/26/17, INR was 4.9, on 12/27/17, INR was held. On 1/2/18, INR was 2.1. On 1/18/18, the patient consented to treatment in eye clinic. On 1/20/18, the warfarin dose was increased; the rationale for this increase was not documented. On 1/27/18, INR was 6.6; the warfarin was stopped for three days. On 1/29/18, a repeat INR was ordered.

In summary, this patient with multiple chronic problems developed an eye problem. The infirmary provider appropriately advocated for an urgent eye appointment and helped convince the patient to accept treatment. The patient was successfully treated. Provider wrote 14 progress notes during the patient's 84 days in the infirmary addressing some more acute bladder, eye, and anti-coagulation concerns. However, it is very questionable to restart anticoagulation in a patient with an IVC filter who had a recent subdural hematoma and who was prone to falls. The provider's note did not provide any rationale for this decision. The INR test was performed five times between 12/9/17 and 1/29/18, two of which had results which were elevated. Since returning from the hospital, the provider did not comment about the control of the patient's diabetes, did not order a HbA1C, microalbumin-creatinine ratio, adjust the insulin dosage even though FSBG ranged from 70-273, and did not offer/administer the pneumococcal vaccine.

⁸⁰ Infirmary Patient #2.

⁸¹ Burr holes are holes drilled through the skull to allow accumulated blood to be evacuated. These are typically done for persons who have subdural hematomas.

- This patient was admitted to NRC on 1/3/18.⁸² Diagnoses: alcohol, cocaine, and hallucinogen abuse, Cryptococcal meningitis as a child that required a VP shunt. On 1/9/18, the patient reported that he was beaten by other inmates. On 1/11/18, he reported that he fell out of his upper bunk injuring his ribs, hand, and maybe his head. Mental health reported that he was delusional and grandiose. On 1/19/18, hand and rib x-rays were normal. The patient was placed on watch in the mental health crisis unit. On 1/20/18, he was transferred to a medical infirmary bed for altered mental status. MD note: r/o dementia, hypertension, and bipolar disorder. On 1/22/18, the RN noted that the patient had periods of confusion. On 1/23/18, a doctor noted that the patient was answering questions but had no dementia. On 1/24/18, an RN described the patient as incoherent. On 1/26/18, an RN described the patient as disoriented but pleasant. On 1/28/18, the patient was less confused. On 1/29/18, an RN described the patient as more alert. On 1/30/18, an RN stated that the patient had bruises on his forehead and top of his head.

In summary, there is no documentation of a neurological exam on this confused and disoriented patient. Fluctuating mental status with transient episodes of confusion and disorientation in a patient with alcohol abuse, recent trauma, and a VP shunt clearly warranted a head imaging study (CT scan) to rule out an intracranial hematoma or increased intracranial pressure. The provider did not note the patient's recent history of trauma, the recent fall from his bed, the bruises on his head, or the VP shunt. It is clear that he did not review the patient's ambulatory medical record. The provider did not even consider these different possibilities. The care of this patient was deficient if not negligent.

- This patient was transferred from Hill Correctional Center.⁸³ He was admitted to the infirmary on 12/23/17. Diagnoses included recent fractured jaw with intramedullary fixation, insulin resistant diabetes mellitus on NPH, and sliding scale regular insulin. On 12/26/17, an oral surgery consultant rewired his jaw. On 1/2/18, a doctor wrote an infirmary admission note 10 days after admission to infirmary. On 1/10/18, a doctor documented low glucose and glucagon was ordered with a subsequent increase of the glucose to 378. On 1/13/18, a RN noted that the inmate was shaking and unresponsive; the blood sugar was 37 and glucagon and oral glucose were given. On 1/13/18, a doctor ordered that sliding scale insulin be held. On 1/14/18, an RN noted a blood sugar of 34. MD again ordered that sliding scale insulin be held. On 1/16/18, a nurse noted blood glucose of 42 and food was given. On 1/17/18, an RN noted blood glucose of 433 and a doctor was called. On 1/22/18, sliding scale insulin was resumed. On 1/23/18, a doctor decreased sliding scale insulin dosages. A urine test of protein was 150. On 1/24/18, the patient was referred to oral surgery. On 1/25/18, the NPH insulin dosage decreased. On 1/26/18, the NPH dosage increased.

⁸² Infirmary Patient #3.

⁸³ Infirmary Patient #4.

In summary, this patient who is on insulin had intermixed episodes of hypo and hyperglycemia. His jaw was wired, and his nutritional intake was entirely liquid. Even though he was using a lower sugar content nutritional supplement, the calorie intake can widely vary. This puts him at risk for surges and drops in his glucose levels. The infirmary provider does not comment on this nor is a treatment plan developed that addresses the risks of giving sliding scale insulin to a patient with a wired jaw and unable to eat normally. Insulin dosages were increased and decreased without the provider commenting on the rationale for each change. The provider's note does not comment on whether this patient has Type 1 diabetes mellitus (produces no insulin and is at risk for ketoacidosis) or Type II (produces insulin and is at decreased risk of ketoacidosis). There may be very limited risks of ketoacidosis and regular insulin may not be needed. The lack of a clear plan about caring for this diabetic who temporarily is unable to eat solids has put this patient at serious risk. The urinalysis reported an elevated level of protein. This test was not repeated nor was a microalbumin-creatinine ratio ordered to determine if this patient should be placed on an ACE inhibitor to protect his renal function. No routine labs were drawn. The patient's renal function was not evaluated. HbA1C was not ordered. Pneumococcal vaccine was not offered or administered. The IDOC diabetes guidelines are not being followed.

Pharmacy and Medication Administration

Methodology: We conducted a comprehensive review of pharmacy and medication services from the time a medication order is written until medication is delivered to the patient. We met with health care leadership and staff involved in pharmacy and medication services, toured pharmacy and medication administration areas, observed medication administration, reviewed medication administration records and continuous quality improvement meeting minutes and reports.

First Court Expert Findings

The First Court Expert Report noted that no security staff was initially available to escort nurses for medication administration. The report also noted that nurses transfer medications from a pharmacy dispensed blister-pack to small white envelopes that nurses use to transport medications to housing units. Officers were supposed to open up food ports so the nurse could administer medications, but this did not take place and medications were passed through a crack in the door. Neither nurses nor correctional staff performed oral cavity checks.

Current Findings

Our review was consistent with the findings in the First Court Expert report. We found that pharmacy and medication administration practices do not assure the five "Rights" of medication administration: the right patient, the right medication, the right dose, the right route at the right time. Our review noted the following problems:

- At medical reception, nurses administer medications to patients from a stock supply, but do not consistently initiate a medication administration record (MAR) and document that medications were administered to the patient.

- Medical records do not contain physician order forms for all ordered medications.⁸⁴
- The nursing medication room is dirty, cluttered, and disorganized. There is no schedule of sanitation and disinfection activities.
- Nurses transfer medications from a properly labeled pharmacy dispensed blister pack into a small white envelope that is not properly labeled.
- To prepare medications, nurses do not consistently compare the MAR against the medication blister pack to ensure that the medication matches the physician order; instead, nurses use white envelopes that are not properly labeled.
- The white envelopes are repeatedly used and not hygienic.
- Inmates are not requested to present their identification badges at the time of medication administration.⁸⁵
- Nurses pass medications to patients through a crack in the cell door, not the food ports.
- Inmates do not have cups to fill with water to take their medications.
- Neither officers nor nurses perform oral cavity checks.
- If inmates are out of cell at the time of medication administration there is no procedure to go back later to administer the medication, even if it is a once a day medication.
- Nurses do not document administration of medications onto a MAR at the time they are administered.
- BosWell Pharmacy prints MARs for the following month for any prescription written by the 15th of the month, requiring nurses to handwrite MARs for all medications orders from the 16th to the end of the month, creating an enormous nursing workload and increasing the risk of transcription errors.
- Review of multiple MARs show numerous blank spaces, demonstrating that nurses do not document the administration status of each medication dose.
- Monthly pharmacy/CQI audits throughout 2017 show pervasive and systemic medication issues, including blanks on MARs, administering medications beyond stop dates, and pharmacy and nursing medication errors.
- Health care leadership has not developed or implemented an effective corrective action plan to address the systemic medication issues.

Information supporting these findings are noted below.

Pharmacy Services

BosWell Pharmacy Services is a national company that provides medication services to NRC through a “fax and fill” process. BosWell dispenses medications in blister packs that are either patient-specific or for stock supply. We interviewed two pharmacy technicians who reported that for prescriptions faxed to BosWell before 2:30 p.m. each day, medications are received within 24 hours via United Postal Services (UPS). Prescriptions faxed after 2:30 p.m. are

⁸⁴ Physicians write medication orders in two places: a physical examination form or progress note, and a physician order form that is used to fax the order to the pharmacy. We found that some records contained the medication order only on the progress note and there was no physician order form. It is unclear whether the physician did not write the order on the physician order form or whether it was not filed in the medical record.

⁸⁵ There are typically two inmates to a cell. Inmate ID badges are posted in the window of the cell rather than the inmate presenting his ID to a nurse.

received in two days. If medications are urgently needed, staff uses a local pharmacy, Jewel-Osco Pharmacy in Joliet, Illinois.

Transcription and Filling of Medication Orders

We toured the rooms where pharmacy technicians receive and sort medications. The rooms were clean and well organized. However, there is a faucet and sink covered with mineral deposits that impede sanitation and disinfection. Pharmacy technicians have established an accountability system for stock medications in which nurses sign out a stock medication blister pack for each patient. Narcotics are not stored in these medication rooms.

A large volume of prescriptions are generated at medical reception. Providers typically write orders onto a physical examination form as a component of the treatment plan and also onto a physician order form which is to be faxed to the pharmacy. However, we reviewed records in which the provider wrote the medication order only on the physical examination form and not a physician order form. *Since the physician order form is the document faxed to pharmacy, this poses a risk that the medication order will not be faxed to the pharmacy.*

After the provider writes the medication order, a reception nurse reviews it and determines whether it is a Keep on Person (KOP) medication available in stock supply in the medical reception area. If so, the nurse retrieves the medication from stock supply, writes the patient's name on it and delivers it to the patient. The nurse writes the number of tablets given to the patient beside the medication order on the physical examination form and/or physician order form. This enables a BosWell pharmacist to know not to fill the prescription. A concern is that when nurses give the patient stock medications, some nurses transcribe the medication order onto a MAR and document that the medication was administered and some nurses do not. *Therefore, some patients are administered medications for which there is no MAR documenting that the patient received the medications.*

Some medications are not administered to the patient in medical reception because it is not available in stock supply, is a nurse administered medication (e.g., psychotropic), or is non-formulary. Nurses do not transcribe these medication orders onto a MAR at reception. The prescription is forwarded to a pharmacy technician who faxes the order to BosWell. Because a nurse did not create a MAR at reception, if for any reason the medication order is not faxed to BosWell or the medication is not received from BosWell, medication nurses do not know to expect the medication and to follow-up if the medication has not been received.

When a medication delivery arrives from BosWell, a pharmacy technician checks off what medications were received along with corresponding BosWell generated MARs. A pharmacy technician separates KOP medications from Nurse Administered (NA) medications and determines the patient housing locations. Pharmacy technicians write MARs for some KOP medications from the blister pack, not the original provider order. A registered nurse does not review these MARs for accuracy with the original physician order. Medications and MARs are transported to the nursing medication room for storage in medication carts and subsequent administration to patients.

Medication Administration

The nurse's medication room is cramped, disorganized and dirty. Metal shelving used to store medical supplies is rusted with bent shelves. Medication cart surfaces are dirty, with tape residue on carts. The refrigerator containing insulin and other medications was not clean. There is no sanitation schedule for cleaning the room or refrigerator. Narcotics are double-locked.

Because inmates are locked down at NRC, nurses deliver medications cell to cell. We observed nurses preparing medications for administration in the medication room. Nurses compared MARs against medication blister packs to ensure the accuracy of the order and then pop medication out of the blister pack into their gloved hands. Nurses then placed medication(s) into a small white envelope that is labeled with the name of the patient, ID, housing location, and name of the medication. The envelope did not contain order start and stop dates. The same envelope is used repeatedly. Thus, nurses transferred medications from pharmacy dispensed properly labeled containers to improperly labeled containers. Nurses then placed medication envelopes into a clear plastic bag to take to the housing units. Nurses did not transport MARs to the housing unit along with the medications.

We accompanied a nurse escorted by a correctional officer to R unit. Each cell had one or two inmates. For each patient receiving medication, the nurse called out the inmate's name and informed him she had medication. The nurse did not identify the patient by having him state his name and a second identifier (e.g., date of birth, inmate ID number). Instead, the nurse looked at the inmate's identification badge taped to the window. The nurse then passed the medication envelope to the patient through a crack in the door rather than an open food port. The patient took the envelope, poured medication into his hand and passed the envelope back to the nurse through the door crack. Several inmates did not have cups of water to take their medications. The nurse asked patients if they had their juice carton from breakfast to fill with water to take medication. Some did and some did not. Neither the nurse nor the officer attempted to perform oral cavity checks.

The nurse did not document administration of the medication onto the MAR at the time she gave the medication. We asked the nurse what happens if the patient is out of cell when she came to the housing unit, and she replied that the patient would miss his medication for that dose. There is no procedure to determine where the patient is and make arrangements to deliver the medication at a later time, even if the medication is to be taken once daily. We reviewed nursing documentation on multiple MARs and found numerous blank spaces, indicating that nurses did not document the administration status of each dose of medication (e.g., given, refused, etc.).

The process we observed is problematic for several reasons:

- Repeated use of the same envelopes is not hygienic, particularly because they are handled by the patient and returned to the nurse.
- We observed torn envelopes which would allow one or more medications to fall out unnoticed.

- Inmates may refuse one or more of the medications, and if they are similar in appearance (both are a small white pill) the nurse will not know which medication to administer and which not to administer.
- In three cells, the light was not working and it was difficult to see and positively identify the patient.⁸⁶
- Failure to perform oral cavity checks for high risk medications (e.g., narcotic, psychotropic, etc.) increases the risk of drug diversion or non-adherence.
- The failure of the nurse to have the MAR and document administration of medications at the time they are given does not meet standards of nursing practice.

Moreover, while we observed nurses preparing medications using the MAR and medication blister pack, CQI minutes show repeated medication errors because nurses used the medication envelope rather than the MAR to prepare medications. Medication audits and CQI minutes throughout 2017 also show pervasive problems with nurses' failure to document on the MAR for scheduled doses.

Changing Medication Administration Records Over at the End of the Month

At the end of each month, BosWell sends a pre-printed MAR for every prescription continuing into the next month that was written before the 15th of the month. The cutoff date of the 15th means that at the end of each month, nurses must handwrite MARs for all medication orders written from the 16th to the end of the month. This equates to hundreds of MARs and is a huge workload. Handwriting each medication order increases the risk of transcription errors with resulting medication errors.

We observed the impact of this practice during the site visit. On 2/1/18, staff reported that nurses on the evening and night shifts were unable to "flip" or transcribe the MARs to February. Several nurses were hurriedly transcribing the MARs and preparing medications for the morning pass, but stated that they would not be able to finish transcribing the MARs before passing medications. The nurses reported that completing transcription of the new MARs would take place on the evening shift. When we asked the nurses how they would document administration of medications given to patients that morning, they did not have an answer. NRC pharmacy technicians proactively suggested that if the cutoff date for BosWell to send pre-printed MARs was the 27th or 28th of each month, the nursing workload would be dramatically reduced, as well as the risk of transcription and medication errors.

Renewal of Chronic Disease Medications

There is not an effective system for timely renewal of chronic disease medications following arrival. At intake, providers write chronic disease medications for a duration of 30 days and refer the patient to the chronic disease program for follow-up. Nurses reported that they review MARs for expiring chronic disease medication orders to notify the provider. However, as

⁸⁶ The inmates in these three cells reported that the lights had been out in their cells since they arrived at NRC. In two cases the inmates had been at NRC for over a month, since 12/21/17. We reported the names of these inmates to the Superintendent. The following day we were informed that the inmates had been moved to other cells and that the cells were "condemned."

noted earlier in this report, nurses do not consistently transcribe MARs for chronic disease medications given to patients at intake. Therefore, there will be no MAR in the book to alert nurses that the medication order requires renewal. If the patient's chronic disease appointment is scheduled to take place prior to 30 days, providers can reorder medications to ensure continuity of medications; however, our review showed lapses in medication renewals.

Continuous Quality Improvement (CQI) Minutes and audits performed in 2017 show systemic and pervasive problems with pharmacy and medication administration at NRC.⁸⁷ These include:

- Pharmacy dispensing errors
- Medication carts that are not clean
- Nurses preparing medications using medication envelopes (with incomplete and incorrect information) instead of using the MAR, which is the legal order for the medication, using the wrong envelope
- Failure to transcribe medication orders onto the MAR
- Medication blister packs not matching the MAR
- Missing medications
- Nurses not documenting on MARs following medication administration
- Nurses not documenting medication order stop dates onto the MAR and administering medications beyond stop dates
- Shortages of sharps, insulin, and tramadol
- Open insulin and Tubersol vials with no documented opening and expiration dates
- Lack of timely tracking and response to medication errors

The 2016-2017 Annual CQI report showed that pharmacy made 14 errors and nursing staff made 66 errors during the review period. However, with respect to nursing performance, this is a gross underestimation of errors when failure to document medication administration is included as an error of omission. Monthly medication room and MAR audits were performed showing systemic problems with medication discrepancies and documentation on the MARs. Of particular concern is the frequency with which audits showed the medication was not available in the medication cart or medication orders had expired and were not discontinued. However, the CQI report does not include root cause analysis, corrective action taken, and reevaluation of performance to determine if the root causes of the problems were addressed.

In summary, the medication administration system creates a systemic risk of harm to patients at NRC. The conditions of confinement (i.e., 24-hour lockdown) are a major contributor to the systemic risk of harm.

Infection Control

Methodology: We interviewed health care leadership, reviewed the Infection Control Manual and other documents maintained related to communicable diseases and infection control.

⁸⁷ NRC Annual CQI Report 2016-2017.

First Court Expert Findings

The First Court Expert Report noted that there were no budgeted infection control positions and that infection control duties were add-on duties rather than a primary assignment.

Current Findings

Our findings are consistent with the First Court Expert's findings. NRC does not have an established infection control program. There is not a budgeted infection control position and infection control duties have not been formally assigned. Leadership reported that a physician assistant has assumed responsibility for submitting case reports to the state health department.

There is no schedule of clinic sanitation and disinfection activities in clinical areas. We found many clinical areas to be dirty and disorganized. Stretchers and chairs were torn and in disrepair, inhibiting infection control. This increases the risk of infection to patients and staff.

As noted earlier in the report, staff reads tuberculin skin tests (TST) through cell windows instead of inmates being escorted to the medical clinic for staff to properly read TSTs by palpating patient arms and documenting the results in the patient's medical record. Medical record review showed that staff does not record TST results in the record. We interviewed a staff member who reported that she records results in the medical record "if she has time."

CQI Minutes and Annual Report shows that staff collects data regarding communicable diseases, including HIV and hepatitis C antibody test results. There is no assessment of HIV, HCV, and TB infection rates among newly arriving inmates. CQI Minutes also report statistics regarding skin infections due to methicillin-resistant staphylococcus aureus (MRSA), but there is no meaningful discussion regarding their significance and whether measures can be taken to reduce the incidence of infection. Data does not include tracking of skin infections due to other pathogens.

As noted earlier in this report, the water supply at NRC is hard, with a high mineral content, causing mineral deposit build-up in pipes, faucets, and sinks throughout the institution. This impedes effective infection control. The institution would benefit from a water softening system, but there is no money in the budget for this expenditure.

In summary, NRC does not have an effective infection control program.

Dental Program

Dental: Staffing and Credentialing

Methodology: Reviewed staffing documents, interviewed dental staff, reviewed the Dental Sick Call Log and other documents.

First Court Expert Findings

- NRC had one full-time dentist, one 20-hour part-time dentist, two full-time assistants, and a full-time dental hygienist.
- One dentist was employed by the IDOC and the rest of the dental staff were Wexford employees.
- CPR training was current on all staff, and all necessary licensing was on file.

Current Findings

We concur First Court Expert that CPR training was current and necessary licensing was on file; however, we identified current and additional findings as follows. Staffing has decreased since 2014; there is one full-time dentist and dental assistant who are both Wexford employees.⁸⁸ The dentist who was present when the First Court Expert visited NRC was replaced approximately three years ago. There is no dental hygienist.⁸⁹ Moreover, the part-time dentist who assists with intake exams is at NRC approximately one-half day, rather than the 20 hours per week in the First Court Expert Report. However, the true staffing is difficult to ascertain because of the free flow of dental personnel between NRC and SCC.

A dentist from SCC assists with intake exams at NRC on Thursday afternoons when it is expected that substantially more examinations will be performed. CPR training is current for dental staff and all necessary licensing is on file; however, the dentist's DEA number is not on file.⁹⁰

There are several impediments to evaluating the adequacy of NRC dental staffing. First, there is no clear delineation of how many hours SCC dental personnel spend at NRC. Even assuming the current staffing is adequate, the one dentist and one dental assistant **officially** assigned to NRC understates the actual staffing, which cannot be determined until we have an accurate accounting of the hours SCC dental personnel spend supporting NRC.

Second, since NRC has only one dentist assigned, when that dentist is ill or is on vacation, is there adequate coverage? The reports provided to us suggest that there was a lapse in coverage in the four-month period for which we reviewed sick call logs ("no Dr. in clinic 8/31/17-9/8/17").⁹¹ Not only did inmates with painful dental conditions have to wait as many as eight days; but given the eight-day backlog, treatment was likely delayed afterwards until the dentist caught up.

⁸⁸ According to the NRC Staffing Spreadsheet, there is a vacant dental assistant position.

⁸⁹ Unless the mission of the dental program has changed markedly since the First Court Expert Report, it is difficult to understand why NRC needed a full-time dental hygienist, since only the small number of MSU inmates are eligible for comprehensive care (that generally includes a cleaning). While the First Court Expert Report noted that there was a full-time dental hygienist at NRC, the position is absent in the current NRC staffing. Oral prophylaxes (cleanings) are performed by the dentist on the small number of MSU prisoners who request them. The dental hygienist said that she does not treat NRC patients but does assist in the intake examination process. Moreover, she stated that she does not provide oral hygiene instruction to inmates at intake.

⁹⁰ "N/A" rather than a DEA registration recorded (Training Records NRC – Stateville, p. 10). Since this information was not made available, we did not have the opportunity to find out whether the dentist has a DEA number that is not on file or has no DEA number.

⁹¹ The first entry in the sick call logs provided to us for a request received 9/6/17.

Finally, it is difficult to determine patient waiting time; that is, the time from making a request to receiving care. This will be addressed in the section on Dental Sick Call.

Dental: Facility and Equipment

Methodology: Toured the dental clinic, radiology area, and dental intake area to assess cleanliness, infection control procedures, and equipment functionality. Reviewed the quality of x-rays and compliance with radiologic health regulations. Observed clinical care.

First Court Expert Findings

- The clinic consists of a single chair and unit which is over 20 years old and showing wear and tear. Free movement around each unit is acceptable. Provider and assistant have adequate room to work. There are two closet-sized rooms adjacent to the clinic for storage, the dental lab, and for sterilization. Some corrosion, fading, and rust is evident. Cabinetry is similarly old and worn. The compressor is in good condition. Hand instruments are in good condition and adequate. The x-ray unit is old but in good repair. Hand pieces are old, and many are not functioning.
- Overall, the clinic was well enough equipped and the dentist felt all equipment was in good shape and functional. She expressed some difficulty in getting equipment repaired due to a lack of funds and administrative support.
- The Panellipse [panoramic] x-ray units are old but functional.

Current Findings

Facilities and equipment have deteriorated since the First Court Expert's Report, particularly the two inadequate panoramic radiograph units in the intake processing area that will be discussed *infra*. However, we identified current and additional findings as follows.

The dental clinic consists of a single chair and unit, and intraoral x-ray device that are approximately 20 years old.⁹² All equipment is in working order except for the film processor, which was out of service for at least three years.⁹³ The dentist stated that it had been repaired recently but necessary chemicals were not on hand. Hand instruments are in good condition and hand pieces are old but functional. The counters are intact and can be disinfected adequately. There is no equipment replacement plan. This is particularly important for the panoramic x-ray devices, which are subject to heavy use due to the high volume of initial exams.

The First Court Expert noted that the equipment was old but serviceable, although many hand pieces were not functioning. Several years after those findings, a dentist reported that repairs were needed on the dental drill ("[w]e are working with 2 right now").⁹⁴ At the next meeting, he reported, "[n]eed repairs on drill and equipment. ASR is done. Referred to Ken Harris office

⁹² We asked for documentation of the age of all dental capital equipment that has yet to be provided.

⁹³ The dentist did not feel that the lack of an intraoral film processor was a major problem, since in his opinion a panoramic x-ray is sufficient for diagnosing dental decay. This is highly problematic and will be addressed later in this report.

⁹⁴ August 15, 2017 NRC Quality Improvement Meeting Minutes, p. 1.

now. Need 2 new and 1 repaired. If all can be repaired, we don't need new.”⁹⁵ The next month, he reported, “[n]o repairs on drill and equipment. Paperwork redone last Tuesday. It is over \$500, so @Springfield level to approve (not Doug or Warden). Joe making call to Ken Harris to update dental ASR. Less hands involved with ASR's is needed.”⁹⁶

The dentist said that equipment maintenance was currently not a problem and that all his hand pieces had been repaired; however, given the recent problems with untimely repairs, there appears to be a systemic problem.

The two rooms adjacent to the dental treatment area are small and cluttered. There is an unserviceable autoclave on the floor under a counter in the sterilization room. We were informed that it will be disposed of when the appropriate approvals are obtained.

A panoramic x-ray unit is in the radiology area and is operated by the dental assistant. There was a lead apron in the radiology area; however, the dental assistant took a panoramic x-ray on patients who were not wearing an apron.⁹⁷

While protective eyewear is available for patients, it is not used consistently because the dentist felt it was not necessary.^{98,99} There is no sphygmomanometer or stethoscope in the clinic.

Dental: Sanitation, Safety, and Sterilization

Methodology: Reviewed Dental Administrative Directives, toured the dental clinic and dental intake exam area, observed dental treatment room disinfection, interviewed dental staff, and observed initial examinations and patient treatment.

First Court Expert Findings

- Appropriate surface disinfection was performed between each patient.

⁹⁵ September 19, 2017 NRC Quality Improvement Meeting Minutes, p. 2.

⁹⁶ October 24, 2017 NRC Quality Improvement Meeting Minutes, p. 2.

⁹⁷ Dental Radiographic Examinations: Recommendations for Patient Selection and Limiting Radiation Exposure. American Dental Association and Food and Drug Administration (2012), p. 14. (While radiation exposure from dental radiographs is low, it is the dentist's responsibility to follow the ALARA Principle (As Low as Reasonably Achievable) to minimize the patient's exposure. Dentists should follow good radiologic practice and (*inter alia*), use protective aprons and thyroid collars.)

⁹⁸ Guidelines for Infection Control in Dental Health-Care Settings ---2003. MMWR, December 19, 2003/ 52(RR17):1:16; pp. 17-18. (“PPE [personal protective equipment] is designed to protect the skin and the mucous membranes of the eyes, nose, and mouth of DHCP [dental health care provider] from exposure to blood or OPIM [other potentially infectious materials]. Use of rotary dental and surgical instruments (e.g., handpieces or ultrasonic scalers) and air-water syringes creates a visible spray that contains primarily large-particle droplets of water, saliva, blood, microorganisms, and other debris. This spatter travels only a short distance and settles out quickly, landing on the floor, nearby operator surfaces, DHCP, **or the patient**. The spray also might contain certain aerosols (i.e., particles of respirable size, <10 µm). Aerosols can remain airborne for extended periods and can be inhaled” and “Primary PPE used in oral health-care settings includes gloves, surgical masks, **protective eyewear**, face shields, and protective clothing (e.g., gowns and jackets). All PPE should be removed before DHCP leave patient-care areas (13). Reusable PPE (e.g., clinician **or patient protective eyewear** and face shields) [...]”). Emphasis added. Moreover, protective eyewear provides protection against objects or liquids accidentally dropped by the provider.

⁹⁹ Why we Take Infection Control Seriously. UIC College of Dentistry. Viewed at <https://dentistry.uic.edu/patients/dental-infection-control>, viewed February 2, 2018 (“We use personal protective equipment [...] **as well as provide eye protection to patients for all dental procedures.**”) Emphasis added.

- Protective covers were utilized on many of the surfaces and most instruments in cabinets were properly bagged and sterilized. The intake examination mirrors were bagged and sterilized in bulk. All hand pieces were sterilized and in bags.
- The sterilization area is in a small closet-like room that is unkempt and cluttered, adjacent to the dental clinic. It has inadequate work space to maintain proper sterilization flow from dirty to sterilized to storage. The ultrasonic cleaner sits between the sink and the autoclave. There was not a biohazard label posted in the sterilization area.¹⁰⁰
- Safety glasses were not always worn by patients and warning signs were not posted where x-rays were being taken to warn pregnant women of possible radiation hazards.

Current Findings

Dental sanitation, safety, and sterilization have deteriorated since the First Expert's Report, primarily due to inadequate hand and surface sanitation by the dentist in the intake area (discussed *infra*). We concur with the findings in the First Court Expert's report. However, we identified current and additional findings as follows.

The dental treatment room was disinfected appropriately between patients and protective covers were used on all surfaces. Instruments were properly bagged and sterilized. All hand pieces were sterilized in bags.

The sterilization area is in a small cluttered room contiguous with the dental clinic. Because the room has inadequate counter space, it is difficult to configure the area to accommodate sterilization flow from dirty to sterilized to storage (as noted by the First Expert). The ultrasonic cleaner sits between the sink and the autoclave. As noted by the First Court Expert, safety glasses were not always worn by patients' and warning signs were not posted where x-rays were being taken.¹⁰¹

Dental: Review Autoclave Log

Methodology: Reviewed the last two years of entries in autoclave log, interviewed dental staff, and toured the sterilization area.

First Court Expert Findings

- Spore testing was performed weekly and was documented. No negative results were recorded.

Current Findings

¹⁰⁰ CFR 1901.145(e)(4). "The biological hazard warning shall be used to signify the actual or potential presence of a biohazard and to identify equipment, containers, rooms, materials, experimental animals, or combinations thereof, which contain, or are contaminated with, viable hazardous agents.")

¹⁰¹ Occupational Safety and Health Standards – Toxic and Hazardous substances. 29 CFR 1910.1096(e)(3)(i). "Each radiation area shall be conspicuously posted with a sign or signs bearing the radiation caution symbol and the words, CAUTION RADIATION AREA". Emphasis in original.

Autoclave log maintenance had improved since the First Expert's Report and is adequate. The sterilization log for the past two years was in order. Testing was performed weekly and documented. No negative results were recorded.

Dental: Comprehensive Care

Methodology: Interviewed dental staff, reviewed randomly selected dental charts of an inmates who received non-urgent care from Daily Dental Reports. Comprehensive, or routine care¹⁰² is non-urgent treatment that should be based on a health history, a thorough intraoral and extraoral examination, a periodontal examination, and a visual and radiographic examination.¹⁰³ A sequenced plan (treatment plan) should be generated that maps out the patient's treatment.

First Court Expert Findings

- Because of the rapid turnover of inmates, most of the records reviewed were very recent from the transient, short-term population.
- Inmates who received non-urgent care received neither a comprehensive examination (to include examination of the soft tissues, a periodontal assessment, and bitewing or periapical x-rays). Nor was a treatment plan documented and they do not receive oral hygiene care as part of the treatment.
- Oral hygiene instructions were never documented. Restorations were provided from the information from the panoramic radiograph, which is not diagnostic for caries.
- There were many record entries that pain medication and/or antibiotics were provided with no documented examination or diagnosis. Many record entries also were "n/s" (no show) and/or reschedule.¹⁰⁴

Current Findings

Comprehensive care is unchanged from the First Court Expert's Report and remains inadequate; and we concur with the First Court Expert. Moreover, we identified current and additional findings as follows.

While most of NRC inmates are assigned for classification and will be transferred to other facilities within several weeks, approximately 188 in the MSU who are housed at SCC and work at NRC are candidates for comprehensive care at NRC. However, the MSU inmates do not stay long; so, at any given time, there are relatively few dental charts of inmates who have received comprehensive care. Since NRC does not have an electronic health record, identifying inmates who have had comprehensive care was challenging and only one¹⁰⁵ such chart was located.

¹⁰² Category III as defined in Administrative Directive 04.03.102.

¹⁰³ Stefanac SJ. Information Gathering and Diagnosis Development. In Treatment Planning in Dentistry [electronic resource]. Stefanac SJ and Nesbit SP, eds. Edinburgh; Elsevier Mosby, 2nd Ed. 2007, pp. 12-15, *passim*.

¹⁰⁴ This will be addressed in the discussion of failed appointments in a later section.

¹⁰⁵ Patient #1 had a composite restoration placed based solely on a panoramic x-ray and without a periodontal assessment or a treatment plan. Furthermore, the chart entry was not legible.

Most of the dentist's time is spent doing intake exams, which are scheduled for Monday, Tuesday, Thursday, and Friday, with the remainder of the dentist's time spent providing urgent care for the newly arrived inmates. A small amount of routine care (principally fillings) is provided to the MSU inmates.

Daily Dental Reports from October 2017 through January 18, 2018 document all dental procedures performed and show that most of the procedures were exams and palliative treatments related to urgent care.¹⁰⁶

Dr. Gambla said that he did not perform a comprehensive examination and produce a treatment plan before providing routine care to MSU inmates because, in his opinion, that is not the mission of his clinic. He said that he bases his routine treatment on the panoramic x-ray from the initial exam and feels that it is sufficient for identifying the problems he treats.¹⁰⁷ In fact, he could not take intraoral radiographs, since the film processor in the clinic was inoperative for three years.

Just as he does not base routine treatment on intraoral x-rays, he stated that does not perform periodontal probing on patients for whom he provides routine care, although there are periodontal probes in the clinic.¹⁰⁸ Failing to perform a periodontal screening using probing is below accepted professional standards and can lead to under diagnosis of periodontal disease, delayed treatment, and preventable tooth loss.¹⁰⁹

While the primary mission of the NRC dental program is performing intake exams and providing urgent care to a transient population, inmates who receive routine treatment should receive the same standard of care that they would receive at any other IDOC facility. That they do not is highly problematic and subjects these patients to risk of harm.¹¹⁰

¹⁰⁶ The Daily Dental Report summarizes the treatment provided to each inmate. It records the procedure (exam, filling, extraction, cleaning), as well as whether the procedure was palliative. Moreover, it records whether an analgesic or antibiotic was dispensed.

¹⁰⁷ Dental Radiographic Examinations: Recommendations for Patient Selection and Limiting Radiation Exposure. American Dental Association and U.S. Food and Drug Administration, 2012. Table 1, pp. 5-6. (Dentate or partially dentate adults who are new patients receive an "[i]ndividualized radiographic exam consisting of posterior bitewings with panoramic exam or posterior bitewings and selected periapical images." Furthermore, recall patients should receive posterior bitewing x-rays every 12 to 36 months based on individualized risk for dental caries. With respect to periodontal disease, "[i]maging may consist of, but is not limited to, selected bitewing and/or periapical images of areas where periodontal disease (other than nonspecific gingivitis) can be demonstrated clinically.")

¹⁰⁸ Stefanac SJ. (A panoramic radiograph has insufficient resolution for diagnosing caries and periodontal disease. Intraoral radiographs (e.g., bitewings) and periodontal probing are necessary), p. 17. Also, (Periodontal Screening and Recording (PSR), an early detection system for periodontal disease, advocated by the ADA and the American Academy of Periodontology since 1992, is an accepted professional standard.), pp. 12-14. See American Dental Hygiene Association. Standards for Clinical Dental Hygiene Practice Revised 2016, pp. 6-9. (Periodontal probing is also a standard of practice for dental hygiene).

¹⁰⁹ Makrides, N. S., Costa, J. N., Hickey, D. J., Woods, P. D., & Bajuscak, R. (2006). Correctional Dental Services. In M. Puisis (Ed.), Clinical practice in Correctional Medicine (2nd ed., pp. 556-564). Philadelphia, PA: Mosby Elsevier, p. 560 (Early diagnosis of periodontal disease is important since the disease is often painless and the prevalence of moderate to severe periodontal disease in correctional populations is high and often not associated with pain).

¹¹⁰ It is possible that the inadequate comprehensive care reflects insufficient dentist staffing. This should be considered when NRC dental staffing is revisited.

Dental: Intake (Initial) Examination¹¹¹

Methodology: Observed the initial examination process; reviewed 20 dental records of inmates that have been screened recently; reviewed Dental Administrative Directive; and reviewed NRC CQI Reports.

The “Initial Examination” is governed by Administrative Directive 04.03.102 (¶II F 2), which states (*inter alia*) that

Within ten working days after admission to a reception and classification center or to a facility designated by the Director to accept offenders with disabilities for a reception and classification center, each offender shall receive a **complete dental examination by a dentist**.¹¹²

First Court Expert Findings

- The dental screening [initial] examination is a cursory mirror and direct view examination of the intra-oral structures, a Panalipse [panoramic] radiograph, and a very sketchy health history. The teeth are charted for pathology from the direct examination and from the Panalipse x-ray. One dentist was there to screen over 70 inmates.
- The inmate was standing while being examined. The examiner’s hands never entered the oral cavity. The exam was very quickly done, taking about 15 seconds. Lighting was poor. Mirrors came from a bulk package of sterilized mirrors from the NRC dental clinic. The Panalipse x-rays are taken two at a time in the same small room.
- The inmates wear no lead apron protection, nor are there any signs warning of radiation hazard. The radiographs are taken and developed by inmates from the MSU, a satellite of NRC.¹¹³ They also reload the cassettes that hold the film. The films are developed, dated, and labeled with inmate information.

Current Findings

While aspects of the intake examination have improved marginally since the First Court Expert’s Report, the improvement is more than outweighed by the dentist’s inadequate hand sanitation and surface disinfection. Our findings with respect to the inadequacy of the intake examination are consistent with those of the First Court Expert; however, we observed patients examined while seated¹¹⁴ using improved illumination rather than standing using poor lighting – only a marginal improvement. Unlike the First Court Expert, we did not observe radiographs taken by inmates; however, we did observe that panoramic x-rays were taken on inmates who were not

¹¹¹ The First Court Expert Report describes the examination performed at intake screening as a “Screening Examination;” however, Administrative Directive 04.03.102 describes it as a “complete dental examination.” We use the terminology of the Administrative Directive and refer to the intake or initial dental examination as a complete dental examination.

¹¹³ We did not observe an inmate taking the x-rays. Inmates taking x-rays would be in violation of the Illinois Dental Practice Act.

¹¹³ We did not observe an inmate taking the x-rays. Inmates taking x-rays would be in violation of the Illinois Dental Practice Act.

¹¹⁴ Dr. Orenstein, an SCC dentist who performs initial examinations, said that both he and the patient stand “because there is not enough time to seat the patient.” A hurried dental examination performed on a standing patient is inadequate on its face and below accepted professional standards.

wearing a lead apron with a thyroid collar.¹¹⁵ The intake examination has not changed materially and remains inadequate. Moreover, we identified current and additional findings as described below.

In 2017, NRC performed intake processing on 15,942 inmates. All inmates have a panoramic x-ray taken and receive a cursory direct-view oral examination that includes a taking scanty health history.¹¹⁶

The dental examination area is a small room with two panoramic x-ray devices set approximately four feet apart and two rooms that have non-functional dental chairs and working dental lamps. Neither room has a sink. Patients sit on straight-backed chairs or stand when they are examined.

Of 20 panoramic x-rays from initial exams performed January 23, 2018, nine (45%) were clinically inadequate,¹¹⁷ characterized by poor contrast (washed out) or the presence of artifacts that interfered with interpretation.¹¹⁸ The NRC dentist did not see this as an area of concern, since he felt that the films were adequate for his purposes (i.e., the initial exam) and if a film is not adequate, he has it retaken. The inconsistent quality was due to a combination of a failing x-ray unit and film processor, and inadequate operator technique.¹¹⁹ There was no signage in the radiograph area warning of radiation hazard.¹²⁰

Although Administrative Directive 04.03.102 requires that dentists chart the oral cavity, none of the intake records we reviewed contained such a charting.¹²¹ Furthermore, the diagram for the charting is too small for the charting to be legible and should it be expanded substantially.

We observed Dr. Gambla perform initial examinations. Both he and the patient were seated; with the patient seated in a straight-backed chair. He worked without a dental assistant and did his own recording.¹²²

¹¹⁵ Dental Radiographic Examinations: Recommendations for Patient Selection and Limiting Radiation Exposure. American Dental Association and Food and Drug Administration (2012), p. 14. (While radiation exposure from dental radiographs is low, it is the dentist's responsibility to follow the ALARA Principle (As Low as Reasonably Achievable) to minimize the patient's exposure. Dentists should follow good radiologic practice and (*inter alia*), use protective aprons and thyroid collars.)

¹¹⁶ The health history taken at the exam (Appendix 3, Fig. 1) is inadequate because it is too abbreviated and omits information necessary for safe dental care.

¹¹⁷ Dental: Intake (Initial) Examination Patients #1, 2, 3, 8, 9, 11, 12, 14, and 20.

¹¹⁸ Our findings were confirmed by an SCC Quality Improvement Study in which intake examination charting was compared with the results of clinical examinations performed on the same patients. Of the 21 NRC charts, 62% had no charting of pathology (e.g., "abscessed teeth, teeth that needed extraction, [and] periodontal disease, (+3) mobility in teeth, grossly decayed teeth, impacted wisdom teeth in the maxillary sinus, and numerous visible dental caries"), with the remainder having only a partial charting. Furthermore, "in all the patients reviewed, visible heavy tartar [calculus] was never charted or indicated. The periodontal needs were never indicated" and "the dental radiographs from NRC varied in diagnostic quality"). Stateville Annual CQI 2016-2017_2, p. 32.

¹¹⁹ We asked to see documentation that the panoramic x-ray devices had been calibrated or inspected by a therapeutic radiological physicist; however, none was produced.

¹²⁰ Each radiation area shall be conspicuously posted with a sign or signs bearing the radiation caution symbol and the words, "CAUTION RADIATION AREA". Occupational Safety and Health Standards – Toxic and Hazardous substances. 29 CFR 1910.1096(e)(3)(i). Emphasis in original.

¹²¹ ¶II F (2)(b).

He donned gloves, selected mouth mirrors from a bag of sterile mirrors that he opened and placed on a bracket table before the first exam. A standard dental light illuminated the patient's mouth. He reviewed the panoramic x-ray and took a cursory health history. He used one or two mirrors to reflect the cheeks and adjusted the light for optimal illumination. While his gloved hands did not always touch the patient, in approximately half the exams we observed, they touched the patient's face, lips, or mouth. He did not change gloves between patients consistently. In fact, there were several instances where he examined a patient wearing the gloves he used to touch a previous patient's mouth or face. He did not wash hands between patients because the exam room had no sink.¹²³

Even when he changed gloves between patients, he used the same (unsheathed) pen to perform his recording; a source of cross-contamination. Similarly, the handles used to position the dental light had no disposable covers and were a source of cross-contamination. Finally, when he reached into the pile of mirrors wearing gloves worn for a previous exam, he ran the risk of contaminating the other mirrors. The dentist performed initial exams the following day, examining at least seven patients without changing gloves.

The dentist did not perform a thorough soft tissue examination.¹²⁴ For example, he did not visualize the lateral and posterior regions of the tongue, a potential site of squamous cell carcinoma.¹²⁵ Performing a thorough soft tissue examination is critical at the initial exam, since unless the inmate requests care, his next exam will be biennial.¹²⁶

Our nursing expert observed the dentist perform initial exams on 2/1/18 and reported that he did not change gloves between patients. ***In fact, he did not have a box of gloves in the room.***

All dental charts of inmates who receive an initial examination have a stamp that indicates that oral hygiene instructions were provided; however, this did not occur in the examinations we observed.¹²⁷ Moreover, the dental program reported 12,477 hygienist contacts at intake in

¹²² The exam has improved somewhat since the First Court Expert Report: now the lighting comes from a dental operatory light; however, the exam is still grossly inadequate.

¹²³ Centers for Disease Control and Prevention. *Summary of Infection Prevention Practices in Dental Settings: Basic Expectations for Safe Care*. Atlanta, GA: Centers for Disease Control and Prevention, US Dept. of Health and Human Services; October 2016, p.7.

¹²⁴ Stefanac SJ. ("Evaluation of head and neck structures for evidence of tissue abnormalities or lesions constitutes an important part of a comprehensive examination."), p. 12. See also Shulman JD, Gonzales CK. Epidemiology/Biology of Oral Cancer. In Cappelli DP, Mosley C, eds. *Prevention in Clinical Oral Health Care*. Elsevier (2008) ("Regular, thorough intraoral and extraoral examination by a dental professional is the most effective technique for early detection and prevention of most oral cancers. [...]") p. 41.

¹²⁵ This is generally done by holding the anterior portion of the tongue with 2x2 gauze and reflecting the tongue with a mouth mirror. This is a professional standard for an oral examination. National Institute of Dental and Craniofacial Research. Detecting Oral Cancer. A Guide for Health Care Professionals.

¹²⁶ This deficiency is compounded by the fact that dentists do not document soft tissue examinations at biennial exams. See section on Comprehensive Care, *supra*.

¹²⁷ The 'uniform record system' sponsored by the American Dental Association is the Code on Dental Procedures and Nomenclature. "In August 2000 the CDT Code was designated by the federal government as the national terminology for reporting dental services on claims submitted to third-party payers." Oral hygiene instructions (Dental Procedure Code D1330) "may include instructions for home care. Examples include tooth brushing technique, flossing, the use of special oral hygiene aids." See Dental Procedure Codes, 2015, American Dental Association Dental Procedure Codes, 2015, pp. 1, 16.

2016-2017.¹²⁸ The SCC hygienist stated that she assists with the intake exams by charting from the panoramic x-ray or taking x-rays; however, she does not provide oral hygiene instruction. Furthermore, adequate oral hygiene instructions cannot be performed in the time allotted to the initial exam.

Dental: Extractions

Methodology: We reviewed records of inmates that have had extractions, reviewed Daily Dental Reports October 2017 through January 2018, and interviewed the dentist.

First Court Expert Findings

- Documentation was poor. For example, none of the records examined had a diagnosis or reason for extraction included as part of the dental record entry.
- Antibiotics were provided to every patient post-operatively who had a dental extraction, even if not indicated.

Current Findings

Dental extraction care has not improved materially since the First Court Expert's Report and remains inadequate. Our findings with respect to inadequate documentation are consistent with those of the First Court Expert; however, we note that none of the patients had post-operative antibiotics prescribed. Moreover, we identified current and additional findings as follows.

Only seven patients had teeth extracted between October 2017 and January 18, 2018 as documented in the Daily Dental Reports for that period. Of five records of patients who had extractions, the quality of documentation was poor. None of the records documented the diagnosis of the tooth that was extracted.¹²⁹ All extractions were accompanied by a signed consent form that listed the tooth number; however, there was no diagnosis. For consent to be informed, the reason for the procedure must be clearly stated. None had post-operative antibiotics prescribed or dispensed. All patients had recent preoperative x-rays; however, patients #4 and #5 had teeth extracted based on panoramic x-rays that were clinically inadequate because they did not provide a clear view of the entire tooth.¹³⁰

Dental: Removable Prosthetics

Methodology: Reviewed Daily Dental Reports from October 2017 through January 18, 2018 and interviewed dental staff.

¹²⁸ The dental program consistently includes "hygienist contacts" or "hygienist contacts/intake." See, for example, NRC Annual CQI Report, 2016-2017, 2 (12,477), NRC Monthly Continuous Quality Improvement Meeting, January 16, 2018, 3 (870).

¹²⁹ Dr. Gambla said that he knows what the SOAP format is but does not use it.

¹³⁰ Extracting a tooth without an adequate preoperative radiograph deprives dentists of the ability to (1) determine that the case is beyond their skill level or unsuitable given the equipment limitations of the clinic, so the patient can be referred to an oral surgeon; (2) assess a potentially difficult procedure so they can adjust the surgical approach accordingly; and (3) ensure that the necessary equipment is available. Furthermore, an adequate pre-operative radiograph can serve as evidence of a potentially life-threatening condition such as a hemangioma.

First Court Expert Findings

- A comprehensive examination and treatment plan was never part of the treatment process.
- Periodontal assessment and treatment was not provided in any of the records. Because there is no comprehensive examination, or any treatment plans developed and documented in any of the records, it is almost impossible to ascertain if all necessary care, including operative and/or oral surgery treatment, is completed prior to fabrication of removable partial dentures.

Current Findings

We did not locate any records that documented the fabrication of complete or partial dentures. In fact, no dentures were fabricated between October 2017 and January 18, 2018 per the Daily Dental Reports for that period.

Dental: Sick Call/Treatment Provision

Methodology: We interviewed dental staff; reviewed and randomly selected charts of patients listed in the Dental Sick Call Log from 10/3/17 through 1/22/18, reviewed Daily Dental Reports from 10/3/17 through 1/17/18, reviewed records of seven inmates who were seen on sick call, and reviewed recent intake examination records.¹³¹

First Court Expert Findings

- Inmate requests are logged into a large bound ledger indicating complaint, date of request and date of appointment. In none of the progress notes reviewed was mention made of the inmate complaint; the only entry was the provided treatment.
- The average appointment date was seven days from the date of the request. A review of several records revealed that they were often seen later than that due to the high no-show and reschedule rate. Many of the inmates had transferred out of NRC by the time of their appointment.
- Often the treatment was prescribing pain medication or an antibiotic with no documentation as to why they were prescribed. Approximately 50% of requests are complaints of pain, swelling, or toothaches.
- Routine care is accessed from the request form and the inmates are seen within 14 days and treatment started. There is no waiting list and reschedules are seen within 14 days.

Current Findings

Our findings are consistent with those of the First Court Expert and we noted no material improvement in dental sick call, which remains inadequate. Moreover, we identified current and additional findings as follows.

Inmates who want to see the dentist (or other health care provider) communicate the request on a piece of piece of paper which they pass through cracks in the cell door since no standard

¹³¹ Dental Bates, pp. 40-46.

health care request forms are available.¹³² These slips are typically picked up by officers or health care staff or given to nurses at medication pass. Once collected, inmate health requests are transported to the medical clinic and placed in an open bin in the main medical clinic. A more detailed description of the process is in the Sick Call section, *supra*.

Per dental staff, requests for dental care are placed in a basket on a counter across from the dental clinic and are recorded in a log kept in the dental clinic.¹³³ While the log records the date of request and the date the inmate was scheduled, it does not capture the date the inmate was treated. Consequently, waiting time for treatment cannot be determined without reviewing individual dental charts.

The Dental Sick Call Log from 10/3/17 through 1/22/18 contained 228 entries, approximately 90 percent of which stated pain or conditions that more likely than not were associated with pain. The median time from request to ***scheduled appointment***¹³⁴ was two days. Requests received Monday through Wednesday had a median schedule time of two days while those received Thursday and Friday had a median of four days.

Median Time for a Dental Sick Call Appointment

Day Request Received	N	Median Wait Time (days)
Monday	84	2
Tuesday	35	2
Wednesday	41	2
Thursday	46	4
Friday	22	3
Monday-Wednesday	160	2
Thursday-Friday	68	4
All Days	228	2

Among inmates whose request suggested a painful condition, one waited eight days, two waited seven days, seven waited six days, and nine waited five days to be scheduled. This is ***not*** time to treatment, which cannot be determined from the available data and is likely to be longer if patients are rescheduled.

There is no triage process, with routine care provided to inmates other than those in the MSU, who will be transferred shortly. Many inmates who are scheduled do not appear for their appointments.

¹³² See discussion of Nursing Sick Call earlier in this report.

¹³³ The First Court Expert noted that the dental sick call requests were recorded in the Offender Request Log; however, this is not done consistently. The dental clinic keeps its own log which contains the inmate's name ID, nature of the request, date received by the dental clinic, and date the patient was scheduled.

¹³⁴ Since appointments were often rescheduled, the actual wait time for treatment for those inmates was longer.

There is no process for nurses, when the dentist is not available, to perform a face-to-face examination on a dental patient who states they have pain to identify pain and infection, and provide analgesics and referral to a mid-level or advanced level provider if immediate treatment is necessary.

Dr. Gambla said that when he sees patients with an urgent care need at intake screening, he tells them to submit a request for an appointment and will occasionally dispense antibiotics for patients with a dental abscess.¹³⁵ Of five records of these patients, all had inadequate documentation as to the diagnosis for which the antibiotic was dispensed.¹³⁶

Dental: Orientation Handbook

Methodology: Reviewed the Orientation Handbook.

First Court Expert Findings

- The NRC is included in the Stateville Offender Orientation Manual. It addresses the orientation screening exam, but in little detail. It states only that the inmate will receive one as soon as possible.
- It explains how to access emergency care but does not explain the requests form system for accessing urgent and routine care. It describes the hours of operation, partial dentures, appointments and cleanings.

Current Findings

Inmate orientation to dental care has improved marginally since the First Court Expert's Report. NRC now has its own orientation handbook, so the First Court Expert's findings are moot. However, we identified current and additional findings as follows.

NRC now has its own Orientation Handbook; however, it erroneously states that every reception offender will receive a **complete** dental exam at NRC.¹³⁷ As discussed supra, the initial examination performed at NRC is in no way a complete exam. Moreover, there is no explanation of the process for accessing urgent and routine dental care.

Dental: Policies and Procedures

Methodology: Reviewed Administrative Directives that deal with the dental program, interviewed dental staff, reviewed dental charts, toured dental clinical areas, and reviewed NRC organizational chart.

First Court Expert Findings: None.

Current Findings

¹³⁵ The dental clinic has limited stock of antibiotics and non-narcotic analgesics.

¹³⁶ Progress note mentioned that the Patient #3 did not want the problematic tooth extracted, but there is no refusal in the record.

¹³⁷ NRC Offender Handbook, April 19, 2017, ¶IV B.

The IDOC dental programs are governed by Administrative Directive 04.03.102 (effective 2012). While the First Court Expert did not include this in the findings (although it was available for review), we nonetheless find that dental policies and procedures are inadequate for reasons stated below.

The NRC dental program is governed by Administrative Directive 04.03.102, amended 1/1/2012. It specifies that within 10 working days after admission to a reception and classification center, offenders shall receive “*a complete dental examination by a dentist*” (¶F2; emphasis added).¹³⁸ In addition, the dentist should chart the oral cavity.¹³⁹ The priorities are Category I (emergency),¹⁴⁰ Category II (urgent care),¹⁴¹ Category III (comprehensive/routine care),¹⁴² and Category IV (low-priority care).¹⁴³

While Administrative Directive 04.03.102 mandates a charting of the oral cavity, the tooth diagram on the chart used for charting restorations and missing teeth (Appendix 3, Fig. 4) is too small. Furthermore, in none of the records reviewed was there evidence of its having been used.

The dentist did not have a thorough understanding of the classification priorities and did not have the Administrative Directive in the clinic. He said that he was “oriented to the Administrative Directive by Wexford.” To illustrate this, Patient #15 had a tooth that was noted as IIa¹⁴⁴ (see Appendix 3, Fig. 2), yet no disposition was indicated (Appendix 3, Fig. 3).¹⁴⁵ The dentist should either treat the tooth at NRC or indicate on Figure 3 that it should be treated immediately at the receiving institution.

Dental: Failed Appointments

Methodology: Reviewed the Dental Sick Call Log, interviewed dental staff, and reviewed Daily Dental Reports.

First Court Expert Findings

¹³⁸ Administrative Directive notwithstanding, in actual practice, the dentist at NRC performs a screening, not a complete examination (see discussion of comprehensive care *supra*). The NRC initial dental examination we observed contravenes the Administrative Directive. Either this was not noticed or was noticed and ignored in the semi-annual internal audits of the dental program per ¶I.C. Note that this error is also reflected in the ¶IV B of the NRC Offender Handbook.

¹³⁹ And document it in the dental chart (Appendix 3, Fig 4). The dental hygienist said that when she does a charting, it is not based on examining the patient’s mouth but from the panoramic x-ray.

¹⁴⁰ Bleeding, pain, and acute infection.

¹⁴¹ A condition, if left untreated, that would cause bleeding or pain in the immediate future (IIa); an oral infection or oral condition which, if left untreated (IIb), a condition that results in difficulty in chewing (IIc).

¹⁴² A medium to large non-painful carious lesion (IIIa), localized gingival involvement (IIIb), tooth fractures (IIIc), deteriorated temporary, sedative, or intermediate restorations that have deteriorated extensively (IIId) and a broken or ill-fitting prosthetic device (IIIe).

¹⁴³ Small carious lesions (IVa), costly restorative procedure (IVb), severe non-functional bite and malocclusion (IVd).

¹⁴⁴ “An oral condition, if left untreated, that would cause bleeding or pain in the immediate future.” Administrative Directive, Attachment A.

¹⁴⁵ There are three choices: 1) schedule immediately at R&C, 2) schedule routine exam at receiving institution, and 3) schedule immediately at receiving institution.

- For a randomly selected 23-day period, there were 409 scheduled appointments, of which 165 patients were seen, which is only 40% of those who were scheduled. The remainder were rescheduled, transferred, or no-showed.
- Of the patients who could have been seen (scheduled minus transferred), 43% failed their appointment. The 20% who were transferred reflect the time from when they were logged into the appointment book to when they were scheduled and the understandable high and rapid turnover rate at the NRC.

Current Findings

The failed appointment issue has not improved since the First Expert's Report. We concur with the First Court Expert's findings. However, we identified current and additional findings as follows.

The findings in the dental sick call section confirm that failed appointments are a problem; however, because of the disorganized sick call system and inadequate record keeping, it is not possible to accurately determine an actual failed appointment rate. This appears not to be a priority at NRC. For example, while the Dental Report in the January 16, 2018 QI minutes list refusals, no information about failed appointments is provided. Similarly, while the number of refusals is reported in the Dental Department Annual Summary, there is no mention of failed appointments.¹⁴⁶

Dental: Care of Medically Compromised Patients

Methodology: Reviewed health history form and records from recent initial exams, observed the dentist taking health history at the initial exam, and interviewed the dentist.

First Court Expert Findings

- There is no system to identify medically compromised patients and red flag those that may need medical consultation prior to dental procedures. The health history review is cursory from the NRC screening examination.
- The dentist does not routinely take blood pressures on patients with a history of hypertension.

Current Findings

Documentation of the health history of medically compromised patients has not changed materially since the First Court Expert's Report and remains inadequate. We concur with the findings in the First Court Expert's report. Moreover, we identified current and additional findings as follows.

The health history (Appendix 3, Figure 1) is too limited and omits conditions relevant to dental care, for example, anticoagulant therapy. There is insufficient room on the form for adding information and the dentist does not routinely update the medical history. Blood pressure is not routinely taken on patients who have a history of hypertension.

¹⁴⁶ NCR CQI 2016-2017 Annual Report, part 3, pp. 24-30.

Dental: Specialists

Methodology: Interviewed dental staff.

First Court Expert Findings

An oral surgeon is utilized by the NRC for oral surgery services. The inmates are scheduled and managed from SCC. More complicated cases, such as facial fractures and those requiring general anesthesia, are referred to Joliet Oral Surgeons, a local group. The information is maintained at SCC.

Current Findings

We concur with the findings in the First Court Expert's report. Moreover, we identified current and additional findings as follows. The dentist refers patients who require complex extractions to SCC, which schedules them for oral surgery. Since the details are not maintained at NRC, this issue will be pursued at the SCC visit and will withhold opinions as to the program's adequacy.

Dental: CQI

Methodology: We reviewed CQI minutes and reports and interviewed dental staff.

First Court Expert Findings

- The dental program contributes monthly statistics to the CQI committee. The NRC participates with the SCC CQI Committee meetings, as part of the entire dental program. These minutes are maintained at SCC.
- No studies were in place for the NRC at the time of this visit. In light of the number of program weaknesses, this is unacceptable.

Current Findings

The NRC dental CQI program has not improved materially since the First Court Expert's Report. We concur with the findings in the First Court Expert's report about the inadequacy of CQI studies and note that NRC now has an independent CQI committee. We were not provided with any CQI studies related to the dental program when we were at NRC.¹⁴⁷ With the many deficiencies identified by the First Court Expert and corroborated by this report, the dental program provides a fertile field for studies.

Internal Monitoring and Quality Improvement

Methodology: Interview facility health care leadership and staff involved in quality improvement activities. Review the internal monitoring and quality improvement meeting minutes for the past 12 months.

First Court Expert Findings

¹⁴⁷ The NRC 2016-2017 CQI Calendar indicated that there was a dental study planned for January 2017. We were subsequently provided with reports of two studies at our SCC visit.

The First Court Expert found that the NRC and SCC quality improvement meetings were conducted as a single meeting, but that there were no NRC QI studies. Because there were no logs (reception, sick call, urgent care, emergency send-out log, and offsite specialty log) there was no data available to examine whether there was a problem. The First Court Expert recommended that the quality improvement program must be re-energized with knowledgeable leadership that has been provided specific training regarding quality improvement philosophy and methodology. The First Court Expert also recommended that the leadership of the continuous quality improvement program must be retrained regarding quality improvement philosophy and methodology, along with study design and data collection.

Current Findings

We agree with all findings of the First Court Expert. NRC now has its own CQI program with separate meetings, which is an improvement. The CQI program, however, remains ineffective. The remaining findings of the First Court Expert remain unresolved.

We identified new findings which include the following:

- The “Traveling Medical Director” provides no leadership for the CQI effort.
- No one in NRC leadership is familiar with current CQI methodology, study design, or data collection. The method of improving CQI at NRC as proposed by IDOC has not been effective.¹⁴⁸
- The CQI coordinator has no training in CQI, does not understand how to perform or lead CQI work, and is so busy that CQI work is a low priority.
- The NRC CQI plan is generic and does not detail a year-ahead view of their CQI work. This is not a plan. The NRC and SCC CQI plans and Medical Director’s reports are identical, indicating that these facilities are not yet performing their own quality improvement.
- NRC is not compliant with multiple requirements of their CQI AD, including:
 - NRC does not maintain a CQI manual onsite.
 - NRC does not monitor whether Wexford performs primary source verification of its physicians working at NRC.
 - NRC does not monitor offsite medical care for quality.
 - NRC does not perform the number of studies in accordance with requirements of the CQI AD.
 - There are no studies that review the quality of medical care.
- NRC fails to use data in a manner that identifies problems.
- Data presented in several studies appeared unreliable.
- The CQI report presents statistical data which has little value from a quality perspective.
- Half of the six studies NRC chose to perform were in areas where there were no problems, thus yielding 100% audit results. While it is useful to know areas that are working well, there were so many problem areas that attention should be given to problem prone areas.

¹⁴⁸ Page 5 in IDOC comments regarding First Court Expert’s report in a letter to Dr. Shansky from William Barnes on 11/3/14.

- The annual CQI report repeatedly documents errors in medication administration yet there was no attempt to discover why this was occurring.
- Wexford's physician and physician assistant peer review differs significantly in comparison with our record reviews. We question its reliability.

The leadership at NRC has not effectively initiated a CQI program. The HCUA started nine months ago and inherited a facility that had not had a full-time and effective HCUA for years. The Medical Director position was vacant for a year before being filled for two months and then vacated again. The current Traveling Medical Director does not provide strong leadership. The HCUA told us that the DON position was vacant for years before being filled in September of 2017. Additionally, because quality improvement work was not being done when the HCUA arrived, she had to start from the beginning. While no quality improvement work was being done at the time of the First Court Expert's report, there has been some progress, but the CQI program is not yet operational or effective.

The IDOC AD requirement is that each facility develops a CQI program that provides "systematic, on-going objective monitoring and evaluation of the quality and appropriateness of offender care."¹⁴⁹ This is not being done. The Chief Administrative Officer is required by the IDOC AD to designate a CQI coordinator to lead that effort. The Warden is the Chief Administrative Officer. The person the Warden designated to be the CQI coordinator was the Director of Medical Records. That person left service sometime last year and the CQI position was vacant. Two months ago, the Warden appointed the newly hired Director of Medical Records to be the CQI coordinator. This person has undergraduate and master's degrees in Health Information Management, but she has no experience or specific training in quality improvement. The lack of knowledgeable leadership recommended in the First Court Expert's report is still not in place. It appears to us that this position is assigned to medical records staff because of the need to have someone organize the paperwork requirements of the CQI committee, including the mandated studies and the meeting minutes. While secretarial and organizational work is important, the main requisite of a CQI coordinator is someone who has the leadership capacity, skill, and expertise to identify problems and provide the leadership to solve the identified problems, and to ensure that the various disciplines are trained and enabled to perform quality improvement work. That is not a skill or expertise of the current CQI coordinator. This coordinator would not be able to train any staff on how to engage in CQI work. She is very well qualified to manage a medical record program but not a CQI program.

Except for attending CQI meetings, the new coordinator has not spent time performing or leading any CQI studies. The time she dedicates to CQI is a few hours a month reviewing data obtained for the CQI reports. Moreover, because the medical records program is in disarray, this person will not be able to dedicate much time to CQI work. She has not read the CQI AD yet and could not answer any questions with respect to the responsibilities of CQI. She did not have a plan of action and was not able to answer questions about how CQI was performed at NRC or how she might lead the CQI effort. The HCUA sat in on the interview with the CQI coordinator

¹⁴⁹ Administrative Directive 04.03.125 Quality Improvement Program policy statement.

on CQI activity and the HCUA responded to the questions, as the CQI coordinator did not know the answers.

The IDOC AD requires that the Agency Medical Director develop and maintain a CQI manual which the HCUA is to maintain locally. The HCUA did not have this manual onsite. The AD requires a CQI plan. The NRC CQI plan is present in the annual CQI report. The CQI plan has no specifics and lists only general goals such as improve quality, update programs, maintain standards, ensure patient rights, and work toward complying with NCCHC standards. These general goals do not constitute a CQI plan of action for the upcoming year. The plan does not state what it attempts to study over the upcoming year or discuss the main problems at the facility and how their CQI work will address those problems. The NRC plan is ineffective. It could be recycled year after year without modification and gives no indication of how the CQI program will be engaged in the upcoming year. We also note that the NRC and SCC CQI plans are identical. These are separate facilities and should have different plans. The Medical Director report for NRC is also identical to the SCC report, with the exception that the SCC report includes a sentence about accreditation.

Multiple requirements of the IDOC AD on the quality improvement program were not being accomplished at NRC. The AD requires a one-time primary source verification of credentials of licensed staff. NRC could provide no verification that this has occurred for their NRC physician. The annual CQI report verifies license and current DEA license, but this was done in 2016-17 and at that time the physicians listed were different from the current physician. In any case, this is not primary source verification of their credentials. Primary source verification is discussed in detail in the section on physician staffing in the section on Leadership, Staffing and Custody functions.

The IDOC AD requires that there is a monthly 100% review of appropriateness *and quality* of offsite medical care. Quality of care is not investigated at all based on CQI reports. Statistics about the number of referrals offsite is given, but there is no analysis or review with respect to quality. We were told by the HCUA that the Medical Director evaluates all hospitalizations and determines if they are appropriate. The HCUA or DON also send an email to the IDOC regional coordinator notifying them that a patient is going to be hospitalized. When the regional coordinator believes it is necessary, he/she may call the Agency Medical Director to determine whether the admission is appropriate. This process only evaluates hospital necessity. It does not evaluate, for example, the quality of care at NRC to determine if with adequate care the offsite or hospitalization could have been prevented. A mere statistical listing of hospitalizations and offsite consults fails to satisfy, in our opinion, the AD requirement to evaluate quality of care.

CQI studies are summarized in an annual CQI report. Studies performed in the CQI program are organized according to a schedule that is defined in the AD for CQI, which at NRC are memorialized in a calendar such that certain studies are done in certain months. NRC performed six studies in only four of the seven medical program areas required by the AD to be

studied on an annual basis. In the 2017 annual CQI minutes dated September 26, 2017, the studies (excluding mental health and injuries) performed to satisfy the AD included:

1. An outcome study that all laboratory results are received from UIC within 72 hours.
2. An outcome study on sick call that sick call slips are reviewed within 24 hours and treatment protocols are used.
3. A process study of chronic illness clinics that laboratory reports are received, signed, and dated within 24 hours and subsequently filed in the medical record correctly.
4. A process study of non-formulary medication that from the request to delivery of medication be less than four days.
5. An outcome study of whether the baseline clinic for a chronic illness problem is done within 30 days of arrival for all patients.
6. An outcome study of sick call that patients are evaluated at RN sick call and referred as per the AD.

None of the outcome studies performed included an acceptable clinical outcome. Clinical outcomes are end point measures of health status. These might be, for example, mortality, hospitalization, an HbA1C level of 7 or less, or normal blood pressure. An outcome study measures interventions that may affect the studied outcome. An example would be to study the effect of colorectal cancer screening on mortality or the effect of increasing the interval of chronic clinic visits on obtaining a normal blood pressure. The studies performed at NRC were not based on a clinical outcome but on performance measures. This demonstrates a lack of understanding of the meaning of outcome studies.

NRC should be credited with having started the CQI process. It is a step forward to have performed these studies. However, study choice and design is not meant to merely obtain a good audit result but is meant to identify problem prone areas, study them and attempt to improve quality of care. Also, this is a health care organization and there were no studies of clinical outcomes or quality of care. These studies have not yet reached that standard. We also note that one of the First Court Expert's findings is that because of the lack of adequate logs which track services, there is a lack of data available to understand whether a problem existed in any area of service. We agree with that finding. Limited data is available at NRC for use by the CQI program. The CQI studies did not appear to rely on adequate data needed to draw a conclusion with respect to the quality of service.

For studies 1, 3, and 4 listed above, it does not appear that these studies are problems at this facility. It is not unexpected that the results were all 100% or at goal. The First Court Expert report documented, for example, that labs were consistently drawn prior to chronic care. Yet one of the few studies done was to assess whether the lab reports were signed before a chronic care clinic. Notably this was 100%. With many known problems at the facility, why choose items which are known to not be problematic?

Study 2 was a study on whether sick call slips were reviewed within 24 hours and whether protocols were completed. We note in the section on nursing sick call that sick call slips have been destroyed and that sick call slips are not all retained. We question the reliability of data

used in this study based on our findings on the sick call process. Also, item 2 studies only whether a protocol was used, not whether the right protocol was chosen or whether the quality of nursing care was adequate. This study fails to critically address this process. Its value as a CQI study is limited. We could not evaluate item 6 because the methodology and data were not included in the annual CQI report.

Study 5 involved an issue that was brought up in the First Court Expert report and we agree with the concept of this study, which is a study of whether newly arrived patients with chronic illnesses are evaluated in a chronic illness clinic within 30 days. As described in the section on chronic illness, NRC fails to enroll all inmates with chronic illness and places only approximately 10% of chronic illness patients on their chronic illness roster. This study was listed as an outcome study, which it is not. Enrollment of persons in chronic illness clinic is a process. Since only 10% of persons with chronic illness are identified at intake, only 10% of patients with chronic illness were assessed as to whether they were seen within 30 days. The 90% of patients not on the chronic care roster are more likely to not have chronic care follow up as required by the AD. These factors were not identified. Also, the study merely studies whether a doctor saw the patient but does not monitor if the quality of care of the chronic clinic was adequate. As we note in multiple medical chart reviews in this report, it is our opinion that the quality of chronic care evaluations is poor. This study would have been improved if it had studied the process of enrollment into chronic care, including how patients are identified as having chronic illness, how they are enrolled in the clinic program, and where patients get missed.

There was an absence of review of quality of clinical care of nurses, physicians, and mid-level providers. It is a requirement of the contract with Wexford that peer review is regularly done.¹⁵⁰ We asked for but did not receive Wexford's peer reviews until a month after our tour. The quality of care in all areas of our record reviews showed quality problems. Yet the peer reviews failed to demonstrate quality issues or, when quality issues were identified, there was no apparent corrective action and the results were not reported to the CQI committee.

The peer review of the Traveling Medical Director at NRC was performed by the Medical Director at SCC. The Traveling Medical Director is a nuclear radiologist performing primary care. He was noted by the First Court Expert to have "clinical concerns" and is on a final written warning by Wexford for clinical performance. We also noted significant clinical problems for this physician. Yet this doctor had a peer review performed by a surgeon who was clinically inadequate based on our record reviews including mortality reviews of preventable deaths. The peer review included reviewing 25 intake records. Ninety-six percent of questions reviewed were adequate and the remaining 4% were not applicable. This doctor, for whom we identified multiple problems, was scored as 100% adequate in this review. It is our opinion that this is ineffective peer review.

¹⁵⁰ Contract between Illinois Department of Healthcare and Family Services and IDOC and Wexford Health Services; Item 2.2.2.19 Participate in physician peer review program and any audit/peer review conducted by an outside review source to ensure compliance with accepted professional standards of performance, which includes, but not limited to, chart reviews; p. 6 of contract.

The nuclear radiologist Traveling Medical Director reviewed physician assistants at NRC. Sixty-five episodes of care were reviewed, 673 questions were answered, 193 questions were not applicable. Of the remaining 480 questions reviewed, 67 questions (13.9%) were found inadequate. Nevertheless, all 65 episodes of care reviewed were found adequate without further explanation. Two reviews stood out. In one review the doctor documented that six questions were not applicable. Four items were found to be inadequate, including:

- Does the plan of care logically follow the history and physical?
- Does the provider account for all positive responses noted on this screening history?
- Are all fill-in areas completed with appropriate responses?
- Is the signature with professional designation legible?

Only two items were found adequate, including:

- Is the problem list complete with medication allergies?
- Is the handwriting legible?

Yet this episode of care was found adequate. One questions how the signature was illegible but the handwriting legible. More important, based on only having a problem list and legible handwriting, the intake assessment was found adequate. This is a defective review.

In another review, the intake physical examination was deemed adequate because the problem list was complete, the provider accounted for positive responses on the history, and the handwriting was legible. On the same record, the reviewer found that the care plan did not follow the history and physical, the intake form was incompletely filled out, a digital rectal examination was not completed based on patient age, and “yes” responses on the history were not explained. These peer reviews appeared to be done only to provide evidence that a peer review occurred. Based on our record reviews of intake assessments and sick call visits in comparison to results of these peer reviews, we find these peer reviews are not identifying important deficiencies of clinical care.

The First Court Expert opined that lack of leadership was a key factor in a lack of CQI activity. The new leadership group has not yet developed a CQI philosophy or sense of purpose in its CQI work. It is our opinion that the lack of understanding on how to perform CQI work is resulting in supervisory staff appearing to blame staff for bad results when the bad result is a systemic problem unrelated to individual employees. This is a failure of leadership to know how to analyze or correct a problem. We note two comments in CQI minutes:

- “Were 18 med errors last month. Corrective action training was held. AW [name deleted] questioned ‘at what point do we take nurses’ license? There is a progressive pattern and adverse patient reaction.’”¹⁵¹
- With respect to medication errors, a comment was made that “Nurses are responsible for accuracy. No excuses.”¹⁵²

¹⁵¹ August 15, 2017 Quality Improvement minutes.

¹⁵² September 19, 2017 Quality Improvement minutes.

These two comments were related to failure of nurses to adequately document on the MAR and failure to appropriately administer medications. These types of medication errors were reported almost every month, as recorded in the annual CQI report. Despite statistically describing the problem, there were no studies or analyses to determine a root cause of why so many errors are being made. This is poor CQI, because employees were held responsible for systemic problems that were likely related to staffing or other process problems that are the responsibility of management. We note, for example, that when nurses administer medication, there is often no support officer. Management has the responsibility to uncover the root cause of the errors and to develop corrective actions to address the systemic issue. Blaming individuals for systemic problems is misguided in our opinion.

We reviewed the last annual CQI meeting report of September 26, 2017. This report consists largely of a report of activity statistics which do not provide useful quality metrics. Tables list the number of provider and nursing encounters without any other variables that would measure the effectiveness or quality of the program. These lists have some usefulness for managers to project staffing needs, but their utility of CQI is limited. NRC does not have performance measures that give an indication of the effectiveness of their programs. Examples of such measures might be:

- Percent of hospital and specialty consultant reports or hospital discharge summaries that are present in the medical record after a consultation or hospitalization.
- The numbers of patients who actually show up for their clinical appointments and the reasons why they do not show up.
- Percent of records sent to destination IDOC facilities which are not properly complete and organized.
- The percent of patients identified with a chronic illness at reception who are found on the chronic care roster.

These types of statistical measures give the program a performance benchmark. We do not see these types of useful measures embedded in the NRC CQI reports.

Another example is the medication report in the annual CQI report of September 19, 2017. This provides a list of the numbers of medication prescriptions for certain types of medications. This type of report is useful for financial management purposes, but it is not useful to assess whether the processes of the pharmacy and medication programs are effective. For example, studies that measure the effectiveness of the medication program might include:

- The number of persons receiving their first dose of medication within 24 hours of a prescription.
- The percent of doses of ordered medication that a patient actually received.
- The number of patients who had disruption of long term medication.

The annual CQI report contains two useful pharmacy studies. One is a monthly audit of the medication rooms. While we did not verify the accuracy or effectiveness of this study, we do

agree with the concept of this study and believe that such audits do promote regular monitoring of the program.

The pharmacy also performs a monthly audit of 20 medication administration records (MAR) in order to assess four items:

1. Whether the start and stop dates are present on the MAR.
2. Whether the drugs in the cart match the MAR.
3. Whether allergies are listed on the MAR.
4. Whether there is documentation of all doses given.

This is a useful audit. We have several comments. Systems that have an electronic medical record can audit 100% of item 4 and perform the audit electronically and more accurately than can be done with paper records. We note that in the annual CQI report, over the course of the year, there was a persistent problem with documentation on the MAR. This persistent problem continued into 2018. Despite this continued identification of this problem, there was no effort in the CQI program to discover why this persistent problem continued. This routine audit continued to identify a problem yet there was no attempt to resolve it.

We also noted in the pharmacy section of this report that many patients do not have a MAR initiated even when they have ordered medication. These significant patient safety problems should be studied in CQI to determine the root cause in order to eliminate the patient safety concern.

Mortality review is part of the CQI program. There were 11 deaths in 2015-16 and only one death in 2016-17. The one death in 2017 included only a death summary and did not include an analysis of the death. This, in our opinion, does not constitute mortality review.

The IDOC requires internal and external reviews of the medical program. We have asked for but have not received the internal and external reviews for NRC.

With respect to the First Court Expert's findings, there is now a CQI program at NRC that is independent of SCC, which is an improvement from the First Expert's report. However, the CQI program is not yet effective and is not performing in a manner that can identify and correct system problems. In part this is a result of not having a CQI leader who understands how to start and maintain a CQI program. The lack of a CQI leader was also a finding of the First Court Expert. Also, though the leadership staff, with the exception of the Medical Director, is eager to learn, they do not have a strong foundation in quality improvement and it will take considerable effort to overcome that deficiency. We believe that the First Court Expert's recommendation to have a full-time quality improvement coordinator is one option to address this problem. Also, we agree with the First Court Expert's finding that without accurate logs and other "structural elements," self-monitoring is impossible to perform. We expand on that finding to state that there is an absence of data useful in self-monitoring. Data used to self-

monitor must be accurate and intentionally maintained for purposes of self-monitoring. The NRC leadership has not yet identified what data is needed and how to use that data to monitor.

In his report, the First Court Expert recommended a full-time quality improvement coordinator at each site. The IDOC stated in its response to this recommendation that the IDOC was committed to improving the CQI process but questioned the need for a full-time CQI coordinator. Since so little has been done to improve CQI and since staffing levels are so low, it is unlikely that staff with other responsibilities are likely to be able to effectively lead the CQI program. Under the circumstances at this facility, we would agree with the recommendation of having a qualified full-time CQI coordinator.

Recommendations

Leadership, Staffing, and Custody Functions

First Court Expert Recommendations

1. *We agree with the First Court Expert's recommendation to have its own leadership team. The IDOC has now included a HCUA, Medical Director, and DON in NRC's budget allocation.*
2. *We agree with the First Court Expert's recommendation that NRC should have its own staffing grid that precludes use of shared staff. NRC should have sufficient staff to meet its staffing needs. We would add to that recommendation the following:*
 - a. *A staffing needs analysis be completed that would be based on current need and to include a relief factor.*
 - b. *The analysis needs to be based on realistic workload evaluations that ensure adequate quality of care, including for physician and physician assistants.*
 - c. *The staffing at NRC needs to include sufficient clerical staff, a qualified nurse to manage infection control functions, and a qualified quality improvement leader.*

Additional Recommendations

3. The Medical Director should be permanently filled with a board certified primary care physician.
4. The use of "Traveling Medical Directors" should not be permitted to contractually fill a Medical Director position. Failure to have a permanent Medical Director should incur contractual penalties. Coverage physicians should be used as necessary but coverage physicians should not constitute a filled Medical Director position.
5. Senior staff at the facility (HCUA, DON, and Medical Director), the IDOC Regional Coordinator, and Agency Medical Director should participate in development of reasonable schedule E and state medical employee staffing documents.
6. A correctional officer staffing analysis should be completed to determine if there are sufficient custody staff to ensure that patients are timely brought for scheduled appointments and that nurses are timely and safely escorted during medication administration.
7. The Wexford Regional Manager should have training in a medical discipline or in medical administration. This should be a contract requirement.
8. An orientation for new health care leadership should be provided so that they are familiar with requirements and responsibilities of their assignments.
9. The facility must have a current staffing document listing all staff.
10. The span of control of the IDOC Regional Coordinator is too large to effectively manage. The span of control should be reduced to increase the onsite time at each facility.
11. Sharing of staff between NRC and SCC should stop.
12. Staffing loads for providers must be reduced so that reasonable time is given to complete a reasonable evaluation of all patients.

13. The physician at this site should not be permitted to provide primary care medical care, as he is a nuclear radiologist, appears unfamiliar with primary care clinical management, and shows repeated clinical concerns. His privileges should be confined to areas for which he has training.

Clinic Space, Sanitation, Laboratory, and Support Services

First Court Expert Recommendations

1. There should be a designated exam room in each housing unit appropriately equipped for conducting sick call. *We agree with this recommendation.*

Additional Recommendations

2. All space used for clinical care must provide privacy, confidentiality, equipment (exam table, oto-ophthalmoscope, handwashing, access to record, light, paper barrier, sanitary equipment, tongue depressors, gloves, and minor equipment), adequate space, and waiting space. This should include segregation areas.
3. There need to be sufficient clinical examination rooms for the number of simultaneous staff (providers, nurses, psychologists, psychiatrists) who need them by shift. There needs to be clinic space for nurses to perform sick call in segregation and in all other areas of service.
4. Clinic examination areas including intake need to be cleaned and sanitized on a regular basis. A sanitation schedule needs to be developed to ensure that this happens.
5. There needs to be an inventory of equipment and a replacement schedule for equipment based on expected life of the equipment.
6. The scheduling system must support the needs of clinical care.
7. Adequate supplies must be available to support the functions of the clinical areas. A standardized system of re-supply must be put into place.
8. There need to be routine environmental rounds.
9. Environmental rounds should include the date, names of participants, findings, and actions taken. The findings should be tracked and monitored by the quality improvement committee.
10. The nurse sick calls rooms on the housing units should be included on the sanitation schedule and equipped with exam tables, desks, chairs, and hand washing and drying supplies.
11. Exam tables in the clinic should have adjustable foot and head sections.
12. Paper memos and announcements currently taped on the walls in the clinical areas should be enclosed in plastic sheaths or removed as a fire safety precaution.
13. Broken clinical and office equipment should be expeditiously repaired or replaced.

Medical Records

First Court Expert Recommendations

1. The medical records of patients at NRC who remain beyond two weeks or who are housed at the minimum security unit must be managed in exactly the same manner as

patients at any permanent institution. *We disagree with the First Court Expert's recommendation that a medical record can be initiated after a two-week period. We agree with the IDOC AD and contemporary medical record standards that a permanent medical record be initiated upon arrival at NRC.*

2. Medical records staffing must be adequate to insure that records of patients who stay more than two weeks or who are housed in MSU are maintained in the same manner per DOC policy as records at permanent institutions. *We agree with the First Court Expert's recommendation that medical records staffing be adequate.*

Additional Recommendations

3. Mental health and dental records need to be incorporated into the record when the record is first initiated, which should be on the day of arrival. A medical record jacket should be completed at the conclusion of intake screening.
4. Medical records should be maintained in accordance with the IDOC AD on medical records 04.03.100 and in accordance with Illinois Department of Human Services guidelines.
5. The medical record room must be enlarged to accommodate the number of staff and records in use at this facility. The room must be made secure. Unauthorized persons must not be allowed to enter, pull, or re-file medical records.
6. A system needs to be put into place of identifying that a medical record has been pulled and who has the record.
7. Given the disorganization of the medical record and inability to provide access to clinicians to a complete and organized medical record, we strongly recommend that an electronic medical record be installed.
8. Consultation reports and offsite hospital reports must be obtained and filed in the medical record within the time period specified in the IDOC AD on Medical Records. Lacking a consultation report, the providers must promptly communicate with the consultant to identify the result of the consultation, recommended therapeutic plans, new diagnoses, and updated status of the patient.

Medical Reception

First Court Expert Recommendations

1. The policy approach to NRC is inconsistent with the reality of service demands. The assumption that patients have their medical intake completed within a week and then are transferred out is not applicable to a substantial number of patients. Therefore, this philosophy must be changed. This is especially true for patients with chronic diseases or who need scheduled offsite services.
2. The intake assessment by an advanced level clinician must include questions regarding current symptoms and include the development of a problem list and relevant plan.
3. Sufficient resources should be available such that the physical exams can be completed within one week of arrival.

4. NRC must begin conscientiously using logbooks, either paper or electronic, for intake processing.

We agree with the First Court Expert findings regarding the medical reception process. The exception is that with respect to receiving electronic data from Cook County Jail, we find that printed medical transfer summaries are adequate.

Additional Recommendations

5. Health care leadership should develop and implement a medical reception tracking log that documents completion of all medical reception/intrasystem transfer activities.
6. IDOC should amend medical reception forms to include a comprehensive review of systems (ROS) to identify serious medical conditions.
7. At medical reception, a station should be established so that at the completion of the process, medical records staff initiates a green jacketed medical record for each patient, with documents filed under the correct tab.
8. Examination rooms should be adequately equipped and supplied, including paper for examination tables to provide infection control barriers between patients. Furniture that is torn or in disrepair should be replaced.
9. Staff should change gloves and wash their hands between patients.
10. Perform HIV testing via opt-out methodology, not opt-in methodology, with written consent.
11. Weight scales should be periodically calibrated (e.g., weekly).
12. Nurses should measure uncorrected and corrected visual acuity in each eye and document results in the medical record. If large Snellen charts are used, the nurse should ensure the patient stands the correct distance away from the chart. Consider smaller hand-held Snellen charts.
13. Nurses should correctly read tuberculin skin tests via palpation and measurement of induration. This should be done in a medical setting.¹⁵³
14. Given problems with tuberculin skin testing and inability to track results, TB screening should utilize interferon gamma blood testing as the primary screening test for tuberculosis. The Mantoux skin test is logistically complicated, and its interpretation is prone to human error. Conditions at this facility make it impossible to adequately read the Mantoux skin test.
15. Nurses should timely document tuberculin skin test results in the medical record (e.g., within 24 hours).
16. Providers should document review of medical transfer information sent by county jails.
17. Providers should perform pertinent review of systems and medical history for each chronic disease and/or significant illness.
18. Providers should order CIWA and/or COWS monitoring in accordance with current guidelines for patients withdrawing from alcohol, opiates, or other drugs.
19. Providers should provide continuity of medications unless there is a clinical indication for changing medication regimens (e.g., glargine to NPH insulin, etc.).

¹⁵³ We give recommendations for the existing program of using Mantoux skin testing but make a strong recommendation to move to interferon gamma blood testing which, in our opinion, would significantly improve the process of screening.

20. Providers should document all significant medical conditions onto the patient's problem list.
21. Nurses should transcribe all medication orders (i.e., KOP and nurse administered) onto a MAR at medical reception and document administration of KOP medications at the time they are administered to the patient.
22. Health care leadership should develop systems to ensure that all physician orders are timely implemented (e.g., EKG, blood pressure monitoring, etc.).
23. Providers should timely follow-up on all abnormal labs.
24. Providers should use a chronic disease form when seeing patients for the first chronic disease appointment within 30 days.
25. Health care leadership should revise medical reception policies and procedures to provide sufficient operational detail to staff to adequately complete each step of the process.
26. Health care leadership should develop and monitor quality indicators related to each step of the medical reception process.

Intrasystem Transfer

First Court Expert Recommendations

1. The intrasystem transfer process must be designed to insure continuity of care for identified problems. *We agree with this recommendation.*

Additional Recommendations

2. IDOC should revise its Administrative Directives to create a statewide policy and procedure regarding intrasystem transfers consistent with NCCHC standards.
3. IDOC should include requirements for an Intrasystem Transfer Tracking log to enable staff to track the provision of required services, such as enrollment into the chronic disease program, medication continuity, tuberculin skin testing, and periodic physical examinations.

Nursing Sick Call

First Court Expert Recommendations

1. Officers must be eliminated from the procedures that enable inmates to request health care services; thus, inmates must either place the requests in a lockbox or give them to health care staff.
2. There must be ongoing professional performance review of both nurse sick call and advanced level clinician sick call, which includes feedback on individual cases in order to improve professional performance.
3. NRC must begin conscientiously using logbooks, either paper or electronic, for sick call.

We agree with these recommendations.

Additional Recommendations

4. Health care staff should ensure that inmates have daily access to medical request forms and writing implements to submit their health requests.
5. Lockable health request form boxes that are accessed only by health care staff should be installed in each inmate housing unit.
6. Inmates must be permitted out of their cells on a daily basis to confidentially submit their health requests into the health request boxes.
7. Health care staff should collect health care request forms seven days per week.
8. Health care staff should legibly date and time receipt of health requests.
9. A registered nurse should triage health requests and document a disposition on the form (e.g., urgent, routine). Nurses should legibly date, time, and sign the form, including credentials.
10. Each health request should be entered onto the sick call log, including the urgency of the disposition.
11. Health requests should be filed chronologically in the medical record.
12. A nurse should schedule patients to be seen in accordance with the urgency of their complaint.
13. Nursing sick call should be conducted in adequately lighted, equipped and supplied rooms with access to a sink for handwashing. This includes a desk and chairs so the nurse and patient can be seated and an examination table, otoscope, scale, etc. Consider installing lockable cabinets to store supplies (e.g., nurse protocol forms, gauze, tape, tongue blades, etc.).
14. Nurses should have the medical record available at the time of the sick call encounter.
15. A registered nurse should perform and document an assessment of each patient in accordance with treatment protocol forms and/or sound nursing judgment.
16. Nurses should refer patients to providers in accordance with the treatment protocol and in accordance with sound nursing judgment.
17. Health care leadership should develop and monitor quality indicators associated with each step of the sick call process.
18. IDOC/Health care leadership should revise policies and procedures to provide sufficient operational detail regarding the sick call process.

Chronic Care

First Court Expert Recommendations

1. The policy regarding chronic diseases must be that patients who remain beyond two weeks must have their initial chronic care visit at NRC before a total of 30 days have passed. This is clearly the case routinely for higher security inmates. *We agree with the First Court Expert's recommendation with a comment. It is our opinion that the initial intake evaluation should identify all chronic illnesses and establish an initial therapeutic plan for each patient with chronic illness. Waiting 30 days for this to occur will result in patients not receiving adequate continuity of care. It is our opinion that the initial intake evaluation needs to adequately identify and initiate an adequate therapeutic plan for all patients with chronic illness. We find this does not now occur. We agree that a follow up chronic illness visit should occur within 30 days.*

2. NRC must begin conscientiously using logbooks, either paper or electronic, for the chronic disease program. *We agree with this recommendation. The chronic disease program must have an accurate roster of persons with chronic illness. Our opinion is that this can be most effectively accomplished with an electronic medical record.*

Additional Recommendations

3. 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.
4. TB screening should utilize interferon gamma blood testing as the primary screening test for tuberculosis. The Mantoux skin test is logistically complicated, and its interpretation is prone to human error. Conditions at this facility make it impossible to adequately read the Mantoux skin test.
5. All NRC admissions with chronic illness should have laboratory tests performed at intake that are typically used to monitor the status of the patient's illness. As an example, persons with diabetes should have HbA1C drawn during the intake reception process.
6. Repeated failures to receive ordered medication due to refusal or other error need to result in intervention, to include, as necessary, a person to person evaluation by a provider. The timeline of referral to the provider must be dictated by the importance of the medication. For example, failure to take anti-rejection medication should result in a same day referral. Refusal to take insulin should result in a two or three day referral. Timelines for referral should be clear to providers and nurses and delineated in policy.
7. Health care leadership and the quality improvement committee should develop, monitor, and report quality indicators that measure and track the quality of care provided to patients with chronic diseases.
8. The provider progress notes should indicate the clinical status of the patient's condition and the rationale for any modification of treatment.
9. The current use of good and fair ratings of status on the chronic care form should be changed to well controlled, moderately controlled, poorly controlled, or undetermined.
10. The care of diabetes and adherence to existing guidelines should be a focus of the Quality Improvement Committee.

Urgent/Emergent Care

First Court Expert Recommendations

1. NRC must begin conscientiously using logbooks, either paper or electronic, for urgent/emergent care. *We agree with this recommendation.*

Additional Recommendations

2. Health care leadership should implement an urgent/emergent care tracking log and monitor it to ensure that it is contemporaneously maintained.
3. The treatment room should be terminally cleaned and disinfected. Equipment in disrepair (e.g., torn stretchers) should be replaced.

4. Emergency equipment, including disaster and emergency response bags, AEDs, oxygen, etc., should be stored together in the main medical clinic.
5. Emergency response bags should be standardized with respect to equipment, supplies and medications. The bag should be secured with a plastic lock. When used, designated staff should replace all used supplies and replace the lock.
6. If emergency response bags contain medications (e.g., glucagon), a sheet is attached to the outside of the bag that notes medications and their expiration dates.
7. Emergency equipment should be checked each shift and noted on the SCC-NRC Machine/Equipment Check Log Sheet.
 - a. When checking AEDs, ensure that electrode pads are not expired.
 - b. When checking oxygen tanks, record how much oxygen is left and when tanks need to be replaced.
 - c. Ensure that oxygen tanks have oxygen tubing and masks readily available.
 - d. Ensure that EKG machines have paper.
8. Emergency response drills should be conducted and critiqued quarterly. Scenarios and critiques should be meaningful and identify areas for improvement. Corrective action plans should be implemented and monitored for effectiveness.

Specialty Consultations

First Court Expert Recommendations

1. Patients whose problems require scheduled offsite services who are a higher level of security must have those scheduled while at NRC. *We agree in part with the First Court Expert's recommendation. We believe this recommendation should apply to all patients undergoing specialty care but only for higher level care that requires offsite referrals. Patients with other less critical specialty care appointments (podiatry, optometry, etc.) can have their appointment scheduled prior to transfer so that there is continuity of care.*
2. NRC must begin conscientiously using logbooks, either paper or electronic, for scheduled offsite services. *We agree with the First Court Expert's recommendation but have an addition to this recommendation. The IDOC, not Wexford, should develop a standardized offsite tracking log on an Excel spreadsheet that should be used at all sites. This tracking log should be used to report timeliness of referrals, collegial reviews, approvals, and appointments to the QI committee.*

Additional Recommendations

3. Wexford must begin placing specialty care documents, including referrals, verification of collegial review, and approvals into the medical record. Referrals for offsite care should be considered a physician order. The original referral form should be filed in the medical record on the date it was initiated by the provider. This should be done prior to the collegial review. Copies of this form can be used by the scheduler to manage scheduling.
4. The collegial review process should be abandoned. Medical providers should be permitted to send patients to offsite consultants without going through the collegial

review process on the basis of patient safety and inability to timely and effectively arrange ordered consultation care when using the collegial process.

5. Any denial of care needs to be documented in the medical record using documentation of the person who denied care.
6. At follow up provider visits after consultations, the provider should be required to document the results of the consultation, update the status of the patient, and update the treatment plan based on the consultation. If consultant reports are unavailable, the provider should use other communication efforts to discuss with the consultant what occurred at the consultation and document this discussion in the medical record.
7. An IDOC physician should review all denials of care, not the IDOC HCUA, who is a nurse.
8. Medical rounds or a “huddle” on offsite visits should occur every day. This huddle should consist of a meeting including the scheduling clerk with the providers as a group to discuss every patient who went offsite, where the report is, when the report will be obtained, what occurred, what follow up is indicated, and to schedule the patient to see the provider timely. These huddles should include review of the referral form that accompanies the patient which has consultant comments on the form. These huddles can be expanded at a later date to include other aspects of managing critical patients.
9. It is critical that consultation reports are all obtained and placed in the medical record within three days, consistent with the requirements of the IDOC AD on Offender Medical Records 04.03.100.

Infirmary Care

First Court Expert Recommendations

The First Court Expert had no recommendations on infirmary care in the NRC report.

Current Recommendations

1. Health care leadership and the quality improvement committee should develop, monitor, and report quality indicators that measure and track provider and nurse adherence to the infirmary policy and the quality of the acute and chronic care provided to infirmary patients.
2. The provider progress notes should indicate the clinical status of the patient’s condition and the rationale for any modification of treatment.
3. The quality and quantity of the bedding and linens should be monitored during the sanitation and environmental rounds.

Pharmacy and Medication Administration

First Court Expert Recommendations

1. Medication administration must include a designated officer to escort the nurse and ensure that patients appropriately identify themselves with their ID card, that they bring water in a container so as to ingest the medication, and so that the officer can do a mouth check after ingestion. *We agree with this recommendation.*

Additional Recommendations

2. At reception, physicians should document all medication orders onto a physician order form.
3. Nurses noting physician orders should transcribe all medication orders onto a medication administration record (MAR). Nurses should document on the MAR the administration of stock medications to the patient.
4. A schedule of sanitation and disinfection activities should be developed and implemented in all medication rooms.
5. The nurses' medication room must be kept clean and well-organized. Rusting shelves should be replaced.
6. Nurses should not transfer properly labeled and dispensed medications from the pharmacy into improperly labeled medication envelopes.
7. Medication carts should be clean, well-organized, and have adequate supplies to properly administer medications, including medication cups and hand sanitizer.
8. Custody leadership should ensure that sufficient officer escorts are available to escort and assist the nurse with medication administration.
9. Nurses should maintain standards of nursing practice with respect to medication administration, including:
 - a. Using two identifiers to identify patients (e.g., ID card and date of birth, etc.).
 - b. Washing hands prior to medication administration and using hand-sanitizer between patients.
 - c. Comparing the medication blister pack against the medication administration record at the time of medication administration.
 - d. Placing medications into disposable medication cups.
 - e. Ensuring inmates have access to a cup and water to take medications.
 - f. Observing inmates take medications, having the patient step aside and an officer performing oral cavity checks using a small penlight.
 - g. Documenting administration of medications onto the MAR at the time of administration.
 - h. If inmates are not in the housing unit at the time of medication administration, nurses should arrange for administration of the medication later in the shift.
9. In order for nurses to perform medication administration in accordance with standards of nursing practice as described above, conditions of confinement must permit inmates to come out of their cells to receive administration of medications.
10. The cutoff date for BosWell to print MARs for the following month should be later in the month (e.g., 27th or 28th) to reduce the number of MARs that nurses must transcribe at the end of the month.
11. Health care leadership should develop a system for timely renewal of chronic disease and other essential medications.
12. Health care leadership should revise the policy and procedure for medication administration to provide sufficient operational guidance to administer medications in accordance with accepted standards of nursing practice.
13. Health care leadership should develop, implement, and monitor quality indicators related to pharmacy services and medication administration.

14. Health care leadership should conduct a root cause analysis and develop a corrective action plan with strategies targeting the causes of performance that fall below expectations.

Infection Control

The First Court Expert Report contained no recommendations regarding infection control. We include our recommendations below.

Current Recommendations

1. An infection control position should be established and budgeted.
2. Health care leadership should establish, implement, and monitor a schedule for sanitation and disinfection activities in all areas of the institution.
3. An analysis should be performed of infectious/communicable disease statistics, including prevalence of TB, HIV, and HCV infection among newly arriving inmates.
4. Track and report skin infections due to all pathogens, not just MRSA, including infestations with scabies or body lice.
5. Medical providers should be educated on the evaluation, staging, and treatment of syphilis infection.
6. Pending the hiring of an infection control nurse, document, monitor, and report to the Quality Improvement Committee and facility leadership the training provided by security to the inmate porters who clean and sanitize the clinical areas, including the infirmary patient rooms.
7. Inmate porters are to change gloves and wash their hands after sanitizing infirmary rooms and between sanitizing each patient's bed. Porters are not to leave infirmary rooms without removing gloves.
8. Protective clothing and gear are always to be worn by porters when cleaning body fluid exposed surfaces and walls.
9. All torn and cracked outer protective coverings of infirmary beds, wheel chairs, examination tables, and gurneys are to be repaired or disposed and replaced.

Dental Program

Dental: Staffing and Credentialing

The First Court Expert Report concluded that staffing was adequate and had no recommendations with respect to personnel. We found staffing to be inadequate and will be even more inadequate after necessary program changes have been made.

Current Recommendations

1. Perform a detailed analysis of the hours SCC dental personnel spend furthering NRC's mission and assign personnel to NRC accordingly.
2. Collect data on patient wait times and failed appointments to inform staffing schedule.

3. While staffing appears to be adequate for current operations, staffing should be re-evaluated if the intake screenings become more thorough and take more time (as we believe they should).

Dental: Facility and Equipment

First Court Expert Recommendations

1. The chair and unit should be considered for replacement in the near future. Hand pieces should be repaired. *We add that there should be a replacement schedule for **all** dental equipment to inform budget preparation.*
2. The examination rooms for the screening exams should be better equipped. Patients should be seated, and lighting should be adequate for the exam. *We note that the lighting has been improved since the First Court Expert Report.*

We agree with these recommendations.

Additional Recommendations

3. Patients should routinely wear a lead apron with a thyroid collar when dental radiographs are taken.
4. The approval process for repairing dental equipment should be streamlined.
5. All x-ray devices should be inspected periodically by a therapeutic radiological physicist to ensure that patients are not subjected to unnecessary exposure to ionizing radiation.¹⁵⁴
6. The clinic equipment should include a sphygmomanometer and stethoscope.
7. The panoramic x-ray units should be replaced immediately.

Dental: Sanitation, Safety, and Sterilization

First Court Expert Recommendations

1. That the sterilization area be made neater and every attempt made to correct the sterilization flow. It may mean reconfiguring the space and the storage utilization therein.
2. That safety glasses be provided to patients while they are being treated.
3. That a biohazard warning sign be posted in the sterilization area.
4. A warning sign be posted in the x-ray area to warn of radiation hazards, especially pregnant females.

We agree with these recommendations.

Additional Recommendations: None.

Dental: Review Autoclave Log

First Court Expert Recommendations: None.

¹⁵⁴ 32 Illinois Administrative Code 360 pdf, p. 47. Also, “[r]ecords of machine calibrations and quality assurance checks shall include identification of the x-ray therapy system, radiation measurements, the date the measurements were performed and the signature of the therapeutic radiological physicist who performed the measurements.” *Id.*, p. 48.

Additional Recommendations: None.

Dental: Comprehensive Care

First Court Expert Recommendations

1. Comprehensive “routine” care be provided only from a well-developed and documented treatment plan.
2. The treatment plan be developed from a thorough, well-documented intra and extra-oral examination, to include a periodontal assessment and detailed examination of all soft tissues.
3. In all cases, appropriate bitewing or periapical x-rays be taken to diagnose caries.
4. Hygiene care be provided as part of the treatment process.
5. That care be provided sequentially, beginning with hygiene services and dental prophylaxis.
6. That oral hygiene instructions be provided and documented.
7. Provide comprehensive, routine care only to the designated, long-term population.

We agree with these recommendations.

Additional Recommendations: None.

Dental: Intake (Initial) Examination

First Court Expert Recommendations

1. Provide a thorough soft tissue examination. This is the most important part of the screening exam and should include intra-oral palpation and a well-lighted examination of all soft tissue surfaces. *We note that this will require that dentists allocate more time to each screening.*
2. Note pathology seen on the Panelipse radiograph. Do not diagnose small carious lesions from this radiograph.
3. Do not provide comprehensive routine care from this examination. This is a screening examination.
4. Do not take the Panelipse radiograph simultaneously with inmates standing next to each other. This is a direct violation of radiation safety. Provide protective lead apron coverage to the inmate receiving the x-ray. *We add that the apron should have a thyroid collar.*
5. Place signage in the radiograph area warning of radiation hazard.
6. Individually bag and sterilize the mouth mirrors or use disposable mirrors.
7. Wash hands and change gloves between patients. *We agree that gloves should be changed between patients but offer the alternative of using an alcohol-based hand rub before donning gloves.*
8. Take a more thorough health history and “red flag” health issues that require medical attention prior to dental treatment.

We agree with these recommendations.

Additional Recommendations

9. The health history should be expanded and printed on a separate form.
10. The IDOC should ensure that dentists perform the charting required by Administrative Directive 04.03.102.
11. The portion of the form for charting is too small and should be increased substantially.
12. The panoramic x-ray units should be replaced immediately.
13. Infection control barriers be used on the light and changed between patients.
14. If the dentist does not have an assistant to record, an infection control barrier (i.e., a disposable pen sleeve) should be used on his/her pen.
15. Valid oral hygiene instructions should be provided and if they are not, the dental chart should not record that they have been provided.

Dental: Extractions

First Court Expert Recommendations

1. A diagnosis or a reason for the extraction be included as part of the record entry. This is best accomplished using the SOAP note form at, especially for sick call entries. It would provide much detail that is lacking in most dental entries observed. Too often, the dental record includes only the treatment provided with no evidence as to why that treatment was provided.
2. Provide antibiotics appropriately from a diagnosis and only when indicated.

We agree with these recommendations.

Additional Recommendations

3. Clinically inadequate preoperative x-rays should not be used for tooth extractions.
4. Consent forms should document the tooth number to be extracted as well as the reason for the extraction.
5. All treatment refusals should be documented to include the reason for the recommended procedure and the consequences of declining the procedure.

Dental: Removable Prosthetics

First Court Expert Recommendations

A comprehensive examination and well developed and documented treatment plan, including bitewing and/or periapical radiographs and periodontal assessment, precede all comprehensive dental care, including removable prosthodontics.

1. That periodontal assessment and treatment be part of the treatment process and that the periodontium be stable before proceeding with impressions.
2. That all operative dentistry and oral surgery as documented in the treatment plan be completed before proceeding with impressions.

*We agree with these recommendations which represent the accepted professional standard for diagnosis and treatment planning.*¹⁵⁵

Additional Recommendations: None.

¹⁵⁵ See, for example, Stefanac SJ. pp. 11-15, *passim*.

Dental: Sick Call/Treatment Provision

First Court Expert Recommendations

1. Implement the use of the SOAP format for sick call entries.
2. Develop a request/sick call system that insures that inmates complaining of pain/swelling/toothaches are seen by a provider and evaluated within 24-48 hours from receipt of the request.
3. Develop a system such that urgent care complaints (pain, swelling, toothaches) are seen in person for evaluation and triage by the next working day, and that care be provided expeditiously. Otherwise, these inmates are transferred and gone if too much time elapses. This should be a primary mission at NRC.
4. Provide routine comprehensive care to the designated MSU population only.

We agree with these recommendations.

Additional Recommendations

5. When the dental clinic is closed, or the dentist will not be available for 24 hours, a mid-level provider should perform a face-to-face examination for all inmates submitting a request that states or implies the existence of dental pain within 24 hours.
6. NRC should develop a standard health care request form that is available to all inmates.
7. All health care requests should be time-stamped and logged, and a record of when the inmate was seen by a provider and the disposition should be maintained.

Dental: Orientation Handbook

First Court Expert Recommendations

1. Ensure that the orientation manual describes fully and accurately how inmates can access both urgent and routine care via the inmate request form system. *We agree with this recommendation.*

Additional Recommendations

2. Modify Administrative Directive 04.03.102, ¶IV B to reflect the fact that every offender at NRC receives a screening exam, and not a “complete dental exam.”¹⁵⁶

Dental: Policies and Procedures

First Court Expert Recommendations: None.

Current Recommendations

1. The initial examination performed at intake should be in accordance with Administrative Directive 04.03.102 (¶F2), or the Administrative Directive be rewritten to reflect what IDOC decides should be done.
2. All Administrative Directives, policies, and protocols relevant to the dental program should be maintained in the dental clinic and the HCUA should ensure that dental personnel review them initially and after any changes.

¹⁵⁶ In most prison systems with which we are familiar, dental screenings are performed at intake and comprehensive examinations are performed typically within 30 days of arrival at the assigned prison.

3. Dental findings classified as Class II at the intake screening exam should be addressed at the NRC or immediately at the receiving institution.

Dental: Failed Appointments

First Court Expert Recommendations

1. Every effort should be made to see inmates complaining of pain or swelling in a timely manner, within 24-48 hours. These inmates need not be scheduled for operative [routine] dentistry. Only palliative care need be provided.
2. A sick call system should be established that can accomplish this goal. Administration should be involved in this project and in assisting the dental program in getting inmates to the clinic or their appointment. The inmate handbook should make it clear who is eligible for routine care.

We agree with these recommendations.

Additional Recommendations

3. The failed appointment rate should be collected and reported as part of the CQI program with other dental program data.
4. Failed appointments should be a priority emphasis of the CQI program.

Dental: Care of Medically Compromised Patients

First Court Expert Recommendations

1. The medical history section of the dental record be kept up to date and that medical conditions that require special precautions be red flagged to catch the immediate attention of the provider.
2. That blood pressure readings be routinely taken of patients with a history of hypertension, especially prior to any surgical procedure.
3. The health history be addressed and updated on every patient and that consultation with medical be provided and documented when indicated. This issue is serious and needs to be corrected immediately.

We agree with these recommendations.

Additional Recommendations

4. The health history should be expanded and printed on a separate form.
5. There is not enough room on the chart to accommodate the tooth diagram used for charting restorations and missing teeth. The diagram should be substantially larger.

Dental: Specialists

No recommendations.

Dental: CQI

First Court Expert Recommendations

1. The CQI process should be used extensively and continuously to assist in correcting the deficiencies noted in the body of this report. A good starting point would be to focus on

addressing urgent care needs in a timely and efficient manner. *We agree with this recommendation.*

Additional Recommendations

2. The dental CQI program (as well as all other components of the dental program) lacks guidance from a dentist with experience in corrections. This expertise should reside centrally at IDOC and not depend on a Wexford employee or contractor.

Internal Monitoring and Quality Improvement

First Court Expert Recommendations

1. The quality improvement program must be reenergized with knowledgeable leadership that has been provided specific training regarding quality improvement philosophy and methodology.
2. The leadership of the CQI program must be retrained regarding quality improvement philosophy and methodology, along with study design and data collection.
3. Training should include how to study outliers to develop targeted improvement strategies.

We agree with these recommendations.

Additional Recommendations

4. The NRC quality improvement plan must be a practical year-ahead work plan for the upcoming year to work on and improve identified problems on a priority basis.
5. NRC must develop an effective methodology to review for quality of clinical care at all levels, including nursing and physicians.
6. NRC needs to re-evaluate its use of data. Data must be reliable and must measure processes determined to be essential services.
7. The CQI program at SCC must be separate from the CQI program at NRC. Annual reports must be uniquely developed. Reports used for NRC should not be used for SCC.
8. The Quality Improvement Committee should adhere to AD requirements including:
 - a. Review primary source verification of physicians.
 - b. Review 100% of offsite clinical events for quality and appropriateness. The review of quality should include whether the quality of care prior to and after the appointment was adequate and appropriate.
 - c. Review of 100% of critical incidents including mortality, new or delayed diagnosis, use of isolation, IDPH reportable cases, and all staff evaluations for occupational exposures. This review should not consist of merely listing the number of these events but should be a critical review.
9. Sentinel event reviews and peer review on any non-primary care provider should be conducted by a non-Wexford physician.
10. NRC needs to develop a method of identifying problems with their processes of care.

Appendix A

NRC Staffing¹⁵⁷

Staff Type	Positions	Vacant	Supervising Authority
HCUA	1	0	NRC HCUA
DON	1	0	NRC HCUA
Nurse Supervisor	2	0	NRC HCUA
Med Room assistant	1	0	Wexford
Office Assistant	1	0	NRC HCUA
Medical Supply	1	0	NRC HCUA
Radiology Technician	1	0	NRC HCUA
CMT (shared SCC and NRC)*	17	11	SCC HCUA
RN	21	5	NRC HCUA
Certified Nurse Assistant	6	5	Wexford
Medical Records Director	1	0	Wexford
Dentist	1	0	Wexford
Dental Assistant	1	0	Wexford
Dental Technician	1	1	Wexford
Medical Director	1	1	Wexford
Staff physician	1	0	Wexford
Physician Assistant	2	0	Wexford
Medical Records staff**	9	6	Wexford
Total	69	29	

*Five shared CMT staff out of 11 are on Leave of Absence and not working and are considered effectively vacant. These positions are shared between NRC and SCC and have been listed on both NRC and SCC's staffing tables.

**An adjusted service request (ASR) for five additional medical record clerks was just filed but these staff are not yet hired and therefore not listed on the grid provided by the Regional Coordinator.

¹⁵⁷ Based on a staffing grid provided by the IDOC Regional Coordinator via email to Expert on January 30, 2018.

Appendix B

Review of Specialty Care¹⁵⁸

Type of referral	Referral present	Collegial present	Approval present	Formal report in record	Days to see Pt after consult	# of consultant recommendations not carried out	Recommendations of Consultant not carried out
Rheumatology Patient 1 Specialty Care (SC)	0	0	0	1	12	2	Check labs and refer to nephrology
Rheumatology Patient 1 SC	1	0	0	1	1	3	Refer to nephrology, GI, and monitor labs
Hospitalization Patient 1 SC						6	Recommended Renal biopsy, transrectal ultrasound, repeat CT scan of abdomen, cystoscopy with bilateral pyelograms, nephrology consult, urology follow up. There no meaningful review of these recommendations and referrals made for nephrology and urology but no collegial review or approval was present. There were no referrals to any of the other investigations.
ERCP procedure Patient 2 SC	1	0	1	1	3	2	Follow up cytology results, FU in GI clinic the following week
Urology Patient 3 SC	0	0	0	1	19	0	
Ultrasound Patient 3 SC	1	0	0	0	9	0	
Oncology Patient 3 SC	0	0	1	0	5	2	Vascular surgery, urology
CT scan Patient 4 SC	1	1	0	0	10	0	CT scan not reviewed

¹⁵⁸ This data comes from review of patients 1 through 7.

Oncology Patient 4 SC	0	0	0	0	3	1	No evidence of an ultrasound done as recommended.
Oncology Appt. with immediate hospitalization Patient 4 SC	1	0	0	0	15		Because there were no reports it was unclear if recommendations were made.
Corneal clinic Patient 5 SC	1	0	1	0	1		Comments by the consultant on the referral form recommend contact lens clinic ASAP and surgery on the cornea.
Contact lens clinic Patient 5 SC	1	0	1	0	6	1	Return to contact lens clinic was recommended on the referral form
Corneal surgery Patient 5 SC	1	0	1	0	4		
Corneal clinic Patient 5 SC	0	0	0	0	3		
Corneal clinic Patient 5 SC	1	0	0	1	2		
Corneal clinic Patient 5 SC	1	0	1	1	1		
Corneal clinic Patient 5 SC	1	0	1	0	1	1	This patient's three month follow up was delayed and occurred only after the patient developed a complication. There was no evidence of a one week follow up at that clinic.
Orthopedic Patient 6 SC	1	1	1	1	1		
Outpatient surgery Patient 6 SC	1	1	1	1	1		
Transplant Center Patient 7 SC	0	0	0	0	4	1	This consultation documented as having occurred in the medical record. Consultants recommended a hepatology consultation. There was a referral and approval for this but this consultation did not occur.
Burn Patient 7 SC	0	0	0	0	4		This consultation documented as having occurred in the medical record.
Transplant Center Patient 7 Sc	1	0	0	0	12		There was documentation in the record that the patient had a transplant clinic visit on 11/6/17

							and there was a referral for a transplant follow up but there was no other information as to what occurred in the record. If there were recommendations, these were not present.
Transplant Center Patient 7 SC	0	0	0	0	Not seen		There was patient after-care paperwork for a 12/18/17 visit to Rush Presbyterian but there was no other information. If there were recommendations, these were not present. There was no provider follow up of this presumed visit.
Totals	14	3	9	8		19	

Appendix C

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Stateville Correctional Center
2nd Court Appointed Expert Report
Lippert v. Godinez

Visit Date: February 26, 2018 – March 1, 2018

Prepared by the Medical Investigation Team

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Table of Contents

Overview	2
Executive Summary	2
Findings	6
Leadership, Staffing, and Custody Functions.....	6
Clinic Space, Sanitation, Laboratory, and Support Services	9
Medical Records.....	16
Intrasystem Transfer	17
Nursing Sick Call	19
Chronic Care.....	24
Urgent/Emergent Care.....	38
Specialty Consultations	48
Infirmity Care	50
Pharmacy and Medication Administration	55
Infection Control	59
Dental Program	62
Internal Monitoring and Quality Improvement.....	75
Recommendations	82
Leadership, Staffing, and Custody Functions.....	82
Clinic Space, Sanitation, Laboratory, and Support Services	83
Medical Records.....	83
Intrasystem Transfer	84
Nursing Sick Call	84
Chronic Care.....	85
Urgent/Emergent Care.....	87
Specialty Consultations	87
Infirmity Care	88
Pharmacy and Medication Administration	88
Infection Control	89
Dental Program	90
Internal Monitoring and Quality Improvement.....	95
Appendix A	97
Appendix B	99

Overview

From February 26 to March 1, 2018, the Medical Investigation Team visited the Stateville Correctional Center (SCC) in Joliet, Illinois. This report describes our findings and recommendations. During this visit, we:

- Met with leadership of custody and medical
- Toured the medical services area
- Talked with health care staff
- Reviewed health records and other documents
- Interviewed inmates

We thank the Warden and staff for their assistance and cooperation in conducting the review.

The SCC facility is one of three maximum security prisons in the IDOC. The Warden of SCC is also the Warden at the Northern Reception Center (NRC), a separate facility with a very different mission and needs. SCC opened in 1925 and is plagued by aging infrastructure. There have been attempts to close this aging facility, but political pressure kept the facility open.¹ In 2016, the “Roundhouse,” a maximum security complex within SCC, was closed. In our introductory meeting, the Warden told us that several additional units have been closed.

SCC is located on a 2200-acre campus with 33-foot walls surrounding the perimeter. It has a population of 1183. SCC has three galleries on unit X for segregation housing with a capacity of 48. SCC has an infirmary unit of 32 beds. Units B, C, D, and E occupy a structure that is 420 feet long and 52 feet high. Each of these units has five floors, each with a housing “gallery.” Inmates on these units are separated by levels of aggression. Dialysis patients are housed in Unit C. Unit E houses inmates with moderate to high aggression. This type of structure, in combination with maximum security classification, makes administration of medication and attendance for medical appointments exceedingly difficult.

The IDOC Agency Medical Director and IDOC Regional Coordinator were present for this tour. The Wexford Regional Manager and Regional Medical Director were not present for our tour.

Executive Summary

Based on a comparison of conditions as identified in the First Court Expert’s report, we find that some conditions appear to have improved by virtue of hiring a permanent Health Care Unit Administrator (HCUA) and improving access to sick call. Most other areas have either not improved or have deteriorated. We find that SCC is not providing adequate medical care to

¹ Stateville to Stay Open; Pontiac Prison to Close; Paul Meincke ABC Eyewitness News 5/5/08 as found at <http://abc7chicago.com/archive/6123448/>.

patients, and that there are systemic issues that present ongoing serious risk of harm to patients that result in preventable morbidity and mortality. The deficiencies that form the basis of this opinion are provided below.

The HCUA position is now filled with a capable full-time administrator. But the Medical Director position is now vacant and the Director of Nurses (DON) is new to the position. All supervisory nurse positions are vacant, resulting in the DON and HCUA having to perform direct line nursing supervision, which detracts from their ability to manage. Staff are still shared with Northern Reception Center (NRC) and the vacancy rate is high (32% including those on leave of absence), resulting in an apparent lack of staffing. A staffing analysis needs to be done and SCC needs its own staff that is not shared with NRC. The prior Medical Director was a surgeon and not appropriately trained in primary care medicine, likely accounting for the preventable morbidity and mortality we identified in record reviews. The lack of appropriately trained physicians was the single most important contributor to preventable morbidity and mortality in our opinion and must be corrected.

Clinic examination rooms were generally clean and appropriately equipped. There were some items in these areas that need to be addressed. Infirmary beds need repair or replacement. All rooms on the infirmary need to be sanitized uniformly and this unit needs pest control to remove cockroaches, flies, and gnats. Negative pressure rooms need to be repaired so they are fully functional and need to be regularly cleaned and inspected. The hemodialysis unit was in deplorable condition from a sanitation and physical plant perspective. This unit should be refurbished and properly sanitized. The inmate kitchen and dining area had birds living in the unit who deposited droppings in the area where inmates eat. This poses a health risk and these birds should be removed from inside the kitchen. The monthly environmental rounds now being performed are an improvement, but these should include the infirmary and hemodialysis unit.

Except for hospital and consultant reports, most documents are filed timely into the medical record. Offsite consultations and hospital records are often unavailable, which adversely affects clinical care. Confidentiality is a problem to a lesser degree than at NRC, but the medical records area needs to be continuously secured. We continue to find problems with use of the excessively large medical records. The problems with the use of the paper record and the clinical problems it causes prompt us to strongly recommend implementation of an electronic medical record.

We found that the intrasystem transfer process has improved since the First Court Expert's report. However, we did find that for approximately 30% of inmates transferring into SCC, their transfer information was incomplete or prescribed care was not continued. We do, however, agree with the First Court Expert's recommendation to initiate quality improvement monitoring of this area of service.

Access to care has significantly improved since the First Court Expert's report and problems identified in that report related to access to care have been resolved. We note, however, that

quality of care of nurses performing nursing sick call exhibit deficiencies that are not currently being monitored by the Continuous Quality Improvement (CQI) program or by nurse supervisory staff. In addition, Licensed Practical Nurses (LPN) continue to perform sick call when this task exceeds the scope of their license.

The chronic care program appears to have deteriorated since the First Court Expert's report based on chart reviews. Physicians appear to be ignorant of currently accepted care guidelines for a number of common medical conditions that adversely affected patients. It is our opinion that this ignorance is related to the defective hiring, credentialing, and privileging process of Wexford. Physicians do not consistently take adequate histories, perform adequate physical examinations, derive adequate assessments, or form appropriate therapeutic treatment plans. The structure of the chronic care management program as described by the First Court Expert contributes to fragmentation of care and this has not been corrected. Evidence of poor chronic illness management is present in record reviews for chronic illness, hospitalization, and mortality reviews. Evidence showed preventable morbidity and mortality that is significant.

With respect to urgent, emergent, and hospital care, first responder bags are not standardized and are inconsistently inspected and maintained. Many ER visits and hospitalizations were preventable and due to inadequate primary care management. With respect to hospitalizations, we identified a preventable stroke and heart attack. We also noted that a metastatic colon cancer may have been prevented or have been identified much earlier with a better result than the metastatic cancer that was identified because of a year delay in performing diagnostic studies. We found these significant problems having reviewed only six records.

Specialty care has not improved compared to the First Court Expert's report. Care at University of Illinois Chicago (UIC) is not timely, yet for patients whose consultative care is delayed, consultation with an alternate service provider is not obtained. We find that this has caused morbidity. Tracking of consultation services is extremely poor and appears inaccurate. We found, for example, that 70% of completed consultations in January of 2017 were dated as completed *before* the referral for the consultation was documented as submitted. It is our opinion that the Wexford collegial review utilization process is a barrier to timely care and should be abandoned. This program has become a patient safety issue.

Medication administration services appear to have deteriorated as compared with the First Expert's report. The current system of medication administration is unsafe and does not ensure that patients receive medication as ordered. Nurses administer medications in an unhygienic manner and fail to document administration at the time medication is administered. There are many errors related to medication administration that the SCC program is aware of. Yet there has been no effort through its CQI program to correct these systemic problems. Also, contract monitoring documents have documented continual violations concerning controlled substance medications, yet no penalties or corrective actions have been taken.

The First Court Expert had no concerns or findings with respect to infection control. We identified multiple findings. These include vermin in patient rooms on the infirmary unit, serious infection control and sanitation issues in the dialysis unit, and birds in the inmate dining room, all of which can promote disease transmission. Negative pressure units on the infirmary used for respiratory isolation in cases of active tuberculosis or other illnesses were not fully functional, cleaned, or regularly serviced. Tuberculosis monitoring was poor. Nurses were not accurately reading Mantoux skin tests. Because the infection control responsibilities were dispersed among several nurses, it is our opinion that a dedicated infection control nurse would be beneficial. This was also a recommendation of the First Court Expert.

The dental program has not changed materially since the First Court Expert Report. Routine treatment is timely; however, it often occurs without a comprehensive oral examination (i.e., intraoral x-rays, a periodontal assessment, and a treatment plan); placing patients at risk of preventable pain and tooth loss. Clinical notes are inadequate and often illegible. Antibiotics and analgesics were often dispensed without a diagnosis having been recorded and post-extraction antibiotics were prescribed without documented evidence of infection. The dental sick call process is disorganized, and it is not possible to determine how long patients wait to be treated, or the failed appointment rate. There is no process for mid-level providers to triage and palliate patients whose sick call request suggests pain or infection. The treatment provided to IDOC inmates remains substantially below accepted professional standards and is not minimally adequate.

While the First Court Expert found the quality improvement program “non-functioning,” we found that the HCUA and his staff have initiated CQI activity, although it is nascent and not yet effectively functioning. The annual CQI plan and annual Medical Director Report at SCC are identical to the NRC CQI plan and Medical Director Report. Several requirements of the IDOC administrative directives (AD) are not performed by the CQI committee, including primary source verification of physician credentials and evaluation of 100% of offsite consultations and hospitalizations for quality and appropriateness. The CQI program does no evaluation of the quality of physician or nursing clinical care. Wexford peer reviews do not appear to identify or correct provider’s unacceptable care. The CQI committee does not perform sentinel event or mortality reviews even though there was preventable morbidity and mortality that we uncovered in record reviews.

We have several recommendations at the end of this report and address the recommendations of the First Court Expert, most of which we are in agreement with.

Findings

Leadership, Staffing, and Custody Functions

Methodology: We interviewed leadership of the health program and the Assistant Warden of Programs. We evaluated staffing documents and discussed these with the leadership. We reviewed other selected documents.

First Court Expert Findings

The First Court Expert found that staffing between NRC and SCC was combined and shared, making adequacy of staffing difficult to assess. Because all staff at SCC are assigned to NRC for part of their work hours, staffing at SCC is unreliable, making SCC out of compliance with policy requirements. Staffing schedules do not account for sickness and vacancies. Management must prioritize staff based on critical needs. Leave of absences and vacancies of state employees were significant. These vacancies are filled by Adjusted Staffing Requests (ASRs), accounting for 40 RN and LPN positions. A single HCUA manages both SCC and NRC and that position was functionally vacant due to prolonged medical leave. The SCC Medical Director was a surgeon who did not provide clinical management of the program.

The First Court Expert recommended that SCC have its own HCUA and staffing allocation, that only primary care trained physicians provide care, and that these physicians be board certified, and that all providers have access to electronic medical references.

Current Findings

We agree with the First Court Expert's findings, although there have been several changes at SCC. We found additional problems.

- Newly appointed SCC leadership has not had an orientation to their positions and are learning on the job.
- There are no nursing supervisors, so the HCUA and DON act as supervisory nurses, making them less effective in their assigned positions.
- Staffing vacancies and sharing staff with NRC contribute to a perceived lack of staffing. Actual staffing needs have not been determined by way of a staffing plan. A staffing plan, including for providers, should be developed.
- Lack of physician credentialing and granting privileges to physicians to perform care in areas in which they have no training has resulted in preventable morbidity and mortality.
- Contract monitoring fails to adequately monitor for vendor quality of care and overall performance.

There have been some changes since the First Court Expert's report, but we agree with the main conclusions of his findings. SCC now has a dedicated HCUA, which was a recommendation of the First Court Expert. This is an improvement. However, this improvement is negated by the lack of a Medical Director. The Medical Director recently died and was replaced about two

months ago by the recently appointed NRC Medical Director. Two weeks after our visit, however, this physician resigned, leaving SCC without a Medical Director. Staffing is still shared between the two facilities and all staff from SCC goes to NRC on occasion to assist in the reception area on busy days. There has been a very recent increase in staffing at NRC which will reduce the need to send staff from SCC to NRC. However, the degree of staff sharing is not known but is still substantial. We did not find that staff vacancies are filled by ASR positions.

The leadership staff at SCC are all recently appointed. The HCUA has been in his position for about a year. The Director of Nursing (DON) has been in her position for about five months and was a staff nurse at SCC for about five years before taking the DON position. The HCUA and DON were both staff nurses prior to their current positions. The Medical Director was in his position for about two months before he resigned shortly after our visit. He had been with Wexford for two years and over those two years had been a Traveling Medical Director or Medical Director at five different facilities. According to a Wexford document, he was listed as Medical Director simultaneously at both NRC and Sheridan between 2/19/17 to 8/12/17.² Overall, this leadership group lacks management experience and is now lacking a Medical Director. However, the HCUA and DON are energetic and willing to learn their assignments.

The IDOC Regional Coordinator for this facility covers 10 facilities, which is a span of control too large to effectively supervise. He and the IDOC Agency Medical Director were present for part of our tour. Neither the Wexford Regional Medical Director nor the Wexford Regional Manager was present for our tour. The Wexford Regional Manager is an ex-warden and we have concerns that a person with criminal justice training will have the skills necessary to manage a clinical medical program.

None of the key leaders indicated receiving specific training for their new roles. All three inherited positions that were vacated and they have been learning on the job. In the case of the HCUA, his predecessor, as described in the First Expert report, was chronically absent and was not performing. He inherited a poorly functioning program. The Director of Nursing inherited the program from a nurse who had performed well. However, the prior DON did not have time before her departure for an orientation for the new DON. The Medical Director had just started in the position as Medical Director when he resigned.

Nursing supervision is significantly deficient. There are two nurse supervisor positions. One supervisor is on leave of absence and the other recently left service, making both positions effectively vacant. The DON and HCUA provide supervision during daytime hours, in addition to their management responsibilities, but there is no evening or night supervision. Having staff work without supervision is not an acceptable situation. The staff is a mixed IDOC/Wexford staff. Dialysis staff is supervised by Naphcare, the dialysis vendor. As with NRC, there are some supervision issues with respect to assignment and discipline when an IDOC employee assigns or supervises a Wexford nurse, or when the Wexford DON assigns or supervises an IDOC employee.

² Document 42P5643 – IDOC Position History 7-1-2015 to 11-22-2017 Bates #520-548 (Requests 1 & 2).

All three key leaders believe that staffing shortages are their number one problem. All staff at SCC can be shared with NRC. The amount of time SCC staff work at NRC is determined on an ad hoc basis by negotiation and discussion between the NRC and SCC HCUAs. Based on a discussion with the HCUA, the staffing at SCC includes 98 positions with 24 (24%) vacant positions and nine on leave of absence or injured.³ The effective vacancies total 33 (34%). This extraordinarily high vacancy rate is made worse by having to share staff with NRC, which results in prioritizing assignments to avoid crises as opposed to ensuring that all needed work is done. Despite these staffing deficiencies, there is no staffing plan that addresses actual needs at SCC. The current official Schedule E is not up to date. None of the existing leadership staff has participated in developing the Schedule E or existing staffing pattern at this facility.

Almost all provider notes lack adequate history, physical examination, assessments, and therapeutic plans. We could not determine whether this deficiency was due to practice issues or lack of staffing. The Medical Director's opinion was that an additional physician is needed. The Medical Director has clinical responsibilities in addition to management responsibilities. The annual CQI report for 2016-17 states that providers see approximately 20-30 patients daily.⁴ The Medical Director's report in the 2016-17 annual CQI report notes that "Depositions and court appearances for pending litigation are continuing to increase. Due to this, provider's time is divided between depositions and patient care." We add that when NRC intake physicals are backlogged, providers from SCC are sent to NRC to assist. The statistics in the most recent annual CQI 2016-17 report list 14,321 provider contacts, which yields about 18 patients a day per provider without infirmary visits, assistance to NRC, or time needed for litigation concerns, which the prior Medical Director deemed significant. The Medical Director also told us that he has asked for extra time to see patients because the medical record documentation is so poor that it is difficult to determine what the patient's problems are. In a well-functioning prison program with 1200 inmates, three providers are typically adequate. Under current circumstances, particularly with the sharing of staff with NRC, it is not certain whether budgeted staffing is adequate. A staffing analysis is necessary.

Based on record reviews, the quality of physician care, particularly care provided by the recently deceased Medical Director, was substandard. This was a serious problem at this facility. We noted multiple cases of morbidity and harm that occurred as a result of poor care. Two death charts reviewed showed preventable mortality. This, in our opinion, is related to use of physicians without primary care training. The recently departed Medical Director was a surgeon who did not appear to know how to manage many primary care problems, resulting in harm to patients. The credentialing and privileging of physicians is inadequate and places inmates at risk of harm. The prior Medical Director had the worst performance on peer review of all providers at this facility (two of whom were nurse practitioners), yet he was assigned the most complex patients and oversaw clinical care. We were told that assignments of Medical Directors are made by the Wexford Director of Operations, Regional Manager, with input from the Regional Medical Director. The recently resigned SCC Medical Director stated that he

³ Appendix A at the end of this report has the staffing grid for this facility.

⁴ Medical Director Annual Summary, Medical Director section of annual 2016-17 CQI presentation.

received his assignment by the Director of Operations. Lay persons do not have the ability to review the qualifications of physicians. Assignment of physicians not trained in primary care to be in charge of primary care at a facility places inmates at risk of harm.

The Assistant Warden of Programs covers both NRC and SCC. According to the HCUA, there are monthly meetings conducted by the Assistant Warden of Programs at which custody impediments can be discussed.

The HCUA monitors the contract by use of a standardized contract monitoring spreadsheet. NRC and SCC are reported as a single facility with respect to contract monitoring. There are three main functions with respect to contract monitoring: bills being paid on time, staffing hours filled, and performance monitoring. With respect to the total number of hours filled, the HCUA lists any hours in excess of the Schedule E that the vendor provides. This is subtracted from the total hours not filled based on the Schedule E. This yields the hours not provided or the total excess hours provided by the vendor in excess of the Schedule E. For the seven months from June 2017 to December 2017, there were 17,681.15 unfilled hours or about 2526 unfilled hours a month or about 14 positions. This accelerated beginning in October 2017, presumably due to the addition of new staff positions which have yet to be filled. Nevertheless, this is a significant amount of unfilled positions.

Performance contract monitoring consists of adherence with both contract requirements and compliance with administrative directives. With respect to administrative directives, the HCUA lists each item of the administrative directives which are not being followed by the vendor. However, this is subjective and does not appear thorough. For the June of 2017 contract monitoring report, as an example, the only medical performance deficiencies reported for SCC were two items related to distribution and documentation of controlled substances. Many ADs do not appear to be followed. As examples, we noted several administrative directives that were not being followed including:

- Failure to file hospital reports in the medical records in three days
- Failure to assess appropriateness and quality of 100% of offsite medical care services
- Failure to perform a one-time primary source verification of physician credentials.

The contract monitoring, in our opinion, fails to identify key failures of the vendor, especially regarding quality of provider care, for which there appears to be virtually no effective monitoring.

Clinic Space, Sanitation, Laboratory, and Support Services

Methodology: Accompanied by a correctional officer and the IDOC Medical Director, the IDOC Regional Coordinator, and the Health Care Unit Supervisor, we inspected the nurse sick call rooms on the housing units, the infirmary, and the main outpatient clinical area which housed medical exams rooms, nurse work areas, an urgent care center, physical therapy, hemodialysis unit, dental clinic, telehealth room, mental health interview rooms, nurse medication

preparation room, medical records department, health care administrative offices, conference room, the inmate cafeteria and dining areas, and the kitchen.

First Court Expert Findings

The First Court Expert found the clinical areas at SCC clean, well maintained, and environmentally comfortable. He recommended that designated exam rooms should be made available with appropriate equipment in cell houses B, E, and F to allow sick call to occur with reduced movement demands.

Current Findings

We had some different findings with respect to sanitation and equipment maintenance. Our findings included:

- The nurse sick call rooms in the housing units (B, C, D, E, X) are adequately sized and properly equipped. Their location in the housing units maximizes the patient-inmates' access to sick call.
- Five of the nurse sick call rooms in the housing unit have sinks with hot and cold water with hand washing supplies. Housing unit B's nurse room does not have a sink but has sanitizing gel.
- The first aid kits in the correctional officer rooms on the housing units are not regularly inspected and re-supplied. Two kits were inspected; the seal was broken on both and there were no gauze or bandages in the kit.
- The infirmary beds were in unacceptable condition. All of them need to be properly repaired or replaced. The low level of the beds makes it difficult and unsafe for the clinical team to properly examine and transfer patients.
- The cleaning and sanitation of the infirmary rooms must be uniformly done and should not vary based on the ability of the patient to assist the cleaning. Pest control must continue to be addressed in the infirmary.
- The negative pressure units in the infirmary are not regularly inspected or cleaned. The units were not fully functional. These units should have documented inspections on a weekly basis (daily if the room is occupied by a patient in respiratory isolation) and the filters changed on a monthly basis or as needed. The unit should be regularly checked during the environmental rounds and the condition noted in the monthly Medical Safety and Sanitation Report.
- The infirmary porters were verified to have received blood borne disease training and hepatitis A and B vaccinations.
- The physical plant, cleanliness, safety, and sanitation of the hemodialysis unit were unacceptable. The deficiencies and concerns noted in this section and the Infection Control sections must be immediately addressed.
- All medical equipment must be inspected and calibrated no less than annually by a bioengineering team. Only the AED and the UIC lab centrifuges had labels documenting inspections within the previous 12 months.

The main housing unit is a long rectangular building that has been subdivided into four quads, B, C, D, and E. Each of the quads houses approximately 260 inmates (capacity was reported to be 277). Each cell on these quads has two single beds with a toilet and a sink. The doors are barred. Large open showers are located on the second floor. The shower in Quad E was in good repair with no obvious mold. There was a plastic shower chair for use by patient-inmates with ambulation issues. There are no elevators in the housing units. All inmates with ambulation issues are housed on the entry level.

The nurse sick call rooms in Quads B, C, D, E, and in the X (disciplinary segregation and protective custody) building were inspected. The location of the nurse sick call rooms in the housing areas enhances the inmates' access to health care services. The sick call rooms have adequate space. Each has an exam table with disposable paper coverage, a blood pressure and vital sign unit, a temperature taking device, a medication cart, a wall mounted ophthalmoscope, a privacy barrier, and a scale. Four of the five nurse sick call rooms had a sink for hand washing and paper towels. Quad B did not have a sink, but there were sanitizing wipes and gel for hand washing. The ophthalmoscopes in two of the sick call rooms (D, E) were not functional. The medication cart in one room was inspected; it was locked and sealed. The medication cart check list/log with a pill count was properly maintained. Although the floor in B was dirty and the sink in D was crusted with mineral deposits, the nurse sick call rooms were generally clean and organized. In a few rooms there were unprotected paper memos taped on the wall; this is considered a potential fire safety hazard.

The first aid kits in the correctional officers' rooms on Quad D and B were not sealed and did not have any gauze or bandages for emergency use. This was reported to the correctional supervisor.

Although there are locked boxes for sick call requests on the housing areas, inmates reported that they use a signup list on the first floor to request a nurse sick call visit. They are asked not to write their medical concerns on the list. All inmates interviewed stated that they are, almost always, seen by the sick call nurse within 24 hours. In the X facility, inmates have to tell the correctional officer or med nurse to sign them up; they also stated that they were seen on the next day. If the nurse referred them to a physician/physician assistant, there was a two to three day wait unless the problem was deemed urgent.

The infirmary has 32 beds; 26 were occupied during this visit. One of the wings has two beds per room and the other is predominantly single beds. Mentally ill individuals in crisis are housed in a single bed room. Nearly 70% of the current infirmary patients were chronically ill (post-CVA, dementia, encephalopathy, ataxia, paraplegia, difficulty with ambulation etc.), with most needing some level of assistance with activities of daily living.

Almost all of the beds in the infirmary need to be replaced. The infirmary beds are low to the floor and cannot be raised. The head of the beds cannot be elevated. Most of the beds had broken or non-functional railings. There were no electrical beds in the infirmary. One patient with dementia was noted in his bed with nearly half of his body hanging over the edge of the

bed. This is a significant safety risk. The condition of the infirmary beds creates a notable safety risk for staff and patient-inmates. There is no replacement plan for the infirmary beds. The mattresses were generally in good condition; the impervious covers were also either intact or taped. Only one mattress had a tear (across the entire end of the covering). The rooms on the two-bed wing had nurse call devices; a review of four rooms verified that the devices were functional. There are no call devices on the single bed wing.

The infirmary had two negative pressure rooms (124 and 126). Room 124 has two HEPA units; the filters in both units were caked with dust. One unit had 1/12/2016 written in magic marker on its surface; presumably this was the last date of inspection. The second unit was undated, had dusty and dirty intake and outflow vents, and when turned on moved a very limited amount of air. In addition, the ceiling air vent was taped over. There was a single HEPA unit in room 126; there were no dates of inspection on this unit. The filter was covered with dust. The nurses demonstrated how they test the negative pressure in these rooms by placing a sheet of toilet paper over the chuck hole to see if the paper is drawn into the room. The test failed in room 124 and had limited draw in room 126. The experts requested the inspection reports for the HEPA units but the reports, if they exist, were not provided. The facility management staff changed the filters that evening, and the tissue paper test demonstrated the presence of negative pressure on the following day.

Inmate porters sweep and mop the floors of the infirmary rooms two to three times a week. They report that they spray and clean the toilets, sinks, and showers on a regular basis. No printed cleaning schedule was provided. Two infirmary porters were interviewed.⁵ They both stated that they had received formal training about their duties and had been vaccinated against hepatitis A and B. The Director of Nursing provided copies of their training curriculum, post-training test and vaccination records that confirmed the information provided by the porters. We did, however, note cockroaches, flies, and gnats on the infirmary unit. The patient rooms in the infirmary varied in degree of cleanliness and sanitation. Rooms in which the occupant participated or primarily did their own cleaning were reasonably clean. Infirmary room 124 was occupied by an individual with dementia; his room was filthy, with debris on the floor. His shower had not been recently cleaned. There were 20 small flies on the wall of the shower. He reportedly would tell the porters not to clean his room. The condition of this room created infection control and health hazards for the entire infirmary. Porters were directed to come in and sanitize this room.

The infirmary tub room in the wing with the two-bed rooms was virtually unusable, having no safety bars and large gaps and cracks in the floor tile. The floor drain does not fully drain. The adjacent shower room was clean with surrounding safety grab bars; however, the ceiling vent and wall towel hooks were completely rusted and thus impossible to sanitize.

The infirmary nurse station was centrally located between the two wings, with access to both hallways. The nurse station was adequately sized and clean. All the chairs in the nurse station

⁵ Infirmary Patients #5 & 6.

were deteriorating, with torn fabric and cushions; these need to be replaced. There was a single box on an upper shelf that was less than 18 inches from the ceiling and this is considered a fire safety hazard.

The health care unit/clinic's exam rooms, nurse work rooms/offices, urgent care room, physical therapy room, telehealth rooms, mental health interview rooms, and phlebotomy/lab prep room were organized and clean. The large elevated exercise mat in physical therapy, a number of examination tables, and the optometry chair had tears in their outer protective surfaces. One of the provider exam rooms had numerous paperback reference books cluttering the desk and a file cabinet.

A large space next to the urgent care area had six rooms. There were two provider exam rooms, each with an exam table, sink, paper towels, desk, and two chairs. The exam tables were adjustable; both tables had tears in the upholstery. Only one table had a paper barrier. The room used by the physician assistant was cluttered with 20-25 paper backed reference texts, some outdated, and food sitting on ice was noted in the sink. Two other rooms with correctional computers were used by nurses to track inmate locations for medication passage. One of the nursing rooms was a former exam room with an exam table with untorn impervious upholstery. The fifth room was the phlebotomy/lab prep room. Two centrifuges owned by University of Illinois (UIC) had been inspected in December 2017. There was a taped biohazard box in the lab that had not yet been moved to the nearby biohazard waste room. The optometrist (two days/week) uses the sixth room; it has an optometry chair with a small tear, optometry equipment that is aging but was reported to be fully functional, a functioning ophthalmoscope, and a desk with a chair. The optometry room was clean, neat, and organized.

The urgent care room had two gurneys with intact mattresses and paper barriers. This room had a functional Gomco suction unit, Automatic External Defibrillator (AED), EKG machine, oxygen tanks, nebulizer units, ambu bag, and oto-ophthalmoscopes. The equipment was verified to have been checked daily on the 11 p.m. to 7 a.m. shift. On every shift, the urgent care nurses count and log the narcotics, sharps, and suture quantities. With the exception of the AED, none of the equipment had been recently inspected by a bioengineering vendor. The last bioengineering inspection of the nebulizer was dated 2005. SCC does not have a crash cart; the institution performs basic CPR, applies the AED, and calls 911 for cardiac arrests. This is an acceptable option for responding to codes/cardiac arrests. A plugged-in radio repaired with duct tape was on the treatment counter in the urgent care room; the condition of the radio rendered it unable to be sanitized. The staff was directed to remove the radio from the unit.

Hemodialysis is performed onsite via a contract with Naphcare, Inc. in a four-chair hemodialysis unit. Hemodialysis treatments are performed Tuesday, Thursday, and Sunday on the evening shifts but these sessions appear to continue into the night. A hemodialysis patient on a housing unit told the experts that he is always moved to dialysis sessions. The chairs were in good condition. The dialysis machines were clean but there were indelible stains (likely betadine) on the top of the machines. During sessions when a hepatitis B infected patient is being dialyzed, a hemodialysis chair is not used exclusively by hepatitis B infected patient(s) nor is a dedicated

dialysis technician/RN assigned to these patients. This is not in accord with Center for Disease Control standards.⁶

The hemodialysis room was in deplorable physical condition. The walls and paint were deteriorating and peeling, the floor was dirty and had not been buffed for a lengthy period of time, there was standing water in the water room, a number of unformed boxes were leaning against a wall, and a large, half-filled garbage container lacked a cover. The water room was cluttered and cramped. Half of the water room was used to store deionization tanks, eight of which were unsecured, creating a safety hazard. The door of the refrigerator in the water room was rusted and deteriorating and cannot be effectively sanitized. The storeroom in the hemodialysis room had boxes on the floor and boxes stacked on shelves up to the ceiling. Hemodialysis units have high risk for blood borne contamination. The hemodialysis unit at SCC does not meet the community standards for hemodialysis centers. SCC maintenance staff, the vendor Naphcare, and the correctional health vendor must jointly work to address the physical plant, safety, and infection control issues in the hemodialysis unit.

The kitchen and dining areas were unsanitary and promoted infectious hazards. The inmate dining halls had sparrows flying above the tables and even landing on the cafeteria line serving counters. Bird droppings were noted on walls, the floor, and ceilings. There appeared to be a nest high on a wall in one of the inmate dining areas. The presence of birds and their droppings in the inmate dining and food serving areas exposes the inmates and staff to preventable risk of infection by bacteria, viruses, fungi, and ectoparasites that are known to be associated with birds, their droppings, and their nests.⁷ Birds and their droppings in the SCC inmate dining and food serving areas is a health risk for the inmates and staff. The birds must be removed from the dining areas and the droppings cleaned using proper safety precautions. A registered sanitarian must be hired to fully inspect the kitchen and correct these deficiencies.

The tray, utensil, pots, and pan-washing and sterilization machine had been broken for three years. The meat freezer does not have rubber/plastic flaps at the entrance, allowing the temperature to rise above freezing temperatures when meat is being brought in and removed from the freezer. An environmental sanitarian should be brought in the fully inspect the kitchen.

The dish cleaning unit in the main kitchen has been broken for three years. Trays, pots, and pans are washed and dried by hand. It was reported that a new unit has been purchased and will be installed in 2018. The meat freezer in the kitchen does not have rubber flaps at the entrance, resulting in an unsafe rise in freezer temperatures above freezing (as noted on the freezer temperature log) in the early morning when frozen meat is moved to the defrost room. The current cleaning of the trays, pots, utensils, and pans is done manually.

⁶ Centers for Disease Control and Prevention, Recommendations for Preventing the Transmission of Infections Among Chronic Dialysis Patients. MMWR, April 27, 2001/50 (RR05); pp. 1-43 as found at <https://www.cdc.gov/mmwr/preview/mmwrhtml/rr5005a1.htm>.

⁷ We note that IDOC had a histoplasmosis outbreak at the Danville facility thought to be due to bird droppings.

In summary, the First Court Expert made no specific recommendations concerning sanitation and infection control. We have recommendations that are found at the end of this report.

Environmental Rounds

Methodology: The HCUA was interviewed and copies of the Monthly Safety & Sanitation Reports (January-May, July-August 2017) and the Medical Safety and Sanitation Reports (September 2017-February 2018) were provided and reviewed.

First Court Expert Findings

The First Court Expert did not report on environmental rounds at SCC.

Current Findings

- Safety & Sanitation Reports were filed monthly from January through August 2017 (July was not provided). These reports were then replaced by the Monthly Medical Safety and Sanitation Report.
- Monthly Medical Safety and Sanitation rounds are being performed and have been reported from September 2017 through February 2018.
- The format of the Monthly Medical Safety and Sanitation report is notably improved. This report includes: 1) Location, 2) Identification of Standards Not Met, 3) Recommendations for Corrective Action, 4) Follow-up on Past and Present Discrepancies.
- The Health Care Unit, hemodialysis unit, and the infirmary have been reported in the monthly reports as having an ongoing pest control (insects, cockroaches, gnats) issues. Exterminators have been contracted. An exterminator was seen entering the facility on the first day of the experts' visit to SCC.
- Cleaning issues in the infirmary and the health care unit were cited in the report, including the cleaning of dirty vents.
- In January 2018 the hemodialysis unit was noted to be in compliance, but the February 2018 report cited water on the floor, cockroaches, and broken floor tiles that need to be repaired in the hemodialysis unit.
- The Clinic Space, Sanitation, and Infection Control sections in this report noted far more deficiencies in the health care unit, the hemodialysis room, and the infirmary than have been reported in the Monthly Medical Safety and Sanitation Reports. The rounds did note and repair mattresses in the infirmary that were in poor condition.

Monthly environmental rounds are being performed by the health care team at SCC. These rounds have identified concerns, some of which appear to have been corrected or are being addressed. The rounds must focus more attention on the beds in the infirmary, the cleaning and sanitation of the infirmary rooms, the repair of impervious covers of exam tables, chairs and patient mattresses, and the deplorable condition of the hemodialysis unit (water room, floors, walls, safety, and infection control standards).

In summary, the First Court Expert made no specific recommendations concerning sanitation and infection control. We have included recommendations that are found at the end of this report.

Medical Records

Methodology: We inspected the medical record room and interviewed staff. We also reviewed many medical records and had an opportunity to assess the organization of the medical record document.

First Court Expert Findings

The First Court Expert did not provide any findings with respect to medical records at SCC.

Current Findings

The medical records program has a Director of Medical Records who is a Registered Health Information Technologist (RHIT), which is appropriate training for this position. There are three IDOC employees and one Wexford employee working in medical records in addition to the Director of Medical Records.

The medical records room appears orderly but is cluttered, with very old carpeting and furnishings. There was insignificant backlog of filing. There is a procedure for filing records and for use of out guides. But these procedures are not always followed. For the most part, medical record staff pull and refile medical records. However, nurses pull some records and we were told that medical records staff re-file only about 80% of medical records. Medical record staff typically are to handle all medical record transactions, especially pulling records and refiling records. This is done in order to ensure confidentiality of the medical record. The medical record room is either occupied by medical record staff or is locked. During daytime hours, the medical record staff does secure the files. Certain staff, during off hours, have keys to the medical records room and can pull and refile records.

While there is no backlog of medical record documents to file, there are a significant number of offsite consultation reports that are not available. Consultation reports from UIC are not filed within three days of the consultation as required by the IDOC administrative directive on medical records. It appears that most reports are filed within three weeks of the consultation. This may account for the provider's lack of knowledge of the clinical status of the patient as represented in the medical record reviews. Some offsite consultants, including St. Joseph's Hospital, do not consistently provide a hospital discharge summary. Several records we reviewed had no information about when a patient was sent offsite and this made it impossible to determine the clinical course of care for these patients. In our discussion with the Medical Director, he stated that he asks the patient what transpired at their consultation visit. This is not a reliable method of understanding what the consultant found. Providers must have a consultation report.

For patients going for consultation at UIC, the program must get a patient release of information for the medical consultation report.⁸ This results in a delay of one to three weeks before the consultation report is provided. Since the IDOC providers are required to evaluate the patient within five days of a return from offsite encounters, the providers almost always evaluate the patient without a consultation report. The referral form, which is available, usually has limited comments by the consultant. However, in our review of records, the lack of availability of the consultation report typically meant that the providers were uninformed with respect to the status of the patient. This appeared to create poor continuity of care for patients.

In using the paper records for our record reviews, we noted that many of the records are large documents. When using the record, the plastic binder holding the chart together frequently came apart. This happened repeatedly, and the current Medical Director expressed the same concern. If paper records are to be used, a better system needs to be developed so that the record is a functional and useable document. Records that come apart can result in misplaced or lost documents.

SCC serves as a dialysis facility; however, the dialysis records are maintained separately from the facility medical record. Medical records should be unified. Doctors at SCC are unaware of nephrologist's notes or recommendations or the status of the patient during dialysis because the records are not kept in the medical record.

We found the paper records very difficult to use. It is not possible to evaluate current medication records, as those are not placed in the record until several weeks after they are completed. Because most charts are multiple volumes, key information about patients was often in older volumes. Given the difficulties in using the paper record system, we strongly recommend implementation of an electronic record. We note that in review of mortality records from SCC we could not make a determination whether the death was preventable in three of seven records reviewed because the medical record was missing documents. This demonstrates a very broken system of maintaining medical records.

Intrasystem Transfer

Methodology: To evaluate the medical screening of inmates received at SCC as transfers from other Illinois DOC facilities, we interviewed health care staff, toured the urgent care area where transfer screening takes place, reviewed the IDOC health status form, the SCC Operations Policy and Procedure P-118 Transfer Screening, and health records of inmates received at SCC.

First Court Expert Findings

⁸ Typically, when a physician refers a patient to a consultant, the consultant sends a report to the referring physician. Why this does not occur in IDOC is not understandable. In our past experience, when situations like this arise, a discussion with the hospital administrator and hospital medical director have resulted in obtaining records. We view this problem as a failure of the Wexford leadership in conducting appropriate negotiations with the consultants.

The previous Court Expert found in more than half the charts reviewed that the transfer summary was incomplete or missing, inmates with chronic diseases were not referred for chronic care clinic, and vital signs were not recorded or not followed up when abnormal.

Current Findings

Transfers to SCC most often take place on Wednesday and average less than 50 per month. Inmates received on transfer are brought to urgent care in the health care area for screening before placement in population. The sending facility documents information about the inmate's health status and treatment on the Health Status Summary Record. This form and the medical record is reviewed by a nurse at SCC upon the inmate's arrival. The nurse also inquires if the inmate is currently receiving treatment or has any other immediate need for medical attention. The nurse then schedules the inmate for subsequent health care (i.e., enrollment in a chronic care clinic, initiation of medications, etc.) as needed. The nurse also provides a verbal explanation and handout about how to access health care at the facility.

SCC does not keep a log, list, or other method to track inmates received on transfer. The medical records department had filed the memos which listed the names of inmates to be received on transfer. Using these memos, the charts of all inmates received in January and February 2018 who were still at SCC as of the date of the site visit were reviewed. A sample of 12 records was obtained. Ten of these inmates had health care requirements that needed continuation at SCC. The transfer process was complete in seven of the 10 charts reviewed of inmates with ongoing health care needs. One transfer summary did not list psychotropic medications that were prescribed, but these were identified by the nurse upon review of the chart and continued.⁹ In another, there was no transfer summary for an inmate with diabetes and hypertension. The nurse who reviewed the chart noted his medical history, enrolled him in chronic care and ensured that his medications were continued.¹⁰ In another chart reviewed, an inmate on prescribed psychiatric medications was not scheduled to see a provider urgently and no other attempt was made to continue medication upon his arrival at SCC.¹¹

Transfer screening at SCC has improved since 2014. However, the record review performed at this site visit revealed transfer information that was incomplete, or care that was not continued as prescribed for 30% of the inmates requiring continuity of care. Continuity of care upon transfer needs to be more reliable.

The First Court Appointed Monitor recommended, "The intrasystem transfer process needs to be appropriately addressed to effectively insure continuity of care for patients who enter with prior diagnosed problems. This should be monitored by the QI program."¹² CQI minutes and related material from SCC that were provided from January 2017 through December 2017 were reviewed. There were no reports monitoring the continuity of care after intrasystem transfers.

⁹ Intrasystem Transfer Patient #11.

¹⁰ Intrasystem Transfer Patient #12.

¹¹ Intrasystem Transfer Patient #10.

¹² Lippert Report, p. 38.

We agree with the First Court Appointed Expert's recommendation. SCC has not implemented the recommendation made by the First Court Appointed Expert in 2014. Inmates are at significant risk of discontinuity in their medical care and treatment resulting from incomplete or inaccurate transfer screening. These deficiencies should be addressed in documented corrective action plans and regular follow-up monitoring done until sustained improvement is demonstrated. We have additional recommendations found at the end of this report.

Nursing Sick Call

Methodology: Nursing sick call was evaluated by reviewing SCC Institutional Directive 04.03.103K Offender Health Care Services, SCC Operations Policies and Procedure P 103 Non-Emergency Health Care Requests and Services, IDOC Treatment Protocols, and the SCC Offender Handbook. We also interviewed the Director of Nursing, nurses, and inmates; observed nurses conducting sick call, inspected the rooms used for sick call, and reviewed tracking logs and health records. The completed sick call log showing the reasons patients requested health care attention for the month of February 2018 was used to select charts to review. Seventeen sick call encounters were selected for chart review.¹³

First Court Expert Findings

The First Court Appointed Expert found that sick call was available to inmates only a few days each week based upon their housing location. The rooms used by nursing staff were not equipped appropriately. There were delays in accessing sick call because it was not scheduled frequently enough and, at times, because security staff would not escort inmates to the nurse sick call room. Nurses failed to document the dates that sick call requests were received and triaged. Nurses also did not adequately assess or document evaluation of inmate health complaints. Inmates who were referred from nurse sick call were not seen or not seen timely by providers. Providers failed to follow up at intended intervals and treatment orders were not completed.¹⁴ Two recommendations were made:

1. Custody issues should not interfere with timely provision of health care.
2. There should be no such thing as a "no show." Patients should be required to report to health care when scheduled. They may refuse care but only to a health care professional.¹⁵

Current Findings

Our review found that problems with daily access to sick call have been resolved. Since SCC has implemented the sign-up log, patients are seen the next day. Documentation of timeliness and disposition of sick call requests is evident from review of the sick call logs. The rooms used to perform sick call are now adequately equipped. There was also no evidence of security staff failing to escort inmates to sick call as described in the First Court Expert's report.

¹³ Sick Call Patients #1-17. We selected patients whose requests were potentially serious (chest pain, abdominal pain, seizure, vomiting, skin infection, diabetic complications, withdrawal, etc.).

¹⁴ Lippert Report, pp. 9-12.

¹⁵ Lippert Report, p. 38.

Problems with sick call identified in the First Court Expert's report that are still evidenced include:

- Nurses do not adequately assess or document evaluation of inmate health complaints.
- Inmates who were referred from nurse sick call were not seen or not seen timely by providers. Providers failed to follow up at intended intervals and treatment orders were not completed.

In addition, we had several additional findings:

- LPNs continue to be assigned to conduct sick call even though the stated practice at SCC is to assign RNs.
- Security practices in segregation do not provide sufficient privacy for patients during the sick call encounter.
- Nurses do not refer patients to providers in accordance with IDOC Treatment Protocols and do not document the urgency of the referral (e.g., urgent, routine).

When inmates arrive at SCC they are provided an orientation handout that states, "Inmate patients needing to see healthcare must sign up on the sick call call-out logs located within each housing unit. The day after you sign up, you will be called to the sick call room located within each cell house."¹⁶ This information is consistent with SCC Operations Policies and Procedure P 103 Non-Emergency Health Care Requests and Services.¹⁷ We observed this process in several of the housing units. The log is prominently posted in the cell block. Inmates wanting to be seen write their name on the sick call log. The sick call logs are collected at night or early in the morning.

Inmates may also use the Medical Services Request form to request dental, eye and mental health services that are not urgent.¹⁸ The inmate puts the request into a clearly labeled box mounted on the wall in each housing unit. Any requests in the box are picked up by CMTs daily when they make rounds of the cell blocks. These requests are then forwarded to the respective department (dental, mental health, optical, pharmacy) to address. Inmates may also use the sick call sign up log for dental, mental health, optical, or any other issues, and are seen at nursing sick call the next day.

The morning after the sick call lists are collected, nurses conduct sick call using the lists. Anyone who has signed up on the sick call log is seen by a nurse that day. The medical service requests are routed directly to the relevant department (dental, mental health, etc.) if the request is for a routine service such as an exam, medication refill, or supply item.

16

 Stateville Access to Care Inmate Handout.

¹⁷ SCC Operations Policies and Procedures, pp. 4-5.

¹⁸ STA 0202 (Rev 4/2103).

The day we observed sick call¹⁹ each of the inmates seen had signed up on the sick call log the day before.²⁰ Of the 17 charts we reviewed, all documented sick call encounters with inmates who had signed up on the log the day before.²¹ Five other inmates interviewed during the site visit confirmed that when they signed up for sick call they were seen the next day.²² Inmates appear to be able to access nursing sick call within 24 hours of signing up. None of the inmates interviewed or who agreed to be observed during sick call voiced complaints about the timeliness or responsiveness of nursing sick call.

According to the Director of Nursing, only registered nurses (RNs) are assigned to perform sick call on a regular basis. However, LPNs are assigned to sick call if there are not sufficient RNs available. Review of the daily assignment roster for the week of February 12, 2018 showed that RNs were assigned to sick call six of seven days.²³ According to the Director of Nursing, LPNs were assigned sick call on six days in January 2018 and eight days in February 2018. Of 17 sick call encounters reviewed in the chart review, five were completed by LPNs.²⁴ From these three sources, we conclude that LPNs are relied upon to complete 20 to 30% of sick call encounters. The Illinois scope of practice does not permit LPN's to perform assessments independent of a registered professional nurse or higher level professional, as is currently being done at SCC.²⁵ There are insufficient RN positions at SCC to conduct sick call. LPNs are assigned to do the work in lieu of available RNs but they are not qualified, and this assignment is not within their lawful scope of practice.

Nurses see inmates in a sick call room that has been established in each of the cell houses. The nurse brings the inmate's medical record to use during the sick call encounter. The sick call rooms are well lighted, generally clean, and capable of providing patient privacy. Each has an exam table with paper and a wall mounted oto-ophthalmoscope. See the description of these rooms in the section of this report on Clinic Space and Sanitation. The space, equipment, and supplies available to conduct sick call are adequate.

We observed three nurses (all RNs) as they were conducting sick call on Monday February 26, 2018. A total of five patients were seen, three of these were in segregation.²⁶ Each of the nurses' evaluation of the patients' complaints was thorough and appropriate. Nurses correctly used the IDOC treatment protocols and the plans derived for each patient were appropriate. The nursing assessment was pertinent to the complaint in 11 of the 17 charts reviewed (64% compliance). The plan of care was consistent with sound nursing judgement or that specified in the nursing treatment protocol in 12 of 17 charts reviewed (71% compliance). Based upon the

¹⁹ Monday February 26, 2018.

²⁰ Sick Call Patients #17-22.

²¹ Sick Call Patients #1-17.

²² Sick Call Patients #23-27.

²³

 Stateville RN Staffing for Sick Call.PDF

²⁴ Sick Call Patients #2, 4, 8, 9 & 12.

²⁵ Illinois LPN Scope of Practice, Section 55-30.

²⁶ Sick Call Patients #18-22.

results of the chart review, nursing assessment and planning care could be improved. However, the adequacy of nursing assessments and the plan of care are not monitored by nursing service as part of the peer review or CQI. We recommend that the adequacy of nursing evaluation and planning at sick call be an area of ongoing monitoring, training, and coaching.

The three patients we observed being seen in segregation were provided neither visual nor auditory privacy during the sick call encounter. One, or sometimes two officers, were at the doorway or just inside the room. They interacted with both the nurse and the inmate during the encounter. The officers also interacted with each other and other traffic passing through the corridor. In one case the officer helped the nurse obtain the patient's weight.²⁷ In another encounter, the officer resisted the nurse's request to remove one patient's arm from the shackles to obtain vital signs.²⁸ This was finally accomplished when a more senior officer arrived to assist. It is not possible to assess and evaluate inmate health concerns when custody staff intrude and impede the encounter in these ways. Custody staff should stand at a distance from the sick call room so that they can see the encounter but not hear the substance of the interaction. Custody staff should be prepared and available to remove restraints as requested by the nurse to complete the evaluation of a health complaint.

We were told by the Nursing Director that patients referred to the provider from sick call are to be seen within 72 hours unless it is more urgent. Based upon the charts reviewed, nurses do not document urgency when referring to a provider and there is no area on the nursing treatment protocols to indicate urgency. From observation of the nurses conducting sick call it was clear that they do make this determination, it just is not documented. The sick call documentation forms should be revised to indicate if the referral is emergent, urgent, or routine.

There were only two charts that documented an urgent referral from sick call; only one was seen within 24 hours of the referral. There were 13 sick call encounters that were referred non-urgently to a provider. Of these, only three patients were seen within 72 hours of the referral (23% compliance). Patients were not seen timely because either the appointment was scheduled out longer than 72 hours or the appointment did not take place and was rescheduled for a later date. CQI studies were completed to study timeliness of patients seen by providers when referred from sick call in December 2016, and January, March, and June 2017. Performance on this measure was less than 80% in four of five studies reported in the annual CQI report. The actions taken as a result of these studies was to repeat the study four times and, in June 2017, to educate the nurses on sick call procedures. Clearly, problems accessing providers persist if only 23% of the 13 referrals from sick call encounters in February 2018 were seen within 72 hours.

The following are examples from the chart review of problems found with sick call.

²⁷ Sick Call Patient #22.

²⁸ Sick Call Patient #21.

- The first patient was seen by an LPN in sick call on 2/13/2018 for a complaint of chronic diarrhea.²⁹ The nurse did not document an adequate assessment of the patient or develop a plan of care per the protocol for diarrhea.³⁰ From a review of the chart it was clear that the patient had been discharged from the infirmary 19 days earlier after a month long stay for treatment of salmonella. The nurse did not refer the patient to a provider and should have done so urgently.
- Another patient was seen at sick call on 2/8/2018 because he was experiencing shortness of breath at night.³¹ The nurse did not assess the patient per the treatment protocol for shortness of breath.³² The nurse provided no intervention and did not make a referral to a provider for further evaluation. This is a symptom of potentially serious cardiorespiratory disease that should have been more thoroughly assessed by the nurse. The assessment would likely have prompted a provider referral.
- Another patient was seen in sick call on 2/9/18 for a painful lump in his breast.³³ The nurse's assessment prompted referral to a provider. The provider appointment was scheduled to take place four days later but was subsequently cancelled. The appointment was re-scheduled for 2/26/18 but did not take place. This was a delay in care for evaluation of a potentially serious condition. After reviewing the chart, we asked that he be seen, so an appointment was scheduled for 2/28/18.
- Another patient was seen by an LPN on 2/13/18 for a skin rash.³⁴ The nurse did not assess the patient per the treatment protocol for rash.³⁵ There was no description of the rash nor did the nurse acknowledge that he had been seen previously for the same condition on 1/6/18 and 1/31/18. The nurse did refer the patient to a provider, but he was not seen promptly. An appointment was originally scheduled for 2/15/18 but did not take place until 2/21/18, or until eight days later.
- Another patient was seen in sick call for a complaint of dizziness on 2/15/2018.³⁶ The nurse referred the patient to a provider per the treatment protocol for dizziness.³⁷ The provider appointment was scheduled to take place five days later, on 2/20/18, but he was not seen. It was rescheduled to 3/2/18 or 14 days after the referral. The provider's evaluation of this patient's serious symptom of dizziness was not timely.

²⁹ Sick Call Patient #4.

³⁰ IDOC Nursing Treatment Protocols, (March 2017), p. 39.

³¹ Sick Call Patient #6.

³² IDOC Nursing Treatment Protocols, (March 2017), pp. 75-76.

³³ Sick Call Patient #7.

³⁴ Sick Call Patient #9.

³⁵ IDOC Nursing Treatment Protocols, (March 2017), p. 70.

³⁶ Sick Call Patient #10.

³⁷ IDOC Nursing Treatment Protocols, (March 2017), p. 40.

- Another patient complained of chest pain when seen on sick call 2/15/2018.³⁸ The nurse did not assess for cardiac risk factors per the treatment protocol.³⁹ The patient's blood pressure was elevated, he was overweight, and being treated for hypertension. The nurse did not confer with a provider per the instructions in the treatment protocol but scheduled him for an appointment four days later. This appointment did not take place until 2/22/2018, or seven days later. The provider documented that the patient had not been taking his medication for hypertension. An EKG done at that appointment revealed an abnormal cardiac rhythm. This patient should have been more thoroughly evaluated by the nurse and the provider notified urgently.
- Another patient was seen in sick call on 2/17/18 because of abdominal pain.⁴⁰ He gave a history of GERD and chronic diarrhea. The nurse scheduled the patient to a pre-existing appointment that was to take place 10 days later. It was poor nursing judgement to schedule a patient with this history and symptom presentation to a pre-existing appointment 10 days later.
- Another patient was seen in sick call 2/2/18 for a complaint of chest pain.⁴¹ He was referred to a provider urgently and seen that same day. The provider ordered the patient's blood pressure to be checked twice a day for three days and then he was to be seen by the provider in follow up. None of the six expected blood pressure readings are recorded in the chart. Twice there is documentation that the patient refused to have his blood pressure taken. The other four times there is no documentation that his blood pressure was taken. The patient also was not seen in follow up by the provider. In this case, ordered care was not completed and the patient who was experiencing chest pain was not followed up.

In summary, we concur with the First Court Appointed Expert's recommendation that custody issues should not interfere with timely provision of health care, especially as it pertains to patient privacy in segregation. With the implementation of practices to see all inmates who sign up for sick call the next day, the other recommendation that refusals be seen by health care professionals has been accomplished. We have additional recommendations found at the end of this report.

Chronic Care

Methodology: The medical records of 13 patients with chronic medical illnesses and conditions were reviewed. There was limited opportunity to interview SCC providers due to restrictions imposed by Wexford. The Office of Health Services Chronic Illness Treatment Guidelines dated March 2016 were reviewed as needed.

³⁸ Sick Call Patient #11.

³⁹ IDOC Nursing Treatment Protocols, (March 2017), pp. 30-31.

⁴⁰ Sick Call Patient #13.

⁴¹ Sick Call Patient #17.

First Court Expert Findings

The previous court expert noted that chronic care patients should be scheduled in accord with their degree of disease control, not at the fixed intervals that a specific chronic disease clinic is scheduled. Diabetics' meals should be served on a predictable schedule to facilitate the timely coordination with insulin administration just prior to food consumption; Type 1 diabetics should receive short-acting insulin prior to each meal, not just at breakfast and dinner; HIV patients should also receive primary care provided by SCC providers; and the chronic care nurse should do no less than monthly medication compliance checks with HIV patients.

Current Findings

We agree with the findings in the First Court Expert's report. In addition, we identified additional findings and confirmed some of the First Court Expert's findings as follows:

- Problem lists occasionally are incomplete or inaccurate.
- Patients assigned to chronic care clinics are regularly seen in these disease specific clinic sessions.
- The chronic clinic visits contain very limited clinical information, do not indicate that appropriate examinations had been performed, do not document the rationale for clinical decisions and therapy modifications, do not modify treatment to attain generally accepted treatment goals, and do not document the patient's treatment plan.
- Management of chronic illnesses is not in accord with either the Office of Health Services Chronic Illness Treatment Guidelines or national standards of care.
- SCC fails to provide basic screening tests and vaccines that are recommended for diabetics in the IDOC Diabetes treatment guidelines and in national standards of diabetes care.
- Chronic care visits strictly focus on a single specific disease and do not address any other associated clinical problems. As examples, abnormal blood pressure values were not addressed in diabetic clinic. Elevated blood glucose was not addressed in hypertension clinic. Neither one of these clinics addressed hyperlipidemia. Managing each chronic care disease in a silo independent of the patient's other illnesses contributes to delays in modification or initiation of treatment for patients with multiple chronic illnesses and can contribute to increased morbidity.
- All patients over 50 need to be screened at regular intervals for colon cancer. The frequency of screening is based on patient characteristics and on the type of screening method used. The charts of seven 50 years of age or older patients were reviewed; only one had documentation in their medical record that they had been screened for colon cancer.⁴²

⁴² Screening for Colorectal Cancer, US Preventive Services Task Force Recommendation Statement, JAMA June 21, 2016; Volume 315, Number 23 as found at <https://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/colorectal-cancer-screening2?ds=1&s=colon%20cancer>.

- Nationally recommended vaccinations for adults are not consistently administered. Pneumococcal, meningococcal, and hepatitis A and B vaccinations were not offered or given as recommended by national age and disease-based guideline.⁴³
- Uncontrolled chronic illnesses that appear to be beyond the expertise of the SCC providers are not referred for specialty consultation.
- The chronic care providers do not document any review of the MAR, the capillary blood glucose tests (CBG), and the nursing and provider sick call notes and blood pressure readings when they see patients in the disease-specific chronic care clinics.

Chronic disease visits are conducted separately for each disease. If a person has three diseases, he will be seen in three separate clinics two or three times a year. This dramatically increases the number of visits. SCC has chronic care clinics for asthma (January & July), diabetes (April, August, & December), high risk (March & September), hypertension (March A-L, April M-Z, September A-L, & October M-Z), seizure disorder (February & August), and tuberculosis (January – December). Individuals with Human Immunodeficiency Virus (HIV) are referred to and managed by the UIC Infectious Disease Telehealth Clinic. All other chronic diseases including hepatitis C are managed by the general medicine clinic (May & November). One physician is assigned to staff all the chronic care clinics with backup (vacation, sickness, conference) by the other SCC providers.

The chronic care nurse manually prepares the provider's log-in sheet, noting the reason for the appointment (e.g. asthma clinic, MD sick call, or follow-up, etc.). Medical record staff types and sends this list to all the housing units. This list is used by the correctional officers in the housing units to move men to the health care unit. The chronic care RN hand writes on the list the time in and time out of those seen and those who have to be rescheduled (no show, no provider, refused).

There were 1,700 chronic care visits at SCC in 2015-2016; this number decreased to 1,384 in 2016-2017. There was a drop of 243 hypertension clinic visits. This reason for this drop in total visits was not able to be determined.

In January 2018, the chronic care provider was scheduled for 19 sessions (8 a.m.-2 p.m.); he only was able to staff 17 of these sessions. 400 patients (23.7/session) were scheduled for the month. The 400 patients were not limited to chronic care patients but included provider sick call appointments, add-ons, and 133 asthma chronic care appointments. 282 (71%) of the 400 scheduled patients were actually seen. The provider treated 17 patients per session or approximately 4.7 per hour. Seeing patients every 12 minutes allows limited time for a provider to evaluate chronically ill patients.

⁴³ CDC Recommended Immunization Schedule for Adults 19 years or Older by Medical Conditions or other Indications, 2018 as found at <https://www.cdc.gov/vaccines/schedules/downloads/adult/adult-combined-schedule.pdf>.

A review of the asthma chronic care clinic statistics for January 2018 showed:

Scheduled Visits	133
Patients seen	65 (52%)
Patients Already Seen	4 (3%)
Rescheduled	32 (25%)
Other	31 (22%)

This data indicates that approximately 55% of all asthma patients scheduled in January 2018 were actually seen on the scheduled visit day or had already been recently seen. It was unclear what the reason for the "Other" category was or whether they were also eventually rescheduled. Some may have refused, others may have been transferred or discharged. The chronic care nurse was not interviewed.

The providers' documentation in the medical record was extremely brief, commonly illegible, and seldom contained pertinent clinical information needed to clarify and understand the state of a patient's chronic illness or justify a change in the treatment plan. The experts found it extremely difficult to track the status of a patient's chronic illness and to comprehend the reasons for a modification of treatment. This lack of clinical documentation is a significant barrier to the continuity and quality of care delivered to the SCC patient population. The experts found no documentation that the chronic care providers had reviewed the MAR (refusals, compliance with prescribed medications), the CBG tests, the nurse and provider sick call notes, and the blood pressure readings taken in the sick call visits when they assessed patients in the disease specific chronic care clinic visits. This failure to review the data and information that had been gathered between chronic care visits contributed to flawed clinical decisions and delays in providing needed care to SCC patient-inmates.

Most of the chronic care patients had completed problem lists. However, four (31%) of the 13 charts reviewed were found to be missing important diagnoses on the problem, list including hypertension, hepatitis C, amputated thumb post human bite, and diabetic foot ulcer. Incomplete problem lists contribute to the failure to adequately monitor and treatment known chronic illnesses.

The care provided to diabetics and patients on chronic anticoagulation, hypertensives, asthma medications, and anti-epileptics was problematic. Diabetics, hypertensives, and patients on warfarin anticoagulation remain uncontrolled for lengthy periods of time, in part because their treatment may only be evaluated in chronic care clinics (two to three times per year) and not as frequently as their condition justifies. Diabetics are not routinely screened for urinary protein and even if they are found to have elevated urine protein, the appropriate medical intervention is not consistently prescribed. Detailed foot and lower extremity sensory exams are not documented in the diabetes chronic care notes. Recommended vaccines are not universally provided to patients whose age or disease warrants such vaccination. Compliance with prescribed medication is important for all chronic illnesses, but the impact of not taking or receiving diabetic, hypertension, anticoagulation, and seizure medications can result in rapid

deterioration and morbidity. There was no documentation in the chronic care provider notes that they were reviewing the MARs or nursing notes to assess compliance with medication and initiating appropriate interventions as needed.

All 13 (100%) of the patient records had problems identified in the provision of care. The following patient summaries highlight the concerns and the findings noted above:

- This is a 42-year-old patient with a problem list noting asthma who was being treated with Xopenex inhaler (beta-agonist), Singulair (Montelukast), and a Medrol Pack (methylprednisolone tabs).⁴⁴ He was transferred to SCC from Menard Correctional Center on 6/24/17. His database noted that he had received the pneumococcal-23 vaccine on 5/28/12. His asthma was not evaluated upon arrival at SCC. The RN incorrectly noted that he was taking Albuterol, did not check a PEFr, and referred the patient to the asthma chronic care clinic. Two months later, on 8/24/17, he was seen in the asthma clinic; his PEFr was 500 L/min, he was assessed as stable, and was referred to a January 2018 asthma clinic. Patient was seen again in the asthma clinic on 1/22/18, and his PEFr was 450-500. Although he had a normal exam and his asthma was controlled, the provider noted that he had bronchitis and ordered an oral antibiotic (amoxicillin). At neither asthma clinic visit did the provider note how frequently the patient was using his relief inhaler, or if was waking up at night with cough or whether the patient still had the pack of methylprednisolone that could be immediately taken by the patient in the case of an acute asthma attack. This patient is very stable, and he likely could be taken off Montelukast. At each asthma clinic the provider should be taking a more detailed history concerning any symptoms of bronchospasm and use of inhaler consistent with generally accepted asthma standards of care. The use of antibiotics to treat bronchitis in a stable asthmatic is against the national standard of care and was not indicated in this patient.⁴⁵ In summary, the failure to document an adequate history of inhaler use and symptoms indicative of bronchospasm was not in compliance with the Office of Health Services Chronic Disease Treatment Guidelines, Asthma.
- Another patient was a 62-year-old patient whose problem list noted insulin resistant diabetes mellitus (IRDM), hypertension, hyperlipidemia, and aortic arteriosclerosis.⁴⁶ His hepatitis C disease was not documented in the problem list. His database noted that he had received the pneumococcal 23 vaccine on 5/23/16 and hepatitis A and B #1 vaccines on 3/26/16. There is no documentation that he received, as required, hepatitis A vaccine #2 or hepatitis B vaccines #2 and #3. During the last 11 months of 2017, he was seen in hypertension clinic two times, in diabetes clinic three times, and semi-annual clinic two times. He also was seen by the optometrist two times. Many of the medical

⁴⁴ Office of Health Services, Chronic Illness Treatment Guidelines, Asthma, March 2016.

⁴⁵ Chronic Care Patient #1.

⁴⁶ Chronic Care Patient #2.

provider notes were barely legible. The diabetes and hypertension chronic care notes contained little clinical information and no rationale for modifying or not changing treatment. Between February and December 2017, HbA1Cs were done monthly (in chronological order) 8.7%, 7.9%, 7.8%, 7.8%, 8.1%, 8.2%, 8.2%, 8.2%; none reflected that his diabetes was under control. NPH insulin was increased to 35UAM/20UPM (4/18/17 DM clinic) and again, eight months later at the next DM clinic to 50UAM/25U/PM (12/4/17 DM clinic). If there were any additional modifications in the insulin dosage it was not documented in the provider notes. Ten HbA1Cs were performed in 2017. The national diabetic standards state the HbA1Cs should be tested every three to four months; more frequent testing offers no valid clinical information to the care of diabetes. The providers are not knowledgeable about the recommended frequency of HbA1C testing and the value of this important diabetes test. There was no documentation that this diabetic had a single foot or sensory neuropathy exam in 2017; this does not meet the standard of diabetes care. Simvastatin 10mg was not increased even though this hypertensive, diabetic, elderly male had a >20% 10-year risk of having heart disease or stroke and should have been taking a high intensity statin drug per national standards of care.⁴⁷ The SCC providers are not able to calculate this risk because they are not allowed to bring in cell phones and do not have access to electronic references. The statin dose was inadequate for this patient's level of cardiovascular risk. This patient was given a diagnosis of hepatitis C, yet there were no tests done to support this diagnosis. This patient's hepatitis C was not being monitored in accord with national standards. At the two semi-annual clinic visits (6/5/17 and 12/19/17), the patient's hepatitis C was evaluated; no organomegaly, edema, or icterus were identified, and the elevated liver enzyme data were documented in the notes. However, the plan was only to return to clinic in six months; there was no estimate of fibrosis using laboratory tests and no order to do a liver ultrasound or a liver fibroscan to evaluate the stage of fibrosis in order to determine if the patient was a candidate for hepatitis C treatment. Episodes of difficulty breathing, propping his head up in bed to breath, waking up suffocating in October-November 2017, were not being adequately evaluated as of the end of January 2018. The initial provider assessment was sleep apnea, but no additional diagnoses (congestive heart failure (CHF), cardiac arrhythmia, COPD, asthma, coronary artery disease) were considered. There was no documented examination of the patient's heart or lungs and no additional tests were ordered (e.g., chest x-ray, echocardiography, CBC, BMP, EKG, pulmonary function test, sleep studies) to evaluate these repeated symptoms of difficulty breathing. This patient was over 50 years old, but he was not offered a colon cancer screening test during 2017 even though he had two semi-annual clinic visits.

In summary, this patient is not being properly monitored for complications of diabetes, including foot ulcers and sensory neuropathy. HbA1Cs are being ordered at an unjustifiably high frequency, indicating that the providers are not knowledgeable about the utilization of this important diabetic test. His diabetes has not been fully controlled

⁴⁷ ACC/AHA ASCVD Risk Calculator.

for over a year. His hepatitis C has not been assessed to determine the presence of liver fibrosis (cirrhosis) that would determine if he is a candidate for treatment. He is not being prescribed the proper dosage of a statin that is warranted by his 10-year risk of cardiovascular disease. The providers are not assessing 10-year cardiovascular risk in elderly patients with diabetes, hypertension, and hyperlipidemia. He was prescribed an antibiotic for the treatment of bronchitis. He has not been properly evaluated for his recurrent episodes of difficulty breathing. He is not being screened for colon cancer. The care provided to this patient is not in accord with national standards of care.

- Another patient is a 65-year-old with diabetes mellitus (DM), hypertension, and hyperlipidemia noted on his problem list.⁴⁸ The database noted that he had received pneumococcal 23 vaccine on 7/23/16 and had negative PPD on 12/10/16. His medications included NPH insulin 24U/10U, sliding scale regular insulin, Metformin 500mg/d, Lasix 40mg/d, Lisinopril, Simvastatin 40mg/d, Nifedipine 30mg/d, and ASA. He was seen every six months in the diabetes and hypertension clinics. He was seen at UIC Eye Clinic in July 2017 and did not have diabetic retinopathy. His blood pressure was generally at goal. Multiple HbA1Cs between August 2016 and November 2017 indicated excellent control, with all HbA1Cs under 6.0%. However, the CBG logs from October 2017 through January 2018 documented elevated glucose levels that were not consistent with the control indicated by the HbA1Cs; this important clinical discrepancy was not discussed at any of the diabetes clinics. This indicates that the diabetes chronic care providers are not regularly, if at all, reviewing the CBG tests or the MARs during the clinic sessions. Labs done on 3/21/17 reported a microalbumin/creatinine level of 60mg/L (normal range 0-30), but sick call and diabetes clinic providers did not comment on this abnormality and did not order, as is indicated for all diabetics, an ACE inhibitor to prevent further kidney damage. There was no documentation of a detailed foot or distal extremity sensory exam in any of the diabetes clinic notes.

In summary, there are significant deficiencies (no detailed foot or sensory exam, failure to initiate an ACE inhibitor for proteinuria, no endocrine consultation to evaluate the discrepancy between the HbA1Cs and the finger stick blood glucoses⁴⁹) in the care and screening of this elderly diabetic patient which do meet the ADA standard of care. This 65-year-old was not offered colon cancer screening during 2016-2017; this is not in accord with national age-based standards of care.

- This patient is a 69-year-old whose problem list noted hypertension and hyperlipidemia.⁵⁰ His database noted PPD positive 37mm since 2007, and did not note the administration of a pneumococcal vaccine in Volume II. His medications included Lisinopril, Nifedipine, spironolactone, metoprolol, and pravastatin. This patient had

⁴⁸ Chronic Care Patient #3.

⁴⁹ The HbA1C test used at SCC is a point of care test (iSTAT). When there is a question of accuracy of test results, a comparison of a same blood sample should be done at a known reliable laboratory comparing that test result with the iSTAT result. The iSTAT equipment typically needs regular calibration and this may have been not properly done.

⁵⁰ Chronic Care Patient #4.

been treated in the past for a positive TB test. He had negative chest x-rays in 2016 and 2017. He is followed in the hypertension clinic, with two visits in 2017. The patient is taking four antihypertensive medications, none of which were at maximum doses. Two of his blood pressure medications retain potassium. It would be safer for this patient if his diuretic was switched to one that did not have the risk of retaining potassium. There was no comment in the provider notes that there was a clinical reason that spironolactone was being prescribed. This hypertensive patient had markedly elevated blood pressure readings at every provider sick call visit (five visits), but perfectly normal blood pressures at the two hypertension clinics. At the 4/4/17 doctor sick call, the provider noted a blood pressure 192/107 but did not comment on the markedly elevated blood pressure and did not modify the blood pressure medication. The hypertension clinic providers made no comment about the elevated blood pressures at the sick call visits, did not document that they reviewed the blood pressures from other visits, or were even knowledgeable of these elevated blood pressures. This 69-year-old had no documentation in his record that he had been screened for colon cancer or had received the pneumococcal 23 vaccine.

In summary, the experts are concerned that chronic care providers do not review the findings or vital signs from other non-chronic care visits. The failure to utilize important clinical information or data from other visits puts the health of patients with chronic illnesses at risk. National age-based standards recommend that patients over 50 years receive colon cancer screening and those over 65 years old be administered both pneumococcal vaccines (13 and 23); there is no evidence that either of these screening and preventive measures were offered to him. The experts are concerned that prescribing of four antihypertensive medications with none at maximal dosage is putting this individual at risk and is not in accord with national standards of care.

- Another patient is 47-year-old whose problem list noted asthma, hypertension, and bilateral knee pain.⁵¹ His database indicated that he received the pneumococcal vaccine on 1/17/16 and a flu shot on 11/30/17. His current medications include Xopenex inhaler, Alvesco 160mg I puff BID, Montelukast 10mg/d, and hydrochlorothiazide 50mg/d. From January 2016 through January 2018 he was seen four times in the asthma clinic, four times in hypertension clinic, and three times in the general medicine clinic. His PEFs recorded in the asthma clinic were 500 on 1/9/17 and 825 on 7/1/17 and 1/26/18, all reflecting excellent control. At some point Montelukast was properly discontinued. The provider notes did not note any symptoms or any justification for the continuation of the steroid inhaler (Alvesco). The patient had eight normal blood pressure recordings from January 2017 to January 2018. He is taking hydrochlorothiazide 50mg/day. Hydrochlorothiazide 50mg has been known for years not to offer greater blood pressure control benefit than 25mg but has some greater risk for dehydration and hypokalemia. He should be given the lower dosage of hydrochlorothiazide. He had increased frequency of urination in June 2017 that was

⁵¹ Chronic Care Patient #5.

clinically suspected to be benign prostatic hypertrophy (BPH), and he was placed on Flomax. The higher dose of the hydrochlorothiazide diuretic may have been contributing to his symptoms and, if decreased, might allow Flomax to be discontinued.

In summary, this patient has been regularly seen in three chronic care clinics. His asthma and hypertension are under good control and he should be monitored to see if any of his asthma medications can be decreased or discontinued. The providers should decrease the blood pressure medication to 25mg for the safety of the patient. The continued prescribing of hydrochlorothiazide 50mg has not been recommended for treatment of blood pressure in the last 15-20 years.

- Another patient is a 36-year-old whose problem list noted seizure disorder.⁵² His database was empty. His medication was phenytoin (Dilantin). He was seen in the seizure chronic care clinic five times from February 2016 through February 2018. The patient had a seizure reported on 1/30/16. At the 2/2/16 seizure clinic he was noted to not have his seizure medications Keep-on-Person (KOP). On 4/26/16, he was reported to have had another seizure; the physician wrote that the patient's history was not consistent with a seizure disorder and Dilantin was ordered to be tapered off. Another seizure in his bed was noted by the RN on 7/17/16. On 7/29/16, the MD wrote "doubt seizure;" again the Dilantin level was sub-therapeutic (2.5). The 8/9/16 seizure clinic provider noted that the patient had seizures while sleeping and that the 7/29/16 Dilantin level was 2.5, but did not increase the dosage. The 2/7/17 seizure clinic wrongly stated that the patient's last seizure was on 1/6/16. A repeat Dilantin level was again sub-therapeutic (2.5) and Dilantin dose was increased to 300mg/d. The Dilantin level was again low (<2.5) on 2/23/17. Nursing noted on 3/17/17 that the patient was non-compliant with taking his seizure medications; there were three unused blister packs in his cell. The RN wrote on 4/2/17 that she had the patient take his AM dose in front of her and she recommended Watch-Take medications. Again on 5/18/17, the nurse stated that the patient was not compliant with taking his antiepileptic medication. There were no MD visits for the next two and a half months. The patient missed seizure clinic on 8/1/17 due to a security lockdown. He was seen in the seizure clinic on 8/12/17; the provider did not comment on the repeated nursing concerns of non-compliance and continued KOP Dilantin. A Dilantin level on 8/22/17 was for the fifth time in 20 months sub-therapeutic (<2.5). At 8/24/17 physician sick call, it was noted that the patient had another seizure "last night," and Dilantin was finally changed to Watch-Take medication administration; however, a loading dose was not given. This switch to Watch-Take occurred over four months after nurses had documented his non-compliance with his seizure medications. A repeat Dilantin level was 3.1, still sub-therapeutic, on 9/5/17. The 9/15/17 physician note was not legible. He was seen again in seizure clinic on 2/2/18. The provider again erroneously noted that "no seizures since January 2016," did not comment on the recent sub-therapeutic level, but continued the Watch Take. This provider clearly did not review the previous physician and nursing notes nor the recent

⁵² Chronic Care Patient #6.

drug level; the Dilantin dose should have been increased or a new medication prescribed.

In summary, this epileptic patient with uncontrolled seizures and multiple repeat sub-therapeutic Dilantin levels was not being adequately treated. Physicians initially doubted that he was having seizures, then failed to expeditiously switch him from KOP to Watch-Take administration after repeated nursing notes documented non-compliance with his KOP medications. The four-month delay in changing the mode of medication administration jeopardized this patient's health. Even after Watch-Take medications were finally initiated, the drug level was not therapeutic, but no clinical action was taken (increased dose or new medication); this was not acceptable care. No repeat Dilantin levels have been tested since the last sub-therapeutic level five months ago. This patient with an unstable seizure disorder will not be followed up until August 2018. This is not acceptable and does not meet the community standard of care.

- Another patient had a problem list noting asthma, Crohn's disease, and hypertension.⁵³ The database noted a negative PPD on 8/20/17. His medications included hydrochlorothiazide 25mg/d, verapamil 180mg 2 tabs/d, and Delzicol (mesalamine equivalent) 400mg 2 tabs TID. He was seen in the hypertension clinic on 3/20/17 and 9/14/17; his blood pressures in the chronic care clinic and in a number of physician sick calls were well controlled. He was evaluated twice (5/16/17 and 11/21/17) in general medicine chronic care for his Crohn's Disease. The provider stated at both visits that the Crohn's disease was "stable." Labs performed four times during the last 12 months were normal. At the 8/10/17 provider sick call, the patient stated that he not received his Delzicol (Crohn's medication) for a month, he was passing blood in his stool, and his abdomen was benign. The assessment was acute flare-up of Crohn's due to no medications. The pharmacy was contacted, and the medications restarted. Patient was seen again in the provider sick call on 10/31/17, complaining of blood in bowel movement two times; a rectal exam was negative, CBC and FOBT was ordered. A physician note on 12/19/17 was illegible. A referral to GI was approved on 12/27/17, although there was no documentation in any notes that the patient was referred to GI. At physician sick call on 1/9/18, patient again reported that he had occasional blood in his stool and had occasional diarrhea. His abdomen was soft. The GI appointment had been scheduled for 3/8/18. Review of the MAR verified that the patient received his KOP supply of Delzicol in June 2017 and August 2017-January 2018, but not in the month of July 2017.

In summary, the failure to deliver his Crohn's medications in July 2017 triggered a flare-up of his disease which persisted intermittently for the next six months. The presence of blood in the stool can be caused by his inflammatory bowel disease and by other conditions, including cancer of the colon. The patient reported passing blood on 8/10/17, 10/31/17, and 1/9/18. Even though he is at high risk for colon cancer, he was

⁵³ Chronic Care Patient #7.

not scheduled to see GI until seven months after his first reported episode and five months after the second visit for blood in stool. This is an unacceptably long delay and does not meet the community standard of care. He was noted in November 2017 chronic clinic as having “stable” Crohn’s disease even though he had had a recent exacerbation in August 2017.

- Another patient is a 51-year-old whose problem list included seizure disorder, hepatitis C, hyperlipidemia, and bipolar disorder.⁵⁴ His medications are Procardia (nifedipine) and Lopressor (metoprolol), both medications for hypertension, which is not on the problem list, and Keppra (levetiracetam) 250/d. He is followed in the hypertension and seizure chronic care clinics. He was seen in the seizure clinic four times and in the hypertension clinic two times in the last 13 months. His blood pressure is generally well controlled. His seizures were assessed as stable in 2017, but at his 2/21/18 seizure clinic it was noted that he had a seizure three weeks prior to the visit. There was no comment on the type of seizure or whether the patient was taking his seizure medications. The patient is being administered his seizure medications as Watch-Take. In September-November 2017 and January 2018, the MARs documented that he received 100% of his doses, but from December 17-30, 2017, he was documented as having received only four of the expected 14 doses. This was not commented on during his 2/21/18 seizure clinic visit, but may have been the reason that he had a seizure near the end of January 2018. By just reading the medical record it was very difficult to identify whether the patient had hepatitis C infection, had been treated for hepatitis C, or whether the disease was active. He was not being followed in the general medicine clinic or in sick call for his history of hepatitis C. The patient was interviewed, and he verified that he had been successfully treated in 2006 with Interferon/Ribavirin while in IDOC. Lab tests showed normal liver enzymes/liver studies but a low normal platelet count (125) was reported on 7/17/17. An abdominal ultrasound exam to screen for hepatosplenomegaly, liver fibrosis, and HCC was not performed in 2017. Patients with hepatitis C, especially those with cirrhosis, which can cause low platelet counts, are at increased risk for hepatocellular carcinoma. He was not being regularly screened with liver ultrasounds.

In summary, the problem list for this patient was incomplete, not noting the presence of hypertension nor indicating that hepatitis C had been successfully treated. This placed the patient at risk for disruption of his care and inadequate follow-up of these conditions. It was very difficult to verify the patient’s history of hepatitis C, his previous treatment, and his current status. The patient should have a liver ultrasound performed to clarify the degree of liver fibrosis and to help determine whether he needs to be regularly screened for HCC. The medical record does not address why the MAR indicates that seizure medications were not consistently administered in December 2017 and whether this contributed to a seizure that occurred in late January 2018.

⁵⁴ Chronic Care Patient #8.

- Another patient is a 55-year-old whose problem list noted hepatitis C post-successful treatment, hepatosplenomegaly, low platelets, BPH, and kidney stones.⁵⁵ His medications included lactulose, finasteride, Tamsulosin, and betablocker. He was successfully treated (Harvoni) for hepatitis C at UIC Hepatology Clinic in 2014-2015. Between October and December 2017, he had an abdominal US, colonoscopy and esophagoscopy performed at UIC which did not identify liver masses/HCC, removed four colon polyps (repeat colonoscopy in 10 years), and found small esophageal varices for which a beta blocker medication was ordered. The liver ultrasound was repeated in January 2018 and showed no masses. Multiple lab tests in 2016-2017 showed low platelets, normal liver enzymes, normal INR, and intermittent mild elevations of total bilirubin. He has received hepatitis A and B vaccines but there is no documentation in the medical record that he has been administered/offered pneumococcal vaccinations. There are no notes by the providers at SCC concerning his cirrhosis and portal hypertension. The patient is not being followed in the SCC chronic care clinic. There are no notes about his mental and cognitive status even though he is taking lactulose for the treatment of hepatic encephalopathy.

In summary, this patient was successfully treated while in IDOC for hepatitis C. He also has advanced cirrhosis. He is being followed by the Hepatology Service at UIC. It is not in the best interest of the patient or the institution that this patient is not jointly monitored in the chronic care clinic for his cirrhosis. SCC's clinical team must be continually aware of this patient's baseline status so that they can expeditiously and appropriately respond to any deterioration in his condition.

- Another patient is a 52-year-old whose problem list notes HIV infection and s/p GSW groin in 1986 with blood transfusions.⁵⁶ His database shows negative PPDs from 2010 to 2017. His medications include KOP Genvoya. There is no documentation that he has been administered pneumococcal or meningococcal vaccinations or had been screened for colon cancer. He has been seen twice by the UIC HIV telehealth specialists; the UIC ID specialist's notes are in the SCC medical record. On 3/20/17, UIC discontinued Atripla and started Genvoya, and his VL was undetectable on 2/6/17. Repeat labs on 4/15/17 (VL undetectable, CD4 851), 5/4/17 (Cholesterol 153, Hct 39.9), and 6/12/17 (VL undetectable, CD4 670) were good. The UIC HIV specialists assessed his HIV to be in good control on 6/22/17. Repeat labs on 10/3/17 (VL undetectable, CD4 687) again reflected good control. This patient is being regularly managed by the UIC telehealth HIV specialists; his HIV is under good control. There are no notes by the SCC providers about his HIV status or in regards to any of his age-based routine health maintenance needs.

In summary, this 52-year-old should have been screened for colon cancer, should have documentation that pneumococcal and meningococcal vaccines had been provided, and should have been considered for a statin for prevention of cardiovascular disease. None

⁵⁵ Chronic Care Patient #9.

⁵⁶ Chronic Care Patient #10.

of these indicated interventions or screening have been done and all of these screening and preventive measures are the responsibility of the SCC primary care medical team. He has been at SCC for at least 11 months and he has not had an annual visit or a chronic care visit. SCC must continue to provide the routine health maintenance needs of all patients, even those with a condition that is closely monitored by offsite specialists.

- Another patient is 42-year-old whose problem list noted hypertension, seizure disorder, hyperlipidemia, and HIV infection.⁵⁷ His medications include Dulera (mometasone/formoterol) inhaler, Albuterol inhaler, hydrochlorothiazide, Lisinopril 20mg/d, Genvoya, gabapentin, Keppra, atorvastatin, and ASA. He was seen in the hypertension clinic one time, hypertension/seizure clinic one time, HIV Telehealth one time, diabetes clinic one time, diabetes/seizure clinic one time, and asthma clinic one time (refused one time) in 2017. His blood pressure is well controlled on his current regimen. He had two HbA1Cs (6.1 and 6.6), consistent with pre-diabetes on the first test and consistent with diabetes on the second test which was unrecognized. His glucoses ranged between 89 and 132 in 2017. The diabetes care provider encouraged lifestyle modifications to treat presumed pre-diabetes but failed to address the 2nd test which was diagnostic of diabetes. His last seizure was reportedly in early 2017, with no further seizures as of January 2018. He was assessed by the UIC HIV Telehealth Infectious Disease specialists on 6/22/17; his VL was undetectable and CD4 617. Repeat VL undetectable, CD4 624 on 10/3/17. His HIV is well controlled on Genvoya. In January 2018, the Genvoya was switched from DOT/Watch-Take to KOP, but the nursing staff continued to give daily doses for the rest of January, even though the patient had received a KOP supply of 30 tabs on 1/18/18. This created a potential risk for the patient of double dosing. It is unclear why the DOT order in the MAR was not discontinued. At the 7/1/17 asthma clinic, his PEFr was 325, and the patient refused to attend the 2/6/18 asthma session.

In summary, this patient's multiple chronic conditions were managed in silos of five separate chronic care or specialty clinics. This division of care has the potential of disrupting this patient's continuity and comprehensiveness of care. Excluding the UIC HIV Telehealth Clinic, the chronic care notes are extremely brief and provide very limited information on the patient's status or ongoing health care plan. There is no documentation anywhere in the asthma, diabetes, or HIV clinics that he had received or been offered the indicated pneumococcal or meningococcal vaccines. Any one of these three clinics could have provided the vaccine(s), but none of them did. There is no comment or rationale for the prescribing of gabapentin in this patient. There was no mention of peripheral neuropathy or nerve pain in the any of the provider notes. The seizure clinic also did not contain any documentation that gabapentin was being used as an epileptic medication in combination with Keppra. Gabapentin is not a benign medication; the provider notes should clarify why this medication is being prescribed.

⁵⁷ Chronic Care Patient #11.

The patient appeared to have an A1c test diagnostic of diabetes which appeared unrecognized.

- Another patient is a 46-year-old whose problem list noted deep vein thrombosis (DVT) secondary to GSW right leg (early 1990s) and hyperlipidemia. His database noted negative PPD on 3/9/17.⁵⁸ His medications include warfarin and Zocor (simvastatin). He was followed in the chronic care clinic (5/1/17, 11/3/17) in 2017. From 12/20/16 through 2/22/18, 12 INRs were performed to assess the level of anticoagulation; only one (11/8/17, 2.3) was in the therapeutic range. The providers did incrementally increase the warfarin dose from 7.5mg/d to 10mg/d over these 15 months. The latest increase was ordered on 10/1/17, but INRs have continued to be sub-therapeutic in December 2017 and January-February 2018. The MARs revealed 100% patient compliance with warfarin doses from November 2017 through January 2018. In summary, the level of anticoagulation for this patient is suboptimal. The frequency of INR testing and warfarin adjustment should have been accelerated. This patient is at risk for another DVT or thromboembolism. The providers at SCC do not seem to understand the urgency of achieving therapeutic levels of anticoagulation using warfarin. In this clinical environment, the use of newer anticoagulants that do not require INR testing and dose adjustments should be strongly considered. Also, DVT is typically treated for three months. This patient was being treated for over a year. While selected patients require long-term treatment, the rationale for long-term treatment needs to be documented in the record. If the patient was being treated unnecessarily, it places him at significant risk due to the potential adverse effects of warfarin.
- Another patient is a 62-year-old whose problem list noted diabetes and hepatitis C.⁵⁹ His database documented pneumococcal 23 vaccination in 2003 and 2011, and hepatitis A and B vaccinations in 2013. His medications include insulin 70/30, metformin 500mg/d, and gabapentin. He was seen in the diabetes clinic seven times and the hepatitis C clinic three times from 12/13/15 and 12/12/17. Over the last two and a half years, this patient's diabetes was never under optimal control, his HbA1C ranged from 7.7-8.7 with a minimum goal of less than 7.0, as in IDOC DM guidelines. His 70/30 insulin has remained at 50U/AM and 30U/PM for a number of months; it was unclear from the notes why and when the insulin dose was decreased from 65U/30U to 58U/30U to 50U/30U. He also takes metformin 500mg/d and on 1/8/18, glipizide 5mg/d was added to his regimen. Urine testing has demonstrated macroproteinuria since 2008 and high microalbumin/creatinine level (1017 mg), yet there is no evidence in the medical record that this patient had been prescribed an ACE inhibitor to minimize the risk of further kidney damage. This diabetic's cardiovascular 10-year risk was 20.2% but he has no documentation in the chart that he is taking a statin medication to decrease his risk of MI or CVA. His blood pressures have never been at goal of <140/90 as required in IDOC guidelines, yet it appears that he is not taking anti-hypertensive medications. There is

⁵⁸ Chronic Care Patient #12.

⁵⁹ Chronic Care Patient #13.

no comment in the chronic care clinic notes that the patient is taking an ACE inhibitor, a statin, or a hypertensive medication. This patient's diabetes is being poorly managed. The rationale for decreasing the insulin dosages was not documented in the progress notes of diabetes clinic. Elevated liver enzymes have been noted at three of the four hepatitis clinic visits. UIC did a liver fibroscan that revealed Stage 4 (advanced cirrhosis) on 11/15/17. A hepatitis C RNA test on 5/31/17 was elevated to 2,775,804. It has been determined that this patient is a candidate for hepatitis C treatment and a referral has been recently made (2/6/18) to Wexford's Dr. Paul for review and approval to treat.

In summary, this patient's diabetes has never been controlled. The treatment plan is unclear from the brief chronic care notes. This patient warrants a referral to endocrinology to establish a plan to optimize the diabetes treatment. It is inexplicable why this at-risk diabetic is not prescribed an ACE inhibitor, a HMG-CoA reductase inhibitor (statin), and a hypertensive medication. This 62-year-old patient should be screened for colon cancer and should have received a pneumococcal 23 vaccine, but there is no documentation in the medical record that these screening and preventive interventions have been done. We also note that referral for treatment for hepatitis C occurred when this patient already had cirrhosis or late-stage disease. This means that this patient will endure long-term risk of cirrhosis, including hepatocellular carcinoma, when earlier treatment may have avoided this complication.

Urgent/Emergent Care

Methodology: We interviewed the Director of Nursing, toured the medical clinic, assessed the availability and functionality of emergency equipment and supplies, reviewed emergency drills, CQI reports, and medical records. Medical records were selected from the list of emergency department (ED) visits in 2017 provided by SCC. This list includes the reason for the ED visit. Records selected for review were those conditions sensitive to ambulatory care, such as seizure, withdrawal, infection, diabetic complications, abdominal pain, chest pain, etc. A total of eight records were reviewed.

First Court Expert Findings

ER reports were absent in all the medical records reviewed and the care of patients was found to be problematic before the ED visit and after the patient's return to SCC. The First Court Appointed Expert recommended the QI program monitor and report results on the timeliness, appropriateness, and continuity of care of patients sent to the ED.

Current Findings

SCC provides basic CPR and first aid. Emergency response equipment consists of first responder bags that contain first aid supplies, stethoscope, blood pressure cuff, cervical splint, and a few medications (i.e., glucagon). There are also two large duffel bags that are considered disaster bags. These contain larger quantities of supplies and equipment needed to respond to multiple injuries. The basic first responder bags and the disaster bags are not locked and there is no list

of contents and their location as required by SCC Operations Policies and Procedure.⁶⁰ An automatic external defibrillator (AED), ambu bag, portable oxygen, EKG machine, suction, nebulizer, and oto-ophthalmoscopes are available in the urgent care room in the clinic at SCC. The presence and functionality of the first aid equipment is checked daily by the night shift and documented on a log. We checked the AED and oxygen tanks and found both to be functional. First aid kits are in the offices on each of the cell blocks. These are not regularly inspected and re-supplied as required by SCC Institutional Directive.⁶¹ Two kits were inspected; the seal was broken on both and there were no gauze or bandages in the kit.

Training records are maintained and nearly all health care staff are current in CPR. The few who are not current are noted on the record; these are staff on leave. SCC's Institutional Directive and Operations Policy and Procedure require that emergency drills be conducted twice a year on each shift. One of these is to be a mass casualty drill involving multiple people with injuries. The annual CQI report for 2016-17 lists the drills that have taken place. Based upon this list, SCC did not comply with either directive. Only one drill was conducted on the 7 a.m. to 3 p.m. shift, and only one mass casualty drill was completed rather than one on each shift. Also, the description of the mass casualty drill conducted on the night shift 8/23/2017 only involved one injured person, so does not meet the definition of a mass casualty drill. The written critiques of these drills are very brief.

We reviewed the medical record of eight patients sent to the emergency department (ED) in 2017 and found that ED visits were often preventable, information and recommendations from the ED were not obtained, or if it was, not incorporated into the patient's subsequent treatment plan. These findings are detailed in the following paragraphs.

- The first patient has a history of uncontrolled hypertension and end stage renal disease.⁶² Documentation of the reason for sending the patient to the hospital emergently on 7/8/17 is very brief - shortness of breath and fluid overload. He was discharged three days later. There is no note summarizing the findings or treatment recommendations from the hospital. No records from the treating hospital were obtained. He was not seen in chronic care clinic following the hospitalization until November. This hospitalization was likely preventable if his chronic disease had been monitored and managed more often than every three to four months. There was no effort to review records from the hospitalization and incorporate this information into the treatment plan.
- The next patient was sent to the ED on 9/18/17 for severe facial swelling and confusion resulting from an assault.⁶³ His problem list includes quadruple coronary bypass, hypertension, and prostatic hypertrophy. The initial response to the facial injury was timely and appropriate. The ED took x-rays and diagnosed a zygomatic fracture and

⁶⁰ P112 Emergency Services, June 2017, p. 20.

⁶¹ 04.03.108 K3 Response to Medical Emergencies May 1, 2016.

⁶² Urgent/Emergent Patient #1.

⁶³ Urgent/Emergent Patient #2.

recommended tramadol for three days, twice a day for pain, and referral to an eye specialist. Upon return to SCC the provider made the referral to an eye specialist, but did not order the pain medication or document a rationale for deviating from the recommendation.

- The next patient was hospitalized emergently on 4/4/17 for abdominal pain, blood in stool and weight loss.⁶⁴ He is a 66-year-old and has diagnoses of hypertension, chronic obstructive pulmonary disease, GERD, and prostatic hypertrophy. He complained of black stool on 4/2/2017 and a sample was positive for blood. On 4/3/17, he was seen by a provider for skin breakdown on his right hip. The provider did not address the problem of blood in his stool. The provider noted that he should be scheduled for a follow-up appointment in one week for results of biopsies from a GI consult at UIC. No follow up appointment was scheduled. His care before the hospitalization and afterwards is episodic. The outbound note from SCC refers to the patient having had a previous stroke and yet this is not on his problem list. Treatment recommendations from the hospital were not followed and there is no documentation of a rationale for an alternative treatment plan.
- The next patient was sent to the ED on 2/9/2017 for severe anemia with shortness of breath and dizziness.⁶⁵ He had been seen at nursing sick call five days earlier for dizziness. He had a history of a gastrointestinal bleed and hypertension. The nurse referred him to a provider urgently on 2/4/2017 because of a rapid pulse (124) and elevated blood pressure (150/72). The provider ordered labs and an EKG. The EKG was not done because it was "broken," and labs were not resulted until 2/8/17. The provider's review of these results prompted the referral to the ED. Upon return from the ED the patient was not seen by a provider in follow up until 2/17/17. Recommendations from the ED were not acknowledged by the provider and there was no documented rationale for deviating from the recommended plan of care. This ED visit would likely have been avoided if the diagnostic labs had been accomplished more quickly and treatment initiated earlier.
- The next patient was sent to the ED on 9/30/17 for intractable low blood pressure.⁶⁶ There are no problems listed on the problem list and it has not been updated since 5/17. However, this patient was being seen by the Medical Director for chronic pain. The Medical Director referred the patient to the UIC chronic pain clinic on 8/9/17. The patient was taking clonazepam and lorazepam and reported these as being ineffective in relieving his back pain. The Medical Director documented that the patient was exhibiting drug seeking behavior. The patient asked for renewal of his medications on 8/30/17 and was scheduled to be seen on 9/5/17. He was not seen that day and made another request to have his medications renewed before they expired on 9/16/17. He

⁶⁴ Urgent/Emergent Patient #3.

⁶⁵ Urgent/Emergent Patient #5.

⁶⁶ Urgent/Emergent Patient #6.

was seen the day before his medications expired and they were renewed. He was seen again on 9/25/17 for back pain and x-rays were ordered. A Toradol injection was ordered on 9/28/17 and he was admitted to the infirmary when his blood pressure dropped from 137/85 at 6:00 p.m. to 114/71 four hours later. He continued to receive Toradol injections on 9/29/17 and 9/30/17. The patient continued to report significant pain and his blood pressure remained low, so the Medical Director sent him to the ED on 9/30/17. The patient returned from the ED with recommendations for Norco. The nurses contacted the Medical Director, who instructed them not to give the patient Norco and ordered clonazepam and lorazepam instead. The patient did not see a provider in follow up until three days after the ED visit on 9/30/17. This patient was not seen by the UIC pain clinic until 1/24/18. Diagnostic imaging of the lumbar and thoracic spine was recommended as well as trigger point injections for radicular and myofascial pain. Chronic pain or the underlying cause of the chronic pain is still not listed on the problem list. Had this patient's chronic pain been managed the ED visit would have been avoided. The referral to UIC took too long to effectuate.

- The next patient was sent to the ED on 8/22/17 for chest pain.⁶⁷ He is 66 years old and his problem list includes Crohn's disease, heart disease, and depression. However, he is not followed in the chronic disease clinic. He was seen for Crohn's disease on 7/25/17, and his blood pressure at that visit is recorded as 91/72. The provider did not remark on this low blood pressure and no additional follow up was ordered. On 8/22/17, he complained of chest pain, and after two hours of monitoring and treatment at SCC he was sent to the ED. At the ED he was diagnosed with esophagitis and GERD. Follow up with cardiology was recommended by the ED. He was not seen following the ED visit until 20 days later. No cardiology referral was made. He was scheduled for an enteroscopy in October 2017 and a follow up appointment for GERD in November 2017. This patient should be followed in a general medicine chronic disease clinic and abnormal vital signs should have been addressed by the provider who saw him in July 2017. In addition, he was not seen timely after returning from the ED and a cardiology referral should have been made.
- The final patient was sent to the ED on 5/4/17 for an acute infection on his right foot.⁶⁸ He was diagnosed with insulin dependent diabetes and hepatitis C. He was seen in both the diabetic and hepatitis C chronic disease clinics. He was seen in chronic clinic for diabetes on 12/1/16 and his HbA1C was noted to be 8.2 (poor control). He was seen again on 4/3/17 and his HbA1C was 8.7 (poor control). In February 2017 he was seen for swelling in his legs and a diuretic (Lasix) was ordered. His legs were documented as still swollen when he was seen by providers in March and April. Reduced sensitivity in his feet due to diabetes is documented by the provider who saw him 4/26/17. No changes were made in his treatment, and the frequency of chronic care appointments to manage his diabetes was not increased. This patient with poorly controlled diabetes and

⁶⁷ Urgent/Emergent Patient #7.

⁶⁸ Urgent/Emergent Patient #8.

neuropathy in his feet stubbed his toe on 5/3/17 sufficient to cause loss of a toenail and severe bruising of the foot. He requested health care attention the next day, was admitted to the infirmary and started on IV antibiotics, but later that day was sent to the ED for treatment. Upon his return to SCC, the recommendations from the hospital are noted and implemented. This ED visit was likely preventable if his diabetes had been more closely monitored and his condition treated more rigorously.

We also reviewed six medical records of patients who were hospitalized to assess their care before and after hospitalization. We found that, as with the persons going to the ED, patients returning from in-patient hospitalization do not consistently have a hospital discharge summary. We noted clinical management problems in all six records reviewed, including significant preventable or possibly preventable harm and risk of harm to patients who had delayed hospitalization, delayed specialty care, or lack of primary care of their underlying medical conditions. The lack of appropriate treatment of their underlying medical conditions resulted in deterioration and harm (myocardial infarction, stroke, and colon cancer) that was preventable if their conditions were treated appropriately. There appears to be a significant knowledge and practice deficit with respect to managing primary care problems, which we attribute to the use of a surgeon instead of a doctor trained in primary care. This is a credentialing and privileging problem. We also note that in two cases there appeared to be a lack of documentation of episodes of care immediately preceding hospitalization. All clinical episodes of care need to be documented in the medical record. We give summaries of these cases below.

- The first patient had listed problems including hypertension, asthma, type 2 diabetes, and GERD.⁶⁹ The patient had three major risk factors for coronary heart disease (hypertension, diabetes, and high blood lipids), but his high blood lipids were not recognized as a problem by facility physicians. Because this condition was unrecognized, he was not treated with anti-lipid medication, which is a standard of care. Providers saw the patient on 24 occasions, with elevated blood pressure dating from May of 2016 until January of 2017, but the blood pressure medications were only minimally adjusted on only two of the 24 episodes of care. The patient's blood pressure remained uncontrolled over the course of an entire year. Once when seen in hypertension chronic clinic and twice in diabetes clinic, the blood pressure was elevated but the only treatment was to add a diuretic (at only the hypertension clinic visit). Hypertension is a risk factor for stroke and coronary artery disease, and not treating blood pressure to an appropriate goal places the patient at increased risk for coronary events. The diabetes was also not well controlled.

On two occasions the patient had chest pain with elevated blood pressure. On one occasion the patient had exertional chest pain with blood pressure of 199/128 which constitutes hypertensive urgency. Exertional chest pain suggests acute coronary syndrome which requires an immediate EKG and evaluation. The nurse called a doctor,

⁶⁹ Hospitalization Patient #2.

but an EKG was not done, and the patient did not receive an evaluation for acute coronary syndrome. The doctor failed to follow generally accepted guidelines or usual standard of care, which should have included evaluation for acute coronary syndrome. On another occasion, a nurse called a doctor because the patient had chest pain with blood pressure of 188/102. The doctor ordered Ativan, nitroglycerin, and a single dose of clonidine, but did not order an EKG or send the patient to an ER. This also failed to follow generally accepted guidelines or usual standard of care to evaluate for acute coronary syndrome. Over the next hour, after this episode of chest pain, an LPN saw the patient four times. During one of those episodes, the patient described chest pain like "someone elbowing me in the chest." Shortly after that, the LPN documented a blood pressure of 204/93, an extremely high blood pressure that in combination with chest pain was a red flag sign. An LPN should not have been making these repeated evaluations, as they are not trained in assessments. As well, the patient did not have timely transfer to a higher level of care.

There were no further notes, but the patient was admitted to a hospital at some time unknown and diagnosed with a heart attack. All care needs to be documented in the medical record, but the episode of care resulting in the transfer was not documented in the medical record. The patient had a stent placed and returned from the hospital on a statin drug. Care for this patient demonstrated a lack of knowledge of primary prevention of heart disease and on treating angina, a common primary care problem. It was similar to care we noted in mortality reviews at a different institution which resulted in death. This heart attack was likely preventable if the blood pressure was treated and if he was placed on a statin drug. Failure of the on-call doctor to admit a patient with typical chest pain and elevated blood pressure placed the patient at significant risk of harm and was grossly and flagrantly unacceptable.

- Another patient with a history of smoking had elevated lipids with cholesterol 232, HDL 54, and LDL cholesterol 153.⁷⁰ The standard of care for these laboratory test results is treatment with a statin drug, which was not done. On 12/8/14, the patient had an elevated HbA1C of 6.6, which is diagnostic of diabetes. The standard of care for his diabetes would have been to treat the condition with an oral agent and to attempt weight loss. Diabetes with high lipids raised the risk for stroke and coronary heart disease, and treatment with a lipid drug was indicated. The patient had approximately a 20% 10-year risk for heart disease or stroke, yet remained untreated for high blood lipids or diabetes for years. Dating from 4/12/16, the patient had elevated blood pressure which was also not treated. Elevated blood pressure is also a risk factor for stroke. Thus, the patient had three major treatable risk factors for stroke for which he was not treated, which was significantly below standard of care. On 7/10/17, the patient developed a stroke. The patient was not treated for his elevated blood lipids or diabetes until after return from the hospital. The patient now has right sided weakness and aphasia (difficulty speaking). Care of this patient was grossly and flagrantly

⁷⁰ Hospitalization Patient #3.

unacceptable. This stroke was preventable if the patient was appropriately treated for his cardiovascular risk factors.

- Another patient had apparent COPD/asthma and obstructive sleep apnea.⁷¹ Tests for these conditions were not evident in the medical record. The patient had no monitoring of his sleep apnea for a year. Also, on review of the current volume of medical records, there was no evidence that the patient had ever had a pulmonary function test, which is recommended as a cornerstone of diagnosis for both COPD and asthma. So, it was not clear that the patient had an accurate diagnosis of his medical condition. For a year, the patient had eight exacerbations of presumed asthma or COPD requiring use of tapering oral steroids. The patient had oxygen saturation at 88% or lower on 10 different occasions despite being on what appeared to be maximal medical therapy (Advair diskus, albuterol nebulization, Singulair, and Xopenex).⁷² The standard of care with this level of oxygen saturation in persons with COPD is to obtain an arterial blood gas and assess whether the patient needs continuous oxygen therapy. Despite indications for oxygen therapy, the patient never received an arterial blood gas or evaluation for the need of oxygen therapy and did not receive continuous oxygen therapy. As well, on six occasions the patient had red flag abnormal vital signs signifying possible need for a higher level of care, but was not referred to a hospital or higher level of care, which placed the patient at significant risk of death. These episodes included:
 - On 5/15/17, the patient had productive cough, labored breathing, wheezing, and oxygen saturation of 82%. A doctor admitted the patient to the infirmary but did not obtain a chest x-ray or laboratory tests. An arterial blood gas should have been performed immediately. The patient should have been sent to a hospital because of the significant oxygen desaturation.
 - On 4/18/17, a nurse found an oxygen saturation of 80% with diffuse wheezing. Even though the oxygen saturation improved to 88% after treatment, a provider did not see the patient. This was a critically low oxygen saturation which should have been resulted in immediate hospitalization for further prompt evaluation.
 - A nurse evaluation for oxygen saturation of 86% and hypotension (blood pressure 81/49). The nurse took no action.⁷³
 - A nurse evaluation for oxygen saturation of 84% with hypotension (blood pressure 88/41). The nurse took no action.
 - A nurse evaluation for oxygen saturation of 84% and hypotension (blood pressure 85/43). The nurse took no action.
 - A nurse evaluation for oxygen saturation of 86% with hypotension (blood pressure 95/43). The nurse took no action.

⁷¹ Hospitalization Patient #4.

⁷² An oxygen saturation of 88% is used by Medicare as the threshold for use of continuous oxygen therapy.

⁷³ Low blood pressure suggests but is not diagnostic of shock. Combined with severely abnormal oxygen saturation, this patient should have been sent immediately to a hospital for diagnosis and evaluation, yet the nurse took no action and did not even consult a physician. The nurse evaluating the patient was an LPN but did not document consulting with a supervising RN, which is required by Illinois nursing regulations when LPNs are involved in assessments.

This patient was eventually admitted to a hospital, but the hospital report was not in the medical record and the prison providers did not document knowledge of what occurred at the hospital or note any hospital recommendations. Providers did not appear to have an accurate diagnosis. If the patient had asthma, he should have been admitted to a hospital on multiple occasions for oxygen desaturation, but was not. If the patient had COPD or overlap syndrome, he should have had an arterial blood gas and considered for continuous oxygen therapy. If the patient had either asthma or COPD, the patient should have had pulmonary function tests. Care for this patient was grossly and flagrantly unacceptable. Providers did not appear to know how to care for this patient's disease and the patient should have been referred to a pulmonologist for better diagnosis and management. The failure to know how to manage this patient placed the patient at risk of harm.

- Another patient was 56 years old and was incarcerated at Graham on 9/15/15 before being transferred to SCC.⁷⁴ His initial weight was 213 pounds. Despite being over 50, there was no documented evidence of preventive screening for colorectal cancer, which is a standard of care. Colorectal cancer screening is recommended for all persons over 50 years of age but does not appear to routinely occur in the IDOC. On 11/8/16, a doctor saw the patient for complaint of blood in his stool. The doctor did a digital rectal examination and felt what he thought was a hemorrhoid. The stool was guaiac positive, which indicates blood. The doctor ordered hemorrhoid cream and a three-month follow up. The standard of care for a guaiac positive stool in a 56-year-old man is colonoscopy to rule out colon cancer or another source of the bleeding. On 11/29/16, a doctor ordered fecal occult blood tests and on 12/1/16, the tests were positive. On 1/4/17, a doctor ordered a GI consultation; the weight was 186 pounds, which was a 27-pound weight loss since incarceration. The doctor failed to document recognition of the weight loss and took no history about weight loss. The standard of care is to obtain timely colonoscopy because weight loss and blood per rectum in a 56-year-old requires exclusion of cancer. Instead, the doctor failed to take sufficient history and ordered a routine work up, which was significantly delayed. There is a known delay in getting GI consultation scheduled at UIC. Instead of obtaining this test at another center, the patient was allowed to wait with a condition that should have been evaluated much sooner.

Four months later, on 4/10/17, an annual history and physical examination of this 56-year-old did not include colorectal cancer screening. The GI consultation ordered on 1/4/17 was approved on 1/11/17 but did not occur until 7/7/17, about six months later. The GI consultant recommended colonoscopy and EGD, but this did not occur until 11/27/17, at which time the patient had locally invasive metastatic rectal cancer. The patient was admitted directly to the hospital from colonoscopy and when he returned to the prison with cancer pain, the pain was not addressed. This patient with need of colorectal screening failed to have it offered. The patient had documented weight loss

⁷⁴ Hospitalization Patient #6.

that was unrecognized for well over a year. When he showed signs of weight loss and bloody stools, it took over a year to obtain a work up for colon cancer. These delays in obtaining specialty care most likely resulted in dissemination and advancement of his colon cancer, which caused harm.

In addition to this event, the patient, who was on psychotropic medication for a mental health condition, developed a hand tremor on only one hand. A doctor diagnosed Parkinsonism without performance of a history or physical examination and started Cogentin, which has no indication for Parkinsonism. This is below standard of care with respect to diagnosis of Parkinsonism. Two weeks later the same doctor, without performing a history or physical examination, ordered Sinemet, a drug used for Parkinsonism. The doctor made the diagnosis without a history or physical examination supporting that diagnosis. Six months later, the patient was referred to a neurologist. The neurology consultation occurred nine months after the referral. When the neurologist saw the patient, he found no evidence of Parkinsonism and recommended tapering the patient off Sinemet. The doctors at SCC did not stop the Sinemet. The doctors at SCC failed to document sufficient history or physical examination to support their diagnosis and failed to follow a neurology recommendation to taper the patient off a possibly unnecessary drug. These two episodes of care for this patient were grossly and flagrantly unacceptable.

- Another patient had a history of gout.⁷⁵ He developed swollen joints and had multiple provider encounters for his complaints but did not have thorough history or physical examinations. Providers were treating the patient with bursts of steroids without having established a firm diagnosis of gouty arthritis and without addressing treatment of his uric acid, which is standard of care in treatment of gout. During two episodes of swollen joints, providers aspirated the joint for a joint culture and treated the patient for gout without obtaining an analysis of the joint fluid for crystals, which is the standard of care for diagnosing gout. After initially treating the patient for gout, another provider started treating the patient as if the patient had rheumatoid arthritis without definitively establishing the diagnosis. It appeared that the providers did not understand how to diagnose either gout or rheumatoid arthritis, and the patient should have been referred to a rheumatologist for consultation. The patient developed redness on the front of the thigh encircling to the back of the thigh; the area was swollen. Despite an extensive area of possible infection, the nurse did not consult a physician, but referred the patient for a three-day follow up. Two days later, the patient developed fever to 103.6°F and a doctor started intravenous antibiotics. The following day the patient was sent to a hospital, where extensive debridement was necessary for an abscess. The referral by the nurse to a provider was not timely and most likely resulted in extension of the infection. The management of this patient's swollen joints failed to follow generally accepted guidelines.

⁷⁵ Hospitalization Patient #1.

- Another patient had a problem list at IDOC including diabetes, hypertension, and HIV infection.⁷⁶ Consultant notes indicated that the patient had hypertension, diabetes, dyslipidemia, HIV infection with AIDS, Bell's palsy, lower extremity neuropathy, and chronic thrombocytopenia. The patient was not being followed at IDOC for all of his medical conditions. The patient also had hypertension. The blood pressure goal for persons with diabetes is optimal when below 130/80. This patient had elevated blood pressure (>130/80) on five occasions when seeing a provider between January and May of 2017. On none of these occasions did the provider adjust the blood pressure medication. In May of 2017, the patient developed chest pain and was admitted to the hospital. There was no hospital discharge report in the record, so it was unclear whether the patient sustained a heart attack, but an IDOC doctor mentioned that the patient had coronary artery bypass surgery.

When the patient returned to prison he was admitted to the infirmary. The patient had exertional chest pain and shortness of breath on two occasions on the infirmary which did not result in nurses calling a doctor. The patient told a nurse that he felt "jittery and my breathing is funny," yet a doctor discharged the patient from the infirmary to general population without evaluating the chest pain and shortness of breath. This is below standard of care, particularly in someone with a recent coronary event. A couple days after discharge from the infirmary a nurse charged the patient \$5.00 to evaluate an episode for chest pain. The nurse cynically wrote that "I/M arrived in HCU for a CMT chest pain call and was more concerned with asking for a new wheelchair." The nurse did not consult a physician for a complaint of chest pain in a patient with recent coronary artery bypass surgery. On 6/8/17, the patient developed a temperature of 100.2°F with a pulse of 128. Documentation was poor, but it appeared that the patient was eventually sent to a hospital, where pulmonary embolism was diagnosed. The hospital record was not in the medical record. The evaluations by nurses on the infirmary and in general population were significantly deficient, as the patient had critical complaints, yet the patient was not referred to a provider and the nurse did not consult a provider. All episodes of care need to be documented in the medical record. The failure of the provider to evaluate the patient on discharge from the infirmary when the patient had complaints of difficulty breathing was below standard of care. The patient may have had pulmonary embolus when discharged from the infirmary which was unrecognized. This placed the patient at risk of harm.

In summary, we concur with the First Court Appointed Expert's findings that ED and hospital reports were often absent in the medical records reviewed and the care of patients was problematic before the ED and hospital visit and after the patient's return to SCC. We also found that SCC is not following its own written directives regarding the emergency response, first aid equipment and supplies, and the frequency and content of drills.

⁷⁶ Hospitalization Patient #5.

We agree with the First Court Appointed Expert's recommendation that the QI program monitor and report results on the timeliness, appropriateness, and continuity of care of patients sent to the ED and hospital. The lack of appropriate medical care before and after hospitalization supports our opinion about the lack of appropriately trained physicians in the IDOC. We make additional recommendations found at the end of this report.

Specialty Consultations

Methodology: We interviewed scheduling personnel, reviewed tracking logs, and reviewed medical records of patients who received specialty care. We reviewed care related to consultation requests.

First Court Expert Findings

The First Court Expert found anecdotal evidence that it takes as long as a month before UIC receives information regarding an approval for a specialty consultation. Nine records were reviewed of patients scheduled for consultations or a procedure. Six of the nine records reviewed demonstrated problems. Problems included no reports and failing to follow recommendations of the consultant.

The First Court Expert recommended that the timeliness of access to specialty services needs to improve and that there needed to be a reliable method of communication between the scheduler and clinician to ensure timeliness of appointments based on urgency of need.

Current Findings

We found no improvement in specialty services since the First Court Expert's report and noted significant problems in specialty care that caused harm to patients.

The procedure for specialty care is the same at SCC as at NRC. A provider is to write a referral *on the date the referral is requested*. Within five working days, a collegial review is to occur followed by approval and then a scheduled appointment. Of 11 consultations we reviewed with respect to this procedure, all 11 had a collegial review documented in the medical record, but only five of the 11 had this collegial review timely. The contract and administrative directive on specialty care calls for a collegial review in five days. We reviewed 35 consultations to assess whether a consultation report was present. Formal reports were present in the medical record in only 19 times (54%). This is similar to the First Court Expert's finding.

For every consultation, a provider is to see the patient to review the consultation results with the patient within five days. In 10 consultations we reviewed for this purpose, a provider saw the patient after all 10 consultations. The patient was evaluated timely in eight of 10 post-consultation visits. However, the quality of the evaluation was very poor. The provider documentation in the medical record did not give the status of the patient. In none was there a history updating the patient's condition with respect to the consultant's findings. In five of the 10 post-consultation provider visits, the doctor documented that he was seeing the patient for a post-consultation visit but failed to document what occurred at the consultation. On two

post-consultation visits the doctor failed to identify that a biopsy had been done, and these biopsy results were never noted in the IDOC medical record. In two post consultation visits, the consultant's recommendations were not addressed.⁷⁷

The First Court Expert found that there was poor communication between the scheduler and the clinician with respect to scheduling. We agree.

Collegial reviews are not consistently timely. We inspected the tracking log for consultations completed from 1/1/17 to 3/31/17. There were 321 completed consultations during this time period. For 35 (11%) consultations, the collegial review was documented as occurring more than two weeks after the date of referral. We also note that referrals are not placed in the record until the consultation is completed, so doctors will not know from the record whether a referral was requested until after it is completed. Since the referral is a medical record document equivalent to a physician order, it is our opinion that these should be placed in the medical record at the time they are ordered to ensure that all referrals are visible to all providers.

The First Court Expert recommended the need to track specialty care steps to ensure timeliness of scheduled offsite consultations. The logs being used for this purpose do not reliably or accurately track this information. We found the tracking log to be unreliable with respect to ability to track the steps of a specialty consult, including the date of referral, the collegial review, the approval, the scheduled appointment date, and the completed appointment date. For the three-month period of study cited above, 22 (7%) of 321 collegial reviews were documented as occurring *before* the date of referral. This is not possible and suggests that the documented date of referral is not accurately provided or that some entries are post-dated. We reviewed the electronic tracking log for the month of January of 2017. There were 86 completed consultations in this log. Of these, 60 (70%) consultations were documented as being completed *before* the consultation was documented as having been referred. Since we received this document late we were not able to discuss this finding with the scheduling clerk.

The IDOC has an arrangement with UIC in which the IDOC is allowed 216 admissions to the UIC hospital and 2160 consultation visits annually free of charge. The incentive to obtain free care appears to result in some patients not receiving timely care, which causes harm. This is especially true for gastroenterology. For the 55 gastroenterology consults *completed* in 2016 and 2017, the average time from referral to completion of the consult was approximately six months. We note that since the referral dates are not accurately stated, these delays may be even longer. Some of these delays were for diagnostic studies which would result in harm if not timely accomplished.

There did not appear to be any effort to reschedule important consults to other centers so that timely care could be obtained. We were told that past due appointments are managed by Wexford and discussed at collegial reviews. We did not see evidence of this. We noted in the

⁷⁷ These consultations were from Specialty Care Patient #3 and included consultations from 3/23/16 through 9/8/17 inclusive.

hospital section of this report a case in which a patient with weight loss and bleeding from his rectum was not evaluated in gastroenterology clinic for over six months and did not receive a necessary colonoscopy for an additional four months, at which time an advanced cancer was noted. When any consultation is delayed beyond what is reasonable standard of care for a condition, the consultation should be scheduled with a different consultant. If Wexford is managing these cases, there needs to be evidence in the medical record of how they are doing this. The doctors in the case of this patient with rectal cancer did not appear aware of the delay in care and its urgency, and did not refer to a provider so timelier care could be obtained. There was no evidence in the medical record that Wexford corporate utilization management was following this delay or considering its effect on the patient. There was no evidence that this sentinel event was reviewed by the CQI committee except to list it as a delayed diagnosis.

The offsite scheduling log does not document in all cases whether a referral is to UIC or to a local provider. However, we were told that most referrals for off-site consultation are to UIC. The use of UIC in preference to local providers even when UIC appointments cannot be scheduled timely creates the appearance of saving money instead of protecting the interest of the patient. The offsite consultation process as it currently exists is a patient safety issue. Until it can be corrected, it should be abandoned, and doctors should be allowed to refer directly to consultants until Wexford can ensure patient safety.

Patients with need of specialty care referral were not always referred for care. We noted in the hospital reviews above a patient who should have received pulmonary consultations and pulmonary function tests who did not receive that care. One patient should have been referred to a rheumatologist to evaluate for his arthritis. This underutilization is not monitored by Wexford or IDOC but is a significant problem. We believe that this is another manifestation of the lack of proper credentialing and privileging of physicians.

Infirmary Care

Methodology: The clinic space and equipment in the infirmary were inspected, nursing staff were questioned, clinical charts audited, porters questioned, and patient-inmates interviewed. There was only limited contact with the infirmary physician.

Fist Court Expert Findings

The First Court Expert recommended that infirmary patients should be seen timely according to policy requirements, and if clinicians choose not to treat patients according to currently accepted recommendations and guidelines, the rationale for these decisions should be articulated in the health record. The expert noted concerns about the frequency, quality, and completeness of documentation.

Current Findings

We agree with the findings of the First Court Expert concerning timely admission and progress notes, the lack of documented rationale for treatment decisions, and the quality and

completeness of the provider documentation in the infirmary. We identified additional findings and confirmed some of the First Court Expert's findings as follows:

- Admission RN and provider notes were generally written in accord with the established timelines.
- Provider progress notes are consistently written on a weekly basis for chronic infirmary patients. Nurse notes are written daily and commonly provide more useful information on the clinical status of a patient than did provider notes.
- Problem lists were found to be incomplete and even inaccurate.
- Provider notes were consistently illegible, often lacked the rationale for modifications in treatment, failed to list reasonable differential diagnoses, failed to develop clear treatment plans, and rarely documented the status of patients' chronic illnesses.
- The care in the infirmary is episodic and primarily focuses only on acute problems.
- There was little if any documentation that pertinent physical examinations were being performed by the providers.
- The quality of care provided by the providers assigned to the infirmary is inconsistent and often inadequate.
- For records we reviewed, throughout 2017 we found no comprehensive provider notes that updated the status and plan of treatment for all of a patient's problems. Only with the assignment of a new provider in 2018 were some comprehensive provider notes written that provided reasonable, readable, understandable documentation of both the current acute and chronic illnesses of patients.
- The care provided to patients on chronic anticoagulation is poor. The use of warfarin and the subsequent need for frequent INR testing creates logistical barriers that may not be adequately addressed in this correctional setting. The use of newer anticoagulation medications that do not require frequent ongoing measurement of the level of anticoagulation should be strongly considered by the IDOC.
- The condition of the patient beds (non-adjustable heads, inability to raise or lower the height of the beds, non-functional railings) interfered with the ability of the nursing and medical staff to provide proper examinations and perform needed treatments. The physical safety of the nurses who are involved with transferring patients from beds to wheelchairs is also put at risk by not having beds that can be raised or lowered. SCC needs to replace all of the current beds with hospital beds. At least one electrical bed is needed in the infirmary.

The infirmary has two wings; one wing has 11 two-bed rooms and the other, 11 single-bed rooms. The two wings are served by an enclosed central nursing station that has doors that open directly into each adjoining wing. It was reported that the infirmary has 24/7 nurse staffing, with at least one RN on each shift. Correctional officers were noted on both wings during the site visit. Patients are examined in their rooms; there is no examination room on the infirmary. There is no dayroom on the infirmary and TVs are not allowed on the unit. Inmates rarely leave their rooms except for testing/offsite consultations, but those whose physical condition allows have access via a ramp to a recreation yard. There are two negative pressure respiratory isolation rooms; neither of the patients in these rooms were in need of respiratory

isolation. Neither of the negative pressure units were fully functional on the first day of the site visit. A new physician, recently assigned to the infirmary within the last one to two months, makes rounds almost daily.

The infirmary has a capacity of 32 patients. During the site visit, 24 beds were occupied. The majority of patients on the unit had chronic conditions and have had or will have lengthy stays in the infirmary. A large number of the patients are disabled and need assistance with activities of daily living. The infirmary has the appearance of a long-term nursing home. There were functional nurse call devices in all of the 2-bed rooms, but some of the patient-inmates lacked the mental capacity or physical ability to use these devices. The nursing station had no capability of direct visual or audio monitoring of any of the patient rooms. Most of the railings on the beds are not operational. The combination of poor audiovisual monitoring capability, an at-risk-for-fall patient population, and non-functional railings creates a potentially unsafe environment for many men in the infirmary. We noted on a death review that a patient with dementia had 13 falls over a year and a half.⁷⁸ Because there were no physical examinations by a physician it wasn't clear if the patient was physically injured. Risk of injury is clearly present on this unit. Only one patient (in restraints) had a correctional officer stationed outside his room for one-on-one observation. A number of the patient-inmates require one-on-one observation due to risk of falls.

IDOC Administrative Directive 04.03.120 Offender Infirmary Services has several requirements, including that nurses must complete admission notes with vital signs on admission and providers must write an admission note within 48 hours of admission. Acute level infirmary patients are to have at least three provider notes per week; chronic patients require only weekly notes. Four infirmary charts of chronic patients were audited (two were long-term patients and their charts had been pared down); the other two had nurse admission notes on the day of admission and provider notes on the next working day. All four of the infirmary charts reviewed had at least weekly provider progress notes and all had daily nursing notes and vital signs measured.

A number of concerns and deficiencies in the care provided to infirmary patients were noted. Two patients had diabetes listed on their problem list, but they were not on diabetic meds and their blood sugars were normal. Neither had HbA1C testing performed to confirm the diagnosis (and control if they indeed had diabetes). None of the provider progress notes ever commented on diabetes for these two individuals. One patient had a single note stating that Wexford replaced his CPAP machine, but sleep apnea was not on his problem list and his medical record and his infirmary chart did not have any provider notes from 2016-2018 addressing sleep apnea or CPAP use. This same patient had a history of significant deep vein thromboses with occlusion of three veins in his abdomen and left leg, yet he was not on blood thinners nor was there a provider comment providing the rationale for not using blood thinners. A patient blacked out on two occasions (blood pressure dropped to 90/60 on second occasion) within a three-week period and was seen three times by a physician without documented neurological or cardiac

⁷⁸ Mortality Review Patient #9.

exams. He was not assessed or tested for orthostatic hypotension, cardiac arrhythmias, or an atypical seizure. The provider notes contained no clinical information or possible cause for these episodes. The patient was eventually referred to UIC Neurology without a reason for referral; this referral could have been a routine follow-up for patient's seizure disorder. The care of patients on chronic oral anticoagulation therapy (warfarin) is inconsistent. One patient with recurrent DVTs on chronic anticoagulation was well controlled for many months, then the warfarin was discontinued without a justification recorded in the progress note. Another patient on warfarin was not adequately anticoagulated after nine weeks of treatment. INRs, all sub-therapeutic, were measured weekly and the warfarin dose was increased three times; however, the frequency of INR testing and pace of dosage augmentation should have expedited as per standard of care. One infirmity patient with hypertension had elevated blood pressure readings for 11 months but his medications were not increased to achieve control. The provider wrote regular very brief notes with little clinical information that were difficult to read and did not comment on why antihypertensive meds were not increased. It was only after a new provider was assigned to the infirmity that blood pressure meds were increased, and hypertension control achieved.

The provider notes on the audited charts were extremely brief, commonly illegible, and contained little clinical information. The lack of comprehensive provider notes made it difficult to understand the patients' current conditions and progress or deterioration. This created barriers to the delivery of adequate care for the nursing staff and providers who cover the unit when the infirmity provider is off duty. The quality and continuity of care provided in the infirmity did not meet the community standard of care.⁷⁹

The following summaries of infirmity patients' records highlight the findings and concerns noted above.

- This patient is a 53-year-old whose problem list includes DM, recurrent DVT, on chronic anticoagulation, left ankle wound/ulcer, and chronic abdominal wound post-aorto-iliac bypass.⁸⁰ Blood sugars were normal and the patient was not on diabetic medication. HbA1C was never performed to confirm the diagnosis. On 1/30/18, the MD wrote that the patient denied a history of diabetes. It is likely that this patient does not have diabetes and this diagnosis should be removed from the problem list. Weekly INRs were performed to measure adequacy of anticoagulation, and warfarin dose was increased four times over nine weeks; all of the INR's were sub-therapeutic (1.1-1.4). Standard of care is to increase the warfarin dose quickly until a therapeutic level is achieved (2.0-3.0) and then decrease the frequency of testing. This patient is still at risk for a recurrent DVT after nine weeks of treatment. UIC specialists ordered warfarin be stopped and the

⁷⁹ We refer also to Mortality Review Patient #9 for another example of this. Over six months on the infirmity, a doctor wrote notes 19 times that stated, "No specific complaint, no change, dementia, continue same care" despite the patient having multiple falls and being hospitalized for heart failure. Then over a nine-month period, the same doctor wrote 30 notes stating, "No specific complaint. No change. Dementia, post colectomy for metastatic ca [cancer]. Continue same care." This was grossly and flagrantly unacceptable evaluation for a person with significant illness.

⁸⁰ Infirmity Patient #1.

anticoagulation switched to injectable low molecular weight heparin before the patient was transferred to UIC for surgical repair of a large post-op abdominal wound. The infirmiry provider discontinued the oral warfarin but failed to order the injectable anticoagulation; this put the patient at risk for a clot.

- This patient is a 58-year-old with coronary artery disease post-percutaneous transluminal coronary angioplasty (PTCA), peripheral arterial disease s/p right Iliac artery stent, DVT, diabetes, seizure disorder, neurogenic bladder, and L-S disc disease.⁸¹ He has regular provider notes and daily nursing notes with vital signs. He had a CPAP machine, but sleep apnea was not on the problem list nor was it ever addressed in any provider progress notes. The patient was on seizure medications, which were increased after he reported to UIC Neurology specialists that he had a seizure a few months prior to his visit. The provider notes never commented, even once, during his seven months in the infirmiry, about the status or control of his seizure disorder. Even though the patient had a history of massive deep vein thromboses, the infirmiry progress notes did not once comment on why this patient was not prescribed anticoagulation medications. There may be a valid reason for not ordering anticoagulants, but the progress notes failed to address this important, even life threatening, issue. The patient was noted to have blacked out on 12/10/17 and again on 12/31/17 (blood pressure dropped to 90/56); MD notes on 12/11/17 only noted that the patient had no complaints and continued present management, and on 12/19/17 stated no change. The patient was not assessed or tested for orthostatic hypotension, cardiac arrhythmias, or an atypical seizure. The provider notes contained no clinical information or possible cause for these episodes and the patient was eventually referred to UIC Neurology without a reason for referral; this referral could have been a routine follow-up for patient's seizure disorder. The patient had another episode on 1/13/18 in which he reported to the RN he might pass out. His blood pressure was again low (90/50). A new provider wrote a comprehensive note on 1/15/18 and referred the patient to Cardiology and Vascular Surgery at UIC. Again, the patient's blood pressure was low, 91/45, and no intervention was ordered by the provider. None of the five provider notes since the second blackout episode in which low blood pressure was recorded documented any consideration that the patient's current treatment included four to five meds that can lower blood pressure and should be pared down.
- This patient has a history of DVT on chronic anticoagulation, s/p total right replacement with joint infection, hypertension, and hyperlipidemia.⁸² There was no problem list in the infirmiry chart. The INRs were consistently therapeutic in 2017; warfarin was discontinued in August 2017. There was no provider note on the rationale for stopping anticoagulation. During the last third of 2017, swelling of his right knee was noted and antibiotics started with orthopedic consultation. The patient underwent surgical removal of the infected prosthesis and right knee fusion. On hospital return, the patient

⁸¹ Infirmiry Patient #2.

⁸² Infirmiry Patient #3.

was readmitted to the infirmary with an RN admission note on 1/26/18, and a physician admission on 1/29/18 (the next working day). The 11 provider notes between 9/18/17 and 1/15/18 contained so little clinical information that it was very difficult to understand the patient's diagnoses and previous surgeries, the reason for the knee joint infection, and the treatment plan. A number of the notes were illegible or so brief as to be uninformative. Unclear progress notes and plans interfere with the provision of quality care and put the health of the patient at risk.

- This 70-year-old patient was admitted to the infirmary on 1/24/17; RN and physician admission notes were on the day of admission.⁸³ The patient's diagnoses included atherosclerotic heart disease (ASHD), congestive heart failure, hypertension, stroke in 2005 with weakness and inability to walk, and benign prostatic hypertrophy (BPH). Nursing notes were written daily and vital signs taken daily. Provider notes were documented weekly, but they contained little clinical information. Some of the provider notes were totally illegible. The patient's blood pressure readings were repeatedly elevated except for the two times the patient attended the hypertension chronic care clinic, which did not comment on the elevated blood pressures taken in the infirmary and did not increase the hypertension medication. A new infirmary provider assumed care of this patient in January 2018 and noted on 1/1/18 that the blood pressure was not controlled; the hypertension medication dose was increased, and at a follow-up visit on 1/10/18, it was noted that there had been a good response to the increased dose and the blood pressure was controlled. On 2/16/18, the patient voiced a concern about increased urinary frequency, urgency, and hesitancy. The provider ordered a urinalysis (normal) and oxybutynin to treat this problem. It is disturbing that the previous infirmary provider failed to address the elevated blood pressure readings during 2017. The practice of SCC providers not addressing uncontrolled chronic conditions and shifting this responsibility to the single illness chronic care clinics resulted in an unjustifiable delay in treatment for this hypertensive patient who had already suffered a stroke. Elevated blood pressure is a risk factor for stroke. Until January 2018, the provider notes were illegible and created a risk to the health of this infirmary patient.

In summary, the lack of quality, legible, comprehensive provider notes that address both the ongoing acute and chronic needs and illnesses of each infirmary patient puts the health and safety of all infirmary patients at risk. We agree with the recommendations of the First Court Expert and have additional recommendations that are found at the end of this report.

Pharmacy and Medication Administration

Methodology: We reviewed medication services by meeting with the DON. We also toured the medication room and observed nurses as they prepared, administered, and documented medication administered. We reviewed medication administration records, medication room

⁸³ Infirmary Patient #4.

inspection reports, pharmacy reports delivered at the monthly CQI meetings, the Wexford–IDOC contract, Administrative Directives, and SCC operational policies and procedures.

First Court Expert Findings

The First Court Appointed Expert made no recommendations in the area of pharmacy/medication administration. The system used, policies, and practices described in that report are unchanged today.

Current Findings

The current system to provide patient medication is unsafe and does not assure the five “Rights:” the right patient, the right medication, the right dose, the right route at the right time. The following practices need to be stopped and safer practices and procedures adopted:

- Handwritten orders and transcription of orders to the MAR
- Pre-pouring medication
- Not using the MAR to document administration of medication at the time it is given.

Chronic disease patients are not monitored to ensure continuity in treatment nor is their compliance with prescribed treatment assessed. Prescription end dates do not coincide with chronic clinic appointments and require patients to request renewals via sick call.

In addition, we found that medication errors are documented and reported, but not analyzed to determine root causes or trended to identify problems and improve patient safety. Persistent problems with medication practices are not subject to corrective action or systematic CQI.

Orders and Delivery of Medication

Medications are obtained from BosWell Pharmacy Services, via subcontract with Wexford. Prescriptions are faxed to BosWell and filled in 30-day “blister packs,” and then transported to SCC. A pharmacy technician at SCC receives and inventories the medications and then puts them into stock supply or onto the medication cart. Staff reported that when prescriptions are faxed to BosWell before 2:30 p.m. each day, medications are received within 24 hours via United Postal Services (UPS). Prescriptions faxed after 2:30 p.m. are received in two days. If medications are urgently needed, staff uses a local pharmacy, Jewel-Osco Pharmacy in Joliet, Illinois.

We toured the medication room in the clinic and the room behind, where the pharmacy technician works, and where medication is stored until it is needed for administration. These two rooms were clean, uncluttered, well lighted, and kept secure. There is a refrigerator with a thermometer and temperature log that was up to date. We conducted a random count of controlled substances and found it to be accurate. Our observation is that the amount of controlled substances was larger than may be necessary, making accountability time consuming and increasing the chance of error and potential for diversion. We recommend that the responsible pharmacist review and perhaps adjust PAR stock levels for controlled substances.

After the provider writes the medication order, a nurse reviews it and if it is a nurse administered medication, transcribes it onto the patient's medication administration record (MAR). When the medication arrives from BosWell, a pharmacy technician checks off that it was received. The pharmacy technician separates Keep on Person (KOP) medications from Nurse Administered (NA) medications and determines the patient housing locations. Nurse administered medications are transported by the pharmacy technician to the medication room for storage in medication carts and subsequent administration to patients. Pharmacy technicians and/or medical technicians distribute KOP medications directly to inmates in the housing units. They also transcribe the KOP order onto the patient's KOP MAR. This was observed being done using the blister pack, not the original provider order. This practice is not sufficient to identify dispensing errors made by the pharmacy. We recommend that the original order be used when transcribing to the KOP MAR.

Transcription errors are by far the most common type of medication error reported to the SCC CQI committee.⁸⁴ These include not transcribing the order onto the MAR, transcribing orders incorrectly, not discontinuing medications on the MAR when ordered, not transcribing orders from one month to the next, or transcribing these incorrectly. While these errors have been reported, there is no documented evidence that this has been identified as a systems problem to be studied and examined for possible improvement.

We also reviewed monthly medication inspection reports completed by a BosWell pharmacist from March 2017 through February 2018. These inspections include verifying MAR documentation using a sample of 20 patients. We found medications not transcribed onto the MAR, medications that have an order to discontinue still being administered, and the medication being administered differing from that transcribed onto the MAR, as examples of problems in the care of individual patients that are documented each month. There is no documentation or other report that medication errors are trended or analyzed to identify systemic sources of error, nor has it been identified as a problem to be addressed by CQI.

The Contract Monitoring Reports provided note continuing violation of the AD concerning control of medications, but no penalty or corrective action is documented. When asked, the HCUA stated that the problem is that nurses do not accurately and completely sign out controlled medications and attributed this to distractions when busy with patient care. The October 2017 Contract Monitoring Report lists this as a violation of ADs and notes the vendor, Wexford, was notified of the problem on 12-14-16. Accountability for controlled substances is a high safety priority and systematic efforts to identify and limit risk of error as well as potential diversion should be in evidence. At SCC there is no documentation of attempts to investigate and revise systems, equipment, or processes to minimize or eliminate this as a source of error.

Medication errors have long been recognized as a substantial area of focus in improving the safety of patient care.⁸⁵ Handwritten orders and transcription have been eliminated in many

⁸⁴ SCC Annual CQI 2016-17, Pharmacy Services.

⁸⁵ Institute of Medicine (2000), *To Err is Human: Building a Safer Health System*. Washington DC: The Academies Press.

correctional health care programs because of error and inefficiency. An obvious solution is to install computerized provider order entry (CPOE) and eliminate transcription by hand using labels generated from the computerized order after it has been reviewed by a pharmacist.⁸⁶ Automated dispensing cabinets are being used more often now to record the withdrawal of controlled substances and eliminate handwritten controlled substances logs, such as that which is in use at SCC. Upgrading pharmacy services in this way requires capital expenditure and would only likely happen as a statewide decision made by IDOC. But if these pervasive problems are not identified, discussed, studied, or reported at the facility level, IDOC is without notice that there is a systemic issue that must be addressed statewide.

Medication Administration

Nurses administer medications to inmates in their cell. Medication administration is scheduled to begin at 7:30 a.m. and 7:30 p.m. and is completed within two hours. We observed nurses preparing medications for administration. Nurses compared MARs against medication blister packs to ensure the accuracy of the order and then popped medication out of the blister pack and put it into small white envelopes. Written on the envelopes is the name of the patient, ID, housing location, and names of the medications. The envelopes do not contain order start and stop dates.⁸⁷ Nurses then place medication envelopes into a clear plastic bag to take to the housing units. Nurses do not transport MARs to the housing unit along with the medications.

We accompanied a nurse escorted by a correctional officer to R unit. Each cell had one or two inmates. For each patient receiving medication, the nurse called out the inmate's name and informed him she had medication and asked to see his identification card, which includes a recent photo. The nurse then gave the medication envelope to the patient through the cell bars. The patient took the envelope, poured medication into his hand, and passed the envelope back to the nurse. If a patient did not want to take a particular medication he put it back in the envelope before returning it to the nurse. Sometimes the nurse performed an oral cavity check. She indicated that she did this for patients taking mental health medications and any others she had a concern about. We observed an inmate ask if he could take his medication later in the morning because he had an appointment to have lab drawn at the clinic. The nurse indicated that she would return later with his medication. The interaction between the nurses administering medication and inmates in the cells was outstanding in professionalism and respect.

The nurse did not document administration of the medication onto the MAR at the time the medication was given. After the nurse finished administering medications she returned to the clinic and documented on the MAR which medications had been administered using the white envelopes. Medication not taken by inmates was discarded.

Problems with medication administration at SCC include:

⁸⁶Patient Safety Network. (2017) Medication Errors, Agency for Healthcare Research and Quality available at <https://psnet.ahrq.gov/primers/primer/23/medication-errors>.

⁸⁷ The SCC Operations Policies and Procedure, p. 128 states that "Medication envelopes will be utilized that will comply with state and federal requirements," but does not specify what those requirements are.

- Repeated use of the same envelopes is a source of transmission for infectious disease because they are handled by the patient and returned to the nurse.
- Nurses do not have a way to verify medication that is not taken. Visual identification is not sufficient.
- The MAR is not available to the nurse at the time medication is administered and therefore is not used as a reference when there is a concern or question at the point of patient care.
- Medication is not documented at the time it is given and contributes to errors and omissions in documentation of patient care.

Renewal of Chronic Disease Medications

Chronic disease medications are provided to patients monthly either as “Keep on Person” (KOP) or each dose is administered by a nurse. The scheduled appointments for chronic disease clinic do not coincide with the end date on medications ordered for chronic disease. Patients are expected to sign up for sick call to request medication renewal before the order expires and is subject to co-pay.⁸⁸ Diabetics taking insulin are expected to draw up and administer their own dose. Diabetic inmates complained that those who are newly diagnosed receive no education about their condition or how to administer insulin.⁸⁹

There is no provision or written directive to regularly monitor continuity of medications or compliance with ordered medications as part of the chronic care program. We interviewed one inmate whose chronic disease medication was not provided for a month. It was only reinitiated when he sought care and finally saw a provider.⁹⁰ Chronic disease patients are not monitored to ensure continuity in treatment nor is their compliance with prescribed treatment assessed.

Infection Control

Methodology: We interviewed health care leadership and nursing staff assigned to infection control duties, reviewed the Infection Control Manual, CQI Minutes, and other documents related to communicable diseases and infection control.

First Court Expert Findings

The First Court Expert Report noted that a specific nurse had responsibility for compliance with IDOC policy concerning communicable diseases, blood borne pathogens, and compliance with Illinois Department of Public Health reporting requirements as well as the HIV and HCV clinics. Inspection of the health care areas and inquiry about infection control practices resulted in no concerns or recommendations from the First Court Appointed Expert.

Current Findings

⁸⁸ Institutional Directive #04.03.103K3.

⁸⁹ Medication Administration Patients #1-2.

⁹⁰ Medication Administration Patients #6.

Responsibility for infection control is dispersed amongst several staff nurses, the DON, and HCUA. The HCUA facilitates and monitors sanitation inspections and is diligent in following up on identified concerns until correction has been achieved. He also submits information required for reportable communicable diseases. One staff nurse is assigned responsibility for managing the HCV clinic and another nurse manages the HIV clinic. The DON has oversight responsibility for compliance with infection control procedures and works closely with the HCUA in this regard.

CQI Minutes and the 2016 Annual Report show that communicable disease data is collected and reported monthly. There is minimal to no discussion of the meaningfulness of the data reported. There has been no assessment of TB conversion at SCC to evaluate the risk for transmission of tuberculosis while in the prison. The Centers for Disease Control (CDC) recommends that such a study be conducted periodically to determine risk of transmission, which then guides prevention and surveillance activities specific to the level of risk.⁹¹ CQI minutes also report statistics regarding skin infections due to methicillin-resistant staphylococcus aureus (MRSA). Data does not include tracking of skin infections due to other pathogens. Equipment and instructions for prevention, response, and reporting of occupational exposures were readily available at the facility. Inmates working in the health care area have received training in personal protective equipment and exposure control; they are also vaccinated for hepatitis A and B.

The IDOC Infection Control Manual was reviewed. It was last updated in 2012. While the material in the manual is thoughtful and many resources are provided, some of them are out of date. The manual should be updated at least every two years. An up-to-date and accurate infection control manual is critically important in guiding the work of staff assigned these duties in the absence of dedicated positions for trained infection control staff, as is the case at SCC. The IDOC Nursing Treatment Protocols, revised March 2017, were reviewed and provide guidance to nurses in the care of common infectious diseases and infections such as scabies, urinary infection, rash, pediculosis, chicken pox, and skin infections.

Many infection control challenges and hazards were observed during our site visit at the facility. These are detailed in the section of this report on Clinic Space and Sanitation. In particular, the Airborne Infection Isolation (AII) rooms were not functional, the equipment to manage airflow had not been serviced for years, and these are not inspected as part of the sanitation rounds. Also, the practices of the hemodialysis program do not comply with CDC recommendations to prevent infections, particularly hepatitis B, among chronic hemodialysis patients.⁹² Finally, a lack of barrier protection on reusable surfaces was observed throughout the health care areas. Fabric covered chairs and tables were torn and sometimes repaired with duct tape, paper

⁹¹ MMWR (2006) Prevention and Control of Tuberculosis in Correctional and Detention Facilities: Recommendations from CDC. ⁵⁵ (RR09). Centers for Disease Control available at <https://www.cdc.gov/mmwr/preview/mmwrhtml/rr5509a1.htm>.

⁹² MMWR (2001) Recommendations for Preventing Transmission of Infections Among Chronic Hemodialysis Patients. Vol. 50/No. 99-5, Centers for Disease Control. See also Update to the 2001 Hemodialysis Recommendations available at <https://www.cdc.gov/dialysis/guidelines/index.html>.

covers were not available in one of the provider exam rooms, and patient care equipment was rusted and could not be cleaned. Environmental controls to prevent transmission of infection are inadequate and risk harm to patients cared for at SCC.

Tuberculosis screening is completed annually. Inmates who were previously positive for latent tuberculosis infection are screened using a questionnaire for symptoms of tuberculosis disease and are referred to a provider if symptomatic. All other inmates are screened using a Mantoux skin test. Symptom screening is not completed. We observed nurses reading skin tests while also administering medication at the cell front. The nurse did palpate the inmate's forearm for induration and documented the results contemporaneously on the skin of her hand to be transcribed to the chart after medication rounds were completed. Reading of the TB skin test should be done in a clinical setting with good lighting and a tool to measure induration, such as the nurse sick call rooms in the housing area. Nurses should not read TB skin tests cell side.

Inmates may request HIV testing at any time and it is also offered to inmates just before release from incarceration. Inmates who are infected with HIV are managed as part of the chronic clinic program with oversight from UIC. Currently 11 inmates are being followed at six-month intervals. Inmates may choose to have their medication given to them to keep and take or they may have the nurse administer it to them dose by dose. This latter method is offered for those inmates who are concerned about maintaining the privacy of their medical information. Medications are written to coincide with their next scheduled HIV clinic appointment. The nurse managing the clinic draws the patient's blood before the appointment so that the results are available to the provider at the time of the follow-up appointment. Peer educators provide regular sessions on Thursdays for newly diagnosed inmates. They also provide pre-release education.

The inmate porters working in the infirmary had documentation that they had received training on blood borne pathogens in prison, including hepatitis B and HIV, restroom sanitation, and on their job description. The records of two infirmary porters were verified that both had been vaccinated or had immunity to hepatitis A and B.

Hepatitis C (HCV) disease is also managed via the chronic care clinic. IDOC physicians with some assistance from a Wexford infectious disease doctor manage the care of patients with hepatitis C. When an IDOC physician determines that the patient needs treatment of the hepatitis C, the patient is referred to a Wexford infectious disease doctor. When the Wexford infectious disease doctor determines that treatment is indicated the patient is referred via telemedicine for treatment with the UIC hepatitis team. All other hepatitis C care needs (cirrhosis management and screening for hepatocellular carcinoma) are managed by Wexford facility physicians. Forty-nine HCV patients are being followed currently; six have been treated and two have been referred for treatment. According to staff interview, the biggest challenge for HIV and HCV clinics is coordinating scheduling and access to the telemedicine equipment that is shared with the mental health program.

Dental Program

Dental: Staffing and Credentialing

Methodology: Reviewed staffing documents, interviewed dental staff, reviewed the Dental Sick Call Log and other documents.

First Court Expert Findings

- SCC has a dental staff of one full-time dentist, one 20-hour part-time dentist, two full-time assistants, and a full-time hygienist.
- Dr. Mitchell is employed by the IDOC and the rest of the staff are employed by Wexford.
- CPR training is current on all staff, all necessary licensing is on file, and DEA numbers are on file for the dentists.
- The number of dentists and hygienists is adequate to meet the needs of this institution.
- The lone assistant is overworked in a clinic with this number of dentists.
- Overall, this is a strong team that works well together to create a very busy and smooth-running clinic.

Current Findings

We agree with the First Court Expert with respect to clinic operations; however, as we noted in our NRC report, it is difficult to assess the adequacy of either NRC's or SCC's dental staffing independently, since personnel move between facilities.

SCC has one full-time dentist (Dr. Orenstein) who serves as Dental Director, two full-time dental assistants, and a full-time dental hygienist⁹³, who are all Wexford employees. In addition, there are two part-time dentists who are IDOC employees.⁹⁴ Dr. Orenstein and the dental hygienist routinely assist NRC with intake dental exams.

Dental: Facility and Equipment

Methodology: Toured dental clinic, radiology area, and dental intake area to assess cleanliness, infection control procedures, and equipment functionality. Reviewed the quality of x-rays and compliance with radiologic health regulations.

First Court Expert Findings

- The clinic consists of four chairs and units in a spacious single room area. One unit is dedicated to hygiene care. The dental units were rather new and in good condition. Free movement around each unit was acceptable. Providers and assistants had adequate room to work, and none of the chairs interfered with each other.

⁹³ The Dental Department 2017 Annual Summary reported that, the "dental hygienist from Stateville comes here to assist with intake on Tuesday, Thursday, and Friday." NRC CQI Annual Report, 2016-2017, p. 23. Consequently, the dental hygienist does not contribute a full FTE to SCC.

⁹⁴ Each provides care 53 days/year per Don Mills, Health Care Unit Manager.

- The chairs were over 20 years old but were not torn or overly worn and functioned well. Cabinetry was very old and worn. Countertops were broken, corroded, and badly water damaged in one of the corners.
- There was extreme water damage in the cabinet under the sink. Work surfaces were badly pitted and catered from use. Plexiglas was placed over these surfaces to provide a smooth work surface capable of disinfection. The x-ray unit is in good repair and works well. The autoclave is rather new and functions well. The compressor is in good repair. The instrumentation is adequate in quantity and quality. The handpieces are old but well maintained and repaired when necessary.
- The ultrasonic unit was not working. I was told that a request for repair had been submitted.
- There was a separate, large sterilization and laboratory area of adequate size. It had a large work surface and a large sink to accommodate proper infection control and sterilization. Laboratory equipment was in a separate area of this space and did not interfere with sterilization. The staff had a separate small room for office space.

Current Findings

Facilities and equipment are unchanged from the First Court Expert's Report and remain adequate. We concur and note that the previously inoperative ultrasonic unit had been repaired. Moreover, we identified current and additional findings as follows.

The clinic is clean, and the chairs are spaced adequately. All equipment is operational. The countertop in the infection control area is cracked and cannot be disinfected properly. The cabinet under the sink shows signs of water damage. Another cracked countertop was covered with plexiglass; however, liquids seep under the plexiglass, creating an environment conducive to bacterial growth. Storage areas are clean and orderly. Antibiotics and analgesics are labeled and accounted for in a log.

There is a laboratory area; however, there is no lathe for model trimming. The dentist said that they send untrimmed casts to the dental laboratory. The infection control area has enough space; however, the sink is in the middle of the area, preventing optimal instrument flow. Despite this, instruments can be disinfected adequately.

Dental: Sanitation, Safety, and Sterilization

Methodology: Reviewed Administrative Directive 04.03.102. Toured dental clinic. Observed dental treatment room disinfection. Interviewed dental staff. Observed screening examinations and patient treatment.

First Court Expert Findings

- Surface disinfection was performed between each patient and was thorough and adequate. Proper disinfectants were used. Protective covers were utilized on some surfaces. Unit recycling was thorough and adequate. The clinic was neat, clean, and orderly.

- All instruments were properly bagged, sterilized, and stored. No instruments were maintained in bulk. All handpieces were sterilized and in bags.
- The sterilization procedures were adequate and proper. Flow from dirty to clean to sterilized was improper, as bagging of instruments was done in front of the ultra-sonic unit. Cleaned instruments were passed back over the dirty area. The ultrasonic was not functioning. There was not a biohazard label posted in the sterilization area.
- Safety glasses were not always worn by patients. Eye protection is always necessary.
- There was no warning sign posted where x-rays were taken to warn pregnant women of possible radiation hazards.

Current Findings

Sanitation, safety, and sterilization have not changed materially since the First Court Expert's Report. We concur with the First Court Expert; however, we identified current and additional findings as follows.

Surface disinfection between patients was adequate although difficult due to cracked counter surfaces. Instrument sterilization procedures were adequate and proper. Flow from dirty to clean to sterilized was improper, as bagging of instruments was done in front of the ultrasonic unit. Cleaned instruments were passed back over the dirty area. There was not a biohazard label posted in the sterilization area.⁹⁵

Safety glasses were not worn routinely but are worn only when large fillings were being removed. Eye protection is always necessary.^{96, 97} There was no warning sign posted where x-rays were taken to warn pregnant women of possible radiation hazards, nor was a lead apron with a thyroid collar used consistently.^{98,99} There is documentation that "those aspects of your

⁹⁵ CFR 1901.145(e)(4). "The biological hazard warning shall be used to signify the actual or potential presence of a biohazard and to identify equipment, containers, rooms, materials, experimental animals, or combinations thereof, which contain, or are contaminated with, viable hazardous agents.")

⁹⁶ "We use personal protective equipment [...] **as well as provide eye protection to patients for all dental procedures.**" We Take Infection Control Seriously. UIC College of Dentistry. Viewed at <https://dentistry.uic.edu/patients/dental-infection-control>, February 2, 2018. Emphasis added.

⁹⁷ Guidelines for Infection Control in Dental Health-Care Settings ---2003. MMWR, December 19, 2003/ 52(RR17):1:16; pp. 17-18. ("PPE [personal protective equipment] is designed to protect the skin and the mucous membranes of the eyes, nose, and mouth of DHCP [dental health care provider] from exposure to blood or OPIM [other potentially infectious materials]. Use of rotary dental and surgical instruments (e.g., handpieces or ultrasonic scalers) and air-water syringes creates a visible spray that contains primarily large-particle droplets of water, saliva, blood, microorganisms, and other debris. This spatter travels only a short distance and settles out quickly, landing on the floor, nearby operatory surfaces, DHCP, **or the patient**. The spray also might contain certain aerosols (i.e., particles of respirable size, <10 µm). Aerosols can remain airborne for extended periods and can be inhaled" and "Primary PPE used in oral health-care settings includes gloves, surgical masks, **protective eyewear**, face shields, and protective clothing (e.g., gowns and jackets). All PPE should be removed before DHCP leave patient-care areas (13). Reusable PPE (e.g., clinician **or patient protective eyewear** and face shields) [...]"). Emphasis added. Moreover, protective eyewear protects against objects or liquids accidentally dropped by the provider.

⁹⁸ Each radiation area shall be conspicuously posted with a sign or signs bearing the radiation caution symbol and the words, "CAUTION RADIATION AREA". Occupational Safety and Health Standards – Toxic and Hazardous substances. 29 CFR 1910.1096(e)(3)(i). Emphasis in original.

⁹⁹ While radiation exposure from dental radiographs is low, it is the dentist's responsibility to follow the ALARA Principle (As Low as Reasonably Achievable) to minimize the patient's exposure. Dentists should follow good radiologic practice and (*inter alia*), use protective aprons and thyroid collars. Dental Radiographic Examinations: Recommendations for Patient Selection and Limiting Radiation Exposure. American Dental Association and Food and Drug Administration (2012), 14.

radiation producing equipment and operating procedures reviewed by the inspector were found to follow applicable Illinois radiation protection regulations;" however, neither the equipment's model and serial number(s) nor the operating procedures reviewed were specified.¹⁰⁰

Dental: Review Autoclave Log

Methodology: Review last two years of entries in autoclave log, interview dental staff, tour sterilization area.

First Court Expert Findings

- A review of spore testing logs revealed that a "Maxi-test" in office biological indicator system was in use. The incubator was maintained in the sterilization area. The results were logged weekly.
- There was a gap in logged results from the last week of January to the first week in April with no explanation provided. I was assured that the testing was done during this period. It is essential that these logs be accurately maintained over a long period of time.

Current Findings

Autoclave log maintenance has improved since the First Court Expert's Report and is adequate. Spore testing was performed weekly and documented. No negative results were recorded. Unlike the finding of the First Court Expert, there were no gaps in the sterilization record.

Dental: Comprehensive Care

Comprehensive or routine care¹⁰¹ is non-urgent treatment that should be based on a health history, a thorough intraoral and extraoral examination, a periodontal examination, and a visual and radiographic examination.¹⁰² A sequenced plan (treatment plan) should be generated that maps out the patient's treatment.

Methodology: Interviewed dental staff, reviewed one dental chart of inmates who received non-urgent care, observed dental treatment, and reviewed Daily Dental Reports.

First Court Expert Findings

- One of the most basic and essential standards of care in dentistry is that all routine care proceeds from a thorough, well-documented intra and extra-oral examination and a well-developed treatment plan, to include all necessary diagnostic x-rays. A review of 10 records revealed no comprehensive examination was performed in three of the records and very minimal examinations were performed in three others.

¹⁰⁰ Letter from Illinois Emergency Management Agency to Walter Nicholson, Assistant Warden, Statesville Correctional Center dated July 21, 2017. CQI 2-16-2017_4. Pdf, p. 7.

¹⁰¹ Category III as defined in Administrative Directive 04.03.102.

¹⁰² Stefanac SJ. Information Gathering and Diagnosis Development. In Treatment Planning in Dentistry [electronic resource]. Stefanac SJ and Nesbit SP, eds. Edinburgh; Elsevier Mosby, 2nd Ed. 2007, pp. 11-15, *passim*.

- We reviewed 10 dental records of inmates in inactive treatment classified as Category 3 patients. In only four records did a meaningful comprehensive examination precede routine care. No examination of soft tissues or periodontal assessment was part of the treatment process.
- Hygiene care and prophylaxis were inconsistent, provided in six of the 10 patient records. A further review showed that bitewing radiographs were part of the treatment process in eight of the 10 records.
- Oral hygiene instructions (OHI) were not always documented in the dental record as part of the treatment process.
- Restorations were, in two of the 10 patients, provided from the information from the Panorex radiograph. This radiograph is not diagnostic for caries. A periodontal assessment was not done in any of the records.

Current Findings

Comprehensive care has not improved materially since the First Court Expert's Report. We concur with the First Court Expert; however, we identified current and additional findings as follows.

Administrative Directive 04.03.102 specifies that "within 10 working days after admission to a reception and classification center [...] each offender shall receive a **complete** dental examination by a dentist" (§11F2, emphasis added). However, the NRC does not perform a complete (or comprehensive) examination.

When the inmates arrive at SCC, a comprehensive (routine) examination is not performed and a treatment plan is not produced unless a routine exam is requested by the inmate or the inmate is due for a biennial exam. Consequently, many inmates will not have a comprehensive exam and treatment plan for two years, if at all.¹⁰³

This was not the practice reported by the NCCHC based on a site visit May 16-19, 2016.

The dentist also completes a **full dental examination** on every newly arrived inmate within one week and provides some oral instruction and written materials on proper oral hygiene and preventive oral education. [...].¹⁰⁴

¹⁰³ Since the intake examination performed at NRC is so cursory and does not include bitewing x-rays or a periodontal probing, inmates may be unaware of existing dental disease, so they would not request a routine examination at SCC. Dentate or partially dentate adults who are new patients should receive an "[i]ndividualized radiographic exam consisting of posterior bitewings with panoramic exam or posterior bitewings and selected periapical images." Furthermore, recall patients should receive posterior bitewing x-rays every 12 to 36 months based on individualized risk for dental caries. With respect to periodontal disease, "[i]maging may consist of, but is not limited to, selected bitewing and/or periapical images of areas where periodontal disease (other than nonspecific gingivitis) can be demonstrated clinically." Dental Radiographic Examinations: Recommendations for Patient Selection and Limiting Radiation Exposure. American Dental Association and U.S. Food and Drug Administration, 2012. Table 1, pp. 5-6.

¹⁰⁴ NCCHC Technical Assistance Report, p. 61. This practice was neither described by the First Court Expert nor found by our team. Furthermore, it is not set forth in Administrative Directive 04.03.102. It is, however, consistent with NCCHC Oral Care Standard P-E-06, which, in addition to requiring a screening within seven days of admission, requires that an oral examination be performed by a dentist within 30 days of admission. National Commission on Correctional Health Care, Standards for Health

Of 10 records of inmates who received routine care, all had recent bitewing or periapical x-rays, and none documented a soft tissue exam or periodontal assessment.¹⁰⁵ Four were without a treatment plan.¹⁰⁶ Treatment plans were scanty and not in a prioritized list format. In three records, treatment was not sequential.¹⁰⁷ Oral hygiene instruction was not documented in two records.¹⁰⁸ We found no evidence of extended wait times or backlog of services.

Dental: Intake (Initial) Examination¹⁰⁹

Methodology: Reviewed 10 dental records of inmates that have received intake (initial) examinations recently. Reviewed Administrative Directive 04.03.102. Reviewed SCC CQI Reports.

First Court Expert Findings

- Reviewed 10 inmate dental records that were received from the reception centers within the past 60 days to determine if: 1) screening was performed at the reception center and 2) a panoramic x-ray was taken, to insure the reception and classification policies as stated in Administrative Directive 04.03.102, section F. 2, are being met for the IDOC.

Current Findings

The dental intake exam has not changed materially since the First Court Expert's Report and remains inadequate. While the First Court Expert reported aspects of the intake examination **process**, we focused on a clinical measure – the quality of the panoramic radiograph and the adequacy of the charting and treatment plan. This explains our divergent findings. In addition, we identified current and additional findings as follows.

While the First Court Expert reported that “policies as stated in Administrative Directive 04.03.102, section F. 2, are being met for the IDOC”, that finding overlooked the most important issue – the inadequacy of the intake examination.

Services in Prisons, 2014, p. 81. Emphasis added. See also National Commission on Correctional Health Care, Standards for Health Services in Prisons, 2018, p. 96, ¶16.

¹⁰⁵ Stefanac SJ. (A panoramic radiograph has insufficient resolution for diagnosing caries and periodontal disease. Intraoral radiographs (e.g., bitewings) and periodontal probing are necessary), p. 17. Also, (Periodontal Screening and Recording (PSR), an early detection system for periodontal disease, advocated by the ADA and the American Academy of Periodontology since 1992, is an accepted professional standard.), pp. 12-14. See American Dental Hygiene Association. Standards for Clinical Dental Hygiene Practice Revised 2016, pp. 6-9. (Periodontal probing is also a standard of practice for dental hygiene).

¹⁰⁶ That is, starting with an oral prophylaxis (cleaning) and proceeding with extractions, periodontal treatment, fillings, and prosthetics. Note that question #6 on the Wexford Peer Review Form for Dentists – PR-001C (“Is a plan for care documented?”) addresses a treatment plan.

¹⁰⁷ Comprehensive Care Patients #3, 5, 7 and 10.

¹⁰⁸ Comprehensive Care Patients #8 and 9.

¹⁰⁹ The First Court Expert Report describes the examination performed at intake as a “Screening Examination;” however, Administrative Directive 04.03.102 describes it as a “complete dental examination.” We use the terminology of the Administrative Directive and refer to the intake or Initial Dental Examination as a complete dental examination.

Of 10 records of inmates who received intake exams at the NRC, one had no dental information¹¹⁰ and all but two of the remaining records (78%) had a clinically inadequate panoramic x-ray¹¹¹ that Dr. Orenstein attributed to the age of the x-ray and film processing units.

“Oral hygiene instructions” was stamped in all the charts. The SCC dental hygienist said that she does not provide OHI at the examinations. Furthermore, the exams occur so quickly, adequate OHI simply cannot be provided by the dentist.

Of the 10 records, only one documented that an initial examination and treatment plan was done.¹¹² Medical histories were filled out in all the records; however, Intake (Initial) Examination Patient #2 had hypertension noted in the problem list in the medical chart but not in the health history in the dental chart. One patient was noted as Classification IIa;¹¹³ however, a recommended disposition¹¹⁴ was not indicated. The inadequacies of the NRC intake dental exam were identified in a Quality Improvement Study report that is discussed the Dental Quality Improvement Committee section of our NRC report.

Dental: Extractions

Methodology: Reviewed records of randomly selected inmates that have had extractions selected from Daily Dental Reports October 2017 through January 2018. Interviewed the dentist.

First Court Expert Findings

- Reviewed 10 dental records of dental surgical inmates to determine: 1) if recent pre-operative radiographs reflecting the current condition of tooth extracted (that is, showing apices of teeth); 2) the reason for extraction is documented; and 3) there is a signed consent form.
- In four of the 10 records reviewed, the reason for the extraction was not documented.
- In two of the records, a proper diagnostic x-ray was not present. This is a serious omission.
- Record entries are often very difficult to follow. Treatment at times seemed disjointed and lacking in continuity. The time between appointments can be long due to rescheduling associated with failed appointments.

¹¹⁰ Intake (Initial) Examination Patient #6.

¹¹¹ The principal problem was inadequate contrast, especially in the middle portion of the face. In addition, several films had the number that links the film to an inmate chart superimposed over tooth roots.

¹¹² Dental: Intake (Initial) Examination Patient #2. The record noted that it had been reviewed 2/6/18; however, there was no clinical entry.

¹¹³ “An oral condition, if left untreated, that would cause bleeding or pain in the immediate future.” Administrative Directive, Attachment A.

¹¹⁴ There are three choices: 1) schedule immediately at R&C, 2) schedule routine exam at receiving institution, and 3) schedule immediately at receiving institution. Since Classification II is urgent care, the problem should have been dealt with at the NRC or immediately upon arrival at SCC.

- Also, antibiotics were often given after extractions without a documented reason. They seemed to be provided prophylactically. This is not a standard of care. They should be prescribed only when indicated by a well-established diagnosis.

Current Findings

Extraction care has improved since the First Court Expert's Report but remains inadequate. We concur with the most of findings in the First Court Expert's report, but note that we found that (of nine charts reviewed) all charts had clinically adequate preoperative x-rays. However, we identified current and additional findings as follows.

We agree with most of the First Court Expert's findings although we found all charts had a signed consent form that identified the tooth number; however, five did not state the diagnosis, that is the reason the tooth was to be extracted.¹¹⁵ Documentation was poor,¹¹⁶ with a diagnosis not being reported for three patients.¹¹⁷ There was no documentation that the health history was updated in four charts.¹¹⁸ Post-extraction antibiotics were prescribed without documented evidence of infection.¹¹⁹

Dental: Removable Prosthetics

Methodology: Reviewed Daily Dental Reports from October 2017 through January 18, 2018. Interviewed dental staff.

First Court Expert Findings

- We reviewed dental records of five patients who received completed partial dentures to determine if restorative procedures were completed prior to fabrication of partial dentures. Removable partial denture prosthetics should proceed only after all other treatment recorded on the treatment plan is completed. Continuity of care is important and the periodontal, operative, and oral surgery needs all should be addressed first.
- In only one of five records reviewed on patients receiving removable partial dentures were oral hygiene instructions provided.
- Periodontal assessment was not provided in any of the records, and in only one of five records was a prophylaxis and/or a scaling debridement provided. Because a comprehensive examination was part of only two records and treatment plans were very incomplete, it is almost impossible to ascertain if all necessary care, including operative and/or oral surgery treatment, is completed prior to fabrication of removable partial dentures.

¹¹⁵ Extraction Patients #2, 3, 4, 6, and 7.

¹¹⁶ For Extractions Patient #1 (Ext #24 7/14/17), chart entries for 9/15/17, 10/4/17, 10/20/17, 11/1/17, 11/15/17, 12/22/17, 12/28/17, and 2/26/18, were illegible. Similarly, the chart of Extraction Patient #5 had several illegible entries.

¹¹⁷ Extraction Patients #1, 2 (illegible), and 4 (illegible).

¹¹⁸ Extractions Patients #1, 3, 6, and 7.

¹¹⁹ Comprehensive Care Patient #1 had teeth extracted 5/4/17 and 5/18/17, and Amoxicillin was prescribed without a documented infection. Similarly, Extraction Patients #3, 5, 7, 8, and 9 had post-extraction Amoxicillin prescribed without a diagnosed infection. Extractions Patient #5's chart contained many illegible entries. The patient returned from having tooth #1 extracted by Joliet Oral Surgeons 9/1/17 and was prescribed Amoxicillin without a diagnosis of infection.

Current Findings

Removable prosthetics care is unchanged from the First Court Expert's Report and remains inadequate. We concur with the First Court Expert; however, we identified current and additional findings as follows.

Of six records selected from a list of completed partial dentures, none of the removable partial dentures were fabricated based on a formal treatment plan. None of the charts documented a PSR; however, one chart¹²⁰ mentioned periodontal status. Two charts¹²¹ did not document that an oral prophylaxis (cleaning) was performed and one patient¹²² had a partial denture impression taken before restorative treatment was complete.

Dental: Sick Call/Treatment Provision

Methodology: Interviewed dental staff. Reviewed Dental Sick Call Log from 10/3/17 through 1/22/18.¹²³ Reviewed Daily Dental Reports from 10/3/17 through 1/17/18. Reviewed records of seven inmates who were seen on sick call. Reviewed recent intake examination records.

First Court Expert Findings

- Inmates access sick call through an inmate request form or via a direct call from a staff member if it is perceived as an emergency, in addition to a "Request Log" that logs inmate request forms.
- An Emergency Log tracks patients seen as "emergency." These inmates are seen the same day as the request. For 2014, thus far, 12 inmates were seen as an emergency. All were toothaches, abscesses, or trauma.
- There is no real triage system in place to evaluate urgent care needs (toothaches, pain, swelling) from the request forms. Of the inmates placed in the Request Log, the average wait for an appointment was about 12 days. This is for all request forms. Of the requests logged in as toothaches, pain, or swelling, the average wait was approximately six to seven days. These inmates should be seen within 24-48 hours.
- In none of the dental records reviewed was the SOAP form used. As a result, treatment was usually provided with little information or detail preceding it. Sick call record entries often did not include clinical observations or diagnosis to justify provided treatment. Little continuity was established.
- In all records, the immediate complaint was addressed. Only emergency care was provided.

Current Findings

While some aspects of urgent care have improved since the First Expert's Report, it remains inadequate, and we concur with the First Court Expert's findings. However, we identified current and additional findings as follows.

¹²⁰ Prosthetics Patient #1. In addition, #1 and #2 were extracted (10/6/16) based on an inadequate and three-year-old panoramic x-ray. There was no consent form and Amoxicillin was prescribed without a documented infection.

¹²¹ Prosthetics Patients #4 and 5.

¹²² Prosthetics Patient #6.

¹²³ Dental Bates 40-46.

Inmates are informed that they can access health care (including dental care) as part of the SCC intake process.¹²⁴ In the alternative, they can submit a specific request for dental care on a form that is collected periodically and delivered to the dental clinic.

Dr. Orenstein's clinical progress notes are extremely difficult to read at best, and indecipherable at worst. A particularly egregious example of this is in the dental chart of Medically Compromised Patient 1, where the entire page comprising entries from 5/3/17 to 8/14/17 is located. There are many similar entries in this chart (as well as other charts).

Of 10 inmates who sought a dental appointment for painful conditions, one did not have a diagnosis documented,¹²⁵ one had the health history updated,¹²⁶ and five did not use the SOAP format.¹²⁷ Three patients received prescriptions for antibiotics although no infection was documented.¹²⁸

Inmates can enter their names in a Sick Call Request Log. The January 2018 RN Sick Call Log contained 11 entries related to dental care, of which seven charts were available for review. All the inmates were seen by nursing and referred to dental; however, two encounters¹²⁹ did not have nursing notes. While most requests were for routine care, three¹³⁰ were for painful conditions.¹³¹ Some nursing progress notes mention pain; however, the nursing protocol for toothache/dental pain was not used and analgesics were not dispensed. Patients #1, 5, and 6 were seen by a dentist in five, 15, and six days, respectively.

Dental: Orientation Handbook

Method: Reviewed the Orientation Handbook and related documents.

First Court Expert Findings

A review of the "Offender Orientation Manual" for SCC and the NRC revealed that dental care was well represented and the instructions as it relates to access to care is adequate.

Current Findings

Inmate orientation to dental care has not changed substantially since the First Court Expert's Report and we agree with the First Court Expert that it remains adequate. Inmates are informed that they can access health care (including dental care) as part of the SCC intake

¹²⁴ SCC Access to Care document.

¹²⁵ Dental Sick Call Patient #1. This patient also had #16 extracted 12/4/17, but a consent form is not present.

¹²⁶ Dental Sick Call Patient #5.

¹²⁷ Dental Sick Call Patients #1, 2, 4, 8, and 10. Note question #5 on the Wexford Peer Review Form for Dentists – PR-001C ("Is the provider documenting in the SOAP format?").

¹²⁸ Dental Sick Call Patients #5 (Amoxicillin 12/12/17), #6 (Amoxicillin 12/22/17), and #7 (Clindamycin 12/19/17).

¹²⁹ Dental RN Sick Call Patients #2 and 3.

¹³⁰ Dental RN Sick Call Patient #1.

¹³¹ Dental RN Sick Call Patients #1, 5, and 6.

process. In the alternative, they can submit a specific request for dental care on a form that is collected periodically and delivered to the dental clinic.¹³²

Dental: Policies and Procedures

Methodology: Reviewed Administrative Directives that deal with the dental program. Interviewed dental staff. Reviewed dental charts. Toured dental clinical areas. Reviewed SCC organizational chart.

First Court Expert Findings

- A well-developed policy and procedures manual insures a dental program that is well understood and run with continuity. It addresses all aspects of the dental program to provide consistency of care and management.
- The policy and protocol manual for the dental program at SCC addresses only dental personnel and their duties and responsibilities. It only states that the dental program is responsible to provide dental care to the offender population. No specifics were provided on access to care, provision of care, clinic management, dental services provided, infection control, etc.
- The dental director said that this was developed by administration who thought it was sufficient.

Current Findings

Dental policies and procedures have not changed materially since the First Expert's Report and we agree that they are inadequate and should be expanded.

Dental: Failed Appointments

Methodology: Reviewed Dental Sick Call log. Interviewed dental staff. Reviewed Daily Dental Reports.

First Court Expert Findings

A review of monthly reports and daily work sheets revealed a failed appointment rate that averaged 40%. This is a very high percentage and reflects a serious problem in getting inmates to the clinic for their appointments. I was told that they shared my concern and were frustrated at the lack of success in addressing this problem. I was told that the reasons for failed appointments included the following: 1) inmates do not get their passes; 2) inmates go to other programs or appointments; 3) inmates go to recreation; 4) inmates go to commissary; and 5) inmates are in lockdown. The percentage does reflect lockdown days, which average about two a month. The problem is compensated for by overscheduling every day. As such, many inmates are seen every day, and a large number also fail to show.

The administrative staff, including the Warden, shared the concern and frustration of the dental staff and want to help them address the problem of failed appointments.

¹³² Access to Care Document.

Current Findings

We concur with the First Court Expert that failed appointments have not improved materially since then and remain inadequate. Moreover, we identified current and additional findings as follows.

The failed appointment rate does not appear to be deemed an important measure by SCC leadership. For example, it did not appear on the six-page October, November, or December Dental Reports¹³³ as a key metric. Failed appointment rates are not reported by the dental department.

Dental: Medically Compromised Patients

Methodology: Reviewed health history form and records from recent intake exams. Compared the health history in the dental chart to the medical problem list.

First Court Expert Findings

A review of six dental records of inmates who were on anticoagulant therapy revealed that three of the records had no health history documentation as part of the dental record. In the other three records, it was documented and red flagged. In all cases of provided dental care to these patients, medical staff was consulted, and anticoagulant therapy precautions were addressed and followed. When asked, the dental providers indicated that they do not routinely take blood pressures on patients with a history of hypertension.

Current Findings

Documenting the health history of medically compromised patients has deteriorated since the First Court Expert's Report. We concur with the First Court Expert that documentation of the health history of medically compromised patients was inadequate. Moreover, we identified current and additional findings as follows.

Several patients had chronic conditions important to dental treatment that were on the medical problem list and on the health history in the dental chart.¹³⁴ Other patients had problems noted on the medical problem list but not on the health history in the dental chart.¹³⁵ There was no documented periodontal assessment nor follow-up for the diabetics, which is particularly problematic given the relationship between periodontal disease and diabetes.¹³⁶

¹³³ CQI Monthly Oct 2017_1.pdf, p. 7; CQI Monthly Nov_2.pdf, pp. 13-18; and CQI Monthly Dec 2017_2, pp. 13-18, respectively.

¹³⁴ Medically Compromised Patient #1 (Coumadin). The record reports that Coumadin therapy was (appropriately) stopped for two days before a planned extraction. Patient #10 (Coumadin). Patient #6, 8, and 9 (diabetes).

¹³⁵ Medically Compromised Patients #4 and 5 (diabetes); Patients #3 and 7 (Coumadin). Patient #7 received an intake screening 12/15/15 but did not receive a complete examination until his 1/11/18 biennial examination. Patient #3 was taking Warfarin 11/23/16 – 2/20/17 and Coumadin from 2/19/17 – 5/18/17 and 3/22/17 – 6/22/17; yet the health history was not updated, and anticoagulant use was not noted.

¹³⁶ See, for example, Herring ME and Shah SK. Periodontal Disease and Control of Diabetes Mellitus. *J Am Osteopath Assoc*. 2006; 106:416–421; Patel MH, Kumar JV, Moss ME. Diabetes and Tooth Loss. *JADA* 2013;144(5):478-485 (adults with diabetes are at higher risk of experiencing tooth loss and edentulism than are adults without diabetes); And Teeuw WJ, Gerdes VE, and Loos BG. Effect of Periodontal Treatment on Glycemic Control of Diabetic Patients. *Diabetes Care* 3 3:421-427, 2010 (periodontal treatment leads to an improvement of glycemic control in type 2 diabetic patients).

Dental: Specialists

Methodology: Interviewed dental staff, reviewed CQI documents, and reviewed dental charts of inmates who were seen by an oral surgeon.

First Court Expert Findings

Dr. Frederick Craig, an oral surgeon, is available on an as-needed basis, usually once a month, sometimes twice. Dr. Craig is also used by several other IDOC institutions. The dental program also utilizes Joliet Oral Surgeons, a local oral surgery group, for more difficult cases and for general anesthesia. Pathology services are the same as for medical pathology. They give the specimen to the appropriate medical person for processing. All radiographs were current, and all record entries were adequate. The NRC utilizes these services through SCC.

Current Findings

Oral surgery consultation has changed substantially since the First Court Expert's Report and is adequate. We concur with the First Court Expert's findings. Questions have been raised about the performance of the onsite oral surgeon and are addressed in the CQI section (*infra*). Dr. Craig has not provided onsite oral surgery services in the past year. SCC has recently located another oral surgeon willing to provide onsite services.

Dental: CQI

Methodology: Reviewed CQI minutes and reports. Interviewed dental staff.

First Court Expert Findings

The dental program contribution to monthly CQI includes a thorough documentation of dental statistics and productivity numbers. There is an ongoing CQI report for the dental program that seeks to improve the ability of segregation inmates to get to the dental clinic for their appointments. It is a study that looks at the reasons why they are not getting to the clinic. These findings must be used to develop procedures to improve this problem. Consideration should be given to conduct ongoing studies with the NRC.

Current Findings

The dental CQI program has improved since the First Court Expert's Report. We agree with the First Court Expert that the dental CQI program should not be limited to reporting data and that studies must be used to drive changes in policy, procedures, and practices. Moreover, we identified current and additional findings as follows.

The SCC Annual CQI Report 2016-2017 mentioned two dental issues. The first was a discussion of the Oral Surgery Study which addressed problems associated with Dr. Craig, an oral surgeon who treats inmates onsite at several IDOC prisons.¹³⁷

¹³⁷ Stateville Annual CQI 2016-17_1.pdf, p.15. pdf p. 15. Dr. Craig is no longer being referred patients from SCC (although he was still seeing patients at other IDOC prisons) due to "performing the wrong procedure and talked patients out of procedures" (*id.*).

A clinical outcome review of 56 inmates referred to Dr. Craig for onsite oral surgery found that he performed the wrong procedure on one patient; 17 patients were sent offsite for their procedure; several patients were sent to an offsite oral surgeon for the procedure or a complication of the onsite procedure; 10 patients refused when informed of potential complications; and 13 were evaluations, follow-ups, or reschedules.¹³⁸ The committee recommended that the issue should continue to be monitored (*id.*). A follow-up study was reported 9/29/17, and another follow-up was planned in six months.¹³⁹ Dr. Meeks recommended a Root Cause Analysis be performed on Dr. Craig. NRC AWP Konopka asked if a Peer Review was performed. Dr. Meeks also suggests that Dr. Funk and Mr. Mote monitor Dr. Craig's progress at other institutions. Dr. Funk commented that Dr. Craig is still employed at Pontiac C.C. and a few other facilities. Dr. Craig is performing minimal surgery procedures, keeping patients onsite per Dr. Funk. Doug Mote will investigate further and report findings to Dr. Meek and Dr. Funk (*id.*, p. 15).¹⁴⁰

The other study focused on compliance with aspects of the Dental Administrative Directive based on dentists' review of dental charts, primarily from NRC.¹⁴¹ Among the findings from the NRC charts were that 62% had no charting of pathology, with the remainder having only a partial charting.¹⁴² Furthermore, "in all the patients reviewed, visible heavy tartar [calculus] was never charted or indicated. The periodontal needs were never indicated" and "the dental radiographs from NRC varied in diagnostic quality."¹⁴³ (*id.*)

Internal Monitoring and Quality Improvement

Methodology: Interview facility health care leadership and staff involved in CQI activities. Review the internal monitoring and CQI meeting minutes for the past 12 months.

First Court Expert Findings

The First Court Expert found that there were no CQI meetings since October 2013 (the visit was in February 2014) and no minutes since July of 2013. The minutes contained no narrative, no analysis of the data presented, and no studies. This program was described as "non-functioning." The grievance process was stated to be "non-functioning" because there was no interview of the grievant.

¹³⁸ Stateville Annual CQI 2016-17_2.pdf, p. 34.

¹³⁹ CQI Monthly Oct 2017_3.pdf, pp. 15-20.

¹⁴⁰ We requested of IDOC and Wexford 1) the root cause analysis that Dr. Meeks recommended; 2) any focused peer review that may have been performed on Dr. Craig; 3) any documentation related to Dr. Funk or Mr. Mote's monitoring of Dr. Craig; and 4) any actions taken re Dr. Craig at the other IDOC prisons where he sees patients (e-mail from Dr. Puisis to Nicolas Staley dated 3/9/18). They have yet to be provided.

¹⁴¹ Specifically, 1) whether a complete dental exam with charting of the oral condition was performed within 10 days of arrival at Reception and Classification Center; 2) whether a diagnostic panoramic radiograph was taken on each inmate; and 3) whether inmates' treatment needs were classified appropriately. Quality Improvement Study. Of 24 charts, 21 were from NRC.

¹⁴² "The missed pathology included abscessed teeth, teeth that needed extraction, [and] periodontal disease, (+3) mobility in teeth, grossly decayed teeth, impacted wisdom teeth, wisdom teeth in the maxillary sinus, and numerous visible dental caries" (*id.*).

¹⁴³ Seven of the Panorex x-rays were of poor quality and unable to obtain any diagnostic information, or 33%" (*id.*).

The First Court Expert recommended reinvigoration of the CQI program. He recommended professional performance reviews with feedback to the clinician and nurses with respect to the sick call process. He recommended that leadership of the CQI program must be retrained regarding CQI philosophy and methodology along with design and data collection, and that the training include how to study outliers in order to develop targeted improvement strategies.

Current Findings

The First Court Expert found that the CQI program was non-functioning. We found that the CQI program was functioning but functioning so poorly that it was effectively non-functioning. We did not evaluate the grievance process because we did not receive the CQI minutes until the Wednesday evening during our tour, too late to evaluate the grievances presented in that report.

The CQI program at SCC was ineffective for the following reasons:

- The Annual CQI Plan has no goals or objectives related to problems areas at the facility.
- The Annual CQI Plan is a generic plan which is a word-for-word duplicate of the plan used at NRC, even though NRC and SCC are different facilities with different missions. The Annual CQI Plan failed to identify the upcoming year's agenda of CQI work.
- Credential *and privilege* reviews of physicians are performed by nurses who do not have the capacity to review physician privileges.
- Review of credentials fails to include one-time primary source verification. The CQI coordinator and HCUA did not understand what primary source verification meant even though it is an administrative directive requirement.
- The Governing Body of the CQI committee consists of the Warden, an ex-warden, and the Agency Medical Director. Health trained staff are underrepresented on the CQI Governing Body.
- The CQI studies do not investigate quality of care or appropriateness of care even when this is required by administrative directives, for example with respect to offsite services.
- The leadership does not appear to understand the difference between outcome and process studies. Outcome studies were not based on a clinical outcome and most outcome studies appeared to be performance measures instead of outcome studies.
- Mortality review is not performed. Instead, a death summary is done by a physician involved in provision of care. This summary fails to include a critical review of the death and does not identify problems in order to prevent further mortality. Though we have found preventable deaths in our death reviews, there is no evidence that the system is attempting to identify problems so that these deaths can be prevented.
- Infection control data appears inaccurate.
- The Medical Director summary in the annual CQI report from NRC is an identical word-for-word duplicate of the Medical Director summary from SCC with the exception of a single sentence about NCCHC accreditation, which NRC is not engaged in. These are different facilities with different missions and should have a different summary by the Medical Director.

- While the concept of internal audits is sound and potentially useful, five of six audits did not include the reported findings. Also, these audits only focus on process issues and should also include quality of care.

The purpose of SCC CQI was not to identify and solve problems in order to improve care. This appears to be a result of lack of leadership. The Director of Medical Records is the CQI Coordinator. She has no training in CQI. She is well trained for her work as a Director of Medical Records but poorly trained for her assignment to be CQI Coordinator. Her knowledge of CQI is to “follow the ADs.” She stated that her role as Coordinator is to set the calendar of studies required by the IDOC, to remind staff to complete their studies, and to manage the paper flow. For this purpose, she spends about four hours a month. She is not involved in developing a CQI plan and stated that the Governing Body (the Warden, an ex-warden, and the Agency Medical Director) develops the plan with the IDOC Regional Coordinator. She believes that all studies required by the AD on CQI are completed. She failed to understand the meaning of some of the required studies. There is no method by which SCC identifies problems. None of the other leaders of the medical program have had any training in CQI.

SCC does not maintain a manual of CQI as required by the AD. The Annual CQI Plan is a generic plan that contains no identified problems and has no specific plans for the upcoming year’s CQI projects. This is inconsistent with the requirements of the AD.¹⁴⁴ The plans from NRC and SCC were identical even though the institutions have different missions and different sets of problems. The plans do not include an agenda for the past or upcoming year with respect to CQI projects that have been identified from problem prone areas. The summary of the annual CQI meeting failed to discuss the prior year’s plan, major findings, or accomplishments based on identification of problems and corrective actions undertaken.

The HCUA and vendor Director of Nursing (both nurses) are responsible for reviewing all professional credentials *and privilege sheets*, but as nurses they are not capable, in our opinion, of reviewing credentials or privileging of the physicians. The CQI AD states that one-time primary source verification is to be done.¹⁴⁵ The CQI AD states that the vendor is to do this. Neither the CQI Coordinator nor the HCUA could tell us what primary source verification meant. There was no evidence that this was done. The CQI plan states that the program reviewed 100% of credentials. Yet for physicians, verification consisted only in verifying that they had a license.

Medical program staff are underrepresented on the Governing Body. The Governing Body of the CQI committee is the Warden, the vendor Regional Manager and the Agency Medical Director. The vendor Regional Manager is an ex-warden with no prior formal training in health care management or in a health care discipline. This means that the controlling votes of the

¹⁴⁴ AD 04.03.125 Quality Improvement Program, item II.F.b. states, “Annually develop or update a Quality Improvement Plan based on a program that *identifies problems and opens channels of communication for appropriate resolution of identified concerns.*” [our emphasis]

¹⁴⁵ AD 04.03.125 Quality Improvement Program item II.I.h. states, “A one-time primary source verification shall be conducted by the comprehensive health care vendor for all licensed contractual staff.”

Governing Body is a current Warden and an ex-warden who works for the vendor. This is unlikely to result in effective direction for the CQI program and also means that two individuals with criminal justice training control the medical CQI program.

An AD requirement to monitor the quality and appropriateness of offsite care is not being done.¹⁴⁶ The annual report merely lists the number of offsite visits, without any evaluation of appropriateness or quality. We discussed a case of delayed diagnosis of colon cancer in the hospital section of this report. This same patient is mentioned in the December 2017 CQI report as a delayed diagnosis. Yet there was no discussion as to why the diagnosis was delayed and no attempt to remedy the root cause problem to prevent these types of delays in order to prevent morbidity and mortality. The AD requires that all UM denials are monitored to ensure that necessary and appropriate care is provided.¹⁴⁷ This task is assigned to the HCUA, who is a nurse. It is our opinion that a nurse is incapable of determining if physician or other provider referrals for offsite care are necessary or appropriate. This should be done by a physician. We noted that aside from providing the numbers of individuals who obtained offsite services, there was no evidence of any monitoring or evaluation for quality of care or appropriateness. To merely list these visits is not evidence of quality of care or appropriateness.

We asked for but did not timely receive the list of denials of offsite care for SCC and were not able to review these before we ended the tour. However, it is not clear from the CQI data presented that the denials were appropriate. These data merely list the number of events that occurred without any evidence that the quality or appropriateness was evaluated or was adequate.

The section of the annual CQI report on offsite services states that over 95% of individuals are evaluated within five days of their offsite appointment without any evidence that the quality of these evaluations is adequate. As we discuss in the specialty care section, post offsite physician evaluations are not of adequate quality. At some of these visits, doctors did not have the consultant report and in others, the doctor did not document what had occurred at the consultation or during hospitalization. Some recommendations of consultants were not addressed. It is insufficient to merely state that a doctor saw the patient.

The CQI studies included two process studies and four outcome studies. Clinical outcomes are end point measures of health status such as mortality, hospitalization, an HbA1C level of 7 or less, or normal blood pressure. An outcome study measures the effectiveness of interventions based on the ultimate outcome measure. An example would be to study the effect of colorectal cancer screening on colon cancer mortality or the effect of increasing the interval of chronic

¹⁴⁶ AD 04.03.125 II.I.2.b Off-Site Offender Care Services item II.I.2. j. states, "A monthly review of the quality and appropriateness of care of 100% of the following cases not to exceed a total of 50 cases in each area shall be conducted by health care staff. A standard comparison and analysis of the current month to the previous month and the current month to the same month one year earlier shall be provided."

¹⁴⁷ AD 04.03.125 Quality Improvement Program item II.I.2.j. Utilization Review states, "A weekly review of 100% of all Utilization Review denials shall be conducted by the Health Care Administrator to ensure offenders are receiving necessary and appropriate care."

clinic visits on obtaining a normal blood pressure. The studies performed at NRC were not based on a clinical outcome, with one exception. SCC studied whether one inmate treated with Harvoni had a sustained virologic response. While this is an outcome, it is not a good study, for two reasons. First, there was only one patient. Secondly, studies have already been done with Harvoni showing its effectiveness with respect to sustained response. This study adds no value to patient care. None of the remaining studies included a clinical outcome. These studies included:

- Whether the pharmacy changed the duration of a non-formulary medication without notice.
- Whether UIC laboratory results were received within 48-72 hours.
- Whether an injury report was signed by a provider.

These are all performance measures and not outcome studies.

None of the individual CQI studies in the annual report evaluated for quality of care. The RN sick call study found that 74% of a sample of nurse sick call appointments was referred timely to a physician. This study did not consider whether the nurse evaluation or physician evaluation was of adequate quality. Also, although the study identifies a problem, it does not investigate causes as to why 26% of patients were not seen timely and did not propose a solution. Half of the patients not seen did not even have a note in the medical record. There was no comment on identification of possible causes for these poor results and no solution except to monitor the providers. A month later this study was repeated, and only 76% of patients referred by a nurse to a provider were seen within 72 hours. The question why this occurred was not answered even though the result was nearly identical to the prior month. The proposed solution was to repeat the study. The study was repeated in March, two months later and 91% of inmates were timely referred. Three months later the study was repeated and only 72% of patient referred by a nurse to a physician were seen within the specified 72 hours. Again, there was no analysis of why this occurred and there was no proposed solution to improvement. This study did not consider the quality of the nurse or physician evaluations. This study was repeated numerous times showing similar poor results without any effort to identify the root cause of the problem or any attempt to seek resolution of the problem.

The laboratory section of the annual CQI report lists the number of phlebotomies done per month. The only important quality metric in this data is the number of re-draws. However, month to month this process seems to be in control. While it is useful to monitor to ensure maintaining control, efforts should be redirected to problem prone areas. We noted that abnormal laboratory tests were often not followed up, patients with abnormal laboratory tests requiring treatment were not followed up, and patients were not always treated. This led to preventable morbidity in two cases (myocardial infarction and stroke). This type of problem should be investigated.

Mortality review is not done. The Medical Director, who may have been responsible for care of patients who die, provides a summary of the death which gives no indication as to whether any problems were identified. This is not a mortality review. It draws no conclusions as to the

quality of care and gives no information as to whether problems exist or improvements are needed. We note that at this facility the physician performing the mortality reviews is a surgeon and does not have the training to adequately perform analysis to determine if care for the primary care problems was adequate.

The data for MRSA do not seem credible. For 2016-2017, only seven persons were treated for MRSA infection at SCC. This does not seem credible, as MRSA is an extremely common infection. In a subsequent email exchange with the HCUA we were told that there was only one positive MRSA culture in 2017, with nine suspected cases. This seems extraordinarily low and may reflect lack of cultures of patients being treated. It would be appropriate for an infection control study to investigate how many patients are currently being treated for this infection at this facility and to investigate whether there is underreporting of this infection.

There were six internal audits done at SCC presented in the annual CQI report. Three of these audits were done on the same day. These audits included:

- Chronic illness clinic is completed in the appropriate month.
- A progress note is completed for all individuals engaging in a hunger strike.
- All inmates have a physical examination as per administrative directive requirements and problem lists are updated.
- A staff signature is present on all admissions to the infirmary. Nurses will complete a nursing admission note and vital signs will be recorded as required.
- The Medical Director reviews the treatment protocols.
- Only a physician discharges a patient from the infirmary.

None of the internal audits reviewed the quality of care. These audits reviewed process items related to administrative directives. These audits are useful to ensure that processes of care are carried out in accordance with requirements. However, they do not assess whether the care provided was of adequate quality. Only one of the six audits included the data and it is therefore unclear whether these audits were actually done. The audit of Offender Infirmary Services noted that in two of 10 files reviewed, a physician, psychiatrist, or dentist did not discharge the patient from the infirmary as required. The remainder of the internal audits did not include any data to verify that the audit had actually been done.

Clinical performance enhancement is a method of periodic evaluation of the clinical performance of individual practitioners. For this purpose, Wexford, as required by their contract with IDOC, performs peer review of its physicians. We were told that Medical Directors perform these reviews for all staff physicians and mid-level providers at their facility and that Medical Directors from another facility perform the review for the Medical Director.

There are four standardized formatted questionnaires used for peer review, which are found in Appendix B. These questionnaires include infirmary, chronic care, sick call, and laboratory/x-ray utilization. There are several questions related to quality of care, particularly related to the plan of care being adequate, but most questions are process related. A single episode of care is used

for each patient and the questionnaire is repeated multiple times for each area of service in which the provider engages.¹⁴⁸

For the physician assistant at SCC there were two reviews, which consisted of reviews of 15 episodes of care for provider sick call and 10 episodes of care for laboratory/x-ray utilization. In total, 328 questions were asked. 327 (99.69%) were found adequate. One question (0.30%) was inadequate. No problems were identified.

For the staff physician, 341 questions were asked and 338 (99.1%) were adequate. The remaining three questions were not applicable. No problems were identified.

The recent Medical Director had two peer reviews by different physicians. In total, 465 questions were asked. 361 (77.6%) were adequate, 55 (11.8%) were not applicable, and 49 (10.5%) were inadequate. The inadequacies consisted of:

- Failing to write notes
- Failing to document clinical correlation to the complaint
- Failing to document clinically significant findings
- Failing to ensure timely follow up
- Failing to document a targeted physical examination
- Failing to have an appropriate plan of care
- Failing to document patient education.

The clinical performance of the Medical Director, a surgeon, was worse than the physician assistant. In our own record reviews, we found many more inadequacies than were found in these reviews. The Medical Director rarely took an adequate history, rarely performed an adequate physical examination, and seldom included an adequate assessment or plan of care. We identified morbidity and mortality as a result of poor care. Yet the peer reviews purport to demonstrate nearly 100% adequate care. We find these peer reviews less than adequate in describing the extent of problems with quality of care. There are no peer reviews of sentinel events, including death.¹⁴⁹ This fails to protect patients from risk of ongoing harm. We noted in the hospital section of this report multiple instances of harm (myocardial infarction, stroke, delayed diagnosis of colon cancer) that resulted from inadequate care and find that the lack of sentinel event reviews results in increasing the risk of harm to patients. The review of clinical care needs to include sentinel events, including appropriately performed mortality review.

¹⁴⁸ An episode of care is a single unique provider-patient visit.

¹⁴⁹ The Joint Commission defines a sentinel event as unanticipated events in a healthcare setting resulting in death or serious physical injury or risk of injury to the patient not related to the natural course of the patient's illness. These events call for immediate investigation and response.

As found at https://www.jointcommission.org/assets/1/6/CAMH_2012_Update2_24_SE.pdf.

Recommendations

Leadership, Staffing, and Custody Functions

First Court Expert Recommendations

1. Stateville requires its own Health Care Unit Administrator position. *We agree with the First Court Expert's recommendation that SCC have its own HCUA. This has been accomplished.*
2. Stateville requires its own staffing allocation specifically to meet the Stateville service demands. *We agree with the First Court Expert's recommendation. We add that in order to ensure the staffing allocation is adequate, a staffing analysis be performed as listed in recommendation 5 below.*
3. Only trained primary care clinicians (Internal Medicine and Family Practice) should be providing primary care to this population. Physicians should be board certified in a primary care field. *We partly agree with the First Court Expert's recommendation. We would find board eligible physicians acceptable at facilities with a low percentage of high acuity patients.¹⁵⁰ Facilities housing complex patients should have a board certified primary care physician.*
4. All health care providers should have access to electronic medical references. *We agree with the First Court Expert's recommendation. We suggest universal access to UpToDate®.¹⁵¹*

Additional Recommendations

5. A staffing plan should be developed that includes appropriate relief factors and that evaluates for expected service requirements.
6. Health care leadership staff need to receive an orientation to their positions that reasonably informs them of the expected assignments.
7. The use of "traveling medical directors" should not be permitted to contractually substitute as filling a Medical Director position. Failure to have a permanent Medical Director should incur contractual penalties. Coverage physicians should be used as necessary, but coverage physicians should not constitute a filled Medical Director position.
8. An additional IDOC Regional Coordinator should be added to reduce the span of control for this individual.
9. Review of physician credentials and privileges needs to be performed by a physician.
10. Privileging of physicians must include verification of residency training for the services expected to be provided. Physicians should not be allowed to be privileged to perform services for which they have no formal training.

¹⁵⁰ Board eligible is a physician who has completed training in a residency but has not yet received certification. In this case, board eligible would mean that a physician has successfully completed residency training in internal medicine, family practice or emergency medicine.

¹⁵¹ UpToDate® is a clinical decision support resource that can be accessed over the Internet or from a dedicated server. It has pharmacy information and clinical decision support for general medical practice.

11. Contract monitoring should include evaluation of quality of care as provided by the vendor.

Clinic Space, Sanitation, Laboratory, and Support Services

First Court Expert Recommendations

1. Designated exam rooms should be made available with appropriate equipment in cell houses B, E, and F to allow sick call to occur with reduced movement demands. *We agree with this recommendation.*

Additional Recommendations

2. The first aid kits in the correctional officer rooms on the housing units should be regularly inspected and re-supplied after each use.
3. The infirmary beds need to be properly repaired or replaced with hospital beds so that the height of the bed can be modified, the head adjusted, and the railings are operational.
4. A quantity of electrical beds that meet the needs of the infirmary patient population should be purchased.
5. Continue to conduct monthly documented safety, sanitation, and infection control inspections/environmental rounds, focusing at a minimum on all health care areas, the infirmary patient rooms including the negative pressure rooms, the hemodialysis unit, and the dietary department, with monthly reporting to the CQI Committee.
6. Pest control must continue to be addressed in the infirmary.
7. The safety and sanitation defects in the infirmary tub room floor must be corrected.
8. The birds in the inmate dining and food serving areas must be removed and the area properly sanitized.
9. A sanitarian should be hired to review sanitation issues including the washing of cooking and eating instruments, the maintenance of required temperatures in the meat freezer, vermin, pests, and other potential environmental sanitation hazards.
10. 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.
11. All medical equipment must have no less than annual documented inspections and calibrations by a bioengineering team. Each individual piece of medical equipment must have a current date of inspection label.

Medical Records

The First Court Expert had no recommendations.

Current Recommendations

1. Install an electronic medical record. Include at the point of care access to UpToDate® for all staff.

2. If an electronic medical record is not used, modify or improve the paper record files so that they do not come apart during routine use.
3. Negotiate with local consultants and hospitals to timely obtain consultation and hospital reports, as this is a major patient safety and liability issue.
4. When records from consultants are unavailable, the providers need to communicate with consultants to timely obtain necessary information about the consultation to protect patient safety.
5. Create a unified record that includes nephrology consultations and necessary information about dialysis, including laboratory testing if done.

Intrasystem Transfer

First Court Expert Recommendations

1. The intrasystem transfer process needs to be appropriately addressed to effectively ensure continuity of care for patients who enter with prior diagnosed problems. This should be monitored by the QI program. *We agree with this recommendation.*

Additional Recommendations

2. Health care leadership develop and implement a tracking log that documents completion of all intrasystem transfer activities and identifies instances of incomplete transfer information.
3. Written directives of IDOC and Wexford be revised to add responsibility for the sending IDOC facility to accurately complete the Health Status Summary in advance of inmate transfer.¹⁵²

Nursing Sick Call

First Court Expert Recommendations

1. Custody issues should not interfere with the provision of timely health care. *We agree with the First Court Appointed Expert's recommendation that custody issues should not interfere with timely provision of health care, especially as it pertains to patient privacy in segregation.*
2. There should be no such thing as a "no show" in a prison. Patients may refuse care but should be required to report to the health services area when scheduled. *This recommendation has been implemented and all inmates who have signed up for sick call are seen by nursing staff and may refuse the encounter at that time.*

Additional Recommendations

¹⁵² Documents to be revised include the IDOC-Wexford contract, Wexford Policy and Procedure, p. 118 Transfer Screening, and SCC Operations Policies and Procedure, p. 118 Transfer Screening.

2. IDOC Institutional Directive 04.03.103K Offender Health Care Services be revised to incorporate the procedure and practices for sick call as reflected in the SCC Operations Policy and Procedure P103 Non-Emergency Health Care Requests and Services.
3. Sufficient numbers of RNs need to be employed so that LPNs are not assigned to conduct sick call.
4. RNs should perform and document an assessment of each patient in accordance with treatment protocol forms and/or sound nursing judgement.
5. RNs should refer patients to providers in accordance with the treatment protocol and in accordance with sound nursing judgment. The urgency of the referral should be documented and used to schedule provider appointments.
6. The sick call documentation forms should be revised to indicate if the referral is emergent, urgent, or routine.
7. The adequacy of nursing assessments and the plan of care should be monitored by nursing service as part of the peer review or CQI.
8. Custody staff should stand at a distance from the sick call room in segregation so that they can provide visual security but not hear the substance of the interaction.
9. Custody staff should remove restraints without delay when requested by the nurse to complete the evaluation of a health complaint.
10. Providers should see patients timely according to the urgency of the referral.¹⁵³
11. Health care leadership should develop and monitor quality indicators associated with each step of the sick call process. There should be evidence of steps taken to address areas of improvement needed for performance that does not meet the quality indicators.

Chronic Care

First Court Expert Recommendations

1. Patients should be scheduled in accordance with their degree of disease control, with more frequent visits when disease control is poor and less frequent visits for those under good control. This is a statewide policy issue which needs to be corrected.
2. For diabetes clinic:
 - a. Meals should be served on a predictable schedule to facilitate the coordination of insulin administration with food consumption.
 - b. Type 1 diabetics should have access to physiological insulin replacement with three to four injections per day.
3. For HIV clinic:
 - a. Patients with HIV infection should be formally enrolled in the chronic care program just as patients with other diseases are.
 - b. Facility clinicians should be providing primary care to this population. This would include actively monitoring this high-risk population for medication compliance, side

¹⁵³ Emergent referrals should be seen immediately, urgent referrals should be seen the same day and routine referrals seen within 72 hours.

effects, and the primary care complications related to the disease and its treatment, such as hyperlipidemia, diabetes, and cardiovascular disease.

- c. The chronic care nurse should be doing medication compliance checks with HIV patients at least monthly.
- d. Problem lists in the medical record must be incomplete and accurate.

We agree with these recommendations.

Additional Recommendations

- 4. Chronic care provider progress notes must be legible, communicate the rationale for modifications in treatment, list reasonable differential diagnoses, document pertinent physical findings and symptoms, and record clear treatment plans.
- 5. The Office of Health Services should use national standards of care for their chronic illness guidelines. A Chronic Care procedure should specify timelines for clinic intervals and laboratory testing.
- 6. Age and gender based routine health maintenance, including cancer screening and immunizations for patients with and without medical conditions, must be provided in accord the United States Preventive Services Task Force (USPSTF) guidelines and other national standards of care. A and B rated guidelines of the USPSTF should be used for the annual health examination.
- 7. Disease specific chronic care clinic visits should end. Chronic care visits must address all medical conditions of the patient. Strictly focusing on a single specific disease and not addressing other associated clinical problems is not in the best interest of the patient and delays needed interventions.
- 8. The chronic care providers must regularly document the review of the MAR, the CBG tests, the nursing and provider sick call notes, and blood pressure readings when they see patients in the disease-specific chronic care clinics.
- 9. Nursing or CQI staff should do monthly medication compliance audits on all patients with HIV, diabetes, chronic anticoagulation, seizure disorders, and other chronic illnesses as needed. The results should be communicated to the providers and to the CQI Committee.
- 10. The IDOC should develop a plan to shift anticoagulation treatments from Vitamin K antagonists (warfarin) to newer types of anticoagulants that do not require frequent ongoing lab testing to determine the adequacy of anticoagulation. The frequent lab testing and medication adjustments are logistically complicated and put patient-inmates at risk for poor outcomes. Utilizing newer anticoagulation medications that do not require frequent ongoing measurement of the level of anticoagulation should be strongly considered by the IDOC.
- 11. Patients with selected chronic illnesses including diabetes, hypertension, and hyperlipidemia should have the 10-year cardiovascular risk calculated to determine if they require a HMG CoA-reductase inhibitor (statin drug) and the proper dosage to minimize the risk of myocardial infarction, stroke, and other cardiovascular diseases.

Urgent/Emergent Care

First Court Expert Recommendations

1. The urgent/emergent program requires review and feedback both with regard to timeliness, appropriateness, and continuity of care. This should be done by clinical leadership and the QI program. *We agree with this recommendation.*

Additional Recommendations

2. Establish a list of supplies and equipment to be included in each of the first response bags and the disaster bags, and to identify where each is located in the bag. This list should be used to resupply any bag after use and to conduct a monthly inventory.
3. Each of the openings in the bag should be sealed with a numbered plastic tag. The integrity of the seal should be checked and documented on the emergency equipment log at the beginning of each shift.
4. Healthcare leadership should review actual practices against the SCC ID # 04.03.108 K3 and the Healthcare Operations Policy and Procedure P112 and identify deviations. Revisions to the written directive should be considered and/or a corrective action plan implemented to bring actual performance into compliance with written directives.¹⁵⁴
5. Because clinical leadership does not appear to understand when a clinical situation is a problem, the IDOC should engage outside medical consultants to examine the quality of care for sentinel events to give feedback and assist in monitoring the clinical care.
6. When the provider at the facility fails to know what diagnosis the patient is or how to manage the patient's problem, that patient needs to be referred to another provider, possibly a consultant, who does know how to manage the patient's clinical problem. This is a particular problem in the IDOC because of the large number of physicians without primary care training.

Specialty Consultations

First Court Expert Recommendations

1. Scheduled offsite services need to be improved with regard to timeliness of access to these services as well as follow up after the service is provided.
2. There should be a reliable method of communication between the scheduler and the clinicians to ensure that patients who require specialty consultation are scheduled commensurate with the urgency of their need.

We agree with these recommendations.

Additional Recommendations

3. If the current process of utilization of offsite care is to be used, the IDOC, not the vendor, should develop a standardized offsite tracking log on an Excel spreadsheet that should be used at all sites. This tracking log should be used to report timeliness of collegial reviews, approvals, and appointments to the QI committee.

¹⁵⁴ For example, the number of drills required at SCC exceeds that required by NCCHC.

4. Referrals for offsite care should be first documented as a physician order in the medical record. The original referral form should be filed in the medical record on the date it was initiated by the provider. Copies of this form can be used by the scheduler to manage scheduling.
5. Medical providers should be permitted to send patients to offsite consultants without going through the collegial review process on the basis of patient safety.
6. When UIC specialty care is significantly delayed, e.g., gastroenterology, an alternate local consultant should be used to obtain care.
7. Any denial of care needs to be documented *in the medical record* using documentation of the person who denied care.
8. At follow up provider visits after consultations, the provider should be required to document the results of the consultation, update the status of the patient, and update the treatment plan based on the consultation. If consultant reports are unavailable, the provider should use other communication efforts to determine what occurred at the consultation.

Infirmary Care

First Court Expert Recommendations

1. Patients should be seen timely according to policy requirements while in the infirmary.
2. If clinicians choose not to treat patients according to currently accepted recommendations and guidelines, the rationale for these decisions should be articulated in the health record.

We agree with these recommendations.

Additional Recommendations:

3. Problem lists in the infirmary charts must be complete and accurate.
4. Provider notes must be legible, communicate the rationale for modifications in treatment, list reasonable differential diagnoses, document pertinent physical findings and symptoms, record clear treatment plans, and write regular comprehensive progress notes that update the status of each and every acute and chronic illness.
5. As noted in the Clinic Space section, the infirmary beds need to be properly repaired or replaced with hospital beds so that the height of the bed can be modified, the head adjusted, and the railings are operational. A number of electrical beds should be purchased for the infirmary. The condition of the infirmary beds puts at risk the safety of patient-inmates and staff.

Pharmacy and Medication Administration

The First Court Appointed Expert made no recommendations concerning pharmacy and medication administration.

Current Recommendations

1. Consider reducing the volume of controlled medications in stock.

2. The original order should be used when transcribing the order onto the MAR; the blister card should not be used.
3. Medication should be administered in patient specific, unit dose packaging. The practice of pre-pouring should be eliminated.
4. The MAR should be used by the nurse to verify the medication, dose, and route of administration is correct immediately before giving the medication to the patient. The nurse should consult the MAR before answering any questions or concerns the patient has about the medication.
5. Medication should be documented at the time it is administered.
6. Printers should be provided so MARs can be printed at the facility at the end of the month and when a new order is written.
7. A system for timely renewal of chronic disease and other essential medications should be developed.
8. Nurses should refer any patient who does not receive three consecutive doses of nurse administered medication prescribed for a chronic disease to the treating provider. The treating provider should meet with the patient and determine if treatment should be modified to improve adherence.
9. Patient adherence with KOP medications prescribed to treat chronic disease should be monitored at regular intervals (monthly by nursing and by the provider at each chronic disease visit).
10. Revise the policy and procedure for medication administration to provide sufficient operational guidance to administer medications in accordance with accepted standards of nursing practice.
11. The CQI program should develop, implement, and monitor quality indicators related to pharmacy services and medication administration.
12. Root cause analysis and corrective action plans should be used to target the causes of performance that is below expectations. Corrective action should consider software and mechanical means to improve patient safety, such as computerized provider order entry, use of bar coding, patient specific unit dose packaging, etc.

Infection Control

First Court Expert Recommendations

1. The First Court Expert had no specific recommendations for infection control for SCC. However, The First Court Expert recommended that each facility have a specific nurse assigned responsibility for infection control, and because SCC did have such a designated nurse at that time, no recommendations regarding infection control were made. SCC no longer has a single designated nurse assigned to infection control. There were important infection control issues identified during our site visit but no one at SCC had identified that these were issues that needed attention. We concur with the First Court Expert's recommendation that each facility, now including SCC, have a designated infection control nurse responsible for compliance with IDOC policy concerning communicable diseases, blood borne pathogens, and compliance with Illinois Department of Public Health reporting requirements as well as the HIV and HCV clinics.

Additional Recommendations

2. SCC should have a designated infection control nurse responsible for compliance with IDOC policy concerning communicable diseases, blood borne pathogens, and compliance with Illinois Department of Public Health reporting requirements as well as the HIV and HCV clinics. This infection control nurse should also be responsible for monitoring and prevention of communicable disease outbreaks.
3. Infections and communicable disease data should be analyzed and discussed as part of the monthly and the annual CQI meetings. This should include discussion of trends, updates from the CDC and review of practices. The risk for transmission of TB infection is one example of a periodic review and analysis that should be done by the infection control program at SCC.
4. Track and report skin infections due to all pathogens, not just MRSA, including infestations with scabies or body lice.
5. Update the IDOC Infection Control Manual now and at least every two years.
6. Airborne Infection Isolation (AII) rooms need to be regularly serviced, inspected by knowledgeable individuals, and monitored regularly. The maintenance of adequate air changes and pressure should be documented on a log specifically as part of the infection control program.
7. Also, the practices of the hemodialysis program need to be brought into compliance immediately with CDC recommendations to prevent infections, particularly hepatitis B, among chronic hemodialysis patients.¹⁵⁵

Dental Program

Dental: Staffing and Credentialing

First Court Expert Recommendations

1. Serious consideration should be given to hiring a second dental assistant. The lone assistant has too many duties to perform and the dentists are often left working without an assistant. This recommendation is moot since a second dental assistant has been hired.
2. All surgeries should be performed with an assistant. We agree with this recommendation.

We agree with these recommendations.

Additional Recommendations

3. NRC and SCC dental staffing should be realigned to reflect the mission of each institution.

¹⁵⁵ MMWR (2001) Recommendations for Preventing Transmission of Infections Among Chronic Hemodialysis Patients. Vol. 50/No. 99-5, Centers for Disease Control. See also Update to the 2001 Hemodialysis Recommendations available at <https://www.cdc.gov/dialysis/guidelines/index.html>.

4. Staffing should be increased to accommodate performing comprehensive dental exams on all prisoners either at intake or within 30 days of arrival from a reception and classification center.

Dental: Facility and Equipment

First Court Expert Recommendations

1. Replace the cabinetry and countertops, as they are very old, worn and irreversibly damaged. Proper infection control is almost impossible on these surfaces. We agree. The countertops should be replaced.

We agree with this recommendation.

Additional Recommendations

2. Patients wear lead aprons with thyroid collars when dental radiographs are taken.¹⁵⁶
3. There should be an equipment replacement plan to inform budget preparation.
4. The clinic equipment should include a sphygmomanometer and stethoscope.

Dental: Sanitation, Safety, and Sterilization

First Court Expert Recommendations: None

Additional Recommendations: None

Dental: Review Autoclave Log

First Court Expert Recommendations

1. That the sterilization spore testing log be accurately maintained and kept on record indefinitely.
2. That safety glasses be provided to patients while they are treated.
3. That a biohazard warning sign be posted in the sterilization area.
4. A warning sign be posted in the x-ray area to warn of radiation hazards, especially pregnant women.

We agree with these recommendations.

Additional Recommendations: None

Dental: Comprehensive Care

First Court Expert Recommendations

1. Comprehensive “routine” care should be provided only from a well-developed and documented treatment plan based on a thorough, well-documented intra and extra-oral examination, to include a periodontal assessment and detailed examination of all soft tissues.

¹⁵⁶ While radiation exposure from dental radiographs is low, it is the dentist’s responsibility to follow the ALARA Principle (As Low as Reasonably Achievable) to minimize the patient’s exposure. Dentists should follow good radiologic practice and (*inter alia*), use protective aprons and thyroid collars. Dental Radiographic Examinations: Recommendations for Patient Selection and Limiting Radiation Exposure. American Dental Association and Food and Drug Administration (2012), 14.

2. In all cases, appropriate bitewing or periapical x-rays be taken to diagnose caries.
3. Hygiene care be provided as part of the treatment process.
4. Care be provided sequentially, beginning with hygiene services and dental prophylaxis.
5. That oral hygiene instructions be provided and documented.

We agree with these recommendations.

Additional Recommendations

6. An examination and sequenced treatment plan should be offered to all inmates within 30 days of transfer from a reception and classification center.
7. IDOC should develop protocols for periodontal diagnosis that include the use of Periodontal Screening and Recording and appropriate radiographs.
8. All routine dental examinations should include a sequenced treatment plan.

Dental: Intake (Initial) Examination

First Court Expert Recommendations: None.

While the First Court Expert found the records in compliance with their evaluation criteria,¹⁵⁷ they did not address the more critical issues relating to the **quality** of the screening that are addressed below.

Current Recommendations

1. The reason(s) for the inadequate quality of the panoramic x-rays should be investigated immediately and the equipment replaced if necessary.
2. Since there is insufficient time at the screening to provide proper oral hygiene instruction, it should not be stamped in the dental chart.

Dental: Extractions

First Court Expert Recommendations

1. A diagnosis or a reason for the extraction be included as part of the record entry. This is best accomplished through the use of the SOAP note format, especially for sick call entries. We note that this is a peer review evaluation criterion.¹⁵⁸
2. Proper diagnostic x-rays be available for every surgical procedure.
3. Prescribe antibiotics only as necessary. Prescribing routinely after extractions is not a standard of care. We agree with this recommendation. Antibiotics should be prescribed after an extraction only when justified clinically and the reason for the prescription documented in the record.

We agree with these recommendations.

Additional Recommendations

4. Consent forms should state the reason for the extraction.

Dental: Removable Prosthetics

¹⁵⁷ Whether screening was performed at the reception center and a panoramic x-ray was taken.

¹⁵⁸ Wexford Peer Review Form for dentists – PR-001C.

First Court Expert Recommendations

1. A comprehensive examination and well-developed and documented treatment plan, including bitewing and/or periapical radiographs and periodontal assessment, proceed all comprehensive dental care, including removable prosthodontics.
2. That periodontal assessment and treatment be part of the treatment process and that the periodontium be stable before proceeding with impressions.
3. All operative dentistry and oral surgery as documented in the treatment plan be completed before proceeding with impressions.

We agree with these recommendations.

Additional Recommendations: None

Dental: Sick Call/Treatment Provision

First Court Expert Recommendations

1. Use the SOAP format for sick call entries. It will assure that the inmate's chief complaint is recorded and addressed, and a thorough focused examination and diagnosis precedes all treatment.
2. Develop a triage system that insures that inmates with urgent care complaints are seen in a timelier manner, 24 to 48 hours.

We agree with these recommendations.

Additional Recommendations

3. When the dental clinic is closed, or the dentist will not be available for 24 hours, a mid-level provider should perform a face-to-face examination for all inmates submitting a request that states or implies the existence of dental pain.
4. All face-to-face assessments should be documented in nursing progress notes.
5. The nursing protocol for Toothache/Dental Pain should be used where clinically appropriate.
6. All requests for dental care should be time stamped and logged and a record of when the inmate was seen by a provider and the disposition should be maintained.
7. The quality and legibility of dentists' progress notes should be addressed in peer reviews.

Dental: Orientation Handbook

First Court Expert Recommendations: None.

Additional Recommendations: Pending - To date we have not received the handbook.

Dental: Policies and Procedures

First Court Expert Recommendations

1. Develop a thorough and detailed Policy and Procedures manual that describes and guides all aspects of the dental program. We agree with this recommendation.

Additional Recommendations: None.

Dental: Failed Appointments

First Court Expert Recommendations

1. Work with the institution administration to develop and implement strategies to address this problem.
2. Utilize a vigorous CQI process to address this problem. Use these findings to implement procedures to continually improve this high rate of failed appointments.

We agree with these recommendations.

Additional Recommendations

3. Require the failed dental appointment rate to be reported to the CQI Committee monthly.

Dental: Medically Compromised Patients

First Court Expert Recommendations

1. The medical history section of the dental record be kept up to date and that medical conditions that require special precautions be red-flagged to catch the immediate attention of the provider.
2. That blood pressure readings be routinely taken on patients with a history of hypertension, especially prior to any surgical procedure.

We agree with these recommendations.

Additional Recommendations: None.

Dental: Specialists

First Court Expert Recommendations: None.

Additional Recommendations: None.

Dental: CQI

First Court Expert Recommendations

1. Because of the number of deficiencies noted in the dental program, a more vigorous CQI program should be implemented to address these deficiencies. From the CQI process, policies and procedures should be established that will continually correct these deficiencies to develop a stronger program. We agree with this recommendation.
2. Include the NRC in this invigorated CQI process. Many areas need to be addressed for improvement at that institution. This recommendation is moot since the NRC has a separate CQI Committee.

Additional Recommendations

3. The dental CQI program (as well as all other components of the dental program) lacks guidance from a dentist with experience in corrections. This expertise should reside centrally at IDOC and not from a Wexford employee or contractor.¹⁵⁹

Internal Monitoring and Quality Improvement

First Court Expert Recommendations

1. The CQI program, which should have identified many of these programmatic deficiencies, must be reinvigorated with leadership that has had appropriate training with regard to CQI philosophy and methodology.
2. There should be professional performance reviews with feedback, both for the advanced level clinicians and nurses, with regard to the sick call process.
3. The leadership of the CQI program must be retrained regarding CQI philosophy and methodology, along with study design and data collection.
4. This training should include how to study outliers in order to develop targeted improvement strategies.

We agree with these recommendations.

Additional Recommendations

5. The CQI program needs to develop methods of identification of problems with respect to both process and clinical quality of care.
6. The CQI program at SCC must be separate from the CQI program at NRC. Annual reports must be uniquely developed. Reports used for NRC should not be used for SCC.
7. Primary source verification should be verified by the IDOC in conjunction with their AD on quality improvement. Whenever a new doctor is utilized at the facility for coverage or permanent placement, the primary source verification for that provider should be reviewed by the Agency Medical Director and local leadership to ensure that the candidate has primary care credentials.
8. The Governing Body of the facility with respect to the medical program should have majority representation of persons trained in a medical discipline.
9. Quality of care and appropriateness of care need to be incorporated into the CQI program.
10. Mortality review and sentinel event reviews need to be included in the CQI program.
11. Internal audits should be performed by medical personnel and need to include the data used to draw their conclusions. These should include a quality of care component.
12. Provider peer reviews should increase emphasis on quality of care.

¹⁵⁹ Dr. Meeks does not have a dentist on his staff and relies on Dr. Sandhu (a Wexford consultant) for dental advice. He would like a dental director on his staff, since relying on a vendor's employee is problematic. See also Dr. Meeks's 1/19/18 interview by Dr. Michael Puisis ("[Question] Is he [Dr. Meeks] responsible for the dental program? Response: He said yes, he is responsible. But he said this with an expression of frustration. [Question] How does he provide that oversight? Response: Basically, he relies on the Wexford Dental Director for this oversight. He acknowledged that this was not a good arrangement and prefers that he have a Chief of Dentistry who is a state employee and part of his regional team." (*id.* questions #35, 36).

13. External reviewers not associated with the vendor should be used for all mortality reviews, all sentinel event reviews, and peer reviews of all non-primary care trained physicians.

Appendix A

SCC Positions

Position Title	Budgeted positions	Vacant Positions	Leave of Absence	Effective Vacancies	Employer
Health Care Unit Administrator	1	0	0	0	IDOC
Medical Director	1	1	0	0	Wexford
Physician	1	0	0	0	Wexford
Physician Assistant	1	0	0	0	Wexford
Medical Record Director	1	0	0	0	Wexford
Director of Nursing	1	0	0	0	Wexford
Supervisory Nurse	2	1	1	2	Wexford
Registered Nurses	28	11	1	12	Wexford
Licensed Practical Nurses	12	2	0	2	Wexford
CMT*	17	5	6	11	IDOC
Certified Nurse Assistant	6	1	1	2	Wexford
Health Information Associate	2	1	0	1	IDOC
Office Associate	3	1	0	1	IDOC
Staff Associate	3	0	0	0	Wexford
Medical Supply Supervisor	1	0	0	0	IDOC
Pharmacy Technician	1	0	0	0	IDOC
Med Room Assistant	1	0	0	0	Wexford
Assistant Site Manager	1	0	0	0	Wexford
Dental Director	1	1	0	1	IDOC
Dentist	1	0	0	0	Wexford

Dentist**	1	0	0	0	IDOC
Dental Assistant	1	0	0	0	Wexford
Dental Assistant	1	0	0	0	IDOC
Dental Hygienist	1	0	0	0	Wexford
Dialysis Registered Nurse	6	0	0	0	Naphcare
Dialysis Technician	3	0	0	0	Naphcare
Totals	98	24	9	33	

*CMTs are either medical technicians or licensed practical nurses (LPN). All newly hired CMT staff are LPNs.

** IDOC hired dentists work half time and are counted and paid as a full-time position.

Appendix B

Provider Peer Review Questions

The sick call questions were:

1. Was the patient seen within 72 hours?
2. Does the encounter reflect the reason why the referral was made?
3. Is the recorded history comprehensive and relevant for the patient's Chief Complaint?
4. Is a targeted physical exam with pertinent findings documented?
5. Was appropriate and comprehensive testing done?
6. Were laboratory and diagnostic tests documented and addressed?
7. Is the plan of care appropriate and documented?
8. Is pertinent patient education documented?

Laboratory/X-ray Utilization questions were:

1. Was the lab test/x-ray appropriate for diagnosis or clinic?
2. Was the lab test result received within 24 hours and x-ray result received within 72 hours?
3. Was the lab test/x-ray result initialed and dated by a physician within 72 hours of receipt?
4. Were clinically significant findings documented in the progress notes?
5. Was plan, as indicated, carried out?
6. When follow-up care was requested, was this carried out in a timely manner?

Chronic Disease questions include:

1. Is the subjective portion comprehensive for clinic (including interval activity for seizure and asthma clinic)?
2. Does the clinic include pertinent vital signs?
3. Is a targeted physical exam with pertinent findings documented, including OHS chronic clinic requirements?
4. Were relevant laboratory parameters documented and acted upon when indicated?
5. Was treatment appropriate for this visit (including additional referrals, additional testing, medication adjustment, ACE inhibitor use, etc.).
6. Was appropriate education for this encounter documented?
7. Was the level of disease delineated?

Infirmiry admissions questions:

1. Is an infirmiry admission note completed with diagnosis?
2. Does the admission history and physical as documented adequately described this patient's condition?
3. Is indication for admission and type of admission (chronic vs. acute) clearly specified?
4. Are three weekly visits for acute admissions and weekly visits by an MD documented?

5. Is the plan of care appropriate for admission diagnosis?
6. Is MD response to significant nursing entries evident?
7. Is a discharge note with follow-up care evident?

Mortality Reviews
2nd Court Appointed Expert Report
Lippert v. Godinez

August 2018

Prepared by Michael Puisis DO

Introduction

We reviewed 33 medical records of patients who died. For each death we assigned a designation of preventable, possibly preventable, or not preventable. Parts of five records were missing and we therefore could not determine whether the death was preventable or not. Of the 33 records, 12 were preventable, seven were possibly preventable, nine were not preventable, and five had missing record documents making determination of preventability not possible.

Definitions we use for these designations are as follows:

Not preventable death – A death that could not have been prevented or significantly delayed despite identified opportunities for improvement in the medical care.

Possibly preventable death – A death wherein opportunities for clinical intervention or errors related to care delivery were identified that MIGHT have prevented or significantly delayed the patient's death.

Preventable death – A death wherein opportunities for clinical intervention or errors related to care delivery were identified that WOULD have prevented or significantly delayed the patient's death.

IDOC Mortality Reviews 2018

Patient List

Patient #1 Danville; Possibly Preventable.....	3
Patient #2 Sheridan; Preventable	4
Patient #3 East Moline; Not Preventable	6
Patient 4 East Moline; Not Preventable	7
Patient 5 East Moline; Not Preventable	7
Patient 6 Decatur; Possibly Preventable.....	8
Patient 7 Dixon; Preventable	9
Patient #8 Dixon; Possibly Preventable	10
Patient #9 Stateville; Not Preventable.....	12
Patient #10 Stateville; Preventable.....	15
Patient #11 Stateville; Insufficient Chart Information to Determine Preventability.....	17
Patient #12 Stateville; Insufficient Chart Information to Determine Preventability.....	18
Patient #13 Stateville; Preventable.....	20
Patient #14 Stateville; Not Preventable.....	23
Patient #15 Dixon; Preventable	23
Patient #16 Stateville; Insufficient Chart Information to Determine Preventability.....	26
Patient #17 Dixon; Preventable	27
Patient #18 Dixon; Possibly Preventable	30
Patient #19 Dixon; Preventable	32
Patient #20 Logan; Not Preventable	34
Patient #21 Menard; Possibly Preventable.....	36
Patient #22 Menard; Preventable.....	37
Patient #23 Menard; Possibly Preventable.....	40
Patient #24 Menard; Not Preventable.....	42
Patient #25 Menard; Preventable.....	43
Patient #26 Menard; Not Preventable.....	45
Patient #27 Menard; Preventable.....	46
Patient #28 Western; Not Preventable.....	49
Patient #29 Taylorville; Possibly Preventable	52
Patient #30 Hill; Preventable	54
Patient #31 Illinois River; Insufficient Chart Information to Determine Preventability	57
Patient #32 Pinckneyville; Insufficient Chart Information to Determine Preventability.....	58
Patient #33 Robinson; Preventable	60

Patient #1 Danville

This patient was 56 years old. Current standards of care recommend colorectal cancer screening beginning at age 50.¹ However, at IDOC annual examinations, the providers only provide an offer of a digital rectal examination with guaiac testing for the purpose of evaluating the prostate and apparently for colorectal cancer screening. Even if the digital rectal examination were done with guaiac testing, this would be inadequate, as an annual colorectal cancer screening will miss more than 90% of colon abnormalities.² The patient was offered a digital rectal exam on 1/5/15 but not during 2016.

The patient began losing weight, first documented on 9/30/15 (six pounds based on a 3/9/15 visit compared to the 9/20/15 visit). The patient transferred from WICC to IRCC on 1/16/17 and the weight was 152 pounds, which was an 18-pound weight loss since 3/9/15. The weight loss was unrecognized until 4/21/17, when a doctor documented a 19-pound weight loss. The patient apparently had been losing weight for about a year and a half, but it had been unrecognized.

An abnormal albumin level was present since at least 2/11/16. The alkaline phosphatase was elevated and total protein low on 4/20/17, yet these abnormal labs were never evaluated. On 4/20/17, the patient also had a hemoglobin of 6, which is extremely low. The patient was sent to an ER, where EGD was done 4/22/17 showing gastritis. Colonoscopy was recommended but not done until 6/15/17. In the interim, on 5/17/17 the patient developed unilateral leg swelling but was not evaluated for this. Generally accepted guidelines for unilateral leg swelling include exclusion of leg thrombosis. This was not done and as a result placed the patient at significant risk of harm.

Advanced colon cancer was identified on 6/15/17. Colorectal surgery follow up was recommended in two weeks, but did not occur for a month. In the meantime, the patient was again evaluated for unilateral leg swelling. The doctor presumably thought that the patient might have a deep vein thrombosis, because he ordered a D-dimer test, a test to evaluate for thrombosis. This condition is life threatening, yet the patient was not admitted to a hospital and the D-dimer test was not done. Instead, the doctor only gave diuretics. This was grossly and flagrantly unacceptable.

The patient was admitted to the infirmary for severe edema on 8/3/17. Aside from prescribing a diuretic, there was no attempt to evaluate why the patient had edema. Two days later the patient was admitted to a hospital, where advanced metastatic colon cancer with ascites and anasarca due to the cancer was noted. The patient had malnutrition (consistent with the low albumin), severe ascites, and non-curable colon cancer. The patient was too high a risk to

¹ U.S. Preventive Services Task Force colorectal cancer screening as found at <https://www.cancer.org/cancer/colon-rectal-cancer/detection-diagnosis-staging/acs-recommendations>.

² American Cancer Society Recommendations for Colorectal Cancer Early Detection as found at <https://www.uspreventiveservicestaskforce.org/Page/Document/RecommendationStatementFinal/colorectal-cancer-screening2#tab>.

perform surgery. The patient expired 8/16/17, nine days after admission to the hospital. We identified 49 errors of care from 1/5/15 until his death on 8/17/17. There were 13 episodes when nurses should have referred to a provider but did not. Key deficiencies were lack of colorectal cancer screening; failure to recognize weight loss; failure to timely refer for evaluation of weight loss, anemia, fever, and abdominal pain; and failure to timely refer to exclude deep vein thrombosis in a person with unilateral leg swelling.

The patient was not offered colorectal cancer screening consistent with contemporary standards. **This death was therefore possibly preventable.** The current standard is to perform colorectal cancer screening for early diagnosis and prevention of colon cancer and cancer death. Failure to perform this service results in preventable death. The colonoscopy was not timely.

Patient #2 Sheridan

This patient was 30 years old. He had repair of a Tetralogy of Fallot³ as a child. He had a late complication of that pediatric surgery (pulmonic valve regurgitation) and was in the process of medical evaluations for replacement of his pulmonic valve prior to his incarceration. Pulmonic regurgitation gives rise to atrial and ventricular heart arrhythmias with risk of morbidity and mortality. In May of 2015, the patient apparently experienced blood clots resulting in a stroke and was taking anticoagulation for that purpose. The patient became incarcerated in the midst of a work up regarding his valve replacement. While at the Stephenson County Jail in Freeport, Illinois, the patient's cardiologist communicated with the jail on 8/26/15, telling them what work up was remaining prior to valve replacement. The jail continued the work up. An MRI angiography, the final diagnostic study prior to surgery, was scheduled for 12/3/15, but the patient was transferred to the IDOC on 11/5/15.

An NRC physician assistant did an intake physical examination on 11/5/15, but failed to take an adequate history and did not attempt to contact the patient's cardiologist or to obtain old records. Despite the Stephenson County Jail having knowledge of the patient's condition, the IDOC apparently did not know the patient's condition, and other than referring to UIC cardiology, made no attempt to find out the patient's diagnosis. The patient's civilian cardiologist's letter to the Stephenson County Jail was in the patient's IDOC medical record but it is not clear when it arrived in the record or whether it was reviewed. The physician assistant at NRC reception made the wrong diagnosis of aortic stenosis, without supporting evidence. The physician assistant took no history and only relied on the nursing history. The physician assistant examination documented a systolic murmur, when pulmonic regurgitation is a diastolic murmur. Although the physician assistant's note documented that an urgent follow up

³ Tetralogy of Fallot is one of the most common congenital heart conditions. The surgery to repair this anomaly can result, later in life, in abnormalities of the pulmonic valve resulting in incompetence of the pulmonic valve. This can result in dyspnea and other symptoms. Cardiac arrhythmias are common when this occurs. When pulmonic regurgitation occurs as a complication, replacement of the valve may be indicated, as it was in this individual.

with a physician was requested, this did not occur. If the diagnosis was unclear, a prompt echocardiogram should have been done.

The patient transferred to Sheridan on 11/18/15, but the transfer form failed to indicate that the patient had pending surgery. A doctor did not evaluate the patient until 12/10/15, a month later. The doctor documented that the patient was to have balloon valvuloplasty surgery prior to incarceration, but made no attempt to contact the patient's cardiologist. Balloon valvuloplasty is a procedure performed on a stenotic heart valve like aortic stenosis but is not used for pulmonic incompetency. The patient was not scheduled for balloon valvuloplasty. The doctor made no attempt to discover what valve was affected. Without documenting the current status of the patient or the urgency of surgery, the doctor referred the patient to UIC cardiology as a routine visit for evaluation of symptomatic *aortic* stenosis, not pulmonic regurgitation. The valve involved could have been identified by performing echocardiogram at a local hospital which should have been done.

As a civilian, the patient was being managed by a pediatric cardiologist due to the nature of his condition, but the doctor sent the patient to a regular cardiologist. The doctor also did a physical examination documenting an irregular heart rhythm with a murmur, and wrote a differential diagnosis of atrial fibrillation with aortic stenosis. The doctor ordered an EKG. There were two EKGs in the chart, both undated and both with sinus rhythm. The patient did not have atrial fibrillation. The doctor ordered metoprolol without giving a reason. Presumably, it was for aortic stenosis with atrial fibrillation, but the patient did not have either of these conditions. This was a potential problem, because metoprolol can cause atrial conduction abnormalities causing arrhythmias, which this patient was at risk for because of his pulmonic regurgitation. The patient's blood pressure was normal, the patient was not in heart failure, and the patient's pulse was 92. Thus, there was no indication for this medication, but it had potential for significant adverse effects. The doctor did not make an appropriate diagnosis and did not base the diagnosis on sufficient diagnostic information. The Wexford physicians did not contact the patient's civilian cardiologist or read his letter, which was in the medical record. Metoprolol carries a warning for its potential to cause heart block, and increases the potential for conduction disturbances. This patient's pulmonic regurgitation already placed the patient at risk for cardiac arrhythmias, and prescribing metoprolol could make this worse and may have been the cause of his death, which was cardiac arrhythmia.

The patient saw a UIC cardiologist on 1/13/16. The cardiologist at UIC was unable to identify a more specific history than the patient was supposed to have repeat surgery on one of his heart valves. The UIC consultation was by a cardiology fellow, who recommended that the facility obtain records from the treating cardiologist, get an echocardiogram to evaluate which valve was involved, and to schedule a follow up. An echocardiogram was done on 2/9/16 and showed severe pulmonic regurgitation but no aortic stenosis. The echocardiograph cardiologist recommended a stress EKG test, and if poor, referral to cardiovascular surgery for pulmonic valve replacement. Doctors did not order the stress test until 4/25/16, almost three months

later; it was approved on 4/27/16. The Sheridan doctor did not call the UIC cardiologist or the echocardiologist to identify urgency.

On 3/24/16, a doctor saw the patient and noted that the patient had his echocardiogram, but the report was unavailable almost two months after the procedure, so the doctor did not know the results of the echocardiogram. There had also been no attempt to call the patient's civilian cardiologist. The blood pressure was low, at 98/62. Despite the low blood pressure, and the patient complaint of having "near falls," and lack of indication, the doctor continued the metoprolol. The patient's symptoms may also have been due to his pulmonic regurgitation, but the IDOC doctors failed to identify his diagnosis despite the recent evidence on echocardiogram. This was the last in-person evaluation of the patient before he died and there are no further in-person evaluation notes.

There is an autopsy indicating that the patient died on 4/28/16, but there are no antecedent notes for the time period immediately before death, so it is unclear where the patient died or what the circumstances of the death were. The coroner listed the cause of death as cardiac arrhythmia. In our opinion, this was likely due mostly to his pulmonic regurgitation, but also possibly due to use of metoprolol.

This death was preventable. A proper history and communication with the patient's civilian cardiologist should have resulted in earlier intervention and valve replacement, which is typically very successful in this condition, particularly in a 30 year old otherwise healthy man. Remarkably, the true diagnosis of the patient was unknown to IDOC medical staff for the entire IDOC incarceration of almost six months, even though the patient's treating cardiologist was collaborative with jail staff at the Stephenson County Jail and even though his letter explaining the treatment plan was in the IDOC file. Also, an echocardiogram identified a critical valve problem but for several months the echocardiogram was not reviewed. As well, the use of metoprolol without clear indication placed the patient at risk of cardiac conduction abnormalities that already affected the patient due to his pulmonic valve disorder. This may have contributed to the patient's arrhythmias, which the coroner said caused his death. The quality of care of physicians was below standard of care with respect to obtaining an accurate history and communicating with a treating physician and with respect to use of metoprolol without a diagnosis or indication. Also, the absence of medical records around the time of death reflects poor medical record keeping or documentation. Over the approximate six months of incarceration in the IDOC, there were 10 errors we identified, principally not following up after consultation, not developing an appropriate treatment plan, and not obtaining an adequate history.

Patient #3 East Moline

This was a 47-year-old man admitted to IDOC with a history of hypertension. The patient transferred to East Moline on 2/8/17. This patient had significant problems identified over the course of several months, including: anemia (hemoglobin as low as 8.9), persistent cough with

decreased peak expiratory flow rates, increased heart size with possible pericardial effusion, elevated sedimentation rate (69 and 98), elevated C-reactive protein of 43.8 (nl <8), and weight loss. While it is our opinion that hospital referral should have been offered as soon as 10/13/17 (for difficulty breathing, 30 pound weight loss, anemia, elevated sedimentation rate, and globular heart on x-ray suggestive of pericardial effusion), a doctor ultimately offered transfer to the hospital on 10/23/17. The patient refused hospital admission. The patient declined and died at EMCC on 11/3/17. An autopsy was not done.

This death was not preventable largely because the patient refused referral to a hospital. However, there was a significant delay in offering to send the patient to a hospital, and the patient was kept at the facility with evidence of a life-threatening condition on 10/13/17.

Patient #4 East Moline

This was a 43-year-old with no history of medical problems who had a sudden collapse and died of a pulmonary embolism. **This death was not preventable.**

Patient #5 East Moline

This was a 75-year-old man who had his reception screening at NRC on 8/8/17. The patient had history of diabetes, hypertension, coronary artery disease, glaucoma, asthma/COPD, sleep apnea, and umbilical hernia. The NRC history was very poor, and though documenting prior cardiac surgery and stent placement, the details were not specified. The patient was on two medications (Brilinta and oxybutynin) for which no indication was given. Although the Brilinta may have been used for the stent, it was not clear, and the date of the stent was beyond the time for which this type of anticoagulant is used.

The patient transferred to East Moline Correctional Center on 8/22/17, and was confused when he arrived. For that reason, he was housed in the health care unit. This apparently was new onset of confusion, as the patient had not been confused at NRC. Despite confusion, the doctor did not order tests to evaluate for this for several days. The patient never had a CT scan, which is often performed for persons with new onset of confusion. On 8/28/17, the patient apparently bit his tongue sufficient to create a large laceration of the tongue, which bled profusely. The patient was on a powerful anticoagulant, which may have contributed to the bleeding. The patient's tongue and lips were swollen, and the patient could not swallow.

The patient was timely sent to a hospital, where the patient died not long after arrival. Doctors judged that the patient had angioedema from being on Lisinopril. The patient should have had an autopsy but did not. It is not clear if the recent confusion was at all related to the cause of death and whether the death may have been due to bleeding rather than angioedema. While the hospital diagnosis was likely, an autopsy should have been performed. **This death was not preventable.**

Patient #6 Decatur

This patient had known cirrhosis, type 2 diabetes being treated with insulin, hypertension, and a long-standing skin disorder. The skin disorder was such that it caused itching and scratching, and became infected. Doctor-directed treatment of the skin rash failed to resolve the problem over a period of at least eight months. Doctors did not make a definitive diagnosis and did not appear to know what the rash was, yet did not refer the patient to a dermatologist for a definitive diagnosis. At autopsy, the pathologist documented that the patient had diffuse psoriatic-like skin lesions.

The patient also had cirrhosis due to hepatitis C. Though the patient had a high level of fibrosis and appeared to pass from compensated to decompensated liver disease under care of the IDOC, the patient was not documented as having been offered treatment for hepatitis C. Though physicians knew that the patient had cirrhosis, they also did not offer generally accepted care for cirrhosis, such as endoscopy screening for esophageal varices, beta-blocker medication to reduce complications of varices, or screening for hepatocellular carcinoma, which is recommended to be done by ultrasound examination every six months. It is not clear why this patient was not sent to the UIC hepatitis C consultants. Doctors also failed to recognize decreasing HbA1C levels, with episodes of hypoglycemia that was likely due to the patient being on insulin and having advanced liver disease. This placed the patient at risk of significant hypoglycemia.

The patient developed fever, abdominal pain, and hypotension consistent with septic shock, but was not sent to the hospital for evaluation for two days. The hospital record was not in the record for this first hospitalization. The patient returned to the facility and was housed on the infirmary. Apparently based on a second hospital admission, the patient was found to have possible cholecystitis with stones and advanced cirrhosis, making surgery too high-risk. The patient returned to Decatur Correctional Center.

On the day of return, the patient began vomiting blood⁴ repeatedly and was hypotensive, indicating shock. Nurses called a physician several times, but the doctor did not send the patient to a hospital until he came into the facility about five hours later. This was grossly and flagrantly unacceptable. The doctor eventually came to the facility and sent the patient to the hospital. Prior to sending the patient to the hospital and during the time the patient was in shock, the doctor obtained a do-not-resuscitate/do-not-intervene status and communicated this to hospital personnel, who then did not attempt interventions. The patient signature on the DNR document was disorganized and unlike the patient's typical signature. The patient died in the hospital not having received aggressive care.

The coroner listed the cause of death as bleeding esophageal varices. **The patient's death was possibly preventable.** If the patient had generally accepted care (including treatment of the

⁴ Vomiting blood in a person with cirrhosis strongly suggests esophageal varices. When this occurs, immediate hospitalization is indicated. If the patient had been on prophylactic beta blocker medication, this may have been avoided.

hepatitis C, endoscopy surveillance with treatment of esophageal varices, and preventive beta blocker treatment for the varices) early in the course of her disease, her death may have been preventable or delayed. The patient should have been under care of the UIC hepatology group, but was not. Aggressive treatment in the hospital may also have delayed death. The method of obtaining “informed consent” during the time that a patient is in shock should call for an internal review of the IDOC practices of obtaining informed consent.

Patient #7 Dixon

This patient was a 51-year-old man with history of obesity, hypertension, and high blood lipids. He also was deaf and did not have medical examinations consistently with an interpreter. He was given hearing aids, but these were malfunctioning for periods of time. The patient also had a history of alcoholism and elevated liver function tests, but these were not followed at least since 2014. The patient had minimal elevation of blood glucose levels. Given his significant obesity (as high as 292 pounds), hypertension, and high blood lipids, screening for diabetes would have been good practice. The patient did receive routine metabolic panels, but it was not clear that the glucose tests being done were fasting. In any case, doctors appeared unaware of the risk for diabetes.

The patient developed cough, tachycardia, and low blood pressure. The blood pressure had recently been elevated. On 10/27/16, the blood pressure was 160/96 and was 98/62 on 11/11/16. This significant and unanticipated drop in blood pressure went unnoticed. The pulse was 112. Despite the abnormal vitals, the nurse did not refer to a provider. Two days later, a nurse referred the patient to a nurse practitioner for vomiting. The patient was deaf and the nurse assisting the nurse practitioner documented that the patient did not understand the nurse’s questions, so the nurse was unable to obtain an accurate history. The nurse practitioner documented that the patient had several days of fever, sore throat, headache, and vomiting. The patient had tachycardia (116). Based on these constellation of symptoms that included fever, unrecognized weight loss, hypotension, tachycardia, and vomiting, the NP diagnosed pharyngitis and dehydration. This was grossly and flagrantly unacceptable and made worse by fact of not having an appropriate translator for this deaf patient. The NP took no history with respect to the vomiting and failed to order any laboratory tests despite the patient not having eaten in four to five days, and having vomiting and dehydration. The NP started an intravenous antibiotic (Ancef) for pharyngitis, which is not typical standard of care. Vomiting and not eating are not associated with pharyngitis and should have resulted in investigation of another diagnosis. Further diagnostic work up was indicated but not done.

The patient was admitted to the infirmary on 11/13/16. A physician saw the patient on 11/14/16, but took no history of the patient’s symptoms of vomiting, not eating, or dehydration. The doctor merely continued the same care as the NP, but ordered next day laboratory tests to assess the dehydration. These lab tests were never done. These tests should have been immediately done.

The patient deteriorated. On 11/14/16, the patient became hypothermic, with temperature of 94.9°F with altered mental status. This new red-flag finding was consistent with sepsis and the patient should have been immediately hospitalized or immediately assessed with diagnostic studies, but the doctor failed to address these problems. Later that same day, the patient became unresponsive. An unresponsive patient, with history of vomiting, dehydration, and hypothermia should be immediately hospitalized. No action was taken, which was grossly and flagrantly unacceptable.

On 11/15/16, the patient was found kneeling and lying on the floor. The nurse did not take his vital signs and did not consult a physician. Despite the patient's altered mental status and weakened status, a doctor did not see the patient on the infirmary unit on 11/15/16. Ordered labs were not done. On 11/15/16, the patient was not talking. This level of altered mental status should have resulted in immediate hospitalization. This was grossly and flagrantly unacceptable care.

On 11/16/16, the patient opened his eyes only to stimulus and was unable to feed himself. At 7:53 a.m. on 11/16/16 the patient was still unresponsive, and the blood pressure was 68/palpable. The patient was in shock and the patient was transferred to a hospital. At the hospital, diabetic ketoacidosis was diagnosed, which had been unrecognized at the prison. The patient was severely dehydrated and had significant abnormalities of his liver function. The patient died the day of arrival.

This death was preventable. On multiple occasions, he should have been sent to a higher level of care for laboratory testing and better monitoring than was available at the prison. The patient had vomiting, abnormal vital signs for three days, and altered mental status for two days, yet was not appropriately evaluated. The patient had vomiting, hypothermia, tachycardia, lower than normal blood pressure, dehydration, and altered mental status. The failure to admit to a hospital earlier in the course of care was grossly and flagrantly unacceptable practice.

Patient #8 Dixon

This was a 45-year-old with a history of smoking and mental illness who brought to medical attention a lump on the neck on 2/5/16. A nurse practitioner and then a doctor saw the patient, but the doctor noted that the 2 by 2 centimeter mass was likely a lymph node and ordered a six month follow up. The neck mass was described as hard. A hard 2 cm neck mass should be considered cancer until proven otherwise. The patient was evaluated multiple times, but the hard neck mass was not evaluated for cancer despite that this presentation must exclude cancer. The patient began losing weight on 3/29/16, but it was unnoticed by physicians. A doctor saw the patient again for a neck mass and swollen uvula on 4/29/16, and started antibiotics for a presumed infection. On 5/9/16, a nurse practitioner identified increased throat swelling and ordered a different antibiotic. The patient had lost weight, but it was unnoticed. The patient was repeatedly evaluated by doctors and nurse practitioners and the neck mass increased to a golf ball size, but it was diagnosed as infectious. The patient was finally sent to a

hospital on 5/15/16, three months after initial symptoms, and a CT scan showed a neck mass, likely a tumor. This could have been diagnosed three months earlier.

The patient continued to lose weight and the patient eventually went to UIC for evaluation, but reports were not obtained and doctors at Dixon failed to document the status or progress of the patient's specialty care. Chemotherapy and radiation therapy apparently started in mid-September 2016, about four months after the initial CT scan showing a likely cancer and seven months after identification of the neck mass. During chemotherapy there were no reports and doctors at Dixon failed to document the progress of the patient's therapy.

The patient continued to lose weight, yet even when described as cachectic, the doctor did not perform a nutritional assessment, and failed to determine whether the patient was able to eat or what he could eat, given his cancer. When the oncologist was preparing the patient for chemotherapy, a doctor at Dixon told the patient to "fatten up," without any evaluation with respect to whether the patient was able to eat, or what his nutritional status was. Except for giving Boost, no action was taken until, when hospitalized for chemotherapy, the patient had a gastrostomy tube inserted.

The patient developed pressure ulcers. Repeatedly, doctors failed to evaluate the ulcers. On two occasions, the patient had an irregularly irregular heartbeat. After the first episode, an EKG was not done but should have been done. On the second occasion, a routine EKG was noted showing premature atrial contractions.

In early September, the patient passed out and had hypotension (60/40). This level of blood pressure is compatible with shock. The patient also had altered mental status. Instead of sending the patient to a hospital, the doctor placed the patient on an infirmary for 23-hour observation. The following day, a doctor presumed the patient had a seizure without ordering or having any diagnostic tests (CT brain, EEG, EKG, laboratory tests) to confirm his diagnosis. Instead of ordering diagnostic testing, the doctor released the patient to general population without any plan except to tell the patient to use a wheelchair.

The patient was hospitalized in November for chemotherapy, but after hospitalization a doctor did not document the therapeutic plan of the patient. Three days after release from the hospital the patient was not responding, was lethargic, and was found on the floor. Instead of sending the patient to a hospital or obtaining an immediate EKG, the doctor ordered neuro checks and asked to be called if the patient became unresponsive. Doctors should not wait until someone becomes unresponsive after a potential syncopal episode; they need to send the patient to a hospital or perform immediate tests to determine the cause of the syncope. The following day, a nurse noted that the patient had unequal pupils. A doctor saw the patient, and although noting that the patient experienced a fall, the doctor failed to perform a neurologic examination and did not order an EKG. This was grossly and flagrantly unacceptable care. The following day, the patient was unresponsive and was sent to a hospital. The patient had experienced cardiac arrest and had atrial fibrillation, but died after arrival to the hospital.

There were multiple missing reports from consultants. The patient had first signs of malignancy in February of 2016, but did not have an appropriate diagnostic CT scan until May of 2016. A biopsy was done sometime in May, but there was no report and it was not clear when this occurred. A PET scan was not done until late June 2016. Chemotherapy and radiation therapy did not start until sometime in mid to late September. Treatment was not started until seven months after first symptoms. Treatment at the facility after chemotherapy and radiation therapy were at times grossly and flagrantly unacceptable. The patient had an irregularly irregular pulse and experienced syncope, but was not sent to a hospital. Three weeks later, a doctor ordered a routine EKG, which appeared to show premature atrial contractions. A radiation oncologist recommended that Dixon evaluate the patient's premature atrial contractions, but there was no report to identify what the concern was. The patient was found to be unresponsive and lethargic, and was on the floor. The nurse called a doctor in the evening and the doctor, instead of sending the patient to a hospital, ordered neuro checks and to call him back if the patient was unresponsive. The following day the patient had unequal pupils, yet the doctor still did not admit the patient to a hospital or evaluate the patient for his syncopal episode. The following day, the patient was admitted to a hospital after being found unresponsive. The patient had atrial fibrillation, developed cardiac arrest, and died. Because of the delay in diagnosis, delay in treatment, failure to evaluate multiple potentially life threatening events (unequal pupils, syncope, and altered mental status), **this death was possibly preventable.**

Patient #9 Stateville

This 79-year-old patient had hypertension, chronic kidney disease, and dementia from an unknown cause. The medical records lacked information to such an extent that it was not possible, on review of the prison records, to determine the status of the patient's conditions at almost any point in his two year stay on the infirmary at Stateville. The only reliable source of documentation was from offsite hospital reports, but these reports were not consistently filed in the medical record. The only partly reliable onsite source of information was from nursing notes.

The patient was apparently a full-time resident of the infirmary since at least 2014. Dating from December of 2013 until June of 2014, the doctor's progress notes, 19 in number, were identical and stated in their entirety, "No specific complaint, no change, dementia, continue same care."

That was the extent of the note which was repeated over and over. There was no effort to monitor the patient for any of his medical conditions until the patient deteriorated and needed to be hospitalized. The nurses were the only health care staff who appeared to be monitoring the patient.

On 6/28/14, the patient was confused, with low oxygen saturation, and was sent to a hospital. The hospital discharge summary was not in the medical record except for an echocardiogram that showed severe left heart dysfunction, an ejection fraction of 30%, and pulmonary

hypertension. This echocardiogram is consistent with significant cardiac and pulmonary disease. When the patient returned from the hospital the patient was on oxygen, but the doctor did not review what had occurred in the hospital, except to note that the patient had a stroke and had respiratory failure. The patient's capacity for performing routine daily activity was not discussed in the patient's therapeutic plan and not addressed. The status of the patient's condition was not described. Despite documenting that the patient had a stroke, the only neurological examination documented was a confusing two word statement which was, "alert, confused," which was unintelligible. None of the findings on the echocardiogram were included in the problem list and none of these findings were followed clinically. The stroke was not clarified, and the status of the patient's neurological status was not established.

After return from the hospital on 7/16/14, the patient started falling in his room. For a year, from 7/24/14 until 7/13/15, the patient fell seven times. Although a doctor ordered x-rays on one occasion, the doctor failed to perform an examination of the patient after any of these falls. There was no documented attempt by the providers to protect the patient, who had a history of stroke and dementia, from injury due to these falls. After return from the hospital on 7/16/14, the patient was on continuous oxygen therapy for unspecified reasons. The doctor eventually documented on 8/27/14 that the patient was doing well without use of CPAP. The doctor discontinued the CPAP and ordered CPAP use "PRN" or as needed. How would a confused demented patient know when to use oxygen? It also appeared that the doctor used the word CPAP when he probably meant BiPAP. CPAP is a device used in sleep apnea but BiPAP is a form of oxygen delivery. There was no evidence that the patient had sleep apnea.

Beginning in July of 2014, after return from the hospital, the doctor again began writing notes that were identical or near identical to previous notes. Many of these were verbatim identical. These notes were similar to the note quoted above. This incompetent documentation continued even when problems occurred, such as a patient fall.

Beginning in May of 2015, nurse documentation revealed that the patient's status was changing. The patient began experiencing diarrhea and became progressively more confused. When nurses called the doctor stating that the patient was confused, the doctor gave a phone order for long-term Ativan, a sedative and anti-anxiety agent. This occurred twice. This drug carries a warning that it may impair mental abilities and must be used cautiously when performing tasks requiring mental alertness. Use in an elderly demented patient with history of falls was bad judgment at best and carries a manufacturers warning to use *extreme caution* when using in patients at risk of falls. The patient was kept on Ativan for over a year despite repeated subsequent falls. This placed the patient in direct risk of harm.

The patient's confusion worsened. On 5/15/15, a nurse described the patient as unresponsive and lethargic. On 5/23/15, the patient was described as walking unsteadily and appearing agitated and confused. The doctor again prescribed Ativan by phone for 30 days without examination of the patient. This was grossly and flagrantly unacceptable care. The patient began complaining of stomach pains and the doctor ordered lab tests by phone twice, which

were not done. Through all of these episodes the doctor continued to write nearly identical notes, which did not represent symptom findings as documented in nursing notes. The doctor never documented a thorough examination of the patient. Most of his examinations were documented as “no change.”

By 7/11/15, a nurse described the patient as “very weak” and “declining.” On 7/12/15, a nurse documented that the patient was not able to feed himself and was not eating. The doctor was notified but took no action. Later that day the patient was incontinent, and a doctor ordered blood tests, which finally were done. The laboratory called the prison because the labs were of critical value, with hemoglobin of 6. The patient was sent to a hospital.

At the hospital, an intra-abdominal abscess was identified, and a laparotomy was done, and a large invasive colon cancer was identified requiring a partial colectomy with an ileostomy. The cancer was so advanced that it was not able to be resected. Given the patient’s dementia, hospice care was recommended.

When the patient returned from the hospital, the doctor continued to write the same notes with nearly identical words from July of 2015 until the patient died in April of 2016. These notes stated, “No specific complaint. No change. Dementia, post colectomy for metastatic ca [cancer]. Continue same care.”

The patient did not appear to receive any specialized care or hospice care. The doctor made no attempt to identify whether the patient was in pain or to assess the comfort level of the patient. The patient fell six more times, based on documentation. The doctor’s notes were the same even after patient falls and episodes of increased confusion or agitation. Despite repeated falls, the patient was kept on Ativan, which carries a warning to use extreme caution in persons at risk of falls. The doctor ordered no labs to monitor the clinical status of the patient. Nutritional status was not documented as monitored by the physician. Comfort measures were not documented by the doctor as taken. The patient soiled himself frequently and pulled off his colostomy bag and soiled the bed and his clothes. During one of these episodes of fecal accidents, a nurse documented that the patient was combative. The nurse wrote, “need more staff to help change.”

The doctor wrote nearly identical notes over 30 times from July of 2015 until April of 2016, giving no updated status of the patient. On 11/23/15, a second doctor was covering the infirmary and diagnosed a pustular otitis media with a tympanic perforation, but on the same day as this episode the doctor wrote his typical identical note without assessing the patient’s ear.

In late November 2015, the patient became lethargic and had diarrhea. A nurse called a doctor and the patient was sent to a hospital, where a urinary tract infection was identified. Blood tests at the hospital indicated that the patient was significantly dehydrated (BUN 56), indicating

lack of attention to nutrition and fluid consumption. When the patient returned from the hospital, the same irrelevant, identical notes were written by the doctor.

On 4/18/16, the doctor wrote one of his typical identical, irrelevant notes. The following day, a nurse noted that the patient was diaphoretic, listless, pale, and was lying in bed without sheets or covers, and appeared to be in pain but was unresponsive. After about five hours and three nursing evaluations, the patient was sent to a hospital. Although the hospital discharge summary was not available, the patient died of sepsis. The autopsy describes the body as having dirty finger and toenails and multiple scars on his extremities and back, apparently from scratching himself.

In summary, this patient received insufficient nursing care likely due to lack of staffing. Nurses were the only clinical staff paying attention to the patient and they appeared less than adequately staffed in performing their tasks. This placed the patient at risk from falls, infections, and lack of attention to nutrition. The Medical Director wrote nearly identical notes over two years despite a changing clinical status of the patient. The notes were nearly identical, even before and after hospitalizations. Significant clinical events (falls, ear infections, change in mental status, alteration of bowel habits, etc.) were either ignored or not commented on by the doctor. The patient's actual clinical status, including nutritional status, was not monitored by the doctors at all. The lack of attention to the patient's pain status and comfort measures by the physician were absent despite a recommendation for hospice care by the oncologist. We identified 255 errors in the patient's care over the two years of record review. Many included failure to take adequate history, perform adequate physical examination, and make an appropriate assessment, due to use of identical documented progress notes despite changes in the patient's status. The patient's medical conditions, which included hypertension, chronic kidney disease, dementia, COPD, and eventually colon cancer, were never monitored during physician visits. **Care was negligent. Careful attention to this patient would probably have prolonged his life to a small extent but the death was not preventable.** More important was the lack of humane care by the physician, which was incompetent, and grossly and flagrantly indifferent. The care of this patient also demonstrates the effect of lack of sufficient nurse staffing on the Stateville infirmary.

Patient #10 Stateville

This 68-year-old inmate from Stateville had hypertension, diabetes, and back pain. He had elevated lipids and carried above a 50% 10-year risk of cardiovascular events or stroke⁵ based on American College of Cardiology criteria, yet this was unrecognized for the entire incarceration and the patient remained untreated for this disorder. Blood pressure was not at control (140/90) on six occasions, but doctors failed to adjust medications. Failure to properly

⁵ The American College of Cardiology and American Heart Association guidelines on lipid therapy recommend that when the 10-year risk of heart disease or stroke is over 7.5% that patients be started on statin medication. A simple calculator for identifying risk is available at <http://www.cvriskcalculator.com/>.

treat the hypertension and lipid disorder placed the patient at risk of cardiovascular events and stroke.

The patient had back pain and was on ibuprofen, a nonsteroidal medication, for almost the entire period of record review without adequate monitoring. This drug carries two black box⁶ warnings; one for increased risk of serious (and potentially fatal) adverse cardiovascular thrombotic events, including fatal MI and stroke, and an increased risk of serious gastrointestinal inflammation, ulceration, bleeding, and perforation (may be fatal). This latter risk is increased in the elderly. The nonsteroidal medication can also exacerbate hypertension or cause renal damage. Despite these serious and significant warnings, doctors routinely and continuously prescribed this medication without considerations of the risk to the patient and without discussing those risks with the patient.

On 4/15/16, the patient experienced an episode of emesis and nausea after awakening. An EKG showed STT wave changes that could be consistent with ischemia. A doctor diagnosed possible nonsteroidal gastritis or angina, both of which were possible in this patient. The doctor did stop the non-steroidal medication and started omeprazole, an anti-ulcer medication, but the doctor did not take action with respect to the potential for angina. The doctor ordered a hemoglobin and it was 10.3, significantly lower than the last hemoglobin of 13.7, yet there was no follow up of this abnormal lab. The patient should have been referred for endoscopy. Also, the doctor stopped the ibuprofen and ordered only a single nitroglycerin tablet, and failed to order anti-anginal medication longer term. Because the patient had such high risk for cardiovascular disease, a stress test or cardiac catheterization should have been done. Yet there was no follow up of this problem. Endoscopy and colonoscopy should also have been done to evaluate the recent anemia and abdominal symptoms.

A different doctor restarted the ibuprofen about two weeks after the episode of 4/15/16 without reviewing the abnormal hemoglobin and without recognizing the black box warnings or the recent dramatic drop in hemoglobin. A week later, the ibuprofen was changed to naproxen, another nonsteroidal medication with the same risks and same black box warnings. Doctors ordered non-steroidal medications six times without consideration of the black box warnings for gastrointestinal bleed, which the patient likely had as manifested by his acute anemia and prior episode of vomiting "black stuff" as early as 2013. The doctors also ignored the potential for cardiovascular thrombotic events with use of non-steroidal medication, likely because they appeared ignorant of the patient's high-risk cardiovascular status. This was likely incompetence.

On 2/5/17, the patient collapsed. CPR was initiated at the facility, but the patient died at the hospital. An EKG done at the facility was consistent with an acute coronary event (MI). A coroner listed the cause of death as atherosclerosis contributed to by gastrointestinal hemorrhage.

⁶ According to the Food and Drug Administration website at <https://www.fda.gov/downloads/forconsumers/consumerupdates/ucm107976.pdf> boxed warnings appear on a prescription drug's label and are designed to call attention to serious or life threatening risks.

This death was preventable. Providers failed to evaluate for peptic ulcer even though the patient had symptoms or signs of this condition (anemia, vomiting, and apparently bloody emesis). The patient's anemia was never properly evaluated despite being suggestive of peptic ulcer disease. Despite potential for ulcer disease and cardiovascular disease providers kept the patient on non-steroidal medication for years despite warnings from the manufacturer regarding risk for gastrointestinal bleeding and myocardial infarction. Providers failed to treat the patient for high blood lipids despite significant risk. Providers failed to manage blood pressure to a level considered a goal for diabetics. Lipid therapy and adequate blood pressure control are modifiable risks for cardiovascular disease. When a doctor on 4/15/16 documented that the patient might have had a coronary event there was inadequate follow up. There were signs on EKGs of ischemic cardiovascular disease (changing patterns of STT wave changes) that indicate possible ischemic cardiac disease. There were multiple modifiable factors for cardiovascular disease yet the patient did not receive evaluation for this disease. Although the patient appeared to the provider to have had an angina episode, follow up stress testing or angiography were not done, and the patient was not treated with anti-anginal medication. If earlier interventions in these areas were undertaken the death would have been preventable. We note that appended to the death summary was a Wexford Mortality Review Worksheet in which the Medical Director who participated in care of the patient opined that earlier intervention was not possible and that there was no way to improve patient care. We disagree for the reasons cited above. We noted 50 errors of management in this patient's care.

Patient #11 Stateville

The records sent for this patient consisted of 20 PDF files which were not in order and were disorganized, making evaluation extremely difficult. This 73-year-old lost about 20 pounds from 2014 to 2015 without anyone noticing or initiating an evaluation. On 10/6/15, the patient developed dysphagia to solid food and a right neck mass was identified. On 10/20/15, an ultrasound showed a likely malignancy. The diagnosis of invasive squamous cell carcinoma of the tongue was not made until 1/8/16, almost three months later.

Few offsite consultation reports were available. Some referral forms were present that had a few scribbled notes by the consultant written on them. The patient started radiation therapy sometime in late February, almost five months after symptoms started. The notes by the SCC doctor were so poor that it could not be determined what the status of the patient was and whether care was appropriate. Most of the doctor's notes stated, "No specific complaint [objective] no change [assessment] throat ca on radiation chemo [plan] continue same care."

This identical note was repeated over and over, giving no update on the status of the patient's chemotherapy or radiation therapy. The patient had hypertension, hyperlipidemia, apparent COPD, and head and neck cancer. Except for the head and neck cancer, none of the physician notes over the last seven months of the patient's life included mention of the patient's other conditions. Almost no notes over the same time period gave an updated status of the head and neck cancer, and the existing therapeutic plan. The patient did not appear to receive care

except by UIC consultants. Since not all of the consultation reports were in the medical record, it was not possible to review whether the therapeutic plan of the oncologists was being carried out. The patient apparently completed chemotherapy and radiation therapy, but a follow-up PET scan was not in the record. The patient had episodes of shortness of breath in July that were not diagnosed. The patient was found unresponsive on the toilet, apparently taken to a hospital, and apparently died. We say apparently because there were no notes documenting what happened to the patient.

The coroner listed the cause of death as hypertensive heart disease. A recent echocardiogram was normal and did not show hypertensive heart disease. The coroner performed an autopsy but the IDOC was unable to find it. The coroner made no mention on the death certificate of the patient's head and neck cancer. This appears to be a mistake.

There were **insufficient medical records to determine if the death was preventable**, as consultation notes were not all available, SCC physician notes were poor, and the autopsy was unavailable. We identified 170 separate errors. Most were combinations of failure to take a history, perform a physical examination, make an assessment, and develop a therapeutic plan. These occurred when the doctor who was the Medical Director wrote notes repeatedly that contained the phrase quoted above. There were multiple errors of not having a medical report available. However, we were unable to determine how many reports were not present, as it appeared that the patient had many more consultations, radiation, and oncology treatments than are documented in the medical record. It was not surprising that there were also multiple episodes of failure to follow up appropriately after a consultation. Because so many consultation reports were not in the record, many more of these were probably also not followed up on. There were few episodes of care documenting review of the consultant's care noting recommendations. Documentation was so poor that it was not possible to determine the course of care for this patient, even to determine whether death was preventable.

Patient #12 Stateville

This patient was incarcerated at Graham Correctional Center on 8/11/15. The patient was transferred to Western Correctional Center. After the intake evaluation at Graham, there is a gap, and medical records for the next year were missing. The record resumes in August of 2016, when the patient was transferred from Western Correctional Center to NRC for a writ at UIC for treatment of liver cancer. After transfer from Graham to NRC, most physicians treating the patient were from NRC, but in February they were from SCC. It was unclear during this time period where the patient was actually housed. The missing record documents from Graham and Western were compounded by multiple missing record documents from NRC. At NRC, most specialty referrals and specialty reports were not in the record, and it was not possible to determine the course of care based on the available record. Also, there were no progress notes for this patient from 1/20/17 until 2/15/17, almost a month. During this time, the patient had life-critical laboratory results and it was not possible to review care for that period. To give a final opinion on this patient with this chart is not possible because the chart is incomplete. We

had asked for two years of the record but only received one year, and there were missing documents in the record we received. Over the entire period at NRC/SCC, doctors did not document understanding of the therapeutic plan of UIC consultants. Because of the lack of reports in the record, it was not clear what that plan was. Despite providers, on multiple occasions, stating that they were waiting for reports and expressing not knowing what the plan was, these reports were not obtained. This took place between August of 2016 and February of 2017, when the patient died. This does reinforce our opinion about the medical record system at NRC, which is completely broken.

The missing record from Western would be important to review with respect to an opinion on preventability. A UIC consultant documented that hepatocellular carcinoma was identified on CT scan in January of 2016, yet the patient was not referred for treatment until August of 2016. It was unclear if earlier knowledge of the diagnosis was available. A biopsy done in May of 2016 showing apparent hepatocellular carcinoma was requested by UIC multiple times but was never provided. This patient did not apparently have timely evaluation or treatment of his condition and his death may have been delayed or prevented given timely and appropriate care. But we will not make that designation without the ability to review the record, which was not present. Because of these missing medical record documents, **there is insufficient medical records to determine whether this death was preventable.**

Despite being unable to determine whether this death was preventable, we did note significant problems with his care. We noted 40 errors; 15 were related to lack of available reports from consultants, which resulted in at least five episodes of lack of follow up. It was not clear if the patient ever went back to UIC for follow up after treatment of his hepatocellular cancer.

There were four episodes of medication error. In one case the patient was started on spironolactone, but the patient had prior and recent hyperkalemia, which required kayexalate. When the spironolactone⁷ was started, monitoring of potassium was not done, although recommended by UIC. This was the first medication error. Almost three months later the patient developed life-critical potassium elevation. This potassium (6.9) was reported by phone by UIC at 5:30 a.m. on 2/11/17, but the patient was not evaluated with an EKG or clinical evaluation, and kayexalate was not given until 2/12/17, in the evening. This was grossly and flagrantly unacceptable practice. The second error was that it was not realized that the patient was still on spironolactone until 2/14/17, when it was stopped. The third error was that the patient had ascites and his diuretics expired and this was not noticed for almost four weeks, at which time the patient had significant ascites and apparent anasarca. The fourth error related to an abnormal laboratory result. At one point, a stat laboratory result was called in from a local hospital. The platelets were 22,000. Thrombocytopenia is characteristic of cirrhosis and no treatment is indicated except to prevent bleeding and to eliminate drugs that may cause

⁷ Spironolactone is a diuretic medication that can cause elevation of the potassium level. A potassium level above 6.5 is considered critical and life-threatening. Immediate evaluation is indicated, along with an EKG to assess whether immediate intravenous medication needs to be given. In this case, the patient was treated casually and not for a day and a half after notification of the abnormality.

bleeding. The Medical Director, who was a surgeon, receiving the report from a nurse by phone incompetently ordered high dose injected steroids and a three-day course of high dose prednisone, apparently thinking that the patient had immune thrombocytopenia, a different disease. This placed the patient at risk of harm, as the drug was unnecessary and given the patient's condition placed him at higher risk of bleeding and infection.

The patient developed severe ascites with decompensated cirrhosis. UIC had recommended him to return if this occurred, yet doctors failed to know the therapeutic plan of UIC because reports were unavailable, so the patient was not returned to UIC. Also, the patient was not seen for about six weeks despite having new onset ascites and life-critical laboratory results, including BUN 149, sodium 125, creatinine 3.88, and potassium 6.9. This lack of access to a physician despite life-critical laboratory results was indifferent.

We note that despite UIC diagnosing and treating the patient for hepatocellular carcinoma, the Medical Director at SCC, a surgeon, wrote the death summary and stated that the patient died of cholangiocarcinoma, a cancer of bile ducts. This diagnosis was nowhere present in the medical record and could not have reasonably been presumed based on a review of the medical record. The coroner listed liver cancer, and UIC physicians documented that the patient had hepatocellular carcinoma. Cholangiocarcinoma and hepatocellular carcinoma are different cancers. This inaccuracy was not corrected as apparently no one reviewed the death critically.

Patient #13 Stateville

This patient was a 38-year-old man with a history of hypertension and on renal dialysis for kidney failure. The reason for being on dialysis was not documented in the medical record and was unclear, but it appeared to be from hypertension. This is a very young age to have kidney failure from high blood pressure, yet the etiology of the renal failure was not documented in the record.

The patient transferred from Graham to Stateville on 9/24/14. The patient was at Stateville 18 months. During that entire 18 months the blood pressure was not controlled. There were 16 episodes of care in the medical record during which a doctor (staff physician or contract nephrologist) saw the patient. At all of these episodes the blood pressure was not at goal and was sometimes significantly elevated. On only three occasions did a doctor modify or increase blood pressure medication. During this time period the patient had only two chronic care visits. The lack of attention to the patient's ongoing high blood pressure was indifferent.

On six occasions, the serum potassium was above 6.7. Three of these values were above seven (7.1, 7.2, and 7.6) and one of the values was extraordinarily high (8.5). All of these values are critical values and require immediate intervention. When the potassium is above 7, the patient is susceptible to cardiac conduction abnormalities (e.g. sinus arrest, idioventricular rhythms, ventricular tachycardia or fibrillation, and asystole) which can cause death. Yet on all of these occasions no actions were taken. On one occasion, when the UIC laboratory called Stateville at

4:00 a.m. for critical potassium level of 8.5, the nurse took no action except to note that the morning nurse would follow up. That did not occur. At 1:30 p.m. that same day, a nurse notified a doctor and the plan was to have the patient followed up the next morning. There was no documentation that this occurred. These were critical values that typically require immediate attention, and the lack of attention to this was grossly and flagrantly unacceptable practice and placed the patient at risk of harm.

Both a vascular surgeon and the nephrologist recommended work up of a murmur. The Stateville doctor referred the patient to cardiology. Wexford denied the cardiology consult but approved an echocardiogram. The patient had an echocardiogram consistent with significant hypertensive heart disease and multiple abnormalities. When the doctor at Stateville saw the patient after this test, the doctor did not review the test or take any action. No one followed up on the murmur or the echocardiogram and the patient never saw a cardiologist. At the same visit the blood pressure was 178/113, but the doctor took no action to improve blood pressure control. The echocardiogram showed cardiac effects of prolonged poorly controlled hypertension. A cardiologist should have been consulted because the Stateville doctor did not review the test or appear to know how to manage the patient's high blood pressure.

The patient was being dialyzed late evenings to early mornings. We do not consider dialysis in the early morning appropriate, particularly when breakfast is also served early morning. Also, when problems occur during dialysis there are no doctors present to evaluate the patient. At about 2:00 a.m. on 1/9/16, the patient was brought by the dialysis nurse to the clinic with nausea, vomiting, profuse sweating, and elevated blood pressure as high as 189/113. This constellation of signs should have prompted a provider evaluation with immediate EKG and laboratory tests or the patient should have been sent to a hospital. Acute coronary syndrome should have been considered. Instead, the patient was given antacids, observed for several hours, and sent back to his housing unit.

On another occasion, the patient had shortness of breath, lightheadedness, fast heart rate (126), weakness, and diaphoresis. An EKG was done and did not have an automated reading on it but appeared to have peaked T waves indicative of possible hyperkalemia. The EKG rate was approximately 145-150. The patient should have been sent to a hospital. Instead, a nurse called a doctor, who ordered a single dose of atenolol and sent the patient back to his housing unit without any follow up. The patient was not evaluated for hyperkalemia. Care was grossly and flagrantly unacceptable.

On another occasion, a doctor saw the patient for not feeling well. The blood pressure was 150/96 and the oxygen saturation was 88%, which suggests significant hypoxemia. These values warrant hospitalization. The doctor referred the patient to the health care unit but there is no documentation in the record that this visit occurred. This placed the patient at risk. There may have been a problem with medical record paper work getting filed.

On another occasion the patient had fever (101.4°F) with elevated blood pressure (170/95) and felt nauseous with chills. The nurse called a doctor, who prescribed Tylenol and an anti-emetic without provider follow up.

All of these cases demonstrate an indifferent attitude to the patient's serious conditions.

On 3/22/16, the patient experienced shortness of breath, elevated blood pressure, elevated pulse, and elevated respirations, and within minutes of being evaluated sustained cardiac arrest and was taken to a hospital, where he was pronounced dead.

The Wexford Mortality Review Worksheet documented that earlier intervention was not possible, there was no way to improve medical care, and the medical response could not be improved.

This death was preventable. The coroner listed the cause of death as hypertensive heart disease. The patient had long standing hypertension. His blood pressure at Stateville was uncontrolled throughout his entire 18 month stay and the system was indifferent to his uncontrolled blood pressure. He was seen in chronic clinic for his hypertension only twice, which is not consistent with IDOC guidelines. Approximately 80% of the time, when a doctor saw the patient with elevated blood pressure no action was taken to modify the patient's medication. According to a four-month sample of medication administration records, the patient received only 60% of his medication. The reasons for this were not clear and there was no counseling or history by providers to determine why this was occurring.

The patient was repeatedly placed at risk of arrhythmias due to hyperkalemia. The monthly nephrology checks in dialysis clinic do document the nephrology prescription of Kayexalate, a binding agent for hyperkalemia. But the episodes of extremely high potassium required additional steps to lower the potassium. The lack of concern for extremely high potassium levels was extraordinary and unacceptable, and appears to demonstrate a lack of basic primary care medical knowledge or indifference to the patient's critical need. The patient had an echocardiogram showing significant hypertensive heart disease, but the test was not even reviewed. The providers appeared indifferent to the patient's serious medical condition, which ultimately caused his death. It is our opinion that improved treatment of his high blood pressure would have prevented or significantly delayed his death from hypertensive heart disease. We do note that the patient's phosphorous, BUN, and PTH were repeatedly elevated. Because the dialysis records are not incorporated into the medical record, the course of dialysis care was not clear. Given the continuously elevated blood pressure, high BUN, and phosphorous, it is possible that the patient was not being dialyzed for sufficient time. We would recommend that the IDOC have an outside nephrologist (from UIC) review this case to evaluate the nephrology care to ensure that dialysis treatment times were adequate.

We noted 44 apparent errors in care for this patient. Most (16) related to not addressing out of control hypertension. Twelve errors related to not timely reviewing abnormal labs (high

potassium) and not instituting prompt action for critically elevated potassium levels. Three errors related to not sending the patient to a higher level of care when apparently indicated. Two errors related to the patient not receiving medication, including a survey of several months of medication record indicating that the patient missed 40% of medication doses over four months.

Patient #14 Stateville

This patient had 33 documented seizures over a four year period or about eight seizures a year. This is not good control. It did not appear that the physician knew how to manage this condition. There was no evidence of an EEG or CT scan, even though these should be done for diagnostic purposes. We only reviewed two years of the record, so these tests may have been done earlier. However, there was no reference to these tests. The doctors did not evaluate for side effects of medication at chronic clinic visits. Failure to control seizures and to know how to monitor this condition is an indication to refer the patient to a neurologist which should have been done.

The patient had a presentation of atypical chest pain with an equivocal EKG, but was not followed up for this. The patient had high blood cholesterol and in 2015 and 2016, his 10-year risk for heart disease or stroke was 26% and 14% respectively. He should have been on a higher dose of statin, but was not. This placed the patient at risk for coronary artery disease.

Shortly after one of the patient's seizures, he became unresponsive. The patient sustained cardiac arrest and died. The coroner listed the cause of death as coronary atherosclerosis, although the autopsy was not available. The patient did not have a myocardial infarction, apparently. Having died from coronary atherosclerosis during a seizure indicates that the seizure may have precipitated an acute coronary event because of the rise in blood pressure and pulse. This is difficult to be certain of and for that reason alone **we determine that this death was not preventable**. However, patients with seizure are at risk for sudden death, a condition known as unexpected death in epilepsy (SUDEP). This condition can have a cardiogenic etiology. It was therefore a significant failure in not referring this patient to a neurologist for accurate diagnosis and management of his epilepsy, because onsite physicians were not able to bring the patient's seizures under control, as evidenced by 33 seizures and inability to obtain control.

We noted 57 errors of management. Most (14) were related to the patient having seizures, with the nurse not consulting a physician. An additional 12 errors were related to not ordering therapeutic drug levels after a seizure.

Patient #15 Dixon

This patient was a 24-year-old man with severe mental illness. He was incarcerated on 8/12/16. He weighed 207 pounds. In the past he had multiple psychiatric hospitalizations. The patient

became unstable when not on medication and would frequently refuse medications. These refusals apparently did not result in referrals to mental health professionals. According to an administrative review, when this patient did not take his medication he became more psychotic with delusions, paranoia, and hallucinations. These episodes of psychosis resulted in multiple crisis watches, often for self-harm. The self-harm included foreign body ingestion, which on two occasions resulted in hospitalization.

On 7/12/17, a nurse documented that an officer observed the patient swallowing two sporks, which are a plastic combination spoon and fork. The nurse documented that the patient "will have no complication from swallowing a foreign object." The nurse did not refer to a doctor. This was grossly and flagrantly unacceptable care. On 7/13/17, another nurse notified a doctor that the patient had swallowed a spork; the doctor ordered an x-ray but did not evaluate the patient. The x-ray showed no radiopaque foreign body. On 7/16/17, the patient told a nurse that he went on hunger strike "because no one cares about the spork I swallowed." The nurse did not consult a doctor. On 7/24/17, a nurse saw the patient on sick call for stomach pain. The patient requested of the nurse, "Don't put any pressure on my stomach." The nurse assessment was "ineffective coping" and abdominal pain of unknown etiology. The nurse did not refer to a doctor.

On 9/27/17, a psychiatrist saw the patient. The psychiatrist documented that the inmate was frustrated with "what he perceives to be indifferent medical attention." The patient told the psychiatrist that he had swallowed two sporks and was not receiving medical attention. The patient was correct.

On 10/2/17, a nurse practitioner saw the patient, who told the NP that he had swallowed two sporks and wanted them removed. The patient weight was 174 pounds, which was a 33-pound weight loss since his incarceration a year ago; the weight loss was unrecognized. The NP documented a soft abdomen. The patient had also embedded an object in his forearm. The NP ordered an x-ray of the forearm but did not address the ingested spork. The NP assessment included that the patient had a foreign body in his GI tract. To not evaluate for the swallowed spork was grossly and flagrantly unacceptable care.

The patient complained to a licensed clinical professional counselor (LCPC) on 10/12/17 that he had stomach pain and wanted to see the nurse practitioner. He said he was only eating snacks because of stomach pain. There was no referral. This was indifferent.

On 10/18/17 the LCPC saw the patient, who again reported that no one was taking care of his medical needs. He complained of vomiting, diarrhea, and weakness and was not eating because he was nauseous. The LCPC documented that he would follow up the next day regarding a sick call request, "given he still had not submitted one per medical." It appeared that the medical program was not going to see the inmate unless he submitted a request. The following day, the patient did not show up for his mental health appointment. The note documented, "He is sick."

On 10/20/17 a nurse saw the patient, who complained of abdominal pain after swallowing sporks months ago. The patient weighed 150 pounds, a 24-pound weight loss over the past month and a 57-pound weight loss since incarceration. The nurse failed to acknowledge the weight loss and appeared unaware that weight loss had occurred. The patient did not complain of black tarry stool or bleeding, but had nausea, diarrhea, and abdominal pain, and it hurt when he ate. The nurse noted pain on palpation in the center of the abdomen. The nurse did not consult a physician. The patient was sent back to his housing unit. This was indifferent, and grossly and flagrantly unacceptable care. The next morning, at morning medication pass, the inmate was found dead in his cell.

On autopsy, the coroner found two sporks in the inmate's duodenum, with deep lacerations of the duodenum and superficial lacerations of the proximal esophagus with blood in the stomach. The death was attributed to a gastrointestinal bleed from lacerations caused by a foreign body.

An IDOC administrative review found no problems with medical care. The report noted that the nurse on 10/20/17 had used the proper nursing protocol and that there was nothing in the nursing assessment indicating an emergency. The review found problems with the inmate not taking his medication and recommended that nursing staff notify a mental health professional if an inmate refused medication on three consecutive days. However, no issues were found with medical.

This death was preventable. On four occasions in July, nurses evaluated the patient for a complaint of having swallowed a spork. Only once did a nurse consult a physician. On that occasion, the physician ordered an abdominal x-ray but did not see the patient, and there was no documented follow up of the x-ray. Three months later on 10/2/17, a nurse practitioner saw the patient, who complained of swallowing a spork. The nurse practitioner took no action. Notably, the patient had lost 33 pounds over the past year, which was unrecognized by the nurse practitioner.

The patient complained to a psychiatrist and a licensed counselor that he had swallowed sporks and was not receiving care. This did not result in referrals to a physician.

On the day before his death a nurse saw the patient, who complained of stomach pain, nausea, diarrhea, and inability to eat because of the stomach pain. The nurse did not refer to a doctor. At this point the patient had lost 57 pounds, which was unrecognized by the nurse. The next day the patient died.

The most common features of an ingested foreign body are dysphagia, problems with eating, and regurgitation of ingested food. The patient appeared to have all of these symptoms for months. The patient had weight loss and multiple complaints of inability to eat normally. Pain in the setting of an ingested foreign body suggests perforation and endoscopic evaluation is indicated. The patient complained of pain repeatedly, yet these symptoms were not properly

evaluated in the context of a foreign body ingestion. Endoscopic evaluation is often necessary, even in the setting of negative x-rays. Plastic often does not show up on plain radiographs and failure to locate an object on a plain radiograph does not preclude presence of a foreign body. Since the spork has sharp prongs on the fork end, urgent endoscopy was indicated, but the patient did not see a physician for over three months. In the only nurse practitioner evaluation, the NP did not appropriately refer the patient. The NP also failed to recognize significant weight loss. Care for this severely mentally ill patient was indifferent, and grossly and flagrantly unacceptable.

We noted nine errors in this death review. Eight were related to either nurses or mental health staff not referring to a provider for a serious medical complaint. Two were related to providers not evaluating the patient related to significant complaints. And one related to failure of the nurse practitioner to initiate a work up for an ingested spork that had not been eliminated for over three months.

Patient #16 Stateville

This was a 54-year-old man with a history of hypertension and asthma. The patient was at Menard. On 8/29/16, while at Menard, pulmonary embolism was diagnosed, and the patient was started on warfarin with a recommendation to continue anticoagulation for six months.

While at Menard, providers failed to treat the patient with a statin drug despite an 8-13% 10-year risk for heart disease or stroke. He also had seven episodes of chest pain while at Menard. Some of these were typical for angina, but for most of these episodes of chest pain the history was inadequate and it could not be determined if it was angina. Nevertheless, providers did not start a statin despite the elevated cardiovascular risk, did not start antianginal medication, and did not refer for possible stress testing.

In late December 2016, the patient was again hospitalized at Chester Memorial Hospital from Menard for respiratory failure. Studies for pulmonary embolism were negative and no DVT was present.

The patient transferred to Stateville on 2/4/17, still on warfarin anticoagulation. On transfer, the patient had a pending sleep study and had diagnoses of hypertension, diabetes, asthma, and pulmonary embolism on anticoagulation. On 2/23/17, a blood count showed anemia (HGB 9.3) and on 3/1/17, a doctor stopped the warfarin. A colonoscopy was ordered but there was no evidence it was ever done. On 4/5/17, the patient asked for a breathing treatment, but the nurse had a dispute with the inmate and no treatment was given. On 5/10/17, the patient developed chest pain and the Medical Director noted that an EKG was normal, but there was no EKG present in the record; it appeared to be missing. On 5/19/17, the patient again experienced chest pain and an EKG showed subendocardial injury. The patient went into cardiac arrest and died. The Medical Director's report documented the cause of death as

subendocardial injury. A death certificate listed the cause of death as pulmonary embolism and documented that an autopsy was done, but the autopsy was not made available to me.

If the EKG apparently done on 5/10/17 was abnormal, the death may have been preventable. The autopsy needs to be obtained. If the patient died from pulmonary embolism, the death was likely not preventable. **The determination of preventability cannot be made pending obtaining the autopsy result and finding the missing EKG.** The missing EKG of 5/10/17 is significant with respect to evaluation of preventability.

We noted 30 errors in this patient's care. Most had to do with failing to make an accurate diagnosis and develop an appropriate therapeutic plan related to not starting statin drugs. This appears to be a systemic issue in IDOC. The evaluation of chest pain was poor. Histories were inadequate, risk factor analysis was not done to determine cardiovascular risk, and management was not consistent with standards of care.

Patient #17 Dixon

This patient was a mentally ill patient. His problems were not monitored well. The patient had Barrett's esophagus, history of esophageal and duodenal ulcer disease, hepatitis C infection, aortic valve replacement, and mitral valve prolapse noted on the problem list. Heart failure, history of prior atrial flutter, history of thoracic aortic aneurysm, and possibly COPD were not on the problem list and we could not find chronic illness clinics for these illnesses over the two year period of review.

The problem list documented Barrett's esophagus as early as 2002. This disease is an erosive disease of the distal esophagus and has a propensity for malignant transformation. For this reason, surveillance endoscopy is recommended. The timing of surveillance depends on the histology of biopsy specimens, but it is recommended at least every three to five years. There was no evidence that the patient was receiving this surveillance or that it was considered or discussed with the patient. The patient was taking omeprazole to reduce gastric acidity, which is necessary for persons with Barrett's esophagus. During one hospitalization, the patient had a life-threatening bleed from his esophagus and stomach, and hospital physicians noted that the facility had stopped his omeprazole because the patient did not show up for medication on several occasions. This should never occur. The medication records for the relevant month were not present in the medical record. The patient had two episodes of gastrointestinal bleeding since 2014. We reviewed two months of medication administration. During June and July of 2015, the patient refused 30 (25%) of 122 doses. Because he was mentally ill, doctors and mental health staff should have met with the patient to determine why he was not taking the medication. This did not occur.

The patient had a scheduled cardiology visit in March of 2014 which did not occur until May. The patient had follow up gastroenterology appointments after the two serious and life-threatening episodes of GI bleeding. Neither of these follow up gastroenterology visits were

documented as having occurred. We did find a Wexford approval for one of these consults, but could not find evidence that it occurred. The patient had life-threatening hyponatremia as low as 114, but there was no attempt to determine why the patient had hyponatremia. It was likely due to mental health medication, but there was no monitoring for this.

The patient weighed 193 pounds on 6/2/14 but began losing weight. The patient told a doctor that he was losing weight on 9/21/15, but the doctor took no history and did not weigh the patient that visit. On 11/5/15, the patient weighed 145 pounds, which was a 48-pound weight loss over about 17 months, but the patient was being seen for weight gain because he had weighed 133 pounds on 8/5/15. No one acknowledged the dramatic weight loss. When a doctor saw the patient on 11/17/15 and the patient weighed 144 pounds, the doctor documented that the "weight gain not a worry." The weight loss was never worked up. Doctors appeared indifferent to the patient's weight loss.

The patient had mental illness and for uncertain reasons started a fast in late November 2015. The patient weighed 133 pounds on 12/31/15 without any acknowledgement by medical staff of the 60-pound weight loss. A telepsychiatry encounter occurred 1/11/16. The psychiatrist restarted the patient on antipsychotic medication and ordered a follow up the following week, but there were no further psychiatry notes that we could find in the record reviewed and there was no evidence that the patient received the antipsychotic medication. Apparently, the patient refused this medication. Despite the psychologist documenting that the patient was unstable, there was no evidence of further psychiatrist's notes. A request for enforced medication was not initiated until 1/27/16, after the patient had been on his fast for well over a month. There was reference to a request for enforced psychotropic medication on 1/26/16 and a note by a psychologist that the patient was on the infirmary and was being considered for forced feeding, but there were no medical notes or evaluations. On 1/28/16, a psychologist documented that enforced medications were approved.

During more than a month of fasting, there was no blood testing or medical evaluations documented in the medical record. A doctor wrote a note on 1/7/16, and documented that a chaplain should talk to the inmate about his fast. There was one further physician note on 1/8/16 documenting that the doctor told the inmate that he might have to be force fed with a gastric tube. This note was incomplete; the full note was not present in the medical record and there were no further notes from physicians or nurses that we could find in the record we reviewed. There were no further weights documented in progress notes after the weight was documented as 137 pounds during a nurse practitioner evaluation on 12/31/15. The patient weighed 193 pounds on 6/2/14 and had therefore lost 56 pounds, yet this was not acknowledged. At this level of weight loss, blood tests to monitor his electrolytes, liver function tests, and nutritional status were indicated but were not done.

On 1/27/16, stat labs were apparently ordered and sent to a local hospital. These labs indicated severe sepsis, significant dehydration, infection, and included a serum sodium of 150, BUN 89, creatinine 2.12, magnesium 2.8 (1.6-2.3), and WBC 16.7 with a left shift. These laboratory tests

should have resulted in immediate hospitalization. The labs were signed as reviewed on 1/28/16, but the patient apparently was not sent to a hospital, as mental health notes continued to be present in the medical record. The patient was apparently hospitalized on 1/31/16, although there are no medical progress notes present in the medical record that we could find. On 1/31/16, two sets of blood cultures were obtained and subsequently grew gram negative rods; these results were reported 2/1/16. The patient died 1/31/16 in the hospital. We can only infer this because there was an x-ray evaluating an endotracheal tube placement after intubation. There was no hospital report in the medical record. There was no death summary, no death certificate, no autopsy, and no documentation in the medical record that the patient died.

This death was preventable. Early and appropriate medical attention to the patient would have prevented his death. As a result of the patient's psychosis, the patient was engaging in a fast that caused dramatic weight loss and eventually cause life-threatening metabolic changes. Despite this medical staff appeared indifferent to his medical conditions. The patient had dramatic loss of weight (60 pounds) dating from August of 2014, yet was not being monitored for this. It was not until the patient began fasting and after the patient had already lost approximately 50 pounds that weight loss was even recognized. During more than a month of not eating, medical staff failed to timely and regularly monitor blood tests to determine the health status of the patient and did not even evaluate the patient. After more than a month of not eating, laboratory tests were done. These tests had life threatening laboratory tests values showing extreme dehydration (sodium 150 and BUN 89), renal failure (creatinine 2.12), and signs of systemic infection (WBC 16.7), which were signed as reviewed on 1/28/16. Yet the patient did not appear to be sent to the hospital for three days. Care appeared to be indifferent, incompetent, and inhumane.

We also note that many medical record documents were not sequentially filed and appeared not to be in chronological order. Many documents appeared to be missing. We asked the Attorney General to check for these documents, but have not received any new documents. The IDOC needs an electronic medical record.

We also noted 35 five errors over the period of record review. The most common (six) were related to lack of hospital records or records being disorganized. There were five medication errors. Two of these were related to a provider prescribing an opioid without even taking a pain history or examining the patient to determine if the patient had pain and whether the pain was severe enough to warrant an opioid. Three were related to not receiving omeprazole, medication for his ulcer. It was not surprising that the patient had two hospitalizations for gastrointestinal bleeding, as he was not receiving/taking the medication, which was not being monitored.

Patient #18 Dixon

This Dixon patient was 70 years old. His problem list did not contain all of the patient's medical problems and the patient was not followed in chronic care clinics for many of his problems, including his cardiac arrhythmias, pacemaker functioning, presumed heart failure, cirrhosis, hyperlipidemia, diabetic nephropathy, or anticoagulation. The patient had a mechanical heart valve and was on anticoagulation, but the anticoagulation goal was not noted in the record. If the goal (typical for mechanical valves) was 2.5 to 3.5, then the patient had sub-therapeutic anticoagulation for more than two years. Twenty-one of 27 INRs noted in the record showed an INR of less than 2.5. The patient also had macrocytic anemia that was mistaken for microcytic anemia, which is a serious and fundamental lack of primary care knowledge. The macrocytic anemia, elevated bilirubin, and low platelets were not investigated for over two years. A B12 and folate level was eventually drawn after two years, but a diagnosis was not made. These laboratory results suggested that the patient had alcoholic cirrhosis, which was never identified. The patient also had chronic kidney disease which was unrecognized for over two years. Failure to investigate these abnormalities was grossly unacceptable and demonstrated a lack of primary care knowledge.

The patient had a serious cardiac arrhythmia (atrial fibrillation) with ventricular bradycardia that required a pacemaker. After the pacemaker was inserted, a cardiology follow up was recommended but never occurred. This failure to follow up with cardiology was never noted and neither the pacemaker nor the arrhythmia was monitored in chronic care clinics. Typically, pacemakers require a check which can be done remotely but needs to be done to ensure they are functioning. In 2015, the patient began developing shortness of breath and edema that were attributed to COPD, but the patient was not adequately evaluated for this. Later in 2015, the patient developed chest pain. Doctors evaluating the chest pain failed to take an adequate history and failed to evaluate the pacemaker function.

The patient had a 25% 10-year risk of heart disease and stroke yet was not placed on anti-lipid medication. On 11/30/15, the patient experienced left-sided chest pain that felt like a pulled muscle. The doctor did not initiate anti-anginal medication and failed to note that the patient had failed to keep his cardiology appointment. The complaint was consistent with angina and the patient should have had a higher level of investigation, including evaluation for coronary syndrome. The following day a doctor evaluated the patient for nausea, but failed to take a history of chest pain that may have been associated with the nausea.

On 12/17/15, a doctor saw the patient for chronic care follow up but failed to address the arrhythmia, possible heart failure, or anticoagulation. Abnormal labs indicating chronic kidney disease and possible alcoholic cirrhosis were not evaluated, except to order a B12 and folate level after two years of having a macrocytic anemia. The arrhythmia and pacemaker function were not addressed. The patient's prior chest pain, shortness of breath, and nausea were not addressed.

A doctor saw the patient on 12/22/15 for a hypoglycemic episode (blood glucose 48), orthopnea, leg edema, shortness of breath, and left chest pressure. The doctor ordered a change in insulin and ordered lab tests with a week follow up. A chest x-ray and EKG were not ordered. Although the doctor's assessment was "COPD vs cardiac? Not exertional," the doctor took insufficient history. The patient should have been hospitalized, given his chest pain with symptoms of heart failure or angina.

On 12/29/15, a doctor saw the patient for edema, shortness of breath, and orthopnea. The patient had a heart rate in the 40s and the doctor questioned whether the pacemaker was malfunctioning. The BUN was 42, creatinine 1.77 and BNP 712, indicating renal failure, possible dehydration, and possible heart failure. The elevation of BNP could have been associated with heart failure, renal failure, valvular heart disease, pulmonary hypertension, or coronary artery disease. The doctor diagnosed exacerbation of heart failure and ordered a diuretic change and blood tests. However, given his symptoms and underlying conditions, the standard of care would have been to admit the patient to a hospital.⁸ Normal pacemaker functioning would have kept the pulse above a set-point, which typically would be about 70 beats per minute. When the heart rate falls below the set rate, it indicates that the pacemaker is not functioning. Keeping this patient at the prison was grossly and flagrantly unacceptable.

On 12/30/15, a nurse at the prison did a pacemaker check that showed two alerts, one of which was that the ventricular pacing was greater than the expected limit. No action was taken. The patient had a pulse in the 40s, which should not occur with a pacemaker.

On 12/31/15, the patient saw a nurse for a nebulizer treatment and told the nurse, "it's not my lungs, it's my heart." A doctor saw the patient the following day but did not take a thorough history and did not note the prior history of chest pain. The doctor assessed heart failure exacerbation and re-started Aldactone. No chest x-ray was taken, and the pacemaker function was not reviewed after the prior day's pacemaker check.

The following day the patient was found dead in his cell. There was no death assessment, no death certificate, and no autopsy in the medical record. The mortality list documented his cause of death as cardiac arrhythmia.

This patient's death was possibly preventable. Although the cause of death was not determined, the death was possibly preventable had the patient been admitted to a hospital. He had multiple conditions that were not followed. He had a pacemaker placed but no follow up with cardiology. Prison doctors were not monitoring the pacemaker. A doctor believed that the pacemaker was malfunctioning and it appeared that it was, since on a couple of occasions the pulse was in the 40s, which is not expected with a functioning pacemaker. At that time, the

⁸ Heart Failure Society of America guidelines as found at <http://www.hfsa.org/heart-failure-guidelines-2/> recommend that patients with suspected heart failure should be hospitalized when they have decrease in renal function, a hemodynamically significant arrhythmia, worsening congestion, comorbid conditions, and a pacemaker with repeated defibrillator firings, all of which this patient had.

patient had chest pain and symptoms of heart failure, yet he was not admitted to the hospital for evaluation. It is likely that his death was preventable if he had been followed by cardiology and if he had been admitted to a hospital for exacerbation of heart failure, bradycardia, pacemaker check, and chest pain.

We identified 62 errors. Twelve were related to failure to follow up on abnormal laboratory results. Twelve errors were related to failure to take an adequate history and twelve errors were related to failure to develop an appropriate treatment plan. Notably, this appeared related to failure to monitor many of the chronic diseases of the patient that were not in the main categories of chronic illness clinics. Providers failed to follow any condition not related to a major disease category. There were also seven episodes of nurses failing to consult a physician for serious illnesses beyond the ability of a nurse to manage.

Patient #19 Dixon

This 75 year old man had underlying ulcerative colitis. He experienced weight loss and had anemia and yet doctors failed to order a colonoscopy, which is below standard of care and placed the patient at risk of harm. The patient had pancytopenia, and then anemia and thrombocytopenia, but was never worked up for these problems except to order iron studies. This was below standard of care. The patient also experienced weight loss, was underweight, and had low albumin, which indicates malnutrition. Yet there was no evaluation for this.

This patient had a prosthetic leg due to an amputation from a prior episode of osteomyelitis. The prosthetic leg did not fit well, and Wexford did not replace the prosthetic leg but tried to repair it, and the patient was not able to use it due to developing ulcers on the stump. As a result, the patient was confined to a wheelchair.

In using the wheelchair, the patient developed a pressure ulcer on his coccyx. A thorough assessment of the patient's activities of daily living was not done to determine how to prevent the ulcer and promote healing. The ulcer was first noted on 6/17/16. At the time of first noticing the ulcer, it appeared from the description to be a stage two ulcer with open blisters and wounds surrounded by erythema. The patient initially was not provided adequate pain medication. By 6/24/16, the wound appeared to be infected. Although a nurse practitioner started antibiotics, the NP failed to order any blood tests or radiological tests to assess for underlying osteomyelitis, which is standard of care. Because of frailty and debility, the patient needed housing on a higher level of care. This could possibly have been an infirmary, but the needs were so great that a skilled nursing unit was indicated, yet the patient remained in general population.

The patient continued to lose weight and by 6/27/16 weighed 127 pounds, which was a 15-pound weight loss over two years. Referral to a nutritionist was not done and the doctor did not complete a nutritional assessment. Adequate nutrition is imperative for healing of pressure ulceration, but this patient never had an adequate nutritional assessment. The doctor ordered

blood tests, and these were abnormal (albumin 2.3; hemoglobin 10; platelets 145; and sedimentation rate 60). This suggested possible osteomyelitis and the doctor reviewed these tests, but apparently did not understand the implications of these laboratory tests and took no actions on these abnormal tests. The doctor appeared not to know how to treat this patient's conditions. An MRI was indicated; blood and or bone cultures were indicated, and it appeared that intravenous antibiotics were indicated. Yet, no action was taken. The patient should have had osteomyelitis ruled out and should have been admitted to a hospital as early as 6/30/16. This was not done. Care was grossly and flagrantly unacceptable.

The patient continued to deteriorate. Aside from adding Boost nutritional supplement, no other action was taken. The wound worsened with tunneling, which was described as deep and was indicative of stage 3 ulceration. The wound deteriorated with no change in treatment. There was no referral for debridement. The patient remained in general population housing and apparently was still in his wheelchair. Eventually, on 7/25/17, bone was visible to a nurse. On 8/2/16, a doctor, shortly after a nurse identified visible bone, described the wound as "healthy." Visible bone usually indicates osteomyelitis or significant infection, especially with a sedimentation rate of 60. Yet the patient was still not sent to a hospital. The doctor's description of a wound with visible bone as "healthy" was grossly and flagrantly unacceptable.

By 8/8/16, the patient started developing altered mental status, first with memory loss. The patient was unable to care for himself. On 8/11/16, the patient urinated on himself while having a dressing change. Despite this and despite increasing evidence of sepsis, the patient was kept in general population and not sent to a hospital. Ultimately a roommate told a nurse that the patient had not eaten in two days and had not voided in days. The patient was so dehydrated that an IV line could not be started. The patient was not responsive and was finally admitted to a hospital on 8/13/16, five days after developing alteration of mental status.

At the hospital, the patient had bacteria and fungus growing in his blood thought to be due to his decubitus ulcer. The patient was extremely dehydrated (BUN 92 and sodium 153) and malnourished (albumin 2.7) on admission. In our opinion, the patient's presentation at the hospital was evidence of neglect at the facility in the weeks prior to admission. The patient was discharged from the hospital on 8/19/16 as a hospice patient. The doctor placed the patient on palliative sedation⁹ on 8/19/16 without documentation of a discussion with the patient's family about palliative sedation. The patient was not capable of making his own decisions. Criticism of palliative sedation includes that it hastens death and can be perceived as a form of euthanasia. Use of this practice should be done with an open and frank conversation with the patient, which in this case was not documented as being done. In lieu of a discussion with the patient, a discussion with the family is recommended. The IDOC should address this on a statewide basis to ensure ethical standards of practice. The patient died on 8/21/16.

⁹ Palliative sedation is a measure of last resort used at the end of life to relieve severe and refractory symptoms. It is performed by the administration of sedative medications in monitored settings and is aimed at inducing a state of decreased awareness or absent awareness (unconsciousness). As quoted from Palliative Sedation section in UpToDate, an online medical reference. The typical palliative sedation combination is a narcotic with a benzodiazepine, which is the combination this patient was on.

This patient's death was preventable. It appeared that doctors did not know how to manage a decubitus ulcer, which is a primary care problem. This is especially problematic because Dixon houses so many geriatric patients who are susceptible to decubitus ulcers. Care appeared indifferent, neglectful, and incompetent, and on one occasion, grossly and flagrantly unacceptable. It is our opinion that early management and treatment of the decubitus ulcer would have prevented or significantly delayed his death.

We noted 68 errors in management of this patient. There were seven to eight errors each of lack of appropriate history, examination, and development of an appropriate therapeutic plan. There were seven errors of providers not ordering appropriate laboratory testing and nine errors of not ordering imaging or other diagnostic testing. On eight occasions it was our opinion that the patient should have been sent to a higher level of care for management. The ultimate delay in hospitalization was mostly responsible for the patient's death, in our opinion. Keeping an 82-year-old patient with altered mental status, incontinence, and unable to care for himself in general population prison housing challenges the boundaries of what it means to be a professional.

Patient #20 Logan

This patient was a 62-year-old woman who had a pancreatic mass identified in 2015 while she was in Iowa. She failed to follow up as a civilian. She became incarcerated and was in Cook County Jail; she was hospitalized for a work-up in October of 2016. A large pancreatic mass was identified. A stent was placed in the pancreatic duct. Unfortunately, a biopsy consisted of an inadequate specimen. The patient was discharged with pathology pending. The patient was on 90 mg of morphine a day for pain management. When the patient left the hospital, the diagnosis was likely pancreatic cancer. The patient was scheduled for a follow up with a gastroenterologist at Stroger Hospital when she transferred to Logan.

Instead of completing the diagnostic work-up of the pancreatic mass, the doctor at Logan initially did nothing, believing that the mass was benign despite the hospital documenting that the mass was likely pancreatic cancer. Also, the doctor at Logan dramatically reduced the pain medication from approximately 90 mg of morphine a day (15 mg SR BID and 15 mg IR Q 4 hour as needed) to one Tylenol #3 pill three times a day. The patient suffered pain throughout most of her incarceration with inadequate pain management.

After about a month after arrival at Logan, the doctor obtained a marker test for pancreatic cancer and it was positive. The doctor referred the patient for an ERCP and biopsy. Wexford denied this test; instead, they sent the patient to a gastroenterologist on a routine basis for evaluation. There was no clinical justification for this denial as this served only to delay evaluation. The patient went to the gastroenterologist in on 2/15/17, almost three months after arrival to Logan. The gastroenterologist recommended a biopsy. This did not occur until late April, approximately five months after arrival to Logan. The patient's diagnosis was therefore significantly delayed, largely as a result of the Wexford utilization process.

In addition to the delay in diagnosis, treatment of the patient's pain was indifferent and bordered on cruelty. Pancreatic cancer is known to cause significant pain. When the patient transferred from Cook County Jail to Logan, the patient was on up to 90 mg of morphine a day. A doctor promptly and dramatically decreased the dose of 90 mg of morphine to one Tylenol #3 tablet three times a day. A Tylenol #3 has 30 mg of codeine, which has an equivalency of about 5.5 mg of morphine. Thus, the pain medication reduction was approximately 80%. Based on nursing notes, the patient did not have adequate pain control, yet this was not adequately monitored or addressed by physicians. When the patient saw a gastroenterologist consultant on 3/21/17, the consultant prescribed a fentanyl patch for pain control. This was not authorized by the Logan physician. The patient remained in severe pain. The doctor did not initiate narcotic pain relief for about five months, until just before the patient died. Three days before the patient died, the doctor prescribed palliative sedation using a combination of morphine every two hours with a benzodiazepine every two hours. A criticism of palliative sedation is that it can be perceived as a form of euthanasia¹⁰. This appears to be a legitimate criticism in this case because of the lack of morphine use or adequate pain management until just before death and because we could find no discussion of palliative sedation with the patient. This raises ethical concerns, particularly because of the lack of pain medication in the preceding five months before the patient died.

We also note in this case significant problems with the medical record. There were multiple episodes of clinical care when identical vital signs were used repeatedly. The medical record software defaults to use of the last recorded vital signs. But it appears to result in nurses and physicians using vital signs from previous encounters even when vital signs are indicated. One episode of using the same vital signs from a previous encounter lasted longer than a week. In one series of episodes, the temperature was listed as 82.7°F, which is a temperature incompatible with life. The patient was documented as having this identical temperature on three separate clinical visits over a period of over a month. No one noticed this unusual temperature. Vital signs should be recorded at the time they are done and only used for the time period of the clinical event when the vital sign is taken. To do otherwise is a significant patient safety concern. This medical record defect needs to be stopped immediately on the basis of patient safety.

While **this patient's death may not have been preventable**, there were serious concerns, including unnecessary delays in consultation care, unacceptable lack of pain management in a patient with an extremely painful condition, and possible inappropriate use of palliative sedation without discussion with the patient. Use of palliative sedation is not governed by policy but was used on patients in three of the 33 deaths we reviewed.¹¹ Because of the potential for misuse or perceived misuse, this practice should be strictly regulated within the IDOC.

¹⁰ This is described in the article on palliative sedation in UpToDate.

¹¹ Mortality Review Patients #19, 20, and 28.

We noted 159 errors in the record review over a six month period. Fifty-two were related to the medical record use of dated vital signs and nurses not using appropriate vital signs even when the patient was being evaluated for a new problem. Twenty were related to nurses not consulting a physician for a significant complaint (pain, vomiting, etc.). Eighteen were related to physician therapeutic plans, mostly related to pain management, which appeared significantly below standard of care. The lack of appropriate attention to nutrition, pain management, and fluid and electrolyte management was so poor that during the last month the patient was neglected, resulting in dehydration and electrolyte disturbances from lack of medical attention. The patient should have been sent to a skilled nursing care unit for management because the patient was not receiving appropriate care at the prison.

Patient #21 Menard

This patient had diabetes, hypertension, and prostate cancer, for which he took hormonal therapy with an oncologist. The patient had a very high risk (as high as 47% 10-year risk of heart disease or stroke) of heart disease, yet was not treated with a statin drug. This happened repeatedly and is a systemic problem in IDOC.

From 3/13/16 until 11/3/16, the patient was evaluated five times for abdominal pain, for which inadequate history and physical examinations took place. Although the patient was losing weight, this was unnoticed. Weight loss with abdominal pain suggests a potentially serious medical condition. On 11/3/16, the patient was sent to an emergency room, where a CT scan showed a large retroperitoneal mass consistent with a lymphoma. The hospital called a Menard physician to advise of this and to recommend follow up. The hospital report was not initially available, and the abdominal mass was not addressed until the patient went for his scheduled oncology appointment for his prostate cancer on 11/21/16. The oncologist noted the abnormal CT scan and recommended a CT guided biopsy and CT scan of the brain ASAP with a three week follow up. This follow up never occurred. Although the biopsy and CT scan of the brain were approved, they were never done. By 12/5/16, a doctor noted that the patient had lost 50 pounds. On 12/29/16, a nurse documented that the patient had 3+ leg edema with a pressure ulcer on his hip and could not walk on his own to the health care unit. The doctor did not admit the patient to the infirmary even though it appeared that the patient was unable to care for himself such that he was developing a pressure ulcer. This was grossly and flagrantly unacceptable care.

The patient appeared lost to follow up until 2/2/17 when security officers complained to a nurse about the patient being unable to care for himself in general population. The patient was admitted to the infirmary by a nurse. The patient was unable to stand on his own without assistance, did not respond appropriately, and did not know what time it was. The following day, a doctor noted that the patient was confused. Nurses noted that the patient was incontinent and appeared delirious as he was talking to people in his cell that were not there. A doctor referred the patient to mental health but did not conduct an evaluation for medical causes of delirium. This was grossly and flagrantly unacceptable care. For five days, the patient

was kept on the infirmary even though he exhibited signs of delirium and should have been immediately hospitalized. By 2/7/17, the patient had become lethargic and confused, yet a doctor who saw the patient did not admit him to a hospital until later in the day when the patient became lethargic with uneven respirations. There were multiple episodes of grossly and flagrantly unacceptable care during the patient's stay on the infirmary. The patient apparently died in the hospital. There was no autopsy or death summary.

This patient's death was possibly preventable. The patient had abdominal pain with weight loss for seven months without adequate evaluation, including adequate diagnostic testing. The weight loss was unrecognized. After an abdominal mass was finally identified on a CT scan, a diagnostic work up was not initiated for three months. The patient died without a diagnosis. The recommendation for an urgent evaluation as recommended by an oncologist was not done over the remaining two months of the patient's life. Though the patient appeared unable to care for himself and had developed a pressure ulcer, the patient was kept in general population and not monitored. Almost three months after the abnormal CT scan, the patient was brought to the attention of a nurse by security staff because the patient could not care for himself. The patient was confused, delirious, had significant edema, and had a pressure ulcer. Despite the new onset of confusion, the patient was kept on the infirmary without adequate evaluation until he became lethargic and was breathing abnormally. The patient was sent to the hospital where apparently he died without a diagnosis. Earlier identification of the abdominal mass and timely treatment of the likely lymphoma could possibly have prevented his death. Care for this patient was grossly and flagrantly unacceptable and demonstrated neglect and indifference.

We identified 83 errors in his care. Most were related to failure to take adequate history, perform adequate examinations, and develop adequate therapeutic plans. We noted that on nine occasions the patient had a serious presentation (shortness of breath, confusion, delirium, diarrhea, and inability to care for himself) and yet the nurse did not consult a physician. We identified nine separate occasions when the patient should have been sent to a higher level of care. A few of these related to not being housed on an infirmary unit when the inmate was unable to care for himself. In other cases, the patient should have been immediately transferred to a hospital but was not.

Patient #22 Menard

This patient was a 46-year-old man with a known history of hypertension, diabetes, and obesity. The annual history and physical evaluation on 7/18/13 identified prior sexually transmitted disease (gonorrhea) and the biannual evaluation on 10/26/15 identified blood transfusions, multiple sexual partners, and prior history of gonorrhea as risk factors. The patient had multiple risk factors for HIV, yet was not offered HIV screening, which is standard of care.¹² That the histories were different on different biannual evaluations was also a problem.

¹² Screening for HIV: U.S. Preventive Services Task Force Recommendation Statement; Annals of Internal Medicine Volume 159, Number 1; pp. 51-60; July 2, 2013. This was an A recommendation, which is that there is high certainty that the net benefit is substantial.

The patient then had low white blood count (1.8) with low lymphocytes (0.6) as early as 8/6/13 which were not followed up on. Low lymphocytes should have prompted evaluation, including whether the patient had HIV infection. This was not done.

On 9/5/15, the patient developed altered mental status with fever. He was a 46 year old man who was urinating on himself. The patient did not have an adequate evaluation for alteration of mental status. He was not provided an adequate history or physical examination for his condition. He should have had a CT scan and other diagnostic testing. Instead, the patient was merely monitored on the infirmary with blood tests. The doctor made a diagnosis of fever of unknown origin. This diagnosis presumes that causes of the fever have been ruled out, which had not been done in this case, as little diagnostic evaluation was performed. The patient should have been hospitalized for his condition but was not. Care was grossly and flagrantly unacceptable.

The doctor presumed that the patient had lupus, but the patient did not have immunologic criteria to qualify for this diagnosis. The providers failed to evaluate for HIV, a common condition in this population and one that the patient had risk factor for (multiple sexual partners, prior gonorrhea, transfusions) and blood tests suggestive for (low white blood count with lymphocytopenia).

Lupus is an uncommon condition in this population as compared to HIV. The diagnosis of lupus depends on satisfying multiple clinical and laboratory criteria which often require experienced clinical diagnosis. Typically, a specialty referral is indicated. The patient did not satisfy immunologic laboratory criteria for lupus; nevertheless, the doctor maintained this diagnosis without searching for more obvious causes of the patient's problem. The patient continued to have high sedimentation rate, intermittent fever, weight loss, confusion, and low white blood counts, sometimes including pancytopenia.¹³ Despite considering lupus, the doctor did not refer the patient to a rheumatologist for five months. On 2/26/16, a rheumatologist would not accept the patient for referral because the patient did not have immunologic criteria for lupus. Still, the doctor failed to screen the patient for HIV, despite the patient having multiple risk factors and suggestive laboratory and clinical findings. The doctor remained steadfast in maintaining lupus as a possible diagnosis for over a year without obtaining immunological tests required for the diagnosis and without excluding other more common diseases (e.g., HIV). This was grossly and flagrantly unacceptable care.

The patient's mental status deteriorated. From September of 2015 through October of 2016, the patient exhibited altered mental status, but was inadequately evaluated for this and was mostly housed in general population, where he appeared unable to adequately care for himself. His care was neglectful and bordered on cruelty. On 3/15/16, a psychiatrist documented that the patient was incontinent of urine and feces while wearing his clothes and noted delusional

¹³ Pancytopenia is low white count, low red blood cell count, and low platelets. These are the three cellular components of blood. This is consistent with numerous conditions, many of which are serious and require immediate attention, sometimes including referral to a hematologist for bone marrow biopsy. In this case, an HIV test would have been a first diagnostic step.

thinking. The psychiatrist believed that the patient had psychosis from a medical condition. Yet, doctors did not pursue further evaluation (CT scan or MRI of brain, possibly lumbar puncture, exclusion of infection including HIV, etc.). No diagnostic action was taken except to monitor the patient and obtain routine blood tests. The patient remained intermittently confused, delusional, and delirious for the remainder of his life. The patient had disordered cognitive function for approximately 13 months without having an evaluation for the cause. This was grossly and flagrantly unacceptable care.

About a year after initially suspecting lupus, a rheumatology consult was finally obtained on 9/28/16. The rheumatologist found no obvious systemic complaints to suggest lupus but ordered additional testing. By accident, apparently, the rheumatologist sent with the patient a prescription for methotrexate with the wrong patient's name on it. This was not identified by staff and the patient received methotrexate inappropriately, which has side effects including decreased blood counts, which already affected the patient. The rheumatologist's type written note did not include prescription of methotrexate. This may have harmed the patient, as shortly after this the patient developed sepsis, a possible complication of using methotrexate in an immune compromised patient.

The patient was admitted back to the infirmary in July of 2016 for inability to care for himself. He was weak, incontinent, and unable to perform routine hygiene for himself. He also developed fever on 7/22/16, yet there was little evaluation for the cause of fever except to order a urine test and blood count. The patient was unable to walk without assistance, and mostly lay in bed. He developed a large (6 inch by 6 inch) pressure ulcer which was identified by nurses but not recognized or evaluated by physicians. He lost a significant amount of weight (>50 pounds) yet the weight loss was unrecognized. Eventually, the patient became hypotensive (90/66) and had hypoxemia, and was sent to a hospital, where he was found to be in septic shock due to complications of HIV infection. The patient died in the hospital.

This patient's death was preventable. The patient had multiple risk factors for HIV infection yet was never screened for this infection. The patient had altered mental status for over a year but never had a diagnostic evaluation for this. The patient had low lymphocytes and low white counts since 2013 but was never evaluated adequately for this. The patient had fever but was never properly evaluated for this. The patient's confusion resulted in inability to take care of his hygiene, but the patient was neglected, resulting in a large, unrecognized pressure ulcer and significant unrecognized weight loss. Care was indifferent, neglectful, and grossly and flagrantly unacceptable. Early diagnosis of HIV should have been made and this would have prevented his death. We note that the physician caring for this patient was a surgeon without primary care expertise. It is our belief that the doctor's lack of training significantly contributed to this patient's death.

We noted 117 errors in care for this patient in slightly over a year of record review. Most were related to inadequate history, examination, or development of a therapeutic plan. It is our opinion that on 18 occasions the doctor should have sent the patient to a hospital but did not.

We also noted that for long periods of time the patient was housed in general population status when he was confused, incontinent, and unable to care for himself. When he ultimately went to the hospital, he had evidence of neglect including severe malnutrition, significant weight loss, multiple pustular sores, and pressure ulcers that were unrecognized at the facility. His care was grossly and flagrantly unacceptable.

Patient #23 Menard

This patient had APRI¹⁴ scores indicating cirrhosis as early as 2012, but was not referred to UIC hepatology for treatment of the hepatitis C in 2012 or 2013. In 2014 and in January of 2015, the patient signed a refusal for care for hepatitis C, but it was not clear what explanation was given to the patient. When he ultimately was evaluated by UIC in April of 2016, he did not even know that he had advanced liver disease or cirrhosis, but he agreed to treatment of his hepatitis C. It does not appear that effective communication with the patient occurred at Menard.

Though the patient had cirrhosis since 2012, he did not receive a screening upper endoscopy to evaluate for varices until 8/7/15. He also did not receive every six month screening for hepatocellular carcinoma until 5/8/15. These are standard recommendations for patients with cirrhosis. That he ultimately died with likely hepatocellular carcinoma is problematic, as he was improperly screened for this condition.

Despite having cirrhosis at least as early as 2012, the patient did not have appropriate management of his ascites. Edema was evident as early as 10/4/12, when a doctor noted 2+ edema on a chronic clinic evaluation. The doctor did not initiate a diagnostic work up for the edema. On 1/4/15, a nurse practitioner identified bilateral leg edema without taking action except to order Ted hose. A CT scan on 5/28/15 documented ascites, which was not documented as a problem, monitored, or treated. An MRI on 10/22/15 showed large ascites yet this was not identified or monitored as a problem. The MAR shows that Aldactone was started on 11/23/15 but discontinued on 11/30/15. There was no progress note on either date, so the reasoning for these actions was not known. Despite evidence of significant ascites in October 2015, doctors did not monitor this or treat the patient. Doctors did not start a diuretic until 6/22/16 when the patient had tense ascites. It appeared that the providers did not know how to manage cirrhosis with ascites.

Though the patient should have been screened for hepatocellular carcinoma every six months beginning in 2012, the patient was not screened for hepatocellular carcinoma until May of 2015, when an ultrasound showed a mass worrisome for a malignancy which was confirmed on a CT scan later that month. Although the ultrasound and CT scan showed a possible malignancy in May of 2015, the patient was not referred for biopsy until 8/25/15. A Wexford utilization

¹⁴ APRI is an AST to Platelet Ratio Index. This score uses common blood tests to estimate the probability of fibrosis and cirrhosis and is used as a means to identify persons with greater degrees of fibrosis. This is currently used for identifying persons at higher need of treatment for their hepatitis C. IDOC does not initiate treatment for hepatitis C until the patient has a fibrosis level nearly equivalent to cirrhosis and the APRI is used as a benchmark for referral.

doctor initially denied the biopsy, instead recommending referral to Dr. Paul, the Wexford hepatitis C doctor. She apparently referred the patient for an MRI, which was done in late October of 2015, showing a wedge shaped fibrotic lesion in the liver. According to a subsequent UIC note, the MRI was to include a liver biopsy, but this did not occur because MCC did not send the ultrasound and CT scan results with the patient. Another liver ultrasound was done on 12/18/15 showing a 2.1 cm liver mass with a recommendation for follow up MRI or CT scan. No action was taken. The patient appeared to have died with or because of possible cancer which was never biopsied for over a year.

On 4/28/16, the patient was referred to UIC for hepatitis C treatment. We believe that the patient should have been referred to UIC in 2012 for treatment, as providers at Menard did not appear to understand the complications of cirrhosis or management of hepatitis C, and treatment options should be explained by a person knowledgeable in treatment of the condition. The UIC consultant documented that biopsy was not done in 2015 because prior ultrasound and CT scans were not provided to the radiologist, and that the patient had a liver lesion suspicious for cancer. The UIC consultant also noted that the patient did not understand that he had complications of liver disease (cirrhosis, varices, and ascites). If the doctors at Menard had not explained the complications of the patient's liver disease to him, what discussion took place with respect to treatment of his hepatitis C? The patient was willing to accept treatment when the UIC doctors discussed treatment with him. Prior to initiating treatment, the UIC doctors recommended a biopsy. This was not documented as done.

The patient was sent for an MRI on 6/22/16, but it was not clear if this was for a biopsy. Upon return to the prison, the patient was noted to have fever (100.4°F), hypotension (96/64), and hypoxemia (oxygen saturation 79%) with tense ascites. The patient had signs of sepsis and should have been admitted to a hospital for paracentesis and blood cultures. Instead, a nurse admitted the patient to the infirmary for observation, but a physician did not examine the patient. This was grossly and flagrantly unacceptable care, as the patient had signs of sepsis.

The following day the patient had fever to 100.8°F with massive ascites. Instead of admitting the patient to a hospital, the doctor only ordered Aldactone 25 mg BID, Lasix 40 BID, and an oral antibiotic (Levaquin) without taking a history and performing only limited examination. This was grossly and flagrantly unacceptable care, as the patient was at risk of death.

The following day the patient again became hypoxic (oxygen saturation 84%), hypotensive (88/60), and had trouble breathing. The doctor sent the patient to a hospital, where he died.

This death was possibly preventable for the following reasons:

1. The patient was not screened for complications of cirrhosis for three years. This was the likely cause of death. Hepatocellular cancer screening is recommended every six months for persons with cirrhosis. Screening, early identification of complications, and treatment for these might have prevented or significantly delayed the death.

2. The patient had a liver mass suspicious for cancer identified in May of 2015 but until his death in June of 2016, the mass was not evaluated with a biopsy and remained undiagnosed. The delay in diagnosis of a possible hepatocellular carcinoma likely contributed to his death and earlier diagnosis and treatment might have prevented or significantly delayed the death.
3. The patient developed tense ascites, fever, hypotension, and severe hypoxemia on 6/22/16 and should have been immediately hospitalized. Instead, the patient was placed on the infirmary for observation without any diagnostic testing on the first day. This was grossly and flagrantly unacceptable care and placed the patient at risk for death. On the second day the patient still had fever. Oral antibiotics and routine blood tests were ordered when the patient should have been hospitalized. This delay may have resulted in his death. Care was grossly and flagrantly unacceptable. On the following day a doctor did not evaluate the patient, but the patient was sent to a hospital for extremely unstable vital signs.
4. We note that the patient told a UIC consultant that he was unaware that he had complications of hepatitis C (ascites, varices, cirrhosis). Although the patient signed a refusal for treatment of hepatitis C, it is unclear how hepatitis C treatment was explained to him if he did not even understand that he had cirrhosis. We question whether effective communication occurred. The patient accepted treatment from the UIC consultant but not the providers at Menard. It is our opinion that once cirrhosis was evident in 2012, the patient should have been referred directly to UIC. The current collegial process of using a Wexford doctor as a gateway for therapy and for testing related to cirrhosis clearly caused delays in care (for treatment of hepatitis C and diagnosis of the liver mass) that resulted in his death. Earlier treatment of his hepatitis C would likely have prevented or significantly delayed death.

We noted 56 apparent errors in the care of this patient. Thirteen were related to lack of referral for evaluation for hepatitis C treatment. We question the effectiveness of communication with patients and believe that their hepatitis C treatment decision should be discussed with an expert, not physicians and other providers in IDOC who do not apparently understand how to manage cirrhosis or hepatitis C. Consent and refusal of consent needs to be informed and this requires a physician who understands the treatment and the consequences. There were 17 apparent errors in not obtaining screening tests for cirrhosis (EGD and ultrasound).

Patient #24 Menard

This 46-year-old man developed abdominal pain. He was evaluated by a nurse on 5/17/17, 5/22/17, and again on 5/31/17. The nurse found no problems, but on 5/31/17 the nurse referred the patient to a physician. The physician saw the patient on 5/31/17. The physician took virtually no history. The doctor documented that the patient had an umbilical hernia and said "it is small. He won't let me touch it or push it back in." Without any other evaluation, the doctor prescribed Tylenol for six months. No diagnostic studies were done. This was not appropriate follow up for a painful condition that was incompletely evaluated.

A month later on 6/30/17, a LPN wrote that her supervisor asked her to evaluate the inmate because his family had called concerned that he needed to see the Medical Director. The LPN did an assessment using a diarrhea protocol stating that the patient had diarrhea four to five times a day with abdominal pain and had lost his appetite. The abdomen appeared rigid and distended to the nurse. The blood pressure was 150/118. The nurse apparently called a doctor, who sent the patient to a local hospital.

At the hospital, an omental/peritoneal mass was identified. A biopsy was performed along with colonoscopy and the patient was discharged on 7/6/17 with a diagnosis of carcinomatosis or disseminated cancer in the abdominal cavity. On 7/10/17, the doctor referred the patient to an oncologist, noting that final pathological reports were pending. During his infirmity stay the patient had repeated pain, but the doctor notes did not address the patient's pain adequately. When the patient went to the oncologist on 7/26/17, inadequate information was sent, and the oncologist did not understand why the patient was being referred. The oncologist asked for a two week follow up with CT scan reports from the hospital, along with additional records.

The patient remained on the infirmity as a chronic admission but was infrequently examined or questioned by doctors regarding his pain, which was complicated by constipation. Physician evaluations included virtually no current history or examination and inadequately addressed pain. Eventually, on 8/9/17 the patient became confused, unable to answer questions and was sent to a hospital where, apparently, he died. There was no autopsy or death summary for this patient.

This patient's death was not preventable, yet there were a few problems. The initial evaluation of the patient on 6/30/17 was indifferent. The patient had complained of several weeks of abdominal pain, yet no history was taken, and little examination was performed. To give a patient Tylenol without having a diagnosis is inadequate and indifferent care. No diagnostic tests were ordered.

The patient's pain on the infirmity was inadequately evaluated as evaluations seldom included a history or physical examination. This also was indifferent.

When the patient went to the oncologist, inadequate medical records were sent with the patient, resulting in a failed appointment. Communication with specialists is critical to coordinated care.

We noted 10 apparent errors in care, mostly related to inappropriate therapeutic plans.

Patient #25 Menard

This 65-year-old patient was recently successfully treated for hepatitis C. During a dental examination, the dentist found an abnormal lesion in his mandibular bone found on x-ray. On

4/14/17, the dentist referred the patient for evaluation. A consultant saw the patient in mid-June and did a biopsy, which on 6/22/17 was positive for B cell lymphoma.

The patient was referred to oncology and after some tests was started on chemotherapy in late August. The chemotherapy regimen was CHOP, which included prednisone and also included rituximab. This regimen can severely depress the white blood cells and platelets, and cause severe life threatening infection. For that reason, the oncologist recommended a drug to increase the white count. This drug, Granix, was to be administered after each episode of chemotherapy. The manufacturer recommends that during the time Granix is used that white counts be checked twice weekly. This was not done at Menard for this patient.

The oncology reports were not all present in the medical record and the blood work done at the oncology office was not typically available to the site. On 11/22/17, the patient received chemotherapy and on return became hypotensive; he went to a local ER and was diagnosed with dehydration. The white count at the hospital was normal.

On 11/26/17, the patient developed a fever to 101.6°F and was too weak to stand up. The nurse did not consult a physician but should have, as fever in a potentially neutropenic patient can represent life-threatening risk. The nurse did place the patient on a special housing unit. Not to call the physician was grossly and flagrantly unacceptable care. The patient should have had immediate white count and/or immediate referral to a hospital for evaluation for infection.

A doctor did not see the patient for two days, until 11/28/17. The patient had fever to 101°F. The patient should have been immediately hospitalized. The patient needed evaluation unavailable at the prison. The patient needed immediate blood cultures, intravenous antibiotics and diagnostic evaluation and monitoring for neutropenic infection. Instead, the doctor ordered an oral antibiotic without identifying a source of infection. The failure to order a white count or hospitalize the patient was grossly and flagrantly unacceptable care in a potentially neutropenic patient on chemotherapy. The doctor also did not check to ensure that the patient had received the Granix medication. We could find no evidence on MARs available in the record that the patient received Granix, significantly increasing the potential for neutropenia.

The following day on 11/29/17, the patient developed hypotension, diarrhea, and felt sick. The doctor stopped blood pressure medication and did order a white blood count, but it was not ordered stat and was never done. Hypotension in the context of neutropenia, especially in someone on prednisone which was part of this patient's chemotherapy, can indicate infection. Failure to immediately check for neutropenia or hospitalize the patient was grossly and flagrantly unacceptable.

On 11/30/17, the doctor noted that the patient had pus coming from his ear and diagnosed otitis externa and changed the oral Levaquin to intravenous Rocephin, another antibiotic. The patient now had an infection and again should have been sent immediately to the hospital. Care was grossly and flagrantly unacceptable.

On 12/1/17, pus was still coming out from the patient's ear and the doctor again did not send the patient immediately to a hospital. The white count was never drawn. Care was grossly and flagrantly unacceptable.

The patient was not seen the following day by a physician which is unacceptable in a potentially neutropenic patient. On 12/3/17, the patient was found unresponsive with blood on his mouth and draining from his penis, with a fever of 101.2°F; and in shock with blood pressure 96/60, pulse 120, and respiration as high as 42. He appeared to be bleeding due to probable loss of platelets likely due to chemotherapy related pancytopenia. The patient was sent to the hospital. The hospital record was unavailable, but the doctor's death summary stated that the patient developed pancytopenia, sepsis, and pneumonia; and died due to sepsis and pancytopenia on 12/12/17.

This death was preventable. Timely treatment with Granix would have prevented the neutropenia would have prevented or significantly delayed death. Timely treatment of the neutropenic sepsis would have, at a minimum, have significantly delayed death. The medical record was disorganized, many consultation reports were not in the record, and information was not available. It appeared that coordination with the consultant was poor. The patient was at high risk for neutropenic infection and was to receive a medication, Granix, which it appeared he did not receive. After developing fever, a sign of neutropenic syndrome, the physician response over a three-day period was incompetent, demonstrated failure to properly manage a potentially neutropenic patient, and was grossly and flagrantly unacceptable. We noted 23 apparent errors in medical care. Seven errors involved not ordering timely blood counts to monitor infection. Five involved inappropriate therapeutic plans, mostly involving treatment of a potentially neutropenic patient.

Patient #26 Menard

This patient was incarcerated in 2008. He died in 2017 when he was 68 years old. He had no medical problems. At annual health evaluations he was not offered colorectal screening, though he did refuse a digital rectal examination, which is inadequate as colorectal screening. He also was not treated for primary prevention with a statin for coronary artery disease for years. In the 2008 reception screening and at every biannual screening dating from 2012 to his death, he had greater than a 7.5% 10-year risk for heart disease and should have been offered statin medication, but was not. This is a systemic issue, as providers under Wexford do not use contemporary risk calculation to determine use of primary prevention for coronary artery disease.

On 3/20/17, a doctor saw the patient for shortness of breath. There was no other history and the doctor did not utilize a full set of vital signs. The only examination was that the patient was very pale with cold hands. The doctor assessed anemia without having a blood count to make that assessment. This was an inadequate evaluation without adequate history or physical examination. The doctor ordered a stat CBC and CMP. Later that day, the doctor wrote that the

labs were normal but that the patient was short of breath. Again, without adequate physical evaluation or history, the doctor ordered a routine chest and abdominal x-rays, and urine test.

The following day a nurse practitioner (NP) noted that the patient had possible pneumonia. The patient had a critical respiratory rate of 38-40 and blood pressure of 152/100. The NP ordered an EKG and sent the patient to a hospital. The hospital was a very small (25-bed) hospital. Atrial fibrillation with heart failure and pleural effusion was diagnosed. The patient had a chest x-ray showing bilateral pleural effusions, possible pneumonia, and compression of the lungs by the pleural effusions. The hospital called the NP, who accepted the patient back to the facility with a plan to order a cardiology follow up. This, in our opinion, was not safe for the patient under these conditions due to the age of the patient, the new onset of the fibrillation, possibility of pneumonia, and significant pleural effusions and heart failure. Given the uncertainty, return to Menard was a poor clinical choice. That decision was made apparently by a nurse practitioner, according to the hospital record.

The patient was admitted to the infirmary. The following day the patient was incontinent of stool and was in shock (86/60), with edema and high respiratory rate (30), and was sent to another hospital.

The patient had myocardial infarction, heart failure, sepsis, ischemic colitis, and developed hospital acquired pneumonia. Due to the heart failure and myocardial infarction, further surgery could not be done. The patient returned to the facility after several weeks at the hospital and died two days after return.

This patient's death was not preventable. However, several errors were made. The patient received no colorectal cancer screening, though contemporary standards recommend this for persons over age 50. Since 2012, the patient had a consistent 10-year heart disease risk greater than 7.5% and should have been on a statin. These are systemic problems in IDOC and should be corrected.

The patient's atrial fibrillation likely was responsible for the ischemic colitis. The initial evaluation of the patient by a physician on 3/20/17 was inadequate. The patient had a serious medical complaint (shortness of breath) yet received no history or physical examination adequate for the complaint. Also, this patient should not have been taken back from the hospital on 3/21/17, as his complicated medical condition (new-onset atrial fibrillation, large bilateral pleural effusions, heart failure, possible pneumonia, and age >65) warranted hospitalization.

Patient #27 Menard

This 48-year-old man had difficulty to control blood pressure. For the entire two years of record review, the blood pressure was uncontrolled. The blood pressure was significantly out of control and as high as 260/130. The blood pressure was above 180/120 which is considered a

hypertensive urgency on 15 separate occasions over a two year period. When the patient was evaluated with hypertensive urgency, the evaluations were inappropriate as they did not include evaluations for ongoing end-organ damage.¹⁵

The patient had HbA1C of 7.3, which was documented as known by a provider on three occasions. This is diagnostic of diabetes, but the doctor did not enroll the patient in chronic care, did not include diabetes as a problem, and did not initiate treatment. It was not clear if the doctor understood that an HbA1C of 7.3 was diagnostic of diabetes.

The patient also had a persistent need for statin treatment which was unrecognized. In 2014, at a chronic clinic visit, we calculated the 10-year heart disease risk was 28%, warranting a moderate to high intensity statin, but no treatment was offered. At a 3/9/16 hypertension chronic clinic, a statin was not recommended. We calculated a 10-year heart disease risk of 47%; the increased risk partly due to the new diabetes which was, however, unrecognized. The untreated hyperlipidemia is a risk for cardiovascular disease.

The patient developed symptoms of episodic shortness breath on 2/4/15 and was admitted to a hospital. At the hospital, the patient had an echocardiogram that showed thickening of the LV and concentric hypertrophy but normal systolic function, verifying hypertensive cardiovascular disease. The patient had a diagnosis at the hospital of hypertensive urgency and hypokalemia, and blood tests were drawn to exclude hyperaldosteronism and pheochromocytoma. The discharge summary included recommendations to follow up with a nephrologist and cardiologist in two weeks to complete a work up for hyperaldosteronism and resistant hypertension. The tests did show an elevated normetanephrine test that suggested pheochromocytoma. This needed to be worked up but was intentionally not done.

Upon return to Menard, the Medical Director, who was a surgeon, did not refer to nephrology or cardiology as recommended and did not undertake an evaluation for pheochromocytoma or hyperaldosteronism. A month later, on 3/6/15, another doctor saw the patient and reviewed the hospital summary, and noted that the hospital referred the patient to nephrology and cardiology. This doctor also noted that the Medical Director made no referral. The doctor did not refer the patient and the patient was never referred.

Notably, the patient had "anxiety attacks" on a number of occasions. On 3/5/14, a doctor noted that the patient was short of breath, which he attributed to anxiety. This was sufficient for the doctor to refer the patient to a psychiatrist. That appointment never occurred. A nurse took a history on 3/27/14 that the patient thought his blood pressure elevations were related to anxiety. The nurse also noted that the patient noticed skipped heart beats. On 4/22/14, the

¹⁵ End-organ damage in hypertensive urgent episodes includes neurologic symptoms such as delirium, agitation or visual disturbances; focal symptoms consistent with stroke; hemorrhages of the retina; signs of increased intracranial pressure; chest discomfort consistent with myocardial ischemia or dissection; symptoms of aortic dissection; and symptoms of pulmonary edema. In addition to evaluations for these various symptoms, additional testing is indicated including EKG, chest radiograph, UA, electrolytes including creatinine, cardiac biomarkers, CT or MRI of the brain or chest.

patient told a nurse that he thought his elevated blood pressure was related to stress. On 8/30/14, a doctor noted that the patient had anxiety and referred the patient to a psychiatrist, but this referral did not occur because the patient refused to be seen. On 10/22/14, a doctor documented that the patient had anxiety and referred the patient again to a psychiatrist, which did not occur. On 10/23/15, a doctor assessed anxiety and referred the patient to mental health, which did not occur. We mention these many references to anxiety because this is associated potentially with pheochromocytoma, which hospital laboratory tests in February of 2015 suggested that the patient might have. The referral to nephrology never occurred and the patient was never worked up for this potential secondary cause of hypertension which he may have had.

Also, the patient had long-standing low potassium, which in the context of difficult to control high blood pressure suggests hyperaldosteronism. Hospital physicians recommended work up for this condition as well, but this never occurred. The potassium was low on six separate occasions. The lowest was a level of 3. Despite a low level of potassium, doctors at Menard never worked up the patient for hyperaldosteronism. Toward the end of his life the patient was on spironolactone, a diuretic that tends to increase serum potassium.

On 10/3/16, officers brought the patient to a nurse for unsteady gait and a near fall off his bunk. The nurse referred to a doctor. The patient was a no-show to clinic twice; on the second occasion he was described as refusing care, but we could not find a signed refusal in the record. The patient died about a month after this. The patient was on five drugs in March of 2015, but by November of 2016, the patient was only on three medications: diltiazem, metoprolol, and spironolactone. The patient continued to have significantly elevated blood pressure.

The autopsy found atherosclerotic coronary arteries with 95% occlusion of one of the coronary arteries. The cause of death was arteriosclerotic and hypertensive cardiovascular disease. There were 113 errors we identified in the care of this patient. Most were related to failure to assess a patient with hypertensive urgency¹⁶ and to ensure timely follow up. We noted that on multiple chronic clinic visits for hypertension, the patient should have been referred to a consultant to exclude secondary hypertension.

This patient's death was preventable. It is our opinion that if the patient's blood pressure were controlled he would not have died from hypertensive heart disease. Part of this failure was a failure to refer for evaluation of possible secondary hypertension and part was a failure to manage hypertensive medication therapy. He had unrecognized and untreated diabetes for over a year which increased his risk for cardiovascular heart disease. He had high risk for cardiovascular disease and yet was not treated with a statin which increased his risk for

¹⁶ When blood pressure is above 180/120, the patient is said to have hypertensive urgency. When this occurs, the provider should evaluate the patient for end-organ damage, and lower the blood pressure below 160/100. This can be done in correctional facilities by observation on the infirmary with frequent checks of blood pressure and modification of blood pressure medications. There should be follow up after this episode to ensure the blood pressure has improved. Tests should be done to assess renal function and evaluation should be done to exclude heart failure.

cardiovascular mortality. He had recognized hypokalemia, but it was not adequately investigated. A hospital recommended referral to a nephrologist to rule out hyperaldosteronism and secondary causes of hypertension, but prison doctors intentionally did not act on this recommendation. A hospital test found elevated normetanephrines and the patient had frequent episodes of anxiety and episodic shortness of breath consistent with possible pheochromocytoma, yet the patient was not referred for work up. Medication administration records were not all in the medical record, but those that were recorded that the patient received his KOP medications. The medication compliance was not frequently addressed. The patient appeared to have symptoms of unsteady gait and a near fall off his bed in November, but was not evaluated and referrals to a doctor did not occur. He was said to have refused a visit, but there was no signed refusal.

Patient #28 Western

This patient was an 81-year-old man with a history of hepatitis C, diabetes, mild heart failure, prior amputation of the forefoot from osteomyelitis, peripheral vascular disease, and diabetic neuropathy. He was being housed on the infirmary at Western Illinois Correctional Center.

The patient fell off his bed on the infirmary and sustained an open dislocation of the middle finger. The patient was sent to a small local emergency room of a 22-bed hospital where full services were unavailable. The laceration was sutured. However, the dislocation was not corrected. The finger remained swollen, yet an orthopedic referral was not initiated. A doctor referred the patient for an urgent wound evaluation, but this was denied by Wexford. This was grossly and flagrantly unacceptable, as the patient had the equivalent of an open joint injury and it needed to be repaired. By the second week after the injury, the wound was draining pus. By the third week, the patient was unable to flex the finger, and finally the doctor obtained approval from Wexford for orthopedic referral. The patient did not go to the orthopedic doctor until 3/30/15, approximately a month after the injury. The orthopedic doctor wrote "I am uncertain as to why this was not reduced prior to now but at any rate would recommend [the hand surgeon] address this issue." The patient had osteomyelitis and eventually had open reduction and internal fixation of the open dislocation that was now infected. This delay resulted in a non-functional finger. There was no orthopedic follow up after this delayed surgery.

The patient had pancytopenia.¹⁷ This was not properly diagnosed. Yet the patient also had iron deficiency anemia. The hemoglobin was as low as 7.7, which is very low. Iron studies showed that this was iron deficiency anemia. This was evident as early as December of 2014. Even with pancytopenia, iron deficiency anemia should prompt evaluation for colon cancer with

¹⁷ Pancytopenia is a condition when all three blood elements are low including red cells, white cells, and platelets. This is a serious condition and typically requires a bone marrow study to determine the cause. This condition can be caused by cirrhosis. On one episode a doctor mentioned that the pancytopenia was caused by cirrhosis. Yet the patient did have iron deficiency anemia. This condition requires investigation as to its cause even when pancytopenia exists. The patient did not receive upper or lower endoscopy to evaluate for this condition.

colonoscopy. Also, because the patient had cirrhosis, the patient should have had upper endoscopy to screen for varices and liver ultrasound to screen for hepatocellular cancer. None of these tests was offered to the patient even though it is a standard of care.

The patient was evaluated four times in hepatitis C clinic (9/9/14, 12/22/14, 6/16/15, and 12/3/15). Despite the patient having cirrhosis at least as early as November of 2014 but probably earlier, cirrhosis was not documented as a problem in the medical record during this time period. We only started review of the record beginning in late 2014. Cirrhosis was not identified as a problem until shortly before he died. The cirrhosis was not managed, including at hepatitis C clinic visits. It is recommended that patients with cirrhosis receive a screening upper endoscopy to rule out varices and semi-annual ultrasound or CT screening for hepatocellular carcinoma. Providers also need to monitor the patient for complications of cirrhosis, including ascites and encephalopathy. The patient did not receive management of any of these conditions.

The patient had cirrhosis and a high level of fibrosis (F4), and was referred for interferon treatment in 2010 but refused interferon. The newer hepatitis C drugs are much safer with significantly less adverse reactions and are better tolerated. The patient should have been offered treatment with the newer hepatitis C drugs as they became available,¹⁸ but was not. A doctor on 6/16/15 documented that the patient was not to be treated because of frailty, anemia, and because the Wexford infectious disease doctor decided that the patient was not a treatment candidate. None of these are contraindications for hepatitis C treatment based on newer agents and the patient should have been referred for treatment.

The patient also developed a diabetic foot ulcer on 12/8/15. Doctors allowed the patient to walk on the foot, failed to probe the wound, did not evaluate footwear, and did not properly evaluate for infection or osteomyelitis. The patient had known neuropathy and peripheral vascular disease and had previously lost his fore foot to amputation with osteomyelitis. In a patient with diabetes and known peripheral vascular disease, an ankle brachial index¹⁹ is indicated, but was not done. The patient never had adequate evaluation to exclude osteomyelitis and was never properly treated for a diabetic foot. The treatment of the foot ulcer was not consistent with current recommendations for a diabetic foot. On 1/13/16, a doctor started an oral antibiotic (clindamycin) and then, based on a wound culture, started Rocephin and clindamycin by intravenous route. Unless the wound is debrided and cleaned, a wound culture is not a useful test. The wound did not improve, and the doctor referred the patient to a wound care specialist, which Wexford denied. This was grossly and flagrantly unacceptable, as the facility doctor did not know how to manage this condition and apparently neither did the Wexford UM doctor. An x-ray and another wound culture were recommended. Within two days of the denial, the patient was admitted to a local hospital for shock (BP 74/35)

¹⁸ Newer hepatitis C anti-viral medications became approved by the Food and Drug Administration in 2013 and 2014.

¹⁹ An ankle brachial index (ABI) measures the arterial blood flow to the lower extremity to determine if it is adequate. In a diabetic with a foot ulcer, an ABI gives an indication if surgery is necessary to correct insufficient blood flow, without which diabetic foot ulcers fail to heal.

and lethargy. Even though the patient had low albumin and low vitamin B12, the patient was not evaluated for his nutritional status with pre-albumin or dietary history.

At the hospital, a 2 cm liver mass was noted with ascites. Colitis was diagnosed but a discharge summary could not be located, and it was not clear what the hospital course was. The lack of hospital records affected care of this patient, as the facility physicians did not understand what had occurred to the patient in the hospital and neither did we. At this point, the patient's unmonitored cirrhosis eventually developed into decompensated cirrhosis and the liver mass was consistent with hepatocellular carcinoma, although the hospital records were incomplete. The patient returned to the prison and developed fever, weight loss, diarrhea, and severe edema. The patient developed worsening swelling from the cirrhosis, fevers, decreased mental status, and abdominal pain, and for a time refused hospitalization. However, it appeared that during the time the patient refused hospitalization, his mental status was abnormal, and his decision capacity was unclear. The patient was ultimately hospitalized again and returned with a diagnosis of liver cancer, cirrhosis, and pressure ulcers. The hospital report was again unavailable. The patient was given palliative sedation with Ativan and narcotics, and died. There was no evidence we could find of a thorough explanation of palliative sedation with the patient; nor was there informed consent. This appeared to be an inappropriate use of palliative sedation and gives the appearance of hastening death without the patient being aware. The death summary documented that the patient was diagnosed with liver cancer and had refused treatment, which is not entirely accurate based on our interpretation of the record. An autopsy showed the cause of death to be hypertensive cardiovascular disease and severe stenosis of the LAD. The autopsy, remarkably, did not list cirrhosis or liver cancer even though cirrhosis and a liver mass were evident on radiologic tests from the hospital.

There were numerous problems with the care of this patient. Many problems were related to lack of appropriate referral for consultative services, including timely orthopedic referral, referral for EGD for someone with cirrhosis, referral for biannual ultrasound for evaluation for hepatocellular carcinoma, referral for ABI to evaluate vasculature in a diabetic foot, referral for wound care, referral for nutritional consultation in someone with a healing diabetic foot, and most important, referral for treatment of hepatitis C. We view **this death as not preventable**. However, the basis of the not-preventable was based on the patient probably having dementia which may not have warranted treatment of his hepatitis C. The patient should have been screened for hepatocellular carcinoma and for varices as early as 2014, but since the patient had symptoms of dementia in 2014, the need for treatment of hepatitis C was less certain and it is on this basis that we determine it was not preventable.

We noted 140 errors in care over the two years of record reviews. Most errors were related to the repeated failure to recognize cirrhosis and to thereby screen for esophageal varices and hepatocellular carcinoma, the ultimate cause of the patient's death. There were 13 episodes we identified when the patient was not timely referred to a consultant and four episodes when he was not referred to a hospital for significant deterioration of his medical status. Several of the denials of care by Wexford were grossly and flagrantly unacceptable. We also note that the

physician initiated palliative sedation in a demented patient without fully informed consent of the patient or his family. This had the appearance of hastening death, which may or may not have been the desire of the patient. This practice needs to be evaluated by the IDOC with respect to its ethical and legal implications.

Patient #29 Taylorville

This was a 66-year-old man with known diabetes and asthma. He was followed in hypertension, diabetes, and asthma chronic clinics. We asked for two years of the patient's record but appeared to receive only one year of record. Nevertheless, the patient was only seen three times for asthma, hypertension, and diabetes. Based on laboratory data, the patient also had diabetic nephropathy and hyperlipidemia. Though these were not documented or followed as problems, the patient did receive treatment, though inadequate, for the hyperlipidemia and was provided an ACE inhibitor.

Based on the January 2014 MAR, the patient was treated with 10 mg simvastatin at least from January 2014 until 3/7/15, when the dose was changed to 20 mg simvastatin. In 2014, the patient had a 10-year risk of heart disease or stroke of 46% (66 years old, diabetic, HTN, smoker, African American) and on 3/4/15 the patient had a 10-year risk of heart disease or stroke of 54%. Yet prior to 2015, the patient was on only 10 mg of simvastatin and after 2015 only 20 mg of simvastatin. His cardiovascular risk called for a high intensity statin, but the patient was only prescribed a low intensity statin. He was not even on a moderate intensity statin. This placed the patient at risk for heart disease.

Persons with diabetes and nephropathy, which this patient had, should have their blood pressure controlled to 130/80. This was not done. Though the patient did not have significantly elevated blood pressure, it was not controlled to 130/80 and medication was not adjusted when it was above that goal. This placed the patient at risk for cardiovascular disease and for further damage to his kidney function.

The patient also had diabetes. The diabetes was very poorly controlled. The HbA1C was 10.4 on 3/21/14 and remained at 10 or above, until it was 9.4 on 7/22/15. The HbA1C declined to 8.4 on 11/25/15, but even this was not good control. During this time, doctors made only minimal changes to improve blood glucose control and the lack of control placed the patient at risk of cardiovascular disease.

Thus, the patient had multiple risk factors for coronary artery disease (age, ex-smoker, high blood lipids, diabetes, and hypertension). His controllable risk factors were not managed well by prison physicians, thus placing the patient at increased risk for cardiovascular mortality.

The patient had asthma. However, the patient did not have evidence of spirometry or pulmonary function tests, which are recommended on all patients with asthma. The patient had several episodes of shortness of breath which were atypical of asthma. Since patients with

diabetes can have asymptomatic or atypical presentations for angina, the shortness of breath should have been considered as a possible angina equivalent. On 1/15/15, a doctor saw the patient in asthma clinic and documented that the patient described shortness of breath. The doctor wrote, "difficult to judge SOB [shortness of breath] etio [etiology] –likely multifactorial, obesity? Sleep apnea?" Indeed, other causes should have been sought. The doctor's acknowledgement that the etiology of the shortness of breath was uncertain required additional diagnostic testing. A stress echocardiogram and pulmonary function test or some equivalents should have been considered. At a minimum, the patient should have had pulmonary function testing at this point but did not. Angina should have been considered especially in light of his diabetes and multiple cardiovascular risk factors but was not.

On 4/21/15, a doctor evaluated the patient for an episode of shortness of breath with exertion. He had no chest pain. An EKG was done, but the tracing was of very poor quality and should have been repeated. It showed non-specific STT wave changes, which can be consistent with angina. However, the quality of the tracing was poor. The patient was not treated for angina; nor was diagnostic testing done for this condition, even though the patient's symptoms were consistent with angina and even though the patient had multiple risk factors. At a minimum, pulmonary function testing and a stress echocardiogram or equivalent tests should have been done.

On 7/13/15, the patient again developed shortness of breath. The doctor wrote, "deteriorating SOB [shortness of breath] but not so sure is asthma contributory." The doctor ordered a chest x-ray, which showed an enlarged heart. But the doctor did not order diagnostic testing (echocardiogram) to determine if the patient had heart failure. Instead, the doctor added Lasix presumably to treat for heart failure without determining if this was the patient's diagnosis. An echocardiogram should have been done.

The patient continued to have shortness of breath and dyspnea on exertion. On 1/28/16, the patient developed chest pain at 4:30 a.m., with an order from a physician to see the patient routinely in physician clinic during working hours. Someone with chest pain should be immediately evaluated, not as a routine. At 9:00 a.m., a physician saw the patient. The blood pressure was 169/94 and the pulse 100. An EKG was done. The doctor documented that there were no acute changes. The EKG in the medical record for this date was a very poor tracing and should have been repeated. One segment appeared to show ST segment elevation in V1-2 but only for one portion. This test should have been repeated, but the existing tracing suggested possible acute coronary syndrome, enough that with the symptoms the patient should have been referred for diagnostic evaluation (e.g. stress testing). The doctor told the patient that *he would need a treadmill test when he was discharged*. This was indifferent care. If the patient needed evaluation of coronary artery disease, it should have been promptly done, as the patient was at very high risk and EKGs seem to suggest this possibility.

Five weeks later on 3/6/16, the patient experienced acute shortness of breath at about 3:00 a.m. The oxygen saturation was 85% and decreased to the 60s. The nurse called an ambulance.

About 40 minutes after the episode started the ambulance arrived but the patient experienced cardiac arrest while transferring to the ambulance. The patient died at the hospital.

The coroner found that the patient died from acute coronary atherosclerosis with a right coronary artery plaque that showed rupture and hemorrhage consistent with acute coronary syndrome. The patient also had hypertensive cardiovascular disease and kidney damage. Pulmonary edema was noted.

This patient's death was possibly preventable. He had very high risk for coronary artery disease, yet his modifiable risks were not properly treated. His blood pressure was under-treated; his diabetes was never under control and poorly managed; and he was treated with only a low intensity statin when he required a high intensity statin.

In addition, the patient had multiple possible atypical presentations of angina that were unrecognized. During one episode of chest pain, the doctor ordered a routine next day visit instead of sending the patient to an emergency room. At the subsequent day evaluation, the EKG was an inadequate tracing but was nevertheless suspicious for acute coronary syndrome. The doctor recommended that the patient get a stress test on discharge from prison, but he took no immediate action to determine if the patient had angina and did not start anti-anginal medication. This was indifferent to the patient's serious medical need. If angina was suspected enough to recommend treadmill testing on discharge from prison, the doctor should have taken timely action to evaluate for cardiac ischemia and treated the patient presumptively for angina. If the patient was treated appropriately for his cardiovascular risk factors and had appropriate diagnostic evaluation of his angina, his death might have been prevented or significantly delayed.

Patient #30 Hill

This 43-year-old patient had an incomplete problem list. The problem list documented seizure disorder with a VP shunt,²⁰ deep vein thrombosis (DVT), and cerebrovascular accident, although there was no clear evidence for a cerebrovascular accident on subsequent notes. The patient was being treated for hypothyroidism, which was not on the problem list. The history of his problems could only be gleaned by piecing together strands from various notes, including hospital discharge summaries. The patient apparently had a serious brain injury in 1993 requiring a ventriculo-peritoneal (VP) shunt and subsequently developed seizures from the injury. Although the patient was described as having hemiparesis on an annual examination in 2012, there was no documented thorough neurological examination in the record that I could find that confirmed this condition. The history of the DVT was never clearly documented, even

²⁰ Normally, cerebrospinal fluid circulates in the ventricles of the brain. Due to injury or congenital abnormalities, there may be defects which cause the cerebrospinal fluid to accumulate, causing excess pressure on the brain. In order to resolve this, a drainage system is created to drain cerebrospinal fluid from the brain to the peritoneal cavity. This ventriculo-peritoneal (VP) shunt is subject to blockage and when a person has a VP shunt, any alteration of mental status should prompt evaluation of the shunt by brain imaging to ensure that excess fluid is not accumulating in the brain.

on chronic illness notes. It was not clear when the DVTs started. The patient appeared to be on life-long anticoagulation, but it was not clear why. Notably, the patient had an inferior vena cava (IVC) filter for his DVT. Typically, patients on an IVC filter are not also anticoagulated. When anticoagulated, the reason why should be clear. One can only speculate as to the reason for the IVC filter and anticoagulation. Persons with severe seizure disorder are prone to injury. In particular, a fall to the head during a seizure while on Coumadin can be life threatening. While this may be why he had an IVC filter, it is not clear why he was still on Coumadin. Also, the patient was on aspirin for an unknown reason. There was no documented reason to be on aspirin, Coumadin, and have an IVC filter. The rationale for these prescriptions was not evident in the medical record or in chronic clinic notes. Keeping someone on Coumadin and aspirin together without indication places this type of patient at life-threatening risk. This evidences incompetence on the part of the surgeon caring for the patient at Menard and the radiologist caring for the patient at Hill.

The patient was seen infrequently for his chronic illness when at Menard. When seen, there was often no history and few meaningful physical examinations. The status and rationale for the continued anticoagulation was not made clear. The patient remained on aspirin and Coumadin with an IVC filter throughout 2015 without explanation. Also, the patient had breakthrough seizures despite being on three antiepileptic drugs. This patient was a very complex patient because of his prior brain injury and VP shunt; and because he had repeated breakthrough seizures on three medications, he should have been managed by a neurologist, but there is no evidence of neurology consultation.

The patient transferred from Menard to Hill on 12/17/15. Before the patient transferred he was living in population and appeared to be able to care for himself. The day of arrival at Hill, the patient had multiple seizures and was evaluated only by a nurse. A doctor gave a phone order for Ativan “for continuous seizure activity” and to “send out if unresponsive to therapy and continuous seizures.” The patient apparently continued to have seizures and was sent to a local hospital, intubated, and sent to a regional hospital where an electroencephalogram was performed while in the ICU. The patient demonstrated presumed seizure activity without any waveform on the EEG indicating epileptiform activity. The patient was discharged with diagnoses of seizures and pseudoseizures.²¹ The medications were not changed.

When the patient returned to Hill Correctional Center, the patient was admitted to the infirmary. Apparently, the patient was discharged from the hospital with a subclavian central venous line, but this was never noticed by providers at Hill. Nurses did not bring this to the attention of providers, apparently thinking it was necessary and began using the port to draw blood from. This unnecessary intravenous line placed the patient at risk of infection and moreover speaks to a significant lack of examination of the patient. How could a central venous line be unnoticed for three weeks?

²¹ Pseudoseizures are episodes that resemble seizures but are psychological in origin as they have no origin in abnormal brain activity.

The patient was admitted to the infirmary after the hospitalization for ataxia²² and frequent seizures. Nurses documented that the patient had ataxic gait. An initial NP infirmary admission note documented that the patient had ataxia and unequal pupils. Unequal pupils are a serious sign of central nervous system disorder and needs to be promptly evaluated. The patient had a CT scan at the local hospital by report before transfer to the reference hospital. Nevertheless, unequal pupils and ataxia in the context of a VP shunt requires immediate imaging studies with CT or MRI. This was not done.

Over the course of the next two and a half months the patient continued to have unequal pupils, had progressively deteriorating mental status, and became progressively unable to care for himself. The patient could not walk without support. Instead of sending the patient to a hospital for an evaluation of why he couldn't walk, the NP ordered that his mattress be placed on the floor. Over time the patient was unable to communicate effectively, did not consistently respond to questions or commands, became incontinent of urine and feces, did not consistently eat food or drink, and was unable to care for himself. Despite a dramatic deterioration of neurological status in the context of a VP shunt, the patient never had a thorough neurological examination or had an imaging study (CT scan or MRI) of his brain. The deteriorating condition of the patient combined with the lack of physical examination or care by providers for the patient was indifferent, and grossly and flagrantly unacceptable care.

Over time the patient developed bruising, first noted on his elbows but then on his back, thighs, legs, and elbows. Despite being on Coumadin and aspirin and having bruising, the provider did not order an INR to assess whether he had supratherapeutic levels of anticoagulants. Supratherapeutic levels of anticoagulation would result in bleeding or bruising. This is a dangerous sign and calls for immediate action to prevent life-threatening harm. The doctor did not assess why the patient was on aspirin, as he had no clinical indication for this drug. Keeping the patient on both drugs and failure to assess the INR was a life-threatening danger to the patient and grossly and flagrantly unacceptable medical care. Eventually the patient began passing frank blood from his urine and stool. The nurse told the doctor, who only ordered ciprofloxacin for a presumed urinary tract infection without evaluating the INR to assess anticoagulation status. This was grossly and flagrantly incompetent care.

During this two month period the patient had a significant deterioration in his mental status and had evidence of bleeding. Despite unequal pupils and ataxia, deterioration of mental status, and bleeding while on anticoagulants, the doctor never performed a thorough history or a thorough neurological examination, including examination of his pupils. The doctor never ordered an INR.

Eventually, the patient became unresponsive and was sent to a hospital. The patient had an INR of 10, which is a life-threatening value. The patient also had a major intracranial bleed as a

²² Ataxia is a non-voluntary lack of coordination of movement that results in gait abnormalities. It is often a sign of central nervous system disorder.

result of the excessive anticoagulation that shifted the brain and caused herniation of the brain, which caused the patient's death. The death was attributed to supratherapeutic anticoagulant levels.

This patient's death was preventable. Care for this patient was grossly and flagrantly unacceptable. The death summary was performed by the doctor caring for the patient and no problems were identified. This doctor is a nuclear radiologist and clearly does not have fundamental medical knowledge sufficient to practice general primary care medicine, and should not be allowed to do so. This is a doctor identified on the First Court Expert report as having performed poorly. Yet he continues to practice. Notably, the hospital notes document questioning why the patient was on anticoagulation. The fact that the patient was at Hill for almost three months and providers failed to identify that the patient had a central venous intravenous line was remarkable. Apparently, this device was inadvertently left in the patient when discharged from the hospital in December but no one at Hill even asked why it was necessary. Also, no one at Menard or Hill apparently knew that the patient had an IVC filter. The medical care was indifferent, and grossly and flagrantly unacceptable.

We noted 110 errors in the care of this patient. The most frequent error was the repeated error of failing to identify the medical indication for the use of both aspirin and Coumadin. This was particularly egregious because the patient had an IVC filter, which makes both Coumadin and aspirin unnecessary. On 16 occasions, the patient had serious, even life-threatening presentation, yet nurses failed to consult a physician. Physician history and physical examination were frequently inadequate and, particularly in the latter stages of the patient's life, failed to further investigate obvious conditions such as bruising and altered mental status that would have been obvious to a layman.

Patient #31 Illinois River

This patient had a history of diabetes, hypertension, and substance use. There were no progress notes in the medical record from 5/27/15 until the patient was diagnosed with squamous cell cancer of the tongue on 9/20/16. This record was incomplete. It was not clear if the patient was not evaluated for a year and a half or whether the record was missing. It appeared that the patient may have been in a transition center, but it was unclear. The initial diagnosis in September of 2016 was squamous cell cancer of the tongue with multiple enlarged metastatic lymph nodes in the neck, and locally invasive cancer. The cancer was stage IV on diagnosis. The patient was admitted to the infirmary after the cancer was diagnosed and died in hospice on 12/2/16.

Based on the record, **it was difficult to determine if the death was preventable or not preventable, as there was a significant part of the record missing.** If the patient was at a transition center and had adequate care and access, then the death would be not preventable. But this is based on speculation. We noted only two errors, both related to lack of medical records.

Patient #32 Pinckneyville

This patient was admitted to NRC on 12/6/16. The patient had hypertension, heart failure, COPD, diabetes, and idiopathic thrombocytopenic purpura (ITP).²³ The patient was on danazol for his ITP. The patient had his spleen removed due to the ITP. The patient's initial laboratory results show that the patient had chronic kidney disease (creatinine 1.87) and low albumin, indicating possible poor nutrition. The patient was incarcerated approximately five months before he died. The diabetes was poorly controlled during the entire approximate five months of incarceration.

The patient's record of treatment of his ITP was not identified at NRC. Old records were not obtained. His prior treating oncologist was not contacted. It was not clear what his therapeutic plan was. The patient was on danazol for his ITP on transfer from a local jail. This drug has a black box warning with respect to causing thromboembolism, some of which can be fatal, and which ultimately apparently caused this patient's death. This drug also is contraindicated in patients with markedly impaired renal function and is noted to worsen diabetic control. This patient had chronic kidney disease. None of these potential problems were monitored by IDOC physicians.

The patient transferred to Pinckneyville from NRC on 1/4/17 without having had his therapeutic plan verified. Doctors at Pinckneyville were unaware of how to manage his ITP. ITP causes destructions of platelets, a blood element that is involved in clotting. His initial platelets were 60,000. Normal platelets are 150,000 to 450,000. The goal in chronic ITP is to keep platelets above 20,000. When the patient arrived at Pinckneyville he was not on danazol, an off label²⁴ medication used for ITP that he had been taking. On 1/9/17, the patient placed a health request, complaining that he was not receiving danazol and had not seen a doctor yet for his ITP. He was upset that his medication was discontinued without having spoken to a doctor about this change.

A doctor saw the patient on 1/17/17, and restarted the danazol without noting a review of contraindications which included markedly impaired renal function. The renal function was not monitored, and doctors did not acknowledge the potential for worsening diabetes control from this medication. While the patient's renal function was abnormal, it was not clear if renal function had deteriorated to a level that made the medication dangerous. Yet the doctor did not initially refer the patient to someone expert in managing ITP, like a hematologist.

In early February, a doctor started large doses of prednisone for the ITP. A major problem with this patient is that his prior treatment program was never identified. Typically, initial treatment of ITP is different from treatment of chronic ITP. Initial treatment included steroids and intravenous immune globulin (IVIG). Treatment of chronic disease utilizes splenectomy, which

²³ ITP is a disease in which platelets are destroyed, often from unknown reasons. Platelets are necessary to properly clot blood and lack of platelets can result in life-threatening bleeding. This disease is typically managed by a hematologist.

²⁴ Off label medications are medications not approved by the FDA for the stated purpose. While these medications are often useful, the FDA has not identified sufficient scientific evidence of their value.

this patient already had, and other medications, sometimes in combination with steroids. After the danazol was started, a creatinine was 2.05, a deterioration, and concerning with respect to the potential for complications.

The patient was sent to a local hospital for an injection of IVIG, but at the hospital the patient received no therapy and left with a recommendation to see a hematologist in his office. At some point around this time, a doctor wrote an undated message to apparently the Wexford Regional Medical Director asking, "What should we do?" There was no plan after return to the prison to send the patient to a hematologist.

About a month later, the patient told a nurse "I'm going to die." The nurse had brought the patient to the health care unit because the platelet count was 6,000, a critical value that placed the patient at risk of life-threatening bleeding. A doctor sent the patient to a hospital. The patient was discharged from the emergency room on high dose steroids again with a recommendation to follow up with a hematologist.

After this second hospitalization on 3/23/17, the Pinckneyville physician referred the patient to a hematologist. The patient was evaluated by the hematologist on 3/30/17, but the report was not in the medical record and it was not clear what the hematologist findings were. Brief comments by the hematologist on the referral form recommended prednisone 100 mg daily with a return in two weeks. It was not clear if the hematologist knew that the patient was on danazol because the consultant note was not present. When a doctor followed up after the hematology consult, the doctor did not document what the hematologist's findings were or what the therapeutic plan was.

On 4/5/17, the white count was 23,200, which may have been a result of the use of high dose prednisone, but could also be from infection. No one evaluated this abnormal test. On 4/6/17, the patient developed abdominal pain, had not been eating, and had not been able to have a bowel movement for two days. The patient was referred to a local hospital, but transferred to a tertiary hospital because he had an ischemic bowel with perforation. Ischemic bowel is often caused by thromboembolism, which is one of the complications of danazol. It is unclear whether the hematologist knew that the patient was on danazol and felt it was necessary. Because the patient was so malnourished and weakened he was not a surgical candidate and the patient also declined having an external ostomy placed. As a result, the patient was sent back to the facility with a recommendation for hospice.

The patient returned from the hospital on 4/14/17 and died on 4/19/17. He was scheduled to see the hematologist on 4/18/17, but the ADA van was unavailable and therefore the appointment was rescheduled.

In summary, coordination of this patient's complex medical condition with consultants was extremely poor. For several months, the patient was not referred. When the patient was referred, the consultation report was not available, and it was not clear what the patient's

status was. Because consultant reports are unavailable, **there is insufficient information to assess preventability.**

We identified 20 errors on this record. The most serious ones were never understanding the therapeutic plan for the patient's serious medical condition or whether the danazol was indicated. A side effect of the danazol likely caused the patient's death, but it was not clear whether the hematologist intended the patient to continue this drug. There were six errors in lack of timely referral to a hematologist for management of a life-threatening condition.

Patient #33 Robinson

This 58-year-old man was at the Robinson Correctional Center and had hypertension and high blood lipids, which were both untreated for eight months of record review. These are both risk factors for heart disease. On 3/16/16, he developed chest pain with atrial fibrillation. The blood pressure was 200/118 and the pulse was 129. The electrocardiogram also showed marked ST depression indicating acute coronary syndrome, a life-threatening event portending a heart attack. The automated reading recommended, "immediate clinical assessment of this individual is strongly advised." He should have been hospitalized immediately for cardiac catheterization and management of his atrial fibrillation. Instead, a nurse evaluated the patient and consulted a doctor, who only ordered 23-hour observation on the infirmary and gave one-time only doses of clonidine and propranolol. This was grossly and flagrantly unacceptable care and placed the patient at risk of death and demonstrated a profound deficit of primary care knowledge.

The following day, a doctor ordered aspirin and statin medication, but failed to refer to a cardiologist and failed to refer for catheterization despite the prior day's EKG result, which was signed as reviewed. Aside from aspirin, anticoagulation due to atrial fibrillation was not considered. These actions placed the patient at risk of death.

The doctor continued to fail to appropriately manage this patient's life-threatening condition. The doctor continued the patient on high doses of non-steroidal medication despite a box warning²⁵ regarding risk for cardiovascular thrombotic events including myocardial infarction and stroke with use of this drug. The doctor eventually began treatment of the patient's high blood pressure with Norvasc, a drug that carries a warning of increased angina or myocardial infarction in persons with obstructive coronary disease, which the patient appeared to have. Eventually, the patient's family called the HCUA because the patient was having chest pain while walking to the dining hall and could not walk without chest pain. The HCUA wrote that the patient was "not in any distress but complains he is unable to walk to dietary." The HCUA referred routinely to a doctor for an appointment five days later. This was indifferent as the patient's need was urgent not routine.

²⁵ A box warning is the strictest warning put in the label of prescription medication by the Food and Drug Administration when there is reasonable evidence of an association of a serious hazard with the drug.

The patient again developed typical chest pain which was helped by nitroglycerin. An electrocardiogram showed moderate ST depression consistent with ischemia. This is consistent with acute coronary syndrome and the patient should have been transferred immediately to a hospital. Instead, a nurse saw the patient and consulted a doctor, who ordered 23-hour observation but no further treatment. At this point, aside from nitroglycerin, the patient was not on antianginal medication. This was grossly and flagrantly unacceptable and placed the patient at risk of death. This was the second episode of acute coronary syndrome which was inappropriately managed.

The patient was seen after this second electrocardiogram verifying acute coronary syndrome and a doctor referred the patient for an elective stress test. Wexford would not approve the stress test and instead recommended as an alternative plan to refer the patient to a cardiologist. This was done on an elective basis though the patient had an urgent need. The cardiologist saw the patient a month after the referral and recommended a cardiac catheterization "in the near future."

The catheterization was ordered, but a week later the patient again developed chest pain. The electrocardiogram showed atrial fibrillation. Our reading shows ST depression in several leads. Chest pain with recurrent atrial fibrillation and acute coronary syndrome should have resulted in immediate hospitalization for evaluation, catheterization, and consideration for anticoagulation. Instead, a nurse consulted a doctor, who ordered 23-hour observation with a next day electrocardiogram. Six hours later the patient was found unresponsive. Cardiopulmonary resuscitation was started, and the patient transferred to a hospital, where he died.

This patient had repeated episodes of acute coronary syndrome and two episodes of atrial fibrillation, each of which should have resulted in hospitalization, which did not occur. The angina was inappropriately treated and was never under control. Cardiac catheterization was not done over three months despite the patient having three episodes of apparent acute coronary syndrome. The atrial fibrillation was never appropriately assessed, and the patient was not anticoagulated despite having atrial fibrillation and acute coronary syndrome on three occasions. The patient's cause of death was listed as coronary atherosclerosis and stroke, both of which were preventable with timely and appropriate treatment. **Therefore, this death was preventable.**

The death summary noted no problems and noted that earlier intervention was not possible. We strongly disagree.

We noted 46 errors in the care of this patient from the time he was transferred to Robinson on 8/21/15 until his death on 6/10/16. These errors included not taking adequate history, not performing a needed physical examination, and not developing an appropriate treatment plan. Additional errors included not treating elevated blood pressure from August of 2015 until March of 2016 despite continuously elevated blood pressure. Despite being 58 years old, this

patient's 10-year cardiovascular risk was apparently not calculated. The patient had blood in his stool and was 58 years old but was not referred for colorectal screening. He had blood in his stool but was kept on non-steroidal medication without investigation. The patient was also prescribed medication that was likely to harm him (non-steroidal anti-inflammatory drugs and Norvasc) without recognition of the potential for harm. The most serious errors, however, were the failure to immediately hospitalize the patient after repeated episodes of acute coronary syndrome and atrial fibrillation, and lack of awareness and acknowledgement of the seriousness of these conditions.

IDOC Mortality Error Classification

Description of Error	Error type	Number having that error
Apparently did not obtain pertinent history and/or findings from examination.	1	276
Apparently did not make appropriate diagnoses and/or assessments.	2	249
Apparently did not establish and/or develop an appropriate treatment plan for a defined problem or diagnosis which prompted this episode of care (excludes laboratory and/or imaging and procedures and consultations).	3	228
Apparently did not carry out an established plan in a competent and/or timely fashion (e.g. omissions, errors, of technique, unsafe environment).	4	44
Apparently did not appropriately assess or act on changes in clinical/other results.	5	7
Apparently did not provide appropriate personnel and/or resources, including getting hospital reports.	6	87
Apparently did not refer or timely schedule for a procedure that was indicated (other than lab or imaging).	7	95
Apparently did not obtain timely appropriate laboratory tests and/or imaging results.	8	119
Apparently did not develop and initiate appropriate discharge from infirmary or failed to follow up after infirmary or hospital discharge.	9	4
Apparently did not follow up appropriately after consultation or health care visit.	10	45
Apparently did not provide appropriate personnel and/or resources, including getting hospital reports.	11	138
Apparently did not order timely, appropriate specialty consultation.	12	81
Apparently did not follow up on patient's noncompliance.	13	4
Apparently failed to timely refer to a higher level of care including hospitalization, skilled nursing unit, or infirmary.	14	93
Apparently failed to follow up on significant findings.	15	28
Apparently, nurse failed to consult/refer timely to a higher level medical staff (provider).	16	143
Apparently did not develop and initiate appropriate discharge from infirmary or failed to follow up after infirmary or hospital discharge.	17	79
Failed to see a patient with potential serious illness.	18	37
Total		1757

Patient #1

1/2/2015 Cholesterol 194; TG 60; HDL 55; LDL 127.

1/5/2015 An annual history evaluation at WICC for this 56 year old. The weight was 184. This nurse evaluation was not performed on the same day as the physical examination.

1/6/2015 A nurse saw the patient because he passed out according to his cell mate. The blood pressure was 162/93. The weight was listed as 166 pounds. The nurse noted that the patient had an appointment the next day so didn't refer the patient or consult a doctor. An EKG was not done.

16 Syncope is a critical sign and requires immediate evaluation. The nurse needed to consult a provider promptly.

1/7/2015 The cholesterol was 194; TG 60; HDL 55; LDL 127.

Patient #1

1/7/2015 An annual health examination showed BP 149/98, weight was listed as 168, which is 16 pounds different from two days before. The NP documented that the patient refused a digital rectal examination for purposes of prostate screening but did not offer colorectal screening (fecal occult blood tests or colonoscopy). On the physical examination form, the rectal examination is listed as a test of the prostate in males over 40 years old. Lack of colorectal screening is inconsistent with contemporary standards of care. The refusal of the digital rectal examination states he refuses performance of a "prostate - digital rectal exam." There was no discussion of colorectal cancer.

7, 15 The nurse noted the day before that the patient would be seen for "passing out" but the NP did not address this. Two days before a nurse documented the weight as 184 pounds. At this visit the weight was recorded as 168 pounds, a 16 pound difference. The differences in weight were so significant as to make weights unreliable. The patient was 56 and should have had colorectal cancer screening. The patient was offered only a digital rectal examination. This examination was offered for prostate screening. Current recommendations of the American Cancer Society state that digital rectal examination is insufficient as a stand-alone test for colorectal cancer. This type of cancer screening will miss 90% of colon abnormalities. The patient should have been offered fecal occult blood testing (not from a digital rectal examination or colonoscopy). This lack of colorectal screening was significant. Care failed to follow generally accepted guidelines or usual practice.

1/12/2015 A doctor saw the patient and noted that the patient reported a right testicle mass which was not appreciated on an NP examination on 1/7/15. The doctor examined the patient and documented an epididymal cyst. The weight was 164.

2/9/2015 Cholesterol 201; HDL 56; LDL 135.

2/19/2015 The cholesterol was 201; TG 48; HDL 56; LDL 135.

Patient #1

- 3/9/2015 The patient was evaluated for HTN clinic. The BP was 148/93. Weight was listed as 170 pounds. No change in BP meds was made; the doctor noted the patient missed his BP meds that morning. The cholesterol was 201; HDL 56; LDL 135. The patient was an ex-smoker. The patient had a 22% 10-year risk of heart disease or stroke and should have been on a moderate to high statin dose.
- 9/30/2015 A doctor saw the patient for HTN chronic care. The weight was 164. Blood pressure was 124/73. Lipids were not addressed.
- 2/11/2016 Lab showed normal metabolic panel except for albumin 3.3. AST/ALT and alkaline phosphatase were normal. Cholesterol was 161, TG 46, HDL 56, LDL 96.
- 3/1/2016 A doctor saw the patient in HTN chronic clinic. The weight was 164 pounds. The BP was 115/65. The doctor noted a cholesterol of 161 and triglycerides of 46. The LDL was not noted. The albumin was 3.3 which is low but the doctor did not initiate any work up. The patient was on lisinopril, Zocor, aspirin, Hytrin and another medication [illegible].
- 7/5/2016 BUN, creatinine and electrolytes were normal.
- 7/7/2016 This was to be the next physician visit after 3/1/16. The patient weighed 158 pounds. The blood pressure was 119/77. A rescheduled visit for 7/26/16 didn't take place.
- 9/2/2016 BUN, creatinine and electrolytes were normal.
- 9/13/2016 A doctor saw the patient for a hypertension clinic. The weight was 156 pounds. The patient was 5 foot 5 inches tall. The doctor checked the box that education was given regarding weight loss. The blood pressure was 140/77. The patient was on aspirin, lisinopril, Zocor, Hytrin and Proscar. No other history was taken.
- 3 The statin dose probably should have been increased to 40 mg of Zocor. The BP meds should have been increased. Care could reasonably have been expected to be better.
- 6 The albumin was low yet the doctor took no action to investigate. Care failed to follow generally accepted guidelines.
- 1 Depending on which weight was used, based on the history (1/5/15) and physical examination (1/7/15) the patient had lost either 28 pounds or 10 pounds. In either case the doctor was not monitoring the weight of the patient. Presumably the purpose of taking weight is to monitor it, but this wasn't done. Care could reasonably have been expected to be better.

Patient #1

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|---|---|
| <p>1/16/2017 The patient transferred from WICC to IRCC. Hypertension and high blood cholesterol were listed as problems. The blood pressure was 150/100 but not addressed. The weight was 152 pounds. On the 1/5/15 annual history the patient weighed 184 pounds. On a health request on 1/6/15, a nurse documented that the patient weighed 166 pounds.</p> | <p>1,16 Nurses failed to address abnormal vital signs. On transfer the nurse failed to appreciate a weight loss of 14 or 32 pounds depending on which weights from January of 2015 were used. What is the purpose of taking the weight? Care failed to follow generally accepted guidelines, as intake screening should be a summary screening of the patient's conditions including weight, and the nurse should have referred abnormal blood pressure to a physician.</p> |
| <p>2/2/2017 The albumin was 3.1; AST, ALT, alkaline phosphatase and bilirubin were normal.</p> | |
| <p>2/10/2017 A doctor performed a general medicine clinic for high blood lipids and prostatic hypertrophy. The weight was 155 pounds. The doctor noted that the patient had nocturia twice a night but took no other history related to the BPH or high blood lipids. The cholesterol level was not documented. The doctor ordered a fasting lipid panel. The doctor failed to address a low albumin.</p> | <p>1, 5, 6 The doctor failed to acknowledge an abnormal lab or follow up. The doctor failed to acknowledge a 11 or 29 pound weight loss since the annual history and physical examination from January 2015. Care failed to follow generally accepted guidelines or usual practice.</p> |
| <p>3/14/2017 A NP saw the patient for an annual HTN clinic. The NP took no history except to note "no complaints F/U altercation." The weight was 155. Labs were not reviewed.</p> | <p>5 The NP failed to note weight loss. Care failed to follow generally accepted guidelines.</p> |
| <p>3/26/2017 A nurse saw the patient for right sided flank and back pain that was constant. The blood pressure was 152/94 and pulse was 119. The nurse assessed that there were no contusions or swelling but there was pain to palpation. The nurse noted "acute severe discomfort" and called a doctor who ordered Toradol 60 mg IM and Ultram 150 mg BID for three days.</p> | <p>15 The patient had abnormal vital signs with back pain yet there was no follow up with the primary care physician. Care failed to follow generally accepted guidelines.</p> |
| <p>4/20/2017 The total protein was 5.7 (6-8); albumin 2.3 (3.4-5) and alkaline phosphatase 167 (40-125). The hemoglobin was 6 (13.2-18).</p> | |

Patient #1

4/21/2017 An LPN documented that the hemoglobin was 6 and the patient had abdominal discomfort. The patient was lightheaded and dizzy for the past month and had nausea and vomiting for a month. The nurse referred to a doctor.

4/21/2017 A doctor saw the patient and noted weight loss, night sweats. The doctor noted anemia, 19 pound weight loss over a month and night sweats. The doctor ordered the patient transferred to a hospital via state vehicle for evaluation.

4/21/2017 ER report from Graham Hospital from the 4/21/17 hospitalization showed hemoglobin of 7.5. The report included a report of an EGD that showed extensive inflammatory changes in the distal esophagus with some ulceration suggestive of Barrett's esophagus. The stomach was essentially normal. The biopsy reported 4/25/17 showed mild reflux changes, chronic gastritis and helicobacter pylori.

4/22/2017 The patient returned from the hospital and was placed on the infirmary.

4/22/2017 A doctor noted that the patient had a history of anemia and received two units of blood. The doctor took no other history. The doctor failed to note the hospital diagnoses. The doctor noted that the patient's hemoglobin was 6 in the ER but didn't note what the current hemoglobin was. The doctor kept the patient on aspirin, started iron, but ordered no laboratory tests and no evaluation for a critical anemia. Despite the patient just being diagnosed with a GI bleed and esophagitis, the doctor kept the patient on aspirin and did not start a proton pump inhibitor or H2 blocker medication.

This EGD should not have accounted for a hemoglobin of 6.

1,3,17 The doctor failed to take a history of the current hemoglobin and did not note the weight loss and abdominal pain and failed to make an assessment of what the patient might have. There was no plan for the significant anemia and weight loss. The doctor continued aspirin therapy in someone with recent GI bleed, gastritis, and esophagitis. Care failed to follow generally accepted guidelines.

Patient #1

4/24/2017 The patient told a nurse that he had constant pain below his right rib with inspiration and when he laid on his right side.	16	The nurse should have consulted a physician.
4/25/2017 A nurse practitioner saw the patient, who weighed 138 pounds, which was somewhere between a 28 to 46 pound weight loss over two years. The NP noted lower quadrant abdominal pain and ordered a CBC and referred for colonoscopy.		
4/25/2017 A referral form from Illinois River documented that the patient had a hemoglobin of 6 and a negative EGD in an ER and that outpatient colonoscopy was recommended. This referral form was not approved.		
4/26/2017 The temperature was 100.6 at 4:00 am and 103.4 at 8:00 pm on the graphic flow sheet.	16	The nurse should have consulted a physician.
4/26/2017 At 5:10 am a nurse documented that the patient had a fever but did not document calling a doctor.	16	The nurse should have consulted a physician.
4/27/2017 The temperature was 103.6 at noon.	16	The nurse should have consulted a physician.
4/27/2017 At 8:30 am a nurse documented that the patient vomited and had a temperature of 102.7 The nurse gave the patient Tylenol but did not call a doctor.	16	The patient had weight loss, anemia, and fever and should have been admitted to a hospital but the nurse didn't even call a doctor.
4/27/2017 A nurse noted that the patient had abdominal pain but did not refer to a doctor.	16	The nurse should have consulted a physician.
4/28/2017 The temperature was 101.4 at 4:00 pm	16	The nurse should have consulted a physician.
4/28/2017 At 4:00 pm a nurse noted that the patient had fever of 101.5 but only gave the patient Tylenol without consulting a physician.	16	The nurse should have consulted a physician.
4/29/2017 The temperature was 100.4 at noon.	16	The nurse should have consulted a physician.
5/1/2017 The temperature was 102.4 at 4:00 pm.	16	The nurse should have consulted a physician.

Patient #1

5/1/2017 A nurse called the NP about whether the blood should be drawn and received an order to draw the CBC in the morning. The temperature was 102.4.

5/2/2017 The temperature was 101.4 at 4:00 am and 100 at noon.

5/2/2017 An NP saw the patient and noted that the patient had abdominal pain, fever. Remarkably, the NP documented that the patient had not been losing weight; the weight was not documented but the patient had actually lost somewhere between 28 to 46 pounds since January of 2015. The NP ordered a stat CBC but should have referred to a hospital for possible acute colitis or other condition causing weight loss, fever, abdominal pain.

5/2/2017 A doctor noted that colonoscopy was approved in collegial review. The doctor noted that a colonoscopy would be scheduled after transfer to Danville. It wasn't clear why the patient needed transfer to Danville for a colonoscopy. Because the patient had fever, abdominal pain and weight loss, a prompt colonoscopy and/or CT abdomen were indicated. This may have required hospitalization.

5/2/2017 At 2:15 pm the patient was transferred to Danville. On arrival at Danville the weight was 140 pounds or a 24 pound weight loss over nine months and a 26 or 44 pound weight loss since January 2015.

5/2/2017 Hemoglobin was 8.3 (13-16.9).

14 This patient should have had a stat CBC upon return from the hospital and then a few days later to assess the hemoglobin level. Because of the fever the patient needed prompt evaluation for his anemia, weight loss, abdominal pain and fever or should have been sent to a hospital for evaluation. Care failed to follow generally accepted guidelines or usual practice.

16 The nurse should have consulted a physician.

1, 14 The NP should have admitted the patient to a hospital because of fever, weight loss, and abdominal pain. The NP history was wrong that the patient did not have weight loss. Fever, anemia, weight loss and abdominal pain are indications for an immediate evaluation. Care failed to follow generally accepted guidelines or usual practice.

12, 14 The delay in specialty care was significant and reflects on the collegial review process. Care failed to follow generally accepted guidelines.

Patient #1

- 5/3/2017 An LPN noted that the patient came to the health care unit inquiring about the decreased hemoglobin. The nurse talked to a doctor who said that a CBC would be done on 5/5/17. The doctor noted that unless the hemoglobin was less than 7 the patient was to follow up next week.
- 5/3/2017 An approval for colonoscopy referral received on 5/2/17 from Wexford UM.
- 5/10/2017 A nurse said that the patient would be rescheduled because the labs were not yet done.
- 5/11/2017 The total protein was 5.8 (6-8); albumin 2.3 (3.4-5); alkaline phosphatase 213 (40-125); AST 41 (10-40); hemoglobin 7.9.
- 5/17/2017 Last dated problem list: hypertension, high blood lipids and prostatic hypertrophy.
- 5/17/2017 An NP saw the patient for semi-annual general medicine clinic. The NP took a history of right leg swelling and pain in his abdomen. The NP noted a hemoglobin of 6 on 4/20/17 with a hemoglobin of 8.3 on 5/2/17. The NP noted that the inmate weighed 150 pounds and was "very cyanotic" with right leg swelling from the knee to the foot. The NP noted that colonoscopy was approved. The only diagnosis was anemia. The blood pressure was 121/79. The NP decreased the Zocor and lisinopril without giving a reason. There were no additional orders.
- 5/18/2017 A doctor wrote a brief note without seeing the patient stating that a GI note from 4/22/17 documented that the patient had chronic gastritis and possible Barrett's esophagus and started triple therapy with follow up in 2-3 weeks with a repeat CBC the next visit.
- 7 Danville did not understand the urgency of the patient's problems. A nurse reviewing the patient on transfer scheduled the patient for a routine PCP visit. The physician ordered a routine CBC for a patient with weight loss, fever and abdominal pain. Care failed to follow generally accepted guidelines.
- 7 This was a delay in evaluating a serious medical condition. These were abnormal labs but were not addressed. Care failed to follow generally accepted guidelines or usual practice.
- 6, 8 Unilateral leg swelling is a significant finding. DVT should have been excluded; this was potentially life-threatening. Recent abnormal lab tests were not acknowledged except for the anemia. Care was grossly and flagrantly unacceptable.
- 4 The patient was over 50 with weight loss, fever, anemia, and abdominal pain and needed an evaluation for this. The doctor did not perform an adequate evaluation of the patient and initiated a treatment plan without evaluation of the patient. Care failed to follow generally accepted guidelines or usual practice.

Patient #1

6/5/2017 Hemoglobin was 7.9.

6/14/2017 A doctor wrote that the patient's symptoms had improved "tremendously" and that the patient was scheduled for colonoscopy. The doctor did not note what the hemoglobin was. The doctor noted that the colonoscopy prep was to be started that day. The doctor diagnosed chronic gastritis.

1,2 The doctor did not obtain an adequate history and did not examine the patient. Previously abnormal labs were not followed up. The weight loss, anemia, low albumin, elevated alkaline phosphatase were inconsistent with chronic gastritis. Care failed to follow generally accepted guidelines.

6/15/2017 A colonoscopy report documented an infiltrative partially obstructing large mass was in the ascending colon. The mass was circumferential. Biopsies were taken. The endoscopist recommended a CT scan, CEA, referral to a colorectal surgeon, a recommendation to screen 1st degree relatives at age 40. The consultant said to "watch for signs of bowel obstruction as the mass was almost completely obstructing the lumen." The consultant recommended a CT scan of the abdomen and pelvis, tumor markers and referral to a colo-rectal surgeon within two weeks.

6/15/2017 A pathology report documented invasive moderately differentiated adenocarcinoma.

6/20/2017 A doctor noted that the colonoscopy results showed an obstructing mass in the ascending colon. The doctor ordered CBC, CEA, CMP, KUB, and follow up with colorectal surgery.

6/21/2017 A referral form on this date referred the patient to colorectal surgery. This was checked as an urgent consult but was not signed as approved.

6/22/2017 Wexford UM approved a colorectal surgery evaluation.

Patient #1

- 7/5/2017 A doctor noted that the patient had swelling of the right lower extremity and that oncology follow up was pending. The patient had 2+ pitting edema of the right leg from mid-thigh to "distal extremity." The doctor ordered a D-dimer, and other tests and ordered ted hose and gave the patient a cane. The blood pressure was elevated at 134/99 and pulse was 113. The doctor still did not document the hemoglobin. The doctor increased HCTZ. To treat suspect DVT with HCTZ was below standard of care. The doctor ordered a "PRN" follow up.
- 7/5/2017 The nurse was unable to draw all labs and rescheduled the D-dimer test. The doctor was not notified.
- 7/5/2017 The BUN was 23 (6-20); albumin 2.2 (3.4-5); alkaline phosphatase 301 (40-125); AST 82 (10-40); WBC 14.6 (3.9-12); hemoglobin 9.1.
- 7/10/2017 An LPN documented that approval was needed for a D-dimer test and did not draw it. The infirmiry nurse was notified and was asked to check with the infirmiry doctor.
- 7/10/2017 Serum iron was <10 (50-180); transferrin 100 (200-400); iron binding capacity 140 (250-450); INR 1.4 (0.9-1.2).
- 7/12/2017 A colorectal surgeon saw the patient. The patient told the surgeon that he lost 50 pounds in the past 3-4 months. The surgeon palpated a left upper quadrant mass suspected to be his liver with a fluid wave consistent with ascites. This note was incomplete and did not include the assessment or plan.
- 4, 8, 15 The doctor apparently thought of pulmonary embolism or DVT because he ordered a D-dimer. If the doctor believed the patient might have a DVT, immediate transfer to a hospital for Doppler was indicated. The doctor did not address the possible etiology of unilateral leg swelling with an abdominal mass-known to be likely cancer. To order a diuretic for unilateral leg swelling without excluding DVT is incompetent. The doctor ordered "PRN" follow up for a potentially life-threatening problem. Care was grossly and flagrantly unacceptable.
- 8 This was a significant test and the delay should have resulted in a call to a physician.
- 8 A D-dimer test is a test for a potential emergency condition (DVT or PE). This test had been delayed five days due to bureaucratic obstructions. The patient should have been admitted to a hospital for a Doppler but even the D-dimer test was significantly delayed.
- 14 This visit was two weeks late. Care could reasonably have been expected to be better.

Patient #1

7/14/2017 A CT scan showed small left pleural effusion; large metastasis in the liver of 16 by 17 cm. There was a large mass involving the ascending colon. There was a large amount of ascites exerting a mass effect and suspicious for pseudomyoma peritonei. There was a large metastasis in the anterior abdomen with peritoneal nodules and a lymph node in the area of the pancreas. The hemoglobin was 7.8. The CEA was 2185 (0-3)

8/3/2017 The patient was admitted to the infirmary for "severe LE edema" to both legs over the past two weeks. The doctor noted 3+ edema in both legs and in the penis and scrotum and started Lasix and ordered CBC, CMP and elevation of the leg and a Foley catheter. The patient was now unable to walk. The provider failed to include in the history that the patient had weight loss, and recent fevers. The doctor noted that the patient had recently diagnosed colon cancer but did not apparently associate the colon cancer with the edema. The doctor provided only symptomatic treatment of the edema without making a diagnosis. It did not appear that the doctor reviewed the hospital record.

8/3/2017 A nurse noted that the Foley catheter could not be placed due to penile edema. The doctor was also unable to insert the Foley catheter but was able to insert a straight catheter. Ultimately, doctor and nurse gave up and gave the patient a urinal.

8/4/2017 The patient vomited approximately 100 CC of yellow bilious vomit with bloody streaks. The nurse called a doctor who advised to send the patient to a hospital.

8/4/2017 A chest and abdominal x-ray showed basilar atelectasis and gas overlying the rectum.

1, 2,3 Starting a Foley catheter without indication can lead to infection. It was not made clear that the penile edema was causing difficulty urinating. As well, the doctor failed to associate the colon cancer recently identified and the edema. The doctor was treating the patient without having a diagnosis for a potentially life-threatening problem. This failure placed the patient at risk of harm. Care was grossly and flagrantly unacceptable.

Patient #1

8/7/2017 A therapeutic paracentesis was performed at Carle Clinic. 6 liters of serosanguinous fluid was drained. A PET scan showed metastatic involvement of right lower abdomen involvement with adjacent lymph nodes, liver involvement with central necrosis.

8/7/2017 A hospital note documented that the patient was admitted for severe ascites, nausea, vomiting and abdominal pain with malnutrition and hypoalbuminemia. The assessment was noncurable metastatic colon cancer. The colorectal surgeon was consulted as was an oncologist. Palliative surgery was suggested but because of malnutrition, he was a surgical risk. He had ascites from the low albumin from malnutrition.

8/17/2017 There were no further notes we could locate. But the patient was listed as dying on 8/17/17 of metastatic colon cancer. There was no death summary or autopsy.

Patient #2

8/26/2015 A letter to a nurse at the Stephenson County Jail in Freeport Illinois from a Pediatric Cardiologist from UI @ Peoria in Rockford IL stating that the patient had repair of Tetralogy of Fallot during childhood and had residual defects. A case conference recommended that he obtain a magnetic resonance angiography of the heart and pulmonary vessels at St. Francis Medical Center in Peoria and a Holter monitor. If the studies confirm their impression they would recommend replacement of his pulmonic valve to resolve his severe pulmonary regurgitation. Next to the inmate's name was written his IDOC number indicating that the IDOC probably had this letter. On the bottom of the letter dated 9/18/15 is a brief note stating "Reviewed PLS schedule tests as recommended." The patient obtained the Holter monitor, but the scheduled MRI was not done as ordered.

This patient had a serious congenital heart disease and his cardiologist was planning to replace his pulmonic valve when the patient became incarcerated.

10/13/2015 The patient had a Holter monitor for a preoperative evaluation at the Children's Hospital. The patient had right bundle branch block. 1509 supraventricular ectopic beats. There were 1.4% premature atrial contractions.

11/5/2015 Intake labs included bilirubin 1.5; ALT 9; AST 25; Alk phos 65; hepatitis C negative; syphilis non-reactive; INR 2.1; an EKG showed NSR with possible left atrial enlargement, right bundle branch block, possible inferior infarct and T wave abnormality-consider lateral ischemia.

Pulmonic regurgitation associated with Tetralogy of Fallot is a diastolic murmur.

11/5/2015 The patient arrived at NRC. A nurse took a history of past cardiac surgery as a child and "pending surgery for leak in heart;" blood clots in the past and currently on coumadin. The patient told the nurse that he was on Plavix since July. The patient was 6 foot tall and weighed 135 pounds.

Patient #2

11/5/2015 A PA saw the patient in NRC for his reception physical examination. The PA noted that the patient had a prior stroke in May of 2015 and was on Plavix but switched to Coumadin and that he had cardiac surgery as a child. The PA did not take a more in depth history but did note that the cardiac surgery was in the 1980s at Swedish American Hospital in Rockford and the CVA was treated at Freeport Memorial Hospital in Freeport IL. The PA documented a systolic murmur II-III/VI. The assessment was history of childhood cardiac surgery, prior stroke, and rule out aortic stenosis. The PA started Coumadin 5 mg and ordered a physician follow up. The PA discussed the case with a doctor who recommended the doctor follow up urgently. The PA did not request old records.

1, 2, 12 The patient was in the midst of a valve replacement due to complications of his pulmonic regurgitation and the PA failed to take an adequate history to uncover this.

11/18/2015 The patient transferred from NRC to Sheridan. The transfer document listed rule out aortic stenosis and post stroke as his two medical conditions. No follow up care or specialty referrals were indicated. The Sheridan nurse scheduled the patient for a routine general medicine clinic and noted that the patient gave a history of having a small valve in his heart with a hole in his heart.

15 The transfer did not include that the patient had pending cardiology work up.

12/3/2015 The patient was scheduled for an MRI at Children's Hospital of Illinois in Peoria.

Patient #2

- 12/10/2015 The patient was seen in chronic care at Sheridan for cardiology clinic. The blood pressure was 118/80, which is normal. The doctor listed warfarin as the only medication. The doctor noted that the patient had childhood cardiac surgery and a prior stroke in 2015 which the doctor wrote was "due to likely embolization of blood clot in heart." The doctor failed to contact the patient's pediatric cardiologist. The doctor failed to obtain a prior record or call the cardiologists. The doctor did write that the history was uncertain and that the patient was not clear on dates. The doctor noted that the patient was supposed to have surgery for balloon valvuloplasty prior to incarceration. On physical examination the doctor documented an irregular heart rhythm with a murmur but did not order a stat EKG. The doctor wrote in the examination space "suspicious for A fib" with aortic stenosis. Despite knowing that the patient was supposed to have surgery, the only plan was to continue warfarin, order a routine EKG, start metoprolol for a year; drew labs, submitted a referral to UIC cardiology and ordered a follow up after the cardiology visit. The indication for metoprolol was not stated. The patient had elevation of blood pressure. Metoprolol is known to increase conduction disorders when they exist and can cause heart block. The patient had known conduction abnormalities due to his pulmonic regurgitation. This unnecessary medication placed the patient at risk of harm. The doctor did not call the patient's cardiologist or continue the plan the patient had prior to incarceration and the doctor made no attempt to find
- 1, 4, 7, 12 The doctor presumed the patient had aortic stenosis with atrial fibrillation without verifying with an EKG or echocardiogram. The doctor should have contacted the patient's cardiologist to determine the status of the patient. Instead, the doctor presumed that the patient was stable. The doctor did not refer the patient to the correct consultant (pediatric cardiothoracic surgeon) which would ultimately delay the surgery. The doctor started metoprolol, a beta blocker, which can increase the potential for conduction disorders in a patient at significant risk for conduction disorders which this patient had as a result of the pulmonic valve disease. This may have been responsible for the patient's death.
- 12/15/2015 A doctor noted that the patient was approved in collegial for UIC cardiology.
- 12/16/2015 Wexford UM approved a cardiology consult at UIC.

Patient #2

12/18/2015 A doctor evaluated the patient for Coumadin clinic. The doctor noted significant cardiac disease. The doctor's heart examination was regular rate and rhythm with no murmur. The doctor noted that the patient had a cardiology appointment in 2-3 weeks.

12/23/2015 The patient was evaluated by a physician after a code 3 [emergency] for sudden onset of mid-sternal chest tightness. The patient had dizziness. An EKG showed RBBB with possible inferior infarct, left atrial enlargement and T wave abnormality consistent with ischemia. The doctor's only examination was documented as "CVS - chest-" implying no findings, yet the patient had a known significant murmur. The doctor assessed angina vs [something illegible]. The doctor ordered ibuprofen and noted that the patient had a UIC appointment in 2-3 weeks.

14 For symptoms consistent with angina in a person with dizziness and a known valvular heart condition and with an EKG suggestive of ischemia, the patient should have been referred to a higher level of care. Instead the patient was not treated with antianginal medication but was noted to have a routine appointment. The care was grossly and flagrantly unacceptable.

Patient #2

1/13/2016 The patient was seen at UIC cardiology. The UIC cardiology fellow did not know what the patient had. The patient had DOE and told the cardiologist that he had two surgeries, one to fix a hole in his heart and the second to correct a dysfunctional valve. The patient didn't know if the valve was stenotic or regurgitant. In May 2015 the patient had a stroke treated at Freeport Memorial hospital. He was started on warfarin. The patient knew his cardiologist (Dr. Foran) at Rockford Children's Hospital. The patient told the cardiologist that he was supposed to have repeat surgery on his valve. The doctor wanted the records from Rockford Children's Hospital and Freeport Memorial hospital and ordered an echocardiogram to evaluate which valve was involved. A four-month follow up was recommended. On the referral form, the cardiology fellow recommended obtaining the records from the prior cardiologist, obtaining an echocardiogram, and to return to the clinic after the echocardiogram.

1/14/2016 A doctor at Sheridan saw the patient after the UIC cardiology visit. The doctor noted that the patient had sinus rhythm at UIC and documented that UIC recommended getting old records and to get echocardiogram. The patient had occasional episodes of dyspnea, palpitations, and presyncope and had irregular rhythm with III/VI systolic murmur. The doctor submitted a referral to UIC for echocardiogram. The doctor did not attempt to get the old medical record or to attempt to find out which cardiologist had cared for the patient.

1/14/2016 A referral to UIC cardiology for follow up was ordered on this date but cancelled on 4/28/16, the day the inmate died.

Patient #2

1/19/2016 A doctor noted that the UIC echocardiogram was approved in collegial review.

1/19/2016 Wexford UM approved an echocardiogram.

2/9/2016 An echocardiogram was done showing normal LV, ejection fraction of 55-60%, diastolic flattening of the septum, mild to moderate enlargement of the right ventricle, moderately reduced RV systolic function and severe pulmonic valve regurgitation with PA systolic pressure not assessed due to inadequate tricuspid insufficiency. An EKG treadmill was recommended to assess exertional capacity and if poor would refer for surgical correction of the pulmonic valve.

2/10/2016 A doctor wrote a note that the patient had congenital heart disease with prior surgery and had a history of stroke with cardiac arrhythmia. The doctor noted that the patient had a pending echocardiogram which had been approved.

10 The doctor did not have the echocardiogram report and failed to note the abnormality.

2/18/2016 A doctor wrote a note without seeing the patient stating he received a communication from a clinical pharmacist regarding a potential drug interaction between Coumadin and ibuprofen. The doctor stopped the ibuprofen and ordered a FU after the echocardiogram at UIC.

10 The doctor did not have the echocardiogram report and failed to note the abnormality. This was a week after the test. The doctor wasn't even aware that the patient had the test already.

2/19/2016 INR was 2.3.

3/7/2016 A doctor wrote a note without seeing the patient, noted that the patient was on Coumadin for anticoagulation because of a congenital heart defect and post stroke. The INR was 2.4. There was no evaluation of the patient. The doctor continued the Coumadin.

10 Almost a month after the echocardiogram, its results were not reviewed. The results, recommending surgery, were unnoticed.

3/21/2016 INR was 3.0.

Patient #2

3/24/2016 A doctor saw the patient and noted that the patient was requesting follow up of his cardiology visit. The doctor noted that the patient had his echocardiogram at UIC but that the report was unavailable. The doctor documented that UIC cardiology would follow up on the results. The patient had irregular rhythm with a II/VI systolic murmur. The doctor made no assessment other than that the patient had a UIC cardiology appointment for follow up of the echocardiogram. The doctor ordered a follow up with UIC and continued the metoprolol. The patient weighed 144 pounds and had a blood pressure of 98/62. The patient asked for a low bunk saying he loses his grip and couldn't pull himself up and has "near falls." The doctor ordered a low bunk but did not address the hypotension, and continued metoprolol.

4/11/2016 INR was 3.6

4/12/2016 A doctor wrote a note without seeing the patient and noted that the patient was on coumadin for a prior stroke secondary to a blood clot in his heart since 12/31/15. The doctor noted the most recent INR on 4/11/16 was 3.6. The doctor held the Coumadin and restarted the next day with an INR in a week.

4/18/2016 INR was 1.9.

4/25/2016 A doctor wrote a brief note without seeing the patient, stating to schedule the patient for cardiology and ordered an EKG ASAP with an addendum to cancel the EKG.

3, 10 The patient had near syncope, low blood pressure, and valvular heart disease yet there was no urgency in the evaluation despite alarming signs (low blood pressure and irregular heart rate). The referral to cardiology was routine. The echocardiogram, which was abnormal, was not obtained. Almost two months after the echocardiogram, the report was not present in the record. The doctor was therefore unaware of the diagnosis or the recommendation for stress test and surgery. Care was grossly and flagrantly unacceptable as the system was indifferent to the patient's serious medical need by not even providing to physicians a critical test (echocardiogram) for almost two months. During the four months in IDOC the diagnosis of the patient or the impending need for valvular heart surgery was unknown to IDOC staff.

Patient #2

4/25/2016 A doctor referred the patient to UIC cardiology for a treadmill test as recommended presumably by the echocardiographer. The doctor did document a note on this date but didn't document review of the echocardiogram.

4/25/2016 A notice of furlough in the medical record indicated that the patient had a cardiology appointment at UIC on 5/3/16.

4/27/2016 Wexford UM approval for exercise stress EKG and Echo at UIC scheduled for 5/3/16. The patient already had the echocardiogram.

4/29/2016 An autopsy was done for the death, which occurred on 4/28/16. The autopsy showed an enlarged heart, there was a patent foramen ovale and no valvular abnormalities. There was minimal atherosclerosis. The diagnoses were pulmonary edema, pulmonary anthracosis, post repair of congenital anomaly, endocardial fibrosis, and patent foramen ovale. The death was determined to be from cardiac arrhythmia.

6/1/2016 These labs were from the wrong patient: total cholesterol 176; TG 94; HDL 61; LDL 96.

Patient #3

- 8/14/2015 The 47 year old patient had reception history at NRC. A nurse documented that the patient had hypertension, and was on Norvasc, aspirin and HCTZ. The BP was 133/87. The provider physical examination included no further history. The doctor said that the patient refused a DRE. The doctor started the patient on his medication. The weight was 200.
- 8/14/2015 Intake labs included a total protein of 8.1; bilirubin of 1.7; hepatitis C was negative. Reactive syphilis titer. The syphilis EIA was unconfirmed. The lab recommended to retest in a month.
- 8/28/2015 The patient was transferred to IRCC. On arrival the BP was 146/80.
- 9/7/2015 AST 90 (10-40); alt 77 (10-50); calcium 9.2; sodium 138.
- 9/16/2015 Total cholesterol 267; TG 132; HDL 32 and LDL 209, hemoglobin was 14.1.
- 9/23/2015 At chronic care clinic the doctor noted that the patient had cholesterol of 267; TG 132; HDL 32; and LDL of 204. The doctor ordered zocor and continued HCTZ, Norvasc, aspirin. The weight was 200 pounds.
- 12/30/2015 A nurse saw the patient for back pain. The blood pressure was 148/90. There was no referral.
- 2/9/2016 The bilirubin was 0.7; total protein 7.3; total cholesterol 232; TG 97; HDL 38; and LDL 175.
- 6 There was no follow up of these abnormal tests. Care failed to follow generally accepted guidelines.
- 4 The patient had a 10-year cardiovascular risk of 9.7% and should have been placed on a moderate to high intensity statin. Instead, the doctor ordered a low intensity statin, which the patient never received. Over the following two years, no one recognized that he wasn't receiving the statin medication.

Patient #3

3/17/2016 An NP saw the patient for HTN chronic clinic. The patient was on HCTZ, Norvasc, and aspirin. The NP did not mention Zocor. The weight was 205. The NP documented that the inmate wanted to try lifestyle modification instead of using a statin drug, although zocor had already been prescribed in 2015.

4/14/2016 The patient asked about his medications. The blood pressure was 140/90.

7/25/2016 The patient saw an RN and asked to see the NP because he had headaches on and off with "pressure behind his eye" leading him to take the Norvasc twice a day instead of once. The BP was 128/80. The nurse took no action and charged the patient \$5.

8/16/2016 Bilirubin 1.1; potassium 3.3; total protein 7.3.

9/19/2016 An NP saw the patient at IRCC for HTN. The weight was 200 pounds. The BP was normal. No changes were made.

2/8/2017 The patient transferred to East Moline CC. The transfer form listed hypertension as his only problem. He was on Norvasc 10, aspirin, HCTZ and KCL.

2/15/2017 Blood glucose 156; bilirubin 1.4; anion gap 13; total cholesterol 216; TG 132; HDL 38; LDL 152.

2/16/2017 A doctor noted that the blood sugar was 156 so he ordered an A1c and RBS. But the doctor failed to note the elevated bilirubin or cholesterol.

6 The doctor failed to act on elevated bilirubin.

2/27/2017 A1c 5.2 and glucose 100.

3/9/2017 A doctor saw the patient for HTN clinic at EMCC. The weight was 212. BP was 144/84. No changes were made.

5 The blood pressure was elevated but the doctor took no action.

Patient #3

6/6/2017 A nurse saw the patient for upper respiratory symptoms. The patient had headache, cough, and stuffy nose. The temperature was 100.1; pulse 109; and BP 112/60. The nurse gave the patient cold tablets and did not refer.

6/19/2017 The patient saw the nurse for a persistent cough that he had for about 10 days. The temperature was 98.6; pulse 102; BP 126/78. The nurse scheduled a physician visit for the following day.

6/20/2017 A doctor saw the patient for cough and headache. Some of the note was illegible. The pulse was 108 and temperature 99.9 with an oxygen saturation of 94%. Parts of the physical examination were illegible. The doctor did not order follow up.

1, 3 Chronic cough with previous low grade fever should have prompted a better history and evaluation including a chest x-ray. The doctor did not evaluate the TB status of the patient. Care did not follow generally accepted guidelines.

7/18/2017 A nurse saw the patient for headache, sore throat, cough, and runny nose. The pulse was 104, temperature 98.4 and BP 124/86. The nurse advised salt water gargles but did not refer to a provider.

8/1/2017 A nurse saw the patient for cough, chest pain and cold sweats. The temperature was 99.1; pulse 100; and blood pressure of 126/58. The weight was 200. The nurse referred the patient to doctor sick call on 8/3/17.

8/4/2017 A doctor saw the patient and ordered a chest x-ray for the chronic cough. The physical examination was normal. The chest x-ray returned and the doctor diagnosed pneumonia and started azithromycin for five days.

8/4/2017 A chest x-ray showed linear atelectasis in lung bases with no consolidation or heart enlargement.

Patient #3

8/11/2017 A doctor saw the patient for FU. The patient had complained of night sweats and cough. The doctor documented that the x-ray was reported as clear with atelectasis. The doctor assessed cough and cold sweats and ordered a CBC, CMP, ESR with a follow up.

8/16/2017 The hemoglobin was 10.9; with microcytic indices. The ALT was 8 and AST 9 which were both low. The sedimentation rate was 69.

8/18/2017 A doctor didn't see the patient but noted that the hemoglobin was 10.9 with a sedimentation rate of 69. The doctor ordered a RF, ANA, iron panel, ferritin and stool for occult blood x 3 with a follow up.

7, 8 The patient had significant anemia with elevated sedimentation rate. Endoscopy should have been considered and CT scan of the chest and abdomen were indicated because the reason for the elevated sedimentation rate and anemia were not known. FOBT was appropriate.

8/21/2017 The patient refused the stool for occult blood.

8/22/2017 The doctor saw the patient, who refused blood tests and stool tests. The doctor's note was partly illegible. The patient felt the cough was better.

9/6/2017 The sodium was 133; glucose 115; anion gap 122; CO2 was 23.

9/14/2017 A doctor saw the patient for HTN chronic clinic. The patient was on aspirin, zestoretic (combination of lisinopril and HCTZ), and amlodipine. Weight was 191 and BP was 138/66 and pulse 110. The doctor noted cough and weight loss and noted that the patient refused further testing.

10/3/2017 The hemoglobin was 8.9 with microcytic indices. The platelets were 357 and WBC 8.

Patient #3

10/13/2017 A nurse saw the patient for flank pain. The pulse was 109; respiratory rate 24; BP 120/48 and the weight was 181, a 19 pound weight loss. The nurse also saw the patient for upper respiratory symptoms. The patient complained of cough, SOB, yellow phlegm. The patient had PEFr of 325/350/400 with a oxygen saturation of 97%. The nurse referred to a physician that day.

10/13/2017 A doctor saw the patient who said he "can't breathe." The patient had cough and dyspnea on exertion. The doctor noted that the patient had lost about 30 pounds in five months. But the doctor took no history with respect to the weight loss, such as whether he was able to eat, swallow, had diarrhea, constipation, and normal bowel movement or whether he had abdominal or any other pain. The patient permitted a digital rectal examination that was negative for occult blood. The doctor ordered a chest x-ray; CBC, CMP, RF, ANA, TSH, T4, and urine culture and analysis. The doctor placed the patient on the infirmary for 23 hours observation.

1, 7, 8 The doctor took inadequate history. Given symptoms, weight loss, and elevated sedimentation rate, a CT scan of the chest and abdomen were indicated due to a lack of a diagnosis. Endoscopies were still indicated.

10/13/2017 A chest x-ray showed enlarged heart in a globular shape; pericardial effusion could not be excluded.

Patient #3

10/14/2017 A nurse saw the patient on the infirmary and noted that the pulse was 116 with a blood pressure of 132/58. The weight was 179 pounds. The nurse documented talking to the doctor who ordered the patient released from the infirmary with instructions to complete the stool for occult blood. The doctor asked for the laboratory tests for 10/16/17 with FU the same day and to notify staff if any changes occurred. On the same day, a nurse documented one stool was negative for occult blood.

10/16/2017 A doctor saw the patient. The pulse was 107; BP was 122/46 and temperature 98.4. The patient felt better. The doctor took no history. The patient had a 2/6 systolic murmur. The doctor didn't know what the patient had except for iron deficiency anemia. The blood tests had apparently not returned. Given the murmur, further work up (echocardiogram) was indicated. Because the doctor didn't know what the patient had, he should have been admitted to a hospital for evaluation. The doctor started iron supplements and ordered follow up in a week.

10/16/2017 The PSA was 0.1; T4 8.9 (5-12); TSH 1.24 (0.35-4); sedimentation rate 98 (0-10); ANA non-detectable and RF <10.

10/19/2017 The doctor noted that the PSA was 0.1; the TSH, T4, ANA, and RF were all negative. The doctor didn't see the patient but ordered a CBC and CRP.

10/20/2017 The CRP was 43.8 (<8). WBC was 9.6 with hemoglobin 8.3.

14 The patient should have been referred to a hospital. He had possible pericardial effusion, significant weight loss, elevated sedimentation rate, new murmur, and anemia. A stat echocardiogram was indicated. Additional testing CT scans and endoscopies were also indicated as the patient had serious illness and no diagnosis.

Patient #3

- 10/23/2017 The doctor saw the patient. The weight was 178 pounds. The pulse was 119 and temperature 97.3. The only history was the doctor statement that the patient felt fine. The doctor was not tracking any symptoms of the patient. The patient has a systolic murmur and anemia. The doctor noted that the patient had anemia and "possible pericardial effusion," although it wasn't clear how the doctor came to that conclusion. The doctor wanted to admit the patient to an ER but the patient refused.
- 1 The history was poor but the decision to admit to a hospital was appropriate, but the patient refused.
- 11/3/2017 A doctor saw the patient, who had pulse of 118; BP 154/82 and weighed 174 pounds. The only history was that the patient wasn't eating because he had no appetite. The patient had a 3/6 systolic murmur. The patient again refused to go to the ER or have blood work done. A mental health referral was submitted.
- 1 The history was poor but the decision to admit to a hospital was appropriate. This patient should have been sent to a hospital and allowed to refuse at the hospital.
- 11/3/2017 At 10:30 am the patient was diaphoretic with pulse of 114 and BP 80/40. The heart rhythm was irregular.
- 11/3/2017 At 8:17 pm the patient was unresponsive. CPR was initiated. The patient died at 8:20 pm.
- 11/3/2017 The death certificate documented that an autopsy was not done.

Patient #4

5/27/2016 The patient had his NRC history. The patient had prior pelvis surgery after a motorcycle accident in 1992. The patient had no identified problems except for mental health problems.

5/27/2016 A psychiatrist note documented that the patient was on Depakote, Risperdal, and Remeron.

5/27/2016 The creatinine was 1.51; the other components of the metabolic panel were normal.

6/8/2016 Total cholesterol 164; TG 151; HDL 41; LDL 93. CBC was normal.

6/13/2016 The patient was transferred to BMR.

11/15/2016 The patient had reception history but the location wasn't documented. The patient had no problems identified except for mental illness. This was an apparent re-incarceration.

11/15/2016 CMP was normal. Creatinine was 1.22 (0.5-1.5).

11/17/2016 The patient had a reception physical examination. No additional medical history was taken except for drug use. The patient had no medical problems identified except for mental health with a prior suicide attempt.

11/29/2016 The patient transferred from NRC to EMCC. The patient was on Remeron.

12/2/2016 Total cholesterol 196; TG 100; HDL 43; LDL 133.

Patient #4

3/22/2017 A nurse assisted the patient at 4:23 pm. He said he was dizzy and had just collapsed. The patient was responsive to questions. The nurse didn't take the patient's vital signs and noted that the patient was able to respond. While the nurse started to take vital signs the patient began seizing. The patient had foam coming out of his mouth and the nurse turned the patient on his side. The patient became combative and seized again. The patient was again rolled on his side. The nurse told custody to call an ambulance. The patient then said he couldn't breathe and oxygen was initiated. The BP was 80/40; pulse 82 and respirations 24 and saturation 90%. The patient tried to remove the oxygen mask when paramedics arrived and the patient again began seizing. The nurse checked for a pulse but could not obtain one so medics began CPR and continued until the patient left for the hospital. There was no timeline for the terminal event.

3/23/2017 A death summary noted that the patient died on 3/22/17 at a hospital. The patient suddenly collapsed, got up, then collapsed again, going into seizure like activity. CPR was initiated after the ambulance arrived but the patient was pulseless. The patient was pronounced dead at the hospital.

3/24/2017 The autopsy showed large bilateral pulmonary emboli with pulmonary congestion. Death was due to pulmonary emboli.

Patient #5

8/8/2017 A nurse completed a reception history. The reception form is defective. It has only a few diseases and nurses do not record problems in the explanation section and only list problems in the assessment. The age of the inmate was not on the form. The CBG was 148. The only history boxes checked were for cardiac. The patient was noted to be on metformin and glargine but the diabetes box wasn't checked. The nurse gave no explanation of his cardiac/HTN problem. In the surgery section, the nurse noted that the patient had history of unspecified open heart surgery in 2012 and had a stent "L side" (it wasn't clear what this meant). In the assessment the nurse documented IDDM, sleep apnea, and glaucoma but did not state what his heart condition was. The patient weighed 220 pounds yet the nurse listed the patient as an IDDM, which did not appear accurate. The patient most likely had type 2 diabetes. The blood pressure was 119/67. The nurse noted that the patient was oriented x 3. This was a very poor history. The nurse made no entries commenting on any alteration of mental status.

- 1 The history was inadequate as it did not identify all of the patient's problems.

Patient #5

8/8/2017 A doctor performed the reception physical examination. The doctor took no history and given the lack of nursing history, the patient ultimately receive inadequate history. The doctor recorded a totally normal examination, mostly checking boxes as normal. The doctor did not assess mental status. The assessment was IDDM, HTN [illegible but looks like HTN], CAD with open heart surgery for unspecified reasons in 2013; post stent placement; glaucoma; asthma; sleep apnea; umbilical hernia. The doctor started a number of medications but they were illegible. The MAR documented that the patient received KOP meds including Ventolin, oxybutynin, folate, omeprazole, atorvastatin, hydralazine, and Brilinta. On a different MAR the patient was started on NPH insulin 14 units BID with a sliding scale regular insulin. The MAR includes eight refusals over a 13 day period for the NPH. The regular insulin was only given twice a day (to accommodate custody) and the patient refused seven times. The reasons for use of oxybutynin was not documented in the record and none of the listed problems were an indication for oxybutynin. The reason for the Brilinta was also unclear. It wasn't clear that the patient had a STEMI in the past, which is an indication for Brilinta. It is clear that the patient was on this medication because of prior stent placement or possibly CABG. This was an extremely poor history and assessment, as it wasn't clear why the patient was using some of his medications.

1, 3 The doctor took an inadequate history of the patient's conditions and did not develop an adequate treatment plan for the patient's problems. Specifically, the doctor documented medication (oxybutynin and Brilinta) without an indication. The doctor modified an established treatment plan (diabetes) without appropriate documentation of the reason for the change or discussing the change with the patient. Care failed to follow generally accepted guidelines or usual practice.

Patient #5

- 8/8/2017 A doctor different than the one who performed the physical examination ordered Coreg, Norvasc, Zestril, hydralazine, atorvastatin folate, and aspirin. A month supply of aspirin, Coreg, Norvasc and Zestril were given to the patient but these were not documented on the MAR.
- 8/8/2017 BUN was 26 (6-20); creatinine 1.79 (0.5-1.5); these abnormal tests were not evaluated at NRC.
- 8/22/2017 The patient wasn't seen again at NRC and on 8/22/17 at 8 pm the patient transferred to EMCC. The problems listed on the transfer sheet included IDDM, HTN, CAD, glaucoma, and asthma. The patient was listed as being on albuterol, NPH and regular insulin, atorvastatin, latanoprost, ticagrelor and an illegible eyedrop, Coreg, Norvasc, Zestril, metformin, oxybutynin. The blood pressure was 150/an illegible number. The patient was referred to chronic care.
- 8/22/2017 At 8:30 pm a nurse documented that the patient was placed overnight in the HCU because the patient was confused. The patient answered questions with "obscure answers" and was unable to walk to the health care unit by himself. The nurse wrote he was "very confused on where he is and why." The medication that was issued as KOP were removed from his control for his safety. The nurse didn't call a physician.
- 8/23/2017 At 4:40 am the patient refused to have an AccuChek and refused his insulin. The nurse referred the matter to the HCUA and DON but did not call the doctor. The nurse returned later and the inmate accepted insulin.
- 6 The doctor did not follow up on this abnormal lab result indicating renal disease which was not a current patient problem.
- 14, 16 A new diagnosis of confusion in a patient without any condition that includes confusion as a symptom should have resulted in an immediate consultation with a physician and referral to a hospital for evaluation.

Patient #5

8/23/2017 A doctor saw the patient. The temperature was 97.5; pulse 53; BP 140/74, and oxygen saturation 99%. The doctor noted that the patient was 75 years old with a history of DM, CAD, sleep apnea, asthma/COPD, glaucoma, GERD, HTN. The doctor noted that the patient used to use a CPAP machine but hadn't use one for two weeks. The doctor noted that the patient had been confused for the past week but took no other history of this problem. The doctor documented that the patient used albuterol twice a week. There was no other history remarkably. On examination the doctor documented that the patient was somewhat forgetful and documented the patient was "A + O" presumably meaning alert and oriented but the doctor didn't perform a mental status examination. The doctor did not perform a neurological examination, examine the cranial nerves or an in depth mental status assessment. The doctor assessed asthma/COPD, HBP, CAD, glaucoma, DM, and OSA, and ignored the confusion. There was no history, physical examination, or evaluation for the recent onset of confusion. The doctor housed the patient in the health care unit without ordering any diagnostic testing.

1, 2, 8, 14 The patient had relatively new onset of confusion. The doctor failed to take adequate history or perform adequate examination. The patient should have been referred for diagnostic testing including possible CT scan, and prompt laboratory testing including for toxicology. This did not occur for five days. Care failed to follow generally accepted guidelines.

8/28/2017 BUN 23 (6-20); B12 283 (181-914); creatinine 1.53 (0.5-1.5); A1c 6.4; cholesterol 122; TG 97; HDL 33; LDL 70; T3 (80-178); hemoglobin 11.2 (13.2-18).

Patient #5

- 9/2/2017 A nurse wrote that the inmate was bleeding from his mouth. The patient had a laceration of the left side of his tongue. There was a flap still attached with gross swelling. The inmate was unable to speak secondary to the swelling. The patient was unable to swallow. The nurse wrote "confusion present as normal for inmate." The patient was sent to an ER. On 9/2/17 the facility was notified that the patient died.
- 9/2/2017 A nurse wrote an incident report documenting that the patient bit his tongue and that it was lacerated and swollen with gross bleeding. There was no evidence of assault. The patient had difficulty swallowing.
- 9/2/2017 A nursing progress note from the hospital documented that the patient was able to state his name and birthdate but that it was difficult to understand what the patient was saying. The BP was 160/90 with pulse between 90-100. Photos were taken of the swollen tongue and lips. The doctor attempted to intubate the patient but was unable to visualize the vocal cords. The patient suddenly stopped breathing. An ICU doctor assessed that the patient had ACE related angioedema.
- 9/2/2017 Unfortunately, there was no autopsy for this patient. The recent new onset of confusion is troubling and was not thoroughly worked up with history, physical examination, or CT scan. It is not clear if this contributed to the patient's death.
- 9/5/2017 The death summary documented that the patient was on the medical unit and developed a swollen tongue for which he was sent to the hospital, where he died suspected of having angioedema from lisinopril.

Patient #6

1/6/2016 A doctor wrote a brief note noting that the patient had multiple scratches on the skin from the inmate scratching herself. The doctor wrote an order to schedule the inmate to come to clinic Tuesday for a femoral phlebotomy that he would perform. There was no evaluation of the inmate. The doctor re-ordered minerin creme.

1/8/2016 Hemoglobin 11.1; platelets 91.

This patient had likely cirrhosis and should have had screening endoscopy and screening for hepatocellular carcinoma on a semi-annual basis.

1/9/2016 INR 1.4.

1/11/2016 A1c 7.6.

1/20/2016 Optometry exam for retinopathy.

2/3/2016 The patient complained bitterly about her treatment. She said that she had the skin problem for months and "I already done the cream you put up inside you once and I have had this problem for months and no one will do anything about it... I have been complaining about it for months and I come over here and pay and nothing gets done." Apparently the patient was going to the HCU for her skin cream.

Patient #6

2/9/2016 A doctor noted that the patient had back "boils." The patient was asking for pain medication. The patient had a raised indurated area on her back with scarring from previous lesions. The doctor noted that the patient could stand and sit without difficulty. There was no other examination. The doctor assessed a "back boil with a few smaller indurated red spots in a diabetic patient." The doctor started minocycline. There was no follow up ordered. The doctor failed to evaluate recent laboratory results indicating that the patient had cirrhosis and anemia.

1, 2, 3 The doctor did not take an adequate history or establish a coherent treatment plan for the rash. The doctor had not established a diagnosis for the problem. With respect to the skin disorder, without a diagnosis, the doctor should have referred to a dermatologist. The patient had cirrhosis but the doctor did not refer for an EGD to screen for varices or an ultrasound to screen for hepatocellular carcinoma. These screening tests are recommended for persons with cirrhosis. Those patients with varices are recommended to start a beta blocker to prevent variceal bleeding. Care failed to follow generally accepted guidelines as the doctor had been trying various creams without effect.

2/12/2016 A nurse noted that the patient had a rash that was unchanged with multiple sores in various stages of healing with no active drainage but with bloody spots on her shirt. Her clothes appeared filthy and had odor and the inmate was unkempt.

Patient #6

2/26/2016 Albumin 2.4; bilirubin 2.8; alk phos 429; AST 116; ALT 57; hemoglobin 12; platelets 96; total cholesterol 54 (100-200); TG 89; HDL 10; LDL 26 (50-129).

These labs were not followed up. The APRI score was 3.021 indicating likely cirrhosis. The patient had a significantly elevated alkaline phosphatase and it wasn't clear if this was due to liver or gall bladder disease. The cholesterol levels were so low as to be of concern. This may have been due to malabsorption, malignancy, chronic infection, or severe illness. Yet none of these abnormalities were evaluated. The liver functions yielded fibrosis scores that warranted hepatitis C treatment but there was no evidence of referral to UIC for evaluation for treatment. This care failed to follow generally accepted guidelines or usual practice.

Patient #6

- 3/3/2016 A doctor saw the patient in hypertension chronic clinic. The blood pressure was 117/77; weight 139 pounds; pulse 98. The doctor took no history. Problems listed included cirrhosis, chronic hepatitis C, diabetes, weight loss, HTN, amenorrhea, and dermatitis. The only medications listed included lisinopril and NPH and regular insulin and minerin cream. Compliance was listed as poor without any explanation. The "pulses" were listed as "wnl." The entire examination was "lungs wnl, heart wnl and edema none; fundoscopy not seen; others multiple spots from dermatitis and micro infected sites- just finished antibiotics; BMI 24." The patient was listed as in good control. The doctor started minocycline apparently for the infected dermatitis. The doctor took no history of the skin problem, no history of the cirrhosis. No labs were evaluated. The diabetes and cirrhosis were not addressed. The hepatitis C was not addressed and it wasn't clear if the patient was treated despite the patient having advanced fibrosis qualifying for treatment. Recent blood tests were not reviewed.
- 1, 6, 7 The doctor did not act on the recent laboratory tests which had significant abnormalities. This included not taking an adequate history or making an appropriate diagnosis or acting on abnormal lab results. Because of the history of cirrhosis the patient should have had an EGD to screen for varices, liver ultrasound to screen for HCC, which were not done. Because of the elevated alkaline phosphatase the patient should have had evaluation of the gallbladder and pancreas by ultrasound or CT scan. The care failed to follow generally accepted guidelines.
- 3/16/2016 A doctor wrote a note that the patient had diarrhea while on an antibiotic. The doctor took no history and wrote that the patient was not seen. The doctor ordered stool for ova and parasites and for c difficile.
- 1 The doctor took action based on anecdote and did not take a history of the patient. It wasn't clear how the doctor obtained the information that led to the change in therapy. The doctor did not inform the patient of the change in therapy.

Patient #6

3/23/2016 A doctor saw the patient in hypertension chronic clinic. The blood pressure was 122/79 and pulse 102. The patient said that she had loose stools from the antibiotic. The doctor took no other history. The examination was brief and consisted of the lungs being "wnl" fundoscopy "not see" and edema "non" with a note "BM was solid light brown and difficult to produce...C dif is not a consideration." The doctor's assessment in its entirety is given verbatim with formatting and spelling mistakes included "Bp is good control and IM stopped taking the minocycline stating trthat someonetold her she might have C. Diff. stool collections set were for ova and parasites and cdiff was not formulary and md wanted to see a specimen today which did not remotely resemble a c diff stool nor did th patient history so no specail non formulary will be done to look for c diffe. the IM was told to restart the minocycline but her skin lesions have improved already so if she refuses again there wil be no further orders for this at this time." This assessment was not coherent. This assessment does not include evaluation of the patient's diabetes, cirrhosis, or hepatitis C. There was no examination of the patient's skin. The patient was documented as having no edema. The doctor noted that the stool was solid light brown inconsistent with C difficile. The doctor did not address any of the patient's other problems.

4 Based on the documented note, it appeared that the physician either has a typing problem or was incoherent for a different unexplained reason. The therapeutic plan was not competently described.

4/1/2016 A1c 6.8.

Patient #6

- 4/7/2016 A doctor saw the patient for diabetes chronic clinic. The pulse was 109 and blood pressure 120/82. The weight was 138 pounds. The problems listed included a number of symptoms which were not problems including "screening for depression," "pruritis," and other events which were not problems, including "well woman examination." Other listed problems were unqualified items such as "loss of weight" and "Np boils." The boxes hypo/hyperglycemia were checked both yes and no without explanation. There was no history for any of the patient's medical conditions. The A1c was 6.8. The examination documented multiple hyperpigmented areas from scratching without open lesions. The fundus was not examined. The remaining examinations were documented as "wnl." Aside from the A1c, no laboratory values were addressed including for blood lipids or liver function tests. The doctor did not address the hepatitis C, cirrhosis, the skin disorder, and ordered a four-month follow up. The doctor noted that the patient had annual diabetic eye screening in January of 2016. The doctor did not address the fast pulse.
- 1, 2, 6, 12 The doctor again documented skin lesions but took no history, performed inadequate examination, and made no attempt to diagnose or establish a thorough therapeutic plan. The doctor failed to address the patient's other problems. The care failed to follow accepted guidelines, as an undiagnosed skin lesion would normally be referred to a dermatologist. The lack of history was striking and also fails to follow usual practice. The doctor did not evaluate CBG test results which were not available or not done.
- 4/9/2016 A nurse saw the patient two days after the chronic care visit of 4/7/16. The vital signs of the nurse were identical to the vital signs on the chronic care visit and it appeared that the vital signs defaulted from the prior note. This is improper, as it does not represent an honest representation of what occurred. The identical vital signs were documented on a 4/10/16 nursing note; a 4/12/16 nursing note; a 4/13/16 nursing note; a 4/17/16 nursing note; and a 4/18/16 nursing note.
- This is a problem in that the medical record permits false vital signs to be incorporated into the medical record.
- 4/19/2016 A nurse saw the patient for a progress note. The vitals recorded at this visit were identical to vital signs used on the subsequent note of 4/20/16.
- 5/13/2016 INR 1.4.

Patient #6

5/13/2016 Bilirubin 1.7; BUN 9; glucose 57 (65-110); albumin 2.5; bilirubin 2.8; alk phos 445; AST 123 (10-40); ALT 69 (10-50). Hemoglobin 12.6 (11.7-16) platelets 78 (150-450).

These labs were mostly abnormal. The low blood glucose was significant, as hypoglycemia occurs frequently in liver disease. Since this patient had cirrhosis, the hypoglycemia should have prompted reduction of insulin so that her glucose was above 65. Failure to do this can result in significant hypoglycemia. The abnormal liver function tests demonstrated cirrhosis and the patient should have been treated for hepatitis C but was not. The patient should also have been screened for varices and HCC but was not. The care failed to follow generally accepted guidelines or usual practice.

Patient #6

5/31/2016 A doctor saw the patient because she had "sores" over her body and had pruritis and that the hydroxyzine helped. The doctor took no history of the patient's condition. The only examination was that the patient was oriented, walked and stood without difficulty, and had many hyperpigmented spots mixed with open sores. The assessment was patchy eczema which the doctor attributed to the advanced liver disease. The doctor also documented that the diabetes could be contributing "some yeast component. a mixed dermatitis." The doctor documented he would evaluate the patient "next month" in hepatitis C clinic and ordered hydroxyzine, hydrocortisone cream, and athlete foot cream presumably all for the skin condition. Patient had a pruritic diffuse skin condition which apparently resulted in scratching and excoriations. Whether this was due to her liver condition or to psoriasis, which the coroner surmised, is unclear. But she did not have adequate evaluation for the condition. The doctor did not competently evaluate the skin condition and did not refer to a dermatologist. The doctor also did not evaluate recent abnormal labs.

6/9/2016 A doctor wrote a note to renew a low concentrated sweet diet for six months. The doctor did not see the patient. Vital signs for this visit were identical to a 6/7/16 nurse note.

1, 2, 6, 12 The patient was not responding to treatment and the doctor was not obtaining appropriate history, performing adequate examination, or making apparent adequate diagnoses. The patient should have been referred to a dermatologist but was not. The doctor also did not act on abnormal laboratory results recently obtained which should have resulted in radiologic studies of the upper abdomen. The care failed to follow generally accepted guidelines or usual practice.

Patient #6

6/21/2016 A doctor saw the patient for hepatitis C clinic. The doctor did not document whether the patient had received hepatitis B or A vaccines. The only examination was to document multiple laboratory values without dates. The doctor performed no examination, listed labs without dates, and concluded that the patient had advanced cirrhosis. His comment about treatment was "advanced cirrhosis in a patient with other unstable issues (DM) and who was consistently noncompliant during her sentence and is not stable with her itching dermatitis has not been a candidate for treatment prior and shows little interest in treatment even as i try to talk to her today about follow up at Stroger." The doctor wrote Harvoni on a piece of paper and gave it to her and told her to ask Fantus clinic to treat her for her hepatitis C. The doctor documented that the patient was to be discharged in three months. The doctor stated that the patient was more interested in cream for her dermatitis. The doctor performed no examination, did not assess for edema, did not order typical studies for someone with cirrhosis including ultrasound of the liver to screen for HCC, EGD, use of beta blocker for variceal control, or assessment of complications of cirrhosis. The doctor documented that the patient was not a candidate for Interferon-Ribavirin but gave no reason even though the electronic form requested a reason.

1, 2,5,7, 8 The patient had cirrhosis and needed hepatitis C treatment but was not referred; apparently because of discharge within a year. A refusal was not evident. There was no documentation that treatment was discussed with the patient. The doctor documented that the patient was non-compliant but it wasn't clear what the patient was non-compliant with. As well, the patient had cirrhosis but was not referred for EGD, HCC screening, and did not have a beta blocker started as prevention for varices. The doctor seemed unprofessional. The patient was upset with a persistent skin condition for which there was no clear diagnosis. The doctor took inadequate history, failed to examine the patient or make an adequate assessment of the skin condition, failed to act on laboratory values indicative of cirrhosis, failed to order EGD, and failed to order screening ultrasound for hepatocellular carcinoma. The care failed to follow generally accepted guidelines or usual practice.

Patient #6

7/18/2016 A doctor saw the patient for her skin rash. The doctor noted that the patient was to parole in 1-2 months and had a chronic rash being treated with steroids. The main problem was a chalazion of the left eyelid. The doctor noted an extensive rash over the trunk "likely eczema" and diagnosed "chronic rash" and prescribed hydrocortisone cream, minerin cream, and hydroxyzine.

12 The patient had rash for at least over seven months with resolution. The doctor was not successful in treating the patient yet continued the same care that wasn't working. He failed to establish an adequate treatment plan as the plan being used was not working. The patient should have been referred to a dermatologist. Care failed to follow generally accepted guidelines or usual practice.

7/29/2016 A1c 5.9.

This A1c was normal but for this person indicated that the patient was possibly being overtreated due to complications of her liver disease. The insulin doses should have been decreased.

8/10/2016 A doctor saw the patient for diabetes chronic clinic. The doctor noted an A1c of 5.9 with no date and noted hypoglycemia 1-2 times per month. There was no history except to document hypoglycemia. The only examination was to state that the patient was alert, had normal pulses and had clear lungs. The patient was documented as in good control. The patient had an A1c of 6.8 at the prior diabetes clinic now at 5.9 and had cirrhosis. The doctor did not express concern that the cirrhosis was affecting the diabetes and did not consider lowering the insulin dosages especially since the patient was experiencing hypoglycemia. The doctor did not review CBG results.

1, 4, 6 The history of hypoglycemia with an A1c of 5.9 warranted decreasing the insulin doses as the patient's cirrhosis (liver failure) was apparently making the patient hypoglycemic. The doctor failed to review any CBG results. The doctor failed to take adequate history. Care failed to follow generally accepted guidelines or usual practice. This placed the patient at risk of harm including mortality.

Patient #6

8/23/2016 At 5:20 pm a nurse evaluated the patient who had malaise and fever and was not feeling good. The temperature was 101.8; pulse 120; and BP 88/50. The nurse noted periorbital swelling such that the patient was unable to open eyes fully. The nurse called a doctor and received orders to admit the patient to the infirmary, push fluids, give Tylenol, perform a urine dipstick, and start Bactrim after the urine dipstick. The doctor indicated that he would consider labs and a chest x-ray in the morning.	2, 14	This patient had fever, tachycardia, periorbital swelling, and hypotension indicative of sepsis yet the doctor, without evaluating the patient, started oral antibiotics for a presumed infection (urinary tract infection) that had not yet been diagnosed and for which there was no basis. This patient should have been referred to a hospital. The patient was also on lisinopril for hypertension and it should have been discontinued as the patient was hypotensive. Care was grossly and flagrantly unacceptable.
8/23/2016 A nurse wrote an infirmary admission note at 6:53 pm. The patient had abdominal distention and fever.	16	The nurse should have consulted a physician because of the additional component of abdominal distention.
8/23/2016 At 6:57 pm a nurse documented that the patient had fever of 100.7; pulse 112; and BP 88/58.	16	The nurse should have consulted a physician. The patient appeared to be in septic shock.
8/23/2016 At 9:00 pm a nurse noted that the pulse was 96 and BP 94/56.	16	The nurse should have consulted a physician. The patient appeared to be in septic shock.
8/23/2016 At 11:34 pm a nurse documented the patient complaint that "I just don't feel good at all." The BP was 88/52 and the nurse documented a distended abdomen and abdominal pain.	16	The nurse should have consulted a physician. The patient appeared to be in septic shock.
8/24/2016 At 1:48 am a nurse documented moderate periorbital swelling.		

Patient #6

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| <p>8/24/2016 A doctor documented an infirmity admission note documenting that the patient had fever, malaise, and right upper quadrant pain. The doctor documented a moderately distended abdomen tender in the RUQ without rebound. The doctor diagnosed advancing liver failure. The doctor did not review any labs including the elevated alkaline phosphatase previously recorded. The doctor ordered a CMP and CBC for a PM pickup. The doctor diagnosed fever without any other assessment.</p> | <p>5, 14 The doctor now knew that the patient had fever and right upper quadrant pain with hypotension. Immediate hospitalization was indicated. Instead the doctor ordered labs that would not be available until the next day. Care was grossly and flagrantly unacceptable.</p> |
| <p>8/24/2016 BUN 13; creatinine 1.38; albumin 1.9; bilirubin 4.4; alkaline phosphatase 376; AST 78; and Alt 37. WBC 14.7; hemoglobin 10.9 and platelets 67.</p> | <p>Because of the patient's complaint of right upper quadrant pain with fever these labs indicate infection, blood loss, and possible biliary obstruction, which is a life-threatening. These labs should have been immediately addressed.</p> |
| <p>8/25/2016 At 3:06 pm a nurse documented a temperature of 98.6, pulse 92 and BP 94/56. The patient apparently was transferred to DMH ER.</p> | |
| <p>8/25/2016 At 3:13 pm a doctor wrote a referral to a local hospital ER documenting that the albumin was 1.9; alkaline phosphatase was 376; ALT 37; AST 78; bilirubin 4.4. The doctor was unable to get access for IV fluids and the patient's blood pressure was dropping to 60 systolic. The doctor sent the patient to the hospital for hypotension. Notably the patient's ALT was 56 and AST 99 with a bilirubin of 2.2 in November of 2015. She should have been treated for hepatitis C at that point but apparently was not.</p> | <p>This was a significant delay in referral to an ER. The patient was sent to an ER two days after developing fever, abdominal pain, and hypotension. Care was grossly and flagrantly unacceptable. The patient went to the ER but there was no hospital report in the record.</p> |
| <p>8/27/2016 The patient had returned from the hospital but there was no report. It wasn't clear what the status of the patient was; this was dangerous. At 5:35 am a nurse documented no temperature but a pulse of 115 and BP of 72/48. The nurse didn't refer to a physician.</p> | <p>16, 18 The nurse should have consulted a physician as the patient was hypotensive. This was dangerous and placed the patient at significant risk of harm.</p> |

Patient #6

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| <p>8/27/2016 At 1:32 am a nurse documented that the patient vomited more than 300 cc of reddish brown emesis. The blood pressure was 78/52 but other vitals were not taken. The nurse did not contact a physician.</p> | <p>16 The patient with cirrhosis had apparent bloody emesis with hypotension but the nurse did not call a physician. This was dangerous and placed the patient at significant risk of harm.</p> |
| <p>8/27/2016 At 2:20 am a nurse documented pulse of 110 and BP of 75/48 and noted that the patient vomited more than 500 cc of dark red color emesis. The nurse documented calling the physician. But received no orders except to "CPM" [continue present management].</p> | <p>14 The patient was in shock and had bloody emesis yet the doctor did not send the patient to a hospital. Care was grossly and flagrantly unacceptable.</p> |
| <p>8/27/2016 At 2:51 am a nurse documented that the patient had a large amount of bloody emesis of approximately 300 cc. The blood pressure was 75/48 and pulse 110. The nurse assessed "throat cancer."</p> | <p>16 The nurse made an inaccurate assessment but bloody vomiting with shock needs to be referred to a physician. This was dangerous and placed the patient at significant risk of harm.</p> |
| <p>8/27/2016 At 3:58 am a nurse documented that the patient had a fourth bloody emesis "this shift." The nurse called the doctor who asked to be called if the patient vomited blood again. The vital signs of pulse 115 and BP 72/48 were identical to prior other nursing encounters on this night.</p> | <p>14 The patient was in shock and had bloody emesis yet the doctor did not send the patient to a hospital. Care was grossly and flagrantly unacceptable.</p> |

Patient #6

8/27/2016 At 5:28 am a doctor at DCC wrote a referral to the ER stating that the patient had advanced liver disease with esophageal varices and DM and was recently sent to the ER on 8/25/16. The patient was vomiting frank dark blood. The patient was hypotensive and the doctor documented he asked the patient if she wished a living will DNR. The doctor documented that the patient was oriented x 3 and declined. The patient was then sent to the hospital. The document that the patient signed had a signature that was disorganized and unlike her prior signatures. Given that the patient was in shock, it is not appropriate to obtain consent for no intervention unless the patient is coherent. This consent was questionably obtained.

This transfer was significantly delayed.

8/27/2016 At 8:48 am a note was entered stating that at 6:15 am the patient left by ambulance to the hospital.

8/27/2016 The patient asked for morphine instead of being sent out to the hospital.

8/27/2016 At 6:02 am the doctor wrote a brief note. The patient's vital signs were 72/48 with pulse of 115. The doctor noted that the patient signed a living will "tonight" and was vomiting blood and needed sclerosing of her varices and sent the patient to the ER.

Patient #6

8/27/2016 The patient was sent to the hospital. According to hospital records the patient was sent to the hospital to evaluate for end-of-life care to be placed in hospice. The hospital noted that the patient had a history of psoriasis, hepatitis C, DM, and HTN and had "continued" swelling and ascites. The hospital physician documented that the facility physician told the hospital that the patient was DNR with a living will. The facility physician documented that the patient would accept morphine and fluids but no invasive procedures. The history was limited given the condition of the patient. The patient was initially alert but became obtunded. The hemoglobin was 6.2 and INR 3.4. The hospital record documented that the patient had been in the hospital two days previous. The hospital noted that two days ago the patient was seen in the ER with RUG pain and diarrhea. A CT scan showed cirrhosis, hydrops GB with cholelithiasis and cholecystitis, but surgery said the risk of surgery was too great and the patient was sent back to DCC for comfort measures. At the current ER visit the hospital doctors talked to the DCC physician who clarified the full supportive measures should be attempted unless she codes because she was DNR, DNI. The patient had vomited blood several times at the facility since Tuesday. The patient needed levophed at the hospital to sustain blood pressure. The blood pressure was 47/22 with pulse of 110. The patient had ascites. The patient was arousable and oriented to person place and time. The patient was deemed to have cirrhosis with hypotension and was DNR. The doctor at the hospital documented that the patient had a living will at DCC and was DNR. This was discussed with the physician at DCC. The patient died at 12:55 in the hospital without interventions except fluids. The hemoglobin in the hospital was 6.3 with a WBC of 16.

At this point and even two days previous the patient had such end-stage liver disease that interventions were unlikely to significantly prolong life. However, earlier interventions including treatment of hepatitis C and particularly screening for varices (which is indicated for persons with cirrhosis) should have been done and may have prolonged her life. In this respect her death was possibly preventable.

8/27/2016 The patient signed a living will but the signature is so disorganized and different from other signatures of the patient that it does not appear that she was capable of physically signing at the time of signature. Whether she was of sound mind is not clear as she was in shock. The will was cosigned by a nurse and a doctor.

This appears to be an inadequately obtained informed consent. The patient should have been treated but was not.

Patient #6

8/28/2017 Autopsy showed that the patient experienced a gastrointestinal bleed filling the stomach. The patient also had evidence of end-stage cirrhosis, ascites, pulmonary edema, congestion of the spleen, cerebral edema, anasarca, diffuse psoriasis, history of HIV, and diabetes. The patient was said to have died from a ruptured esophageal varices.

Patient #7

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| <p>9/30/2003 The patient had increased liver enzymes documented on the problem list without more specificity. The patient also had a history of obesity, alcohol abuse, peptic ulcer disease, and sickle cell trait.</p> | <p>3 The patient had a history of alcoholism and elevated liver functions documented but these were not followed up regularly and this problem was lost to follow up. Care failed to follow generally accepted guidelines or usual practice.</p> |
| <p>7/16/2014 An NP saw the patient for an annual evaluation. The weight was 262 pounds. The patient was 49 years old. The NP noted problems as high blood lipids and HTN and noted that the patient had elevated liver function tests but wasn't more specific. The NP did note alcoholism. The patient was noted to be deaf. The NP documented that the patient voiced no problems but the patient couldn't hear and it wasn't clear how a history was taken. The patient did not have investigation regarding the elevated liver function tests.</p> | <p>3 The patient had a history of alcoholism and elevated liver functions documented but these were not followed up regularly and this problem was lost to follow up. Care failed to follow generally accepted guidelines or usual practice.</p> |
| <p>11/7/2014 The patient was deaf and asked for headphones. The NP wrote "headphones NSD" but it wasn't clear what that meant.</p> | <p>11 The patient was deaf. His deafness was not accommodated with respect to obtaining history and physical examinations. The patient did not receive functioning hearing aides or sign translators who could assist in obtaining an adequate history. Care failed to follow generally accepted guidelines or practice.</p> |
| <p>11/12/2014 A doctor saw the patient. The blood pressure was 120/70. High blood pressure and high blood lipids were listed as problems. The patient was on HCTZ 25, metoprolol 100 BID, Lisinopril 40, Zocor, and aspirin.</p> | <p>11 The patient was deaf. His deafness was not accommodated with respect to obtaining history and physical examinations. The patient did not receive functioning hearing aides or sign translators who could assist in obtaining an adequate history.</p> |

Patient #7

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| <p>11/17/2014 Someone wrote that interpreter services with provider would be scheduled for the inmate to address his medical concerns.</p> <p>11/19/2014 An NP saw the inmate with an interpreter in the "blue room." The inmate stated that his knee gives out. The inmate also had cough with an irritated throat at night. The NP ordered a knee brace and cough syrup.</p> <p>2/24/2015 Glucose 112 (65-110), potassium 3.4; cholesterol 188; triglycerides 204; HDL 35; LDL 112.</p> | <p>8 The patient had an elevated glucose and a risk factor (obesity) and should have received a hemoglobin A1c. Care could reasonably have been expected to be better.</p> |
| <p>3/16/2015 A doctor documented that the patient walked out of the clinic during the encounter and documented that the patient does not want to listen to advice. But the patient was deaf and probable did not hear the doctor. The blood pressure was 128/89. The potassium was 3.4 and the doctor added potassium.</p> <p>7/9/2015 A nurse saw the patient for athlete's feet. The nurse noted that the patient was taking diabetic medication and blood pressure medication. The weight was 255 pounds.</p> | <p>11 The doctor failed to document that appropriate accommodation was provided to the patient, given his deafness.</p> |
| <p>7/28/2015 Someone [title not provided] wrote that the patient had bilateral hearing aids and was given a permit to purchase headphones for use indefinitely. The weight was 247.</p> | <p>4 The nurse documented that the patient was on diabetic medication but the patient was NOT on diabetic medication. This raises the concern that the patient could not hear the nurse, leading to an inaccurate history.</p> |
| <p>9/30/2015 Potassium 3.7.</p> | |

Patient #7

- 10/13/2015 At HTN chronic clinic the patient complained of back pain and requested pain medication. The doctor prescribed Naprosyn 375 BID as needed for three months. There was no other history. The blood pressure was 120/68. The doctor documented the patient in good control and continued current medication, stating that high blood lipids were also in good control.
- 11/9/2015 An NP saw the patient for a low bunk renewal. The patient weighted 264 pounds.
- 2/18/2016 Glucose 98; potassium 3.4; cholesterol 149; TG 126; HDL 37; LDL 87.
- 3/8/2016 A doctor saw the patient in HTN clinic. The blood pressure was 124/86. The weight 240. The doctor took no history. The doctor did a brief examination and documented the hypertension and high blood lipids in good control. The doctor continued the same medications. The doctor did not note any labs.
- 4/28/2016 A nurse practitioner saw the patient with an interpreter. The patient had cough. The lungs were clear. The NP said the cough might be from the ACE inhibitor but ordered cough medication. Weight was 265.
- 6/23/2016 The patient was evaluated in the "blue room" and complained of sore throat and cough. The patient said the hearing aid didn't work well. The throat was red. The NP ordered amoxicillin without a culture or other tests. The NP requested a repair of the hearing aids. Vital signs were not taken even though the patient was treated for an infection.
- 1, 3 The history was inadequate and treatment was therefore based on a symptom without establishing a diagnosis.
- 1 The history was inadequate.

Patient #7

7/6/2016 Glucose 113 (65-110); potassium 3.8; cholesterol 148; TG 186 (45-150); HDL 30; LDL 81.

The elevated glucose and triglycerides should have prompted a hemoglobin A1c test to screen for diabetes. Care failed to follow generally accepted guidelines or usual practice.

7/27/2016 An NP did another annual evaluation. Again, a nurse obtained history, noted elevated liver enzymes but nothing more specific. The weight was 277 pounds. The NP took a history of drinking "a lot." Even though the patient was 51, colorectal screening was not done. The NP did write that the inmate declined a digital rectal examination. No laboratory tests were evaluated. The patient's prior elevated liver function tests had not been evaluated for two years even though the patient had a history of alcoholism.

7, 8 The patient was over 50 and should have received colorectal screening but did not. The patient had a history of alcoholism with elevated enzymes but there was no follow up. The glucose was previously elevated and the NP should have ordered an A1c. Care failed to follow generally accepted guidelines or usual practice.

8/23/2016 Glucose 105; potassium 4.1.

9/9/2016 A nurse practitioner saw the patient for hypertension clinic. The NP documented that the patient had a cough. The BP was 148/100. The patient said he had just taken his medication and didn't want to change medications. The NP did not evaluate lipid values. The NP made no changes in medication. The NP ordered BP checks two times a week for three weeks.

9/11/2016 Blood pressure was 152/88.

9/13/2016 Cholesterol 155; TG 131; HDL 29; LDL 100.

9/14/2016 Blood pressure was 148/90.

9/18/2016 Blood pressure was 152/98.

9/21/2016 Blood pressure was 158/98.

9/25/2016 Blood pressure was 150/100.

9/28/2016 Blood pressure was 158/98.

Patient #7

10/5/2016 An NP saw the patient and noted that the blood pressure was high (186/106) The patient weighed 292 pounds. The NP increased lisinopril to 40 mg BID and scheduled a follow up for 11/1/16.

10/9/2016 Blood pressure was 150/82.

10/12/2016 Blood pressure was 158/88.

10/16/2016 Blood pressure was 162/100.

10/19/2016 Blood pressure was 140/80.

10/23/2016 Blood pressure was 138/88.

10/26/2016 Blood pressure was 130/80.

10/27/2016 An NP saw the patient. The BP was 160/96. The weight was 255. This would have been a 37 pound weight loss over three weeks. The patient complained that his headphones were broken and he couldn't afford a second set. The NP sent the patient to the ADA coordinator about the headphones. The NP continued naproxen for six months without a clear indication despite the HTN and without addressing the high blood pressure.

1, 4 Based on weights in the medical record, the patient had a 37 pound weight loss over three weeks. While this is probably due to a malfunctioning scale or inaccurate weights, the NP should have inquired about this but no history was taken and the patient's weight was not checked. Also, the blood pressure was elevated but the NP did not modify treatment. Care failed to follow generally accepted guidelines or usual practice.

11/1/2016 An NP saw the patient for elevated blood pressure. The blood pressure was 148/88. The NP ordered a PRN follow up but took no action regarding the elevated blood pressure. The weight was listed as 265, a 10 pound weight gain in four days but a weight loss over the past month.

1, 4 The blood pressure was elevated but the NP took no action. The patient had documented weight loss but no history was obtained. Was the patient's deafness an issue? Care failed to follow generally accepted guidelines or usual practice.

Patient #7

11/11/2016 A nurse saw the patient for "upper respiratory infection." The patient had cough. The pulse was 112 and the blood pressure was 98/62 without change in medication. The oxygen saturation was 93%. The nurse did not refer the patient despite the patient having tachycardia and low blood pressure, especially given the patient's recent elevated blood pressures. A provider should have been consulted. The nurse documented that the patient would be referred to the NP in the "blue room" apparently where sign language assistance could be provided. However, this referral didn't take place.

11/13/2016 A nurse saw the patient at 1:25 pm but the nurse couldn't take an adequate history. The nurse wrote, "patient deaf, does not speak, communicates by writing notes, short words, does not understand all the nurses questions." The patient was vomiting. The patient had a "musty" odor from his mouth with sore throat for four days. The patient was drinking "lots" of water. The temperature was 96.3, pulse 116; BP 120/70 and oxygen saturation 98%. The patient hadn't eaten in 4-5 days. The nurse told the NP about the patient's condition.

16 The patient had abnormal vital signs and given the patient's complaint, a provider should have evaluated the patient. The blood pressure had been elevated and had dropped significantly and was now hypotensive without any intervention. This should have prompted consultation with a physician but this didn't occur. Care failed to follow generally accepted guidelines or usual practice.

11 The patient was vomiting, had tachycardia, and hadn't eaten in 4-5 days. The nurse appropriately referred the patient to a provider but the inability to take an adequate history because of the deafness needed to be addressed or referred to a higher level of care.

Patient #7

11/13/2016 An NP saw the patient at 2:00 pm who complained of being sick for several days. The patient had headache, fever, and vomiting. The NP used the nurses prior vitals. The throat was beefy red. The NP diagnosed pharyngitis and dehydration and placed the patient on the infirmery. The NP ordered IV fluid of 500 cc bolus and then 250 cc per hour, with vital signs every four hours and intravenous Ancef 1 gram every six hours for five days. The NP did not order any labs.

1, 8, 14 The patient had fever, vomiting, unrecognized weight loss, low blood pressure, tachycardia, and hadn't eaten in days. It is not clear how a diagnosis of pharyngitis was made given the patient's symptoms and presentation. This appears incompetent. Pharyngitis is not generally treated with intravenous antibiotics. Since the NP diagnosed dehydration and started IV antibiotics, laboratory tests were indicated to assess the degree of dehydration (particularly since the patient hadn't eaten in 4-5 days) but were not ordered. This patient should have been sent to a hospital. Care was worse by virtue of being unable to obtain a history because the patient was deaf and staff as documented by the nurse earlier were unable to obtain a history. Care was grossly and flagrantly unacceptable.

11/13/2016 The NP ordered a 500 cc bolus followed by 250 cc/ hour for two hours then at 125 cc hourly for 1 liter then to just maintain the IV.

11/13/2016 At 9:00 pm the patient said he was thirsty. The patient had "abdominal distress" at 4:00 pm and refused medication. The patient had a large liquid BM and then took oral meds. The temperature was 97.9; pulse 85; BP 118/64. The patient had voided 700 cc of urine.

16 The patient was known to be dehydrated and told the nurse he was thirsty. In addition to abdominal distress the patient had diarrhea. The nurse should have referred the patient to a provider or consulted a provider.

Patient #7

- 11/14/2016 The patient had sore throat and was admitted to the infirmary the evening before for observation. The doctor wrote that the patient had headache, fever, and vomiting for several days and documented that the exam was consistent with pharyngitis and dehydration. The doctor did not obtain a history with respect to the vomiting, or clinical course. This may have been due to the patient being deaf. The BP was 120/70; pulse 116; respirations 18; and temperature 96.3. On examination the throat was described as red with tender submandibular area but no other abnormalities. The doctor diagnosed pharyngitis, hay fever, and dehydration. The doctor noted that the patient was on intravenous antibiotics (Ancef) and had received 2 liters of intravenous fluid. The doctor ordered a CBC, CMP and ESR in the morning. These apparently were not done.
- 11/14/2016 At 8:25 am a nurse described the patient as lethargic with temperature of 95.9. The nurse documented stated that the blood pressure was faint and difficult to hear and that "possible reading 118/78." The assessment was "weakness." The nurse consulted a doctor, who didn't feel that the patient needed to be sent out.
- 11/14/2016 At noon the temperature was 94.9, pulse 68, and blood pressure 114/68.
- 11/14/2016 At 4:00 pm a nurse wrote an admission note to the infirmary. The patient wasn't responding to questions. The temperature was 94.9. The patient was still on aspirin, HCTZ, Lisinopril, metoprolol, KCL, Ancef and Tylenol.
- 1, 2, 14 Vomiting, fever, not eating, and dehydration are inconsistent with pharyngitis. This diagnosis was not competently made. Notably, the patient was deaf and couldn't give a good history. The doctor failed to take a history of the patient's problems. Stat labs were indicated because the patient hadn't eaten in five days and had vomiting. Orthostatic blood pressure should have been obtained. Since the patient had recent elevated blood pressure, the low blood pressure should have been cause for concern. The patient should have been referred to a hospital because of lack of ability to obtain a history and need for immediate blood tests (metabolic panel, CBC, lipase, amylase). Care was grossly and flagrantly unacceptable.
- 14 Altered mental status with the patient's other symptoms of vomiting, diarrhea, dehydration, and fever warranted hospitalization. The doctor should have sent the patient to a hospital. Care was grossly and flagrantly unacceptable.
- 14,16 The patient now had hypothermia in addition to lethargy, dehydration, fever, and diarrhea. The patient needed hospitalization. The nurse failed to refer to a provider and the patient should have been sent to a hospital.

Patient #7

11/14/2016 BUN 32; sodium 130; calcium 8.2; albumin 2.3; bilirubin 3.3; alk phos 472; AST 165; ALT 119.

14 An unresponsive patient with lethargy, dehydration, vomiting, hypothermia, diarrhea, and low blood pressure is consistent with sepsis. Because the nurse was having trouble recently obtaining a blood pressure, the patient may also have been in shock. The patient should have been immediately transferred to a hospital. Care was grossly and flagrantly unacceptable. Giving the patient additional fluid without having immediate lab access placed the patient at significant risk of harm.

11/14/2016 A doctor ordered IV fluid NS at 125 cc per hour for 4 liters. This was equivalent to about two and a half liters a day.

11/14/2016 At 11:50 pm a nurse noted that that the patient was lying in bed but did not document vital signs.

11/15/2016 A nurse noted that the patient was not talking but "no s/s of distress." The assessment was weakness without being more specific. Vital signs were not noted.

11/15/2016 At 4:00 am the temperature was 95.2, respiratory rate 14, and BP 116/90.

11/15/2016 At 8:30 am a nurse noted that the patient wasn't talking. The nurse documented temperature of 95.2. The nurse took no action despite the low temperature.

16 If the patient wasn't talking and unable to communicate, a physician should have been consulted. The patient should have been referred to a hospital.

11/15/2016 At 6:20 pm a nurse noted that the patient wasn't talking.

Patient #7

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| <p>11/15/2016 At 8:40 pm a nurse noted that the patient's cell mate said that the patient was kneeling on the floor and laid on the floor. The patient was placed back in bed but the nurse didn't take the inmate's vital signs.</p> | <p>14, 16 This gives an impression of disorientation or delirium. Despite significant deterioration on 11/15/16 with respect to the patient's mental status, a doctor did not evaluate the patient. The lack of physician evaluation was grossly and flagrantly unacceptable.</p> |
| <p>11/16/2016 At 7:20 am a nurse noted that the patient opened his eyes to severe stimulus. The patient took fluids with "coaching" and swallowed AM med. The patient was unable to eat his breakfast on his own and was waiting for a porter or CNA. The nurse assessment was "weak."</p> | <p>14, 16 The patient was unable to eat independently. He was dehydrated, hadn't eaten in days, was vomiting, had diarrhea, and was hypothermic. Why was he not sent immediately to a hospital. Care was grossly and flagrantly unacceptable.</p> |
| <p>11/16/2016 A nurse wrote that the inmate was unresponsive at 7:53 am. An apical pulse was 52 and the BP 68/palpable and the blood sugar was "high" times two. A second IV line was started by a nurse practitioner. An ambulance was called and the patient left grounds at 8:25 am, unresponsive.</p> | |
| <p>11/16/2016 At the hospital the patient had rales bilaterally, 1+ edema and a small RLL infiltrate. The initial assessment was DKA, ARF, hyperkalemia, and respiratory failure due to pneumonia. The patient was in septic shock and unresponsive. The initial blood work included WBC 11.9; hemoglobin 12.2; platelets 102; glucose 606; potassium 6.8; BUN 106; creatinine 5.01; albumin 2.3; ALT 650; ALT 1441; INR 1.6; and CPK 1404. The bicarbonate was 12. Later the glucose rose to 790 with a CO2 of 8. The patient was intubated.</p> | |

Patient #7

11/17/2016 The Medical Director from Dixon wrote a death summary stating that the patient was admitted to the infirmary with sore throat, headache, and vomiting for several days. The doctor noted that the patient was hypothermic on admission and that the patient developed increased weakness, recurrence of hypothermia, and decreased responsiveness on the night of the 15th and was sent to the hospital on the morning of the 16th. The doctor noted that the patient was in DKA and had prior normal fasting blood sugars [which is not accurate]. The patient died on 11:20 pm on 11/16/16 with presumptive cause of death diabetic ketoacidosis. The doctor said an autopsy wasn't available.

Patient #8

1/23/2015 The patient had an annual history and physical examination. The patient was a smoker and had mental illness. His weight was 159 pounds. The patient was noted to weigh 165 in 2013 but 160 in 2010. The patient was noted to have a "good" oral examination.

6/26/2015 The patient weighed 160 pounds on a nurse evaluation.

2/5/2016 An NP saw the patient for an enlarged lump on the neck. The weight was 157 pounds. The lump was tender. The NP diagnosed parotiditis and prescribed antibiotics for seven days. Lymphadenopathy was a consideration.

2/10/2016 The NP saw the patient in follow up of the neck mass. The patient still had a hard lump about 3 cm in size. The NP took no action and ordered a two week follow up.

2/23/2016 A doctor saw the patient for the left sided neck mass. The doctor noted a "likely enlarged 2 x 2 cm non-tender LN [lymph node]." The doctor took no action and ordered a six month follow up to "monitor likely a chronically enlarged lymph node."

12 The parotid gland is on the face in front of the ear. When infected, swelling can occur from the pre-auricular area to the angle of the jaw. The parotid gland is not in the neck and it is incompetent to diagnose parotiditis based on neck swelling. The patient should have been referred to an ENT surgeon for biopsy.

12 Neck masses in adults can be congenital, inflammatory, or neoplastic in origin. In adults, the potential for malignancy should be excluded before a benign diagnosis is given. A 3 cm sized hard mass suggests malignancy and should be referred to an ENT specialist.

4, 12 The patient had a neck mass for at least a month. The doctor did no evaluation to identify a source of infection which should have been present if this was a lymph node. Malignancy should have been excluded in an adult with a neck mass. A six month follow up for a neck mass was indifferent and incompetent or both. Because of the size the patient should have been referred to an ENT doctor. Care was incompetent.

Patient #8

3/29/2016 The patient saw a doctor. The weight was 152 pounds which was an eight pound weight loss. The doctor took no history regarding the neck mass except that it resolved according to the patient. The doctor examined the neck and indicated that there was no further mass noted. The doctor did not address the weight loss.

4/9/2016 A nurse saw the patient who complained of a sore throat especially when he swallowed. The nurse noted a right sided neck mass. The nurse called a physician who ordered prednisone by phone.

4/29/2016 A nurse saw the patient for an upper respiratory infection. The patient complained of cough, headache, fever, and swollen glands. The weight was 150 pounds, a 10 pound weight loss. The nurse noted a swollen uvula and a swollen lymph node on the right. A doctor saw the patient the same day. The doctor started antibiotics and 10 day follow up. The weight loss was not addressed.

5/9/2016 An NP saw the patient in follow up. There was increased swelling of the right side of the throat. The weight was 148 pounds. The patient was afebrile. There was "notable swelling to the [right] pretonsillar area." The NP diagnosed tonsillitis. The NP started a different antibiotic and ordered a follow up visit.

The doctor failed to take history of weight loss. It is unlikely that a 2-3 cm mass in the neck resolved and likely that the doctor incompetently examined the patient but based on the documented examination

4, 12 The doctor started prednisone tapering over 10 days. There was no diagnosis and we could not even imagine what the doctor might have been thinking by prescribing prednisone for painful swallowing with a neck mass. The patient should have been referred to an ENT specialist or to a hospital for evaluation. Care was incompetent.

12 The patient had a neck mass noted for over two months. Moreover, the patient was losing weight. Weight loss with a neck mass is most likely malignancy. Neck masses in adults may be infectious but malignancy need to be excluded before other diagnoses are maintained. The doctor should have referred to an ENT consultant. Care was incompetent.

12 This patient had neck swelling for three months with weight loss. This was very unlikely to be tonsillitis. A swollen lymph node or mass is unlikely to be trivial when it is present for three months. The patient should have been referred to a surgeon for biopsy. Care was incompetent.

Patient #8

5/11/2016 An NP saw the patient in follow up. The right neck was described as firm and was painful. The NP documented that the tonsillitis was worsening and admitted the patient to the infirmary. The doctor's infirmary admission history and physical documented starting clindamycin and Levaquin, two antibiotics. Ironically, the nurses documented that the patient had a mass on the right side of the neck the size of a golf ball. The doctor only documented a firm nodule at the angle of the right jaw. The patient's weight was not taken on admission to the infirmary and the weight loss was unrecognized.

8, 12 A firm neck mass is unlikely to be tonsillitis. A golf ball sized lesion is unlikely related to tonsillitis. The patient should have been referred to an ENT specialist. Because the mass was worsening a prompt CT scan should have been performed. Care failed to follow generally accepted guidelines or usual practice.

5/13/2016 A doctor saw the patient and noted that the patient didn't feel better. The doctor noted no fever yet the diagnosis was peritonsillar cellulitis vs. abscess. The doctor ordered salt water gargle, increased Naprosyn, and added tramadol.

8,12 A firm neck mass is unlikely to be tonsillitis. A golf ball sized lesion is unlikely related to tonsillitis. If an abscess was considered the patient should have had a CT scan or referral for incision and drainage. The presentation was not of an abscess as there was no fever. The doctor also did not order a white count. The patient should have been referred to an ENT consultant. Care failed to follow generally accepted guidelines or usual practice.

5/15/2016 The patient asked a nurse, "are you going to let me die?" The nurse referred to a NP. The NP saw the patient and diagnosed bilateral peritonsillar abscess despite that there was no fever. The NP sent the patient to the ER for "airway management and management of the peritonsillar abscesses."

5/15/2016 The patient returned from the hospital the same day.

Patient #8

5/15/2016 A hospital WBC 4.8 and hemoglobin 14 (14-18). Sodium was 131; BUN 7, a CT of the neck showed a neck mass likely a cancer. The mass was 4 by 2.4 by 2.8 cm. The mass was worrisome for metastatic lymphadenopathy. The was also an ill-defined 3 by 3.7 by 3.5 soft tissue mass worrisome for a neoplastic process. There were several lymph nodes worrisome for metastatic lesions.

The neck mass was not evaluated appropriately for over three months.

5/15/2016 At 10:00 pm a nurse noted that the patient no longer wanted to have an IV and IV antibiotics, wanting to see the doctor saying, "I don't want that IV it's not working." He requested a new treatment plan.

5/16/2016 A doctor saw the patient. The patient had diarrhea. The patient wasn't eating solid food. The doctor noted a serum sodium of 131; potassium 3.9; WBC 4.8; and hemoglobin 14. The doctor documented that the ER documented that a CT scan was more consistent with a tumor. The doctor ordered an ENT consult.

5/18/2016 A doctor told the patient that a CT scan was consistent with cancer.

5/18/2016 The patient was approved for UIC ENT on this date which was prior to the referral.

5/19/2016 The patient went to UIC ENT but there was no report in the record.

5/20/2016 A doctor noted that the patient said a biopsy was recommended. The doctor documented that the report was unavailable. The doctor told the patient to wait for the ENT recommendations.

11 Care was delayed because there was no report from UIC ENT. It is not clear whether a biopsy was done.

5/23/2016 The doctor noted that the ENT report was still unavailable. The doctor discharged the patient from the infirmary with a 1-2 week follow up pending review of the ENT report.

11 Care was delayed because there was no report from UIC ENT.

Patient #8

7/11/2016 The patient went for a test on this date but it was unclear what test the patient was undergoing. It was unclear from documentation in the record what the diagnosis of the patient was and what the therapeutic plan was.

7/11/2016 The PET scan showed soft tissues in the neck consistent with malignancy and cervical lymph nodes consistent with metastatic lesions. The left hip was suggestive of metastasis.

7/27/2016 A doctor saw the patient. The patient weighed 120 pounds. The doctor documented that a PET scan was consistent with metastatic cancer. The doctor did not have a clear plan except for follow up with UIC ENT or oncology.

8/5/2016 A doctor saw the patient. The doctor noted seeing the patient the day before when he was found on the floor bleeding from the nose. Notably the patient did not have a documented note from the previous day. The doctor documented that the patient felt weak and fell. The doctor noted that the patient had a follow up with ENT the following week and ordered a wheelchair. The doctor did not take a history except that the patient said his legs got weak and wobbly when he was walking and he fell. The history was inadequate, the examination only included listening to the heart and lungs, and the only assessment was generalized weakness. The doctor did not have a diagnosis.

8/5/2016 An approval for follow up with ENT after the PET scan.

11 Reports were not in the record and therefore the therapeutic plan was not documented.

4, 8, 11 This is an incompetent system of care when a patient with known cancer since 5/15/16, over two months ago, still had no diagnosis or therapeutic plan. The patient's weight loss was even worse, yet the doctor still did not perform a nutritional assessment or order labs for that purpose. Care failed to follow generally accepted guidelines or usual practice.

1, 2, 4, 8, 14 The patient had an apparent syncopal episode the day before yet the doctor failed to take an appropriate history, perform an appropriate examination, or make a diagnosis. Diagnostic lab tests or EKG were not ordered. There was no effort to make a diagnosis for the patient's syncope. The only intervention was to give the patient a wheelchair for long distances, which failed to address the patient's problem. This was indifferent to the patient's serious medical need. Care was grossly and flagrantly unacceptable. The patient should either have been sent to an ER or had multiple blood tests and EKG.

Patient #8

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| <p>8/11/2016 A brief note on a referral form to ENT documented complete involvement of the oropharynx with invasion of the larynx and bilateral nodal disease. The recommendation was for chemotherapy and radiation therapy.</p> | <p>12 The ENT consult occurred three months after cancer was diagnosed on CT scan and six months after initial symptoms. This delay was significant and unacceptable. Care failed to follow generally accepted guidelines or usual practice.</p> |
| <p>8/18/2016 A doctor saw the patient, who now weighed 117 pounds. The doctor noted that the patient had a metastatic oropharyngeal cancer and was cachectic. Yet the doctor took no action to determine if the patient's nutritional status was adequate. The doctor documented that chemo and radiation therapy was to follow at UIC.</p> | <p>4, 8 The doctor failed to order laboratory tests to assess nutritional status or to modify therapy so that nutritional status was adequate despite documenting that the patient was cachectic. This was indifferent.</p> |
| <p>8/23/2016 A doctor saw the patient and noted that chemotherapy and radiation therapy were planned and advised the patient to "fatten up." The doctor noted that the patient had two pressure ulcers on the buttock and one on the hip, yet did not place the patient on the infirmary or order wound care. The only order for the pressure ulcers was to order an egg-crate mattress.</p> | <p>4 This was indifferent. Advising the patient to "fatten up" without making an evaluation of what the patient was able to eat, how much he was eating, and what his current nutritional status was is indifferent. This patient had head and neck cancer and in the past said he was unable to swallow, yet the doctor made no attempt to determine what the patient was able to eat. The doctor also failed to competently address three pressure ulcers. Care was incompetent.</p> |
| <p>8/30/2016 A doctor saw the patient and discussed upcoming chemo/radiation therapy but did not indicate when this was to occur. The doctor did not address the pressure ulcers but did note that the patient hadn't received his egg crate mattress yet.</p> | <p>4 The doctor failed to develop a timely or thorough treatment plan. It wasn't clear whether reports were available or whether the doctor was simply indifferent to the patient's serious medical illness. The doctor failed to pay any attention to the pressure ulcers if they still existed except to note that the mattress hadn't yet arrived. Care failed to follow generally accepted guidelines or usual practice.</p> |
| <p>8/31/2016 Chemotherapy and radiation therapy was approved.</p> | |

Patient #8

- 9/5/2016 A nurse saw the patient for dizziness. The nurse documented blood pressure of 94/62 with irregular pulse. Yet, the patient was not referred to a provider. 16 The patient had a significant symptom and abnormal vitals with an irregular pulse. Not sending the patient to a provider placed the patient at risk of harm.
- 9/8/2016 A nurse saw the patient who had "blanked out." The nurse used a seizure protocol. The blood pressure was 60/40. The nurse documented that the plan was to call a physician. When the physician saw the patient, he did not order an EKG, order blood tests or perform orthostatic blood pressure. The doctor documented, "When I initially saw pt. I was asking him how he felt, + he looked at a distant + started losing consciousness [with] mild body shaking no hx of sz." Notably the doctor didn't even examine the patient with blood pressure consistent with shock. The plan was to put the patient on the infirmary for 23 hour observation and to observe for loss of consciousness. The doctor's assessment was loss of consciousness without known etiology, possible seizure, and possible brain metastasis. Yet the doctor did not refer to a higher level of care. 1, 2, 14 The patient had syncope and hypotension at a level consistent with shock, yet the doctor failed to take adequate history, ordered no blood tests or EKG, and failed to thoroughly evaluate the patient who should have been sent to a hospital as the doctor felt that the patient might have had brain metastases; a CT of the brain was indicated. The BP was consistent with shock. Care was grossly and flagrantly unacceptable and most likely reflected incompetent or poorly trained physicians.
- 9/9/2016 A doctor saw the patient and said that the patient felt fine and wanted to return to his housing unit. The doctor did not check the blood pressure. The doctor told the patient to use a wheelchair. The doctor noted that the patient had experienced possible loss of consciousness and he suspected a seizure. Because the diagnosis was uncertain a CT brain was indicated. The doctor discharged the patient back to general population. Notably the doctor did not check the patient's pressure ulcers. 4, 8, 11 Because the patient had prior possible loss of consciousness and because the doctor did not have a diagnosis, a CT brain and EKG were indicated. The doctor sent the patient back to his housing unit without assessment of the patient's pressure ulcers or without assessing the patient's nutritional status. This was indifferent care. The doctor did not document what the therapeutic plan was and it was not clear exactly what the plan of the oncologist and radiation therapist was.

Patient #8

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| <p>9/15/2016 An oncologist wrote a brief note on the referral sheet stating that inpatient admission for high dose cisplatin chemotherapy and radiation therapy needed to be scheduled.</p> | <p>11, 12 There were no consultant reports so the status of the patient was unclear. It had been 4 months since it was known that the patient had cancer and 7 months since first symptoms yet he had not yet started therapy. This was a significant delay that placed the patient at risk.</p> |
| <p>9/19/2016 Approval for change of the G tube placement.</p> | |
| <p>9/19/2016 Radiation therapy was approved. Apparently the patient went for a radiation oncology visit.</p> | |
| <p>9/22/2016 A doctor saw the patient and noted that the patient saw UIC oncology on 9/12 and they recommended admission for chemotherapy. A dental evaluation and radiation therapy were also recommended. Consultant reports were not available. The doctor documented that the patient "saw UIC (Onc or ENT?)." The doctor did not know the current therapeutic plan because reports were unavailable. The doctor noted that the patient had an on-site dental evaluation scheduled for 9/19/16. The doctor noted that the staff was checking on the admission dates for chemo and radiation therapy. The doctor documented that the patient had an irregular pulse and the doctor ordered an EKG within the next seven days.</p> | <p>2, 8, 11, The patient had an irregular pulse which could reflect atrial fibrillation. An immediate EKG should have been promptly obtained, yet the doctor ordered an EKG as a routine. This placed the patient at life threatening risk. The doctor failed to examine the pressure ulcers or verify that they had resolved. The lack of reports significantly contributed to fragmented care, resulting in lack of knowing what the treatment plan was. Care was grossly and flagrantly unacceptable.</p> |
| <p>9/26/2016 An EKG showed multiple premature atrial beats that probably accounted for the irregular pulse previously noted.</p> | |
| <p>10/17/2016 A doctor noted that the patient had received five radiation treatments so far.</p> | <p>12 The patient started receiving treatment for his cancer after five months, which placed the patient at risk. Care failed to follow generally accepted guidelines or usual practice.</p> |
| <p>10/26/2016 A nurse documented that the patient remained at UIC after a scheduled visit and would be admitted.</p> | |

Patient #8

10/24/2016 A radiation oncologist recommended six cans of Boost daily, increased pain medication, and evaluation of the patient's premature atrial contractions.

11/11/2016 During the hospitalization it was noted that the patient had an unresectable tumor and that the patient had significant weight loss and cachexia and that a PEG tube was placed 10/27/16. The patient had multiple laboratory abnormalities which on return to Dixon were not noted.

11/12/2016 The patient was discharged from the hospital.

11/14/2016 The patient was admitted to the infirmary after return from UIC where he was admitted for chemotherapy and a PEG tube. This was not discussed in physician notes previously. The doctor noted that the hospitalization was complicated by a tube leak, free air leak, electrolyte abnormalities, and pneumonia. The patient required transfusion. Remarkably, the doctor did not document what the laboratory abnormalities were and did not order any lab tests. The patient also had mucositis for which an antiviral agent was prescribed. The doctor noted 2+ edema without assessing why the patient had edema. The only assessment was oropharyngeal cancer and dysphagia. The patient had multiple problems that the doctor did not assess. From this note, the extent of the patient's problems were not known. This placed the patient at risk.

11/15/2016 The patient left for radiation therapy.

12 It is not clear whether the five month delay in treating the patient resulted in a possibly treatable cancer becoming untreatable. Doctors at Dixon failed to evaluate the patient's nutritional status. Ultimately the patient needed a feeding tube. Whether this was avoidable is uncertain, yet doctors at Dixon were indifferent to this with respect to appropriate evaluation and treatment. Care failed to follow generally accepted guidelines or usual practice.

4 An appropriate treatment plan was not documented. The hospital report was available but the doctor didn't document all of the patient's problems or document the plan for the patient's problems. The extent of the patient's problems and therapeutic plans were unknown to the prison doctor. This placed the patient at risk. Care failed to follow generally accepted guidelines or usual practice.

Patient #8

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| <p>11/15/2016 At 8:00 pm a nurse noted that the patient was not responding verbally and was found on the floor. The patient was lethargic. A doctor was called but instead of sending the patient to a hospital ordered neuro checks and to call him if the patient became unresponsive.</p> | <p>14 The patient was unresponsive yet the doctor failed to evaluate the patient and did not refer to a higher level of care. Care was grossly and flagrantly unacceptable. The patient had a serious condition and the doctor should have referred the patient to a hospital.</p> |
| <p>11/16/2016 At 8:00 am a nurse documented that the patient had a left dilated pupil and was scheduled for a writ. The patient had bilateral leg swelling. The nurse called a doctor, who ordered morphine for an unclear reason. The patient was apparently scheduled for a medical appointment but there was no evidence in the record that this appointment took place.</p> | <p>14 A unilateral dilated pupil and bilateral leg swelling were not evaluated. The doctor should have evaluated the patient, as a dilated pupil indicates a serious life-threatening problem. Care was grossly and flagrantly unacceptable.</p> |
| <p>11/16/2016 A doctor saw the patient and noted that the patient had requested pain medication and increased the morphine sulphate, but the history of pain was not taken and the extent of pain was not clear. The doctor noted that the patient had a fall the night before. The doctor documented that there was no serious injury. There was no evidence on his examination that the pupil was examined. Neurologic examination was not done, an EKG wasn't done, the doctor didn't evaluate the pressure ulcers, the doctor didn't document what the treatment plan was.</p> | <p>1, 2, 4 The patient had a fall yet the doctor didn't determine why the patient fell or if this was due to complications of his illness or other condition such as cardiac abnormality. Failure to address this placed the patient at risk of harm. The doctor failed to address the abnormal pupil, and failed to inquire as to why the patient fell. Care was indifferent.</p> |
| <p>11/16/2016 At 7:00 pm a nurse performing neuro checks identified a dilated right pupil. The nurse did not document calling the doctor.</p> | <p>16 The nurse should have notified the doctor.</p> |

Patient #8

11/17/2016 A nurse found the patient unresponsive. The patient was sent to a hospital. The hospital performed an EKG that documented that the patient was in atrial fibrillation. A CT scan of the brain showed mild atrophy but no masses or acute intracranial abnormality.

Patient #9

12/24/2013 A doctor wrote a note stating "no specific complaint, no change [assessment] dementia [plan] continue same care."

1, 2, 4 This doctor wrote identical notes multiple times without documenting a history, physical examination, or appropriate assessment. This is indifferent. The doctor was a surgeon and did not appear to know how to manage primary care problems.

12/30/2013 A doctor wrote an identical note to the 12/24/13 note.

1, 2, 4 The doctor didn't document an adequate history, physical examination, or plan. The doctor wrote the identical brief note 24 times without any specificity regarding changes in the patient's status. This doctor was a surgeon and did not appear to have knowledge on appropriate evaluation of patients.

1/3/2014 The patient fell after taking a shower. A doctor saw the patient and noted no problems.

1, 2, 4 The doctor didn't document an adequate history, physical examination, or plan. The doctor wrote the identical brief note 24 times without any specificity regarding changes in the patient's status. This doctor was a surgeon and did not appear to have knowledge on appropriate evaluation of patients.

1/16/2014 A doctor wrote an identical note to the 12/24/13 note.

1, 2, 4 The doctor didn't document an adequate history, physical examination, or plan. The doctor wrote the identical brief note 24 times without any specificity regarding changes in the patient's status. This doctor was a surgeon and did not appear to have knowledge on appropriate evaluation of patients.

Patient #9

1/20/2014 A doctor wrote an identical note to the 12/24/13 note.

1, 2, 4 The doctor didn't document an adequate history, physical examination, or plan. The doctor wrote the identical brief note 24 times without any specificity regarding changes in the patient's status. This doctor was a surgeon and did not appear to have knowledge on appropriate evaluation of patients.

1/22/2014 A doctor wrote an identical note to the 12/24/13 note.

1, 2, 4 The doctor didn't document an adequate history, physical examination, or plan. The doctor wrote the identical brief note 24 times without any specificity regarding changes in the patient's status. This doctor was a surgeon and did not appear to have knowledge on appropriate evaluation of patients.

2/5/2014 A doctor wrote an identical note to the 12/24/13 note.

1, 2, 4 The doctor didn't document an adequate history, physical examination, or plan. The doctor wrote the identical brief note 24 times without any specificity regarding changes in the patient's status. This doctor was a surgeon and did not appear to have knowledge on appropriate evaluation of patients.

2/11/2014 A doctor wrote an identical note to the 12/24/13 note.

1, 2, 4 The doctor didn't document an adequate history, physical examination, or plan. The doctor wrote the identical brief note 24 times without any specificity regarding changes in the patient's status. This doctor was a surgeon and did not appear to have knowledge on appropriate evaluation of patients.

Patient #9

2/19/2014 A doctor wrote an identical note to the 12/24/13 note.

1, 2, 4 The doctor didn't document an adequate history, physical examination, or plan. The doctor wrote the identical brief note 24 times without any specificity regarding changes in the patient's status. This doctor was a surgeon and did not appear to have knowledge on appropriate evaluation of patients.

2/24/2014 A doctor wrote an identical note to the 12/24/13 note.

1, 2, 4 The doctor didn't document an adequate history, physical examination, or plan. The doctor wrote the identical brief note 24 times without any specificity regarding changes in the patient's status. This doctor was a surgeon and did not appear to have knowledge on appropriate evaluation of patients.

3/4/2014 A doctor wrote an identical note to the 12/24/13 note.

1, 2, 4 The doctor didn't document an adequate history, physical examination, or plan. The doctor wrote the identical brief note 24 times without any specificity regarding changes in the patient's status. This doctor was a surgeon and did not appear to have knowledge on appropriate evaluation of patients.

3/12/2014 A doctor wrote an identical note to the 12/24/13 note.

1, 2, 4 The doctor didn't document an adequate history, physical examination, or plan. The doctor wrote the identical brief note 24 times without any specificity regarding changes in the patient's status. This doctor was a surgeon and did not appear to have knowledge on appropriate evaluation of patients.

Patient #9

3/19/2014 A doctor wrote an identical note to the 12/24/13 note.

1, 2, 4 The doctor didn't document an adequate history, physical examination, or plan. The doctor wrote the identical brief note 24 times without any specificity regarding changes in the patient's status. This doctor was a surgeon and did not appear to have knowledge on appropriate evaluation of patients.

3/27/2014 A doctor wrote an identical note to the 12/24/13 note.

1, 2, 4 The doctor didn't document an adequate history, physical examination, or plan. The doctor wrote the identical brief note 24 times without any specificity regarding changes in the patient's status. This doctor was a surgeon and did not appear to have knowledge on appropriate evaluation of patients.

4/15/2014 A doctor wrote an identical note to the 12/24/13 note.

1, 2, 4 The doctor didn't document an adequate history, physical examination, or plan. The doctor wrote the identical brief note 24 times without any specificity regarding changes in the patient's status. This doctor was a surgeon and did not appear to have knowledge on appropriate evaluation of patients.

4/23/2014 A doctor wrote an identical note to the 12/24/13 note.

1, 2, 4 The doctor didn't document an adequate history, physical examination, or plan. The doctor wrote the identical brief note 24 times without any specificity regarding changes in the patient's status. This doctor was a surgeon and did not appear to have knowledge on appropriate evaluation of patients.

Patient #9

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| 5/7/2014 Calcium 7.9; sodium 136; potassium 4.6. No LFTs done. | 1, 2, 4 The doctor didn't document an adequate history, physical examination, or plan. The doctor wrote the identical brief note 24 times without any specificity regarding changes in the patient's status. This doctor was a surgeon and did not appear to have knowledge on appropriate evaluation of patients. |
| 5/21/2014 A doctor wrote an identical note to the 12/24/13 note. | 1, 2, 4 The doctor didn't document an adequate history, physical examination, or plan. The doctor wrote the identical brief note 24 times without any specificity regarding changes in the patient's status. This doctor was a surgeon and did not appear to have knowledge on appropriate evaluation of patients. |
| 6/9/2014 A doctor wrote an identical note to the 12/24/13 note. | 1, 2, 4 The doctor didn't document an adequate history, physical examination, or plan. The doctor wrote the identical brief note 24 times without any specificity regarding changes in the patient's status. |
| 6/28/2014 A nurse documented finding the patient in bed with his left face swollen, weakness of the right arm, and confusion with oxygen saturation of 89%. The patient was sent to a hospital. | The repeated failure to monitor this patient was grossly and flagrantly unacceptable care. |
| 6/28/2014 The patient was admitted to the hospital. On 7/14/14, the patient had an echocardiogram showing moderate LV enlargement, severe LV dysfunction with EF 30%, mitral and tricuspid regurgitation, and moderate to severe pulmonary hypertension. This hospital record was incomplete and only included the echo. | 11 The hospital discharge summary was not available and placed the patient at risk of harm. |
| 7/16/2014 The patient returned from the hospital. The patient was on oxygen therapy. He was admitted to the infirmary. | |

Patient #9

- 7/17/2014 A doctor wrote an infirmity admission note documenting that the patient had a stroke with subsequent respiratory failure. The therapeutic plan was brief, stating to continue all discharge medications. The doctor did not discuss oxygen therapy or the need for it. Activity of daily living monitoring was not mentioned. The doctor did not document a neurological examination except "confused alert," which was a very confusing statement. The patient's neurological status had not been clarified with respect to activity of daily living monitoring. A blenderized diet was prescribed but nutritional status not identified.
- 1, 2, 4 The doctor failed in his history to document what the therapeutic plan upon discharge from the hospital was. The examination was inadequate and the plan was incompetently performed.
- 7/18/2014 The inmate was found on the floor by his bed. The nurse found no injury but it was not witnessed how the inmate came to be on the floor. Blood pressure was 96/54. A doctor didn't see the patient but co-signed the form on 7/21/14.
- 16 The patient was hypotensive and appeared to have had a syncopal episode shortly after hospitalization for stroke. The nurse should have consulted a doctor.
- 7/21/2014 A doctor noted that a cardiology consult at UIC was approved at collegial.
- 7/22/2014 A doctor saw the patient and noted that the patient had no specific complaint. The only documented examination documented was "alert confused." The doctor ordered oxygen saturation daily for two weeks.
- 1, 2, 3 The history and physical examination were inadequate particularly since the patient experienced an apparent syncopal episode four days previous.
- 7/22/2014 A Wexford approval for cardiology post hospitalization.
- 7/24/2014 The patient was found by a nurse on the floor in front of his chair. The nurse noted no injuries. A doctor co-signed the injury report on 7/24/14. The nurse documented that the inmate was not able to explain how the fall happened and wrote ("as normal for I/M").
- 1, 2, 3 The patient experienced a fall. A doctor signed an incident report but did not examine the patient. The nurse documentation presumed that falling was a normal event for the inmate. Care was indifferent.

Patient #9

- 8/5/2014 A doctor's note included "S. No specific complaint, takes diet well, [objective] no acute finding [assessment] post CVA [plan] continue same care". 1, 2, 4 The doctor failed to document an adequate history, physical examination, or plan. This was especially problematic because the patient had two falls since his stroke and the doctor did not evaluate why the patient fell.
- 8/13/2014 A doctor noted no specific complaints. There was no history. The only physical examination was to state the lungs were clear. The only assessment was dementia. The doctor ordered to give oxygen PRN when the oxygen saturation was below 91%. The doctor did not order pulse oximeter checks. 1, 2, 4 The history and physical examination were inadequate. The plan was incompetent. To give oxygen "as needed" when the saturation was below 91% gave unclear direction to the nurse. What conditions would qualify as "as needed?" This order was confusing and not competently written.
- 8/21/2014 A nurse completed an injury report that the inmate was found on the floor. The nurse noted that the inmate was confused and was wrapped in a cover. The patient was evaluated by a CN 2. A doctor co-signed this injury report on 8/26/14. 16 The nurse should have referred a confused patient who just fell to a physician for immediate examination.
- 8/21/2014 BUN 35; creatinine 1.59; albumin 2.7; cholesterol 195; TG 129; HDL 31; LDL 138; hemoglobin 11.3; MCV 77.
- 8/21/2014 A nurse found the patient on the floor at 2:30 pm wrapped in a cover and confused.
- 8/21/2014 A doctor saw the patient at 4:00 pm. The entire note was "S: no complaint alert [objective] no change [assessment] dementia [plan] continue same regimen." The doctor didn't evaluate whether there were injuries in the recent fall. 1, 2, 4, 6 The patient just had a fall. Yet the doctor did not evaluate the patient. This appeared indifferent or incompetent. The doctor also failed to assess recent abnormal laboratory test results.
- 8/27/2014 A different doctor saw the patient and noted that the patient was doing well without use of CPAP. To date, it wasn't clear that the patient was on CPAP. The only assessment was post-CVA, dementia, and COPD. This was the first mention of COPD. The doctor ordered CPAP as needed. This is an inappropriate plan, as how would a patient know he needed CPAP during sleep. 4 This was an incompetent plan. CPAP is used during sleep for sleep apnea which is not a condition that requires as needed use. The doctor appeared to not know how to treat sleep apnea.

Patient #9

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| <p>9/4/2014 A doctor wrote a note identical to the 12/24/13 note.</p> | <p>1, 2, 4 The doctor didn't document an adequate history, physical examination, or plan. The doctor wrote the identical brief note 24 times without any specificity regarding changes in the patient's status. This doctor was a surgeon and did not appear to have knowledge on appropriate evaluation of patients.</p> |
| <p>9/17/2014 A nurse completed an injury report. During rounds a nurse found the inmate on the floor. The treatment plan was to encourage the patient to call staff for help.</p> | <p>16 The nurse should have referred the patient to a doctor.</p> |
| <p>10/9/2014 A doctor wrote that the patient had no complaint and that the patient was not using oxygen and was breathing "normal" without BiPAP. This patient had dementia and it was unclear how it was determined that the patient was consciously not using the oxygen or whether the patient was just demented and didn't know he was supposed to use it. The plan was to continue the same care. This patient was confused and apparently unable to care for himself. The patient was incapable apparently of intentionally deciding to use or not use oxygen. The doctor made no attempt to objectively discover whether the patient needed oxygen therapy. The doctor did not document oxygen saturation, did not stress the patient and check oxygen saturation, and the doctor did not even document why the patient was initially placed on oxygen so it wasn't clear why the oxygen should be stopped.</p> | <p>1, 2, 4 The doctors history, examination, and plan were not competent and failed to determine whether use of oxygen was still necessary.</p> |
| <p>10/23/2014 The inmate fell to the floor while eating breakfast on his bed. A doctor co-signed the injury report on 10/29/14.</p> | <p>16 The nurse should have referred the patient to a doctor.</p> |

Patient #9

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| 10/29/2014 A doctor wrote a note identical to the 12/24/13 note, except the doctor added that the lungs were clear. | 1, 2, 4 The doctor didn't document an adequate history, physical examination, or plan. The doctor wrote the identical brief note 24 times without any specificity regarding changes in the patient's status. |
| 11/10/2014 A doctor wrote a note identical to the 12/24/13 note. | 1, 2, 4 The doctor didn't document an adequate history, physical examination, or plan. The doctor wrote the identical brief note 24 times without any specificity regarding changes in the patient's status. |
| 12/29/2014 BUN 24; creatinine 1.52 (0.5-1.5); albumin 3; cholesterol 174; TG 127; HDL 30; LDL 119. | |
| 12/31/2014 A doctor wrote an identical note to the 12/24/13 note except to add that the patient "takes diet well." | 1,2, 4 The doctor didn't document an adequate history, physical examination, or plan. The doctor wrote the identical brief note 24 times without any specificity regarding changes in the patient's status. |
| 1/24/2015 An identical doctor note to the 12/24/13 note. | 1, 2, 4 The doctor didn't document an adequate history, physical examination, or plan. The doctor wrote the identical brief note 24 times without any specificity regarding changes in the patient's status. This doctor was a surgeon and did not appear to have knowledge on appropriate evaluation of patients. |
| 1/31/2015 An identical doctor note to the 12/24/13 note. | 1, 2, 4 The doctor didn't document an adequate history, physical examination, or plan. The doctor wrote the identical brief note 24 times without any specificity regarding changes in the patient's status. |
| 3/19/2015 An identical doctor note to the 12/24/13 note. | 1, 2, 4 The doctor didn't document an adequate history, physical examination, or plan. The doctor wrote the identical brief note 24 times without any specificity regarding changes in the patient's status. |

Patient #9

- 4/6/2015 An injury report documented the patient fell and asked, "help me please, it hurts." The doctor was called and ordered an x-ray but did not examine the patient. An ADA van was unavailable and the patient didn't go for the x-rays until 4/10/15, four days later.
- 5/5/2015 The patient developed diarrhea noted by a nurse but not addressed by a provider.
- 5/15/2015 The patient had been progressively more confused. On this day the patient stated he needed to get out the back door which made no sense. The nurse documented that the patient was very confused and called the doctor. Instead of an evaluation, the patient was medicated by phone order with Ativan, which was ordered every 12 hours for seven days without a physical examination. Later that day the doctor ordered a CMP and CBC. These tests were not done.
- 5/15/2015 A nurse follow up note documented that the patient was sitting in the chair unresponsive except to sternal rubs. He was described as slightly lethargic. The nurse did not call a doctor. There was no nursing note the following day.
- 5/23/2015 At 10:00 am the patient was agitated and confused. The nurse called a doctor who ordered Ativan IM every eight hours for agitation for 30 days *without evaluation of the patient*.
- 11, 19 The patient had a potential serious medical condition after a fall. The doctor neglected to evaluate the patient and the x-ray was delayed four days. This is indifferent treatment.
- 19 The doctor neglected the patient's condition.
- 1, 2, 3, 11, While the confusion may have been due to the patient's dementia, an evaluation was indicated. The doctor performed no history, performed no examination, and the treatment plan of Ativan actually placed the inmate at risk of harm. The manufacturer recommends *extreme caution* when using in persons at risk of falls. This patient had multiple falls. To prescribe this drug over the phone without fall precautions is dangerous and placed the patient at risk of harm. The lack of an ADA van placed the patient at risk of delayed diagnosis. The ordered labs were never done. Care was grossly and flagrantly unacceptable.
- 16 The prescription of Ativan may have adversely affected the patient. A patient who is unresponsive needs to be evaluated. The nurse should have called the doctor.
- 8, 19 The patient was a fall risk and this drug needs to be given with extreme caution for those with fall risk. Also, the doctor had not made a diagnosis of the patient's confusion and agitation and diagnostic (labs, CT scan brain) evaluation was indicated, but the doctor did not even evaluate the patient. This was indifferent care and grossly and flagrantly unacceptable.

Patient #9

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| <p>5/23/2015 A nurse documented that the patient was ambulating unsteadily and appeared agitated and confused. When the nurse approached the patient he fell. The pulse was 120. The nurse noted no injuries. The nurse called the doctor, whose only order was to monitor the patient.</p> | <p>8, 19 The patient likely had a change in status (confusion and agitation). Additional testing was indicated including labs and CT scan. Instead, nothing was done. The doctor failed to recognize that his prescription of Ativan may have worsened the patient's condition.</p> |
| <p>5/24/2015 A nurse documented that the patient appeared more confused than usual. There was no referral or physician examination.</p> | <p>16 The nurse should have referred the patient to a doctor.</p> |
| <p>5/26/2015 A doctor saw the patient and wrote that the patient had no specific complaint despite the patient being unable to give a history. The doctor noted that the patient was agitated and confused and that mental health was to evaluate the patient. The only examination was to document, "no acute findings." A diagnosis of Alzheimer's disease was made without any objective assessment of the patient. The plan was to "continue same care."</p> | <p>1, 2, 4 The doctor attempted no history. The doctor performed no neurologic examination or mental status examination. The doctor ordered no laboratory tests to determine if the patient had a reason for the confusion. CT scan should have been considered. The doctor did not evaluate the potential for falls given his prescription of Ativan. Care was indifferent and incompetent.</p> |
| <p>5/26/2015 The patient complained that his stomach didn't feel well. The nurse informed the doctor, who gave a phone order for a CMP and CBC. There was no documented follow up of these tests and it appeared that they were not done.</p> | <p>11, 19 Ordered tests were not done. The patient needed evaluation but no examination was done.</p> |
| <p>6/23/2015 A doctor hadn't documented a note for a month. The doctor wrote an identical note to the 12/24/13 note.</p> | <p>1, 2, 4 The history, physical examination and assessments were inadequate.</p> |

Patient #9

- 7/8/2015 A nurse saw the patient at 6:30 am and wrote that the patient couldn't get up to eat. The nurse noted that the patient was totally dependent for activities of daily living including feeding and that his condition "is declining." He was missing his dentures and needed a dental referral. A doctor saw the patient at 9:35 am and wrote that there was no change in status and that the patient needed help in ambulation. The only examination documented "no change." The plan was to "continue same care."
- 7/11/2015 A nurse documented that the patient appeared "very weak" and that his condition was "declining." It wasn't clear what the nurse perceived as wrong but no referral was made.
- 7/12/2015 A nurse documented that the patient was very weak and needed to be held up to be fed and ate only a few spoonfuls of breakfast. The nurse documented notifying the doctor.
- 7/12/2015 At 1:35 pm the patient was incontinent of bladder and bowel. The nurse notified a doctor, who ordered CBC, CMP, UA with culture in the morning. The blood was actually documented as drawn that day and at 6:35 pm a nurse documented that the hospital called that the hemoglobin was 6.1. The doctor was called and the doctor ordered the patient to be sent to the hospital.
- 7/12/2015 WBC 20.4; hemoglobin 6.1.
- 7/13/2015 Patient admitted to UIC for anemia.
- 7/16/2015 Surgical path report indicating terminal ileum indicating infiltrating poorly differentiated adenocarcinoma. The size of the specimen was 15 by 8 by 5.6 cm.
- 1, 2, 4, 19 If there were no change in status, how was it that the patient needed help in ambulation unless his need had previously been ignored. Since the doctor determined that the patient needed help with ambulation, a change in therapy was indicated but the doctor documented "no change." He did not initiate how to help the patient with ambulation. Care was indifferent.
- 16 The nurse should have referred to a physician.
- These tests were significant and indicate possible infection and significant blood loss and required immediate action.

Patient #9

7/24/2015 A final report documented that the patient was transferred from OSH to UIC after a hemoglobin of 6 was found. At UIC the hemoglobin was 5.5. After transfusion a RLQ mass was palpated. A CT scan found a RLQ mass concerning for malignancy. The patient developed fever. A laparoscopic study found abscess with necrosis and biopsy found poorly differentiated adenocarcinoma. A partial colectomy with ileostomy were performed. The patient had poorly differentiating adenocarcinoma arising from a tubular adenoma infiltrating through the ileum and muscularis adenocarcinoma.

7/24/2015 An oncology consultation in the hospital documented that the patient had a history of chronic kidney disease, HTN and was admitted for a hemoglobin of 6 and a RLQ mass. The oncologist noted that a biopsy was positive for cancer and that the patient had 12/14 lymph nodes positive for metastases. The oncologist stated that the patient did not have the capacity for decision making regarding treatment options. Chemotherapy was not planned due to the patient's condition. Nutritional support was recommended.

7/27/2015 The patient was discharged from the hospital. In the hospital the patient developed fever and was treated for an intraabdominal abscess. The patient had exploratory laparotomy with ileocecotomy and ileostomy. Pathology on the specimen yielded poorly differentiated adenocarcinoma arising in a tubular adenoma. Due to the advanced stage of the malignancy no chemotherapy was planned.

7/27/2015 A nurse documented that the patient had staples on his 14 inch abdominal wound and that the patient had liquid stool covering the wound and under the patient's nails. The patient was described as confused.

UIC physicians were able to palpate an abdominal mass which was unidentified at Stateville likely because either the doctor did not examine the patient or because the doctor could not appreciate the mass. It appeared based on notes that the doctor did not examine the patient.

Patient #9

7/27/2015 When discharged from the hospital, the hospital recommended to perform calorie counts and follow up with nutrition recommendations for diet.

7/28/2015 A doctor ordered a pureed diet for six months.

7/29/2015 A doctor admitted the patient to the infirmary post colon resection. The patient was on aspirin, and Norvasc. The doctor took no history of what had occurred in the hospital including the recommended therapeutic plan. The patient's current condition was documented as "healing wound abdomen good condition." The doctor ordered a general diet and activity "as tolerated" despite repeated past falls and inability to care for himself. The doctor's physical examination was that the patient was alert and oriented x 4. The doctor documented that the patient was functioning well.

8/1/2015 A nurse documented that the patient was very combative and "need more staff to help change." The colostomy bag had come off and the nurse described the inmate "in a total mess."

8/2/2015 The nurses were changing the colostomy bag and the patient swung at two nurses with two correctional officers present. The nurse called a doctor who ordered an increase of the Ativan to 1 mg IM every six hours *for 60 days!*

4 The hospital had recommended a calorie count and nutritional follow up. Instead the doctor ordered a pureed diet without consideration of its nutritional content.

1, 2, 4 The doctor performed an incompetent history and physical examination and appeared unaware of the patient's existing status. This was indifferent to the patient's serious medical condition. The doctor did not assess the patient's nutritional status or ensure that the patient was safe and protected despite his grim prognosis.

11 This patient needed a skilled nursing unit or hospice care but it was clear that there were insufficient staff to care for the patient.

4 The patient was at risk of falls. The Ativan was dangerous. The doctor made no attempt to discover what was causing the agitation. Care was grossly and flagrantly unacceptable.

Patient #9

- 8/3/2015 A doctor wrote a brief note stating "confused returned from med writ. Had skin staples removed. Recommendation consult oncology." The only examination was "no change healing abdominal wound." The plan was to "continue same care." Despite the patient being confused, the doctor continued the Ativan order.
- 8/3/2015 Later that day a nurse found the patient on the floor. The patient's cell mate said that the patient attempted to get out of bed and fell.
- 8/3/2015 On a referral form to the surgeon at UIC seen for follow up, the surgeon noted that the staples were removed and recommended to review the pathology and oncology recommendations. A CEA baseline was recommended which was not done. The doctor appeared to ignore or not review the oncology recommendations.
- 8/4/2015 Collegial review approved an oncology visit.
- 8/4/2015 Wexford approved an air mattress.
- 8/4/2015 Wexford approved an oncology appointment.
- 8/6/2015 The doctor wrote "spells of agitation and restlessness. Violent behavior toward nurses." The only documented examination was "confused restless." The assessment was Alzheimer dementia and the doctor prescribed Ativan for 30 days.
- 1, 2, 4 The doctor failed to take any history by way of review of nursing notes or other documents, documented minimal examination, and continued the same care which included Ativan for agitation even though the patient continued to experience falls.
- 16 The nurse did not refer to a doctor.
- 19 Doctors at UIC made recommendations which were ignored.
- 4 The doctor made no attempt to identify risk factors for the delirium including hydration, medication side effects, and supportive care measures. The use of a benzodiazepine for Alzheimer's delirium has a limited role. The risk of falls in this patient should have led the doctor to choose a neuroleptic drug and to check for metabolic problems and supportive care measures. This treatment was harmful to the patient, as it placed him at continued risk for falls and may have been responsible for worsening of the agitation.

Patient #9

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| <p>8/10/2015 The doctor note was virtually the same documenting "no specific complaint. Confused. [objective] no change [assessment] dementia Alzheimer, post colectomy [plan] same care."</p> <p>8/19/2015 At 4:00 am a nurse documented that the patient was in acute distress and was agitated and refused ileostomy care and diaper change. The nurse documented that additional help was needed to change the patient, who remained "uncooperative" during care. The patient was wearing mittens apparently to prevent disrupting the ileostomy.</p> | <p>1, 2, 4 The doctor's continued failure to document a reasonable history, physical examination, and assessment appeared indifferent.</p> |
| <p>8/19/2015 The doctor noted that the patient had no specific complaint and that there was a good response to Ativan. The doctor's plan was to continue same care. There was no examination except a statement that the ileostomy was functioning.</p> | <p>1, 2, 4 The doctor failed to note prior nursing notes that the patient at 4:00 am was agitated and uncooperative. The doctor was not incorporating nursing information into his assessments despite the patient's inability to give a history.</p> |
| <p>8/25/2015 An injury report documented that the patient fell to the floor getting up out of bed. The nurse noted no injuries and stated, "no medical treatment necessary." A provider did not examine the patient.</p> | <p>16 A doctor should evaluate the patient after a fall. There was no assessment given the use of Ativan.</p> |
| <p>8/26/2015 An injury report documented that the patient fell to the floor attempting to get up out of chair. The nurse said there were no injuries and declared that no treatment was needed. A doctor did not examine the patient. The nurse documented that a doctor would follow up as needed.</p> | <p>16 A doctor should evaluate the patient after a fall. There was no assessment given the use of Ativan.</p> |
| <p>8/26/2015 A doctor documented the same note except adding that the patient had metastases. There was no other comment. The plan was to continue same care. The doctor failed to note that the patient had two recent falls.</p> | <p>1, 2, 4 The doctor did not document new findings in the history, or document a reasonable examination or assessment, and failed to note that the patient had recent falls. Care was indifferent.</p> |

Patient #9

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| <p>8/31/2015 A different doctor saw the patient and wrote a very brief note stating that the patient had an erythematous coccyx without skin breakdown, which is an early decubitus. The doctor made no changes to prevent a decubitus ulcer.</p> | 3 | <p>The doctor should have ensured that preventive measures were taken to prevent pressure ulcers.</p> |
| <p>9/1/2015 At 3:30 am a nurse documented that when they removed the ileostomy bag the patient's clothes and bed linens were full of feces. The patient had been scratching around his ileostomy.</p> | | |
| <p>9/1/2015 At 7:35 am a doctor saw the patient. The entire note was "no specific complaint [objective] no change [assessment] dementia post colectomy for metastatic ca [plan] continue same care." The doctor failed to note the patient's pruritis and interference with the ileostomy causing contamination with feces. The doctor failed to review the nursing notes.</p> | 1, 2, 4 | <p>The doctor failed to note significant patient management problems apparently due to indifference to nursing management problems complicating patient care.</p> |
| <p>9/6/2015 A nurse found the patient with feces all over his bed linen. The patient had pulled off the ileostomy bag. The patient had mittens placed on his hands but he had removed these as well.</p> | | |
| <p>9/9/2015 The doctor wrote an identical note to the 9/1/15 note.</p> | 1, 2, 4 | <p>The doctor was indifferent to the status of the patient and unaware of what was happening to the patient.</p> |
| <p>9/14/2015 The doctor wrote an identical note to the 9/1/15 note.</p> | 1, 2, 4 | <p>The doctor was indifferent to the status of the patient and unaware of what was happening to the patient.</p> |
| <p>9/22/2015 The doctor wrote an identical note to the 9/1/15 note.</p> | 1,2, 4 | <p>The doctor was indifferent to the status of the patient and unaware of what was happening to the patient.</p> |
| <p>9/25/2015 The patient fell off the toilet. A nurse documented that the patient fell while trying to transfer off the toilet. The nurse documented that the patient was confused.</p> | 16 | <p>The nurse should have referred to a physician.</p> |

Patient #9

10/5/2015 A different doctor wrote documenting that the patient was confused. The doctor did not update the patient's status, perform any examination except to note confusion and a colostomy, and did not update the status of the patient.	1, 2, 4 The patient was having repeated falls. There was no evaluation of medications, attempts to protect the patient, or evaluate the patient's metabolic status.
10/26/2015 A doctor wrote an identical note to the 9/1/15 note.	1,2,4 The doctor was indifferent to the status of the patient and unaware of what was happening to the patient.
10/29/2015 A doctor wrote an identical note to the 9/1/15 note.	1,2,4 The doctor was indifferent to the status of the patient and unaware of what was happening to the patient.
11/2/2015 A doctor wrote an identical note to the 9/1/15 note.	1,2,4 The doctor was indifferent to the status of the patient and unaware of what was happening to the patient.
11/9/2015 A doctor wrote an identical note to the 9/1/15 note.	1,2,4 The doctor was indifferent to the status of the patient and unaware of what was happening to the patient.
11/16/2015 A doctor wrote an identical note to the 9/1/15 note.	1, 2, 4 The doctor was indifferent to the status of the patient and unaware of what was happening to the patient.
11/23/2015 A different doctor saw the patient for pus coming from the ear. The doctor noted a perforated TM with pus and diagnosed otitis media and started Bactrim for seven days.	
11/23/2015 Remarkably, a couple hours later the usual doctor (Medical Director) saw the patient and wrote an identical note to 9/1/15 not noting the otitis media.	1, 2, 4 This was clearly indifferent.
11/24/2015 The patient was sent out on a writ.	

Patient #9

11/24/2015 This oncology appointment was approved 8/4/15 and didn't take place for more than three months. The oncologist write a brief note on the referral form. There was no report. The note said that given the advanced dementia and extensive malignancies, no treatment was recommended. Hospice/palliative care was recommended. No follow up was recommended.

11/26/2015 A doctor ordered a clear liquid diet for 24 hours based on a nurse call that the patient had liquid stool draining from the ostomy site.

11/27/2015 A nurse noted that the patient was lethargic and had diarrhea. The patient was sent to a hospital.

11/29/2015 The patient returned to the infirmary from the hospital. There was a nurse admission note to the infirmary but no physician note. The first physician evaluation was on 12/3/15 when the doctor wrote an identical note to the 9/1/15 note.

11/29/2015 The patient was discharged from UIC on 11/29/15 after an 11/27/15 admission. The patient was admitted for altered mental status. The patient was treated with antibiotics and improved. A urinary infection was diagnosed. C difficile was negative. Chest x-ray was negative. Patient was transitioned to Bactrim. The patient's initial BUN was 56 and improved with hydration. So the patient was significantly dehydrated on arrival. X-rays of the abdomen and chest showed no acute problems.

12/3/2015 This was the first note after hospitalization and the doctor wrote an identical note to the 9/1/15 note.

1, 2, 4 Care was indifferent, as the doctor failed to even review hospital notes, note the status of the patient, or assess whether the patient had improved or not after hospitalization. Care was grossly and flagrantly unacceptable.

Patient #9

12/7/2015 A doctor's note was identical to the 9/1/15 note.	1, 2, 4	The doctor was indifferent to the status of the patient and unaware of what was happening to the patient.
12/14/2015 A doctor's note was identical to the 9/1/15 note.	1, 2, 4	The doctor was indifferent to the status of the patient and unaware of what was happening to the patient.
12/23/2015 A doctor wrote that the patient had no specific complaints. The examination was "no change" and the assessment was "dementia post metastatic ca colon resection." The plan was "continue same care."	1,2, 4	The doctor was indifferent to the status of the patient and unaware of what was happening to the patient.
12/29/2015 A doctor wrote a note that was identical to the 12/23/15 note.	1, 2, 4	The doctor was indifferent to the status of the patient and unaware of what was happening to the patient.
1/5/2016 A doctor wrote a note that was identical to the 12/23/15 note.	1, 2, 4	The doctor was indifferent to the status of the patient and unaware of what was happening to the patient.
1/11/2016 A doctor wrote a note that was identical to the 12/23/15 note.	1, 2, 4	The doctor was indifferent to the status of the patient and unaware of what was happening to the patient.
1/18/2016 A doctor wrote a note that was identical to the 12/23/15 note.	1, 2, 4	The doctor was indifferent to the status of the patient and unaware of what was happening to the patient.
1/25/2016 A doctor wrote a note that was identical to the 12/23/15 note.	1, 2, 4	The doctor was indifferent to the status of the patient and unaware of what was happening to the patient.
2/2/2016 A doctor wrote a note that was identical to the 12/23/15 note.	1, 2, 4	The doctor was indifferent to the status of the patient and unaware of what was happening to the patient.
2/8/2016 A doctor wrote a note that was identical to the 12/23/15 note.	1, 2, 4	The doctor was indifferent to the status of the patient and unaware of what was happening to the patient.
2/15/2016 A doctor wrote a note that was identical to the 12/23/15 note.	1, 2, 4	The doctor was indifferent to the status of the patient and unaware of what was happening to the patient.

Patient #9

2/16/2016 At 6:00 am a nurse found the inmate on the floor who asked, "help me." The nurse identified no injuries.	16	The nurse should have referred to a physician.
2/23/2016 A nurse found the inmate on the floor yelling "help me." A doctor saw the patient and wrote, "IM fell again today." The doctor assessed no injuries.	4	The doctor wrote that fall precautions should be used but didn't specify what these were. The doctor wrote to continue the present management. It appeared that the patient was still on Ativan.
2/29/2016 A doctor wrote a note that was identical to the 12/23/15 note.	1, 2, 4	The doctor was indifferent to the status of the patient and unaware of what was happening to the patient.
3/7/2016 A doctor wrote a note that was identical to the 12/23/15 note.	1, 2, 4	The doctor was indifferent to the status of the patient and unaware of what was happening to the patient.
3/14/2016 A doctor wrote a note that was identical to the 12/23/15 note.	1, 2, 4	The doctor was indifferent to the status of the patient and unaware of what was happening to the patient.
3/21/2016 A doctor wrote a note that was identical to the 12/23/15 note.	1, 2, 4	The doctor was indifferent to the status of the patient and unaware of what was happening to the patient.
3/28/2016 A doctor wrote a note that was identical to the 12/23/15 note.	1, 2, 4	The doctor was indifferent to the status of the patient and unaware of what was happening to the patient.
4/5/2016 A doctor wrote a note that was identical to the 12/23/15 note.	1, 2, 4	The doctor was indifferent to the status of the patient and unaware of what was happening to the patient.
4/11/2016 A doctor wrote a note that was identical to the 12/23/15 note.	1, 2, 4	The doctor was indifferent to the status of the patient and unaware of what was happening to the patient.
4/18/2016 A doctor wrote a note that was identical to the 12/23/15 note.	1, 2, 4	The doctor was indifferent to the status of the patient and unaware of what was happening to the patient.

Patient #9

4/19/2016 At 1:30 am a nurse noted that the patient was listless and notified a doctor. The patient was pale, diaphoretic, and listless. He was lying in bed without any sheets or covers and appeared to be in pain and was not responding as usual.

4/19/2016 At 3:00 am a nurse documented that the patient was in bed and condition was unchanged since 1:40 am. The doctor was notified and ordered the patient sent to the hospital.

4/19/2016 At 6:25 am a nurse noted that the patient was sent to a hospital and had acute encephalopathy, hyperkalemia, and elevated troponin.

4/21/2016 An autopsy was done. Fingernails were medium length and dirty, the patient had multiple scars on the extremities and back. The toenails were dirty. The cause of death was sepsis.

It was clear that the patient's status had not been monitored at the facility.

Based on the autopsy, it appeared that the patient had been neglected at the facility.

Patient #10

- 1/7/2013 Patient was seen at HTN chronic clinic. The presence of risk factors line was blank even though the patient had multiple risk factors.
- 7/1/2013 The patient complained to a CMT that he was "throwing up black stuff and also defecating black stool all day. I haven't eaten anything all day cause of my vomiting." The CMT documented referring the patient to a doctor the following day. This referral did not occur. There was no evidence of evaluation of this potential GI bleed.
- 7/16/2013 A doctor saw the patient in diabetes chronic clinic. The doctor did not address the patient's very recent complaint of possible GI bleeding. The doctor took no history. The doctor also saw the patient for hypertension clinic and noted no chest pain. The blood pressure was 106/84. Lipids were not addressed.
- 10/9/2013 A provider saw the patient for HTN chronic care clinic. Blood pressure was 120/68; pulse was 92. The patient was lightheaded. The patient was on Vasotec 20 BID, HCTZ 25, 120, ASA. The provider decreased the verapamil from 120 to 80 mg daily despite the blood pressure being in good control. This was done because the patient was lightheaded. The patient was not listed as having high blood lipids despite very high risk and contemporary recommendations for high dose of statin.
- 7, 16 The patient had symptoms of gastrointestinal bleeding and was on a NSAID and aspirin and should have had endoscopy. Instead, the patient wasn't even referred to a provider. Subsequent providers failed to identify these symptoms. Care failed to follow generally accepted guidelines or usual practice.
- 1, 2, 8 The doctor failed to take history of the very recent possible GI bleed. The patient should have been referred for endoscopy. The doctor also did not assess lipid therapy in a 68-year-old male with multiple cardiovascular risk factors. Care failed to follow generally accepted guidelines or usual practice.
- 2, 4 The provider failed to assess lipids. The patient had multiple cardiovascular risks and should have been assessed for lipid disorder. Because of age and multiple risk factors, the patient likely needed to be on a statin medication, but this was not done. Care failed to follow generally accepted guidelines or usual practice.

Patient #10

1/15/2014 The patient was seen in HTN chronic clinic. The blood pressure was 139/82 which is considered elevated for a diabetic. The doctor assessed good control but didn't increase the medication. Lipids were not addressed.

2, 3 The provider assessed good BP control when control was questionable. A reasonable goal is 130/80 or less especially with cardiovascular risk factors. Although the goal is 140/90, consideration of the patient's cardiovascular risks should have been made. The doctor did not assess whether the patient had lipid disorder in a patient at high risk of cardiovascular disease. Blood pressure medication should have been considered to be adjusted and a statin drug should have been started.

1/28/2014 A doctor wrote a chart note documenting review of labs. The doctor documented "control of hyperlipidemia fair" but did not institute treatment.

2 The doctor diagnosed fair lipid control but it is unclear what this meant. The patient probably needed treatment with a statin drug but this was not done. Care failed to follow generally accepted guidelines or usual practice.

Patient #10

- 5/6/2014 A PA saw the patient in diabetes chronic clinic. The blood pressure was 140/80. The PA documented that the patient was on Motrin without addressing why. The blood pressure was listed as in good control when it was elevated for a person with diabetes. The PA listed the total cholesterol of 161 and HDL of 41. According to the American Heart Association 10 year risk calculator the patient had a 53% 10 year risk of heart disease or stroke and should have been recommended a high intensity statin drug. The PA did not address lipid treatment apparently not understanding the risk factors of the patient.
- 12/17/2014 A doctor renewed Motrin for six months at 800 mg a day without an evaluation. The doctor did not note the Black box warnings or HTN. This was an error.
- 1/26/2015 A1c 7.1; cholesterol 190; TG 79; HDL 44; LDL 130; HGB 14.9.
- 2/7/2015 The patient had an annual physical examination. Colorectal screening was not offered but a digital rectal examination was done, which was guaiac negative.
- 2, 17 The PA failed to appreciate the cardiovascular risk to the patient. Ibuprofen (Motrin) carries a FDA black box warning for serious cardiovascular thrombotic events. The warning states, "Nonsteroidal anti-inflammatory drugs (NSAIDs) cause an increased risk of serious cardiovascular thrombotic events, including myocardial infarction, and stroke, which can be fatal. This risk may occur early in treatment and may increase with duration of use. Ibuprofen is contraindicated in the setting of coronary artery bypass graft (CABG) surgery." A second black box warning is that Ibuprofen can increase risk of serious gastrointestinal (GI) adverse events including bleeding, ulceration, and perforation of the stomach or intestines, which can be fatal. These events can occur at any time during use and without warning symptoms. Elderly patients and patients with a prior history of peptic ulcer disease and/or GI bleeding are at greater risk for serious GI events." Motrin can also exacerbate hypertension and can cause renal disease and carries a warning to use with caution in persons with hypertension.
- 17 Care failed to follow generally accepted guidelines or usual practices.
- 7 The patient should have had colorectal cancer screening consistent with contemporary guidelines. This was especially true since the patient had prior episode of GI bleeding.

Patient #10

4/17/2015 Diabetes chronic clinic BP 163/89, weight 203; A1c documented as 7.3. The doctor did not address the elevated blood pressure. The patient was on NPH 20 units and metformin 850 BID. On a different HTN chronic clinic form the HTN was addressed. The doctor documented good hypertension control even though it was not, and fair high blood lipid control even though the patient was not on anti-lipid therapy. The doctor did increase the verapamil from 80 to 120 mg. The patient was also on lisinopril, metformin, NPH insulin, HCTZ, verapamil, aspirin, and 800 mg Motrin once daily. The use of Motrin should not be continuous as it was because of the risk for kidney disease and risk for thrombotic events. The doctor documented the LDL cholesterol as 133 which is high.

4/30/2015 Sodium 134; A1c 7.3; cholesterol 191; TG 71; HDL 44; LDL 133; HGB 16.3

7/22/2015 A1c 7.1.

8/13/2015 A provider saw the patient for HTN clinic. The blood pressure was 158/95. A repeat was 146/85. The blood pressure was listed as in good control and blood lipids were listed as in good control. There was no change of medication despite the elevated blood pressure. The A1c was listed as 7.1. The doctor ordered an EKG. The doctor noted that the creatinine was 1.48. The patient was still on Motrin yet the doctor did not identify why the patient was taking this medication and that it might be damaging his kidney.

2, 4 The doctor failed to make an accurate diagnosis of the blood pressure control. The doctor assessed good control when it was poor control; yet medication was increased. This patient had an American Cardiology 10-year risk of heart disease or stroke of 65%. There should have been aggressive treatment of cardiovascular risk factors including addition of a statin drug and the Motrin should have been discontinued. Care failed to follow generally accepted guidelines or usual practice.

2, 4, 6 The doctor failed to make an accurate diagnosis of the blood pressure control. The doctor assessed good control when it was poor control; medication should have been increased. This patient had an American Cardiology 10-year risk of heart disease or stroke of 65%. There should have been aggressive treatment of cardiovascular risk factors including addition of a statin drug and the Motrin should have been discontinued. Also, the doctor noted an elevated creatinine but did not review use of the Motrin. Care failed to follow generally accepted guidelines or usual practice.

Patient #10

8/23/2015 An EKG shows non-specific STT wave changes that could be consistent with ischemia.

11/22/2015 A1c 6.7.

12/21/2015 A provider saw the patient for a periodic semi-annual diabetic evaluation. The blood pressure was 151/87. The doctor did not address the elevated blood pressure. The doctor renewed Motrin for three months, restricting the patient to 10 tablets a month.

2/24/2016 Total cholesterol 172; TG 82; HDL 42; LDL 114.

3/17/2016 Diabetes chronic clinic BP 163/89, weight 203; A1c documented as 7.3. The doctor did not address the elevated blood pressure. The patient was on NPH 20 units and metformin 850 BID. On a different HTN chronic clinic form the HTN was addressed. The doctor documented good hypertension control even though it was not, and fair high blood lipid control even though the patient was no on anti-lipid therapy. The doctor did increase the verapamil from 80 to 120 mg. The patient was also on lisinopril, metformin, NPH insulin, HCTZ, verapamil, aspirin, and 800 mg Motrin once daily. The use of Motrin should not be continuous as it was because of the risk for kidney disease. The doctor documented the LDL cholesterol as 133 which is high.

3/23/2016 Microalbumin/creatinine ration 37 (0-30); A1c 8; cholesterol 175; TG 88; HDL 47; LDL 110.

6 This EKG could have been consistent with ischemia yet was not documented as reviewed with respect to the patient's clinical picture.

17 Blood pressure medication should have been adjusted. Same comments as above related to treatment with a statin and use of Motrin. However, the doctor did decrease the amount of Motrin the patient was given.

4 The blood pressure was adjusted but was done with verapamil. Since the patient had prior angina, a beta blocker should have been considered. The doctor did not address lipid risk. The patient had a 45% 10-year risk of heart disease or stroke based on recent labs. He should have been on a high intensity statin. The doctor ordered Motrin when it placed the patient at significant risk of thrombotic events. Care failed to follow generally accepted guidelines or usual practice.

Patient #10

4/14/2016 A doctor saw the patient for annual diabetic clinic. The doctor noted that the A1c was 8 but said the lipids were "OK" which they were not. The blood pressure was 139/88. The doctor wrote that he discussed statin coverage with the patient who wanted to defer starting. The doctor wrote that he referred the patient to Dr. Obaisi. The doctor increased NPH insulin to 26 units HS but did not address the elevated blood pressure.

4/15/2016 An EKG shows non-specific STT wave changes that could be consistent with ischemia. The changes are different from the previous EKG of 8/23/15.

4 The blood pressure was not considered elevated but because the patient had high cardiovascular risk, medication increase should have been considered. The doctor did not address lipid risk and treatment, and ordered Motrin when it placed the patient at significant risk. Care failed to follow generally accepted guidelines or usual practice.

Patient #10

4/15/2016 A doctor saw the patient who complained of waking up feeling nauseous and became cold and clammy and vomited. The doctor noted that an EKG showed sinus tachycardia. [The EKG showed also non-specific STT wave changes that could be consistent with ischemia]. The blood pressure was 112/74, which is low for this patient and the heart rate 92. The doctor took no other history. The doctor's assessment was diabetes R/O coronary event or NSAID gastritis and dehydration. These assessments appeared to be accurate. However, the plan and follow up was below standard of care. The doctor ordered CBC, CMP, troponin, CK-MB, stopped Motrin, and started omeprazole for a week and gave a liter of fluid and gave the patient a dose of NTG. The doctor did not take a history usual for angina. The CBC was drawn and showed hemoglobin of 10.3, which is very low but was never followed up. This was consistent with a GI bleed, as the patient had a prior normal hemoglobin. The patient had a prior normal hemoglobin of 13.7. The CMP, CK-MB, and troponin were not done or were unavailable in the medical record. The doctor also only prescribed a single nitroglycerin tablet but did not order long-term anti-anginal medication. The omeprazole was only ordered for seven days. The doctor did not follow up. Given the high risk of this patient, a possible anginal event should have prompted a stress test or cardiac catheterization.

4/18/2016 An EKG shows resolution of STT wave changes from 4/15/16. This is significant because it supports a suggestion of ischemia. Given the patient's history a stress test or cardiac catheterization were indicated.

14 On this day, especially given the drop in blood pressure, the 10-year risk of heart disease or stroke was 38%. If the blood pressure of 4/14/16 (139/88) was used, the patient had a 10-year risk of heart disease or stroke of 52%. This was a very high risk patient. The doctor failed to take an adequate history for acute coronary syndrome but did acknowledge the possibility. Also, the patient was on long-term Motrin which carries a black box warning for cardiac thrombotic events. Since the EKG was abnormal and suggested ischemia, the patient should either have been referred to a hospital to rule out MI or been placed on regular anti-anginal medication and referred for urgent stress test or angiography. Ordering tropinin levels in a prison is not a good idea because if positive, the prison could not reasonably treat the patient appropriately and the patient's access to hospital care would be delayed. After this lack of referral, subsequent physicians did not order routine cardiology referral, increase anti-anginal drugs, or order stress testing or cardiac catheterization. This patient had multiple risk factors for a cardiac event (smoker, HTN, diabetes, high blood lipids, male sex, age). Care failed to follow generally accepted guidelines or usual practice. This place the patient at risk of cardiac thrombotic event.

Patient #10

4/18/2016 Hemoglobin 10.3. There was no evidence in the progress notes of follow up of this significantly abnormal test.

6 This significant laboratory finding was not acted on, placing the patient at significant risk. The patient should have been referred for upper endoscopy. Care failed to follow generally accepted guidelines or usual practice.

4/18/2016 A doctor saw the patient for follow up of the dehydration. The blood pressure was 101/61. The patient was able to eat. The doctor took no history typically used for angina. The doctor repeated the EKG but did not comment on it. The EKG was now normal when on the 15th it showed STT changes consistent with ischemia. This reversal of ischemic changes is significant and demonstrates that the patient had ongoing angina.

1, 7 The doctor should have obtained a history given the recent event on 4/15/16. The doctor failed to document review of the EKGs in sequence and assess in light of the patient's cardiovascular risks. Because of the reversal of EKG changes, the patient should have been referred for stress testing. Care failed to follow generally accepted guidelines or usual practice.

5/5/2016 The Medical Director saw the patient. The blood pressure was 149/83 and the pulse 98. The doctor did not discuss the recent possible anginal episode. The doctor addressed back pain but took no history, diagnosed chronic back pain, and prescribed 600 mg Motrin twice a day for 60 days despite the elevated blood pressure. The doctor did not discuss the blood pressure or evaluate the recent lab showing a significant drop in hemoglobin.

1, 2, 3, 7, 17 The doctor failed to review the abnormal hemoglobin of 10.3. The doctor failed to adjust medication for elevated blood pressure. The doctor failed to assess the patient's recent possible anginal episode in light of the patient's risk factors. The doctor prescribed Motrin despite a possible recent anginal episode and despite the black box warning for risk of thrombotic cardiac events. The patient should have been referred for stress testing. Care failed to follow generally accepted guidelines or usual practice.

7/20/2016 A1c 6.7

8/1/2016 A doctor saw the patient for diabetic clinic. The blood pressure was 135/82 which is not elevated blood pressure for persons with diabetes but is considered possibly elevated for persons with diabetes and cardiovascular disease. The A1c was 6.7. The doctor made no changes to therapy and did not address the blood pressure.

2, 3 The doctor should have considered adjustment of blood pressure medication but did not. The doctor should have initiated lipid therapy or discussed with the patient but did not. Same comments as above for statins and Motrin. The abnormal hemoglobin was unnoticed. Care failed to follow generally accepted guidelines or usual practice.

Patient #10

8/3/2016 Cholesterol 157; TG 99; HDL 42; LDL 95; hemoglobin 12; MCV 71 (80-99);		
8/12/2016 A doctor wrote a very brief illegible note. A nurse took blood pressure of 142/95 but it was not addressed.	2, 3	The blood pressure was elevated but medications were not adjusted. The doctor did not address lipid risk despite a 36% 10-year risk of heart disease and ordered Motrin when it placed the patient at significant risk. Same comments as about these issues. Care failed to follow generally accepted guidelines or usual practice.
9/5/2016 A doctor saw the patient for HTN chronic clinic. The blood pressure was 150/87 and a retake was 133/83. The doctor assessed "good" HTN control but the control was questionable. The doctor made no changes.	2, 3	The blood pressure was initially elevated but medications were not adjusted. The doctor did not address lipid risk and treatment and ordered Motrin when it placed the patient at significant risk. Same comments as about these issues. Care failed to follow generally accepted guidelines or usual practice.
11/30/2016 A1c 7.		
12/6/2016 A doctor saw the patient for diabetic clinic. The blood pressure was 145/91. The A1c was 7. The doctor made not changes and did not adjust the blood pressure medication.	2, 3	The blood pressure was elevated but medications were not adjusted. The doctor did not address lipid risk and treatment and ordered Motrin when it placed the patient at significant risk. Same comments as about these issues. Care failed to follow generally accepted guidelines or usual practice.
1/6/2017 Sodium 134; cholesterol 167; TG 77; HDL 39; LDL 113; hemoglobin 13.7 MCV 72.7 (80-99).		

Patient #10

- 1/6/2017 A nurse saw the patient for back pain. The blood pressure was 151/97. The nurse referred to a doctor who saw the patient the same day. The doctor addressed the back pain and increased the Motrin at 800 BID without addressing the elevated blood pressure and without recognizing the prior episode of decrease in hemoglobin. This needed to be considered because both Motrin and aspirin can cause GI bleeding which the patient appeared to have sustained. The Motrin was prescribed at a high dose 800 mg BID but apparently for two weeks.
- 1/10/2017 A doctor discontinued the Motrin and started Naprosyn another NSAID at a dose of 500 mg BID. The patient had received 28 Motrin tablets as a KOP medication on 1/9/17 and received the Naprosyn on 1/23/17 which was when the Motrin would have been completely used up if taken as prescribed. Nevertheless, giving the patient another NSAID when the patient was on aspirin and had a recent presumed GI bleed was problematic. The doctor apparently failed to appreciate the Black Box warnings for this drug as well as its effect on hypertension.
- 1/13/2017 A doctor wrote an illegible note. A nurse obtained blood pressure was 102/70 and the pulse was 101.
- 1/16/2017 The inmate was not seen in eye clinic due to lock down.
- 1/18/2017 The patient was not seen by a nurse because of lock down.
- 1/19/2017 The patient was not seen by a doctor due to lock down.
- 1/26/2017 The patient was not seen by a doctor due to lock down.
- 4, 17 The doctor failed to treat elevated blood pressure. The doctor failed to note the prior abnormal hemoglobin and failed to appreciate black box warnings for Motrin which placed this patient at significant risk. Care failed to follow generally accepted guidelines or usual practice.
- 17 The doctor failed to appreciate black box warnings for a NSAID in light of this patient's risk factors. Care failed to follow generally accepted guidelines or usual practice.

Patient #10

1/31/2017 An annual physical examination was done. A digital rectal examination included a negative guaiac test. It appears that this constitutes colorectal cancer screening, which is inadequate screening.

2/5/2017 A nurse was asked to emergently assess an inmate but on arrival the inmate was lying face down on the floor. The patient was unconscious and not breathing. CPR was started and the patient was sent to a hospital, where he died. An EKG on this date showed acute ischemia.

2/5/2017 A death certificate documented that an autopsy was done but it wasn't in the record. The death certificate listed the cause of death as coronary atherosclerosis with gastrointestinal hemorrhage as a secondary cause of death.

2/6/2017 A Death Summary by the Medical Director at Stateville documented that the patient had 90% occlusion of a coronary artery and "limited patchy gastrointestinal hemorrhage." In a Wexford Mortality Review Worksheet the doctor documented that earlier intervention was not possible and that there was no way to improve care.

7, 8 The patient should have had colorectal cancer screening consistent with contemporary guidelines. This was especially true since the patient had prior episode of GI bleeding. The patient should have had screening for lipid disorder but doctors did not appear to appreciate the patient's risk for heart disease.

Patient #11

3/11/2014	Total cholesterol 176; TG 71; HDL 42; LDL 120; hemoglobin 14.1; MCV 101.1.		
4/5/2014	The patient was evaluated in HTN chronic clinic. The weight was 180. The blood pressure was 106/69.	3	The patient had a 10-year risk of heart disease or stroke of 16.6% and should have been on a moderate to high intensity statin.
7/3/2014	Total cholesterol 178; TG 136; HDL 35; LDL 116; hemoglobin 14.5; MCV 101.7; platelets 148.		
7/10/2014	The patient was evaluated in HTN chronic clinic. Blood pressure was 120/73. The weight was 173, a seven pound weight loss over seven months. This was not addressed.	3	The patient had a 10-year risk of heart disease or stroke of 22% and should have been on a moderate to high intensity statin.
11/11/2014	Total cholesterol 189; TG 117; HDL 38; LDL 128. CBC was normal.		
11/25/2014	The patient was evaluated in HTN chronic clinic. The weight was 178. Blood pressure was 120/75.	3	The patient had a 10-year risk of heart disease or stroke of 22% and should have been on a moderate to high intensity statin.
2/12/2015	Potassium 3.4; cholesterol 166; TG 107; HDL 36; LDL 109.		
5/16/2015	A doctor saw the patient the weight was 171 pounds.		
6/3/2015	A doctor saw the patient for a cold. The weight was 160 pounds. The pulse was 117. Neither the 20 pound weight loss nor the tachycardia was addressed.	1, 2, 3	The doctor failed to take adequate history regarding weight loss and did not evaluate adequately for the tachycardia. The treatment plan should have contained evaluations to determine why the patient had tachycardia and weight loss.
6/12/2015	Potassium 3.4; cholesterol 155; TG 123; HDL 36; LDL 94.		
8/24/2015	BMP was normal.		

Patient #11

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| <p>10/6/2015 A doctor saw the patient for dysphagia for solid food. The doctor took no history. The weight was 163 and the patient had lost 17 pounds since 4/5/14. The doctor noted that the patient had a right neck mass. The doctor ordered an antibiotic and follow up in 10 days.</p> | <p>7, 8 Neck mass and dysphagia is consistent with carcinoma which needs to be ruled out before more benign conditions are considered. It wasn't clear what infection the doctor was considering but a simultaneous EGD and/or neck CT were indicated.</p> |
| <p>10/16/2015 The doctor saw the patient in follow up. The neck mass was still there and was described as the size of a golf ball. The dysphagia was worse. The doctor noted a 17 pound weight loss over seven months. The doctor ordered an ultrasound with a follow up with the Medical Director in 4-6 weeks.</p> | <p>Ultrasound is not a preferred test for evaluation of neck mass but was an option. A 4-6 week follow up was too long.</p> |
| <p>10/20/2015 An ultrasound showed nodular densities on the right side of neck question of adenopathy or neoplasm.</p> | |
| <p>10/27/2015 A collegial review approved an ultrasound. This was a low value test for this condition. The patient needed a biopsy. A CT scan would have been reasonable.</p> | |
| <p>10/28/2015 The Medical Director saw the patient. The only note was "U/S [presumably ultrasound] neck masses R neck, CXR this week." This patient needed a prompt biopsy of the mass.</p> | |
| <p>10/28/2015 A US of neck was approved for right neck mass with dysphagia. The patient had already had the test.</p> | |
| <p>10/30/2015 A chest x-ray showed diffuse emphysema, COPD, tortuous aorta.</p> | <p>2 These abnormalities were not incorporated into the assessment of the patient and were not managed.</p> |
| <p>11/10/2015 A collegial review approved a UIC oncology visit.</p> | |
| <p>11/18/2015 The Medical Director saw the patient. The doctor noted that the patient had a fixed neck mass and assessed throat neoplasm and appeared to order a local ENT consultant.</p> | |

Patient #11

- 11/30/2015 A Joliet ENT doctor saw the patient and noted a neck mass and recommended a PET scan, laryngoscopy with biopsy, bronchoscopy, and esophagoscopy.
- 12/3/2015 The Medical Director saw the patient and noted that the patient returned from a writ. The Medical Director noted that the patient has a tumor on the posterior tongue and was to have endoscopy, laryngoscopy, bronchoscopy, and biopsy.
- 12/8/2015 A collegial review approved a PET scan and laryngoscopy with biopsy.
- 12/18/2015 The patient returned from a PET scan. His weight was 154 pounds. The pulse was 128 but not addressed.
- 12/18/2015 A PET scan was consistent with malignancy on the right side of the tongue with nodal metastases.
- 12/22/2015 A doctor saw the patient, who now weighed 151 pounds. The doctor noted that the PET scan showed metastatic tongue cancer and that the inmate was scheduled for chemotherapy and radiation therapy.
- 12/30/2015 The patient complained to a nurse that he was coughing up blood. The pulse was 113. The nurse referred to a doctor. The Medical Director saw the patient. The doctor documented that there was no change in the neck mass, the lungs were clear. The doctor assessed cough with bloody sputum "once". The doctor ordered a chest x-ray and prescribed Claritin an antihistamine.
- 1/4/2016 A chest x-ray was reported as "negative study."
- 1/8/2016 The patient had a laryngoscopy and biopsy. The heart rate was 107.
- 1/8/2016 A tongue biopsy showed invasive squamous cell cancer moderately differentiated.
- 3 The doctor did not mention a PET scan which had been recommended.
- 2, 3 Cough with bloody sputum in a patient with head and neck malignancy should prompt concern that there was an open wound in the area of the cancer, but this was not a concern apparently.
- 7 It was three months since the patient first had symptoms of a neck mass and dysphagia until the time of diagnosis. The diagnosis was not timely.

Patient #11

- 2/16/2016 The Medical Director saw the patient after a writ but didn't say what the writ was for or what occurred. It wasn't clear what the treatment plan was.
- 2/16/2016 A CT scan of the neck was approved in collegial.
- 2/17/2016 Potassium 3.4; cholesterol 130; TG 50; HDL 38; LDL 82; hemoglobin 12 (13.2-18); platelets 160.
- 2/22/2016 A nurse wrote that the patient just returned from UIC radiation oncology. The nurse noted that the patient needed a CT scan which did not appear accurate. Since there was no report it wasn't clear what happened.
- 2/22/2016 There was no report but radiation oncology noted that a CT planning scan was done.
- 2/25/2016 The patient went to head and neck oncology clinic. The patient had a T2N3M0 stage IVb tongue cancer. Laryngoscopy was done. The plan was radiation and chemotherapy with cisplatin. A port was placed. An echocardiogram was scheduled for 2/29/16. The note documented that radiation oncology wanted a CT scan to assess a lung lesion. The patient was to follow up in 2-3 weeks in head and neck oncology and was to start cisplatin with medical oncology and also receive radiation therapy.
- 2/29/2016 The patient went to UIC for an echocardiogram. It wasn't clear from Stateville doctor's documentation that an echocardiogram was to be done. The report of the echocardiogram showed normal LV function and normal EF.
- 10, 11 The therapeutic plan and ongoing treatment of the patient were unclear based on progress notes. It was not possible to determine from the medical record what therapy the patient was receiving and when he received it.
- 10, 11 There was no report. The plan was unclear and follow up didn't occur.
- 11 There was no report.

Patient #11

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| 2/29/2016 The Medical Director wrote that the patient needed cardiology clearance for chemotherapy and radiation therapy. An as needed follow up was ordered. It wasn't clear what was occurring, as the doctor did not document what occurred at recent UIC visits. | 10, 11 | The doctor was not reviewing consultation reports and the therapeutic plan was not described. Since there were no formal reports it wasn't clear exactly what the plan was. |
| 3/1/2016 A radiation oncologist wrote a brief note stating that Chest CT and pulmonary consult were indicated because there were suspicious LN on CT simulation performed for radiation treatment purposes only. Bronchoscopy was indicated to evaluate these LNs to exclude malignancy, infection, granulomatous disease. | 10, 11 | It was three months since the patient first had symptoms of a neck mass and dysphagia until the time of diagnosis. The diagnosis was not timely. The recommendation for pulmonary and bronchoscopy were not done. There was no evidence of a report. |
| 3/2/2016 A staff physician saw the patient and noted that the patient had a Port-a-Cath in his right chest and was getting chemotherapy. This was the first mention that the patient had actually received chemotherapy. It wasn't clear what the therapeutic plan was for the patient. | 10, 11 | Hospital records were unavailable and the doctor didn't know what occurred at the hospital. Follow up of oncology was not being done. They had recommended return if the patient decompensated, which had occurred. |
| 3/7/2016 There was no report but the oncology clinic referral form had comments written on the bottom and noted that the patient received cisplatin and would need daily RT M-F for six and a half weeks. They noted that the patient had received radiation the day before. The patient was to return daily for radiation M-F and weekly for chemotherapy. The actual note was not present. | 11 | There was no report. |
| 3/8/2016 A nurse documented that the patient went for radiation therapy and was to return the following day for the next dose of radiation. | | |
| 3/9/2016 The patient went for radiation therapy. | | |

Patient #11

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| <p>3/10/2016 The patient received another PET scan. The lesion was mildly increased since the last PET scan. Cervical lymph nodes were also mildly increased but there were otherwise no changes from the prior study.</p> | <p>10, 11 This was an unnecessary PET scan. The oncologist wanted the PET scan film not a repeat PET scan but the report was not present and the doctor did not correctly review the recommendations on the referral comments.</p> |
| <p>3/14/2016 A medical oncologist saw the patient for cisplatin. The recommendation was to encourage fluids and administer an antiemetic for nausea and to return in a week.</p> | |
| <p>3/21/2016 The patient was given radiation therapy. The medical oncologist noted that the patient had mucositis. The radiation oncologist recommended to increase Boost to six times a day with a teaspoon of salt as the patient had lost eight pounds over the past week due to dysphagia. A PEG feeding tube was recommended. The also recommended morphine 10 mg every three hours. They mentioned something illegible about blood pressure medication noting that the BP was normal.</p> | <p>11 We couldn't find the prescription as the record was so disorganized.</p> |
| <p>3/21/2016 The Medical Director documented that the patient had pain and UIC oncology recommended morphine and to keep on the infirmary. The doctor admitted to the infirmary and started morphine. The doctor had not been monitoring the patient's pain or status other than when told by UIC what to do.</p> | <p>10 The doctor was not documenting a careful review of consultants or documenting their complete therapeutic plan but was only documenting certain items.</p> |
| <p>3/21/2016 The patient was admitted to the infirmary. He weighed 149 pounds. The patient was on a soft diet and the doctor ordered two additional cans of Boost three times a day. The nurse documented that the patient was having increasing dysphagia and losing weight and was admitted to the infirmary to monitor this. The patient was still on Cardura and dyazide for hypertension.</p> | |

Patient #11

3/26/2016 The Medical Director wrote a note. The entirety of the note was "S: no specific complaint O: no changes A: oral ca on radiation P: continue same care." This gave no information as to the status or progress of the patient.

1, 2, 3, The doctor was taking no history, not performing adequate examination, or documenting a plan consistent with one recommended by the consultants. It isn't clear from documentation that the doctor understood the status of the patient. The doctor did not update any of the patient's other medical conditions or monitor for them.

3/28/2016 The doctor wrote a note stating "S: no specific complaint, O: no changes, A: oral cancer on radiation P: continue same care." This note failed to identify the therapeutic plan or recent consultant recommendations and did not address whether the patient was still in pain. The doctor did not address the mucositis or pain or evaluate the weight or whether the patient could eat.

1, 2, 3 The doctor was taking no history, not performing adequate examination, or documenting a plan consistent with one recommended by the consultants. It isn't clear from documentation that the doctor understood the status of the patient.

3/30/2016 The patient asked a nurse for more Boost. The nurse did not refer the patient.

3/31/2016 The patient went to radiation. They noted that the patient had difficulty swallowing due to thrush. The patient had lost six pounds. Continued treatment for oral thrush was recommended. Boost was recommended eight times a day and salt water and baking soda mouth wash. Liquid Pepcid or famotidine were recommended for reflux. These recommendations were unnoticed at the prison.

The doctor appeared to be treating ITP. Prednisone is not indicated in thrombocytopenia from cirrhosis. This was incompetence and demonstrated lack of knowledge of primary care by this surgeon. The diagnosis and treatment were therefore inappropriate and placed the patient at risk.

3/31/2016 UIC recommended in a letter to Stateville that an x-ray of his knee should be taken as the patient complained of knee pain.

4/4/2016 The patient wasn't able to get chemotherapy due to low platelets of 67. He did receive normal saline presumably due to dehydration. There was no report but this information was on the referral form.

Patient #11

4/5/2016 The doctor wrote that the patient was at UIC hospital under oncology care but it wasn't clear what was happening to the patient. The doctor did not review UIC notes or document understanding what the status of the patient was. The doctor hadn't seen the patient since 3/28/16.

4/8/2016 The patient returned from the hospital and a nurse documented that the patient received a G-tube. On admission to the infirmary the nurse noted that the patient had failure to thrive. The patient was still on six cartons of Boost a day instead of the eight recommended. The hospital note was not located.

4/8/2016 A nurse documented that the patient insisted on feeding himself through his G-tube. He was angry and accused the Medical Director of "putting him in the condition he is in now. He stated the MD ignored him 6 years ago."

4/11/2016 The patient was seen in oncology clinic. The patient was dehydrated and hypotensive with WBC 1.2 and ANC of 0.7. The recommendation was to watch for petechial rash and take neutropenic precautions by separation from general population. The patient was to shower daily and give saltwater and baking soda mouth wash for mouth soreness.

1, 10 The patient failed to review prior UIC recommendations or note the updated status of the patient. The UIC recommendation for a knee x-ray wasn't noted. The doctor didn't appear to prescribe additional Boost and MARs did not show that the patient received additional nutritional supplement.

11 The report was not available and it wasn't clear what occurred at the hospital.

Patient #11

4/11/2016 The Medical Director documented seeing the patient at 4:00 pm, although based on hospital notes it appeared that the patient was at the hospital from 4/11/16 to 4/12/16. The doctor documented that the patient had difficulty swallowing and was on a liquid diet by the oncologist. The doctor didn't obtain the weight or document understanding of the nutritional status or caloric intake of the patient. The only examination was documented as "no change." The plan was "continue same care." It appeared that the doctor documented the wrong date.

The doctor appeared to document a note when the patient was hospitalized.

4/12/2016 The patient returned from the hospital for hypotension. It was noted that the patient's blood pressure was 78/50. The patient was found to have gout of the right toe and was started on a tapering prednisone dose. Fluconazole was started for the thrush.

4/18/2016 The Medical Director noted that the patient left for radiation therapy. The examination was documented as "no changes." The plan was "continue same care." The doctor failed to see the patient since his hospitalization for hypotension and gout and did not acknowledge the mucositis.

10 The doctor failed to review the recent hospitalization failing to note that the patient was treated for gout, hypotension and had thrush. The doctor was ignorant of the patient's status.

4/21/2016 The oncologist wrote on a referral form that the patient received IV hydration with magnesium and that a CT/PET scan needed repeating in three months. A month follow up was requested. A report of this visit was present in the record.

4/25/2016 The Medical Director note stated "S:no complaint O: no change A: Ca throat on chemo P: continue same care." He did not note the recent oncology note or document the plan.

10 The doctor failed to review the consultation notes and failed to note the current status of the patient. He also failed to update the patient's ongoing medical conditions.

Patient #11

- 4/29/2016 A staff physician saw the patient for chest pain and feels acid reflux in his throat. The doctor continued Pepcid, added metoclopramide and advised the patient to take smaller portions of liquid when feeding. It wasn't clear if the patient continued to feed himself.
- 5/2/2016 The Medical Director note stated "S:no complaint O: no change A: Ca throat on chemo P: continue same care." 1,2,3 The Medical Director documented no knowledge or recognition of the patient's status and did not document evaluation of the patient.
- 5/9/2016 The MD note stated "S: no specific complaint O: no change A: throat ca P: continue same care." 1,2,3 The Medical Director documented no knowledge or recognition of the patient's status.
- 5/16/2016 The doctor wrote a note stating "S: requests medical shower O no change A: throat ca P: medical shower 3x a week x 3 months." 1,2,3 The Medical Director documented no knowledge or recognition of the patient's status.
- 5/19/2016 A radiation oncologist wrote comments on a referral form stating that Boost needed to continue and the patient needed a restaging CT PET scan in two months and should follow up with medical oncology. Massage of the neck was recommended post radiation.
- 5/23/2016 The doctor documented that the patient had no specific complaint but then wrote "discomfort neck post radiation UIC - massage." The examination stated "no acute findings" and the doctor ordered PT to massage the neck once a week.
- 6/1/2016 A staff doctor noted that the patient was waiting for re-staging. The patient had less dysphonia and dysarthria.
- 6/6/2016 The Medical Director wrote "S:no specific complaint O: no change A: throat ca on radiation chemo P: continue same care." There was no monitoring of weight or ability to eat, the gout, or any of the patient's other problems. 1, 2, 3 The doctor failed to address any of the patient's chronic conditions, took no history, failed to document examination, and failed to establish a plan of care.

Patient #11

6/13/2016	The Medical Director wrote that the patient still had dysphagia and had burning in the chest. The examination was documented as "no change." The doctor ordered Carafate suspension.	1,2,3	The doctor failed to update any of the patient's other problems.
6/20/2016	The doctor documented that the patient was feeling better but that the swelling in the anterior upper neck was less and the patient was able to swallow better. There was no examination except to state "no change" and the plan was "continue same care."	1,2,3	The doctor failed to update any of the patient's other problems.
6/27/2016	The doctor noted that the patient was swallowing better but needed more viscous lidocaine. The examination was documented as "no change." The doctor ordered viscous lidocaine.	1,2,3	The doctor failed to update any of the patient's other problems.
7/5/2016	The doctor noted that the patient's feeding tube was partly clogged. The examination was "no acute findings" and the plan was to irrigate the feeding tube as needed.		
7/5/2016	Albumin 2.8 BUN 15 creatinine 0.8.		
7/6/2016	WBC 3.2; HGB 9.2; MCV 104.		
7/10/2016	A nurse wrote that the patient couldn't breathe and was audibly wheezing. The nurse called a doctor who ordered prednisone and albuterol without evaluation. The respiratory rate was 20; P 88; BP 146/87 and oxygen saturation 97%.		
7/12/2016	The doctor wrote "S: no specific complaints O: no change A: post radiation tongue ca P: continue same care."	1,2,6	The doctor failed to address any of the patient's chronic conditions, took no history, failed to document examination, and failed to establish a plan of care. Abnormal labs were not addressed. The doctor even failed to address the patient's difficulty breathing that occurred two days previous. The doctor failed to mention that the patient was on prednisone and albuterol.

Patient #11

<p>7/25/2016 The doctor wrote the patient had "same cough + SOB-" The only examination was the statement "lung breath sounds diminished." The doctor ordered a nebulizer and albuterol BID.</p> <p>7/27/2016 At 4:30 pm the patient complained to a nurse that he was having trouble breathing and was coughing and having trouble getting sputum up. The doctor was notified who ordered a DuoNeb.</p> <p>7/27/2016 At 8:00 pm the patient complained that he couldn't breathe. The oxygen saturation was 99%, BP 133/88, P 113, and respirations 26. The Medical Director was notified and ordered DuoNeb therapy. Stat labs were ordered but it wasn't clear what labs were done.</p> <p>7/27/2016 At 10:50 pm a nurse documented labs as glucose 108; BUN 17; HGB 10.9.</p> <p>7/27/2016 Lab results from St Joseph Medical Center showed WBC 4.3; HGB 10.9; MCV 100; platelets 123; but there was no hospital report.</p> <p>7/28/2016 The Medical Director documented that the patient returned from ENT and a PET scan was recommended for three months.</p> <p>7/31/2016 At 1:30 am the patient complained that he couldn't breathe. The BP was 126/94; P 120 R 22 and O2 sat 98%. The nurse received a phone order for Rocephin.</p> <p>7/31/2016 At 3:10 am the patient was short of breath. The temperature was 99.3; P 125; R 22; BP 121/66 and oxygen saturation 98%. The doctor ordered Vistaril.</p>	<p>1,2,3,8 The doctor took no history, performed no examination, and the plan of a nebulizer was based on no clear diagnosis. The doctor ordered no labs or x-rays but should have.</p> <p>2, 3 The doctor was treating the patient based on no specific diagnosis. The assessment was therefore uncertain and the treatment plan was apparently a guess.</p> <p>1, 2, 3 There was no history, the doctor did not examine the patient and the plan was made without a diagnosis.</p> <p>10, 11 There was no evidence of an ENT consultation. There were labs from the St Joseph Medical Center but we could not locate an ENT consultation. Reports were not available.</p> <p>1,2,3 The doctor was ordering parenteral antibiotics without taking a history, performing an examination, making a diagnosis. This was an inappropriate way to make a therapeutic plan.</p> <p>3 Vistaril is not a medication for shortness of breath.</p>
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Patient #11

7/31/2016	At 5:30 am a nurse documented vitals of temperature 99; P 113; BP 143/90; oxygen saturation 94%. Based on these vitals the doctor ordered the patient to be sent to a hospital.		
8/5/2016	The patient returned from the hospital. It wasn't clear what occurred.	11	There was no report from the hospital and it wasn't clear what happened.
8/5/2016	A doctor wrote an infirmary admission note. The doctor noted that the patient was treated for pneumonia but didn't document any other detail of what occurred in the hospital.	1	The history was so poor it wasn't clear that the treatment plan was appropriate. The doctor as usual did not address any of the other problems of the patient.
8/8/2016	A doctor noted that the patient was requesting to stop morphine as it didn't agree with him. The examination was "no change." The doctor started Vicodin. The doctor didn't take history or assess the patient's pain or ask why he didn't want the morphine.	1, 2, 3	The history was inadequate. The doctor didn't evaluate any of the patient's other problems and the therapeutic plan only addressed the morphine.
8/15/2016	A doctor wrote that the patient wanted renewal of Tums. The examination was "no change" and the plan was to order Tums two tabs three times a day as needed for six months. There was no other history, physical examination, assessment, or documentation of a therapeutic plan for his problems	1, 2, 3	The history, physical examination, assessment, and plan were inadequate as the doctor did not address any of the patient's main problems.
8/16/2016	Sodium 134; albumin 3.		
8/22/2016	A doctor noted that the throat pain was worse and that Norco was not relieving the pain. The patient was requesting morphine. The doctor ordered morphine. The only examination was "no change."	1, 2, 3	The history, physical examination, assessment and plan were inadequate as the doctor did not address any of the patient's main problems.
8/29/2016	The doctors note was identical to the 6/6/16 note.	1, 2, 3	The doctor again failed to take history, perform examinations, or make assessments based on the patient's problems.

Patient #11

9/6/2016	The doctor wrote that the patient had no specific complaint except dandruff. The doctor noted that the PET scan showed no sign of recurrence. The only examination was "no acute finding." The plan was to order tar shampoo.	1, 2, 3, 11	The PET scan report wasn't found in the medical record. The doctor failed to take history, perform examinations, or document the therapeutic plan of the patient.
9/13/2016	The doctor's note was identical to the 6/6/16 note.	1, 2, 3	The doctor again failed to take history, perform examinations, or make assessments based on the patient's problems.
9/19/2016	The doctor's note was identical to the 6/6/16 note.	1, 2, 3	The doctor again failed to take history, perform examinations, or make assessments based on the patient's problems.
9/25/2016	The doctor's note was identical to the 6/6/16 note.	1, 2, 3	The doctor again failed to take history, perform examinations, or make assessments based on the patient's problems.
9/27/2016	The doctor wrote that the patient had a leak around the feeding tube. The examination was "small amount of leak." The assessment was that the doctor was to address the G-tube leak after the PET scan on 9/29/16. What was unusual is that the doctor wrote on 9/6/16, only 23 days earlier, that the PET scan showed no recurrence. This wasn't clear and there were no reports in the record.	1, 2, 3	Aside from assessing the G-tube, the doctor took no history and performed no other examination. The doctor made no assessments of the patient's main problems. The doctor did not assess the nutritional status of the patient.
9/28/2016	The patient was found non-responsive on the toilet. He was unresponsive and CPR was started and he was transferred to a hospital taken by local paramedics. The patient expired at the hospital.		

Patient #11

9/28/2016 The coroner's certificate of death on 9/28/16 listing the cause of death as hypertensive cardiovascular disease.

While the patient had hypertension, an echocardiogram was normal less than a year before the patient's death. It seems extremely unlikely to have a normal echocardiogram and yet die of hypertensive cardiovascular disease. Notably, the coroner made no mention of the head and neck cancer.

Patient #12

8/11/2015 The patient was incarcerated at Graham CC. The reception history documented Huntington's disease and hepatitis C. The weight was 203 pounds. The physical examination did not explain the Huntington's disease or hepatitis C. The rectal exam was refused. All exam boxes were checked normal. The plan was illegible.

8/18/2015 An intake physical examination was done. The PA documented hepatitis C, but did not document a history of Huntington's disease as documented on the history. Some of the assessment was illegible.

6/13/2016 The patient was at WCC.

7/22/2016 AST 90 (10-40); alt 77 (10-50); calcium 9.2; sodium 138.

7/28/2016 The patient was at Western and there was a note documenting that the patient was scheduled with medical oncology at UIC and the patient would transfer to Stateville NRC for appointments.

11 There was a gap of a year in the medical record.

7/28/2016 There was a note at WCC that the patient was being transferred to NRC for a UIC oncology appointment.

8/2/2016 The patient transferred from WCC to NRC on writ status.

8/4/2016 Comments from oncology on the referral form stated that the patient had hyperkalemia, HCC, and HCV. The patient was given kayexalate with directions to NRC to manage the hyperkalemia. It was recommended to get a triple phase CT scan, with a follow up in two weeks. The potassium was 5.5. The oncologist prescribed 15 gram of kayexalate rectal suppository for two days with recommendation to repeat the BMP in two days.

11 There was no consult report.

Patient #12

- 8/5/2016 A doctor at NRC documented that the patient was there for a writ to go to UIC oncology. The problems listed included hepatitis C, hyperkalemia, and dry eyes. The doctor noted that he would check with manager to clarify recommendation with Barbara at UIC. The doctor asked the unit manager to follow up with UIC to clarify the next steps of management.
- 8/23/2016 Wexford UM wrote an approval that a surgical appointment on 8/4/16 and oncology FU on 8/11/16 were rescheduled to 8/30/16. A requested referral was not yet received. This means that Wexford obtains the referral after the appointment is scheduled.
- 8/29/2016 Wexford approved a CT scan and follow up oncology visit. The referral was still not received by Wexford UM. This was very late, as the oncologist requested a two week follow up and the CT scan had yet to be done.
- 8/30/2016 The CT chest and pelvis were done, showing hepatocellular carcinoma.
- 9/1/2016 A doctor saw the patient post-UIC writ. The doctor documented that the patient had a CT scan. The doctor noted that the report was to follow. The doctor noted no follow up date on the consult with oncology.
- 9/8/2016 EKG normal sinus rhythm.
- 9/12/2016 The patient was admitted to the hospital for two days and discharged on 9/13/16. hepatic angiogram was done and lipidol and chemotherapy was administered in the hepatic artery for hepatocellular carcinoma. They recommended CMP drawn on 9/15/16 and faxed to coordinator at clinic and to start calcium carbonate. A PA wrote an order for waist chains and leg irons during movement.
- 10, 11 There was no consultation report. This led to not knowing the therapeutic plan.
- 12 The recommended CT scan was not timely performed.
- 10, 11 There was no report and the doctor didn't know the follow up date. Follow up after the consultation was not informed.

Patient #12

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| <p>10/5/2016 The patient went to liver clinic. There were a few brief lines on the referral form. Further treatment was pending a discussion with oncology. The report documented that the patient had compensated cirrhosis. They recommended continuing with embolization and if the disease worsened to consider hospice. They recommended return to clinic if hepatic decompensation occurred. Waist chains and leg irons were ordered for movement.</p> | <p>11 The report was not available only comments on the referral form. It is not clear anyone was aware of these recommendations.</p> |
| <p>10/7/2016 A doctor noted that the patient was seen by GI at UIC and has FU pending with oncology. The doctor noted that the patient had advanced HCC/ cirrhosis. The doctor did not assess any labs or note what the plan was at UIC.</p> | <p>11 The doctor did not document review of the report.</p> |
| <p>10/11/2016 The patient went to radiology. There were a few brief lines on the referral form. A two month follow up was recommended. A procedure was recommended in 45 days. They recommended a CMP. There was a oncology note in the record that summarized the patient care. It said that HCC was found January 11, 2016 found on ultrasound screening. A CT scan was done on 2/26/16 noting cirrhosis and 3 cm hypodense lesion in the lateral lobe; an MRI 3/23/16 showing a large infiltrative mass of the L lobe ; in April 2016 the AFP was elevated; and a CT guided biopsy was done not until 5/24/16 and a PET scan was done 5/26/16. The patient wasn't seen at UIC until 8/4/16 and the patient didn't have treatment of the HCC until 9/12/16. The note documented that the CT guided biopsy results from 5/24/16 were requested multiple times but not received.</p> | <p>12 The oncology note documents that HCC was identified in January of 2016 but treatment wasn't given until September of 2016, a nine month delay. Repeated requests for biopsy results were not heeded. This was a significant delay in access to necessary care. Also, It is not clear what occurred at the Western facility and whether there was delay there as well.</p> |

Patient #12

10/21/2016 Glucose 115; Calcium 8.5; albumin 2.5; alk phosphatase 186 (40-125); AST 126 (10-40); ALT 58 (10-50); platelets 112

11/12/2016 WBC nl platelets 181; glucose 102; creatinine 0.6; sodium 133; potassium 4.4.; albumin 2.8; AST 89; ALT 40; alk phos 214; bilirubin 1.6; calcium 8.2.

11/13/2016 A CMT wrote a note that Provena St Joseph's Lab called with stat lab results. When the call was returned no personnel in the labs were present to take the call.

11/14/2016 CT abdomen done. Liver tumor invasion of vein was worsened. Leg irons and waist chains were ordered for movement. The CT scan showed cirrhosis with infiltrative tumor on the left lobe with tumor thrombosis, hepatic and retroperitoneal adenopathy. This was consistent with hepatocellular carcinoma.

11/15/2016 A PA wrote the patient went to UIC on 11/14/16. The PA noted a fluid wave and noted labs including albumin 2.8; alk phos 214; bilirubin 1.6; sodium 133 and potassium 4.4. The PA ordered 40 mg of Lasix for 30 days and Aldactone 50 mg daily for a month. The patient had an MRI but results were pending. The PA wrote she would try to get an earlier GI appointment than the 12/10/16 appointment. Lasix 40 and spironolactone 50 were ordered for 30 days. The PA failed to know that consultants at UIC had noted that on 8/4/16 the patient needed kayexalate for hyperkalemia. Spironolactone exacerbates hyperkalemia and when used the manufacturer recommends monitoring potassium, which was not done.

10, 11, 17 The patient apparently had a CT scan not an MRI. The PA did not have the CT results and didn't know that the patient went for a CT not an MRI. The lack of reports caused confusion and created an unsafe condition of practice. The PA started spironolactone in a patient with prior recent hyperkalemia without establishing monitoring parameters.

Patient #12

- 11/21/2016 A PA followed up with the patient. The MRI results were still pending. The patient had lost five pounds. The PA documented that the patient had abdominal ascites and peripheral edema. The PA said that patient had end-stage hepatic coma but the PA didn't perform a mental status exam and didn't note that the patient had encephalopathy. The PA requested the MRI result and noted that GI FU was pending.
- 11/30/2016 A MAR for November documents that the patient received a two week supply of KOP meds on November 30, 2016. A nurse documented that a new order was needed for these meds.
- 1/8/2017 A nurse wrote an infirmary admission note documented that the patient complained that he couldn't breathe and for that reason was apparently admitted to the infirmary. There was no provider notes. There was a telephone order for Lasix 40 and spironolactone 50 daily.
- 1/9/2017 BUN 36; sodium 130; potassium 5.4; albumin 2.5; bilirubin 3.7; alk phos 696; AST 305; ALT 173; WBC 13.7 platelets 202.
- 1/9/2017 A doctor admission to the infirmary noted that the patient had increased abdominal girth and shortness of breath and was on Lasix and spironolactone but that this medication expired about four weeks ago. The doctor ordered a CBC, CMP, chest x-ray, and asked for the oncology notes from the last visit which were still not present. The doctor increased the spironolactone to 100 mg daily.
- 1/10/2017 A nurse documented the doctor as saying that he would arrange to pull the fluid out [presumably ascites].
- 2, 11 The PA diagnosed hepatic coma but the patient did not have evidence for encephalopathy or coma. The failure to receive reports continued. The PA believed that the patient had an MRI when the patient had a CT scan.
- 17 The medication renewal process didn't work and the patient's medication stopped in mid December and wasn't started again until 1/8/17, about 3-4 weeks later.
- The patient couldn't breathe and should have been seen by a provider. The patient had significant ascites on 11/21/16 but hadn't been seen in over six weeks. Care was grossly and flagrantly unacceptable.
- 6 These labs did not appear to be reviewed based on progress notes.
- 11, 19 Reports were not present. The patient had been lost to follow up for six weeks and missed critical medication for 3-4 weeks resulting in exacerbation of ascites.

Patient #12

- 1/11/2017 A nurse documented that the patient had "gross" edema of both legs. The nurse called a PA who saw the patient, diagnosed decompensated liver disease and liver coma and sent the patient to St. Joseph Hospital. Although the patient said he couldn't breathe the vital signs were normal. The patient did have ascites. There is a St. Joseph hospital prescription on a patient information form indicating that the patient was in the hospital on 1/11/17.
- 1/11/2017 A PA evaluated the patient but did not review labs from 1/9/17. The PA sent the patient to the hospital for paracentesis.
- 1/14/2017 The patient was discharged from the hospital. The discharge summary was not available but the discharge instructions noted that the patient had ascites, hyponatremia, and liver cancer with instructions to follow up at UIC ASAP for paracentesis.
- 1/14/2017 A nurse admitted the patient to the infirmary post hospitalization.
- 1/15/2017 A nurse called Boswell pharmacy twice for Aldactone which was apparently unavailable.
- 1/16/2017 The doctor noted that the patient had paracentesis at the hospital. The doctor referred the patient for repeat paracentesis. The oncology records were still not present. The recent hospital records were also unavailable. The doctor ordered spironolactone to 50 mg daily and titrate as needed. Aside from getting a paracentesis the doctor did not know what had occurred at the hospital. The doctor ordered a CMP on 1/18/17. The doctor documented that the patient would probably need repeat paracentesis. The status of the HCC was unknown.
- 11 A hospital report was not available.
- 11 UIC records were still not present and providers did not know recommendations for care. The hospital records were also unavailable so the status of the patient wasn't known.

Patient #12

- 1/17/2017 A chest x-ray showed an elevated diaphragm consistent with ascites.
- 1/17/2017 An incident report documented transferring the patient to the hospital.
- 1/18/2017 BUN 32; sodium 130; calcium 8.2; albumin 2.3; bilirubin 3.3; alk phos 472; AST 165; ALT 119.
- 1/19/2017 A doctor noted that the abdominal girth was 44 inches. The patient had 2+ edema. The doctor documented that the records were still pending and that the patient had a history of HCC but the plan wasn't apparently known. The doctor didn't know what had occurred at the hospital.
- 1/20/2017 There is a gap in progress notes from 1/20/17 until 2/15/17. Labs, MARs, prescriptions were present but there were no progress notes.
- 2/1/2017 Lactulose was started but it wasn't clear who ordered it or why. To date the patient did not have evidence, documented in the record of hepatic encephalopathy. Ciprofloxacin, lactulose, Levaquin and 60 mg of Lasix were ordered by phone order but there was no note.
- 2/2/2017 A referral form was present signed 2/2/17 for UIC emergency room for paracentesis.
- 2/10/2017 BUN 149; potassium 6.9; sodium 127; creatinine 3.88; CO2 17; anion gap 12; albumin 12; bilirubin 8.1; alk phos 397; AST 173; ALT 158; WBC 15.9; hemoglobin 12.2; platelets 133; INR 1.9.
- 2/11/2017 Glucose 33; creatinine 4; sodium 125; potassium 6.6.
- 2/12/2017 Glucose 44; BUN 138; creatinine 3.9; sodium 124; potassium 6.8.
- 10, 11 Hospital records were unavailable and the doctor didn't know what occurred at the hospital. Follow up of oncology was not being done. They had recommended return if the patient decompensated, which had occurred.
- 11 The absence of a record was significant. It is unclear what happened to this patient and it appeared that he was ignored for a month although this is unverifiable. It wasn't clear if the patient was evaluated by providers over this time period.
- 19 It appeared that the patient was treated for infection by phone without physician evaluation. The lack of medical records was significant.
- 6, 17
- 6 The patient was in hepatorenal syndrome and the diuretic should have been adjusted. The potassium was critical and should have been addressed.

Patient #12

2/14/2017	Glucose 47; BUN 157; potassium 6; sodium 130; creatinine 4.18.	6	The patient was in hepatorenal syndrome and the diuretic should have been adjusted. The potassium was critical and should have been addressed.
2/15/2017	The patient signed an agreement to participate in the Hospice Program.		
2/17/2017	Glucose 95; BUN 164; potassium 3.9; sodium 128; creatinine 3.8; calcium 8.2; albumin 2.2; bilirubin 6.5; alk phos 304; AST 199; ALT 145.	6	The labs were significantly abnormal but there was no evidence of review.
2/20/2017	Hemoglobin 11.4; glucose 64; creatinine 3.2; sodium 123; potassium 2.8; calcium 7.8; WBC 12.6; hemoglobin 11.4; platelets 22.	6	
2/20/2017	A doctor saw the patient. This was the first visit since 1/19/17, a month ago despite the patient having a life threatening condition. The doctor failed to take any history or give an update of the status. The only history was "no specific complaint." The only examination was to note that the patient had greater abdominal girth and petechiae on the skin. The assessment was hepatic cancer with metastases. The only plan was "continue same care" without specifying what the care was. The patient's plan was unknown.	1, 2, 3	The doctor failed to take adequate history, failed to adequately evaluate or diagnose the patient's condition and failed to develop a proper therapeutic plan. The patient was in hospice but the doctor did not address any comfort issues with the patient. Care was indifferent.
2/20/2017	A nurse documented receiving a call from St Joseph hospital for a lab result. Platelets were 22,000 and WBC 12.6. The nurse notified Dr. Obaisi who ordered depomedrol 80 mg IM stat and prednisone 60 mg daily for three days by phone order.	2, 17	The doctor appeared to be treating ITP. Prednisone is not indicated in thrombocytopenia from cirrhosis. This was incompetence and demonstrated lack of knowledge of primary care by this surgeon. The diagnosis and treatment were therefore inappropriate and placed the patient at risk.
2/25/2017	A doctor ordered to measure the sacral wound weekly and to clean the sacral wound with saline and apply wet to dry dressings.		
2/26/2017	A doctor ordered a stat dose of Lasix by phone.		

Patient #12

- 2/27/2017 A death certificate documented the cause of death as liver cancer. An autopsy was performed. The secondary cause of death was cirrhosis.
- 2/28/2017 A Wexford Mortality Review worksheet documented cholangiocarcinoma as the cause of death but it appears to have been hepatocellular carcinoma from his hepatitis C. The form documented that earlier intervention was not possible.

Patient #13

7/9/2010 The problem list included alcohol and tobacco abuse, stage II hypertension, and stage IV chronic renal disease.

This patient had chronic kidney disease at a very young age. It wasn't clear why he had kidney disease.

5/8/2014 PTH 576 (12-88)

6/6/2014 BUN 55 Creatinine 14.58; ferritin 355; phosphorous 8; hemoglobin 11.4; PTH 648

Treatment goal for phosphate is 3.5-5.5; calcium < 9.5; and PTH less than 2-9 times the upper limit of the lab. However, PTH levels >400 have a higher risk of bone turnover disorders (osteitis fibrosa and mixed uremic osteodystrophy), African Americans may be more vulnerable to bone disease at lower PTH levels. For the UIC lab the normal limits are 12-88, so the goal would be < 792. Dialysis patients with a phosphate > 5.2 have a 1.34 greater mortality risk.

7/3/2014 PTH 500.

7/3/2014 BUN 55; creatinine 13.5; ferritin 359; cholesterol 116; TG 65; HDL 42; LDL 61; phosphorous 5.3; hemoglobin 10.2; MCV 105.9, hepatitis BsAg negative.

7/4/2014 Hepatitis C negative, hep B Ab +

7/21/2014 HTN clinic; BP 159/98. The doctor documented fair control but did not adjust medication.

3 The patient's blood pressure was elevated but not treated. Given that the patient had end-stage renal disease this was not competent care. Care failed to follow generally accepted guidelines or usual practice.

7/31/2014 A nephrologist wrote a few brief lines on a referral form and recommended increasing labetalol to 400 mg BID. The blood pressure was not documented.

8/7/2014 PTH 949; BUN 61; creatinine 14.87; ferritin 311; hemoglobin 11.8.

3 The PTH and BUN were both high, indicating possibly insufficient dialysis time. This apparently was not checked.

Patient #13

8/20/2014	A nephrologist wrote a few brief lines on a referral form and recommended changing sessipor to 60 mg daily and obtaining a fistulogram.		
9/4/2014	BUN 61; creatinine 14.79; ferritin 343; phosphorous 6.7; hemoglobin 11.8; MCV 106.3; PTH 963 (12-88)	3	The phosphorous and PTH were high indicating possibly insufficient dialysis time. This apparently was not checked.
9/8/2014	Wexford approval of fistulogram.		
9/18/2014	A nurse documented the patient going out on writ. The blood pressure was 168/100. Later the same day a nurse documented blood pressure of 171/109. No referral was made.	16	The nurse should have consulted a physician.
9/19/2014	The patient obtained a fistulogram.		
9/22/2014	A doctor saw the 38 year old patient in follow up of the fistulogram. The blood pressure was 175/108. The doctor noted that the fistulogram was working. The doctor did not address the elevated blood pressure.	3	The doctor failed to address the elevated blood pressure.
9/24/2014	The patient transferred from Graham to Stateville. The patient had hypertension and was on dialysis.		
9/24/2014	A nurse took a phone order for kayexalate 15 gm Wednesday and Sunday for three months.		
9/25/2014	A prescription for kayexalate and four other medications was not signed or noted as a phone order.		
10/8/2014	Apparently a nephrologist wrote a brief note stating will adjust BP meds if not improved by next visit.		
10/29/2014	BUN 52; potassium 5.4; creatinine 13.07; calcium 11; hemoglobin 10.6; MCV 101.6		
11/4/2014	A doctor noted that the patient returned from UIC. The patient told the doctor he had six months to live. The doctor did not document what had occurred to the patient at UIC. The doctor noted a repeat CT scan was needed in two months.	2	The assessment of good control of blood lipids without evaluation of the lipids is inappropriate and not based on objective findings.

Patient #13

- 3/26/2015 HTN clinic; the BP was 135/88; the patient had a 2/6 diastolic murmur. The doctor assessed good control for both blood pressure and lipids and continued the same medications. The provider did not discuss in the history whether the patient was receiving medication. It appeared that the patient was only receiving 64% of his medication.
- 4/2/2015 Apparently a nephrologist wrote that the blood pressure was 157/104. The doctor increased lisinopril to 40 mg and increased clonidine to 0.3 mg and recommended referral to UIC vascular surgeon to evaluate a pseudoaneurysm.
- 4/22/2015 Wexford approved a vascular surgery evaluation at UIC.
- 5/22/2015 Apparently a nephrologist saw the patient. The BP was 183/103. The consultant noted that the patient was out of blood pressure medication and therefore did not change dosages.
- 6/3/2015 A RN received a call from UIC lab about a critical potassium of 6.7. This lab was not in the medical record.
- 1, 7 The patient had a murmur and should have had an echocardiogram ordered. For persons on dialysis, it is recommended by UpToDate consultants that blood pressure be maintained to a goal of 130/80. The pressure was not at a good goal for a dialysis patient and medication should have been adjusted. Also, examination of the MAR showed that the patient was not receiving his medication timely and had only received approximately 64% of his medication from December through April of the current time period. Yet the doctor was not obtaining this history from the patient. Care failed to follow generally accepted guidelines or usual practice.
- 17 The patient had not been receiving his medication and the nephrologist should have brought this up with prison nurses and doctors to address.
- 6, 19 The potassium was a critical level but no one addressed it. This is systemic failure and care was grossly and flagrantly unacceptable, as the program should have a system to respond to hyperkalemia given the dialysis population.

Patient #13

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| <p>7/8/2015 A RN received a call from UIC lab about a critical potassium of 7.2. The nurse informed the Medical Director. There were no orders. This lab was not in the medical record.</p> | <p>6, 19</p> | <p>The potassium was a critical level but no one addressed it. This is systemic failure and care was grossly and flagrantly unacceptable as the program should have a system to respond to hyperkalemia given the dialysis population.</p> <p>The nephrologist was the first doctor to address the high potassium that occurred repeatedly recently.</p> |
| <p>7/17/2015 Apparently a nephrologist saw the patient. The blood pressure was not noted. Kayexalate was recommended once a week.</p> | | |
| <p>8/19/2015 The patient returned from a writ. The blood pressure was 169/96. The nurse noted that the patient had a medical director appointment on 8/24/16. Nothing was done to address the increased blood pressure.</p> | <p>16</p> | <p>The nurse should have consulted a physician.</p> |
| <p>8/19/2015 Vascular surgery saw the patient at UIC over four months after referral. The blood pressure was 164/94. The surgeon said that no intervention was indicated. The vascular surgeon noted that there was a 4/6 murmur radiating to the neck that warranted further work up.</p> | | |
| <p>8/22/2015 A dialysis nurse took a phone order from a nephrologist for kayexalate 15 gm Wednesday and Sunday for six months.</p> | | |
| <p>8/24/2015 The Medical Director saw the patient for a post-writ visit. The doctor noted that the patient went to UIC access clinic which indicated no need for revision of the shunt. There was no other history. The examination was "no change" the assessment was "post med writ" and the plan was "FU prn." The doctor did not address the elevated blood pressure of 168/103. The doctor also failed to note the surgeon's recommendation to evaluate the murmur.</p> | <p>3</p> | <p>This is indifferent care to have elevated blood pressure but not address it. Care failed to follow generally accepted guidelines or usual practice.</p> |
| <p>9/1/2015 Collegial review approved an echocardiogram.</p> | | |
| <p>9/2/2015 Wexford approved an echocardiogram.</p> | | |

Patient #13

- 9/2/2015 Wexford denied a cardiology visit to evaluate the murmur but approved an echocardiogram. This presumed that there was someone at Stateville who could evaluate a murmur. When the echocardiogram was completed no one at Stateville documented reviewing its results.
- 9/4/2015 UIC lab reported BUN 62; potassium 6.6 creatinine 13.09, albumin 3.8; alk phos 139; Ferritin 923; transferrin 186 (200-400); cholesterol 111; TG 114; HDL 39; LDL 49, hemoglobin 10.6.
- 9/10/2015 Apparently a nephrologist saw the patient. Blood pressure was 155/97 and potassium 6.6. The doctor did not address the elevated BP documenting that the patient just took clonidine. The nephrologist stopped kayexalate and started a different medication.
- 10/10/2015 A doctor saw the patient who complained of not feeling good. The blood pressure was 148/88 and oxygen saturation was 88%. A recheck of BP was 150/96. The only history pertinent to his complaint was that the patient was in no acute distress and that the patient had difficulty breathing. The lungs were clear. The assessment was "dyspnea [with] HTN + dialysis". The patient was sent to the health care unit but there were no further notes indicating that the patient was examined in the health unit.
- 6, 19 The BUN should have prompted concern for inadequate dialysis time. The elevated potassium was also high and should have been promptly evaluated. It appears that no one did anything about these lab results. Prompt provider evaluation should have occurred.
- 3 The blood pressure had been elevated for over a year and the potassium was high, there was no apparent consideration or documentation of dialysis time or adjustment of blood pressure medication. The dialysis record was not available so it is difficult to determine the nephrologist's thinking.
- 2, 14 The patient had significant findings with hypoxemia, shortness of breath. The patient needed to have a diagnosis made, should have had an x-ray, and should have had further evaluation including with laboratory testing. Yet there is no evidence in the record that the patient was evaluated. The patient should probably have been sent to a hospital. Care failed to follow generally accepted guidelines or usual practice.

Patient #13

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| <p>10/28/2015 At 4:00 am a nurse noted that UIC lab called about a critical 8.5 potassium level. The nurse took no action except that the am nurses would follow up with the doctor. At 1:30 pm the same day a nurse documented that a doctor was notified about the critical lab. The nurse documented that the patient would follow up in following morning. This lab was not in the medical record.</p> | <p>6, 19 A potassium of 8.5 is life threatening and required immediate attention yet it was treated as a routine. There was no evidence that this test was evaluated. Care was grossly and flagrantly unacceptable.</p> |
| <p>10/28/2015 Apparently a nephrologist saw the patient. The BP was 168/95. The doctor did not address the elevated blood pressure.</p> | <p>3 The doctor did not adjust blood pressure medication or apparently ordered increased dialysis time.</p> |
| <p>11/6/2015 At 3:00 am a nurse noted that UIC lab called about a critical potassium of 7.6. The dialysis nurse notified the am nurse to follow up.</p> | <p>6, 19 The potassium was a critical level but no one addressed it. This is systemic failure and care was grossly and flagrantly unacceptable as the program should have a system to respond to hyperkalemia given the dialysis population.</p> |
| <p>11/27/2015 Apparently a nephrologist saw the patient. The BP was 150/84. The potassium was 5.9 and the doctor increased kayexalate. The doctor did not address the elevated blood pressure.</p> | <p>3 The doctor did not adjust blood pressure medication or apparently ordered increased dialysis time.</p> |

Patient #13

12/1/2015 A nurse evaluated the patient for non-specific discomfort. The blood pressure was 143/89. The nurse called a doctor who ordered a stat only dose of atenolol. The patient had shortness of breath, lightheadedness, tachycardia (126), weakness and diaphoresis. An EKG was done but there was no documentation of the results. Notably the EKG is not an automated machine so it has no interpretation and the nurse, being unable to evaluate the EKG could not inform the doctor of the results. One EKG showed a rate of about 145 with non specific STT wave changes. T waves appeared peaked. The patient should have been sent to a hospital to evaluate for acute coronary syndrome.

1/3/2016 Apparently a nephrologist saw the patient. The BP was 170/107 and potassium 5.8. The doctor increased labetalol to 400 mg BID. And gave a stat dose of clonidine.

1/9/2016 A medical staff [unclear if this was a nurse or doctor] documented an evaluation. The patient was brought to the clinic at 1:50 am by the dialysis nurse with nausea, vomiting profuse sweating and abnormal vital signs including P 96; oxygen saturation 90; BP 178/105. The temperature was 94.6, which is hypothermia. The BP increased to 189/113. The patient was monitored for several hours, given Tums, and eventually the BP came down to 161/98 and the patient was sent to his housing unit. If this was a nurse evaluation a doctor was not called. The nurse gave the patient his am medication apparently about 1:30 am.

14 Ordering a stat dose of atenolol under these circumstances is incompetent. The patient should have been admitted to a hospital for evaluation. A stat potassium should have been obtained. The T wave did appear peaked which may have been consistent with hyperkalemia. The patient had Care was grossly and flagrantly unacceptable.

14,16 It seems inappropriate to conduct dialysis at 1:30 am when breakfast is only a couple hours later. It wasn't clear if this note was from a doctor or a nurse. In either case, the patient had vomiting, diaphoresis, hypothermia and significantly elevated blood pressure. These signs are consistent with sepsis or possibly acute coronary syndrome which should have been ruled out. The patient should have had stat laboratory tests and an EKG but instead nothing was done except to give him TUMS. The patient should have been sent to a hospital. It appears that dialysis is being done in the early morning. Care was grossly and flagrantly unacceptable.

Patient #13

1/14/2016 The patient received the echocardiogram requested more than four months previously. The echocardiogram showed mild to moderate increased left ventricle, elevated left atrial and ventricular end diastolic pressures, EF of 60-65%, diastolic dysfunction, severely dilated left atrium, moderately dilated right atrium, elevated pulmonary artery pressure,

This echocardiogram was not timely. This is not a difficult test to obtain. The echocardiogram showed significant hypertensive heart disease.

1/18/2016 The Medical Director saw the patient. This note was brief stating "post echocardiogram at UIC, report pending, no complaint O no acute findings A post med writ P FU prn." The blood pressure was 178/113 but not addressed by the doctor. The doctor did not evaluate the results of the echocardiogram and, based on notes, no one ever reviewed these results.

3, 10 The doctor failed to review the echocardiogram results which were abnormal and showed significant hypertensive heart disease. The doctor also failed to modify blood pressure medication despite significantly elevated blood pressure. Care failed to follow generally accepted guidelines or usual practice.

2/4/2016 Apparently the nephrologist saw the patient. The BP was 178/82. The nephrologist recommended a vascular surgery visit. Blood pressure was not addressed.

3 The doctor failed to modify medication for elevated blood pressure. The dialysis sessions may have needed to be longer.

2/9/2016 The Medical Director noted that Wexford approved an appointment with the UIC fistula clinic.

2/21/2016 At 10:15 am nurse saw the patient for a cold. The temperature was 101.9 and the BP 160/102. The nurse documented "to UC for eval" but it wasn't clear what this meant.

Patient #13

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| <p>2/21/2016 At 10:30 pm a nurse noted that the patient felt nauseous and he had chills. The temperature was 101.4 and BP 170/95. The patient said he was sent up from sick call for increased temperature and blood pressure. The nurse notified a doctor and received orders for Tylenol, Compazine and to monitor the temperature for two days. There was no evidence of monitoring. There was no follow up.</p> | <p>1, 2, 3, 19</p> | <p>The patient had fever, elevated blood pressure, and nausea. There was inadequate history. At a minimum, the patient should have been placed on the infirmary for an ASAP chest x-ray and blood work. Instead, the doctor only gave the patient something to reduce nausea. The patient should have been examined in person but was not. Care failed to follow generally accepted guidelines or usual practice.</p> |
| <p>3/8/2016 Apparently a nephrologist saw the patient. The potassium was 6.2; BP 198/102. The doctor made no change to BP medication.</p> | <p>3</p> | <p>The doctor failed to modify medication for elevated blood pressure. The dialysis sessions may have needed to be longer.</p> |
| <p>3/22/2016 A RN saw the patient in his cell and the inmate complained of shortness of breath. The BP was 160/86 and pulse 114 with respiratory rate 28-32. A CMT escorted the inmate to the health unit in a wheelchair.</p> | | |
| <p>3/22/2016 A nurse saw the patient at 10:35 am. The inmate was wheezing with pulse 116; R 32 and BP 160/80. Within two minutes the patient collapsed and CPR was initiated. Within 15 minutes paramedics arrived and the patient was intubated and transferred to a hospital.</p> | | |
| <p>3/22/2016 The Wexford Mortality Review Worksheet documented that earlier intervention was not possible, there was no way to improve medical care, and the medical response could not be improved.</p> | | |
| <p>3/23/2016 A death certificate lists the cause of death as hypertensive heart disease. An autopsy was done. The anatomic diagnoses were concentric LV hypertrophy, cystic granular kidneys, pulmonary edema, and cerebral edema. The cause of death was hypertensive heart disease.</p> | | |

Patient #13

3/22/2018 A review of the MARs for five months from December 2014 through April 2015 for hypertension medication only revealed that the patient received only 3/5 monthly packets of Labetalol; 5/5 packets of lisinopril; 3/5 packets of nifedipine; 2/5 packets of Furosemide and 3/5 packets of hydralazine. The total % received was 16/25 packets or 64% of his medication.

17 The patient was not receiving medication as ordered. No one was monitoring this.

Patient #14

- 1/11/2013 The Medical Director documented that the patient had a grand mal seizure and hadn't had one in several months. The doctor sent the patient back to his cell house and ordered serum dilantin and Tegretol levels next week. No follow up was ordered.
- 3/2/2013 The patient had a seizure. The BP was 162/98. The nurse sent the patient to the ER but there was no evidence that the patient was seen in the ER.
- 4/2/2013 A PA noted that the patient had a seizure. The PA ordered dilantin and Tegretol levels and referral to the doctor's clinic.
- 4/11/2013 Annual seizure clinic. The patient said he had seizures once a month. The patient also described repetitive stereotypical behavior. The patient was on Dilantin 200 BID and Tegretol 600 BID watch take. The doctor documented that the patient had absence seizures and complex partial seizures. The doctor documented that the anticonvulsant levels were therapeutic. The doctor documented poor seizure control but the doctor made no changes. This patient should have been referred to a neurologist. The doctor also saw the patient for HTN clinic. The patient wanted to go off statin medication. The blood pressure was 136/97 with a repeat blood pressure of 130/100 but the doctor made no change of blood pressure medication and stopped the statin. The doctor documented that the patient didn't want to change his blood pressure medication at this time.
- 4/11/2013 Cholesterol 152; HDL 40; LDL 95.
- 4/17/2013 The patient had an unwitnessed seizure. The doctor was notified and the patient sent to his cell house.
- 5/29/2013 The patient had a seizure. The LPN took no action; did not notify a doctor and sent the patient back to his housing unit.
- 10 The doctor should have ordered follow up after a seizure.
- 12 Drug levels were not in the medical record. The patient had three seizures over the past three months. There was no evidence that the patient had ever had brain imaging or an EEG. There was also no evidence that the patient was ever evaluated by a neurologist. The patient had poor seizure control but was not referred. Care failed to follow generally accepted guidelines as the patient should have been referred to a neurologist .
- 8 Therapeutic drug levels should have been ordered.
- 8 Therapeutic drug levels should have been ordered.

16 The CMT should have consulted a doctor.

1 The history failed to contain mention of medication monitoring. Notably, drug levels were not in the medical record. The patient was not monitored for side effects of his medications.

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1, 3, 15 The history was inadequate and failed to address the seizure and therefore there was no follow up of this. The patient's recent seizures were not addressed by the physician; therapeutic drug levels should have been drawn. The recent elevation of blood pressure wasn't addressed.

16 The referral to a provider never occurred.

16 The referral to a provider never occurred.

Patient #14

<p>12/3/2013 The patient had a seizure. The blood pressure was 166/95 and pulse 103. A doctor was notified but the patient was sent back to his housing unit.</p> <p>12/5/2013 The patient had a seizure. The note was extremely brief. It stated, "Presents to HCU for follow up s/p seizure. Has been on Keppra, Tegretol + Dilantin. Hadn't had a seizure in a few months but he had a couple since then." That was the extent of the evaluation. There was no review of therapeutic drug levels, no examination, and no order of drug levels.</p> <p>12/11/2013 A doctor wrote a note without seeing the patient reminding a nurse apparently to check drug levels for follow up in seizure clinic.</p> <p>12/26/2013 The patient had a seizure. A CMT referred the patient to the HCU where a nurse saw the patient. The nurse did not consult a physician.</p> <p>12/31/2013 A nurse completed a seizure clinic database. The blood pressure was 140/100. The nurse noted that the patient was on Dilantin 200 BID, Tegretol 600 BID, and Keppra 500 BID. The nurse apparently ordered a repeat dilantin level and ordered follow up in 2-3 weeks. There did not appear to be consultation with a physician. A doctor apparently signed the note but a nurse appeared to write the note. The nurse or doctor did not document seizure frequency or compliance with medication or describe a history of when the seizures occurred or what may have precipitated the seizures. There was another note on the same day for HTN clinic. The BP was elevated but the doctor took no action to adjust medication or to note compliance except to state that medication compliance was reviewed. The doctor did note that the dilantin was subtherapeutic but took no action. A repeat Dilantin level was ordered with follow up in 2-3 weeks.</p>	<p>8</p> <p>2, 6, 8</p> <p>16</p> <p>11</p>	<p>The doctor should have ordered a therapeutic drug level</p> <p>The doctor failed to make an adequate assessment after a seizure. There was no evaluation of prior drug levels and the doctor didn't order drug levels after a seizure.</p> <p>The nurse should have consulted a physician.</p> <p>It appeared that the nurse was completing a seizure clinic note instead of a doctor. This constituted performing out of the scope of one's license.</p>
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Patient #14

2/14/2014 A doctor wrote that the patient said he hadn't had a seizure for "a good while." The blood pressure was 140/98. The doctor increased the lisinopril to 30 mg daily.

4/24/2014 The patient was seen in HTN clinic. The blood pressure was 129/91 and 103/79. The doctor made no changes. The doctor noted that the last seizure was four months ago. The patient was on Dilantin, Keppra and Tegretol. No change was made. The doctor didn't document drug levels.

5/18/2014 A nurse documented that the patient was brought to the health unit after a seizure. The blood pressure was 226/109 and the pulse 121. The patient was confused. The nurse notified a doctor but no actions were taken. A half hour later the blood pressure had decreased to 132/84 with pulse 105. The patient was discharged to his housing clinic.

8 Drug levels should have been obtained. Old levels should have been reviewed.

5/19/2014 A nurse saw the patient. The blood pressure was 150/86. No action was taken.

6/18/2014 The patient had a seizure and was seen by an LPN. The nurse took no action.

16 The nurse should have consulted a physician.

7/4/2014 The patient apparently had a seizure. A nurse saw the patient and documented BP of 151/90 and 148/87. The Medical Director was notified and sent back to his housing unit.

8 Drug levels should have been obtained. Old levels should have been reviewed.

8/7/2014 A doctor saw the patient in HTN clinic. The blood pressure was 126/76. The doctor noted that the Dilantin level was 7.7 on 7/10 and 8.2 on 7/28. The Tegretol was 5.2. The doctor noted that the last seizure was between 3-12 months ago even though the patient had at least two seizures since 6/18/14. The doctor increased Dilantin to 300 mg BID.

Patient #14

9/22/2014 A doctor saw the patient and noted that the patient said Dilantin 300 mg was too much as he was groggy and uncoordinated, so the patient decreased the dosage to 200 BID. The doctor did not examine for nystagmus or ataxia and decrease the Dilantin to 100 BID then 100 daily and then discontinue. The doctor noted that the Dilantin had been subtherapeutic since 7/4/14.

11/21/2014 A nurse saw the patient for post seizure. The blood pressure was 158/90. The patient refused to go to the HCU. The Medical Director was notified.

11/29/2014 A doctor saw the patient and noted that the patient had a seizure two weeks ago. The doctor documented "coidental discontinuation dilantin." The doctor continued the Keppra and Tegretol but did not obtain drug levels and wrote "no need to adjust meds."

1/15/2015 The Medical Director saw the patient. The blood pressure was 158/85. The doctor saw the patient for a leg discrepancy and ordered an x-ray of the pelvis, lumbar spine, and left knee but did not address the elevated blood pressure or epilepsy.

1/22/2015 Wexford approved an orthopedic appointment.

2/2/2015 A CMT saw the patient post seizure. The CMT was told by the patient had a seizure a month ago. The CMT noted that the last Dilantin level was 8.2 but the patient was no longer on Dilantin. The CMT did not consult a physician but noted that the patient was scheduled to see the Medical Director on 2/3/15 and ordered a Dilantin level for 2/2/15.

8 Drug levels should have been obtained. Old levels should have been reviewed.

16 The nurse should have consulted a physician.

Patient #14

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| <p>2/3/2015 The Medical Director saw the patient and noted that the patient had his hip x-ray which showed severe degenerative arthritis of the left hip and an old subcapital fracture. The entire examination was documented as "no change." The doctor told the patient that he was scheduled for orthopedic clinic. The doctor did not address the seizure disorder.</p> | <p>2, The x-ray showed severe arthritis with an old fracture yet the doctor failed to properly examine the patient</p> |
| <p>2/3/2015 A doctor saw the patient in seizure clinic. The patient was noted to have a seizure the day before. The doctor took no other history. The drug levels were not checked. The doctor did order a Tegretol level and noted that the patient was on Keppra 500 am and 1000 hs. The patient was also evaluated for HTN. The BP was 121/78. The doctor made no changes.</p> | <p>1,6 The doctor failed to take an adequate history including review of prior therapeutic drug levels.</p> |
| <p>2/21/2015 The patient experienced a seizure. The BP was 194/92. The patient has several superficial lacerations to the neck, R cheek and chin. The Medical Director was called and he prescribed 50 mg of atenolol stat and sent the patient back to his housing unit.</p> | <p>2, 3 The patient had elevated blood pressure after a seizure which typically occurs. The doctor treated this with a single dose of atenolol which was inappropriate. If the doctor had waited until the post-ictal state resolved no treatment probably would be indicated. If the blood pressure remained elevated, long term medication adjustment would be indicated not a stat dose of medication. This doctor was a surgeon who did not appear to know how to treat this problem.</p> |
| <p>3/17/2015 A nurse saw the patient for dizziness and lightheadedness. The blood pressure was 160/92. No action was taken.</p> | <p>16 The nurse should have consulted a physician.</p> |
| <p>4/26/2015 The patient was seen post seizure. The blood pressure was 210/99. The Medical Director was called and prescribed clonidine 0.2 mg with his hs medication. It was 8:25 pm. The nurse documented that the patient would be seen by the Medical Director on 5/4/15 but this visit never occurred.</p> | <p>2, 3, 10 Stat medication for post-ictal high blood pressure is not indicated. The patient should have been re-evaluated after the post-ictal state resolved. There was also failure to follow up.</p> |

Patient #14

5/21/2015 A doctor wrote an extremely brief note. The blood pressure was 150/83. The doctor increased the Procardia to 60 mg a day with follow up in HTN clinic. There was no history, no history of medication compliance, and no examination other than vital signs.

7/28/2015 Wexford approved a CT of the hip.

8/5/2015 The Medical Director saw the patient post writ and noted that a CT scan of the L hip was recommended. The doctor took no history, there was no examination and no documented plan.

10 Consultant recommendations were not followed up.

8/6/2015 Cholesterol 217; HDL 35; LDL 154.

8/20/2015 A doctor saw the patient in HTN clinic. The patient was on Procardia 60, aspirin, Zocor 20, HCTZ, and lisinopril. The BP was 141/91 but no changes were taken. With respect to seizures, the history was that the last seizure was 2 months ago. Tegretol level was noted to be 9.3. The doctor ordered tapering Tegretol to discontinue. The doctor noted that the patient was responding to Keppra.

3 The patient's 10-year risk of heart disease or stroke was 26%. He should have been on a moderate to high dose statin. He should have been on 40 mg of Zocor. His blood pressure medication should probably have been adjusted.

8/23/2015 A nurse saw the patient post seizure. The BP was 199/101 and pulse 109. The nurse called a doctor who ordered a single dose of Keppra.

3 A single dose of Keppra after a seizure is incompetent care.

9/3/2015 A doctor saw the patient and noted that the patient had a seizure three days after his Tegretol was decreased. The patient was on a Tegretol taper and was currently on 100 mg of Tegretol BID. Despite the recent seizure, the plan was to continue the planned taper of Tegretol with a physician follow up the following week. That visit didn't occur.

3, 10 The plan of tapering Tegretol appeared to have resulted in a seizure. Scheduled follow up did not occur.

Patient #14

9/15/2015 A doctor noted that the inmate had "erratic mental status change" attributed to seizures. He was found on the floor unconscious. The doctor noted that the patient developed seizures five years ago. The doctor noted that there had been no formal diagnosis by a neurologist. The doctor noted that most seizures were unwitnessed and no one had reported generalized tonic clonic movements. The patient was disoriented and had an expressive aphasia but no repetitive motor movements. The doctor had a differential diagnosis of R/O organic causes, dementia, or schizophrenia. The doctor ordered blood cultures x 3, CBC, CMP, folate, RPR, TSH, ESR, ANA, Tegretol level, urine drug screen, and mental health referral and then discharged the patient with a month follow up. There was no follow up of these labs and these lab results were not found in the medical record. It did not appear that the patient received the blood tests.

9/22/2015 BUN 32; sodium 130; calcium 8.2; albumin 2.3; bilirubin 3.3; alk phos 472; AST 165; ALT 119.

9/22/2015 A CT of the hip was done. There was chronic deformity of the femoral head and neck with superimposed severe osteoarthritis which was thought to be due to a developmental etiology (slipped capital femoral epiphysis) vs acquired trauma.

9/28/2015 A doctor noted that the CT scan results were not in the medical record. The doctor took no action.

9/30/2015 A CMT saw the patient post seizure. The blood pressure was 180/120 with pulse of 122. A nurse documented receiving orders but it wasn't clear what these orders were.

8, 10 A different doctor saw the patient and wanted to re-evaluate the patient's apparent seizures. Ordered laboratory tests were not done and ordered follow up did not occur.

10, 11 A report was unavailable. The result was not followed up. Based on the x-ray report the patient probably needed evaluation for hip replacement but this did not appear to occur.

Patient #14

<p>10/10/2015 A nurse saw the patient post seizure. The nurse noted that the inmate had an appointment with the Medical Director on 10/12/15. No consultation was made and no further action occurred.</p> <p>10/11/2015 The patient had another seizure. The nurse noted that the patient had an appointment the next day with the Medical Director.</p> <p>10/12/2015 The Medical Director saw the patient. The patient had BP of 104/69. The doctor noted that the patient was having repeated epileptic seizures ever since Tegretol was stopped. The only documented examination was "no change." The patient agreed to an increase of Keppra, which was increased to 1500 mg BID for six months with a one month clinic follow up.</p> <p>10/15/2015 A doctor saw the patient and noted that the patient had no new seizure events. The doctor continued Keppra.</p> <p>11/12/2015 The Medical Director noted that the Keppra was controlling the seizures. The patient signed a release of information to obtain the CT scan result. The doctor took no action.</p> <p>11/17/2015 The Medical Director noted that ortho clinic was approved by collegial review.</p> <p>11/18/2015 The patient had another seizure. The Medical Director was notified and a next day FU with the Medical Director was scheduled.</p> <p>11/18/2015 Wexford approved an orthopedic appointment.</p> <p>11/19/2015 The Medical Director saw the patient and documented "sustained epileptic seizure yesterday." The doctor performed no examination, drew no therapeutic drug level, and increased the Keppra to 2000 pm 1500 am.</p> <p>11/20/2015 The patient had another seizure. The pulse was 115 and BP 154/81. The nurse notified a doctor, who took no action.</p>	<p>16</p> <p>16</p> <p>2</p> <p></p> <p></p> <p></p> <p></p> <p></p> <p>16</p> <p></p> <p>2, 8</p> <p>8</p>	<p>The nurse should have consulted a physician.</p> <p>The nurse should have consulted a physician.</p> <p>The doctor failed to examine the patient. We view a comment "no change" as no examination.</p> <p></p> <p></p> <p></p> <p></p> <p>The nurse should have consulted a physician.</p> <p></p> <p>The doctor performed no examination and did not obtain therapeutic drug levels despite raising the medication. Therapeutic levels should have been reviewed.</p> <p>Therapeutic drug levels should have been ordered.</p>
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Patient #14

11/25/2015 The Medical Director saw the patient post medical writ. The blood pressure was 98/61. The patient had gone to orthopedic clinic but the doctor did not document what occurred at the ortho clinic. The doctor did not address the seizure disorder.

12/16/2015 An orthopedic surgeon saw the patient. The consultant wanted medical clearance before surgery could be done to replace his hip.

12/24/2015 Wexford approved surgery for L hip joint replacement.

1/4/2016 LFTs normal CBC normal; carbamazepine <2

1/8/2016 The patient presented to the health care unit after a seizure. A doctor ordered Ativan stat. The blood pressure was 170/98 but not addressed. A doctor saw the patient, who was described by the doctor as delirious, incoherent, and disoriented. The blood pressure was retaken and was 150/90 with pulse of 120. The doctor ordered that the patient remain in the ER until the heart rate and blood pressure normalized. A doctor saw the patient later. The BP was 114/70 and the pulse 130. The inmate was oriented and coherent. The doctor released the patient with a follow up with the Medical Director on Monday.

1/29/2016 An x-ray showed very advanced degenerative arthritis with marked loss of joint space.

1/30/2016 A LPN went to the cell house for a report of the inmate having a seizure. The patient was alert and oriented. An RN didn't evaluate the patient and the LPN took no history. The LPN noted that the patient was oriented and asked staff to contact the HCU if the patient had any issues.

16 The nurse should have consulted a physician.

Patient #14

2/2/2016 Seizure annual clinic. The patient was on Keppra 1500 mg am and 2000 mg pm. The doctor noted that the patient had been on 3.5 gram of Keppra per day since Nov 2015 with occasional breakthrough seizures. The doctor documented 2-3 urgent care episodes since the last visit, presumably for seizures. The only examination was to state that the patient walked with a crutch and "neuro intact," whatever that meant. The doctor noted that the patient had monthly seizures "but so far not compromising ADL." The doctor noted that the Keppra was "supramaximal dose-will adjust and monitor." The idea is to not compromise. At this point, referral to a neurologist would be appropriate as the patient had continued seizures, did not have a clear seizure type documented, and was unable to be controlled. Despite monthly seizures, the doctor reduced the Keppra to 3 grams a day and return in two weeks.

2/11/2016 A doctor saw the patient after the patient had a seizure after Keppra was reduced. The BP was 128/89. The patient was noted to be stable after medication changed. The patient needed clearance for upcoming hip surgery and the doctor said he would talk to the medical director about this.

2/11/2016 The Medical Director noted the patient was approved for hip joint replacement.

3/5/2016 The patient was brought to the health unit post seizure. The BP was 154/85 and pulse 121. Ativan 2 mg IM and Dilantin 300 mg was given stat by phone order. The patient was initially confused but after 30 minutes the patient was oriented and sent back to his housing unit.

12 The doctor should have referred to a consultant, as the doctors were unable to control his seizures.

8 Therapeutic drug levels should have been ordered.

Patient #14

3/10/2016 The Medical Director saw the patient for shoulder pain. The only examination was "abduction 90 degrees only;" the assessment was "seizure DJD L shoulder." The plan was to schedule the patient for a steroid injection next week.

3/28/2016 A PA wrote a note that the patient was scheduled for a shoulder injection on 3/16/16, but that appointment didn't happen due to time constraints and was rescheduled for 3/21, which didn't happen and was rescheduled for 3/20/16.

3/29/2016 CMP normal; total cholesterol 178; TG 182; HDL 31; LDL 111.

3/30/2016 A doctor performed a shoulder injection.

4/4/2016 At 4:30 am a nurse saw the patient for left chest pain "like my muscle down there is sore." The blood pressure was 170/102. An EKG was done and the Medical Director was notified. The Medical Director ordered clonidine 0.2 mg stat, NTG SL, and Tylenol with an order to monitor the patient for an hour. If the pain persisted the nurse was to call him back. If the pain resolved the patient was to be released with a morning follow up. The nurse didn't ask again about the chest pain but the vitals were better with BP 142/88 and pulse 74 and the patient was sent back to his housing unit.

4/4/2016 At 9:30 am a doctor saw the patient. The doctor noted that there were no EKG changes and the pain was not responsive to NTG. The patient had point tenderness over the back and left shoulder. The doctor assessed gastritis secondary to NSAID and ordered Zintec 150 hs.

4/4/2016 An EKG automated reading read atrial flutter, but a doctor overrode this and wrote normal sinus rhythm. There were five EKGs, none of which appeared to show atrial flutter. Four of the five EKGs did not include automated readings.

Patient #14

- 4/25/2016 The doctor saw the patient for annual chronic clinic for hypertension. The patient was on Zocor 20 mg, lisinopril 30 and aspirin. The blood pressure was 130/85. The doctor documented that the patient's labs were all "WNL." The labs weren't documented in the doctor's note.
- 4/26/2016 A LPN saw the patient on the housing unit after a reported seizure. The inmate was on the floor "playing with his T shirt. No seizure activity noted." The LPN sent the patient to the health care unit. The patient was observed in the health unit for 40 minutes and then sent back to his housing unit.
- 4/30/2016 A nurse saw the patient for a suspected seizure. The BP was 181/105 and pulse 121. The patient was drooling and confused. The inmate was sent to the health care unit. There were no notes from the health care unit.
- 5/10/2016 The Medical Director noted an orthopedic appointment at UIC was approved.
- 5/11/2016 Wexford approved a UIC ortho appointment for DJD of the hip for a slipped femoral epiphysis.
- 5/26/2016 The patient apparently had a seizure. The pulse was 106 and BP 146/88. The patient was confused and had garbled speech post-ictal. The Medical Director was called who ordered a one week follow up.
- 6/2/2016 The Medical Director documented that the inmate was inquiring about his hip surgery. The doctor appeared to tell the patient that the surgery would be soon. There was no examination.
- 6/21/2016 The patient went to UIC ortho but pre-operative laboratory tests didn't accompany the patient so the appointment was rescheduled.
- 3 The patient had a 10% 10-year risk of heart disease and stroke but was only on a low intensity statin.
- 16 The nurse should have consulted a physician.
- 16 The nurse should have consulted a physician.
- 10 Sooner follow up was indicated.

Patient #14

6/21/2016 A brief comment by UIC ortho on the referral form stated that the patient had hip osteoarthritis and needed pre-op labs and paperwork before surgery could take place. They recommended return to clinic when these had been done. The report by the orthopedic service stated that the patient needed the prison doctor to medically clear the patient and that pre-op labs had to be done.

6/23/2016 The Medical Director saw the patient post writ and noted that the patient needed lab work and paperwork. The doctor did not evaluate the patient for his seizures despite recent seizures.

6/28/2016 CMP normal except CO2 21 and anion gap 13. CBC normal.

7/16/2016 The patient had an unwitnessed seizure. BP was 152/91. The nurse took no action. 16 The nurse should have consulted a physician.

8/2/2016 Phenytoin 3.3 (10-20); CBC normal.

8/9/2016 A doctor saw the patient in semi-annual seizure clinic. Much of the note was illegible. The patient had no urgent care episodes, presumably seizures. The Dilantin level was 3.3 and the Keppra level was pending. It isn't clear how the patient got on Dilantin and the history didn't explain the change in therapy. The doctor noted that the patient was on Dilantin 300 mg and Keppra 1000 mg BID. A follow up in two weeks with serum drug levels was ordered.

8/16/2016 An EKG without a legible date was signed as reviewed on this date. Was NSR with septal infarct age indeterminate.

8/24/2016 A nurse saw the patient for an apparent seizure. The pulse was 114 and BP 132/81. The patient was given his seizure medication and sent back to his housing unit. 16 The nurse should have consulted a physician.

10/2/2016 EKG sinus bradycardia with voltage criteria for LVH.

Patient #14

10/6/2016 Metabolic panel normal except C02 23; cholesterol 133; TG 83; HDL 33; LDL 83.

10/17/2016 A doctor saw the patient in semi-annual HTN clinic. The patient was on HCTZ, Procardia, aspirin, lisinopril and Zocor 20. The BP was 111/76. An EKG was ordered with follow up in six months.

10/18/2016 Glucose 118; Cholesterol 158; TG 115; HDL 27; LDL 108. CBC normal.

3 These lipid values with the 10/17/16 BP values yield a 13.6% 10-year risk of heart disease or stroke. A moderate to high intensity statin was indicated.

12/14/2016 The Medical Director documented that orthopedic follow up was approved. This was based on the June UIC ortho pre-operative surgery appointment that was cancelled because the patient didn't come with pre-operative laboratory tests.

12/14/2016 Wexford just received the request for orthopedic follow up and approved an orthopedic appointment. This was six months after the prior ortho visit.

1/10/2017 A nurse saw the patient for a seizure. The pulse was 128 and BP 190/97. The pulse came down to 112 and BP 155/91. After the confusion improved the Medical Director was notified. No orders were given and the patient was sent back to his housing unit.

8 Drug levels should have been obtained. Old levels should have been reviewed.

1/10/2017 The orthopedic clinic documented that the patient needed to get medical clearance from APEC. Apparently this is a UIC unit.

1/11/2017 The Medical Director saw the patient post UIC ortho write. The patient needed medical clearance. The doctor had no plan.

1/13/2017 A doctor saw the patient for seizures. The doctor noted that the patient was taking Dilantin and Keppra. The only examination was to note that the patient was alert and "PE [physical examination] unremarkable." The doctor ordered a Dilantin and Keppra level and a follow up.

Patient #14

1/26/2017 A doctor saw the patient to follow up on lab work. However, the tests were not done and the doctor ordered follow up when the lab tests were done.

1/26/2017 Phenytoin 5.3 (10-20).

1/28/2017 At 11:56 am a nurse noted that the patient was brought to the ER after a seizure. The BP was 184/96 and pulse 96. The patient was unable to follow directions and had a laceration on his chin. A few minutes later the patient was alert and responding. A doctor placed three sutures in the chin and wrote a note. The doctor noted that the patient was alert with confusion initially but became alert. The only neurologic examination was to note the pupils were equal and reactive. The doctor placed sutures, dressed the wound, and ordered a Dilantin and Keppra level but did not order any medication. The doctor ordered follow up in two days.

The patient was on Lisinopril 30; HCTZ 25; Nifedipine 60; simvastatin 20; ASA, Keppra 1500 BID; Dilantin 300 QD.

1/28/2017 At 5:30 pm a LPN was called to a cell house for the patient having a seizure. The patient was unresponsive and sustained a cardiac arrest. CPR was started and apparently continued until paramedics arrived. The patient was pronounced dead at the hospital at 6:16 pm.

1/29/2017 The death certificate listed coronary atherosclerosis as the cause of death. The death certificate indicated that an autopsy was done but the autopsy report was not in the medical record.

Patient #14

2/1/2017 A death summary was completed by Dr. Obaisi. He stated that the patient was incarcerated 25 years previously and was on treatment for hypertension and epilepsy. Medications at the time of death included lisinopril, HCTZ, Nifedipine, simvastatin 20 mg, ASA, Keppra, Dilantin, alendronate 70 mg weekly, oscar 1000 mg daily and famotidine 20 mg. He noted that the patient was scheduled for hip replacement. The only remaining discussion was the day of his death in which the patient experienced seizures twice.

The goal of epilepsy management is to derive an accurate diagnosis, measure of seizure frequency, monitor medication side effects, and evaluate for disease related psychosocial problems. UpToDate states it is usually appropriate to refer to a neurologist to make the diagnosis and formulate a treatment strategy. Referral to an epilepsy specialist may be necessary if there is doubt about the diagnosis and/or if the patient continues to have seizures. Drugs are typically designed for the seizure type. Keppra is a drug used for a broad range of seizures; phenytoin and Tegretol treat a narrow range of seizure types. Keppra is used for myoclonic, partial onset and tonic-clonic seizures. For Keppra the patient should be monitored for ataxia, abnormal gait, psychiatric or behavioral symptoms with CBC if patients experience fever or recurrent infection. Tegretol levels should be checked every two months until levels are constant.

Patient #15

8/12/2016 The patient was admitted to NRC from Cook County Jail. He weighed 207 pounds and was identified with mental illness.

1/13/2017 An x-ray of the chest and abdomen showed a metallic density in the right lower pelvis suggesting a foreign body.

6/2/2017 There was a rectangular foreign body in the left upper quadrant extending to the left upper mid abdomen measuring up to 19 cm. Recommend continued follow up.

7/12/2017 At 5:30 pm a nurse noted that an officer witnessed the patient swallowing a spork. The nurse documented that the inmate "denies need for medical @ this time." The nurse did not consult a doctor. The nurse noted, "Will have no complication from swallowing a foreign object." There was no referral to a doctor.

7/13/2017 At 12:40 pm a nurse documenting notifying a doctor that the inmate said he swallowed another spork. The nurse called a doctor, who ordered an abdominal x-ray.

7/13/2017 No radiopaque foreign body is seen in the abdomen or pelvis.

7/16/2017 A nurse saw the patient who said, "I went on hunger strike because no one cares about the spork I swallowed." The nurse did not address the complaint of having swallowed a spork.

7/23/2017 A nurse evaluated the patient with a laceration noted on his right arm. The patient said he did it with a spork. The pulse was 148. The nurse described the laceration as 10 by 3 cm, which is large. The nurse placed steristrips but did not refer the patient despite a large laceration and a significant tachycardia.

16 Care was grossly and flagrantly unacceptable. Swallowing a foreign body such as a spork with a sharp end is potentially life-threatening and to state that the patient denies a need for medical care when the
7, 19 The doctor should have examined the patient. A plastic item will not show up on x-ray and the patient should have been followed, and if the item was not retrieved in the stool then

19 The complaint was ignored and a physician should have evaluated the patient.

16 The nurse should have consulted a physician.

Patient #15

7/24/2017	At 9:15 pm a nurse saw the patient for abdominal pain. The patient asked to be put on sick call. The nurse documented the patient saying, "Don't put any pressure on my stomach." The pulse was 104 and the temperature was 100. The nurse assessment was "ineffective coping; pain R/T unk etiology ABD C/O abdominal pain." The nurse did not refer the patient to see a physician. The patient was on a crisis watch.	16	The nurse should have consulted a physician.
8/7/2017	The patient refused sick call.		
9/27/2017	The inmate had a discussion with a psychiatrist that he had swallowed sporks and wasn't receiving medical attention. The psychiatrist said that the inmate was frustrated with "what he perceives to be indifferent medical attention." The psychiatrist discussed "some of the motivations for self-harm." The psychiatrist did not refer the patient to medical.	16	The psychiatrist should have consulted a physician
9/29/2017	The patient was evaluated for suicide potential by a licensed mental health staff. The patient complained that he was concerned about being refused sick call and wanted to go to an outside hospital. The patient was angry and wanted to see a doctor. The licensed staff wrote that the last suicide attempt was on June 12th and June 13th when the inmate swallowed sporks. However, the more recent episode of swallowing a spork was not mentioned. There was no referral to medical.	16	It is unclear whether the mental health staff knew that the patient had swallowed a spork. If so, the patient should have been referred to a physician.
10/2/2017	The patient saw a nurse practitioner and complained that he had swallowed "sporks" a long time ago and wanted surgery to have these removed. The patient weighed 174 pounds, which was a 33 pound weight loss over the past year. The NP documented a soft non-tender abdomen with normal bowel sounds. The patient had a history of self harm. The patient also said he had pain from a piece of a nail clipper embedded in his forearm. A palpable lump was present on the forearm. The NP ordered an x-ray of the arm but took no action about the spork. The NP noted in the assessment that the patient had a foreign body in the GI tract.	7	The NP failed to properly evaluate for an ingested spork. An ingested item failing to evacuate should have resulted in referral for endoscopy. Care was grossly and flagrantly unacceptable.

16 The mental health staff should have referred the patient to a provider.

16 The patient wasn't referred to a
provider despite legitimate
complaints.

16 The patient wasn't referred to a
provider despite legitimate
complaints.

16 The patient had significant weight loss, abdominal pain, and history of ingestion of an object. The patient should have been immediately referred to a physician. Care was grossly and flagrantly unacceptable.

10/20/2017 A nurse saw the patient for a complaint of swallowing sporks "months ago." The patient's weight was 150 pounds, which is a 24 pound weight loss over the past month and 57 pound weight loss over the past year. The patient complained that about a week ago he started having abdominal pain that was sharp and burning. The patient did not notice black or tarry stool and didn't think he had any bleeding. The patient had nausea, diarrhea, and pain in the center of his abdomen. It hurt when the patient ate. The nurse noted pain on palpation in the center of the abdomen. The nurse did not consult a physician and gave the inmate Pepto-Bismol.

Patient #15

10/21/2017 At sometime around 7:00 am a nurse noted during medication pass that the inmate was in bed unresponsive. The patient had no respirations or pulse and no signs of life. The patient was stiff and in apparent rigor mortis. The patient had blood tinged drainage from his mouth. There was blood in the toilet. CPR was started. Paramedics arrived. It is not clear a doctor was on the scene but the nurse documented that the patient was declared dead by 7:40. It isn't clear if this was the paramedics or a doctor.

12/1/2017 An autopsy reported that there were two sporks in the proximal duodenum and the mucosa was deeply lacerated. The patient had deep lacerations of the proximal duodenum with 20 ounces of clotted blood present in the stomach with superficial lacerations of the proximal esophagus. The death was attributed to a GI bleed caused by ingestion of foreign objects (two sporks).

The most common features in history of foreign body ingestion are dysphagia, refusal to eat, and regurgitation of undigested food. Perforation of the mid or distal esophagus may result in severe chest or upper abdominal pain. Endoscopic evaluation is required even in the setting of negative radiographs. Plastic is not readily seen on plain films so failure to locate an object on radiographic examination does not preclude its presence. In patients with persistent symptoms, an endoscopic evaluation should be performed even if the radiographic examination is negative. A sharp pointed object in the duodenum or stomach require urgent endoscopy.

Patient #15

1/5/2018 An administrative death review was completed. This review found that the inmate had an autopsy that showed two sporks inside his stomach that had lacerated the small intestines which was determined to have caused the death. The administrative review found that the patient had an x-ray on 7/14/17 that showed no foreign body. The review also noted that the inmate had been seen in nursing sick call on 10/20/17 for abdominal pain and diarrhea. During the assessment the patient complained of having swallowed sporks two months ago. The review documented that the nurse assessed a soft and non-tender abdomen, vital signs were normal, and that a proper protocol had been chosen and that there was nothing in the nursing assessment that indicated an emergency. The review noted that he had a number of crisis watch placements for episodes of self harm including swallowing objects. He was sent to a hospital twice (5/3/17 and 6/2/17) for swallowing objects. He swallowed a wire on the 6/21/17 admission but there was no hospital report. No problems with medical care were identified on this review. The review noted that his medication compliance was sporadic at best. It appeared on quick review that the inmate would refuse as much as nearly half of his medication. The review noted that his symptom intensity was related to his medication compliance with more hallucinations, paranoia and delusions when not taking his medications. The review also noted that the patient was concerned about not receiving proper medical care and that he also discussed swallowing two sporks. The review did make a recommendation that psychiatrist should make referrals for enforced medication if a patient showed inconsistent compliance that resulted in crisis watches, disciplinary infractions, and increased symptoms and that nurse should refer patients to a mental health professional when a patient refused medication for three consecutive days.

Patient #16

11/16/2012 Problem list documented HTN and asthma; no other diseases were listed.

6/5/2013 An EKG showed a normal sinus rhythm

8/20/2014 A chest x-ray showed clear lungs. The heart was not enlarged. There was no active pulmonary disease.

12/29/2014 An EKG showed a normal sinus rhythm.

1/24/2015 The patient was seen in asthma clinic at Menard. The PEFrs was 550 and the patient was described as mild persistent. The patient was using Xopenex only. There was no history

2/2/2015 Cholesterol 115; HDL 40; LDL 70.

3/17/2015 The patient was seen in HTN clinic at Menard. The blood pressure was 142/80; weight was 350. There was no history. Cholesterol was 115; HDL 40; and LDL 70. The patient was on HCTZ and amlodipine.

7/22/2015 A doctor saw the patient and noted that the patient was being seen for chest pain amongst other items. The doctor noted that an EKG was normal. The doctor noted "to be up and about and walking;" "initially he was not able to walk but later he walked OK No chest pain No chest pain No SOB." The doctor prescribed Motrin 200 mg 1-2 tabs TID prn; 18 tabs were given.

7/23/2015 A nurse saw the patient for chest pain. The patient had the pain for about an hour. The pain was sharp and felt like tightness. The patient had dyspnea, dizziness, and had pain in the arm. An EKG was done. The pulse was 86 with BP 108/70. The nurse referred the patient to a physician.

7/30/2015 The patient was seen in asthma and HTN clinic at Menard. The BP was 130/80 and PEFr was 550/550. The patient was listed as mild persistent. There was no history noted for either disease. The patient was on Norvasc and HCTZ.

17 Because the patient was a smoker, he had a 10-year risk of heart disease and stroke of 10% and should have been placed on a moderate to high intensity statin. This did not occur.

11, 17 We could not locate the EKG in the record. Notably, Motrin can increase risk of serious cardiovascular thrombotic events. Use of this drug should have been considered in a patient with multiple cardiovascular risk.

11, 16 We could not locate the EKG in the record. Referral to a physician should not be routine for chest pain.

17 The patient had an 8.6% 10-year risk of heart disease or stroke and should have been prescribed a moderate to high intensity statin.

Patient #16

- 10/21/2015 Patient was seen in HTN clinic at Menard. BP 120/84; pulse 108; the patient had 3+ pitting edema. The patient was on Norvasc, HCTZ, Lasix; and KCL. The patient was noted in good control. 3+ edema is of concern but was not addressed. It may have been due to the Norvasc.
- 12/2/2015 Cholesterol 134; HDL 40; LDL 84.
- 1/20/2016 Menard asthma and HTN chronic clinics. Weight 387; BP 138/86; pulse 107; PEF 560/500; noted as in good control for HTN on Lasix 40; Norvasc 5; HCTZ 25; KCL 25.
- 2/26/2016 A nurse saw the patient for chest pain that was stabbing in nature lasting 3-4 minutes. The blood pressure was 170/68 with pulse 100. The nurse did not appear to consult a physician but a chest x-ray was ordered along with Tylenol and CTM. It appeared that a physician signed this note.
- 3/1/2016 A chest x-ray showed bilateral hilar prominence may be due to lymphadenopathy. Findings may be due to sarcoidosis. For more complete evaluation, CT study of the chest with contrast is suggested.
- 3/16/2016 A doctor noted that a chest x-ray showed hilar adenopathy. A referral was made for a CT scan.
- 4/7/2016 CT of chest was normal without enlarged lymph nodes.
- 4/14/2016 A doctor noted that the patient had a CT scan but the results weren't available. The blood pressure was 154/100 and the doctor noted that the patient had been off his BP meds for three days. The patient was given reassurance.
- 6/9/2016 Glucose 118.
- 6/18/2016 A doctor noted that the CT scan suggestive of sarcoidosis-recommendation was CT with contrast.
- 7/1/2016 Glucose 93; albumin 3.2 (3.4-5); cholesterol 120; TG 58; HDL 36; LDL 72.
- 2 The doctor did not evaluate why the patient had edema.
- 19 A physician should have evaluated the patient and an EKG should have been done. The patient had chest pain with abnormal pulse and blood pressure.

Patient #16

7/25/2016 Asthma and HTN clinics; weight 410; BP 132/64; PEFR 540/500; the patient had 3-4+ edema with pitting and listed in good control. The patient was on Lasix 40; Norvasc 5; HCTZ 25; and KCL with ASA started for a year.

8/11/2016 A doctor saw the patient for chest pain when walking, increased with deep breathing. Some of the note was illegible but it appeared that the patient was short of breath. The doctor diagnosed atypical chest pain and ordered an EKG. The EKG was not reviewed but showed inferior infarct age undetermined. The actual tracing was poorly copied and we were unable to review accurately. The rest of the note was illegible.

8/11/2016 A nurse documented a nurse protocol for chest pain. The nurse documented shortness of breath with exertion and experienced chest pain while walking and it felt like tightness. The nurse referred to a doctor, who saw the patient and diagnosed atypical chest pain.

8/29/2016 A nurse noted that the patient was dizzy and short of breath. A doctor saw the patient who was short of breath and diaphoretic. The doctor sent the patient to a hospital.

8/29/2016 An EKG showed normal sinus rhythm with possible inferior infarct age indeterminate

8/29/2016 The patient was admitted to Memorial Hospital in Chester IL. The patient was admitted for shortness of breath and diagnosed with pulmonary emboli. The patient was also diagnosed with new onset diabetes with hemoglobin A1c of 7. The patient was placed on coumadin. The etiology of the emboli were not determined. The recommendation was anticoagulation for six months. The patient had a hemoglobin in the hospital of 11.1

2 The doctor did not evaluate why the patient had edema.

2 The patient had symptoms consistent with angina but was diagnosed with atypical chest pain. The patient had multiple risk factors for coronary artery disease including being a smoker, hypertension, elderly, and male. His cardiovascular risk was around 10% and he should have been on a statin. It appeared that the doctor made an inaccurate assessment based on the history the patient provided.

Patient #16

8/29/2016 The patient's annual examination at Menard listed obesity, GERD, HTN, history of rectal bleed, and questionable hilar nodes as problems.

8/29/2016 A nurse documented that the patient returned from the hospital with a diagnosis of pulmonary embolism and was on anticoagulation.

8/29/2016 A D-dimer test in the hospital was 8.25 (0-0.5) protein C or S or lupus anticoagulant were not done.

8/30/2016 Chest angiography showed bilateral pulmonary emboli within segmental and subsegmental RLL, lobar, and RUL and LUL and LLL segmental branches.

8/30/2016 The patient asked a nurse when he would get his medication for his blood clots. The nurse documented that the patient would see a doctor in the morning.

8/30/2016 The patient was admitted to the infirmary and listed as on coumadin and Lovenox.

9/6/2016 INR 2.56

9/6/2016 INR 2.56

9/7/2016 A doctor noted an INR of 2.56. There had been no history or physical examination since the admission note. The patient was discharged with a diagnosis of bilateral pulmonary emboli. Notably, at the hospital there was no evaluation what the etiology of the bilateral emboli was. There was no echocardiogram, no lab tests for clotting diseases.

10, 17 The patient wasn't seen for a week after a hospitalization for pulmonary embolus. Follow up was inadequate. Based on the recent diagnosis of diabetes the 10 year risk of heart disease or stroke was 16% and the patient should have been on high intensity statin.

9/13/2016 An EKG showed normal sinus rhythm with possible inferior infarct age indeterminate

9/14/2016 Gen Medicine clinic at Menard. BP 134/90. The weight was 380. The doctor started or continued coumadin 8 mg for bilateral pulmonary embolism with "fair control." There was no history of the pulmonary embolism and it was unclear when this started. There was no history at all.

9/15/2016 A1c 7.5; INR 2.3

Patient #16

9/21/2016 A NP saw the patient and noted that the patient had no abnormal bleeding and had new diagnosis of diabetes and was on coumadin. The patient was on coumadin 8 mg and metformin 500 BID.

10/11/2016 INR 2.5.

10/19/2016 An EKG showed normal sinus rhythm with nonspecific ST abnormality

10/19/2016 A NP saw the patient for chest pain with shortness of breath. The NP took virtually no history of the chest pain except that the patient had no diaphoresis. An EKG was done and the NP documented that it was normal; it was not. It showed non-specific STT wave changes. The NP documented that the patient was laughing and making "joke with staff." The NP documented normal assessment. The NP ordered a chest x-ray and follow up with a physician.

1, 2, 3 The NP failed to take an accurate history. The history that was taken of chest pain with shortness of breath is not inconsistent with angina. The EKG was interpreted as normal by the NP but actually showed nonspecific STT wave changes which is consistent with ischemia. The patient also had multiple risk factors for ischemic heart disease including diabetes, hypertension, smoker, male and elderly and had a 16% 10 year risk of heart disease or stroke. The patient also had repeated episodes of similar pain which appeared to be angina. The NP should have placed the patient on anti-anginal drugs and a high intensity statin and referred for exercise stress testing, stress echo or catheterization.

10/21/2016 A doctor wrote a note that the patient had chest pain but took no history, performed no examination and only noted an INR of 2.6 and ordered a chest x-ray and ordered Tylenol.

1, 2, 3 The doctor failed to take a history, did not perform an examination, and made no assessment of the chest pain. The only plan was to order Tylenol and refer for a chest film. Care was indifferent.

11/1/2016 In November the patient missed two doses of coumadin

11/16/2016 INR 2.

12/1/2016 In December the patient missed eight doses of coumadin; he was at a hospital for several days.

12/16/2016 Glucose 115; calcium 8.5; albumin 3.3; cholesterol 129; HDL 40; LDL 80; INR 2.7.

Patient #16

12/20/2016 A chest x-ray showed borderline heart size is seen with haziness in the perihilar region. This may indicate mild pulmonary vascular congestion. Please correlate clinically.

12/20/2016 An EKG showed normal sinus rhythm.

12/20/2016 A nurse evaluated the patient using a chest pain protocol. The blood pressure was 132/84 and pulse 88. The patient had ronchi noted in the R lung. An EKG was documented as RRR. The patient had numbness radiating to the arm without shortness of breath or nausea. The nurse consulted a physician who made orders but these were not documented in the note.

12/20/2016 A NP saw the patient for chest pain and shortness of breath since the morning. The chest pain radiated to the left arm. The patient had cough. The NP documented the EKG as normal; it was normal. URI was diagnosed. Cough syrup was prescribed and a chest x-ray was ordered.

1, 2, 3 The history with respect to the chest pain was inadequate. The patient had multiple cardiovascular risk factors and a 13% 10 year cardiovascular risk. The patient also had multiple episodes of chest pain. He should have been placed on a statin, antianginal drug and referred for possible stress test or cardiac catheterization.

12/21/2016 An NP saw the patient in follow up. The patient had no improvement but diagnosed URI and ordered a follow up as ordered.

12/21/2016 A nurse saw the patient for shortness of breath since last night. The patient was on Xopenex. The patient had cough. PEFr were 380/400/390 and oxygen saturation was 97% and the patient had ronchi. A physician was not consulted and prn follow up was ordered.

12/23/2016 Chest x-ray from Memorial Hospital in Chester IL shows placement of an endotracheal tube.

12/23/2016 A nurse saw the patient for shortness of breath. The patient had a pulse of 110 and BP of 138/90 with PEFr 250 and oxygen saturation of 94-97. The nurse consulted a doctor who ordered the patient sent to a local hospital.

Patient #16

12/24/2016 A chest x-ray showed an endotracheal tube was removed. The heart and lungs were normal.

12/25/2016 A CT scan showed discoid atelectasis and ground glass nodular opacity in the right upper lobe. There was a 12 mm nodule in the left adrenal gland. A repeat CT scan in 12 months was recommended. The study was non-diagnostic for pulmonary embolism.

12/26/2016 A chest x-ray was normal at Memorial Hosp in Chester.

12/26/2016 Duplex scan was negative for DVT in both legs.

12/27/2016 The patient returned from the hospital with diagnoses of respiratory failure; asthma exacerbation. The patient was on Ceftin 250 BID and azithromycin 250 daily both for three more days, a prednisone taper, Lasix 60 mg for 30 days and continuation of other medications.

12/28/2016 A doctor wrote a very brief note stating, "SOA no Cs denies SOB chest clear" The plan was to discharge the patient to his cell with follow up in a week.

1,3 The doctor's documented history was inadequate. It wasn't clear he reviewed the hospital note and it wasn't clear what the therapeutic plan was for this patient at this time.

1/1/2017 The patient received all doses of coumadin.

1/7/2017 A NP saw the patient for the hospital follow up. The NP noted that the patient was doing well and noted that the patient was referred for sleep study. The NP did not document what occurred at the hospital.

1 The history was inadequate and it wasn't clear what happened at the hospital.

1/17/2017 INR 2.4.

1/18/2017 The patient was approved for a sleep study.

2/1/2017 The MAR showed that the patient refused seven doses of coumadin. The patient missed six of the first eight doses after transfer from Menard.

2/4/2017 The patient transferred to Stateville. The patient was documented as having HTN, asthma, PE, and DM. The patient was listed as being on Tylenol, Lasix, aspirin, Coumadin, HCTZ, Glucophage, Norvasc, Pepcid, and Mobic.

Patient #16

2/16/2017 A PA saw the patient and noted that he was a new patient to Stateville. The PA noted that the patient had HTN and was due to have a sleep study. The PA noted that the patient was already referred to chronic clinic. The PA noted morbid obesity, HTN, type 2 DM, asthma and history of PE in August of 2016. The PA ordered a PT, PTT, CMP, CBC, and Lasix.

2/21/2017 A sleep study showed very severe sleep disordered breathing. CPAP was recommended. Or referral to ENT for possible surgery.

2/23/2017 Hemoglobin 9.4; MCV 69.5; MCH 20; MCHC 28.8; INR 1.2 This was the first CBC in the record at an IDOC facility. The patient had a hemoglobin of 11.1 at a hospital in Chester IL in August 2016.

3/1/2017 A normal chest x-ray was reported.

3/1/2017 The Medical Director noted that the patient was post sleep study and was to be presented to collegial for a CPAP device. The doctor wrote that the patient had a history of pulmonary emboli and was on coumadin. The doctor ordered an EKG, chest x-ray, CBC, CMP A1c and follow up in a month. The blood pressure was 151/84 and pulse 94. The doctor did not address the elevated BP. The doctor did not check the INR or note the significant anemia while on coumadin. This was the first physician visit at Stateville.

6 The doctor failed to take note of the recent abnormal hemoglobin and subtherapeutic INR. This placed the patient at significant risk.

3/1/2017 The MAR showed that the patient received coumadin until 3/9/17, when it was discontinued. The patient received no further doses.

3/3/2017 A doctor saw the patient. The patient had back and neck pain. The note was partly illegible. The doctor ordered an x-ray of the neck and back and ordered Robaxin with follow up when the x-ray was done.

3/5/2017 An EKG showed normal sinus rhythm.

3/7/2017 A1c 7.2; hemoglobin 9.2 with microcytic indices.

Patient #16

3/10/2017 The Medical Director saw the patient and noted that the hemoglobin was 9.2 and ordered fecal occult blood for a week. The doctor noted that a rectal examination noted a mass in the rectum and diagnosed anemia with GI bleeding and a rectal polypoid lesion. The Medical Director stopped the coumadin and aspirin and requested ferritin and serum iron and an INR, folate and B12 with follow up in a week. The doctor gave no reason for stopping the coumadin. It appeared that this was done due to the anemia and the apparent bleeding in the rectum. The pulse was 121. The doctor did not document the most recent INR. The doctor made no attempt to evaluate the status of the pulmonary embolism. The patient had received six months of warfarin, but follow up on this should have occurred.

3/14/2017 B12 445 (180-914); folate 16 (>5.8); iron 20 (50-180); iron binding capacity 402 (250-450); transferrin 287 (200-400); INR 1.2.

3/14/2017 A collegial review approved a GI referral.

3/16/2017 A PA saw the patient. The patient asked for a refill of his Lasix. The PA performed virtually no examination but assessed HTN, pretibial edema, and sleep apnea. The blood pressure was 135/93. The PA ordered a HTN chronic clinic but did not adjust BP medication or address the INR result.

3/17/2017 A doctor saw the patient for follow up of neck pain. The BP was 141/82. The neck was better. The rest of the note was illegible.

Patient #16

3/28/2017 HTN clinic at Stateville. Patient on Lasix 40; Norvasc 5; HCTZ 25; KCL; BP 138/57 weight illegible; note illegible; HCTZ was discontinued ASA was continued.

2, 3 The patient had a 13% 10-year cardiovascular risk with repeated episodes of angina yet was not started on a statin drug. Also, unappreciated was that the patient was on a non-steroidal drug with significant cardiovascular risk. Yet this was not considered.

3/29/2017 The Medical Director noted that the patient had a collegial review and had blood testing. The exam was "no change" and the assessment was only "GI bleeding" without comment on the pulmonary embolism. The patient was informed he would soon see GI. There was no other plan or evaluation of the patient's other patient's problems.

4/3/2017 A doctor referred the patient for colonoscopy and hemorrhoid banding.

4/3/2017 The Medical Director saw the patient post writ and said that the patient was to have a colonoscopy and possible hemorrhoid banding. The GI note was not in the record. The doctor made no other comment.

4/5/2017 The patient asked the nurse for a breathing treatment. The patient didn't have wheezing but the nurse took no history but did note no shortness of breath. The nurse wouldn't give the patient a treatment and the patient became angry and left.

4/11/2017 The Medical Director noted that colonoscopy was approved.

Patient #16

5/10/2017 The patient developed left sided chest pain and was noted by a nurse to be in mild distress. Though the patient was walking when the pain started according to the nurse note, the nurse documented that the pain was not exertional. The Medical Director saw the patient and noted that the patient developed pain when walking. The doctor noted that the pain was pressure like and lasted about a half hour. The doctor noted that an EKG was normal. This EKG was not in the chart and I asked the Attorney General's office to locate it but the HCUA could not locate the EKG. The doctor assessed "chest pain resolved" and ordered Coreg for six months, a CBC and CMP.

3 The doctor did start a beta blocker. But high intensity statin was indicated. Also, depending on the EKG tracing, hospitalization may have been indicated.

5/16/2017 Glucose 116; hemoglobin 8.7; with microcytic indices; platelets 487 (150-450).

5/19/2017 An EKG showed sinus tachycardia with ST depression, consider subendocardial injury or digitalis effect.

5/19/2017 The patient felt chest pain, dizziness, cold and clammy going to the dining hall and was brought to the health care unit. An EKG was performed showing acute subendocardial ischemia. The patient then experienced cardiac arrest and CPR was started and the patient was transferred to a hospital where he died.

Patient #16

5/25/2017 The Medical Director filed a death summary. The patient's diagnoses were listed as acute coronary syndrome with fatal cardiopulmonary arrest; severe asthmatic COPD with acute pulmonary failure in 2016; severe OSA; pulmonary sarcoidosis; GI bleeding with low iron and rectal mass; type 2 DM, HTN, GERD, but the summary failed to document prior pulmonary embolism. The document stated that the patient transferred to Stateville on 2/8/17 and at Stateville was found to have blood in the stool with anemia; a rectal mass was identified in the rectum and the patient had a guaiac + test and was seen 4/3/17 by GI and was scheduled for colonoscopy. The doctor noted that the patient had a subendocardial injury on EKG. At the time of death the patient was on carvedilol, amlodipine, aspirin, Lasik, HCTZ, Prilosec, and metformin.

5/27/2017 The coroner filed a death certificate. The certificate states that the cause of death was pulmonary embolism secondary to deep vein thrombosis. The certificate documents that an autopsy was done but it was not present in the medical record.

Patient #17

3/6/2001 The problem list documents an esophageal stricture.

4/12/2001 The problem list documents duodenal ulcer and esophageal ulcer.

8/12/2002 The problem list documents mitral valve prolapse.

11/12/2002 The problem list documents Barrett's esophagus and PUD

3/14/2011 The problem list documents aortic valve replacement

6/19/2013 An annual physical examination was refused but the doctor documented the problems as aortic valve replacement, hepatitis C, Hx of CAD and heart failure, history of esophageal bleeding, history of atrial flutter, GERD and duodenal ulcer, history of thoracic aortic aneurysm with aortic root repair at the same time of his aortic valve replacement, atrial flutter with ablation at UIC, old compression fx of L4

2/11/2014 A doctor noted review of the EKG showing prolonged PR interval and L atrial abnormality.

2/19/2014 An LPN wrote that the inmate wanted a heart test that had been scheduled after surgery for aortic valve replacement. The patient complained of dizziness when he walked. The patient stated, "Stateville wouldn't order test." The nurse referred the patient to the doctor. The patient didn't see a doctor for this.

3/10/2014 A writ to UIC cardiology was cancelled but there was no explanation why.

3/13/2014 The patient complained of getting winded walking to chow. The nurse documented that the inmate was anxious and breathing "hard and fast" and with "pursed lips." The nurse took no vital signs and the only comment was "pursed lip breathing no change."

This problem was not being monitored on chronic disease visits.

These problems were not monitored. There was no surveillance for the Barrett's esophagus.

- 2 There was no monitoring of the Barrett's esophagus. Multiple problems of this patient were not being followed consistently including aortic valve replacement, thoracic aortic aneurysm, atrial flutter, and COPD

Patient #17

3/14/2014 A nurse saw the patient for shortness of breath. The respiratory rate was 32. The oxygen saturation was 83% on room air. The nurse noted shortness of breath when walking. The nurse noted that the patient's cardiology clinic was cancelled by UIC. The nurse observed the patient in the infirmary on oxygen and referred to a doctor but it wasn't clear when. Later a nurse practitioner saw the patient and noted increasing SOB over the past few weeks. The NP ordered 40 mg of Lasix stat and admission to the infirmary and oxygen to keep the saturation above 90%.

This patient needed a stat blood gas and chest x-ray and should have been sent to an emergency room for this.

3/14/2014 A NP infirmary admission note documented history of GERD, Barrett's esophagus, aortic stenosis with prior valve replacement with heart failure, atrial flutter ablated in 2011, and aortic aneurysm repair in 2011. The NP did not order a chest x-ray but did order a CBC but no CMP. An EKG was not ordered. There was no referral for echocardiogram. The NP noted that the oxygen saturation was 83%.

3/14/2014 On the 3-11 shift a nurse documented that the patient had audible expiratory wheezes with dyspnea on exertion and an oxygen saturation of 88% on 2 liters of oxygen, so the nurse increased the oxygen to 2.5 liters and the oxygen saturation increased to 91%.

3/15/2014 A nurse noted that the patient's oxygen saturation was 80% off oxygen and was 92% on oxygen. No action was taken.

3/18/2014 A nurse noted that after walking short distances the oxygen saturation dropped to 88% but was above 90% on oxygen.

Patient #17

3/20/2014 The patient wanted to go back to his housing. He had oxygen saturation of 93% on room air. There had not been a documented physician note since admission on 3/14/14.

3/21/2014 A physician saw the patient for the first time on the unit. The doctor documented that the patient did not get hemocult test as ordered on 3/15/14. The doctor did not document review of the CBC or even note that it had been done. The doctor listened to the chest and noted a few rales and a murmur and discharged the patient with a 3 day follow up with the NP. A metabolic panel was ordered. The diagnosis was heart failure. The NP didn't see the patient for 10 days.

3/22/2014 Sodium 137; AST 39; ALT 27; hemoglobin 13.2; platelets 459.

3/31/2014 The NP noted that the patient had been on the infirmary for respiratory distress. The NP noted clear lungs and assessed that the shortness of breath resolved without documenting a presumed diagnosis. No diagnostic tests had been done in the infirmary to ascertain the reason for the shortness of breath. The NP continued the higher 40 mg dose of Lasix and started Ultram 150 BID for four months for unclear reasons. A CMP was ordered for six weeks with follow up in eight weeks. The NP did not document review of the CMP; it appeared as if it was not done. The weight was 181.

Patient #17

4/3/2014 A doctor saw the patient and noted that the patient said he was to have an echocardiogram and Holter at UIC but it hadn't been done at Stateville. The doctor reassured the patient that he had an upcoming appointment at UIC.

5/8/2014 Sodium 133; AST 57; ALT 57.

5/12/2014 A NP saw the patient for increasing shortness of breath in the evening and at night. The NP noted a few rales in the bases and 1+ pedal edema. The NP increased the Lasix to 40 am and 20 pm for four months but did not order a chest x-ray or EKG or CMP.

5/22/2014 The patient went to UIC. But the report was not in the medical record. A referral form had comments from the cardiologist, who noted that a stress test was negative and an echocardiogram showed 55-60% EF with NL function. Since the EF was normal the findings on exam might be symptoms of overload vs COPD. The consultant recommended increased diuresis, lung x-ray to monitor progress and if not better consider CXR and referral to pulmonary for PFT to rule out COPD.

6 The NP failed to review recent abnormal laboratory findings.

11 Failure to obtain reports results in not knowing the status of the patient.

Patient #17

5/29/2014 A doctor documented that the patient had been seen in cardiology, who recommended increasing the diuretic and if no improvement get a pulmonary function test and follow up in six months. The doctor ordered a CMP and started Lasix 60 mg in the morning and 20 in the evening for two months with follow up with the NP in 3-4 weeks. The weight was 180. The doctor did not document review of the report and it wasn't clear what the status of the patient was based on the report. The weight was 180 pounds. The doctor took no history and did not perform a physical examination. The only assessment was heart failure.

1, 2 The doctor took inadequate history and performed no physical examination post-UIC visit.

6/2/2014 The patient saw a NP. The patient asked to be pushed in a wheelchair because it was hard to get to chapel. The weight was 193. The NP documented that the Lasix had been recently increased and that the patient had a murmur but no peripheral edema. The problems listed were CAD/CHF/valve replacement. The patient asked for renewal of Norco but the NP took no history, no examination, and no assessment of the status of pain. The NP noted that the patient had a follow up scheduled for 3-4 months and that he should follow up sooner if needed. The NP did not note the 13 pound weight gain over the past several days. The NP prescribed Norco without evaluation for pain.

17 Prescribing an opioid without clarifying whether the patient had pain or the degree of the pain is extremely poor practice and promotes opioid addiction.

6/3/2014 Potassium 5.4; sodium 125; chloride 97; AST 63 ALT 42 (10-50).

Patient #17

6/4/2014 A doctor wrote a brief chart review note on reviewing labs. The doctor noted that the potassium was 5.4 and that sodium was 125 with chloride of 97. The doctor continued the Lasix of 60 am and 20 pm and decreased the potassium to 20 mcf "OD" apparently meaning either daily or every other day. The doctor wrote for fluid restriction "30-40 oz /day" and ordered repeat electrolytes in two weeks.

6/23/2014 Potassium 4.5; sodium 131.

7/8/2014 A NP saw the patient. The BP was 110/56 and the weight 190. The inmate reported SOB with walking but no edema of legs. He had pain in his feet. The patient had no SOB or cough at night. The NP documented considering COPD and ordered a chest x-ray as recommended by UIC about two months earlier in May. The NP ordered a wheelchair for long distance with a three week follow up.

8/22/2014 A NP saw the patient, whose weight was 197 pounds. The patient was being seen for review of a chest x-ray. The patient still had shortness of breath walking long distances. The chest film was documented as showing "mild changes of CHF + emphysema." The assessment was CHF with mild emphysema and bioprosthetic aortic valve. Because of the potential for having both heart failure and COPD, PFTs should have been done for diagnostic reasons and to establish the baseline for this patient.

7 Pulmonary function testing should have been ordered. This was suggested by the cardiologist and we concur.

Patient #17

9/17/2014 A NP saw the patient for renewal of Norco. The NP noted an open sore on the great toe. The NP changed the Norco to Tylenol #3 for 30 days. It wasn't clear what pain was being treated and what the status of the pain was. The NP gave the patient eight bandages for his ulcer. Weight was 183.

10/14/2014 A NP saw the patient. The weight was 186 and BP 110/60. The patient requested renewal of Tylenol #3. the patient had a quarter sized lesion on his toe. The NP advised the patient to tie his shoes [presumably this was thought to have caused the ulcer].

10/15/2014 Sodium 134.

12/15/2014 Sodium 140 potassium 4.5.

1/4/2015 A partly illegible mental health professional note documented that the patient was on a religious fast and hadn't eaten for several days.

1/9/2015 A PsyD saw the patient and noted that the patient was being seen daily since he began "fasting" on 12/24/15. The patient appeared delusional but denied hallucinations and there was no evidence for auditory or visual hallucinations. The insight and judgment were "poor." The assessment was "appeared mentally unstable."

1/15/2015 BUN 22; sodium 137; creatinine 1.8; hemoglobin 12.1 (13.2-18); platelets 211; AST 26; ALT 19

17 It is bad practice to prescribe narcotics without taking a history of the pain or performing a physical exam to document the extent and severity of the pain.

These lab tests document kidney disease and mild anemia. These tests were not documented as reviewed in the progress notes.

Patient #17

3/2/2015 The patient was admitted to Katherine Shaw Bethea Hospital for bleeding rectally and vomiting blood and discharged 3/5/15. His heart rate was 130s. The doctor documented that because the patient was absent from the med line his anti-ulcer medication was discontinued after 2/12/15. The doctor told the facility physician and a nurse that a refill check that failed should end and that the chart should be flagged that he never go off the PPI due to having had multiple life threatening GI bleeds. The patient was discharged with acute upper GI bleed with anemia secondary to blood loss, diastolic heart dysfunction, hepatitis C, and antral ulcer. The hospital recommended never to stop the PPI. The patient had endoscopy showing a deep antral ulcer treated with electrocautery, hiatal hernia, duodenal erosions, and fibrinous material in esophagus, probably acid reflux disease. The patient was transfused four units of blood. The patient had a diagnosis of Barrett's esophagus, porcine aortic valve replacement, mitral valve prolapse, CAD, HTN, CHF, schizophrenia.

3/10/2015 Sodium 141; potassium 4.2; AST 54 (10-40); ALT 60 (10-50).

3/13/2015 Hemoglobin 11.8; platelets 384.

3/15/2015 Hemoglobin 11.4; platelets 306.

3/24/2015 A doctor saw the patient for cardiac chronic clinic for the aortic valve replacement and Barrett's esophagus. The doctor noted that the patient was on Prilosec but did not discuss surveillance of the Barrett's esophagitis. The doctor noted that the ulcer was not currently bleeding.

3 The doctor should have had a plan for surveillance of Barrett's esophagus.

Patient #17

4/2/2015 A doctor saw the patient for hepatitis C clinic. The doctor noted that the patient had hepatitis C since 2003 and was seen by Dr. Paul in the past via telemedicine. This was the Wexford ID doctor. However, the patient did not see the UIC hepatitis doctor. The doctor noted that the patient had no RUQ pain and noted that the ALT was 60 and AST 54 and platelets 384 with an APRI of 0.35. The doctor ordered a six month follow up.

5/7/2015 BUN 23; creatinine 1.73; bilirubin 1.8; AST 28; ALT 18; hemoglobin 11.7; platelets 224

5/28/2015 Total protein 8.1 (6-8); hemoglobin 12.5

6/1/2015 The patient refused omeprazole 13 of 60 doses. Ten of the refusals were the evening dose.

6/4/2015 BUN 27; creatinine 1.92; cholesterol 114; HDL 31; LDL 65

7/1/2015 The patient's MAR showed that the patient refused omeprazole 17 of 62 doses.

7/8/2015 A1c 4.8.

7/17/2015 Sodium 137; total protein 8.2; AST 43 (10-40); ALT 37 (10-50).

8/9/2015 The weight was 152. A doctor saw the patient. The doctor noted that the patient had an appointment with GI. The doctor ordered a CBC and CMP to check the sodium.

8/14/2015 The patient developed a boil on his buttock and a nurse ordered warm compresses but did not refer the patient.

17 Since omeprazole was so important for this patient, a physician should have been notified and discussed the refusal with the patient.

17 Since omeprazole was so important for this patient, a physician should have been notified and discussed the refusal with the patient.

16 The nurse should have referred to a physician.

Patient #17

- 8/17/2015 An NP saw the patient for a sore on his L great toe and left buttock. Apparently a doctor gave a phone order for Bactrim on 8/14/15. The PA continued the antibiotic and offered the inmate a different pair of shoes which he declined. The patient had a dime sized lesion on his toe on top of the left great toe and a 3 cm buttock boil.
- 8/20/2015 A mental health progress note documented that the patient was in segregation for having been in possession of razor blades. The patient questioned why he was in segregation when he "should be in INF placement given medication condition." The patient had refused a visit with his psychiatrist. The patient was argumentative.
- 8/27/2015 A NP saw the patient and documented that the patient said he saw a doctor two days ago even though there wasn't a note in the record. The buttock "sore" was healing but the patient still had sores on both feet. The patient also had a swollen lymph node. The NP recommended to clean his wounds with soap and water and observe for drainage.
- 8/31/2015 A mental health note. The patient was not seen. He was in segregation but there was no officer for escort so the patient wasn't seen.
- 9/3/2015 A mental health note. The patient was still in segregation. He said he would refuse mental health medication and refuse to see the psychiatrist. The mental health worker documented that his paranoia was less.

Patient #17

9/10/2015 The patient stated "I'm a Christian. I can heal without meds."
The patient intended to refuse psychotropic medication.
Based on the note, the patient appeared psychotic. On the same day another mental health note documented that the patient left segregation status.

9/13/2015 An RN saw the patient at 7:30 am. The oxygen saturation was 89%. The nurse took no history of why the patient was being seen but noted that the inmate "doesn't know how he fell."
The nurse documented BP 160/80; pulse 113; and weight 150. The patient felt weak. The nurse additionally used a contusion protocol but the history was so poor that it couldn't be determined what precisely happened based on the note. The nurse documented 30 cc of blood but it wasn't clear what this was from. The nurse placed the patient on the infirmary for observation. It wasn't clear if a doctor was consulted but the nurse wrote to do neuro checks every six hours and notify the doctor of any changes.

9/13/2015 Hospital admission sodium 114; chloride 81; BUN 42; creatinine 0.87; ALT 74; AST 130.

9/13/2015 At 8:30 pm a nurse documented that the blood pressure was 88/46 and that a doctor was notified, who recommended increased fluid. At 10:00 pm a nurse wrote another note and noted that a doctor was called and ordered to start 0.9 NS via IV. Apparently the patient was sent to a hospital, although notes are lacking.

16 The nurse should have referred to a physician immediately. Placement on the infirmary might normally be appropriate but this patient had unstable vitals with hypoxemia and tachycardia with possible altered mental status and should have been immediately evaluated.

11 Either documentation was poor or the medical record is missing documentation. It wasn't clear how the patient was sent to a hospital.

Patient #17

9/14/2015 At 6:35 there was a movement form that included documentation that the inmate fell the day before with a head injury and fell again this day that was unwitnessed. The patient's blood pressure was 78/40; pulse 92; oxygen saturation 92; and there was blood in the patient's stool. It isn't clear what happened to the patient.

9/14/2015 At 11:00 am a doctor wrote an admission note to the infirmary. The doctor noted that the patient fell and had a head injury on 9/13. The sodium was 114. The doctor noted that the patient was admitted over the weekend. The doctor started IV fluid without specifying the type of fluid 100 cc /hour. Notably the doctor did not perform a neurological examination despite a sodium of 114.

9/14/2015 At 2:30 am the pulse was 117 and blood pressure 114/60.

9/14/2015 At 6:10 a nurse noted that the patient was on the floor and was incontinent of bowel and bladder. The patient was weak and unsteady and his stool was positive for blood. The nurse called a doctor who ordered the IV opened full open and sent the patient to a hospital.

2, 14 Typically, altered mental status with gait disturbance in a patient with severe hyponatremia requires hypertonic saline not normal saline. Typically it is safer to admit this type of patient to a hospital and this should have been done.

Patient #17

9/14/2015 A hospital consultation note from a GI consultant in the hospital noted that the patient had history of hepatitis C, Barrett's esophagus, CAD, HTN, aortic stenosis, Mitral valve prolapse, CHF, and schizophrenia. The patient was noted to have been found passed out in his cell with blood around him and had a hemoglobin of 4.2 in the emergency room. The patient's INR was 1.2. The patient had a known bleed in March of 2015. The patient had a serum sodium of 117 and was in atrial fibrillation. An upper endoscopy showed a coffee ground bezoar in the stomach with a healing ulcer. Protonix was recommended. The hospital noted that he had not received the omeprazole as prescribed at the prison [that the patient refused so it was discontinued]. The patient required multiple transfusions. A repeat endoscopy and colonoscopy were recommended. The hemoglobin corrected to 8.5 on discharge with a platelet count as low as 149. On admission the BUN was 48 with a serum sodium of 117, chloride of 89, AST 161, ALT 74, albumin 2.4. Remarkably the creatinine was 0.66. The EKG was sinus tachycardia with rightward axis and NSSTT changes.

9/16/2015 The patient returned from the hospital. The doctor didn't appear to see the patient until 9/18/15.

9/18/2015 The patient was on the infirmary but it wasn't clear how he got there. There were no notes in sequence related to the hospital discharge.

9/18/2015 The doctor noted that the patient was transfused four units of blood and noted the EGD findings. The doctor noted the follow up with GI in six weeks for EGD and colonoscopy.

17 The patient failed to receive ordered protonix or refused and no one evaluated him for this despite his mental health condition. This is indifferent. The severe hyponatremia speaks to lack of monitoring while on psychotropic medication.

6 Since the patient had severe hyponatremia, serum sodium should have been ordered.

Patient #17

9/20/2015 The patient told a nurse that he was in the hospital. The infirmary admission notes were not present in sequence for this patient. The chart was disordered. The patient had a wound on top of his forehead.

9/21/2015 Hemoglobin 9.6; sodium 136; BUN 6.

9/21/2015 A doctor saw the patient and noted that the patient was "feeling OK." The doctor noted no blood in stool. Vital signs were normal. The patient had trace leg edema, a systolic murmur. The doctor assessed HTN, CAD, hep C, GERD, PUD, thoracic aortic aneurysm, AVR, CHF, and psych disorder. The doctor also assessed "GIB" apparently gastrointestinal bleed and noted that the 9/18/15 RN note should be reviewed. The doctor ordered a CBC. The doctor also noted hyponatremia and ordered another sodium. The doctor documented "? WT [weight] loss- per pt." but took no history and did not document the weight. Indeed the patient had lost weight. The doctor restarted Lasix at 40 mg in the morning and ordered daily weights. This was the last infirmary note so the admission and discharge infirmary notes were in a different PDF of this chart.

11 Records were not in order.

Patient #17

9/22/2015 A psychiatrist saw the patient via telemedicine. The psychiatrist noted the patient saying "Patient indicated he was admitted on medical furlough for community inpatient endoscopy and transfusion due to GI bleed. 'It's my fourth, I'm used to it'." The psychiatrist stated that the patient was "fully oriented" and "thoughts were well organized, logical, and sequential. No current symptoms, No odd or bizarre thoughts and no preoccupations evident." The psychiatrist noted no acute or gross psychopathology evident. The doctor noted that there were no records of his recent medical furlough nor mental health records relating to the past few weeks so he requested these with a two week follow up.

11 Hospital reports were unavailable.

9/23/2015 Albumin 2.9; sodium 136; AST 40; ALT 47; hemoglobin 10.4.

9/23/2015 A doctor wrote a discharge summary and noted that the patient was admitted to the infirmary on 9/13/15 and had sodium 114 with hemoglobin 8.5 and he was admitted where hemoglobin was 4.2 and sodium 117 . It wasn't clear when the patient was admitted. The records were disorganized, with July 2015 and September 2015 mixed together. The doctor noted that the patient needed follow up with GI in five weeks for EGD and colonoscopy. The doctor ordered a next week follow up.

9/24/2015 The patient was described by a mental health worker as taking all of his mental health medications.

9/29/2015 Sodium 127; chloride 96; hemoglobin 10.1.

10/6/2015 The psychiatrist stopped prolixin and artane, two of the patient's psychotropic medications.

Patient #17

- 10/8/2015 A MAR documented that Prolixin and Artane were discontinued on 10/8/15.
- 10/11/2015 A physician assistant saw the patient for hepatitis C clinic. The PA noted that the patient had ALT of 97 and AST 40 with platelets 357 for an APRI of 0.28 and was stable. A six month follow up was ordered.
- 10/12/2015 Wexford approved a colonoscopy and EGD. There was no evidence that this occurred.
- 10/14/2015 The patient signed an "affidavit" that he would refuse contact with his telemedicine psychiatrist and preferred a face to face contact which allowed more interaction.
- 10/17/2015 The patient complained to a nurse of weight loss and burning in his stomach. The nurse told the patient to avoid "trigger" foods.
- 10/23/2015 A doctor saw the patient for HTN clinic. The note was incomplete. One of the sheets was not in order and couldn't be located.
- 10/27/2015 Sodium 130; iron 33 (50-180); transferrin 274 (200-400); IBC 384 (250-450); % transferrin saturation 9 (20-50); hemoglobin 13.2.
- 11/1/2015 A MAR documented that the patient started refusing Clonazepam around 11/11/05. The patient was not on any ordered mental health medication until prolixin and artane were ordered as enforced medication on 1/28/16.
- 11/4/2015 AST 25; ALT 20; hemoglobin 12.9.
- 11/4/2015 The patient told a mental health staff that he wanted to sign a consent to again see the telemedicine psychiatrist. The mental health staff told the patient that he was already scheduled to see the telemedicine psychiatrist and the patient asked to see him earlier.
- 8 The PA failed to review important abnormal blood test results including albumin 2.9, sodium 127 and hemoglobin 10.1.
- 7 There was failure to complete a recommended procedure.
- 16 The nurse should have referred to a physician especially given the history of Barrett's esophagus and prior GI bleeds.
- 11 Records were not in order.

Patient #17

11/5/2015 A doctor saw the patient, who now weighed 145 pounds.

Ironically, the patient was being seen for a chief complaint of "weight gain." Someone documented that the patient weighed 133 on 8/5/15. The patient wanted Tylenol #3. The doctor took no history related to his medical conditions but did document "Happy about WT gain." The patient asked about getting his medication KOP. The doctor took no history, documented a very brief physical examination and documented that his note was continued on the next page, but this page was not present in the medical record.

11/16/2015 A telepsychiatrist saw the patient. The patient was described as alert, engaged, cooperative, well kempt with fair insight and fair judgment. The thoughts were organized and there were no delusions or bizarre content. The summary was that there was no acute or gross psychopathology. A six week follow up was ordered.

11/17/2015 A doctor saw the patient. The weight was 144 pounds. The doctor noted that the patient was recently hospitalized for transfusion and had esophageal varices and Barrett's esophagitis. Except for documenting that the patient said he was OK there was no history. The doctor noted that the hemoglobin was 12.9 and that the patient signed a refusal for his PM medication including Prilosec- the following line was illegible. The doctor documented that "weight gain not a worry"- however the patient had lost significant weight over the past two years. The doctor advised the patient not to refuse his Prilosec. The patient verbalized understanding. The doctor ordered a CBC in six weeks.

2 The patient did not have varices but had a GI bleed from ulcers.

Patient #17

- 12/29/2015 The patient was seen while on hunger strike. The patient said it was religious fasting. The licensed social worker who saw him documented that he was not delusional and his thought processes were "linear."
- 12/31/2015 A NP saw the patient. The weight was 137 pounds; the inmate was still fasting. The patient was drinking fluid. The NP ordered the nursing staff to asses daily urine dipstick. The NP scheduled a visit the following Monday 1/4/16 but did not order any labs.
- 1/5/2016 The patient refused to see the NP. The NP noted that the cell smelled of urine.
- 1/7/2016 A doctor documented that at a care conference it was agreed to ask the chaplain to see the patient and to obtain a competency evaluation by mental health.
- 1/7/2016 A mental health note documented that the patient was "in segregation where he continues to reside following refusal of housing after an initial IDR while residing on HCU-3. The patient refused to "cuff up to come to interview room." An assessment occurred in the cell with security present. The purpose of the contact was to request further explanation from the patient regarding his "fast." The patient denied any hallucinations. The patient's judgment and insight were "questionable as pt.'s decision making is affecting general health."
- 1/8/2016 A doctor documented that the patient was refusing to eat and told the patient that if he continued to refuse food he would be force fed. This note was incomplete and the full note was not in the medical record. There were no further medical notes on this patient.
- 8 The patient had weight loss and was fasting. Baseline labs should have been obtained.
- 8 The doctor should have ordered laboratory tests because of the fast.

Patient #17

- 1/10/2016 A licensed counselor saw the patient and noted that the patient was not eating because of religious convictions. The patient was described as unstable and the counselor's plan was to "consider appt. w/ [the psychiatrist] if appropriate."
- 1/11/2016 A psychiatrist saw the patient via telemedicine. The psychiatrist dictated his note but this dictated note was not present in the medical record we reviewed. The psychiatrist did write a brief note documenting that the MAR was not present and no primary care mental health records were present. The psychiatrist re-started Prolixin and continued Klonopin. There were no MARs indicating that the patient received Prolixin. A next week follow up was ordered but did not take place.
- 1/13/2016 A licensed counselor saw the patient at the request of an officer. The patient was "remarking that the room vents were suffocating him. His speech was pressured, he had paranoia, and his behavior was disorganized. The patient was assessed as unstable.
- 1/14/2016 The patient was on 30 minute checks and asked how many meals he has to eat before he could move "upstairs." It wasn't clear if the patient was eating.
- 1/15/2016 A mental health staff documented that the patient was told that if he ate a meal he could get his clothes back. The inmate said he hadn't eaten because "this was a lie."
- 1/16/2016 A QMHP saw the patient and documented that the inmate "smells like puke." No referral was made.

Patient #17

1/21/2016 Although the patient was being seen daily, on this day the patient was observed lying on his bed completely covered by a security blanket. The patient refused to answer questions. The counselor was unable to fully assess the patient. The patient was also unable to be assessed on 1/22/16 and 1/23/16 for the same reasons.

1/24/2016 A PsyD saw the patient and noted that the patient said he had not eaten food since Christmas for spiritual reasons. The patient was apparently drinking water. The patient was not weighed. The PsyD documented that the patient said he was not taking psych meds but this was not checked vs the MAR. The patient was assessed as unstable.

1/25/2016 A QMHP saw the patient and documented that the patient refused to move the blanket from his face, refused breakfast and medication, and was no longer drinking water and would not speak to his psychiatrist. Remarkably there were no psychiatrist evaluations documented on this severely ill patient.

1/26/2016 A QMHP saw the patient and noted that the patient refused to remove the blanket which was over his face. The patient was refusing food, liquids, medication, and assessment. The QMHP was unable to assess the patient and documented the patient as unstable.

1/26/2016 A form requesting emergency involuntary administration of psychotropic medication was initiated. The patient was documented as being on the infirmary.

19 Not eating for almost a month is significant and should have resulted in a physician evaluation and laboratory testing which were not done. This is lack of access and indifferent.

Patient #17

1/27/2016 Labs in KSB Hospital sodium 150; BUN 89; creatinine 2.12; AST 35 (8-33); ALT 24; bilirubin 1.9; magnesium 2.8 (1.6-2.3); WBC 16.7 with left shift; hemoglobin 15.2; platelets 161. These labs were signed as reviewed on 1/28/16.

6, 14 These labs were critical and indicated severe dehydration causing renal failure, liver damage, and indicated infection (WBC 16.7 with left shift). These should have been reviewed promptly and the patient should have been hospitalized.

1/27/2016 A licensed counselor saw the patient and documented, "we are aware pt. is being considered for 'forced feeding.' We are aware pt. is scheduled for enforced medication 1/28. He is currently administered psych med under emergency enforced [illegible] (prolixin). The plan was to "assess staff [with] assessment for 'forced feeding.'"

1/28/2016 A psychologist documented that the treatment review committee concurred for enforced medication and notices were made.

1/29/2016 A QMHP documented that security said the patient was more cooperative but was unstable and that dayroom privileges were approved.

1/31/2016 A PsyD documented that the patient said he was OK. It was not clear if the patient was eating.

1/31/2016 Blood cultures collected on 1/31/16 were reported 2/1/16 and showed 2 bottles were growing gram negative rods. Results were called to a nurse in the DOC and the lab was told that the patient had been transferred to St. Anthony's hospital but had expired.

11, 19 It is not clear what happened because documentation was so poor. While this may have been due to record keeping, a physician should have been seeing the patient daily under the circumstances but this did not appear to be happening.

1/31/2016 A note from a hospital documented that the patient had a post intubation x-ray so it appeared that the patient was not hospitalized until 1/31/16.

Patient #17

Patient #17

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0.3

Patient #18

10/14/2015 The problem list documented hypertension, diabetes, COPD, anemia, prostatic hypertrophy, and reflux disease.

10/10/2013 Ammonia was 165 (<56); hemoglobin 11.4; MCV 106.3; INR 2.

11/12/2013 Hemoglobin 10.9 MCV 100.9; platelets 136; INR 1.9.

12/9/2013 BUN 28; creatinine 1.53; bilirubin 2.2; cholesterol 123; HDL 53; LDL 58; folate >25 (>5.8); hemoglobin 11.7; MCV 101.5; platelets 147; AST 34; ALT 20; INR 2.

1/10/2014 BUN 33; creatinine 1.55; bilirubin 1.5; A1c 6.5; hemoglobin 10.2; MCV 102; platelets 128; INR 2.3.

2/11/2014 Hemoglobin 11; MCV 102.8; platelets 138; INR 2.1.

3/10/2014 Hemoglobin 10.7; MCV 97.2 (80-99); platelets 145; INR 1.8.

3/20/2014 A nurse saw the patient for trouble breathing. The patient had audible wheezing, a pulse of 40 and respiratory rate of 24 with a PEFr of 350. The nurse noted that a doctor was seeing the patient that day.

3/20/2014 A doctor saw the patient as a writ return and noted that the patient was evaluated by cardiology and noted that the cardiology recommended to increase the hydralazine and to obtain an echocardiogram and event monitor. The doctor ordered a month follow up and requested the echocardiogram. The doctor didn't evaluate the shortness of breath. The doctor did not conduct a physical examination of the patient.

The problem list did not document prosthetic heart valve, atrial fibrillation, alcoholic cirrhosis, chronic kidney disease, and diabetic nephropathy.

These values are consistent with alcoholic liver disease which had yet to be diagnosed and was not on the problem list.

6 These values show chronic kidney disease, possible dehydration, and anemia consistent with cirrhosis from alcoholic liver disease yet these labs were not evaluated. Kidney disease was not a diagnosis. The reason for the anemia was not on the problem list.

1, 2, 6, 19 The doctor did not evaluate the multiple serious significant laboratory abnormalities. The doctor did not evaluate the patient's shortness of breath even though that was the presumed reason for the visit. The doctor took no history, failed to examine the patient, and failed to make an assessment with respect to the shortness of breath. Care failed to follow generally accepted guidelines or usual practice. Abnormal labs and symptoms of trouble breathing should have resulted in an evaluation to determine the cause.

Patient #18

3/26/2014 A doctor noted that an event monitor was approved in collegial.

4/3/2014 EKG showing atrial fibrillation with LAD, probably old inferior infarct, anterior fasciculate block and bradycardia 47.

4/4/2014 Wexford approved an echocardiogram.

4/4/2014 Wexford approved a 30 day event monitor from UIC cardiology.

4/8/2014 An NP saw the patient and noted that bumex was on ordered and would bridge this pending order with Lasix.

4/30/2014 INR 3.1.

5/9/2014 A nurse wrote a note that the patient was placed on the infirmary. The note was partly illegible. The patient was placed on IV fluid but it wasn't clear why.

5/10/2014 A nurse noted that the patient was having a hard time breathing and had respiratory rate of 28. The nurse gave the patient a wedge to put under his mattress. In a later note a nurse documented notifying Dr. Sood. A nurse noted that the patient was receiving IV fluid but it wasn't clear why.

5/12/2014 BUN 30; creatinine 1.52; bilirubin 1.6; GFR 55; TSH 1.31; A1c 5.9; hemoglobin 10.1; MCV 104; platelets 103; INR 2.3.

5/14/2014 A NP saw the patient for a swollen left finger. The NP noted that the patient also had leg edema and reported not taking his water pill at night because he became incontinent when he did. The NP ordered a hand x-ray and requested a Texas catheter. The NP did not consider giving the Lasix in the morning. The NP did not address the prior episode of shortness of breath and since ordering a hand x-ray failed to include a chest x-ray to assess for heart failure.

Notably atrial fibrillation was not on the problem list.

Illegibility is a reason for an electronic medical record.

19 The doctor should have evaluated the patient in person.

These labs again showed possible dehydration, chronic kidney disease, and macrocytic anemia with low platelets consistent with alcoholic liver disease.

6 Despite significant abnormal labs and leg edema with shortness of breath, the NP failed to form an appropriate assessment of the abnormal labs and new symptoms. Care failed to follow generally accepted guidelines as those abnormal labs and symptoms should have been evaluated.

Patient #18

6/10/2014 Hemoglobin 11.5; MCV 101; platelets 130; INR 2.3.

6/26/2014 A doctor saw the patient for HTN, DM, and COPD/asthma. The BP was 120/70 . The doctor noted that the patient had heart sounds of regular sinus rhythm despite the patient having long standing atrial fibrillation. The patient had mild expiratory wheezes and PEFr of 350. The doctor took no history with respect to COPD/asthma but diagnosed moderate persistent asthma and made no changes to therapy. The doctor noted that labs were reviewed but made no comment about these. The patient's anticoagulation or cardiac rhythm disturbances were not addressed.

7/11/2014 Hemoglobin 10.7 MCV 106.1; platelets 130; INR 3.

7/17/2014 At a hospital, hemoglobin 12.3; MCV 96.9 (80-94); platelets 124; INR 3.2; BUN 39; creatinine 1.44; AST 40 (8-33); bilirubin 2.2.

7/17/2014 A doctor saw the patient and was feeling "out of it." The doctor took no more in depth history. The doctor noted that the patient was oriented to person place and time. The doctor noted facial symmetry and no weakness. The doctor made no assessments, did not evaluate for the prior episodes of shortness of breath. The doctor ordered a CBC, CMP, INR and ammonia. The doctor made several addendums to this note. The doctor added that the patient "can't think." On a later note the doctor documented that a nurse told the doctor that the patient was scheduled for a dental appointment and faked being sick, canceling the dental appointment so that he could go to commissary.

8/8/2014 An echocardiogram was done as requested on 3/20/14 and approved on 4/4/14.

7, 17 The doctor failed to establish a reasonable treatment plan in evaluation of the patient's lung symptoms. A chest x-ray, consideration of pulmonary function testing, and evaluation for heart failure should have been done. The patient also had a 26.4% 10 year risk of heart disease or stroke and a high intensity statin was indicated. Care failed therefore to follow generally accepted guidelines.

1, 6 The doctor failed to take adequate history. Prior blood tests were not evaluated. Care failed to follow generally accepted guidelines or usual practice.

Patient #18

8/8/2014 A doctor noted that the patient went to UIC for a cardiology appointment and had a 30 day monitor attached. The doctor noted that the patient had an echocardiogram.

8/11/2014 Hemoglobin 11.2; MCV 102.7; platelets 106; INR 3.

8/12/2014 A doctor noted reviewing the echocardiogram results and that the patient had an event monitor placed.

8/27/2014 Echocardiogram showed right atrium and ventricle mildly dilated; left atrium moderately dilated but L ventricle normal size but moderately thickened. Moderate concentric hypertrophy with 50% EF; normal appearing prosthetic AV with trace regurgitation, moderate tricuspid regurgitation. Diastolic dysfunction and severely elevated pulmonary artery pressure.

9/3/2014 A doctor noted that the patient was approved for a cardiology appointment in collegial review.

9/8/2014 The patient went to cardiology for the 30 day event monitor more than five months after the collegial. The referral for this was dated 3/20/14.

9/12/2014 EKG showing idioventricular rhythm with nonspecific intraventricular block and inferior and anterolateral infarcts age indeterminate.

9/12/2014 The patient was evaluated in EP clinic for scheduled follow up. The cardiologist stated that the patient was seen two months ago for a fib/flutter with slow ventricular response. The plan was to hold all AVN blocking agents. The cardiologist reviewed the echocardiogram and last Holter from 2013. The cardiologist recommended a pacemaker and that this should be done in the hospital.

9/12/2014 Hemoglobin 11.4; MCV 104.4; platelets 135; INR 3.4.

Patient #18

9/17/2014 A doctor noted that the patient was discussed in collegial and approved for admission for pacemaker placement.

6 Abnormal labs were not followed up.

9/18/2014 Wexford approval of hospitalization management prior to pacemaker placement.

9/26/2014 EKG showing irregular rhythm with no p waves [looks like atrial fibrillation] with intraventricular block and PVCs

9/26/2014 The patient told a nurse that he was not feeling well. The pulse was 41. The patient was sent to a local ER via ambulance.

9/28/2014 The patient returned from the hospital but the nurse did not note what had occurred at the hospital or whether there were new orders.

11 The hospital report was not available.

9/29/2014 A doctor noted that the patient returned from the hospital for shortness of breath and stated that "they didn't adjust meds or do anything but hold coumadin for upcoming procedure." The upcoming procedure wasn't specified so it wasn't clear whether this was the pacemaker placement or another procedure.

10/3/2014 INR 1.5.

10/14/2014 INR 1.4.

10/15/2014 A doctor wrote a brief chart review note stating that the INR was 1.4 and increased the coumadin to 7 mg daily with an INR in seven days.

Patient #18

- 10/17/2014 The patient was seen for diabetic clinic. The BP was 124/58 and the A1c was documented as 5.6. The doctor took no history with respect to any disease and noted an irregular heart rhythm and expiratory wheezes. The diabetes was listed as in good control. The doctor did not address whether the patient had hypoglycemia, especially given the low A1c. Anticoagulation and the cardiac arrhythmia were not addressed. Despite the asthma/COPD being described as moderate persistent, the doctor had taken no history and made no changes to therapy.
- 10/22/2014 A doctor renewed an order for a Texas catheter but it wasn't clear on prior notes that the patient was using this device.
- 10/22/2014 BUN 33; creatinine 1.71; bilirubin 1.7; hemoglobin 11; MCV 105; platelets 113; AST 32; ALT 18; INR 1.6.
- 10/22/2014 INR 1.6.
- 10/23/2014 A doctor wrote that he called UIC heart center as the patient was on coumadin and a pacemaker was planned for 10/27/14. The INR was 1.6.
- 10/24/2014 At 9:20 am a nurse documented telling the inmate that coumadin was to be held from this day through 10/27/14.
- 1, 2, 6, 12 The doctor failed to evaluate many of the patient's existing problems including atrial fibrillation, high blood lipids, heart failure, diabetic nephropathy, anticoagulation, and cirrhosis and the doctor failed to evaluate the prior abnormal labs. The doctor failed to adequately evaluate the pulmonary symptoms presumably assigning these to asthma/COPD when they may have been due to heart failure, or liver failure. The patient should have been referred to a cardiologist. Care failed to follow generally accepted guidelines or usual practice.
- 6 These abnormal laboratory values were not followed up on. They appeared to show cirrhosis from alcoholic liver disease, chronic kidney disease and dehydration which were all unidentified. Care failed to follow generally accepted guidelines or usual practice.
- 6 Patients with most mechanical heart valves require an INR between 2.5 to 3.5. Certain valves (On X valves) require an INR of 1.5-2.5. This patient's valve type or anticoagulation goal was never documented but was presumed to be 2.5 to 3.5. The type of valve and anticoagulation goal needed to be documented in the record.

Patient #18

10/24/2014 at 5:20 pm a PA documented that a nurse from UIC cardiology called to say that the cardiologist recommended NOT stopping the coumadin and wanted the INR close to 2. The PA ordered to continue the coumadin at 7 mg.

10/27/2014 A pre-EP procedure history and physical at UIC noted non-obstructive CAD with COPD, HTN, HLD, DM, mechanical AVR in 1995, chronic a fib/flutter with junctional escapes in for permanent pacemaker. A pacemaker was placed St Jude PM 1240 VVI. A two week follow up was recommended.

10/29/2014 A doctor noted that the patient had a pacemaker installed on 10/27/14 and had some pain and ordered Tylenol. The pacemaker function wasn't checked. The hospital report was not reviewed and follow up was not identified.

10/30/2014 Apparently a physician reviewed written paperwork and noted that a two week follow up with cardiology was recommended.

11/5/2014 The patient was approved for follow up of the pacemaker. There were no progress notes following this visit for some time.

11/14/2014 Hemoglobin 10.1; MCV 104.1; platelets 110; INR 2.4.

12/10/2014 Hemoglobin 11.3; MCV 101; platelets 130; A1c 5.7; INR 1.8.

1/12/2015 Hemoglobin 11.8; MCV 102.3; platelets 126; INR 2.

2/9/2015 Hemoglobin 11.4; MCV 101.8; platelets 123; INR 2.3.

2/27/2015 A nurse evaluated the patient using the shortness of breath protocol. The oxygen saturation was 95% and respiratory rate of 12. The patient was listed as being on Xopenex, albuterol, Atrovent and Alvesco inhalers. PEFs were 250/200/250. The nurse took no action except to give the patient a nebulization treatment.

10 The two week follow up with cardiology never occurred and was unrecognized as not occurring. Care failed to follow generally accepted guidelines or usual practice.

10 The doctor failed to follow up on the UIC report. Care failed to follow generally accepted guidelines.

10 The doctor did not ensure that the patient was referred to cardiology. Care failed to follow generally accepted guidelines or usual practice. Though this referral was approved, there was no evidence that it occurred. Care failed to follow generally accepted guidelines or usual practice.

16 The nurse should have consulted a physician.

Patient #18

- 3/3/2015 A doctor saw the patient because a nurse wanted evaluation of the baclofen. The patient wanted Neurontin discontinued. The doctor wrote that the patient had no spinal injury or MS and that the patient was using the baclofen because his left leg became spastic. The doctor stopped both baclofen and Neurontin and ordered a follow up. The doctor took no history of why the patient was put on these medications and did no physical examination. The doctor did not address any problems. The patient hadn't been seen since return from the hospital for his pacemaker and the doctor did not address whether the patient had his cardiology follow up.
- 3/10/2015 Hemoglobin 11.6; MCV 103.7; platelets 143; INR 2.1.
- 4/6/2015 A PA saw the patient for follow up of discontinuation of baclofen and Neurontin. The PA noted that the patient complained of hip pain and LLE "shakiness." The physical examination documented "shakiness" but it wasn't clear what that meant. The plan was to monitor the shakiness and "jerkiness," continue physical therapy and Tylenol for pain.
- 4/25/2015 A nurse evaluated the patient using the shortness of breath protocol. The respiratory rate was 14. The PEFR were 250/300/300 . The nurse took no action and the patient returned to his housing unit.
- 6, 15 The doctor failed to review any of the prior abnormal lab results and failed to follow up on the patient's recent symptoms or problems. Care failed to follow generally accepted guidelines or usual practice.
- 6 The PA failed to follow up on the abnormal labs dating from 11/14/14 which had not been reviewed.
- 16 The patient had a serious complaint and the nurse should have referred the patient to a provider.

Patient #18

- 5/13/2015 A doctor saw the patient for HTN, DM and COPD chronic clinics. No history was taken. The A1c was 5.7. The heart was described as regular rhythm and the lungs clear. PEFR wasn't taken. There was no history of symptoms. Though the patient had mild pitting edema, there was no assessment. The assessment listed anemia but it was not addressed. There was no change in plan. The conduction abnormalities or anticoagulation were not addressed. The status of the patient wasn't clear from this note.
- 6/5/2015 A NP saw the patient for constipation and ordered Colace. None of the other patient problems were addressed.
- 8/8/2015 An annual history was completed by a nurse. The nurse documented that the patient was on apresoline, coumadin, proscar, cozaar, Xopenex, Aldactone, fibertabs. Problems were listed as heart failure, type 1 diabetes, aortic stenosis, prior valve replacement, and prior TURP. A provider physical examination added no further history. Though the patient was 70 years old colorectal cancer screening was not offered. The provider listed HTN, type 1 diabetes, AV replacement with pacemaker for atrial fibrillation, heart failure and peptic ulcer disease. No changes to treatment were made.
- 8/10/2015 A doctor saw the patient. The doctor noted that the patient was on lactulose for constipation and was having diarrhea. The doctor continued the lactulose if the patient needed disimpaction for his constipation. The doctor did not address any of the patient's other problems.
- 8/12/2015 The patient experienced a fall. The nurse documented writing an injury report but there was no progress note for this problem.
- 1, 2, 3, 6 The doctor failed to address all of the patient's serious medical problems including his anticoagulation, follow up with cardiology after the pacemaker, recent shortness of breath and current edema, diabetic nephropathy, heart failure, high blood lipids, to address or develop a plan for the anemia. History for these conditions was not taken, the patient wasn't examined for these conditions and there was no therapeutic plan. If the patient had suspected cirrhosis, an ultrasound should have been done. The patient's pacemaker function was not addressed.
- 1, 2, 3, 7 The nurse obtaining this history, examination, and plan failed to address all of the patient's problems including the anemia, atrial fibrillation and cardiac conduction abnormality, peptic ulcer disease. The doctor following up with a physical examination failed to make a diagnosis related to the anemia, failed to acknowledge or follow up on the cardiac arrhythmia, and failed to note that the patient had missed cardiology follow up at UIC. The patient was not offered colorectal cancer screening despite this being a current standard of care. Care failed to follow generally accepted guidelines or usual practice.
- 16 The nurse should have consulted a physician.

Patient #18

8/25/2015 The patient asked for a breathing treatment.

8/26/2015 The patient asked for a breathing treatment.

8/27/2015 A nurse saw the patient using a shortness of breath protocol and noted that the patient was out of his Atrovent for two months. The PEFr was 200. The nurse sent the patient for a breathing treatment and strongly recommended that the patient pick up his Atrovent at medline.

9/15/2015 A doctor noted that the INR was 2.2 and increased the coumadin to 8. There was no evaluation of the patient.

9/22/2015 A doctor noted that the INR was 2.7 and he maintained the coumadin at 8.

10/14/2015 A doctor saw the patient for HTN, DM, and COPD chronic clinics. The doctor noted that the patient was on coumadin for AVR and had microcytic anemia but the reason for this was not provided. The only history was that the patient was "generally well, got here in his wheelchair. Taking his meds + coming for AccuChecks + insulin BID." That was the only history. PEFr were 230/230/240. The A1c was listed as 6.1. HTN, DM, and COPD were all listed as in good control. The doctor did not address the anemia, anticoagulation or arrhythmia. There was no change to therapy.

10/14/2015 The problem list was updated and documented HTN, DM, COPD, *microcytic anemia* BPH and GERD. Multiple diseases weren't included.

11/19/2015 A doctor didn't evaluate the patient but noted that the INR was 1.9 and increased the coumadin to 8.5 mg.

11/25/2015 A nurse evaluated the patient for nausea for 2-3 weeks duration. The patient was not vomiting. The nurse took no action.

16 The patient had a serious complaint and the nurse should have referred the patient to a provider.

1, 2, 3 The doctor noted that the patient had a microcytic anemia when the patient had a macrocytic anemia. The doctor failed to establish a diagnosis for the anemia and failed to acknowledge other abnormal labs including chronic kidney disease, and laboratory evidence suggestive of cirrhosis. The doctor did not address the anemia, anticoagulation, or arrhythmia despite the patient having recent shortness of breath. The patient had multiple recent episodes of shortness of breath that were not addressed. Care failed to follow generally accepted guidelines or usual practice.

This demonstrates a significant gap in knowledge related to primary care.

16 Vomiting is a serious condition in a diabetic and the nurse should have referred the patient to a provider.

Patient #18

11/30/2015 EKG showing pacemaker spikes with underlying atrial fibrillation and IVCD. QRS consistent with septal infarct probably old.

11/30/2015 A nurse evaluated the patient for chest pain. The patient was rushing getting ready for commissary. The pain felt like a pulled muscle. The nurse ordered an EKG and a doctor saw the patient.

11/30/2015 A doctor noted that the patient developed L chest pain while rushing to go to commissary that felt like a pulled muscle. The patient had no diaphoresis or shortness of breath. The doctor documented that there was a tender area on his chest with palpation. The doctor noted an irregular heart rhythm and reviewed the EKG, noting that it showed irregular rhythm, PVCs and pacing. The plan was that if the chest pain didn't resolve over 3-6 weeks he would see the patient in sick call. The doctor ordered an overread of the EKG but did not order an antianginal medication. The doctor failed to note that the patient failed to have follow up with the cardiologist.

1, 3, 7, 12 The patient with a serious cardiac arrhythmia and chest pain that was consistent with angina was not adequately evaluated. The doctor failed to take a risk factor assessment but the patient had multiple cardiovascular risk factors including diabetes, hypertension, age, male sex, and had a 10-year heart disease risk of about 25%. His risk was therefore considerable. While the doctor felt that this was atypical chest pain, the patient's history required a higher level of investigation. The doctor ordered no anti-anginal medication and to give a 3-6 week follow up in sick call was indifferent. The patient should have been referred for stress testing or cardiac catheterization to evaluate for acute coronary syndrome. At a minimum the patient should have been started on a statin and anti-anginal medication and referred to a cardiologist. Care failed to follow generally accepted guidelines or usual practice.

12/1/2015 A doctor saw the patient for a complaint of nausea. The patient was taking Prilosec. The doctor took no history with respect to chest pain. The doctor diagnosed nausea from Prilosec and stopped the Prilosec and started Zantac. Zantac can result in cardiac conduction abnormalities and should have been used with caution in this patient with known severe conduction abnormalities.

1 The doctor failed to take a thorough history. Nausea can be an anginal equivalent. The doctor failed to note the prior complaints of chest pain and this was not investigated. Care could reasonably expected to be better.

Patient #18

12/17/2015 A doctor saw the patient for HTN, DM, chronic clinics. The doctor mentioned that the patient was on coumadin and had COPD. The doctor took no history to determine the status of the patient's progress with respect to any of his diseases. The A1c was documented as 6.6. PEFR was documented as 240/230/230. The last INR was documented as 1.9. BP was 122/64 and the pulse 93. The doctor noted that the patient had a macrocytic anemia and appeared to order a B12 level but the note was illegible. The patient's COPD, cardiac arrhythmia, were not addressed. The doctor made no changed to therapy.

12/22/2015 At 10:10 am the patient complained to a nurse of leg swelling and shortness of breath with pitting edema. The nurse notified a doctor.

12/22/2015 At 10:40 am a nurse noted that the patient was lightheaded and had a blood glucose of 48. The patient was nauseated cold and clammy. The nurse gave the patient juice and checked him in 15 minutes and his blood sugar was 102.

1, 3 The doctor failed to take a thorough history of the patient's conditions. The doctor failed to address the patient's COPD or cardiac arrhythmia. Even though these were chronic medical conditions, they were not being followed in chronic care clinics. The doctor noted the macrocytic anemia and ordered a B12 level but failed to associate the macrocytic anemia with the abnormal bilirubin, and thrombocytopenia which can be associated with cirrhosis. The doctor failed to address the patient's prior episodes of chest pain even though the patient had history of cardiac arrhythmias and history of coronary artery disease. The patient had a 25% risk of heart disease and was not started on a statin.

Patient #18

- 12/22/2015 A doctor saw the patient subsequent to the hypoglycemic episode. The doctor said he was seeing the patient for low blood sugar and leg edema with shortness of breath. The doctor noted orthopnea, and left chest pressure that lasted 10 minutes with gradual onset and no resolution. The doctor noted 1-2+ lower extremity edema. The doctor decreased the 70/30 insulin from 25 to 20 units, restarted the alvesco and ordered a CBC, BNP, BMP and INR and ordered follow up in a week. The doctor did not order an EKG. The assessment of the chest pain was "COPD vs cardiac? not exertional" but the doctor didn't take a history sufficient to exclude this. The leg edema did not include rule out diagnoses. Although the doctor documented shortness of breath and a history of heart failure a chest x-ray was not done.
- 12/26/2015 A nurse saw the patient who said, "I don't know what's wrong with me but something isn't right. I can't sleep cause I'm so short of breath." The nurse recommended that the patient rest and hydrate. Later that day a pacemaker check was done.
- 12/28/2015 EKG showed aberrant intraventricular conduction with ventricular escape complexes with WPW pattern type A. Overread was requested.
- 12/29/2015 EKG showing aberrant intraventricular conduction with PVCs and WPW pattern and rightward axis.
- 1, 8 The doctor failed to take adequate history with respect to leg edema and shortness of breath. The "chest pressure" was not addressed adequately as it may have been due to angina. The patient's possible cirrhosis may have resulted in the hypoglycemic episode but this was unrecognized. Though the patient had chest pressure the doctor did not order an EKG or assess the patient for angina. Though the doctor documented non-exertional chest pain, the history was insufficient to draw this conclusion. The doctor failed to establish potential diagnoses that may have caused the leg edema. Despite shortness of breath and history of heart failure a chest x-ray was not done. Care failed to follow generally accepted guidelines or usual practice.
- 16 The patient had a serious complaint and the nurse should have referred the patient to a provider.

Patient #18

12/29/2015 A doctor saw the patient and noted that the patient went to UIC for pacemaker check in the past and had the pacemaker placed two years ago. The doctor failed to note that follow up with cardiology never occurred. The doctor did note that the patient had leg edema and his weight had increased by 17 pounds over the past week and that the BNP was 712 and hemoglobin of 9.1 with an INR of 3.3. The doctor noted increased shortness of breath, orthopnea, and edema. The doctor questioned whether the pacemaker was malfunctioning. and noted that the heart rate was in the 40s. The doctor noted a heart rate of 44, which is significant bradycardia. The doctor noted recent labs as BUN 42; creatinine of 1.77; BNP 712. The doctor diagnosed heart failure exacerbation and increased the bumex to 2 mg and stopped the hydralazine and zantac and restarted omeprazole. The doctor wanted to admit the patient to the infirmary but he was "averse" and the doctor recommended decrease of salt. The doctor did not order a chest x-ray. An EKG showed aberrant intraventricular conduction with ventricular escape. The tracing appears to show 3 pace maker firings. The doctor's plan included a cardiology evaluation if his plan failed. However, the patient had multiple indications for hospital admission based on Heart Failure Society of America guidelines for admission to a hospital.

12/30/2015 Pacemaker check indicated two alerts: one was a high ventricular rate (40) was detected and the ventricular percent pacing greater than limit. The pacemaker was functioning normally.

1, 14 The patient had 17 pound weight gain over a week with elevated BNP and leg edema suggestive of heart failure. The doctor failed to obtain a chest x-ray. The doctor failed to ask the patient about chest pain. The doctor ordered an EKG but didn't document evaluation of the EKG. The EKG showed aberrant ventricular complexes that made it difficult to evaluate for angina. The EKG showed three pacemaker firings with a slow heart rate. The doctor noted a heart rate of 44. The heart rate shouldn't be 44 if the pacemaker was functioning but this apparently was unrecognized. The doctor failed to recognize that the patient had never had cardiology follow up after the pacemaker set up. The patient had ventricular escape complexes with apparent pacing spikes. The doctor assessed exacerbation of heart failure but did not order a chest x-ray, a repeat BNP, or repeat metabolic panel. Laboratory tests were noted which were not present in the medical record showing renal failure and elevated BNP. Given the number of serious cardiopulmonary problems, heart failure under these circumstances should be admitted to a hospital. This was particularly true because the doctor documented that he thought the pacemaker might be malfunctioning. Under these circumstances, the patient needed to be evaluated by a cardiologist in a hospital especially in the context of heart failure and possible angina. <http://www.hfsa.org/heart-failure-guidelines-2/Care> was grossly and flagrantly unacceptable.

A greater pacing rate with heart failure should have resulted in hospitalization.

Patient #18

- 12/31/2015 A nurse saw the patient who said, "It's not my lungs, it's my heart." The patient was being seen for a nebulizer treatment. The nurse noted that the edema was already addressed by a doctor on 12/29/15. Although the patient complained of a heart problem, the nurse took no history and continued the same care and referred to a doctor the following morning.
- 12/31/2015 A doctor saw the patient and noted that the patient felt better. The doctor took no history related to the patient's chest complaint. The doctor assessed heart failure exacerbation and restarted spironolactone and scheduled the patient for 1/6/16 with labs.
- 1/1/2016 A nurse noted receiving a phone call from an officer that the inmate was not responding. The patient had died and was in rigor mortis on arrival at 4:30 am. Medics brought the patient to a hospital where he was pronounced dead.
- 16 The patient had chest pain but was not referred to a doctor. The nurse should have referred the patient to a doctor.
- 1, 3, 6 The doctor failed to review the pacemaker check alerts including high ventricular pacing. The doctor failed to take an adequate history of the patient's history that same day of chest pain. Care was grossly and flagrantly unacceptable.

Patient #19

10/25/2000 The problem list documented alcohol abuse and chronic diarrhea secondary to prior surgery for peptic ulcer disease.

1/4/2002 The problem list documented hypertension.

3/6/2014 A chronic care flowsheet documented that the patient weighed 142 pounds.

6/30/2014 A chronic care flowsheet documented that the weight was 133 pounds.

6/30/2014 The patient was evaluated in hypertension and diabetes clinics but he did not have either disease. The blood pressure was 104/60. The A1c was 5.5 and the patient was not on any medication for blood pressure or diabetes. The NP seeing the patient documented that the patient did not have diabetes or hypertension and switched the patient to general medicine chronic clinic. The NP noted that the patient had ulcerative colitis but took no history and evaluated no labs. The NP did not note the nine pound weight loss.

1 The NP failed to note the weight loss despite the patient having ulcerative colitis.

10/8/2014 BUN 27; cholesterol 119; HDL 53; LDL 52 (50-129); Albumin 3.5 (3.4-5)

10/15/2014 A nurse documented that it was not possible to take the weight since the patient couldn't stand. The patient was 81 years old.

10/17/2014 A PA saw the patient saw the patient for his prosthetic leg. The weight was 133 pounds. The PA noted that the patient had a poor fitting prosthetic and referred the patient for orthotic evaluation. Presumably the weight was taken with the prosthetic.

10/21/2014 A nurse noted that the weight was approximately 133 and was deferred.

Patient #19

10/28/2014 An annual history and physical examination documented prior back surgery, prior cholecystectomy, alcohol abuse as medical problems. The history documented dietary restrictions but did not document what these were or why the patient needed dietary restrictions. The nurse taking the history documented that the patient said he had cataracts and couldn't read the eye chart. The doctor completing the physical examination added that the patient had prior surgery for peptic ulcer disease without specifying what was actually done and noted that the patient had prior osteomyelitis without more specificity. The assessment documented that the patient had a below knee amputation but didn't state why the patient had an amputation. The doctor noted that the patient had diabetes in 2012 but wasn't now being treated for this. The patient refused rectal examination. Colorectal screening was not done. The weight was 136.

11/10/2014 The patient's weight was 136.

1/27/2015 The patient developed a lesion on the right stump and saw a doctor. The weight was 134. There was a 1 cm ulcer. DuoDERM was ordered.

2/2/2015 A nurse noted changing the dressing on the stump that had a moist wound on the stump with a foul odor.

4/23/2015 A PA saw the patient for a stump wound. The PA noted that the prosthetic didn't fit "right." There was a 2 cm lesion with "irritation" on the stump. The PA referred the patient to the orthotic specialist.

4/29/2015 Wexford approved an evaluation by Rockford Ortho for refitting of right artificial leg.

7 The patient wasn't offered colon cancer screening. The patient was 81 but screening should stop when the estimated life expectancy is less than 10 years. Estimated risk should have been done as part of the annual assessment. Care failed to follow generally accepted guidelines or usual practice.

Patient #19

5/13/2015 The patient went to ophthalmology clinic and it was noted that he was using a wheelchair. The transfer note also documented that he was on a mechanical soft diet with no bread and had to sit up straight when he ate and that he had chronic diarrhea.

6

5/14/2015 Rockford ortho saw the patient. There was no report except for comments on the referral form. Those comments noted that the prosthesis was causing re-occurring sores and skin breakdown. They believed that the socket no longer fits adequately and would continue to cause problems. They recommended a socket replacement for the prosthesis.

6/1/2015 Wexford denied a new socket until a price quote was available.

11 What was the patient supposed to do? The prosthesis was broken. This should have been fixed.

6/3/2015 A nurse evaluated the patient for a toothache and documented a weight of 129.

6/11/2015 Wexford again denied a new socket until a price quote was available.

Patient #19

6/15/2015 The patient was seen in General Medicine chronic clinic for ulcerative colitis, GERD and BPH. The patient weight estimated at 129 pounds on the flow sheet. The patient was 5 foot 11 inches. There was no history of any of the patient's medical conditions on the progress note. The BMI was not calculated on the note but was 18, which is considered underweight. The nurse practitioner made no mention of this. Without any history or documentation of status on any of the patient's conditions, the NP prescribed Lomotil for diarrhea as needed, Colace, fiber, milk of magnesia, terazosin, zantec, Tylenol and Maalox. It wasn't clear why the patient needed these medications as there was no history. The assessment was ulcerative colitis "controlled," GERD controlled, and anemia. The etiology of the anemia was not documented and apparently was not understood. The NP failed to review labs that showed that the patient had malnutrition with low albumin. The thrombocytopenia was not acknowledged and the anemia not worked up.

6/25/2015 The patient obtained a new socket for his prosthesis.

7/9/2015 The patient signed a "living will" that if he had an incurable and irreversible disease judged to be terminal that procedures that would prolong the dying process be withheld or withdrawn.

7/23/2015 Vit B12 674 (180-914); Iron 21 (50-180); ferritin 23 (10-259); folate 18.4 (>5.8).

1, 2, 7 The patient had ulcerative colitis, weight loss, and anemia yet a colonoscopy wasn't done. This was especially important since risk of colon cancer is higher in persons with ulcerative colitis. Also the patient had pancytopenia that was unrecognized. A bone marrow should have been considered. At a minimum a repeat CBC should have been done. The low albumin in addition to the ulcerative colitis and weight loss suggested malnutrition but no evaluation was done. The doctor did not address the broken prosthesis. Care failed to follow generally accepted guidelines or usual practice.

Patient #19

8/5/2015 A doctor saw the patient for review of labs and hemocult. The weight was 134 pounds. The doctor noted that the patient was pale. The doctor noted a history of ulcerative colitis and documented that the patient didn't want a hemocult done. The hemoglobin was 9.6 and the B12 and folate were normal and serum iron was low. The doctor diagnosed iron deficiency anemia and started iron supplements. The doctor noted that the patient had no diarrhea or black stool and had a history of constipation. The doctor did not order a colonoscopy. The doctor did not note the possible malnutrition.

8/6/2015 UIC ophthalmology noted "visually significant cataracts both eyes" and recommended surgery with the right eye first.

8/10/2015 UIC performed right cataract surgery.

8/12/2015 A doctor saw the patient for follow up of a medical writ. The weight was 124 pounds, which was a 18 pound weight loss which the doctor did not notice. The doctor noted that the patient had cataract surgery and needed follow up at UIC in a week. The doctor did not address any of the patient's other problems.

8/18/2015 The patient saw ophthalmology at UIC. They recommended cataract surgery in both eyes. A Dixon physician documented that the patient would need approval "but does not have DMZ so don't think he meets criteria."

2, 3, 7, 12 The doctor should have ordered a colonoscopy given anemia, ulcerative colitis, and weight loss. The patient had low albumin which was unrecognized and should have had an evaluation for malnutrition. The doctor should have considered referral to hematology for pancytopenia.

1 The doctor failed to notice the weight loss. Care could reasonably have been expected to be better.

Patient #19

8/21/2015 A doctor saw the patient. The weight was 123 pounds. The doctor noted that the weight was 142 pounds on 3/14 and was 123 pounds "today." The doctor also noted that the patient had a hemoglobin of 9.6. The history was that the patient had prior osteomyelitis of his right leg which presumably accounted for the amputation. The doctor assessed a 19 pound weight loss over 17 months. The doctor also noted the albumin of 3.2. Despite the anemia and weight loss the doctor assessed that the weight loss was due to needing dentures. The doctor ordered a CMP, TSH, iron, ferritin, CBC, but did not order colonoscopy or order a nutritional inventory with a nutritionist. The doctor also noted anemia and prior pancytopenia and documented that the patient might have a dyscrasia but did not refer to a hematologist. The doctor ordered a two week follow up.

8/25/2015 BUN 23; sodium 133; albumin 3.5 (3.4-5); iron 34 (50-19=80); Ferritin 48 (10-259); TSH 3.26 (0.35-4); WBC 7 (3.9-12); hemoglobin 11.1; platelets 135.

9/8/2015 Patient had follow up for his cataract surgery and UIC noted that the second cataract was scheduled for 9/5/15.

9/17/2015 A doctor saw the patient who now weighed 120 pounds. The doctor documented that corrected vision in the post surgical eye was only 20/80 and he re-referred the patient for cataract surgery on the second eye. The doctor failed to address the hematologic abnormalities identified on the 8/21/15 note. The doctor failed to note the continued weight loss.

10/5/2015 Wexford denied removal of the 2nd cataract as patient "does not meet criteria" for removal. The denial was appealed and then approved on 10/2/15.

2, 7 The doctor concluded that low albumin, weight loss, and anemia were due to needing dentures without conducting other evaluations. The patient needed a colonoscopy and needed a nutritional survey to determine if the patient was getting sufficient nutrients and food. Care failed to follow generally accepted guidelines or usual practice.

The labs still showed anemia, borderline albumin and thrombocytopenia but there was no follow up. Care failed to follow generally accepted guidelines or usual practice as abnormal labs were no followed up.

1, 6 The medication renewal process didn't work and the patient's medication stopped in mid December and wasn't started again until 1/8/17, about 3-4 weeks later.

Patient #19

11/2/2015 Glucose 129; BUN 27.

11/2/2015 The patient weighed 131 pounds wearing his prosthesis.

11/4/2015 A NP saw the patient who had a "nickel" sized pressure ulcer on the stump. The patient weighed 130 pounds. The NP ordered dressing changes for the wound.

11/8/2015 A NP saw the patient in chronic clinic for ulcerative colitis, GERD and BPH. The NP documented that the patient got up 3-4 times a night to urinate. The NP also did not review any symptoms related to the GERD or ulcerative colitis. The weight was 127 pounds which was a weight loss of 15 pounds since March of 2014. Yet the NP did not note this and did not discuss this especially in the context of the ulcerative colitis. The only labs reviewed were a glucose of 129; BUN 27 and creatinine 1.03. The recent anemia, thrombocytopenia were not evaluated. The latest low albumin indicating malnutrition was also not evaluated. The GERD and ulcerative colitis were assessed as "stable" without having taken any history and without evaluation of the anemia, thrombocytopenia, weight loss or low albumin indicative of malnutrition.

11/16/2015 A doctor saw the patient and addressed the orthotic and stump ulcer but did not address the anemia or malnutrition.

12/9/2015 A doctor saw the patient post orthotic visit. The weight was 128. The doctor did not address the weight loss or abnormal blood test.

1, 3, 6, 7 The NP failed to note the weight loss despite the patient having ulcerative colitis. The NP also failed to note abnormal labs. Given the anemia and ulcerative colitis, the patient should have been offered a colonoscopy. The NP also failed to identify the previously abnormal albumin with respect to the patient's nutrition and ulcerative colitis. The nutritional status should have been evaluated. To assess the ulcerative colitis as stable was not correct as the patient was losing weight and the doctor took no history to verify stable ulcerative colitis. Care failed to follow generally accepted guidelines or usual practice.

Care could reasonably have been expected to be better as the doctor might have noted the weight loss.

Patient #19

- 3/1/2016 A nurse saw the patient for nausea. The patient described feeling weak, vertigo. He was going to the bathroom when he fell to the floor and became nauseous. He didn't vomit. The blood pressure was 98/50 but orthostatic blood pressure was not taken; the nurse documented that she was unable to assess this for unexplained reasons. The nurse consulted a doctor who ordered compazine for seven days without scheduling an evaluation or without ordering lab tests.
- 4/25/2016 A nurse documented a brief note stating that the prior evening the patient had sudden weakness, dizziness, and problems walking but these had resolved and the patient didn't want to be seen. The nurse didn't take vital signs or refer to a physician.
- 5/6/2016 A NP saw the patient in chronic illness clinic for GERD, ulcerative colitis, and BPH. The NP documented dizziness but the only history was that the "only med on that may affect that is Hytrin." The NP documented adequate hydration and only rare diarrhea. The weight was 130, a 12 pound weight loss over two years. The patient also had low albumin indicative of malnutrition which was not acknowledged or reviewed. The NP did not discuss diet and nutrition with the patient despite the significant weight loss with ulcerative colitis. The BMI was documented as 19 but with a weight of 130 and height of 5 foot 11 inches, the BMI was 18.1, which is underweight. This would be significant in a person with ulcerative colitis. The anemia, thrombocytopenia, and hypoalbuminemia were not acknowledged. The blood pressure was 98/58, which is low but was not evaluated. The NP assessed the patient as in good control and continued the same medications.
- 14, 19 The doctor should have seen the patient to assess the patient for syncope, low blood pressure, nausea, and a fall as these were serious problems. Failure to see the patient was indifferent. If this was after hours, the patient should have been sent to a hospital. Care failed to follow generally accepted guidelines or usual practice.
- 16 The nurse should have referred the patient to a physician.
- 1, 2, 7, 8, 12 The NP failed to take adequate history or perform adequate examination for the dizziness. An EKG should have been done. The patient's weight loss and anemia and UC warranted a colonoscopy but this was not done. The patient was underweight and had low albumin and his nutrition should have been evaluated by someone who understood how to do this. The thrombocytopenia should have been evaluated. Care failed to follow generally accepted guidelines or usual practice.

Patient #19

6/17/2016 A doctor saw the patient. The weight was 130 pounds. The doctor noted that the patient had a blister formation on his coccyx and was experiencing pain. The doctor noted that the inmate was "thin" and used a wheelchair much of the time. The doctor noted that the patient had a donut for use but had redness and thin sensitive skin over the coccyx with a blister and a small open ulceration without sign of infection. The doctor diagnosed a "superficial pressure irritation and blister" on the coccyx. The doctor ordered daily cleaning of the affected area and advised the patient to sleep on his side as much as possible. The doctor recommended avoiding sitting for long periods of time to relieve buttock and back pressure. However, the patient needed a wheelchair, presumably due to an ill fitting prosthetic. The doctor did not address whether the patient could walk, had a good fitting prosthesis, or the extent to which the patient was using the wheelchair. This should have been done. The doctor did not assess nutritional status.

6/20/2016 Wexford approved UIC ophthalmology for pre-op cataract removal visit.

6/20/2016 BUN 32; sodium 130; calcium 8.2; albumin 2.3; bilirubin 3.3; alk phos 472; AST 165; ALT 119.

6/22/2016 The patient complained to a nurse of needing something for pain. The nurse didn't acknowledge what the pain was from. The nurse assessment was "knowledge deficit" and the nurse referred the patient to the doctor line for pain medication.

1, 3 The doctor failed to take an adequate history with respect to risk for decubitus in this patient and failed to take other protective measures. This patient was 81 years old, frail, malnourished, with underlying ulcerative colitis. He appeared to need housing on a specialized medical unit. Care failed to follow generally accepted guidelines or usual practice.

16 The patient now had a decubitus ulcer and was mostly confined to a wheelchair and should have been referred to a physician.

Patient #19

6/23/2016 The patient was evaluated in UIC ophthalmology. A brief comment on the referral form documented that the patient needed to take AREDS2 vitamins and needed both cataracts removed. A 7/11/16 follow up was requested. AREDS 2 vitamins are a combination vitamins prescribed for reducing risk of age related eye disease.

6/23/2016 A doctor saw the patient to evaluate for flex cuffs but did not see the patient for the coccyx wound.

6/24/2016 A NP was asked by a nurse to see the patient for the coccyx wound. The patient said, "I am in so much pain, I can't stand it." The patient said the DuoDERM falls off and he had drainage from the wound. The NP noted that the patient was a thin and "fragile" man with two pressure sores on his coccyx; one was 3 by 3 cm and the other 1.5 by 1 cm with surrounding inflammation. There was serous and purulent drainage. The NP ordered Augmentin, Toradol, Ultram and recommended that the patient not lay on his back or sit for long periods but did not admit to the infirmary.

1, 2, 8, The NP failed to assess the stage of the ulcer. The NP
14 failed to assess the nutritional status of the patient. Although the NP started antibiotics, the NP failed to order appropriate tests to assess the level of infection or to rule out osteomyelitis. The NP failed to identify preventive measure necessary to take to prevent extension of the ulcer. The patient should have been placed on an infirmary or skilled nursing unit. Care failed to follow generally accepted guidelines or usual practice. This care should have been familiar to staff given that it housed the geriatric unit.

6/27/2016 A doctor saw the patient for the pressure sores. The doctor noted that the tramadol helped with the pain and that the patient was getting daily wound care. The doctor noted decreased appetite with nausea. The doctor noted extensive bruising of the wrists from cuffing. The patient weighed 127 pounds and the doctor noted weight loss of five pounds from 10/2/15. The doctor added that the patient lost three pounds since 6/17/16 and would add "Boost" if meets UM or weight [loss] criteria." The patient was referred for an air mattress and ordered labs (CBC, CMP and ESR) and ordered flex cuffs and Compazine. The doctor did not note that the patient was taking antibiotics and did not document examination of the coccyx wounds.

1, 2, 7, The doctor failed to take adequate history, failed to
8, 12, 14 order nutritional assessment or order appropriate nutritional supplement; failed to adequately examine the patient or assess the depth of the ulcer and did not order radiologic testing to assess for osteomyelitis. He should have been placed on an infirmary. Care failed to follow generally accepted guidelines or usual practice.

Patient #19

6/28/2016 A nurse documented that the patient complained of a leaking wound; the patient was wearing diapers. There was no evidence of daily dressing changes. The drainage was yellow in color and the nurse documented a plan to continue to do dressing changes.

6/29/2016 Glucose 116; BUN 22; calcium 7.8 (8.6-10.6); Total protein 5.7 (6-8); albumin 2.3 (3.4-5); WBC 4.2 (3.9-12); hemoglobin 10; platelets 145 (150-450); sedimentation rate 60.

6/29/2016 The patient complained "it's really draining." The nurse noted yellow exudate on his pants and underwear. The nurse noted that a NP assessed the patient who now had a 5 cm coccyx ulcer with yellow tissue present.

6/29/2016 A NP saw the patient for dressing changes. The NP noted that the patient continued to have serous drainage from the sound and thought that the wounds were improved.

6/30/2016 A doctor wrote a lab review in the record documenting that the ESR was 60; hemoglobin 10; and albumin 2.3. The doctor ordered boost one can TID. The doctor took no action about the hemoglobin or especially the ESR of 60 which indicated probable infection and possible osteomyelitis.

7, 8, 12, 14 The laboratory results indicated serious infection or even osteomyelitis. The patient should have had a CT scan, probing of the wound, and possibly bone culture. IV antibiotics should have been considered. Since this appeared beyond the expertise of local doctors the patient should have been referred to an infectious disease specialist, wound care specialist or both. The doctor took no action. The doctor failed to address significant low albumin and anemia. The patient should have been considered for hospitalization as this doctor did not know how to manage this patient. The doctor did not appear to have adequate primary care experience, especially for a geriatric population. Care was grossly and flagrantly unacceptable.

Patient #19

- 6/30/2016 The patient told a nurse that the coccyx wound was draining a large amount and the abdomen was soaked with drainage. The nurse described the upper coccyx wound a 5 cm in diameter and the lower wound 1.5 cm with boggy tissue covering both wounds.
- 7/5/2016 A doctor saw the patient for a pressure sore that was larger. The doctor wrote "pt has no 'vaseline.'" The doctor noted that the patient had no fat and that the patient was having a difficult time staying on his side. The doctor noted a whitish pressure ulcer. The doctor's plan was to order an egg crate mattress while waiting for an air mattress. The doctor ordered daily wound care. The doctor failed to review the laboratory tests.
- 7/8/2016 A doctor noted that the nurse doing the dressing changes noted tunneling of the pressure wound toward the buttock. The doctor noted that the wound was being packed with 1/2 inch iodoform gauze. The doctor referred the patient to the UIC wound clinic but ordered no labs, x-rays, or MRI to evaluate for osteomyelitis and did not initiate antibiotic treatment despite the elevated sedimentation rate or 60. There was no referral to wound clinic in the medical record.
- 7/8/2016 A nurse described the wound as being covered with green flesh-like material. The nurse described tunneling on both wounds
- The boggy tissue implied that debridement was necessary but was unnoticed by doctors.
- 6, 11, 12, 14 The doctor did not appear to competently evaluate the stage of the ulcer and develop a competent plan to manage it. The doctor failed to evaluate prior abnormal labs including the elevated sedimentation rate. The patient should have been referred to a surgeon for debridement, to a wound care center, and/or to a hospital for evaluation and treatment with IV antibiotics and evaluation for osteomyelitis. Resources to manage this pressure ulcer were apparently unavailable but should be as Dixon has a geriatric unit. As an alternative to transfer to a skilled nursing hospital, infirmary care was indicated
- 8, 12, 14 The wound appeared to be at least a stage 3 ulcer with a sedimentation rate of 60, should have resulted in evaluation for osteomyelitis. This did not occur. The doctor appeared to have referred the patient to a wound care center but this never occurred. IV antibiotics appeared indicated. Care was grossly and flagrantly unacceptable and appeared to result from ignorance on how to manage the patient. This may be a credentialing issue.
- This wound should have been debrided.

Patient #19

7/9/2016 The patient signed a living will on a preprinted formatted document which stated that if he had incurable or irreversible illness and that death was imminent he directed that any procedures that would prolong the dying process should be withheld.

7/11/2016 Wexford approved a UIC ophthalmology evaluation the day it was requested.

7/11/2016 A nurse described that the patient had diarrhea and had only three more days of Boost.

7/14/2016 The patient told a nurse that "It's totally worthless." The nurse described a creamy drainage.

7/14/2016 A nurse documented that the patient had diarrhea and presumed it was from the Boost. The nurse consulted a doctor, who wasn't sure how to treat. The doctor recommended continuing the boost and to "work around diarrhea."

7/18/2016 A brief note on the referral form from UIC ophthalmology documented that the patient needed to see anesthesiology two weeks prior to his scheduled surgery date and would also need to be seen the day after surgery or later the same day.

7/19/2016 The patient complained of a painful wound. The nurse noted deep tunneling of the wound with large thick yellow drainage.

7/22/2016 Wexford approved UIC anesthesiology pre-op evaluation.

The wound appeared infected.

8, 12, 14 The doctor didn't know how to treat the patient and should have referred to a higher level of care. The patient needed laboratory testing because of the diarrhea and needed a level of expertise unavailable at the prison. Care failed to follow generally accepted guidelines or usual practice.

Patient #19

7/22/2016 A doctor saw the patient on writ return from UIC ophthalmology. The doctor mentioned that the patient had some tunneling of the coccyx decubitus. The doctor noted that the patient had diarrhea. The doctor performed no physical examination. Remarkably, the doctor wrote, "Please notify me next week when in wound care so I can see wounds." The doctor could have and should have removed the bandages to inspect the wound. The doctor ordered Imodium and increased tramadol . The doctor ordered no blood tests or radiological tests. Vital signs were not taken.

7/24/2016 The patient was evaluated in anesthesiology. A brief note by the anesthesiologist documented that the patient had bradycardia but that the patient could proceed with surgery.

7/25/2016 A nurse noted that bone was visible within the wound with a moderate amount of green exudate.

7/27/2016 A nurse documented visible bone with tunneling 7 cm deep.

8/1/2016 A nurse noted that the doctor was present to see the wound and ordered to discontinue packing and to start wet to dry dressings only. The doctor did not document a note.

8/2/2016 A doctor saw the patient. The temperature was 96.8. The doctor noted that the patient was cleared for cataract surgery. The doctor noted that the wounds on his back appeared "healthy" without erythema or significant drainage. The patient noted that the patient was approved for cataract surgery. However, the doctor had no treatment plan for the decubitus. The doctor ordered no labs or imaging studies.

2, 3, 7, 8 This was indifferent. The doctor should have removed the bandage and inspected the wound. Appropriate laboratory and radiologic testing was not done. The plan of care was inadequate. IV antibiotics should have been considered. Care failed to follow generally accepted guidelines or usual practice.

This indicates a stage 4 ulcer. Osteomyelitis should have been promptly ruled out.

The doctor should have documented a note.

2, 14 The nurses had documented visible bone. To inspect such a wound and to describe it as "healthy" appears incompetent. The patient needed hospitalization to rule out osteomyelitis. Care was grossly and flagrantly unacceptable.

Patient #19

- 8/8/2016 A nurse noted that the air mattress was leaking. The nurse also noted that the patient was losing weight and not taking his medication. The weight was listed as 100 pounds and the nurse noted that this was a 27 pound weight loss [it appeared to be a 42 pound weight loss over two years]. The patient lacked appetite and was "forgetful." The nurse assessment was "self care deficit." The plan was to schedule the patient to see the doctor. The patient was unable to care for himself and should have been placed on the infirmary or should have been hospitalized.
- 8/11/2016 A nurse noted that during a dressing change the inmate urinated foul smelling urine on the table. The inmate stated, "I can't help it." The nurse noted that the inmate was unable to put on his underwear or pants and that he needed a roommate to assist him with activities of daily living. The nurse wrote "poss infirmary placement."
- 8/12/2016 A nurse noted that the wounds were draining purulent material.
- 8/13/2016 At 3:30 am a nurse noted that the patient fell and the nurse wrote an injury report. The nurse did not document an assessment in the progress note or consult a physician.
- 16, 19 The patient had lost 42 pounds, had malnutrition, a stage 4 decubitus ulcer with a sedimentation rate of 60. The patient was now showing signs of altered mental status which suggested serious sepsis. Care was negligent. The nurse should have immediately contacted a doctor but it appeared that doctors didn't know how to care for the patient.
- 16,19 The altered mental status was of serious concern and suggested sepsis. The nurse needed to refer the patient immediately to a physician.
- 16 This was a serious problem and the nurse needed to consult a physician.

Patient #19

8/13/2016 At 5:30 pm an nurse noted that the patient's roommate reported that the patient hadn't eaten in two days and hadn't voided. The nurse described the patient as weak. The nurse placed the patient on the infirmary and called the doctor, who ordered a CBC and CMP and UA and IM Rocephin for seven days without evaluating the patient. The doctor also ordered an IV but the nurse was unable to start an IV secondary to what the nurse perceived was dehydration. At 7:45 pm the nurse noted that the patient responds to pain. At 7:50 pm a nurse noted a temperature of 100.1 a pulse of 115 and blood pressure 100/50. The patient wasn't responsive and the nurse called a doctor, who ordered the patient to a local hospital.

8/13/2016 A hospital blood culture documented gram positive cocci growing in two bottles. These were identified as Beta strep Group A and diphtheroid. There was light growth of methicillin resistant Staph aureus and streptococcus agalactiae- Group B strep. The WBC was 15.8.

8/14/2016 A hospital lab report showed BUN 92; creatinine 2.06; sodium 153 (137-145); chloride 116 (98-110); albumin 2.7.

8/14/2016 A hospital history and physical noted that the patient had been lethargic for 2-3 days and had low grade fever and mental status changes. The admitting diagnoses were mental status changes, dehydration, acute kidney injury, stage 3 pressure ulcer, and sepsis. The hospital was told that the patient was DNR as communicated to them by the Dixon physician. The patient was described as lethargic for 2-3 days.

8/15/2016 A hospital lab report showed a blood culture growing budding yeast on gram stain with the aerobic bottle positive.

8/17/2016 A hospital lab report showed WBC 4.9, hemoglobin 8.5; platelets 55.

Patient #19

8/18/2016 A doctor spoke with the hospitalist who indicated that the patient had positive blood cultures with bacteria and fungus with the source likely from his back. The patient was being returned to the prison for comfort measures only. The discharge summary indicated that the hospital contacted the daughter who agreed with nonaggressive care. The patient was not fully oriented. The patient was returned to the prison for hospice.

8/19/2016 The patient was admitted to the infirmary on discharge from the hospital. The doctor ordered Ativan, morphine, and atropine only. The doctor documented confirming that the daughter had agreed with hospice care. The doctor did not discuss palliative sedation with the daughter. On admission the nurse noted that the patient was crying in pain.

8/21/2016 The patient was discharged from the hospital. The discharge summary documented that the patient had sepsis from infected decubitus. The patient was very "debilitated" and the daughter noted how "much he had gone downhill since she had seen him last and opted for nonaggressive care." The patient needed debridement but the daughter opted against this. The patient was sent back without antibiotics and on morphine.

8/21/2016 The patient died on the infirmary.

Patient #20

10/28/2016 The patient was discharged from Stroger hospital. The patient was discharged on 15 mg of morphine every four hours for pain. The patient reported losing about 80 pounds since the diagnosis. The diagnosis was likely pancreatic cancer. This hospital report was printed on 11/9/16, so this report likely went with the patient to Logan.

11/9/2016 The patient was transferred from Cermak HS on Tylenol, albuterol, amlodipine, docusate, metoprolol 25 BID; morphine 15 SR BID **and** 15 mg IR Q 4 hours for pain, olanzapine, trazodone, pantoprazole 40 mg. Hepatitis A, B, and C were all positive yet were repeated in IDOC. The patient had an upcoming appointment at GI on 11/17/16

11/9/2016 The patient was admitted to Logan CC. The patient was 5 foot 5 inches tall and weighed 152 pounds. The nurse history documented that the patient had asthma, a prior positive TB skin test but never completed therapy, was a smoker, had a prior biopsy of her pancreas on October 27th and had a stent in the liver. The reason for the biopsy of the pancreas or stent were not explained. The nurse performing the intake screening scheduled a routine examination though the patient had a serious problem (liver stent with undiagnosed pancreatic problem). The nurse did not list medications on the intake screening. Also, there was no evidence of an order for medication. This screening was performed by a LPN.

1 The history was poor. The patient had HTN but it was unrecognized. The patient had a high likelihood of pancreatic cancer and it was unrecognized. The patient was on morphine but the patient didn't receive it. Instead the patient received one Tylenol #3 TID instead of 30 mg SR morphine and 90 mg of IR per day. The three Tylenol #3 tablets had a morphine equivalency of only 15 mg of morphine whereas the patient was receiving 120 mg of morphine. No pain history was taken. Care failed to follow generally accepted guidelines or usual practice.

Patient #20

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|---|--|
| 11/9/2016 A nurse admitted the patient to the infirmary. The reason for admission was not stated. Under subjective the nurse wrote "colon cancer" without any other explanation. The blood pressure was 146/107. The weight was listed as 152 pounds. The examination section allowed for checking boxes as normal; the entire examination was normal by checking boxes as so. The assessment was "alteration in comfort r/t colon cancer." | 1 The nurses failed to understand the patient's problems. The failure to take a history of HTN resulted in no BP medication for the first day. |
| 11/9/2016 GGT 341 (6-60); amylase 55 (25-125); lipase 17 (22-51); CMP normal except albumin 3.3 bilirubin 3 and alk phos 182 (40-125). | |
| 11/10/2016 A nurse wrote a brief note documenting blood pressure of 158/93. The patient asked for pain pills for a headache. The patient stated asked for diapers for leakage of bowels. The nurse assessment was colon cancer. | 1 The patient had diarrhea yet the nurse failed to ask why. To use diapers for diarrhea is a significant problem and should have resulted in questioning about why this was occurring. |
| 11/10/2016 A nurse saw the patient for pain in her head and stomach. The blood pressure was 145/105. The nurse documented "continue current plan" although the plan was not specified and it wasn't clear if the patient was on pain medication. | The patient was abruptly discontinued from morphine and not provided adequate substitute. |

Patient #20

- 11/10/2016 Comments from oncology on the referral form stated that the patient had hyperkalemia, HCC, and HCV. The patient was given kayexalate with directions to NRC to manage the hyperkalemia. It was recommended to get a triple phase CT scan, with a follow up in two weeks. The potassium was 5.5. The oncologist prescribed 15 grams of kayexalate rectal suppository for two days with recommendation to repeat the BMP in two days.
- 2, 7, 12 The patient transferred with notes from Cook County Hospital and Jail documenting that the patient likely had pancreatic cancer. The patient had a follow up at Stroger hospital the second week of November and was on up to 90 mg of morphine a day. The doctor failed to continue the work up for the pancreatic mass. Ultimately, this was delayed such that a diagnosis did not occur for five months. The patient had a pancreatic mass for which there was no diagnosis. Because the biopsy was inadequate, the doctor presumed that the patient had a benign tumor? The patient should have been sent for a diagnostic ERCP. Moreover, the patient had pain and the doctor significantly decreased pain medication without even performing a pain assessment. This was indifferent. The doctor took no action for a patient that had likely pancreatic cancer. The doctor failed to document review of the discharge hospital summary. It was unclear why the doctor took these actions as they were clearly not in the best interest of the patient and were below standard of care for someone with an undiagnosed pancreatic mass.
- 11/10/2016 At 10:21 pm a nurse noted that the patient was complaining of pain and diarrhea. The blood pressure was 167/126. The nurse administered ordered medication but did not call a provider.
- 16 The nurse should have called a provider.
- 11/11/2016 At midnight the BP 147/91; the nurse called a doctor, who increased metoprolol to 50 mg. The patient had been on amlodipine when she came in. The nurse noted that the patient had colon cancer.

Patient #20

11/11/2016 At 4:21 am the BP was 143/96. The patient had breakfast.

11/11/2016 At 1:56 pm the BP was 130/97. The patient had pain and was given a "pain" pill. The nurse did not document medication given except described as "pain meds."

11/11/2016 A doctor saw the patient and documented consideration of a CT guided biopsy when "she is stronger." The doctor wrote to repeat LFTs next week. The doctor took no history including of pain. The doctor performed no exam.

4 This was nothing but a delay in initiating a work up. The patient had likely pancreatic cancer. The pain was not likely to improve and the patient not likely to get stronger. A work-up should have been started. The doctor was indifferent to the patient's pain.

11/11/2016 The BP was 170/114. Metoprolol increased to 50 BID.

11/12/2016 A doctor wrote a note only documenting lab values. Again there was no history. The hemoglobin was 9.4; WBC 5.9; ferritin 615; normal B12 and folate. Anemia of chronic disease diagnosed.

1 The doctor again failed to determine the history of the patient.

11/12/2016 Metoprolol was ordered 25 mg. The order stated that the medication would need to be reordered or discontinued in Pearl.

11/14/2016 The patient was discharged from the infirmary with a diagnosis of pancreatic mass, biliary duct obstruction, anemia of chronic disease, and HTN. Though the patient had elevated bilirubin and known biliary duct obstruction, the doctor did not order an urgent CT scan to determine the whether there was still obstruction or to determine what the diagnosis was. The only plan was a CBC & CMP and a low bunk for a year. There was no imaging study.

8 The doctor failed to obtain an imaging study (CT scan) in lieu of obtaining a history. The staff discharged the patient from the infirmary without establishing her actual status.

11/14/2016 Amlodipine ordered 5 mg BID; the order was electronically signed on 11/17/16.

Patient #20

11/16/2016 A PA saw the patient for an initial examination. The PA documented that the patient had a history of a pancreatic mass and had lost 70 pounds of weight from Dec 2015 to June of 2016. The PA noted that the patient had an ERCP and bile duct stent on 10/27/16. The PA noted HTN and hepatitis C infection. Despite having taken this history the PA checked the weight loss box as "no." The PA checked all examination boxes as "normal." The blood pressure was 115/88. The electronic record allows the examiner to check a box "normal" for the examination. This is a defective record system as it does not record the examinations performed. The assessment was pancreatic mass "benign ERCP biopsy (sub-optimal)," HTN, + PPD, and substance abuse. The PA did not list hepatitis C as a problem even though he documented this in the subjective section. The PA did not address the nurse finding of asthma as a history. The plan was to complete gonorrhea and chlamydia testing, a mammogram, and scheduling for the general medicine and hypertension clinics. The pancreatic mass was to be addressed in the general medicine clinic. The PA referred the patient to hepatitis C clinic but did not include hepatitis C as a diagnosis in the assessment. The PA did not mention labs in the record but did make oblique reference to elevated GGT when referring to the patient's hepatitis C. There was no physician admission note for this patient.

1, 2 A 70 pound weight loss with a pancreatic mass requiring a liver stent is not indicative of a benign problem. This patient's old records should have immediately been obtained and radiologic imaging performed to identify and serious pancreatic or liver problems. The assessment was inaccurate.

Patient #20

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| <p>11/22/2016 At 8:22 pm a nurse saw the patient. The blood pressure was 82/59. The patient was found on the floor having "fell out." She fell a second time. Remarkably, the nurse took no action except to tell the patient not to take "sleeping medication." The patient was on omeprazole, metoprolol, Tylenol #3, amlodipine, trazadone, and lamotrigine. The nurse did not call a provider.</p> | <p>16 The patient lost consciousness and should have been examined by a doctor. This was grossly and flagrantly unacceptable care.</p> |
| <p>11/22/2016 A doctor saw the patient. The hemoglobin was 10.8; creatinine 0.76; BUN 8; albumin 3.3; bilirubin 2. The doctor did not take a history, perform an exam, or develop a treatment plan. The doctor noted that the liver function tests were improved. No action was taken.</p> | <p>1, 2, 3, 6 The patient had a serious medical condition but the doctor failed to take any action to address the problem. The doctor also failed to address labs.</p> |
| <p>12/8/2016 A doctor saw the patient. The patient weighed 149 pounds. The doctor took little history except that the patient had increase in pain and was having normal bowel movements. Remarkably, the doctor did not take a history of the patient's illness. The doctor didn't qualify the pain. The doctor noted that the patient had decreased appetite. The doctor still took no action with respect to the pancreatic mass except to order a CMP and "observe" the patient.</p> | <p>1, 2,3 The patient had a serious medical condition but the doctor failed to take any action to address the problem.</p> |
| <p>12/8/2016 Tylenol #3 1 tab TID was prescribed for three months.
12/9/2016 BUN 8 (6-20); albumin 3; CA 19-9 220 (0-37).</p> | <p>This test showed that the patient likely had pancreatic cancer.</p> |

Patient #20

- 12/12/2016 The patient was seen in hepatitis C clinic. This note had questions about contraindications to interferon even though interferon is not used. There was little history, viral load was not checked. The AST was 22, INR 2, and platelets of 183 were noted. The patient was determined to be immune to hepatitis A and B. The NP documented that the patient "needs sober for 6 months."
- 12/13/2016 A doctor wrote a brief note without seeing the patient. The doctor noted that the CA19-9 marker was 220 which was high. The doctor wrote she would consider a CT guided biopsy of the mass and would discuss in collegial. There was no evidence of a collegial review and no evidence of a collegial review in the tracking log.
- 12/15/2016 A NP saw the patient in HTN chronic clinic. The temperature was 82.7 with P 67; R 18; BP 128/92 and weight 150. The NP took little to no history and documented a normal examination. The BMI was documented as 25. The NP ordered a six month FU but did not address the pancreatic mass or asthma. The NP did not address the clearly abnormal temperature or the anemia which she documented on the record.
- 1, 3, 6 The NP failed to take an appropriate history with respect to hepatitis C. Being "sober for 6 months" is not a contraindication for hepatitis C treatment by the UIC protocol. The NP failed to note the CA-19-9 test which was abnormal and indicated likely cancer.
- 6 This test shouldn't have been "considered," it should have been done. The CA 19 test indicated that the patient had likely pancreatic cancer and given the history a work up should have been continued.
- 3, 11 This demonstrated a systemic problem with the medical record. This record is defective. It allows dated vital signs to be re-used in an inappropriate manner. Vital signs should be documented when they are done. If old vitals are to be used, it should be noted as such. To do otherwise is a significant patient safety issue. This ridiculous example gives a temperature which is incompatible with life. Yet it wasn't recognized and was re-used. The NP failed to develop an appropriate treatment plan for the pancreatic mass.

Patient #20

- 12/21/2016 A Wexford authorization form. The patient had come from CC Jail with a recommendation for a repeat ERCP with biopsy. The CA 19 was elevated. The approval stated, "no definitive results of path report were noted in records sent-decided will send this patient to GI to eval and make recommendations as to plan of care." This would only delay the diagnosis. It couldn't be clearer what the patient needed. The patient was approved for a GI consult. Below this in the medical record was a denial of a CT scan with FNA biopsy based on insufficient information. What information was required?!!!. They stated, "records sent in by site and no definitive results of path report were noted in records sent." Notably, although this information was present on a referral form, it was not documented in the medical record as a request. This gives the appearance that physicians are improperly not working patients up when the fault lies with the vendor who is denying requested care.
- 7 This referral occurred six weeks after intake. Now the biopsy would be delayed again until the patient went for the GI consult. This acts only as a delay of care. The Wexford collegial review system is a systemic barrier to care and a significant patient safety issue and needs to be abandoned.
- 1/1/2017 A nurse noted that the patient was called to the health care unit for two health requests but didn't show up. The nurse did not check on the patient.
- 1/4/2017 An unsigned referral to GI was written on this date by the doctor.
- 1/5/2017 On an optometry note the patient had temperature 82.7 with P 72, R18, BP 122/86 with weight 150. These vital signs were identical to those from 12/15/16.
- 11 The medical record has systemic deficiencies that is a patient safety issue. This record should immediately fix this problem or consider return to paper.
- 1/13/2017 On a dental vitals were listed as temperature 82.7!! The vitals were identical to 1/5/17 vitals done for optometry. But not addressed.
- 11 The medical record has systemic deficiencies that is a patient safety issue. This record should immediately fix this problem or consider return to paper.

Patient #20

1/24/2017 The patient went offsite for an appointment but the nurse didn't document where the patient went.

1/24/2017 A GI consultant saw the patient on this day. The consultant noted that an EGD was done on 10/27/16 with a balloon dilation of the CBD and a stent was placed with a small sphincterotomy. The patient complained of diarrhea and abdominal pain. The consultant recommended a CT scan ASAP and might require ERCP. The doctor noted that the patient had been on Tylenol #3 but this was changed to Motrin because of a tooth infection.??? The patient complained of weight loss up to 70 pounds in the last several months.

1/25/2017 A doctor wrote a note without seeing the patient. The doctor noted that the patient saw a GI consultant and had diagnoses of obstructive jaundice, pancreatic mass, and diarrhea. The doctor did not document review of a report. The doctor started pancreaolipase and ordered a CT scan with contrast.

1/25/2017 A CT scan was requested by the doctor but NOT on an urgent basis despite the recommendation for an ASAP test.

7 Doing this as a routine test was inconsistent with the recommendation to perform the CT scan ASAP.

1/31/2017 A doctor wrote a handwritten note. The patient had weakness. The patient weighed 143 pounds. The patient was still on only one Tylenol #3 pill BID prn. The doctor noted that the patient was to get a CT scan and GI follow up for probable ERCP and biopsy. The doctor noted that the patient was found cheeking Tylenol #3.

3 Pain medication was poorly addressed. Liquid medication can be given under observation to avoid cheeking, It was likely that the patient had untreated pain.

2/1/2017 A CT scan was approved in collegial review.

2/2/2017 Amylase 88 (25-125); albumin 2.8.

2/3/2017 Hemoglobin 10.8; platelets 148.

Patient #20

2/15/2017 A CT scan was done. Only part of the report was available. The CT scan noted diffuse anasarca and ascites. There was a 4.7 pancreatic mass with encasement and occlusion of multiple veins resulting in varices. The findings were consistent with unresectability.

2/16/2017 A doctor saw the patient. The patient weighted 146 pounds. The doctor noted a nine pound weight gain, but this was unclear. The doctor noted that the albumin was 2.8 with anemia of chronic disease. The doctor noted that the CT scan showed a mass in the head of the pancreas of 4.7 cm with encasement of the splenic vein causing varices by virtue of encasement of splenic and superior mesenteric veins and collaterals. The mass was apparently unresectable based on the doctor's comments. The doctor noted that "will need tissue biopsy if chemotherapy is indicated. In view of all her varices, not sure it is amenable to EGD US guided biopsy." The doctor referred to an oncologist.

2/21/2017 A doctor saw the patient and noted that the diarrhea was better on pancreaze. The doctor noted that pain was controlled with Tylenol #3. The plan was to refer to GI for a biopsy and then to an oncologist.

2/21/2017 A doctor wrote a referral for a GI follow up as a routine.

12 The patient should have had an urgent referral.

2/24/2017 A nurse saw the patient after a fall. The BP was 119/72. The patient passed out. The patient fell on her face. The nurse called a doctor, who admitted the patient to the infirmary.

2/24/2017 A nurse documented an infirmary admission note. There were no orders. The nurse documented that the patient had signed a DNR that day.

Patient #20

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| <p>2/24/2017 A doctor wrote an admission note. The doctor took no history of the pain, ability to eat, comfort measures, or ability to function.</p> | 3 | <p>The plan for the patient was insensitive to actual needs and lacked professionalism. The patient was on blood pressure medication but passed out, yet the doctor did not evaluate blood pressure medicine to determine if these were still necessary.</p> |
| <p>2/24/2017 At 8:48 pm the patient asked for extra Tylenol due to pain. The nurse documented that there was no order for additional Tylenol so none was given. The patient was still listed as weighing 146 pounds.</p> | 3 | <p>Not treating the patient's pain was below standard of care.</p> |
| <p>2/27/2017 A nurse saw the patient. The weight was 136 pounds. It appears that the weight on 2/24/17 was not accurate. The blood pressure was 97/70.</p> | 3 | <p>The blood pressure is so low that blood pressure medication needed to be lowered.</p> |
| <p>2/28/2017 A nurse saw the patient. The vital signs were identical to the vitals from 2/27/17. This medical record function needs disabling.</p> | 11 | <p>The medical record falsely records vital signs and weights.</p> |
| <p>2/28/2017 Albumin 2.7; cholesterol 89 (100-200); TG 71; HDL 28; LDL 47 (50-129).</p> | | |
| <p>3/1/2017 A nurse saw the patient. The vital signs were identical to the vitals from 2/27/17. This medical record function needs disabling.</p> | 11 | <p>The medical record falsely records vital signs and weights.</p> |
| <p>3/2/2017 A doctor saw the patient. The vital signs and weight were identical to 2/27/17. Yet the doctor noted that the patient had lost weight since coming into the infirmary. The doctor noted that the abdominal pain was controlled with Tylenol #3 since it was increased to TID. The patient had no place to stay after discharge from prison in June. The doctor noted that the patient had a follow up GI consultation and "May need CT guided bx." The doctor discontinued the amlodipine and noted that metoprolol was changed to propranolol.</p> | 7, 11 | <p>The medical record falsely records vital signs and weights. The patient had been at Logan for almost three months and had yet to obtain a biopsy of her pancreatic mass. This is an unacceptable delay.</p> |

Patient #20

3/3/2017 A nurse saw the patient. The vital signs were identical to vitals from 2/27/17.	11	The medical record falsely records vital signs and weight.
3/5/2017 A nurse saw the patient. The vital signs were identical to vitals from 2/27/17.	11	The medical record falsely records vital signs and weight.
3/6/2017 A nurse saw the patient. The blood pressure was 61/52. A nurse noted that the patient almost fell getting on an examination table. The nurse documented calling the chronic care nurse to clarify blood pressure medication as pressure was very low. The nurse documented notifying the doctor but did not take any orders.	19	The patient had blood pressure consistent with shock, yet the doctor ignored the patient. This was indifferent.
3/6/2017 The GI referral from 2/21/17 was approved as a routine.		
3/6/2017 A NP saw the patient in HTN clinic. The BP was 102/75. The NP took no history outside of the check box format, including the box "if obese advise to lose weight" even though the patient had pancreatic cancer and had lost over 80 pounds. The NP took no other history of the patient's other medical problems.	1, 2, 3	The NP failed to take appropriate history. The patient had extremely low blood pressures previously and needed medication lowered or discontinued. The NP did not address the patient's pancreatic mass and update the status of the workup.
3/7/2017 A nurse saw the patient. BP 130/95. The nurse documented "acute pain" but no pain assessment was done.		
3/8/2017 At 4:22 am a LPN saw the patient. The blood pressure was 120/89. The patient complaint was "Still the same old stabbing pains at times on my right side." The nurse noted that the patient was on one tablet of Tylenol #3. The nurse documented that the patient reported that the pain medication was effective.		
3/8/2017 At 2:48 pm a nurse saw the patient. The vital signs were identical to the 4:00 am vital signs.		

Patient #20

<p>3/8/2017 At 3:34 pm a doctor saw the patient. The vital signs were identical to those done at 4:00 am. The doctor noted abdominal pain and that it was hard to sleep. The plan was to follow up with GI for possible biopsy. Labs were noted showing albumin of 2.7, and HGB 10.8 but these abnormalities were not addressed. The doctor did not adjust the pain medication. The assessment included likely pancreatic cancer but the biopsy was still being delayed. The doctor documented anemia and moderate malnutrition but no action was taken.</p> <p>3/9/2017 A nurse saw the patient and the vitals were identical to those from 3/8/17. The patient complained of pain and asked if there was another pain medication order. The nurse told the patient that there was no new order for pain medication. The assessment was "acute pain." The nurse documented a plan to inform the doctor of the pain.</p> <p>3/10/2017 The MAR shows patient received amlodipine. Instead of giving the patient morphine, Tylenol #3 was ordered one tablet TID for only two weeks. But there was no discussion of why this was done. The patient was on 15 ER morphine BID and 15IR Q four hours as needed. Substituting Tylenol #3 1 TID is a significant reduction in pain control.</p> <p>3/10/2017 A nurse saw the patient. The vitals were identical to 3/8/17. The patient asked for pain medication. There was no pain assessment.</p> <p>3/11/2017 A nurse saw the patient. The vitals were identical to 3/8/17. The patient had pain but there was no pain assessment.</p> <p>3/12/2017 A nurse saw the patient. The vitals were identical to 3/8/17.</p>	<p>6, 11, 12</p> <p>11</p> <p></p> <p></p> <p></p> <p></p> <p>11</p>	<p>The medical record falsely records vital signs. Abnormal labs were noted but no action was taken. The doctor took no action to determine how to improve nutrition or even establish the degree of malnutrition. The doctor did not evaluate for pain. The GI consult was significantly delayed.</p> <p>The medical record falsely records vital signs.</p> <p></p> <p>Vital signs were identical.</p> <p>Vital signs were identical.</p> <p>Vital signs were identical.</p>
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Patient #20

3/13/2017 A nurse saw the patient. The BP was 121/93; the temperature and respiratory rate were identical to 3/8/17. The weight was listed as 140 pounds.	11	Vital signs were identical. Notably, these vital signs do record the date they were done but what this means is that vital signs are not refreshed when patients are seen and dated vital signs are used for evaluations.
3/14/2017 A doctor wrote a brief note without seeing the patient. The doctor noted that the KUB showed an unremarkable gas pattern with gallstones in the CBD stent.		
3/14/2017 A nurse saw the patient. The vitals were identical to 3/13/17. Pain assessment was not done as usual.	11	Vital signs were identical.
3/15/2017 A nurse saw the patient. The vitals were identical to 3/13/17.	11	Vital signs were identical.
3/15/2017 A doctor saw the patient. The vitals were identical to 3/13/17. No pain assessment was done. The plan was still to follow up with GI. The doctor ordered tramadol but only one tablet daily. The doctor added Boost one can daily.	11	Vital signs were identical.
3/16/2017 A nurse saw the patient. The vitals were identical to 3/13/17. The nurse documented that the patient had stomach pain and asked for pain medication.	11	Vital signs were identical.
3/17/2017 A nurse saw the patient. The vital signs were identical to 3/13/17. The weight was 140. The patient had pain. The patient's pain improved after tramadol.	11	Vital signs were identical.
3/18/2017 Identical vital signs.	11	Vital signs were identical.
3/19/2017 Identical vital signs.	11	Vital signs were identical.
3/20/2017 The patient complained of abdominal pain. The vitals were T 97.9; P 79; R 18; BP 120/80 and weight 137. The nurse took no action about the pain.	16	The nurse should have called a provider.
3/21/2017 The patient complained of pain. T 98.3; P 90; R 16; BP 104/79. The nurse did not address the pain.	16	The nurse should have called a provider.

Patient #20

<p>3/21/2017 A GI doctor saw the patient. The doctor noted that the patient had been diagnosed with a pancreatic mass in Iowa in 2015 but was lost to follow up and subsequently was seen at County hospital in Chicago where the FNA was nondiagnostic. The patient had abdominal pain with significant weight loss. The liver on the CT scan showed cirrhosis. The consultant scheduled an ERCP and FNA. On hand written notes the doctor prescribed Fentanyl patch 25 mcg/hr.</p>		<p>The consultant clearly disagreed with the use of Tylenol #3. He was the second consultant to weigh in on pain management.</p>
<p>3/22/2017 At 11:40 am the patient complained of pain. T 98.3; P 90; R 16; BP 104/79. The nurse did not address the pain.</p>	16	<p>The nurse should have called a provider.</p>
<p>3/22/2017 At 1:39 pm the patient told a doctor that the Tylenol #3 helped better than tramadol. The patient was in pain and asked for better pain control. The doctor stopped the tramadol and started one tablet of Tylenol #3 four times a day. The vital signs were identical to the 3/21/17 vitals.</p>	3, 11	<p>This bordered on cruelty. Pancreatic cancer pain is significant and pain management should have included a narcotic. Apparently for a physician visit, dated vitals were used.</p>
<p>3/24/2017 A nurse saw the patient. The vitals were identical to the 3/21/17 vitals. The patient had stomach pain and asked for pain medication. The nurse did not contact a doctor about the pain.</p>	11, 16	<p>Vitals were dated, the nurse needed to refer to a doctor for pain management.</p>
<p>3/24/2017 A nurse saw the patient. Temperature not taken; P 67; R 18; BP 152/92. No pain history taken.</p>		
<p>3/25/2017 A nurse saw the patient. Vitals identical to 3/24/17. The patient complained of pain.</p>	11	<p>Dated vitals used</p>
<p>3/26/2017 A nurse saw the patient. Vitals identical to 3/24/17. The patient complained of pain.</p>	11	<p>Dated vitals used.</p>
<p>3/27/2017 A nurse saw the patient at 1:15 pm. Vitals T 98; P 66; R 16; BP 140/88; weight 140. The patient had no complaints.</p>		
<p>3/27/2017 A nurse saw the patient at 3:39 pm. Vitals were identical to two hours before.</p>	11	<p>Dated vitals used.</p>

Patient #20

3/28/2017 A nurse saw the patient who complained of abdominal pain. The vitals were identical to 3/27/17. The pain was not addressed.	11, 16	The nurse needed to call a provider and dated vitals were used.
3/29/2017 A nurse saw the patient who complained of abdominal pain. The vitals were identical to 3/27/17.	11, 16	The nurse needed to call a provider and dated vitals were used.
3/30/2017 A doctor saw the patient at 1:27 pm. The vitals were identical to 3/27/17. The doctor wrote "Saw GI who mentioned about biopsy and planned to change plastic biliary to metallic stent." The doctor did not document review of the report. The doctor documented without taking a pain history that the pain was controlled with Tylenol #3. The doctor documented she would discuss a biopsy and replacement of the stent at collegial review.	1, 3, 11	It is hard to believe that the patient, who had complained of pain to a consultant and to nurses six times over the past two weeks was pain free. The pain plan was not addressing the pain. The vital signs were dated.
3/30/2017 A nurse saw the patient at 10:01 pm and the patient said that "My back and stomach have been hurting all day." The vitals were identical to 3/27/17.	11, 16	The nurse needed to call a provider and dated vitals were used.
3/30/2017 A doctor referred the patient for an ERCP for biliary stent exchange and a follow up GI appointment.		
3/31/2017 A nurse saw the patient. The vitals were identical to 3/27/17. The patient asked for pain medication.	11, 16	The nurse needed to call a provider and dated vitals were used.
3/31/2017 Albumin 2.3; total protein 5.7 (6-8); CA 19-9 564 (0-37).		
4/1/2017 The patient complained of pain all over. The vital signs were identical to 3/27/17. The nurse gave pain meds as ordered but did not discuss the pain with the doctor.	11, 16	The nurse needed to call a provider and dated vitals were used.
4/2/2017 A nurse documented the patient saying "I am doing OK only have belly pain I always have it." The vital signs were identical to 3/27/17.	11, 16	The nurse needed to call a provider and dated vitals were used.
4/3/2017 A nurse documented temperature of 98.1; P 75; R 18; BP 123/86 with a weight of 144.		

Patient #20

4/4/2017	The nurse documented that the patient said, "I just have the back pain and pressure like I always do nothing new to me." The vital signs were identical to 4/3/17. The nurse took no action.		
4/5/2017	A doctor saw the patient. The vital signs were identical to 4/3/17. Without much history the doctor wrote "Pain is fair controlled with Tylenol #3." The albumin was 2.3. The doctor noted that GI was going to change stents and that the patient had no metastases.	1, 11, 12	The doctor used dated vital signs for an evaluation. The pain history was not consistent with the patient's ongoing complaints of pain to nurses. The doctor failed to refer to assess nutritional status. The delay in evaluation was significant.
4/5/2017	An ERCP and biopsy were approved by Wexford.		
4/6/2017	A nurse saw the patient. The vital signs were identical to 4/3/17. The patient stated, "just the same old aches and pains in my stomach."	11, 16	The nurse needed to call a provider and dated vitals were used.
4/7/2017	A nurse saw the patient. The vital signs were identical to 4/3/17.	11	Vital signs were dated.
4/7/2017	A doctor prescribed Tylenol #3 1 tab BID for a month.		
4/8/2017	A nurse saw the patient. The vital signs were identical to 4/3/17.	11	Vital signs were dated.
4/9/2017	A nurse documented that the patient had stomach pain. The vital signs were identical to 4/3/17. No action was taken.	11, 16	The nurse needed to call a provider and dated vitals were used.
4/10/2017	A nurse documented T 97.8; P 81; R 16; BP 139/103; weight 142.		
4/11/2017	A nurse documented that her stomach hurt "like it always does." The vital signs were identical to 4/10/17. No action was taken.	11, 16	The nurse needed to call a provider and dated vitals were used.
4/12/2017	A nurse documented identical vitals from 4/10/17.	11	Vital signs were dated.
4/13/2017	A nurse documented identical vitals from 4/10/17.	11	Vital signs were dated.

Patient #20

- 4/13/2017 A doctor saw the patient. The vitals were identical to 4/10/17. The Tylenol #3 was causing constipation and the doctor decreased the dose to TID. The patient was documented as anicteric. There was no change to the plan except the decrease of pain medication. 1, 2, 3 Given complaints of pain to nurses, a decrease in pain medication seemed cruel. The doctor did not appear to appreciate the degree of pain the patient was in and didn't assess for this.
- 4/14/2017 A nurse documented identical vitals from 4/10/17. The patient apparently was to go offsite for a FNA biopsy and biliary stent exchange.
- 4/14/2017 At 9:24 pm a nurse documented T 87.5; P 81; R 16; and BP 93/65. The nurse took no action regarding the low blood pressure. The weight was 142 pounds. 16 The nurse should have called a provider.
- 4/14/2017 A doctor prescribed Tylenol # 3 one tab TID for two months.
- 4/16/2017 A nurse noted that the patient complained that the medications weren't working and she was having breakthrough pain. The vitals were identical to 4/14/17. Remarkably, the nurse wrote to continue the current orders and did not talk to a physician. 16 The nurse should have called a provider.
- 4/17/2017 A nurse documented that the patient was having discomfort in her abdomen and had nausea and vomiting "this weekend." The T 97.9; P 95; R 14; BP 128/74 and weight 128 pounds. 16 The nurse should have called a provider.
- 4/17/2017 Albumin 2.9; BUN 5; potassium 3.1 (3.5-5.3).
- 4/18/2017 A nurse saw the patient, who complained that she had vomited twice since the night before. The patient couldn't eat without pain. The nurse remarkably used the identical vitals since the day before even though the patient had been vomiting. The patient had diarrhea, vomiting, and wasn't eating. The nurse told a doctor about the vomiting and weight loss. 11, 19, 8 Dated vitals used. Apparently the doctor didn't evaluate the patient for diarrhea, vomiting, and not eating. This was indifferent, as the doctor was ignoring serious medical conditions. Laboratory tests should have been ordered due to the vomiting to assess for dehydration.

Patient #20

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| <p>4/19/2017 A nurse saw the patient. The vital signs were identical to 4/17/17. The nurse documented that the patient couldn't move without pain and that if she ate she vomited the food. Remarkably, though in the narrative note, the nurse documented that "increased rate of respirations noted" even though the vital signs documented were identical to 4/17/17 and the respiratory rate was 14, which is normal.</p> | <p>11, 16, 8 The nurse used dated vitals and failed to call a physician for serious medical conditions. Labs should have been ordered because of the vomiting.</p> |
| <p>4/19/2017 At 10:01 pm a nurse documented that the patient was having "foul smelling vomiting." The nurse noted that a doctor saw the patient and that mag citrate and Zofran were ordered. The vitals were identical to the vitals from 4/17/17.</p> | <p>11, 16, 8 The patient had a serious event and the nurse used dated vitals. The nurse should have consulted a doctor and labs should have been ordered.</p> |
| <p>4/19/2017 At 11:31 pm a doctor documented a note. The patient complained of vomiting since her procedure 4-5 days ago. The doctor noted identical vitals to 4/10/17. The doctor reviewed labs from 4/18/17. The potassium was 3.1.; the alkaline phosphatase was 300; albumin 2.9. The BUN was not given. The doctor documented that the stent "exchange was attempted but unsuccessful per verbal report 4/14/17." The doctor ordered a CMP and advised to decrease narcotics until symptoms improve. Zofran was ordered along with an abdominal x-ray.</p> | <p>11, 14, 8 There was no report from the GI consultant. The patient had four days of vomiting with abnormal labs from the day before. The patient was in pain yet the doctor discontinued pain medication. The doctor did not attempt to obtain orthostatic vitals to assess for dehydration. Under these circumstances admission to a hospital was indicated. Instead, the doctor stopped pain medication, ordered an antiemetic, and an abdominal x-ray. Intravenous fluid was indicated as the patient was unable to take by mouth. The doctor should have ordered labs. Care was grossly and flagrantly unacceptable.</p> |
| <p>4/20/2017 At 5:11 pm a nurse saw the patient. The patient hadn't been seen since the night before. The vital signs were identical to the 4/10/17 note. The patient had significant pain and couldn't eat or drink.</p> | <p>11, 16, 8 The nurse used dated vitals and failed to call a physician for serious medical conditions. Labs should have been ordered due to not eating.</p> |

Patient #20

- 4/20/2017 At 11:04 a nurse saw the patient. The vital signs were identical to the 4/10/17 note. The nurse noted that the patient vomited 200 cc. There was no assessment or consult with a doctor. At 11:05 a nurse wrote a second note using the same vital signs. The nurse documented the patient saying that the patient was "25." There was no assessment or plan. 11, 16, 8 The nurse used dated vitals and failed to call a physician for serious medical conditions. Labs should have been ordered due to vomiting.
- 4/21/2017 A doctor prescribed 15 mg morphine every six hours. 4/21/2017 A doctor saw the patient. The vitals were identical to 4/10/17. The doctor told the patient that the biopsy showed adenocarcinoma. This diagnosis was five months after incarceration. The patient was sad and crying. The patient had a June out date. She had two sons and 15 grandchildren. The patient was agreeable to stronger pain medication. The doctor documented that she would assist the patient with application for compassionate release and consult the oncologist for prognosis and would maximize pain management. But the pain medication order was not in this note and it was unclear what maximize pain management meant. The doctor did not order additional pain medication. 11, 8 The doctor evaluated the patient but used dated vitals. The doctor started morphine only after obtaining a diagnosis. There was no therapeutic plan for this patient. Due to the recent vomiting labs should have been ordered.
- 4/21/2017 A nurse saw the patient. The vital signs were identical to the 4/10/17 note. The patient was now on a fentanyl patchy which was "helping with the pain." The patient had constipation. The patient was given Miralax.
- 4/21/2017 Albumin 3.4; potassium 2.9 (3.5-5.3); alk phos 239.
- 4/21/2017 A morphine fentanyl patch was prescribed for four days.
- 4/21/2017 A doctor prescribed 0.5 mg morphine QID at 11:09 am.
- 4/21/2017 A doctor prescribed 5 mg morphine QID at 11:16 am. 3 This is an extremely low dose. The morphine should have been titrated to the patient's pain.

Patient #20

- 4/21/2017 The MAR showed that the patient received a single fentanyl patch on 4/21/17. This was good for 72 hours. The medication was discontinued on 4/24/17.
- 4/22/2017 A doctor wrote a note that the hypokalemia was worse from 3.1 to 2.9 and that the patient was refusing potassium supplementation. The doctor wrote that she was unable to enter orders since the computer was locked by the nurse. The nurse left the infirmary and the computer was unable to be used.
- 4/22/2017 An LPN saw the patient. The patient was able to sleep a little since the fentanyl patch. The patient wasn't eating. The patient said the fentanyl patch was helping quite a bit. The patient was able to tolerate liquid Boost.
- 4/22/2017 Morphine was prescribed 15 mg Q 6 hours but this was stopped on 4/24/17.
- 4/22/2017 A MAR showed the patient received one day of 15 mg morphine every six hours.
- 4/23/2017 A nurse saw the patient. The vitals were identical to 4/10/17. The patient still had pain despite the fentanyl patch.
- 4/23/2017 A nurse noted that the patient wasn't talking much and the patient was very weak. The vitals were identical to 4/10/17. At 2:48 pm the patient was sent to a hospital. It wasn't clear why.
- 4/23/2017 At 10:16 pm a nurse noted that the patient returned from the hospital and ordered to discontinue the patch. The temperature was 93.6; pulse 120; BP 122/96. The assessment was hypotension although the blood pressure was not low.
- 11 To have an electronic medical record that locks because another individual is using it is unacceptable.
- 11 Vitals were dated, the nurse needed to refer to a doctor for pain management.
- 11 Vitals were dated.

Patient #20

4/23/2017	The patient was sent to a hospital. The discharge diagnoses were hypokalemia, cancer pain, and dehydration.	4	Given dehydration and hypokalemia, it is clear that providers at the facility were not appropriately monitoring the patient's condition. She had vomiting and did not have laboratory monitoring to assess whether the vomiting was affecting her electrolyte status.
4/24/2017	A nurse documented identical vitals from the day before. The patient was too weak to sit up. The patient wasn't speaking and only nodded her head in response to questions. Tylenol #3 was given for pain.	4	The patient needed to be on a stronger narcotic.
4/24/2017	At 1:02 pm the patient told a nurse "I need more pain meds I hurt so bad." The blood pressure was 84/52. The patient vomited. Morphine was crushed and given in pudding but the patient vomited after eating. An IV was started and Zofran was given IV.	14	The facility was unable to care for this patient who needed skilled nursing care and a doctor who understood pain management and end-stage cancer management. She needed transfer to a higher level of care.
4/24/2017	At 6:38 pm a doctor saw the patient. The vitals from 1:00 pm were used on the note. The patient was now on morphine sulfate 10 mg every two hours. Family had come for a visit. The doctor added lorazepam every two hours.	4	The patient was placed on palliative sedation with morphine and lorazepam but it wasn't clear that the patient was involved in the decision and should have been.
4/24/2017	A nurse saw the patient at 11:41 pm and noted identical vital signs from early that day.	11	Vital signs were identical
4/24/2017	Morphine sulphate was ordered 10 mg every four hours at 3:44 pm.		
4/24/2017	Morphine sulphate was ordered 10 mg every two hours at 6:12 pm.		
4/24/2017	Lorazepam 2 mg IM was ordered every two hours for seven days at 12:55 pm.	4	This was an extraordinary dose of lorazepam intravenously. This was clearly palliative sedation and needed to be discussed with the family and patient, but it wasn't clear that this occurred.
4/24/2017	Lorazepam 2 mg IV push every two hours was ordered for three days. The order was at 6:52.		

Patient #20

4/24/2017 A doctor prescribed morphine 10 mg every 2 hours PRN and lorazepam 2 mg IV every two hours.

4/24/2017 A doctor prescribed .25 mg morphine every six hours. This was discontinued the same day.

4/24/2017 A doctor prescribed 5 mg morphine every six hours.

4/25/2017 Just after midnight a nurse noted identical vital signs from the day before. Ativan was given IV.

11 Vital signs were identical.

4/25/2017 At 3:45 am a nurse saw the patient. The vital signs were identical to the day before. Ativan was being given every two hours. At 7:00 am the patient was lethargic. Vital signs continued to be from the day before. At 3:54 pm the patient expired.

Patient #21

- 11/2/2011 Annual health examination documents prostate cancer, DM, and HTN as problems. The weight was 174. Refused rectal examination.
- 6/26/2012 EKG showing NSR but looks like flat ST segment in lateral leads.
- 10/23/2013 Annual health examination documents prostate cancer, DM, and HTN as problems. The weight was 194. Rectal examination deferred.
- 2/4/2014 PSA 10.9 (0-3.9).
- 3/4/2014 Microalbumin 7 (0-30); glucose 121; A1c 6.1; total cholesterol 181; TG 101; HDL 40; LDL 121; TSH 0.73; creatinine 1.02.
- 5/13/2014 PSA 2.4; creatinine 0.89.
- 8/4/2014 A doctor saw the patient in diabetes and HTN chronic clinics. The weight was 174 pounds. The blood pressure was difficult to read but appeared to be 131/84. The doctor noted that the LDL was 121 and the most recent A1c was 5.6. The doctor took no history and did not address what medications the patient was taking except to note that the patient had a current prescription for Lopressor until 1/25/15. The doctor assessed the patient in good diabetic control. The doctor did not address apparent weight loss of 20 pounds since the 2013 annual exam. The diabetic medication apparently was discontinued in July but no mention was made of this. The doctor did not check recent CBGs . The recent A1c was about the time the medication was discontinued. The doctor did not order any follow up. The patient had a 44% 10-year risk of heart disease and stroke yet was not placed on a statin drug.
- 1, 17 The history was poor. The plan did not include use of a statin despite high risk. Weight loss was not evaluated.
- 11/4/2014 PSA 8.7; creatinine 0.89.

Patient #21

- 12/30/2014 A doctor saw the patient for diabetes and HTN chronic clinics. The weight was 182. The BP was 131/70. The doctor took no history. He noted the recent LDL of 121 and A1c of 5.5. Only a brief examination was done. The only assessment was good hypertension and diabetes control. The doctor didn't discuss medications. Apparently diabetic medication was discontinued in July but the doctor didn't mention this. 1, 17 The history was poor. The plan did not include use of a statin despite high risk. Weight loss was not evaluated.
- 3/3/2015 Microalbumin 34; A1c 6.5; cholesterol 199; TG 131; HDL 43; LDL 130; PSA 1.4; testosterone 23 (300-720); creatinine 0.9.
- 3/10/2015 EKG showing sinus rhythm with moderate ST depression.
- 3/17/2015 BUN 21; PSA 1; testosterone 20.
- 4/17/2015 A NP saw the patient for diabetes and HTN chronic clinics. The BP was 120/70. The weight was 192. The NP noted a recent LDL of 130 with cholesterol 199 and HDL 43. The NP noted that medication for diabetes had been discontinued on 7/15/14. The NP noted that the patient was on Lopressor and ASA but did not mention a statin drug. 3, 6, 17 The patient had a recent EKG with ST depression and high cardiovascular risk but these were unnoticed. The patient had a 39% 10-year risk of heart disease or stroke and should have been offered high intensity statin.
- 7/5/2015 A nurse evaluated the patient for generalized weakness. The weight was 193.
- 7/13/2015 A1c 8.3.
- 7/31/2015 A nurse saw the patient for medication refill. The weight was 189.

Patient #21

<p>8/20/2015 A doctor saw the patient for diabetes and HTN chronic clinics. The weight was 187. The blood pressure 128/64. The doctor took no history. The doctor did note that the recent LDL was 130 and A1c was 8.3. The doctor noted that the patient was taking HCTZ, Lopressor ASA and metformin 1000 mg BID. At the last chronic disease clinic the patient had been on no diabetes medication. The doctor started glipizide 5 mg daily . The doctor did not address the lipids.</p> <p>8/28/2015 A1c 7.9; cholesterol 172; TG 145; HDL 34; LDL 105; creatinine 0.9.</p> <p>9/1/2015 Hepatitis C negative; cholesterol 168; TG 129; HDL 37; LDL 109.</p> <p>9/22/2015 PSA 3.4.</p> <p>10/23/2015 Annual health examination documents HTN, DM, prostate cancer, and blindness in L eye. Weight is 182.8. No offer of rectal examination.</p> <p>11/3/2015 A1c 5.7; creatinine 0.79.</p> <p>12/6/2015 A doctor saw the patient for diabetes and HTN chronic clinics. The BP was 138/72, recent LD 109; and recent A1c 5.7. The doctor took no history and did a brief exam and continued HCTZ, ASA, Lopressor, metformin, and glipizide.</p> <p>1/6/2016 A clerk documented that the patient was presented to collegial review for an oncology follow up.</p> <p>1/7/2016 PSA 3.3; creatinine 0.96; hemoglobin 14.3.</p> <p>1/12/2016 A doctor noted that the patient returned from Lupron injection. There was no history, exam, review of the report, discussion of the status of the patient or discussion with the patient.</p>	<p>1, 17</p> <p>7</p> <p>1, 17</p> <p>10</p>	<p>The patient had high cardiovascular risk but these were unnoticed. The patient had a 39% 10-year risk of heart disease or stroke and should have been offered high intensity statin. The NP should have taken a history of chest pain or angina equivalents.</p> <p>Colorectal screening was not offered.</p> <p>The patient had a 10-year risk of heart disease or stroke of 47% and should have been offered a statin drug. The doctor did not ask about any problems with the new diabetic medication.</p> <p>The doctor didn't follow up appropriately after the consultation. The report wasn't reviewed and the doctor didn't discuss with the patient.</p>
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Patient #21

1/17/2016 The patient complained of weakness and being wore out. The patient complained of night sweats but no weight loss. The weight was 186 pounds. The nurse took no action except to give the patient allergy medication and cough syrup even though the patient did not complain of upper respiratory symptoms.

2/4/2016 A doctor saw the patient for shortness of breath. The patient weighed 181. The note was mostly illegible. The doctor appears to have diagnosed upper respiratory infection and bronchitis and prescribed amoxicillin for 10 days with an as needed follow up.

3/13/2016 The patient saw a nurse for a complaint of abdominal pain. The weight was 179. The patient thought he had possible blood in his stool. The patient complained also of weakness. The nurse referred the patient to a physician.

3/16/2016 A clerk documented that the patient was presented to collegial for an oncology follow up.

3/16/2016 A doctor wrote a brief note stating that the patient had abdominal pain and constipation. The doctor noted that the patient was moving his bowel and that there was no bright red blood. The doctor noted that the patient refused a rectal exam. There was no other history or examination. The doctor ordered milk of magnesia and stool softener but no other diagnostic tests. The doctor did not ask about ability to eat or identify whether the patient lost weight.

4/5/2016 Cholesterol 191; TG 114; HDL 42; LDL 126; creatinine 0.91.

5/19/2016 The patient went to the oncology follow up appointment.

7 The patient had blood in his stool but since there was no active bleeding the doctor took no action. The patient was 72 years old and had abdominal pain and blood per rectum and should have had a colonoscopy.

Patient #21

- 5/19/2016 A nurse saw the patient after his oncology appointment. The blood pressure was 160/90.
- 5/25/2016 A NP saw the patient post-oncology visit. The NP documented review of the oncology notes and started antibiotics as recommended by the oncologist.
- 6/20/2016 A nurse saw the patient for upper respiratory symptoms. The patient had a cough. The nurse documented a weight of 174.8. The nurse failed to notice the weight loss. The nurse gave the patient CTM and ibuprofen by protocol without referral. 16 The patient had respiratory symptoms for several months with cough. The nurse should have consulted a physician.
- 7/3/2016 A nurse saw the patient for abdominal pain. The patient described "occ constant pain" which seems inherently contradictory. The patient said he had the pain for several weeks. The weight was 177 pounds. The nurse referred the patient to a provider.
- 7/6/2016 A1c 5.3; creatinine 0.92.
- 7/14/2016 A doctor saw the patient and wrote an extremely brief note. The doctor wrote that the patient had "burning sensation upper abd R>L postprandial." That was the entire history. The doctor did not obtain a weight, determine the quality or intensity of pain, determine whether the patient was able to eat normal, had diarrhea, or constipation. The history was inadequate. There was no assessment or differential. The doctor stopped Pepcid and started Prilosec with a follow up in two weeks. 1, 2, 7 The history and evaluation were inadequate. The patient had abdominal pain for five months. Without adequate evaluation the doctor ordered an anti-acid medication. Due to age, prior blood per rectum, and abdominal pain for five months, colonoscopy was indicated.

Patient #21

- 7/29/2016 A NP saw the patient in follow up for the abdominal pain. The only history was that the patient had recently been started on Prilosec and was "some" better but the patient still had pain. The NP documented that the patient had normal bowel movements. The NP exam was that the abdomen was firm, with "sluggish" bowel sounds. Based on this limited history the NP diagnosed "?ulcer" and ordered a KUB with follow up in two weeks. The blood pressure was 148/80, but the NP did not address this.
- 1, 7, 8 The history was inadequate. The severity and duration of pain was not obtained. Associated symptoms were not obtained. Precipitants, quality, temporal elements, and radiation were not obtained. The physical examination was extremely brief. No laboratory tests were ordered. A KUB was ordered but this would unlikely be of clinical value with the patient's complaint. The NP failed to establish an appropriate treatment plan and failed to obtain appropriate laboratory tests (CBC, CMP) or colonoscopy.
- 8/19/2016 An NP saw the patient. The blood pressure was 170/90. The weight was not taken. The NP noted that there was no x-ray report yet. The film had been done on 8/8/16. The NP took no history regarding the patient's symptoms. The only examination was to state "abd soft - No reddened skin." The NP ordered no follow up without even asking if the patient still had symptoms. The weight wasn't checked. The NP did ask that the blood pressure be checked twice a week for two weeks.
- 3, 15 The NP failed to modify BP meds despite significant elevation of blood pressure. The NP failed to follow up on the abdominal pain which the patient had for over five months and didn't order follow up despite not reviewing the x-ray.
- 8/26/2016 A CMT noted that the patient's BP had four blood pressure checks including: 146/74; 150/82; 138/84; and 144/76. All of these were not at goal for a diabetic except for one.
- 8/29/2016 A CMT BP was 148/78.
- 9/2/2016 A CMT saw the patient for a dry cough and shortness of breath for 5-6 days. The weight was 174. The nurse used an upper respiratory protocol and identified no problems. The nurse gave the patient over-the-counter medication and sent the patient back to his unit.
- 16 The CMT should have called a doctor as the patient had a serious condition beyond the scope of practice of a CMT to address.

Patient #21

- 10/5/2016 A CMT saw the patient for weakness, fatigue and cough. The patient weighed 172 pounds. The blood pressure was 150/80. The patient complained of shortness of breath. The patient had weight loss, fatigue, and weakness. He also had prior abdominal pain that was not worked up and the nurse didn't ask about this. The CMT gave the patient Tylenol with no referral.
- 10/30/2016 A NP saw the patient for weight loss. The patient weighed 160 pounds. The blood pressure was 140/74. The only NP history was that that patient lost weight. The only physical examination was that the patient could walk to the scale, had a soft abdomen and clear lungs. The assessment was weight loss. The NP plan was to give the patient a lay in permit with a slow walk permit. The NP ordered weekly weights for three months and ordered CMP, CBC and UA with another KUB and chest x-ray.
- 11/3/2016 X-ray showing punctate density over lower pole of left kidney likely representing a stone. US recommended.
- 11/3/2016 Microalbumin 79; BUN 24 (0-20); sodium 134; creatinine 1.31 (0.5-1.5); A1c 5.6 (4-6); hemoglobin 12.3 (13.2-18).
- 11/3/2016 An NP wrote that the patient presented to the ER with abdominal pain with 12 pound weight loss over the past month. The NP noted that the recent KUB showed stool. The NP sent the patient to a hospital for right lower quadrant pain.
- 16 The CMT should have consulted a provider.
- 1, 2, 3 The NP took inadequate history and made an inadequate assessment. The patient had recent shortness of breath and more remotely abdominal pain which were not considered. Abdominal x-ray is unlikely to be useful in an evaluation of weight loss. Colonoscopy was indicated. CT of the abdomen should have been considered. The other labs and chest film were appropriate.

Patient #21

- 11/3/2016 An incident report documents that the inmate was sent to Chester Memorial Hospital. There was a CT scan report which documented a large retroperitoneal mass suspicious for lymphoma. The hospital documented speaking with Dr. Siddiqui who in coordination with Dr. Trost and the NP would coordinate further care.
- 11/3/2016 A NP noted that the patient returned from the hospital and had an abdominal mass. The NP sent the patient back to his cell and ordered a follow up with a doctor on 11/7/16. The patient's weight was 152 pounds. The NP didn't ask the patient whether he was eating or about any symptoms.
- 11/7/2016 The weight was listed as 153.6.
- 11/8/2016 Security did not bring the patient for his physician follow up appointment. 11 Patients should be transported for their appointments.
- 11/9/2016 A clerk documented that the patient was to be presented at collegial for his oncology follow up for his prostate cancer. Wexford UM cancelled the collegial call for the week. UM was going to make a decision on their own.
- 11/11/2016 An NP saw the patient. The weight was 149 pounds. The NP noted that the patient was scheduled for a follow up of an offsite visit from Memorial Hospital. The NP noted that there were no notes from the hospital in the chart yet. The NP noted that the patient could walk to the scale and get up out of the chair and had a good BM after taking magnesium citrate. That was the extent of the examination. The NP documented that labs were pending from the hospital. The NP noted that the patient was to follow up with the doctor. 10, 11 Follow up of the hospital report was not done because there was no report. The NP did not address the weight loss.
- 11/14/2016 A CMT took a weight of 148.2 pounds.

Patient #21

- 11/17/2016 A doctor saw the patient and the patient was anorexic and felt weak. The doctor noted that the patient lost 26 pounds over the past three months. The doctor documented that the CT scan was noted. There was no history, no evaluation as to whether the patient was able to function on his housing unit, whether he was able to eat, or whether he needed a higher level of care. There was no assessment. The only plan was a collegial referral to oncology. The weight was 146 pounds. The patient had lost six pounds over the past two weeks and should have been considered for infirmary care and had an expedited evaluation for biopsy.
- 1, 3, 8 The doctor took no history and failed to establish a plan that protected the patient and addressed his needs. Nutritional status was not obtained. It wasn't clear whether the patient could function in population. The doctor ordered no labs to determine the metabolic status of the patient.
- 11/21/2016 The patient was seen at Illinois Oncology Inst for his six month follow up of prostate cancer. They noted that the patient had been increasingly fatigued over the past few months and was only able to walk seven feet before getting fatigue. He had constipation and only had one BM a week and was drinking only 20 ounces of water a day. He had low back and abdominal pain intermittently. They noted that a recent CT scan showed a large mass in his abdomen. They described the mass as 10.7 by 9.9 cm in the upper abdomen extending into the right renal bed and retroperitoneum involving the periaortic lymph node region with right hydronephrosis. They recommended a CT guided biopsy ASAP or in the next two weeks to test for non-Hodgkin's lymphoma. They also recommended a CT of the brain ASAP. They noted "if his physical condition deteriorates at the correctional center, I do recommend transfer him to the infirmary and start him on IV fluid." They also recommended a three week follow up.

Patient #21

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| <p>11/21/2016 An NP noted that the patient returned from oncology. The NP documented that orders were noted and that paperwork was sent to med furlough. It wasn't clear what this meant. The NP ordered a follow up in five days, allopurinol, Pepcid, dexamethasone, Reglan, ensure, and senakot. The patient should have been placed on the infirmary.</p> | <p>10, 11,
14</p> | <p>The NP failed to review the oncology notes for a biopsy and CT brain. The NP also failed to appreciate the note about hydration and infirmary placement.</p> |
| <p>11/26/2016 An NP documented that the patient was being seen for medical furlough return. The weight was 141.6. The NP took no history and noted that the patient appeared pale. There was no exam except to note that bowel sounds were hypoactive. The NP ordered a CBC, CMP and two week follow up. There was no mention of the CT findings.</p> | <p>10, 11,
14</p> | <p>The NP failed to review the oncology notes for a biopsy. The NP also failed to appreciate the note about hydration and infirmary placement. It appeared that the patient may have had a CT of the brain but there was no report and it wasn't clear what happened.</p> |
| <p>11/28/2016 A CMT took the weekly weight, which was 141.2. No action was taken.</p> | | |
| <p>11/30/2016 BUN 28; sodium 134; creatinine 2.06; albumin 3.7; hemoglobin 12.1; platelets 287.</p> | | |

Patient #21

12/3/2016 A nurse practitioner saw the patient for a quarterly chronic clinic for diabetes and hypertension. The weight was 132. The nurse noted that the recent A1c was 5.6 and was improved. The NP noted that the patient was in good control and decreased glipizide to 2.5 mg daily from 5 mg daily and metformin to 500 BID from a gram BID. The NP made no mention of the significant weight loss and did not address the retroperitoneal mass. With respect to hypertension clinic, the blood pressure was 110/70. The NP noted that recent LDL was 126. The NP noted keeping the patient on Lopressor 25; HCTZ 25; and ASA 81 daily. The NP did not address the elevated cholesterol. More critically, the NP made no mention of the significant retroperitoneal mass which had not yet been biopsied.

1, 3, 6, The NP failed to take adequate history or review the
10 oncology notes. As a result, the plan was inadequate. Based on recent labs which were not reviewed, the patient appeared mildly dehydrated and had worsening kidney function and had persistent anemia, which were unnoticed.

Patient #21

12/3/2016 An NP saw the patient. The weight was 132. The NP noted that the patient had a recent oncology visit. The NP noted that the patient had a 15-20 pound weight loss, had poor appetite. The NP noted that the diabetic medication had been decreased and that the A1c was now 5.6. The NP took no other history, did not determine whether it was safe to be in general population and made no effort to determine why the patient was losing so much weight. The NP documented that the patient was to follow up with a doctor "regarding code status - and inmate's concern of life /death options." This was remarkable given that a diagnosis had yet to be made. There was no concern about the urgency of the diagnosis. The NP ordered a CBC, CMP, UA, vitamin D level, A1c and decreased the glipizide to 2.5 mg daily, continuing the metformin at 500 BID. The NP wrote "referral Dr Trost - code status (CANCER)." Remarkably, the NP did not initiate any diagnosis and was presuming it was a cancer.

12/3/2016 A CMT took a weight of 139.2.

12/5/2016 A CMT documented that the patient felt better. The CMT documented that the patient was to be starting on ensure. The weight was documented as 146.6.

12/5/2016 A doctor saw the patient but the note was extremely brief. The doctor noted that the patient had anorexia, was weak, and had lost 50 pounds. The doctor noted no nausea or vomiting or abdominal pain. The only plan was to issue permits. The doctor noted that the patient was to go out soon for oncology.

7, 14 The NP was more concerned about code status than about getting a necessary biopsy of an abdominal mass. The delay in biopsy was significant and unnecessary. The patient should have been considered for a higher level of care (infirmary).

10 The doctor failed to review the oncology note or recommendations.

Patient #21

- 12/5/2016 A doctor referred the patient for a CT of the brain and CT guided biopsy. There was an approval for a CT of the brain and another approval for a CT guided biopsy, both dated 12/5/16.
- 12/8/2016 A doctor presented the patient to collegial for oncology follow up. Wexford UM cancelled the collegial call and the note by the clerk documented that UM would make the decision on this case.
- 12/14/2016 A clerk documented that the patient was approved for oncology follow up as authorization # 465355597.
- 12/15/2016 A doctor saw the patient and noted GERD symptoms. The weight was 138 pounds. The doctor performed no examination and took to history except for GERD symptoms. The doctor noted that the patient was to go out for a CT scan and biopsy of the mass. The doctor ordered two cans of Boost for six months.
- 12/28/2016 A nurse saw the patient, who said that he was unable to urinate except to dribble. The patient needed to be taken to the health care unit in a wheelchair. The nurse noted that the patient had 3+ leg edema and had a stage II pressure ulcer on his hip. The nurse placed the patient on the doctor's sick call for 12/29/16. This patient should have been seen that day.
- 12/29/2016 A doctor saw the patient, who weighed 150 pounds. The doctor noted that the patient had an ulcer on his hip. Much of the note was illegible. The doctor ordered a UA, Flomax, with a follow up in two weeks. The patient was getting edema but this wasn't evaluated. The doctor did not admit the patient to the infirmary even though the patient was clearly unable to care for himself to the extent of developing a decubitus ulcer. This was neglect.
- 1, 2 The history and exam were inadequate. The doctor didn't determine whether the abdominal mass might be the cause of the symptoms.
- 14, 19 A doctor should have seen the patient. The patient clearly couldn't care for himself in general population and was debilitated. He needed to see a doctor and needed higher level of housing, neither of which occurred.
- 1, 2, 3 Care was grossly and flagrantly unacceptable. The patient had serious problems and complications causing debility and inability to care for himself, which were ignored. This was indifferent care.

Patient #21

12/30/2016 Creatinine 1.47 (0.5-1.5); albumin 3.3; AST 16; ALT 29; alk phos 113; hemoglobin 10.4; platelets 488; normochromic.

1/9/2017 The weight was 160. The large weight gain was likely fluid due to edema but it appeared unrecognized except by a nurse.

1/23/2017 The weight was 162.

1/30/2017 The weight was 170.

2/2/2017 A nurse saw the patient for diarrhea that was reported to medical staff by the patient's cellie. The patient had been neglected and should have been on the infirmary. The LPN noted a pulse of 113; BP 150/96. Remarkably, the nurse took no action and did not refer the patient.

2/2/2017 A nurse admitted the patient to the infirmary as a chronic patient based on decline in status based on security complaint. The nurse documented a weight of 180, which was clearly inaccurate. The BP was 152/94. The nurse noted 2-3+ edema of both legs. The nurse did not document review of the decubitus ulcer.

2/2/2017 An NP performed an admission note to the infirmary. The NP noted decrease in activity of daily living functioning. The NP did not take further history of what was problematic or what the patient was unable to do or why this recent change in status. The NP examination was significantly abnormal. The NP only noted that the patient was unable to stand without assistance, was oriented to person and place, but had a slow response to knowing what time it was.

2/3/2017 A doctor saw the patient. The entire note was SOA No c/o's confused ambulates OK P [plan] CPM [continue present management].

16 The nurse should have consulted a physician.

It was remarkable that lay custody officers and the nurse as opposed to a doctor recognized infirmary care need. It speaks to the deficiency of the provider staff.

1, 2, 3 The NP failed to take adequate history, failed to perform adequate exam, and did not establish a reasonable therapeutic plan based on the patient's condition.

1, 2, 3 There was inadequate history, physical examination, or plan based on the patient's condition. Care was grossly and flagrantly unacceptable.

Patient #21

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| 2/4/2017 A nurse saw the patient and noted that the patient was confused. The nurse wrote that the patient had altered mental status but a physician did not evaluate the patient. | 16, 19 | The nurse should have consulted a physician. Confusion is a significant finding and required immediate attention. |
| 2/5/2017 At midnight a nurse saw the patient, who was still confused. The nurse noted that the patient was incontinent. Despite this, the patient was not admitted to a hospital. | 14, 16, 19 | The nurse did not consult a physician. A physician needed to immediately evaluate the patient. The patient needed to be hospitalized. None of these happened. Care was grossly and flagrantly unacceptable. |
| 2/5/2017 At 4:15 am a nurse documented the patient stating "come on guys. Aw come on." The nurse noted that the patient was apparently talking to people in his cell who weren't there. The nurse noted that the patient was incoherent. The nurse assessed alteration in thought process and referred the patient to mental health without discussing the altered mental status with a physician. | 14, 16, 19 | The patient appeared delirious. Instead of referring to a doctor, the nurse referred to mental health. The patient needed admission to a hospital. Care was grossly and flagrantly unacceptable. |
| 2/6/2017 A nurse noted that the patient was confused, incontinent, and was scheduled to see mental health. | | |
| 2/6/2017 At noon a nurse saw the patient, who was confused with 3+ edema of his legs. The nurse noted a wound on the hip. It was not clear that there were orders for monitoring or dressing this as the nurses did not mention the decubitus ulcer. | 14, 16, 19 | Altered mental status, edema in a patient with a known abdominal mass should have prompted physician evaluation and admission to a hospital, which did not occur. |
| 2/7/2017 A nurse saw the patient who was still confused with 2-3+ edema. The nurse noted no wounds and apparently the decubitus was not being evaluated. | 14, 16, 19 | Altered mental status, edema in a patient with a known abdominal mass should have prompted physician evaluation and admission to a hospital, which did not occur. |

Patient #21

2/7/2017 A doctor noted that the patient was lethargic, confused, and mumbling unintelligibly and had a superficial decubitus ulcer on his hip. The doctor noted that the patient was having rapid clinical decline and apparently ordered daily dressing changes. The doctor took no action with this patient who had altered mental status, new onset edema, decubitus ulcer, and undiagnosed abdominal mass. Care was grossly and flagrantly unacceptable.

2/7/2017 At 10:30 am a nurse cleaned the hip ulcer described as a three and a half wide area with 1/2 inch deep.

2/7/2017 At 11:35 am the patient was described by a nurse as lethargic with uneven respirations and tachycardia although vital signs were not documented. The patient was sent to a hospital.

14 The plan of this doctor was incompetent. The patient needed immediate hospitalization but was ignored. Care was grossly and flagrantly unacceptable.

This speaks to the neglect of this patient.

Patient #22

2/27/2013 The patient transferred to Menard from Pontiac. The patient was on enalapril 20; Procardia XL 30; Lopressor 25; ASA.

5/1/2013 Total protein 8.2 (6-8).

6/19/2013 The patient was evaluated by a doctor referred by the optometrist for an elevated blood glucose of 130. The doctor failed to note that the patient had fever. The BP was 156/102 and the temperature 100.8. The doctor said that the patient didn't take his blood pressure medication.

2 The doctor failed to note or evaluate an abnormal vital sign.

6/19/2013 A1c 6.4.

6/26/2013 Diabetes and HTN chronic clinic; weight 255; temperature 99.4; BP 144/89; A1c 7.9; Procardia was increased to 60 mg.

7/3/2013 RN notes BP 160/98.

7/16/2013 BP 156/86.

7/18/2013 Annual examination weight 250 pounds. No identified problems. Notably history of IV drug use, prostitution, multiple partners, blood transfusions, and homosexual activity were all checked "no." Although the patient did have gonorrhea in 1986.

7/23/2013 BP 170/100.

7/26/2013 BP 160/98.

8/6/2013 A1c 6.4; WBC 1.8; HGB 13.5 (13.2-18); neutrophils 0.9 (1.3-7.5); lymphocytes 0.6 (1.3-4.2).

8/18/2013 Chronic clinic flowsheet documents a weight of 260.

8/19/2013 BP 146/84; weight 260; temperature 98.6; chronic clinic for diabetes and HTN. No changes to medications. No review of CBGs; most recent A1c 6.4.

1, 2, 3, 6 The doctor failed to adjust medications for high blood pressure. The doctor failed to review significantly abnormal white count of 1.8 and took no history and failed to evaluate.

11/13/2013 A1c 6.1.

Patient #22

12/4/2013 Diabetes and HTN chronic clinic; weight 247; temperature 99.4; BP 126/88; Patient now on 90 of Procardia. A1c 6.1.

3/5/2014 Total protein 8.8 (6-8); A1c 6.2.

4/23/2014 Diabetes and HTN chronic clinics weight 238; BP 136/90; no changes to medication.

7/2/2014 A1c 6.1.

8/1/2014 Diabetes HTN chronic clinics. BP 137/76 weight 240; 5 foot 10 inches. A1c 6.1. No changes made.

11/9/2014 A1c 6.1.

11/18/2014 CMT note documents weight 230 and BP 136/70.

1/8/2015 Diabetes HTN chronic clinics. BP 124/90 weight 240; most recent A1c 6.1; no changes made.

3/20/2015 Total protein 8.6 (6-8); A1c 6.2.

5/25/2015 Diabetes HTN chronic clinics. BP 100/70; weight 240; A1c 6.2; no changes made.

6/5/2015 Hepatitis A ab negative; hepatitis B core negative; hepatitis B ab negative; hepatitis C antibody negative; total protein 8.1 (6-8).

7/17/2015 A1c 6.3.

9/5/2015 At 3:30 am an RN saw the patient, who was lying on floor having urinated on himself. He was weak for the past 3-4 days and said he thinks he ate some bad food. The pulse was 120; temperature 103 and BP 146/90. The nurse called a doctor who ordered stat CBC, CMP and UA; IV fluid and observation on the infirmary.

9/5/2015 WBC 8.7; HGB 11.4; platelets 151; total protein 7.4 (6.6-8.7); urine culture grew e Coli.

Patient #22

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| <p>9/8/2015 A doctor wrote a discharge note to the infirmary. The doctor noted fever of unknown origin and the diagnosis was R/O lupus. The patient had been treated with Septra but had an unexplained fever and a facial rash. The plan was to work the patient up for lupus or connective tissue disease. Notably there was no history or physical examination for this admission. A week follow up was ordered.</p> | <p>1, 2, 12 This was a 45 year old man. Incontinence was not expected. The patient had anemia, prior leukopenia and fever. The diagnosis of lupus had no basis. The patient should have been referred to a infectious disease specialist as the doctor appeared incapable of making a diagnosis. In this population, HIV should have been excluded. Care was grossly and flagrantly unacceptable.</p> |
| <p>9/16/2015 A nurse saw the patient. The temperature was 102.6, pulse 110, and BP 105/70. The nurse noted that the patient was brought to the HCU with confusion, was incontinent and was weak. The nurse referred to a doctor urgently.</p> | |
| <p>9/16/2015 A doctor saw the patient because of mental status changes. Remarkably the doctor took virtually no history. The only examination was that the patient had warm dry skin and apparently normal cranial nerves 1-7. The temperature was 104. The doctor assessed an E coli urinary tract infection and ordered a chest x-ray, urine culture, blood culture, RPR, and CBC. The doctor started levofloxacin. The patient should have been admitted to a hospital.</p> | <p>1, 2, 14 The doctor took inadequate history, performed inadequate physical examination, and the plan was inadequate. The patient had confusion and fever and should have been admitted to a hospital. He was 45 years old. Starting outpatient antibiotics in a confused man with fever without a diagnosis was grossly and flagrantly unacceptable care.</p> |
| <p>9/16/2015 A nurse practitioner wrote the admission note to the infirmary. There was little history. The patient had fever of 102.6 with pulse 110.</p> | <p>1, 14 The history was inadequate. The therapeutic plan for fever was inadequate. The patient should have been hospitalized.</p> |

Patient #22

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| <p>9/17/2015 The doctor discharged the patient on 9/17/15 without any review of labs. There was no history and no physical examination. The doctor noted that the patient was admitted with UTI, fever, and dehydration. The doctor noted that IV fluid was given with Levaquin. The doctor ordered a week follow up and discharge diagnoses of UTI, fever, and ?lupus. Yet the doctor did not order tests to evaluate for lupus. The doctor did not note the discharge temperature</p> | <p>1, 2, 8, 12 The history was inadequate. The therapeutic plan for fever was inadequate. The evaluation was inadequate. Additional labs should have been drawn to exclude infections common in this population including HIV, blood cultures should have been considered. The patient's problems were beyond the expertise of this physician and he should have referred the patient to an ID expert.</p> |
| <p>9/17/2015 A doctor noted that the temperature was 103 but took little history except that the patient was voiding. The doctor took no relevant history and did not examine the patient; and reviewed no labs stating that he believed the fevers were not related to a UTI but possible lupus. The doctor noted that the patient had fevers for "years." The doctor discharged the patient without any evaluation. This patient should have been referred to an infectious disease consultant as the physician didn't know how to evaluate the patient. The doctor did not evaluate any lab results.</p> | <p>1, 2, 12 This was incompetent. To presume that fever for years was normal is incompetent. The history, examination, and plan was inadequate and the patient's problem was beyond the expertise of this doctor and he should have referred to an ID specialist. Care was grossly and flagrantly unacceptable.</p> |
| <p>9/17/2015 The patient had returned to his cell and was feeling so weak he ate sitting on the floor. His pulse was 127 and temperature 102.8. The nurse sent the patient back to the infirmary for 23 hour observation.</p> | <p>14 At this point the patient needed a higher level of care, as the facility did not know how to manage his care. Care was grossly and flagrantly unacceptable.</p> |
| <p>9/17/2015 Chest x-ray negative.</p> | |
| <p>9/17/2015 ANA none detected; creatinine 1.11 (0.5-1.5); total protein 7.7 (6-8); WBC 3.5 (3.9-12); HGB 10.9 (13.2-18); sedimentation rate 88. There was no documentation by a provider of review of these tests.</p> | <p>6 The patient had anemia and low white count with a significantly elevated sedimentation rate but these were not reviewed.</p> |

Patient #22

- 9/18/2015 A nurse noted that the patient felt better. The temperature was 98.9 and BP 146/92 with P 70. The patient was kept on the infirmary until 9/21/15 and was afebrile during that time.
- 9/18/2015 A doctor admitted the patient to the infirmary. There was no history except that the patient was being admitted with high fever. The only examination was that the patient was alert, oriented, had clear lungs, and had a soft, non-tender abdomen. The doctor remarkably ordered no diagnostic studies yet the admitting diagnosis was UTI and "fever of unknown origin; ? lupus."
- 9/21/2015 A doctor wrote a note stating that the patient was afebrile for 72 hours. The only documented history was that the patient had no complaints. There was no examination, no review of laboratory tests and no orders for diagnostic studies. The doctor discharged the patient to his cellhouse with follow up in a week. On a separate note the doctor noted that the workup would proceed as an "outpatient."
- 10/12/2015 The patient wasn't seen in a week as scheduled. On 10/12 a CMT wrote that there was a level 1 lockdown and a doctor appointment was cancelled.
- 10/26/2015 Annual examination weight 235 pounds. Problems HTN, DM, history of smoking and drug use but no IV drugs. On this annual examination the reviewer documented multiple sexual partners and prior blood transfusions which were not documented on prior annual history and physical evaluations. Given prior transfusions.
- 1, 2, 8, 12, 14 The doctor failed to examine the patient appropriately for someone with unexplained fever. The doctor should have ordered RF, HIV, blood cultures, Quantiferon test or TB skin test, ANA, SPE, and obtained CT scans of the abdomen and chest. Because of the altered mental status a CT brain was indicated. The patient should have been admitted to a hospital and/or referred to an ID specialist. Care was grossly and flagrantly unacceptable.
- 12 The doctor had no planned "workup" and appeared to not know what to do. The patient should have been referred.
- 11 Lockdowns shouldn't prevent scheduled doctor's appointments.

Patient #22

<p>10/26/2015 Diabetes HTN chronic clinics BP 164/90; weight 232; last A1c 6.3. No changes made.</p> <p>10/26/2015 The annual physical examination documented that the patient did not use IV drugs but did have multiple sexual partners and the patient had gonorrhea in the past.</p> <p>11/22/2015 A CMT wrote the that the patient said he wanted his blood pressure medication changed because it made him feel "different." The patient said he wasn't taking his medication. The blood pressure was 160/100.</p> <p>12/7/2015 Diabetes HTN chronic clinics BP 140/80, temperature 99.8 weight 225; last A1c 5.6. HGB noted to be 10.9. No changed in medication. CBC, CMP, LDH, ferritin, B12, folate and stools for occult blood ordered.</p> <p>12/14/2015 A doctor saw the patient and noted that the patient had anemia with low ferritin and B12 and a "butterfly" rash on his face. The ANA test was negative. The doctor noted that the patient had low grade fever and that the white count was 2.1. There was no history, no physical examination and the doctor referred the patient to Dr. Trost (apparently the Medical Director) to consider a colonoscopy. This patient needed an ID evaluation, as it appeared that the physicians didn't know how to evaluate the patient. The patient was started on vitamin B12 injections.</p> <p>12/14/2015 Ferritin 268 (10-259); WBC 2.1; HGB 12 (13.2-18); platelets 169; neutrophils 1.1 (1.3-7.5); lymphocytes 0.7 (1.3-4.2); B12 125 (180-914).</p> <p>12/15/2015 Stool negative for occult blood times 3.</p>	<p>3</p> <p>1, 8</p>	<p>The blood pressure was elevated and medication should have been adjusted.</p> <p>In light of this updated history the prior history of fever should have prompted HIV testing.</p>
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Patient #22

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| <p>1/12/2016 A doctor saw the patient and again took no history and performed no physical examination. The doctor noted that the patient was feeling better but "still believe he may have lupus." The doctor ordered a B12 level, CBC, CMP, sedimentation rate and rheumatoid factor with a return in two weeks as he was going to present something at collegial review.</p> | <p>1, 8, 12 The doctor failed to note or take a history obtained at the annual physical that the patient had multiple sex partners and prior gonorrhea and should have ordered an HIV test. The doctor did not have the expertise to manage this patient and should have referred. The leukopenia with lymphocytopenia with anemia is characteristic of HIV infection yet was unrecognized. ID referral was indicated but the doctor didn't have the sense to do this either.</p> |
| <p>1/12/2016 A doctor referred the patient to a rheumatology consultant. This was approved on 1/22/16.</p> | <p>4 The patient had no evidence of lupus serologically</p> |
| <p>1/19/2016 B12 1104 (180-914); sed rate 73.</p> | |
| <p>1/22/2016 The scheduling clerk documented that a rheumatology referral was approved.</p> | |
| <p>1/25/2016 A doctor wrote an extremely brief note documenting only that lab tests were pending and scheduled a week follow up. The blood pressure was elevated at 148/100 but no action was taken.</p> | <p>3 Blood pressure medication should have been adjusted.</p> |
| <p>1/29/2016 A doctor saw the patient and noted that the sedimentation rate was elevated [either 23 or 72]. The blood pressure was 120/98 but the doctor didn't address the elevated BP. The doctor ordered an ANA test and scheduled a four month follow up.</p> | <p>1, 8 The doctor should have adjusted blood pressure medication. HIV testing was indicated. A 4 month follow up was too long given the patient's problems.</p> |
| <p>2/2/2016 ANA not detected; BUN 33; creatinine 1.52 (0.5-1.5); A1c 6.4.</p> | |
| <p>2/26/2016 A rheumatology clinic note documented that the patient wouldn't be scheduled for rheumatology to evaluate for lupus because the ANA was negative. The sedimentation rate was presumed to be from a urinary tract infection. If there was concern for the skin rash a referral to dermatology was recommended for biopsy.</p> | |

Patient #22

- 3/14/2016 A nurse wrote that the patient was scheduled to see a physician but "for some reason MD denied request."
- 3/15/2016 A nurse noted a blood pressure of 170/102, pulse of 116, and temperature of 99.8. The nurse noted that the patient appeared confused as he didn't give correct response when asked about his medical issues. The nurse documented referring to a doctor.
- 3/15/2016 A psychiatrist saw the patient and documented that the patient was incontinent of urine and feces and was incontinent while wearing his clothes. The psychiatrist also noted delusional thinking. The assessment was psychotic disorder due to medical condition.
- 3/15/2016 A doctor saw the patient and noted that the patient was admitted [presumably to the infirmary] for psychosis of new onset and "connective tissue disorder." The only history was that the patient had "no lateralizing symptoms." The doctor admitted the patient for 23 hour observation and that mental health was going to monitor the patient.
- 3/15/2016 A nurse noted vital signs of temperature 99.4, pulse 110, BP 148/96, and a weight of 212 pounds. Though this was approximately a 40 pound weight loss it was unrecognized.
- 3/15/2016 At 11:45 pm a nurse documented that the patient said, "You don't understand, I'm a confidential informant. These people in here are not listening to me!"
- 3/16/2016 A nurse documented being unable to take the patient's temperature but documented a pulse of 132 with blood pressure of 126/70. The patient was unable to answer questions appropriately. The patient told the nurse that he was not well but didn't elaborate.
- 1, 2, 14 The patient had confusion, was incontinent, had prior fevers, had low white count and anemia with elevated sedimentation rate and the doctor had no plan. HIV testing was indicated but apparently beyond the expertise of the doctor. A CT brain was immediately indicated. The patient should have been hospitalized for diagnosis. Care was grossly and flagrantly unacceptable.
- 16 The patient appeared delirious and should have been referred to a physician.
- 16 The nurse should have consulted a physician.

Patient #22

3/16/2016 A nurse documented that the inmate was escorted off the infirmary by security to be taken to an outside medical furlough. The patient was brought back the same day.

3/16/2016 A nurse documented that the patient was delusional.

3/16/2016 The patient was seen in the Belleville Memorial Hospital emergency room for mental status changes. The WBC was 2.5; hemoglobin 11.8; and platelets 144. BUN was 25; creatinine 0.9; globulin 3.9. The ER documentation noted that the patient was delusional but answered questions appropriately.

3/17/2016 A nurse documented that the patient was "very delusional" and that it took considerable effort to get the inmate to take his food tray and medications. The nurse referred the patient to mental health but a doctor did not examine the patient.

3/17/2016 A doctor wrote an extremely brief note documenting that the patient was "alert, delusional, tearful at times." There was no history, no examination, and the doctor ordered no diagnostic tests. The only plan was "admit."

3/18/2016 A doctor admitted the patient to the infirmary. There was no history except "new onset acute psychosis R/O SLE." The only examination was "alert, delusional butterfly rash on face, chest clear BS [normal] cardiac RRR." The only orders were for an ANA and for mental health to see the patient.

3/18/2016 A doctor wrote a very brief note stating "no c/os mentation improved." The only plan was ANA.

The records in the chart indicate that the patient was seen in Belleville Hospital for mental status changes and that he was delusional. Their history was that the patient denied fever. They apparently thought that the patient was delusional for mental health reasons. There was no comment on their part regarding the low white count.

1, 7, 8 The doctor was fixated on lupus as a diagnosis but the patient had no serologic evidence for this condition. A CT brain and HIV test were indicated but not done. The patient should have been hospitalized. Care was grossly and flagrantly unacceptable.

Patient #22

<p>3/20/2016 A nurse documented that the patient was "laying in bed yelling out intermittently" and "yells and curses for unknown reason." The inmate refused to converse with staff.</p>	
<p>3/21/2016 ANA not detected.</p>	
<p>3/23/2016 A doctor saw the patient and wrote an extremely brief note stating "remains delusional. Medically stable P. ANA."</p>	<p>12 The doctor kept ordering an ANA test but it was done and was negative. The doctor should have referred the patient.</p>
<p>3/25/2016 A doctor wrote another very brief note which consisted of "SOA [apparently meaning subjective objective and assessment] Delusional. Alert P. mental health to see."</p>	<p>8 The doctor had not excluded physical causes of altered mental status. A CT of the brain had not been done.</p>
<p>3/28/2016 A doctor's note consisted of "SOA delusional alert in NAD. P vitals daily."</p>	
<p>3/28/2016 A psychiatrist saw the patient and noted that the patient was intermittently delusional and stated, "medical etiology unknown at this time," implying that the patient did not have a mental health problem as the source of his delirium. The psychiatrist plan was to note that "medical working to find underlying medical problem" and "suggest serum iron level."</p>	<p>12 The psychiatrist confirmed that a mental condition was not the cause of the patient's confusion and delirium. Because the doctor, who was a surgeon, did not have expertise or training in this area he should have referred to another physician.</p>
<p>3/29/2016 A doctor saw the patient. The only note was to acknowledge review of the mental health note and to order an iron study and to discontinue iron supplementation.</p>	<p>12 The doctor was following the recommendation of a psychiatrist. Both the psychiatrist and surgeon had no training in evaluation of confusion with leukopenia, anemia, elevated sed rate, and fever. The patient should have been referred.</p>
<p>3/31/2016 A doctor wrote another very brief note stating that the patient was alert and delirious. The plan was to continue present management.</p>	<p>14 The patient should have been admitted to a hospital. Care was grossly and flagrantly unacceptable.</p>
<p>4/1/2016 A doctor wrote another brief note stating "face [with] dry skin." The doctor prescribe a lotion for his dry skin.</p>	

Patient #22

4/4/2016 A doctor wrote a brief note that the patient had no complaints and was alert and in "NAD." The doctor didn't examine the patient and discharged him to his cellhouse with follow up in a week. The doctor had not completed an evaluation for the patient's delirium. The doctor noted on the discharge summary that the patient's delirium had "resolved." However, there was no history, no physical examination, and no documentation of diagnostic studies related to this problem. The doctor wrote, "Mental health evaluated patient and felt he had delirium. Delirium ?etiology cleared."

14 It was not competent to send a delirious patient with altered mental status to general population, as he had not exhibited ability to care for himself. The patient needed a diagnosis and higher level of care housing and should have been hospitalized for a diagnosis. Care was grossly and flagrantly unacceptable.

4/6/2016 A nurse saw the patient, was stated he couldn't walk. The weight was 200 pounds. The nurse placed the patient on the infirmary for 23 hour observation.

4/6/2016 At 4:30 a nurse documented that the patient was delusional with respect to his conversation with the nurse.

4/7/2016 A doctor wrote a very brief note stating "alert, Thought process organized. Able to ambulate. P. security hold." In a subsequent note a nurse documented that the patient was discharged from the medical third floor and was made a security hold. The patient was not medically monitored while on security hold, although it appeared that the patient remained on the infirmary unit.

4/28/2016 Diabetes HTN chronic clinics. BP 130/82; weight 212; last A1c 6.4; No changes made.

4/30/2016 A doctor wrote a very brief note stating, "Butterfly skin rash face, Refer to Dr. Trost for eval of connective tissue disease." That was the entirety of the note.

Patient #22

5/12/2016 Dr. Trost wrote I/M seen for above. P. Collegial referral." It wasn't clear what the doctor was referring to.

5/12/2016 Dr. Trost referred the patient to rheumatology for elevated sed rate of 88 to rule out lupus.

6/21/2016 An NP wrote that the patient was not brought to the clinic for a B12 injection. The NP ordered a CBC with B12 level with two week follow up.

6/24/2016 WBC 2.6; HGB 10.5; platelets 131; B12 609 (180-914); lymphocytes 0.6 (1.3-4.2).

7/8/2016 An NP wrote that ordered labs were not in the chart. The patient weighed 188. The NP wrote a ? after the weight but did not investigate the 60+ pound weight loss. The NP rescheduled the patient "when lab results avail."

6 It was two weeks since the labs were reported yet were not in the record.

7/15/2016 BUN 23 (6-20); sodium 148 (135-145); potassium 3.9; A1c 5.8.

7/17/2016 A nurse documented that the patient told her, "I need help I can't hold my bowels." The nurse noted that the patient was unable to ambulate without assistance. The nurse referred the patient to a doctor.

7/18/2016 A doctor saw the patient. There was no history, no physical examination, and no assessment. The doctor ordered labs (CBC, CMP, CRP, and sedimentation rate) and ordered an x-ray of the LS spine and ordered Motrin, ointment, iron supplements and a steroid cream all for four months without documenting why he was ordering these items.

1, 2, 6, The patient was so disordered that he was incontinent.
14 The doctor took no history, performed no exam, failed to note recent labs showing pancytopenia. The patient should have been sent to a hospital. Care was grossly and flagrantly unacceptable.

Patient #22

- 7/22/2016 A different doctor saw the patient, who had a temperature of 101.2. The doctor noted that the patient might have "probable SLE." The doctor noted that the patient wasn't "doing personal hygiene." The doctor did not review labs or assess the weight. The doctor admitted the patient for 23 hour observation and ordered a UA, CBC, and ordered Levaquin for 10 days without specifying what infection he was treating.
- 2, 14 The diagnosis of lupus cerebritis would require exclusion of other causes of psychosis and would require serologic evidence of lupus, which this patient did not have. If the doctor thought that the patient had lupus the patient should have been admitted to a hospital for CT, MRI, and possibly LP to confirm the diagnosis. Furthermore, if the lupus was this significant, treatment should have been immediately initiated and for that reason as well the patient should have been referred to a tertiary care hospital, as this condition was beyond the expertise of these physicians. Care was grossly and flagrantly unacceptable.
- 7/24/2016 A nurse documented that the patient was brought to the infirmary in a wheelchair and showered with "much assistance."
- 7/25/2016 A nurse documented that the patient needed assistance to sit up in bed. The patient was voiding dark amber urine in small amounts.
- 7/25/2016 Dr. Trost saw the patient but wrote an extremely brief note writing, "c/o weakness, alert, in NAD. P admit observe labs." On the same day the same physician wrote an infirmary admission note. The history was only that the patient had generalized weakness. The physical examination only documented, "alert in NAD; moves all extremities; facial rash." The assessment was weakness and fever of unknown origin. On the nurses admission note the temperature was 99.8.
- 1, 2, 14 This surgeon had no expertise in managing this type of condition and did not take an adequate history, failed to perform, and adequate examination and the therapeutic plan was incompetent. The patient should have been admitted to a tertiary care hospital. Care was grossly and flagrantly unacceptable.
- 7/26/2016 BUN 16; potassium 3.4; WBC 3.1 (3.9-12); HGB 10.1; platelets 139 (150-450); lymphocytes 0.4 (1.3-4.2) neutrophils normal; sed rate 51 (0-10).

Patient #22

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| <p>7/27/2016 Dr. Trost saw the patient and again wrote an extremely brief note documenting "no c/os; alert in NAD, oriented P. labs CPM." Notably, nursing noted were describing that the patient couldn't move from his bed and needed assistance to even sit up.</p> | | |
| <p>7/29/2016 Dr. Trost saw the patient. His only note was "requesting shower stable. P. CPM."</p> | <p>1,2, 6,
14</p> | <p>The patient had pancytopenia. The doctor failed to take adequate history, performed inadequate examination, and had an incompetent plan. The doctor failed to note pancytopenia and confusion. The patient should have been referred to a tertiary care hospital. Care was grossly and flagrantly unacceptable.</p> |
| <p>8/2/2016 Dr. Trost saw the patient. The only note was "No c/os Labs [change] status to chronic."</p> | <p>1, 2, 6,
14</p> | <p>The patient had pancytopenia. The doctor failed to take adequate history, performed inadequate examination, and had an incompetent plan. The doctor failed to note pancytopenia and confusion. The patient should have been referred to a tertiary care hosp. Care was grossly and flagrantly unacceptable.</p> |
| <p>8/3/2016 Dr. Trost saw the patient, who complained of right sided abdominal pain with deep breaths. There was no other history. The only examination was "face [with] dry skin abd nontender." "P CPM."</p> | <p>1, 2,</p> | <p>The doctor failed to take adequate history for the complaint, failed to conduct adequate examination, and made no diagnosis.</p> |
| <p>8/5/2016 A nurse documented that the patient stated he couldn't get up out of bed. The nurse noted that the patient was observed by staff to be up out of bed. The patient refused to come to the door for his meds and food tray and the nurse had the patient sign a refusal.</p> | <p>16</p> | <p>The nurse assumed that the patient was malingering. This was indifferent care.</p> |
| <p>8/8/2016 Quarterly DM, HTN chronic clinic. Weight not taken. BP 130/80. Last A1c 5.8. No change in medication.</p> | | |

Patient #22

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| <p>8/9/2016 Dr. Trost saw the patient and wrote a brief note stating "I/M requesting wheelchair P. CXR." Why the doctor ordered a chest x-ray is unclear as the doctor documented no history, physical examination, or assessment.</p> | <p>1, 2, 14 The doctor didn't even ask why the patient was requesting a wheelchair. There was no examination and no diagnosis. Apparently the patient couldn't walk. There was no diagnosis or plan except to give the patient a wheelchair and a chest x-ray for inexplicable reasons. The patient should have been referred to a hospital. Care was grossly and flagrantly unacceptable.</p> |
| <p>8/11/2016 Chest x-ray negative.</p> | |
| <p>8/17/2016 Dr. Trost saw the patient and wrote a very brief note documenting "alert, in NAD, no c/o's facial skin dry flaky P. CPM."</p> | <p>1, 2, 14 The doctor again failed to take any history, performed inadequate exam, made no diagnosis, and failed to refer to a hospital.</p> |
| <p>8/24/2016 Dr. Trost wrote a very brief note documenting "no c/o's P. obtain assistive device for ambulation."</p> | <p>1, 2, 14 The doctor again failed to take any history, performed inadequate exam, made no diagnosis, and failed to refer to a hospital.</p> |
| <p>8/31/2016 Dr. Trost wrote a brief note documenting "exam unchanged P. rheumatology consult." This was a strange note as Dr. Trost had almost never examined the patient so it wasn't clear what "exam unchanged" meant.</p> | <p>1, 2, 14 The doctor again failed to take history, examine or diagnose the patient and referred the patient incompetently to a rheumatologist for confusion, pancytopenia, incontinence, and weight loss. There was no evidence of a rheumatologic disease. The patient should have been referred to a hospital.</p> |
| <p>9/7/2016 Dr. Trost wrote a brief note documenting "exam unchanged P. rheumatology consult." This was a strange note as Dr. Trost had almost never examined the patient so it wasn't clear what "exam unchanged" meant.</p> | <p>1, 2, 14 The doctor again failed to take history, examine, or diagnose the patient and referred the patient incompetently to a rheumatologist for confusion, pancytopenia, incontinence, and weight loss. There was no evidence of a rheumatologic disease. The patient should have been referred to a hospital.</p> |
| <p>9/7/2016 The scheduling clerk noted that the inmate was scheduled for a rheumatology consultation on 9/28/16.</p> | |

Patient #22

9/28/2016 Dr. Trost documented that the patient was requesting a wheelchair but didn't say why. There was no history and the only physical examination was "alert in NAD weak dry scaly skin on face. P. CPM."

9/28/2016 A rheumatologist saw the patient. There was an order sheet and some prescriptions. The rheumatologist ordered CMP, CBC, CK, TSH, free T4, sedimentation rate, CRP, RF, anti-CCP antibody, ANA, DS DNA, SSA and SSB antibodies, RNP antibodies, Smith antibodies, SCL 70 (scleroderma) antibodies, and LDH. The rheumatologist also ordered an EMG of the right upper extremity based on diagnosis of neuropathy. There was a prescription for methotrexate but it was for a different patient. This was not picked up and Dr. Trost ordered methotrexate and the patient inappropriately received this medication for the first weekly dose.

Patient #22

9/28/2016 A rheumatologist saw the patient and denied any joint swelling but had tingling in his hands and nonspecific pain in his legs. The patient complained of numbness in his fingers and had non-specific weakness. The patient arrived at the clinic in a wheelchair. The patient had excoriated lesions on his hands and face, had no obvious synovitis, no significant joint tenderness with palpation, and mild decreased strength in his lower extremities. The rheumatologist diagnosed polyarthralgias and myalgias that were nonspecific. The possible etiologies were inflammatory myositis vs. inflammatory arthritis including RA or other connective tissue disorders such as lupus or lupus like illness "however at this point I do not see any obvious systemic complaints to suggest this." The doctor ordered labs and EMG and asked for a follow up in a month to determine if further treatment was warranted.

9/29/2016 A nurse documented that the patient said, "they think I have lupus." The patient had gone on a furlough the day before.

10/3/2016 A nurse took a verbal order from Dr. Trost for methotrexate 12.5 mg weekly with a CMP, CBC, CK, TSH, free T4, sedimentation rate, CRP, RF, anti-CCP antibody, ANA, LDH.

10/3/2016 Dr. Trost referred the patient to neurology for neuropathy and a month follow up with rheumatology. The rheumatology follow up was initially denied but then approved, "since symptoms persist." The neurology evaluation and EMG was denied. The UM reviewer asked for the typed rheumatology notes before proceeding.

17 The facility received an inaccurate prescription for a different patient and gave methotrexate to a patient with pancytopenia, which place him at significant risk of harm.

Patient #22

- 10/4/2016 RF normal; albumin 3.2; CPK normal; CRP 6.6 (0-0.8); WBC 11.8; HGB 9.6; platelets 193; lymphocytes 20 (25-45); sed rate 37 (0-10). These lab results are not consistent with lupus.
- 10/5/2016 Dr. Trost saw the patient. He did not document review of the rheumatology note. He wrote a brief note documenting, "weakness unchanged Tol PO [apparently tolerating oral fluid] exam unchanged P. rheumatology eval in progress." 1, 2, 14 The doctor again failed to take history, examine, or diagnose the patient and referred the patient incompetently to a rheumatologist for confusion, pancytopenia, incontinence, and weight loss. There was no evidence of a rheumatologic disease. The patient should have been referred to a hospital.
- 10/11/2016 A nurse documented that the patient was "still refusing to sit up, demanding to have a wheelchair." The nurse noted that the inmate had a stage 2 open ulcer to his lower back about 6 by 6 inches that was cleaned with saline. The doctor wasn't notified.
- 10/11/2016 A nurse documented that the patient was becoming increasingly weaker. The nurse noted that the oxygen saturation was in the 70% range on room air and was 90-% on 4 liters of oxygen. The pulse was 128 and blood pressure 90/66. Dr. Trost was notified and the patient was sent to a local hospital.

Patient #22

10/12/2016 An ID consult at Barnes Jewish Hospital noted that the patient was transferred from another hospital with HIV infection- newly diagnosed with respiratory distress and skin lesions. The patient told the ID consultant that he had night sweats and weight loss over the past 3-4 months. The patient had oxygen saturation of 77% on room air. At the local hospital in Chester Illinois, the patient was in shock with BP 60/40 with pulse 128 and temperature of 90.9! He was diagnosed with septic shock. Blood cultures were growing gram positive organisms. The creatinine was 4.28. The patient was transferred to Barnes Hospital. Blood cultures grew Meth Sensitive Staph aureus. The ID consultant noted that the patient had a pustular lesion on the left leg and right foot, abrasions on the hip and shoulder, an ulcer on the right hip, a shallow ulceration on the penis, and macerated skin in the left groin. None of this was noted at Menard only two days previous. There were scattered small nodules in the lungs, some of which appeared cavitory. These were thought to possibly be septic emboli or metastatic lesions. The consultant initially thought that the patient had septic emboli from staph septicemia, possibly pulmonary TB or other fungal infection. Further work up was needed. The consultant thought that the patient's encephalopathy might be due to HIV encephalopathy vs. opportunistic infection or septic brain emboli.

Initial presentation at the hospital show that the patient was in a state of neglect when he arrived. He was in shock, hypothermic, and in renal failure with multiple lesions on his body apparently unrecognized by providers at the facility. He also had unrecognized severe malnutrition. Overall care at the facility was grossly and flagrantly unacceptable. On multiple episodes the patient had confusion with intermittent fever and neutropenia and needed acute care hospitalization, yet this did not occur. These were grossly and flagrantly unacceptable care.

10/12/2016 A dermatologist at Barnes Hospital saw the patient. A biopsy from that date showed focal parakeratosis that in the context of methotrexate "could represent medication-related toxicity."

Patient #22

- 10/12/2016 A Jewish Hospital note documented that the patient has severe malnutrition.
- 10/15/2016 An MRI of the brain had findings consistent with HIV encephalitis. Incidentally noted was an intramuscular ring enhancing right sternocleidomastoid mass which was consistent with an intramuscular abscess or Kaposi's sarcoma.
- 10/16/2016 A note from the hospital noted that the patient had a CD4 count of 46. The patient has started on azithromycin and Bactrim for prophylaxis. Lesions from the lungs grew MSSA and culture of the decubitus ulcer grew MRSA.
- 10/17/2016 The patient had a cardiac arrest and a Doppler test was done and identified an acute DVT in the common femoral vein on the right. The patient also had an abnormal EEG post-cardiac arrest.
- 10/20/2016 A chest x-ray showed the patient was still intubated and had collapse of the right middle and lower lobes. The patient apparently died on this day. There was no autopsy or death summary.

Patient #23

3/23/2012 The patient was incarcerated at NRC. The initial weight was 220 pounds. The patient had a history of prior lung cancer with surgeries and radiation in the late 1990s; hypertension and hepatitis C.

3/23/2012 AST 82; ALT 66.

5/2/2012 The patient was transferred from NRC to Menard. The problem list documents only hypertension, DM, prior lung cancer, and hepatitis C as problems. Cirrhosis was not listed as a problem.

5/8/2012 A hepatitis C progress note performed by a nurse documented that further laboratory testing was needed including CBC, CMP, INR, and HIV tests. There was no history or physical examination. The status of the patient wasn't documented.

5/23/2012 AST 99; ALT 78; platelets 121.

6/1/2012 AST 96; ALT 72; platelets 129.

6/11/2012 A NP saw the patient in hepatitis C clinic. The patient's projected release date was > 18 months. The platelets were documented as 129; AST 96 and ALT 72. This yielded a FIB 4 score of 4.91 likely consistent with cirrhosis. The APRI score was 1.86, likely significant fibrosis with possible cirrhosis. Except for noting that hepatitis A and B vaccinations were done, no action was taken. This patient had probable fibrosis and cirrhosis, should have been referred for treatment and should have had routine cirrhosis screening performed including every six month ultrasound, EGD to screen for varices, and possible institution of a beta blocker.

6/15/2012 Hepatitis C genotype and viral load was ordered.

The APRI was 1.86 indicating likely significant fibrosis with possible cirrhosis.

7, 8, 12 The patient had APRI indicating cirrhosis. The NP did not discuss or offer treatment. There was no evaluation for complications of cirrhosis (i.e. every six months ultrasound and EGD to screen for varices and treatment of other complications of cirrhosis). The NP should have referred the patient to UIC for EGD and ultrasound as lab testing indicated significant fibrosis with possible cirrhosis. Care failed to follow generally accepted guidelines or usual practice.

Patient #23

- 6/15/2012 A NP filled out a Wexford Initial Hepatitis work sheet. The NP documented faxing the form "again" to Dr. Paul on 8/26/12 and documented referring to an MD for "discussion of Tx if he will maintain compliance." It wasn't clear what maintaining compliance meant.
- 7/2/2012 AST 96; ALT 74; platelets 125; hepatitis C genotype 1A; quantitative HCV 2,111,740.
- 8/5/2012 A NP wrote that information was to be submitted to Dr. Paul for evaluation for hepatitis C treatment.
- 9/21/2012 AST 108; ALT 91.
- 9/26/2012 An RN noted that according to Dr. Paul, the patient could be referred when he agreed to compliance with therapy. A nurse documented a history of refusal, but what was refused was not documented.
- 10/1/2012 A doctor obtained a signed release for medical records from Cook County Hospital for treatment of his lung cancer. The doctor did not address the hepatitis C infection.
- 10/4/2012 A doctor saw the patient for hypertension and diabetes chronic clinic. The blood pressure was 150/104. The doctor increased the Vasotec. The last A1c as documented as 6.2. The patient was not on medication and it wasn't clear that the patient had diabetes. The doctor noted that the patient had 2+ pedal edema. The etiology of the edema was not addressed.
- 12 The patient had cirrhosis and should have been referred to UIC. The referral to Dr. Paul had no purpose. We view this as a delay in necessary treatment. The meaning of maintaining compliance was confusing. What compliance were they discussing? Care failed to follow generally accepted guidelines or usual practice.
- The APRI was 1.92 indicating significant fibrosis with possible cirrhosis.
- 12 We view these referrals as delays in referral to UIC. What purpose does Dr. Paul play? The patient has laboratory evidence of cirrhosis. Why delay referral? The patient should have been referred to UIC. Care failed to follow generally accepted guidelines or usual practice.
- 12 When the patient was ultimately referred to UIC he apparently agreed to treatment. Was the purpose of treatment explained to the patient. This was never documented.
- 1, 2, 7 The patient had unexplained edema which was not evaluated. Given that the patient had possible cirrhosis, the patient should have other diagnostic work up including for cirrhosis and heart failure. Additional testing was indicated including ultrasound of the liver and possible echocardiogram. These should have been based on history, which was inadequate.

Patient #23

1/3/2013 A provider saw the patient for HTN chronic clinic. The BP was 134/87 and weight was 225 pounds. No changes were made.

1/3/2013 An NP saw the patient for hepatitis C chronic clinic. A high viral load was documented with genotype 1A. Treatment was not addressed; there was no reason given for not pursuing treatment. The patient's likely cirrhosis was not evaluated or monitored.

1/3/2013 A provider saw the patient for diabetes clinic. The A1c was documented as "ordered." The status wasn't clear.

1/10/2013 AST 112; ALT 85.

4/8/2013 A PA noted that the inmate wanted to hold off treatment at this time. It appeared that the patient didn't want treatment for his hepatitis C at this time.

4/8/2013 The patient signed a refusal for hepatitis C treatment and workup.

4/11/2013 A doctor saw the patient in hepatitis C clinic. The doctor noted ALT 85 and AST 111. The FIB4 or APRI scores were not documented but the patient already had probable cirrhosis on prior tests. There was no monitoring of the patient's cirrhosis. The patient was noted to have signed a refusal for treatment and "conservative follow up" was the plan.

4/11/2013 A doctor saw the patient in hypertension chronic clinic. The blood pressure was 136/88. The patient was also seen in diabetic chronic clinic. The A1c was 6.2 and the patient was not on medication. This A1c level is not diagnostic of diabetes. There was no change in therapy.

8/27/2013 Albumin 3.3; AST 94; ALT 71; platelets 97.

7, 8, 12 The patient should have been referred to UIC where treatment could be explained to him. He should have had EGD and ultrasound of the liver. Care failed to follow generally accepted guidelines or usual practice.

7,8 The patient had APRI indicating cirrhosis. The NP did not discuss or offer treatment. There was no evaluation for complications of cirrhosis (i.e. every six months ultrasound and EGD to screen for varices and treatment of other complications of cirrhosis).

Patient #23

- 8/29/2013 A doctor saw the patient in hypertension and diabetes chronic clinics. The blood pressure was 132/82. The weight was 225. The most recent A1c was 6.3. No change in therapy was made.
- 8/29/2013 A doctor saw the patient for hepatitis clinic. The platelets were 99; AST 94; and ALT 71. This yielded an APRI score of 2.37 and FIB4 score of 6.31, both indicating likely cirrhosis, yet the patient was not evaluated or monitored for cirrhosis. It was documented that the patient refused treatment, but it is not clear what was explained to the patient with respect to treatment. There was no referral to UIC to discuss treatment. Conservative follow up was the plan but the patient wasn't treated for his cirrhosis. The doctor noted trace edema of the lower extremity. No action was taken with respect to the edema. Treatment wasn't explained to the patient. At this time new hepatitis C drugs were on the market and made treatment significantly easier.
- 11/8/2013 Albumin 3.2; alk phos 136 (40-125); AST 113; ALT 81; platelets 106.
- 12/21/2013 A NP saw the patient for hepatitis C clinic. Platelets were 113, AST 113, and ALT 81, yet the patient wasn't monitored for cirrhosis. No action was taken except "conservative follow up."
- 12/29/2013 A NP saw the patient for hypertension and DM chronic clinic. The BP was 130/62. The last A1c was 6.3. No changes to therapy were initiated.
- 12 The patient should have been referred to UIC where treatment could be explained to him.
- The increasingly abnormal albumin and alkaline phosphatase indicated more severe liver disease that was not evaluated.
- 7, 8, 12 The patient should have been referred to UIC where treatment could be explained to him. The NP should also have ordered an EGD and ultrasound or CT scan of the liver as blood tests were consistent with cirrhosis.

Patient #23

3/7/2014 Platelets 98; albumin 3.1; bilirubin 1.6 (0-1.2); alk phos 144 (40-125); AST 102; ALT 69.

The increasingly abnormal albumin and alkaline phosphatase indicated more severe liver disease that was not evaluated.

4/22/2014 A NP saw the patient for hypertension and DM chronic clinic. The PP was 134/82. The last A1c was 6.2. The weight was 235.

4/24/2014 An NP saw the patient in hepatitis clinic. Platelets were 16; AST 102; and ALT 69. Yet the patient wasn't evaluated for cirrhosis complications. Treatment wasn't discussed.

7, 8, 12 The patient should have been referred to UIC where treatment could be explained to him. The NP should also have ordered an EGD and ultrasound or CT scan of the liver, as blood tests were consistent with cirrhosis. Newer drugs were now available which made treatment significantly easier.

6/17/2014 The patient signed a refusal for hepatitis C treatment and workup but it wasn't clear what was explained to the patient.

7/23/2014 The patient was transferred to Stateville CC.

9/10/2014 The patient was transferred from SCC to Menard.

9/16/2014 Albumin 3.1; total bilirubin 1.2 (0-1.2); Alk phos 132 (40-125); AST 132; ALT 67; MCV 100.2; platelets 91.

The low albumin, elevated alkaline phosphatase and elevation of bilirubin indicated deterioration of liver function that was not evaluated. The patient should have had an ultrasound or CT scan of the liver.

9/24/2014 An NP saw the patient in hepatitis clinic. The APRI was calculated as 3.10. There was no monitoring of the patient's cirrhosis. One NP referred to another NP for the increased APRI. "Conservative follow up" was the plan.

7, 8, 12 The patient should have been referred to UIC where treatment could be explained to him. The NP should also have ordered an EGD and ultrasound or CT scan of the liver.

9/24/2014 The patient was seen for hypertension and diabetes chronic clinics. The BP was 130/94. The weight was 230. The latest A1c was 6.1. No changes were made to therapy.

Patient #23

10/1/2014 Albumin 3.2; alk phos 133 (40-125); AST 161; ALT 91.

11/5/2014 Platelets 79.

11/25/2014 The patient returned to Menard after a writ return.

1/14/2015 An annual physical examination showed a weight of 180 or a 40 pound weight loss since incarceration in 2012. The patient had HTN, DM, lung cancer, and hepatitis C as problems. A provider found a stool that was guaiac positive. Cards for guaiac testing were given. The NP also documented in the assessment that the patient had 2+ pitting edema of both legs. The NP ordered Ted hose but did not start a diuretic and did not document ascites as a problem so it could be monitored.

1, 2, 3 The provider failed to take a history of the weight loss. Indeed it was unrecognized. The patient should have had a thorough history, physical examination, and plan for the weight loss. A diagnosis was not made for the edema and it was possible that the patient had cirrhosis.

1/14/2015 An NP saw the patient for hepatitis clinic and noted that the patient had APRI of 3.22 but was ineligible for treatment at this time due to a refusal of treatment on 1/14/15. The explanation of the refusal was not documented and it wasn't clear that the patient understood what he was refusing.

7, 8, 12 The patient should have been referred to UIC. The NP should also have ordered an EGD and ultrasound or CT scan of the liver.

1/14/2015 A NP saw the patient for hypertension clinic. The blood pressure was 136/84. No changes were made to therapy.

1/14/2015 The patient signed a refusal for hepatitis C treatment and workup but it wasn't clear what was explained to the patient.

12 The patient should have been referred to UIC. IDOC personnel failed to document what was discussed with the patient. Because of new drugs, treatment was significantly improved and it is unclear whether this was understood by IDOC personnel.

3/20/2015 Albumin 2.9; bilirubin 1.4 (0-1.2); alk phos 138 (40-125); AST 134; ALT 76.

4/13/2015 A NP saw the patient for hypertension clinic. The BP was 126/84. No changes to therapy were initiated.

6 Recent significant lab abnormalities were not reviewed.

Patient #23

- 5/1/2015 Albumin 3; bilirubin 1.8; alk phos 144; AST 173; ALT 83; platelets 83.
- 5/4/2015 Apparently Dr. Paul wrote a note without seeing the patient and documenting that the patient had an APRI of 5.21. Dr. Paul recommended having him called over to discuss his decision to refuse HCV treatment and have him sign a refusal. A liver ultrasound and EGD were recommended.
- 5/6/2015 Wexford approved an EGD with comments that the patient had an APRI of 5.21. In addition to EGD, Dr. Paul recommended yearly discussion of treatment with the patient and liver ultrasound to R/O HCC.
- 5/6/2015 Wexford approved an abdominal ultrasound.
- 5/8/2015 An ultrasound of the liver showed cirrhosis, a 2.5 cm mass "worrisome for a possible malignant lesion" and a second mass in the right lobe of the liver measuring 2.35 cm. There was also splenomegaly.
- 5/14/2015 A NP wrote an email to Dr. Paul that the EGD was delayed as the doctor who typically performed EGDs was out after an accident.
- 5/15/2015 Dr. Paul wrote an email to an NP at Menard recommending a CT scan of the abdomen to evaluate an abnormal US.
- 5/15/2015 A CT scan was referred. This was approved on 5/18/15.
- 5/19/2015 A doctor saw the patient and informed him of the ultrasound results. The weight was 224. The doctor notified the patient of a pending CT scan.
- 5/27/2015 A nurse documented a weight of 230 pounds.
- 12 The patient should have been referred to UIC to have treatment adequately explained to him.
- The patient had a liver lesion possibly HCC but this was not evaluated with biopsy.
- 3 If a CT scan were ordered it should have been an interventional radiology test so that biopsy could be done. This would only serve to delay evaluation of the lesion.

Patient #23

<p>5/28/2015 A CT scan report documented a hypodense lesion in the right lobe of the liver measuring 6.2 cm. This was suspicious for malignancy. Cirrhosis of the liver was also found with ascites and splenomegaly.</p>	<p>The patient had a liver lesion possibly HCC but this was not evaluated with biopsy.</p>
<p>6/17/2015 An NP saw the patient for hepatitis C clinic. The NP documented that the APRI was 5.3 and the NP documented that the patient refused therapy on 1/14/15. The NP documented that the CT results were given to the patient. There was no evaluation for complications of cirrhosis.</p>	<p>7, 17 The patient should have been sent for his EGD. The patient should have been considered for a diuretic due to ascites.</p>
<p>6/22/2015 A nurse documented a weight of 219 pounds.</p>	<p>1 The weight loss was unrecognized. As the patient's cirrhosis worsened, the weight increased likely as a result of ascites.</p>
<p>8/4/2015 A nurse documented a weight of 240 pounds.</p>	<p>This may have been ascites or an error.</p>
<p>8/6/2015 A doctor documented seeing the patient in follow up of a CT scan. The note was partly illegible but appeared to refer the patient to hepatitis clinic.</p>	
<p>8/7/2015 The patient had endoscopy showing grade II esophageal varices. The recommendation was to start beta blocker medication.</p>	
<p>8/14/2015 Albumin 2.5; bilirubin 2.5; AST 67; ALT 34; MCV 101; platelets 71; INR 1.3 (0.9-1.2).</p>	
<p>8/25/2015 The scheduling clerk documented that the Wexford UM physician decided to refer a referral matter to Dr. Paul. The specific referral was not documented.</p>	
<p>8/25/2015 Dr. Trost documented that the patient EGD showed varices with possible hepatic tumor. The doctor referred to collegial for an unknown referral but did not start a beta blocker.</p>	<p>17 The doctor should have started a beta blocker due to the varices.</p>
<p>8/25/2015 Dr. Trost referred the patient for interventional radiology biopsy of a liver mass.</p>	

Patient #23

<p>8/31/2015 Wexford UM physician did not approve a liver biopsy but requested that the referral be sent to Dr. Paul</p> <p>9/10/2015 Inderal 20 mg BID was ordered.</p> <p>9/22/2015 BUN 4; chloride 110 (98-108); MCV 101.8; platelets 81.</p> <p>9/24/2015 Dr. Trost referred the patient for interventional radiology biopsy of a liver mass.</p> <p>9/25/2015 MRI was approved by collegial. The approval noted that the radiologist recommended an MRI.</p> <p>10/22/2015 An MRI showed right lower lobe pneumonitis, large ascites, splenomegaly, varices, wedge shaped confluent hepatic fibrosis of right hepatic lobe.</p> <p>10/26/2015 An MRI was done.</p> <p>10/30/2015 BUN 4; calcium 8.3; albumin 2.3; bilirubin 1.7; alk phos 151; AST 81; ALT 34; MCV 100.9; platelets 59; INR 1.4 (0-1.2).</p> <p>11/23/2015 A doctor saw the patient for hypertension clinic. The BP was 142/90. The patient weighed 224. The patient asked the doctor about a liver transplant. The doctor noted edema and added Aldactone. The doctor noted that the patient was on propranolol 20 mg BID.</p> <p>11/25/2015 A MAR documented that the inderal was on hold. It wasn't clear why.</p> <p>12/1/2015 Dr. Trost wrote a note. There was no history or physical examination. The note stated "I/M inquiring about liver transplant. Process including need for matching donor, finding, etc. All D/W I/M" P. F/U HRC."</p>	<p>7 This was a significant delay in evaluating a possible liver mass.</p> <p>6, 7 This was four months from the abnormal ultrasound. This delay was excessive. Significantly abnormal labs were not reviewed.</p> <p>11 A biopsy was ordered but the patient received an MRI.</p> <p>6 Significantly abnormal labs were not addressed.</p> <p>17 The patient should have been on a beta blocker due to his varices.</p>
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Patient #23

12/3/2015 A doctor saw the patient in hepatitis chronic clinic. The doctor noted that the patient had a hepatic mass found in May of 2015. The doctor noted that the APRI was 6.3. The doctor concluded that the patient had liver cirrhosis and a questionable liver mass. The doctor referred the patient to Dr. Trost, the Medical Director.

12/7/2015 Wexford approved an abdominal ultrasound. Notably Wexford UM also approved this same procedure on 12/8/15.

12/14/2015 Dr. Trost saw the patient. The entire note was "RIH on exam, reducible. P. observe."

12/18/2015 An ultrasound of the liver showed cirrhosis, a possible 2.1 cm liver lesion, and ascites. An MRI or CT surveillance was recommended to evaluate for hepatocellular carcinoma.

12/24/2015 Dr. Trost saw the patient. The entire note was "No c/o's
Unclear why I/M scheduled. P. F/U PRN."

2/18/2016 A nurse noted that an email was sent to UIC with appointment sheet and paperwork.

3/24/2016 INR 1.6; albumin 2.1; bilirubin 2.2; alk phos 204; AST 76; ALT 30; MCV 100; platelets 65.

12 The patient should have been referred to UIC or to
another hepatologist for treatment as it appeared
beyond the expertise of the surgeon who was Medical
Director.

1, 2, 3 Given the condition of the patient, the history, examination, and plan were all inadequate. The doctor did not appear to know how to care for the liver mass and cirrhosis.

Patient #23

4/28/2016 A UIC consultant saw the patient and noted that the patient deferred treatment in the past because "tumor eat you faster." Notably, the patient was unaware that he had any associated liver disease. The patient said he was first diagnosed with hepatitis C at Stateville in 2012 and had genotype 1A with a RNA level of 2,111,740 on 7/2/12. The UIC consultant noted that the patient was unaware of having any complication of his liver disease. The UIC consultant noted that varices were diagnosed 8/7/15 but that the patient wasn't treated for these, though a nurse found a prescription for propranolol that the patient had not picked up. The doctor noted that a CT guided biopsy was not done "because images from US and CT were not provided to guide the biopsy in 2015." The failed biopsy was documented as not occurring on 8/28/15. The consultant documented that the US showed an ill-defined 2.5 cm mass in the liver. A CT scan on 5/28/15 showed no enhancing lesions, although there was an ill-defined hypodensity in the right lobe of the liver. The ill defined lesion was suspicious for malignancy. The CT scan also showed cirrhosis, ascites, and splenomegaly. The patient agreed to treatment. The consultant recommended a liver biopsy, the MRI results, and after the biopsy to have the patient return to clinic for treatment.

Notably, the patient agreed to treatment at UIC. The patient was unaware of his liver disease, making it appear that there had been ineffective communication with the patient. The patient was sent without the MRI.

4/28/2016 A doctor saw the for annual hypertension clinic. The BP was 110/80. The doctor found no abnormalities on physical examination and made no changes to therapy.

Patient #23

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| <p>4/28/2016 A doctor saw the patient for hepatitis clinic. The doctor noted that the patient was ineligible for treatment because of low APRI. The APRI was 2.92, likely representing cirrhosis and warranted treatment. Nevertheless, the doctor documented he would refer to Dr. Trost to refer the patient to the telemedicine clinic for hepatitis C.</p> | 4 | <p>This doctor did not appear to know what the guidelines were.</p> |
| <p>5/25/2016 Dr. Paul referred the patient for an MRI. This was approved on 5/31/16.</p> | | <p>The use of Dr. Paul caused delays and confusion in therapy. It was understandable that she was involved because the doctors didn't know how to manage hepatitis C, but a different system should have been established.</p> |
| <p>6/1/2016 The scheduling clerk documented that an MRI of the abdomen was scheduled for 6/21/16.</p> | | |
| <p>6/7/2016 Albumin 2.1; bilirubin 3.5; alk phos 149; AST 79; ALT 27.</p> | | |
| <p>6/21/2016 The patient returned from an offsite MRI. A nurse practitioner saw the patient. The patient was short of breath and had oxygen saturation of 79%. The patient was started on oxygen and admitted to the infirmary for observation. There was no effort by the NP to identify why the patient had hypoxemia. Care was grossly and flagrantly unacceptable. The patient should have been admitted to a hospital. The NP did not document a complete set of vital signs. A nurse note on the same infirmary admission documented a blood pressure of 96/64.</p> | 14 | <p>The patient had significant hypoxemia with hypotension of new onset and should have been admitted to a hospital.</p> |
| <p>6/21/2016 A nurse on the infirmary noted that the BP was 96/64 and the oxygen saturation 93% on oxygen. Hypoxemia and hypotension of unknown etiology warranted hospitalization.</p> | | |

Patient #23

- 6/22/2016 At 5:45 am a nurse documented that the patient had fever (100.4). There was no physician referral but the nurse placed the patient on the infirmary for observation. 16 Fever, hypoxemia, and hypotension warranted hospitalization. This nurse didn't refer to a physician.
- 6/22/2016 At 8:30 am a doctor admitted the patient to the infirmary for decompensated cirrhosis, massive ascites and hypoxemia. There was no investigation to determine the cause of the hypoxemia except to order routine labs, and this remained undiagnosed. The doctor took no other history. The physical examination documented decreased breath sounds and massive ascites and 3-4+ peripheral edema. The only diagnoses were HTN and HCV yet the doctor's plan was to initiate Levaquin and antibiotic for unnamed reasons. The doctor ordered a CBC, CMP, and chest x-ray. The doctor failed to acknowledge the fever, which should have prompted admission to a hospital for possible sepsis. The doctor did not even take vital signs, but a nursing note at the same time documented temperature of 100.8, oxygen saturation 93% presumably on oxygen with BP 115/78. 1, 14 Care was grossly and flagrantly unacceptable. The patient should have been admitted to a hospital. The history and therapeutic plan were inadequate.
- 6/23/2016 Dr. Trost wrote a brief note documenting that the patient was still short of breath. The exam was very brief, noting decreased breath sounds and unchanged edema. There was no history, limited physical examination, no review of laboratory tests, no acknowledgement of fever the day before, and no assessment. The doctor increased the Aldactone but did not review labs or initiate any diagnostic work up for the patient's serious illness.
- 6/23/2016 Albumin 1.4; AST 63; ALT 24; bilirubin 2.4; hemoglobin 10.3; MCV 103.6; platelets 41.

Patient #23

- 6/24/2016 A late entry note for 7:00 am documented at 1:30 pm documented that the patient's respiratory rate was 28, BP 88/60, and oxygen saturation of 84% on 4 liters of oxygen. The nurse documented talking to Dr. Trost, who advised admission to a hospital. The patient wasn't transferred for 45 minutes.
- 6/24/2016 At 3:30 pm a nurse documented that the patient appeared "to be breathing [with] accessory muscles." This note appeared inaccurately dated as the patient was already hospitalized at this time and date.

Patient #24

- 9/11/2014 HTN chronic clinic; weight 160; BP 132/88; LDL 122. The patient was on lisinopril 10.
- 2/6/2015 Cholesterol 189; HDL 77; LDL 106.
- 3/9/2015 HTN chronic clinic; weight 178; BP 132/84; cholesterol 189; HDL 77; LDL 106.
- 4/17/2015 Hepatitis A, B, and C negative. CMP normal; cholesterol 152; HDL 57; LDL 90.
- 6/15/2015 Annual history evaluation; no risk factors identified. Was 46 years old. Vaccinations not updated.
- 8/14/2015 CMP normal.
- 10/16/2015 Varicella IgG antibody negative.
- 10/26/2015 The patient developed a generalized rash and was admitted to the infirmary with apparent varicella zoster. The patient had a temperature of 99.8.
- 10/27/2015 The patient had fever of 100.8.
- 10/30/2015 The patient was afebrile for 48 hours and discharged the patient to general population. The doctor noted that varicella titer was negative.
- 11/13/2015 A nurse saw the patient for symptoms of chicken pox. The patient had temperature of 99. The nurse noted no rash.
- 11/14/2015 A nurse saw the patient for symptoms of chicken pox. The patient had temperature of 98.8. The nurse noted no rash.
- 11/15/2015 A nurse saw the patient for symptoms of chicken pox. The patient had temperature of 98.6. The nurse noted no rash.
- 11/16/2015 A nurse saw the patient for symptoms of chicken pox. The patient had temperature of 98.6. The nurse noted no rash.

Patient #24

- 11/18/2015 A nurse saw the patient for symptoms of chicken pox. The patient had temperature of 98.8. The nurse noted no rash.
- 11/19/2015 A nurse saw the patient for symptoms of chicken pox. The patient had temperature of 98.8. The nurse noted no rash. The patient wasn't referred to a doctor.
- 11/20/2015 A nurse saw the patient for symptoms of chicken pox. The patient had temperature of 98.6. The nurse noted no rash.
- 11/21/2015 A nurse saw the patient for symptoms of chicken pox. The patient had temperature of 98.8. The nurse noted no rash. The patient was seen 11/22/15; 11/24/15; 11/25/15; 11/26/15; 11/27/15; 11/28/15; 11/29/15; 11/30/15.
- 2/24/2016 CMP normal; cholesterol 192; HDL 72; LDL 113.
- 3/9/2016 Chronic clinic for HTN. Cholesterol 192; HDL 72; LDL 113; BP 122/82.
- 9/6/2016 HTN chronic clinic; BP 118/82; recent LDL 123.
- 2/17/2017 Cholesterol 179; HDL 62; LDL 110.
- 5/12/2017 Cholesterol 194; HDL 63; LDL 121.
- 5/17/2017 A nurse saw the patient for abdominal pain. The pain was described as constant of 4-5 days duration. The nurse gave the patient ibuprofen by protocol with no referral.
- 5/22/2017 A nurse saw the patient for abdominal pain for the past week. The patient noticed no bleeding or black stool. The vitals were normal. The abdomen was soft. The nurse gave the patient antacids by protocol with no referral.

Patient #24

5/31/2017 The patient complained of abdominal pain which he said he had since 5/11/17. The pain felt like a knife. There was no bleeding. The blood pressure was 140/110 with a pulse of 76. This was an elevated BP for this patient who previously had normal blood pressures. The nurse noted that the abdomen was "rigid" around the umbilicus with guarding. The nurse documented no plan but apparently referred to a doctor.

5/31/2017 A doctor saw the patient. The doctor noted that the patient had an umbilical hernia. The doctor wrote "It is small. He won't let me touch it or push it back in." There was no other history or examination. The doctor gave the patient Tylenol for six months with no other intervention.

6/19/2017 Annual history evaluation; no risk factors identified. Was 46 years old. Vaccinations not updated.

6/19/2017 HTH chronic clinic; BP 120/72; weight 176.

6/30/2017 At 8:00 am an LPN wrote a note stating that her supervisor directed her to examine the inmate because the family was calling concerned that the inmate needed to see the Medical Director. The nurse wrote that the inmate had been seen multiple times in nurse sick call and refused part of the physician's examination. The nurse assessment was "risk for dehydration" and noted that the patient already had an appointment for 7/6/17. The nurse assessment utilized a diarrhea protocol. The inmate complained of diarrhea 4-5 times daily with abdominal pain 8/10. The patient had lost his appetite. He weighed 176 pounds, which was his usual weight. The pulse was 95 and blood pressure 150/118. The abdomen appeared distended and rigid to the nurse.

3 A painful abdomen with the patient not allowing anyone to touch the abdomen needs to be evaluated. To give the patient six months of Tylenol without diagnostic evaluation (ultrasound or CT scan) and without follow up was inappropriate.

Patient #24

- 6/30/2017 At 4:45 pm a LPN noted that the patient was being transferred to Carbondale Memorial Hospital. There was no clinical note related to this communication. The patient remained hospitalized until 7/6/17.
- 7/5/2017 A CT scan showed peritoneal/omental masses extending into the umbilical hernia.
- 7/6/2017 A nurse documented that the patient returned from the hospital. The blood pressure was 168/100. The weight was documented as 177. The nurse did not document the hospital diagnosis but did document that the patient had a colonoscopy.
- 7/6/2017 A biopsy of a descending colonic polyp showed tubular adenoma with high grade features possibly with atypia.
- 7/7/2017 A doctor saw the patient and noted that the patient had biopsy and colonoscopy. Some of the note was illegible. The doctor admitted the patient to the infirmary and started hydralazine, Pepcid, and Zofran. On the infirmary admission note the doctor wrote also that the patient had a CT biopsy. Much of the note was illegible. The assessment appeared to state abdominal pathology but it was unclear.
- 7/8/2017 The blood pressure was 160/100. The nurse noted that the patient had an abdominal dressing. A band-aid was applied. Later that day at 4:00 pm the patient had blood pressure of 110/78 with temperature of 99.9.
- 7/9/2017 The patient asked the nurse for pain medication. The blood pressure was 140/88. The nurse noted that the patient had pain in the stomach area and that the patient had a large abdominal mass "R/O CA." Later that day the patient asked "when will I get to see a doctor?" The nurse assessed newly diagnosed cancer.

Patient #24

7/10/2017 A doctor saw the patient and wrote that the patient had slight abdominal pain. The doctor noted that the patient had abdominal carcinomatosis. There was no examination. The doctor noted that oncology appointment was recommended in collegial. The patient was discharged from the infirmary; the doctor stated that the final pathology report was pending. The patient was to follow up in doctor clinic. The nursing discharge note documented a blood pressure of 140/100 but it was unnoticed by the doctor. The doctor did not address pain medication. The doctor also did not summarize the hospital course or document what occurred in the hospital.

7/13/2017 A clerk documented that the patient was approved for oncology.

7/17/2017 A doctor wrote an admission to the infirmary for a chronic patient. The doctor noted that a CT scan showed peritoneal metastases but a needle biopsy showed no malignant tissue. The plan was a CEA, CA-19; CBC, CMP, and await the oncology consultation.

7/18/2017 A nurse documented on her note that the heart was irregular but took no action.

7/20/2017 A doctor wrote an extremely brief note. The entire note was "No pain abd carcinomatosis Had requested CA-19 CEA Awaiting onc consult."

7/21/2017 CEA 0.7 (<3); albumin 3.1; hemoglobin 11.6; CA-19 4 (0-37).

7/23/2017 The patient complained of abdominal pain 6/10. The nurse documented being given a phone order for Norco on a prn basis.

Patient #24

7/24/2017 The patient complained of stomach pain to a nurse. The inmate was afraid to take the pain medication because of constipation. The doctor did not evaluate the patient.

7/26/2017 The patient went for an oncology appointment.

7/26/2017 An oncologist saw the patient. The oncologist wrote that the patient was a poor historian and "no records that we have received from the prison is a 60 document was 2 pages of labs and four pages of handwritten physician documentation." The patient told the doctor he had cancer. The CT scans were unavailable to the oncologist. The patient had massive tense ascites. The oncologist stated that he would request the CT scans from the hospital and would try to get more records. A two week follow up was requested with more information.

11 Adequate information needed to be sent with the patient for his appointment.

7/27/2017 A doctor saw the patient and noted that there was no oncology report. The doctor noted that the CEA and CA-19 were negative. The doctor took no history of the patient and did not examine the patient. He noted that the patient had abdominal carcinomatosis "? no Path prognosis very poor, refer to Carbondale for repeat Bx.(initial Dx no tumor seen)."

11 Hospital records were unavailable and the doctor didn't know what occurred at the hospital. Follow up of oncology was not being done. They had recommended return if the patient decompensated, which had occurred.

7/30/2017 The patient told a nurse "I'm hurting" but the nurse took no further history.

8/1/2017 The patient told a nurse, "What do I need to do to get some help. I'm deteriorating." The nurse did not refer to a physician and a physician had not seen the patient for almost two weeks. The patient complained of stomach pain.

Patient #24

- 8/2/2017 A doctor wrote that the patient had abdominal carcinomatosis but that there was no pathological diagnosis. The needle biopsy done in Carbondale was not diagnostic and "have requested for repeat bx for path diagnosis abd remains distended tense with umbilical hernia." That was the entire note. There was no history from the patient and no updated laboratory or physical examination. 1, 2, 3 The doctor failed to take history, evaluate the patient, or make a plan consistent with the patient's pain. The patient had not been seen for a couple weeks and the doctor did not even evaluate the patient.
- 8/2/2017 The patient told the nurse he was "worn out." The nurse noted that his pain was unrelieved but that he didn't want his prn pain medication at this time.
- 8/4/2017 A nurse documented the patient saying, "You gotta help me. These pain pills don't work." The nurse noted severe pain despite Norco. A doctor was notified that the patient had a large abdomen that was tender to touch. The patient was sent to a hospital.
- 8/4/2017 A clerk documented that Dr. Siddiqui's referral for repeat CT guided biopsy was approved. A second referral for oncology follow up was approved as well.
- 8/8/2017 The patient was readmitted to the infirmary as a chronic patient. The doctor admission noted that the patient had a repeat needle biopsy and that CA-19 and CEA were negative. The patient was on hydrocodone 7.5 mg QID and Zofran. The doctor noted that the biopsy results were pending.
- 8/8/2017 A doctor noted receiving a call from the surgeon who told him that the biopsy needle may have hit a small bowel loop. The doctor noted an abdominal x-ray [ordered at Menard] showed no free air. The doctor noted that the patient had an oncology appointment in two days.

Patient #24

8/9/2017 The patient told a nurse that the pain medication wasn't helping and that he had trouble breathing. The nurse noted that she had difficulty listening to his lungs due to the patient making noise. The nurse called a doctor who ordered an additional dose of Norco.

19 The doctor should have evaluated the patient who stated he couldn't breathe.

8/9/2017 A doctor wrote that the patient still had abdominal pain and constipation. He ordered MS contin and Vicodin and Miralax.

1, 2, 3 The doctor did not apparently evaluate the patient and instituted a plan without evaluation of the patient. The patient's trouble breathing was not evaluated.

8/9/2017 A nurse wrote that the inmate was mumbling, was confused and unable to answer questions. The patient was sent to a hospital.

Patient #25

- 4/14/2017 The dentist saw the patient and documented referral for evaluation of radiolucency.
- 4/17/2017 A referral for evaluation of a radiolucency of the left jaw by a dentist. The dentist diagnosed dentigerous cyst r/o ameloblastic changes of the L mandible.
- 6/22/2017 Pathology reported Diffuse large B cell lymphoma with bone involvement 12 It took over two months to get a biopsy of an abnormal bony lesion.
- 6/27/2017 A referral form to oncology noting that a left mandibular cyst showed diffuse large B cell lymphoma with bone involvement.
- 6/29/2017 A scheduling clerk noted that Dr Siddiqui presented at collegial for oncology for a mandibular cyst. The referral was approved.
- 7/3/2017 A scheduling clerk noted that an appointment was scheduled with Illinois Oncology on 7/7/17.
- 7/7/2017 Part of an oncology note was present. The oncologist recommended CT scan chest, abdomen, pelvis, PET scan, MUGA.
- 7/13/2017 A scheduling clerk noted that Dr. Siddiqui referred the patient for bone scan, CT scan and MUGA scan. These were approved.
- 7/14/2017 A Wexford approval for a bone scan, MUGA scan, CT of neck, thorax, abdomen and pelvis.
- 7/25/2017 CT chest abdomen and pelvis showed no lymphoma.
- 7/31/2017 An US of the abdomen was not done due to lockdown.
- 8/4/2017 Wexford approved a referral to oncology.
- 8/8/2017 A MUGA scan showed uptake only in the mandible.
- 8/11/2017 An oncologist stated that he would start CHOP which would start on 8/18/17. The patient was to receive six cycles every three weeks of cyclophosphamide, doxorubicin, vincristine and prednisone. The regimen included use of pegfilgrastin after chemotherapy. 12 It took four months to start chemotherapy. This could have been more timely.

Patient #25

8/17/2017 A scheduling clerk noted that chemotherapy was approved for every three weeks.

8/18/2017 WBC 5.9; HGB 15.6; platelets 189.

8/25/2017 WBC 7.1; HGB 15.5; platelets 188; HCV undetectable.

8/31/2017 An untitled note documented that an oncologist ordered cipro for 10 days, Ativan, prednisone on days 1-5 of each 21 day cycle, and Compazine. The oncologist also ordered Rituxan every three weeks. The oncologist also ordered neulasta 6 mg after each CHOP treatment as directed and asked that the oncologist be notified if approved.

It appeared that the patient received chemotherapy on this day but we could not find all chemotherapy reports in the record.

9/1/2017 A NP wrote that Boswell was substituting Granix for Neulasta and ordered it daily for seven days every three weeks after "treatment," presumably chemotherapy for three months.

There was no evidence we could find in the record that the patient received Granix although it was on the MAR.

9/8/2017 A nurse wrote that the patient returned from chemotherapy. There was an order for ciprofloxacin.

8, 6, A doctor did not see the patient post chemotherapy and the white count post chemotherapy was not checked.

9/8/2017 WBC 0.4; HGB 13.2; platelets 69; and the ANC was 100 which was critical.

These labs were from the oncology office.

9/11/2017 A nurse evaluated the patient for abdominal pain post chemotherapy. The patient said he had bright red blood in his stool. The patient was apparently on Motrin. A nurse noted that the patient was unable to stand and had a distended abdomen which was hard and painful to touch on the left side.

9/11/2017 A nurse noted that the patient was brought to the HCU for abdominal pain and received a verbal order for an abdominal x-ray, a UA for culture, with orders for fiberlax and MOM with a PRN follow up.

9/21/2017 The patient returned from chemotherapy.

Patient #25

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| <p>10/3/2017 A doctor noted that the patient had NHL and was being treated with CHOP and the next chemotherapy was 10/12/17. There was no status update for the patient. The note was extremely brief. There was no physical examination. The doctor wrote "?CBC." The doctor noted that the patient was to start prednisone for five days. The doctor didn't review blood counts or the oncology report.</p> | <p>6, 1, 11 The doctor failed to review the history of what happened in oncology clinic and did not review the report. We could not find an oncology report for this date. The doctor failed to check the white count despite that this was critical as the patient was subject to neutropenia.</p> |
| <p>10/12/2017 The patient returned from a medical furlough.</p> | |
| <p>10/13/2017 A nurse documented that the patient returned from a medical furlough. The oncologist note documented that on 11/2 the patient was to receive Rituxan and neulasta.</p> | |
| <p>10/31/2017 The October MAR listed Granix but there was no evidence that it was administered.</p> | |
| <p>11/1/2017 A doctor noted that the patient was seen by oncology for chemotherapy. The doctor did not update the status of where in treatment the patient was.</p> | <p>6, 8 The doctor did not order or review CBC counts to ensure the patient wasn't neutropenic.</p> |
| <p>11/2/2017 A oncology order documented that the patient would return 11/22/17 for the next chemotherapy infusion.</p> | |
| <p>11/9/2017 The patient told a nurse he was concerned about adverse effects of prednisone.</p> | |
| <p>11/11/2017 A doctor saw the patient. The note was illegible but brief.</p> | |
| <p>11/21/2017 WBC 6.7; hemoglobin 10.4; platelets 221.</p> | |
| <p>11/22/2017 On return from chemotherapy the blood pressure was 86/56 and a nurse notified a doctor who sent the patient to a hospital.</p> | <p>This was a pre-chemotherapy CBC.</p> |

Patient #25

11/22/2017 The patient went to Chester Memorial Hosp for weakness, dizziness, and diaphoresis. The hospital note documented that the patient was on amlodipine, filgrastim 480 mcg, ibuprofen, metoprolol, prednisone, prochlorperazine and ondansetron. The WBC was 6; HGB 9.7; platelets 196. The patient was diagnosed with dehydration and sent back to Menard.

11/26/2017 A nurse saw the patient for nausea. The temperature was 101.6. The patient was too weak to stand. The nurse placed the patient "on the third floor."

11/28/2017 A doctor saw the patient and noted that the patient was on chemotherapy and had nausea and diarrhea which had resolved. The doctor assessed dehydration and ordered IV fluid and Levaquin. The patient had a 101 fever and a pulse of 113. Without an diagnostic effort the doctor ordered Levaquin. There was no diagnosis and it wasn't clear what the doctor was treating. The doctor did not order a white count or ensure that the patient was receiving gramix. The doctor ordered Levaquin daily for five days, stopped amlodipine and metoprolol, started IV saline and Zofran.

11/29/2017 A nurse noted that the patient had blood pressure 90/60 and temperature 98. The patient felt sick and had diarrhea.

1, 8 The patient had a fever to 101.6 which if present in a neutropenic patient constitutes a neutropenic fever. It was imperative for the doctor to take a history to identify any signs of infection and to obtain a stat CBC to determine if the patient was neutropenic. This error was grossly and flagrantly unacceptable.

8 The patient still had fever of 101. It was imperative to exclude neutropenia, which the doctor did not do. Care was grossly and flagrantly unacceptable.

Patient #25

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| <p>11/29/2017 At 8:00 am doctor wrote an infirmary admission note and noted that the BP was 90/60. The doctor noted that the patient had dehydration after developing nausea and vomiting after chemotherapy. The doctor noted that the blood pressure medication was discontinued.</p> | <p>8 Hypotension in the context of possible neutropenia can indicate infection, particularly if the patient is on prednisone, which this patient was taking. It was imperative for the doctor to order an immediate white count to ensure the patient wasn't neutropenic. Care was grossly and flagrantly unacceptable.</p> |
| <p>11/29/2017 At 9:00 am the patient said his ear hurt and the nurse notified the doctor. The nurse documented that there was drainage from the ear which was painful. The nurse admitted the patient to the infirmary. The temperature was 99.8 and pulse 102. This was not noted by a doctor. The doctor ordered a CBC and CMP.</p> | <p>16 The nurse should have notified the doctor even though the doctor had just seen the patient.</p> |
| <p>11/30/2017 A doctor noted that the patient had pus coming from the left ear and changed the Levaquin to IV, but since Levaquin was unavailable, he started Rocephin. The diagnosis was Otitis externa.</p> | <p>8, 14 The doctor should have obtained an immediate CBC to ensure that the patient was not neutropenic or send the patient to a hospital.</p> |
| <p>12/1/2017 A doctor noted that there was still pus from the ear and did not change therapy.</p> | <p>8, 14 The doctor should have obtained an immediate CBC to ensure that the patient was not neutropenic or send the patient to a hospital.</p> |
| <p>12/3/2017 A NP saw the patient who was found unresponsive with blood on his mouth, and blood draining from his penis. The NP sent the patient to a hospital. The patient had fever of 101.2, BP 96/60; pulse 120, respirations as high as 42.</p> | |

Patient #26

- 8/26/2008 Cholesterol 158; HDL 47; LDL 99; ACA 10-year risk 7.1 % and no indication for a statin.
- 9/3/2008 An NRC reception physical examination documented no medical problems except alcohol use.
- 9/3/2008 The patient was transferred to Menard.
- 1/27/2010 Cholesterol 158; HDL 47; LDL 99; ACA 10-year risk 7.1 % and no indication for a statin.
- 2/24/2010 A doctor saw the patient and noted that the patient passed out and fell but said, "I was informed that I was hit in the face by a guard." The doctor ordered a facial x-ray that showed no fractures or dislocations. The doctor ordered ibuprofen for pain. The doctor apparently presumed that the patient sustained blunt trauma and did not pass out. No other diagnostic studies were performed (EKG, Holter monitor, glucose).
- 3/13/2012 Total cholesterol 134; HDL 29; LDL 96.
- 3/13/2012 Cholesterol 134; HDL 29; LDL 96; ACA 10-year risk 7.6% and indication for moderate to high intensity statin.
- 1/27/2014 Cholesterol 144; HDL 40; LDL 95.
- 1/27/2014 Cholesterol 144; HDL 40; LDL 95. ACA 10-year risk 9.2% and moderate to high intensity statin indicated.
- 12/31/2014 Dr. Trost wrote that the "I/M [without] S/S of chickenpox. P. RTC prn." It wasn't clear what this meant as there was no history or physical examination.
- 12/14/2015 Albumin 3; cholesterol 168; HDL 42; LDL 117.
- 12/14/2015 Cholesterol 168; HDL 42; LDL 117; ACA 10-year risk 10.8% and indication for moderate to high intensity statin
- 7, 8 The patient passed out and should have had an EKG and glucose test. The doctor should have considered a Holter monitor.
- 17 Since 2012 the patient had a 10-year risk of heart disease of at least 7.5% and should have been offered statin therapy to reduce cardiovascular risk.

Patient #26

- 1/23/2016 The patient had biannual examinations in 2010; 2012; 2014; and on this date in 2016. At each of these the patient was not offered standard colorectal screening. The patient did refuse a digital rectal exam which apparently was being offered as colorectal screening. The patient was above 50 years old at each of these examinations and the patient was 67 years old at this examination.
- 3/20/2017 A doctor wrote that the patient was short of breath. There was no other history. The doctor wrote "vitals questionable. Patient very pale, hands cold." That was the entire examination. The vitals were not documented except a oxygen saturation of 97% and a number 199 which was unintelligible. The assessment was "anemia" and the doctor ordered a CBC and CMP stat. In a later note the doctor noted that the labs "are within an acceptable limit. However patient gets extremely fatigued with any type of physical exertion." The assessment was shortness of breath. The doctor ordered a chest x-ray and abdomen x-ray and UA.
- 3/21/2017 The problem list documented heart failure and atrial fibrillation. No other problems were listed on the problem list.
- 3/21/2017 A NP noted that the patient was an add on to clinic. The NP documented that the chest x-ray showed "?pneumonia." The BP was 152/100 and respiratory rate 38-40 with a temperature of 96.2. The NP ordered a stat EKG.
- 7, 17 The patient was not offered colorectal screening consistent with contemporary guidelines and was not offered a statin medication.

Patient #26

3/21/2017 An EKG showed atrial fibrillation with a rate of 91. A chest x-ray showed moderate sized pleural effusion right with a smaller pleural effusion left. Patchy opacities are seen perihilar regions suggesting heart failure or pneumonia.

3/21/2017 The patient was admitted to Memorial Hospital in Chester IL, a 25-bed hospital. The evaluation in the ER was that the patient had an irregular heart rate with 2+ pitting edema and bilateral trochanteric ulcers worse on the right. The BUN was 25; CK MB was 7.3 (1-7); troponin <0.01; albumin 2.7; hemoglobin 13.7; WBC 6.4; INR 1.31; an EKG showed atrial fibrillation with a ventricular rate of 93; bilateral pleural effusions, cardiomegaly, bibasilar infiltrates and heart failure. The hospital note documented consulting with a primary care provider and the NP at Menard who sent the patient, and the NP agreed to accept the patient back to the facility. The patient was in heart failure with new onset atrial fibrillation and the patient should have been sent to a regional center for management, as it was not safe to accept the patient back at the facility. The only diagnostic testing done was a chest x-ray that showed "large bilateral pleural effusions and there is mild to moderate bilateral compression atelectasis caused by the effusions." There was a 14 mm hypodense nodule in the thyroid gland and there was a prominent suprahilar node. The heart was enlarged. Pneumonia couldn't be excluded.

14 The NP accepted a patient back to the prison when it was not safe to do so. The patient had pneumonia, pleural effusions, heart failure, and new onset atrial fibrillation.

Patient #26

3/21/2017 A NP admitted the patient to the infirmary for dyspnea and anemia. The examination only noted that the patient was pale, dyspneic, without breath sounds on the right. The NP noted that the patient was sent to a hospital in the morning and had a diagnosis of atrial fibrillation, heart failure, and decubitus ulcer. The NP noted that the patient was on Eliquis, lisinopril, and Lasix. The NP ordered a CXR, CBC, CMP, HIV, hep C, RPR, Hep panel, FLP, AFT, sed rate, CRP, magnesium, TSH, B121 and referral for cardiology, and CT of abdomen. The pulse was 108; respirations 16; and BP 130/82. The NP did not discuss the EKG or perform another EKG.

3/21/2017 A NP referred the patient to a cardiology consultation for A fibrillation. The NP also referred the patient for a CT of the chest and abdomen because the patient appeared thin.

3/22/2017 A nurse noted that the patient was incontinent of stool. The patient had a respiratory rate of 30 with blood pressure of 86/60 with 2 + pitting edema and was short of breath with exertion. The patient was sent to a hospital.

3/22/2017 AFP 0.9 (<9); CRP 0.6 (0-8); cholesterol 127; HDL 36; LDL 84; magnesium 1.5 (1.8-2.4); TSH 4.12 (0.35-4); sedimentation rate 68 (0-10); HIV negative; syphilis non reactive.

3/22/2017 Cholesterol 127; HDL 36; LDL 84. The ACA 10-year risk was 13.1% and indication for moderate to high intensity statin.

Patient #26

3/23/2017 The patient was hospitalized at Memorial Hospital in Carbondale, a 125-bed facility. The patient had an NSTEMI and had systolic heart failure with renal failure and low albumin and required bowel resection with colostomy for ischemic bowel. The surgery included partial colectomy with colostomy, splenectomy, and construction of a stoma. The patient developed sepsis due to aspiration pneumonia. A venous Doppler was done showing no evidence of a deep vein thrombosis. The patient had MGUS. The bone was negative for lytic lesions and the urine was sent for electrophoresis. A chest x-ray showed a slight improvement in both lung bases with mild decrease in the infiltrates. There was mild cardiomegaly and perihilar markings were still prominent. Pneumonia could not be excluded. Based on hospital records, it appears that the ischemic bowel was identified on 3/28/17 after developing GI bleeding on 3/26/17. It is uncertain when the ischemic bowel started. The ischemia was in the rectosigmoid area.

3/28/2017 Wexford UM denied the cardiology consultation and CT chest and abdomen because the patient was currently in the hospital.

4/18/2017 The Wexford Regional Medical Director wrote a note that the patient was in preparation for hospital discharge. The doctor wrote a list of medications that the patient was on, including lisinopril, pantoprazole, Lasix, Eliquis, docusate, MS , ondansetron, lorazepam, and hold scopolamine patch.

Patient #26

- 4/19/2017 The patient was admitted to the infirmary from the hospital for comfort care. The admitting diagnoses were ischemic colitis, atrial fibrillation, acute renal failure and a comment "*see additional list." The orders were for oxygen, condom catheter, turn the patient every two hours, follow up with Dr. Gonzales in 1-2 weeks, keep the incision clean and dry and colostomy care.
- 4/19/2017 An undated note a nurse wrote a discharge note. This was immediately after the admission note on 4/19/17. The note had no vital. The discharge summary was s/p hospital stay ischemia colitis, ARF, CHF. The objective note was "I/M discharged dlt death." The discharge location was "funeral home." This note appears to have been written before the inmate died.
- 4/20/2017 A nurse entered his room at 3:55 am to find the patient unresponsive.

Patient #27

2/4/2005 EKG showed moderate voltage criteria for LVH and infarct age indeterminate

1/24/2011 On this annual physical examination the blood pressure was 130/80.

1/31/2014 Amlodipine 10, carvedilol 50 BID, HCTZ 50, losartan 50 BID, spironolactone 50 daily, terazosin 7 mg.

2/12/2014 Potassium 3.7 (3.5-5.3); cholesterol 165; HDL 34; LDL 110.

2/31/14 Amlodipine 10, carvedilol 50 BID, HCTZ 50, losartan 50 BID, spironolactone 50 daily, terazosin 7 mg.

3/5/2014 HTN chronic clinic BP 210/140. The doctor noted shortness of breath which the patient attributed to anxiety. The doctor did not check for end-organ damage despite the significantly elevated blood pressure. The doctor added Cozaar to Norvasc, Aldactone, and Coreg and stopped HCTZ and Hytrin. The doctor referred to psychiatry. The doctor did not order follow up to ensure that the blood pressure returned to a reasonable level.

1, 2, 8, 12, 15 The blood pressure was significantly elevated The doctor did not evaluate for encephalopathy or renal damage. Although the doctor made a change in therapy, the doctor did order a timely follow up for this degree of hypertension and did not ensure that the patient's blood pressure was lowered to a safe level. The doctor took no history of compliance. The patient was on five antihypertensive medications with extremely high blood pressure. The patient should have been sent for evaluation of secondary hypertension to a specialist.

3/18/2014 A doctor saw the patient. The blood pressure was 180/110. The doctor did not examine the retina, or check for renal damage. The doctor discontinued Norvasc and documented that the patient was on nifedipine 120, Aldactone 100, HCTZ 50, carvedilol 50BID, Cozaar 50 BID, minoxidil 2.5 mg daily, and Hytrin 10 mg daily. The nifedipine and minoxidil appeared to be added to the regimen but the doctor didn't reflect this in his note.

3/27/2014 A nurse saw the patient and noted that the patient complained of his heart skipping beats.

Patient #27

3/27/2014 The patient complained to a nurse that his blood pressure of 234/140 was related to anxiety. A doctor saw the patient but didn't document a change in therapy.

3/31/2014 Carvedilol 50 BID, losartan 50 BID, Aldactone 100, HCTZ 50, BID, minoxidil 7.5 daily, Hytrin 10 Q day.

4/22/2014 A doctor increased minoxidil but took no history and no physical exam.

4/22/2014 The patient told a nurse that his blood pressure of 210/140 was related to stress.

4/23/2014 Dr. Trost wrote an extremely brief note and referred the patient to on outside hypertension clinic. The blood pressure was 170/104.

4/24/2014 Dr. Trost noted that at collegial he was to give all meds DOT.

4/28/2014 Wexford denied referral to an outside hypertension clinic based on "insufficient information." A recommendation for DOT was made and to represent if needed.

5/3/2014 The inmate complained about getting DOT medication.

5/18/2014 Calcium 7.9; sodium 136; potassium 4.6. No LFTs done.

5/22/2014 Wexford denied a visit to HTN clinic asking that medication be DOT and to represent in a few weeks if needed. The reason for denial was insufficient information. This was appealed and apparently approved on this date.

5/31/2014 Carvedilol 50 BID, losartan 50 BID, Aldactone 100, HCTZ 50, Cozaar 50 BID, minoxidil 7.5 daily, Hytrin 10 Q day, Nifedipine 120 daily.

6/4/2014 Potassium 3.1; BUN 5.

15 The blood pressure was significantly elevated. The doctor did not ensure that the blood pressure was lowered to a safe level. The doctor did not evaluate for end organ damage and did not schedule the patient for follow up in a few days to ensure that the patient was safe. The doctor took no history of compliance.

16 The patient should have been referred to a doctor due to the extremely elevated blood pressure.

12 This patient had clear indication for evaluation for secondary hypertension and should have been approved for that.

Patient #27

6/15/2014 The inmate refused medication, not wanting to take DOT medication.

6/25/2014 Dr. Trost documented that the patient would review medication if not DOT. The doctor noted BP 220/120, resumed KOP meds and referred the patient to an outside HTN clinic.

6/30/2014 Carvedilol 50 BID, losartan 50 BID, Aldactone 100, HCTZ 50, BID, minoxidil 7.5 daily, Hytrin 10 Q day, Nifedipine 120 daily.

7/10/2014 An NP saw the patient for HTN chronic clinic. The BP was 226/142. The NP took little history and noted that the patient was scheduled to see a hypertension specialist. The patient refused to take Norvasc so the NP made no changes and referred to Dr. Trost. A statin should have been started but was not. Medication compliance was not discussed.

7/16/2014 Dr. Trost noted that the patient was taking BP medication. The BP was 230/126. There was no history or physical examination. The plan was to refer to HTN clinic consultant.

6, 17 The doctor did not note the prior low potassium. Low potassium in the context of difficult to control blood pressure should lead to an evaluation for secondary hypertension. Medication should have been adjusted. Because of the extremely high blood pressure the doctor should have scheduled follow up in a few days to assess whether it returned to normal.

1, 2, 3, 8, 12, 15, 17 The 10-year risk of heart disease was 29% and a statin should have been started. The patient had hypertensive urgency and should have been assessed for end-organ damage and monitored in the clinic until the blood pressure returned to a lower level or a couple day follow up was indicated. Modification of blood pressure regimen was indicated. The patient should have been referred for evaluation of secondary hypertension.

1, 2, 8, 12, 15 Given the blood pressure the consultant visit should have been sooner. The patient had hypertensive urgency and apparently was taking medication yet the doctor did not add medication or monitor the patient until the blood pressure returned to a lower level. The doctor ordered no follow up to ensure that the blood pressure returned to a lower level. The doctor did not take history or perform examination to exclude end-organ damage.

Patient #27

7/31/2014 Carvedilol 50 BID, losartan 50 BID, Aldactone 100, minoxidil 7.5 daily, HCTZ 50, spironolactone, Terazosin 10.

8/27/2014 The patient went to an outside HTN consultant at Barnes Hospital.

8/27/2014 The patient went to Barnes Hospital HTN clinic. The doctor had no labs available. The doctor documented that the patient stated that he was anxious. The BP was 212/147. The doctor noted that the patient wasn't currently taking medication. The doctor recommended that the patient start back on HCTZ, spironolactone, and to add other medications back slowly. The doctor said she would try to call to discuss.

11 The labs were not sent with the patient specifically the low serum potassium was not known to the consultant.

8/30/2014 A doctor saw the patient after the Barnes consultant visit. The blood pressure was 208/156. The doctor noted that the patient had anxiety problems and that the consultant would speak with Dr. Trost but that there were no notes about these communications in the chart. The doctor referred the patient to psychiatry to evaluate his anxiety. The doctor did not evaluate for end-organ damage by history or physical examination. The doctor did not adjust blood pressure medication or ensure that a follow up was ordered to ensure that the blood pressure safely was reduced.

1, 2, 3, 8, 10, 13, 15 The doctor did not document review or did not talk to the consultant about care. Referral to psychiatry was a questionable strategy. The patient had hypertensive urgency yet the doctor did not evaluate for end-organ damage or ensure that the blood pressure was reduced to a safer level. The doctor should have added blood pressure medication and assessed for compliance.

8/31/2014 Carvedilol 50 BID, HCTZ 50, Losartan 50 BID, Minoxidil 7.5 mg daily, Aldactone 50.

9/12/2014 A NP documented that the patient was only taking Aldactone and HCTZ. The NP took no action and blood pressure wasn't taken.

9/17/2014 A NP noted the BP was 204/104. The NP did not assess for end-organ damage or ensure that the blood pressure was lowered before discharging the patient. The NP consulted the Medical Director but no action was taken. Compliance was not checked.

1, 2, 3, 8 15 the NP should have checked compliance, evaluated for end-organ damage, and scheduled a follow up to ensure blood pressure was coming down.

Patient #27

- 9/20/2014 A doctor noted the patient would refuse all medication until something was found that works. The BP was 210/124. The doctor referred the patient to Dr. Trost. The doctor stopped all treatment.
- 9/30/2014 HCTZ 50, Aldactone 100, Hytrin 10 mg, minoxidil 7.5, Cozaar 50 BID, carvedilol 50 BID.
- 10/1/2014 Potassium 4.1.
- 10/11/2014 A psychiatrist documented the patient saying he didn't need to see a psychiatrist and felt fine. The psychiatrist documented no follow up.
- 10/22/2014 A doctor saw the patient for elevated BP 178/124. The doctor noted that the patient needed to see a psychiatrist for his anxiety. The doctor assessed anxiety reaction.
- 10/22/2014 A provider saw the patient for HTN clinic. The BP was 178/124. No history was taken. The doctor documented referral to psychiatry and made no changes to medication. Medication compliance was not discussed.
- 11/1/2014 A MAR documented that the patient was on Remeron at night, which he remained on although the patient mostly refused this medication.
- 12/10/2014 Potassium 3.5 (3.5-5.3); BUN 6; creatinine 1.07; cholesterol 178; HDL 32; LDL 119.
- 1, 2, 3, 8, 15 The patient had hypertensive urgency but the doctor took no history and performed no examination to exclude end-organ damage. The doctor did not ensure follow up would occur to safely follow up on this patient with extremely elevated blood pressure. Probably, the patient should have been placed on the infirmary.
- The medication renewal process didn't work and the patient's medication stopped in mid December and wasn't started again until 1/8/17, about 3-4 weeks later.
- 13
- 1, 2, 3, 8, 12, 17 The doctor failed to assess for end organ damage in a patient with hypertensive urgency. The doctor did not assess for compliance. The 10-year risk of heart disease was 24% and a moderate to high intensity statin should have been started. The BP meds should have been adjusted as the blood pressure was elevated. This patient should have been referred for evaluation of secondary hypertension.

Patient #27

1/20/2015 On this annual physical examination the blood pressure was 130/88.

2/4/2015 Dr. Trost sent the patient to a hospital for "exercise intolerance and PND." He documented that the EKG showed SVT for which there was no evidence.

2/4/2015 An EKG showed st flattening but sinus rhythm with rate of about 100.

2/4/2015 Potassium 3.7; cholesterol 180; HDL 36; LDL 117 urinary glucose 300; serum glucose 110.

2/4/2015 EKG showed possible LAE and LAD.

2/4/2015 EKG showed sinus rhythm with PVCs; LAD and voltage criteria for LVH.

2/5/2015 The patient returned from Carbondale Hospital.

2/5/2015 A discharge instruction sheet from the hospital recommended an appointment for cardiology and nephrology in two weeks but a written comment on this document states that "no F/U request per Trost."

17 The 10-year risk of heart disease or stroke was 15% and the patient should have been started on a moderate to high intensity statin.

2 The doctor misdiagnosed an EKG tracing.

Hospital records were unavailable and the doctor didn't know what occurred at the hospital. Follow up of oncology was not being done. They had recommended return if the patient decompensated, which had occurred.

Patient #27

2/5/2015 A hospital note documented an elevated glucose of 115 and 120; potassium of 3.1; elevated troponins. The patient felt short of breath and had similar episodes but there was never a work up according to the hospital chief complaint. There was no chest pain. The patient was a former smoker. The patient described stopping anti-hypertension medication because they were not helping him. The discharge summary documented diagnoses of hypertensive urgency with mild troponinemia due to hypertensive urgency and episodes of shortness of breath due to HTN, hypokalemia, and resistant hypertension with hypokalemia concerning for hyperaldosteronism. Labs were sent out. An echocardiogram showed concentric hypertrophy and thickened LV wall. A follow up with nephrology to rule out hyperaldosteronism was recommended. The aldosterone was in normal range but the patient was on Remeron, though mostly refusing it. The renin was normal. The normetanephrine was elevated to 1.13 but not over 2 x normal (0-0.89). In the hospital the cholesterol was 148; HDL 23 and LDL 96.

2/5/2015 EKG showed possible LAE and nonspecific STT changes.

2/6/2015 Dr. Trost saw the patient post hospital return and sent the patient back to his cellhouse but failed to make referrals to cardiology and nephrology as recommended and did not make note of the hypokalemia or elevated metanepherines.

3/5/2015 A doctor saw the patient in hypertension clinic and the blood pressure was 200/140. The doctor presumed that the blood pressure elevation was due to anxiety and referred the patient to a psychiatrist. The doctor stopped HCTZ and Hytrin but started Cozaar.

10 The doctor failed to review the hospital notes failing to note the recommendation to refer to nephrology to rule out hyperaldosteronism and to cardiology.

Patient #27

- 3/6/2015 A doctor saw the patient for his elevated BP of 170/108. The doctor mentioned that Carbondale hospitalists recommended referral to cardiology and nephrology in two weeks and that Dr. Trost made no referral. However the doctor took no action.
- 3/7/2015 A psychiatrist documented that the patient was a no show to clinic and rescheduled the patient.
- 3/8/2015 The KCL supplement was discontinued.
- 3/16/2015 A doctor saw the patient for HTN clinic. BP was 190/128. The cholesterol was documented as 180, HDL 36, and LDL 117, but a statin was not started despite a 27% 10-year risk of cardiovascular disease. The doctor checked the retina but did not evaluate for other potential end-organ damage. The doctor referred to Dr. Trost. The doctor noted that the hospital recommended referral to nephrology and cardiology but that this didn't happen. Medication compliance was not addressed.
- 10 The doctor decided not to refer as recommended to a nephrologist and cardiologist.
- 1, 2, 3, The doctor did not assess for end-organ damage except
8, 10, 17 for a retinal examination. The patient's blood pressure medication should have been adjusted. The doctor did not assess for compliance. The doctor should have ensured that the blood pressure was lower prior to discharge from the clinic or admitted the patient to the infirmary. The patient should have been started on a statin. The doctor should have documented why the referrals to cardiology and nephrology were not done.
- 3/31/2015 Benicar 40 daily, diltiazem 180, hydralazine 75 TID, isordil, metoprolol 25 BID, KCL, spironolactone 25 daily.
- 4/16/2015 An EKG showed rate of 68 with nonspecific STT changes.
- 4/31/15 Aspirin, diltiazem 180 daily, hydralazine 75 TID, isordil, metoprolol 25 BID, spironolactone 25 daily. The Benicar was stopped.
- 5/31/2015 Aspirin, diltiazem 180, hydralazine 75 TID, isordil, metoprolol 25 BID, spironolactone 25 daily.
- 6/31/15 Aspirin, diltiazem 180, hydralazine 75 TID, isordil, metoprolol 25 BID, spironolactone 25 daily.
- 7/1/2015 The Remeron appears to have stopped.
- 7/13/2015 The patient wrote a note to health care on a piece of paper saying he might have a bronchial infection with "shortness of breath attacks."

Patient #27

- 7/14/2015 A doctor saw the patient and noted that the patient was short of breath. BP 190/118 but oxygen saturation 94%. The doctor wanted to rule out heart failure and ordered an EKG, chest x-ray CMP and BNP but these were not done stat and a week follow up was ordered. The patient wasn't seen in a week and wasn't evaluated until a NP saw the patient apparently on 10/9/15.
- 7/14/2015 Potassium 3.3; glucose 114; BNP 13 (<100).
- 7/31/2015 Hemoglobin A1c 7.3.
- 7/31/2015 Aspirin, diltiazem 180, isordil, hydralazine 75 TID, metoprolol 25 BID, spironolactone 25.
- 8/24/2015 Potassium 3 (3.5-5.3); glucose 139.
- 8/31/2015 Aspirin, diltiazem 180, hydralazine 75 TID, isordil, metoprolol 25 BID, spironolactone 25 daily.
- 9/20/2015 The patient wasn't seen in cardiac clinic because of the doctor coming in late.
- 9/30/2015 Aspirin, diltiazem 180, hydralazine 75 TID, isordil, metoprolol 25 BID, spironolactone 25 daily.
- 10/9/2015 An NP saw the patient for shortness of breath. BP was 220/120 and pulse 87. The NP noted a potassium of 3. The NP ordered an EKG which showed nonspecific STT changes and PVCs. A chest x-ray was not done. The retina weren't checked. The patient had no edema.
- 10/9/2015 An EKG showed nonspecific STT changes with PVCs.
- 10/9/2015 Potassium 3.2; glucose 169.
- 1, 2, 3, 8, 10, 14, 15 The doctor did not evaluate for end-organ damage or appropriately manage hypertensive urgency. The patient should have had stat testing and been placed on the infirmary. The patient appeared lost to follow up for 3 months and ordered tests weren't done. The doctor failed to modify blood pressure medication.
- 6 A provider signed this lab as reviewed on 8/5/15 but took no action. The lab result indicated that the patient had diabetes but the patient was never treated for this.
- 1, 2, 3, 6, 8, 15 The blood pressure indicated hypertensive urgency. Even though the patient had shortness of breath, the NP did not evaluate thoroughly for heart failure. No other end-organ evaluations occurred. The NP did not monitor the patient until the BP improved and did not house the patient on the infirmary. the NP did not adjust medication. noted the low potassium but took no action. The NP failed to note an A1c of 7.3 indicating diabetes which was therefore untreated.

Patient #27

10/19/2015 Cardiac chronic clinic was cancelled because the MD was not in.

10/23/2015 Blood pressure was 164/88. A doctor noted that the patient had anxiety and referred the patient to mental health. The doctor noted that a chest x-ray was negative and the A1c was now 7.3. The doctor took no action on the elevated A1c. This was the same doctor who saw the patient on 7/14/15 but was following up three months late.

10/25/2015 A doctor referred the patient to cardiology.

10/25/2015 A provider saw the patient in HTN clinic. BP 200/130. The doctor took no history but wrote that cardiology needs to follow the patient and referred to cardiology and increased metoprolol and added diltiazem. Medication compliance was not addressed.

10/31/2015 Aspirin, diltiazem 360, Lopressor 50 BID (10/25), hydralazine 75 TID, isordil, spironolactone 25. Diltiazem was increased.

11/30/2015 Aspirin, diltiazem 360, Lopressor 50 BID (10/25), hydralazine 75 TID, isordil, spironolactone 25.

12/30/2015 Aspirin, diltiazem 360, Lopressor 50 BID (10/25), hydralazine 75 TID, isordil, spironolactone 25.

1/6/2016 Dr. Trost saw the patient in HTN chronic care. There was no history. The BP was 140/100. No change to therapy was made. The patient was not on a statin.

3, 6 The doctor failed to note the low potassium which suggested secondary hypertension. The patient had diabetes and the doctor took no action to treat which is inappropriate.

12 The diltiazem increased to 360 daily, the referral to cardiology never occurred.

1, 2, 17 The doctor took no history, did not make an adequate assessment, as he failed to diagnose or treat diabetes, failed to note the low potassium which can be associated with hyperaldosteronism, and failed to start a statin despite a high 10-year risk of heart disease.

Patient #27

- 1/28/2016 A doctor noted that the BP was 212/140. The patient refused observation housing. The doctor referred to Dr. Trost, the Medical Director. The patient refused clonidine. The doctor increased the hydralazine to 100 TID and Lopressor to 150 BID. The doctor noted that the A1c was 7.3 but took no action. The doctor did not assess the patient for end-organ damage but did try to place the patient on protected housing.
- 1/31/2016 Aspirin, diltiazem 360, hydralazine 100 TID, Lopressor 150 BID (1/28/16); Aldactone 25.
- 2/24/2016 Potassium 3.1; glucose 97; cholesterol 174; HDL 32; LDL cholesterol.
- 2/28/2016 Aspirin, diltiazem 360, hydralazine 100 TID, Lopressor 150 BID spironolactone.
- 3/9/2016 An NP saw the patient in HTN clinic. The retina was not examined. The patient was not assessed for end-organ damage with labs. BP was 201/110. The NP added Maxide but stopped hydralazine. The potassium was noted to be 3.1 but no action was taken. The cholesterol was 174; HDL 32 and LDL 120, yielding a 49% 10-year risk of heart disease and stroke. Apparently the patient was compliant with medication as the medication compliance box was checked.
- 3/9/2016 Maxide was started despite hypokalemia. There was no potassium supplement.
- 1, 2, 6, 8, 17 The doctor failed to assess for end-organ damage by history, physical examination or lab testing. The doctor noted a hemoglobin A1c of 7.3 but did not treat the patient for diabetes.
- 1, 2, 6, 3, 12, 15,17 The therapeutic plan was inappropriate. The patient had a low potassium and in the context of difficult to control hypertension, hyperaldosteronism should have been ruled out. The patient should have been referred to a nephrologist for better blood pressure control and for possible hyperaldosteronism, and the patient should have been on a high intensity statin because of high risk for heart disease. Also, the patient had diabetes which was unrecognized and untreated. The NP failed to evaluate for end-organ damage despite hypertensive urgency. The NP failed to ensure that the blood pressure came down before leaving clinic, did not admit to the infirmary or ensure the patient had follow up. Starting maxide in a person with hypokalemia without adding potassium supplement was an error also.

Patient #27

- 3/29/2016 A nurse saw the patient for an episode of shortness of breath that resolved. BP 240/140. The nurse called Dr. Trost, who took no action.
- 3/31/2016 The MAR showed that the patient was on aspirin, diltiazem 360 ER daily, isosorbide, spironolactone 25 daily (stopped in March), Maxide 75/50, metoprolol 25 BID,
- 4/29/2016 An NP saw the patient for BP 260/130. The NP gave a couple stat doses of clonidine, increased metoprolol, and documented consulting with Dr. Trost. The blood pressure came down to 170/118, but the NP should have ensured the blood pressure came down further before discharge. The NP did not assess for end-organ damage except to note that the patient had no headache. An elective EKG was ordered. A two week follow up was ordered, although this interval should have been less due to the degree of elevation of the blood pressure.
- 5/25/2016 A NP noted BP 230/110 and wrote "cardiologist visit before that has not helped." The NP started clonidine 0.1 BID which the inmate subsequently refused. The NP took an appropriate history for end-organ damage but ordered no tests, (renal function). The NP ordered an EKG but did not review. The NP should have placed the patient on the infirmary. The follow up in a week was insufficient given a blood pressure of 230/110.
- 5/31/2016 The patient was on 180 Diltiazem daily, isordil, metoprolol 50 BID, Maxide 75/50, started clonidine 0.1 BID 4/26.
- 6/1/2016 The patient refused to take clonidine and a nurse referred him to a physician clinic.
- 6/2/2016 An EKG showed marked sinus arrhythmia with probable old inf wall infarct.
- 3 The doctor should have adjusted medication.
- 1,2,3, 8, 15, The NP did not evaluate for end organ damage or ensure that blood pressure was reduced to a reasonable level before discharge or did not admit to the infirmary. The NP did not order timely follow up given his blood pressure level. He should have been admitted to the infirmary.
- 8, 15
- Hydralazine was stopped.

Patient #27

- 6/3/2016 An NP documented that the BP was 150/100. The NP wanted to give the patient stat clonidine but he refused. A two week follow up with Dr. Trost was ordered. The NP ordered a GFR and TSH.
- 6/6/2016 A nurse obtained blood pressure of 220/110 but did not consult a provider. 16 The nurse should have consulted a doctor
- 6/7/2016 The BP was 200/100 but the nurse did not consult a physician 16 The nurse should have consulted a doctor.
- 6/10/2016 A nurse documented BP 200/100 but did not consult a physician 16 The nurse should have consulted a doctor.
- 6/10/2016 Creatinine 1.24.
- 6/12/2016 A nurse documented that the patient was refusing medication. This was later documented as clonidine.
- 6/14/2016 An NP noted the BP was 170/100 The NP reviewed the MAR and noted that the inmate was refusing only clonidine because it was DOT.
- 6/16/2016 An NP documented that BP was 234/138. The NP noted that he refused clonidine, so she increased the metoprolol. The NP documented that the inmate refused infirmary admission. The history and lack of testing was inadequate for evaluation of end-organ damage. 1, 2, 3, 8, The NP should have evaluated for end-organ damage (renal function, EKG, better history and examination of retina).
- 6/21/2016 Dr. Trost note stated in its entirety "BP same as always." The BP was 220/120. He ordered a "prn" follow up. 1, 2, 3, 8, 13, This was indifferent care. The doctor did not evaluate for end-organ damage. The blood pressure needed control and the doctor should have referred to a higher level consultant to manage the patient. The doctor failed to rule out hyperaldosteronism and failed to discuss the degree of noncompliance and its possible impact on blood pressure control.
- 6/31/16 Aspirin, diltiazem 180, metoprolol 50 BID increased to 100 Bid on 6/16, Maxide 75/50, clonidine stopped 6/16/16, Aldactone 50 BID started 6/16.

Patient #27

7/30/2016 Aspirin, clonidine 0.1 BID, diltiazem 180 daily, metoprolol 100 BID, Maxide 75/50, Aldactone 50 BID.

8/12/2016 Potassium 3.3; glucose 96.

8/30/2016 Maxide, aspirin, diltiazem 180 , metoprolol 100 BID, spironolactone 50 BID.

10/3/2016 Officers brought the patient to nursing sick call for a low bunk gallery because the patient was unsteady and was almost falling off his bunk. The BP was 250/140. The inmate refused to go to the health care unit and the nurse made a referral to a doctor.

16 The nurse should have consulted a doctor and have the patient brought to the clinic.

10/13/2016 The patient was no show to a doctor clinic.

10/19/2016 The patient was a no show to clinic. The CMT wrote that the inmate refused.

11/11/2016 The patient was unresponsive. CPR was started but the patient died. There was no timeline of CPR.

11/12/2016 An autopsy found normal adrenal glands, no disease of the pancreas, or GI tract. The coronary arteries showed varying degrees of atherosclerosis including 75% RCA, LAD 95%; 50% circumflex. The cause of death was atherosclerotic and hypertensive cardiovascular disease.

Patient #28

8/6/2014	A doctor noted that the patient had been in the infirmary since 8/6/14 due to falling in general population and decreased mobility. The patient had no medical issues listed. The patient apparently was in a wheelchair. The doctor did not list the patient's medical problems.	1, 2,	The doctor didn't take a history or make an assessment even though the patient was on the infirmary.
8/10/2014	A nurse stated that the patient was alert but thought it was September when it was August. The one consistent item nurses monitored was whether the patient fell.		
8/14/2014	A doctor saw the patient but noted none of the patient's medical problems so it was not possible to know what was wrong with the patient. The doctor wrote "see MD note 4/10/14 for HP infirmary and PMHx." But that note was not available.	1,2	The doctor didn't take a history or make an assessment even though the patient was on the infirmary.
8/15/2014	A nurse noted that the patient was up for his insulin. So I could know that he had diabetes, but neither nursing notes nor physician notes list his problems. Nurses do not document vitals or CBGs on their notes.		

Patient #28

- 8/20/2014 A doctor's note was more informative. The assessment documented that the patient had been in the infirmary since 1/28/13 [this contradicts the note from 8/6/14 although written by the same doctor] due to falls in population. The patient had multiple falls using a cane and walker and was said to be "noncompliant" with the walker and "resisting instructions in correct use" and "in late May 2013 put himself in an empty wheelchair subsequently refusing walker entirely." The patient had a special needs placement form for handicapped prison done 1/28/13 but apparently there was no place for him to go. The doctor listed problems as type 2 DM, mild heart failure, HCV, knee arthritis, and post-amputation of right fore foot from osteomyelitis and ASPVD and neuropathy. The doctor did not monitor sugars or note any clinical benchmarks for this patient.
- 3 There was no therapeutic plan for this patient.
- 8/27/2014 A doctor saw the patient but noted no problems. There was no history, no assessment of existing problems, and no documented therapeutic plan.
- 9/2/2014 Albumin 2.8; alk phos 171 (40-125); ast 53 (10-40); WBC 3.3; HGB 8; platelets 144 (150-450); A1c 6.1.
- 9/2/2014 A doctor saw the patient but documented no problems. There was no assessment of problems and no therapeutic plan.

Patient #28

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|---|--|
| <p>9/9/2014 A doctor saw the patient apparently for hepatitis C clinic. The doctor noted that HCV was diagnosed in 2007 at Stateville. The doctor noted that the patient consistently declined interferon therapy but made no mention of whether the patient wanted or didn't want treatment with the newer antiviral medications. The doctor noted that the patient had been vaccinated for hepatitis A and B. The APRI was 0.92. The doctor noted that the patient had cirrhosis, type 2 diabetes, mild heart failure, HTN, degenerative arthritis, post forefoot amputation in 1995 from osteomyelitis, macrocytic anemia with low body weight but the anemia had become microcytic. The doctor noted that the patient still did not want interferon and was discontinued from HCV telemedicine clinic since September of 2010. The doctor ordered stool for guaiac three times. These cards were completed and negative according to nursing notes. The doctor did not refer to Dr. Paul, did not refer to UIC telemedicine clinic, did not order an EGD or US for the cirrhosis.</p> | <p>2, 6, 7, 8, 12 The patient had likely cirrhosis with an APRI of 0.92, a low albumin, elevated alk phos, low platelets, low white count, and anemia. The doctor did not document whether the patient had an EGD or ultrasound to screen for varices or hepatocellular carcinoma. the patient should have been referred to UIC telemedicine clinic unless there were contraindications.</p> |
| <p>9/15/2014 Doctor note addressed no medical issues. A brief examination was done. But the only assessment was that the patient was an infirmity patient since 2013 and referred to a 8/20/14 note for details.</p> | |
| <p>9/17/2014 A nurse noted that the patient was incontinent of urine.</p> | <p>This demonstrates altered mental status.</p> |

Patient #28

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| 9/22/2014 | A doctor saw the patient in diabetic clinic. The patient was noted to be 81 years old and had been on insulin since age 60 and was now on NPH 14 am and 8:00 pm with 4 Reg TID after meals with metformin 500 mg pm. The doctor noted that the patient refused a diuretic for mild heart failure and HTN, and had macrocytic anemia with low B12 levels. BP was 123/62 and weight 179. The doctor could not feel the distal pulses and the patient could not feel the monofilament. Not clear if the patient ever had ABI. The doctor noted that the recent A1c was 6.1 and that the patient had good control. The meds were insulin, metformin, aspirin, lisinopril, B12, and vit B6. The doctor didn't document recent lipid values, recent microalbumin level, recent creatinine. | 1, 7 | If the patient could not feel a monofilament test the patient should have had ABI to evaluate the distal vasculature. It was not clear what the patient's mental status was. The doctor made no mention of the incontinence in his note. It appeared that the patient might have dementia that was unrecognized. |
| 9/30/2014 | A nurse noted that the patient was alert but thought that Thanksgiving was two weeks away. | 1 | The patient appeared to have some degree of dementia but it wasn't documented in the record and did not appear to be tracked. |
| 10/2/2014 | A doctor saw the patient. The assessment did not include an assessment of his problems. No problems were listed. The doctor performed an examination but made no assessment of existing problems. These evaluations appear to be every two week evaluations that are not clinically relevant. | | |
| 10/17/2014 | A doctor saw the patient and repeated the same assessment virtually verbatim, stating that the inmate was in the infirmary since 1/28/13 due to falls in population with a cane and that he was "non-compliant" with a walker in the infirmary and had no acute issues. The doctor referred to prior notes for the past medical history. The doctor as usual did not address any interval status of the patient's clinical problems. | | |

Patient #28

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| <p>11/4/2014 Albumin 2.8; alk phos 205; AST 47 (10-40); cholesterol 104; HDL 59; LDL 39 (50-129); HCV 2,050,457.</p> <p>11/17/2014 Fibrosure score indicative of cirrhosis at 0.77 (0-0.21).</p> <p>12/4/2014 A1c 6.2.</p> <p>12/8/2014 A nurse evaluated the patient using a "cough" protocol for congestion and appearing drowsy all day. The temperature was 98.1. The nurse gave the patient OTC medications by protocol.</p> <p>12/11/2014 A doctor saw the patient. As usual the doctor wrote a descriptive history of the patient's reason for being on the infirmary but did not address any of the patient's medical issues. The doctor noted that a special needs placement form was completed 1/28/13 but apparently hadn't yet been addressed. The patient needed a nursing home but there was no where to go so he remained on the infirmary.</p> <p>12/22/2014 A nurse documented that Dr. Paul saw the patient in hepatitis C clinic and referred to her progress notes.</p> | <p>1,2, 3, 6, 7, 8 The doctor did not take an adequate history or assess the patients problems. The doctor did not address recent labs. If the patient had cirrhosis, EGD should have been done and every six months ultrasound to screen for hepatocellular carcinoma. The albumin was low and there was no assessment of nutritional status. The alkaline phosphatase was elevated but not addressed. It was not clear why the patient was not referred to UIC for treatment.</p> |
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Patient #28

- 12/22/2014 A hepatitis C chronic clinic. Dr. Paul saw the patient and noted that a fibrosure was done on 11/17/14. The provider noted that the hep C viral load was 2,050,457 and the A1c was 6.2. The doctor noted the recent labs including albumin of 2.8; alk phos 171; INR 1.2; WBC 3.3; HGB 8; platelets 144; and assessed F4 fibrosis. The provider noted that the patient was anemic since 2013 and "needs anemia FU ACAP → T/C C-scope but patient frail." The provider [presumably a NP] stated the it was for Dr. Bauer [presumably the Medical Director] to decide if anemia precluded HCV treatment or work up. Dr Paul said, "will need EOD liver ultrasound once anemia resolved." The anemia was persistent for years. The patient had fibrosis consistent with cirrhosis but this wasn't diagnosed and the patient wasn't scheduled for EGD and semi-annual ultrasound or CT scan to evaluate for HCC. The patient certainly should have been referred to UIC hepatology but it wasn't clear who was to do this.
- 7,8,12 The patient had cirrhosis but wasn't being provided typical care. For reasons not stated the patient didn't receive EGD, ultrasound, or colonoscopy to work up his anemia. The statement that he was frail is not an indication not to work up his anemia. The statement that he had anemia since 2013 demonstrated significant delay. The statement that liver ultrasound would be done when the anemia was resolved but then to not work up the anemia was making excuses for not working the patient up. This was all a significant delay in colonoscopy, ultrasound, and EGD. Also the patient should have been referred to UIC.
- 12/29/2014 Diabetic chronic clinic. There were no changes to medications. The weight was 160; BP 137/62; the doctor noted a right fore foot amputation. The form contains a preprinted recommendation that ABI is indicated when pulses are low. This was true at a prior evaluation but ABI was not ordered. The pulses and feet were not checked at this visit.

Patient #28

- 12/30/2014 The doctor at this visit documented history and some additional assessment based on a review of the 12/22/14 Dr. Paul note. The doctor noted macrocytic anemia with low B12 and B6. The doctor noted that the patient was "referred by Dr. Paul for anemia since 2013." It wasn't clear what that meant. The doctor noted that the patient "denies sources of blood loss. Refused /AMA for DRE 11/12/12 and 11/14/14, will recheck CBC." The doctor noted that the patient had prior pancytopenia due to hepatitis C. The plan was to get three stool samples for guaiac, CBC reticulocytes, iron studies and other tests. The doctor wrote down all the CBC results dating from March of 2012; there were 12 all showing anemia with the lowest hemoglobin 8 and the highest 10.9. Yet the patient hadn't had a colonoscopy!!
- 12/30/2014 Iron 13 (49-181); TIBC 454 (250-450); WBC 2.2; HGB 7.7; platelets 108; neutrophils 35% or 0.8 (1.3-7.5); vitamin B12 74 (70-180) whole blood.
- 1/5/2015 B12 135 (180-914) plasma.
- 1/9/2015 The doctor noted that the patient had pancytopenia WBC 2.2, hemoglobin 7.7, and platelets 108. The serum iron was low and TIBC high; three hemocult cards were negative. The doctor documented that labs were consistent with iron deficiency anemia but because three hemocult cards were negative there was no source of blood loss. The only treatment was to prescribe iron supplementation. This is inconsistent with standards as the patient should have had endoscopies. To say that there was no source of blood loss without looking for it diagnostically was inaccurate.
- 7,8, 12 The doctor was using DRE as screening for colorectal cancer, which is inappropriate. The patient should have been scheduled for colonoscopy since he had anemia. The patient also should have had ultrasound screening and EGD since he had cirrhosis. The patient should have been referred to UIC telemedicine clinic.
- 2, 6, 7, 8 The patient had pancytopenia yet the doctor made no diagnosis and came to no conclusion why the patient had pancytopenia. The patient had iron deficiency anemia yet the doctor did not order colonoscopy and endoscopy. The doctor should also have ordered an ultrasound of the abdomen to screen for hepatocellular carcinoma. The only treatment was to order iron supplements.

Patient #28

2/9/2015	A new doctor saw the patient and didn't follow up on the anemia and listed only two problems: DM and ID [it wasn't clear what ID was]. This doctor took no history and made no assessment of the status of any condition.	1, 2, 3	The doctor took no history, made no assessment and no plan. The doctor failed to follow up on the pancytopenia and iron deficiency anemia and addressed none of the patient's problems.
2/10/2015	Iron 13 (49-181); TIBC 470 (250-450); WBC 3.4; HGB 7.7; platelets 143; neutrophils 50.8%.		
2/19/2015	A doctor saw the patient and documented all problems including anemia/pancytopenia without documenting an updated status and plan for any problem except CHF, noting that the patient was on diuretic and lisinopril.	2, 3	The doctor made no diagnosis based on abnormal labs and no therapeutic plan for the given abnormal labs.
2/26/2015	A doctor saw the patient and noted that the hemoglobin was still 7.7 with microcytic indices. The doctor noted that the patient still had pancytopenia (3.4; 7.7; 143) and stated that there was "no source" of bleeding found. The doctor documented the low reticulocyte count. The doctor wrote that though the patient was taking B12 and B6 supplements the B12 was still low and he wrote "?absorption?" and wrote that he would try B12 injections. The doctor added vitamin C to the iron to try to increase absorption. The doctor did not refer for a colonoscopy or upper endoscopy.	7, 8	This did not appear competent. The patient had pancytopenia and iron deficiency anemia yet the doctor did not refer for endoscopy and colonoscopy. Because of the cirrhosis, ultrasound screening should have been done.
3/2/2015	The patient fell off the bed onto his hand. The patient had a 2.5 cm laceration on the palmar surface of the phalanx with visible tendon. The right middle PIP was deformed and subluxed. An X-ray showed a dislocated PIP but "no acute fracture seen." The patient couldn't flex his right finger. The doctor assessed a laceration and dislocation and sutured the finger but could not reduce the dislocation, so sent the patient to an ER. The patient returned from the ER with instructions to return in 10 days to remove sutures.		

Patient #28

3/2/2015	The patient was seen in the ER at the Sarah Culbertson Memorial Hospital. An x-ray showed a subluxation of the third finger on the right; fracture was not definitively seen. The wound was sutured and the patient returned to the prison.		A subluxed finger requires reduction of the subluxed finger. This required follow up with an orthopedic surgeon for possible surgical reduction.
3/2/2015	X-ray of the right third finger showed dorsal dislocation without obvious fracture.		
3/4/2015	A doctor saw the patient and noted that there were no ER records; he asked for them to be obtained. The doctor did not document knowing what was diagnosed or done in the ER.	11	The failure to obtain records resulted in clinical deficiency
3/9/2015	A doctor saw the patient whose hand was now swollen. The doctor documented a verbal report from the ER that the patient did not have a dislocation but stated that the x-ray report showed a 6 mm subluxation. The doctor prescribed empiric treatment with Keflex for 10 days and a repeat x-ray. It wasn't clear if the patient had seen a hand surgeon or orthopedic surgeon. Blood tests were not done.	12	The doctor needed to consult an orthopedic surgeon as the patient had a subluxation. A subluxation with swelling indicates possible infection.
3/11/2015	A doctor noted that the right middle finger was still dislocated with the middle phalanx subluxed. The doctor documented he would discuss in collegial review but didn't state for what reason.	12	The doctor needed to consult an orthopedic surgeon as the patient had a subluxation.
3/12/2015	A doctor noted that the finger was still swollen and that there was some drainage in the morning. No changes were made.		
3/13/2015	Wexford denied referral for urgent wound clinic evaluation. Wexford asked to get foot x-rays and wound culture if not done and re-present the patient in the next collegial review.	12	The Wexford utilization decision was grossly and flagrantly unacceptable. The patient had an subluxation with infection and this needed immediate attention. Because the wound was open and sutured, it appeared to be the equivalent of an open fracture.

Patient #28

3/16/2015 A nurse documented a "grossly swollen" right middle finger. Later that day five sutures were removed from the finger by a nurse. Later, a doctor saw the patient and noted that the finger was swollen and that the patient was unable to flex the finger. The doctor documented that he referred the patient to orthopedic or hand surgery for closed reduction. This was approved.

3/16/2015 A doctor referred the patient to an orthopedic surgeon for closed reduction of the finger.

3/20/2015 A Wexford doctor approved the orthopedic surgeon visit.

3/26/2015 Ferritin 28 (10-259); iron 29 (50-180); WBC 3.7; HGB 8.8; platelets 158; B12 1049 (180-914).

3/27/2015 A nurse noted some yellow discharge from the finger wound.

3/30/2015 A doctor noted that the patient was at the hand surgeon's office and spoke with the surgeon who said that the patient had an open dislocation with pus coming from an open wound. The joint was visible. Surgery was indicated "tonight." The patient had surgery and returned on vancomycin IV on the infirmary upon return.

3/30/2015 An orthopedic doctor wrote in the ER that the patient sustained an open dislocation of the finger and said, "I am uncertain as to why this was not reduced prior to now but at any rate would recommend [the hand surgeon] address this issue." Surgery was done that evening.

12 The referral was two weeks after the injury. The delay likely resulted in extension of the infection. The referral needed to be immediate, not even urgent, as the patient was likely infected.

12 The referral was delayed almost a month for an open
dislocation. The UM process was grossly and flagrantly
unacceptable and resulted in osteomyelitis, a
preventable condition.

Patient #28

- 4/1/2015 A doctor noted that the patient had ORIF of the finger [apparently there was a open fracture with pus]. The patient needed six weeks of treatment for osteomyelitis. Osteomyelitis was diagnosed.
- 4/2/2015 A doctor referred the patient for post-op follow up orthopedic visit.
- 4/6/2015 A post operative follow up was approved in collegial review.
- 4/9/2015 A doctor noted that the hand surgeon wanted to see the patient in the ER for a follow up visit, which the doctor noted couldn't be done. The doctor noted anemia was improved and the HGB now 8.8 from 7.7. No action was taken except to continue iron and B12 supplements.
- 6, 7, 10 Follow up of the anemia was unacceptable. The patient had iron deficiency anemia and colonoscopy and EGD were indicated but not done for undocumented reasons. Follow up with the surgeon was also indicated and not done because apparently IDOC would not take the patient to the ER.
- 4/15/2015 A nurse documented soaking the affected finger in a solution of Epsom salts for 20 minutes. Not sure if this was ordered treatment.
- 4/16/2015 Urine microalbumin 140; albumin 2.9; alk phos 202; AST 69 (10-40); A1c 5.3; cholesterol 118; HDL 61; LDL 47 (50-129).
- 4/20/2015 The patient sustained an open fracture dislocation of this right middle finger and was being seen in the ED for a suture removal. The fracture was healing adequately.
- 4/20/2015 A doctor noted that the patient was seen post orthopedic visit but that the notes were unavailable. The pins were reportedly removed and the patient had a follow up in a month. The doctor asked medical records to obtain a dictated report.
- 11 The doctor was unable to determine the status of the patient because consultant notes were unavailable.
- 4/20/2015 A hand surgeon saw the patient in the ER and removed sutures and the patient was discharged.

Patient #28

4/22/2015	A doctor reviewed the orthopedic notes that the sutures were removed and the wound healing.	
4/22/2015	A doctor renewed medications as NPH 14 am and 8:00 pm with aspirin, lisinopril 5 mg daily, metformin 500 with dinner B12 and B6 supplements.	
4/22/2015	Diabetic chronic clinic. The doctor noted mild CHF, DM, chronic hep C, anemia, and mobility disorder. BP was 142/86; a foot exam was done but did not take off his shower shoes. The A1c was 6.2. The patient was documented as in good control and no action was taken.	
4/27/2015	Glucose 59 (65-110).	
4/29/2015	A doctor saw the patient and noted that the patient still had anemia. The doctor noted that the last CBC on 3/26/15 showed HGB of 8.8 and that he would continue the same therapy.	7
5/6/2015	Iron 30 (50-180); % transferrin 8 (20-50); WBC 2.9; HGB 9.2; platelets 105.	
5/13/2015	Dr. Baker referred the patient to a hand surgeon after a failed closed reduction. The patient was unable to flex the right middle finger at all.	1, 2, 6, 7, The patient's recent labs showed pancytopenia with iron deficiency anemia. The doctor should have referred for EGD, colonoscopy, and ultrasound of the liver to screen for hepatocellular carcinoma. The doctor appeared to fail to review the labs.
5/13/2015	A doctor noted that the patient completed the vancomycin and that referral was made for ortho follow up.	
5/13/2015	A doctor referred the patient to the hand surgeon for follow up.	
5/22/2015	The patient told a doctor he couldn't bend the finger. The doctor took no action.	

Patient #28

- 5/28/2015 A doctor noted that weight was 158; did not address any labs and noted that the patient still needed to be scheduled for ortho follow up. The doctor didn't address any of the patient's other problems.
- 6/4/2015 A doctor saw the patient but didn't address any of his problems.
- 6/8/2015 An orthopedic surgeon saw the patient. The patient had intra-articular fracture of the third PIP on the right. There was advanced DJD of the DIP and PIP joints. The orthopedic surgeon stated that he needed to investigate options for the patient and might need to refer to a hand surgeon. The patient said the finger was useless and he would rather have it amputated than continue in the current situation. The x-ray showed residual irregularity of the joint; infection could not be excluded.
- 6/8/2015 The hand surgeon saw the patient. The doctor noted that the patient had pins removed from the ORIF several months ago. The patient said he wanted amputation of the finger instead of other care. The surgeon said he needed to investigate options and would get back to the prison.
- 6/9/2015 Glucose 313; albumin 3; alk phos 214; AST 55 (10-40); ALT 38 (10-50); WBC 2.9; HGB 10.8; platelets 108.
- 6/10/2015 A doctor saw the patient and noted that the patient saw the surgeon and told the surgeon to cut off the finger as it was not useful. The surgeon said he would get back to them. The surgeon report wasn't available so the doctor asked for it.
- 6/16/2015 A doctor saw the patient and documented that he documented a hepatitis C note that day but it was not in the medical record chronologically.

Patient #28

- 6/16/2015 A doctor saw the patient for hepatitis C clinic. The doctor said that the patient was followed by Dr. Paul in HCV telemedicine clinic and was last seen 12/22/14. The doctor noted that the WBC was 2.9; HGB 10.8; platelets 108, and APRI 1.27. The doctor stated that the patient would not be treated because of frailty, anemia, and was followed by Dr. Paul, who decided the patient wasn't a treatment candidate. The doctor noted that Dr. Paul was to see the patient "this month?" Though the patient had cirrhosis, the doctor did not assess this. Nor did the doctor order EGD or screening ultrasound for HCC.
- 7/1/2015 A doctor said that the orthopedic surgeon would research options for a nonfunctional finger and get back to them.
- 7/9/2015 A doctor wrote a note with considerable history about the finger issue but failed to address any of the patient's other problems. The patient's injured finger was tender and the doctor empirically treated with Bactrim even though there was no sign of infection.
- 8/11/2015 A1c 8.2.
- 8/12/2015 As of this date the doctor stated that the orthopedic doctor had not gotten back to him with options. The doctor did not address any of the patient's other issues except through chronic clinic notes, including the pancytopenia or cirrhosis. Cirrhosis wasn't even documented as a problem.
- 8/21/2015 The patient had a runny nose with cough and the doctor prescribed CTM.
- 12, 7, 8 The patient should have been referred to UIC for assessment. Frailty is not a contraindication to treatment. In any case, the patient should have received EGD to screen for varices, and ultrasound or CT scan to screen for hepatocellular carcinoma. The patient had iron deficiency anemia and should have received colonoscopy. The pancytopenia was likely a result of the cirrhosis but is of concern.
- 12 The doctor failed to refer the patient to an orthopedic surgeon. There was no attempt to determine how the finger affected ability to function. This was a preventable injury.

Patient #28

8/26/2015	A doctor saw the patient in diabetic clinic. The A1c was 8.2. The doctor increased the metformin to 500 BID and increased NPH to 16 am and 10:00 pm.	7, 8	The doctor did not address the pancytopenia, anemia, cirrhosis, or other conditions. The patient should have been referred for colonoscopy, EGD and ultrasound.
9/7/2015	The patient thought it was close to Halloween. The patient was encouraged to change clothes and shower. The nurse noted that the patient's pants smelled of urine.		
9/22/2015	A different doctor began seeing the patient and wrote an extremely brief note noting that the patient now agreed to take metformin. There was no assessment.	1, 2, 3	The doctor failed to review nursing notes and address the patient's incontinence. If this was due to dementia it was unrecognized. If it was due to something else it was undiagnosed.
9/29/2015	The new doctor saw the patient and noted that the patient had DM and an "ortho foot problem [secondary] to falls." The doctor did not address any of the other patient problems including pancytopenia, cirrhosis, CHF, or low albumin.	1, 2, 7, 8	The doctor was a new doctor for this patient yet failed to establish a reasonable plan for his cirrhosis and anemia. They took inadequate history, made no assessment of the patient's problems, and failed to establish a reasonable plan. The doctor failed to refer the patient for EGD and colonoscopy and ultrasound.
10/6/2015	The new doctor saw the patient and noted that the patient had DM and "ortho foot problems." The doctor did not address any of the other patient problems including pancytopenia, cirrhosis, CHF, or low albumin. The doctor noted 1-2+ edema on exam but made no assessment or plan for this.	1, 2, 7, 8	The patient had apparent new onset edema yet the doctor took no history, made no attempt at diagnosis, and failed in the assessment to address any of the patient's conditions. The doctor should have referred for EGD, colonoscopy, ultrasound, and considered an echocardiogram based on the history.
10/13/2015	A doctor saw the patient and noted that the patient had DM and a "ortho foot problem." The A1c was documented as 8.2. The doctor ordered a CMP and A1c with a week follow up.		
10/14/2015	A1c 8.2.		

Patient #28

- 10/20/2015 A doctor saw the patient and noted elevated A1c 8.2 and increased the metformin to a gram BID, which was a significant increase.
- 11/3/2015 A1c 8.5.
- 11/4/2015 A doctor saw the patient and noted that the last A1c was 8.2 on 10/14; a repeat had not returned yet. Without evaluating CBG levels the doctor increased metformin to 850 TID. For an elderly man this was a large increase.
- 11/11/2015 A doctor saw the patient and ordered another A1c and said he would add another drug if the A1c was still high. No other problems were addressed.
- 11/13/2015 A nurse documented that the patient had periods of forgetfulness without any evaluation.
- 11/14/2015 Annual physical examination documents hepatitis C, mild CHF, ASPVD, DM, arthritis of knees, and the weight was 162. 1, 7, 8 The provider failed to review the nursing history of forgetfulness and prior incontinence and integrate that information into the problem list. The provider failed on the annual physical to obtain an EGD, colonoscopy, or ultrasound. Nutritional assessment was not done. The patient's functional capacity was not assessed.
- 11/18/2015 A doctor saw the patient. The doctor noted that the A1c was 8.5 but that the patient refused any increase of insulin. The doctor addressed no other problems.
- 11/18/2015 A1c 8.6.
- 11/25/2015 A doctor saw the patient and noted only diabetes, fall risk, and a partial foot amputation as problems.
- 11/25/2015 Albumin 2.9; alk phos 231; AST 57; ALT 37; phosphorus 2.9; WBC 3.1; HGB 11.3; platelets 115.
- 12/3/2015 A doctor saw the patient and noted that the patient had hepatitis C and diabetes. The doctor referred the patient to the hepatitis C clinic with BMP, T4 and TSH.

Patient #28

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| <p>12/3/2015 A doctor saw the patient in hepatitis C clinic. The doctor noted albumin 3; HGB 10.8; platelets 108; AST 55 and ALT 38. The doctor didn't note that the patient had cirrhosis and referred the patient to see Dr. Paul in hepatitis C clinic. Ironically, the doctor was seeing the patient in hepatitis C clinic. It appeared that the doctor didn't know how to manage cirrhosis.</p> | <p>12, 7, 8 The patient hadn't seen doctor Paul for a year. The patient had cirrhosis. He should have been referred to UIC to determine whether treatment was indicated. He should have been referred for EGD, colonoscopy, and ultrasound.</p> |
| <p>12/8/2015 A doctor noted that the patient had a "skin tear" on the bottom of his left foot and was walking using shoes. The doctor noted a 2 1/2 cm tear on the skin and ordered betadine soaks of the left foot with daily dressing changes and tetanus update. The doctor did not off-load the foot.</p> | <p>3 The patient was diabetic. A foot wound in a diabetic is cause for concern and typically needs off-loading to reduce use of the foot. This was not done and exposed the patient to continued damage to the foot.</p> |
| <p>12/9/2015 A doctor saw the patient and noted that he was disoriented and confused. There was no history with respect to the altered mental status. The doctor noted that the patient didn't have pain and had a tear on the foot with no evidence of infection. The plan was only antibiotic ointment. The patient continued to walk on the foot.</p> | <p>1, 2, 7, 8, 14 The patient was confused but the doctor failed to take a history and performed no examination with respect to the altered mental status. The doctor should have obtained a metabolic panel, ammonia level, and probably obtain a CT brain. Alternatively, the patient should have been sent to a hospital.</p> |
| <p>12/9/2015 A1c 8.7.</p> | |
| <p>12/15/2015 A nurse noted that the patient had a "scant" amount of drainage and that the tissue between the toes was white with an odor and that there was an open area on the side of the foot that "remains swollen slightly and discolored."</p> | |

Patient #28

- 12/15/2015 A doctor saw the patient and continued the antibiotic ointment. The doctor noted that the wound was healing well. 2, 3, 7, 8 The patient had a diabetic foot with pus. The doctor should have probed the wound, obtained sedimentation rate and CRP test, and x-ray or CT scan to assess for osteomyelitis. The patient should have been off-loaded. Although the patient was in a wheelchair, he should not have been walking on the foot. Antibiotics should have been started.
- 12/16/2015 A nurse noted that the patient was forgetful when it comes to the time of day. The patient asked what time it was after saying that it was night. A doctor saw the patient that day and noted that the foot was healing well. The doctor continued wound care. 1, 2, 8 The patient had altered mental status but it was unrecognized. The doctor didn't review the nursing note or take any history of the patient. No diagnosis of the altered mental status was made. The patient should have had a serum ammonia, CMP, and CT scan.
- 12/16/2015 A1c 8.5.
- 12/22/2015 A doctor saw the patient and noted that the foot was healing and that the patient had DM with neuropathy and a healing wound. The doctor didn't check the distal pulses, order an ABI, or probe the wound. No labs were ordered. No change in therapy.
- 12/23/2015 A doctor saw the patient in diabetic clinic. The A1c was documented as 8.5. The patient was listed as having type 1 diabetes, which he didn't have. The doctor did not document a change in medication. The doctor noted that the A1c was 8.5 and that the patient refused any increase in insulin. Except for noting no edema, the foot wound wasn't examined. The doctor assessed only type 1 diabetes and ordered a BMP. 3, 7, 8 The patient had a diabetic foot with pus. The doctor should have probed the wound, obtained sedimentation rate and CRP test and x-ray or CT scan to assess for osteomyelitis. The patient should have been off-loaded. Although the patient was in a wheelchair, the plan should have been to completely off-load the foot.
- 12/24/2015 A nurse noted that the inmate had periods of forgetfulness.
- 12/29/2015 A1c 8.

Patient #28

12/30/2015	A doctor noted that the weight was 158 and increased NPH to 16 units in the am and pm, which was a significant increase. The only assessment was DM with neuropathy. The doctor made no comment about blood sugars. The doctor documented that there were no ulcers on the L foot or R stump even though the patient had a diabetic foot.	4, 15	The doctor appeared to follow up a diabetic foot for which the patient was being treated. This did not appear to be a competent evaluation.
1/5/2016	A1c 7.8.		
1/6/2016	A doctor saw the patient. The BP was 143/53. The A1c was 8 decreased from 8.5 on 12/29/15; the patient had 2 + edema but the doctor didn't examine the foot with the tear. The doctor ordered weights every visit and added HCTZ and ordered an EKG and BMP.	4, 15	The doctor failed to follow up on the diabetic foot. The doctor noted 2+ edema but did not document a foot examination. It appeared that the diabetic foot problem was lost to follow up.
1/6/2016	HCTZ was started at 25 mg.		
1/8/2016	A nurse noted after a shower that the inmate had an open ulcer with peeling edges on the left foot and reported it to an NP. An NP saw the patient and documented a dime sized ulcer with no drainage and 2 + pulses. The patient told the NP that the wound "just won't heal." Left foot ulcer was diagnosed but no action taken except wet to dry dressings.	1, 2, 3, 7, 8	The patient had a non-healing diabetic ulcer for over a month. The NP should have probed the wound. Although pulses were palpated, an ABI was indicated due to the non-healing nature of the wound. The patient should have been off-loaded. Sed rate, CRP, blood count, and x-rays or MRI should have been done to exclude osteomyelitis. Antibiotics should have been started.
1/8/2016	A nurse noted that the inmate had periods of forgetfulness.		
1/9/2016	A nurse noted that the inmate smelled of BM and urine and was advised to take a shower. The ulcer was dressed.		
1/10/2016	A nurse noted slight drainage from the ulcer.		
1/11/2016	A nurse noted that the patient was washing soiled sweatpants and had periods of confusion.		
1/13/2016	A nurse noted that the inmate had unsteady gait.		

Patient #28

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| <p>1/13/2016 A doctor saw the patient. The doctor noted that the patient had an ulcer on the right foot of the metatarsal area and heel and ordered a culture, BMP and CBC and clindamycin BID with follow up in a week.</p> <p>1/13/2016 WBC 3.75; HGB 11.3; platelets 128; a wound culture showed many proteus susceptible to Rocephin and Clindamycin. But this was a wound culture.</p> <p>1/14/2016 A nurse noted unsteady gait and periods of confusion and that the left foot had scant drainage.</p> <p>1/15/2016 A nurse noted that the patient took off the left foot dressing and there was an open area.</p> <p>1/21/2016 A doctor noted that the patient had a plantar ulcer on the first metatarsal area and that it was not healing; he ordered a BMP, A1c, CBC, and follow up.</p>
<p>1/27/2016 A doctor referred the patient with a diabetic foot ulcer resistant to normal care for wound care. There was extension of the wound. The doctor documented prior amputation for a prior diabetic foot ulcer.</p> <p>1/27/2016 A nurse called a doctor in to see the wound which had scant drainage with peeling edges.</p> <p>1/27/2016 A1c 7.6; WBC 3; HGB 10.6; platelets 115.</p> <p>1/28/2016 Wexford denied referral for urgent wound clinic evaluation. Wexford asked to get foot x-rays and wound culture if not done and re-present the patient in the next collegial review.</p> | <p>1,2, 7, 8 The patient had recent episodes of forgetfulness and incontinence which were not even noted. The patient should have been worked up for altered mental status. The patient should have had ABI, and radiologic study to evaluate for osteomyelitis.</p>
<p>1, 2, 3, 7, 8 The patient had recent episode of confusion and unsteady gait. The doctor took no history, performed no pertinent examination, and did not order appropriate diagnostic testing (ammonia, CT brain). The doctor also did not probe the bone, order sedimentation rate or CRP, or order x-rays or MRI to exclude osteomyelitis.</p>
<p>12 Wexford UM denied referral for a diabetic wound when the local doctor did not know how to care for the wound. Care was grossly and flagrantly irresponsible.</p> |
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Patient #28

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| <p>1/28/2016 A clerk documented denial of urgent wound care referral with alternative plan an x-ray and wound culture.</p> <p>1/28/2016 A doctor noted that there was no osteomyelitis on x-ray.</p> <p>1/28/2016 A doctor apparently ordered Rocephin because a nurse administered this drug, but there was no physician note. Later that day at 6:00 pm the Rocephin was changed to gentamycin. Again there was no note documenting why. On later notes it appeared that the patient was receiving both gentamycin and Rocephin without documented reason. Apparently it was for the foot ulcer.</p> <p>1/28/2016 Medical records wrote a note that urgent wound care was denied and x-ray and wound culture was recommended.</p> <p>1/30/2016 At 7:30 am the patient came for meds in his wheel chair and he was lethargic and unable to wheel himself with slurred speech. The blood pressure was 74/35 and the patient was sent to a hospital.</p> <p>1/30/2016 The patient was referred from Rushville for hypotension (74/35) and lethargy to a hospital.</p> | <p>Plain x-rays may not show osteomyelitis until late in the course of osteomyelitis. Also, wound culture of an open wound is not useful, as the culture will likely be contaminated.</p> <p>11 This is a documentation problem. It wasn't clear why IV Rocephin was started as there was no documentation in the medical record.</p> |
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Patient #28

- 1/30/2016 Magnesium 1.6 (1.8-2.4); BNP 473; WBC 2.2; HGB 10.5; platelets 83; neutrophils 89.2%. Sedimentation rate 29 (0-15); PO2 63 (80-100); HCO3 12 (22-26); PCO2 19 (35-45); glucose 146; calcium 7.5; Total protein 6.1 (6.4-8.2); albumin 2.4; ALT 41 (16-63); AST 76 (15-37); ALK PHOS 237; total bili 1.2 (0-1) and blood cultures at four days were negative. These labs were done at the hospital. The patient was admitted with altered mental status and hypotension. A CT scan showed colitis- colonoscopy was recommended. CT of the brain showed no acute process but small vessel ischemic changes. EKG showed right atrial enlargement.
- 1/31/2016 A doctor in the hospital wrote a consultant note documenting that he was asked to see the patient for lactic acidosis and CT scan showing colitis. The patient had profound lactic acidosis with HCO3 of 8.8; the patient refused colonoscopy and it was recommended to continue cipro and flagyl. The patient had no masses in the liver on a CT scan but the CT scan was without contrast.
- 2/4/2016 At St John's Hospital an abdominal ultrasound showed a 2 cm hypoechogenic lesion which "may represent a cyst or other etiologies are not entirely excluded," diffusely coarse echotexture of the liver with nodular surface and moderate ascites.
- 2/6/2016 The inmate returned from the hospital and had a Foley catheter. The assessment was colitis.
- 2/7/2016 A nurse documented that the patient had 1+ edema. A doctor had yet to see the patient on return from the hospital. It wasn't clear what the discharge diagnoses were.

Patient #28

- 2/7/2016 A nurse called a doctor who ordered blood cultures by phone and ordered Levaquin by phone. A doctor had yet to see the patient and it wasn't clear what the patient's diagnoses were. In a later note a nurse noted that Levaquin wasn't available so the doctor ordered IV Rocephin by phone. It wasn't made clear why the doctor was prescribing IV antibiotics.
- 2/7/2016 A nurse noted that the patient's temperature remained above 100.4 after Tylenol. The doctor was called and the nurse documented that blood cultures were drawn
- 2/8/2016 A doctor wrote an admission note to the infirmary. The doctor noted that the patient had cellulitis of the foot and had diarrhea and 10 pound weight loss. The doctor did not acknowledge what occurred at the hospital. The patient had 3+ edema of both legs. New medications included Lasix, Levaquin, nebulization treatments, Rocephin. The admitting diagnosis was heart failure but it wasn't clear what occurred at the hospital or why the patient was being treated with two different antibiotics. It may have been the foot cellulitis. but it wasn't clear. The problem list was incomplete.
- 2/8/2016 A nurse noted 2-3+ edema of the leg , blistered areas with discoloration of the right lower leg.
- 2/8/2016 A doctor wrote an additional note that the patient had tachypnea, shortness of breath, and orthopnea. The doctor noted rales in the base and 3-4+ edema. The doctor assessed heart failure and UTI. The doctor ordered IV push Lasix, nebulization with albuterol, decreased salt intake, and BNP and BMP and EKG.
- 2/8/2016 Lasix 20 mg BID was started.
- 3, 11 There was no hospital report and the doctor didn't understand what occurred at the hospital or understand the therapeutic plan. The doctor was unable, therefore, to develop a therapeutic plan.
- 8 The doctor should have added a chest x-ray.

Patient #28

2/9/2016	A doctor noted that the patient was breathing easier. The doctor noted no wheezing, a protuberant abdomen, swollen scroum and 3-4+ leg edema. The diagnoses were cellulitis of the foot, heart failure, ascites and COPD. The doctor increased Lasix and ordered BNP.	1, 2, 8, 11, 14	The failure to obtain records resulted in the doctor not knowing what occurred at the hospital. The patient now appeared to have anasarca probably from his cirrhosis. Diuretics were appropriate, but because the doctor didn't know the diagnosis, higher level of care-admission to a hospital, was indicated. The doctor should also have ordered stat BMP.
2/9/2016	A nurse wrote that the patient had 1+ edema of the hand, was incontinent of bowel, the scrotum was swollen and the abdomen was distended. COPD and heart failure were the diagnoses as documented by a nurse.		
2/9/2016	BUN 22; sodium 134 (135-145); potassium 3.2; creatinine 1.58 (0.5-1.5).		
2/10/2016	A nurse noted that the patient was forgetful and on fluid restriction. The patient refused to wear his oxygen cannula. The nurse documented that the patient had open areas on the buttock without drainage and the scrotum was swollen. Later the patient needed to be assisted to the bathroom and had a liquid BM.		
2/11/2016	A doctor saw the patient. The doctor still did not document the summary from the hospital. The doctor noted DM and cellulitis of the right leg. The doctor noted that the patient had generalized abdominal pain. The patient refused to go to the hospital. In the assessment, the doctor noted ascites with cirrhosis and a mass on the liver and cellulitis of the right leg.	14	The patient had altered mental status and should have been sent to a hospital as he could not be cared for at the prison and he appeared to no be competent to make his own decision.
2/11/2016	BUN 34; sodium 134; CO2 19; creatinine 1.93; WBC 6; HGB 10.3; platelets 178; BNP 75 (<100).		
2/13/2016	The patient was incontinent of liquid stool.		

2/15/2016 Amylase 57 (25-125); BUN 38 (6-20); potassium 5.5 3.5-5.3); CO2 17; creatinine 1.99; anion gap 12 (3-11); INR 1.3; WBC 4.7; HGB 10.5; platelets 183.

Patient #28

- 2/22/2016 There were patient discharge instructions stating that the patient was hospitalized for hemoptysis, cirrhosis, chronic hepatitis C, diabetes, HTN, urinary retention, chronic indwelling Foley catheter, normochromic anemia, peripheral vascular disease, stage 2 sacral pressure ulcer, acute blood loss anemia, and liver mass. This was not a discharge summary but a summary for the patient. There was no discharge summary.
- 2/22/2016 A doctor admitted the patient to the infirmary and noted that the patient had diagnoses of liver cancer and upper GI bleed. The patient was on DNR status. The admission note had virtually no history and no physical examination. The assessment was hepatitis C, cirrhosis, and hepatic cancer. None of the patient's other problems was addressed.
- 2/22/2016 A nurse noted that the patient had a 10 cm open area between the gluteal folds and multiple open areas on the buttock. The nurse noted that the scrotum was swollen and irritated.
- 2/23/2016 A nurse noted that the patient was back from the hospital and wrote down the hospital diagnoses, which was the first time these diagnoses were listed. They included: hemoptysis, hepatitis C, cirrhosis, hepatic cancer, diabetes, hypertension, decubitus ulcer of the foot, urinary retention, anemia, peripheral vascular disease, acute blood loss post-GI bleed, sacral pressure ulcer, hepatic cancer. The doctor ordered comfort measures.
- 2/23/2016 Inderal was started at 10 mg TID.
- 2/23/2016 BUN 16; creatinine 1.17; total protein 5.5 (6-8); albumin 2; alk phos 143; AST 59; ALT 34; WBC 4.9; HGB 9.6; platelets 56.
- 11 There was no hospital report, making it very difficult to manage the patient.
- 11, 10, The doctor failed to review the hospital note and therefore follow up was poor. The doctor did not understand all of the patient's problems and the therapeutic plan was therefore deficient. The patient had an indwelling Foley catheter and open sacral decubitus, for example, but there were no orders for this.
- 1, 2, 3

Patient #28

2/28/2016 Ativan 1 mg TID was started.

17 The doctor was starting palliative sedation but there was no discussion with the patient documented in the record that we could find. This is inappropriate, as this action needed to be fully discussed with a cooperative patient and family if needed.

2/28/2016 Fentanyl patch was started 12 mcg per hour.

17 The doctor was starting palliative sedation but there was no discussion with the patient documented in the record that we could find. This is inappropriate, as this action needed to be fully discussed with a cooperative patient and family if needed.

2/29/2016 A doctor added Aldactone, and stopped HCTZ.

3/1/2016 Lisinopril, potassium, vitamin B12 were discontinued.

3/3/2016 Aspirin, furosemide, Inderal, metformin, Zofran, insulin, and Cardizem were held.

3/7/2016 A doctor stopped Lasix and added Ativan IM for "restlessness."

17 Restlessness is not an indication for Ativan. The doctor
appeared to be using palliative sedation without a
discussion with the patient, which has significant ethical
concerns.

3/8/2016 Oxycontin 5 mg every four hours was started.

3/9/2016 Fentanyl patch 50 mcg patch was started to be used every third day with Ativan 1 mg every six hours.

3/11/2016 The patient died.

3/16/2016 Dr. Butler, the Medical Director, wrote a death summary stating that the patient had known hepatitis C, DM, and cellulitis. The doctor said that the patient developed hematemesis and was sent to a hospital and had liver cancer diagnosed. The doctor said the patient refused treatment and was DNR.

Patient #28

3/18/2016 A death certificate documented that an autopsy was done and showed hypertensive cardiovascular disease, severe stenosis of the LAD, and thin renal cortices with pulmonary edema. The death certificate made no mention of the patient's liver mass or cirrhosis.

Patient #29

3/15/2013 An EKG had wandering baseline but showed NSSTT changes.

1/31/2014 The January 2014 MAR documents that the patient was on only 10 mg simvastatin; 60 units NPH am and 30 units pm with sliding scale insulin 5 mg Lisinopril, amlodipine; Xopenex, furosemide 40 BID.

3/21/2014 Urine microalbumin 256; BUN 23; creatinine 1.76; A1c 10.4; cholesterol 157; HDL 37; LDL 102.

7/22/2014 A1c 10.

11/5/2014 BUN 21; creatinine 1.64; A1c 10.4; Total cholesterol 170; HDL 39; LDL 111.

11/10/2014 An annual health visit documented BP 128/64; weight 236 with height of 5 foot 6 inches. The only problem listed was diabetes even though the patient had high blood lipids, HTN, nephropathy, and heart failure. The doctor noted that the patient needed to lose weight and increased insulin to 64 am 34 pm NPH. The patient was 66 years old and was a smoker and African American.

12/3/2014 Insulin was changed to 66 u NPH am and 34 units pm.

1/13/2015 A doctor referred the patient for a sleep study.

1/14/2015 The doctor noted the patient had approval at collegial review for a sleep study.

1/15/2015 Asthma chronic clinic. The doctor noted that the age of onset wasn't know except it was thought to be when he was an adult. The patient had a prior history of smoking. The patient had BP 155/85; PEFs were 350/370/300. The patient was described wheezing at times. The doctor took insufficient history to determine the status, but diagnosed intermittent asthma and stated, "difficult to judge SOB etiol - likely multifactorial obesity? sleep apnea." The patient was diagnosed with good control and the doctor said he would refer for a sleep study. The patient did not have pulmonary function testing.

17 Minimal increase of insulin but no follow up of diabetes in significantly out of control patient. The patient's 10-year risk of heart disease or stroke for a 66 year old African American smoker with diabetes and hypertension was 46%. He needed a high intensity statin but was on a low intensity statin drug.

7 Given the patient's age, and long-standing hypertension, the doctor could have considered heart failure. In any case, the patient should have had pulmonary function tests to clarify his diagnosis.

Patient #29

1/20/2015 Wexford approved a sleep study.

1/21/2015 BUN 21; creatinine 1.81; cholesterol 168; HDL 39; LDL 98.

1/27/2015 The sleep study result was very severe sleep disordered breathing. The recommendations were to utilize a CPAP device but to refer to ENT to reduce risk of mortality. The patient had irregularity of the pulse rate and suggested "if clinically appropriate, further cardiac evaluation is suggested."

1/28/2015 The sleep study was completed at the prison.

2/5/2015 A doctor referred the patient for a CPAP device.

2/18/2015 Wexford approved a CPAP machine.

2/20/2015 Calcium 7.9; sodium 136; potassium 4.6. No LFTs done.

2/25/2015 A CPAP unit was provided to the patient.

2/26/2015 Creatinine 1.72; cholesterol 156; HDL 35; LDL 97.

3/4/2015 HTN chronic clinic. The doctor documented that the patient just started with a CPAP machine. The BP was 145/76. The creatinine was documented as 1.72 and urinary protein was noted. The doctor noted fair control and increased lisinopril to 10 mg daily. The doctor did not mention blood lipids.

3/7/2015 Simvastatin was increased to 20 mg daily and lisinopril was increased to 10 mg daily.

6 The doctor failed to review labs which showed chronic kidney disease and cholesterol levels consistent with a 46% 10-year risk of heart disease or stroke. The doctor should have changed the statin to a high intensity statin.

17 At this point based on recent labs, the patient had a 54% 10-year risk of heart disease and should have been on a high intensity statin. This was not done. The patient had chronic kidney disease and the doctor increased the lisinopril. Caution should have been documented and the creatinine and potassium should have been monitored more closely when starting the increased dose.

Simvastatin 20 mg is not a high intensity statin. It is not even a moderate intensity statin.

Patient #29

3/17/2015 A doctor saw the patient for the annual HTN clinic. This was only two weeks after the last HTN chronic clinic visit, both of which were documented as annual visits. The doctor noted that the patient was now on CPAP. The BP was 140/68. The doctor took little history and noted that the blood pressure was in good control when it was not good control for a diabetic. The doctor noted that the patient was on 10 mg of simvastatin but made no evaluation of lipids or changed the dose to a proper dose for this patient. The creatinine was noted to be 1.72 but the patient wasn't diagnosed with nephropathy. Because of both diabetes and nephropathy the blood pressure should have been lowered to 130/80.

4/9/2015 Urine microalbumin 678; creatinine 1.64; A1c 10.2; cholesterol 144; HDL 34; LDL 93.

4/15/2015 NPH increased to 68 am and 36 pm.

4/15/2015 A doctor saw the patient for annual diabetic clinic. The doctor took no history with respect to diabetes. The BMI was 41.5. The doctor did check the box that the patient had no hypoglycemia episodes. The A1c was listed as 10.4; the creatinine was listed as 1.64 which was elevated, the urine microalbumin was 678. The lipids were listed as in good control because the LDL was <100. The doctor diagnosed poor control but added "control stable." The doctor made a minor increase to insulin to 68 NPH am and 36 pm.

4/20/2015 The patient complained to a nurse of shortness of breath. The nurse referred to a doctor.

3, 17 With diabetes, hypertension and nephropathy a blood pressure of 130/80 is typically the goal. Being on Lisinopril with nephropathy was a concern. The patient should have been on a high intensity statin.

17 The doctor did not utilize a high intensity statin.

Patient #29

4/21/2015 A doctor saw the patient for shortness of breath. The blood pressure was 148/75. The patient complained of three weeks of shortness of breath making him stop and rest on his way to the dining hall. He had no chest pain and was using his CPAP regularly. The doctor diagnosed "CHF?" and ordered only a CXR, EKG, BNP and increased Lasix to 40 BID with a follow up in two weeks. The doctor did not order an echocardiogram.

4/22/2015 BNP 139 (<100).

4/23/2015 A chest x-ray showed mild to moderate cardiomegaly.

4/27/2015 An EKG was done. The tracing was technically very poor and should have been repeated. It showed NSSTT wave changes indicating possible lateral ischemia.

4/29/2015 A nurse saw the patient using a "cold" protocol. The patient had productive cough for 10 days with some shortness of breath. The nurse auscultated wheezing and assessed a complication of asthma and referred to a physician.

4/29/2015 A doctor saw the patient and noted that he had cough for nine days. No additional history was taken beyond what the nurse obtained. The doctor noted that the patient had a recent chest x-ray and noted that there was cardiomegaly. The doctor noted that the BNP was not significantly elevated. The doctor started Augmentin for 10 days.

5/7/2015 A doctor saw the patient in follow up and the patient was improved. No additional steps were taken.

5/7/2015 For unclear reasons the doctor discussed a "living will" with the patient who told the doctor that his brother had power of attorney and he wished a no code status. A DNR was filled out.

5/15/2015 Alvesco was started for asthma added to Xopenex.

7 The patient could have had angina or heart failure. An echocardiogram should have been considered and stress testing should have been considered given the patient's risk profile and symptoms.

7 Given the patient's symptoms and chest film, a stress echocardiogram and pulmonary function testing should probably have been done as the doctor did not know the diagnosis and apparently was working on hunches.

Patient #29

5/15/2015 A doctor saw the patient. The BP was 153/78. The patient had shortness of breath with exertion but no chest pain. The patient was using Xopenex regularly. The patient had a history of smoking. The doctor diagnosed dyspnea due to obesity and deconditioning. The doctor ordered a BMP and added Alvesco.

5/15/2015 Creatinine 1.62.

7/6/2015 A nurse saw the patient using a "cold" protocol. The nurse documented cough and sore throat. The BP was 132/71; oxygen saturation was 96%. The nurse gave the patient cold tablets by protocol.

7/13/2015 Oral prednisone was started at a tapering schedule.

7/13/2015 A doctor saw the patient for asthma chronic clinic. The doctor noted that the patient was on Alvesco and Xopenex and described increased shortness of breath 2-3 days. The BP was 140/75. The breath sounds were decreased with wheezing. The PEFs were 275/150/150. The doctor diagnosed moderate persistent asthma and added "deteriorating SOB but not so sure is [secondary] asthma contributory." The doctor ordered a chest x-ray and ordered a tapering prednisone dose.

7/20/2015 A chest x-ray showed enlarged heart and haziness in perihilar regions possibly indicative of mild heart failure.

7/22/2015 A1c 9.4.

7/23/2015 A doctor saw the patient for follow up. BP was 145/78; PEFs were 300/285/250. The doctor had started prednisone and mentioned that "prednisone helped." The patient was "breathing heavy" and had shortness of breath. The patient said it was seasonal. The doctor ordered prednisone every other day for two weeks and increased the Alvesco dose.

8/8/2015 Lasix increased to 60 BID; atenolol started 25 mg daily.

7 The doctor should have ordered pulmonary function testing and echocardiogram. Stress testing should have been considered.

7 The doctor should have ordered pulmonary function testing and echocardiogram. Stress testing should have been considered. The doctor did not appear to know the condition of the patient.

1, 7 The doctor took inadequate history about the shortness of breath. He should have obtained pulmonary function testing and echocardiogram as the doctor didn't appear to understand the diagnosis of the patient. The doctor diagnosed asthma but other evidence (CXR) was consistent with heart failure. The history may have helped but was not done.

Patient #29

8/8/2015 The patient was admitted to the infirmary for shortness of breath at rest and with exertion. The doctor thought he heard an S3 heart sound and there were basilar crackles in the lungs. There was 1+ bilateral pitting edema. The doctor diagnosed heart failure and ordered Lasix increased to 60 mg BID but did not order an echocardiogram, a basic diagnostic evaluation of persons with heart failure. The BP was 136/74; pulse 90; R 20 and oxygen saturation 92%.

8/8/2015 A doctor saw the patient in diabetes clinic. The patient had used insulin for 29 years. The doctor noted retinopathy, nephropathy, and neuropathy. The BP was 136/74 and BMI 42.9. The doctor noted that the patient had a chest x-ray showing cardiomegaly. The doctor examined the feet, noted that the optometrist had seen the patient, noted an A1c of 9.4 and LDL of 93 and creatinine of 1.62 with urine protein of 678. The doctor ordered an EKG, TSH, and admitted the patient to the infirmary for heart failure and increased the Lasix to 60 BID. Remarkably, there was no history with respect to why the doctor thought the patient had acute heart failure. The doctor did not change the statin dose. The doctor noted that the patient was in poor diabetic control but made no change to therapy. The doctor documented good lipid control and fair HTN control but did not change medication.

8/10/2015 An EKG was done. The tracing was poor quality and should have been repeated. It showed NSSTT changes.

8/13/2015 Without seeing the patient on the infirmary, a doctor discharged the patient on 8/13/15. The doctor documented that the edema was decreased, ordered a BMP and told the patient to stop using Ramen noodles.

7 The patient likely had heart failure but the doctor did not order an echocardiogram a basic diagnostic test for this condition.

Patient #29

8/13/2015 An EKG was done. The tracing was very poor and none of the limb leads were present. The automated reading stated that inferior infarct could not be ruled out.

8/13/2015 BUN 25; creatinine 1.97.

8/29/2015 A doctor saw the patient. The BP was 150/64. The doctor said that the patient was doing better. The doctor assessed heart failure, stopped Norvasc and started atenolol.

7 The doctor should have referred the patient for echocardiogram.

9/26/2015 A doctor saw the patient and the BP was 138/76.. The doctor noted no chest pain. The doctor noted that the hypertension was "controlled" and that the patient had no exercise intolerance. No changes were made.

10/1/2015 BUN 21; creatinine 1.88; glucose 304.

10/14/2015 A doctor saw the patient for HTN clinic and noted that the patient also had heart failure, DM, and sleep apnea. The doctor noted that the patient had dyspnea on exertion and shortness of breath. The blood pressure was 139/72. The creatinine was 1.88; glucose 304 and cholesterol 144. The patient was listed as in good hypertension control.

7, 17 The doctor failed to order echocardiogram, pulmonary function tests and stress testing. The doctor did not start a high intensity statin.

11/25/2015 A doctor saw the patient. The BP was 152/89. PEFrs were 200/175/150. Oxygen saturation was 94%. The patient had shortness of breath and DOE. The patient wanted to change back to Norvasc. The patient's DNR status was changed at his desire to attempt resuscitation. The doctor stopped atenolol and restarted Norvasc at 5 mg a day.

7 The doctor should have ordered echocardiogram and PFT and stress testing.

11/25/2015 A1c 8.4.

12/29/2015 A doctor saw the patient for diabetes chronic clinic annual. There was virtually no history except to check a few of the formatted boxes. The blood pressure was 136/76. The A1c was listed as 8.4. The diabetes was documented as fair control; lipids in good control and BP in good control. There was no change in therapy.

17 The doctor should have started high intensity statin.

Patient #29

1/15/2016 Lisinopril was changed to 20 mg daily.

1/15/2016 A doctor saw the patient in asthma chronic clinic. The doctor noted daytime symptoms but no night time symptoms. The blood pressure was 138/78. PEFs were 225/225/230. The patient had bilateral ronchi. The doctor diagnosed moderate persistent asthma.

1/28/2016 A doctor saw the patient for chest pain which occurred at night when he was lying in bed. The blood pressure was 169/94 with pulse 100. The chest pain was described as right sided without radiation, not pleuritis, without shortness of breath, and without prior similar episodes. The patient had previously told a nurse that exertion relieved the pain. The doctor noted a prior family history of CAD. The patient had 1+ edema. The doctor documented review of an EKG and noted "no acute changes." Remarkably, the doctor told the patient that, "He will need a treadmill when discharged." Yet the doctor did not discuss getting a treadmill currently for the patient's acute symptoms. If the doctor thought that the patient needed a treadmill he should have ordered it. The doctor increased the Norvasc to 10 mg and recommended decreasing salt.

1/28/2016 An EKG on this date was a poor tracing and should have been repeated. It showed NSST changes but the limb leads were technically poorly traced and unreadable and this study should have been repeated. V1 and V2 showed ST elevation on one portion. This should have been repeated but should otherwise have been considered consistent with possible ischemia.

7, 14 The patient was very high risk for heart disease and had a questionable history of angina. The doctor should have ordered stress testing and echocardiogram. He was 66 years old, smoker, diabetic, with hypertension and abnormal lipids. This panel of conditions is very high risk for heart disease. The EKG supported ischemia sufficient to warrant evaluation. The doctor should have considered sending the patient to a hospital for evaluation. To tell the patient to get a treadmill test on discharge was indifferent.

Patient #29

3/6/2016 At 3:10 am a nurse saw the patient for "sudden" shortness of breath. The patient had 2+ edema. The nurse did not take BP but the pulse was 107 and the pulse oximeter reading was 85%. The nurse called a doctor. Oxygen was started. The doctor ordered IM Lasix by phone. The oxygen saturation decreased to the 60s and the doctor ordered the nurse to send the patient to a hospital. The ambulance arrived at 3:40 am. As ambulance personnel were transferring the patient he experienced cardiac arrest and CPR was initiated but the patient was pronounced dead at the hospital.

3/7/2016 A Wexford death summary documented a brief death summary without any critical evaluation. The doctor noted that "The last time I saw the patient 12/28/15 and his ECG was normal." No problems were identified.

It was not accurate that the EKG was normal. The tracing was poor but showed STT wave changes that could be interpreted as acute ischemia.

3/24/2016 A coroner concluded that the patient died from coronary atherosclerosis contributed to by hypertensive cardiovascular disease and diabetes mellitus. There was "marked" edema in the lungs. Cross sections of coronary arteries showed 75-100% stenosis of the RCA with mid segment plaque and focal acute rupture and hemorrhage. The "left sided coronary arteries show between 75-85% stenosis with atherosclerotic plaque." Cardiomegaly with hypertrophy were diagnosed and sclerosis of the kidneys consistent with hypertensive cardiovascular disease. Pulmonary edema was noted.

Patient #30

7/10/2012 The problem list was updated indicating seizure with VP shunt; DVT, CVA.

10/15/2012 An annual physical documented that the patient had DVT, hemiparesis, seizure disorder, and hydrocephalus with VP shunt in 1993. It didn't document why the patient had a VP shunt or hemiparesis. The patient was documented as DNR.

9/25/2014 The patient was evaluated for seizure and general medicine clinics at Menard. The doctor documented two seizures and documented that the INR was 1.8. There was virtually no history. The doctor listed hyperthyroidism and DVT as problems. The TSH was listed as 2.16. There was no change to medication.

1, 3, 17 There was no history so it couldn't be determined what was wrong with the patient. The patient had history of DVT but the INR was subtherapeutic, yet the doctor made no attempt to modify medication. The patient had two seizures which is not good control, yet the doctor did not modify medication. The patient was on both aspirin and coumadin yet had repeated seizures. There was no documented clinical reason for being on aspirin. It placed the patient at significant risk, especially since he had a VP shunt.

10/22/2014 An annual physical exam listed seizures, history of DVT on anticoagulation, and VP shunt for unspecified reasons.

11/30/2014 A NP saw the patient for general medicine chronic clinic. There was no history, no physical examination, and the only relevant data was documentation of a TSH of 2.16.

1, 2, 3, 17 There was no history or examination and therefore the anticoagulation, VP shunt, and prior CVA were inadequately addressed and therefore, the therapeutic plan was inadequate. The NP failed to address why the patient was on aspirin *and* coumadin. There was no clinical indication for both drugs. It placed the patient at risk.

Patient #30

1/8/2015 CT scan showed left sided VP shunt with no evidence of ventricular dilation and no cerebral edema.

1/8/2015 The patient was sent to Chester Memorial Hospital for a seizure. The hospital noted that he had a VP shunt and was on multiple seizure medications and had uncontrolled seizures. A CT scan did not reveal unusual problems. Laboratory studies were "unremarkable." The patient did have a hemoglobin of 9. He was admitted for observation and discharged on 1/9/15.

1/8/2015 A nurse noted that the patient had seizure. The patient was sent to Chester hospital from Menard.

1/15/2015 Hemoglobin 9; MCV 70.7 (80-99); platelets 321; Keppra 26 (12-46).

1/15/2015 A nurse noted that the patient had repetitive seizures, apparently witnessed, called a doctor. The doctor ordered Ativan, Tegretol, Keppra, and phenobarbital levels in the morning and send-out to Chester hospital. The nurse noted that the patient had a subclavian port-a-cath but it wasn't clearly stated why the patient had the central line catheter. There was no mention of this in progress notes.

1/16/2015 Carbamazepine 8.6 (4-12); phenobarbital 18.4 (15-40); phenytoin <2.5 (10-20).

Patient #30

- 1/16/2015 The inmate told a nurse he had a seizure. A doctor saw the patient later and there was no history and the only examination was "neuro intact." No action was taken.
- 1, 2, 12, 17 The history and physical examination were inadequate. The patient had repetitive seizures and had a VP shunt. The patient should have been referred to a neurologist because the facility physician was unable to get the seizures under control and the patient had a complicated case, having a VP shunt. The patient had a microcytic anemia yet the doctor took no history of whether there was blood loss and did not initiate a work up for this. The doctor should have noted why the aspirin was indicated, as in combination with coumadin placed the patient at significant risk with respect to his seizures.
- 1/18/2015 The patient had an unwitnessed seizure and was admitted to the infirmary for observation.
- 1/19/2015 A doctor wrote an admission note but took no history. The only neurological exam was "neuro intact." No new actions taken. The same day the doctor discharged the patient without follow up. Later on the same day a doctor noted microcytic hypochromic anemia and the only plan was to order iron and stool for fecal occult blood x 3.
- 1, 2, 6, 8, 17 The doctor took no history and the examination was inadequate. The doctor should have ordered iron laboratory studies but did not. Obtaining fecal occult blood tests was appropriate and starting iron was reasonable. But the doctor needed further work up for the anemia. The doctor also failed to assess prior therapeutic drug levels. The doctor also failed to indicate why the patient was on both aspirin and coumadin. Since the patient had seizures, this placed him at significant risk.

Patient #30

1/22/2015 INR 3; carbamazepine 8.7 (4-12); Keppra 24 (12-46).

2/2/2015 A doctor noted that the patient had no seizures. Aside from stating no seizures 1, 2, 3, 6 The doctor took no history and performed no examination. The doctor made no assessments or plan. The doctor noted that the seizure medication levels were OK. Recent labs from 1/22/15 were normal but labs from 1/16/15 showed a subtherapeutic dilantin level which was unnoticed.

2/21/2015 A doctor saw the patient for seizure disorder. The doctor noted that the patient had >6 seizures since the previous clinic and noted normal drug levels. There was virtually no history. The doctor diagnosed the patient as having "stable" disease. Despite normal drug levels and multiple breakthrough seizures, a prior history of significant brain injury and a VP shunt, the patient was not referred to a neurologist. There was no change in therapy despite the breakthrough seizures.

1, 7, 17 The doctor took inadequate history. Since the patient had a complicated seizure problem and the facility doctor (who was a surgeon) couldn't control the inmate's seizures, the doctor should have referred to a neurologist. The doctor should have noted why the aspirin was indicated as in combination with coumadin placed the patient at significant risk with respect to his seizures.

3/22/2015 A nurse documented that the patient had a seizure. The nurse took an order from the doctor to leave the inmate in his cell.

3/23/2015 INR 2.8.

4/24/2015 INR 2.3; hemoglobin 12.9; MCV 83; MCH 25.8 (26-35); MCHC 31 (32-37).

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Patient #30

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| <p>6/7/2015 The patient was evaluated apparently in general medicine clinic. There was no history, no examination, and the only documentation was that the TSH was 3.29. The patient was listed as stable and in good control but his condition was not documented, although presumably he was being seen for hypothyroidism.</p> | <p>1, 2, 3, 17 There was no history, physical examination or assessment of the patient's multiple problems including epilepsy, VP shunt or anticoagulation. The patient still had anemia which had not been worked up appropriately. The doctor should have noted why the aspirin was indicated as in combination with coumadin placed the patient at significant risk with respect to his seizures.</p> |
| <p>6/17/2015 INR 2.3.</p> | |
| <p>7/7/2015 INR 2.2; phenobarbital 19.6 (15-40); Keppra 27 (12-46).</p> | |
| <p>7/17/2015 A nurse saw the patient for a seizure. The nurse tried to call a doctor 3xs but was unsuccessful and admitted the patient to the infirmary.</p> | |
| <p>7/18/2015 The doctor noted that the patient's last seizure was four months ago. The doctor did not order therapeutic drug levels. A doctor wrote that the patient could return to the housing unit. The doctor didn't take an adequate history and there was no change of plan.</p> | <p>1, 8, 17 The doctor took inadequate history and should have ordered therapeutic drug levels. The doctor should have noted why the aspirin was indicated as in combination with coumadin placed the patient at significant risk with respect to his seizures.</p> |
| <p>7/23/2015 Hemoglobin 14 (13.2-18); MCHC 31.8 (32-37).</p> | |
| <p>8/5/2015 INR 2.9.</p> | |

Patient #30

- 9/8/2015 A NP saw the patient for seizure chronic clinic. The last documented seizure was two months ago. The patient was documented as having no signs of bleeding and was documented as on coumadin. The Keppra and phenobarbital levels were documented. The only medications documented were Keppra and Tegretol. The patient was on aspirin and coumadin which in combination, particularly because of the seizures, was potentially dangerous. The INR wasn't mentioned. There was insufficient information in this note to give a sense of the current management or the future therapeutic plan for the patient.
- 9/10/2015 INR 3.3.
- 10/1/2015 INR 1.5.
- 10/1/2015 A nurse documented that the patient had dizziness, blurred vision and lethargy. The nurse noted that the patient still had a subclavian catheter and that it was accessed for a blood draw.
- 10/17/2015 A nurse noted that an officer witnessed the patient having a seizure. The nurse called a doctor who ordered drug levels in the morning. The nurse documented that cellies and officers witnessed the event.
- 10/19/2015 A nurse noted that the subclavian catheter flushed but could not be aspirated. The next day the nurse was able to obtain blood from the port.
- 10/20/2015 INR 3.9; carbamazepine 10.4 (4-12); Keppra 25 (12-46).
- 6, 17 The NP failed to check the INR and did not note that the patient was on both coumadin and aspirin which, given his seizure disorder, placed the patient at risk.
- 15 The doctor failed to see the patient or follow up after a seizure.
- The medication renewal process didn't work and the patient's medication stopped in mid December and wasn't started again until 1/8/17, about 3-4 weeks later.

Patient #30

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| <p>10/22/2015 Dr. Trost saw the patient and noted that the INR was 3.9. There was no history, no examination, and no assessment. The coumadin was held for seven days and then resumed at 4 mg daily.</p> | <p>17 The doctor did not indicate why the patient was receiving aspirin. The doctor should have noted why the aspirin was indicated, as in combination with coumadin, placed the patient at significant risk with respect to his seizures.</p> |
| <p>10/25/2015 The NP noted a supratherapeutic INR but did not adjust medication and did not note that the patient was on both coumadin and aspirin which, given his seizure disorder, placed the patient at risk. The history was inadequate for seizure disorder and anticoagulation and the NP asked no questions about the VP shunt.</p> | <p>1, 17 The NP noted a supratherapeutic INR but did not adjust medication and did not note that the patient was on both coumadin and aspirin which, given his seizure disorder, placed the patient at risk. The history was inadequate for seizure disorder and anticoagulation and the NP asked no questions about the VP shunt.</p> |
| <p>10/30/2015 A nurse noted that the patient had a reported seizure and was brought to the health unit in a wheelchair. The patient had headache. The nurse called Dr. Trost, who sent the patient back to his cell with follow up as needed with nurses.</p> | <p>15 The doctor should have seen the patient and should have ordered follow up as a seizure is a significant event.</p> |
| <p>11/3/2015 A nurse noted that the patient had seizure. Dr. Trost gave a phone order for the patient to return to his cell.</p> | <p>15 This was indifferent. The doctor should have evaluated the patient.</p> |
| <p>11/20/2015 INR 2.4.</p> | |
| <p>11/22/2015 A nurse saw the patient for an unwitnessed seizure. The nurse documented calling a doctor but did not document what the doctor ordered. The patient was sent back to his cell. Later that day a doctor saw the patient. The doctor documented an episode of convulsion for four minutes. The doctor documented no abnormalities on exam and sent the patient back to his cell.</p> | |
| <p>11/29/2015 A nurse saw the patient for a seizure. The patient was returned to his cell.</p> | |
| <p>12/14/2015 INR 2.</p> | |

Patient #30

12/17/2015 The patient transferred to Hill from Menard. The transfer summary documented seizures and VP shunt as problems. The reason for either of these was not mentioned.

12/17/2015 Shortly after the patient transferred to Hill he had a seizure. A nurse witnessed the seizure for an hour. The nurse called Dr. Sood, and Ativan was repeatedly given. Dr. Sood wrote an order to give Ativan 2 mg IM stat for "continuous seizure activity" the "send out if unresponsive to therapy and continuous seizures." After multiple injections of Ativan the patient was sent to a hospital. The patient went to Cottage ER. From the local hospital the patient was transferred to OSF St. Francis Hospital in Peoria.

12/22/2015 The patient returned to the Hill facility and a doctor saw the patient. The doctor did not document what occurred at the hospital. The doctor reviewed the patient instructions. The doctor noted that the patient had history of ataxia [presumably from the hospital] but documented no ataxia. The doctor initiated the patient's seizure meds (Depakote and phenobarbital) and apparently sent back to his cell.

12/22/2015 At 6:29 pm a nurse documented that the inmate's cell mate noted that the inmate was having a seizure. Dr. Sood ordered IM Ativan 2 mg. The nurse noted two further seizures, after which Dr. Sood ordered IM Ativan. After the fourth seizure the patient was sent to a hospital.

12/22/2015 At 10:56 pm a nurse documented that the hospital stated that the inmate was having non-epileptic convulsions, was not having seizures and would return to Hill.

12/22/2015 The patient was admitted to a local hospital and transferred to a regional hospital in Peoria. He transferred from the local hospital intubated but was extubated the same day. He had EEG leads in the ICU and while having "seizures" there was no EEG activity and ultimately was determined to have pseudoseizure activity. The INR was 2. The hospital noted that at the local hospital a CT scan showed no acute bleed.

11 The lack of review of reports is a serious problem. The physician did not know what occurred at the hospital or the basis of the therapeutic plan.

Patient #30

- 12/23/2015 A nurse noted drawing blood from the central IV port which was in for the past year without clear indication.
- 12/23/2015 The patient was admitted to the infirmary post hospitalization. The reason for admission was frequent seizures and ataxia. The nurse documented that the patient had ataxic gait.
- 12/23/2015 An NP performed an infirmary admission note. The NP documented that the patient fell twice on the infirmary on 12/23/15 due to ataxic gait. The NP noted that the left pupil was larger than the right and that the patient had delayed speech and repeated himself. The NP did not examine for ataxia. The NP noted that the patient had a VP shunt and that the epilepsy was not well controlled and that the patient had ataxia with falls. The NP ordered to have the mattress placed on the floor, neuro checks every shift, and for Dr. Sood to evaluate the patient. 2, 14, 17 The patient was said to have ataxia but there was no examination for this. Ataxia and unequal pupils in a person with VP shunt requires immediate hospitalization for brain imaging. To merely place a mattress on the floor was grossly and flagrantly unacceptable care. Also the staff did not assess why the patient was on aspirin as the combination of aspirin and coumadin placed the patient at risk of significant harm.
- 12/23/2015 At 4:30 pm a nurse documented that the patient was incontinent of urine. The nurse documented that the hospital would fax the neurology report and discharge note. 16
- 12/23/2015 At 7:30 am a nurse documented that the patient fell twice. The nurse noted that the patient's Lt pupil was larger than the right. On a later note at 3:00 pm, a nurse documented that the patient fell twice today. 16 These were all red-flag type symptoms and signs and the patient should have been referred to a physician immediately. Care was grossly and flagrantly unacceptable.
- 12/24/2015 INR 3.1.
- 12/24/2015 At 6:20 pm the patient rang the emergency call light. When the nurse arrived the patient was off the floor mattress and was incontinent of urine. The nurse presumed that the patient had a seizure. The nurse apparently called a doctor but there were no orders documented.

Patient #30

12/24/2015 Dr. Sood saw the patient on rounds and noted that the staff said the patient had incontinence of urine. The doctor documented good eye contact, that the patient was sitting on the mattress. The doctor did not perform an adequate neurological examination. The assessment was intractable seizures. The doctor did not assess why the patient had incontinence. The doctor did not assess the unequal pupils or ataxia. The patient was to continue the same management.	1, 2, 4, 17	The doctor's history failed to determine why the patient was incontinent or whether he had a seizure. There was inadequate neurological examination. The doctor did not assess the pupils; apparently the patient still had unequal pupils. The doctor did not assess the ataxia. The doctor had no plan for the incontinence, ataxia, unequal pupils, or abnormal behavior. The doctor did not assess why the patient was on both aspirin and coumadin. Care was grossly and flagrantly unacceptable.
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Patient #30

12/24/2015 A nurse documented that the inmate was attempting to stand but needed assistance. The nurse described the inmate as able to swallow water and making intermittent eye contact but was not otherwise interacting in conversation and was uncooperative with the neuro examination. No action was taken. On a later note at 4:00 pm, a nurse documented that the patient was attempting to sit up without assistance. His pulse was 122. The patient was not responsive to commands but was responsive to painful stimuli. The nurse documented unequal pupils. The patient was staring out without being responsive. The nurse applied oxygen but it wasn't sure there was an order for this. The nurse noted that the patient had urinated on the bedsheets. Three people were required to assist the patient in getting up. The nurse applied diapers. The nurse documented that the patient had a seizure but it appeared that the patient was continuously disorganized, lethargic, and confused. The nurse didn't document consulting a doctor. Later at 5:00 pm, the patient's cellie called the nurse back to the room because the inmate was trying to get up again. This was not normal behavior and should have been immediately evaluated. The patient should have been sent to a hospital. The nurse diagnosed post-ictal status. But the behavior had been ongoing for two hours. The nurse documented that the patient was still not responding to commands and since he wasn't drinking water, she held his oral medication. At 7:00 pm, the patient was in a reclining chair and earlier had drinking some water but the nurse noted that he hadn't eaten. At 8:00 pm, the patient took his meds with some pudding. At midnight with assistance of two inmates the patient was placed on the floor and was noted to be incontinent.

16 Nursing assessments without referral were grossly and flagrantly unacceptable. The patient should have had a better history, a thorough examination, and should have been sent to a hospital. The nurse needed to consult a physician.

Patient #30

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| <p>12/25/2015 The patient wasn't responsive, barely moving legs and opening his eyes just a slit. He wasn't answering questions. The nurse noted that the left pupil was larger than the right. The assessment was post ictal. At 9:30 am the patient was incontinent. The patient needed assistance to get off the mattress and was unable to drink with a straw. Later a nurse reported to Dr. Sood and was instructed to continue to observe the patient. At 4:15 pm a nurse noted that the inmate responded to tissue being moved across his eyes. The nurse documented that Dr. Sood was made aware of the patient's condition. Later at 8:30 pm the patient was incontinent.</p> | <p>14, 15 The patient showed several red-flag signs of significant life-threatening illness including unequal pupil, altered mental status, and lack of responsiveness. The doctor should have sent the patient immediately to a hospital and immediately evaluate the patient.</p> |
| <p>12/26/2015 At midnight the patient was still unresponsive and was incontinent. The nurse described the patient as "post-ictal like state." The patient was not drinking. By 8:00 pm the patient was responding verbally to questions and his speech was sluggish but intelligible. The patient ate some food. Nurses continued to document unequal pupils.</p> | <p>16 The patient had red-flag signs of significant life-threatening illness. The nurse should have consulted a physician.</p> |
| <p>12/27/2015 At 3:00 am the inmate was trying to get up out of bed but was unsteady. He was incontinent of urine. At 5:20 am the inmate was found on the floor and placed back in bed. At 6:00 am the patient was found with his chair on top of him. The patient was now eating. At 4:30 pm a nurse documented that there was bruising on both elbows and the left elbow with a 3 by 3 cm purple area that was pliable. Since the patient was on coumadin the patient should have been promptly evaluated for bleeding problems and there was concern for a CNS bleed. A stat INR should have been obtained. At 8:00 pm a nurse noted that the patient ate 100% of his dinner.</p> | <p>16</p> |
| <p>12/28/2015 A nurse noted that the patient was incontinent and the bedding was saturated with urine. At 7:15 am the patient was noted to be responding to commands but slow to follow orders.</p> | <p>16 The patient had red-flag signs of significant life-threatening illness. The nurse should have consulted a physician.</p> |

Patient #30

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| <p>12/28/2015 Dr Sood saw the patient. The only history was that the patient was responding to commands. Dr. Sood noted that the patient was sitting on the floor and that according to staff he had eaten yesterday and took all of his medication. The doctor didn't assess for ataxia, didn't assess the unequal pupils, and performed no neurological examination. The doctor assessed seizure recurrence. There was no plan.</p> | <p>1, 2, 8, 14, 17</p> | <p>The doctor failed to take an adequate history. The doctor failed to note bruising identified by nurses earlier. The doctor failed to document a neurologic examination despite being called several times for altered mental status. The doctor failed to assess why the patient was on aspirin and coumadin or check an INR despite bruising. Altered mental status and bruising in someone with a VP shunt and on Coumadin and aspirin should have resulted in hospitalization for immediate brain imaging. The lack of history and examination was indifferent and grossly and flagrantly unacceptable care. The doctor did not address why the patient was on aspirin despite the bruising.</p> |
| <p>12/28/2015 A nurse noted that the patient had constipation. The patient was still incontinent of urine.</p> | | |
| <p>12/29/2015 Dr. Sood saw the patient. The doctor noted that the patient was sleeping on the mattress. Dr. Sood noted that the patient's bloody elbows were resolving with decreased swelling. The doctor changed the patient's status to chronic. The doctor had yet to examine the patient's eyes, perform a neurologic examination, or evaluate the patient for problems with anticoagulation in light of the patients severe altered mental status and recent bruising. The doctor made no changes except to lower the acuity status of the patient.</p> | <p>1, 2, 8, 14, 17</p> | <p>The doctor again failed to take adequate history or try to discover how the patient developed bloody elbows. The doctor failed to adequately examine the patient or order an INR to assess anticoagulation despite the patient having a bruising problem. The doctor failed to ask why the patient was on aspirin and coumadin. There was no clinical indication for the aspirin. The patient should have been sent to a hospital.</p> |

Patient #30

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| <p>12/29/2015 A nurse noted that the patient was climbing up and down out of the reclining chair. He ate some food. He was answering yes and no questions. At 11:00 pm the patient was incontinent of stool and was again unresponsive to verbal stimuli.</p> <p>12/30/2015 Carbamazepine 4.8 (4-12); phenobarbital 34.7 (15-40); valproic acid 38.1 (50-100).</p> <p>12/30/2015 The patient was incontinent of stool at 6:45 am. At 3:30 pm a nurse noted that the patient had bruising on his right arm and was on blood thinners. No action was taken.</p> <p>12/31/2015 The patient was still incontinent. At 2:00 pm a nurse noted bruising on both elbows and to bilateral knees, and lower back. There was no evaluation for supratherapeutic INR or excess anticoagulation. The inmate did ask to use the commode but did not have a bowel movement.</p> <p>1/1/2016 The patient was incontinent of urine. At 8:30 pm a nurse noted that he was sometimes responsive and sometimes unresponsive. The nurse noted persistent bruising on various areas of the body including the elbows.</p> <p>1/1/2016 Notably the patient was on 4 mg of coumadin and 81 mg of aspirin throughout his stay at Menard and Hill without any indication of why he needed aspirin or why he was on coumadin when he had an IVC filter. The IVC filter was apparently not known to staff.</p> <p>1/2/2016 The patient knew that he was in prison. The nurse noted large ecchymoses on his arms and thighs. Yet there was no evaluation of INR level.</p> <p>1/3/2016 At 4:30 am the nurse responded to an emergency call light and the patient was standing naked in the middle of the cell saying he had to go to the bathroom. The nurse assisted him to the toilet with a gait belt. At 5:30 am the nurse responded to the call light and the inmate was sitting on the floor saying he was hungry.</p> | <p>16 The patient had red-flag signs of significant life-threatening illness. The nurse should have consulted a physician.</p> <p>16 The patient had red-flag signs of significant life-threatening illness. The nurse should have consulted a physician.</p> <p>16 The patient had red-flag signs of significant life-threatening illness. The nurse should have consulted a physician.</p> <p>16 The patient had red-flag signs of significant life-threatening illness. The nurse should have consulted a physician.</p> <p>16 The patient had red-flag signs of significant life-threatening illness. The nurse should have consulted a physician.</p> <p>16 The patient had red-flag signs of significant life-threatening illness. The nurse should have consulted a physician.</p> <p>16 The patient appeared to manifest altered mental status and the nurse should have consulted a physician.</p> |
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Patient #30

- 1/4/2016 At 6:05 am a nurse noted that the patient was sitting naked in the chair with his diaper on the floor. There was urine on the floor. The nurse noted that the inmate was confused as to the source of the liquid.
- 1/4/2016 Dr Sood saw the patient. He noted that the inmate was sitting in the chair. Dr. Sood noted that the patient made "good eye contact" but didn't evaluate the pupils which were described previously as unequal. Dr. Sood noted that the patient was responding to commands. He performed no neurological examination except to note that the patient was responding to commands. He did not examine the bruises or initiate evaluation for excessive anticoagulation or evaluate the obvious altered mental status of this patient. No labs or diagnostic tests were ordered.
- 1/4/2016 At 1:30 pm the patient was incontinent of stool. The patient was walked in the hall and had unsteady gait. At 6:40 pm a nurse saw the patient standing in his cell door with blood on his nose and in front of his gown. The inmate didn't know what happened but blood was on the wall and beside the toilet at head height. The inmate had a 2.5 cm laceration to the bridge of his nose. The INR wasn't checked. Dr. Sood was notified that it was hard to get the bleeding stopped. He did not order an INR. Later a nurse noted that the pupils were still unequal. The nurse noted bruising to the right buttock about 8 cm in diameter, on the lower back and noted "assorted bruising in various stages of healing to bilateral arms and legs." The nurse also noted unequal hand grips.
- 16 The patient had red-flag signs of significant life-threatening illness. The nurse should have consulted a physician.
- 2, 8, 14, 17 The doctor's physical examination was inadequate and he failed to note obvious abnormalities identified by nurses, especially the bruising and altered mental status. An INR should have been immediately done. The doctor should have identified why the patient was on aspirin and coumadin; the bruising was life-threatening and unrecognized by the doctor. The patient should have been sent to a hospital. Care was grossly and flagrantly unacceptable.
- 14 The patient had significant bruising and difficult to control bleeding with altered mental status and the doctor should have immediately transferred the patient to a hospital. Care was grossly and flagrantly unacceptable.

Patient #30

- 1/5/2016 At 6:50 am a nurse documented giving a report to the MD nurse regarding seepage of blood from the wound and red-tinged urine and bruising to back. Dr Sood saw the patient at 8:00 am. The only history was that he was seeing the patient because a nurse documented seeing the patient bleeding. There was no other history. His examination was poor. He noted that the patient was sitting in a chair responding to commands with conversation. He noted that there was active bleeding and ecchymosis on the buttock, lower back, and bilateral arms. The doctor sutured the nasal laceration but remarkably did not check an INR level to assess for potential for bleeding. The doctor made no evaluation of the altered mental status and performed no neurological examination but did order nasal bone x-rays.
- 1/5/2016 At 7:30 am a nurse noted that the patient still had unequal pupils. Notably Dr. Sood never evaluated this once. A nurse noted blood in the stool. At 7:02 pm a nurse noted moderate amount of blood in the toilet. The nurse called Dr. Sood and was awaiting a call back.
- 1/6/2016 X-ray showed no evidence of nasal fracture.
- 1/6/2016 A nurse showed Dr. Sood the urinal where the nurse noted "gross blood." Dr. Sood did not check the INR but ordered ciprofloxacin for five days and ordered a repeat dipstick urine. Later a nurse noted unsteady gait.
- 1/6/2016 UA showed 3+ blood.
- 1/7/2016 The inmate was able to feed himself with minimal assistance and complained he had been up all night and had "a lot of migraines."
- 1, 2, 8, 14, 17 The doctor failed to take adequate history and failed to perform an adequate examination particularly a neurological examination. The doctor failed to assess an INR despite numerous bruises and difficult to control bleeding. The patient had altered mental status and there was no evaluation. The doctor failed to assess why the patient was on aspirin and coumadin. The patient should have been sent to a hospital. Care was grossly and flagrantly unacceptable.
- 15 A physician should have seen the patient.
- 4, 14, 17 The patient was on coumadin and aspirin and had gross blood in his urine yet the doctor treated the patient with antibiotics for a presumed urine infection without checking an INR. The doctor failed to associate the coumadin and aspirin with bloody urine. This was incompetent and grossly and flagrantly unacceptable care. The patient should have been sent to a hospital.

Patient #30

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| <p>1/7/2016 Dr. Sood saw the patient and noted he was watching TV but took no history. It was difficult to read the note due to legibility but it did not appear that the doctor performed a neurologic examination. The assessment was pseudoseizure and DVT. Even though assessing DVT, Dr. Sood did not order an INR to evaluate for excess anticoagulation despite bruising, bleeding in his urine and in his BM. He took no action.</p> | <p>1, 2, 8, 14, 17</p> | <p>The doctor failed to take adequate history and failed to perform an adequate examination particularly a neurological examination. The doctor failed to assess an INR despite numerous bruises and difficult to control bleeding. The patient had altered mental status yet was not evaluated for this. The doctor failed to assess why the patient had bleeding while on coumadin and aspirin. The doctor failed to address why the patient was on aspirin. The patient should have been sent to a hospital. Care was grossly and flagrantly unacceptable.</p> |
| <p>1/7/2016 At 4:30 pm a nurse noted a moderate amount of blood in his urine. No action was taken.</p> | <p>16</p> | <p>The patient had red-flag signs of significant life-threatening illness. The nurse should have consulted a physician.</p> |
| <p>1/8/2016 At 9:30 am a nurse noted that the patient had bruises in both eyes. There was blood in his urine and he had bruises in various stages of healing. At 3:40 pm a nurse obtained urine for a UA and gross hematuria was observed. At 7:00 pm the patient had a BM and there was blood in the toilet.</p> | <p>16</p> | <p>The patient had red-flag signs of significant life-threatening illness. The nurse should have consulted a physician.</p> |
| <p>1/8/2016 At 11:50 pm a nurse noted that the inmate was standing at the door yelling "can you help me" and when asked what help he needed he said "I don't need any help." The nurse noted "some confusion." No action was taken.</p> | <p>16</p> | <p>The patient had red-flag signs of significant life-threatening illness. The nurse should have consulted a physician.</p> |
| <p>1/8/2016 UA showed 3+ blood.</p> | | |

Patient #30

1/9/2016 At 7:15 am the inmate was making sounds but didn't understand and needed assistance with gait. There was a new purple bruise on his right hip and the top of his head had dried blood. Dr. Sood was called and said to monitor the patient. At 11:00 am Dr. Sood ordered the patient sent to a hospital in another hour if there was no change. At 2:00 pm there was no change in the patient's condition. His pupils were fixed bilaterally based on a nurse evaluation. There was no response to sternal rub. An EKG was done and an ambulance took the patient off to the hospital at 2:15 pm.

1/10/2016 The patient died.

1/10/2016 A hospital record documented that the patient arrived at the hospital unresponsive. He had an INR of 10 and the CT scan showed a massive herniation and massive right sided subdural hematoma with a 16 mm shift of the brain across midline. Pupils were fixed and dilated. At the hospital they noted that it wasn't certain why he was on anticoagulation. On examination the patient had fixed dilated pupils, a contusion and laceration on top of the head. The WBC was 17.9; hemoglobin 9.3; INR 10; potassium 3.4. The diagnosis was hypercoagulable state secondary to coumadin with large subdural hematoma with brain herniation. The patient was not recoverable under admitting conditions. A CT scan of the abdomen and pelvis showed a possible contusion/hematoma overlying the right greater trochanter without fracture. Notably the hospital noted that the patient had a right central venous line in place with an implantable port. It was not clear why the patient had this device as he was not on chemotherapy.

14, 15 The patient had further bruising, was confused, and needed assistance to walk. The doctor should have immediately sent the patient to a hospital. Care was grossly and flagrantly unacceptable.

The patient had a brain bleed due to over anticoagulation while on both coumadin and aspirin. The patient had repeated manifestations of excessive anticoagulation and repeated manifestations of altered brain function yet was not appropriately evaluated. Care was grossly and flagrantly unacceptable.

Patient #30

1/12/2016 Dr. Sood wrote a death summary stating that he was transferred from Menard to Hill on 12/17/15 with a history of seizure disorder secondary to a craniotomy in 1996. The patient had multiple DVTs and PE in the past and had LV shunt placement in 1996 secondary to hydrocephalus. The patient developed bacterial meningitis in 2001. In 2005 the patient had an IVC placed for unclear reasons. Dr. Sood said that the patient had a chronic left subdural hematoma in 2001.

Patient #31

- 6/24/2013 Problem list documents DM, HTN, substance abuse, umbilical hernia,
- 8/1/2013 The patient was transferred from NRC to Taylorville.
- 8/13/2013 HTN and DM clinics documented BP 135/68 with weight of 300 pounds. The patient also had diabetes and therefore the blood pressure was not at recommended goal yet the patient was listed as "in control." The patient had 1-2+ edema. The doctor noted that the patient had diabetes and added aspirin and simvastatin. The patient was also on metformin, lisinopril, and HCTZ.
- 11/15/2013 A nurse saw the patient at the request of the Warden who asked to evaluate a large growth on his left ear that was bleeding.
- 11/19/2013 A doctor noted that the patient had a left ear growth. The doctor referred the patient to an ENT consultant.
- 11/19/2013 A doctor referred the patient for removal of a growth.
- 11/30/2013 The ENT referral was denied; instead the patient was sent to plastic surgery.
- 1/7/2014 A nurse saw the patient. The BP was 153/79. The patient was off for a medical writ but the nurse didn't document what occurred.
- 1/7/2014 An ENT doctor recommended removal of the ear and cheek growths and correction of the ectropion.
- 1/17/2014 CMP and CBC normal.
- 1/31/2014 An annual examination was done. The BP was 151/81.
- 2/6/2014 A doctor noted that the patient was scheduled for an outpatient surgery appointment on 2/10/14.

Of note, there is not much difference in referral to a plastic surgeon vs an ENT surgeon for this condition. It merely depends on access in the community.

Patient #31

2/10/2014 The patient had outpatient surgery to remove the ear mass apparently. The return note did not document what occurred.

2/10/2014 A biopsy of the left ear was a basal cell carcinoma. The surgical margins were negative for tumor.

2/17/2014 A doctor saw the patient and noted that the growth had been removed. The doctor did not document what the pathological diagnosis was. A PRN follow up was ordered. The blood pressure was 144/81.

8/29/2014 CMP normal; cholesterol 171; TG 158; HDL 33; LDL 106.

9/3/2014 A progress note documented that the patient was seen in HTN and diabetic clinic but there was no note. 11 We could not locate a note.

11/18/2014 A1c 5.8.

12/9/2014 A progress note documented that the patient was seen in diabetic clinic but there was no note. 11 We could not locate a note.

2/18/2015 CMP normal; cholesterol 122; TG 121; HDL 33; LDL 65.

4/10/2015 CMP normal; cholesterol 131; TG 117; HDL 35; LDL 73.

4/29/2015 A doctor saw the patient for follow up of blood pressure. The blood pressure was 169/77 but the doctor made no changes. The doctor noted that the patient recently started Festeritic.

5/8/2015 BUN 21; glucose 126; cholesterol 127; TG 155; HDL 34; LDL 62.

5/14/2015 An annual examination was done. The BP was 156/76. The weight was 315. Aside from diabetes and HTN no other problems were mentioned. Apparently, a doctor re-did the blood pressure, which was 138/80.

5/22/2015 CMP normal; CBC normal.

Patient #31

- 5/27/2015 A doctor saw the patient. The blood pressure was 130/80. The weight was 310. The only examination was to record the blood pressure. There was no history except that the patient felt OK and had decreased caloric intake, was tolerating the ace inhibitor, had no chest pain and no dyspnea. That was the last note until the patient was diagnosed with squamous cell cancer.
- 6/5/2015 A discharge medical summary was written from Taylorville. There were no further notes and it wasn't clear where the patient went. It appeared that the patient was transferred to an adult transition center. The patient didn't come back to the prison until after a hospitalization where cancer was diagnosed. It is not clear what care the patient received in the adult transition center.
- 9/20/2016 An OSF Health care note. A CT scan was done. The history was that the patient had a right tongue mass for the past 2-3 months with right ear pain. The CT scan showed an ulcerated mass in the right anterior oral tongue measuring 4.7 cm with multiple abnormal lymph nodes and a left orbital intraconal mass between the lateral rectus muscle and the optic nerve sheath.
- 10/3/2016 An MRI showed an oral cavity squamous cell carcinoma on the right side of the tongue with multiple lymph nodes suspicious for metastatic adenopathy. A PET scan was recommended.
- 10/5/2016 A PET scan showed large malignancy of the right tongue with multiple lymph nodes. There were multiple pulmonary nodules suspicious for malignancy.

Patient #31

- 10/28/2016 An oncologist saw the patient and noted stage IV squamous cell cancer of the tongue. Radiation therapy was not an option. The oncologist recommended palliative chemotherapy. The patient had hyperkalemia. The patient weighed 242 pounds.
- 11/10/2016 A doctor admitted the patient to the infirmary for a history of oral squamous cell cancer with metastases. The doctor did not document a history of the patient's recent treatment.
- 11/17/2016 Glucose 167; T protein 5.7 (6-8); albumin 2.5 (3.4-5); WBC 18.6; hemoglobin 11.7 (13.2-18); platelets 561.
- 12/2/2016 The patient died while in hospice care at the facility.

Patient #32

- 12/6/2016 The patient was admitted to NRC. The medications on entry were not listed and there was no evidence of what the patient said he was taking. A PA did an initial physical examination and documented asthma, HTN, heart failure, COPD, diabetes, and ITP. There was no history of the ITP except that the patient had prior splenectomy. A blood glucose was 154. The patient's medication was listed as insulin NPH38 am and 20 pm with sliding scale regular insulin. Lisinopril, Coreg, Lasix, Zocor, and Flomax. Two other drugs were prescribed but the names were illegible.
- 12/6/2016 A transfer summary from the Lake County Jail documented that the patient was on NPH insulin, olanzapine, gabapentin, regular insulin QID, albuterol inhaler, carvedilol, ciclesonide inhaler, danocrine 600 BID, Lasix 40 Bid, ipratropium inhaler, lisinopril, tamsulosin, atorvastatin. Danocrine is danazol.
- 12/6/2016 BUN 23; glucose 157; creatinine 1.87 (0.5-1.5); albumin 2.9.
- 12/7/2016 A1c 9.4; cholesterol 136; HDL 29; LDL 96; WBC 14.6; platelets 60.
- 12/14/2016 Creatinine 1.36 (0.5-1.5).
- 12/28/2016 A nurse saw the patient for constant hip pain radiating to his back. The nurse plan was not clearly documented.
- 1/4/2017 The patient was transferred from NRC to Pinckneyville. It does not appear that blood tests had been done at NRC. The transfer form listed HTN, diabetes, asthma, and thrombocytopenia with prior splenectomy as problems. A blood sugar wasn't done on transfer.
- 1 ITP is a serious medical illness. The history of this condition was inadequate with respect to medication and current status and treatment. Old records should have been obtained.

Patient #32

- 1/6/2017 A doctor did a chart review to review medications. The doctor stopped Atrovent, danazol, ciclesonide, Zocor; increased ellipta, kept the patient on Neurontin and ordered chronic clinic as needed. The doctor also renewed insulin. Notably, it did not appear that the patient had a chronic clinic visit to date.
- 1/6/2017 Danazol was discontinued.
- 1/9/2017 An LPN wrote that the patient complained of not getting his medication and said that he hadn't seen a doctor yet and said that his hematologist had ordered his medication. The patient was upset that his medications were discontinued without having spoken with a doctor. The nurse noted that old records were needed. The nurse referred to a doctor.
- 1/17/2017 A doctor saw the patient who was concerned about not receiving Danazol, a drug he was previously prescribed. The doctor said the patient was taking this drug for low platelets in the past and that the last platelet count was 60 on 12/8/16. The doctor couldn't find a reference source that this drug was indicated for the patient's condition. The doctor documented that he would start the danazol and request old records. Danazol was started at 300mg BID for six months. This drug has an FDA box warning for thromboembolism, thrombotic, and thrombophlebitic events including life threatening or fatal strokes. The manufacturer also warns to use with caution in persons with diabetes as insulin requirements may increase. They recommend careful monitoring. Liver and renal function and hematologica and lipids are recommended to be monitored.
- 3 The doctor stopped a medication being used for ITP without documenting a therapeutic plan for the ITP. Old records should have been requested.
- 12 The doctor was using a medication without clear knowledge of use of the drug. The medication had multiple side effects. The doctor should have referred the patient promptly to a hematologist for management because the patient's condition was beyond the management ability of the physician.

Patient #32

1/18/2017 Danazol was re-started.

12, 17 The patient had elevated renal function in the past. Danazol is contraindicated in persons with markedly impaired renal function, so it needed to be monitored. The patient was on a fairly high dose of Danazol which had a black box warning for thromboembolism, thrombotic and thrombophlebitic events, and life-threatening or fatal strokes have been reported. The doctor should have referred the patient to a hematologist.

1/18/2017 Urine 300 mg/DL protein; microalbumin 1303 (0-30).

1/25/2017 A doctor saw the patient in hypertension chronic clinic. The blood pressure was 131/68. Renal function was not noted. The doctor stopped lisinopril, started Cozaar, and continued Pravachol, Lasix, and Coreg. The only problem noted was hypertension. There was no history related to chronic kidney disease or heart failure or the patient's other medical conditions except that dyslipidemia was noted. There was also a diabetic chronic clinic for this date. The patient was documented as having prior hyper and hypo glycemia without being more specific. The doctor noted that the patient had diabetic neuropathy but did not mention the nephropathy. The blood sugar wasn't checked and the A1c wasn't documented. The doctor continued the same diabetes medication. The doctor also saw the patient for "asthma" documenting on a separate note for this. The doctor documented daytime and nighttime symptoms. The PEFs were 225/200/200. The doctor noted that the patient was on Xopenex and increased Ellipta.

1, 12 The doctor did not monitor all of the patient's medical conditions. The doctor should have referred the patient to a hematologist because the ITP wasn't being monitored by someone who knew how to manage this disease.

Patient #32

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| <p>2/7/2017 A doctor wrote a brief note without seeing the patient. He documented that the platelets were 50 and therefore he was going to start prednisone, which he started at 60 mg daily tapering over a month and stopping at 10 mg.</p> <p>2/14/2017 BUN 29; sodium 133; glucose 548; creatinine 2.05; albumin 2.7; A1c 9.4; WBC 17; platelets 10.</p> <p>2/16/2017 A doctor documented discussing the problems with low platelets with a hematologist, who recommended giving the patient IVIG. The doctor sent the patient to a hospital in Carbondale who agreed to give the patient IVIG in the ER. The doctor referred to the ER. The patient should have been referred to a hematologist for evaluation. The doctor did not discuss the Danazol.</p> <p>2/17/2017 The doctor documented that the patient went to the ER and that platelets were 10 and that repeat platelets were 34. The doctor noted that no treatment "per hematology." The doctor's plan was to continue present therapy and returned the patient to general population. The doctor did not document whether hematology saw the patient.</p> <p>2/17/2017 The patient was seen at SIU Hospital ER. The WBC was 21, and platelets were 34 K. The albumin was 2.9; glucose 351; BUN 27; creatinine 1.5 (1.3). The ER note documented that the ER doctor consulted the hematologist who didn't see the patient. The doctor noted that the hematologist would see the patient in his office.</p> | <p>12 The doctor should have referred the patient to a hematologist to manage the ITP. The doctor should also have attempted to obtain old records for this patient.</p>
<p>6, 12 The doctor failed to note recent extremely high blood glucose and other lab abnormalities. The doctor should have referred the patient to a hematologist instead of attempting to manage a disease he was uncertain about.</p>
<p>10, 11 Apparently, when the patient went to the ER, the ER doctor called a hematologist, but the IDOC physician failed to review what the hematologist said because there was no record. There was no follow up.</p> |
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Patient #32

2/20/2017 The doctor at Pinckneyville wrote an undated note to Steve, presumably the Wexford Regional Medical Director. The note stated that the patient had a history of thrombocytopenia "(?ITP)" and that he was transferred to Pinckneyville and was off medication for weeks which were resumed on arrival. The doctor noted that the patient was on Danazol. The doctor noted that the last platelet count was 10K and the "release date 2/20/17." The doctor asked, "What should we do?"

12 The doctor clearly didn't know how to manage the patient and should have referred the patient promptly to a hematologist.

2/20/2017 WBC 17.5; platelets 60.

3/17/2017 A doctor apparently in chart review wrote "dental caries [with] thrombocytopenia." The doctor ordered a visit the following week with a blood count.

3/22/2017 Urine microalbumin 615 (0-30); BUN 22; glucose 348; creatinine 1.72 (0.5-1.5); albumin 2.3; A1c 13.9; platelets 6; WBC 11.8. The platelets of 6 were noted by the lab to be a critical level.

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3/23/2017 At 8:00 am the patient told a nurse "I'm going to die." The nurse documented that the patient was brought to the health care unit for a platelet count of 6. The nurse consulted a doctor, who ordered the patient to be sent to the hospital.

3/23/2017 The patient was sent to Memorial Hospital in Carbondale. He was discharged from the ER on 50 mg prednisone twice a day with instructions to follow up with a hematologist with a diagnosis of chronic ITP.

3/23/2017 At noon a nurse documented that the patient just returned to the facility from a furlough and was placed on 23 hour observation. A doctor ordered prednisone 50 mg BID "x 30 tabs" with follow up in the morning with a doctor and for collegial and infirmary discharge.

Patient #32

3/23/2017 BUN 22; glucose 348; creatinine 1.72; calcium 8.3; albumin 2.3; T protein 5 (6-8); WBC 11.8; platelets 6.

3/24/2017 A doctor admitted the patient to the infirmary as an acute admission. The doctor noted that the platelets were recently 6 and that prednisone was started. The patient was still on 300 mg Danazol BID. The assessment was very low platelets. There was no documented plan to see a hematologist.

3/24/2017 A doctor referred the patient to a hematologist for follow up. This was a routine appointment. But the Wexford UM documented the request as urgent.

3/25/2017 Lisinopril was restarted.

3/28/2017 A clerk wrote that the patient had an appointment with a hematologist on 3/30/17.

3/30/2017 A hematologist saw the patient. The consultant wrote comments on the referral form that the patient had ITP with splenectomy and now with relapse and without active bleeding. The consultant recommended continuing prednisone 100 mg with return in two weeks with a blood count. The hematologist did not document that the patient was on Danazol.

11 There was no report so it was unclear what transpired with the hematologist.

3/30/2017 A doctor referred the patient for hematology follow up on 3/30/17 for a two week follow up.

3/31/2017 A doctor documented that a hematology consultation was approved at collegial review.

3/31/2017 A nurse wrote that the patient had a high glucose but didn't document the value.

16 The nurse should have referred the patient to a physician.

Patient #32

4/1/2017 A doctor saw the patient. The note was partly illegible but appeared to state that the patient saw a hematologist without stating what occurred. The assessment was thrombocytopenia and the plan was to continue the current plan and that the patient was waiting to see a hematologist.

4/3/2017 The patient had a blood sugar of "hi" and the nurse administered 15 u regular insulin apparently as sliding scale. The patient didn't want vital signs.

4/5/2017 A nurse documented a blood sugar of 347. This was the first blood sugar documented on infirmary progress notes. The nurse took no action.

4/5/2017 Wexford UM approved follow up hematology.

4/5/2017 WBC 23.2; platelets 10.

4/6/2017 A nurse documented that the patient had pain in his "waist." The nurse noted that the patient was refusing insulin because he wanted to leave the infirmary. The nurse referred to a doctor ASAP. A doctor didn't see the patient. Vital signs and glucose values were not documented.

10 The doctor did not have a report and therefore didn't appear to know what transpired at the hematologist consultation and what the therapeutic plan was.

16 The nurse should have referred the patient to a physician.

Patient #32

4/7/2017 Pinckneyville Comm Hosp EKG showed recent anterolateral infarct with ST elevation V4-5. This hospital found that the patient had air fluid levels in the bowel with findings suspicious for enterocolitis. There was no free air on plain film but a CT scan showed free air indicating perforated viscus with findings reflecting ischemic bowel. The creatinine was 3.52 with GFR of 17.6; BUN 93; potassium 6.1 and glucose 357. Platelets were 29; WBC 18. The patient was transferred to Barnes Hospital and discharged 4/13/17. The patient had ischemic bowel with perforation. The patient was not a surgical candidate due to comorbidities, high dose steroids and severe malnutrition. The patient wanted to stop treatment and was sent back to the prison.

4/7/2017 At 5:00 am a nurse documented that the patient had stomach pain and was grimacing. The abdomen was distended. The patient said his last bowel movement was two days ago and that he hadn't been eating. The patient refused vital signs due to pain. The nurse noted that the patient was to see a doctor that day.

4/7/2017 At 8:23 am a doctor saw the patient. The doctor noted that the patient complained of abdominal distention over the past three days with vomiting and watery diarrhea. The patient had shortness of breath with difficulty taking a deep breath. The patient was only able to eat a little breakfast. The patient had no bleeding and was unable to speak full sentences. On examination the abdomen was markedly distended with a fluid wave. The doctor referred the patient to a local hospital.

Patient #32

- 4/13/2017 At noon a nurse documented that the patient returned from the hospital and had a Texas condom catheter in place.
- 4/14/2017 A nurse documented that the patient was incontinent and that his clothes were changed. The patient was incontinent three more times during the day.
- 4/14/2017 At 9:10 am doctor wrote a note that the patient returned from the hospital with diagnosis of perforated bowel which was ischemic. The doctor documented that the patient was without significant abdominal pain. But it wasn't clear what the patient's pain status was. The patient agreed to sign a DNR. The doctor continued insulin and ordered a tapering prednisone dose and continued the Danazol. The patient was on plain Tylenol for pain.
- 4/14/2017 At 9:15 am a nurse saw the patient immediately after the doctor saw the patient and asked if he could have something for pain. The nurse gave the patient the plain Tylenol that was ordered for him.
- 4/15/2017 At 11:30 pm a nurse noted that the patient said, "I hurt bad." The nurse noted that she would call the doctor about the pain. The nurse then took a phone order for Tylenol #3 1-2 tablets every four hours for pain.
- 4/16/2017 At 8:00 am the patient complained of pain. A nurse gave the patient Tylenol #3.
- 4/18/2017 Custody cancelled a medical furlough to Carbondale to apparently the hematologist because the ADA van was unavailable. The appointment was rescheduled for 4/27/17.
- 4/19/2017 A nurse assisted the patient to sit up and he became unresponsive and died.

Patient #33

8/21/2015 The patient transferred from Graham to Robinson CC. The BP was 147/81 and weight was 236. No problems were noted except knee pains. Despite the elevated blood pressure the patient wasn't referred.

8/27/2015 A nurse saw the patient for knee pain and blood per rectum. The blood pressure was 143/82 but there was no referral. The nurse on a "hemorrhoid" protocol noted that the patient had blood on toilet paper and had occasional rectal pain. The nurse noted no protrusion of a hemorrhoid yet presumed that the patient had hemorrhoids. The nurse referred to a physician. Since the patient was 58, he should have had colonoscopy.

8/31/2015 A doctor saw the patient for hernia, knee pain, and hemorrhoids. The blood pressure was 154/74. The only history regarding hemorrhoids was that the patient complained of hemorrhoids. The doctor noted knee pain for five years but took no other history of the knee pain. The doctor noted crepitation. The doctor did not perform a rectal examination or perform guaiac testing; did not order a blood count and did not refer for colorectal screening. The doctor ordered ibuprofen and hemorrhoid pads without having taken a history or performed an examination. The doctor didn't treat the elevated blood pressure even though the patient had elevated blood pressure at least three times. The doctor prescribed 600 TID of ibuprofen.

1, 2, 3, 7, 8, 17 The patient had elevated blood pressure that was not treated. The doctor presumed that the patient had hemorrhoids for a patient complaint of blood per rectum without examination. The doctor took inadequate history and performed inadequate physical examination. The treatment plan failed to include treatment of blood pressure and diagnostic studies (blood count, fecal occult blood testing, colonoscopy) which were indicated for his complaint. Use of a NSAID in someone with possible rectal bleeding without evaluating the source is inappropriate since NSAID can increase bleeding risk. Also the patient had high blood pressure and NSAID should be used with caution in persons with hypertension. The dose of the NSAID was also quite high.

9/1/2015 The patient was on ibuprofen 600 TID for the month.

10/1/2015 The patient was on ibuprofen 600 TID for the month.

11/1/2015 The patient was on ibuprofen 600 TID for the month.

Patient #33

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| <p>1/28/2016 A doctor saw the patient who was still complaining of rectal bleeding. The doctor noted that the patient had rectal bleeding for over two years. The doctor did not examine the rectum, did not order a blood count or refer the patient for colonoscopy. The blood pressure was 166/91, but the doctor did not start antihypertensive medication. The doctor noted that the patient had a torn knee cartilage and had prior surgery, and reviewed an x-ray which he documented showed osteoarthritis.</p> <p>2/1/2016 The patient was on ibuprofen 600 daily for a month.</p> <p>2/3/2016 A nurse saw the patient for knee pain. The blood pressure was 167/91. The nurse gave the patient ibuprofen by protocol but did not refer the patient for hypertension.</p> <p>2/5/2016 A doctor saw the patient to renew ibuprofen. The blood pressure was 145/94. The doctor took no history and recommended reduction of salt, exercise, and weight loss but did not start blood pressure medication. The doctor also ordered ibuprofen.</p> <p>2/22/2016 A doctor saw the patient for a refill of ibuprofen. The blood pressure was 150/80 but the doctor did not start antihypertensive medication. The doctor did renew ibuprofen.</p> <p>2/26/2016 A doctor saw the patient for follow up of knee x-rays. The blood pressure was 155/98 but it was unrecognized and not treated. The doctor started Mobic 7.5 mg daily for six months.</p> <p>3/1/2016 Ibuprofen was discontinued on 3/8/16 and Mobic 7.5 mg daily was started for six months.</p> | <p>1, 2, 3, 7, 17 The patient still had rectal bleeding but there was inadequate history, inadequate physical examination, and no diagnostic studies ordered. The doctor failed to treat hypertension. Colonoscopy should have been ordered. The patient was 58 years old with history of blood per rectum. The patient was on NSAID and had GI bleeding but the doctor failed to adjust medication or evaluate the bleeding.</p> <p>16 The blood pressure was elevated but the nurse didn't consult a physician.</p> <p>3, 17 The doctor failed to treat the high blood pressure and ordered long-term NSAID that should be used with caution in persons with high blood pressure because long term NSAID can result in renal damage.</p> <p>3, 17 The doctor failed to treat hypertension and failed to assess renal function when prescribing a NSAID to a person with hypertension.</p> <p>3 The doctor failed to treat the hypertension.</p> |
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Patient #33

- 3/7/2016 A doctor saw the patient for follow up of a knee x-ray. The blood pressure was 155/98. The doctor noted that the x-ray showed osteoarthritis. The doctor prescribed Mobic but failed to address the high blood pressure.
- 3/10/2016 The patient had a periodic examination.
- 3/11/2016 Cholesterol 238; HDL 39; LDL 166.
- 3, 17 The doctor failed to treat hypertension and continued NSAID without having evaluated the patient's history of GI bleeding.
- This patient had a 10-year risk of heart disease or stroke of 23% (BP 155/98 untreated, lipids as given, age 58 in a smoker) and should have been started on a moderate to high intensity statin and aspirin. Notably, the NSAID he was using was a cardiovascular risk for serious adverse cardiovascular thrombotic events including MI and stroke.
- 3/16/2016 At 5:03 pm an EKG showed atrial fibrillation with rapid ventricular response (rate 142) and *marked* ST depression with subendocardial injury. The automated read which was accurate, recommended "immediate clinical assessment of this individual is strongly advised." This was signed as reviewed.

Patient #33

- 3/16/2016 A nurse saw the patient for chest pain at about 6:00 pm. The patient had dyspnea and nausea and increased pain with movement. The blood pressure was 200/118 and the pulse was 129. The nurse documented that the patient had chest pain since 5:50 pm but an EKG done at 5:03 pm showed marked ST depression consistent with subendocardial injury. The automated reading stated, "immediate clinical assessment of this individual is strongly recommended." The nurse called Dr. Vipin Shah who gave a phone order for Inderal 20 mg and clonidine 0.1 mg stat and recheck the blood pressure in 30 minutes and to call back if the pressure was elevated. The nurse placed the patient on the infirmary for 23 hour observation. The nurse did not discuss the EKG. A doctor signed the EKG as reviewed but the date wasn't legible.
- 7, 12, 14 The EKG showed evidence of acute ischemia and new onset atrial fibrillation with unstable vital signs. The patient should have immediately been transferred to a hospital. Care was grossly and flagrantly unacceptable. Failure to send the patient to a hospital, refer to a cardiologist or refer for cardiac catheterization placed the patient at risk of death. The treatment only with stat doses of clonidine and Inderal was grossly and flagrantly incompetent. This patient had atrial fibrillation with probable acute coronary syndrome and should have been anticoagulated and should have been hospitalized for testing including echocardiogram and cardiac catheterization.
- 3/16/2016 At 7:10 pm a nurse noted that the pulse was irregular and the blood pressure was 152/78. The nurse called the doctor, who ordered to recheck the BP every four hours. At 11:16 pm the blood pressure was 133/80 and at 3:30 am the blood pressure was 110/74.

Patient #33

3/17/2016 At 7:30 am Dr. Shah saw the patient and noted that the patient had chest pain the prior evening. He noted that the patient had pain when he walked and that it occurred with nausea and shortness of breath. The pain was described as squeezing in the upper chest. He noted no history of heart problems and said that the patient was not on BP or cholesterol medication. He noted that the patient was a smoker. The blood pressure was 126/65. The doctor reviewed an EKG done at 6:25 am and noted RBBB. The doctor did not review the EKG from the evening before. The assessment was chest pain and the doctor started Zocor and aspirin but no antianginal drug and did not refer for cardiac catheterization. Beta-blocker was not started. The doctor did not stop the NSAID. The doctor enrolled the patient in cardiac clinic.

3/17/2016 At 6:25 am an EKG showed sinus bradycardia with incomplete RBBB. There appeared to be some flattening of the ST segment of V4-6 but not specific. The rate was normal sinus rhythm. This was signed as reviewed.

3/17/2016 At 12:30 pm a nurse documented that the patient had BP of 162/87 and documented that the doctor noted the results and started lisinopril. At 2:15 pm the inmate was sent back to his housing unit from the infirmary.

6, 7, 14, 15 The doctor failed to review the EKG from the previous day. The patient described symptoms of typical angina, which given the prior day's EKG, should have resulted in prompt cardiac catheterization and referral to a hospital and/or referral to a cardiologist promptly. The doctor did start a statin and aspirin but did not start anti-anginal medication. The doctor did not stop the NSAID despite the manufacturer's black box warning about cardiovascular thrombotic events resulting in possible MI or stroke. The patient had recent atrial fibrillation. Though the CHAD score was 1, the patient had recent acute coronary syndrome and should have been anticoagulated. Anticoagulation wasn't even considered. Care was grossly and flagrantly unacceptable. The doctor clearly did not know how to manage this patient's condition. The patient was placed at risk of myocardial infarction and/or stroke.

Patient #33

3/24/2016 A doctor saw the patient in follow up of chest pain and requested pain medication. The doctor noted that the patient had a "code 3" on 3/16/16 but had no more chest pain. The BP was somewhat illegible but appeared to be 180/101. The doctor started Mobic, a NSAID and increased lisinopril. The patient was still not on an antianginal drug. Mobic has a black box warning for cardiac events.

3/31/2016 The HCUA received a call from the family stating that the patient was having pain when walking and because of having pain when walking was not going to the dining hall. A counselor also called and stated that the inmate couldn't walk to these and was "having heart issues." The HCUA wrote that the patient was "not in any distress but complains he is unable to walk to dietary." The HCUA placed the patient on the doctor line on 4/4/16 to evaluate cardiac related issues.

17 The doctor started a NSAID (which has a black box warning regarding risk for cardiovascular thrombotic events including MI and stroke) in a patient with angina and ischemic heart disease.

5, 16 The patient had continued chest pain sufficient that his family called. Since the complaint was serious (angina) and placed the patient at risk of death, the patient should have been referred immediately to a physician.

Patient #33

- 4/4/2016 Vipin Shah saw the patient for baseline hypertension clinic. He documented angina but failed to include the recent history of ischemia. The blood pressure was 194/84 and 185/106. The assessment was fair stable control. This was presumably of HTN but it wasn't clear. The doctor added Norvasc. Lipids were not discussed. The doctor ordered a wheelchair for long distance (gym and chow).
- 4, 7, 15, 17 The patient had angina. The doctor did not start antianginal medication; instead offered the patient a wheelchair. Presumably, wheeling himself would likely constitute exertional strain similar to walking. The patient had angina and elevated blood pressure. The doctor started Norvasc. This drug carries a warning the increased angina or myocardial infarction have occurred with initiation of this drug in patients with obstructive coronary disease especially when beta blockers are not used. The doctor was treating the patient with potentially harmful drugs without realizing it. This was incompetent management. The patient should have had prompt catheterization. Care was grossly and flagrantly unacceptable.
- 4/5/2016 At 9:35 am a nurse evaluated the patient for chest pain while walking which improved while sitting then began again when he walked to the health care unit. The blood pressure was 174/82. The nurse noted a "normal" EKG. The nurse noted 1+ leg edema. The patient said his chest just hurt but there was no tightness, squeezing, pressure or shortness of breath. The nurse referred emergently to a doctor.

Patient #33

- 4/5/2016 The patient went to radiology. There were a few brief lines on the referral form. A two month follow up was recommended. A procedure was recommended in 45 days. They recommended a CMP. There was an oncology note in the record that summarized the patient care. It said that HCC was found January 11, 2016, found on ultrasound screening. A CT scan was done on 2/26/16 noting cirrhosis and 3 cm hypodense lesion in the lateral lobe; an MRI 3/23/16 showing a large infiltrative mass of the L lobe; in April 2016 the AFP was elevated; and a CT guided biopsy was done not until 5/24/16 and a PET scan was done 5/26/16. The patient wasn't seen at UIC until 8/4/16 and the patient didn't have treatment of the HCC until 9/12/16. The note documented that the CT guided biopsy results from 5/24/16 were requested multiple times but not received.
- 4/6/2016 An EKG showed normal sinus rhythm. This was signed as reviewed.
- 4/13/2016 Wexford denied request for wheelchair. This had been requested because of severe osteoarthritis and new cardiac diagnosis with elevated cholesterol needing the wheelchair for long distance travel.
- 4/15/2016 An EKG showed ST depression of the lateral leads suggesting anterolateral ischemia. Clinical correlation was advised. This was signed as reviewed.
- 14, 17 The patient had prior acute coronary syndrome and had recurrent angina. The doctor diagnosed chest wall pain but started NTG and Norvasc. The patient should have been placed on a beta blocker. Norvasc carries a warning of myocardial infarction in patients with obstructive coronary disease. The patient was not referred to a cardiologist or for cardiac catheterization.
- Wheelchairs are not appropriate therapy for angina in the absence of appropriate medical therapy.

Patient #33

4/15/2016 At 2:50 pm a nurse saw the patient for chest pain on an emergency basis. The patient had pain for about 10-20 minutes and occurred while working in the laundry. The patient had diaphoresis with the chest pain. The patient took a nitroglycerin and it helped "a lot." The pulse was 102 and BP 151/77. The nurse called Dr. Shah, who ordered 23 hour observation but no further orders were given. An EKG was done and showed "moderate ST depression rule out anterolateral ischemia." Clinical correlation was advised. The ST depression was in the anterolateral leads V3-6. The nurse didn't specifically document review of the EKG but under heart rhythm wrote "normal sinus regular." The nurse advised the patient that if he has difficulty walking to chow or working he should try to get a different assignment to avoid precipitating chest pain.

4/15/2016 At 11:20 pm a nurse saw the patient on the infirmary. The blood pressure was 154/82.

4/16/2016 At 8:00 am the patient said he had no pain and was ready to leave. The blood pressure was 157/82. The nurse contacted a doctor who discharged the patient without seeing him.

4/19/2016 A doctor referred the patient for a *routine* stress test because of frequent chest pain and shortness of breath. The doctor wrote that the patient had a history of heart disease and a new diagnosis of high blood cholesterol. The doctor also noted that the EKG was normal, which it was not.

5, 6, 14 The patient had chest pain with EKG findings of acute ischemia consistent with acute coronary syndrome. He should have been immediately referred to a hospital for cardiac catheterization. Instead the doctor only ordered 23 hour observation and the nurse advised the patient to get a different job. Care was grossly and flagrantly unacceptable. Care was also indifferent.

9 The patient had unrecognized acute coronary syndrome and without a doctor evaluating the patient, the doctor discharged the patient from the infirmary.

Patient #33

- 4/19/2016 A doctor saw the patient for follow up of the code 3. The doctor noted that the patient had chest pain 2-3 times a day and was using the nitroglycerin. The pain was substernal with diaphoresis. The blood pressure was 143/70. The doctor documented that the 4/15/16 EKG was normal. The doctor referred the patient to cardiology for a stress test. The doctor did not address the elevated blood pressure.
- 4/25/2016 The doctor documented that the patient was approved in collegial for a cardiology appointment.
- 5/24/2016 A cardiologist saw the patient and recommended adding Imdur and to arrange for a cardiac catheterization at Carlisle Hospital in Urbana.
- 5/24/2016 A cardiologist saw the patient. His report documents the progressive angina. His report also reviewed EKGs showing atrial fibrillation with ST segment depression on 3/16/16; the EKG of 4/15/16 showing ST segment depression in V3-6. The consultant assessed worsening chest pain suggestive of progressive angina and recommended adding Imdur and a cardiac catheter "in the near future."
- 5/31/2016 A doctor (Vipin Shah) referred the patient for cardiac catheterization on an urgent basis.
- 5/31/2016 A doctor saw the patient post cardiology visit and noted that the cardiologist wanted to do "some tests." The assessment was "cardiac." The plan was illegible as was much of the note.
- 6/1/2016 Wexford approved cardiac catheterization.
- 6/7/2016 The doctor noted that the cardiac catheterization was approved in collegial the day before.
- 4 The patient had two episodes of acute coronary syndrome, one with atrial fibrillation, yet the doctor referred the patient for a routine stress test. The patient should have been referred promptly for cardiac catheterization, as the patient still had ongoing chest pain. Beta blockers were not prescribed. The treatment plan was not competently carried out.

Patient #33

6/10/2016 An EKG showed atrial fibrillation with incomplete RBBB. Although the automated reading did not indicate it, there appeared to be ST depression in several lateral leads.

6/10/2016 At 1:30 pm a nurse evaluated the patient for chest pain. The nurse appears to have seen the patient earlier, as an EKG was done just after noon. The pulse was 98 and the BP 129/89. The nurse documented that an EKG showed "A fib same as previous." The patient noted the pain while working in the laundry. There were no associated symptoms. The nurse called Dr. Shah, who recommended 23 hour observation and an EKG the following morning. At 3:05 pm the patient was without complaints but the nurse did not perform vital signs. At 5:00 pm the BP was 143/74 and pulse 57 and the nurse noted that the patient "feels fine." At 7:25 pm the patient was found laying face down on the floor by his bunk with a small amount of vomit and small amount of blood on the forehead. The patient had no pulse or respirations. CPR was started until an ambulance removed the patient to a hospital.

6/19/2016 Vipin Shah completed the death summary. The death summary was inaccurate, as it did not state that the EKG on 3/16/16 showed anterolateral ischemia but did state that the patient had atrial fibrillation. He documented that the EKG on 4/15/16 showed ST depression and that cardiology was requested. Apparently an autopsy was not done. The cause of death was listed as atherosclerotic heart disease and temporal lobe infarction. It was not clear if an autopsy was done.

5, 6, 14 The patient had return of atrial fibrillation with chest pain. The patient had prior ischemic changes and acute coronary syndrome and should have been immediately referred to a hospital, anticoagulated, and had a cardiac catheterization. To place the patient on 23 observation was incompetent as the doctor did not appropriately evaluate the change in status. Care was grossly and flagrantly unacceptable and likely resulted in the patient's death.

Either the doctor failed to recognize an EKG finding of acute ischemia or was not being accurate. This physician should not have reviewed a death in which he was the treating physician.

**UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF ILLINOIS
EASTERN DIVISION**

DON LIPPERT, et al.,)	
)	
Plaintiffs,)	No. 10-cv-4603
v.)	
)	Judge Jorge L. Alonso
JOHN BALDWIN, et al.,)	Magistrate Judge Susan E. Cox
)	
Defendants.)	

NOTICE OF FILING

To: All counsel of record.

PLEASE TAKE NOTICE that on November 14, 2018, **the Report of the Second Court-Appointed Expert** was filed with the Clerk of the United States District Court for the Northern District of Illinois, Eastern Division, at the U.S. Courthouse, 219 S. Dearborn St., Chicago, IL 60604.

DATED: November 14, 2018

Respectfully submitted,

By: /s/ Camille E. Bennett
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CERTIFICATE OF SERVICE

The undersigned, an attorney, certifies that on November 14, 2018, she caused a copy of the above and foregoing **Report of the Second Court-Appointed Expert** to be served on all counsel of record via the Court's electronic filing system (CM/ECF):

/s/ Camille E. Bennett