Alabama Department of Corrections

Medical Program Report

July 5, 2016

Prepared by Michael Puisis, D.O.

/s/ Michael Puisis

Contents

Overview **5**

Executive Summary **5**

Qualifications **8**

Organizational Structure and Facility Leadership **9**

Staffing, Credentialing and Peer Review **11**
Staffing 11
Lack of Critical Positions 12
Low Levels of Nursing Staff 12
Low Levels of Physician Staff 13
Credentialing 15
Inadequate Oversight by Regional Medical Director in Hiring Physicians 17
Minimal and Inadequate Requirements for Physicians 20
High Rate of Medical Misconduct and Criminal History 21
Peer Review 22
Poor Oversight by OHS 23
Lack of Clarity in Peer Review Policy or Procedure 23
Inadequate Peer Review Process 24
The Impact of Poor Peer Review and Credentialing 26

Health Care Operations, Clinic Space and Sanitation **27**

Health Records **31**

Policies and Procedures **34**
Administrative Regulations 34
Standard Operating Procedures 35
OHS Policies and Procedures 36
Failure of OHS Policies and Procedures to Provide Adequate Guidance 37
Corizon Regional and Facility Specific Policies 38

Internal Monitoring and Quality Improvement Activities **41**
Quality Improvement Requirements and Policy 41
Leadership Lack of Involvement in QI Process 43
Medical Advisory Committee 45
OHS Audits of Medical Care 46
Inadequate Staffing of OHS Audit Team 48

Medical Reception **50**
Inadequate OHS Policies Result in Poor Screening Practices 50
Examples of Poor Screening Processes 54

Sick Call **59**
Location of Sick Call Boxes and Health Request Slips 60

The Relatively High Cost of Care 60
The Impact of Inadequate Nursing Staff on Patient Care via Health Requests 61
Examples of Inadequate Sick Call Process Identified in Chart Reviews 62

Chronic Disease Management 65
Lack of Policy Guidance for Chronic Illness Management 67
Poor Definition of Chronic Illness Governing Who Is Seen In Chronic Illness Clinic 68
Deficiencies in Chronic Illness Clinics 68
Examples of Patients Receiving Poor Chronic Care Management 69

Pharmacy/Medication Administration 76
Pharmacy Policy and Implementation 76
Failure to Document Medication Administration and Errors in Medication Administration 78
Examples in Chart Reviews of Delays and Medication Administration Errors 79

Urgent/Emergent Care/Hospitalizations 81
Chart Reviews Demonstrating Lack of Timely Hospitalization 84

Specialty Consultations 86
Lack of OHS policy on Specialty Care 87
Failure to Refer Patients for Necessary Specialty Care 88
Examples from Chart Reviews of Specialty Care Problems 88
Delay in Specialty Care Caused Harm 89
Preventable Death from Lack of Appropriate Specialty Care 92
Delays and Risk of Harm Inherent in Specialty Approval Process 95

Infirmary Care 98
Insufficient Nursing Care and Physician Coverage on Infirmaries 100
Examples of Inadequate Infirmary Care Resulting in Harm and Preventable Death 100

Mortality Review 106
Lack of OHS Involvement in Mortality Review Policy, Procedure, and Practice 108
Discontinuation of Mortality Review Meetings and Lack of Effective Mortality Review 109
Sentinel Review Process 111
Lack of Patient Centric Advanced Directives 112
Examples of the Poor Mortality Review and Failure to Recognize Deficiencies and Preventable Deaths 114

Infection Control 125

Findings: 126
Lack of a Formal Infection Control Program 127
Failure to Designate an Individual Responsible for Infection Control 128
Impact of Infection Control Deficiencies on Tuberculosis Outbreaks 129
Tuberculosis Outbreaks at Donaldson and St. Clair 131
Examples from Chart Reviews of Poor Tuberculosis Clinical Care and Infection Control Practices 134
Hepatitis C 140
Cases Demonstrating Lack of Adequate Treatment of Hepatitis C 143
Scabies 143

Conclusion **144**

Appendix A **145**

Appendix B: Description of Facilities **147**
Holman 147
Tutwiler 148
Kilby 151
Fountain 154
Limestone 156
Hamilton Aged & Infirm 158

APPENDIX C: Chart Reviews **160**
Patient 1 160
Patient 2 167
Patient 3 193
Patient 4 208
Patient 5 226
Patient 6 237
Patient 7 265
Patient 8 272
Patient 9 274
Patient 10 283
Patient 11 304
Patient 12 312
Patient 13 316
Patient 14 339
Patient 15 345
Patient 16 353
Patient 17 361
Patient 18 382
Patient 19 384
Patient 20 392
Patient 21 401
Patient 22 433
Patient 23 448
Patient 24 450
Patient 25 451
Patient 26 453

Appendix D: Curriculum Vitae and Fee Schedule **460**
CURRICULUM VITAE 460
Fee Schedule 466

Appendix E: List of Documents Reviewed **467**
Documents Reviewed through Discovery Process 467
Patient records reviewed in report: 468
Additional charts reviewed: 469
Additional documents and references 470

Overview

The Southern Poverty Law Center (SPLC) has filed a class action complaint, *Dunn et al v. Dunn et al*, for declaratory and injunctive relief against the Alabama Department of Corrections (ADOC). Plaintiffs have retained me to assess and opine on the medical care provided to inmates in ADOC custody. This report is the medical expert report with respect to SPLC's class action complaint.

This report is organized into sections that comprise essential components of a correctional health program. Some of these components are further divided into subcomponents. For each component, I provide the sources of information that were utilized to form the basis of my opinion. My methodology for assessing the system of care is the same that I have used in numerous other cases in which I have been qualified as an expert. After describing the source of information, I give my opinion(s) with respect to the component being evaluated. After my opinion(s), I give my findings. I provide a summary of my opinions in an executive summary. Because a large number of documents have been produced in the months after the close of discovery and continue to be produced, I reserve the right to supplement or amend my opinions to incorporate additional information upon review of recently produced or yet to be produced records.

With respect to chart reviews, over 2,300 episodes of care were evaluated, including over 900 episodes of provider care. The chart reviews were focused on a set of individual inmates with serious medical conditions. A pattern of practice emerged in these reviews that was consistent throughout all charts reviewed. This gives me confidence that the pattern of practice is representative and would continue to be the practice identified in whatever number of charts I reviewed. None of the charts reviewed demonstrated overall good provider quality of care.

Executive Summary

I completed a systemic review of the Alabama Department of Corrections (ADOC) medical program. This review includes: non-clinical aspects of the medical program including administrative and organizational structure; staffing levels and qualifications of the medical staff; supervision of clinical staff; adequacy of housing units; medical clinics, equipment, supplies, and sanitation; adequacy of health records; adequate guidance via policy and procedure; analysis of performance and attempts to improve care including mortality review; support services including provision of medication; and monitoring functions related to infectious and contagious disease. These non-clinical aspects of care are integral to adequate performance.

This review also includes clinical processes of care that incorporate clinical quality of care of providers and nurses. These include medical reception screening; sick call; chronic care management; urgent/emergent and hospital care; infirmary care; and referral to specialty care.

The following are the opinions I have formed based on my review of these components of care.

1. The ADOC Office of Health Services (OHS) provides inadequate leadership and oversight over the medical care program.
2. The OHS lacks physician involvement in their oversight of the medical program.
3. The medical vendor physician leadership is not adequately monitoring physician quality.
4. The OHS does not have sufficient staff to adequately monitor the medical program statewide.
5. There are insufficient physicians.
6. There are insufficient nurses.
7. The physician hiring process and physician credentialing fail to ensure that physicians are properly trained and have adequate competency to perform as primary care physicians.
8. The OHS does not set a standard for minimal physician training requirements that ensures that physicians can provide adequate primary care to patients.
9. The peer review process fails to provide adequate oversight over physician practice and appears to be done on a pro forma basis only.
10. The OHS provides no oversight over physician or nurse quality of care.
11. The peer review process fails to address physician quality in a manner that protects patients from harm.
12. The setting of care including space, equipment, and supplies is inadequate. This is a considerable barrier for all staff in performance of their professional roles. Space and equipment issues also directly harm inmates by exposing inmates to conditions that do not protect their safety resulting in exposure to contagious and infectious diseases, health hazards from lack of ADA facilities, life safety hazards on living units, and lack of equipment and supplies necessary to protect against harm.
13. The paper medical charts do not include information necessary to adequately manage health care for inmates.
14. The ADOC does not have an adequate coherent and definitive source of policy and procedure to guide medical care.
15. The OHS and Corizon do not have dedicated staff involved in quality improvement activity.
16. The OHS and Corizon management do not provide leadership to ensure that adequate quality improvement efforts occur.
17. The OHS and Corizon quality improvement efforts focus on pro forma compliance efforts that fail to identify significant existing problems and quality concerns that cause patient harm and mortality.
18. Medical intake screening fails to adequately identify and treat incoming inmates for their serious medical conditions for several reasons: (1) LPNs perform initial nurse intake screening, but are not trained to perform independent assessments. RNs need to perform intake assessments. (2) The only history obtained is completed by nurses. Providers need to perform a history as well as a physical examination. (3) The history and physical examination needs to include all current conditions of the patient. (4) The provider examination needs to include vital signs and other pertinent point of care test

results. (5) Nurse and provider quality on intake history and physical examinations are poor. (6) The ADOC does not ensure that patients coming into prison receive all needed medications timely. (7) The initial therapeutic plan does not address all of the problems of patients.

19. Barriers to accessing care through the health request process are significant. These include: (1) inaccessibility of health request forms; (2) remoteness of the health request boxes; and (3) cost of health care to inmates that is out of proportion to inmate earnings.
20. Registered Nurses (RNs) need to perform health request triage and evaluation including those for emergency evaluation. Licensed Practical Nurses (LPNs) are not trained to perform independent assessments and cannot work except under supervision of an RN.
21. The ADOC lacks an adequate policy for chronic illness management that ensures: continuity of medication; proper enrollment and discharge from chronic care; intervals of chronic care visits; and requirements for what conditions are managed in chronic care clinics.
22. The ADOC fails to define what a chronic condition is. As a result, some chronic conditions are not followed in chronic care clinics.
23. The quality of chronic care management is poor. Problems with chronic care management include the following: (1) Nurse practitioners manage most chronic care even when they fail to understand how to manage some conditions. (2) All providers fail to take adequate history, fail to perform adequate physical examinations, and fail to develop adequate assessments and therapeutic plans. (3) Quality of provider chronic care management is poor but there is no systematic manner to adequately evaluate chronic care management. (4) Laboratory results are inconsistently incorporated into chronic care management. (5) When providers see patients for chronic care, they do not consistently address all of the patient's chronic care problems.
24. Patients do not consistently receive needed and prescribed medications as ordered.
25. Medication refill procedures appear to be a barrier to inmates receiving needed medication.
26. Current policies fail to adequately define the process for medication administration given the new electronic medication system.
27. Patients on non-formulary medication appear to have delays in receiving medication.
28. There are no urgent and emergent nurse evaluation policies and procedures.
29. Physicians fail to timely or appropriately hospitalize patients whose care cannot be safely provided at the prison.
30. Preventable hospitalizations are not studied with respect to identification of care management problems with an aim to improving care.
31. Patients whose care requires referral to a specialist or requires specialized diagnostic testing do not consistently receive that care.
32. The utilization review process is a barrier to obtaining adequate and timely specialty care.
33. The OHS lacks policy guidelines for specialty care.
34. Some patients who require specialty care supervision are managed at prisons by providers who do not know how to manage that care.

35. Infirmary units do not have appropriate equipment and infrastructure to adequately house infirm patients.
36. The ADOC fails to adequately house the elderly and patients with significant medical conditions who cannot be safely housed in general population.
37. Infirmary units do not have adequate nursing staff.
38. Patients are housed on the infirmary who should be in hospitals or skilled nursing facilities.
39. Care on infirmary units is substandard.
40. The ADOC has high rates of mortality, but fails to adequately review mortality with an aim of reducing death.
41. There is inadequate policy on mortality review.
42. Corizon mortality review is ineffective; biased; fails to identify problems; and fails to recommend solutions to problems evident in patient deaths.
43. ADOC lacks a patient-centric advanced directive policy, procedure and practice.
44. ADOC lacks adequate policy on infection control.
45. The failure of the ADOC to address infection control type problems has resulted repeatedly in the outbreaks of infectious or contagious disease. These outbreaks resulted in the Alabama Department of Public Health to assuming control of investigation of these outbreaks because of inability of ADOC to manage the problem.
46. Corizon medical leadership has not assumed responsibility for management of infection control issues, necessitating intervention by the Alabama Department of Public Health.
47. ADOC does not protect inmates or staff from exposure to contagious tuberculosis.
48. ADOC does not protect inmates from exposure to scabies.
49. ADOC undertreats hepatitis C with anti-retroviral medication.
50. Hepatitis C management including screening and management of cirrhosis is inadequate and does not meet criteria set out in OHS policy.

Based on these opinions, I have concluded that the Alabama Department of Corrections medical program fails to provide adequate and safe health care to individuals incarcerated in its prisons system-wide. This report will demonstrate how this failure places inmates at risk of harm and causes harm, including death. The inadequacies are widespread through every essential component of the health program.

Qualifications

I have worked as a physician in correctional environments for over 30 years. During that time, I served as Assistant Medical Director, Medical Director, and then Chief Operating Officer for the Cook County Jail, one of the largest jails in the country. I also served as Regional Medical Director for the state of New Mexico for Correctional Medical Services, and corporate Medical Director of correctional facilities for Addus Health Care.

I have served as an expert or consultant in cases throughout the country since 1989. I have been retained by United States Department of Justice and by the Federal Court in the Northern

District of California, as well as numerous lawyers and governmental jurisdictions who either seek to improve care or are challenging the provision of care in prisons and jails. I have also been a court-appointed expert in numerous cases, including *Laube et al v. Campbell* and *Plata v. Davis*. I am currently serving as an expert or consultant in the following cases:

- Lake County Jail, Indiana; medical monitor
- Dallas County Jail; medical monitor
- *Plata v. Davis*; Court's medical expert
- Consultant to Department of Homeland Security
- *Duval et al v. Hogan*; State of Maryland, medical monitor
- *Dunn et al v. Thomas*; medical expert for plaintiffs
- *Lewis v. Cain*; medical expert for plaintiffs
- *Hall v. County of Fresno*; medical monitor

I have also published numerous articles related to correctional healthcare.

My curriculum vitae, which further details my qualifications and lists my publications, is attached as Appendix D.

Organizational Structure and Facility Leadership

Methodology: Review transcript of depositions, review of the Request for Proposal and ADOC/Corizon contract, and review of selected ADOC Administrative Regulations.

Opinions:

1. The ADOC OHS provides inadequate leadership and oversight over the medical care program.
2. The OHS lacks physician involvement in their oversight of the medical program.
3. The medical vendor physician leadership is not adequately monitoring physician quality.
4. The OHS does not have sufficient staff to adequately monitor the medical program statewide.

Findings:

The aim of leadership and management of a health care organization are multiple and include: to establish the purpose and goals of the organization; ensure that there are sufficient staff, equipment, and supplies; ensure that support services work appropriately; ensure that the quality of the staff is adequate; ensure that policies are adequate and in place; ensure that pharmaceutical services are adequate; provide leadership for quality improvement efforts; and ensure that overall quality of medical care is adequate. The OHS fails to provide this leadership.

Oversight of the medical care in the Alabama Department of Corrections (ADOC) is the responsibility of the Office of Health Services (OHS) Associate Commissioner. This relationship is memorialized in ADOC Administrative Regulation 700 Office of Health Services Division. The OHS Associate Commissioner is responsible for management, implementation and oversight of health services for inmates assigned to the custody of the ADOC.

Corizon Correctional Healthcare, a for-profit company, provides contracted medical care to inmates in the ADOC. Ms. Naglich testified in deposition that Corizon was the only bidder for the medical services contract in the 2012 Request for Proposal for provision of medical services to the ADOC.[1] The contract requires Corizon to serve as the clinical health authority with respect to clinical management of treatment, providing direct patient care, and serving as advisor to the Associate Commissioner on protocols and clinical matters.

The ADOC has established an Office of Health Services and created a position of Associate Commissioner to direct that office. The duties of the Associate Commissioner are defined in ADOC Administrative Regulation 700.

The Associate Commissioner is "responsible for management, implementation, and oversight of the health services, care, treatment, and programs provided for inmates assigned to custody of the ADOC".[2] This includes amongst her duties:

- Implementing and monitoring provision of health services and providing direction and oversight to the health services vendor.
- Initiating Administrative Regulations, directives, policies, and procedures as relative to ADOC and the OHS Division. It is not clear in Administrative Regulation 700 whether the Associate Commissioner is responsible for all health care policy and procedure.
- Selecting, directing, and supervising the ADOC contracted Medical Director.

The ADOC OHS does not have the leadership capacity to adequately evaluate whether the contracted medical vendor is performing its role as clinical health authority responsibly. The current ADOC Associate Commissioner, Ruth Naglich, is a nurse, yet is responsible for selecting and supervising the Regional Medical Director, a physician. The lack of a physician in the ADOC OHS leadership group is a significant deficiency. The vendor physician quality of care is insufficiently monitored or supervised and the leadership structure of the ADOC OHS is not capable of performing this task. The OHS has a position titled Medical Health Director but this position is filled by a nurse. Multiple areas of service are not monitored even when the contract requires it. These will be addressed later in the report.

[1] Deposition of Ruth Naglich Case No. 2:14 – CV – 00601 – MHT – TFM; Dunn et al. vs. Dunn et al. conducted on April 7, 2016; page 211

[2] State of Alabama Department of Corrections Administrative Regulation Number 700 Office of Health Services Division, November 8, 2010 as found at http://www.doc.state.al.us/docs/AdminRegs/AR700-H.pdf

Corizon, the contracted medical vendor, has physician leadership that is not adequately monitoring physician quality. This will be specifically addressed later in this report.

The lack of physician leadership in the ADOC program is a leadership gap that has significant implications and results in risk of harm to inmate-patients. At the facility level, there is generally only one physician per facility. This results in the single physician also being the medical director of that facility. Credentialing procedures of Corizon are relatively opaque, but based on hiring practices, physicians are chosen who are ineffective as medical directors. As a result, many facilities have inadequate medical leadership resulting in harm to patients.

Staffing, Credentialing and Peer Review

Methodology: Review minimal staffing requirements in the Request for Proposal. Review documents and policies for credentialing, peer review and annual performance evaluations. Review credential files.

Opinions:

5. There are insufficient physicians.
6. There are insufficient nurses.
7. The physician hiring process and physician credentialing fail to ensure that physicians are properly trained and have adequate competency to perform as primary care physicians.
8. The OHS does not set a standard for minimal physician training requirements that ensures that physicians can provide adequate primary care to patients.
9. The peer review process fails to provide adequate oversight over physician practice and appears to be done on a pro forma basis only.
10. The OHS provides no oversight over physician or nurse quality of care.
11. The peer review process fails to address physician quality in a manner that protects patients from harm.

Findings:

Staffing

The ultimate test for adequacy of staffing levels is whether necessary tasks are accomplished. When a state jurisdiction utilizes a medical vendor, the staffing requirements need to include state central office staff for the purposes of monitoring the quality of vendor medical care. When this does not occur, the vendor does not have incentive to perform adequately. When a jurisdiction attempts to reduce hospitalizations and referrals to specialists by performing hospital and specialty care in-house, appropriately trained staffing needs to be increased to accommodate the increased workload.

The ADOC OHS is responsible for monitoring health care quality of its vendor. However, all OHS staff has numerous other assignments and can only dedicate part of their time to monitoring. Additionally, there is no physician who participates in monitoring evaluations. The vendor is poorly monitored and the quality of physician services isn't monitored by OHS at all. The OHS needs a full time monitoring team that includes a physician. This significant staffing deficiency in the OHS needs to be addressed so that patient safety is protected.

The ADOC medical programs require provision of comprehensive health care services. Staffing requirements are found in an Appendix A to the 2012 contract between ADOC and Corizon, Inc.[3] The total staffing requirement is 493 staff. This is for a population of 24,189 inmates housed within its prisons.[4] Provider, nurse and specialty positions are deficient with respect to numbers of staff for this given population.

Lack of Critical Positions

There are a few glaring staffing deficiencies. Neither ADOC's OHS nor Corizon have any dedicated positions in infection control or quality improvement, which are two essential programs that need to be present in a correctional medical program. Both of these areas suffer from neglect. For example, there have been two tuberculosis outbreaks in the ADOC extending since at least 2009, as well as scabies outbreaks and ongoing scabies infestations, all of which resulted in extraordinary interventions by the Alabama Department of Public Health. Yet there is no infection control staff in the minimal staffing grid. Quality improvement is limited and consists mostly of performing compliance audits developed by the OHS. There is no dedicated staff for this function.

In a deposition, Ms. Naglich testified that staffing levels were determined based on task analysis.[5] It was not clear in that testimony precisely how this was done or the numerical analysis of how the staffing numbers were obtained. I find that in the areas I reviewed, there were staffing deficiencies.

Low Levels of Nursing Staff

Nursing staffing is low. Based on chart reviews and depositions, it appears that many nursing tasks are not completed. In a deposition, Ms. Naglich acknowledged that of 2,800 inmates with a positive tuberculosis test in 2010, one-third had not had initial tuberculosis screening. Of those with a positive test, 59% did not have verified treatment. When debilitated patients are placed on infirmary units, they do not consistently have appropriate monitoring or care. There

[3] Appendix A to the 2012 contract between ADOC and Corizon, Inc.
[4] Alabama Department of Corrections Monthly Statistical Report for March 2016 (Fiscal Year 2016); compiled and published by The Research and Planning Division as found at http://www.doc.state.al.us/docs/MonthlyRpts/2016-03.pdf
[5] Deposition of Ruth Naglich, Joshua Dunn, et al. v Jefferson Dunn, et al. Civil Action No.:2:14-cv-00601-MHT-TFM, taken on December 7, 2015 page 187-189

were examples in chart reviews of deterioration of patients on infirmary units as a result of lack of nursing attention. As another example, in chart reviews, one patient who was to have infusion of a critical medication failed to have adequate nursing monitoring during his infusions. That may have contributed to a significant adverse reaction to his medications that contributed to his death. These types of nursing deficiencies are directly related to staffing.

At the Hamilton Aged and Infirm facility, the ADOC houses a significant portion of the severely infirm and aged individuals in the ADOC. This facility houses approximately several hundred elderly infirm patients with 20 individuals on the infirmary. Many of the infirmary patients are bed ridden and require complete care. Many of the remaining patients at the facility also, because of age and illness, require significantly more nursing care than a typical population. Infirmaries typically should have approximately 2.5 nursing hours per patient day. For the population of 20 infirmary patients, the Hamilton facility should have 50 nursing hours per day on the infirmary alone. This amounts to 6.25 nursing staff over a 24-hour period dedicated to infirmary patients. The nurse staffing for this facility consists of 11.2 LPNs and 4.2 RNs in total for all three shifts 7 days a week. This is approximately 1 RN and 2.5 LPNs per shift on a 7 day a week basis without accounting for time off, vacations, or vacancies. This is approximately 10.5 nurses (RN and LPN) per day. Given that approximately 6.25 nurses are typically needed in the infirmary and 10.5 are available for the entire facility, there are only approximately 4 nurses per day to handle the rest of care at this facility. This does not account for time off, vacations and sick days. This number of nurses is grossly insufficient to perform sick call assessments, pass medication, address all chronic care nursing issues and manage all the other nursing tasks outside of the infirmary. The number of nurses may not even be sufficient to manage the nursing care of the infirmary patients depending on their acuity level. In chart reviews, there were several cases of significant harm to patients, including death that resulted from infirmary care management. These will be presented later in this report.

Nursing staff is inadequate in most facilities. Instead of hiring sufficient registered nurses (RN) to provide independent assessments, the ADOC utilizes licensed practical nurses (LPN) who are not trained or licensed to provide independent assessments of patients. Because RNs do not review the work of LPNs, the LPNs providing independent assessments place inmates at risk of harm. This was evident in chart reviews and will be presented later in this report.

Low Levels of Physician Staff

Physician staffing is low. As of March 10, 2016 when Dr. Hood was deposed, 2 of 13 medical director positions in ADOC were vacant (Fountain and Holman) 1 was filled in an acting capacity by Dr. Lovelace, the northern region medical director, who had to split his time between his regional duties and the facility (Hamilton A & I), and another medical director was out due to surgery (Donaldson).[6] Thus 4 of 13 (30%) medical directors were not fully engaged positions. In chart reviews, some patients suffered neglect of their medical conditions because there were

[6] Deposition of Hugh Hood, Joshua Dunn, et al. v Jefferson Dunn, et al. Civil Action No.:2:14-cv-00601-MHT-TFM, taken on March 10, 2016, page 58-59

no available staff and medical care appeared to be managed remotely by the Regional Medical Director by phone.

Most providers are mid-level providers and not physicians. Excluding the Regional Medical Director and assistant Regional Medical Director, there are 15.6 physicians and 19.8 mid-level providers for the entire population of approximately 26,000. Mid-level providers manage almost all chronic care cases except for a small number of high acuity cases. This is insufficient physician time dedicated to patients with chronic disease. Given the acuity of patients, 1 physician at Hamilton A & I is low. Although some inmates at Hamilton A & I are medical workers, most are elderly and have multiple complex diseases, and many of the general population inmates at Hamilton would typically be on infirmaries in other prison systems. One physician typically can't handle this number of complex patients. The Staton facility staffing, which covers the Draper, Elmore and Staton facilities, has only 1 physician and 3 nurse practitioners. This is insufficient amount of physician coverage for well over 3,000 inmates. Since the physicians cover infirmaries, see high acuity patients, and perform all administrative functions, the nurse practitioners and physician assistants are left to manage most of chronic illness care, which places patients at risk of harm.

Providers work 8-hour days but because of lock-downs, meals, etc., the amount of time spent directly with patients must be approximately 6.5-7 hours a day. Providers indicated in depositions that they see approximately 20-25 patients a day, meaning that physicians are spending about 15 minutes per patient. In chart reviews, I noted that almost all notes lacked an adequate history and physical examination with respect to the patient's problems and existing complaint. While part of the reason for this might be performance quality, lack of time and staffing is another likely cause.

Chart reviews give an indication of this problem. In a chart review from Elmore, a patient[7] with a prior stent from coronary artery disease, hypertension, and high blood lipids failed to follow up with a cardiologist. Based on documentation in the medical record initially provided to me, he was not seen from December of 2009 until 1/7/14, a period of about 4 years. Several weeks before this report was due, I received additional medical records that were apparently not filed in the original document. These records included 2 chronic care visits for 2013. This verifies that the patient was seen twice in 4 years. When finally seen, providers failed to address all of his problems. Even though he appeared to be developing heart failure based on symptoms and x-ray results, providers failed to evaluate the patient for this condition. It appeared that there was no physician at this site for an extended period of time resulting in lack of attention to this patient. This lack of physician attention appears to be harming the patient. The medical records also appear to be disorganized.

Another patient[8] who suffered because of inadequate staffing was at Limestone. His care will be discussed in more detail in the infirmary section of this report. However, there was no

[7] Patient number 5
[8] Patient number 7

physician at this facility. The patient's serious medical condition was frequently managed remotely by the Regional Medical Director because there was no provider on site. This contributed to his loss of a testicle and placed him at risk of loss of life from infection.

Another patient[9] did not have evidence in the medical record of a chronic clinic evaluation for years despite having presumed advanced COPD. A mid-level provider contacted the Regional Medical Director for consultation on management, but almost all care was provided episodically by mid-level providers or via phone orders to nurses.

Another patient[10] at Staton with a suprapubic catheter, diabetes, hypertension and high blood lipids was followed almost entirely by a nurse practitioner. On multiple occasions, the nurse practitioner wanted a physician to see the patient, but none was available so the patient was rescheduled several times. Several weeks later, the Regional Medical Director, apparently covering the facility, saw the patient. On another occasion, a nurse called the Regional Medical Director about a patient that the Regional Medical Director had asked about. After waiting an hour and a half the patient was sent back to his housing unit and the evaluation never occurred. The nurse practitioner managing the patient was repeatedly treating the patient with antibiotics when the patient had a colonized bladder.[11] Ultimately, the nurse practitioner began using intravenous antibiotics for this purpose when it was unnecessary. This nurse practitioner appeared unsupervised in this situation. An outside specialist recommended that the intravenous antibiotics be stopped. The lack of supervision resulted in unnecessary treatment which placed the patient at risk of harm.

Credentialing

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 health care needs of patients are typically primary care which requires physicians who have residency training in internal medicine or family practice. Emergency medicine physicians may also be acceptable in certain situations.

In a typical credentialing process, a prospective physician applicant must submit an application, curriculum vitae, and all current licenses, degrees, and certifications. The application typically includes an attestation by the applicant as to whether there has been prior malpractice, adverse action, criminal offense, or other adverse events affecting ability to practice. The

[9] Patient number 6
[10] Patient number 2
[11] Patients with indwelling bladder catheters frequently are colonized with bacteria. It is currently recommended that these colonized infections not be treated with antibiotics unless the patient has symptoms or shows signs of systemic infection. Repeated treatment can result in antibiotic resistance.

credentialing body typically also obtains and reviews a National Practitioner Data Bank (NPDB) report and verifies information on the application along with the other submissions. The applicant is typically interviewed and accounts for problems identified on the documents obtained by the credentialing body. The sum of these reviews and interviews is acted on by a credentialing body to decide whether the practitioner is trained properly and capable of providing safe and effective care to patients and whether the type of training of the candidate is sufficient given the expected assignment of the candidate. This latter function of a credentialing body, for example, would prevent a psychiatrist from performing surgery because they had no training to perform surgery. This type of credentialing process does not appear to be in place in the ADOC and credentialing is inadequate and places patients at risk of harm.

With respect to protecting patient safety, the NPDB is a key resource. President Reagan signed the Health Care Quality Improvement Act in 1986 to protect peer review bodies and to prevent incompetent practitioners from moving state-to-state without disclosure of previous damaging or incompetent performance. This act led to the development of the NPDB which was initiated to collect adverse information on all providers nationwide. In 1990 the NPDB began openly supporting peer review and credentialing organizations. The NPDB is managed by the U.S. Department of Health and Human Services. This service collects information: on medical malpractice payments; adverse licensing actions; adverse privileging actions; negative actions by state licensing authorities; negative actions by accreditation organizations; and civil judgments or criminal convictions that are health-care related. Access to information in the NPDB is limited to health care entities that use them to make licensing, credentialing, privileging, and employment decisions.

Use of NPDB is recommended by the National Commission on Correctional Health Care (NCCHC) standard on credentialing and is part of the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) standards on credentialing. The OHS requires that the vendor adhere to NCCHC standards[12] and that it use JCAHO standards with respect to credentialing. The Corizon re-credentialing procedure does require review of the NPDB,[13] but the initial credentialing procedure does not require review of the NPDB. It is not clear from Corizon policy and procedure whether or how the NPDB is used in their initial credentialing process. The Corizon Regional Medical Director, who is responsible for interviewing and determining suitability of candidates, does not use the NPDB in his deliberations.[14]

The ADOC Request for Proposal for health services requires that:

> "Vendor is responsible for credentialing and certification of its staff. Vendor will utilize the standards of the Joint Commission on Accreditation of Healthcare Organizations and

[12] Essential standard Credentials P-C-01, Standards for Health Services in Prisons 2014, National Commission on Correctional Health Care

[13] Corizon Policy/Procedure Re-credentialing Practitioners, Number CR-007; Date of Origin 4/01/2012, Revised 7/01/2014, page 2 of 2

[14] Deposition of Dr. Hugh Hood, M.D. Civil Action No. 2:14 –cv-00601 – MHT-TFM Dunn et al. vs. Dunn conducted on March 10, 2016 in Birmingham Alabama, page 52

> Accreditation Manual for Hospitals for Medical Professional Staff appointments. Credentials are confirmed annually and a record of the credentialing activity will be maintained as part of the employee's personnel file. Credentialing is defined as the process by which an applicant's training, degrees conferred, certification by specialty societies, state and other licenses, teaching positions, appointments, and other professional experience are confirmed or reconfirmed."[15]

But OHS does not monitor whether Corizon credentials physicians in accordance with requirements of the RFP or whether the quality of credentialing is adequate with respect to protecting patient safety. None of the OHS audits address credentialing. In deposition, Ms. Naglich stated that "The Department does not credential".[16] She also stated that it was the contractor's responsibility to perform appropriate credentialing.[17] She also testified that, for Corizon employees, she didn't review malpractice claims or complaints against them by the medical board because they were not her employees.[18] She added that she couldn't recall ever recommending that Corizon couldn't hire someone. Even though the Associate Commissioner for Health Services is responsible for the quality of the medical care, there appears to be no effort by the OHS to ensure that the vendor has qualified staff other than to stipulate that the vendor credential its staff — which the OHS does not verify is adequately happening. While it is the responsibility of the vendor to perform appropriate credentialing, it is very much the responsibility of OHS to ensure that the vendor's credentialing is appropriately performed.

I received 30 physician credential files. There are only 17.6 physicians in the budget. It wasn't clear from documentation in the credential files which of the 30 files were for active physicians. Two of the current medical directors (Darbouze and Roddam) did not have credential files. A physician should not work unless credentialed.

Inadequate Oversight by Regional Medical Director in Hiring Physicians

Hiring competent physicians is one of the most important responsibilities of senior medical staff. Supervisory medical personnel must ensure that competent and qualified physicians are hired as these individuals play such a significant role in delivery of medical care. When screening, interviewing, and hiring physicians senior medical staff need to review all aspects of a candidate's professional experience.

[15] Alabama Department of Corrections Request for Proposal No. 2012-02 Comprehensive Inmate Health Care Services, July 17, 2012 pages 100-101.
[16] Deposition Ruth Naglich. Civil Action No. 2:14 –cv-00601 – MHT-TFM Dunn et al. vs. Dunn conducted on April 7, 2016 in Montgomery, Alabama page 15

[17] Id. at page 198
[18] Id. at page 149-150

The Corizon Regional Medical Director is responsible for interviewing and determining whether physician candidates are suitable to hire.[19] However, the Regional Medical Directors for Corizon appear to have a passive role in credentialing and hiring of physicians. Dr. Crocker, the former Regional Medical Director, testified that he was involved in interviewing physicians and mid-level providers. He stated that he reviewed their CV and application and added that he couldn't recall that he received an application form for every person that he talked to. Later he stated that he couldn't remember what was sent to him for every candidate.[20] To review only the CV and application is an inadequate evaluation.

Dr. Hood, the current Regional Medical Director, didn't recognize a Corizon credentialing policy when shown one during a deposition and didn't know whether it was the current policy.[21] Dr. Hood also testified that when he interviewed physician candidates he did not review the National Practitioner Data Bank information.[22] Dr. Hood indicated that the NPDB was used by recruiters to clear physicians which he described as meaning that the provider had no sanctions against their license that prevented them from practicing medicine. Physicians who have no current sanctions against their license may still have significant past malpractice issues; prior sanctions; past criminal behavior; or loss of privileges. It is imperative to carefully review these issues to ensure that the qualifications of physicians protect patient safety. In that regard, Dr. Hood also testified that he did not have information about past malpractice suits or encumbrances on their licenses when he interviewed physicians for positions, even though the policy he was shown stated that he was responsible for determining the suitability for the position.[23] All interviews should take place with full information with respect to prior liabilities and sanctions. This needs to include review of the NPDB. If this is not done, it is a patient safety risk.

When asked about current medical directors at various sites who had prior license restrictions, Dr. Hood could only recall 1 physician, when there were 5. When reminded of two other physicians who had previously lost their licenses, he couldn't remember the details of why they had lost their licenses. He appeared unaware that one of his associate Regional Medical Directors had prior limitations on her license because of impairment and was unaware that another of his facility medical directors also had prior limitation of his license due to impairment.[24] When supervisory physicians are unaware of prior sanctions and liabilities of physicians during employment interviews it places patients at risk of harm. When a medical supervisor responsible for hiring decisions is unaware of prior medical sanctions and

[19] Corizon Policy/Procedure Professional Review, Number CR-002, date of origin 4/01/2012 revised 7/01/2014 page 2 of 5
[20] Deposition of Dr. Bobby Crocker, M.D. Civil Action No. 2:14 –cv-00601 – MHT-TFM Dunn et al. vs. Dunn conducted on February 25, 2016 in Atlanta, Georgia pages 160-67
[21] Deposition of Dr. Hugh Hood, M.D. Civil Action No. 2:14 –cv-00601 – MHT-TFM Dunn et al. vs. Dunn conducted on March 10, 2016 in Birmingham Alabama, page 160-161

[22] Id. at page 52
[23] Id. at page 95-98
[24] Id. at page 84-100

impairments of his staff, it shows indifference with respect to protecting the safety of the patients.

Dr. Hood also testified that Corizon goes out of its way to take physicians who have problems with their license. The following is part of his testimony:

> "Q. How does information about
> 2 current encumbrances affect your
> 3 decision-making process for hiring?
> 4 A. Depends on the encumbrance.
> 5 Q. Okay. Explain that a little
> 6 bit.
> 7 A. We work with the Board of
> 8 Medical Examiners, and for some of the
> 9 physicians who have been taken out of
> 10 practice because of some legal issue or some
> 11 encumbrance in their license, we like to be
> 12 an avenue for them to get back in practice
> 13 and to redeem themselves. And we've reached
> 14 out to the Board of Medical Examiners to
> 15 allow us to interview some candidates that
> 16 they think would be safe to practice medicine
> 17 in a correctional environment, with strong
> 18 supervision, to help rehabilitate those
> 19 physicians."[25]

While rehabilitation of physicians is reasonable, the primary responsibility of ADOC and Corizon is the safety of patients under their care. When a large percentage of physicians have a history of impairment, it appears that the program is more concerned about filling positions and rehabilitating physicians than it is in protecting the safety of the inmate patients. Also, if the program recruits impaired physicians as a programmatic strategy, it should have a system of monitoring and supervision, which is not evident in the Corizon peer review program.

Of the 30 physician credential files I reviewed, there was documentation in the files of only 9 interviews with a Regional Medical Director. These interviews were documented on a form with typically only a few words written on them. There were no opinions or comments on these interview forms about the candidates even when the candidate had serious prior adverse actions. One physician was in an impaired physician program but the Regional Medical Director did not ask the physician why or address the ability of the physician to safely care for patients. In two other interviews, the Regional Medical Directors failed to document identification of prior medical board sanctions or discuss these with the physician. The Regional Medical

[25] Id. at page 100

Directors failed to appropriately review the credentials of physician candidates, thereby failing to ensure that the safety of the inmate-patients is protected.

Minimal and Inadequate Requirements for Physicians

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 typically obtain privileges to deliver babies or perform appendectomies. And physicians trained and credentialed in obstetrics cannot typically obtain privileges to provide primary care.

Correctional medical care is mostly primary care internal medicine. Consistent with that need, correctional physicians should be primary care trained physicians which include physicians trained in internal medicine, family practice and perhaps physicians trained in emergency medicine. Every correctional medicine program should strive for hiring physicians with this training. Board certification in one of these fields means that the physician has completed a residency training in one of these fields and has passed a qualifying examination by a nationally recognized board of that specialty.

In the ADOC, the RFP does not establish any credentialing requirements that set standards for the types of physicians that the vendor hires. Ms. Naglich testified that requirements for credentialing were not included in the 2012 request for proposal.[26] This means that the only requirement for a physician to be hired in the ADOC is an active license. The RFP also does not require that either the Regional Medical Director or facility medical directors have any credentials other than a valid license. Thus the types of physicians hired by the vendor can be below an acceptable standard.

The Corizon corporate credentialing procedures do not establish the minimum requirements for providing primary care medical care. Typically, this includes training in a primary care residency (family practice, internal medicine). In the ADOC it appears that the only requirement is a medical license. This results in permitting non-primary care specialty physicians (obstetrician, surgeons, etc.) to provide primary care. There is no evidence in credential files that the credentialing of providers is aligned with their proposed assignments. For most providers, a privileging sheet is not part of the credential file. In performing their work, a credentials committee or review body must have as its prime mission protection of the safety of patients under care of the health care organization. One of the ways this is done is by

[26] Deposition of Ruth Naglich, Joshua Dunn, et al. v Jefferson Dunn, et al. Civil Action No.:2:14-cv-00601-MHT-TFM, taken on April 7, 2016, pages 208-209

ensuring that the training of physicians is consistent with the work the physician will be hired to perform. When this is not done the safety of the patient is endangered.

There are 4 obstetricians and 1 general surgeon who have received credentials. The training of these physicians is insufficient to treat primary care medical conditions because they have not had training sufficient for that purpose. The general surgeon who received credentials from Corizon had also retired in 2009 to pursue a music career and had not practiced medicine for 5 years. Having a retired surgeon provide primary care medicine is a patient safety concern. Having a retired physician who has not practiced in 5 years and who is not trained in primary care is a significant patient safety concern.

It is not clear what all of the 4 obstetricians on staff are credentialed for because privilege sheets are not consistently included in the credential files. However, at least one of them is a medical director and is the physician responsible for providing primary care to female inmates even though his training is insufficient for that purpose. As an example, a patient with coronary artery disease or rheumatoid arthritis would not go to an obstetrician for routine management of their coronary artery disease or rheumatoid arthritis. Yet the system allows inmates to be subject to these practitioners. Patients should be treated by physicians who have training in the areas of care that they are providing. In the civilian world, no patient with an internal medicine problem (diabetes, as an example) would go for routine care to a surgeon, a psychiatrist or an obstetrician. It should be no different in a correctional medical program. This places the inmate patient at risk of harm.

High Rate of Medical Misconduct and Criminal History

The credentialing process does not protect the safety of inmate-patients. I reviewed 30 physician credential files exclusive of the current and prior Regional Medical Directors. Of these 30 physicians, 12 (40%) either had current or prior restrictions of their license, prior adverse reports from the medical board, or had lost privileges either entirely or on a temporary basis. Two of the 12 had prior sexual misconduct issues, 6 were impaired physicians, 3 lost privileges in health care organizations, and 1 had falsely reported medical education credits which were not obtained. At least 3 of 12 had criminal charges related to their transgressions. Malpractice issues were only addressed by what the physician acknowledged on the application as an NPDB report was not present in any files.

Of the site medical directors and Regional Medical Directors as of March 10, 2016, 1 of the associate Regional Medical Directors had a prior impairment which her supervisor appeared unaware of. The other Regional Medical Director did 10 months of a pathology residency and 14 months of an internal medicine residency before dropping out. Despite this, he was placed in a supervisory role to manage physicians caring for high acuity patients. Of the 13 site medical director positions, 2 were vacant and 2 did not have credential files. Of the remaining 9 medical directors, 5 (55%) have had prior problems. Three had prior medical board sanctions

or revocation of license and 2 had prior loss of medical privileges. In 1 case of loss of privileges, the credential file contains no verification as to why this had occurred.

This is a large number of problematic physicians. When a physician is properly trained for the expected type of work but has current or prior substance impairment, that physician can be integrated into well-managed and supervised programs. In ADOC this is difficult because for the most part, there is only one physician for each facility and there does not appear to be an adequate program of supervision. Other character, behavior, or clinical practice problems are difficult to supervise. When such a large proportion of the staff has such problems, it demonstrates a lack of concern for the safety of the inmate-patients.

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 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 error or exhibits a serious character or behavior problem and needs to be evaluated with respect to possible reduction of privileges. 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. Neither of these types of peer reviews is adequately performed in the ADOC. The latter type of peer review does not appear to be done at all. [27]

The RFP of 2012 requires that the vendor perform individual physician peer review. The RFP states:

> "Vendor will minimally provide a physician peer review program as directed by its corporate Medical Director and/or the ADOC Physician Consultant. The program will consist of at least four (4) hours of on-site physician time every four (4) months, three (3) times a year to conduct chart reviews of each facility. Vendor's Program Physician Director or State Medical Director and the ADOC Physician Consultant will provide peer review in the following areas:
>
> 1) Physician sick call/outpatient encounters;
> 2) Infirmary admissions;
> 3) Inpatient hospitalization;
> 4) Specialty referrals/off-site procedures;
> 5) Prescribing patterns; and
> 6) Ancillary service utilization.

[27] Dr. Hood testified about a single occurrence of reviewing a physician's work, but no documents relating to this review have been produced. The review is discussed in further detail below in the section on the Impact of Poor Peer Review and Credentialing.

Each area must be reviewed annually."[28]

The requirements of the RFP are not met by the vendor. Only 3 of the 6 areas of service are reviewed. The only peer review performed for physicians is an annual 15 question formatted checkbox review of sick call, infirmary admissions and chronic care. Specialty care, prescribing patterns and ancillary services utilization are not reviewed. Peer review is frequently not performed on-site and it is only performed once a year. Based on review of the documents produced, peer review documentation is not consistently maintained.

Poor Oversight by OHS

The OHS does not evaluate whether the vendor is performing its peer review obligation. Ms. Naglich, the ADOC Associate Commissioner Health Care, testified that ADOC never participates in peer review.[29] In a second deposition, Ms. Naglich did not directly answer a question about whether Corizon's peer review process for physicians was adequate. To that question she answered,

"A. We have good quality physicians
19 and personnel.
20 Q. How do you know that?
21 A. Because we have very little
22 issues with the day-to-day delivery of care.
23 Q. How do you know that?
1 A. Because we monitor."[30]

In the same deposition, Ms. Naglich stated that she didn't monitor peer review as part of the OHS monitoring program, could not describe Corizon's peer review process, didn't know anything about Corizon's peer review process, and didn't know whether Corizon ever found any problems in peer review.[31] The lack of concern by the OHS with respect to peer review exposes inmates to less than qualified providers.

Lack of Clarity in Peer Review Policy or Procedure

Corizon policy and procedure addresses peer review in their clinical performance enhancement policy. Taking Kilby policy as an example, the Corizon Kilby policy manual has 2 policies on

[28] Alabama Department of Corrections Request for Proposal No. 2012-02 Comprehensive Inmate Health Care Services, July 17, 2012 page 63

[29] Deposition Ruth Naglich. Civil Action No. 2:14 –cv-00601 – MHT-TFM Dunn et al. vs. Dunn conducted on December 7, 2015 in Montgomery, Alabama pages 139-40

[30] Deposition Ruth Naglich. Civil Action No. 2:14 –cv-00601 – MHT-TFM Dunn et al. vs. Dunn conducted on April 7, 2016 in Montgomery, Alabama page152

[31] Id. at pages 16, 153, 154, and 155 respectively

clinical performance enhancement. The first policy issued in 2012 has only 2 procedural details. It states:

> "The Associate Regional Medical Director is responsible to assure annual peer reviews are completed. The site Medical Director performs monthly peer reviews for the mid-level providers"[32]

The second policy was issued in 2014 and has only 4 brief procedural details. The one that addresses physician peer review is the first procedural detail which states:

> "The Health Services Administrator is responsible to assure annual peer reviews are completed for practitioners".[33]

There is no description in policy or procedure describing what these reviews are to consist of, who is to receive copies of these reviews, and what is to occur if the review is problematic. In his deposition, Dr. Lovelace testified[34] that the peer review system substantially utilizes the same policy and procedure throughout the system, so presumably the policy at Kilby is the same as at all other sites.

Inadequate Peer Review Process

Dr. Hood testified that the annual peer review consists of review of 30 episodes of care that include records from 3 categories: sick call encounters, chronic care encounters, and infirmary admissions and discharges.[35] The deposition of Dr. Lovelace, who is the associate medical director of the north region, gives further details on how the peer review process works. According to Dr. Lovelace's testimony, the physician reviewer may or may not perform his evaluation on-site. The health administrator selects 10 records of episodes of care for patients seen in sick call and more than 10 seen in chronic care. These are either emailed to the reviewer or made available for on-site review. Dr. Lovelace indicated that about 30 episodes of care are reviewed. The reviewer reviews the records of the episodes of care and gives an evaluation to the physician.[36] Dr. Lovelace later testified that as northern region associate medical director he was responsible for performing peer reviews.[37] He testified that he was sent episodes of care for 20 patients, (10 from chronic care and 10 from sick call). No other

[32] Corizon General Health Services Policy & Procedures Kilby Correctional Facility Policy No. P-C-02.00 Clinical Performance Enhancement Issued 10/29/12
[33] Corizon General Health Services Policy & Procedures Kilby Correctional Facility Policy No. P-C-02.00 Clinical Performance Enhancement Reviewed and revised 09/2014
[34] Deposition of Jerry Lovelace, MD, Civil Action No. 2:14 –cv-00601 – MHT-TFM Dunn et al. vs. Dunn conducted on December 21, 2015 in Birmingham Alabama, page 167
[35] Deposition of Dr. Hugh Hood, M.D. Civil Action No. 2:14 –cv-00601 – MHT-TFM Dunn et al. vs. Dunn conducted on March 10, 2016 in Birmingham Alabama, page 136
[36] Deposition of Jerry Lovelace, MD, Civil Action No. 2:14 –cv-00601 – MHT-TFM Dunn et al. vs. Dunn conducted on December 21, 2015 in Birmingham Alabama, pages 30-33
[37] Id. at pages 108-109

criteria were used in selection of these records. It takes him 2 hours to review the 20 records. To perform this task he uses a formatted Corizon sick call and chronic care peer review form.

The health services administrator of Bullock testified that she collects paperwork from charts and emails them to the Regional Medical Director.[38] The choice of charts appears to be random and not based on quality concerns of the organization. Corizon uses 3 formatted peer reviews: chronic illness, infirmary, and sick call. The chronic care and sick call formats have 15 questions and the infirmary format has 14 questions. Most of the questions are not related to quality-of-care. Questions common to all 3 formats include:

- Whether the proper format was used
- Whether the note was legible
- Whether the note included a date
- Whether the note had a time
- Whether the note was signed
- Whether the provider's title was included

These are useful questions but have little to do with quality of physician care. On the infirmary form other questions are present that do not address the quality of care, including:

- Admission to infirmary was ordered by a practitioner
- Frequency of progress notes are consistent with health status
- A treatment plan established by the provider is documented
- A discharge summary is documented
- Patient education was documented
- Follow-up within a week is documented

None of the 44 questions on these peer review audits asks whether the overall quality of care was adequate. Few of the questions actually address whether the physician provided care at a contemporary standard of care. To give a comparison, the Office of Audit Services of the Department of Health and Human Services (HHS), in order to ensure quality of service for Medicare patients, has a two-prong quality audit. It screens charts for quality concerns and utilization issues. Quality concerns are defined as those in which care results in significant or potentially adverse effect on the patient.[39] When quality concerns are identified, physicians review those charts of patients who had significant or potentially adverse effects in their care management. Typical negative ratings of care for these cases are separated into cases that show gross or flagrant violations of standard of care, fail to follow generally accepted guidelines or practice, or could reasonably have been expected to do better. The audits then result in corrective actions meant to improve overall quality of the organization.

[38] Deposition of Jessica Duffell. Civil Action No. 2:14 –cv-00601 – MHT-TFM Dunn et al. vs. Dunn conducted on November 3, 2015, page 176

[39] Quality Concerns Identified Through Quality Improvement Organization Medical Record Reviews; Department of Health and Human Services Office of Inspector General; May 2007 OEI-01-06-00170

The types of peer reviews initiated by HHS are far different from the peer reviews Corizon performs. Corizon's peer reviews do not choose charts of those identified with potential quality concerns. They have a lay person apparently pick charts randomly. They do not thoroughly assess quality of provider care. They uniformly do not result in any corrective actions meant to improve quality of the organization. The audits of Corizon are a pro forma type of audit meant to complete a peer review requirement. However, the peer reviews performed have not added anything to improvement of quality of care of patients.

In the credential files, Corizon verifies that peer review was done by placing a peer review certificate in the file. There are no details of the peer review included so it isn't clear what was reviewed. The facility medical directors do have annual peer review certificates in their credential files. However, it appears that peer reviews identify no problems even when problems exist.

Dr. Lovelace testified that he always received good scores on his annual reviews, never had any feedback, and never received any criticism.[40] He performed the same studies for his mid-level provider and reviewed 10 episodes of care but never had any criticism except that she should remember to put a time on when she wrote her note. Later, Dr. Lovelace testified[41] that the only deficiency that he identified was the provider failing to document the time that the note was written.

The Impact of Poor Peer Review and Credentialing

The problem with the Corizon's credentialing and peer review process is evident in the recent firing of a facility medical director. With respect to credentialing, the doctor who was fired had only completed an internship and would not have been an optimal candidate for hiring on that basis. But in addition, he had a prior felony conviction for selling drugs and his license to practice medicine was revoked in 1999. Between 1998 and 2004 he was not working as a physician. His license was re-instated with conditions in 2004 after he took a 50-hour remedial course. He worked from 2004 until 2014, after which he applied for a job in the prison system. He was credentialed in July 2014. But there was no evidence of an interview with this physician. There was no documentation of a discussion by the credential committee or the Regional Medical Director about his training being marginal or his prior conviction and loss of license in the credential file although some medical board filings were present in the file. The verification sheet listed that he had a prior discipline against his license.

The statewide medical director did a review of the doctor's prescriptive practices at 30, 60, and 90 days, which was the only stipulation when he was hired. These reviews were found to be adequate. Dr. Hood, the current Regional Medical Director, performed a peer review on

[40] Deposition of Jerry Lovelace, MD, Civil Action No. 2:14 –cv-00601 – MHT-TFM Dunn et al. vs. Dunn conducted on December 21, 2015 in Birmingham Alabama, pages 32-33
[41] Id. at pages 111-112

7/23/15, but the only document present in the credential file is a peer review certificate which presumably meant that his performance was adequate. While Dr. Hood apparently found no serious problems on his annual peer review requiring follow-up and Dr. Crocker found no problems with respect to his prescriptive practices, the physician presumably did have issues in prescriptive practices and in practice.

An associate Regional Medical Director covering for this physician identified problems on charts she reviewed during her coverage assignment and relayed these problems to Dr. Hood. This was around December of 2015. The doctor was apparently ordering unnecessary tests for patients with normal examinations, and ordering medications for conditions that didn't exist such as thyroid medication when the patient did not have a thyroid condition. Because of these problems, Dr. Hood reviewed this information and discussed the issues with the physician, who was unable to adequately explain his performance. Dr. Hood discussed the problems with Corizon's VP of Operations. After reviewing more of the physician's work, Dr. Hood identified a case in which the physician diagnosed cancer when the patient had an ischemic leg. After continuing to identify more serious problems with this physician, a decision was made to terminate the physician. The physician was not subjected to a peer review process but his termination resulted from a discussion between the Regional Medical Director and the VP of Operations.

This case points out the deficient hiring, credential process, and peer review process that in this case harmed at least one patient and may have subject many other patients to risk of harm. Dr. Hood had hired this physician but did not interview the candidate and apparently did not review the doctor's lack of training, many years of not working, and significant criminal and conduct history. This physician should probably not have been hired. Dr. Crocker, the prior Regional Medical Director, had performed 3 reviews of prescriptive practices, but found no problems although clearly the doctor had problems with prescriptive practices which were discovered later. Dr. Hood later did a peer review, but found no problems even though the physician was not performing well. Ultimately the physician was not subject to a formal peer review, but was terminated when poor care was serendipitously discovered. If the associate Regional Medical Director had not been covering for this physician, it is unlikely that his poor care would have been discovered. This demonstrates an inadequate credentialing or routine peer review process that puts patients at risk.

Health Care Operations, Clinic Space and Sanitation

Methodology: Limited tours of 6 facilities and review of documents. Review of photos taken during tours.

Opinions:

12. The setting of care including space, equipment, and supplies is inadequate. This is a considerable barrier for all staff in performance of their professional roles. Space and equipment issues also directly harm inmates by exposing inmates to conditions that are unsafe resulting in exposure to contagious and infectious diseases, health hazards from lack of ADA facilities, life safety hazards on living units, and lack of equipment and supplies necessary to protect against harm.
13. There is inadequate protected housing for the elderly and for persons with complex health conditions and disability.

Findings:

In civilian life, accommodations are made to address the problems of the elderly, disabled and infirm. When individuals are incarcerated, similar accommodations need to be created or the elderly, disabled and infirm will suffer. Additionally, it is more efficient and safer when incarcerated individuals with serious illness are housed together in prisons. This facilitates medical care delivery and protects these vulnerable inmates from the risks of general population existence. For this reason, specialized housing is typically arranged for disabled, elderly and those with serious medical illnesses. This housing is separate from the infirmary. This housing is typically as much as 10% of the prison bed space.

Additionally, the provision of medical care requires adequate clinic space, equipment, supplies and support services (laboratory, radiology, etc.). This also includes availability of sufficient electrical, communications, and plumbing services that support modern provision of health care and housing of the aged and infirm. These support systems are no different from what physicians use in the civilian community. The older a prison system is, the more difficult it is to provide adequate space and operational support because of aging infrastructure.

The State of Alabama has the third highest incarceration rate in the United States at 633 incarcerated per 100,000.[42] Based on design capacity, the Alabama Department of Corrections (ADOC) is the most overcrowded prison system in the country.[43] As of March 2016, the Alabama Department of Corrections (ADOC) held 30,495 inmates under its jurisdiction. Of these, 24,189 inmates were housed within its prisons which were designed to house only 13,318 inmates (181.6% of design capacity). [44] On the ADOC website facility tab, the ADOC lists 15 major correctional facilities and 13 community based facilities and community work centers.[45] Within these groups of facilities, the ADOC established 42 unique facility

[42] E. Ann Carson, Prisoners in 2014; US Department of Justice, Bureau of Justice Statistics, September 2015, NCJ 248955, as found at http://www.bjs.gov/content/pub/pdf/p14.pdf
[43] Id.
[44] Statistical information in this section comes from the Alabama Department of Corrections Monthly Statistical Report for March 2016 (Fiscal Year 2016); compiled and published by The Research and Planning Division as found at http://www.doc.state.al.us/docs/MonthlyRpts/2016-03.pdf
[45] Alabama Department of Corrections website Facilities section under About ADOC tab found at http://www.doc.state.al.us/FacAddr.aspx

designations for the purpose of calculating occupancy with respect to design capacity. In total, the ADOC facilities are at 181.6% of their design capacity. None of the 42 functional facility designations except the death row unit Donaldson (87.5%) are under design capacity. Seventeen of 42 of these functional units are over 200% of design capacity. As of 2014, according to the Department of Justice (DOJ), the ADOC had the highest custody population as a percent of the lowest of either design, operational, or rated capacity of all prisons systems in the country.[46] This DOJ report states that "the majority of Alabama prisons are operating in a state of overcrowding". The ADOC data suggest that all prisons[47] house inmates in excess of the design capacity of the facility. Of the 30,495 inmates under its jurisdiction, 5,984 (19.6%) are over the age of 50 and 2,596 inmates are female (8.5%).

The ADOC system is extremely overcrowded and inmates are housed in old, often unsuitable facilities. These overcrowded conditions result in inadequate toilet and showering arrangements at all facilities I visited. This can result in inadequate hygiene which affects patient's health. At least for the facilities I toured, the ADOC facilities lack appropriate design features necessary to provide adequate medical care and do not appear to have adequate infrastructure (e.g. radiology equipment, network capacity, electric, plumbing, etc.) necessary to operate an adequate and effective correctional medical program and to care for prisoners with disabilities, chronic illness and with acute illness. The oldest facility, Draper, was opened in 1939, over 76 years ago. Most facilities were opened in the 1980s, approximately 30 years ago. The newest facility, Bibb, was opened in 1997 about 18 years ago.

Based on observations made on the tours of selected facilities, the ADOC does not appear to have made necessary physical plant changes to either accommodate the increased number of inmates or to ensure that adequate housing exists to accommodate the disabled and chronically ill based on newer contemporary standards of care. Overcrowding and lack of appropriate infrastructure negatively impacts delivery of health care and housing of disabled and chronically ill inmates.

Examination space is insufficient at all facilities I visited. All clinical examinations conducted by nurses, mid-level providers and physicians need to be in a clinical examination room that is properly equipped and lighted. None of the facilities I visited met these requirements. In several facilities nurses examine patients in hallways in chairs without benefit of examination tables. At 1 facility, nurses evaluated patients in the x-ray room, which lacked equipment for examinations. I witnessed a nurse practitioner evaluating a patient in what appeared to be a storage room. None of the examination rooms had typical fixed medical equipment such as oto-ophthalmoscopes and blood pressure cuffs. I was told that staff brings this equipment with them; it wasn't always present in rooms that were being used by staff. Sanitation of clinical space was poor and most clinical space was cluttered. Food was present in several clinical examination areas. At times sinks were covered and not apparently being used. It was not

[46] E. Ann Carson; Prisoners in 2014, U.S. Department of Justice Bureau of Justice Statistics, September 2015, NCJ 248955

[47] The only two functional units that are not over design capacity are Donaldson's and Tutwiler's death rows. See Alabama Department of Corrections Monthly Statistical Report for March 2016 (Fiscal Year 2016).

always evident that there was appropriate equipment to sanitize hands after examination of patients. Supplies were not standardized with some examination rooms not having any supplies at all.

Space for medication administration was insufficient for the numbers of patients needing medication. X-ray equipment was very old.

Some space was clearly not built for its intended purpose. Telemedicine gear was set up for use in surgical scrub areas, and in very tiny office space that had no place for a patient to be clinically examined and no place for the patient to sit. Many other examination spaces were set up such that it was not possible for the patient to lie flat on the examination table for an examination.

Infirmary spaces lacked proper shower and toilet facilities for the disabled. Infirmaries did not have beds suitable for bed-ridden patients, subjecting inmates to the risk of decubitus ulcers. A call system for patients to notify a nurse for emergencies was not present for each patient. Some single cells used for isolation of infirmary patients did not have a call system. Negative pressure rooms did not appear to be negative pressure to adjacent hallways. Sanitation on infirmaries was poor.

Work spaces for nurses were extremely poor, including in medication rooms, nursing stations, and spaces used to conduct sick call.

There was inadequate housing for the elderly, infirmed, or patients with multiple or severe chronic illness who needed protective housing. The Hamilton A & I facility was being used as a proxy for a nursing home but was so crowded that it was unsafe from a fire safety or patient safety perspective. Units used to house the elderly or disabled at other facilities did not have adequate showers or toilets. Also these units were remote from health care units that created barriers for the elderly or infirm to gain access to care or services such as medication.

The dialysis unit at Tutwiler was significantly undersized; did not appear to have an isolation room for dialysis of hepatitis B patients required by regulation; was extremely cluttered and filthy; and did not appear adequate or appropriate for use as a dialysis unit. This clinical unit was connected to the medical records unit and potentially exposed medical records staff to blood borne pathogen exposure.

Several negative pressure rooms did not appear to be at negative pressure to adjacent hallways. This means that there was potential for transmission of tuberculosis. These rooms were converted cells without a call system and some did not have showers.

Medical record rooms were extremely cramped and in some cases, disorganized and cluttered without clear separation of active and inactive records. Two facilities (Tutwiler and Kilby) were so poorly designed and arranged that it is difficult to understand how records could be properly stored. The Tutwiler medical records room has an open door to a dialysis room which appears to be a safety hazard.

Sanitation was poor throughout most facilities and all medical areas had clutter with supplies and records stored on floors. Many areas had missing tiles, damaged walls and ceilings.

I toured six of the 15 major ADOC facilities including Holman, Tutwiler, Kilby, Fountain, Limestone and Hamilton Aged and Infirm. A detailed description of those facilities is in Appendix C.

Health Records

Methodology: Tour medical record areas of 6 facilities. Review medical record to determine ease of navigation and ability to locate health information. Review policy on medical records.

Opinions:

14. Medical record staff fail to maintain the paper medical record necessary to adequately manage health care for inmates.

Findings:

Medical records contain systematic history of documents relevant to provision of medical care across time. Failure to document care provided falls below the standard of care. For a prison system, these documents need to include the consultative reports and discharge summaries of hospitalizations, as well as reports of any specialized testing that inmates undergo. Inmates move from facility to facility within a prison system. They also move from location to location within individual prisons. They also are paroled from prison and may be re-incarcerated. Because of this, the medical record system must be capable of maintaining these records given these inmate movements. Because of the difficulty and adverse patient safety issues with respect to use of paper records, many correctional centers are moving to electronic medical records.

Medical records in ADOC consist of paper files. For inmates who are incarcerated for extended periods of time, their files contain many volumes. Medical record rooms in the ADOC are all undersized and can't hold all current volumes of existing patients. Therefore, additional storage space is used to hold non-current volumes. The OHS policy on health records[48] requires that when a new health volume is generated, a prior year of pertinent health record information is moved forward to the new volume. The immunization records, which include tuberculosis screening, original intake history and physical, and current problem list among other items, are supposed to be moved forward. This is not happening as it is often difficult to determine in a record if the patient has a prior positive tuberculosis skin test. In review of records sent to me, I seldom found an original intake history and physical document. These do not appear to be moved forward even when they are required by OHS policy. This impairs the

[48] Alabama Department of Corrections Office of Health Services policy Number H-1 ADOC Inmate Health Record, approved 6/3/09

ability to care for people, as old volumes are not obtained when seeing patients for routine encounters.

Ms. Naglich testified that records are retained for the current year plus 7 additional years.[49] The OHS record retention policy[50] item 25 states that records are maintained for the length of time authorized by the State of Alabama but does not give a source for this statement. The Alabama Board of Medical Examiners rule on medical records states that physician should maintain records for a period of time necessary to treat the patient.[51] A retention policy of 8 years is appropriate as long as prior information is not important in the care of current patients and active patient records are not discarded. Appropriate and pertinent records are clearly not being retained with respect to essential patient problem areas. For example, the record of tuberculosis screening is not consistently available in the current record volume.

The record rooms at all facilities I inspected are so undersized that proper medical record processing appears difficult to accomplish. There was insufficient space to store active records and extremely limited space for staff to work in. The Kilby and Tutwiler facilities had extremely crowded medical records units. Floor to ceiling shelving made sorting and retention of records extremely difficult. The entire state system has a single certified records clerk with all other technicians treated by this 1 certified technician. Managing the volume of paper records under these circumstances appears daunting.

The results of this are that it did not appear that all records were properly filed or readily available. Based on chart reviews, many documents do not appear in records. Tuberculosis skin testing results, hospital reports, laboratory reports, etc., often appear to be missing. Also, initial medical records requested by me sometime around August of 2015 were first provided to me in spring of 2016. These records at times appeared to be incomplete records. This deficiency was brought up to the ADOC, and in June of 2016, hundreds of pages of additional medical records were produced. This demonstrates a disorganized medical record system that is incapable of providing a complete record in a timely fashion. [redacted]
When I toured facilities, it took several hours to obtain some requested records. Many of the records I reviewed were missing outside consultant reports or hospital reports in the record. This is inappropriate, as these records are essential to understand how to care for and manage the patients. Practitioners also did not thoroughly document what had occurred at hospitals or specialty consultations. It was often difficult to understand what had occurred to the patient while being cared for at outside facilities. It was not always clear that providers knew what had occurred during a hospitalization or specialty care visit.

[49] Deposition of Ruth Naglich, Joshua Dunn, et al. v Jefferson Dunn, et al. Civil Action No.:2:14-cv-00601-MHT-TFM, taken on April 7, 2016 page 306
[50] Alabama Department of Corrections Office of Health Services policy number H-2 Health Record Information; Confidentiality, Release of Information, Retention, approved 2/4/13
[51] Alabama Board of Medical Examiners & Medical Licensure Commission of Alabama; Board ruling concerning medical records as found at http://www.albme.org/medrecrule.html
[52] Lines throughout this document highlighted in grey are intended "for attorneys' eyes only."

Additionally, the OHS policy on medical records does not provide guidance on obtaining the old record of re-incarcerated inmates. Their old records appear to be stored at Tutwiler for women and Kilby for men. The medical information from prior incarcerations can be important in the current management of patients, especially diagnoses and tuberculosis screening information. I reviewed a chart of an inmate who was re-incarcerated several times. The prior record was not reviewed and providers did not know the previous medications or diagnoses of the patient even though the incarcerations were within a year of each other.[53] Major diagnoses and therapies for the patient were not continued, but would have been known if the old record was reviewed. This placed the patient at risk of harm.

These medical record deficiencies are a significant barrier to adequate care. During a recent tuberculosis outbreak investigation, ADOC could not find tuberculosis testing data for the Alabama Department of Public Health (ADPH) for a significant number of patients. This information was not consistently present in the record and it wasn't clear if the screening tests weren't done or whether the results weren't documented in the record. Problem lists are also not consistently present or completed accurately.

Also, with respect to this legal action, Plaintiffs in this case requested 25 death records but it appeared that for 9 of these 25 (36%), the medical record was either not produced in its entirety or exhibited significantly deficient medical encounters. For example, I was provided with a medical record of a patient[54] who died on 5/22/15. The last physician note documented in the medical record was on 5/23/14. The patient was being discharged from the infirmary for hyponatremia and a hip fracture. There was no problem list in this record. There were no intake documents for this patient. These documents are required by OHS policy to be present in every current medical record. Most notes were intermittent assisted living assessment tool notes. Based on the medical record, it appears that the patient was not seen by a physician for about a year before his death. If this is accurate then the level of care for this patient was considerably below the standard of care. If the medical record is lost it speaks to the problems with medical records.

This system needs an electronic medical record system. This would eliminate most of these difficulties.

[53] Patient number 21
[54] Patient number 8

Policies and Procedures

Methodology: Review policies and procedures. Review depositions with respect to statements about policies and procedures. Policies and procedures reviewed included the ADOC Administrative Regulations, OHS policies, ADOC Standard Operating Procedures, and Corizon policies and procedures.

Opinions:

15. The ADOC does not have an adequate coherent and definitive source of policy and procedure to guide medical care.

Findings:

An employee of an organization should be able to go to a definitive source of policies and procedures and obtain guidance on the expectation for performance. Policies and procedures allow employees to clearly understand what their roles and responsibilities are. This is not the case in the ADOC. Policies and procedures are issued from multiple sources and therefore it isn't always clear what the expectation for performance is based on policy.

Policies and procedures for medical care are found in five separate areas: ADOC Administrative Regulations; facility specific ADOC Standard Operating Procedures; Office of Health Services policies and procedures; Corizon regional policies and procedures; and Corizon facility specific policy and procedures. These five different sources of policy are not synchronized in a manner that provides a coherent single set of policy and procedure statements to staff. This arrangement results in a disorganized and confusing set of directions to staff and in some instances provides inaccurate procedural statements that do not reflect current practices. The presentation of policies is so disorganized that it was not possible to determine what procedures were in place at the ADOC by reading any single group of policies.

Administrative Regulations

The ADOC promulgates Administrative Regulations that govern all ADOC facilities. There are 6 ADOC Administrative Regulations pertaining to medical care:

1. Administrative Regulation (AR) 700 Office of Health Services Division describing the function of the Office of Health Services Division;
2. AR 701 Food Services Administration describing food services and special diets;
3. AR 703 Inmate Co-Payment for Health Services;
4. AR 705 Hearing Impaired Inmates
5. AR 706 Management of Hazardous Medical Devices
6. AR 708 Medical Furlough Program describing how inmates can obtain a medical furlough

None of these Administrative Regulations addresses clinical care. They focus on administrative procedures for select areas of service with little guidance in areas of clinical care. These policies do not constitute an adequate set of guidelines for medical care services.

Standard Operating Procedures

The ADOC also has facility Standard Operating Procedures. These are issued by the wardens at each facility but include several policies that address the medical program. ADOC Administrative Regulation 018 Institutional Standard Operating Procedures directs that each facility warden is responsible for maintaining a standard operating procedure manual that is up to date. Standard operating procedures are supposed to be updated annually but clearly this is not happening. The latest date of review for a few policies was 2014. The earliest year of last reviews for some policies was 1994[55]. No policies appear to be reviewed annually. Most of these policies are old and these policies do not appear to be maintained or updated. The relationship between these Standard Operating Procedures and policies issued by the Office of Health Services and Corizon are not clear and can result in confusing guidance to custody and health care employees.

I was provided with standard operating procedures from only 12 facilities even though there are 15 major adult facilities.[56] No policies were available for Bullock, Draper or Elmore, although these facilities may be covered by other facility policies. Draper and Elmore may be considered operationally under the Staton facility policies, but there were no Standard Operating Procedures for Bullock. None of these facility Standard Operating Procedures were standardized. Policies covered include:

- Handling the inmate's institutional and medical file;
- Responsibility in handling emergencies including medical emergencies;
- Security on the medical unit and with respect to access to and from the medical unit;
- Responsibility of officers on the medical unit;
- Inmate pill call;
- Prescribed medication;
- Medical procedures;
- Inmate hospice/palliative care volunteer program
- Over the counter (OTC) and keep-on-person (KOP) medication
- Segregation issues including medical issues

These Standard Operating Procedures do not cover all essential areas of a correctional health program. More importantly, these Standard Operating Procedures (SOP) allow wardens to direct health policy. As an example, the Fountain SOP 12-3 Sick Call dictates that:

[55] SOP VII-8 Inmate Pill Call from Kilby and SOP C-42, Medical Emergencies and C-45 Inmate Medical Treatment/First Aid Kits both from Easterling

[56] Bibb, Donaldson, Easterling, Holman, Fountain, Hamilton, Kilby, Limestone, St. Clair, Staton, Tutwiler, Ventress

"Sick call with clinic appointments will be conducted 7 days a week"[57]

The OHS policy E-7 Health Services Inmate Sick Call Request is silent with respect to the frequency of sick call. Fountain's Corizon policy P-E-07.00 Non-Emergency Healthcare Requests (Sick Call) states that sick call is conducted 6 days a week. The frequency of sick call should be a policy directive issued by the health authority for the state not individual facility wardens.

OHS Policies and Procedures

The OHS policies are another set of policies governing operations of health services. The OHS policies and their last date of review include:

1. Medical Services-Systems Audits - 2014
2. Health Classification, Assessment Coding, and Communication of Needs - 2014
3. Hepatitis C Evaluation and Treatment - 2014
4. Hepatitis B Evaluation and Treatment - 2014
5. Pandemic Influenza Plan - 2009
6. Health Services-Work Release / Work Center - 2011
7. Keep on Person (KOP) and Over the Counter (OTC) Medication Programs - 2013
8. The OHS Inmate Handbook - September 2014
9. Intake-Health Screening and Assessment - 2012
10. Pre-Transfer Inmate Health Screening and Transfer / Receiving Screening of Inmates - 2009
11. Transfer Screening – Court Appearance - 2012
12. Inmate Periodic Health Assessment -2010
13. Health Services Inmate Sick Call Request - 2014
14. Inmate Release for ADOC – Discharge Planning - 2011
15. Clinically Assigned Beds - Infirmary, Observation, Assisted Living, and Sheltered Housing - 2014
16. Medical Profiles - 2011
17. Hospice Care - 2014
18. A.D.O.C. Inmate Health Records - 2009
19. Health Record Information; Confidentiality, Release of Information, Retention - 2013
20. Living Wills, End of Life Care, and Organ & Tissue Donation - 2014
21. Kitchen Hold Tray - 2011
22. Institutional Meat Cooking Temperatures - 2011
23. Bleach as Disinfectant - 2011
24. Institution Barber Shop and Beauty Salon Guidelines - 2012
25. Institutional Laundry Carts - 2013
26. Scabies Sanitation Procedures - 2014

[57] State of Alabama Department of Corrections, Fountain Correctional Center Standard Operating Procedure number 12-3 Sick Call

27. Emergency Handwashing Stations - Food Services - 2014

Failure of OHS Policies and Procedures to Provide Adequate Guidance

Most of these policies are administrative policies, but several are clinical in nature. The contract between ADOC and Corizon does not require that Corizon provides health care policies and procedures for each facility. The scope of work of the contract as described in the request for proposal directs that the vendor is to follow ADOC OHS policies and procedures and National Commission on Correctional Health Care (NCCHC) standards. Under all circumstances, ADOC-OHS policy or procedure is the ultimate policy benchmark even when ADOC-OHS policy is contrary to current national standards for correctional health care. As stipulated in the request for proposal of 2012:

> "The objective of this RFP is to secure a qualified Vendor who can manage and operate a comprehensive health care services system at full capacity and in a cost-effective manner, as well as deliver quality health care services in compliance with ADOC Office of Health Services (OHS) policies and procedures as well as ACA and NCCHC standards published as of 2008. Formal NCCHC and/or ACA accreditation is not a requirement. Should a potential conflict in ACA, NCCHC, and OHS policies and procedures arise, OHS policies and procedures will prevail."[58]

However, ADOC OHS policies and procedures do not address all areas necessary for providing policy guidance to a health program. There are 26 OHS policies and an inmate handbook. Seven of these policies are not essential policies including: Pandemic Influenza Plan; Kitchen Hold Tray; Institutional Meat Cooking Temperatures; Bleach as Disinfectant; Institution Barber Shop and Beauty Salon Guidelines; Institutional Laundry Carts; and Emergency Handwashing Stations– Food Services. The OHS policies therefore cover 19 policies essential for health services. The National Commission on Correctional Health Care (NCCHC), whose standards are required to be followed by contract requirements, has 73 important and essential health care standards. There is no direction in the RFP or contract between Corizon and ADOC or in OHS policy and procedure directing whether any gaps in policies are covered by Corizon's policies and procedures.

OHS policy does not cover many areas of medical services covered by NCCHC and considered essential to a correctional health program including:

- Infection Control
- Environmental Health and Safety
- Credentialing
- Medication Administration
- Pharmaceutical Operations and Medication Management

[58] Request for Proposal No. 2012-02 Comprehensive Inmate Health Care Services, July 17, 2012 Alabama Department of Corrections page 46

- Clinic Space, Equipment, and Supplies
- Management of Chronic Disease
- Care of Pregnant Women
- End of Life Decision Making
- Prison Rape Elimination Act issues

Corizon Regional and Facility Specific Policies

Corizon regional and facility specific policies and procedures are another set of policies and procedures apparently governing the medical program. When Corizon produced its policy for purposes of discovery, it apparently sent all policies ever used by Corizon or its parent company in the state of Alabama under the existing contract. Because none of these policies are signed as reviewed, it is hard to tell which policy is the one currently being used or whether it was ever reviewed. Many policies provided to me for review included a header "Correctional Medical Services," which was the parent company of Corizon prior to merger with Prison Health Services in 2011. These policies are confusing and disorganized and fail to give effective guidance to staff.

A few of the Corizon facility specific policy manuals sent to me included an attestation signature sheet. This sheet states that Corizon is contractually obligated to use OHS policies. When OHS policies and procedures are silent on a particular matter, then Corizon Health Service's policies and procedures are to be used. This attestation sheet does not include the Corizon policies which are to be used. But since the Corizon manual contains many policies that are included in the OHS group of policies, it isn't clear when the duplicate Corizon policies are to be used and when they are not to be used. The attestation sheet from Kilby, as an example, was signed 4/1/13 at Kilby by the health service administrator and medical director. However, there was not a signature sheet acknowledging review and revision of policies on an annual basis. The face sheet documenting review of policies by the administrator and medical director at Kilby was last signed in February 2010. This face sheet contained the company logo as Correctional Medical Services, which ceased to exist in 2011 when Correctional Medical Services merged with Prison Health Services to form Corizon.

Corizon's facility specific policies and procedures are based on generic corporate policy and were not written specifically for ADOC. These documents are a template form developed by the corporation and are meant to be modified so that the facility can develop its own policy from the template. These template policies are downloaded from a Corizon website.[59]

Development of individual facility policies using these generic template formats is not done well. Policies sent to me were disorganized, had multiple versions of the same policy, and did not appear to define the current practice. This was confusing for me and I am sure it is confusing for staff.

[59] Deposition of Teresa Ergle, health services administrator from Donaldson taken on 11/4/15 p. 174

The Corizon regional policies include templates that each individual facility needs to use to develop its own procedure. However, in individual facility manuals I reviewed, the facility did not always develop a procedure but copied the regional manual verbatim without developing a local procedure. When the template is not modified, the policy is not sensible.

It was also evident that policies are not reviewed on an annual basis. Policies should be reviewed and signed annually. This is a standard practice in correctional medical programs. I could not find policies which were signed as reviewed including the date of review. Given that policies do not appear to be reviewed, it is not surprising that outdated, unnecessary and duplicated policies are present in Corizon policy manuals.

As current regional policy, Corizon sent 2 regional office policy manuals; 1 issued 2012 and 1 issued in 2003. Neither of these has any revisions. Neither of these is signed as approved or reviewed. These manuals contain procedure statements of the NCCHC and ACA but these procedure statements are not procedures that appear to be followed at every facility and appear to represent the recommendations of the NCCHC and not the procedure of the facility. This is misleading and appears to represents that the ADOC actual procedure is reflected in the NCCHC procedure statement.

As an example, the NCCHC procedure statement for continuous quality improvement states that facilities greater than 500 perform at least 2 process and 2 outcome studies annually. This is not part of the quality improvement program in the ADOC. The purpose of having these NCCHC/ACA procedural statements is unclear. They do not give guidance and statewide requirements, they do not appear to describe existing policy or procedure, and they may misrepresent what is actually occurring.

The regional policies and procedures also give "procedure detail instructions" for each policy that instructs the individual facility on how to write their procedure. These instructions are not always used and sometimes are inaccurately used. As an example the 2012 regional policy and procedure for infection control[60] has a procedure instruction stating:

> "After completing your facility specific procedures, please delete the following paragraph.
>
> The procedure detail questions are meant to be a guide to assist you in developing the detail necessary to ensure your procedures are facility specific. They are not intended to be a comprehensive list that takes into account every aspect of your facility operations. It is expected that you would add to, amend, or delete the questions to ensure that your procedure provide clear direction for your employees in your facility.

[60] Corizon General Health Services Policy and Procedure Alabama Regional Office Infection Control Program Number P-B-01-00 Issued 10/29/12 and revised 11/27/13

1. Who (by position title) is responsible for creation and approval for the facility exposure control plan?
2. All other procedure statements are addressed in the Infection Prevention Manual."

The St. Clair facility, where they have had a recent tuberculosis outbreak, has a policy manual that does not include the 2012 Corizon regional infection control procedural detail recommendations. It does, however, include a mix of older 2003 and 2008 Corizon generic policies. The latest St. Clair policy on tuberculosis screening was implemented in 2009.[61] The stated procedure in this document for tuberculosis screening is the following:

1. How are inmates screened at your site for TB?
2. What is done with those inmates who demonstrate signs or symptoms of tuberculosis?
3. Are special steps taken for inmates who are HIV + such as CXRs –This is CDC recommendation.
4. What are your local health department's guidelines and state laws regarding diagnosis, treatment and reporting?
5. What is done with inmates who refuse screening processes or who are non-compliant with drug therapy?
6. When is TB skin test (TST) implanted and how is it documented-remove TB testing sheet and log in this manual and replace if site-specific form used.
7. How are inmates who have a previous history of a positive TB skin test handled at your site?
8. When is your TB skin test (TST) read?
9. What educational material or referrals are given to inmate with a positive TB skin test (TST)?
10. What educational counseling topics are approached during the inmate's care at your facility? Such as liver studies and medication compliance.
11. How are inmates who are taking TB medication handled when they are released from or transferred to another facility?
12. TB information can be found on CDC website-www.cdc.gov

None of these questions is answered in the St. Clair manual for its latest policy revision on infection control. There is an earlier second policy on the management of tuberculosis in the St. Clair policy manual.[62] This earlier policy has questions similar to the 2009 procedure but on the 2008 procedure there is an answer to most of the questions.

[61] Correctional Medical Services Health Services Policy and Procedure Manual St. Clair Correctional Facility number P-B-01.02 Management of Tuberculosis Corporate Revision Date 10/1/08, Site Implementation 6/30/09, with no revisions and not signed.

[62] Correctional Medical Services Health Services Policy and Procedure Manual St. Clair Correctional Facility number P-B-01.1 Management of Tuberculosis, Distribution Date 6/03/03, Implementation Date 11/1/07, Revision 02/12/08

Since the St. Clair policy manual is not signed as reviewed annually, it appears that the 2009 policy is in effect. But this policy gives no guidance on how to manage tuberculosis. It appears that the St. Clair facility merely inserted the regional policy in their manual and it wasn't reviewed annually. Therefore, with respect to TB, in an institution where there was a major tuberculosis outbreak, the policy and procedure for screening and treatment of tuberculosis is confusing. The patients at St. Clair endured an outbreak of tuberculosis when existing policy in that area appears ineffective.

Corizon policies also sometimes give guidance that is not possible to follow. For example, the Corizon Holman policy P-E-07.00 Non-emergency Health Care Requests for Service dated as revised on 10/29/12 has policy statement that states,

> "Sick call and clinicians' clinics are conducted on a timely basis in a clinical setting by qualified health care professionals"

The reality is that nurses sometimes evaluate the patients in the hallway of the health unit which is not a clinical setting. The policy statement makes it appear that the practice at the facility is other than it actually is.

Internal Monitoring and Quality Improvement Activities

Methodology: Review of policy and procedure. Review of depositions. Review of Medical Advisory Committee (MAC) meeting minutes. Review of Quality Improvement minutes.

Opinions:

16. The OHS and Corizon do not have dedicated staff that are involved in quality improvement activity.
17. The OHS and Corizon management do not provide leadership to ensure that adequate quality improvement efforts occur.
18. The OHS and Corizon quality improvement efforts focus on pro forma compliance efforts that fail to identify significant existing problems and quality concerns that cause patient harm and mortality.

Findings:

Quality Improvement Requirements and Policy

Quality Improvement is an essential component of correctional medical programs. Quality improvement should include involvement of all disciplines within the organization. Typically, unless medical leadership actively participates and supports quality improvement efforts, these do not succeed. A key goal of quality improvement is to identify and correct problems within

the system. With respect to correctional systems, an effective and functioning quality improvement program is an essential program that needs to be demonstrated to be in place with respect to termination of Court monitoring as this verifies that the program has a means to self-monitor.

The ADOC quality improvement efforts focus almost entirely on statistical data that are not useful in measuring quality. The quality improvement efforts are ineffective in assisting in preventing harm from serious medical illness.

The scope of work in the RFP[63] requires that the vendor maintain an evidence based quality assurance program. Yet, the minimal staffing requirements[64] of the medical contract with Corizon do not include a single individual dedicated to a quality improvement function.

Item 5.22 of the RFP[65]requires that Corizon specify guidelines and procedures for a Comprehensive Quality and states:

> "Vendor will specify guidelines and procedures for a Comprehensive Quality Improvement Program (CQIP). Vendor's corporate medical director will establish a program for assuring that quality care and services are provided to inmates. The CQlP will evaluate the health care provided to inmates at both on-site and off-site facilities for quality, appropriateness, continuity of care, and recommendations for improvement. Reports of the findings will be presented at the monthly ADOC Medical Advisory Committee (MAC) meetings.
>
> a) Vendor will provide a management information system capable of providing statistical data necessary for the evaluation and monitoring of health services.
>
> b) Information gathered by Vendor will be utilized for the preparation of the following documents:
>
> 1) Monthly reports of services to include, but not limited to, report outline in Appendix G;
> 2) Reports for administrative meetings with ADOC officials; and
> 3) Semi-annual and annual reports for the analysis of services provided.
>
> c) Data collection will be monitored by the on-site physician and supervised by the Health Services Administrator. Monthly reports will be generated and presented for discussion at each Quality Improvement Committee meeting. Any significant variances in the data will be investigated and discussed during these monthly meetings. All

[63] Item 5.1 (A) Purposes of the Project-Medical Services item X found on page 47 of Alabama Department of Corrections Request for Proposal No. 2012-02, Comprehensive Inmate Health Care Services Issued July 17, 2012
[64] Appendix A to 2012 Contract between Alabama Department of Corrections and Corizon, Inc.
[65] Item 5.22 (A) Comprehensive Quality Improvement Program found on page 62 of Alabama Department of Corrections Request for Proposal No. 2012-02, Comprehensive Inmate Health Care Services Issued July 17, 2012

> Documents pertaining to health care services will be forwarded for evaluation to the Quality Improvement Committee."

Items a, b, and c of this list of requirements in the RFP relate to reports that Corizon is required to submit to ADOC OHS. These reports are statistical data on numbers of health care activities including the numbers of persons on the infirmary, numbers seen in sick call, numbers seen in chronic clinic, etc. These types of reports are useful with respect to tracking volumes of care but have no relationship to quality. Most of the quality improvement efforts of Corizon focus on repeating the same audits that the OHS performs on an intermittent basis. The requirement that the vendor's continuous quality improvement program will evaluate the health care provided to inmates at both on-site and off-site facilities for quality, appropriateness, continuity of care, and recommendations for improvement is not being met and is not evidenced in the existing quality improvement efforts.

The ADOC OHS policies do not include a policy on quality improvement. Corizon's policies are disorganized and appear ineffective in giving direction with respect to quality improvement or even with respect to quality improvement requirements of the RFP. Corizon's CQI policies do not reflect the actual practices in the ADOC.

Leadership Lack of Involvement in QI Process

Corizon medical and administrative leadership have almost no role in quality improvement. Dr. Crocker, the prior Regional Medical Director testified with respect to a question as to whether he had any responsibilities regarding quality assurance,

> "Not -- I mean, indirectly, we tried -- we provided good medical care to the inmates. But I wasn't a quality assurance monitor or someone, that wasn't my function."[66]

And later in the same deposition Dr. Crocker answered a question as to whether he had any role in continuous quality improvement while being Regional Medical Director,

> "Not under the specific title continuous quality improvement".[67]

To another question on whether audits were discussed at the CQI meetings, Dr. Crocker responded,

> "Well, if you want to do good on an audit, so I guess there were some available, maybe you would discuss it. I just don't remember. I didn't attend many sites' CQI meetings at all."

[66] Deposition of Bobby Crocker MD, Civil Action No. 2:14 –cv-00601 – MHT-TFM Dunn et al. vs. Dunn conducted on February 25, 2016, page 21
[67] Id. at page 22

When asked how care would be examined in order to improve it, he responded:

> "I'm not a big CQI participant, so I cannot specifically tell you how they do it."[68]

Dr. Crocker couldn't remember in his deposition who from Corizon Regional Office was most involved in CQI, how the Regional Office monitored CQI, how often quality improvement meetings occurred at individual facilities, how often he participated in quality improvement meetings, whether there were meeting minutes, how items were identified as items for evaluation, or any specific items that were discussed at the meetings. He had no recollection as to whether ADOC audits were discussed at the CQI meetings.[69] He also testified that he never received or reviewed facility CQI reports.[70]

Dr. Hood, the current Regional Medical Director, testified that he did not attend MAC meetings, the purpose of which was quality improvement.[71]

Ken Dover, the Vice President of Operations for Corizon, is the lead regional administrator for the Corizon program. He was asked whether he participated in quality improvement meetings. His response was that he didn't directly participate in quality improvement meetings. He indicated that Corizon regional nurses and facility administrators utilize the OHS audit tools regularly to perform their own audits of care. This was not evident in my review of the MAC meeting minutes, which are supposed to include a report from the CQI Committee. Mr. Dover wasn't involved in quality improvement but provided oversight of the process of Corizon leadership staff in performance of OHS audits. He acknowledged that he did not routinely attend quality improvement meetings, MAC meetings or morbidity and mortality meetings.[72]

Dr. Gams, the medical director at Tutwiler, and Dr. Rahming, the medical director at Kilby, testified in their depositions that CQI meetings mostly address going over statistical information and internal audits performed by Corizon staff using OHS audit tools.[73] This conforms to what Mr. Dover said in his deposition. These CQI activities mostly look at statistical information with little relevance to quality and fail to address quality of care. Additionally there is a lack of participation of clinical leaders in this effort. Dr. Rahming stated that he was never required to present anything at CQI meetings, did nothing to prepare for these meetings, and that the meetings lasted about a half hour to an hour.[74] He also indicated that he was never required to do anything differently following a CQI meeting. An exchange in his deposition was as follows:

---

[68] Id. at page 36
[69] Id. at pages 34-35
[70] Id. at page 48
[71] Deposition of Hugh Hood MD, Civil Action No. 2:14 –cv-00601 – MHT-TFM Dunn et al. vs. Dunn conducted on March 10, 2016 page 323
[72] Deposition of Ken Dover, Civil Action No. 2:14 –cv-00601 – MHT-TFM Dunn et al. vs. Dunn conducted on February 24, 2016, pages 74-80
[73] Deposition of David Gams MD, Civil Action No. 2:14 –cv-00601 – MHT-TFM Dunn et al. vs. Dunn conducted on December 8, 2015, pages 164-165
[74] Deposition of Wilcotte Collingwood Rahming MD, Civil Action No. 2:14 –cv-00601 – MHT-TFM Dunn et al. vs. Dunn conducted on February 18, 2016, page 98

"2 Q. So you basically just go to the
3 meeting and review the stats on how you are
4 doing?
5 A. Yes.
6 Q. Does the meeting impact the way
7 you do your work in any way?
8 A. No."[75]

Medical Advisory Committee

The Medical Advisory Committee (MAC) meetings are to include a report of quality improvement work. But these meetings appear to be pro forma meetings and rarely document any discussion of quality improvement. Sentinel events and mortalities are not discussed. These meeting consist mostly of review of statistical data that does not include outcome data. Some of these meetings last as little as 5 minutes.[76] At most facilities, medical directors attend inconsistently and participate rarely. I reviewed multiple meetings at several sites. Meeting content was mostly informational and included discussion of operational issues but did not include any CQI efforts. At Easterling Correctional Facility the medical director, Dr. Darbouze chairs the CQI meeting, but that meeting is mostly informational, not about problem solving.

The meeting minute titles appear to be based on a template which makes the date of the meeting impossible to evaluate. For example the Bullock facility had a MAC meeting titled,

"Mini MAC Meeting For June 2015
Bullock Correctional Facility
Review of: October 2015 MiniMAC Meeting
Held On: November 20, 2015."

There was another MAC meeting with different minutes with the same title as above including the meeting date of November 20. The same facility had another meeting titled:

"Mini MAC Meeting For June 2015
Bullock Correctional Facility
Review of: June 2015 Mini MAC Meeting
Held On: June 19, 2015"

There was yet another meeting with the title:

"Mini MAC Meeting For June 2015

[75] Id. at page 100
[76] MAC meeting at Easterling Correctional Facility conducted Tuesday, April 7, 2015; started at 10:31 and adjourned at 10:36.

Bullock Correctional Facility
Review of: May 2015 Mini MAC Meeting
Held On: June 12, 2015"

It was difficult, if not impossible, to tell what months these meetings covered.

The Holman facility also uses a template that uses cut and pasted parts of the meeting minutes. For 4 different meeting dates, parts of the minutes were identical. Aside from items I and II, the 1/29/15 and 12/22/15 meeting minutes had 3 pages that were identical including the adjournment time. Items I and II of the 12/22/15 and 1/21/16 meetings were identical. Items III through V from 1/21/16 and 12/22/15 were identical including adjournment time. The 11/18/15 meeting minutes items I and II were identical to items I and II of the meeting conducted on 12/22/15. Given these types of errors, it is not credible that the meeting minutes actually reflect whether the meeting occurred and if it did what happened at the meeting.

None of the MAC meetings I reviewed included reports from CQI except for 2 facilities. A meeting from the March MAC meeting conducted on 4/17/15 at Bullock included a CQI report that gave audit scores for the month of February. Also, the Bibb minutes for January 2016 include CQI meeting minutes. The CQI Committee met on the same day as the MAC meeting. The MAC meeting started at 1:45 and adjourned at 2:30 pm. The CQI meeting with the identical participants as the MAC meeting started at 2:15 pm and adjourned at 2:25 pm. The CQI meeting minutes reported audit results for January and included several items that were identical to the MAC meeting minutes. At this facility these meetings appear to be occurring concurrently.

These MAC meeting minutes list a number of items such as the number of deaths, numbers of persons going to specialty clinics and outside hospitals, number of grievances, number of cases of various infections, numbers of chronic care patients seen, etc. These items are useful management metrics but are not quality measures. Overall, Corizon appears to have an ineffective quality improvement program.

OHS Audits of Medical Care

The ADOC OHS independently evaluates medical care of Corizon by performing audits. The OHS audits address only 11 important processes of care and fail to address quality of care in those audits it performs. Important areas of service that are not evaluated by these audits include:

- Policies and procedures
- Continuous quality improvement efforts
- Privacy of care
- Patient safety
- Federal sexual abuse regulations
- Credentials

- Clinic space, equipment, and supplies
- Receiving screening
- Initial health assessment
- Care of the pregnant female
- Health records effectiveness
- End-of-life decision making
- Mortality review processes

Many of these items are important or essential NCCHC standards, which is a required benchmark for the vendor as stipulated in the RFP.

According to Ms. Naglich, the OHS monitors quality of care through audits, reports of ADOC regional managers, reports from Corizon, and meetings.[77] The ADOC OHS audits are found in an appendix in the 2012 request for proposal for medical care.[78] There are 21 individual audit forms along with required ADOC monthly operational report formats. The operational reports track statistical data on the numbers of certain types of events that occur such as receiving screenings, sick call requests triaged, admissions to the infirmary, etc.

The 21 audit forms contain 177 questions averaging about 8 questions per form with a range of 3 questions to 27 questions. The audit titles with the numbers of questions for each audit are:

1. Segregation - 4 questions
2. Sick Call - 7 questions
3. Annual Health Screen - 27 questions
4. Medication Administration - 10 questions
5. Infirmary Care - 12 questions
6. Infectious Disease-HIV - 7 questions
7. Skin Infection - 7 questions
8. Cardiac-Hypertension - 4 questions
9. Dental Services - 9 questions
10. Discharge Planning - 5 questions
11. TB Therapy - 9 questions
12. Pulmonary Chronic Clinic - 6 questions
13. Specialty Care - 7 questions
14. Seizure Disorder - 3 questions
15. Hepatitis C Treatment - 14 questions
16. Hepatitis C Non-Treatment - 6 questions
17. Diabetes - 15 questions
18. Grievance Log - 4 questions

[77] Deposition of Ruth Naglich, Joshua Dunn, et al. v Jefferson Dunn, et al. Civil Action No.:2:14-cv-00601-MHT-TFM, taken on April 7, 2016 pages 14-16

[78] Appendix E Performance Indicators in the Alabama Department of Corrections Request for Proposal No. 2012-02 Comprehensive Inmate Health Care Services July 12, 2012

19. Anticoagulation Therapy - 4 questions
20. Intra-System Transfer - 8 questions
21. Coding - 9 questions

Ten of the 21 audit forms address clinical conditions (diabetes, hepatitis C, HIV, etc.). None of these 10 clinical audits assess for quality of care. In that respect, the audits do not effectively audit for provider or nursing quality of care. Almost all questions on these clinical audits are compliance type questions. For example, they address whether the patient had his problem identified on a problem list, was enrolled in a proper clinic, was scheduled for an appointment and had necessary testing. These compliance type audit questions fail to determine whether someone with a serious medical illness is properly cared for. For example, someone with a serious medical illness may be scheduled to see a physician, may obtain appropriate tests and may be enrolled in a chronic care program. However, if the provider seeing the patient fails to properly care for the patient, the patient will suffer and their condition will deteriorate. Failure to address quality of care is causing harm and risk of harm on an ongoing basis but there is no means in the quality improvement program to address this issue.

The remaining 11 audit forms address processes of care such as sick call, medication administration, infirmary care, etc. These audits, as well, mostly address compliance issues such as whether paperwork was properly filled out, patients were scheduled or seen, or testing was performed. Quality of care with respect to the audit topic is not addressed. For example, in the sick call audit, there are 7 questions. The questions address whether the request was timely triaged and seen, whether an appropriate protocol was used, whether vital signs were recorded, whether education was provided, whether paperwork was filled out and whether follow-up was scheduled. The audit doesn't address whether the quality of the nurse evaluation was appropriate, whether RN staff reviewed assessments conducted by LPN staff, or whether the quality of assessment was of sufficient quality to prevent harm with respect to serious medical needs. Evidence in chart reviews shows multiple episodes when nursing evaluations resulted in harm but the system has no effective mechanism in place to address these quality issues. While the compliance issues are worth studying, failure to monitor quality of care and outcomes will result in risk of harm to patients with serious medical illness.

Inadequate Staffing of OHS Audit Team

The OHS audits are performed by the 2 regional managers and an administrative services employee. They are all nurses. These employees all have many other assignments so performance of audits is a part-time endeavor. Ms. Naglich oversees the audit process and occasionally participates in audits. There is no physician involved in auditing and physician quality is not an item that is audited, but is an area of significant deficiency and one that results in significant harm to patients with serious medical illness.

Brandon Kinard, the regional manager for the northern facilities, has multiple assignments. He is the hepatitis B and C coordinator for the entire state, he oversees the hospice program, he is the hepatitis B vaccine coordinator, he investigates inmate complaints, keeps statistical data for

drug screens and he performs audits.[79] Lynn Brown, the regional manager of south facilities described her job duties as

> "10 An investigator, a policy
> 11 participation, inmate grievance monitoring,
> 12 auditing, reviewing medical files for
> 13 affidavit purposes, reviewing medical files
> 14 for access timeliness, general policy
> 15 compliance, participating in coordinating and
> 16 facilitating problems or concerns or
> 17 reportable things with Public Health, being a
> 18 support facilitator for the mental health,
> 19 overseeing the intake facilities, and women
> 20 health issues."[80]

Laura Ferrell, whose job responsibilities are administrative services, develops policy, works with the Alabama Department of Public Health on various issues, works with information technology on forms, and performs audits when requested.[81] Having only 3 employees engaged part time in performance of audits that take about several days to perform is inadequate for the scope of auditing that needs to be performed. The ADOC should have an audit team that includes a physician and quality of clinical care in their audits.

The audits and reports do not address quality problems affecting patients with serious medical illness. In part, this is a result of the lack of physician participation in evaluation of care. The OHS does not have a physician participant in reviewing clinical quality of vendor medical care. The OHS is made up entirely of nurses. This is a disadvantage with respect to evaluation of physician quality. Ms. Naglich was asked if she ever recalled seeing something on a hospital report that caused concern about care provided by ADOC and she replied, "No, not specifically, no."[82] However, there were a significant number of adverse events in patients with serious medical conditions that I identified in chart reviews. Hospital reports need to be evaluated by physicians, not nurses, with respect to quality. As was already discussed in the section on peer review and as will be discussed in the sections on sentinel event and mortality review, the current review of physician and mid-level provider quality is ineffective with respect to prevention of harm to persons with serious medical illness.

[79] Deposition of Brandon Kinard, Joshua Dunn, et al. v Jefferson Dunn, et al. Civil Action No.:2:14-cv-00601-MHT-TFM, taken on January 12, 2016, page 40-44

[80] Deposition of Lynn Brown in Civil Action No. 2:14 –cv- 00601 – MHT-TFM, Dunn et al. vs. Dunn et al. given on February 9, 2016

[81] Deposition of Laura Ferrell, Joshua Dunn, et al. v Jefferson Dunn, et al. Civil Action No.:2:14-cv-00601-MHT-TFM, taken on February 16, 2016, pages 38-48

[82] Deposition of Ruth Naglich, Joshua Dunn, et al. v Jefferson Dunn, et al. Civil Action No.:2:14-cv-00601-MHT-TFM, taken on April 7, 2016 page 104

OHS audits need to be strengthened by investigation of quality of care of both nurses and physicians. This will require a more robust OHS staff than now exists. Use of outcome data in development of quality metrics would be a useful addition to OHS audits. However, use of outcome data requires digital data which is not now available in the ADOC. Installation of an electronic medical record would immeasurably help the ADOC not only in maintaining medical record documents but also in obtaining outcome data that can help in measuring quality of care.

Medical Reception

Methodology: Tour both intake facilities: Tutwiler and Kilby. Review medical reception/intrasystem policy and procedure. Review intake and intra-system transfers in charts reviewed.

Opinions:

19. Medical intake screening fails to adequately identify and treat incoming inmates for their serious medical conditions for several reasons. (1) LPNs perform initial nurse intake screening but are not trained to perform independent assessments. RNs need to perform intake assessments. (2) The only history obtained is completed by nurses. Providers need to perform a history as well as a physical examination. (3) The history and physical examination need to include all current conditions of the patient. (4) The provider examination needs to include vital signs and other pertinent point of care test results. (5) Nurse and provider quality on intake history and physical examinations are poor. (6) The ADOC does not ensure that patients coming into prison receive all needed medications timely. (7) The initial therapeutic plan does not address all of the problems of patients.

Findings:

Inadequate OHS Policies Result in Poor Screening Practices

Intake screening ensures that incoming inmates are appropriately screened for contagious disease, have all of their medical conditions identified, have all of their needed medications continued or started, have an initial treatment plan developed, and, based on any disability or illness, are appropriately housed within the prison. Timeliness of screening is critical, especially for those inmates taking prescription medication that must be immediately continued and for those whose medical treatment plan requires immediate action. Accurate identification of medical conditions is paramount as failure to do so can result in harm to the patient and others in the ADOC. Correctional systems typically include an arrival nurse screening that identifies if an urgent problem exists and identifies medications so that they can be continued promptly. Correctional systems also include a provider history and physical examination. The timeframe of this examination is scheduled based on the acuity of an individual's medical condition.

While OHS has a policy on intake medical reception screening and assessment, Corizon also has 2 policies and procedures on receiving screening from October of 2012 in their regional policy manual[83] and 1 or more policies on receiving screening in each facility manual[84]. The regional Corizon policy on receiving screening does not refer to the OHS policy and the individual facility policies I reviewed also do not refer to the OHS policy. The OHS policy gives specific instructions on which forms to use and procedures that are to be followed with respect to intake evaluations. The Corizon policies do not include this level of detail. Having multiple conflicting policies is confusing and potentially places the patient at risk.

The OHS policy on receiving screening has several critical deficiencies. It does not give a timeline for continuation of medication or specific details on how this is done except to state that medication is continued at the discretion of the provider. The intake facilities, Tutwiler for women and Kilby for men, also do not address how soon medication is to continue after arrival and how this is to occur. Needed medication should continue within 24 hours of arrival but this is not stated in policy or procedure.

The timeline of continuation of critical interventions is not stated. For example the OHS policy states that dialysis should be validated and continued at the discretion of the provider. But initial assessments are not expected to be completed for 7 days and it is not stipulated when patients with critical needs are addressed. Incoming patients need to have an acuity scale which determines the timeline of evaluation. Those with high acuity and on critical medications or interventions (on oxygen, on dialysis, receiving chemotherapy, etc.) need to be seen with 24 hours and have those interventions started the day of arrival or synchronized to their existing civilian treatment regimen. This is not covered by policy.

The OHS requires use of 8 separate forms to document intake information. Five of these forms are numbered and 3 are unnumbered. The unnumbered forms include an intake tracking form and 2 medication forms, 1 to list the patient's current medications and one for providers to order medications.[85] The numbered forms include a mental health screening form (Form1).

Form 2 identifies if there is an immediate medical need and if specialized housing is needed.[86] This is the first medical screening an inmate receives and is completed by an LPN. LPNs are not

[83] Dunn(Corizon)_00540-00543 and Dunn(Corizon)_00127-00130 Corizon General Health Services Policy and Procedure, Alabama Regional Office Policy number P-E-02.00 Receiving Screening; date of issue 10/29/12 and Correctional Medical Services Health Services Policy and Procedure Manual, Alabama, policy number P-E-02 Receiving Screening – Intake Unit, corporate effective date: 08/01/03

[84] For example, at Tutwiler these two policies were Dunn(Corizon)_17835-17838 Corizon General Health Services Policy and Procedure Tutwiler Prison for Women policy number P-E-02.00 Receiving Screening reviewed and revised 09/2014 and Dunn(Corizon)_17843-17847 Corizon General Health Services Policy and Procedure Tutwiler Prison for Women Policy number P-E-04.00 Initial Health Assessment reviewed and revised 09/2014

[85] Intake Tracking Log ADOC000908; Intake Medication Review Form ADOC000909; and Intake Medication Review Form ADOC000910

[86] New Arrival Intake Screening – Form 2, ADOC000912

trained to perform assessments. This initial assessment should be performed by an RN as it determines if an immediate need for care is required.

Form 3 is a list of intake procedures that must be accomplished for every intake evaluation including instructions to the inmate, diagnostic tests, eye examination, vital signs and tuberculin skin testing.[87] This is filled out by an LPN.

Form 4 is a review of immunization history and a review of systems and history of selected prior medical conditions.[88] This form is a check box format form filled out by an RN. The form elicits questions about selected conditions only and has no space to write additional conditions that the inmate has. For example, there is no check box for ulcerative colitis, rheumatoid arthritis or high blood lipids. There are no specific instructions on how to record this information and where it is to be recorded. And there is no place on the form to record this additional information. This deficiency is likely to result in an incomplete history to be obtained by nursing staff.

Form 5 is a form on which to document an initial intake physical examination.[89] This form is completed by a mid-level provider. This form has 17 body systems with a single line on which to document physical finding for each of the body systems. There is a small open text area for surgical history. There is no space for a provider medical history and in practice these are not done. It appears that providers utilize the nurse history which is inadequate as a history. The provider's initial evaluation should be, at a minimum, a focused history and physical examination related to all of a patient's medical conditions. This history and physical should result in a complete problem list, an assessment of all current conditions of the patient, and an initial plan for each identified problem.

The ADOC utilizes nurses to perform the initial history of the patient and the providers to perform only the physical examination. Even if providers were reviewing the nursing histories, they should be required to perform their own history of the patient's illnesses, including a review of systems. If the inmate has a chronic condition, a provider is required to complete a chronic disease initial baseline form. These chronic disease baseline forms do not contain thorough histories. Based on review of records, nurses and providers failed on numerous occasions to identify a patient's medical conditions during reception screening.

Providers also complete the initial history prior to evaluation of laboratory results. It is optimal if the provider performs a thorough history and physical examination that includes review of laboratory results. Review of laboratory results can affect therapeutic plans.

As well, the provider is required to complete the health coding form for each inmate. Health coding information is entered into the ADOC computer system either directly by health staff or

[87] New Arrival Intake Screening – Form 3, ADOC000913
[88] New Arrival Intake Screening – Form 4, ADOC000914
[89] New Arrival Intake Screening – Form 5, ADOC000915

by written communication to ADOC. Coding is a means to classify inmates with respect to their medical condition so presumably they can be safely housed. However, at times LPNs complete these coding forms and they do not have the training or experience to give recommendations for safe housing. I noticed examples on chart reviews of practitioners coding patients as healthy and suitable for any institution when they had significant problems. This places patients at risk of harm.

A variant of the reception process is the intra-system transfer process. When inmates transfer between ADOC facilities, there needs to be a system to ensure continuity of medication and therapeutic plans. The OHS has a policy[90] on intra-system transfer that requires completion of an Intra-System Transfer / Receiving Screening form. The policy requires completion of the form and transfer of all prescription medications and health records to the receiving institution. The receiving institution must also complete a receiving institution portion of this form that ensures continuity of all medical services. Although the policy is adequate, the practice is not consistent. In a case I reviewed, a patient was hospitalized twice due to poor transfer practices that will be discussed later.

The Corizon regional office has a policy on intra-system transfers that states that Corizon will comply with the OHS policy.[91] However, individual facility policy manuals maintain policies on intra-system transfers that are not consistent with OHS policy. For example, Tutwiler has a transfer screening procedure that is inconsistent with OHS policy.[92] The OHS requires the problem list to be reviewed, the medical and mental health codes to be located, identification of whether a person is a medical hold, chart review by the site medical director and referral to ADOC when this is done. Corizon's policy at Tutwiler does not address these requirements. Corizon's policy at Tutwiler does address how continuity of follow-up care is arranged, but the OHS policy does not. This is confusing guidance. The Tutwiler policy does not reference that OHS policy is the existing policy. Also, the Tutwiler policy manual has an intra-system transfer form which is not the form used in the ADOC.

The reception system as described in the policy has multiple deficiencies that place inmates at risk of harm.

- The LPN initial screening does not identify all of a patient's medical conditions promptly, which can place inmates at risk of harm if a serious condition is not identified. At a minimum, Form 2 should include a text box to include any medical conditions.
- These screenings should be done by RNs because LPNs are not trained to make an assessment. When a nurse is uncertain if it is safe for the patient to wait for a provider evaluation, the nurse should contact a provider.

[90] Alabama Department of Corrections, Office of Health Services, Policy number E-3 Pre-Transfer Inmate Health Screening and Transfer / Receiving Screening of Inmates, approved 11/18/2009

[91] Dunn(Corizon)_00131-2 Corizon General Health Services Policy and Procedure, Alabama Regional Office, policy number P-E-03.00 Transfer Screening, issued 10/29/12

[92] Dunn(Corizon)_17839-17842 Corizon General Health Services Policy and Procedure Tutwiler Prison for Women, policy number P-E-03.00 Transfer Screening, reviewed and revised 09/2014

- The RNs who perform the complete intake screening use a check box format to document their history. The form does not include space to document other diseases. Form 4 should include a text box space for a nurse to document any additional history that is not available in the check box format.
- Form 5 used by the providers has no place to document a history. The providers need to take a history sufficient to establish an appropriate plan of care. Not having providers take a history places the inmate at risk as the only documented history is from nurses who are either not trained in assessments because they are LPNs or are not documenting a complete history. Also there are some historical elements that can only be elicited by provider history.
- Not performing vital signs on the provider physical examination will result in missing key abnormal findings. Vital signs need to be part of all provider evaluations.
- Providers also are not performing a reliable physical examination. Based on examinations reviewed, NPs performing these examinations are documenting normal examinations when patients have significant physical abnormalities.
- Another significant deficiency in intake screening is the failure to consistently ensure that patients receive all necessary medication for management of their chronic disease. The continuity of medication needs to be stated in a procedure that ensures that inmates who come into prison on medication for chronic illness reliably receive that medication timely at the prison.

Examples of Poor Screening Processes

Examples of these problems were evident in chart reviews. One patient[93] was a 73 year old man for whom a nurse completed intake screening Form 2 on 2/26/15. The only medical condition the LPN documented on Form 2 was diabetes. However the patient had prior stroke, hypertension, high blood lipids, chronic renal failure, a possible cerebral venous malformation and anemia. The LPN missed multiple medical conditions of the patient.

The NP documented the physical examination for this same patient on Form 5 on 2/26/15. The NP documented a completely normal examination but took no medical history. The patient was enrolled in chronic illness clinic. The problems identified on the problem list by the NP included only diabetes, hypertension and coronary artery disease, which the patient had no evidence of having. The chronic kidney disease, possible venous malformation, prior stroke, high blood lipids and anemia were not noted as problems or identified. This type of evaluation will result in missing follow-up of important diagnoses.

Form 4, the complete nurse screening, was filled out by a different nurse on 2/27/15, the day after the NP did the physical examination. The nurse checked the boxes “yes” for stroke, high blood pressure, diabetes, and kidney disease, but failed to note high blood lipids, possible

[93] Patient 16. Many of the cases discussed in this report reflect numerous problems and could, as result, be included in multiple sections. The patient medical chart reviews have been placed in accordance with the largest issues they present; however, most medical charts demonstrate multiple significant problems.

cerebral venous malformation, diabetic neuropathy, and anemia. A nurse screening by an RN should be the first screening the patient receives. This needs to be followed by a history and physical examination by a provider focused on the patient's identified problems. In this case, the nurse took a better history than the NP. The NP initial evaluation needs to include a thorough history and physical examination. It is best to have the NP review an RN's screening history and then to perform their own history after review of information obtained by the nurse.

Excluding psychotropic drugs, the same patient came into the facility on 2/26/15 and was taking aspirin, Plavix, Neurontin, Lipitor, Lisinopril, Prilosec, chlorthalidone, Novolog insulin and Levemir insulin. Lipitor and 70/30 insulin (30 units twice a day) were started on 2/26/15 and Plavix, Lisinopril and HCTZ (equivalent to chlorthalidone) were started on 2/27/15. The NP did not prescribe 3 of the patient's medications (aspirin, Neurontin, and Prilosec), despite not taking any history to identify whether these medications were still indicated. As well, the insulin dosage was changed from a long acting insulin (Levemir) combined with a rapid acting insulin (Novolog) to pre-mixed insulin (70/30). These should be converted on a unit to unit basis. But the patient was on 50 units of long acting insulin and 90 units a day of rapid acting insulin in 3 divided doses (30 units 3 times a day) but was changed to 60 units of premixed insulin, a difference of 80 units of insulin. This was done without taking any history of the patient. Within 2 weeks the patient was hospitalized for, among other conditions, diabetic ketoacidosis with significantly out of control diabetes. The intake screening harmed the patient. The lack of intake history and failure to continue his needed medication as previously ordered contributed to the harm.

Another inmate[94] was screened by an intake nurse on 11/17/11. The LPN identified diabetes, a prior stroke, a prior cardiac stent and a hernia. On 11/17/11, an LPN verified that the patient was taking metformin, HCTZ, Prilosec, Vasotec, Zocor, Zoloft, aspirin, and 70/30 insulin 20 units in the morning and 10 units in the evening.

On 1/17/11, an RN evaluated the patient for suicide watch and documented that the patient was unable to name any president of the USA or governor of Alabama. He could not remember his medication and did not know the name of the facility he was currently in. He told the nurse that he had memory problems because of his stroke.

An NP completed an initial chronic disease baseline data form on 11/18/15. The NP documented a prior stroke, stents being placed in 2009, questionable kidney disease, hypertension, diabetes and high blood lipids. The NP did not take any history about these conditions but only documented that the patient had these conditions. The history needs to include historical details of the patient's condition so that an effective plan could be developed. The physical examination documented left hemiparesis without specifying what the specific findings were. The NP did document that the patient used a cane and dragged his left foot. His neurological condition was described as having no gross deficits. One can't have a grossly

[94] Patient 15

normal neurological examination and have a left hemiparesis with foot drop. The NP also failed to identify that the patient had severe memory loss and cognitive disorder. This was an unreliable physical examination. It isn't clear what the actual status of the patient was. The NP documented hypertension, coronary artery disease, high blood lipids, and diabetes as problems in the assessment.

On 11/18/11, a psychiatrist documented that the patient had prior stroke and had dementia due to the stroke. The psychiatrist documented that the patient was diabetic and had a prior stroke with cognition and memory problems as a result. He diagnosed vascular dementia. The NP failed to identify this history.

An NP performed the intake physical examination on 11/21/15. This examination was documented on a checkbox format. The NP checked all boxes as normal. The NP noted that the patient had prior cardiac stents 2 years ago and that the patient was in a wheelchair. Yet the neurological examination was checked as normal even though the patient had severe memory problems and significant paralysis of the left lower extremity. This form had no space to write an assessment, but there was no initial assessment by the provider on this document. The physical examination was inaccurate. The NP failed to properly evaluate the patient's serious medical conditions.

On 5/22/13, an LPN completed a Form 2 intake screening on another patient.[95] The nurse identified a heart problem, but failed to identify that the patient had hypertension, 2 prior coronary stents, and, given the 220 blood sugar, might have had diabetes. The elevated blood sugar should have been mentioned as a problem. The LPN identified that aspirin was the only medication that the patient took, though the patient was later verified as taking aspirin, HCTZ, metoprolol, and Zocor. This was a poor history performed by the LPN, a nurse not trained in making assessments.

On 5/23/13 an RN completed Form 4, the complete nursing intake screening. This nurse identified prior heart attacks, hypertension, bronchitis, arthritis, back and neck pain and hay fever. The patient's high blood lipids were not identified as problems and the elevated blood glucose was not identified as a problem.

On 5/23/13 an NP completed a physical examination. No history was taken related to any of the patient's medical conditions, except the NP did note that the patient had 2 prior stents. This was the only history with respect to this condition. The patient's blood pressure wasn't taken, so it wasn't clear whether the patient's blood pressure was under control. The NP documented "steady gait" as the only physical examination of the extremities. The NP also documented that a rectal examination and stool for occult blood was "not clinically indicated" which is inaccurate. Colorectal cancer screening is recommended for all adults aged 50 through 75 years of age and this test should have been done on this 72 year old man. The NP did not take note of the previous elevated blood sugar. The NP documented hypertension, high blood

[95] Patient 19

lipids and coronary artery disease as the chronic illnesses. The NP ordered HCTZ, metoprolol, aspirin, and Zocor.

Five days after the NP examination which documented a normal extremity examination, the patient placed a sick call request for chronic swelling of his feet. After having had an extremity examination by the NP as part of the initial intake examination that identified only "steady gait", a nurse identified swelling in both feet. The patient was referred to an NP who documented chronic swelling of the feet for a year and identified 1+ edema of both feet to the ankle. Without taking any detailed history of the swelling the NP ordered a diuretic without attempting to identify why the patient had swollen feet. Liver, heart, and kidney causes of the swelling should have been investigated. The NP failed to adequately evaluate a serious medical condition of the patient. The patient didn't receive a chronic disease clinic evaluation for 7 months.

Another patient[96] had multiple re-incarcerations. He had 6 different problem lists, none of which identified the same problems. In combination, the problem lists identified hypertension in 2003, hepatitis C in 2005, a stroke with residual right sided weakness in 2005, and stents placed in 2008 after a heart attack. The patient had abnormal liver function tests in 2012, and with a history of hepatitis C, he probably had active hepatitis, but this was never identified.

In October of 2013, the patient appeared to be re-incarcerated as he had intake labs done at Kilby along with reception mental health and dental screening. No medical screening occurred. On 11/1/13 a physician assistant gave the patient a medical coding of 1 which implied that the patient was generally healthy. Yet the prior medical record was consistent with liver disease, hypertension, stroke and prior heart attacks. During this incarceration, doctors diagnosed heart failure. The patient also had laboratory evidence consistent with cirrhosis, but this was not diagnosed.

The patient was paroled or furloughed in August of 2014 and received discharge medication including Zocor, Coreg, Lasix, Norvasc, aspirin, Lisinopril and potassium.

He was re-incarcerated in December of 2014. The first medical screening that was done for this patient was the NP physical examination on 12/23/14. This intake examination did not include a history and the only abnormality was 2+ extremity edema. The NP took no history. Even though some of the patient's diagnoses were present in his medical record from his prior incarceration, the NP only diagnosed hypertension. Even though the NP identified foot edema, the NP did not initiate a work up for heart failure, liver disease or kidney disease. There were several serious systemic deficiencies. The patient's prior history of heart failure was missed in intake screening. This diagnosis could have been picked up by reviewing the old record with the patient's information. This was not done. The NP failed to take any history. The NP failed to follow up on an abnormal finding (edema). Nurses failed to perform a timely intake evaluation. This screening failed to identify the patient's serious and significant medical

[96] Patient 21

problems. The NP did not identify the patient's medication and did not start any medication. This is a substandard intake evaluation and placed the patient at significant risk of harm.

The patient did not have the initial nurse screening on Form 2. But the complete nurse intake screening on Form 4 was completed on 12/31/14, about a week after the intake physical examination. The nurse identified prior stroke, a heart condition, high blood pressure, asthma, arthritis and alcoholism as problems. A chest x-ray done on 12/31/14 documented cardiomegaly. The patient's medication wasn't verified until 12/30/14. Only aspirin and Lisinopril were verified as current medication even though only 4 months prior to this incarceration the patient was discharged on 7 medications. The patient didn't receive any medication for a week after incarceration and then only received Lasix, Lisinopril and aspirin. The patient failed to receive Zocor, Coreg, Norvasc and potassium. This placed the patient at risk of harm. On 1/5/15 the patient was admitted to the infirmary because he needed assistance with activity of daily living. This series of inadequate intake evaluations placed the patient at significant risk of harm.

Another patient[97] had hypertension, heart failure, prior myocardial infarctions, cirrhosis, prior encephalopathy, and hepatitis C. A physician assistant performed a medical coding on 11/11/13 and assigned a code 1 status to the patient meaning that he was generally healthy and could be housed at any facility. This patient was not a well patient and needed supervised housing. Coding performance such as this places the patient at risk of harm. The same patient was transferred from Kilby to Elmore in January of 2014 but there was no intra-system transfer form in the medical record. It appeared that the patient did not receive medication at Elmore, which resulted in hospitalization 2/20/14 for heart failure. The hospital physician documented a statement from the patient that he had not been receiving medication. After hospitalization the patient went to Kilby but after 3 days was transferred to Elmore. Again there was no intra-system transfer form and again the patient failed to receive medication. Again the patient deteriorated and was hospitalized. The lack of adhering to OHS policy resulted in the patient not receiving medication and being harmed (deterioration to the point of needing hospitalization). After returning to Elmore, the patient transferred to Limestone on 4/18/14, but there was again no intra-system transfer form in the medical record.

I note that the OHS audits for intake do not include any questions with respect to intake evaluations by either nurses or providers.

[97] Patient 21

Sick Call

Methodology: Review policy and procedures. Review Corizon statistical data. Review charts.

Opinions:

20. Barriers to accessing care through the health request process are significant. These include: (1) inaccessibility of health request forms; (2) remoteness of the health request boxes; and (3) cost of health care to inmates that is out of proportion to inmate earnings and charges for care related to ongoing chronic illness or contagious disease.
21. Registered Nurses (RNs) need to perform health request triage and evaluation including those for emergency evaluation. Licensed Practical Nurses (LPNs) are not trained to perform independent assessments and cannot independently perform assessments.

Findings:

Sick call is a means for inmates to receive attention for non-emergency health concerns. This type of system exists because inmates are not free to seek care as they wish and do not have access to drug stores for purchase of a wide variety of over-the-counter medications. In typical correctional systems, as many as 10% of inmates can be expected to request sick call on a daily basis.[98]

Key elements of an adequate system include reasonable access of the inmate to placing a request, having it responded to timely, and evaluation by a qualified health professional in a clinical setting that is appropriately equipped and supplied for the purpose of health evaluations. When necessary, this may also require referral to an appropriate professional for further evaluation (dentist, doctor, mental health staff, etc.). Typically, nurses triage health requests daily and within 24 hours. Routine requests are evaluated no later than 72 hours after receipt and urgent requests are evaluated immediately.

In efforts to reduce the number of requests, some correctional jurisdictions have initiated a co-payment practice. The National Commission on Correctional Health Care (NCCHC) opposes any co-payment system that restricts access to care or that includes charges for routine services, such as chronic care or contagious disease management.[99]

The Corizon monthly client March 2015 report[100] has data on the number of health care request slips placed and triaged within the prior 6 months. From October 2014 through March

[98] Catherine Knox and Steve Shelton; Sick Call chapter in Clinical Practice in Correctional Medicine, 2nd edition Mosby 2006, page 50
[99] Position Statement: Charging Inmates a Fee for Health Care Services, National Commission on Correctional Health Care as found at http://www.ncchc.org/filebin/Positions/Charging_Inmates_a_Fee_for_Health_Care_Services.pdf
[100] Corizon Health Alabama Regional Office Monthly Client Report March 2015 Dunn(Corizon)_8054

2015, 40,006 health care requests were triaged in the ADOC. Of these, 28,665 (71%) resulted in a nurse sick call encounter. If only the 15 major prison facilities are included, the 40,006 health care requests result in an average of approximately 15 health requests per day per facility. This is an extremely small number of requests suggesting that there are barriers to placement of health requests. Of the 40,006 health requests triaged, nurses evaluated 28,665 health requests over the 6-month period, or about 11 per day per facility, or about 6 requests per thousand inmates. This is less than 1% of inmates on a daily basis. This is an extremely low number of health requests and suggests barriers to placement of these requests. In chart reviews I noted few health care requests confirming the low numbers of health requests. There are several areas where potential barriers to access exist.

Location of Sick Call Boxes and Health Request Slips

The OHS has a policy on inmate sick call requests.[101] The procedure addresses all elements required for this process. The procedure requires that sick call requests forms are available at identified locations established at each facility. However, on tour we noted that some facilities did not keep requests on inmate housing units. Therefore inmates had to go to the health care unit to pick up a health requests. These slips should be available on each housing unit. When inmates are sick it is may be difficult to go to the health unit to obtain one. As well, sometimes units are locked down inmates will be unable to obtain a request.

The OHS sick call procedure permits each facility to determine where the collection boxes for health requests are located. In facilities I toured, there was only a single collection box for the entire facility. We were told that inmates always had access to these on a daily basis because they were located in places inmates would walk by when going for meals. This is also subject to problems in the case of lock downs. The lack of ready access to requests and location of boxes not in the housing units is a potential barrier to placement of a health request.

The Relatively High Cost of Care

Another potential barrier to access with respect to health requests is cost. The ADOC has introduced a co-payment fee related to health requests.

> "It is, therefore, a legitimate exercise of ADOC's authority to impose medical co-pay designed to reduce malingering among inmates and to deter the abuse of inmate sick call."[102]

Inmates are charged a fee of $4 for an encounter with LPNs who are not trained to perform assessments. They are charged regardless of whether their evaluation is competently performed. They are also charged an additional charge of $4 for each medication provided in

[101] ADOC000948 Alabama Department of Corrections Office of Health Services policy number E-7 Health Service Inmate Sick Call Request approved 10/6/14

[102] ADOC000795 Office of Health Services Division Manual Policies and Procedures, Alabama Department of Corrections, Administrative Regulation number 703 Inmate Co-Payment for Health Services

addition to the encounter fee. In addition, inmates are charged $8 if they refuse an on-site specialty appointment, $12 if they refuse an off-site appointment and $20 if they refuse to be seen after being taken to an off-site specialty appointment. This appears disproportionate to the amount of money an inmate can earn.

Most health request visits result in the patient seeing a licensed practical nurse who is not trained in making health assessments. This is a very high price for a service performed by someone not trained to perform the necessary evaluation and is likely one of the contributing causes to the very low numbers of health requests. Also, when a nurse provides a drug like ibuprofen, the number of pills may vary, but on some evaluations I reviewed, nurses gave 24 tablets of ibuprofen. At $4 per medication this equates to 16 cents for a tablet of ibuprofen. At Costco online, I was able to find 1,000 pill bottles of ibuprofen that costs $13.99 or a little over a penny a tablet. Inmates were paying over 10 times the price that civilians could obtain these drugs for. The proportionality of these charges disadvantages inmates and is a barrier in obtaining care and in my opinion is cruel and unnecessary.

Notably, the Alabama Department of Public Health noted in an investigation of a scabies outbreak at Ventress that charging inmates for sick call was a barrier to curtailing this outbreak.[103]

The Impact of Inadequate Nursing Staff on Patient Care via Health Requests

Health requests are mostly evaluated by LPNs. These professionals do not have training in their educational programs to make patient assessments and should not perform health assessments. The OHS requires that, if an RN does not perform this evaluation, then the LPN's evaluation must be reviewed by an RN. This does not appear to be happening in a timely or adequate manner.

The OHS allows nurses to use nursing protocol sheets that Corizon developed. These are called NET tools. When these forms are properly used, they can be adequate for the purpose of nurse health request evaluation. However, there are a limited number of NET tool forms. When the patient has a complaint that is not appropriately addressed by a NET tool, the patient will receive a poor evaluation. This occurred in several patient charts reviewed.

The OHS has an audit tool for sick call. As described the audit tool only assesses for compliance issues. Quality of care is not assessed. However, quality of nurse care is one of the major problems in this process particularly since LPNs appear to perform most health request evaluations.

[103] ADOC Scabies Situation and ADPH Recommendations, ADPH document 001373- 001377

Examples of Inadequate Sick Call Process Identified in Chart Reviews

I identified multiple problems with nurse evaluations during chart reviews.

For one patient[104], the patient did not have a request slip and placed a health request on an inmate request slip for custody issues. The inmate needed a special shoe because of a diabetic foot problem and placed a request stating that his foot and hip were hurting and swelling because he didn't have a proper shoe. A nurse responded to the inmate by stating that the inmate would have to sign up for sick call. This inmate had a hard time walking and apparently had difficulty accessing the sick call process and was using the wrong form for this purpose, yet the nurse did not assist the inmate in overcoming this barrier.

The same inmate had a severe hypoglycemic episode on 11/29/12, losing consciousness with a blood sugar of 34. An LPN evaluated the patient. The LPN gave the patient glucose but did not refer the patient to a physician and didn't consult a physician. This referral should have been done. A RN did not sign this evaluation as reviewed. Since emergency referrals to a provider do not result in a charge, the patient would not have been charged if the LPN had appropriately referred to a physician. On 12/29/12, the patient again lost consciousness with blood glucose of 37. Another LPN evaluated the patient. This evaluation was also not reviewed by an RN. Instead of referring to a provider, the LPN sent the patient back to his housing unit after giving the patient glucose. The following day, the inmate placed a health request wanting to see a physician to adjust his insulin because of hypoglycemia. Nurses did not see the patient, but a nurse practitioner did see the patient on 12/31/12. It isn't clear whether the patient was charged for this service. However, the LPN on the 11/29/12 episode failed to recognize the seriousness of the risk to the patient and the LPN's work was not reviewed by an RN. The LPN evaluations also placed the inmate at risk of harm.

Another patient[105] placed a health request on 7/13/14 complaining of a sore throat for a week. An LPN noted on 7/14/15 that the inmate was a no-show and was charged $4. The very next day the inmate placed another request stating that his throat hurt. The triage nurse scheduled the patient for nursing sick call. It appeared that the patient was not brought for his appointment yet was charged.

Another patient[106] had recent kidney stones that were not timely addressed. The patient ultimately had urologic surgery to remove the stones and was placed on a medication (Tamulosin) to relax the smooth muscles of the urinary tract. One of the adverse actions of this medication is hypotension (low blood pressure). The inmate placed a health request on 5/15/14 for back pain which he thought was related to the recent kidney surgery. A RN evaluating the patient took a history that the patient had a urethral stent placed 3 months previous and couldn't sit still due to pain. The nurse took a history that the patient still had blood in the urine and had flank pain which were most likely related to his recent urologic

[104] Patient 4
[105] Patient 5
[106] Patient 11

surgery. Even though his complaint was related to an ongoing health condition, the triaging nurse charged the patient $4 for an evaluation and $4 for medication. Since this complaint was related to his recent surgery, there should not have been a charge.

On 5/18/14, the same patient placed another complaint of having passed out in his cell over the last few days. This was most likely related to the new medication that the urologist started. An LPN evaluated the patient on 5/20/14 for this complaint and referred the patient to a provider. An NP saw the patient on 5/27/14 and obtained a very low blood pressure of 98/64 supine and 102/62 while standing. Tamulosin, the medication started by the urologist, is noted to cause hypotension but this was unrecognized by the NP. The only assessment was syncope. The NP ordered an EKG but did not evaluate the medications.

On 5/27/14 the patient placed another sick call request stating that his back was hurting and he was having blackouts and dizziness. A nurse triaged this request on 5/29/14 and charged the patient $4 for an evaluation of back pain. The LPN evaluating the patient noted that the patient was unable to urinate and had back pain and that the patient had recent kidney stones. The nurse referred the patient to a provider. This sequence of 3 health requests were all related to recent surgery and a side effect of the medication prescribed to the patient by an urologist. LPNs evaluated the patient and failed to provide an adequate assessment. A follow-up with a provider failed to identify that the medication prescribed to the patient could cause the patient to pass out. Despite all 3 requests being related to an ongoing condition of the patient, nurses charged the patient for 2 encounters and for medication. This was inappropriate and creates a significant barrier to accessing care.

When the same patient saw a provider on 6/3/14 based on the 5/29/14 referral, the NP noted that the patient had un-witnessed episodes of passing out. The NP did not take a medication history but noted that the EKG and drug screens were normal. The patient became upset when asked about his kidney pain, stating that the NP should know what was wrong with him. He raised his voice and was escorted out of the clinic. The NP failed to competently take a medication history. The result was a failed visit and an angry patient.

The same patient placed another sick call request on 6/13/14 stating that he was still having blackouts and stated that either his blood sugar or blood pressure were “dropping”. He complained about being charged twice for the episodes of blackouts. He also complained about an infection on the back of his leg. A nurse triaged the complaint on 6/13/14 and again charged the patient $4. An LPN saw the patient on 6/13/14 and noted pulse of 120 with a temperature of 99 and a dime sized abscess on the left buttock. The LPN did not address the blackouts. The LPN referred the patient to a provider who didn’t see the patient for 4 days. By that time the abscess had ruptured and was draining pus placing other inmates at risk for transmission of MRSA. The NP started two antibiotics and ordered follow-up. The NP didn’t perform a culture of the draining abscess. The inmate was charged 3 times for sick call requests. For the complaint of blackouts, the symptom was incompetently evaluated. For the complaint of abscess, the evaluation by a provider was not timely resulting in rupture of the abscess and potentially exposing other inmates to MRSA. The patient was never properly

evaluated for his complaint of syncope and blackouts. The blackouts were most likely an adverse reaction to one of his medications (Tamulosin).

Another patient[107] did not have a sick call request in the medical record, but an LPN evaluated the patient on 1/2/12 for complaints of coughing, vomiting and a runny nose with a respiratory NET tool. Because the LPN used a respiratory NET tool there were no questions asked about the patient's vomiting. Vomiting is a serious problem. The nurse ordered 3 medications (sinus pills, Coricidin, and an antacid) without performing an appropriate assessment. This placed the patient at risk of harm. Presumably, the patient was charged for this incompetent evaluation.

On 2/19/12, the patient complained again of nausea and vomiting. There was no sick call request for this episode. A RN used a gastrointestinal NET tool for this evaluation. The nurse's history was inadequate in that the nurse failed to assess the patient's ability to eat, weight gain or loss, and the quality of the vomitus (e.g., whether there was blood in the vomit). The nurse also documented that this was a new symptom even though the patient had had the problem over a month. The nurse documented that the patient refused bismuth tablets. This patient went on to have multiple ongoing complaints that were inappropriately evaluated. These will be addressed in the infection control section of this report. This patient ultimately had tuberculosis and infected numerous people. He incurred harm and to himself and multiple other inmates as a result of inadequate evaluations.

Another inmate[108] placed a request on 12/11/12 to have his wheelchair checked because it was falling apart. The inmate placed the request on a custody form not intended for health care complaints. The health services administrator evaluated the complaint 10 days later and wrote on the request that an appointment was scheduled for the patient. An NP didn't see the patient until 12/27/12, over 2 weeks from the time of the complaint.

Another patient[109] with a history of uncontrolled hypertension and signs and symptoms of heart failure complained on 10/17/13 of swelling in his feet, ankles, knees and thighs, which is a sign of heart failure. An LPN evaluated the request on 10/18/13, and the patient was charged a co-pay, despite this being a condition that should have been managed in chronic care. The patient's blood pressure was 160/80 (normal < 140/90). The LPN noted that the patient had poorly controlled hypertension and that the swelling had been ongoing for months. The LPN referred the patient to a provider. The patient had not had his blood pressure controlled through the chronic care program and to charge the inmate for a nurse encounter that provided nothing but a referral and for a provider visit that was related to poor management of his chronic illness was inappropriate. The patient should have had his blood pressure controlled through the chronic care program and to charge the patient for this was unreasonable. The provider visit based on this referral did not occur.

[107] Patient 13
[108] Patient 15
[109] Patient 17

On 11/20/13, the same inmate placed another sick call request stating that since the last NP visit when the NP increased his Lasix, he was told if he didn't improve he should put in another sick call request. An LPN triaged the patient complaint without seeing the patient and referred the patient to a nurse but did not charge the patient. The patient refused the nurse evaluation. The patient had exacerbation of heart failure and needed to be seen by a provider promptly but no provider follow-up evaluation occurred. An NP evaluated the patient 12/12/13 almost 3 weeks later. The NP failed to take an adequate history with respect to the possibility of heart failure and noted that a test for heart failure (BNP) ordered on 11/7/13 had not been done. The patient had elevated blood pressure (150/90) and swelling up to the knees. The NP mistakenly thought that the patient had an orthopedic problem and ordered Naprosyn, which placed the inmate at risk of harm by not treating his heart failure. The BNP test was not done because the blood was placed in the wrong type of tube. For this patient, the chronic care program was ineffective in helping him manage his chronic illness. His attempt to use the health request system to manage his chronic care problem was also ineffective. This patient's blood pressure remained uncontrolled and he went on to have a stroke, one of the consequences of poorly controlled hypertension.

Chronic Disease Management

Methodology: Review charts with respect to chronic illness management. Review policy and RFP. Review selected depositions.

Opinions:

22. The ADOC lacks an adequate policy for chronic illness management that ensures continuity of medication; proper enrollment and discharge from chronic care; intervals of chronic care visits; and requirements for what conditions are managed in chronic care clinics.
23. The ADOC fails to define what a chronic condition is. As a result, some chronic conditions are not followed in chronic care clinics.
24. The quality of chronic care management is poor. Problems with chronic care management include the following: (1) Nurse practitioners manage most chronic care even when they fail to understand how to manage some conditions. (2) All providers fail to take adequate history, fail to perform adequate physical examinations, and fail to develop adequate assessments and therapeutic plans. (3) Quality of provider chronic care management is poor but there is no systematic manner to adequately evaluate chronic care management. (4) Laboratory results are inconsistently incorporated into chronic care management. (5) When providers see patients for chronic care they do not consistently address all of the patient's chronic care problems.

Findings:

Chronic illness is defined as a condition that requires physician monitoring over an extended period of time. The standards for managing common chronic illnesses are promulgated by national organizations. These standards are readily available at no cost on the Internet. As examples, standards for some common illness typically seen in a correctional facility are the following:

- 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
- Global Initiative for Chronic Obstructive Lung Disease updated 2016 as found at 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_mngt.pdf

There are other illnesses that are less common such as cancers, ulcerative colitis, etc. Standards of care for these illnesses can be obtained by using reference texts. Up-To-Date® is an online textbook-like resource for obtaining decision support for managing chronic and acute illness. Many correctional centers have this resource available for practitioners for use. This is particularly helpful when physicians are practicing alone in remote locations.

Aside from standards of clinical management, there are operational processes that are generally present in correctional management programs for chronic illnesses. These include:

- Identification of the chronic illness. This is typically done at intake for existing conditions. Chronic illnesses are generally documented on a problem list and are also

documented on every chronic care note. This task is made easier with electronic medical records. Typically, at a chronic illness visit all of a patient's chronic illnesses are addressed.

- Initiation of a chronic illness plan at intake that includes identification, evaluation and a plan for all of a patient's illnesses. This initial plan needs to be timely based on the acuity of the patient's condition.
- Tracking patients with chronic illness (typically on a registry) so that they are not lost to follow-up.
- Ensuring continuity of medications.
- Ensuring diagnostic testing that is timely and needed based on the patient's condition.
- Ensuring follow-up with specialists when chronic care management exceeds the capacity of the on-site providers to manage. Notably, in correctional centers that do not utilize primary care physicians, many common conditions are not able to be managed by the physicians hired by the jurisdiction.
- Follow-up evaluations at intervals appropriate for the patient's condition.
- A plan for how to address inmate refusals of care.

Lack of Policy Guidance for Chronic Illness Management

The OHS does not have a policy or procedure with respect to management of chronic illness. The RFP requires that the vendor maintain chronic clinics but does not provide clear directions on how this is to be done or metrics that measure outcomes of chronic care management.

Corizon has a regional policy for chronic disease services.[110] This policy has no specific procedure. It offers 3 questions that are to be used for individual facilities to develop their chronic disease program including:

- What is the process for enrolling patient into the chronic disease clinic?
- What is the process for scheduling chronic disease clinic?
- How is the list of chronic disease patient maintained?

Individual facilities have mostly old policies on chronic illness. Tutwiler has 2 chronic illness policies. Both of these policies are old and have not been annually reviewed or revised. One from 2003 is titled Management of Chronic Disease.[111] This policy states that chronic disease management is based on recognized care guidelines issued by Correctional Medical Service (CMS), the Federal Bureau of Prison guidelines and other recognized guidelines but does not name these guidelines. The CMS guidelines are stated to be found on the Intranet. The

[110] Corizon General Health Services Policy and Procedure Alabama Regional Office policy number P-G-01.00, Chronic Disease Services, issued 10/29/12

[111] Correctional Medical Services Health Services Policy & Procedure Manual Julia Tutwiler Prison for Women, policy number P-G-01.00 Management of Chronic Disease, corporate effective date 10/1/03

minimal interval for chronic clinic visits is one year. The second policy[112] is similar to the first policy.

Poor Definition of Chronic Illness Governing Who Is Seen In Chronic Illness Clinic

The Corizon policy at Tutwiler defines chronic disease as "an illness or condition that has been present at least 6 months and is generally not curable but is manageable".[113] Generally, a chronic illness places the patient at significant risk of death, acute exacerbation / decompensation, or functional decline if untreated.

Many chronic conditions are not followed in chronic disease clinic. Corizon chronic illness clinics monitor conditions that fall into one of their pre-defined chronic illness categories which include:

- Pulmonary/Asthma/COPD
- General Medical
- Liver Disease/HCV
- Other
- HTN/CV
- Seizures
- Diabetes
- TB
- HIV

Chronic illnesses not defined in the Corizon chronic illness categories appear to be followed episodically via the sick call process if the problem deteriorates. Presumably, the "other" category in this list should include all other illness not named on this list but in practice this is not occurring. Problem lists identifying chronic illness are not consistently complete which further compounds the problem of losing patients with chronic illness to follow-up.

Deficiencies in Chronic Illness Clinics

Almost uniformly, chronic care notes do not include thorough history or physical examinations. This is evident, especially at the intake physical examination for which a history is not taken by design. Providers seldom document what medications the patient has been prescribed and inconsistently document whether the patient is receiving or taking medication or whether the patient might be having side effects from the medication. Providers often do not document an accurate degree of control stated. Laboratory results pertinent to the chronic illness are inconsistently followed in clinic visits. New abnormal laboratory results that indicate a different

[112] Corizon General Health Services Policy and Procedure Tutwiler Prison for Women, policy P-G-01.00 Chronic Disease Services, reviewed and revised 9/2014

[113] Correctional Medical Services Health Services Policy and Procedure Manual Julia Tutwiler Prison for Women, policy number P-G-01.00 Management of Chronic Disease, corporate effective date 10/1/03

and new disease are seldom identified or followed up. Providers do not typically list all of the patient's chronic diseases. For diseases they do list, they do not consistently list the status or degree of control for the disease. Therapeutic plans are inconsistently present. For persons with diseases not in control, providers often fail to adjust the therapeutic plan to bring the patient into control. Based on chart reviews, it does not appear that providers are adhering to standards of disease management or documentation for the patient's conditions.

Chronic disease care is provided almost exclusively by NPs and physician assistants. Physicians are supposed to provide care for the patients with higher acuity chronic care conditions. However, based on chart reviews, it appears that mid-level providers are managing both simple and high acuity patients for most patients with chronic illness. This may be due to the frequent absence of a site medical director. Involvement of physicians in chronic care management is noticeably absent. The net result of these deficiencies is that patients are harmed or placed at risk of harm. This is evident in multiple patient records.

Examples of Patients Receiving Poor Chronic Care Management

One patient[114] presented with diabetes with a Charcot foot. Charcot foot is advanced diabetic neuropathy from which develops a progressive destructive arthropathy. The patient had prior surgery and was being followed by an orthopedic surgeon for possible osteomyeliltis when he was incarcerated. During acute episodes of this condition, patients need to be non-weight bearing. Management by an orthopedic surgeon who specializes in Charcot foot is the standard of care for these individuals. Yet, over the nearly 3 years of incarceration, the patient never was sent to see an orthopedic surgeon, even though ADOC providers knew that these specialists were managing his care prior to incarceration and knew the Alabama surgeon who was caring for the patient. The patient's foot disorder was largely unrecognized or ignored through his incarceration. One provider documented a referral to an orthopedic surgeon, but this referral never took place.

Because the on-site providers did not know how to manage this patient's unusual condition, they mismanaged his treatment. As a result, the patient's foot deformity worsened over the course of the incarceration. Diabetic foot ulcerations were also mismanaged, which placed the patient at risk of loss of limb. The prison providers never followed up with the orthopedic surgeon who was evaluating the patient for osteomyelitis. This evaluation never took place. On multiple occasions, nurses and a physician failed to understand how to assess his diabetic neuropathy and documented that he had no neuropathy or minimal neuropathy when he actually had advanced neuropathy. This promoted further damage to the patient's foot. Patients with Charcot foot should not use the foot during acute exacerbations. Yet the patient was forced to ambulate either with a crutch or with shoes that did not fit. This worsened his condition. The patient asked for specialized footwear, but the regional medical staff denied this request for specialty care stating that the providers should manage the problem on-site. This was cruel because it forced the patient to continue to use crutches and use the foot in a

[114] Patient 4

manner that caused pain, exacerbated the condition and caused further deformity. This was also not a rational response, as the facility providers could not manage a condition onsite that required construction of diabetic footwear.

Ultimately, after filing a grievance, special footwear was allowed. But, the footwear provided to the patient was so poor that it caused the patient to develop ulcerations which placed the patient at risk of loss of limb. The failure to appropriately care for this problem caused the toe to be deformed at a 90-degree angle to the sole of the foot making use of the first orthotic impossible. This deformity is likely to be a life-long consequence of the mismanagement of his condition.

As well, the patient's diabetes was poorly cared for and his diabetic problems were largely ignored. Over the first year of incarceration the patient lost approximately 66 pounds based on comparison of the initial nurse screening weight of 242 on form 2 on 7/18/12, as compared with the weight taken at a chronic care clinic of 176 pounds on 7/10/13. This weight loss was never recognized throughout the entire incarceration. This is significant indifference.

The patient's hemoglobin A1c, a test of long term diabetes control, was never controlled while he was incarcerated. This measure of control was worse at the time of discharge (9.4) as compared to what it was at intake (8.8). The goal of management is to have this number below 7 for most patients. The patient experienced 29 episodes of severe hypoglycemia over the 32 months of incarceration or almost 1 a month. These episodes sometimes were so severe that at times the patient was unresponsive or passed out. These can be life-threatening. Yet, despite these episodes, physicians did not appropriately adjust insulin to prevent these episodes from occurring.

For this same patient, I evaluated almost 60 separate provider interactions of various types over the 2 and a half years of incarceration and they were consistently inadequate. This involved multiple different providers. The lack of appropriateness of management was consistent. The result was poor management, indifference to his serious need and harm to his foot and overall diabetes control which has long term health consequences.

Of the 60 provider interactions, 14 were for chronic care clinic which is intended to thoroughly cover management of the patient's chronic conditions. On only 1 of these chronic care visits did the provider document that the patient had neuropathy, one of his significant diabetic complications. This was the only note that documented that the patient had diabetic foot ulceration due to his neuropathy, even though the patient had a diabetic foot on-and-off for almost his entire incarceration. Diabetic foot ulceration requires specialized treatment which the patient did not receive. This placed the patient at risk of osteomyelitis which he may have had when he was discharged.

Of the 14 chronic care visits, an adequate foot examination was not performed once. For these 14 visits the gross deformities of the foot were documented on only 7 of 14 visits. On 2 visits

the foot was not examined and, remarkably, on 4 evaluations the foot examination was documented as within normal limits.

With respect to neurological assessments, on the 14 chronic care visits, providers did not perform a neurological examination 7 times. On 1 examination, the provider documented that the neurological examination was "grossly intact," which it was not. On 5 visits the provider documented normal examinations. On 1 examination the provider used the term GIT which is not intelligible. Notably this patient had severe and advanced diabetic neuropathy with Charcot foot which caused a severe foot deformity and ulcerations of his foot.

The 14 chronic care visits recorded only 11 of the patient's 29 episodes of hypoglycemia. For 6 of 14 chronic care visits there was no documentation whether or not the patient had hypoglycemia; no history was taken. For 1 visit the provider documented that the history of hypoglycemia was not applicable. So for half of the visits, the providers failed to take sufficient history to even determine if the patient was experiencing hypoglycemia even though the patient was experiencing multiple episodes of life-threatening hypoglycemia. Providers ignored a serious complication of the patient's medical condition.

The patient was never in good diabetes control throughout his incarceration. On 1 occasion (8/21/14), a doctor documented that the patient was in good control when the patient had 2 episodes of hypoglycemia in the 2 months before this visit and when the most recent A1c value 4 days before the chronic clinic visit was 7.8 which is not at goal. For the other chronic clinic visits, providers assessed fair or poor control. Despite the diabetes being recognized as not at goal, providers adjusted medication or explained why they did not adjust medication in only 6 of the 14 visits.

Another patient[115] housed at the Elmore had a history of high blood lipids, coronary artery disease and had 2 stents placed in his coronary arteries. He also had hypertension and hyperuricemia, an elevation of uric acid in his blood that placed him at risk for kidney stones and kidney disease. However, this elevation of uric acid was never addressed over multiple years. The patient was being treated with multiple medications including aspirin, niacin, Toprol, simvastatin and isosorbide.

Over a 4 year period of time, the patient frequently missed needed medications necessary to treat his serious medical conditions and had to place numerous health requests and grievances to obtain needed medications. From 2010 until 1/7/14, the patient filed 5 grievances for not receiving needed medications, which were addressed without a provider visit. The patient also submitted 2 health requests over medication issues which were addressed by nurses. During this same 4 year time period, the medical record documents only 2 provider visits. It appeared from the record that the patient was developing heart failure but this was never evaluated, in part because of lack of physician attention. Multiple abnormal laboratory and an x-ray were not followed up on, it appears because of lack of physician coverage. This lack of attention may

[115] Patient 5

have resulted in deterioration of his heart condition and at a minimum placed the patient at risk of harm.

On 1/2/14, a nurse documented that the patient was staggering and unable to work. The nurse referred the patient to a provider who evaluated the patient in chronic care on 1/7/14, at the patient's first chronic care visit since 2010, when the current volume of medical records began. That visit didn't address the patient's coronary artery disease or abnormal laboratory results that had been present over the past including abnormal bilirubin suggesting chronic liver disease and elevated uric acid. Except for documenting that the patient complained of "staggering from side to side at times when walking" no history was taken. The provider documented "WNL" for the physical examination but didn't document what examinations were performed. The complaint of "staggering" was not addressed at all. The coronary artery disease was not addressed. The provider did not address medication issues. No laboratory tests were ordered and no prior abnormal laboratory tests were reviewed. Within a week of the visit the patient filed a grievance stating that the cardiologist had previously recommended a higher dose of aspirin. The provider should have addressed this with the patient in the clinic visit.

The patient didn't receive a chronic care follow-up appointment for 8 months until 8/25/14. In the interim, on 7/25/14 the patient's bilirubin was mildly elevated but there was no follow-up. When the patient complained of a sore throat on 8/1/14, the provider ordered a trial of antibiotics and ordered a chest x-ray, thyroid panel, sedimentation rate and an HIV test and documented that an ENT referral might be indicated. The chest x-ray was done 8/6/14 and showed bilateral interstitial markings indicative of pulmonary edema, atypical pneumonia or underexposure of the x-ray. A provider ordered an ASAP follow-up in clinic for the patient, but this follow-up didn't occur.

On 8/13/14 the patient placed a health request complaining about his throat and that he was having a problem with his medication. As a result of the request, a provider saw the patient on 8/19/14 and documented that the patient might have an abnormal lymph node on the left and that the patient might have pneumonia. The doctor ordered antibiotics and a repeat chest x-ray. A follow-up was ordered after the x-ray was done. Neither the x-ray nor the provider follow-up were done.

A provider evaluated the patient in chronic clinic on 8/25/14 but did not address the throat pain or abnormal x-ray. The provider took a history of shortness of breath when lying flat, which is consistent with heart failure. The provider did not address the prior chest x-ray indicating possible heart failure. Only hypertension and high lipids were listed as problems. The patient's coronary artery disease, painful throat, abnormal x-ray, or potential for heart failure were not addressed. A 90-day follow-up was scheduled. This is a significant departure from standard of care.

On 9/3/14, a blood count showed a MCV[116] test of 105.7, which is very abnormal. Given the prior elevated bilirubin the patient likely had serious liver disease. On 9/8/14, a provider ordered a thyroid panel, chest radiograph, blood count and x-ray of the neck with a return to clinic in 2-3 weeks. Two chest x-rays were done. One of them was normal and another documented right lobe atelectasis. A provider evaluated the patient on 10/8/14 and documented discussing the x-ray results, but it isn't clear which x-ray result was discussed. The x-ray should probably have been repeated or a CT scan ordered.

On 11/25/14, an NP saw the patient for chronic care follow-up. The NP only addressed hypertension and high lipids and failed to address the patient's coronary artery disease or the abnormal chest x-ray of 9/15/14 which appears not to have been addressed. A recent abnormal lab test (MCV 105) was not addressed. Prior abnormal blood tests (elevated uric acid and bilirubin) were not addressed. Medication was not addressed.

On 2/13/15, the patient filed a grievance stating he did not have an order for his niacin, which had been prescribed previously for him to address his high triglycerides. The nurse responded that he did not have a current order for niacin and must place a sick call request. The niacin was not addressed by the NP at the latest chronic care visit in November including whether to continue or discontinue the medication. Notably, over the past year, medication administration record (MAR) documents no longer verified receipt of medication. There were no documents in the medical record verifying receipt of medication. Only medication orders are present in the medical record.

On 2/19/15, an NP saw the patient for chronic care but only documented hypertension and high blood lipids as problems. The most recent laboratory tests for lipids were not mentioned. The other abnormal blood tests were also not addressed. The patient complained of chest pain but his angina was not listed as a problem and not addressed. The NP did not address the patient's grievance that he was no longer receiving niacin. A 90-day follow-up was ordered.

On 3/4/15, the patient had blood tests indicating abnormal triglycerides and MCV of 101.8. There was no follow-up of these abnormal tests.

On 5/13/15, an NP saw the patient for chronic care but documented only hypertension and high blood lipids as problems. The previously abnormal laboratory tests were not addressed. Medications were not discussed. The comments under head and neck examination were illegible.

On 6/17/15, the patient placed a health request complaining of shortness of breath at night and swollen feet. He also described chest pain with walking. A nurse did not evaluate the request stating that the patient left before being seen. These symptoms are consistent with heart failure. The patient had also had an abnormal x-ray and symptoms in August 2014 that

[116] The MCV or mean corpuscular volume measures the size of the red blood cell. A large MCV which this patient had can represent a variety of conditions ranging from vitamin deficiencies to chronic liver disease amongst others.

suggested heart failure. These signs and symptoms of heart failure were ignored. This placed the patient at risk of harm. The failure to evaluate the patient for this condition was significantly below the standard of care.

For 3 years this patient was neglected with respect to his chronic medical conditions. He even failed to receive needed medication and had to file grievances to obtain his medication. When providers started seeing the patient in chronic care clinic, providers ignored critical signs and symptoms and failed to evaluate the patient for heart failure a complication of his hypertension and coronary artery disease. The providers also failed to follow up on abnormal laboratory values that indicate that the patient had serious liver disease. The care for this patient fell significantly below the standard of care and was neglectful.

Another patient,[117] who was 53-years old, had presumed emphysema and a hepatitis C infection. The cornerstone in diagnosis of emphysema or COPD is pulmonary function testing. This test can differentiate COPD from asthma and also differentiate COPD from other pulmonary diseases. Staging this disease is also done with pulmonary function testing which needs to be periodically performed over the course of treatment. Yet over the 5 year period of medical records reviewed, there was no indication that this patient ever had this fundamental diagnostic test for his stated condition. The patient also had a complex presentation and another abnormal test (ANA) that suggested a different diagnosis (pulmonary fibrosis or autoimmune hepatitis) than emphysema. Because the patient's condition was beyond the capacity of facility staff to manage, he should have been referred to and managed by a pulmonologist or specialist in hepatitis C, but this did not occur.

The medical record did not document a formal chronic care visit for several years. Care was mostly episodic. While at the Staton facility, there was apparently no medical director, and a number of physicians, including the Regional Medical Director, oversaw nurses managing the patient during episodes of exacerbation of COPD. An order for hospice was made over the phone and did not appear to include a physician-patient discussion. Hospice care is typically reserved for persons with terminal conditions. This patient did not have a terminal condition, yet was assigned to hospice due principally to lack of physician involvement and lack of diagnosis of the patient's conditions. The patient remained in hospice for over 4 months but eventually the patient asked to be taken off hospice status. The patient was apparently still alive two years after placement in hospice. Such a lengthy survival after placement on hospice care indicates the diagnosis of the patient's condition was flawed.

This episodic care, provided apparently by multiple covering physicians, resulted in failing to properly manage the patient's problems. The patient remained on oral steroid medication for COPD for over a year without a clear indication for the medication. Long term oral steroids are not recommended in COPD; inhaled steroids are recommended. The patient began developing adverse side effects of steroids, but these were not managed. When the patient started hospice, he was placed on narcotic medication without a clear indication, except that he had

[117] Patient 6

entered hospice. After several months on hospice the patient improved and was removed from hospice, but the narcotics were continued for about 9 months without indication and without the providers assessing the patient for pain. The narcotics were abruptly stopped after 9 months without consideration that the patient may have become habituated and in need of withdrawal treatment.

The patient had multiple conditions or abnormal tests that were not evaluated properly. The patient had a diagnosis of COPD but never had a pulmonary function test, which is an essential test to establish the diagnosis. The patient had an abnormal ANA test that indicates possible pulmonary fibrosis or autoimmune hepatitis, but the patient never had a work up for these conditions. Provider's evaluations frequently contained no history, inadequate physical examinations, and lacked reliance on diagnostic testing such as pulmonary function tests and specialty consultation especially with pulmonologists. The lack of physician presence often resulted in management by nurses who consulted physicians by phone.

Other medical problems appeared to never be evaluated appropriately. On an annual nurse evaluation on 11/30/10, the patient had a weight of 110 and measured 5 foot 9 inches. His typical weight should have been approximately 161 pounds. He was approximately 50 pounds underweight. This problem was never addressed by medical staff. The patient reported to the nurse that he had a growth on his anus. This was never thoroughly evaluated and followed up. The patient had a right atrial enlargement suggesting possible heart failure. This was never evaluated by echocardiogram. The patient had evidence of coronary artery disease, but this was seldom followed by ADOC physicians. The patient had bullous emphysema, but never had a thorough evaluation with CT scan or referral to a pulmonologist.

On several occasions the patient's acute and serious conditions were managed by nurses or nurse practitioners without physician direction. In September of 2012 the patient developed symptoms of serious infection including fever, shaking chills, cough, shortness of breath, and chest pain. Nurses consulted a physician by phone. A nurse practitioner saw the patient twice, but did not recognize the seriousness of the patient's condition. Eventually a nurse called a physician who ordered the patient sent to a hospital. The patient was admitted immediately to the intensive care unit with respiratory failure and pneumonia in an advanced state. When the patient returned to the prison, a CT scan recommended by the hospital was not done.

On several other episodes, nurses managed care by phone consultation with the Regional Medical Director who ordered parenteral antibiotics and steroids without a physician evaluation. I reviewed over 80 provider interactions with this patient over a 5 year period and none were of adequate quality. Most had significant deficiencies demonstrating inadequate chronic care management.

Pharmacy/Medication Administration

Methodology: Review medication administration records and policies and procedures.

Opinions:

25. Patients do not consistently receive needed and prescribed medications as ordered.
26. Medication refill procedures appear to be a barrier to inmates receiving needed medication.
27. Current policies fail to adequately define the process for medication administration given the new electronic medication system.
28. Patients on non-formulary medication appear to have delays in receiving medication.

Findings:

Pharmacy services are managed by a subsidiary pharmacy of Corizon through a remote pharmacy arrangement. Though there are medication rooms at each prison, there are no pharmacies within the ADOC.

Pharmacy services are an essential support services for any correctional health program. Inmates entering correctional facilities may already be on medication. It is critical that these medications be continued and if changed, the change is clearly demonstrated as necessary based on a revised treatment plan. Medication needs to be provided as prescribed. There should not be unreasonable barriers in obtaining necessary medication. Inmates with cognitive disorders or mental health disorders need to have special attention with respect to administration of their medication because they may be unable to understand how to take their medications. Medication administration rules need to be reasonable and not unduly burdensome to inmates. Medication administration needs to take place in sanitary conditions. Administration needs to be hygienic. Documentation of medication administration must accurately represent the administration that occurred and documentation needs to occur at the time medication was administered. Medication renewal policies and practices must ensure that patients continuously receive needed medications.

Pharmacy Policy and Implementation

The OHS has 1 policy on medication related to keep-on-person medications (KOP).[118] This policy gives guidelines with respect to who can participate in the KOP program. The policy states that if an inmate doesn't pick up medication in 3 days, the inmate is to be contacted. It doesn't appear that this is occurring based on documentation in the medical record. Inmates are responsible for notifying the medical vendor when their medication is running out and a refill is necessary. They are to bring the medication package to the pill call line and present it to

[118] Alabama Department of Corrections Office of Health Services policy number D2 Keep on Person (KOP) and Over the Counter (OTC) Medication Programs, originated February 2008 and approved 6/6/13

a nurse. Inmates who do not return the package to nurses are considered non-compliant even though there may be cases when this occurs through circumstances beyond the inmate's control.

The Corizon regional policy manual has multiple policies, some of which are duplicates with dates of 2003 and 2012. The 2012 regional policies have adequate procedures for medication administration except that the procedure was written prior to the introduction of the electronic MAR. Therefore, the procedure needs to be updated. This regional policy however, does not address individual details of medication administration that may be in place at individual facilities.

Using Tutwiler as an example of an individual facility, Tutwiler's 2003 policies has no policy on medication administration. The September 2014 Medication Services policy[119] has details on general pharmacy matters, but there is no specific policy on medication administration. Medication administration details are found in a 2010 policy in the Tutwiler manual.[120] This policy was last revised before the introduction of the electronic medication administration record and is therefore outdated. It also states that when a nurse has to administer medication on "pill rounds" in a remote location the nurse can document administration of medication at a later time in the MAR book. This is an unacceptable practice. All medication needs to be documented as given at the time of administration of the medication. This policy is not pertinent to the current practice because the method of documenting administration was not available at the time this policy was written.

There are no current policies on non-formulary medications in the Tutwiler manual. The latest policy on non-formulary medication is in the 2003 policy on formulary and non-formulary requests.[121] Similarly, there is no guidance on starting medications on inmates coming in at intake. This lack of guidance of these essential aspects of correctional care places the inmates at risk of harm.

Corizon utilizes a web-based medication ordering system. This process is not defined in policy and it isn't clear how it actually occurs. The system should have up to date policy and procedure on these essential elements of care.

For keep-on-person medications, the inmate is responsible for notifying the health care unit when their medication is about to expire. Refills of KOP medication require the patient bringing the medication card to the medication window when a nurse is available. The nurse will order a refill of the medication. This process relies on the inmate being able to get to the window timely, the nurse correctly re-ordering medication, the pharmacy timely dispensing the

[119] Corizon General Health Services Policy & Procedure Tutwiler Prison for Women policy number P-D-02.00 Medication Services, reviewed and revised September 2014

[120] Correctional Medical Services, Health Services Policy & Procedures Manual Alabama, policy number P-D-01-12 Medication Administration, Distribution date 06/08; revision 03/30/10

[121] Correctional Medical Services, Health Services Policy & Procedures Manual, Julia Tutwiler Prison for Women, policy number P-D-01.01 Formulary and Non Formulary Request, effective date 08/01/03

medication, timely transportation of medication to the facility, and administration to the inmate. When these steps do not work, the inmate is blamed for non-compliance. This process is not studied in quality improvement but it appears that there may be other defects in this process than just the inmate's failure to bring his card to the window. As an example, one patient[122] was on Zocor, a drug for high blood lipids. During 2012 almost every month, his KOP medication was delivered late, accounting for 56 missed days of medication in 2012 or about 15% of his medication doses. While it is convenient to blame the inmate for this problem, other issues can arise and should be studied. Notably, the electronic pharmacy system was introduced on a rolling basis in 2013 and 2014. In the existing paper medical records there is no record of medication administration so it was not possible to review whether administration occurs. Providers rarely document this in their notes.

Failure to Document Medication Administration and Errors in Medication Administration

Prior to introduction of the electronic system, medication administration was documented on paper forms. On inspection of multiple copies of MAR forms there were numerous cases of delays in giving KOP medications to inmates. It is easy to understand how there can be delays in a patient receiving medication. Except for segregation inmates and inmates on the infirmary, all inmates who are to receive medication go to a central location for medication administration for both KOP and nurse administered medication. At times, there may be a single medication window for administration of medication.

To take Fountain as an example, there are two medication windows. The October 2014 Corizon monthly report[123] notes that approximately 55% of inmates were on active medications. Assuming that there are 55% of the approximately 1,500 Fountain inmates on prescription medication that would mean that on average every window must accommodate approximately 412 patients over a 2 hour period to receive directly observed medication, KOP refills, and to bring soon to expire medication cards to the windows. KOP medication is obtained only monthly. Still, this is a very heavy load of medication to administer in the required timeframe.

The standard for nurse administered medication is for medication to be given 1 hour before to 1 hour after the prescribed time. If medication is ordered twice a day, for example, the responsible physician and pharmacy would decide that 7 am and 7 pm are the twice a day times. Medication therefore would need to be given between 6 am and 8 am for the dose to be timely. Given the numbers of inmates on medications and the numbers of medication windows and nurses administering medications, it doesn't appear possible to timely administer medication.

The reasons for failure to ensure continuity of KOP medication are not documented in the medical record. It isn't clear whether this is due to a fault of the inmate or the system. Because

[122] Patient 1
[123] Corizon Health, Alabama Regional Office Monthly Client Report, October 2014

some inmates are elderly or disabled getting to a medication window and waiting in line to let the nurse know that a refill is needed can be burdensome.

In addition, inmates who want to advise a nurse that their KOP medication needs to be refilled must wait in line with other inmates getting their medications. This is also burdensome because of the waiting. Some facilities I toured had a small waiting area near the medication window but if the waiting area was filled inmates would wait exposed to the weather. Also, the medication hours are extremely burdensome. Pill call at Limestone for example is at 4:30 am, 11:30 am, and 4:30 pm. Inmates who are elderly or disabled would have difficulty with the 4:30 am pill call, but when they miss their medication because it is difficult for them to arise at 4:30 they are considered non-compliant with medication. One inmate whose chart I reviewed failed to take his medication because he had to get up at 3 am to receive his medication. He was elderly and had difficulty getting up that early. The facility made no accommodation for this individual. This medication system therefore promotes non-compliance by making it difficult for the inmate to receive their medication.

Also, during chronic care encounters, providers almost never document review of medications. In reviewing patient records, it is seldom clear what medication the patient is taking, whether the patient is compliant, and whether the patient has side effects from medication he is taking. I was told that the electronic pharmacy system can give precise compliance rates for all medications, so the lack of documentation implies that providers are not using this system.

I have already described the problems with starting new medications in intake. A different version of this problem is when inmates return from outside hospitalization and are prescribed a new urgent medication. Nurses receive these patients in the health units and can call a physician for orders. However, when the medication is a non-formulary or medication unavailable in the pharmacy, there doesn't appear to be a good back up. Although Corizon has arrangements with local pharmacies for these purposes, this system appears to be faulty.

Examples in Chart Reviews of Delays and Medication Administration Errors

These problems are evident in chart reviews. One patient[124] had hypertension, high blood lipids and a prior coronary artery stent in 2009. A PA saw the patient on 1/4/12 for a complaint of chest pain for 2 months. The PA ordered a cardiology consultation and follow-up for a month. About a month later a cardiologist evaluated the patient and recommended catheterization. When the PA saw the patient in follow-up, the patient complained of continued chest pain but the PA did not modify the anti-angina medication, which should have been done. A few weeks later the patient had catheterization and significant stenosis was noted in one of the coronary arteries and a bare metal stent was inserted into one of his coronary arteries. When these stents are used, it is imperative to use a medication called

[124] Patient 3

clopidogrel, or a similar anticoagulant medication, otherwise the stent can clot resulting in risk for heart attack. The cardiologist therefore prescribed aspirin and clopidogrel on discharge.

Upon return to the prison on 2/21/12, the patient didn't receive clopidogrel for 6 days. The PA did not evaluate the patient upon return except to order his medication. The medication required a non-formulary request but this wasn't filled out until 2/23/12. On 2/26/12, the patient placed a health request stating he was having problems with his heart and needed to go to chronic care. The health request wasn't evaluated until a PA saw the patient for worsening chest pain on 2/29/12. The PA re-admitted the patient to the hospital. His recently placed stent had clotted due to not receiving the clopidogrel. The delay in follow-up of the health request and failure to receive prescribed medication harmed the patient as his coronary arteries showed additional clotting (3 vessels) than had previously been present. A nuclear study on 3/1/12 showed that there was evidence of infarction in several sections of the heart. The patient needed 3 vessel coronary bypass surgery, which was performed 3/2/12. On discharge, hospital physicians recommended Coreg, a different beta blocker than the one the patient was taking.

When the patient returned to prison on 3/6/12, Coreg was prescribed, but the other beta blocker Atenolol was not discontinued for 3 weeks on 3/28/12. The MAR for April shows that the patient didn't receive Coreg for most of April. There was no evidence on the April MAR that the patient received his KOP aspirin and Zocor (his anti-lipid medication). When the PA saw the patient for chronic care on 4/25/12, he didn't verify that the patient had received his medications. On 4/27/12 the PA ordered the clopidogrel for an unclear indication but the patient never received the medication. The May MAR documented that the patient first received Coreg on 5/23/12 about 2 months after it was recommended upon discharge from the hospital.

The patient continued to receive KOP medications late on several occasions. A cardiologist recommended increasing the Coreg on 9/10/12 but this wasn't done until 11/12/12 about 2 months after the recommendation. This patient suffered harm (clotted stent and probable damage to heart muscle) due to lack of timely medication.

Another patient[125] from Staton with diabetes and high blood lipids was initially not treated for high blood lipids for an extended period of time. The dosage of medication was inadequate and his blood lipids remained elevated. The patient failed to consistently receive his medication over a period of years. For his diabetes, the failure to provide timely medications resulted in significant deterioration of his diabetes on multiple occasions. This placed the patient at risk of harm. There appeared to be no effort to identify why the patient wasn't getting his medication except to blame the inmate for non-compliance when it appeared that the patient wasn't actually receiving medication.

[125] Patient 2

Another patient[126] from Limestone had high blood lipids (LDL cholesterol and high triglycerides). This patient's anti-lipid medication was not provided on 2 separate occasions resulting in elevation of his blood lipids. On one of these occasions the inmate resorted to filing a grievance to bring attention to the matter. The system did not appear to have a mechanism to correct this problem outside of the grievance process.

Another patient[127] from Limestone had diabetes and high blood pressure. His blood pressure was not controlled for a period of 3 years. At times, the pressure was dangerously elevated (200/120). The patient had evidence of heart damage from the uncontrolled blood pressure (EKG showing left ventricular hypertrophy). Despite the uncontrolled blood pressure, a nurse practitioner's referral attempt to investigate if there was secondary hypertension was denied. The patient also had elevated blood lipids which were not treated for several years. For over a year, documentation on the medication administration record demonstrated that the patient was not receiving his medication appropriately.

In the third year of management, a nurse practitioner documented that the patient was not showing up for his afternoon doses of medication. Although the nurse practitioner counseled the patient on "compliance", the nurse practitioner never asked the patient why he was missing the afternoon doses of medication as he was consistently showing up for his morning doses. Furthermore, the patient was a deaf mute whose malfunctioning hearing aid and deaf condition was ignored for years. The patient could use sign language but the providers seeing the patient did not document how they effectively communicated with the patient. The lack of effective communication with the patient probably resulted in a lack of understanding about why the patient was missing medication. It wasn't clear how the nurse practitioner could effectively counsel a deaf mute or effectively communicate about medication issues. The nurse practitioner could have started keep-on-person medication but did not. Also, there are many extended release and single day dosing medications that could have been used in this case where the patient was missing medications. Instead, the providers ignored the problem, told the patient to show up for his medications and allowed his blood pressure to remain elevated. Besides the elevated blood cholesterol which was untreated, the patient also had evidence of possible cirrhosis which was not evaluated over several years.

Urgent/Emergent Care/Hospitalizations

Methodology: Review charts with episodes of urgent and emergent care. Review of policy.

Opinions:

29. There are no urgent and emergent nurse evaluation policies and procedures.
30. Physicians fail to timely or appropriately hospitalize patients whose care cannot be safely provided at the prison.

[126] Patient 7
[127] Patient 14

31. Preventable hospitalizations are not studied with respect to identification of care management problems with an aim to improving care.

Findings:

Emergencies occur at any hour of the day. Often emergencies occur when physicians are not present at the correctional facility. There needs to be adequate policy and practice so that nurses who evaluate emergent needs do so properly. Nurses performing these evaluations need to be licensed and trained for independent assessment. This is typically the responsibility of an RN. These evaluations need to be thoroughly documented including the content of conversations with on-call providers.

When the health needs of inmates exceed the capacity of the prison to manage, the inmate needs to be referred to a higher level of care. This is typically a hospital but may include a skilled nursing or long-term care facility. The health program should have a mechanism of review of hospital cases to ensure that patients are timely referred to a higher level of care and to identify if primary care management of the patient could be improved to reduce unnecessary hospitalization and harm to patients.

The OHS policy on sick call requests does not address emergency health needs. No other OHS policy addresses onsite emergency evaluation of patients. Corizon regional policy does not address emergency requests for care but does address emergency transportation to a hospital. Using Tutwiler as an example, a policy for emergency services is in place but it was written in 2003 and has never been revised. This policy[128] implies but does not state that on site nursing staff evaluates emergencies. It also does not state how an inmate accesses emergency services. Nurses can call the on-call provider who is supposed to be available 24/7. However, there is no guidance for how the nurse is to decide whether to call a physician. Because LPNs perform most of these emergency evaluations and because RNs do not appear to review the work of the LPN, the professionals who are making emergency evaluations are not trained to do so placing the inmates at risk of harm. The quality of these evaluations is frequently poor. The 2012 Tutwiler policy gives no guidance on how an inmate accesses emergency services, which staff performs emergency evaluations, and how nurses make decisions to contact physicians.[129]

The Tutwiler policy manual also has a “man down” procedure, but this was also written in 2003 and hasn’t been revised since. A “man down” procedure is a procedure for how to respond in an emergency situation. This policy sets a training goal of a 4 minute response time for medical staff to arrive at the scene of the emergency. However, most emergency evaluations have such poor documentation, that time documentation is seldom included in emergency evaluations. In some cases there is no documentation at all for events such as cardiac arrest.

[128] Correctional Medical Services Health Services Policy and Procedure Manual, Julia Tutwiler Prison for Women policy number P-E-08.00 Emergency Services, effective 10/1/03 with no revisions

[129] Corizon General Health Services Policy & Procedure Tutwiler Prison for Women, policy number P-E-08.00 Emergency Services, reviewed and revised 09/2014

In practice it appears that LPNs perform most emergency assessments even though they are not trained to do this. Documentation of these events is poor. Decisions on contacting providers are also poor. The contents of the nurse discussion with the provider are seldom included in the documentation. Quality of nurse assessments is also poor. The result of these deficiencies is risk of harm to patients, as is evident on chart reviews.

When patients are hospitalized, the discharge summaries do not consistently appear to be in the medical record and prison physicians do not always document review of these records. In chart reviews in multiple sections of this report, significant errors occurred after patients returned from the hospital. Yet there is no quality improvement effort to identify or correct these problems. This process needs to be codified in a policy/procedure.

Correctional facilities, including ADOC facilities, do not have the capacity to manage acutely ill patients in lieu of hospitalization. Yet, in chart reviews there were examples of patients who needed hospitalization but were kept at the prison instead. Several of these patients died. In 1 case the Regional Medical Director and site physician asked multiple times to take the patient back to the prison when the hospitalist was reluctant to discharge the patient and said that the patient wasn't ready for discharge. This patient was sent back to the prison and died within a month and without receiving the interventions suggested by the hospital. There appears to be no explanation for the clinical behavior other than the financial benefit accrued by not hospitalizing the patient.

In 2 charts[130] I reviewed, patients experienced cardiopulmonary resuscitation. The resuscitative efforts were not documented. In neither case was the patient sent to a hospital after the event. In both cases, it appeared that the patients suffered a stroke. This lack of appropriate referral to a hospital caused significant harm to one patient. For the other patient, there was no documentation of the patient's condition after this event so it is unclear if he was harmed as well. These patients had serious medical needs that were inappropriately addressed by medical staff.

When patients go to a hospital and return to a correctional facility, a provider should evaluate the patient upon return to ensure that changes in therapy and new information are used to update the treatment plan. The ADOC has a practice of sending recently hospitalized patient to Kilby for stabilization. This is a reasonable strategy but must be properly implemented. If the providers at Kilby do not evaluate the patient, this practice will not be effective. In chart reviews, one patient[131] was hospitalized for a syncopal episode along with very high blood pressure. The patient returned to Kilby on 4/2/14 and was admitted to the P-ward. The patient was discharged back to Elmore without having seen a physician at Kilby. There was also no transfer form filled out when the patient transferred.

[130] Patients 22 and 17
[131] Patient 17

There is evidence on many charts reviewed of preventable hospitalizations. There is no effort in the quality improvement program to identify preventable hospitalizations in order to study how quality of on-site care can be improved to prevent hospitalization.

Chart Reviews Demonstrating Lack of Timely Hospitalization

Multiple medical charts demonstrate a lack of timely hospitalization. In one case, a patient[132] was incarcerated at Kilby with a history of diabetes, diabetic neuropathy, hypertension, coronary artery disease, high blood lipids, prior stroke, chronic kidney disease and a brain dural malformation. At intake, providers failed to identify chronic kidney disease, diabetic neuropathy, and prior stroke. Providers at the prison changed his insulin dramatically. He was previously taking 50 units of long acting insulin and 30 units of short acting insulin three times a day. The prison providers prescribed 30 units of a mixed insulin (70/30) twice a day. This appeared to result in significant elevation of his blood glucose.

A nurse practitioner evaluated the patient for fever (as high as 101.9), hypotension (BP 98/58), and cough. The patient had prior elevated blood pressure of 160/90 only a month before at intake. The nurse practitioner prescribed cough medicine and Tylenol. The patient's blood sugar was not even checked. The patient needed immediate blood testing to exclude sepsis and probably should have been hospitalized, and instead was not evaluated by a provider for 4 days.

Three days later, a nurse evaluated the patient for altered mental status and incontinence with fever, hypotension (90/54), and tachycardia (114). The patient couldn't produce urine. The nurse called a physician and emergency blood tests showed significant abnormalities including a blood glucose of 582, sodium of 125, hemoglobin of 9.2, creatinine of 3.39, and acidosis. These values, along with the presentation of the patient, indicated septic shock with renal failure and diabetic ketoacidosis. The patient should have immediately been hospitalized. Instead, the doctor placed the patient on the infirmary unit and gave subcutaneous insulin. This placed the patient at significant risk.

The following day the patient was evaluated by a provider who sent the patient to a hospital. It took an hour and a half for the patient to be transported. At the hospital the patient was in septic shock with pneumonia and renal failure. He died in a few days later.

[redacted] This patient's death was preventable. The poor clinical quality of care of the nurse practitioner and physician also contributed to this patient's death. The modification of the insulin dosage at intake may also have contributed to his death. The failure to timely hospitalize contributed to this preventable death.

[132] Patient 16

Another patient[133] from Elmore with hypertension had a sudden collapse. Instead of transferring the patient to a hospital, the patient was transferred to the Staton infirmary. The next day the Staton doctor documented that the patient required cardiopulmonary resuscitation by officers. Despite this, the patient wasn't brought to a hospital. This is a substantial departure from the standard of care. At Staton, the doctor also did not immediately hospitalize the patient. She discussed the case with the Regional Medical Director and they agreed to keep the patient at the prison. Finally, after 26 hours the patient was hospitalized. At the hospital, it was discovered that the patient had a stroke. The delay in transporting the patient to a hospital prevented the use of de-clotting medications. The patient suffered significant brain damage that may have been preventable if the patient had been timely transferred.

Another patient[134] from Ventress had hepatitis C and cirrhosis and developed a groin infection. He was hospitalized and brought back to the prison system quickly and treated with intravenous antibiotics at the prison. About 6 months later, the patient needed re-hospitalization for severe swelling with discoloration of the right leg with serous oozing of the lower leg. The infection appeared to affect the entire leg. The infection was in the same location as the first groin infection and may have been an ongoing infectious process. The hospital was initiating a work-up. DVT had been ruled out. An infectious disease specialist needed to see the patient and the hospitalist thought that a surgery consultation was indicated. The hospitalist said that the site medical director called him 3 times asking to bring the patient back to the prison. Then the Regional Medical Director called and asked to have the patient sent back to prison. The hospitalist reluctantly sent the patient back but documented that he thought the patient needed continued hospitalization.

The patient was initially sent to Kilby where he remained on intravenous antibiotics for about 2 weeks. Despite still having ongoing infection with ulceration, necrotic tissue and oozing, the patient was discharged from the infirmary on oral Keflex which is inadequate for a serious infection which the patient still appeared to have. After another week the patient was transferred back to Ventress.

At Ventress the patient was admitted to the infirmary. The doctor described continued significant infection with ulcerated, necrotic wounds that were draining and oozing fluid. Both legs were extremely swollen and it appeared difficult to distinguish infection from the complications of cirrhosis. Nevertheless, despite diagnosing the patient with cellulitis the doctor did not treat the patient with antibiotics for about 2 weeks. The patient worsened. The ulcerations blistered. The necrotic tissue was extensive based on descriptions in the chart. The ulcerations were oozing drainage. The patient developed early renal failure and had evidence of severe complications of cirrhosis. Despite this, the patient was kept on the infirmary at Ventress without antibiotics. The patient should never have been released from the hospital

[133] Patient 17
[134] Patient 9

and needed to return to return to a hospital at the time he was admitted to Ventress on 11/19/14. On 12/5/14, the patient developed a life-threatening cardiac arrhythmia with hypotension and was sent emergently to a hospital. At the hospital the patient had septic shock and died about 2 weeks later. This was a preventable death. The Regional Medical Director and site medical directors should never have asked for him to return to the prison as the prison was unable to care for his needs and failed to care for his needs. This resulted in his death.

Aside from the problems with hepatitis C management, there were several key problems with this patient's care. The patient had end-stage liver disease that placed the patient at high risk for infection. As well, the edema from the end-stage liver disease and development of chronic kidney disease complicated his infection. The prison did not have ready access to infectious disease consultants, surgeons, and diagnostic testing (CT scans). Nursing care at the prison is not comparable to the nursing care in a hospital. For these reasons the patient should have remained in the hospital. Secondly, the doctor at the Ventress prison diagnosed an infectious condition but for weeks but did not give antibiotics to the patient. The doctor apparently did not have the diagnostic ability to understand that the patient needed antibiotics. For this reason as well, the patient should have been hospitalized so he could have access to a physician who knew how to treat his illness.

Specialty Consultations

Methodology: Review medical records with respect to specialty services. Review selected depositions. Review policies.

Opinions:

32. Patients whose care requires referral to a specialist or requires specialized diagnostic testing do not consistently receive that care.
33. The utilization review process is a barrier to obtaining adequate and timely specialty care.
34. The OHS lacks policy guidelines for specialty care.
35. Some patients who require specialty care are managed at prisons by providers who do not know how to manage that care.

Findings:

When a patient has a medical condition for which the clinical management exceeds the capacity of the prison physician to manage, that patient needs to be referred to a specialist. In cases where the prison jurisdiction fails to hire appropriately trained and credentialed physicians, the threshold for referring to specialists is lowered, sometimes dramatically. The referral to a specialist needs to be timely and based on the condition of the patient. Delays in treatment can cause harm to patients. It is necessary that prison physicians read and understand consultative reports and timely continue recommended treatment, including follow-up visits, or give a reason why recommended treatment is not being followed.

Correctional medical programs frequently use utilization management to ensure that referrals for specialty care are appropriate. These programs need to ensure that their guidelines are consistent with contemporary standards of care. When specialty care is denied, the medical leadership needs to ensure that an alternative adequate clinical therapeutic plan is in place. While correctional programs perform utilization review for referrals to specialists, they need to be aware of under-utilization. Under-utilization occurs when a patient needs specialty care but fails to receive it. This is typically seen in correctional systems that have overly aggressive utilization management strategies and in systems where physicians are poorly trained and do not understand when a patient needs specialty care. These incidents should be picked up in mortality reviews, sentinel event reviews, and routine reviews of hospitalization.

Lack of OHS policy on Specialty Care

The OHS does not have policy with respect to specialty consultations. The RFP requires that the vendor is responsible for management and referral of all specialty care and outside diagnostic services.[135] However, the RFP does not provide any guidance or benchmarks with respect to performance or with respect to outside use of consultants or diagnostic studies. There are no guidelines for timeliness of completion of these consultations or studies. Corizon policies also do not give specific guidance on these issues. As a result, there is no guidance on who should receive specialty care, the timeliness of that care based on the acuity of the patient, how records of offsite encounters are reviewed by providers and filed in the medical record, and how follow-up of consultative requests is to occur.

In practice, it appears that when providers want an offsite test or consultation evaluation, they fill out a consultation request for offsite care. This request is sent to the regional office and approved or not approved. Dr. Hood testified that the regional office receives about 80-100 requests for care a week.[136] He also testified that he never denies a request; instead he offers an alternative treatment plan. Dr. Crocker stated in deposition that the site medical director

[135] Alabama Department of Corrections Request for Proposal No. 2012-02 Comprehensive Inmate Health Care Services, July 17, 2012, section 5.9 (A) Specialty Services page 54

[136] Deposition of Hugh Hood. Civil Action No. 2:14 –cv-00601 – MHT-TFM Dunn et al. vs. Dunn conducted on March 10, 2016 in Birmingham, Alabama p 205

could override the disapproval, but there is no policy that describes how this occurs and in practice and I did not see evidence of this in chart reviews.[137] Also, these alternative treatment plans sometimes make no sense and in effect amount to a denial of care. Based on chart review, it appears that the alternative treatment plan is typically to manage on site, which is not a plan. Often the referring provider is a mid-level (NP or PA) who may not know how to manage the patient, which is why they are seeking to send the patient to a higher level of care. The lack of further instructions to a mid-level places them in a position of not knowing how to care for the patient.

Failure to Refer Patients for Necessary Specialty Care

Sometimes, the site medical providers attempt to manage care for which they have no experience. Even when they may clearly not know how to manage the patient, they do not consistently refer these patients for offsite care. There are also some facilities where attempts are made to perform interventions at the prisons when the prison is not capable of conducting the intervention. These can result in harm to the patient, including death. This is evident in chart reviews.

While the focus on specialty care is based on referrals, there are many patients in need of care who are not referred for specialty care. This under-utilization will not be identified in review of the specialty care process. This is a more serious problem. At times this under-utilization is a result of apparent lack of knowledge often when nurse practitioners are managing complex patients when the patient should be managed by a physician. At times, under-utilization results from inadequate physician management. All of these types of problems are observed in chart reviews.

Examples from Chart Reviews of Specialty Care Problems

I have already cited the example of a patient[138] who had a complication of diabetes that typically needs the care of a team of specialists. The patient was never referred for his Charcot foot and sustained further damage to his foot.

Another patient[139] already cited in the section on medication management, had a hearing aid that malfunctioned. The patient couldn't hear and could only communicate by sign language. The patient had medication issues that required effective communication. It did not appear that staff could use sign language, so it appeared that there was ineffective communication that significantly affected the patient's care. Over a period of years, the patient was not referred to a specialist to evaluate his hearing problem. The same patient had uncontrolled hypertension for years that was damaging his heart. An attempt to initiate a work up for a source of

[137] Deposition of Bobby Crocker MD, Civil Action No. 2:14 –cv-00601 – MHT-TFM Dunn et al. vs. Dunn conducted on February 25, 2016, page 172
[138] Patient 4
[139] Patient 14

secondary hypertension was denied without explanation. While the patient should have been referred to a specialist in hypertension, the problem was ignored.

Another patient[140] had almost continuously elevated blood pressure for at least over a year, but was not consistently receiving his medications. Providers or nurses did not attempt to discover why the patient wasn't receiving his medication. During 2013, the patient developed signs of heart failure (significant edema of legs up to his thighs). A provider appropriately ordered an echocardiogram to evaluate the patient for heart failure. Despite this being the standard of care, the echocardiogram was cancelled by the Regional Medical Director. Instead, the Regional Medical Director wrote an order to perform a chest x-ray and to schedule the patient to be seen by the Regional Medical Director at an upcoming chronic care clinic. The Regional Medical Director didn't show up to see the patient and the necessary test was never done.

Another patient[141] came into prison in August of 2013 and was eventually housed at Limestone. He had a profound hearing loss that resulted in loss of balance. For this reason he needed hearing aids to maintain his balance. While the loss of hearing would not be remedied by the hearing aids, the loss of balance placed the patient at risk for harm and the hearing aids were indicated for that.

Medical staff had difficulty achieving effective communication with this patient. When he had a broken nose, medical staff presumed that the fracture was related to old trauma, but came to this conclusion without an effective communication with the patient. Providers documented difficulty in communicating with the patient. The lack of sign interpreters was apparent.

The request for hearing devices to help the patient maintain his balance was initially approved but then denied by the ADOC OHS. The vendor attempted to obtain an over the counter device that would not be appropriate for the patient's need. After multiple requests the device was finally approved. There were additional delays in obtaining this device. The patient received hearing aids several weeks before being paroled, about a year and a half after incarceration.

Delay in Specialty Care Caused Harm

Another patient[142] had a kidney stone that was painful. He was sent to an urologist who recommended screening the urine for the stone and medications with a 3-4 week follow-up. The patient was subsequently transferred from Kilby to St. Clair, but the intra-system transfer form failed to include the urology appointment so this was lost to follow-up. The patient's pain medication and other medications were not continued as well. When the patient was first evaluated at St. Clair about 2 months later, the provider made an urgent urology appointment, which took place about 2 months late. The urologist documented that the patient now had

[140] Patient 17
[141] Patient 12
[142] Patient 11

urinary obstruction and recommended surgery as soon as possible. This delay may have resulted in kidney damage and caused unnecessary pain to the patient.

In another case,[143] a patient was identified with type II diabetes and hypertension. The patient's problems also included high blood lipids, chronic renal failure, and microalbuminuria, although the high blood lipids were unrecognized as a problem for most of the incarceration. The microalbuminuria was never recognized. Although this patient came into prison with a urinary bladder catheter, the medical record had no information with respect to why the patient had a suprapubic catheter in place and it appeared unrecognized as a problem for years. This was a significant deficiency.

The patient apparently had an injury from which he developed a significant urethral stricture. Prior to incarceration, sometime around 2006, specialists had recommended urethroplasty or reconstruction of another urethral opening so that the patient could urinate normally. This apparently was not done, as the patient was incarcerated. After the patient was incarcerated the procedure was not immediately performed. A urethral stricture makes urination difficult, as the urethra is the tube connecting the urinary bladder through the penis to the exterior. In this case the patient's urethra was completely occluded which required surgery to create a new urethral orifice. Instead of referring the patient for this surgery, the Alabama Department of Corrections medical program continued to have the patient utilize a suprapubic catheter connecting the urinary bladder, via a latex tube, with an exterior urinary bag attached to the patient's leg. In this case the suprapubic catheter system should have been a temporizing solution until the urethroplasty could be performed.

This caused harm to the patient. The patient did not have an indication for use of a urinary catheter except on a temporary basis. Use of urinary bladder catheters without indication is not recommended due to the potential for risk of infection, sepsis, leakage, fistula formation, and potentially cancer. Also, unnecessary long-term use of this device is degrading and uncomfortable. This patient, according to an urologist's note, had a prior perineal abscess with sepsis (which is potentially life-threatening) sometime around 2009. He also had almost continuous colonization of his urine with bacteria and appeared to have multiple infections requiring antibiotic treatment and leakage of the catheter during the course of the medical records reviewed.

Providers never indicated the reason for the suprapubic catheter even though it is not recommended to use this device unless there is a bonafide indication, which the patient did not have. Providers did not monitor the status of this device at any chronic care visit even though it was a long term chronic care problem of the patient. Providers, in chronic care notes, did not even address infectious urine problems when they occurred.

In April of 2013 a provider referred the patient to an urologist for urinary tract infection. This referral never occurred, but in October of 2013, 7 months later, another provider documented

[143] Patient 2

that he was cancelling the referral because the referral was "unnecessary" even though a recent urine test had demonstrated that the patient was still infected. The provider did not document the reasoning for the decision.

In January of 2013 another provider referred the patient again to an urologist because of a suspected fistula. The urologist ruled out a fistula but in May of 2013 documented that the patient needed an urethroplasty because of a urethral stricture. The urologist recommended sending the patient to University of Alabama. This did not occur until October of 2013, 5 months later. An urethroplasty was performed November 11, 2014, which ultimately corrected the patient's problem. The suprapubic catheter was removed February of 2015, approximately 9 years after it should have been removed. The failure to remove the indwelling catheter was degrading and harmful to the patient. The system failed to timely address the patient's urethral stricture and forced the patient to continue use of a suprapubic catheter for urination which is not recommended as a long-term solution for this condition. This placed the patient at risk of harm for infection, sepsis, and potentially cancer. The patient had sepsis and repeated infections which were unnecessary risks for this patient.

In addition to urinary catheter issues, care for this patient was inadequate and caused harm to him. Over the course of over 3 years of medical record documents, the patient failed to continuously receive his medication. In May of 2012 the patient failed to receive his medication for diabetes for several months, resulting in extremely high blood sugar values (blood sugar > 500 [normal is < 110] and A1c > 12 [normal is <6.5]). Providers implied that the patient was non-compliant with his medication on several occasions, even though medication records verify that the patient did not receive his prescribed medication. When the absence of medication was identified, instead of simply restarting the oral diabetic medication, providers added long acting insulin in addition to the oral anti-diabetic medications, which appeared to make the patient hypoglycemic. This was unrecognized. The patient ultimately asked to have the insulin stopped yet the providers failed to recognize that the patient had a better understanding of his needs than they did.

This occurred again in 2014. When the patient received his diabetic medications (Metformin and Glipizide) the patient's diabetes was in control. However, again in June of 2014, the patient failed to receive his glipizide for approximately a 6-month period of time which resulted in the diabetic control deteriorating (HgbA1c of 9; normal <6.5). After May of 2014, medication records were not available in the medical record so it was not possible to determine whether the patient received medication. Glipizide was re-ordered by a practitioner in late June and by August 8, 2014 the hemoglobin A1c improved to 7.7. However, by March of 2015 the hemoglobin A1c deteriorated again to 9.2. However, medication records were no longer available in the medical record after June so it was not possible to verify whether the patient received medication.

During these episodes of failing to provide medication to the patient, practitioners implied or directly stated on several occasions that the patient was non-compliant with medication. The program failed to identify its own deficiencies in providing medication to patients.

The patient also had high blood lipids (cholesterol). High cholesterol is a major risk factor for heart attacks, particularly in persons with diabetes. In January of 2012 the patient had high blood lipids with LDL cholesterol of 130. This is abnormal for a person with diabetes and therapy should have been initiated. Instead, providers failed to identify high blood lipids as a problem in chronic care clinics and the patient remained untreated until November 30, 2012 when a physician started a very low dose of an anti-lipid drug. During subsequent chronic care visits, providers failed to monitor the patient's progress with respect to his high blood lipids which remained consistently elevated. It wasn't until November of 2013, about 10 months later, that a provider noticed that the blood lipids remained elevated (LDL cholesterol 149-goal for a diabetic is < 70) and increased the dose to 10 mg of Zocor, still a small dose of anti-lipid therapy. High blood lipids were never documented as a problem in the patient's chronic care visits. Except for these 2 occasions over a 3 year period, blood lipids were never monitored. The providers also never assessed liver function tests which can become abnormal for people taking this medication. Providers also never asked the patient whether he had muscle pain, which is a common side effect of this medication.

Preventable Death from Lack of Appropriate Specialty Care

Another patient[144] had a very unusual disease called scleromyxedema. This rare disease can affect any and multiple organs, but its most prominent manifestations are in the skin. It has a chronic, progressive and unpredictable course. Its treatment is difficult and because the medications used to treat this disease can result in death, treatment needs to be managed by clinicians and nurses familiar with use of the medications. It is recommended to perform monthly skin checks. Typically, a multidisciplinary team follows these patients including dermatologist, hematologist, cardiologist, pulmonologist, gastroenterologist and possibly surgeons. The use of specialists depends on the course of the disease.

Patients with this condition often receive intravenous immunoglobulin (IVIG). Patients receiving this medication need to be monitored carefully while it is administered. Pre-treatment with intravenous fluid is typically done, and during treatment nurses typically monitor the patient.

The chart for this patient begins around February of 2013. At that time the IVIG had been stopped but the patient developed symptoms of dysphagia, a complication of the disease. A gastroenterology evaluation was supposed to occur but apparently did not. At the prison, the practitioners who monitored the patient for chronic clinics did not always appear to know how to follow the patient's care. For example, on 4/26/13 an NP checked all boxes on the chronic care form "no" but didn't ask questions pertinent to the patient's condition. The condition can cause problems with swallowing but the NP failed to assess whether the patient's swallowing was impaired. The NP also did not ascertain whether the patient's pending appointment with the gastroenterologist was scheduled. The NP also did not appear to know what medication

[144] Patient 20

the patient was receiving and therefore was unable to understand the potential side effects of the medication.

In late April of 2013 the patient went to an oncology center and began receiving monthly infusions of IVIG. The patient's symptoms improved. These visits continued for over a year and a half and the patient did well. The oncology infusion center followed with blood tests, did monthly examinations of the patient and arranged for infusions of IVIG in their infusion center. This arrangement seemed to work for the patient and ensured reliable and competent management of his condition.

On 12/17/14 a doctor at Kilby documented on a chronic clinic note that he "will see about giving IVIG on site". This was not a good strategy as the facility had not shown the ability of its primary care providers to monitor the disease without expert consultative help. The rarity of the condition was such that care of this patient was above the level of competence of nurses and doctors at the prison. Also the patient was on an unusual medication. Giving this medication on site at a prison would require several hours of infusion. Long-term infusion therapy is not done at prisons typically, and the lack of nurse knowledge regarding this medication placed the patient at risk of harm.

Despite that, the first on-site infusion was done on the P ward at Kilby. The patient needed 5 consecutive daily infusions every month. Each infusion lasted about 6 hours. The patient needed a pre-treatment with intravenous fluid followed by the infusion. Pre-treatment with intravenous fluid is standard for this medication. The FDA gives a boxed warning[145] for this drug that acute renal dysfunction can rarely occur and has been associated with fatalities. For this reason it recommends that for patients at risk for renal dysfunction to ensure adequate hydration prior to administration and to discontinue treatment if renal function deteriorates. The facility started these infusions in the evening around 7 or 8 pm, which was a very bad idea, as the facility physician was no longer on site. There were days when the pre-treatment fluid treatment was not given. Nurses did not document monitoring the patient consistently and at times the patient wasn't monitored at all. Nurses did not always document giving pre-treatment hydration. As well, the doctor at Kilby did not appear to be familiar with the boxed warning for this drug.

On 2/15/15, the patient placed a health request stating he felt bad and had a cold. He was charged $4 and was evaluated by an LPN who documented vomiting, diarrhea, weakness and dizziness for 3 days. The second page of the NET tool note was not in the medical record so it wasn't clear what the LPN did. Since vomiting and diarrhea can cause dehydration, the patient

[145] In its Guidance for Industry: Warnings and Precautions, Contraindications, and Boxed Warning Sections of Labeling for Human Prescription Drug and Biological Products – Content and Format published by the FDA (found at http://www.fda.gov/downloads/Drugs/.../Guidances/ucm075096.pdf) boxed warnings or black box warnings are the strongest warning that the FDA gives. The FDA stated in its guidance that the boxed warnings indicate that "in using the drug in question there is an adverse reaction so serious in proportion to the potential benefit from the drug (e.g. a fatal, life-threatening or permanently disabling adverse reaction) that it is essential that it be considered in assessing the risks and benefits of using the drug".

should have had a metabolic panel. But this did not happen. The IVIG should not have been given without knowing the hydration status of the patient.

On 2/17/15 at 10 am, an LPN evaluated the patient for abdominal pain, sore throat and dizziness. The second page of this evaluation was also not present in the medical record.

Since the patient had at least 5 days of nausea with some vomiting, it was important that prior to giving the IVIG the patient's renal function be assessed. Yet, on 2/17/15 at 4:10 pm a nurse documented administering IVIG without a pre-infusion hydration and without assessment of the patient's condition. The infusion was completed at 7:56 pm. At 9:29 pm, a nurse assessed the patient for not feeling well. He complained of nausea. The nurse described the patient as "generally ill". The second page of this evaluation was also missing from the record. However, it appears that the nurse called a physician and stat blood tests were ordered. These were timed as reported on 2/17/15 at 11:56 pm and showed a white count of 18.3 with a BUN of 60 and a creatinine of 2.54. This indicated that the patient had a significant infection with severe dehydration and renal failure. The patient should have immediately been admitted to a hospital as the renal failure was likely due to the IVIG. He possibly had a systemic infection. Despite that, he was not hospitalized until almost 24 hours later.

A nurse wrote a note at 6:20 am on 2/18/15, stating that the doctor was notified of the abnormal laboratory results, but the doctor gave no orders. At 10 am on 2/18/15, a doctor evaluated the patient. He documented that the patient was not feeling well and documented the abnormal laboratory test results and noted that the patient was given IVIG despite feeling ill. The doctor admitted the patient to the infirmary with dehydration due to viral illness. His physical examination consisted of writing "WNL" and drawing an arrow through the entire physical examination form. His plan was to encourage oral fluid and order another blood count and metabolic panel the following day. The doctor did not immediately discontinue the IVIG. Nor did the doctor admit the patient to a hospital.

Given that the patient had just received IVIG, the laboratory results were critical, life-threatening values and the patient should have been immediately sent to a hospital to rule out infection and renal damage from the IVIG. This is a known scenario for fatality based on current FDA warnings that come with the medication. Yet the physician did not seem to appreciate the warnings associated with use of this medication. This is why these infusions should not have been performed at the prison where staff is unfamiliar with use of the drugs.

The patient presumably was on the P ward anticipating another dose of the IVIG when, at about 5 pm on 2/18/15, the nurse noted that the patient appeared ill and fell while attempting to use the bathroom. He was confused and weak and unable to stand. He had hypothermia (temperature 95). The patient was moved to the ER at Kilby for warming, and warm saline bags were placed under his arms. The inmate became incontinent and, when the doctor was notified, the patient was sent to an ER. The patient died on 2/20/15 of sepsis.

Although an autopsy was not done, it appears that this death was preventable. There is no adequate clinical explanation for wanting to provide infusion therapy with a potentially dangerous product when the staff was insufficiently trained to monitor the patient. When the patient had warning symptoms and signs of dehydration (2/17/15 health request at 10 am), those signs were not considered with respect to giving IVIG. The nurse in the infirmary who administered IVIG did not properly monitor the patient prior to infusion and did not give a pre-treatment hydration which is usually given. The nurse did not assess the patient for symptoms prior to infusion. The physician who initiated giving the IVIG also appeared not to know about the black box warning about the drug including the cautions with patients with renal failure. Performing this complex infusion therapy at the prison instead of at an infusion center appears to have cost this patient his life.

Another patient[146] was a 78 year old man housed at the Easterling Correctional Center with chronic obstructive pulmonary disease (COPD). He stopped having colorectal screening after age 75 but had intermittent symptoms of acid reflux. On 9/19/12 the patient had mild anemia (hemoglobin 12 [normal 12.3-17]) but never had a follow-up for this. On 10/25/13 he had a significantly abnormal anemia (hemoglobin 10.9). The patient was evaluated 5 times in chronic clinic but the abnormal hemoglobin tests were ignored over 2 years until a doctor noticed the abnormal test on 11/13/14.

At that time the patient initially refused an upper endoscopy test but did have Hemoccult tests that were positive. The anemia worsened until it was so low that the patient needed transfusion. At the same time the patient developed a very high white blood count, indicating systemic infection. A few weeks after the patient initially refused the endoscopy, the patient agreed to a CT scan of the abdomen to search for a source of the infection. Multiple metastatic liver lesions were identified. A carcinoembryonic antigen (CEA) test was extremely high (1038 [normal < 3.8]). This test suggested colorectal cancer as a source of the metastases. The doctor made the patient a hospice patient, and the patient died on 12/18/14, about a month after identification of the cancer. The patient should have had follow-up care related to his anemia on 9/19/12, about 2 years before he died. By failing to evaluate abnormal test results in a timely manner, providers contributed to a preventable death.

Delays and Risk of Harm Inherent in Specialty Approval Process

Many diagnostic work ups in the community are now performed on an outpatient basis as opposed to hospitalization. This cost reduction strategy is effective but depends on rapid out-patient diagnostic capacity that the medical community has put into place. In the ADOC, the utilization review process and scheduling creates delays in care. As a result there can be significant delays in treating patients with serious illness.

[146] Patient 25

An example of this is a patient[147] who was being followed in a contact investigation with respect to a tuberculosis outbreak in 2014. The patient had an x-ray done but the report of this x-ray is not in the medical record. On 3/3/14 a physician requested a CT scan to follow up on the x-ray because there was a suspicious lesion on the chest x-ray. The CT scan was ordered, approved and scheduled, but not done until 4/9/14. This CT scan showed a 3.4 centimeter mass in the lung with enlarged lymph nodes. This type of lesion would require a biopsy. Instead of calling an oncologist and arranging for a bronchoscopy, a referral to an oncologist was made. The referral was approved and then scheduled and an oncologist saw the patient on 6/4/14.

The oncologist documented that a tissue diagnosis was necessary and recommended a PET scan and a biopsy via bronchoscopy. These tests were ordered and scheduled. For the PET scan, a preliminary CT scan was required. The CT scan was done on 6/26/14 and showed an enlarging mass suspicious for bronchogenic carcinoma. A bronchoscopy was done on 7/3/14. The tissue diagnosis was non-small cell carcinoma. Another referral back to oncology was made, approved and scheduled. The patient saw an oncologist on 8/12/14 and the oncologist recommended chemotherapy. Before chemotherapy, the patient needed an indwelling catheter through which chemotherapy would be administered. The catheter was inserted 9/17/14 and the patient started receiving chemotherapy on 9/22/14, more than 6 months after a suspicious lung lesion was identified. This type of delay could have been avoided by coordinating care and developing relations with specialist to coordinate work-ups. Unless this is done, there will be delays in treatment placing the patients at risk of harm.

After chemotherapy was completed the oncologist recommended a follow-up CT scan. This was recommended for the same day as the follow-up oncology visit. When the oncologist saw the patient 1/19/15, the oncologist recommended a 3-4 month follow-up. There was no referral request for this visit in the medical record and the last note in the medical record was dated 3/16/15. It does not appear that this follow-up appointment was ordered or scheduled.

Another patient[148] was housed at Hamilton A & I. This patient had diabetes, COPD, hypertension, coronary artery disease and risk factors for peripheral vascular disease. On 3/15/12, he began complaining about pain in his left leg from the foot to the knee. He had already had an amputation of the right leg below the knee. However, there was nothing in the chart indicating why he had the amputation. The doctor evaluating the patient took almost no history, did identify a weak pulse, but established no diagnosis and developed no treatment plan.

The patient placed 4 health requests about his left foot pain before an NP evaluated him. The NP failed to take an adequate history and didn't even palpate the pulses. The NP made no diagnosis and established no plan.

[147] Patient 1
[148] Patient 26

The patient filed his first medical grievance, stating that he wanted a second opinion because he didn't feel his care was adequate. The nurse responded that the assistant Regional Medical Director would see the patient "today". The assistant Regional Medical Director saw the patient. He was providing coverage at the facility[149]. The doctor took a very brief history, did only a brief physical examination, diagnosed diabetic neuropathy and increased the patient's Neurontin.

The patient submitted another health request form, stating that he had pain in his right leg stump and in his left leg. He then filed another grievance stating that he had lost his right leg because of not being timely attended to and didn't want to lose his left leg. The patient followed the second grievance up with another health request stating he wanted to see a specialist for the pain. The patient appeared correct in his concerns, as he appeared to have claudication and should have had a Doppler ultrasound test. A nurse responded to the grievance stating the patient was on a list to see the assistant Regional Medical Director.

When the assistant Regional Medical Director saw the patient on 4/18/12, he ordered arterial Doppler studies of the legs to evaluate for peripheral vascular disease. These were done 5/7/12 and indicated > 50% stenosis on the left leg. Given the patient symptoms, medical management should have been optimized and the patient should have been considered for a vascular surgery evaluation.

The patient wasn't seen by a provider for 4 months and when seen by an NP, the NP didn't have the Doppler studies for review and didn't address the peripheral vascular disease by history, physical examination, or therapeutic plan. A doctor saw the patient a couple weeks later and added a medication for peripheral vascular disease, but did not address exercise with the patient. The doctor noted that the patient wanted to know the results of his ultrasound study but apparently didn't discuss the test with the patient.

The patient developed leg edema consistent with heart failure and had a chest x-ray showing an enlarged heart. Because the patient had hypertension, an echocardiogram should have been done but was not. The patient developed ulceration on his right amputation stump. This was a sign of critical peripheral vascular disease, but the patient was still not sent to a vascular surgeon.

The patient was followed for about 2 more years with inadequate evaluations (poor history, physical examination, and failure to send to a vascular surgeon). In March of 2014 the patient again began writing health requests asking to see a specialist because he was afraid of losing his leg. These requests did not even result in adequate evaluations by the NP caring for him. On 3/29/14 the patient wrote a third grievance stating that he had a constitutional right and wanted a second opinion about his leg as he felt he was being ignored. He stated that if he had a second opinion he might not have lost his right leg. Finally in June of 2014, more than 2 years after he started complaining about claudication, he was sent to a vascular surgeon. Procedures

[149] See above, section on Low Levels of Physician Staff.

were performed on both legs to correct vascular insufficiency by September of 2014 about 2 and a half years after he started complaining. The patient's access to a specialist was extremely poor. Over the 2 years of care, providers appeared to lack concern about his medical complaints. The patient had a serious medical condition and was placed at risk of harm and only gained access to care by virtue of filing grievances.

Infirmary Care

Methodology: Tour facilities and inspect infirmaries. Review policies. Review records of patients on the infirmary.

Opinions:

36. Infirmary units do not have appropriate equipment and infrastructure to adequately house infirm patients.
37. The ADOC fails to adequately house the elderly and patients with significant medical conditions who cannot be safely housed in general population.
38. Infirmary units do not have adequate nursing staff.
39. Patients who should be in hospitals or skilled nursing facilities are housed on the infirmary.
40. Care on infirmary units is substandard.

Findings:

Infirmaries are locations in correctional facilities where inmates are housed who are too sick to be in general population but not sick enough to hospitalize. Generally the number of infirmary beds are 0.5-1% of the number of inmates in a correctional population.[150] There is a wide spectrum of infirmary arrangements in correctional facilities. General requirements for infirmary care include:

- RN supervision and presence;
- Being within sight and hearing of a nurse so that a nurse can immediately see all inmates on the unit and can hear them if they call for help;
- Nursing and physician interval visits based on the acuity of the patient;
- Special documentation including admission and discharge notes by physicians;
- Admission by physicians only.

Nurse staffing on infirmary units depends on the acuity of the patients. When severely incapacitated patients are present, the nurse staffing may need to increase. In general, a nurse staffing of 2.5 hours per patient day is adequate.

[150] Elizabeth Sazie, Mary Raines; Infirmary Care chapter in Clinical Practice in Correctional Medicine 2nd edition, Mosby 2006

Severely incapacitated patients may need specialized equipment. Patients on specialized treatments including chemotherapy may require nurses and physicians with specialized training. When specialized equipment or training is required and prison staff do not have that equipment or training, the patient needs to be transferred to a higher level of care so that care is appropriate.

Every one of the major facilities I toured had an infirmary. In October of 2014 the average daily census on infirmary units statewide was 144. This is slightly less than 10 patients per facility per day on average. The infirmaries I toured were all in old facilities and did not consistently have appropriate call systems, accessible toilets or showers for the disabled. The Hamilton infirmary with a large aged population is extremely crowded and does not appear to have adequate space for the numbers of infirm individuals housed there.

The OHS policy on infirmary care[151] describes a 4 color acuity scale of red, orange, yellow or green. These acuity levels do not address the levels of care, but address who admits the patient to the infirmary. Patients with red acuity status must be admitted by a physician and seen by a physician no fewer than 3 times a week, and vital signs taken and be seen by a nurse no less than every 8 hours. Admission and discharge must be by order of a physician. Patients with an orange status can be admitted for observation by a nurse but a physician order is required to keep the patient longer than 24 hours. Nursing notes and vital signs during the observation day are every 8 hours by a nurse which must be reviewed by a provider the next onsite provider day. Patients with yellow status are an assisted living status, which must be ordered by a provider. These patients are to receive vitals once every day and have a face-to-face nursing encounter once a day using an assisted living assessment tool. Only providers can discharge a patient from assisted living status. Patients with green status are sheltered housing patients. Providers need to evaluate these patients no less than every 90 days. Nursing notes intervals are not defined.

Infirmaries are locations in a correctional facility where patients can be housed whose condition does not require a level of care of a skilled nursing unit or acute care hospital but requires greater care than can be provided in the general population of a correctional facility. In several cases I reviewed, the ADOC uses the infirmary care in lieu of hospitalization even when it is dangerous for the patient. The ADOC facilities are not comparable to even skilled nursing units. The facilities are poorly designed. They do not appear to have adequate staffing. At times, there is no physician coverage and the Regional Medical Director covers the facility by phone. This is inadequate physician coverage.

The number of infirmary beds statewide is small. However, as of January of 2015, 13.6% of the population of the ADOC was above the age of 50.[152] This means approximately 3,500 inmates

[151] Alabama Department of Corrections Office of Health Services policy number G-3 Clinically Assigned Beds-Infirmary, Observation, Assisted Living, and Sheltered Housing approved 9/30/14

[152] Alabama Department of Corrections Monthly Statistical Report for January 2015, compiled and published by The Research and Planning Division found at http://www.doc.state.al.us/docs/MonthlyRpts/2015-01.pdf

are elderly. Many of these individuals will develop disabilities, advanced chronic illness, and other problems that do not require infirmary care but do require some type of protected housing. There currently is no official protected housing governed by OHS policy. Hamilton Aged and Infirm is a facility meant specifically to house the aged. But it has a rated capacity of 123 and a population of 296. It is therefore at 238% of rated capacity and extremely crowded. During my tour of Hamiltion A & I, I was told that many of the people housed there are workers. This number of beds for the aged is woefully insufficient to accommodate the numbers of elderly inmates who need protected housing in the ADOC.

Some facilities I toured had units that were set aside to house the elderly. However, these units do not have specialized rules to accommodate the elderly. As a result, many elderly live in general population type arrangements and abide by rules set up for general population inmates even when their disabilities and frailties make it difficult for them to do so. All facilities require inmates to go to a centralized dining hall and to go to the health care unit for their medication. Many elderly find this difficult to do. This is especially true since pill call occurs as early as 3 am. This ensures that many of the most vulnerable patients will have increased barriers to eat and obtain necessary medication.

Insufficient Nursing Care and Physician Coverage on Infirmaries

Infirmary care typically requires significant nursing time. This appears to be deficient in the ADOC. Patients on infirmary units do not appear to have appropriate nursing services and are often assessed by LPNs when they should be cared for by RNs. In charts reviewed, patients who needed long-term nursing care did not consistently receive it, and in one case a patient developed significant decubitus ulcers because of lack of nursing care and lack of appropriate equipment. Physician care is also inadequate. Physician vacancies at some sites are left uncovered. Some are covered by the regional or associate Regional Medical Directors who are not always present onsite. On chart reviews, I noticed significant periods where there were no physicians and the Regional Medical Director was covering the facility by phone. Some patients with serious problems that deteriorate are managed by nurses. Abnormal vital signs are not always reviewed by physicians. Even though patients who are red acuity need to be seen 3 times a week, this is a minimal requirement. At times, patients with acute deterioration were not seen on infirmary units by physicians. This causes harm to patients. Also, patients who need hospitalization are sometimes kept on infirmary units, which cause significant harm to patients. The following chart reviews demonstrate these deficiencies.

Examples of Inadequate Infirmary Care Resulting in Harm and Preventable Death

A patient[153] at the Limestone facility developed a swollen testicle. An LPN evaluated the patient on 3/17/12. The note was not signed as reviewed by an RN. This 45 year old man had a swollen testicle for 3 days. It hurt when he walked. Without contacting a provider, the nurse

[153] Patient 7

gave the patient ibuprofen and advice to sign up for sick call if the problem didn't improve. However, swollen testicles are urological emergencies that require immediate attention as the risk of testicular torsion or infection may risk loss of the testicle. This was a serious error made by a nurse not trained in assessment. This shows systemic indifference to the patients and placed the patient at risk of harm.

On 3/19/12 a provider evaluated the patient who then had an extremely swollen testicle. The provider ordered an ultrasound of the testicle with a blood count, urine test and metabolic panel with bed rest. The patient didn't have fever. Because of the size of the swelling, the patient should have been sent directly to a hospital as this was a urological emergency. The blood count was reported at 2:17 pm and showed a white count of 27 thousand and the BUN was 50 with a creatinine of 6.3 and a sodium level of 131. This signifies renal failure with significant infection. This was consistent with sepsis. Ordering tests delayed admission by at least a half day.

The patient was admitted to the hospital on 3/20/12. He was in septic shock and had an abscess in the scrotum that was obstructing urine flow and caused obstructive renal failure. There was extensive necrotic tissue and the patient required orchiectomy (removal of his testicle). The patient was discharged from the hospital on 3/27/12, but didn't see a provider at the prison after that. On 3/30/12 the patient saw an urologist and the wound was healing. However, the patient should have been evaluated at the prison on frequent basis to determine whether the wounds were healing.

On 4/1/12 the patient was admitted to an infirmary with significant post-operative wounds. On 4/3/12 the patient still had an elevated white count indicative of ongoing infection, but his renal function had significantly improved. On 4/5/12 an urologist noted that the patient still had a Foley catheter because of urethral stricture.

There was no evidence of a single provider evaluation in general population or on the infirmary between 3/27/12 when the patient was discharged from the hospital until 4/15/12. There were no nursing notes between 3/27/12 and 4/15/12 documenting nursing care on the infirmary including that the Foley catheter had been checked or that the wound or drains had been checked or cleaned. Documentation on the MAR was the only evidence that nurses had evaluated the patient. The MAR documented dressing changes from 3/29/12 to 3/30/12 and from 4/5/12 until 4/14/12. The MAR documents that the patient was allowed a daily shower from 4/10/12 until 4/14/12. This level of care is an extreme departure from the standard of care and was most likely responsible for the patient's re-infection. Wounds were not cleaned, drains not evaluated, and the catheter was not inspected. Vital signs of the patient were not done. The status of the patient was not attended to at all. On 4/15/12 an RN evaluated the patient and noted that the antibiotics ended on 4/15/12 but that the patient had extensive cellulitis. It is not surprising that he became infected. The patient was sent to a hospital.

A second surgery was required to debride necrotic tissue in the inguinal area which was infected with methicillin resistant staphylococcus aureus (MRSA). When the patient was

discharged on 4/21/12, his hematocrit was 26 and was thought to be nutritional deficiency. The discharge note recommended packing of the wounds daily and intravenous vancomycin for 2 weeks. The vancomycin was ordered by the Regional Medical Director by phone indicating that there was no physician at the site.

There was no evidence of nursing notes or provider follow-up at the facility after this second hospitalization, although the patient did follow up with the surgeon as directed. As of 6/4/12 the patient still had anemia with hemoglobin of 10.8 but no one at the facility had evaluated the patient for this problem. The only evidence of care was on the MAR. Nurses documented that except for a morning dose of vancomycin on 4/30/12, the patient received all ordered vancomycin. Dressing changes were missed 2 times in April and 7 times during May. There were no nursing notes documenting inspection of the drains, performing vital signs, or otherwise attending to the patient during this entire infirmary stay. This is an extreme departure from the standard of care. The patient was on the infirmary from 3/19/12 until 6/5/12 but there were no admission or discharge notes, no provider notes, and no nursing notes documenting care. No vital signs were taken. Recommended therapy was not consistently provided. The patient was re-hospitalized and required a second surgery because of infection most likely caused by inattention on the unit. This patient's care was managed remotely by the Regional Medical Director and there was no nursing documentation of care except for administration of medication and some dressing changes. This caused harm to the patient.

Another patient[154] had uncontrolled blood pressure for over a year when he had a stroke. This patient was briefly discussed in the hospital section. When he suffered the stroke he was unresponsive and the doctor at the prison didn't know it was a stroke. The patient had collapsed and needed cardiopulmonary resuscitation at Elmore but instead of being brought to a hospital, the patient was taken, presumably by state vehicle, to Staton. The doctor at Staton didn't admit the patient to a hospital until the following day. The delay was 26 hours. The stroke was then untreatable by then and the patient had significant brain damage. After returning to the prison the patient was sent to Kilby and placed on the infirmary on 7/31/14.

The doctor at Kilby documented that due to his severe brain damage that

> "He is likely to remain in a vegetative state [with] extremely poor prognosis. Neurology consult @ JH confirmed that nothing further can be done for him and recommend palliative care. He will be made DNR. Placed in Hospice".

The doctor made this decision without consulting someone from the patient's family. The doctor did not order any nursing management of the patient, who was apparently in a completely vegetative state. No specialized bed was ordered. Turning the patient, which prevents formation of decubitus ulcers, was not ordered. Raising the head, which prevents aspiration pneumonia, was not ordered. The patient had a Foley catheter for which there was

[154] Patient 17

no indication except convenience of the staff. The doctor did not order the Foley catheter to be periodically changed or monitored. The only nutrition that the doctor ordered was a can of Ensure three times a day with 40 cc of water.

The patient did not die and slowly recovered, but the doctor did not intensively manage the patient medically. For example, he didn't adjust blood pressure medication when the blood pressure was high, even though the patient had just had a stroke. He wrote that he would continue "supportive care, DNR/hospice". The doctor documented on an Attending Physician's Do Not Resuscitate Order that the patient was in a terminal condition and that the patient was incapable of making an informed decision. A doctor gave direction to all medical personnel to withhold cardiopulmonary resuscitation, in the event of cardiac arrest. He also directed personnel to provide other medical interventions to provide comfort care or alleviate pain.

The patient continued to live. He received no physical therapy. The nursing care for the patient was a significant departure of the standard of care for an infirmary patient. The doctor didn't write an order to turn the patient for over a month. Even after that, the nursing notes do not describe turning the patient every two hours, which should have been done. Since the patient did not have a specialized bed and wasn't frequently turned, the patient developed decubitus ulcers on his buttock and heels by early September. Later, when the decubitus ulcers were larger, nurses would occasionally check the box on their nursing documentation form that there were no skin lesions.

In late September, the patient had a fever of 100.3 with hypotension (103/62). The doctor didn't initiate treatment. Two days later the patient developed respiratory difficulty and the Foley catheter was purulent. While the patient didn't even have indication for a Foley, it wasn't changed and was now infected. The doctor started an antibiotic and wrote "supportive care only".

The patient showed signs of malnutrition (low serum albumin), renal failure and urinary tract infection. Yet the doctor still didn't intervene for these conditions.

By October the patient's decubitus ulcer was a stage 4 ulcer, which is an ulcer with exposed bone, tendon or muscle. These ulcers are often underestimated because they undermine intact skin. There was necrosis that was malodorous. At this point, a nurse initiated an attempt to get a better bed but this apparently was unsuccessful. The wound became necrotic and the necrotic part of the ulcer was 11 by 17 cm. Since the patient was incontinent, fecal matter contaminated the wound.

The patient's urinary tract infection that started in late September was treated with oral antibiotics, but the patient also had renal failure, fever, and abnormal vital signs suggestive of sepsis. Intravenous antibiotics were indicated but the doctor only wanted to provide "supportive care".

In October the doctor ordered an alternating pressure mattress. But by this time the decubiti were very large. It did not appear that the alternating pressure mattress was ever obtained. The patient developed another urinary tract infection in October and the patient's white count started elevating indicating systemic infection. By late October the white count was 51,000, which is an extremely high white blood count indicating severe systemic infection. The patient needed hospitalization. The patient became hypotensive, suggesting septic shock. Instead of hospitalizing the patient for intravenous antibiotics, the doctor added 2 oral antibiotics to the 2 oral antibiotics the doctor had already prescribed. Generally, oral antibiotics do not attain the blood levels necessary to fight systemic infection.

In early November the doctor had a conference call with the regional and assistant Regional Medical Directors. The patient had hemoglobin of 5.5, which is a life-threatening anemia typically requiring transfusion. The patient also had exceedingly high white blood count suggesting systemic infection. Although the doctor wrote that he would manage the patient's care onsite and not send to a hospital because the prognosis was poor, he added intravenous antibiotics and the patient slowly improved.

In November the patient was talking and eating. Despite these improvements, the doctor did not re-discuss the advanced directive with the patient or attempt to identify the mental status of the patient.

Nursing care remained extremely poor. The patient developed pubic and penile abscesses from the decubiti and the patient developed Clostridium difficile[155] infection. His decubitus wounds grew methicillin resistant staphylococcus aureus (MRSA) and enterococcus, a fecal contaminant. The patient even had decubitus ulcerations on his earlobes, something not typically seen even in long-term bed-ridden patients.

By March the patient developed fever with tachycardia and hypotension, signs of septic shock. The nursing care remained inadequate. On a visit to the patient, the doctor documented "pubis area wet, scrotum resting in feces". The doctor ordered "strict hygiene".

The doctor and a second physician wrote notes documenting a second "do not resuscitate" (DNR) status. The second doctor's DNR note appears to have been written remotely and did not appear to involve a physical examination of the patient.

Nursing care remained poor. A nurse documented that the wounds were necrotic with:

> "big gob of slimy slough hanging out of his right hip wound and necrotic tissue on his L hip wound and right heel"

[155] C difficile is an infection is an opportunistic infection that is promoted when antibiotic use alters the normal intestinal flora and allows this organism to thrive. It is related to antibiotic use in susceptible and weakened patients.

Nurses also describe testicular swelling and bloody fluid draining from his penis. A day before the patient died, the doctor prescribed morphine and a fentanyl patch, which appeared to be a considerable amount of narcotic. The following day the patient died.

The patient lived 8 months after his stroke. The initial DNR was based on expectation of a terminal condition. However, the patient survived and was basically a stroke victim who needed skilled nursing care. Over 8 months he failed to receive skilled care in the prison infirmary, which was not capable of managing his needs. The inability to provide skilled nursing care should have resulted in the patient being transferred to a skilled nursing facility. Instead the patient remained at the prison and appeared to endure much unnecessary suffering.

The record included medication records from February 1 through March 15 (the patient was on vancomycin from Feb 6-Feb 19), a problem list, annual health evaluations for 2011-2014, provider notes from 2/23/15, 3/3/15, 3/4/15, 3/9/15.

This patient's death was preventable. For a long period of time at the Elmore prison, the patient had uncontrolled blood pressure but did not consistently receive his medication. The uncontrolled blood pressure harmed him by contributing to his stroke. Then the patient sustained a cardiac arrest but instead of sending the patient to a hospital the patient was kept at the prison and transferred to another prison. The patient's condition was a result of a massive stroke that was most likely related to his uncontrolled blood pressure. The delay in treatment of the stroke prohibited treatment with anti-clotting drugs. Management of this episode was significantly below the standard of care. The mortality review committee should have identified the lack of adequate hypertension management and the lack of timely admission to the hospital.

Additional problems included the nursing care on the infirmary. The mortality review committee should have evaluated:

- Whether nursing staff was adequate;
- How decubiti are managed and prevented in prison infirmaries without adequate beds and equipment;

- How long-term patients receive appropriate nutritional support;
- The DNR and hospice process as it appeared that the patient was recovering and should have had his DNR status re-evaluated; and
- Whether it is appropriate to have a remote physician sign a DNR order for the patient.

This death was preventable. [redacted] The mortality review was inadequate as a means to identify problems.

Another patient[156] was diagnosed with active tuberculosis and was placed in a negative pressure isolation room in the Donaldson infirmary. These negative pressure rooms are single cells that are similar to typical prison cells and do not contain medical beds or call systems for emergencies. This patient was very ill and appeared to need a level of care of an acute care hospital. He had lost 30 pounds. He had unstable vital signs (pulse as high as 163, blood pressure as low as 80/60, and fever for weeks). He had abnormal laboratory tests (hyponatremia, elevated white count, low albumin, elevated glucose). This combination of signs indicates sepsis which is not a condition that can be safely managed at the prison. Doctors suspected him of having adrenal insufficiency, a life threatening medical emergency. To keep such a patient in a single isolation cell placed the patient at significant risk of harm. He should have been hospitalized.

At the prison infirmary, nurses sometimes only evaluated the patient daily. Physicians sometimes did not see the patient for days. The Regional Medical Director provided phone consultation when direct face-to-face management was indicated. This lack of physician coverage may have been due to insufficient staffing. An Alabama Department of Public Health (ADPH) physician managed tuberculosis care remotely via ADPH nursing staff but coordination of care between the ADPH and ADOC medical staff was not apparent in the medical records.

Mortality Review

Methodology: Review policy and procedure. Review depositions. Review death records and selected sentinel event reviews of deaths.

Opinions:

41. The ADOC has high rates of mortality but fails to adequately review mortality with an aim of reducing death.
42. There is inadequate policy on mortality review.
43. Corizon mortality review is ineffective; biased; fails to identify problems; and fails to recommend solutions to problems evident in patient deaths.

[156] Patient 13

44. ADOC lacks a patient centric advanced directive policy, procedure and practice.

Findings:

Because errors in provision of health care are a leading cause of death and injury,[157] adverse events and in particular mortality need to be studied with an aim to identify and eliminate preventable errors in provision of care. In order to study mortality, it is generally necessary to know the precise cause of death. This is determined by autopsy. For this reason, most deaths in correctional centers should include an autopsy, and the autopsy should be reviewed in conjunction with a mortality review.

Organized mortality review should be performed for every death. Participants in this review are generally senior physician, 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 illness of the patient and can be 6 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) so as to prevent the error or problem from occurring again.

When a jurisdiction contracts with a vendor to provide health services, identification of errors can be perceived by the vendor as a liability concern. When this occurs, the vendor may fail to identify errors or hide errors to reduce their liability. When this occurs, significant errors remain unaddressed. The needs of the jurisdiction and vendor are contraposed to the needs to protect patient safety. For these reason, when vendors provide medical care, the hiring authority should lead or participate in mortality review to ensure that patients are protected.

Do not resuscitate (DNR) orders relate to those individuals who are terminally ill and whose death is imminent. The order relates to whether resuscitation should be attempted in those who experience sudden cessation of heart or lung function. These orders are made after discussion with the patient and consent of the patient to the order is given. Typically, when a patient is incompetent, a family member is allowed to provide consent. These orders relate to terminal events. They do not relate to non-treatment of patient with long-term incurable condition such as multiple sclerosis, dementia, or other similar conditions. Because these types of orders involve death, unambiguous procedures must be developed to ensure protection of patients and to reduce confusion on the part of medical staff.

[157] To Err Is Human; Building a Safer Health System: Institute of Medicine, National Academy Press 2000

The U.S. Department of Justice tracks inmate deaths. For 2013, the latest year of available statistics, Alabama has the fifth highest mortality rate of all state prison systems in the United States. Alabama trails Louisiana, West Virginia, Mississippi, and Utah. Multiple deaths I reviewed were preventable, yet the ADOC does not have an adequate mortality review process. It does not demonstrate an effort to prevent unnecessary death.

Lack of OHS Involvement in Mortality Review Policy, Procedure, and Practice

The ADOC OHS does not have a policy and procedure for mortality review. The Corizon policies and procedures with respect to mortality review are disorganized and do not describe the current process. Corizon currently describes their mortality review practice as a sentinel event review.[158] However, this practice is not described in policy. The regional policies do not contain policies on sentinel event review. Corizon has a regional policy and procedure on mortality review, but it was effective in 2003 and is not consistent with current practices. As examples of facility policy, Ventress has a mortality review policy that was effective 10/1/99 and revised 1/1/11.[159] This policy is not consistent with current practices. Tutwiler has a mortality review policy that was effective 8/1/03 and has not been revised since the effective date.[160] This policy is not consistent with current practices. Tutwiler also has a procedure in the event of a death that states that, "details are outlined in the Corizon Sentinel Event Process".[161] The sentinel event process document is not in the Tutwiler policy manual, but a sentinel event checklist follows the policy. It describes steps that are apparently the current sentinel event practice. It isn't clear what the current policy or procedure is based on. There should be a standardized procedure for this process. It should be clear to all employees what the current practices are.

When an inmate dies, Ms. Naglich at OHS does not have a standardized procedure for what information is reviewed. Generally, Ms. Naglich reviews the name, date of birth, general history and who responded to the emergency.[162] In the past, Ms. Naglich did not attend Corizon's morbidity and mortality meetings.[163] She indicated that Corizon has stopped having morbidity and mortality meetings and now uses an "evidenced-based system" called STAR to review

[158] Deposition of Hugh Hood. Civil Action No. 2:14 –cv-00601 – MHT-TFM Dunn et al. vs. Dunn conducted on March 10, 2016 in Birmingham, Alabama p 242
[159] Correctional Medical Services, Inc. Company Policy and Procedure Number 10/11 Issue 6, Mortality, Morbidity, and Sentinel Event Report and Review; Effective 10/1/99 and revised 1/1/11
[160] Correctional Medical Services, Health Services Policy and Procedure Manual, Julia Tutwiler Prison for Women, Number P-A-10.01 Mortality Review, Corporate Effective Date: 08/01/03
[161] Corizon General Health Services Policy & Procedure; Tutwiler Prison for Women, Number P-A-10.00 Procedure in the Event of an Inmate Death Reviewed 09/2014, Revised 09/2014
[162] Deposition of Ruth Naglich, Joshua Dunn, et al. v Jefferson Dunn, et al. Civil Action No.:2:14-cv-00601-MHT-TFM, taken on April 7, 2016 page 107-108
[163] Id. at page 124

deaths.[164] Ms. Naglich indicated that the STAR system was used in hospitals and other systems to review deaths and that it "is based on evidence-based criteria which evaluate the outcome based on the treatment provided."[165] However, Ms. Naglich was uninformed with respect to the actual process of mortality review used by Corizon. She was asked, "Do you know what Corizon looks at for deaths in the Department of Corrections in Alabama in the morbidity and mortality review process?" She answered "No."[166]

ADOC OHS does not review Corizon mortality reviews or Corizon's sentinel event reviews for persons who have died as part of its monitoring process, but it does review the charts of persons who have died.[167] The ADOC does not currently have a physician on its OHS medical clinical staff. Its reviews of death charts therefore do not include physician participation. Ms. Naglich testified that Corizon's sentinel event review process was adequate.[168] When asked to describe the sentinel event process, she stated, "I know that they, as a result, they're identifying issues and bringing them to us".[169] Later in that deposition, Ms. Naglich was asked if she knew what the sentinel event process is, and she answered "No."[170] She also testified that she didn't know what Corizon does in its sentinel review process, what is reviewed in the sentinel event process, or whether Corizon ever identified problems in its sentinel event process. Despite a lack of knowledge of the process and despite not reviewing their reports, Ms. Naglich testified that the process was adequate.

Discontinuation of Mortality Review Meetings and Lack of Effective Mortality Review

Dr. Crocker, the previous Regional Medical Director, testified that a mortality review was conducted for every death, but a mortality review meeting did not occur for every death.[171] Sometimes he would only talk to the facility medical director. He erroneously indicated that a mortality meeting was not required. In 2013 the requirement to have mortality review meetings was discontinued. This change was not a contract requirement according to Dr. Crocker but was a change made by Corizon.[172]

Prior to 2013 the mortality review meetings were attended by the site medical director, director of nursing, the administrator and other staff selected by the administrator. The Regional Medical Director or assistant medical director would attend when possible. Prior to 2013 the mortality meetings consisted of a review of the clinical circumstances surrounding the

[164] Id. at page 125-126
[165] Id. at page 129
[166] Id. at page 132
[167] Id. at page 18
[168] Id. at pages 155-156
[169] Id. at page 156
[170] Id. at page 157
[171] Deposition of Bobby Crocker MD, Civil Action No. 2:14 –cv-00601 – MHT-TFM Dunn et al. vs. Dunn conducted on February 25, 2016, page 30
[172] Id. at page 32-33

death including chart review. Dr. Crocker couldn't remember whether a summary was completed.[173] When asked what the purpose of conducting mortality review meetings, Dr. Crocker engaged in this exchange:

> "Q. What was the purpose of doing mortality review meetings?
> A. I believe it was an expectation in the correctional world.
> Q. Okay. Do you know why?
> A. It to satisfy that expectation.
> Q That's the purpose of it?
> A. To examine the – Yeah. That's the purpose, it's an expectation.
> Q. So it's not to learn from the death?
> A. If there's anything to learn.[174]

Dr. Crocker went on to add that he could not think of any process that was changed as a result of a mortality review meeting.

Dr. Crocker further testified that after 2013 when the mortality review meetings were discontinued, the only change in the process in his mind was that the mortality review meeting was no longer required.[175] After 2013, Dr. Crocker testified that site medical directors were required to write a mortality review (case summary) of all deaths on a separate sheet of paper.[176] Also, a mortality review form with a check box format was used. These were filled out by the site medical director and sent to the Regional Medical Director, who would then discuss the case with the site medical director over the phone.

From his seven and a half years as Regional Medical Director, Dr. Crocker could not recall a single problem with quality of care identified from mortality review.[177] Dr. Crocker testified that there was no documentation of the discussion or findings of the mortality review. Dr. Crocker did testify that he would write feedback to the site medical director on the mortality review form, but also testified that the feedback was not specific.[178] An example he gave was that there may be room for education.[179] After the mortality review form was signed, it was sent to the Corizon committee that reviewed deaths. Dr. Crocker had no recollection of the name of the Corizon committee that reviewed mortality and didn't recollect any contact with the committee with respect to any questions that they might have surrounding any death. The only reason the Corizon committee that reviewed mortality contacted him was to remind him to complete the form.[180] Other than noting that the mortality review was complete, there was

[173] Id. at pages 53-54
[174] Id. at page 59-60
[175] Id. at page 62
[176] Id. at page 64
[177] Id. at page 83
[178] Id. at page 96
[179] Id. at page 101
[180] Id. at page 103-104

no discussion with the corporate sentinel event committee with respect to death.[181] After the corporate sentinel event committee reviewed the death, the case was closed. Dr. Crocker could not recall any information being returned to the Regional Office with respect to the death.[182] He did recall receiving emails with the committee's assessment of the death. When asked whether the committee ever found a problem with care he said he couldn't answer, "Because I don't remember the terminology they used."[183] This exemplifies significant disengagement of the Regional Medical Director from the mortality review process.

Sentinel Review Process

The only difference between mortality review and sentinel event review is the fact that in mortality review a patient died.[184] Sentinel events were identified by site or Regional Medical Directors.[185] Dr. Crocker described the sentinel review process as one in which a site medical director or Regional Medical Director could initiate a sentinel event review. A report would be sent to a corporate sentinel event committee, which was the same committee that reviewed mortality. The report to this committee included a narrative summary and completion of a form. After completion of the form and narrative summary, the Regional Medical Director was to discuss the case with the site medical director. The site medical director was to then write a corrective action plan and submit all this information to the Regional Medical Director corporate sentinel review committee.

The current Regional Medical Director, Dr. Hood, stated in deposition that as Regional Medical Director he had participated in all sentinel event reviews.[186] He went on to describe the STAR system. He stated that it was a web-based process in which all deaths and other non-mortality sentinel events require the site medical director to provide a narrative surrounding the sentinel event. This narrative and pertinent portions of the medical record (the last 60 days) are scanned into the STAR web-based system. Then the site medical director answers some questions in the STARS program from drop down boxes or text boxes. After the site medical director answers his questions, the Regional Medical Director receives an email notice. The regional medical then reviews the site medical director's narrative and responses and forms his own opinion with respect to whether there was a quality issue or not. The Regional Medical Director writes a comment with respect to whether he agreed or not with the site medical director.

After the Regional Medical Director reviews the site medical director's responses and enters his own comments into STAR, the corporate sentinel event committee reviews the Regional

[181] Id. at page 112
[182] Id. at page 113
[183] Id. at page 123
[184] Id. at page 138
[185] Id. at page 129-130
[186] Deposition of Hugh Hood. Civil Action No. 2:14 –cv-00601 – MHT-TFM Dunn et al. vs. Dunn conducted on March 10, 2016 in Birmingham, Alabama p 241-242

Medical Director's version and decides whether or not the death was avoidable or not and whether or not a corrective action is indicated. The sentinel event committee can ask for a corrective action plan. The sentinel event committee sends their final determination to the Regional Medical Director and to the site leadership.

Dr. Crocker would not talk about any recommendations issuing from the sentinel event committee or the mortality committee on the basis of privilege.

In her second deposition Ms. Naglich stated that generally everyone who dies within the ADOC receives an autopsy. However, there is no evidence that the autopsy results are utilized in mortality review or in quality improvement activity.[187] This has been ongoing for the prior 24 months.

Lack of Patient Centric Advanced Directives

The ADOC had a practice of allowing 2 physicians to act as a proxy for a patient in decision making for do-not-resuscitate directives. The existing OHS policy[188] on living wills and end of life care establishes that end-of-life decisions are voluntary and un-coerced. The policy states that Alabama code[189] on this matter will be followed. This is important for persons who are unconscious or otherwise unable to give consent. The Alabama code states that 2 physicians can act as a proxy for a dying patient "if no duly appointed health care proxy is reasonably available." It does not appear though that physicians executing this policy in ADOC ever attempt to talk to family members in the event the patient is unable to communicate. If patients recover and are able to effectively communicate, it does not appear that physicians attempt to revise the DNR order in line with the patient's wishes.

The Alabama code also stipulates that the physicians must certify in writing that the patient has a terminal illness or injury or a condition of permanent unconsciousness. This is not happening. In one case that is described below, the physician declared a patient DNR who was recovering from a stroke. The patient subsequently regained consciousness sufficient to carry on a conversation with a mental health worker, but the DNR status wasn't revisited.

The Alabama code also stipulates that withholding or withdrawing the life-sustaining treatment will not result in undue pain or discomfort. This does not appear to be happening based on chart reviews especially in the case of patient 17 as described below.

The ADOC also has an additional practice called "allow natural death" (AND) which presumably allows a patient to die without any medical interventions for an unspecified period of time

[187] Deposition of Ruth Naglich, Joshua Dunn, et al. v Jefferson Dunn, et al. Civil Action No.:2:14-cv-00601-MHT-TFM, taken on April 7, 2016, page 38

[188] Alabama Department of Corrections Office of Health Services Policy number I-4 Living Wills, End of Life Care, and Organ & Tissue Donation, approved 9/17/14

[189] ALA CODE §22-8A-11: Alabama Code-Section 22-8A-11 found at http://codes.lp.findlaw.com/alcode/22/1/8A/22-8A-11

before death. These decisions are made by a Corizon physician ostensibly in the same manner as required by the DNR policy. It is not clear what "allow natural death" means. What are the boundaries of the word "allow"? Does the nurse still attend to wounds and toiletry needs of the patient? Are bed-ridden patients turned frequently so they do not develop bedsores? Is pain addressed? The term does not have definition in policy but because it is used in practice, the implementation appears subjective. Because prison health programs serve a vulnerable population who depend entirely on the medical program for their care, they should be protected from any potential punitive measure that may cause harm including allowing them to die without an advocate for their protection.

As in one case discussed below, the decision AND/DNR was apparently made for a person who was not terminally ill but who had severe dementia. What does it mean to "allow natural death" to someone who has stable diabetes and hypertension but has severe dementia? This language is troubling because the potential implementation strategies of clinical staff. This practice needs to be codified in a bright line policy that includes protection of the patient's right to autonomy and maintains the best interests of the patient.

Ms. Naglich testified that this practice was not in existence. This was the testimony:

> "13 Q. Do you have any understanding of
> 14 whether there has been a practice in the
> 15 Department of Corrections -- in Corizon in the
> 16 Alabama Department of Corrections of two
> 17 physicians deciding that a person should have
> 18 a do not resuscitate order without the input
> 19 from the patient?
> 20 A. That process that you're
> 21 referring to refers to the free world. It
> 22 doesn't refer to the individual responsibility
> 23 of the Corizon's physicians.
> 1 Q. Okay. So, to your knowledge,
> 2 Corizon doesn't do that, and hasn't done that?
> 3 A. Not that I'm aware of."[190]

However, Ms. Naglich was aware of this practice because she suggested giving a AND/DNR status to one of her regional coordinators with respect to a patient that will be discussed below. This practice appears unethical and callous toward vulnerable patients.

Some death records were reviewed in other areas of this report. The following are reviews of additional death records. Review of death records show numerous problems in care and in the evaluation of care through the mortality review process.

[190] Deposition of Ruth Naglich, Joshua Dunn, et al. v Jefferson Dunn, et al. Civil Action No.:2:14-cv-00601-MHT-TFM, taken on April 7, 2016 page 109-110

Examples of the Poor Mortality Review and Failure to Recognize Deficiencies and Preventable Deaths[191]

The first patient[192] discussed in this section had a life sentence. He had dementia, diabetes mellitus, hypertension, atrial fibrillation, cardiomyopathy, prior prostate cancer, and history of heart failure.

The patient was at Staton and transferred to Bullock on 5/22/13. On the transfer form, a medical staff wrote "*is a DNR*". The patient had no terminal illnesses and the basis for the DNR status was not clear. There was no advanced directive in the record I reviewed that documented a discussion with the patient. He did have significant chronic illness but was not in a terminal state. He was able to conduct a conversation even though his dementia was significant. A DNR status relates to interventions performed for a patient at the end-of-life and relates to extraordinary efforts to maintain life. However, it appeared that the interpretation of DNR by ADOC staff was that they need not provide routine care to patients with disabling cognitive problems. The providers' position appeared to be that they could allow this individual with a serious cognitive disorder to die without providing typically routine interventions. This is a serious ethical issue. Using this logic, one would allow all nursing home patients with cognitive disorders to die without routine interventions. This is a disturbing and unsettling interpretation that appeared to have the sanction of senior ADOC administrative staff.

After transfer, the medical doctor at Bullock referred the patient to mental health for evaluation because he wasn't making sense. A psychiatrist evaluated the patient and documented that the patient had dementia. A CT scan done about a week after the patient arrived at Bullock showed brain atrophy. There was no documentation of modification of the DNR status at Bullock for this patient even though he was not terminal. His diabetes, hypertension, atrial fibrillation and heart failure were in control. The patient was not given anti-coagulation for the atrial fibrillation, but this was understandable given the risk for bleeding in someone with his condition.

The patient remained at Bullock for 20 months until his death. The initial medical record provided does not have a single medical provider progress note or chronic care note for the entire 20 months of the patient's stay at Bullock. I identified that the patient's medical record might be incomplete. [redacted] It was unclear to me whether the medical record filing system was significantly defective or whether information was intentionally withheld. The patient was evaluated in chronic care 16 times during 2013 and

[191] The discussions of care in this section are provided to give a context for opining on the adequacy of the mortality review. Additionally, the medical chart reviews are further examples of the systemic deficiencies in care discussed throughout this report.
[192] Patient 22

2014. However, providers at these visits ignored abnormal laboratory tests and did not appear to have concern regarding the progress of the patient's medical conditions. Few laboratory tests to monitor his medical condition were ordered. The patient was initially housed on an assisted living unit at Bullock and then was moved apparently to an infirmary. When he was moved, he was monitored weekly by a nurse. The notes were extremely brief and did not indicate adequate nurse monitoring of the patient at the level of a nursing home type patient. The patient had inmate helpers who provided all assistance with daily living care.

The inmate began picking at his skin and hitting his head against the wall and door. Yet when he was in assisted living the daily nursing notes sometimes described his conditions inaccurately. Nursing notes on 7/9/13 describe the patient as having a normal skin assessment. On 7/25/13 another nurse documented 20 different sores or bruises over various parts of his body. One of these was 23 by 10 centimeters in size. The patient also had a 6 by 6 centimeter head wound. Yet from 8/19/13 to 8/31/13, nursing notes describe a normal skin assessment. For none of these skin lesions did the patient see a physician. On 9/20/13 the daily nursing notes ended and nurses wrote extremely brief weekly nursing notes that did not detail the condition of the patient and did not include vital signs. The level of monitoring decreased significantly.

On 11/14/13, Ms. Naglich wrote the following to her regional coordinator Lynn Brown regarding this patient.

> "In addition, may want to look at AND/DNR status. It will have to be done by [names redacted -- site and Regional Medical Directors]. I know he is not in an acute medical state at this time, but does have other chronic issues. I would rather be proactive than reactive."[193]

As noted above, Ms. Naglich subsequently testified that she was unaware of this type of DNR or AND status. She also appeared to recognize that the patient was not terminal. The transfer summary from Staton already documented that the patient was on DNR status. There was no evidence in the medical record of a discussion of DNR or AND even though DNR status was documented. The suggestion by Ms. Naglich to place DNR/AND status on this patient was unethical because the patient did not have terminal illness and because she was not a treating physician. It also means that at the highest level, the OHS was aware of this practice and even encouraged it.

During this time and subsequently, the patient was often injured and yet there was no documentation of a provider evaluation after the injuries. Some of these injuries were significant. On 2/24/14 the patient went to a local hospital for a serious injury. There was no documentation in the medical record that the patient had been evaluated at the prison prior to the hospital visit. The hospital diagnoses were facial laceration, orbital blow out fracture, facial hematoma, facial fractures, and comminuted maxillary bone fractures. These injuries were

[193] Email from Ruth Naglich to Lynn Brown copied to Danny Gould and Martha Haynes sent 11/14/13

ascribed to a fall, but the extent of these injuries appear unlikely from a fall that could have occurred at the prison. These injuries are most often seen after fights and other serious traumatic events such as motor vehicle accidents. The patient also had 2 small subarachnoid hemorrhages which imply bleeding around the brain. Except for a nursing note accepting the patient back from the hospital, there was no record that the patient was evaluated by a provider upon return. [redacted] there were two provider notes that indicated that surgical and neurosurgical follow-ups were scheduled, but these never occurred. There was an order for short-term neurological checks by nurses, but no provider evaluation. The only pain medication the patient received after return from the hospital with these significant injuries was 2 Tylenol tablets twice a day for 3 days. There was no attempt at trying to assess whether the patient was in pain. This was cruel.

The patient experienced progressive deterioration of his renal function. He also had abnormal liver function tests. There was no acknowledgement or evaluation of these abnormalities.

A medical record document [redacted] documents that an NP documented that the patient became unresponsive in the bathroom and chest compressions were done. An EKG was not done. The NP documented that the patient had normal vital signs. It isn't clear who did chest compressions (cardiopulmonary resuscitation) and there is no note by anyone performing chest compressions. The NP documented that the patient became alert and verbal presumably after chest compressions, but because of his dementia the NP was unable to take a history. Remarkably, the NP did not order an EKG despite documenting that the patient had atrial fibrillation and cardiomyopathy and had a pulse of 58 which may indicate digoxin toxicity and just had a cardiac arrest. Persons experiencing cardiopulmonary resuscitation need to be hospitalized.

Shortly after this episode of cardiopulmonary resuscitation the patient was described by a nurse as having slurred speech. Still providers did not initiate a diagnostic effort. Within a couple months, the patient developed elevated white count indicating systemic infection. The patient became hypotensive and expired.

This patient had dementia, was vulnerable and completely dependent on the ADOC for his survival. The ADOC and Corizon decided, even though he did not have a terminal illness, that they would stop intervening medically in his care and allowed him to die, giving him a DNR status. Dementia is not a legitimate reason to make someone DNR. This is unethical and appeared to be done for the convenience of the ADOC and not for the benefit of the patient.

Documents [redacted] document that the patient was seen 16 times in chronic care clinics during 2013 and 2014. One of these visits included no heart examination. On 16 of those visits the patient was documented as having a regular heart beat even though the patient was in atrial fibrillation, an irregular heartbeat. Although the patient was unresponsive because of his severe dementia, providers documented "no" to the patient's symptoms related to cardiovascular items such as chest pain, shortness of breath, and palpitations. They could not have obtained reliable answers to these questions. The patient was on digoxin, a drug meant

to control heart rate in persons with atrial fibrillation. The levels of this drug in the blood can rise to dangerous levels if the kidney is not functioning because the drug is excreted by the kidney. Despite this the digoxin level was never documented as reviewed in 2 years. When the patient's kidney function deteriorated, the digoxin level was not assessed. This placed the patient at risk of harm. The hemoglobin A1c test, a test reflecting diabetic control, was never reviewed even when they were done. The patient had mild iron deficiency anemia and low platelets but this was never noted. The inmate's mental status was never documented. The inmate's hypertension and diabetes were documented as in fair control consistently even when his blood pressure was normal and even when there was no laboratory evidence of diabetic control documented in their note.

Although this patient with dementia was similar to many patients who reside in nursing homes, providers failed to provide reasonable care to address life threatening events. Antibiotics were provided on occasion when the patient had infection, but there were no provider notes documenting the extent of the infection, laboratory tests were not ordered, and evaluation and follow-up did not occur. The patient had an apparent cardiac arrest and possible stroke but was not sent to a hospital for evaluation. His care was a significant departure from standard of care.

[redacted] Problems that appeared in this patient's care included the following.

- The cause of the patient's dementia was never specifically diagnosed.
- The patient had DNR status but there was no documentation of this in the medical record. There were ethical issues with how the DNR status was interpreted. The OHS and senior medical leadership of Corizon supported this DNR process. The patient's family did not appear to be contacted with respect to the DNR status.
- The patient sustained significant facial trauma including multiple serious facial fractures but had no recommended follow-up with a surgeon and neurosurgeon. His pain medication was not appropriate.
- The patient experienced a cardiopulmonary arrest but was not sent to a hospital.
- Laboratory and other abnormal tests were not followed up.

The mortality review was inadequate. It failed to address multiple problems with the care of this patient.

Another patient [194] was incarcerated at least since 2007. His record started in 2014 with a few documents from earlier time periods. This patient had multiple chronic illnesses including hypertension, severe coronary artery disease with a prior myocardial infarction, heart failure, peripheral vascular disease and cirrhosis probably from hepatitis C infection. The patient had a

[194] Patient 21

known ejection fraction[195] of 25%, which is very low. The patient had evidence of cirrhosis since January of 2013 but this was unrecognized and untreated. Since the patient had hepatitis C, the patient should have been considered for treatment but was not. A further work up for cirrhosis should also have been done but was never done.

The patient appeared to have 4 re-incarcerations from 2012 to 2014. After each of these re-incarcerations, providers were not consistently aware of his multiple medical problems and failed to treat all of his conditions. It did not appear that the prior record was reviewed with each new incarceration. He was re-incarcerated in September of 2012 and was quickly transferred to Bibb. There was no medical transfer summary for this transfer. In October of 2012 a provider saw the patient for a chronic illness baseline evaluation at Bibb. He remained at Bibb until September of 2013 when it appeared he was discharged. His chronic care management at Bibb was not good. He was seen twice in chronic care from October of 2012 until September of 2013. Both evaluations were poor. On 4/12/13 a provider at Bibb stopped all blood pressure medication, stating that the patient was non-compliant. At the time this occurred, the patient received treatment for encephalopathy that can cause mental disturbance. To stop medication for non-compliance in a patient with potential for altered mental status shows lack of concern for the patient. These patients need additional supervision not discontinuation from chronic care management.

In October of 2013, the patient appeared to be re-incarcerated at Kilby, but no medical screening was documented. In January of 2014 a MAR showed the patient was at Elmore, but the MAR had no evidence that the patient received any medication. In January there were laboratory results for this patient from Staton in the medical record but there were no provider visits from Elmore or Staton in the medical record. From January through February, there was no evidence that the patient received any of his medications. On 2/20/14 the patient was hospitalized for heart failure. The patient told a hospital physician that he took no medication because he wasn't given any medication.

During the period of time from admission to Kilby in September of 2013 to just prior to hospitalization there were no provider evaluations of the patient. The patient appeared neglected.

When the patient returned from the hospital he was placed on the infirmary unit at Kilby overnight. The patient received medication at Kilby. But on 3/4/14 the patient was transferred to Elmore. There was no medical transfer summary for this transfer. There was no evidence that medical personnel at Elmore evaluated the patient. The patient received no medication at Elmore. On 3/8/14 the patient was hospitalized with hypotension. The failure to provide medication and medical supervision for this inmate resulted in harm (hospitalization).

[195] The ejection fraction is a measure of how well the heart pumps. A normal value is approximately between 50 and 70. An ejection fraction of 25% indicates a severely damaged heart.

Upon return from the hospital on 3/10/14, a doctor at Kilby placed the patient on P ward. But the patient was never evaluated by a physician at Kilby. Instead, on 3/12/14 the patient transferred to Elmore again. There was no medical transfer summary for this transfer. A doctor evaluated the patient on 3/18/14 just over a week after discharge from the hospital and did a brief evaluation and documented that the patient would be followed in chronic care clinic. On 4/18/14 there was a medical intake checklist from Limestone. The patient was subsequently released again from prison.

The patient was re-incarcerated on 12/23/14, the final incarceration of this patient. Multiple problems were unrecognized in this patient. Cirrhosis, which the patient probably had as early as 2013 was unrecognized until the patient was hospitalized in 2015. His cirrhosis wasn't treated. Initially, the patient's heart failure was unrecognized even though this diagnosis was known at an earlier incarceration.

The patient was housed on the P ward at Kilby, which is used as a type of infirmary. Examinations of the patient on this unit were poor with a physician at times writing "WNL" and drawing an arrow through the entire physical examination section even when the patient had significant physical findings. Major abnormal physical conditions of the patient appeared to be ignored.

The patient began developing swelling of the legs with ulcerations but the physician failed to appropriately diagnose this condition. The condition worsened without appropriate interventions to determine a cause of the patient's condition. The patient developed multiple sores, ulcerations, and symptoms consistent with peripheral vascular disease but was never worked up for this condition.

The patient's condition worsened over months. One day, the patient was found in his cell incontinent, not having bathed and not using prescribed oxygen. This altered mental status was not evaluated. Instead, the physician blamed the patient for not using his oxygen. The doctor did not evaluate the patient's altered mental status. The patient experienced increasing signs of deteriorating infection of his feet, was having more and more difficulty breathing, and developed generalized body swelling (anasarca). The patient's liver function tests indicated cirrhosis but this was not investigated. The patient became incontinent but the doctor did not investigate why the patient's mental status was deteriorating except to send the patient to a psychiatrist. The patient's foot ulcers became necrotic but this was unrecognized by the physician.

The deterioration continued. The patient had a fall. The day afterwards, the doctor stated that the patient had a fall and exaggerated trauma as if to imply that the patient was faking a traumatic injury. The physician's examinations often failed to identify the purulent drainage identified by nurses and often failed to identify the deterioration of the leg wounds. Nurses noted necrotic eschar tissue on one of the patient's legs, but this wasn't noted by the physician for a week. On 3/27/15 a laboratory result was reported showing elevated troponin, a sign of significant disease including possibly myocardial infarction or other serious illness like sepsis.

This test result wasn't reviewed for 3 days and when noticed, the doctor didn't immediately send the patient to a hospital, instead he ordered a repeat test. After several months of deterioration, the physician sent the patient to a hospital where the patient was diagnosed with gangrene, peripheral vascular disease, heart failure, arm deep vein thrombosis, and mild acute renal failure. The patient had an amputation of one of his legs below the knee. The description of the hospital physician was:

> "blackish discoloration of the skin over all of his toes and also all over the foot area with a large ulcer over the dorsal aspect of the right foot with pustular foul-smelling wound base. He also has pus drainage from the intertriginous area between his toes."

This description is in stark contrast to the prison doctor's description of the patient at the prison. The prison doctor's care was significantly below an acceptable standard of care.

When the patient returned to prison, the care did not improve. The doctor appeared not to know that the patient had a deep vein thrombosis and wrote that the patient was on deep vein prophylactic therapy. The doctor failed to properly monitor the patient's anticoagulation and at one point when the patient had bleeding from the stump, the doctor sent the patient back to the hospital.

The patient did not stay long at the hospital as the prison doctor asked to have the patient returned to the prison. When the patient returned to the prison it was recommended he continue intravenous antibiotics. But because an intravenous line could not be inserted, the doctor changed the patient to oral antibiotics. Oral antibiotics do not attain the same blood levels as intravenous antibiotics and are typically an unacceptable substitute. The patient didn't do well. He was not evaluated daily and deteriorated. He fell on the floor of the toilet but wasn't evaluated by a physician. Review of the case report of this patient in the appendix gives a more in-depth portrayal of the lack of physician care for this patient. At one point the patient asked to be re-hospitalized but was not. Ultimately, the patient developed signs of sepsis with blistering ulcerations of the non-amputated leg but was still not admitted back to the hospital. When the patient returned to the vascular surgeon's office, the surgeon immediately hospitalized the patient. The patient was septic with heart failure and needed the opposite leg amputated due to infection. The patient was discharged again on 3 intravenous antibiotics. The patient had lost both legs below the knees in part from inattention to his condition.

The patient wasn't seen timely by a physician upon return from the hospital and received only 2 of 3 of the recommended antibiotics. There were no medication administration records in the medical record so I couldn't verify that the patient received the 2 intravenous antibiotics that were ordered. The patient returned to prison with an indwelling Foley catheter. But it did not appear from review of the medical record that the doctor gave orders to monitor the Foley catheter and may not have recognized that the patient had a Foley catheter. The patient appeared incoherent and was making noises but there didn't appear to be an attempt to find out why this was occurring. Nursing notes showed signs of a urinary tract infection (cloudy

urine) which was not brought to the doctor's attention. The patient was not monitored adequately for any of his problems. After almost 2 weeks back at the prison, the patient developed fever, deteriorating kidney function, abnormal urine testing, and an elevated white blood count which indicate sepsis from urinary tract infection. These abnormalities weren't timely evaluated. More than a day after the patient had laboratory and clinical signs of sepsis, a life-threatening condition, the patient was sent to the hospital again.

At the hospital the patient had septic shock with multi-organ involvement and an acute myocardial infarction. The sepsis was secondary to urinary tract infection, most likely caused by the indwelling Foley catheter that was not being monitored. The urine was turbid with crusting around the catheter and the catheter was removed. It does not appear to have been changed at the prison and the doctor didn't appear to know that the patient had a Foley catheter. On physical examination at the hospital the patient was unresponsive. He had extensive edema throughout his entire body and was weeping fluid from his skin because of the excessive edema. There was edema from the jawline down. There was 4+ weeping edema of all extremities. The patient was obtunded. There were areas of breakdown along the incision lines of the bilateral lower extremities. The description of the patient by physicians at the hospital is a stark contrast to descriptions of the patient as documented by the prison doctor in his physical examination notes verifying the lack of concern for the patient at the prison. The patient's level of anticoagulation (INR) was exceedingly excessive in part because it was not monitored at the prison. The patient was hospitalized for 5 days.

On the first day back from the hospital on 5/26/15, the doctor ordered that the patient be made DNR. Two weeks after return from the hospital, the patient was able to engage in a conversation with the mental health counselor. Despite this, the doctor did not re-engage with the patient to discuss the DNR status. The DNR status continued and medical staff stopped interventions. The patient died about 6 weeks after return from the hospital.

Care for this patient was significantly below the standard of care on multiple levels. The death was preventable. The decision to allow the patient to die without intervention was unethical as it did not involve consent of the patient or a reasonable patient proxy. The patient appeared coherent after his infection resolved, but there was no attempt to have a discussion with the patient about advanced directives.

[redacted] It appeared to me that the physician caring for the patient should have been subjected to peer review for performing below standard of care. While I found multiple problems with care of this patient, [redacted]

Another patient[196] was a 72 year old male with a history of hypertension, high blood lipids and prior insertion of 2 coronary stents. The intake history on form 2 by an LPN was poor and failed to identify hypertension and high blood lipids as active problems. Later, an RN completed a form 4 intake screening form and failed to identify high blood lipids as one of the patient's problems. The NP performing the physical examination took no history at all but commented that the patient had prior coronary artery stents. The intake history and physical examination was inadequate.

On 5/27/13 the patient placed a health request complaining of swollen feet. The LPN evaluating the patient documented that the patient had had swollen feet for a year. This was only a week after intake screening when swollen feet were not identified. The NP next evaluating the patient ordered a chest x-ray, but an echocardiogram was indicated as the patient had hypertension and heart disease and swollen feet are a sign of heart failure. This test was not ordered.

The patient was transferred to Bibb. On 4/19/14, an LPN evaluated the patient for chest pain. The patient described 10 minutes of left sided chest pain that was crushing and constant. He had no associated nausea or shortness of breath. The blood pressure was slightly elevated at 145/79. This should have been referred to a physician. Instead, the LPN gave the patient Zantec and Mylanta and ordered a nurse follow-up. The symptoms were consistent with myocardial ischemia. LPNs are not trained to perform independent assessments and an RN did not review the LPN assessment. Having LPNs perform these types of assessments places patients at risk of harm which happened in this case.

A physician did see the patient on 4/21/14, but the note was extremely brief. The patient denied current chest pain or shortness of breath. The doctor documented that the patient ate a hot dog and felt like he did when he had a stroke in 2012. He had 15 minutes of left chest pain with diaphoresis but no shortness of breath and no nausea. Although this is consistent with cardiac ischemia, the doctor diagnosed non-cardiac chest pain. The doctor wrote that the patient should return to the clinic if he had any problems and at that time he would be sent to the ER or cardiology. An EKG in the record shows STT wave changes that were different from a prior EKG done in May of 2013 and consistent with ischemia. Typical chest pain with a changed EKG consistent with ischemia should have prompted admission to a hospital for acute cardiac syndrome workup. At a minimum, the doctor should have started or increased anti-angina medication and scheduled an urgent stress test and referral to a cardiologist. This was not done.

About a month later, on 5/19/14 the patient collapsed and experienced cardiac arrest and died. [redacted]

This death was possibly preventable.

[196] Patient 19

I reviewed the mortality review committee folder for this death. [redacted]

This review was inadequate. There were several additional problems with this death:

- The intake process failed to identify all of the patient's problems. Although these were identified later, it does point out the inadequate intake process.
- On 5/28/13 the NP should have ordered an echocardiogram as the patient had signs of heart failure.
- LPNs should not be performing independent assessments. The staffing plan for this facility should have been evaluated with respect to RN staff. If RNs are unavailable, the option can be to send patients with urgent problems to an emergency room. This is a significant systemic deficiency and should have been identified. [redacted] However, referral to a provider should have been immediate. If a provider could not immediately evaluate the patient, the patient should have been sent to an emergency room.
- [redacted]

[redacted] This failure may have caused the patient's death. There was no criticism of the physician but there should have been a peer review and comment in his credential file.

This mortality review was inadequate.

Another patient[197] was a 42 year old man without identified problems. His intake medical records were not available. On 5/10/14, he placed a sick call request for upper abdominal pain and burning sensation with a bloated feeling for a week. The blood pressure was 140/92. An LPN performed the evaluation. The LPN gave OTC medication by protocol but no referral.

On 5/12/14 an NP saw the patient and noted that the patient complained of gas and bloating. His BP was 150/88. The NP did not address the elevated blood pressure. The NP prescribed Prilosec, simethicone, and advised the patient to notify medical if pain worsened. The NP did not treat or order follow-up for the elevated blood pressure.

On 8/30/14 an LPN evaluated the patient emergently. The patient woke up sweating and felt nauseated with back pain. He vomited 3 times. The nurse took no other history. The nurse assessed possible acid reflux. These symptoms are consistent with myocardial ischemia. An LPN would not be expected to know how to take a history and should not have been placed in a position to perform independent assessments because LPNs do not have this training. The nurse documented that the patient was supposed to be on Prilosec but wasn't taking the medication. An EKG was done and the physician was notified. The EKG was consistent with anterolateral ischemia with sinus bradycardia. The EKG was faxed to the physician. The nurse documented that the doctor wanted the patient to see a nurse practitioner in the morning. The physician, upon review of the EKG, should have taken a better history over the phone. Because of the EKG and the symptoms, the patient should have been referred to a hospital for immediate evaluation of acute coronary syndrome.

On 9/2/14 an NP evaluated the patient in follow-up of the 8/30/14 nurse evaluation. The NP took a very poor history. The NP documented that the patient said he sweat on one side of his body and had an episode of nausea and vomiting over the weekend that had since resolved. The NP documented that the patient had been dealing with sweating over the past 10 years. The NP did a brief examination and diagnosed resolved gastroenteritis. The history of the NP was insufficient to make the diagnoses of gastroenteritis. The NP did not review the EKG that showed ischemic changes and took no history of cardiac symptoms despite those changes. This failure was a critical error.

On 9/7/14, the patient was found on the floor vomiting and seen by a nurse at 9:38 am. The documentation in the medical record is poor. It isn't clear what happened to the patient.

[197] Patient 23

There was a hospital general information sheet for the patient but no other information. The patient died 9/7/14.

[redacted] However, this patient's death was most likely preventable. There were multiple problems including the following.

- The EKG was abnormal and indicated anterior ischemia. This should have been recognized and treated.
- The LPN initially examining the patient was not trained in nursing assessments and should not have been performing an independent assessment of the patient.
- The nurse consulted a physician and faxed the EKG to the physician. The physician should have asked further questions of the patient based on the symptoms obtained. Based on the EKG the physician should have referred the patient to a hospital for evaluation. This fell below the standard of care.
- The NP seeing the patient in follow-up failed to take an adequate history. The NP did not evaluate the EKG. This evaluation fell below the standard of care.
- A month later when the patient collapsed and was found on the floor, the documentation of the nurse did not include documentation of whether cardiopulmonary resuscitation was initiated or when the emergency medical services arrived. This documentation was below standard of care.

The sum of these errors resulted in the patient not reaching a higher level of care that might have saved his life.

[redacted] This is an inadequate mortality review.

Infection Control

Methodology: Review of patient medical files with respect to tuberculosis, review of the RFP, review of policies and procedures, review of Alabama Department of Public Health (ADPH) documents with respect to tuberculosis and scabies, review of depositions, and interview with officials from the ADPH.

Opinions:

45. ADOC lacks adequate policy on infection control.
46. The failure of the ADOC to address infection control type problems has resulted repeatedly in the outbreaks of infectious or contagious disease. These outbreaks

resulted in the Alabama Department of Public Health assuming control of investigation of these outbreaks because of inability of ADOC to manage the problem.

47. Corizon medical leadership has not assumed responsibility for management of infection control issues necessitating intervention by the Alabama Department of Public Health.
48. ADOC does not protect inmates or staff from exposure to contagious tuberculosis.
49. ADOC does not protect inmates from exposure to scabies.
50. ADOC undertreats hepatitis C with anti-retroviral medication.

Findings:

Incarcerated individuals have higher rates of contagious diseases as compared to the civilian community. This includes tuberculosis, HIV, and hepatitis C. Being incarcerated is a risk factor for tuberculosis and hepatitis C. For this reason, it is essential for correctional systems to make infection control part of their health program.

Tuberculosis screening is institutionalized in correctional health care programs. The Centers for Disease Control has a specific correctional guideline for management of tuberculosis. Screening for tuberculosis has improved in correctional centers over the years. In my experience, there are few cases of tuberculosis that develop during incarceration. Almost all cases of tuberculosis should be identified at intake screening. When large numbers of tuberculosis cases develop within a prison system, it indicates a breakdown of screening and surveillance systems.

Routine voluntary screening for hepatitis C is recommended. Current standards of care for hepatitis C recommend treatment with anti-retroviral medication for all patients with this disease except those with short life expectancies.[198] Standards of management for persons with cirrhosis are consistent with Federal Bureau of Prisons (FBOP) guidelines, which are supposed to be the standard in the ADOC.

Scabies is a skin infestation with a mite and is a transmissible disease. Overcrowding, infested bedding and clothing, and person-to-person direct contact are the typical means of transmission. These infestations are common in correctional facilities but at low rates. Infection control measures including quick identification, change of bedding and clothing, and typical infection control practices including surveillance and sanitation keep these infestations at low rates.

Because inmates have high prevalence of contagious and infectious disease, infection control programs are typically an essential feature of a correctional medical program. In larger systems, an infectious disease physician directs the infection control program with nursing staff reporting to the physician. In smaller systems, nurses manage the infection control program

[198] HCV Guidance: Recommendations for Testing, Managing, and Treating Hepatitis C; American Association for the Study of Liver Diseases and Infectious Disease Society of America, April 2016 version as found at http://hcvguidelines.org/full-report-view

and report to a staff physician. In all correctional health programs I have evaluated or managed, the internal correctional health program manages infection control surveillance and outbreak control. When a state or local department of health becomes involved in outbreak management, it indicates a serious breakdown of infection control practices.

Lack of a Formal Infection Control Program

The ADOC does not have a dedicated or independently organized infection control program. Ms. Naglich testified that the ADOC did not have an infection control nurse.[199] There is no ADOC policy with respect to infection control.

The various responsibilities of infection control are distributed to various individuals and are not under a single responsible person. The responsibilities fall on 3 separate entities: the ADOC, the Alabama Department of Public Health, and Corizon. The greatest responsibility falls on the vendor, Corizon.

Ms. Naglich testified in a deposition that two of her assistants who are Regional Clinical Managers have some responsibilities for infection control.[200] Ms. Naglich testified that Mr. Brandon Kinard is the coordinator for infectious disease and Ms. Laura Ferrell is a Regional Clinical Manager responsible for policy and procedure coordination with Public Health.

Mr. Kinard, the ADOC Regional Clinical Manager Northern Region, testified however that he only has minimal responsibilities for infectious disease. Among his duties in managing the Northern Region, he is responsible for coordinating care for hepatitis B and C.[201] This involves tracking all persons who are referred as candidates for treatment of hepatitis B and C and reviewing them with the treating infectious disease physician. This responsibility includes monitoring the cost of hepatitis C medications. He also secures hepatitis B vaccine and distributes it to various facilities. He also reports tuberculosis cases to the Alabama Department of Public Health (ADPH) but does not track tuberculosis infections. He also reports scabies infections and sexually transmitted disease infections to ADPH, but has no other infection control duties including reporting of other reportable conditions. Alabama has 64 conditions for which there are mandatory reporting requirements. Based on depositions, it is not clear who is responsible for these reporting requirements.

[199] Deposition of Ruth Naglich, Civil Action No. 2:14 –cv-00601 – MHT-TFM Dunn et al. vs. Dunn conducted on April 7, 2016 page 148
[200] Id. at page 20
[201] Deposition of Brandon Kinard, Joshua Dunn, et al. v Jefferson Dunn, et al. Civil Action No.:2:14-cv-00601-MHT-TFM, taken on January 12, 2016

Failure to Designate an Individual Responsible for Infection Control

The responsibility for infection control appears to rest with the medical vendor. The scope of work in the RFP[202] requires that the vendor maintain an infection control program. Yet the minimal staffing requirements[203] of the medical contract with Corizon do not include a single individual dedicated exclusively to infection control. The RFP set out the requirements of the infection control program.

> "5.24 (A) Infection Control Program
> Vendor will establish a comprehensive Infection Control Program based on Centers for Disease Control and Alabama Department of Public Health regulations and ACA and NCCHC guidelines.
>
> a) The program will include Vendor's infection control processes and activities as related to surveillance, prevention and control of infections, employee training and education, and reporting processes, in accordance with state and federal law.
>
> b) Vendor will provide a copy of their Infection Control Manual, with supplemental updates, to the ADOC.
>
> c) At each facility, the site Medical Director will designate a specific medical services staff member to assist in establishing, maintaining, and monitoring an Infection Control Program. The use of tracking logs is expected, i.e., Skin Infections and Wound Care.
>
> d) The site Medical Director will be the facility chairperson of the Infection Control program and committee. Vendor's State-wide or Regional Director of Nursing will coordinate the dissemination of information related to a potential compromise in infection control. Upon the confirmation of communicable infection or disease of an inmate, the ADOC Office of Health Services Regional Clinical Managers, Director of Medical Services, and/or Associate Commissioner of Health Services will be notified prior to contact with the Alabama Department of Public Health, when feasible."[204]

Even though Corizon is responsible for establishing a comprehensive infection control program, it appears that this effort has no dedicated staff. Also, Corizon does not provide clear and unambiguous guidance with respect to infection control. The Corizon infection control program is described in the company's Infection Prevention Manual.[205] This manual consists of 23 policies. The policies are generic Corizon corporate policies that are not specifically written for Alabama. As with other corporate Corizon policies, the infection control procedure details a series of questions meant for the local regional office to fill out. However, the infection

[202] Item 5.1 (A) Purposes of the Project-Medical Services item X found on page 47 of Alabama Department of Corrections Request for Proposal No. 2012-02, Comprehensive Inmate Health Care Services Issued July 17, 2012
[203] Appendix A, 2012 Contract between Alabama Department of Corrections and Corizon, Inc.
[204] Alabama Department of Corrections Request for Proposal No. 2012-02 Comprehensive Inmate Health Care Services, July 17, 2012 page 64
[205] Corizon Infection Prevention Manual Dunn(Corizon)_02506

prevention manual provided to me did not have the questions filled out. So, for example, the second question in the procedure details of the Infection Surveillance policy[206] states, "Who (by position title) is responsible for maintaining the list of communicable diseases reportable to the local Public Health Department?" This is not filled out. In the Corizon regional policy manual, the policy for infection control[207] states in the NCCHC procedure statements that there is an infection control plan approved by the Medical Director located in the Corizon Infection Prevention Manual. But there is no infection control plan in the Corizon Infection Prevention Manual.

Dr. Crocker, the former Regional Medical Director, did not include responsibility for infection control in his list of responsibilities.[208] So presumably, the term medical director in the policy refers to site medical directors. The St. Clair policy[209] on infection control states that the Medical Director or designee is responsible for creation and approval for the facility exposure control plan and that this exposure control plan is located in the Corizon Infection Prevention Manual. However the manual does not have an infection control plan. This is policy that lacks guidance on how to manage infections at the facilities.

Impact of Infection Control Deficiencies on Tuberculosis Outbreaks

The St. Clair facility that recently had an outbreak of tuberculosis has multiple infection control policies. The latest policy[210] states that details of the infection control program are addressed in the Corizon Infection Prevention Manual. It also states that the infection control committee (or designated staff member) meets as part of the Quality Improvement Committee and provides written reports to the Quality Improvement Committee. For specific procedures the St. Clair policy refers to the CMS Infection Control Manual. The policy refers to the manual but the manual does not have specific information. This is confusing and ineffective guidance.

The St. Clair policy on management of tuberculosis[211] is a 2008 policy that has not been updated. It includes a list of questions from the regional policy that are supposed to be filled out by the site but were not. Based on this evidence in the St. Clair policy manual, there is no policy on tuberculosis at St. Clair, a site where there has been a major tuberculosis outbreak.

---

[206] Corizon Infection Prevention Program Policy & Procedure, Alabama Regional Office, policy number IP-10.10 Infection Surveillance, issued 10/29/12 with no revisions.
[207] Corizon General Health Services Policy & Procedure, Alabama Regional Office policy number P-B-01.00 Infection Control Program, issued 10/29/12, last revised 11/27/13
[208] Deposition of Bobby Crocker MD, Civil Action No. 2:14 –cv-00601 – MHT-TFM Dunn et al. vs. Dunn conducted on February 25, 2016, page 19-21
[209] Corizon General Health Services Policy & Procedure, St. Clair Correctional Facility, policy number P-B-01.00 Infection Prevention and Control Program, reviewed and revised 09/2014
[210] Id.
[211] Correctional Medical Services Health Services Policy & Procedure Manual, St. Clair Correctional Facility, policy number P-B-01.02 Management of Tuberculosis corporate revision date 10/1/08, site implementation date 06/30/09

The effectiveness of an infection control program in a correctional program is evidenced by the ability of the program to identify and treat and to prevent transmission of infectious and contagious diseases among the inmates residing in its correctional facilities. The ADOC has a program of screening all incoming inmates for tuberculosis, treatment of all tuberculin skin test (TST) positive inmates with prophylactic therapy and annual TST of all previously negative inmates. Despite this, since 2010 there have been 38 cases of active tuberculosis in ADOC facilities. This includes 2 major tuberculosis outbreaks; one at Donaldson in 2010 and one at St. Clair in 2014. These outbreaks demonstrate the failure of the tuberculosis screening programs, failure of infection control within the ADOC, and the lack of an effective infection control program. The ADOC has acknowledged this deficiency in the St. Clair vulnerability analysis. The report states:

> "The recent discovery of active TB cases has shown a vulnerability to be able to control infectious diseases within the facility. Due to the way the disease spreads it is dangerous to all persons inside the facility. The active disease prevents the movement of inmates out of the facility, which in turns hinders the ability to transfer inmates to other facilities for custody reductions, remove inmate enemies from the facility, assist other facility by accepting higher level security inmates, etc. This situation is further exacerbated by the lack of negative pressure housing areas."[212]

When these outbreaks of tuberculosis occurred, the infection control infrastructure within the ADOC was ineffective. As a result, the Alabama Department of Public Health (ADPH), needed to intervene to assist in controlling the outbreaks. This is an extraordinary step that reflects an ineffective and poorly managed infection control program within the ADOC. The relationship with the ADPH is not codified in any policy or procedure of OHS or Corizon.

The ADPH performs genotyping of all tuberculosis organisms that it isolates. Genotyping consists of microbiological analysis to determine the DNA gene sequence of tuberculosis organisms. Due to the manner of reproduction of the mycobacterium organism, almost all cases of a new TB organism have identical DNA to its progenitor organism. This allows for detection of transmission of organisms between different patient-cases and to identify the source of reactivation of tuberculosis in patients who had been infected in the past.[213] The combination of genotyping and epidemiologic surveillance data are the analytic tools used to control outbreaks and to possibly identify root causes of outbreaks.

[212] Alabama Department of Corrections, Institutional Vulnerability Analysis: Saint Clair Correctional Facility, ADOC066909

[213] Guide to the Application of Genotyping to Tuberculosis Prevention and Control, Handbook for TB Controllers, Epidemiologists, Laboratorians, and Other Program Staff, Prepared by the National Tuberculosis Controllers Association / Centers for Disease Control and Prevention, Advisory Group on Tuberculosis Genotyping June 2004 as found at http://www.cdc.gov/tb/programs/genotyping/images/tbgenotypingguide_june2004.pdf

Tuberculosis Outbreaks at Donaldson and St. Clair

Based on the genotype analysis of cases in the ADOC from 2010 through part of 2015, it is clear that there were at least 2 major tuberculosis outbreaks. Nine of the 38 cases of tuberculosis did not yield a genotype; these cases were clinically diagnosed. Of the clinical cases, it appeared that 5 were related to the St. Clair outbreak and 2 were related to the Donaldson outbreak. Of the 29 cases with known genotype, 8 were from the St. Clair outbreak that started in 2014 and 12 were from the Donaldson outbreak which started in 2010. The Donaldson outbreak genotype continues to persist in the system. Not counting the clinical cases, this genotype caused at least 6 cases in 2010, 3 cases in 2012, 2 cases in 2014 and 1 case in 2015.

Tuberculosis is a slow growing organism, which is why it takes 6 months to a year to complete treatment. The organism divides slowly and must be exposed to the antibiotics for an extended period to ensure that newly reproducing organisms are killed. When a person has active tuberculosis disease, if the infection is in the lungs, coughing can cause release of the TB organism in an aerosol which when air borne can be inhaled by others in close proximity. The crowded facilities of the ADOC promote transmission of tuberculosis. When a person inhales the aerosolized TB organism, the organism can reside in the lungs and become walled off by host cells. This walled off complex prevents the infection from becoming active disease. At a later date, if the immune system of the host is lowered, this walled off complex can reactivate and cause active tuberculosis disease. Once the host has inhaled the TB organism and it is walled off, the presence of this early stage of infection can be detected by a screening skin test or a blood test. When either of these tests is positive and the chest x-ray does not show active infection, the person should be offered anti-tuberculosis preventive therapy. The evidence of genotyping shows that both the immediate detection of tuberculosis disease as well as the follow-up screening and prophylactic treatment of infected individuals was deficient and caused harm to multiple inmates and probably staff as well.

The genotype list for Donaldson TB cases is evidence that there has been transmission of the mycobacterium tuberculosis organism within the facility which caused multiple cases in 2010. As well, it shows that there have been reactivation cases of tuberculosis 2, 4, and 5 years later. This verifies that screening and prophylactic treatment programs are also defective.

How these types of outbreaks occur should be subject to investigation and root cause analysis to determine what operational defects need to be remedied to prevent such an occurrence from happening again. A main problem with the ADOC approach to these outbreaks is that they appear to deny that they even have a problem. In a deposition, Ms. Naglich testified on the issue of the number of cases of TB at Donaldson.

> "18 Q. In its most recent TB outbreak.
> 19 A. You keep using the word
> 20 outbreak.
> 21 Q. Uh-huh.
> 22 A. And I'm not aware of a large

23 number of TB cases, which I would refer to as
1 an outbreak. So I guess that's what's gotten
2 me a little confused here."[214]

Ms. Naglich was also asked whether the diagnosis of cases at Donaldson in 2014 having the same genotype as cases found at Donaldson in 2010 gave her any concern. The following is the testimony.

"Q. Okay. All right. Did the
12 diagnosis of cases at Donaldson in 2014 that
13 were of the same strain as were found at
14 Donaldson in 2010 give you any particular
15 concern?
16 A. Understanding the incident of
17 latent TB, it did not give me any concern.
18 Q. Okay. Did it give you any
19 concern about the screenings that were being
20 done?
21 A. No.
22 Q. Did it give you any concern
23 about people who had tested positive but not
1 been treated?
2 A. If you're referring to this, it
3 doesn't state no one was being treated.
4 Q. Do you recall that we looked at
5 a study done by Corizon in 2010 that indicated
6 that 59 percent of the people who had tested
7 positive had not -- could not have it verified
8 that they had received any treatment?
9 A. I do remember.
10 Q. Okay. When you discovered in
11 2014 that someone at Donaldson had the same
12 strain of TB that had been at Donaldson in
13 2010, did that give you any concern about
14 there not being treatment for people who had
15 tested positive?
16 A. No."[215]

She also testified the following.

[214] Deposition of Ruth Naglich, Civil Action No. 2:14 –cv-00601 – MHT-TFM Dunn et al. vs. Dunn conducted on April 7, 2016 in Montgomery, Alabama pages 279-280
[215] Id. at page 279-80

"Q. Have there been -- Do you have
13 any concerns today about the way tuberculosis
14 is being addressed in the Department of
15 Corrections?
16 A. No."[216]

Mr. Ken Dover, the Vice President of Corizon in Alabama, also appeared to deny the existence of an outbreak of tuberculosis. He testified as follows:

"23 Q. If there was an outbreak of
1 some sort of disease, like tuberculosis for
2 example, would that be conveyed on this
3 report?
4 MR. LUNSFORD: Object to the
5 form.
6 A. An outbreak?
7 Q. Yes.
8 A. I don't know about an outbreak."[217]

The reasons for the tuberculosis outbreaks appear to stem from 2 major causes. The first cause is a failure of the TB screening and surveillance. This includes intake screening, annual screening, and appropriate management of positive skin test cases. The second cause is a failure to identify and diagnose active cases of tuberculosis before they spread the disease to others. This is a problem of competence of the medical staff. The effectiveness of the isolation rooms may also be a problem but because the monitoring data was not made available, I was not able to evaluate that aspect of the program. Failure to recognize and address these issues will result in continuation of outbreaks of tuberculosis.

Ms. Naglich testified that in 2010, Corizon did an evaluation after the TB cases at Donaldson that showed that over 2,800 people had prior positive TB skin tests. About a third of the 2,800 had not had an initial TB screening, and a third of 2,800 had not had annual TB screening. She also testified that, of those with a positive test, 17% did not have a positive tuberculin skin test listed on their problem list, and that 59% of persons with positive skin tests did not have prophylactic treatment verified.[218] This describes a significant systemic problem of tuberculosis control and prevention. These types of defects are verified in an email obtained from the Alabama Department of Public Health regarding skin testing at the Fountain facility regarding a tuberculosis investigation at that facility, which stated:

[216] Id. at page 281
[217] Deposition of Ken Dover, Civil Action No. 2:14 –cv-00601 – MHT-TFM Dunn et al. vs. Dunn conducted on February 24, 2015 in Birmingham, Alabama page 57-58
[218] Deposition of Ruth Naglich, Civil Action No. 2:14 –cv-00601 – MHT-TFM Dunn et al. vs. Dunn conducted on April 7, 2016 in Montgomery, Alabama pages 262-63

> "I concluded skin test reading for employees at Fountain this past Friday evening. Every employee has been accounted for in some way. There were numerous issues regarding this investigation that were problematic. Most of it centered around documentation from the medical facility. Tests were read but were not documented, negatives were misread (many of those tested this past week said they had the same red/indurated reaction on the first round but was told it was negative), positives were read but not reported or x-rayed, etc."[219]

In chart reviews there was also evidence of inaccurate tuberculin skin testing. One patient[220] had a 20 mm positive TST in 2007; 0 mm in 2013; 15 mm in 2014; and 0 mm in 2015. This test result should not go from positive to negative to positive to negative. These results indicate an inaccuracy in recording or performing tuberculosis skin testing. To deny that these problems exist results in a persistence of the problem.

Examples from Chart Reviews of Poor Tuberculosis Clinical Care and Infection Control Practices

A chart review of the index tuberculosis case in one of the tuberculosis outbreaks also provides evidence of serious deficiencies in clinical care and tuberculosis management. The patient[221] described here had been incarcerated in the ADOC for years. Based on the medical record, it wasn't possible to determine when he was first incarcerated. The problem list documented that on 3/22/07 he had a positive tuberculin skin test of 22 mm. On 8/20/10 someone documented on the problem list that the patient was non-compliant with tuberculosis preventive medication. Presumably, this should have been offered in 2007 so the sequence of events wasn't clear and the medical record provided to me did not include documents from those years. Documentation from the ADPH stated that the patient had completed only a portion of his preventive therapy for tuberculosis. However this information wasn't identified by ADOC staff when it occurred. In fact, the medical coding for the patient in 2011 indicated that the patient had no critical non-compliance issues.

On 1/2/12, when the patient was at St. Clair, an LPN evaluated the patient for coughing, vomiting and a running nose. The LPN who by license is not trained in assessments used the wrong NET tool (upper respiratory) to evaluate the patient and concluded that the patient had a common cold and cough. The nurse did not ask specific questions about the cough and stated that the tuberculosis skin test was not applicable to his complaint. The nurse did not document the weight even though the patient complained of vomiting. The nurse gave the patient antacid and cold pills. This LPN evaluation was not reviewed by an RN.

[219] Email dated 09/26/2011 at 03:06 pm from Kimberly Taylor ADPH to Eric Morgan and Pam Barrett
[220] Patient 21
[221] Patient 13

On 2/19/12, another nurse evaluated the patient for complaints of nausea and vomiting. The patient apparently wanted something for a cold and when the nurse wouldn't give it, an argument ensued and the patient left the clinic in anger.

On 6/7/12, a nurse evaluated the patient for nausea and vomiting and a cold. The nurse didn't weigh the patient. On 8/21/12 a nurse performed a TB screening form and checked "no" to all symptom questions. The nurse did not document the usual and present weight, which was supposed to be documented.

On 12/31/12 the patient complained of chest pain and productive cough which was evaluated by an LPN on 1/1/13. The patient had fever of 100.8 and gave a weight of 137 pound. The nurse didn't ask about weight loss even though this was a prompted question on the NET tool. The only history was to check some of the boxes on the formatted questions. The nurse checked as positive the questions about productive cough and fever. The nurse referred to a provider. This evaluation didn't occur. The refusal form was signed by officers not the inmate.

On 1/16/13 the patient placed a health request complaining of chest pain and productive cough. A nurse wrote a brief response on the health request documenting that she gave cold tablets and a pain medication to the patient and referred to a mid-level provider. On the NET tool the nurse failed to take a weight.

When an NP finally saw the patient on 1/23/13 the history was inadequate. The only examination conducted was to listen to the lungs. The NP ordered a chest x-ray and ordered antibiotics. The chest x-ray showed two-lobe pneumonia and was signed as reviewed on 1/25/13. On the same day as the review of the x-ray a provider ordered a different antibiotic. On 1/29/13 the NP saw the patient in follow-up. The patient still had cough. The NP listened to the lungs but performed no other examination. This evaluation was inadequate for a person with 2 lobe pneumonia, which is a more extensive pneumonia. A blood count, blood gas test, oxygen saturation, metabolic panel and follow-up x-ray were indicated. Questioning the patient about tuberculosis would have been expected especially in a correctional facility. The NP ordered a follow-up visit in a week. This follow-up never occurred and the patient wasn't seen for about a year. The patient probably had tuberculosis at this time and for the subsequent year was infecting patients and staff who were being exposed to tuberculosis without their knowledge. This harmed many individuals and placed many, many individuals at risk of harm.

A year later, on 1/7/14, the patient had trouble breathing. The patient complained of productive cough and weight loss although the nurse failed to take the patient's weight. The patient's pulse was 131 and the blood pressure 90/80. These values should have resulted in an immediate physician evaluation as they suggested sepsis, possibly shock, or an unstable patient. Instead, the nurse called a physician who ordered parenteral Rocephin and oral Levaquin for 10 days by phone. This is a significant departure from standard of care in that a patient with unstable vital signs and unstable presenting symptoms was treated without a face

to face evaluation. The patient should have been sent to a hospital if a physician wasn't available to evaluate the patient. This placed the patient at risk of harm.

On 1/8/14 the patient had still not been evaluated by a physician and complained on a sick call request that he had lost 30 pounds and was very weak. The nurse charged the patient a co-pay fee and evaluated the patient. The nurse identified a pulse of 123 and a weight of 110 pounds verifying the approximate 30 pound weight loss. The nurse referred the patient to a physician. To charge the patient for a clearly urgent evaluation is cruel.

A provider didn't see the patient until 1/10/14. The doctor appeared to use the vital signs obtained by the nurse on 1/8/14 for his evaluation. The doctor noted abnormal lung sounds in the right lung and ordered a chest x-ray and started intravenous Rocephin and continued the Levaquin. The doctor did not order any other tests (CBC, metabolic panel, blood culture, oxygen saturation and blood gas) that are typically ordered to evaluate a person with suspected pneumonia. This falls below the standard of care.

The patient was admitted to the infirmary for 23 hour observation but remained there apparently for 3 days without being seen by a provider. Vital signs on the infirmary were abnormal and suggested hypotension and tachycardia suggestive of sepsis. The patient had serious illness and needed to be hospitalized but was not. This placed the patient at significant risk of harm. No blood tests were ordered and a physician didn't evaluate the patient daily on the infirmary.

Even though the patient should have been seen daily, there were no notes in the record between 1/12/14 and 1/15/14 when a chest x-ray was ordered. The x-ray showed bilateral interstitial infiltrates with a large cavitary lesion in the left upper lung. TB and cancer were suggested and a CT scan was recommended. The doctor at the prison wrote on the x-ray report "agree" and he ordered a CT scan. This was a significant departure from standard of care. If the x-ray suggested tuberculosis, the patient should have immediately been hospitalized and isolated. Instead the doctor ordered a CT scan which was not completed for a couple weeks. The request for this test was not in the record but the test was done on 2/4/14. The results showed a cavitation on the right with lower lobe infiltrate strongly suggestive of tuberculosis. The ADPH notes on this patient state that he lost about 34 pounds, going from 150 to 116 pounds and had massive loculated cavitary infiltrate with dissemination of tuberculosis through the right and left lungs. The patient wasn't transferred to negative isolation at Donaldson until 2/5/14 a day after the test. As a result of these failures, many individuals acquired tuberculosis infection and some acquired active pulmonary tuberculosis disease. This incident harmed many individuals and placed many others at risk of harm.

This patient's care demonstrates the incompetent management of a patient with signs and symptoms of tuberculosis. The patient had signs and symptoms of tuberculosis for over a year but failed to have a diagnosis made. Nurses failed to perform adequate assessments of health requests on 5 occasions in 2012 and 2013. A tuberculosis screening in late 2012 by a nurse failed to ask about weight loss. In January of 2013, an NP failed to follow up on a patient with

two lobe pneumonia for over a year. In 2014, the patient had serious abnormalities suggestive of serious infection and should have been hospitalized yet was kept at the prison without physician monitoring for several weeks. When an x-ray suggested tuberculosis, the physician failed to immediately isolate the patient. These multiple clinical failures resulted in an extended period of time when the patient was infectious and transmitting tuberculosis to numerous inmates and probably employees as well. This case should have resulted in a peer review and a root cause analysis of the reason why his tuberculosis was missed. This systemic incompetence resulted in harm to the patient with tuberculosis and to many other individuals who acquired active tuberculosis and many others who acquired tuberculosis infection.

Despite the clear deficiencies in his care, Ms. Naglich had no concerns about assessments of the patient with respect to his evaluation and subsequent identification with pulmonary TB. From Naglich's testimony the patient received adequate care.

> "Q. Okay. Did [name redacted] receive
> 14 adequate medical care?
> 15 A. I didn't provide that medical
> 16 care. He saw licensed practitioners who
> 17 prescribed that care. And he had access to a
> 18 physician as well as a nurse practitioner. So
> 19 I would say, yes, he did receive adequate
> 20 care."[222]

Access to a physician does not alone define adequacy of care. When the person responsible for oversight of health care in the ADOC believes that this care was adequate, it indicates significant indifference because the care was obviously substandard.

[redacted]

[redacted]

[222] Deposition of Ruth Naglich, Civil Action No. 2:14 –cv-00601 – MHT-TFM Dunn et al. vs. Dunn conducted on April 7, 2016 in Montgomery, Alabama page 275

The ADOC tuberculosis screening form already has adequate questions. The issue is that appropriate staff does not ask the questions properly.

The medical records that were reviewed for this case included (1) ADPH documents about diagnosis of TB; (2) the 2/14/14 CT scan report; (3) the contact investigation of the ADPH from 2/4/14; (4) an infirmary admission of 2/6/14; and (5) laboratory data confirming TB and the initial labs on admission to the infirmary.

Notably the 2013 episode and the physician's initial evaluation of 2014 and a review of care of the patient after admission to the negative pressure room at Donaldson were missing from review. The sentinel event review committee did not issue a report but only a feedback page that did not include who conducted their review.

[redacted] When a doctor reviews his/her own work, there is a higher probability that mistakes will be overlooked, which occurred in this case. [redacted] the doctor who failed to immediately isolate the patient for tuberculosis in early January of 2014 when the patient had signs and symptoms of tuberculosis and a chest x-ray consistent with tuberculosis. This was a critical error showing significant clinical deficiency but was ignored [redacted] This mistake resulted in many individuals being exposed to tuberculosis.

In this case, the quality of the nursing and physician care were not addressed. On multiple occasions in 2012 and 2013, nurses performed poor health request evaluations that may have identified tuberculosis. The lack of staffing appears to have contributed to having LPNs perform these evaluations when they are untrained to do so. Nurse assessment quality was deficient and should have been part of the corrective action.

Failure to successfully schedule the patient for follow-up after the first incident of pneumonia in early 2013 was a significant failure. The patient was apparently scheduled but there was no follow-up. The system blames the patient for this failure but they failed to evaluate their own processes to identify if there were errors. A patient with 2 lobe pneumonia should never be lost to follow-up.

The care of the patient in the negative pressure room at Donaldson was also extremely deficient. It appeared that there was inadequate physician coverage and the Regional Medical Director managed some of the care by phone. The patient was very sick and needed a level of nursing and physician care that was unavailable at the facility. Specialized tests (testing for adrenal insufficiency) were not properly done. Abnormalities were not attended to. Laboratory and other diagnostic testing were not performed as needed. These elements of care were not addressed in the sentinel event review.

The apparent lack of physician and nurse staff was not considered as a root cause of some of the physician and nursing deficiencies but this appears to have contributed to this deficiency.

Counseling of the physicians caring for the patient with respect to significant clinical errors did not take place. When this does not occur the system does not improve.

The paper medical record is a significant factor that was also ignored. High percentages of tuberculosis screening records are not present in the paper records. This system needs an electronic medical record.

Since 2006 it has been recommended that treatment of latent tuberculosis be provided by directly observed therapy, which was not done in ADOC. There is no evidence in the medical record that the patient received directly observed therapy. This was not part of the corrective action plan.

Dr. Crocker, the Regional Medical Director for Corizon during this episode, appeared to blame the patient for the development of tuberculosis. He indicated that the patient was non-compliant with tuberculosis treatment, didn't seek treatment for weight loss, and failed to come back for follow-up treatment. Dr. Crocker suspected that the patient had TB disease about 2-3 months prior to his ultimate diagnosis.[223] This shows a lack of responsibility, indifference, and a failure to critically review the case. The failure to acknowledge error is a significant impediment to improvement.

Another patient[224] was a 69 year old man with a history of emphysema. This information comes from ADPH tuberculosis reports. He was housed at the Limestone facility from 12/18/00 until 1/18/11 when he transferred to Hamilton A & I, where he was housed when he was hospitalized for chest pain. He had a prior positive tuberculin skin test in 1980 for which preventive therapy was completed. Department of Health records show that he had abnormal chest CT scans and x-rays beginning in February of 2010. These studies showed interstitial fibrotic changes, but beginning in April of 2010 interstitial infiltrates began to appear. The patient apparently was not worked up for these pulmonary abnormalities until he was admitted to Brookwood Medical Center on 9/21/11 for chest pain over a year later. Hospital clinicians documented that the patient had over 100 pounds weight loss over a 4-5 year span of time. If this was due to tuberculosis, it suggests long-standing disease. The patient underwent cardiac catheterization which showed multi-vessel coronary artery disease. The patient was not a candidate for stent placement and was considered a poor risk for bypass surgery. While hospitalized, a pulmonologist was consulted and hospital records document that the pulmonologist discussed follow-up with a provider at Hamilton A & I. On 9/22/11, tuberculosis smears were collected and reported as positive at the hospital at 5:29 pm on Friday 9/23/11. The hospital discharged the patient on 9/23/11, which was a Friday, but the patient was not isolated at Kilby until Monday 9/26/11. Both his smear and culture results were positive for Mycobacterium Tuberculosis. He was placed in isolation at Kilby on 9/26/11 and died shortly after tuberculosis treatment was initiated. The Department of Public Health reported a positive probe for tuberculosis disease. This inmate's tuberculosis genotype was unique with respect to the other identified infections. This inmate was most likely contagious for a considerable period of time while at Hamilton A & I as well as at Limestone.

Hepatitis C

Besides tuberculosis, there are other infection control issues present in the ADOC. It is estimated that the prevalence of hepatitis C infection in correctional facilities is between 16% and 59%.[225] The March 2015 Monthly Client Report[226] reported that there were 2,398 known

[223] Deposition of Bobby Crocker MD, Civil Action No. 2:14 –cv-00601 – MHT-TFM Dunn et al. vs. Dunn conducted on February 25, 2016 in Atlanta, Georgia pages 274-77
[224] Patient 24
[225] Altice F, Douglas B, Hepatitis C Virus Infection in United States Correctional Institutions, Current Hepatitis Reports- August 2004, 3:112-118
[226] Corizon Health Alabama Regional Office Monthly Client Report, March 2015 page 19

hepatitis C cases in the state of Alabama prison system. The population as of March 2015 was listed as 25,860. This means that the prevalence rate of known hepatitis C is 9%. This implies that hepatitis C is probably significantly under-diagnosed in the ADOC. Although the ADOC tests incoming inmates for HIV, syphilis, PAP smear for females, Chlamydia and gonorrhea, inmates are not screened for hepatitis C even though more inmates have this condition, even though national public health agencies recommend voluntary routine screening, and even though adequate treatment is now available.

The ADOC has a policy for the evaluation and treatment of hepatitis C.[227] This policy states,

> "The current (2012) Federal Bureau of Prison Guidelines (FBOP) for the management of Hepatitis C is to be utilized in the evaluation, and consulted, in the appropriate treatment modalities."

The current FBOP guidelines are from 2016. However, in reviewing those guidelines, the FBOP recommendations include in part:

1. Voluntary testing of all sentenced inmates
2. Vaccination for hepatitis A and B for all hepatitis C positive inmates
3. Assessment for fibrosis and cirrhosis
    a. Inmates with APRI score of 2 can be used to identify cirrhosis and these inmates should have abdominal ultrasound
    b. All inmates with cirrhosis should have a CTP score given
4. For those with cirrhosis
    a. Offer pneumococcal vaccine
    b. Perform liver ultrasound every 6 months to screen for hepatocellular carcinoma
    c. Perform esophagogastroduodenoscopy (EGD)
    d. Non-selective beta blockers for prevention of varices
    e. Antibiotic prophylaxis if risk factors present for spontaneous bacterial peritonitis
    f. Optimized diuretic therapy for ascites
    g. Lactulose and Rifaxmimin for encephalopathy
5. Prioritize patients for treatment based on AST to Platelet Ratio Index (APRI)[228] and Child-Turcotte-Pugh (CTP) scores [229]

While the ADOC OHS policy requires hepatitis C screening for persons at risk of hepatitis C, they do not identify risk factors in their screening assessments. Risk factors for hepatitis C include:

- Past or current intravenous drug use

[227] Alabama Department of Corrections, Office of Health Services policy number B-1 (c) Hepatitis C Evaluation and Treatment approved 8/25/14

[228] The AST to Platelet Ratio Index (APRI) is an algorithm to identify the patient's risk of liver fibrosis and cirrhosis using routine blood tests. This avoids the necessity of biopsy in determining fibrosis.

[229] Evaluation and Management of Chronic Hepatitis C Virus (HCV) Infection, Federal Bureau of Prisons Clinical Practice Guidelines, April 2016 as found at https://www.bop.gov/resources/pdfs/hepatitis_c.pdf

- Prior blood transfusions
- Long-term hemodialysis
- Born to a HCV-infected mother
- **Incarceration** [my emphasis]
- Intranasal drug use
- Getting an unregulated tattoo
- Any percutaneous blood exposure[230]

Both the CDC and the US Preventive Task force consider incarceration a risk factor for hepatitis C. This implies that all inmates should be screened for hepatitis C. However, with the exception of incarceration, the ADOC intake forms asks only 1 question about other risk factors for hepatitis listed above. Form 2, the New Arrival Intake Screening form has no questions about hepatitis C risk. Form 4, the New Arrival Intake Screening form does not address these risk factor questions except to ask if inmates abuse drugs. There is no box on Form 4 or Form 3 to indicate that inmates were vaccinated for hepatitis B or A, which are recommended for persons with hepatitis C. It appears from the current intake screening process that a significantly smaller number of hepatitis C inmates will be identified, and the prevalence supports that thesis.

With respect to chronic clinic evaluations for hepatitis C, the most that providers appear to do in the evaluation of patients with hepatitis C in chronic clinic is to document that patients have the disease. Even this is not always done. I could not find evidence of providers documenting that persons with hepatitis C have received vaccination for hepatitis A and B. Based on chart reviews, persons with hepatitis C do not have evidence of receiving treatment consistent with item 4 above. In charts I reviewed of patients with hepatitis C and obvious cirrhosis, providers did not even identify that the patient had cirrhosis much less undertake screening evaluations listed above. The management of cirrhosis appears to be significantly below the standard of care.

Few persons are actually treated for hepatitis C. Because of newer more effective medications, the Infectious Disease Society of America (IDSA) recommends treatment with anti-viral medication for all persons with hepatitis C infection except those with short life expectancies.[231] Because the new anti-viral medications are extremely expensive it is not unreasonable to have a graded protocol for initiating treatment. However, the ADOC treats an extremely small number of individuals. Mr. Kinard testified that the ADOC treated only 20 patients for hepatitis C in 2015 out of over approximately 2,400 (less than 1%) individuals with this condition. This is a very small number of individuals treated.

[230] Moyer V; Screening for Hepatitis C Virus Infection in Adults: US Preventive Services Task Force Recommendation Statement; Annals of Internal Medicine September 2013; 159: 349-357 found at file:///C:/Users/mpuisis/Downloads/hepcfinalrs2%20(1).pdf

[231] HCV Guidance: Recommendations for Testing, Managing, and Treating Hepatitis C; Infectious Disease Society of America and American Association for the Study of Liver Diseases found at http://www.hcvguidelines.org/full-report-view

The ADOC policy on hepatitis C treatment states that the site medical directors are to notify the northern regional clinical manager, Mr. Kinard, of patients who meet the criteria for evaluation for hepatitis C treatment. The northern clinical manager consults with a consulting physician to decide who is to be treated. This policy does not define criteria for evaluation or the criteria for treatment. The Treatment Referral Form that is used for purposes of this communication has a number of laboratory items and criteria items. In chart reviews, I could not find evidence of its use by providers evaluating persons for hepatitis C. This process appears to be established to be a barrier to treatment.

Cases Demonstrating Lack of Adequate Treatment of Hepatitis C

As an example, one patient[232] appeared to be incarcerated sometime in 2007. He had a hepatitis C infection. In January 2012, the patient had an APRI score of 1.35, suggesting significant fibrosis and cirrhosis was possible. At his next chronic clinic visit on 3/7/12 the provider listed hepatitis C as in fair control but did not check whether the patient had been vaccinated for hepatitis B or A. By December of 2012 the APRI score was over 3 and indicative of likely cirrhosis. The patient was not evaluated for treatment of hepatitis C and his cirrhosis was unrecognized as a problem by providers. The cirrhosis wasn't recognized until a hospital admission in June of 2013. Hepatitis C interventions were not done and this condition was ignored by ADOC medical staff for much of his stay. He was never vaccinated for hepatitis A and he never had an ultrasound to verify the diagnosis of cirrhosis.

After staff concluded he had cirrhosis on clinical grounds, they failed to intervene with standard of care interventions for cirrhosis. These include ultrasounds every 6 months to evaluate for hepatocellular carcinoma, use of a beta blocker for esophageal varices prevention, pneumococcal vaccination, and an EGD. The patient was also never vaccinated for hepatitis A. The doctors continued to follow the patient every few months for his disease, ordered laboratory tests and watched the patient deteriorate until he developed end-stage liver disease. He was asked if he would consider treatment after he developed end-staged cirrhosis. At that time the patient wasn't sure he wanted treatment.

Scabies

Scabies is an infestation caused by a mite. The mite burrows under the skin, feeds and lays eggs which hatch resulting in advancement of the infestation. The infestation causes severe itching and results in linear arrangements that result from the mite's burrowing movements. These infestations are mostly diagnosed by clinical examination. An experienced clinician can identify characteristic lesions and areas of involvement. These infestations are common in correctional centers due to crowded conditions and unsanitary bedding. Rates in Alabama, however, are extraordinary, and are higher than any scabies rate I have ever seen. Alabama is

[232] Patient 9

an extremely overcrowded prison system. Scabies appears endemic at very high rates and affects a significant number of individuals.

Medical Advisory Committee (MAC) meetings report on the certain infectious diseases. For Easterling in 2015, they reported 362 cases of scabies over 11 months of 2015. As of January 2015, there were 1,525 inmates incarcerated at the Easterling facility. 362 cases yield a prevalence of 24% of the population infested with scabies at some point during the year. This is extraordinary. This is an extremely high infestation rate and speaks to the ongoing overcrowding and lack of sanitation and proper bedding.

This extraordinary rate of infestation at Easterling followed an outbreak of scabies at the Ventress facility in 2013. The 2013 Ventress outbreak was documented on a Quality improvement report. The Ventress Correctional Facility Continuous Quality Improvement notes on scabies dated January 15, 2014 documents that there were 539 (34%) confirmed cases of scabies at the Ventress which had a population of about 1600 inmates.[233] The ADPH investigated this outbreak. The ADPH review[234] of this outbreak and their investigation of the outbreak resulted in a document in which the ADPH identified a number of existing problems in the ADOC with respect to scabies. Some of the identified problems included:

- Inadequate hot water and equipment to properly sanitize clothing;
- Failure to follow physician directions to treat active cases;
- Charging for health care discouraged inmates with active scabies from coming forward for treatment;
- Failure to screen incoming inmates for scabies;
- Failure to follow an appropriate scabies treatment guideline specifically the Federal Bureau of Prison's scabies guideline.

Conclusion

As outlined above, I have concluded that the Alabama Department of Corrections medical program fails to provide adequate and safe health care to individuals incarcerated in its prisons system-wide. This failure places inmates at risk of harm and causes harm, including death. The inadequacies are widespread and systemic. They are found within every essential component of the health care program, including the moment an inmate enters the ADOC at intake, through routine and chronic care, infirmary and emergent care and, for the most serious cases, in care for the dying and sentinel event review. These problems should be addressed through changes to the system of medical care delivery.

[233] Ventress Correctional Facility, Continuous Quality Improvement Scabies 2013-2014: Date of Report: January 15, 2014 Document ADOC0144568

[234] ADOC Scabies Situation and ADPH Recommendations document number 001373- 001377

Appendix A

APPENDIX A[235]

Facility	Designed Capacity	Month End Populations	Occupancy Rate	Date of Opening/Construction[236]
Holman	581	802	138%	1968-69
Death Row Holman	56	158	282.1%	
Kilby	440	1288	292.7%	1969
St. Clair	984	1220	124%	1983
Tutwiler	417	692	165.9%	1942
Female Death Row (Tutwiler)	5	5	100%	
Donaldson	968	1456	150.4%	1982
Death Row Donaldson	24	21	87.5%	
Limestone	1628	2228	136.9%	1984
Bibb	918	1901	207.1%	1997
Bullock	919	1585	172.5%	1987
Draper	656	1204	183.5%	1939
Easterling	652	1515	233.4%	1990
Elmore	600	1176	196%	1981
Fountain	719	1255	174.5%	1955
Hamilton Aged and Infirmed	123	270	219.5%	1981
Montgomery	192	290	151%	
Staton	508	1374	270.5%	1978
Tutwiler Annex	128	250	195.3%	
Ventress	650	1311	201.7%	1990
JO Davis Minimum Security	250	394	157.6%	
Alex City Work Center	35	56	160%	
Atmore Work Center	112	247	220.50%	

[235] The Design Capacity, Monthly End Population, and Occupancy Rate were obtained from Alabama Department of Corrections Monthly Statistical Report for March 2016 (Fiscal Year 2016) found at http://www.doc.state.al.us/docs/MonthlyRpts/2016-03.pdf

[236] Based on information obtained from the facility tabs at the ADOC website at www.doc.state.al.us

Birmingham Work Center	30	129	430%	
Camden Work Center	15	125	833.3%	
Childersburg Work Center	151	251	166.2%	
Decatur Work Center	37	440	1189.2%	
Elba Work Center	15	24	160%	
Frank Lee Work Center	109	139	127.5%	
Hamilton Work Center	25	51	204%	
Loxley Work Center	120	217	180.8%	
Mobile Work Center	15	63	420%	
Red Eagle Work Center	104	336	323.1%	
Alex City Work Release	145	178	122.8%	
Birmingham Work Release	120	141	117.5%	
Camden Work Release	40	50	125%	
Childersburg Work Release	176	186	105.7%	
Decatur Work Release	91	250	274.7%	
Elba Work Release	40	172	430%	
Frank Lee Work Release	119	157	131.9%	
Hamilton Work Release	91	153	168.1%	
Loxley Work Release	175	271	154.9%	
Mobile Work Release	135	158	117%	
In-House Totals	**13318**	**24770**	**186%**	

Appendix B: Description of Facilities

Holman

The Holman facility opened in 1968. Excluding death row inmates, Holman is designed to house 581 inmates but in March 2016 it housed 802 inmates (138% of design capacity). The death row unit has a design capacity of 56, but houses 158 (282.1% of design capacity). Holman's medical unit was designed and built before 1968. All medical rooms I toured were poorly designed, cluttered and poorly sanitized. The design features of this medical unit were inadequate for a contemporary correctional medical program. The medical clinic was extremely small and there was insufficient space for the existing staff to work in and provide safe and effective medical care. Except for the medication room, none of the other rooms in the medical clinic appeared to have doors that were functional or in place so it appeared that no medical evaluations occurred in privacy.

At one end of clinic was a medication room that I was not permitted to enter to inspect. Next to the medication room there were 2 carts that were described to me as medication carts for death row inmates. Although these carts were locked, they were left in an open hall that civilians and custody staff had access to. I was told that the cart contained narcotic medication.

There was a single examination room that had a gurney. I was told that the doctor and other staff used this room. This was the only examination space with an examination table even though there were up to four different clinical staff who might simultaneously need to evaluate patients. The single examination room was shared by nursing staff, the mid-level provider and the physician. However, this meant that for parts of every working day, nursing or provider staff might evaluate patients without benefit of an examination table which promotes lack of necessary physical examination. There were no doors for this room and it was open to several other rooms or halls; it did not appear to me that a private patient interview could occur in this room. The examination room did not have fixed equipment such as oto-ophthalmoscope or blood pressure cuff.

There was a space of approximately 50 square feet across from the examination room that was adjacent to a hall but had no door. This was used by nurses to performed charting and other nursing tasks. This space also contained telemedicine equipment. When the telemedicine unit was in use, a portable screen was used to separate the nurses from the telemedicine activity. There would be no sound privacy under these conditions. This space was inadequate for its stated purpose.

There was no designated space specifically intended for use by nurses conducting nursing sick call and review of health service requests. I was told that the nurse with this assignment worked in the very narrow hall interviewing the inmates in a chair. Alternatively the nurse could use the single examination room when not in use. Because there may be a physician, nurse practitioner, and 1-2 nurses simultaneously examining patients, there are insufficient

examination rooms to conduct routine care. Except for the doctor's examination room, none of the rooms had examination tables.

In another very small room there was a portable x-ray machine. This room was open to the hall and I wasn't confident that x-rays would not expose staff or other inmates walking down the hall. I was not permitted to interview a staff member to adequately determine how the process of taking x-rays occurs and whether the staff working in this area took appropriate precautions when x-rays were being taken. I did not see nursing or other staff in this area wearing radiation dosimeter badges.[237] The x-ray equipment was portable. The quality of portable x-rays is not equivalent to standard x-ray units and should not generally be used as a substitute for routine radiology studies.

Office space was extremely limited. The only office space in this unit was for the Director of Nursing. However, this office was very cluttered and doubled as a storeroom for supplies, break room, and contained the staff refrigerator and photocopy machine. The medical records room was too small to hold all paper records so only the most recent folder of active records for each inmate was kept in this room. Older volumes of active records were stored elsewhere. The medical record clerk was not a certified medical record technician.

Holman has a small infirmary. These beds share 2 buzzers to notify nursing of problems. A buzzer is not available for each individual bed. The shower is not American Disability Act (ADA) acceptable because there was a large (approximately 6 foot by 8 foot) concrete platform on which the shower unit was built. Inmates with movement disorders or disabilities utilizing wheelchairs would not be safely able to take showers.

I also toured one of the units where medically disabled inmates were housed. The showers and commodes for this unit were not ADA acceptable. The water nozzle for the shower was gerrymandered with a short piece of hose and the location and spacing of the hot and cold handles was not positions so that someone with a disability could effectively use this system. Also, I turned on the water and was not able to obtain reasonably hot water. Wall mounted grab bars did not appear to be ADA acceptable.

Tutwiler

Tutwiler is an all-female facility. Tutwiler and Tutwiler Annex have a combined design capacity of 545 but house a population of 942 (173% of design capacity) as of March 2016. Tutwiler opened over 73 years ago in 1942.

Tutwiler's overcrowding and aged infrastructure are significant impediments with respect to provision of adequate medical care. Many of the rooms in the medical unit appear to have

[237] Radiation dosimeter badges are wearable devices that monitor the amount of radiation exposure sustained by an individual working in an area where x-rays are taken in order to determine whether staff is not exposed to harmful doses of radiation.

been initially constructed for other purposes and have been remodeled haphazardly in attempts to create space for necessary programs.

The medical records room is too small to hold all current medical records. This room is extremely cluttered and appeared disorganized. Medical record files are placed on shelving that covers all walls and extend to the twelve foot high ceiling. Staff uses a large ladder on wheels to reach the upper shelves but there are multiple boxes of papers and desks on the floors so that the ladder can't be moved to another location without rearranging the boxes and desks that are on the floor. Only the latest file of active records is kept in this room. Earlier files of a patient's medical record are stored elsewhere. While I was not permitted to ask staff about the organization of the record and operational aspects of the medical records program, the unit appeared to be disorganized and unsuitable for an effective medical records operation.

Immediately adjacent to medical records is a room used for dialysis. Clearly, this room was not built or originally intended for dialysis. This room has two dialysis chairs, dialysis equipment and supplies, as many as two concurrent patients, and a nurse all cramped into approximately 70 square feet. One of the chairs has a leg extension that when extended is directly in the path of the swing of the door to the room. There is insufficient space to safely navigate this passage during dialysis with or without a wheelchair.

The Department of Veterans Affairs promulgates guidelines for construction of dialysis units.[238] These guidelines can be used as a benchmark for requirements of dialysis centers. The guidelines recommend 150 net square feet (NSF) for each isolation negative pressure bed, 80 NSF for each cubicle chair station, 80 NSF for storage of clean supplies, 100 NSF for equipment storage, 20 NSF for a crash cart alcove, 110 NSF for nurse station, and 80 NSF for storage of sterile supplies. A net square foot is the gross square footage of the room minus square footage of any fixed obstructions or equipment. This room is significantly less than 70 NSF but for 2 chairs would need well over 500 square feet. Even though some of these numbers could be reduced to pro-rate to the number of beds, I do not see how the square footage of the Tutwiler dialysis room can reasonably meet standards. This room does not appear to meet recommendations for square footage for a single chair discounting requirements for space for supplies and staff work areas. With respect to ADA requirements, it did not appear possible for a person on a wheelchair to navigate through the maze of obstacles in this room to safely reach a dialysis chair. When Ruth Naglich was asked whether the dialysis chairs at Tutwiler met all licensing requirement, she said she didn't know.[239]

This room was extremely cluttered and did not appear adequately sanitized. The door between the dialysis unit and the medical records unit was open during our tour and I don't understand how potential cross contamination between medical records and dialysis could be prevented.

[238] PG-18-19: Space Planning Guide, March 2008, Revised October 01, 2015; Chapter 316: Dialysis Center as found at http://www.cfm.va.gov/til/space/SPchapter316.pdf

[239] Deposition of Ruth Naglich, Joshua Dunn, et al. v Jefferson Dunn, et al. Civil Action No.:2:14-cv-00601-MHT-TFM, taken on April 7, 2016, page 146-147

It appeared that patients enter dialysis through medical records. The room used for dialysis was so cramped that it was difficult to understand how proper contamination procedures could occur within this room. The Alabama State Board of Health requires that an isolation room be provided for all Hepatitis B antigen positive dialysis patients. [240] This unit has no isolation unit but I was prohibited from asking staff whether they perform dialysis on patients with hepatitis B. Supplies do not appear to be properly or safely stored to prevent contamination. The room does not appear to be ADA accessible. It is my opinion that this unit, as configured and used, would not be permitted to be used for dialysis for non-incarcerated individuals in the United States and should not be used as a dialysis unit at Tutwiler.

The infirmary unit has a shower area for patients in the same room as the janitor's closet such that cleaning equipment is placed in the same room where patients wash. The infirmary also had no accommodation for sound privacy such that it did not appear that any medical interview was conducted in private.

The clinic examination spaces were also not apparently originally intended as examination spaces and were open bay like arrangements that did not promote privacy. Nurses performing sick call evaluations evaluated patients in chairs in a common busy hallway making privacy impossible and prohibited nurses from evaluating patients on an examination table which is a standard of care in correctional and civilian environments.

I was not permitted to enter the pharmacy room, so could not evaluate its adequacy. I did review the showers in the ADA dormitory housing disabled women. The shower nozzles were modified in an attempt to make the shower ADA accessible. However, when a patient would sit properly and safely on the bench intended for the disabled, the shower spray from the modified nozzle only reached the feet of the person taking the shower. In order to have the shower spray reach their body, the person taking a shower would have to move off the bench negating the intended safety measure of the bench. This affects the hygiene of inmates negatively and places them at safety risk of either adequately washing and placing themselves at risk for fall or inadequately washing and placing themselves at risk of lack of hygiene. I confirmed this as a problem in inmate interviews. One inmate who was diabetic and had an amputation for bone infection indicated that transferring in the shower was difficult and that she had to stand on her one leg in order to properly wash. She indicated that she had fallen several times. She also said that it was difficult to transfer to the commode or shower required hopping which is not safe. Another inmate with an amputation indicated that although she had not fallen in the shower, she had people help her into a chair which she sets in the shower as opposed to using the ADA bench. This person complained for inability to rinse soap off due to low water pressure in the facility.

[240] Rules of Alabama State Board of Health, Alabama Department of Health, Chapter 420-5-5; End Stage Renal Disease Treatment and Transplant Centers Amended December 18, 2007 as found at http://www.adph.org/HEALTHCAREFACILITIES/assets/ESRDrules.PDF

Kilby

Kilby opened in 1969 with a design capacity of 440 inmates but as of March 2016 it held 1288 (292.7% of design capacity). It serves as the intake facility for males and has the main infirmary for males in ADOC custody.

The room where an LPN performs initial intake screening was cluttered and not sanitary. It was a large room without an examination table. A nurse evaluated inmates from behind a large office desk with the inmate sitting on a chair. An officer was in the room standing near where the nurse was interviewing inmates so there was no privacy. There was no fixed equipment in this room and the only supplies were supplies brought in by the nurse and placed on the desk. The only equipment in the room on the day of my tour was a thermometer, glucometer, stethoscope, blood pressure cuff and scale. Part of this intake screening room was used for storage. Based on descriptions on the tour, this room is used to complete intake forms 2 and 4. These interviews require privacy which is not occurring in this arrangement.

A second nurse intake screening room had 2 desks in it. It did not have an examination table. Nurses sat by a large office desk and interviewed inmates who sat in a chair next to the desk. Equipment (blood pressure cuffs, oto-ophthalmoscopes, etc.) was not wall mounted. There was no sink in this room but there was a hand sanitizer on the wall. Gloves were on a cabinet and on a sharps container on the wall. The remaining supplies were on the nurse's desk.

Kilby is used as a statewide repository of medical records for persons no longer in the ADOC. There was a medical record area consisting of 3 connected rooms along with another storage area on the prison facility but remote from the medical record room. I examined only the medical record area in the medical unit and not the additional storage area. The medical record room was a labyrinth of rooms with shelving placed in a manner that created extremely tight walkways between shelving. Shelves were completely filled with records from floor to ceiling with additional boxes of records in many corners of these rooms occupying floor space and obstructing shelving. Records were in carts in aisle space making it extremely difficult to walk in this room. A ladder was placed in 1 of the rooms to reach top shelves, but the walk ways between shelving was so tiny that the ladder did not appear to fit in all walk ways between shelves. The room was so cluttered and filled with records that it appeared difficult to be able to locate records accurately or quickly. It was not clear which files were active and which were inactive. Only one of the shelves in this labyrinth of rooms had "active files" written on it with a permanent marker. This medical records unit appeared so disorganized that maintaining accurate accessible records did not seem possible. This placed the inmates at risk of harm by not ensuring access to a complete and accurate medical record.

The x-ray equipment was very old. Tiles in the x-ray room were broken and many tiles were missing. The room was not properly sanitized. A room with a sign that said "Laboratory" was used for a phlebotomy room. There was a phlebotomy chair in the center of the room but it did not have a hard backed syringe disposal unit nearby. This is a patient and employee safety issue as needle disposal does not appear to be designed into the arrangement. A plain garbage

can was next to the phlebotomy chair. Open boxes were open and stored on the floor. A canister with a biohazard sign was not upright and was lying on a box on the floor. Boxes of laboratory supplies were stored on the floor with loose papers on top of the boxes on the floor. An empty bottle was stored on top of a pile of such papers. Blood was stored in a tray immediately adjacent to a sink and on the other side was a bin for mail.

The nursing sick call room had an examination table without paper covering to be changed between patients. The paper covering was on a refrigerator near the table. There was no fixed equipment except a radiology film viewer. Nurses kept equipment on the desk where they interviewed patients. The nurse had an otoscope, a thermometer, pulse oximeter, stethoscope, and a blood pressure cuff. Supplies were on a cabinet and on a refrigerator. A chair was placed in front of a sink. Nurses would sit at a desk to interview inmates who sat in a chair next to the desk. The desk where the nurse sat did not have access to a computer to access medication information. This device was on a counter on an opposite wall. There were 2 scales in the room. I didn't check whether either of them worked.

The medication room consisted of a room with a number of shelves which held individual specific medication on bingo cards which were kept in large bins. Medication was administered from a transaction window built into one of the doors to the room. This arrangement was clearly not built for its intended purpose. A small rolling table was placed in front of the door and contained supplies nurses would use when they administered medication. A wall mounted computer screen was adjacent to the door and presumably used by nurses to record administration of medication. There was a garbage bin and a red backed sharps container on the floor in front of the door. A clip board was on the sharps container. There was no sink or hand sanitizer near where nurses were administering medication. Two Styrofoam cups sitting in the top of an open medication container contained capsules and pills. These pills were not protected and appeared to contain over-the-counter medications used by nurses during medication administration. This was not a hygienic or sanitary arrangement. The medication room also had boxes of medication stored on the floor between shelves.

At some point in the past, Kilby had a small procedure room or surgical suite which was now being used as an emergency room. This was a large room with a ceiling mounted surgical lamp and a wall mounted cardiac monitor which no longer worked but had not been removed from the room. An examination gurney was available. Electrocardiogram equipment was next to the gurney. The examination gurney did not have fixed equipment (oto-ophthalmoscope, blood pressure cuff, etc.) nearby. There was no evidence of hand equipment for physical examination purposes. A Gomco suction device was on a table about 8 feet from the examination table. Supplies were in a cabinet against the wall. This room had a large television on a mobile shelving device. The purpose of the television was not clear. Open cardboard boxes were on the floor and on tables. This room had a slit lamp in it that I was told was used for eye clinic but it isn't clear where the equipment was being used. This room was inadequate as an eye clinic.

Adjacent to this emergency room was a narrow room (approximately 5 feet wide) with double surgical sinks presumably used to scrub prior to procedures. This room had 2 large red

contaminated waste containers. There was a telemedicine monitor and camera in this room that was used for telemedicine visits. However, there was no examination table or place for a patient to sit. There was a metal stool in front of one of the sinks but this was not in view of the camera. This room had no doors and was a passage way between the hall and the emergency room. This scrub area was being used as a clinical examination space which it was not designed for.

There were 3 examination rooms located in the main medical area. In 1 of these rooms which was used for performing intake physicals, a box of medical records was on the examination table which had no paper covering. This table did not appear to be used. An otoscope was the only equipment in the room.

In another room, a rolling computer table was apparently being used by a provider to write notes on and the computer was on an adjacent counter with the keyboard placed on top of papers and other objects so that it was tilted. There was paper clutter on the counter. There was no fixed equipment. Equipment was scattered on a rolling table and included otoscope and ophthalmoscope heads without the battery, K-Y jelly, guaiac developer, and a reflex hammer. Tongue depressors and disposable otoscope covers were in jars and a plastic bin on the table contained guaiac cards, and more K-Y jelly. This was disorganized. A telephone was on a table next to the examination table on top of a pile of books. A radio was on a lower counter of this small table. Telephone wires were lying in a pile on the floor. This space was poorly organized.

An examination room used for chronic clinic was extremely cluttered. Supplies were piled on top of a small refrigerator. There was a large file cabinet in front of a door that apparently is no longer used. A provider used a small rolling table to interview inmates but this table had no computer equipment so medications could not be looked up. The computer was across the room at another desk which was extremely cluttered. The examination table had manila envelopes and miscellaneous papers on it. The examination table had a decorative bow on it and did not look like it was being used for purposes of examination. There was no fixed equipment near the examination table (e.g. blood pressure cuff, oto-ophthalmoscope, etc.). The only visible equipment was in a small box on a shelf across from the table and appeared to contain a blood pressure cuff and a thermometer. Two hard backed sharps containers were immediately adjacent to the examination table making it a potential safety hazard. The only sink in the room was in a corner and was completely surrounded by a heater and miscellaneous paper. The sink itself was covered by personal handbags with employee lunches and did not appear to be used. A sandwich in a plastic container was on a pile of papers adjacent to the sink.

Kilby has a 38-bed infirmary. The Nursing station has an alcove with two sinks. There were cabinets in this room that were almost completely filled with toilet paper. Boxes were stored on the floor. Miscellaneous equipment was cluttering this room. There were two large plastic water coolers on the counter.

The infirmary was a dormitory style arrangement with beds set in rows within the room. Patient's supplies were stored on the beds that patients were sleeping in. Some beds had no mattresses and miscellaneous supplies in boxes were stored on the bed frame. The entry to the shower and commodes did not appear to accommodate a wheelchair. There was a bathing tub in the infirmary whose water faucets did not work. Only 1 shower had a functional faucet handle; 3 others had no handles. There were no grab bars and a single filthy plastic commode chair that presumably was a shared device. A plastic chair was beside the commode chair. Presumably this was used as an ADA device but was unsuitable for that purpose. A single grab bar was in the corner of the room next to a shower that had no faucet handle. This room was filthy. The commode and urinal area had ADA grab bars in a corner but these were not located near a toilet. There were no grab bars around the toilets. There was a large open garbage can in the corner of the room. The infirmary showers and toilets were not very different from toilets in other dormitories.

Adjacent to the infirmary are 3 cells used as medical cells for persons in segregation. In addition there are 2 private medical cells in the corridor used for medical patients. However these rooms which are isolated have no call bell system. These rooms present a danger with respect to housing of anyone who is ill. These rooms do not have ADA fixtures.

A dormitory is used to house multiple inmates who use wheelchairs, yet the sinks and showers are not ADA accessible. The shower has a single grab bar and a plain plastic chair for an accommodation but this does not appear adequate.

Kilby has two negative pressure rooms near the M dormitory. The water didn't work in the one room I checked. These negative pressure rooms have no ante-room. Having an ante-room is standard for negative pressure rooms. I held a piece of paper near the gap at the bottom of the door and the pressure, in 1 of the rooms, appeared to be positive to the hallway. I could not verify how these negative pressure rooms are monitored.

Fountain

The Fountain facility opened in 1955. It has a rated capacity of 719 inmates but at the end of March 2016 held 1255 inmates (174.5% of capacity). This facility is connected to a minimum security facility that maintains cattle and has agricultural operations. The health care unit is contained within a single corridor that is lined by rooms on either side. There are insufficient examination rooms in this unit such that nurses utilize the radiology unit to perform sick call assessments. The rooms in the medical area include:

- Two "safe cells"
- An x-ray unit
- A small phlebotomy area
- An emergency evaluation area
- A nurse practitioner examination room
- A medical record room

- A provider room
- A dental area
- A medication room
- A waiting cell

The emergency evaluation area has an examination table but no nearby oto-ophthalmoscope or blood pressure cuff. This room also has telemedicine equipment but the monitor is fixed on a wall not immediately adjacent to the examination table so it isn't clear how these evaluations occur. In the corner of this room is a corner wrap around counter with overhead cabinets that is used as a provider desk. There is a computer on the counter to presumably look up medications. A chair is adjacent to the counter where a patient presumably sits.

A nurse practitioner room has a small table with a stool for the nurse practitioner and a chair for the patient. The foot of the examination table in this room has 1 end that is partly under a counter. The other end of the table has a storage bin next to it so that it does not appear possible to fully lie on the table appropriate for an examination. There is also no paper covering on this examination table. This room has no fixed equipment. I was told the staff carries equipment in with them. There were no obvious supplies in the room.

The laboratory is a small narrow room with a phlebotomy chair. The x-ray room contains all the physical films filed in storage shelving on one side of the room. The x-ray equipment is old. There is an EKG machine in the x-ray room. Because there is insufficient space, EKGs are performed in the radiology room. Wires are snaked across wall mounted paper folders. The x-ray room is also used for physical examinations. It contains a desk bureau with built in shelving that is used by a nurse to conduct sick call because there is insufficient examination space in the clinic. There is only a single chair in the room so the only other place for an inmate to sit is on the x-ray table which is behind the nurse evaluating the patient. This is unacceptable as a clinical space to conduct examinations. There is no fixed equipment in the room.

The safe cells have thick steel doors with a small food port about 24 inches up off the floor. There is a single small approximately 6 by 8 window in the door with a small grating below it to communicate with people in the hall.

There is a 10-bed infirmary. On the wall in the nursing station there is a white board listing the inmates. This board has the following information: bed, name, AIS #, race, DOB, admission date and home location of the inmate. The commode for disabled on the infirmary is a large plastic chair on wheels that is wheeled over the existing stainless steel commode. There is a grab bar against the wall near the commode. Because the large plastic chair is on wheels, it may not be stable when transferring from a wheelchair. The shower is an extremely narrow space less than 3 feet wide. It is filthy. There is mold and fluorescence from the brick on the lower cinder blocks and on the tile. There is a portable commode chair that presumably is used as a chair to sit on while taking a shower. The single grab bar is opposite the shower and it is not clear how someone who was disabled would be able to use this arrangement to take a shower. There do not appear to be faucet handles on the shower water faucets. The infirmary has no privacy and

privacy examinations are done using a portable curtain is used. Exposed cables and wires from the TV are hanging in the room.

The medical records room is a small room with wooden shelving with records stored floor to ceiling. There is a small medication room. All directly observed medications are placed into 2 medication carts each with 3 drawers. Keep on person medication is stored on shelves of the medication room until picked up by inmates. This room has a small transaction window built into the wall. Inmates come from their housing units to a small caged area with this transaction window on one wall. The transaction window had steel bars vertically in the window with a space for the nurse to administer medication. There is a second window which opens into another space that nurses can use to administer medication. Corizon statistics describe that approximately 55% of inmates are on medications. This facility has slightly over 1500 inmates meaning, on average, about 750 will be on medication. In this type of arrangement, it does not seem possible for to administer all medication to inmates in the required two hour time.

There is a single small room used as a supply storage area. This room is used to store intravenous solutions as well as other supplies. Boxes of supplies are on the floor.

Inmates who use wheelchairs are housed in K dorm which is also used to house the aged and infirm. This unit has a handicapped shower with a grab bar about 4 feet high and shower faucet handles about 5 foot high. This unit is not functional for a disabled person who can't stand. There is a plastic chair in this room for use by persons who are disabled, but the arrangement appears dangerous because it is difficult to transfer to the chair and very difficult to turn on the water if one is paralyzed below the waist. The shower area for the disabled serves also as a janitor's closet and mops and buckets are in area where inmates shower. Other dormitories at Fountain that house disabled persons in wheelchairs have curbs in the doorway to the shower areas that make use of a wheelchair impossible.

Like other prisons, Fountain is very overcrowded. Multiple windows in dormitories are broken and covered with plastic. Ceiling mounted light fixtures are broken with exposed wire in view. Like other prisons, the dormitories are ventilated by large floor and ceiling mounted fans. The overcrowded conditions and lack of adequate ventilation promotes the spread of certain contagious disease such as tuberculosis.

Limestone

Limestone opened in 1984. It has a capacity of 1,628 but housed 2,228 (136.9% of capacity) at the end of March of 2016.

Limestone has a doctor and chronic care examination rooms even though there are is a need for at least 4 simultaneously used rooms (physician, nurse practitioner, nurse sick call, emergency evaluations and dressing changes, etc.). In the doctor's examination room, there is an examination table but there is no fixed equipment mounted on the walls near the examination table. The table is about a foot from a partial wall and a cabinet and it would be

difficult to examine the patient from this side of the table. There is a desk for a staff member to use with a computer on the table to check pharmacy records. But there is no chair for the patient to sit on. Presumably the patient sits on the examination table but when sitting on the table there is not direct vision to the staff member sitting at the desk. Portable equipment was lying on a counter in the room including a thermometer, blood pressure cuff, stethoscope, and an otoscope. There was no ophthalmoscope.

The medical records are stored in the x-ray room so presumably records can't be accessed when a film is being taken. There is also a medical records file room that has floor to near ceiling shelving for records. This room is very crowded without adequate space. There is a small lab for phlebotomy.

The chronic care room is very small. It has a desk arranged so that the swing of the door almost hits the desk. The desk is opposite an examination table which is where the inmate sits when the provider takes the history of the inmate. The computer for searching medications is in the corner next to a microwave which sits on top of a refrigerator. Eating or preparing food should be prohibited in clinical spaces for hygiene, safety, and sanitation reasons. There is no fixed equipment in the room but a thermometer, pulse oximeter and blood pressure cuff were on the desk. There was no oto-ophthalmoscope. Immediately adjacent to the chronic clinic examination space there is another room separated from the chronic clinic room by a doorway without a door. This room had a desk with a computer. I was told that this was the officer station. This eliminated the possibility of privacy.

There is a nursing station that serves as a medication room. This room has a single transaction window covered with a metal grating. The medications are stored on shelves and cabinets behind the window. The shelving is open. A wall mounted computer is near the window so that the nurse can access the eMAR. A keyboard is laid on top of a rolling table. Some cardboard boxes of medications are stored on the floor. This is not appropriate storage for medication.

The medical equipment storage room was extremely cluttered and disorganized. Isolation rooms had showers without nozzles. The shower nozzle arrangement consisted of a pipe with a shut off valve at the top. The end of the pipe did not have a nozzle but had a piece of a towel wrapped around the pipe.

An emergency room was a large room lined with multiple cabinets. There was an examination table in the middle of the room toward one wall.

There is an infirmary of 22 beds, 3 of which are in suicide rooms and 2 of which are in negative pressure rooms. The negative pressure rooms do not have an anteroom and there is a large gap of about an inch or an inch and a half between the bottom of the door and the floor. I placed a piece of paper against the door and it appeared to be positive pressure from the room to the hall which makes this room unsafe to use to house patients with tuberculosis. The ADA shower has grab bars and a large plastic chair on wheels. The chair appears to be unstable as it

is on wheels and does not appear to be safe for a disabled patient to use. The shower faucet handles are about 5 feet high and the shower head is in a fixed position which makes this shower extremely difficult to use by a disabled patient.

Near the infirmary, there was a small counter in a common hallway. A nurse had a couple chairs and conducted sick call at this counter. There was no privacy, no equipment, and no examination table or other place to examine the patient except in the chair. This is not appropriate space in which to conduct a physical examination.

Around the corner from where the nurse was examining patients in the hall, a nurse practitioner was examining a patient in what looked like a converted storage area. This space did not have a door. The inmate sat in a chair looking in the same direction as the nurse practitioner who was sitting at a desk. This space had no fixed equipment and no examination table. This is an inadequate examination space.

I dorm and the segregation units housed persons with disabilities. The shower in I dorm had a doorway that was barely 3 feet by estimation. It previously had a curb that was taken out and a steep concrete ramp up and then down into the shower area. This would be extremely difficult to navigate with a wheelchair. This was the accessible shower. It also served as a janitor's closet and on the day of our tour had cleaning buckets in the shower. There was no shower nozzle. Instead there was a short piece of flexible garden hose about 2 feet long coming out of the pipe where the shower nozzle should be. There were grab bars on the edges but there was no bench or place for a disabled person to sit.

Hamilton Aged & Infirm

Hamilton Aged and Infirm opened in 1981. It has a rated capacity of 123 but has a census at the end of March 2016 of 270 (219.5% of rated capacity). This facility has an extremely small medical unit.

The medical records room is a small room with files stacked on shelves of two walls of a narrow room. There are files on the floor and stacked on the floor. Record technicians work side by side at small desks. Telemedicine equipment is stationed in the x-ray room where the x-ray films are also stored.

A treatment room has an examination table and an open shelf supply storage area. This room has shelving with bins of intravenous fluid, and other supplies. There is no fixed equipment. Supplies are also stored in plastic bins on the floor. A Gomco suction unit is covering a cabinet door as is a hardback sharps container. This room is also used for phlebotomy and some shelf space is used to store blood tubes.

An examination room has an office desk with a chair beside the desk for the patient. The desk has a computer for checking medications. Next to the desk is a small table with a box with

paper files on it. Employee personal bags were on this table. An examination table is opposite the desk but there is no fixed equipment near the examination table.

There is a very narrow medication room about 2 and a half feet wide from counter to shelving. At the end of the room there is a Plexiglass transaction window with a small opening which is used to pass medication. On one wall there are shelves which contain the medication. In the corner, bolted to the corner is a computer used to access the eMAR.

The infirmary is extremely crowded. It has 20 beds in about 1300 square feet. This is approximately 65 square feet per bed. This includes walking space which is configured only by placement of beds. Beds are placed against three walls and in a paired configuration in the center of the room. Each patient has a small rolling table approximately 2 by 4 feet on which all of their supplies are stored. One inmate had his toilet paper on the table. Medical equipment is stored on this table with food utensils. This unit was extremely crowded.

The shower in the infirmary was about 2 and a half feet wide such that a single shower chair on wheels would fit in the shower but it is hard to imagine how a person could sit on this chair and fit in the shower. This shower has a bench that was in a raised position but the shower handle appeared difficult to reach while sitting on the bench. Grab bars are present on two walls but not on the wall that has the bench affixed to it. Another shower had a similar arrangement but was filled with janitor's supplies and was clearly being used as a janitor's closet. The commode was surrounded by grab bars on two sides. In chart reviews, a patient[241] who appeared to be housed on the infirmary at Hamilton, fell while taking a shower and fractured his hip. It wasn't clear if the patient was on the infirmary at the time of the fall or in other housing at Hamilton since the medical record had so few notes. However, the showers at Hamilton were all unsuitable for use by persons with disabilities and particularly unsuitable and unsafe for elderly. The person who fell sustained multiple fractures including a fracture of his hip.

Other housing units in this facility are makeshift and were not originally built for the purpose of housing. Some units had shower units in hallways without proper privacy. Some shower units had no nozzles. Water emitted from the end of a flexible hose like a garden hose. These makeshift housing units had peeling plaster, exposed metal plaster lath, and holes in ceilings. Some units were so cramped that is was clearly difficult to understand how the inmates using wheelchairs navigated through the room. There were double bunks with narrow passage ways that barely accommodated a wheelchair. In a fire these room would be a significant fire safety hazard for the inmates living there. These units placed the infirm and disabled inmates at significant risk of harm.

None of the facilities was originally built as ADA acceptable medical units. ADA renovations were done at a later time and therefore the facility design is gerrymandered and is unsatisfactory with respect to design and functional features.

[241] Patient number 8

APPENDIX C

CHART REVIEWS

Patient 1

Date	Summary	Comment
1/28/1999	PPD 20 mm positive. A TB record documented that the patient received INH 3/5/99	
1/5/2012	A physician assistant saw the patient for chronic illness clinic for his hyperlipidemia.	
2/2/2012	Received 30 days of Zocor which would run out on March 2nd. But the patient didn't receive medication until March 8th missing 6 days.	The inmate did not continuously receive medication timely.
3/14/2012	LDL =111. CMP done along with CBC and thyroid tests. WBC = 12.24 but no follow-up.	There was no documented follow-up of two abnormal laboratory tests.
4/4/2012	Chronic illness visit by PA. Noted to be in good control except LDL was 111. No changes to medication.	The LDL cholesterol was not in good control but was documented as in good control.
4/6/2012	Received 30 days of Zocor on April 6th which was when his current medication ran out. This packet was due to run out on May 5th.	
5/10/2012	The patient received 30 days of Zocor on 5/10/12 but his medication ran out 5/5/12 and he missed 5 days of medication. This packet was due for continuation on June 3rd.	The patient did not receive medication timely
6/14/2012	The patient received 30 days of medication missing 11 days of medication. This packet was due to continue on July 14th.	The patient did not receive medication timely
6/19/2012	Labs done. LDL = 109 and WBC 12.55 both of which are high. Thyroid testing was done again and was again normal.	The was no documented follow-up of abnormal laboratory tests
6/28/2012	A PA saw the patient for chronic illness clinic. The PA noted that the lipids were in good control but were slightly elevated. The PA did not discuss missing medication.	The practitioner failed to identify a condition not at goal and failed to address lack of continuity of medication.
7/19/2012	The patient received 30 days of Zocor when it should have arrived on 7/14/12. The patient missed 5 days of medication. The next packet should arrive on 8/17/12.	The patient did not receive medication timely
8/30/2012	The patient received Zocor late missing 13 days of medication.	The patient did not receive medication timely
9/27/2012	The patient received Zocor 1 day early.	

11/1/2012	The patient receive Zocor but it was 5 days late.	The patient did not receive medication timely
11/21/2012	Labs done. LDL = 131; WBC 11.23 which was normal.	The abnormal LDL cholesterol was not followed up.
12/17/2012	A PA saw the patient for chronic illness but listed the patient as in good control even though LDL was elevated and not in control. Missing medication was not discussed.	The provider did not address whether the patient was receiving medication which he was not and did not document review of the abnormal blood tests. The LDL cholesterol was not in good control.
12/20/2012	Patient received 30 days of Zocor but it was 19 days late.	The patient did not receive medication timely
12/27/2012	The patient received a second packet of Zocor on 12/27/12. These 2 packets would be good until Feb 17th.	
12/29/2012	Received 30 days of Zocor which would run out on 1/28/13 but he wouldn't receive medication again until 2/2/13 missing 5 days.	This appears to be a systemic deficiency in that the inmate continuously did not receive medication timely.
1/31/2013	The patient received 30 days of Zocor 18 days early. He should receive another 30 days on 3/19/13.	
3/7/2013	The patient received 30 days of Zocor 12 days early.	
4/4/2013	The patient received 30 days of Zocor 2 days early.	
5/2/2013	Labs were done. The LDL was 117 and the WBC was high at 12.5.	The LDL cholesterol and white blood count were elevated but not addressed.
5/9/2013	The patient received medication 4 days late.	The patient did not receive medication timely
6/13/2013	PA saw the patient for chronic illness. The lipids were described as in good control. Medication was not discussed. The white count was not addressed.	The PA failed to address abnormal lipids and white blood count and documented lipids as in good control when they were not.
6/13/2013	The patient received 30 days of medication but this was due 6/8/13; the patient missed 6 days of Zocor.	The patient did not receive medication timely
7/22/2013	The patient received medication 10 days late.	The patient did not receive medication timely
8/29/2013	The patient received medication 9 days late.	The patient did not receive medication timely
10/2/2013	The patient received medication 4 days late.	The patient did not receive medication timely

11/7/2013	The patient received medication 11/7/13 5 days late. But it appears that the patient did receive single doses of medication for 4 of the 5 missing days. After November, there are no further MARs in the record documenting receipt of medication. An order for medication is in the record dated 5/22/14 for renewal of simvastatin from 5/23/14 until 11/19/14 but no record if the patient received the medication.	
12/9/2013	A PA saw the patient in chronic clinic. The patient was listed as in good control although labs were not checked.	The degree of control was documented without evaluating lab results needed to determine degree of control.
12/12/2013	Labs returned and the LDL was 142	The LDL cholesterol was high but not followed up.
2/28/2014	The ADH documented an x-ray was done on this date but the x-ray report is not in the medical record.	Medical record paperwork is missing.
3/3/2014	An Alabama Department of Public Health contact investigation document on 3/3/14 documents that the patient had not completed prophylactic treatment for a positive skin test in 1999 even though prior records indicate completed treatment. The note documents that the patient received a chest x-ray for screening purposes and a hilar mass was detected. The x-ray was 2/28/13 and is not in the medical record. The ADH practitioner recommended INH therapy	There is a discrepancy between documented treatment and subsequent investigation of treatment by the Alabama Department of Public Health. Medical record paperwork is missing.
3/3/2014	A physician requested a CT of the chest with contrast but there was no evaluation of the patient. This request was approved the same day.	
3/5/2014	Appears to be a physician note on this date. No history at all was taken. The doctor noted that the patient had a quarter sized mass in the left lung. A brief physical examination was noted and the plan was to obtain a CT scan. The ongoing work up for TB was not noted. The physician wrote no assessment.	The physician failed to document a history or assessment.
3/18/2014	The patient was placed on INH prophylaxis	

3/18/2014	A PA saw the patient for a positive TB skin test. Remarkably, the PA note was immediately below the physician note of 3/5/14 which documented ordering a CT scan for an abnormal chest x-ray. Yet the PA note states, "INH TX discussed with inmate and all questions answered. Chest x-ray was negative. No signs or symptoms of TB noted". This was completely inaccurate and the patient had symptoms consistent with either TB or other disease (loss of appetite and cough) and had an abnormal chest x-ray. This indicates that the PA did not review the physician note immediately above his note.	The PA failed to read the prior note and therefore failed to appreciate the condition of the patient.
3/18/2014	The patient was placed on INH prophylaxis	
3/21/2014	Labs LDL = 119	The LDL cholesterol is still abnormal but still not addressed.
3/21/2014	Labs show normal alk phos, AST and ALT	
4/2/2014	Appears that the INH was discontinued, but there was no note in the medical record documenting why this was done.	There was no documentation of the plan of the providers.
4/7/2014	A PA ordered Isoniazid	
4/9/2014	Nurses performed symptom screening for tuberculosis symptoms.	
4/9/2014	CT of chest showed a 3.4 cm mass with enlarged hilar nodes with a 1.8 cm nodule in the right lower lobe consistent with either an inflammatory or neoplastic mass.	
4/11/2014	A nurse saw the patient for weakness and numbness of the L arm for a day with cough. The nurse noted that INH was started on 4/7/14. The patient had a fever of 101.8. The nurse gave the patient Tylenol and held the patient on the infirmary for a follow-up temperature check. When the temperature was checked about 2 hours later it was 99.8 and the nurse returned the patient to his cell. The nurse documented that urgent intervention was not required and referred the patient to a practitioner as a routine for medication review. The nurse noted that the patient had a recent CT scan for a lung infiltrate.	Febrile illness with an abnormal chest x-ray should have prompted an immediate physician evaluation. The nurse failed to properly refer the patient.

4/15/2014	A physician documented discussing with the patient the abnormal CT scan results which indicated a 3.4 cm mass. The physician documented discussing referral to an oncologist for work up of the mass. A diagnosis had yet to be made. Referral to an oncologist was premature. The physician should have referred for a bronchoscopy and biopsy of the mass. This would result in a delay.	The physician did not appreciate the typical work up of an abnormal mass. Before cancer was diagnosed, the physician referred to an oncologist. A diagnosis was necessary so a biopsy of the mass was indicated. This would delay the diagnosis and treatment of the patient.
5/14/2014	A nurse saw the patient for throbbing chest pain. The temperature was 98.8. The nurse didn't note the ongoing work up for a lung mass. The nurse took no action and referred the chart for practitioner review but did not schedule an appointment. The nurse performed an EKG which was normal except the rate was 55	
6/4/2014	An oncologist saw the patient and took a history of recent respiratory tract infection, 5 pound weight loss, and intermittent chest pain. The oncologist stated that the INH had recently been stopped for a marked rise in liver enzymes although there were no lab results in the medical record showing this dramatic rise. The prior liver enzymes in the record from 3/21/14 were normal. The oncologist recommended a biopsy via bronchoscopy. A PET scan was also recommended if the lesion were cancerous.	The referral to the oncologist first delayed diagnosis and treatment by at least 6 weeks. It appeared that lab test results were not in the medical record.
6/4/2014	A pulmonary consult, PET scan, and bronchoscopy were ordered.	
6/11/2014	A CT scan of the chest was ordered	
6/26/2014	Nurses performed symptom screening for tuberculosis symptoms.	
6/26/2014	The patient received a CT scan of his chest. The results show an enlarging chest mass on the left and a stable mass on the right. This was documented as highly suspicious for carcinoma.	
7/3/2014	The patient underwent bronchoscopy and preliminary biopsy was nonsmall cell carcinoma.	
7/7/2014	A physician saw the patient but took no history. The physical examination was normal. The doctor said he was awaiting the biopsy result.	The physician should have taken a history of the patient's condition.
8/12/2014	The patient saw an oncologist who recommended chemotherapy that would require a portacath placement.	This was more than 5 months after the abnormal lung mass was identified.

9/10/2014	AFB - by ADH and cultures negative	
9/10/2014	An NP ordered chemotherapy Q 3 weeks for 4 courses	
9/10/2014	An NP ordered a portacath placement	
9/10/2014	An NP requested chemotherapy as recommended by the oncologist.	
9/11/2014	The patient was sent to Brookwood Medical Center for unclear reasons. The patient did not receive chemotherapy because he did not yet have a catheter.	
9/12/2014	ADH documented results of 3 negative AFB and culture results and noted that the lung infiltrate was inconsistent with TB. The ADPH noted that the patient had loss of appetite, cough and weight loss which symptoms had not previously been picked up by DOC nurses.	It isn't clear why the ADPH had to exclude the diagnosis of tuberculosis as this is typically done by medical staff of the prison.
9/15/2014	ADOC nurses perform symptom screening for TB but note no loss of appetite, cough or weight loss even though the Alabama Dept. of Health just identified these symptoms 3 days previous.	This demonstrates poor quality of evaluation by ADOC staff which likely promotes tuberculosis disease being detected.
9/17/2014	An NP ordered a vascular surgery follow-up appointment for 10-14 days	
9/17/2014	The patient received the portacath.	
9/19/2014	Labs Alk Phos 60, AST13, ALT11; LDL 106	
9/22/2014	ADOC nurses again failed to identify cough, weight loss or loss of appetite on symptom screening.	The patient had symptoms related to his lung cancer but these were not identified by nurses screening for tuberculosis. This demonstrates poor quality of evaluation by ADOC staff which likely promotes tuberculosis disease being detected.
9/22/2014	Patient went to clinic for chemotherapy	From the first evidence of an abnormal x-ray to initiation of chemotherapy was approximately 26 weeks. This is an excessive amount of time.
10/3/2014	3rd of 4th courses of chemo given	
10/7/2014	Labs done ALT 44 otherwise normal. LDL not done	
10/10/2014	Las done. Glucose 101 otherwise normal.	
10/30/2014	labs; AST 108 and phosphorous 2.5	
11/3/2014	4th course of chemotherapy	
11/6/2014	Provider saw the patient for chronic illness. The patient had not been seen for chronic illness since 12/9/13. The provider noted that the patient was doing well after chemotherapy but took very little history and did not note what the follow-up would be for the patient. The LDL was 106 from 9/19/14 which was documented as good control.	The follow-up of the major chronic illness of the patient was poor and did not provide details that the provider knew what the plan was for the patient. The providers continue to not understand the appropriate treatment goal for LDL cholesterol.

11/26/2014	DOC nurses did symptom screening for TB but identified no loss of appetite, cough or weight loss.	This demonstrates poor quality of evaluation by ADOC staff which likely promotes tuberculosis disease being detected.
11/26/2014	A FU CT of the chest was requested on 11/26/14 for 4 weeks	
11/26/2014	A nurse documented that the patient returned from his last chemotherapy session	
11/26/2014	The oncologist recommended a FU CT scan in 4 weeks with a follow-up clinic visit the same day as the CT scan	
12/2/2014	A doctor wrote a very brief note documenting that the patient was doing well and needed a CT scan in 4 weeks. There was no history or physical examination.	The doctor did not document the progress of the patient. An appropriate history was not taken.
12/2/2014	A physician ordered a FU CT of the chest and an oncology follow-up for the same day	
1/19/2015	The oncologist saw the patient in follow-up. The oncologist recommended 3-4 month follow-up with CT of the chest and an MRI of the brain. The CT of the chest showed a significant decrease in size of the mass to 2.7 from 3.7 cm	
1/22/2015	A physician saw the patient and noted that the patient had metastatic lung cancer. The doctor noted that there would be a 3-4 month follow-up with the oncologist, a follow-up CT and an MRI of the head.	
1/22/2015	A physician signed a nursing note of 1/19/15 documenting that the patient returned from the oncology visit.	
2/9/2015	A physician saw the patient for chronic illness follow-up. He noted that he reviewed a nursing note of 1/19/15 which he signed on 1/22/15. He did not identify review of the oncology notes or the oncology recommendations for CT and MRI. He noted that the patient had "TB watchful waiting", which is the term used by the Alabama Dept. of Health with respect to the possibility of TB when the abnormal chest x-ray was first noted. Since multiple cultures were negative, TB had been excluded. Nevertheless, the doctor ordered AFB and cultures for TB along with AST and ALT and monitoring of the patient in TB clinic monthly with a 3-month chronic clinic follow-up.	This physician was unaware of the status of the patient and unaware of testing that had already been done. The doctor appeared to misunderstand how to manage tuberculosis.
2/11/2015	AFB - by ADH	

2/11/2015	The patient received an x-ray for tuberculosis but the report stated "Port catheter is followed to SVC. The cardiac silhouette, mediastinum, lungs, and pleural spaces show no gross acute abnormalities. If there are unexplained symptoms, follow-up radiography is suggested. Conclusion: No active tuberculosis". The radiologist apparently missed the lung cancer unless it had completely regressed. Also, the facility left the portacath in place after chemotherapy without consideration for how long it would be needed.	This demonstrates poor follow-up. Indwelling catheters place the patient at risk of harm because of potential for infections and clots. The physicians following this patient should know when the catheter should be removed.
2/12/2015	AFB - by ADH	
2/13/2015	DOC nurses identified no cough or loss of appetite on TB symptom screening.	This demonstrates poor quality of evaluation by ADOC staff which likely promotes tuberculosis disease being detected.
2/13/2015	AFB - by ADH	
2/28/2015	AFB - by ADH	
3/3/2015	AFB- by ADH	
3/4/2015	AFB - by ADH	
3/6/2015	A provider documented that the patient returned from an offsite visit and that the MRI of the head was "OK". The doctor documented "no C/O". There was no examination. The doctor wrote "off chemo now" and wrote he would check on the follow-up with the oncologist.	
4/17/2015	Culture for TB - by ADH	

Patient 2

Date	Summary	Comment
4/1/2010	The problem list for this patient included angina, type 2 diabetes, and hypertension. There was no mention of a reason for the indwelling suprapubic catheter which the patient had for several years while at ADOC. The patient had an indwelling suprapubic catheter since 2010 without any documentation of a diagnosis requiring this device.	Indwelling urinary catheters should only be in place for specific reasons. The Centers for Disease Control recommends using catheters only for appropriate indications and only as long as needed. This patient did not have a documented indication for a urinary catheter for years. This placed the inmate at risk of harm as it did not appear that the patient had an indication for the catheter.
1/18/2012	LDL =130; A1c= 7.1; Creatinine 1.11; glucose 144	The LDL cholesterol, A1c, and glucose are elevated but not followed up.
1/21/2012	Nurse saw the patient for right hip pain and cramping. The blood pressure was 150/90. The nurse did not address the high blood pressure and told the patient to sign up for sick call if he didn't improve.	The patient had an abnormal vital sign but this was ignored by the nurse.

1/23/2012	Patient complained to a nurse about burning when he urinates and pain in his testicle which was documented on a GU/GYN NET tool form. The nurse referred him to a provider because the urinalysis was abnormal but the nurse didn't document what the abnormality was. The nurse also gave the patient ibuprofen.	
1/23/2012	A provider saw the patient and only addressed the hip pain but not the testicular pain and abnormal urine. The provider was not certain about the hip pain diagnosis and thought it might be sciatica. The provider prescribed toradol.	The provider didn't address the testicular pain, abnormal urine, or urinary catheter. The patient had obvious symptoms of urinary tract infection but these were not evaluated.
1/23/2012	At 8:30 PM the patient complained to a nurse about leg pain. The FBS was 258. The nurse took no action and wrote that she would continue to monitor and report changes to the physician.	
1/24/2012	Patient complained again of leg and hip pain. The nurse documented notifying a provider but didn't document the discussion with the provider.	The nurse should document what was discussed with the provider.
1/26/2012	Patient complained of leg and hip pain. The nurse referred the patient to a provider.	
1/26/2012	A provider saw the patient. No history was taken except to note that the leg hurt and was swollen. No examination took place except to note that the patient had a urine bag and had no edema. DJD was diagnosed without having performed an examination. The provider prescribed Motrin. The provider then wrote an addendum saying that the patient complained of persistent leg and hip pain. The provider took no further history and performed a minimal examination and concluded that the patient had no leg pain and was stable. The provider concluded that the pain might be sciatica. This assessment appears contradictory in that it states that the patient had no leg pain but might have sciatica. The provider did little examination to determine whether the patient had a neurological component.	The history and physical examinations were inadequate.
1/30/2012	Patient complained of leg and hip pain. The nurse referred the patient to a provider.	
1/30/2012	Another provider saw the patient, noted back and hip pain and assessed low back pain suggestive of sciatica. The provider continued Motrin and added steroids (125 mg Solumedrol and a prednisone dose pack for 10 days) and ordered an x-ray.	The indication for Solumedrol was not clear. The history and physical were inadequate.

2/1/2012	LS spine x-ray normal	
2/1/2012	A provider saw the patient for chronic illness visit listing diabetes and hypertension as problems. The provider history mentioned that the patient was still using crutches but did not describe why the patient needed crutches. The provider did not mention that the patient had a suprapubic catheter and did not note why the patient had a catheter and did not take any history with respect to this. The provider didn't take any history with respect to medication and did not note that the patient had gaps in medication. The provider took no history with respect to diabetes except that the patient had no hypoglycemia. The LDL cholesterol was 130 which is elevated for a diabetic but the provider did not address it. The patient was not on anti-lipid medication. The provider noted that the blood sugar was 363 and A1c was 7.1(this test was collected 1/17/12) and noted that the diabetes control was good. .	The provider failed to address why the patient had a suprapubic catheter and did not address the indication of the catheter. The provider failed to address medications and failed to treat an abnormal LDL cholesterol. Persons with diabetes should have their LDL controlled at least < 100.
2/5/2012	A provider renewed isosorbide, Lisinopril, Zante, Maxide and atenolol all for 90 days but failed to renew diabetic medication.	
2/6/2012	The suprapubic catheter was changed	
2/7/2012	Patient complains of back pain to nurse. The nurse referred to a provider.	
2/17/2012	Patient received 30 days of multiple KOP medications including atenolol, isosorbide, Lisinopril, macrodantin, ranitidine, and Maxide.	
2/19/2012	Patient saw a provider for back pain. The provider noted that the back pain had completely resolved.	
2/22/2012	The patient asked to see a provider about his catheter.	
3/7/2012	A nurse changed the patient's catheter; the nurse noted that there was blood in the urine.	
3/17/2012	A nurse changed the suprapubic catheter.	
3/28/2012	The patient received macrodantin and atenolol but none of his other KOP medications. The medication was delivered 11 days late.	The patient failed to receive ordered medication.
4/1/2012	A nurse changed the suprapubic catheter.	

4/5/2012	Patient complained to a nurse about testicular and penile pain with polyuria. The nurse contacted a provider. The urinalysis showed blood, white cells and was nitrite positive indicating a possible infection. The patient was referred to a provider for the abnormal urine test.	A provider failed to see the patient after a referral by a nurse.
4/10/2012	A provider renewed isosorbide, Lisinopril, Zante, Maxide and atenolol all for 90 days but failed to renew diabetic medication.	
4/12/2012	The patient complained to a nurse about penile and testicular pain. The nurse noted that the patient had previously been seen by a nurse and given Motrin. A physician had not seen the patient in follow-up. The blood sugar was 516 which is very high. The nurse thought that there might be a catheter issue. A urinalysis showed white cells, nitrites, protein, blood, and small ketones. Even though there were ketones the nurse did not immediately call a physician. The extremely high blood sugar was not addressed.	The nurse should have contacted a physician as the blood sugar was extremely high and there were ketones in the urine. The patient's blood sugar was in part high because he hadn't received his diabetes medication.
4/13/2012	A provider saw the patient for the scrotal pain. The provider documented that the patient wore the suprapubic catheter after past trauma. The provider identified "no significant abnormalities" of the scrotal or perineal areas. The provider made no changes to therapy as the patient was already on an antibiotic (macrodantin). The provider did not address the very high blood sugar or order a urine culture.	Prior trauma is not an indication for permanent indwelling catheterization. The provider should have explored the patient's prior medical records or taken a better history from the patient. The provider failed to address the prior blood sugar of over 500 and failed to address why the patient was not receiving his diabetes medication.
4/25/2012	The patient's Maxide was due to stop on 4/5/12; the patient last received this medication on 2/17/12. The medication was renewed on 4/10/12 and the patient received this medication along with his other medications on 4/25/12. The Maxide was late 39 days. Atenolol and macrodantin were given on time. The other medication was also 39 days late as the prescriptions were renewed on 4/10/12.	The patient failed to receive ordered medication.

4/30/2012	A nurse saw the patient for penile pain and a greenish yellow discharge from the catheter site. The nurse noted a very high blood sugar of 417 and documented that the patient was noncompliant with medication even though providers had failed to renew his diabetic medication and the patient was not receiving any diabetes medication. The urine was described as dark brown with a sediment. As described this appears infected. The nurse gave the patient Motrin and referred the patient to a provider to be seen. The urine had white cells, nitrite positive, protein, blood, and moderate ketones, and glucose. There was no evidence in the medical record that the patient was seen by a provider for his high blood sugar.	The nurse blamed the patient for noncompliance with medication when the patient hadn't received medication. The patient appeared to have a urinary tract infection and was referred to a provider but this visit never occurred.
5/2/2012	A nurse saw the patient for pain and drainage from around his suprapubic catheter. The patient described that his urine was cloudy. He described pain so bad that he couldn't touch his testes. The nurse documented blood sugar of 551/515/ and 493. The pulse was 106 and the blood pressure was 134/94. The nurse noted that the patient had purulent drainage around the urostomy tube. The nurse remarkably did not refer to a physician but advised the patient to seek sick call if the signs or symptoms became more severe. The nurse did not check for ketones. The nurse did state that the notes would be given to a provider to review. It appeared that a provider wrote on the nursing note that the blood sugars were high and wrote that the inmate was out of his diabetic medication for 2 months. The provider said he would renew the medication. The nurse should have immediately referred to a provider. The provider started glipizide 10 mg twice a day and metformin 500 mg twice a day with a stat dose only of 70/30 insulin. This is a long acting insulin and not intended for short term use.	Drainage around the catheter, elevated blood sugar and cloudy urine suggested infection. The nurse should have immediately spoken with a physician. This is significantly below the nursing standard of care. The use of 70/30 insulin as a stat dose was unusual.

5/3/2012	A provider saw the patient. The patient weighed 217 pounds and based on a provider note from 1/23/12 when the patient weighed 235 pounds, the patient had lost 18 pounds over approximately 4 months. This was possibly from untreated diabetes. The provider examined the patient and found no penile swelling, no lesions and normal testicles. The doctor diagnosed "stable" "genital discomfort" and poorly controlled diabetes. The doctor felt that patient's symptoms were due to diabetes. The doctor started insulin for 14 days along with another antibiotic - Bactrim. The doctor did not order a culture of the urine or assess for infection or order a white count but did order a hemoglobin A1c and a chemistry panel. The doctor also did not check the blood sugar or urine ketones. The doctor did not assess the current status of the patient's diabetic medication. Although the doctor prescribed Bactrim, the doctor gave no instructions with respect to macrodantin, another antibiotic the patient was taking long term. It appeared therefore that the patient was on 2 different antibiotics. The doctor started 15 units of 70/30 insulin	There was a discrepancy between the nurse seeing a discharge and the provider not seeing a discharge. At a minimum the provider should have ordered a urine culture. The reason for the catheter should have been questioned. The length of time since the last catheter change should have been noted.
5/9/2012	Labs: The creatinine was 1.27; LDL-cholesterol was 132; A1c was 12.6	The renal function has deteriorated, the cholesterol is still high and untreated and the A1c is extremely high.
5/10/2012	The patient went to the health care unit to have his urostomy bag and catheter changed.	
5/12/2012	The patient went to the health care unit to have his urostomy bag and catheter changed even though it had just been changed 2 days previous.	
5/14/2012	A nurse saw the patient for groin pain. The patient told the nurse that he had stopped taking macrodantin because a doctor had recently prescribed another antibiotic. The patient was correct as a physician had prescribed Bactrim. The nurse referred the patient to a physician but the patient was not seen.	In part the patient was observant when the provider was not. This referral did not occur.
5/15/2012	A nurse saw the patient for shortness of breath stating he couldn't breathe. The nurse obtained PEFRs of 400/430/and 450 which are all abnormal. The pulse was 99.6. The nurse obtained no pulmonary findings and the patient was sent back to his housing unit.	Difficulty breathing, with minimally elevated temperature, and abnormal peak expiratory flow rates should have prompted a referral. Instead the nurse sent the patient back to his housing unit. It appeared that the nurse was an LPN. LPNs are not trained to make assessments and should have referred to an RN.

5/22/2012	The patient did not show up for a medical appointment.	
5/29/2012	It appeared that the patient did not receive medication in May based on documentation in the MAR. The nurse note does not document that medication was given but only states that the order was rewritten. A provider had renewed the medication in chronic illness clinic on 5/29/12 and apparently, this resulted in a delay in getting medication. Ironically, another provider had renewed some of the medication on 4/10/12 but this was not noted. This resulted in the patient not receiving medication.	The patient failed to receive ordered medication.
5/29/2012	A provider saw the patient for chronic illness care for diabetes and hypertension. Except for identifying that the patient had no hypoglycemia and had lost 5 pounds, the provider took no history with respect to diabetes even though the A1c was extremely high. The provider stated that the patient was not compliant with his medication according to the MAR stating that he reviewed the KOP cards "and pt is not taking medication daily". However, review of the MAR indicated that the patient had not received diabetes medication for 2 months and had not received his other medications timely. Although the provider documented that the patient was not taking medication, under the box titled "Patient adherence (Y/N) with medications?" the provider wrote "Yes". The provider documented that the patient had diabetes in poor control and hypertension and recommended medication compliance. He increased the 70/30 insulin to 18 units, ordered a urine test but did not address the increased blood lipids which were high and should have been treated. This provider appears to be blaming the patient for a failure of the system to timely provider this patient medication. The provider did not note the failure to timely provide the patient with his other medication and did not address the possibility of urinary tract infection. The provider renewed atenolol, isosorbide, Lisinopril, Zante and Maxide although these prescriptions were still active as they were renewed on.	The provider blamed the patient for the system's inability to provide timely medication. The provider failed to treat the patient's LDL cholesterol placing him at risk of harm. The provider failed to address whether the cloudy urine may be resulting in a kidney infection that could worsen his diabetes control. The provider failed to take any history with respect to diabetes except that the patient didn't have hypoglycemia. The prior episodes of > 500 blood sugar were not mentioned. This is an inadequate chronic care follow-up.
6/2/2012	It appears from a finger stick blood record form that the patient has a blood sugar of 45. There was no associated comment or note for this date.	
6/4/2012	A normal chest x-ray was reported.	

6/7/2012	A provider saw the patient for follow-up of his blood sugar. The provider noted that the A1c was 12.6. This was not addressed in the recent chronic clinic visit. The provider took no history, performed no examination, stated that there were no blood sugar sheets available to review and concluded by continuing current treatment. Because the sheets were unavailable, the provider did not know that the blood sugar was 45 on 6/2/12.	The blood sugar sheets should be available when providers see diabetic patients. No action was taken. The provider did not appear to know that the insulin had recently been increased.
6/15/2012	An NP saw the patient for FU of diabetes. The patient described being shaky because of the insulin. The A1c was 12.6. The NP did not change management.	
6/13/2012	The urine micro albumin was abnormally high at 50	
6/14/2012	The patient complained about having pain and wanted to see a provider. A nurse saw the patient on 6/18/12. A provider saw the patient on 6/15/12 for diabetes follow-up but did not address the pain issue with the patient during the evaluation.	This request did not appear to be addressed.
6/15/2012	A provider saw the patient for diabetes follow-up. The provider stated that the patient didn't take the insulin because it made him shake. This is consistent with the low blood sugar of 45 on 6/2/12. When the patient had missed months of his oral diabetic agents, providers prescribed insulin in addition to his oral medication. This was probably not indicated for this type 2 diabetic. The provider said that the patient was only eating noon and evening meals implying that not eating might be the cause of the hypoglycemic symptoms. The patient was 220 pounds and a type 2 diabetic and was recently started on insulin therapy due to extremely high blood sugars. The provider said that the patient refused several blood sugar tests but did not document review of the tests that the patient agreed to. The provider wrote that he discussed the complications of diabetes with the patient and the necessity of eating when taking insulin. The provider failed to overall assess the diabetes status by taking into account that the patient had not received his oral diabetic agents for about 2 months and that the insulin might be resulting in hypoglycemia. The provider did not assess the high micro albumin, although the patient was already on an ACE inhibitor. The provider did not assess the pain symptom or the urinary catheter and possibility of prior infection. The provider	The attitude of the provider toward the patient was to blame the patient when medication problems were more a reflection of system deficiencies. The provider was not treating the patient from a perspective of understanding what was happening to the patient.

	didn't discuss whether the patient should continue macrodantin. The provider did not discuss the patient's high blood lipids or start medication for this condition.	
6/18/2012	A nurse saw the patient for groin pain. The nurse assessed that the pain was due to the urinary catheter but took no action except to provide about 3 weeks of Motrin.	The nurse should have talked to a provider.
6/27/2012	The patient received his KOP medication. The documentation seems to imply that the patient last received glipizide and metformin 5/12/12. The documentation on the MAR appears to document that the last doses of atenolol, Lisinopril, and isosorbide were 4/25/12 indicating that the patient missed a month of medication for some medication and a couple of weeks for the diabetic medication.. The patient received atenolol, glipizide, isosorbide, Lisinopril, and metformin on 6/27/12.	The patient failed to receive ordered medication.
6/29/2012	A provider renewed Maxide, atenolol, isosorbide and Lisinopril for 180 days.	
7/30/2012	The patient received KOP medication 4 days late. The patient was now on glipizide and metformin	The patient failed to receive ordered medication.
8/9/2012	Labs: A1c =7; LDL = 91; TG 314	Now that the patient was receiving diabetes medication his A1c is in control. The triglycerides were high.

8/23/2012	A provider saw the patient for chronic illness care. The patient said he got shaky when his blood sugar was in the 80s. The weight was 220. The creatinine was 1.02 and the A1c was noted as 7. The provider did not assess the urinary catheter. The provider decreased the glipizide from 10 mg to 5 mg but did not document that the patient still had an order for insulin but was not taking it. It was probably unnecessary and might have been causing hypoglycemia. Based on the August MAR, the patient had been refusing insulin multiple times; there was no documentation with respect to more than half of the doses of insulin that were to be administered in the evening. The provider failed to take notice of the medication that the patient was receiving and thereby failed to adequately address the patient's complaint of hypoglycemia while on insulin. This placed the patient at risk of harm of hypoglycemia.	The providers continue to ignore the urinary catheter as a problem. Even though the LDL cholesterol was 91 the patient still should have been placed on statin drugs as the triglycerides were high. The provider should have reviewed the diabetes medication and modified medications to reduce hypoglycemia risk. It did not appear that there was need for insulin.
9/3/2012	The patient received KOP medication 5 days late. The diabetes medication was received 8 days late. Based on the MAR the patient received on 1 day of his evening insulin yet this was not brought to the attention of a provider.	The patient failed to receive ordered medication.
9/12/2012	The patient refused an eye examination.	
9/23/2012	The patient was admitted for 23 hours observation with vital signs Q shift, Ultram and Toradol.	
10/5/2012	A nurse changed the suprapubic catheter.	
10/17/2012	The patient received KOP medication 17 days late. Notably, nurses were now noting that the patient was refusing insulin. Despite refusing insulin there was no notification of a provider. His CBG values were in the low 100s and his A1c value was about 7 now that his oral diabetic medication was being given to him. This is good diabetic control. Providers did not discontinue the insulin failing to realize that it was unnecessary. This also demonstrates that when a critical medication such as insulin is not given, there is no notification to a provider.	The patient failed to receive ordered medication.
11/1/2012	A provider renewed 70/30 insulin 18 units in the morning and 15 units in the evening even though the patient had seldom taken the evening insulin for the prior several months and even though if the patient actually took the insulin it would probably cause him harm.	The provider renewing medication failed to know about the recent hypoglycemia so the renewal was probably done with benefit of using the medical record to review the therapeutic plan.

11/9/2012	Labs: A1c= 6.5; LDL cholesterol 149; cholesterol 212. There was no follow-up of the elevated LDL cholesterol.	The LDL cholesterol is again very high and needs treatment.
11/21/2012	The patient received metformin 6 days late. The patient did not appear to receive any of his blood pressure medications. The MAR for November demonstrates an absence of documentation for many days with respect to insulin. Also, the patient refused insulin on multiple occasions but this was not brought to the attention of providers.	The patient failed to receive ordered medication.
11/23/2012	The patient complained to a nurse that his catheter hurt. The weight had increased to 230 pounds from 220. The nurse took no action and did not discuss the patient's problem.	This is poor nursing practice. The nurse should have discussed the problem with a provider.
11/29/2012	A provider saw the patient for chronic illness follow-up. The patient told the provider that he didn't want insulin. This was a proper question to bring up since the patient was hardly taking it anymore and it was probably dangerous for him to be on it. Despite the fact that the insulin was unnecessary, providers had continued to order it and nurses failed to communicate to providers that the patient was frequently refusing it. The insulin had been ordered during a time when the system failed to provide oral medications timely to the patient. The patient hadn't taken insulin for months. The doctor stopped the insulin. The provider documented an LDL of 149 and started a statin on 11/30/12. Also the provider didn't address the urinary catheter. The patient typically took macrodantin but the prescription expired and the provider didn't notice.	The urinary catheter was not addressed. Prophylactic macrodantin expired which was unnoticed by the provider. If the patient had a urine infection, the catheter might have been causing the infection. The provider should have checked when it was last removed and consider changing it.
12/4/2012	The patient received KOP medication atenolol, Lisinopril, and Maxide but it appears that the last delivery of KOP medication was in October. It appears that the patient did not receive medication in November. .	The patient failed to receive ordered medication.
12/11/2012	The patient complained again of urinary symptoms and the nurse referred the patient to the provider because the patient had no prescription for antibiotics and typically took macrodantin. The patient did not appear to see a provider.	The nurse referral to a provider did not occur.
12/14/2012	A provider discontinued Maxide and started hydrochlorothiazide but did not discuss this with the patient. The provider renewed the glipizide, atenolol and isosorbide but not the metformin.	

12/18/2012	The patient complained of boils on his body. The nurse saw the patient on 12/19/12 and noted a boil on the patient's neck and referred the patient to a provider but a provider did not see the patient.	Again a nurse referral to a provider failed to occur. This placed the patient at risk of harm.
12/19/2012	A nurse saw the patient in evaluating the health request of the day before and noted a boil on the neck, a healed lesion on the chest and a small scab on the thigh. A provider wrote on the nursing NET tool note and wrote a prescription for 2 Bactrim BID.	
12/21/2012	A nurse gave the patient a 30-day supply of metformin KOP.	
1/5/2013	A nurse documented giving KOP meds simvastatin, glipizide, Isordil, Zestril, atenolol. These were 3 days late. The January MAR did not document delivery of metformin. The last delivery of metformin was 12/21/12.	The patient failed to receive ordered medication.
1/6/2013	A nurse changed the suprapubic catheter.	
1/16/2013	A nurse saw the patient for 3 separate boils on his neck, buttock, and chest. The nurse apparently prescribed Bactrim DS 2 tabs BID. It is not clear that a physician ordered this medication.	
1/16/2013	The patient left before seeing a provider for the boils assessed by a nurse almost a month ago. This is a significant delay in a provider referral for a health request especially for a suspected infection.	This appointment was significantly delayed.
1/22/2013	The patient complained about pain in his catheter. The Regional Medical Director saw the patient and documented that the patient had perineal pain from the catheter. The RMD wrote that the patient had neurogenic bladder which was not accurate. There was no evidence of a neurogenic bladder. The provider documented an infection, presumably in the urine. The provider ordered another urine culture. The culture referred to was not in the medical record provided.	Failure to obtain sufficient history from the patient and prior providers led to an erroneous problem of neurogenic bladder. The patient did not have this condition.
1/23/2013	A urinalysis showed white cells, positive nitrite, protein, and blood.	
1/24/2013	A provider evaluated the patient for testicular pain and infected urine. The provider ordered Bactrim 2 tabs DS BID with a follow-up in 10 days. The patient was already on Bactrim for a skin infection.	The provider should have determined when the catheter was last changed and considered changing it. The provider prescribed an antibiotic the patient was already on.

1/26/2013	A urine culture collected 1/23/13 and reported 1/26/13 showing e coli resistant to Bactrim but sensitive to nitrofurantoin (macrodantin). This was not reviewed until 1/30/13. The reviewer documented wanting to add macrodantin and discontinue Bactrim but it appears that the Bactrim was not stopped until the 4th of February.	The provider failed to timely change antibiotics as the patient was resistant to the antibiotic he prescribed for urinary tract infection. In general, long-term indwelling catheters become colonized.
2/4/2013	A provider saw the patient and noted that the patient complained of only receiving 4 days of his Bactrim. The MAR documents that the patient receive Bactrim for 9 days. The provider noted that the urine was growing e coli sensitive to macrodantin so the provider discontinued the Bactrim which was to stop on 2/4/13 anyway. The provider prescribe 30 days of macrodantin.	The provider should have determined when the catheter was last changed and considered changing it. It isn't clear whether the patient needed treatment as long-term indwelling catheters become colonized and are often only treated when symptomatic.
2/8/2013	Labs: creatinine 1.25, LDL was 150 but the patient was receiving only a low dose (5 mg of simvastatin) of medication; A1c 5.9; urine turbid with protein, ketones, blood, nitrites and large leukocyte esterase with many white cells and many bacteria which grew e coli.	The patient should have been on a higher dose of simvastatin.
2/13/2013	The patient received KOP medication ten days late.	The patient failed to receive ordered medication.
2/15/2013	A provider visit to follow up on a urinary tract infection was rescheduled.	
2/18/2013	A provider saw the patient and wrote a very brief note without any examination of the patient. The provider wrote to check a urine culture and treat accordingly.	
2/23/2013	The urine was again turbid and had protein, blood, nitrites, leukocyte esterase, bacteria and white cells. The urine grew pseudomonas.	The patient had a urinary tract infection. The reason for the suprapubic catheter was still not identified.
2/26/2013	A provider prescribed macrodantin for 180 days. This was a prophylactic antibiotic.	
2/28/2013	A provider wrote that he saw the patient and discussed urinalysis results and the need for antibiotic treatment. The patient agreed. The patient noted drainage from the left thigh but the provider did not find drainage on examination. The same provider dated a prescription 2/27/13 for gentamycin IM for 5 days with a metabolic panel in a week. There was no follow-up of the patient.	The provider should have determined when the catheter was last changed and considered changing it. The indication for gentamycin was not clear. It did not appear that the patient needed this medication.
3/4/2013	Lab: creatinine 1.35	This elevation of creatinine is a likely side effect of use of gentamycin.
3/5/2013	A provider renewed isosorbide for 180 days.	

3/11/2013	A urine sample was collected for culture which was reported 3/16/13 and positive for pseudomonas resistant to gentamycin which was the antibiotic used to treat his recent infection.	The provider should have determined when the catheter was last changed and considered changing it.
3/13/2013	A provider saw the patient for chronic illness clinic for diabetes and hypertension. The provider did not address the prior urinary tract infections. The provider did not ask the patient about his medications or ensure that the patient was receiving the correct medication. The patient's blood pressure was 130/80. The provider documented that the patient was in good control and did not change therapy. Although the LDL was 150 the provider did not address it, assess whether the patient was receiving medication or whether medication should be adjusted. The patient had recently been treated with intramuscular antibiotics for a urinary tract infection but the provider did not address it or follow-up with a urine culture.	The provider failed to address all of the patient's problems in this chronic care visit. The LDL cholesterol was high and the patient should have had an increased dose of lipid drug.
3/16/2013	The patient received KOP verapamil and also received Zocor which was last given as a 30-day supply on 1/5/13 so this was over a month overdue.	The patient failed to receive ordered medication.
3/30/2013	Metformin given as KOP and last given 2/5/13 so it was over 3 weeks late.	The patient failed to receive ordered medication.
4/12/2013	A provider renewed Zocor, Glucophage, verapamil and HCTZ for 120 days.	
4/14/2013	The patient received KOP atenolol, HCTZ, and Lisinopril but had last received a 30-day supply of these medications on 2/13/13 so this was a month late.	The patient failed to receive ordered medication.
4/18/2013	The patient complained of urinary symptoms and penile discomfort. An LPN saw him documenting on a General Sick Call NET tool form. The nurse ordered a stat urine and urine culture, ordered Motrin and referred to a provider. The urine test showed leukocytes, protein, and blood. There was no provider note but a nurse took a phone order for a blood count and metabolic panel for the morning. There was no physician available so the nurse called Dr. Crocker the Regional Medical Director who gave her orders.	There was no available physician onsite. The nurse referral never occurred. This was addressed telephonically. The lack of physician coverage resulted in phone management of the patient.

4/18/2013	Labs reported 4/18/13 showed: sodium 134, white count 12, urine turbid, with protein, blood, leukocyte esterase and 2+ bacteria. This result was not reviewed until 4/25/13. The urine culture from this specimen was positive for pseudomonas	The provider should have determined when the catheter was last changed and considered changing it.
4/18/2013	A provider ordered a referral to an urologist because of the infected urine. The referral documented that the appointment would be 4/23/13 but there is no evidence that it occurred.	It appeared that this referral was delayed.
4/19/2013	A nurse saw the patient for urinary discomfort. The temperature was 96.3. The patient had abdominal tenderness and contacted a physician who gave a phone order to change the suprapubic catheter and to give pain medication. The nurse changed the urinary catheter.	The lack of on-site physician coverage was resulting in management by phone.
4/21/2013	A nurse documented calling the patient to the prison ER by orders of Dr. Crocker. The nurse then called Dr. Crocker who wanted to be called but the nurse didn't get a return call. The patient waited apparently in the prison ER for an hour and a half. The patient wasn't evaluated.	The patient didn't have access to a physician as there was no onsite physician. Remote management did not appear to be working.
4/20/2013	Lab reported 4/20/13: white count 9.6	
4/28/2013	A nurse filled out a non-adherence medication form. The medical staff documented that the patient was non-adherent with glipizide, atenolol and hydrochlorothiazide. The patient wrote a comment on this document which he signed stating that he picked up his medication on time. There appeared to be a disagreement with respect to inmate's picking up medication.	Since this problem was apparent in other inmate's charts, it seems that it should be studied in a quality improvement effort. The medical program didn't consider that the problem of getting medication to inmates timely might be their fault.
5/8/2013	Labs: LDL 132; TG 243; A1c 6.5	The LDL cholesterol was still high. A higher statin dose was indicated. The triglycerides were also elevated and not addressed.
5/8/2013	The patient received KOP metformin 10 days late.	The patient failed to receive ordered medication.
5/15/2013	Patient received KOP meds atenolol, HCTZ, Imdur, Lisinopril, and verapamil 2 days late.	The patient failed to receive ordered medication.
5/24/2013	A nurse saw the patient for urinary symptoms and pain. The nurse appears to have scheduled the patient to see a provider.	

5/24/2013	A provider saw the patient for rash and pus around the scrotal area. The doctor noted a furuncle and started Bactrim. Remarkably the provider wrote that the suprapubic catheter was clear and not infected. The patient had almost continually infected urine for months. The bladder appeared colonized which was unrecognized by this provider.	
5/30/2013	A provider saw the patient for chronic illness. The provider documented no complaints but did not address the patient's ongoing symptoms of urinary discomfort. The LDL was listed as 132 but was not assessed as a problem and it did not appear that the patient had received his anti-lipid medication for the prior two months. The provider documented that the patient was on 5 mg of Zocor, the antilipid drug, but the MARS for April and May do not document that the patient received this medication. The 5 mg dose was probably inadequate. The last documented delivery of KOP Zocor was 3/16/13. The provider didn't check whether the 4/18/13 referral to an urologist had occurred.	The provider failed to address all of the patient's problems in this chronic care visit. The LDL cholesterol was high and the patient should have had an increased dose of lipid drug. The urinary catheter and ongoing infections were not addressed at all.
6/15/2013	The patient received KOP medication metformin, Lisinopril, atenolol, and verapamil 3 days late. The patient did not receive Zocor, glipizide, HCTZ, or Imdur.	The patient failed to receive ordered medication.
7/18/2013	The patient received atenolol, Lisinopril, metformin 1 day late. There was no documentation that the patient received glipizide, HCTZ, Imdur, or Zocor	The patient failed to receive ordered medication.
8/6/2013	Labs: LDL 134; A1c 5.9; creatinine 1.4	The LDL was elevated and a higher dose of statin was indicated. The creatinine was now abnormal and the providers should have assessed whether the ongoing urinary infections were causing a kidney problem.
8/8/2013	A provider renewed verapamil, HCTZ, Zestril, glipizide, atenolol, Zocor and metformin.	
8/21/2013	The patient received KOP atenolol, metformin, and Lisinopril 5 days late. Nurses documented that the patient also received verapamil and Zocor and it appears from documentation that the patient had missed more than a month of medication.	The patient failed to receive ordered medication.

8/29/2013	A provider saw the patient for chronic illness visit. The provider took no history in follow-up of the recent urinary tract infection and did not mention whether the ordered referral to an urologist from 4/18/13 had occurred. The history was meager. Although the LDL was 134 the provider did not identify high blood lipids as a problem and did not evaluate the treatment including whether the patient was actually receiving medication.	The provider failed to address all of the patient's problems in this chronic care visit. The LDL cholesterol was high and the patient should have had an increased dose of lipid drug. The urinary catheter and ongoing infections were not addressed at all.
9/10/2013	There was a prescription in the chart starting Bactrim on 9/10/13 for 10 days with a notation "F/U this Thursday skin infection". However there was no note associated with this prescription.	It appears that medical record documents are missing.
9/17/2013	A nurse practitioner saw the patient for a follow-up of a skin infection. The initial encounter for this problem could not be found in the medical record. The NP wrote that the visit would have to be rescheduled for when a physician was available. The NP noted that symptoms have improved since starting Bactrim. However, the NP did not elaborate what symptoms improved. Although the NP did not document an examination the NP assessed a skin fistula and ordered a 3-5 day follow-up.	There appears to be a lack of on-site physicians. It isn't clear why the NP couldn't evaluate the patient.
9/19/2013	The NP saw the patient again in follow-up of the fistula and again the physician was unavailable. The NP documented that there was a fistula in the perineum but that there was no drainage. The NP ordered follow-up in 7-10 days.	There was no available physician. The patient should have been referred to an urologist.
9/20/2013	The patient received KOP HCTZ, metformin, verapamil on time. The patient received Imdur but had last received a 30-day supply on 5/15/13 so this was several months late. There was no evidence on the MAR that the patient received glipizide Lisinopril, atenolol, or Zocor.	The patient failed to receive ordered medication.
9/26/2013	The NP saw the patient in follow-up; the physician did not see the patient. The NP noted that there was no further infection and that it had resolved.	
10/2/2013	The patient received verapamil. This was 17 days early.	

10/9/2013	The Regional Medical Director saw the patient and noted that the patient had a urinary catheter that was "stable" and said that although a prior urology consult was requested in April it was cancelled saying "He does not require such now". The provider did not check the urine culture. The provider did not explain why the urology appointment was unnecessary.	The patient did need a urology consult because he had a suprapubic catheter without indication. If the ADOC had reviewed prior medical records they might have discovered that the patient had a temporary catheter pending corrective surgery which they should have had done. ADOC providers failed to review the patient's previous health records and failed to identify the reason for the suprapubic catheter.
10/16/2013	Lab: urine cloudy, with blood, nitrite, leukocyte esterase, WBCs and bacteria.	The urine was still infected.
10/18/2013	A provider renewed isosorbide	
10/23/2013	The patient received Imdur 4 days late.	The patient failed to receive ordered medication.
10/25/2013	The patient received KOP HCTZ, metformin 6 days late. There was no evidence on the MAR that the patient received glipizide, atenolol, Lisinopril, Zocor.	The patient failed to receive ordered medication.
11/18/2013	A provider renewed glipizide, atenolol, Zocor, metformin, verapamil, Lisinopril, and HCTZ.	
11/18/2013	Labs urine culture pseudomonas sensitive to macrodantin	
11/18/2013	The patient received verapamil, HCTZ, Zestril, glipizide, atenolol, Zocor and Glucophage. The verapamil, HCTZ and metformin were timely. The others had been missed for a longer period. I could not find documentation that the glipizide had been given since January which raises the issue of whether it was necessary and why the provider at the chronic care visits was unaware of whether the patient was taking the medication. The patient was on a low dose of Zocor 10 mg even though the LDL remained out of control.	The patient failed to receive ordered medication.
11/22/2013	Labs: A1c 6.4; LDL 138	The LDL cholesterol is again high and additional medication is indicated.
11/23/2013	Urine growing E coli and Pseudomonas	The patient has a bladder that is now colonized from the catheter.
12/5/2013	A provider saw the patient for chronic care. The provider asked no questions about the catheter and did not evaluate it. The LDL cholesterol was documented as 138 and the provider documented that the LDL should be under 70 and increased the statin to 10 mg a very small dose. The LDL had not been at goal for a couple years and a very small dose of Zocor was started in November of 2012. The physician didn't inquire about whether the patient was actually getting his medication.	Problems with the urinary catheter were a chronic problem and needed to be addressed in chronic care.

12/17/2013	The patient received a catheter change.	
5/22/2014	The patient received a catheter change.	
6/18/2014	The patient received a catheter change.	
12/13/2013	Patient received KOP Zocor 3 days late. No evidence in the MAR that the patient received atenolol, glipizide, Imdur, or Lisinopril.	The patient failed to receive ordered medication.
12/24/2013	The patient complained of painful symptoms related to his catheter. The nurse referred the patient to a provider.	
12/24/2013	A provider saw the patient for straining to void. The patient had tenderness and the provider ordered a urinalysis, blood count and urine cytology and said he would consider a CT scan of the pelvis because he considered a fistula. The doctor also ordered a blood count and metabolic panel. The provider did not consider a urology consultation.	The patient should have been sent to an urologist.
12/27/2013	The hemoglobin was 10.7; triglycerides 194;	The hemoglobin was a low value consistent with anemia. This needed follow-up, which was not done.
12/27/2013	Patient received KOP verapamil, HCTZ, metformin 10 days late.	The patient failed to receive ordered medication.
12/30/2013	The urine cytology was reported and showed many inflammatory cells and bacteria but no malignant cells.	
12/30/2013	Lab: The urine collection appeared contaminated.	
1/2/2014	A provider documented that the follow-up was for urinary discomfort and a lab. The patient had perineal pain. However, the provider documented that the urine culture wasn't done yet and ordered follow-up when the test was done. The blood pressure was elevated at 130/100 but not addressed. The provider documented that urine cytology was normal.	The elevated blood pressure should have been addressed.
1/5/2014	The urine was turbid and had blood, protein, leukocyte esterase, and many bacteria	This indicates infection
1/19/2014	The urine test was cloudy, turbid, large leukocyte esterase and bacteria, may white cells, blood, and protein. This test was reported on 1/19/14 and was signed as reviewed on 1/29/14.	This indicates infection
1/21/2014	The provider re-ordered a urine analysis and culture noting that the prior ordered test had not been done. A follow-up was ordered when the urine test was completed. The cytology done previously 12/30/13 was documented as normal.	

1/23/2014	The provider who apparently was an NP saw the patient with a physician. The NP documented that the doctor said the patient had a fistula and would be sent back to the urologist.	The patient was being referred to an urologist several years after incarceration. This referral was indicated years earlier and it was harmful to the patient (repeated infection) to not do this.
1/23/2014	The patient received HCTZ, metformin, and verapamil 2 days early. But the Zocor was 6 days late. There was no evidence that the patient received atenolol, glipizide Imdur, or Zestril.	The patient failed to receive ordered medication.
1/29/2014	An NP noted that the patient was non-compliant with medication. It was not clear on what basis this determination was made as it appears that the patient was not consistently receiving timely medication.	
1/29/2014	A physician referred the patient to an urologist for a fistula.	
2/4/2014	normal chest x-ray	
2/5/2014	Lab: A1c 7; LDL 117	The A1c was starting to rise but was still at goal. The LDL cholesterol was high.
2/19/2014	An urologist saw the patient. The history by the urologist was that the patient had a history of perineal abscess and sepsis 5 years ago and had a 2-4 week drainage from the groin. The urologist recommended a cystogram to evaluate.	
2/19/2014	A provider ordered a cystogram.	
2/19/2014	The patient received metformin, Zocor, verapamil, and HCTZ. The February MAR did not document delivery of any medication. And the January MAR documented delivery of HCTZ, verapamil, and Zocor, on 1/27/14. It appears that many medications were late or were not provided. The March MAR documented receipt only of metformin, Zocor, verapamil and HCTZ.	The patient failed to receive ordered medication.
3/6/2014	The MAR documents receipt of metformin, Zocor, verapamil, and HCTZ	

3/10/2014	A provider saw the patient for chronic care follow-up. The potential fistula was not discussed. The provider listed the medications but made no attempt to document whether the patient was actually receiving medication or whether the patient was not taking medication. The provider listed the LDL as 117 which was still not at goal but there was no attempt to modify treatment. The patient's weight increased at least 20 pounds to 240 but the provider made no attempt to discuss. The lipids were not in control but were not assessed as not in control.	The provider did not address all of the patient's problems. The lipids needed better management. The weight increase should have been discussed.
3/13/2014	A cystoscopy report indicated that the cystogram was normal with no fistula.	
3/27/2014	An NP saw the patient in follow-up of the cystogram and noted that although the cystogram was normal, the patient still had a perineal discharge and wrote that the patient had a follow-up with the urologist.	
3/27/2014	The patient received KOP Zocor, metformin, verapamil, and HCTZ. The MAR did not document whether the patient received atenolol or Lisinopril. The medication that was received was 3 days late.	The patient failed to receive ordered medication.
4/7/2014	The MAR documents receipt of Zocor, metformin, verapamil, and HCTZ but the patient didn't receive glipizide or atenolol. The patient last received glipizide in November of 2013 almost 5 months previous.	The patient failed to receive ordered medication.
4/7/2014	An NP referred a patient to the urologist stating that although the cystogram showed no fistula, there was concern that the patient might have a fistula not involving the bladder.	
5/1/2014	The May MAR did not have documentation of delivery of any medication. The patient had not received glipizide for over 5 months and the diabetic control was deteriorating.	The patient failed to receive ordered medication.
5/9/2014	Lab: urine had blood, leukocyte esterase, casts and protein. The A1c was 9. The LDL was 63, the micro albumin was 63 which is high. The high A1c was most likely due to the patient not having received his glipizide for the past 5 months.	Failure to receive medication again resulted in deterioration of blood sugar control. The urine remains infected.
5/22/2014	A nurse saw the patient for pain from his catheter. The nurse did not refer the patient.	

5/27/2014	A provider saw the patient for pain in his penis. The doctor documented that the penis looked normal. Aside from noting that the penis hurt and looked normal there was no other history or examination. The doctor ordered a PSA.	
5/27/2014	A nurse saw the patient for pain from his penis. The patient said he was unable to sit. The nurse referred the patient to a doctor.	
5/28/2014	The patient saw an urologist. The urologist documented that 8 years ago prior to incarceration an urologist at UAB saw the patient and was ready to perform an urethroplasy. The urologist stated that there was no vesicourethral fistula but that the patient had a chronic urethral stricture and recommended that the patient return to see the UAB urologist.	The failure to take a proper history and obtain old records resulted in having the patient have an indwelling bladder catheter for years. .
6/11/2014	An NP saw the patient for chronic illness clinic. The NP did not discuss the urethral problem. There was a comment that the patient was missing metformin; otherwise there was no discussion of medication. The patient weighed 230 pounds. The LDL was listed as 63. The A1c was 9. The diabetes was listed as in poor control. The NP documented increasing the metformin to 1000 mg twice a day but the patient did not appear to have been receiving the medication. Also, the patient did not appear to be receiving his glipizide so it would have been more appropriate to ensure that he received his usual medication instead of increasing the dose. The NP did not document what was occurring with the patient's medication and did not document review of whether the patient was receiving glipizide. The June MAR was not in the record so I wasn't able to check whether the patient received glipizide or metformin in June. It appeared that the patient had not been receiving medication.	The lack of medication resulted in poor diabetes control. The NP did not address all of the patient's problems (urinary catheter).
6/13/2014	Lab: The PSA was 1.3 which is normal.	
6/27/2014	A physician reviewed the urologist's note of 5/28/14 and stated that he called the UAB urologist and the UAB urologist had not seen the patient previously but would be willing to see him.	

6/27/2014	An NP who saw the patient for chronic illness clinic saw the patient based on an urgent nurse referral for penile pain and noted that the patient had abdominal pain and was unable to void via his suprapubic catheter. The NP ordered a change of the catheter and get a urine analysis. Later that day the NP stated that there was sediment in the urine specimen with blood, nitrite, and leukocytes. The A1c was documented as 9 but the NP did not check the finger stick blood sugars. The NP documented increasing the glipizide to 10 mg twice a day (even though there was no evidence in the MARs that the patient had received glipizide for over 6 months), started Levaquin (an antibiotic) and started 70/30 NPH insulin along with regular insulin. In a later note the NP documented stopping the glipizide to prevent hypoglycemia. The NP had just two weeks earlier had increased the metformin and had not evaluated whether the patient had been receiving his glipizide or metformin. The patient did not need insulin. The patient needed to receive his prescribed oral medication. This was poor diabetes care.	The issue of the patient's diabetes control was one of ensuring that the patient received his oral medication timely. The response of starting insulin when the patient was not receiving his medication could potentially cause a problem if the patient started also receiving his oral medication. The root cause of this problem is a failed system of providing medication to the patient. This root cause was never evaluated.
6/27/2014	An NP saw the patient for pain in the abdomen and inability to void via the catheter. The NP ordered a flush of the catheter and a urine test.	
6/27/2014	The patient saw a nurse for pain in his penis. The nurse referred the patient to an NP.	
6/27/2014	A nurse replaced the suprapubic catheter	
6/27/2014	An NP ordered 10 mg of glipizide twice a day and levofloxacin for ten days.	
6/28/2014	A referral to UAB urology was approved.	
6/30/2014	Lab: the urine culture reported pseudomonas	
7/2/2014	An NP saw the patient in follow-up. The patient was refusing insulin which was appropriate. The NP documented that the patient was non-compliant. The patient should have been receiving his oral medication. The NP documented re-starting glipizide.	The patient needed to receive his usual oral medication. When this occurred the diabetes was controlled. The patient was correct but the response was to document that the patient was non-compliant. In this case the patient was correct.
7/2/2014	A nurse replaced the suprapubic catheter	
7/2/2014	urine cloudy, large leukocytes, many bacteria blood moderate, 1+ protein, 21-40 WBC	
7/30/2014	A nurse replaced the suprapubic catheter	
7/30/2014	I could not find MAR records for June, July, August, or September.	MARs were no longer available as an electronic system was being used. Although paper MARs were supposed to be printed and placed in the record, this did not appear to happen.

8/8/2014	A nurse saw the patient for scrotal pain and referred the patient to a provider.	
8/8/2014	Labs: LDL 98; A1c 7.7	The patient's diabetes control improved after receiving his medication.
8/8/2014	An NP saw the patient and documented that the patient had a UTI. The NP prescribed antibiotic but didn't document what antibiotic in the note. The NP documented that the patient had a urology appointment.	
8/25/2014	An NP saw the patient for painful urination. The NP documented a "large leak, large blood". The NP started ciprofloxacin and ordered a culture.	
8/25/2014	Lab: A urine culture showed pseudomonas	
9/1/2014	urine was still infected and growing pseudomonas	
9/8/2014	An NP documented that the urine was growing pseudomonas. The NP ordered IM tobramycin. The NP did not see the patient. The tobramycin was documented as ordered 9/24/14 to 9/25/14. It wasn't clear in the record when the patient actually received this medication.	The patient was colonized. The long standing infection was a complication of long-term use of an indwelling catheter. The indication for the catheter should have been determined and if unnecessary, the catheter should be removed. To begin using parenteral antibiotics was questionable.
9/17/2014	An NP saw the patient for chronic illness clinic. Very little history was taken. The follow-up of the urethral issue was not discussed including the pending visit to the urologist. The blood pressure was documented as 160/84 which is high yet the NP documented blood pressure in good control and did not change therapy. There was no mention of medication use and there were no MARs in the record. The A1c was 7.7 which is not at goal. The NP documented that the patient was only taking 500 mg of metformin twice a day so the NP decreased the dosage of metformin even though the patient was not in control. There was no documented discussion with the patient with respect to the use of metformin. The LDL was 98.	Not all of the patient's problems were addressed. The NP did not address the patient's high blood pressure. Without discussing the medication change the NP decreased metformin when the diabetes was not at goal.
9/8/2014	An NP documented that the urine was growing pseudomonas. The NP started an antibiotic but it was illegible.	
9/28/2014	The urine remained infected on testing and a few yeast were seen on a urinalysis so a culture was sent.	
10/5/2014	A urine culture from 9/26/14 and reported 10/5/14 grew yeast.	
10/1/2014	A urine culture from 10/4/14 grew pseudomonas.	

10/8/2014	An NP documented starting Diflucan for the yeast growing in the urine.	
10/8/2014	The patient was admitted to an infirmary for intravenous antibiotic for the pseudomonas infection but was discharged on 10/17/14. The urologist recommended not treating with antibiotics unless symptomatic. There had been no mention in the chart about this. The patient was treated with one day of imipenem-cilastatin.	There was a lack of physician coverage at this site. An NP was treating asymptomatic colonization of the bladder with parenteral antibiotics. This was unsupervised by a physician until the urology consultant advised not to do this.
10/16/2014	The patient went to an urologist who recommended a retrograde urethrogram before an urethroplasty. The urologist also recommended not treating with antibiotics unless the patient had symptoms.	
10/17/2014	A retrograde urethrogram showed complete occlusion of the urethra.	
10/31/2014	An NP documented that the patient needed surgery and documented that a referral was submitted. The NP was not specific so it was unclear what the patient was being referred for.	
11/4/2014	An urologist saw the patient and discussed the urethroplasty.	
11/4/2014	Labs: TG 333; glucose 192; A1c 7.5; LDL cholesterol 103	The triglycerides were very high and should have been addressed. The LDL cholesterol was not at goal for a diabetic. The A1c was not at goal.
11/7/2014	A nurse saw the patient for pain to the groin and referred to a provider.	
11/10/2014	An NP documented that the patient was seen following a complaint of dysuria. The NP did not examine the patient but wrote that there was pseudomonas in the urine and that the patient was scheduled for surgery. No other action was taken.	
11/11/2014	The patient had an urethroplasty with end to end anastomosis.	The patient had a suprapubic catheter for multiple years unnecessarily.
12/5/2014	The patient saw the urologist. The urologist recommended Keflex an antibiotic and Norco for pain.	

12/17/2014	A provider saw the patient for chronic care follow-up. The provider did not address the recent surgery for urethroplasty. The blood sugar was 371 but the recent A1c of 7.5 was not mentioned. The provider did not discuss whether the patient was taking his medication or receiving medication. There was no evidence in the record that the patient was receiving medication. The provider listed medications as metformin, atenolol, HCTZ, and verapamil. The provider did not list glipizide or Zocor as medication and it wasn't clear that the patient was receiving this medication.	The provider failed to address whether the patient was receiving medication. Based on the NP note, it appeared that the patient was not currently prescribed necessary medication (anti-lipid drugs). The NP did not address follow-up of the urethroplasty.
1/2/2015	The patient returned to the urologist who pulled the penile Foley.	
1/5/2015	The patient was seen by an NP for dysuria. The suprapubic catheter was clamped. The NP said that the patient was on antibiotics.	
1/13/2015	The patient complained of dysuria. The NP told the patient to drink more water. The NP documented that the patient was on Keflex. However there was no prescription for Keflex. The patient had a prescription for ciprofloxacin. But there was no accompanying progress note documenting why ciprofloxacin was started.	This was poor documentation.
3/10/2015	An NP saw the patient for chronic illness follow-up. The recent urethroplasty was not mentioned. The A1c was listed as 7.5 and the blood sugar was documented as 230. The blood pressure was 140/86. The LDL was listed as 103. The blood pressure was listed as in good control but was not. Medications were not discussed and it was not possible from the record to determine if the patient was receiving any of his medication.	The blood pressure, LDL cholesterol, A1c, and Triglycerides were not at goal. Yet the diabetes and hypertension were listed as in good control and the lipids were not even assessed as a problem. The issue of medication was not addressed. It was not clear that the patient was receiving medication.
2/4/2015	The urologist wrote a brief note on a consultation referral form stating that the suprapubic catheter was removed.	
3/19/2015	Lab: A1c 9.2 indicating poor diabetic control. There was no evidence that the patient had received glipizide regularly since November of 2013 or metformin since April of 2014.	Control of diabetes for this patient appeared directly related to whether he received medication and there was no evidence in the medical record that the patient received his medication.

Patient 3

Date	Summary	Comment
1/4/2012	A physician assistant (PA) saw the patient in chronic clinic for hypertension, high blood lipids and coronary artery disease with a prior stent in 2009. The patient was taking Maxide, Zocor, atenolol and aspirin. The inmate complained of chest pain with exertion for 2 months. The PA ordered a cardiology consultation. This should have been an urgent consultation and the PA should have increased the antianginal medication (atenolol or added nitroglycerin) because the patient had angina. A 30-day follow-up was scheduled.	Because the patient had known coronary artery disease and new chest pain, anti-angina medication should have been increased. Because the patient had typical pain, the PA should have sent the patient to a hospital for evaluation. At a minimum, the PA needed to obtain an electrocardiogram to evaluate the chest pain. The PA should have consulted a physician.
1/8/2012	Approval of cardiology consultation.	
1/30/2012	The patient went to cardiology and a cardiac catheterization was recommended. The consultant's report was not in the medical record. The blood pressure upon return was 138/96 which is high and should probably have been addressed.	All consultant reports should be in the medical record.
2/1/2012	A utilization management form for a cardiac catheterization was approved. A nurse ordered scheduling of a cardiac catheterization on a physician order form that was not co-signed by a provider.	
2/1/2012	A nurse noted that the patient went to cardiology and a cardiologist recommended a cardiac catheterization and she noted scheduling it.	
2/2/2012	A PA saw the patient for chronic care follow-up. The PA noted that the patient had occasional chest pain and that the chest pain occurred with exertion. The PA noted that the cardiac catheterization was pending. The PA did not modify the anti-angina medication.	The anti-angina medication needed to be increased.

2/20/2012	The patient had a cardiac catheterization showing LMCA normal; LAD proximal 95% stenosis, L circumflex normal; R coronary 30-40% stenosis with anterior apical hypokinesis with LVEF 35%. A proximal LAD bare metal stent was placed without complications. The discharge recommendations were for daily aspirin 325 and Plavix 75 mg daily.	When bare metal stents are placed, it is imperative that Plavix or a similar drug be used to reduce clotting of the stent. Failure to do this can result in clotting, failure of the stent and possible myocardial infarction.
2/21/2012	The patient was discharged from the hospital	
2/21/2012	Hospital discharge summary with cardiac catheterization results and stent placement results were signed as reviewed 2/27/12. Recommendations included Plavix and sublingual nitroglycerin. The Plavix was ordered by a nurse but the nitroglycerin was not.	
2/22/2012	An NP reviewed the nurse return sheet for the cardiac catheterization and documented that the results of the cardiac catheterization were pending and to schedule with a physician when they were available. The hospital discharge summary which included the cardiac catheterization results were signed as reviewed on 2/21/12.	Providers failed to obtain information from the hospital that was vital for the patient. The NP failed to continue the Plavix.
2/23/2012	75 mg Plavix was ordered but the MAR for February does not document administration of this medication. A for absent was documented from 2/23/12 to 2/29/12.	A vital medication was ordered 2 days late. There was no evidence that the patient received this vital medication.

2/23/2012	A nurse noted that the patient returned from a cardiac catheterization during which a stent was placed. The nurse noted a recommendation for Plavix 75 mg daily and ordered a prn follow-up.	
2/23/2012	An NP placed a non-formulary request for Plavix. The date of approval was not indicated on the form but the patient did not receive the medication during the month of February according to the MAR.	Failure to obtain medication timely may have been due to the medication being a non-formulary medication.
2/26/2012	The patient placed a health request stating he was having heart problems and had just had a stent placed and needed to go to chronic care. The patient was not seen until 2/29/12.	This health request was never evaluated.
2/29/2012	A provider ordered 300 mg of Plavix stat and transfer to a local emergency room.	
2/29/2012	A PA saw the patient and noted that the patient had chest pain after his stent placement and noted that the patient had not yet received Plavix. The PA gave 300 mg of Plavix stat and sent the patient to a hospital for evaluation.	
2/29/2012	The patient was admitted with a clotted stent. On this angiogram report the Left main coronary artery was now 70% occluded with 100% LAD occlusion; 30-50% circumflex occlusion and 70% occlusion of the R coronary artery. This was a significant deterioration now with 3 vessel coronary artery disease and a totally occluded LAD stent and new left main occlusion. There was a moderately large area of severe LV systolic hypokinesis.	Because of failure to obtain necessary medication the patient suffered a deterioration of his heart function, a clotted stent and necessity of bypass surgery. This event caused harm. This should have been identified in a sentinel event review with a quality improvement project to eliminate this problem. This patient did not have a sentinel event review even though he had what I would consider was a sentinel event, a clot failure due to failure to obtain timely medication.
3/1/2012	The March MAR documents unavailability of Plavix March 1st through March 6th when the medication was held. The Plavix and atenolol were documented as held on 3/6/12. The Coreg was given starting 3/7/12 in the PM but the AM dose wasn't started until 3/10/12.	

3/1/2012	The patient had a persantine stress test prior to bypass surgery. There was no evidence of ischemia but fixed anterior, septal, and anterolateral infarction and severe septal and apical hypokinesis and an ejection fraction of 29%.	
3/2/2012	The patient had 3 vessel coronary artery bypass surgery CABG.	
3/6/2012	The patient was discharged from the hospital after CABG with recommendations to start Percocet (a pain reliever). Plavix was no longer recommended.	
3/6/2012	The patient was admitted to the infirmary post CABG. The physician admission note documented holding Plavix but it had been discontinued. Coreg was recommended instead of atenolol	
3/7/2012	The patient was discharged to population a day after bypass surgery with a follow-up in 2 weeks.	The patient should have been monitored on the infirmary for a longer period of time.
3/14/2012	The hemoglobin was 9.6. A provider noted on 3/16/12 that the patient had a recent CABG and would recheck in 2 weeks.	
3/20/2012	The inmate complained of chest pain. An LPN saw the patient using a musculoskeletal protocol form for the assessment. The BP was 134/96. The nurse took a history of right sided pain with movement of the right arm. The nurse didn't discuss this with a provider; instead gave the patient Motrin. The protocol requires an EKG and the EKG showed probable lead reversal and anteroseptal infarction age undetermined.	The nurse didn't address the elevated blood pressure or consult a physician about a patient with recent CABG and chest pain. The nurse was an LPN who is not trained in assessment. Also there was no evidence of an RN review of the LPN's assessment.
3/20/2012	Hemoglobin was 10.9	This is consistent with anemia.
3/21/2012	A provider saw the patient in FU and did a very brief evaluation saying that the surgery FU was pending and that the chest wounds were healing. The provider documented that the patient had no chest pain even though a nurse had just evaluated the patient the day before for chest pain. However the CT surgery appointment hadn't yet been requested.	The provider history appeared inaccurate. The provider failed to acknowledge the chest pain of the day before and investigate whether it was important.
3/28/2012	A PA stopped the atenolol and started Cozaar 25 mg daily. The patient was already on carvedilol.	

3/28/2012	A PA saw the patient for chronic illness clinic. The PA noted the recent CABG and the abnormal hemoglobin. The blood pressure was 132/80 yet the PA started another blood pressure medication (Lisinopril 2.5 mg) even though the pressure was normal. No reason was given for this prescription. The hypertension was assessed as in good control. The PA did not document anemia as a problem and had no plan for it.	The anemia was not addressed.
3/30/2012	A cardiothoracic surgery appointment was scheduled.	
4/1/2012	Plavix continued to be documented as held on the April MAR. It appears that the Coreg was unavailable during most of the month of April as it was documented "A". The April MAR documented that atenolol, Plavix and Mylanta were being held. A KOP Protonix was given 4/6/12; Coreg was marked "A" for the month which did not correspond to a nurse initial and appears to represent absent. Maxie was documented as held. Simvastatin was documented KOP and SNO but it wasn't clear what SNO meant and there was no documentation that the patient received the medication. Colace was stopped 4/7/12; aspirin, Zocor and Tylenol were documented as KOP but no evidence that they were delivered to the patient.	The patient failed again to receive a necessary medication. Documentation in the MAR did not verify receipt of medication.
4/2/2012	The site medical director approved the CT surgery consultation 4 days after requested. UM approved the request on 4/4/12	
4/25/2012	A PA saw the patient and noted that the patient was taking Cozaar, Protonix, Coreg, Maalox, aspirin, and Zocor but there was no evidence in the MAR that the patient had received any of these medications. The PA did not address whether the patient was receiving medication. The BP was 130/76. The PA assessed hypertension, high blood lipids and post CABG.	The documentation of the PA appeared to contradict evidence in the medication administration record.
4/27/2012	A PA ordered Plavix on a non-formulary form and submitted the form. This medication. This was circled as approved but the approval date was not documented and the person approving the medication did not sign the form.	This medication was to be discontinued by recommendation of the hospital physicians. The PA did not appear to know what medication the patient needed.

5/1/2012	The May MAR documented that the patient received Maxide, Mylanta, ibuprofen, aspirin, Coreg, Cozaar on 5/23/12 and Zocor and Protonix on 5/24/12 about a week after prescription. There was no evidence that the patient had received Coreg since discharge from the hospital. The patient also received a month supply of aspirin KOP on 5/2/12 along with Cozaar, Zocor, and Tylenol and Protonix. Another May MAR documented Coreg was "A “for multiple days in May but not all days were filled in. Under this 2nd MAR Plavix was documented as on hold and the discontinued 5/6/12. Another MAR documented that Maxide was on hold.	The patient continued to fail to receive ordered and needed medication.
5/9/2012	The patient went to see a consultant but it wasn't clear which consultant. The recommendation was to continue aspirin, Lipitor (which the patient wasn't on), antihypertensive and Plavix. It appears that this might have been the cardiovascular surgeon.	All consultant reports should be in the medical record.
5/10/2012	An NP reviewed the 5/9/12 consultant recommendations on a return from offsite form and documented that the patient had current orders for aspirin, Zocor, Maxide, Cozaar, Coreg and Plavix. However the Plavix and Maxide were held since February.	
5/16/2012	PA Guthrie ordered Motrin, aspirin, Coreg, Cozaar, Zocor, Maxide, Plavix and Tylenol. The Maxide and Plavix had not been continued after discharge from the hospital post CABG.	The PA did not appear to know what medication was to be on. The PA ordered Plavix without clear indication which placed the patient at risk of harm.
5/16/2012	PA Guthrie saw the patient for chronic care. The PA documented discussing medication with Dr. Talley and called the cardiologist. Apparently the cardiologist recommended stopping the Plavix and continuing other medication. The BP was 134/84. PA Guthrie ordered Protonix, Zocor, Maxide, Mylanta, Motrin, aspirin 325 mg daily, Coreg, Cozaar and stopped Plavix and Tylenol.	It took 3 months to clarify the recommended medications for this patient. This placed the inmate at risk of harm.
6/1/2012	The June MAR documents that the patient received KOP Maxide and Mylanta, aspirin, Coreg, Motrin, Cozaar, Protonix and Zocor on 6/27/12. This meant that the patient missed 6 days of medication because he last received medication on 5/23/12 and 5/24/12.	The patient did not receive medication timely.
6/4/2012	LDL cholesterol was 63 and hemoglobin was 13.6	

7/1/2012	The MAR for July documented receipt of KOP medication on 7/25/12 for Coreg, Cozaar, Protonix, Zocor, Maxide, and Mylanta	
7/23/2012	TSH was 4.29 which is high (0.27-4.2)	This test was minimally abnormal. There was no follow-up of this abnormal test.
8/1/2012	On 8/23/12 the patient received KOP medication Maxide, Naprosyn, Coreg, Cozaar, Mylanta, Protonix, Zocor	
8/15/2012	6-month cardiology post CABG follow-up requested.	
8/15/2012	A PA saw the patient for chronic illness follow-up. No post-op problems were noted. The PA referred the patient to doctor Talley but it isn't clear if this was the cardiologist or another doctor. The PA ordered a 90-day follow-up.	
8/20/2012	cardiology consultation approved	
9/1/2012	The September MAR documented receipt of Maxide, Naprosyn, aspirin, Coreg 3.125 BID, Cozaar, Mylanta, Protonix, and Zocor on 9/27/12 meaning that the patient received medication about a week late.	The patient did not receive medication timely.
9/10/2012	A cardiologist saw the patient. BP was 138/90. The cardiologist recommended increasing the Coreg, a 2 D echocardiogram and lipid follow-up. Upon return to the prison the Coreg was not increased.	The cardiologist recommended increasing the Coreg but this was not done.
9/11/2012	A physician reviewed the cardiology consultation and documented that he called the cardiologist who agreed that a BP of 132/95 is acceptable.	132/95 is an elevated blood pressure based on current recommended standards of the JNC VI and needs to be brought down consistent with recommendations made by the cardiologist.
10/1/2012	The October MAR documented receipt of KOP Maxide, aspirin, Coreg, Cozaar, Protonix, and Zocor on 10/31/12 five days late.	
10/23/2012	TG 219, LDL 57, TSH 1.47	
11/1/2012	The November MAR documented receipt of KOP Tylenol, aspirin, Cozaar, Protonix, Zocor, and Maxide on 11/28/12. Coreg had been prescribed on 11/12/12 but not received until 11/28/12.	The patient did not receive medication timely.
11/12/2012	Coreg was increased to 6.25 BID. There was no note associated with this prescription. It appeared that the prescription was initiated 2 months after the cardiology recommendation.	The patient failed to have the cardiologist's recommendation enacted for 2 months.

11/12/2012	A PA saw the patient for chronic illness. The BP was 124/74, weight was 228, LDL was 57 and the patient had no complaints. The echocardiogram ordered 9/10/12 had not been done. The PA ordered FU in 90 days but made no comment about the echocardiogram.	
12/1/2012	The December MAR did not document delivery of any medication.	The patient did not apparently receive medication timely.
12/6/2012	The echocardiogram showed an ejection fraction of 20% with depressed systolic function. These results were signed as reviewed on 12/10/12.	
1/1/2013	The January MAR documented receipt of Maxide, Tylenol, aspirin, Cozaar, Coreg, Protonix, and Zocor on 1/2/13 and 1/31/13. The 1/2/13 doses were 3 days late. Coreg was administered as 6.25 on 1/2/13 but the prescription had been written on 11/12/12 almost 6 weeks previous.	The patient did not receive medication timely.
1/23/2013	glucose was 103 (high0 and TG 286 (high)	
2/1/2013	The February MAR documented receipt of aspirin, Cozaar, Protonix, Zocor, Coreg, Tylenol and Maxide on 2/27/13 which is on time. The Coreg was for 3.125 which had been increased to 6.25 on 11/12/12. The Coreg change wasn't made for almost two weeks after it was ordered.	The patient did not receive medication timely.
2/11/2013	PA Guthrie saw the patient who was feeling weakness and tiredness which the PA ascribed to Coreg. The BP was 134/78. The Coreg was decreased to 3.125.	
3/1/2013	The March MAR documented receipt of aspirin, HCTZ, Zocor, Protonix, Cozaar, Tylenol on 3/27/13 which were given on time. Although the MAR listed HCTZ as given, the patient was actually on Maxide. Maxide is not the same as HCTZ. Maxide is HCTZ plus triamterene, another diuretic.	
3/13/2013	PA Guthrie wrote a note stating that he saw the patient who had weakness and fatigue and he told the patient to hold the Coreg until his next visit in 60 days.	
4/1/2013	The April MAR does not document that the patient received any medication in April.	The patient did not receive medication timely.
4/25/2013	TG were 271 which is a steady rise over months. The LDL was 71.	The statin drug might have been increased or gemfibrozil added. The patient was on 20 mg of simvastatin.

5/1/2013	The May MAR documented receipt of KOP meds on 5/1/13 and 5/29/13 including Protonix, Zocor, Tylenol, aspirin, Coreg, HCTZ, Cozaar	
5/13/2013	A PA saw the patient and restarted the Coreg because of decreased ejection fraction and ordered another echocardiogram.	
6/1/2013	The June MAR documented no medications given.	The patient did not receive medication timely.
6/5/2013	TG were 93 and LDL 89.	
7/1/2013	The July MAR documented receipt of KOP Zocor, Tylenol, aspirin, Coreg, HCTZ, Cozaar, and Protonix on 7/3/13 about 4-5 days late. Meds were also given on 7/31/13 which would have been on time.	The patient did not receive medication timely.
7/10/2013	The echocardiogram showed an ejection fraction of 50%	
7/23/2013	TG 231	This is a high level for triglycerides but was not noted.
8/1/2013	There was no August MAR in the record but the September MAR documented receipt of medication on 8/28/13.	
8/12/2013	A PA saw the patient for chronic care. BP was 124/84. The patient complained of ear pain but on examination the ears weren't examined. The PA made no changes to therapy.	Although the patient had a complaint, the complaint wasn't addressed.
9/1/2013	The September MAR documented no administration of any medication.	The patient did not receive medication timely.
10/1/2013	The October MAR documented receipt of KOP Tylenol, aspirin, Coreg, HCTZ, Cozaar, Protonix, and Zocor on 10/2/13 which was 4 days late.	The patient did not receive medication timely.
10/26/2013	TG166, glucose 103	The patient was borderline diabetic and should have been encouraged to lose weight.
11/1/2013	The November MAR documented receipt of KOP Tylenol, aspirin Coreg, HCTZ, Cozaar, Protonix and Zocor on 10/30/13.	
11/11/2013	A PA saw the patient for chronic illness clinic. The BP was 126/78 and the patient had no complaints. No changed were made. Lifestyle modifications were recommended but it wasn't clear if weight was discussed.	
12/1/2013	The December MAR documented receipt of KOP Tylenol, aspirin, corgi, HCTZ, Cozaar, Protonix and Zocor on 12/4/13.	
1/1/2014	The January MAR was not present.	Not all documents are filed in the medical record

1/20/2014	It appears that multiple notes are missing including progress notes, labs and verification of medication administration for the months from July through January of 2014.	It appears that multiple notes are missing from the record.
1/28/2014	The patient complained of an earache to a nurse who referred the patient to a medical provider. The LPN evaluated the patient. RNs should make assessments.	LPNs should not perform independent assessments.
2/1/2014	The February MAR was not present.	
2/5/2014	A provider saw the patient for earache and diagnosed tinnitus and prescribed CTM.	
2/10/2014	A PA saw the patient for chronic care. The patient had chest tightening with exertion. The PA had never started the NTG as recommended on discharge from the hospital. The PA did not prescribe NTG or any other anti-angina drug. The PA did order an EKG and referred the patient to cardiology. The PA did not perform an adequate history for the chest pain even though this was a serious complaint. The only problems listed were coronary artery disease, hypertension, and high blood lipids.	Given the chest tightness the anti-angina medication should have been increased but was not even evaluated. The PA took no history of anti-angina medication use. This placed the patient at risk of harm. The PA should have discussed the patient with a physician.
2/10/2014	The EKG showed septal infarct age indeterminate.	
3/1/2014	No MAR was present for March so it wasn't possible to determine if the patient received medication.	
3/3/2014	A PA saw the patient and documented no complaints the CAD was listed as in good control. Although the patient gave no complaints and the PA found no problems on physical examination and had no new assessments, there was a prescription listed that is illegible. Because there were no MARs or medication notes in the record I wasn't able to know what this prescription was for.	The PA listed that the patient had coronary artery disease in good control even though the patient had previously had exertional chest pain. The PA did not follow up on the chest pain from several weeks prior and did not address the status of the cardiology follow-up.

3/11/2014	The patient went to cardiology and was diagnosed with recurrent angina. The cardiologist recommended increasing the Cozaar to 50 and starting Imdur an antianginal drug and return in 2-3 months. The cardiologist documented that the patient had episodes of angina. The cardiologist also recommended NTG which the patient had not been on. The cardiologist also recommended a SPECT at the next available opportunity. The cardiologist recommended improved BP control as the BP was 138/94.	
3/11/2014	Cozaar was increased, and imdur and nitroglycerin started.	
3/14/2014	Patient placed a health request about ringing in his left ear and said the prior treatment didn't work. The nurse referred the patient to a provider. I could not find a provider note in follow-up of this referral.	
3/19/2014	A provider saw the patient. The doctor noted shortness of breath but did not take any further history. The blood pressure was 181/100 but the provider wrote "vss" or vital signs stable. 181/100 is not a stable blood pressure. The provider did not evaluate the ringing in the patient's ear brought up recently. The doctor did not increase blood pressure medication	Doctor failed to address elevated blood pressure or the patient's recent ear problem. The doctor failed to take an adequate history of the patient's problems.
3/31/2014	A PA saw the patient for chronic care follow-up. The PA noted that the stress test was pending and that the patient had no current complaints. The BP was 128/88 but the PA increased the Coreg to 6.25 without explanation.	The PA increased a medication without an apparent reason.
4/10/2014	The patient had a stress test. The patient had a mild to moderate perfusion defect in the anterior, anterolateral and septal walls with an EF of 23% and intermediate risk on the treadmill score. The stress test findings indicated high risk.	
4/14/2014	A provider documented a note but it has no history except that the patient just had a stress test. The note documented that the patient was "doing well" but made no comment about the results of the test or necessary follow-up. An as needed "prn" follow-up was ordered.	Provider's notes need to contain sufficient history to understand what happened to the patient. This note contains no history.

4/30/2014	A PA saw the patient for FU of the stress test almost 3 weeks after the test. The PA noted that the stress test results weren't yet available. The PA took a history that the patient had no chest pain. The PA ordered FU in 3 months. He listed the CAD as in good control which was not consistent with the stress test result.	This visit was almost 3 weeks after the stress test and the result should have been available. The follow-up was poor. 3 months was too long a follow-up with a pending a stress test result.
5/2/2014	The stress test result was signed as reviewed but the report appeared to have been dictated 4/10/14. Someone wrote on this report that the cardiologist wanted a cardiac catheterization which was ordered by Guthrie on 5/1/14 and approved 5/5/14.	
6/16/2014	Cardiac catheterization was done. The LAD was still occluded and unchanged. There was now 2 vessel obstructing CAD involving LAD and obtuse marginal vessels. The distal and mid LAD were also affected but insufficient for a stent. The RCA graft was occluded. LV function was severely depressed and spironolactone was started.	This patient with LVEF < 20% probably should have been placed on an infirmary unit.
6/18/2014	A PA saw the patient for follow-up after the cardiac catheterization. The provider documented no significant change in the coronary artery disease and decreased the aldactone without a specific reason. The provider took no history and performed no physical examination. The provider documented discussing the catheter results with the inmate.	The catheterization results were actually worse that previous. The PA did not appear to know how to interpret the catheterization results. He decreased a medication without an apparent reason. He should have examined the catheter insertion site but did not. He should have asked about chest pain.
6/30/2014	Cardiologist saw the patient. The patient was on aldactone, Coreg, Losartan, aspirin, Zocor and Imdur. The patient still had chest pain with walking across the room. The cardiologist prescribed ranolazine. The cardiologist stated that the CAD was much worse including occluded LAD, right graft occlusion, and moderate RCA disease with low ejection fraction. He said the patient needed an ICD placed and follow-up echo in 6 months and that the ICD would be coordinated after the echo. Ranolazine is an antianginal agent.	There is a discrepancy between history taken by the cardiologist and facility physicians. Although it is possible that the patient recently developed chest pain, it isn't clear whether the facility physicians take a careful history. The PA on 6/18/14 took no history and misinterpreted the catheterization results.
6/30/2014	A PA documented return from a cardiology visit and noted ordering ranolazine and a telephonic order was in the record.	

7/1/2014	Because MARs are not present it wasn't clear how to verify receipt of medication. Another type of medication form is in the record but it isn't clear how to interpret its meaning.	
7/10/2014	A provider noted the catheterization results but only stated to continue current medical management.	
8/11/2014	A provider (illegible) saw the patient for chronic disease follow-up. There was no history at all except the check box "chest pain" was checked none. CABG was listed as a problem and the degree of control was listed as good and status as the same. This is despite a recent angiogram showing significant deterioration of the CAD and worsening ejection fraction necessitating a recommendation for a defibrillator in the future. The provider did not comment on the cardiology or cardiac catheter reports or cardiology recommendations. It appeared that these documents weren't reviewed. No action was taken. The provider did not verify that the patient was receiving his medications and since there were no MARs in the record, it was not possible to verify whether the patient was receiving medication. The provider ordered a 90-day follow-up. This was a very poor evaluation.	The provider took little history. He documented the degree of control of the coronary artery disease was in good control even though the cardiac catheterization had worsened and the patient had chest pain as described by the cardiologist. This provider ignored significant results that placed the patient at risk of harm. The provider failed to address the cardiologist recommendations for a defibrillator. The provider didn't address medications.
10/27/2014	A cardiologist note verified that an echocardiogram on 10/27/14 showed an apical thrombus. The cardiologist recommended ICD placement which had not been done; increase of the Coreg to 12.5, increasing Losartan to 100 and increase aldactone to 50. The cardiologist recommended starting warfarin because of the thrombus in the heart. The cardiologist again recommended an ICD placement.	
10/27/2014	Warfarin was started upon return from the cardiologist.	
10/30/2014	A nurse documented a "return from offsite" form and noted that a recommendation was made to increase Coreg to 12.5 and Cozaar to 100 but did not comment about the warfarin and stated that there was no plans for infirmary admission even though the patient probably needed an infirmary as he had pain walking across the room and was starting warfarin.	

10/30/2014	A provider followed up after the echocardiogram noting that there was a thrombus and that warfarin was necessary. The provider started 5 mg of warfarin but did not document increasing the other medications as recommended.	This does not indicate a careful review of the cardiologist's note and recommendations.
11/6/2014	A provider saw the patient for chronic care follow-up. The patient was now on warfarin but it isn't clear when that was prescribed as there were no orders or MARs in the record. The patient was on an unknown amount of warfarin and had no bleeding. There were no INR results prior to this date in the record. The provider didn't document an INR but wrote to hold a Coumadin dose and noted that the patient was waiting for an ICD placement. The provider listed the CAD as in good control despite recent notes to the contrary by a cardiologist. The history was poor. Except for noting no bleeding there was no written history.	Lack of documented history is a problem. Documenting that the patient is in good control is not reflective of cardiology notes. The doctor didn't discuss any of the patient's medications.
11/10/2014	INR 2.4 warfarin now 3 mg	
11/13/2014	INR 3.1 warfarin 3 mg	
11/20/2014	INR 3.1 warfarin decreased to 2.5	
12/4/2014	INR 1.8 warfarin appears to be changed to 2	
12/4/2014	A doctor saw the patient for chronic illness. The patient had no bleeding. The CAD was listed as in good control. No history taken with respect to chest pain except "no c/o"; the doctor did check the chest pain box as no chest pain. The provider ordered increase of warfarin to 2.5 but there was no associated order in the record. The provider ordered 30-day follow-up.	This note did not take adequate history with respect to exercise pain or capacity.
12/8/2014	A cardiologist recommended ICD placement.	
12/11/2014	INR 4.1 warfarin was 2.5	
12/11/2014	glucose was 154	
12/18/2014	INR 2.3	
12/23/2014	Patient had ICD defibrillator placed.	
12/24/2014	A post defibrillator procedure note was recorded but the name was illegible. The staff noted that the inmate needed a bottom bunk,	
12/29/2014	An unsigned non-formulary request for Ranexa was in the record. It isn't clear if this medication was ordered or given to the patient based on documents in the record.	

12/31/2014	INR 1.0 warfarin increased to 3 mg	This is a sub-therapeutic INR so anticoagulation was not adequate.
1/3/2015	INR 1.5 warfarin increased to 4 mg	This is a sub-therapeutic INR so anticoagulation was not adequate.
1/5/2015	A doctor saw the patient for chronic illness and documented no bleeding or pre-syncope. The only other history utilized check boxes. The patient was listed as in good control for CAD despite his condition. The history was inadequate. The patient had no bleeding. The doctor increased warfarin to 4 mg but didn't indicate what the INR was. The provider didn't address the prior elevated glucose of 154.	The history was inadequate. The doctor didn't document the rationale for his treatment plan. The doctor failed to address an abnormal lab result (glucose 154).
1/6/2015	A1c was 5.6 (normal <5.7)	
1/9/2015	The patient reported falling outside of pill call. The said it just happened. The nurse took a poor history and used a skin nursing protocol. This patient had a defibrillator and was on multiple blood pressure medications. The nurse should have referred to a provider but did not.	The RN took a poor history using the wrong NET tool for the purpose. It would have been better if the nurse had not used a NET tool as there was no appropriate NET tool for this problem. The nurse did not check medications or take orthostatic blood pressure. A provider should have evaluated the patient who also needed an EKG.
1/15/2015	INR 4 warfarin held	
1/20/2015	A provider saw the patient and documented an INR of 3.1. The patient had no bleeding or bruising. The doctor noted to check on the ICD and to decrease the Coumadin from 2.5 mg and to return in a week. The provider documented ventricular thrombus as a problem.	
1/26/2015	A cardiologist saw the patient. The patient had his defibrillator interrogated. The patient did not describe his recent fall and the facility physician didn't communicate that to the cardiologist. The blood pressure was 105/72.	
1/29/2015	INR 1.1 warfarin at 2 mg	
2/2/2015	INR 1.7 3 mg	
2/5/2015	INR 2.1 3 mg	
2/9/2015	INR 2.4 warfarin now 3 mg	
1/29/2015	A brief provider note documented that the patient saw the cardiologist and would follow up in 6 months. Little history was taken. The provider noted blood pressure of 98/60 but did not address this especially with respect to the recent fall.	The provider should have adjusted blood pressure medication. The blood pressure was low.
2/9/2015	A provider noted that the blood pressure was 96/56 and the patient had postural symptoms and provider held the next doses of HCTZ and Cozaar.	This one time therapy would be inadequate. The dosage of medication should have been lowered.

2/10/2015	The BP was documented as 94/60 and a nurse was instructed to hold HCTZ and Cozaar for 2 days. The patient should have been on an infirmary unit.	This one time therapy would be inadequate. The dosage of medication should have been lowered.
2/11/2015	The BP was 116/80	
2/20/2015	Glucose was 134 and BUN was 21.	
2/12/2015	The BP was 118/84 a provider held the HCTZ and restarted Cozaar at 2.5 mg	
2/16/2015	The BP was 114/78 and the provider noted generalized swelling but no shortness of breath or chest pain. The provider re-started HCTZ. The provider did not ask about orthopnea, dyspnea on exertion or PND and didn't order an x-ray or note the abnormal glucose or BUN.	Swelling suggested heart failure and the provider should have questioned the patient about symptoms of heart failure.
2/1/2015	Through February and March the INR log showed that the values were therapeutic on 2.5 mg of warfarin.	
3/6/2015	A doctor saw the patient but only for Coumadin clinic. He took no history of bleeding or dietary issues. He did not note the INR and only documented that the anticoagulation was in good control. No follow-up was ordered.	

Patient 4

Date	Summary	Comment
12/10/2009	Arthrodesis of right ankle for Charcot arthropathy	Charcot foot is an end-stage neuropathic state affecting persons with diabetes. The nerve damage results in varying degrees of bone and joint disorganization. This disorder requires management by a team of physicians including an expert in diabetes and orthopedic physicians. Failure to manage this condition can result in loss of limb. During acute phases of this condition, the most important treatment element is off-loading or placing the person at rest so the foot is not used. Sometimes this is done with a total contact cast which should be frequently changed. Evaluation by an orthopedic doctor who specializes in this condition is important. This patient already had surgery in 2009 to ameliorate this condition.
3/5/2010	Adjustment of right external fixator	

8/24/2010	Orthopedic surgeon recommends total contact insert with arch filling shoe lift with rocker sole for normalizing gait. Recommended orthotic.	
11/25/2010	Admitted to a hospital for a major depressive disorder.	
2/28/2012	Developed stress fracture through Charcot arthropathic ankle. They planned on immobilizing him. CT scan showed a nondisplaced undulating fracture of distal right tibia.	
3/26/2012	Pt now in ADOC and had hypoglycemia. The blood sugar was 27 and increased to 145 after glucagon.	There were no medical records with respect to this patient's intake or the months after intake. The record provided did not include the initial history and physical examination even though these documents are to move forward to subsequent records according to OHS policy. It was not possible in this record to determine when the patient came into prison. There was another intake evaluation in July. It isn't clear whether this person was re-incarcerated because documents indicating what happened are not present in the medical record.
6/19/2012	At orthopedic surgery. Persistent fracture site. Ortho felt he might have osteomyelitis. They ordered CRP, ESR, and white count and wanted to see him back after labs. The orthopedic surgeon was contemplating a cast to immobilize him but was concerned that the patient might have osteomyelitis and wanted to wait to exclude infection before placing a cast.	It appears that this occurred when the patient was a civilian or possibly from a local jail. In any case, the surgeon wanted to exclude infection and immobilize the patient.
7/18/2012	The patient had intake screening by an officer	
7/18/2012	Patient saw a nurse emergently. BP 140/76. Pt said he broke his ankle in the county jail. The patient was on crutches and had a leg brace. The patient was placed in general population.	The nurse failed to identify that the patient had a Charcot joint and did not understand how to treat this.
7/18/2012	A nurse completed intake form 2 the new arrival screening. The weight was documented as 242 pounds and the blood sugar upon arrival was 350. A repeat sugar was 63 on 7/19/12. The blood pressure was 140/100.	
7/19/2012	EKG form; blood pressure listed as 140/100	

7/19/2012	A nurse completing intake Form 3 indicated that the patient was to have had follow-up with orthopedics but failed to go to that appointment. This apparently was not communicated to the provider who did not order follow-up with an orthopedic physician who specializes in Charcot foot. The nurse noted that the patient was to be non-weight bearing.	This nurse history appears disconnected from the subsequent provider examination. The patient needed follow-up with an orthopedic physician and this was known to ADOC but through poor communication and history, providers appeared to ignore this need.
7/19/2012	The initial provider history and physical did not document that the patient had a Charcot foot with a follow-up tibial stress fracture. The problem list entry for 7/19/12 did list Charcot foot. No plan for follow-up was developed. The physician documented chronic scarring of the right leg but no other sign of infection.	This included virtually no history as it did not document important elements of the patient's history. The provider failed to order a necessary follow-up with an orthopedic specialist. This was necessary because the ADOC did not have that expertise available. Although the patient was known to need non-weight bearing status, he was placed in general population. He should have been placed on an infirmary unit so he would not be forced to ambulate.
7/19/2012	An unknown medical staff documented a monofilament test of the inmate and documented that the patient had appropriate footwear and was wearing properly fitted shoes. Although the patient had R foot drop no reason was given as an etiology. The staff documented no loss of protective sensation.	This demonstrates a lack of understanding of Charcot foot and a neuropathic evaluation. Charcot foot results in loss of protective sensation so it isn't clear how the nurse could document that this person had no loss of protective sensation. The form used by the nurse has a check box for Charcot foot but the nurse appeared to not understand that the patient had this condition.
7/19/2012	A physician ordered clindamycin for 10 days; it wasn't clear what this was for. The insulin order was 70/30 50 units BID	It appears the medical records are missing or a provider prescribed an antibiotic without documenting a note.
7/20/2012	MAR for July show he received only 17 of 20 doses of clindamycin.	The patient did not receive prescribed medications.
7/21/2012	Humalin 70/30 was changed to 40 units BID.	
7/21/2012	The patient was seen emergently for lethargy. The blood sugar was 29. Glucagon was given.	The nurse failed to refer to a physician so the insulin could be adjusted. A physician was notified but no appointment made to adjust insulin.
7/22/2012	A1c 8.8; alk phos 246; creatinine 0.7	These are abnormal values and were not followed up.
7/24/2012	Patient complained about his sugars being up but the nurse didn't check the blood sugar or note his blood sugar values.	A nurse failed to appropriately assess the patient.
7/26/2012	A nurse performed a wound evaluation. The patient had a healed ulcerated area of his right lower extremity with edema. The nurse thought the patient had chronic hidradenitis.	The patient had a diabetic foot and should have been placed on the infirmary and had a work up for osteomyelitis. This was the same work up initiated by the orthopedic physician a month previous. No one identified this as a problem.

8/7/2012	A blood sugar log from 8/7 to 8/15 shows all values very high with 4 values over 400. These were twice a day tests.	
8/12/2012	Patient placed a health request asking to see a doctor about his leg. He said his leg was broken and something needed to be done. He mentioned that his leg was numb.	The numbness is consistent with the neuropathy. The ADOC nurse had previously documented that the patient had no neuropathic changes.
8/14/2012	A nurse saw the patient and noted that the patient had a broken leg and had constant pain. The nurse noted discoloration and swelling of the leg. The nurse referred to a mid-level.	
8/14/2012	X ray showed healed tibial fracture	
8/14/2012	Pt saw a mid-level who noted that the patient had yet to have an x-ray. The provider documented that the patient had Charcot arthropathy and noted increased swelling. The mid-level noted a chronically edematous ankle with post-surgical deformity. The mid-level requested an orthopedic FU.	There was no evidence of a request for orthopedic consultation in the medical record. It does not appear that this referral was made. The ADOC was ignoring this important need and the patient was at risk of losing his limb.
8/16/2012	Blood sugar log 8/16 to 8/24 showed 6 values over 400 with the highest 469	The providers were not managing this patient's diabetes very well.
8/20/2012	Chronic disease clinic. The history was very poor. The review of systems noted no foot problems, weight gain, hypoglycemia, or leg swelling even though the patient had a Charcot foot, weighed 218 pounds at 6 foot (BMI 29), had a recent severe hypoglycemic episode and had recent leg swelling. In a comment section, the provider did document that the patient had prior ankle surgery 3 years ago and was told he had a stress fracture. There was no discussion of the multiple recent blood sugars of over 400. The A1c was documented as 8.8 and the patient was listed as in fair control which given blood sugar values is inaccurate. No change in medication was ordered and no follow-up with orthopedics was ordered.	This provider ignored multiple serious problems of the patient including his Charcot foot, abnormally elevated blood sugars and diabetic foot ulcer. He did not adjust insulin and did not order evaluation for osteomyelitis. This placed the patient at risk of harm and at risk for loss of limb.
8/24/2012	Blood sugar log from 8/24 to 9/1 showing 6 values above 400.	
8/30/2012	Levemir ordered 50 units PM in addition to 70/30 30 units AM with sliding scale insulin.	
9/1/2012	Blood glucose log from 9/1 to 9/8 improved with only 1 test over 400.	

9/2/2012	A1c 9.5; a provider wrote on this lab report that the insulin was being adjusted and that the A1c would be checked in 2 months.	The blood sugar control significantly deteriorated over 6 weeks of incarceration. To adjust insulin without evaluating or discussion with the patient is extremely poor practice.
9/9/2012	Blood glucose log from 9/9 to 9/15 highest value 335	
9/12/2012	AM 70/30 changed to 34 units	
9/12/2012	Chronic clinic visit. The doctor noted that the patient was receiving Levemir 50U pm and 70/30 30U am with a sliding scale in addition. This is an unusual combination as it included long acting, intermediate acting and regular on a fixed basis. Doctor didn't note the A1c values but increased the 70/30 to 34 units. The doctor noted edema of the left and right leg. The doctor failed to note that the patient had Charcot foot and did not evaluate whether the patient still had a foot ulcer. He did not include Charcot foot as a problem. The doctor did not assess whether the patient was weight bearing and whether the pain was improved in the foot.	It appeared that the doctor completely ignored the diabetic foot and Charcot foot as problems. The doctor also failed to ensure that the patient saw an orthopedic surgeon. The use of intermediate and long acting insulins is unusual.
9/16/2012	Blood glucose log with highest value 425 and 3 above 300	
9/23/2012	Blood glucose log highest value 336	
9/30/2012	Blood glucose log 9/30-10/7 highest value 314 generally better values	
10/6/2012	Blood glucose log; highest value 358 but mostly improved.	
10/13/2012	Blood glucose log only 4 above 200	
10/16/2012	Chronic care visit. The provider took virtually no history with respect to diabetes except that the patient had 2 hypoglycemic episodes. Although the patient complained of right ankle pain, the doctor took no history of weight bearing or progress of the neuropathy. Note said CBG values mostly 100-200 rarely 300. The provider made no change to therapy, stating that the patient was doing well on the current regimen when control was not at goal. Although the patient was still using crutches, the doctor didn't address the foot problem or refer to orthopedics. The diabetes was listed as in fair control yet no change to therapy.	The provider ignored a problem that placed the patient at risk of loss of limb. The blood sugars were not at goal and the doctor should have adjusted medication.
10/20/2012	Blood glucose log with 6 values > 200	
10/26/2012	Seen emergently for BS 33 at about 9 am; was incoherent. Glucose gel and glucagon were provided. No referral to a	A provider should have evaluated the patient. The insulin regimen should have been re-assessed.

	provider.	
10/27/2012	Blood glucose log with 1 above 300 several > 200	
10/30/2012	Pt seen emergently for BS 37. Pt confused and diaphoretic. Glucose was given. Nurse advised him to eat a snack.	This is the second serious hypoglycemia episode within a week. A provider should have evaluated the patient.
11/2/2012	A1c 8.4; LDL-C 83	The A1c value was improved but not at goal.
11/3/2012	BS log 4 values in 200 most in 100s	
11/10/2012	BS log with a 339 value and 2 > 200 mostly in 100s	
11/12/2012	Patient placed a health request asking about his special shoe because one of his legs was 2 inches shorter than the other. An orthopedic doctor recommended this so he could walk without crutch. This caused hip pain and swelling in his ankle. A nurse wrote on this request that he would need to sign up for sick call so he could be re-evaluated. But this is why he placed the health request.	This created an unnecessary barrier to care.
11/17/2012	BS log; only 2 >200 most in mid 100s	
11/25/2012	BS log; 5 >200 2 >300	
11/29/2012	Seen emergently for passing out. Nurses found him diaphoretic, unresponsive with BS of 34. Glucose given along with meal. This was 9:35 am.	The patient was having morning hypoglycemia. His insulin should have been adjusted.
12/2/2012	BS log 3 in 300s; 3> 200 most in high 100s	
12/9/2012	BS log 5 > 300; 1 > 200, 1 < 100. Still doing only BID BS.	
12/16/2012	BS log with 1 >300; 3> 200	
12/23/2012	BS log with 3 >300; 2> 200; 1 < 100	
12/29/2012	Seen emergently for BS of 37 at 9:20 am	The patient was having morning hypoglycemia. His insulin should have been adjusted.
12/30/2012	BS log with 3 > 300; 3 > 200; 1 < 100	
12/30/2012	Patient place request to see doctor about his insulin because of his hypoglycemia.	Nurses did not respond to this request
12/31/2012	A nurse practitioner saw the patient for his symptoms of low blood sugar. The nurse documented that the low sugars typically occurred around 7 or 8 am. The plan documented giving the patient an extra peanut butter sandwich in the morning.	This patient should have had his insulin adjusted.

1/3/2013	Chronic illness clinic. Doctor noted that the patient was on 34 units of 70/30 in am and 50 units of Levemir in pm with sliding scale. He documented that the patient was getting an additional snack and had only 1 hypoglycemic episode. The patient weighed 204 pounds which was a 38 pound weight loss since intake. This was unnoticed by the doctor. (At the chronic clinic of 9/12/12 the patient weighed 219; at intake [form 2] the patient weighed 242). The doctor documented that the last A1c was 8.4 and despite this poor control the patient was getting snacks. Instead of evaluating the weight loss the doctor implied that the patient was merely attempting to get additional snacks and so the doctor discontinued the additional snack. The doctor did not address the unusual insulin regimen which was most likely causing the hypoglycemia. The doctor made no comment about the low blood pressure of 90/50.The doctor documented poor control and said that the patient was non-compliant with diet even though the patient was losing weight. The doctor discontinued the additional snack but did not adjust the medication. The doctor performed no physical examination and did not address the Charcot foot.	The patient had 5 severe hypoglycemic episodes since the last chronic care clinic but the doctor documented only 1. The doctor failed to note significant weight loss. The doctor failed to recognize that the insulin regimen might be causing the hypoglycemia. Instead of adjusting insulin the doctor blamed the patient for trying to use hypoglycemia to get snacks. This was an extremely cynical attitude toward the patient. The doctor also failed to examine the patient and address the ongoing Charcot foot which was untreated.
1/6/2013	BS log 2>300; 2 > 200; 1 < 100	
1/6/2013	A1c 8.1	
1/13/2013	BS log 3 > 300; 4 > 200; none < 100	
1/20/2013	BS log 2 > 300; 2 > 200; 1 < 100	
1/27/2013	BS log 1 > 300; 4 >200; none < 100	
2/22/2013	Chronic clinic visit. The doctor failed to notice the 38 pound weight loss. Aside from noting no hypoglycemia, no history of the patient's diabetes was taken. The patient's leg was not addressed. The patient was listed as in fair control but no change in therapy. This was a 33 year old with a long history of diabetes. The A1c of 8.1 did show mild improvement but this was still not at goal.	Chronic clinic visits continue to fail to address the patient's serious chronic medical conditions.
3/10/2013	The patient placed a health request to get his orthotic shoe and his foot and hip hurt.	This should have been done in conjunction with his chronic clinic visits but was ignored.

3/12/2013	A nurse saw the patient after he complained about not getting his orthopedic shoe. The nurse documented that the patient had been using a crutch for 7 months. A mid-level provider then requested an evaluation for an orthotic due to Charcot foot, chronic hip pain and leg length discrepancy.	This should have been done in conjunction with his chronic clinic visits but was ignored.
3/12/2013	A mid-level provider saw the patient and noted that the patient was limping. The weight was 189 which was a 53 pound weight loss since intake. This was unnoticed.	A 53 pound weight loss was a significant finding that was ignored.
3/13/2013	Pt wrote a grievance complaining that he needed an orthotic shoe but was given a pair of "diabetic shoes" which did not allow him to walk as he had a leg discrepancy. There was no response to the grievance.	The patient needed to file a grievance to communicate with providers. The patient's serious need was ignored.
3/14/2013	The request for an orthotic was denied by Dr. Hood with a comment to manage the problem onsite. There was no appropriate way to do this as the prison did not have an onsite orthotic specialist.	This placed the patient at risk of harm and loss of limb.
3/25/2013	The patient was given a size 12 diabetic shoe. This would not have been specially fitted.	This placed the patient at risk of harm and loss of limb.
4/1/2013	The patient experienced hypoglycemia of 35. A nurse treated him with glucose gel.	The patient should have had insulin adjusted
4/26/2013	The patient filed another grievance stating that his legs were not equal length and that he was advised that he needed an orthotic to be able to walk without losing balance. He said that he had filed a previous grievance but had not heard back. There was no response on this grievance.	This placed the patient at risk of harm and loss of limb.
5/1/2013	An NP saw the patient who asked to be seen for his orthotic. The NP noted that UAB physicians had recommended the orthotic and placed another referral for the orthotic.	The NP should have placed a consult for orthopedic surgery as well.
5/2/2013	A mid-level ordered a consult for an orthotic shoe.	
5/9/2013	The request for orthotic was approved.	
5/14/2013	The patient apparently saw an orthotist who stated that the right leg was 1 3/4 inches shorter that the left and he would need a special shoe. The patient was to return for fitting.	

5/20/2013	Patient passed out from hypoglycemia. BS 36 treated with glucagon and glucose and given a food tray.	The patient should have had insulin adjusted
5/29/2013	Patient found unresponsive from hypoglycemia. BS 37.	The patient should have had insulin adjusted
6/2/2013	A1c 7.7	This is an improvement but the repeated hypoglycemia suggests that the insulin regimen should have been adjusted to try to avoid the hypoglycemia.
6/10/2013	Chronic clinic visit; there was little history. The doctor noted a few episodes of hypoglycemia, but failed to note the 52 pound weight loss. The A1c was documented as 7.7 and the doctor listed the patient in fair control yet decreased the am 70/30 insulin to 28 units.	The A1c was not at goal. To decrease the insulin would worsen diabetes control. The patient needed adjustment of the insulin regimen not necessarily a decrease in dose. The doctor failed to notice significant weight loss and failed to address one of the significant complications of his diabetes- the Charcot foot. The patient needed to see his orthopedic surgeon and orthotist.
6/12/2013	Lemevir decreased to 40 units pm from 50	
6/12/2013	The patient was found disoriented with hypoglycemia. BS was 32.	Instead of considering changing the unusual regimen of long and intermediate insulin the doctor decreased insulin. Long term, this would worsen control.
6/20/2013	The patient experienced hypoglycemia of 40. Glucagon was given.	
7/10/2013	Chronic disease clinic done by a doctor. The weight was now 176 or a 66 pound weight loss since intake. It was remarkably unnoticed by providers demonstrating significant carelessness. Since the last visit the patient had 2 severe hypoglycemic episodes but the doctor documented that the patient was not having any more episodes of hypoglycemia. The doctor documented that the patient was not compliant with diet but was not specific. The doctor noted that the A1c was 8 when the last A1c was 7.7. The doctor assessed fair diabetes control. The BS was 468. The doctor changed the 70/30 insulin to 20 units pm even though the patient was getting 70/30 insulin previously in the morning and Levemir in the pm. Using both Levemir and 70/30 in the pm would not be appropriate and might cause hypoglycemia. It ends up the prescription for 40 units of Levemir pm and 28 units of 70/30 am continued through August. The doctor did not assess the Charcot foot.	The doctor stating that the patient was non-compliant with diet implied that the patient's poor diabetes control was because he was eating too much. This is inconsistent given that the patient had lost 66 pounds. The doctor did not appear to thoroughly evaluate the patient.

7/15/2013	A nurse [title illegible] documented on a diabetic monofilament checklist form that the patient was using appropriate footwear and that the patient had no loss of protective sensation. The patient had advanced neuropathy with Charcot foot. This nurse performed this evaluation extremely poorly	The nurse appeared ignorant about how to perform this evaluation.
7/18/2013	micro albumin < 1.2	
7/19/2013	Patient seen emergently at 1:25 pm for hypoglycemia BS 41 & patient was treated with glucose.	The recent change of insulin combining intermediate and long-acting insulin at night was likely responsible for the hypoglycemia.
8/2/2013	Nurse responded emergently at 2:39 pm for hypoglycemia. BS 41. Glucagon was used. The patient was unable to respond to commands.	The recent change of insulin combining intermediate and long-acting insulin at night was likely responsible for the hypoglycemia.
8/5/2013	Crutches were discontinued.	Because the Charcot foot had yet to be evaluated by the orthopedic surgeon, it is not clear that it was appropriate for the patient to bear weight on the foot.
8/5/2013	The patient received his orthotic shoes with 1 3/4 inch build up. The patient stopped using crutches and instead used a cane. The precise shoe as described on a 1/15/14 note was a men's depth inlay shoe with neoprene heel and sole elevation.	Because the Charcot foot had yet to be evaluated by the orthopedic surgeon, it is not clear that it was appropriate for the patient to bear weight on the foot.
8/11/2013	The patient placed a health request stating that he hurt his toe and it was bleeding. The LPN didn't refer the patient but should have.	The shoe did not fit and caused bleeding. Use of the shoe should have been discontinued immediately as use of the shoe could result in ulceration, infection and risked loss of limb. The LPN was not trained in assessment and should not have evaluated the patient. There was no RN review of this note.
8/12/2013	A nurse saw the patient and noted that he scraped his big R toe and sustained bleeding from a bruise. The nurse did not refer the patient	The nurse should have referred the patient to a provider.
8/12/2013	A nurse responded emergently at 9:35 am for hypoglycemia with BS 24	
8/14/2013	An optometry diabetic eye exam only included visual acuity but no dilated eye examination results. This does not constitute an adequate diabetic eye examination.	Diabetics should have their retinas evaluated annually by someone trained in diabetic eye examinations.
8/15/2013	Nurses at 10 am emergently found the inmate unresponsive due to hypoglycemia with BS 38. Glucagon was administered.	The insulin should have been adjusted.
8/21/2013	A1c 7.9	
8/22/2013	Emergently seen at 9:45 am for hypoglycemia. BS 39	The insulin should have been adjusted.

8/29/2013	The patient was due for an annual TB check but a PPD was not planted due to a tuberculin shortage. Quantiferon was not used.	If tuberculin was not available, quantiferon should have been used.
9/4/2013	Emergently seen at 10:45 am for hypoglycemia. BS reading was LO which is too low to register. Glucagon was given.	The insulin should have been adjusted.
9/15/2013	The inmate placed a health request asking for treatment of his injured toe from an injury over a month ago. This was evaluated by an LPN who gave the patient education and sent the patient back to his cell.	An LPN should not be making assessments. An RN did not review this note. The foot problem should have been evaluated as part of chronic care but was ignored. It was even ignored by the nurses.
9/17/2013	Chronic illness clinic. The provider [who did not indicate his or her title] documented 1 episode of hypoglycemia since the last visit although there had been 5 episodes. The weight loss was now 59 pounds but was not addressed at all. The doctor took no history of medication use or timing of his insulin to uncover why the patient was experiencing repeated hypoglycemia. The A1c was listed as 7.9 and in only fair control yet the provider documented no changes to therapy. The provider did not address the patient's foot and it appears that examination of the extremities and neurological examinations were normal.	The provider failed to address the patient's serious medical problems of hypoglycemia, weight loss, and Charcot foot. This placed the patient at risk of loss of limb.
9/17/2013	On a special needs communication form a doctor signed the form ordering antibacterial soap and a post-op shoe "until foot heals!!!!" but the chronic illness clinic of the same day did not identify a problem with the foot.	
9/17/2013	A nurse saw the patient in follow-up of the health request and noted that the skin of the R big toes was being rubbed off in the shoe. The LPN evaluating the patient noted "?infected" with respect to the toe lesion. The nurse referred to a practitioner.	LPNs should not perform assessments. This was not reviewed by an RN.
9/17/2013	A provider ordered clindamycin for 10 days along with antibacterial soap and bacitracin.	

9/17/2013	A provider who did not sign their note wrote that the patient had a lesion on the R toe secondary to an injury sustained about a month previous. The toe had a large abrasion and drainage. There was no further documentation of an assessment or plan although on the same day there was an order for antibiotic. This was a diabetic foot which should have prompted infirmary admission, off-loading the foot and laboratory work to rule out infection and x-ray to consider osteomyelitis. The shoe should have been evaluated to assess whether it was contributing to the injury. It appears that this was a mid-level provider. The patient did have foot drop in this foot.	The PA inappropriately treated the patient's diabetic foot.
9/19/2013	The patient was acting bizarre due to a BS of 35. The nurse treated the patient with glucagon.	The patient should have had insulin adjusted
9/25/2013	An NP saw the patient for FU of the toe lesion. The NP noted that the patient was on Bactrim and clindamycin and that the wound was improving although the wound was still open. There was no assessment or plan.	Treatment for diabetic foot typically involves keeping the person off the foot. The patient should have been housed on the infirmary. He should also have had an x-ray, blood count and sedimentation rate.
10/1/2013	The patient was combative due to hypoglycemia with BS 42.	
10/3/2013	The patient was not able to walk because of hypoglycemia of 41. A doctor documented that because of the toe infection the patient was unable to wear his orthotic shoe and made his own "flip/flop" by connecting 5-6 flip flop soles together to correct for his leg length discrepancy. The orthotic shoe was tight and causing pressure on the wound. The nurse documented that the patient related multiple morning episodes of hypoglycemia. The patient told the doctor that after taking the 70/30 am insulin he experienced hypoglycemia. The toe had a dressing on it but there was no sign of swelling or cellulitis. The doctor changed the am 70/30 to 15 units and Levemir to 35 units.	The decrease in insulin dosage was larger than it should have been and would likely result in a deterioration of blood sugar control. The management of the diabetic foot and Charcot foot was a significant departure from standard of care. The patient should not have been weight bearing and therefore should have been housed on the infirmary. As well the doctor should have evaluated the patient with an x-ray and blood test to ensure that the patient didn't have infection. The doctor should have ensured that the patient had proper footwear because he had Charcot foot and because he had an ulcer. The patient should have been sent to an orthopedic surgeon.

10/3/2013	An NP saw the patient in FU of the toe lesion. The toe was noted to be rubbing against his shoe. The NP said that the toe was healing and did not appear infected and assessed that the wound was slowly healing. No change in therapy was recommended.	The NP should have housed the patient on the infirmary so that the patient would not bear weight on the foot. Also, an x-ray, blood count and sedimentation rate were indicated. Also the wound should have been probed to assess how deep the wound was.
10/16/2013	The patient's BS was 502; 2 hours later the blood sugar was 192.	This is a very high blood sugar. The ketones should have been checked. The insulin should have been evaluated.
10/16/2013	The patient refused to see a provider for his toe.	
11/8/2013	A mid-level provider documented draining open wounds of the buttock and a bullous wound on the finger. The assessment was an abscess of the buttock. The midlevel started Bactrim for 10 days.	The blood sugar should have been checked.
11/8/2013	The patient placed a health request because he said he was sick. An LPN saw the patient in FU of the health request. The patient complained of a swollen painful buttock abscess and a similar lesion on his L finger. The LPN referred the patient to a provider.	
11/12/2013	The laboratory called regarding a wound culture which was positive for MRSA. The MRSA was sensitive to Bactrim.	
11/12/2013	The mid-level saw the patient in FU of the wounds which were resolving. A 1 week follow-up was ordered.	
11/12/2013	A1c was 8	
11/21/2013	A1c 8.8	The blood sugar control was deteriorating
11/21/2013	NP saw the patient in FU of infection. The infection had resolved.	
11/26/2013	The inmate placed a health request stating simply "infection"	
11/27/2013	NP saw the patient in FU of infection. There was a firm red area remaining on the buttock without drainage. The NP diagnosed early soft tissue infection and started clindamycin.	Because the patient had multiple MRSA infections to his finger and buttock and a second infection on the buttock despite appropriate antibiotics, this should have been reported to infection control and the patient's living unit should have been inspected. The provider should have questioned the patient about hygiene issues.
11/27/2013	A nurse saw the patient for the health request and noted that the patient complained of infection of his buttock for 2 days. The nurse referred to an NP.	

12/5/2013	An NP saw the patient in FU of the buttock infection and documented that the infection had resolved.	
1/1/2014	A nurse saw the patient for a blood sugar of 60. The weight was now 185. Glucose and a snack were provided.	
1/24/2014	Levemir was discontinued and 70/30 was used at 36 units am and 18 units pm.	This did not take place in the context of a face to face encounter. The doctor should have discussed this change with the patient.
2/1/2014	February blood glucose logs now show very high morning BS. With 1 value 558 and 7 of the values > 400. This was for 30 days.	This showed deterioration of blood sugar control.
2/2/2014	A nurse noted that the BS was 422 but did not refer to a provider.	This was a high blood sugar and the provider should have been notified.
2/2/2014	A provider on call note documented that the patient had a BS of 558. The provider ordered 14 units of regular insulin but no follow-up. Ketones were not checked.	A provider should have followed up the patient. Also, ketones should have been checked.
2/13/2014	A1c 8.5	The diabetes control was poor.
2/20/2014	Chronic care visit by physician. The doctor did not take any history except that the patient had a hypoglycemic episode that morning and checking preformatted boxes that were not pertinent. Medication changes, or other hypo or hyperglycemic episodes were not noted. The weight was 188 or about 56 pounds of weight loss since arrival. The doctor noted poor diabetic control and discontinued sliding scale insulin but no other changes. The doctor did not evaluate the diabetic foot or Charcot foot.	The doctor did not evaluated the foot which ignored a significant problem that placed the patient at risk of harm. Discontinuing regular insulin at a time when the blood sugar control was not good was not likely to improve blood sugar control.
2/23/2014	A1c 8.4	
2/24/2014	The patient placed a health request stating his shoe was too small and rubbing on his foot. This is an important point for diabetics and should have been immediately attended to. An LPN charged him $4 to see a nurse but the patient then refused the visit.	The patient was trying to get attention for a serious medical need which was not being attended to by the medical team and he was charged.

2/26/2014	A doctor saw the patient for chronic illness visit. The doctor noted 1 episode of hypoglycemia and noted the usual blood sugars as 3-400 in am and 2-400 in pm. The doctor noted that as a civilian the patient's blood sugar was well controlled on 50 units of Lantus with regular insulin TID. The patient had cut the orthotic shoe because it fitted poorly. The A1c was listed as 8. The doctor assessed the diabetes as poorly controlled. For the first time the foot deformity was listed as a problem and was listed as in fair control. The doctor noted she would attempt to get non-formulary Levemir and request a follow-up with the orthotist. The weight was now 192 so the patient was gaining weight but it wasn't noted. Levemir was started as 35 units in pm along with 20 units of 70/30 insulin. Prior orders were discontinued for 70/30 and Levemir. The doctor continued the sliding scale insulin.	The doctor still did not recognize the Charcot foot or refer the patient to an orthopedic surgeon. The patient had been well controlled apparently on a long acting insulin with short acting insulin for meals but this treatment which is standard in the community was considered not acceptable in the ADOC. This resulted in ongoing poor diabetes control which placed the patient at risk of harm.
3/19/2014	The patient saw the orthotist who said that he could not repair the shoe because the patient now had a trigger toe at 90 degree angle to the bottom of the shoe. A new shoe was needed.	The patient's Charcot foot had deteriorated and now the patient's toe was deviated 90 degrees to the bottom of the shoe. The patient should have been evaluated by an orthopedic surgeon expert in Charcot foot as he probably needed surgery.
4/28/2014	A doctor saw the patient for chronic illness visit. No history was taken with respect to diabetes. Medication and blood sugars were not documented as reviewed since the last visit. Weight was now 190 but not mentioned. The A1c was not listed. The patient was listed as in poor control for diabetes and the plan was "look into resuming Levemir ". Otherwise no changes were made to therapy. It appears that a prescription was written on this date for 36 units of 70/30 in the pm. Although the doctor documented that the patient had pain in the right hip and ankle, the foot issue was not addressed except to prescribe Naprosyn a pain medication.	The degree of diabetes control listed as poor but insulin treatment was not documented as addressed. The non-formulary request for Levemir in February was apparently not approved. The foot was not addressed even though the patient's Charcot foot was deteriorating. The patient should have been sent to an orthopedic surgeon. This was below standard of care.
4/28/2014	A nurse saw the patient for hypoglycemia with BS 44	
5/15/2014	The patient signed for his new shoe.	

6/3/2014	Chronic clinic visit. The provider noted that the patient recently had an increase of pm insulin to 36 units. The Levemir insulin apparently had not been approved and the patient was on 70/30 insulin twice a day. The A1c was 8.5 which was not good control. The doctor noted an ulcer/abrasion on the tip of his toe. The doctor noted that the patient had neuropathy despite repeated prior normal monofilament tests by nurses. The diabetes and ulcer were listed as in fair control and neuropathy in poor control. This is the first time neuropathy was noted as a problem. The doctor didn't change the insulin dose. The doctor did not evaluate for osteomyelitis, start antibiotics, or put the foot at rest which are typical treatments for diabetic feet.	The chronic ulcer should have been evaluated for osteomyelitis and the patient should have been placed on the infirmary to avoid walking on the foot. The patient was still in poor diabetes control but no adjustment of insulin was made. The patient should have been sent to an orthopedic surgeon.
6/3/2014	A doctor used a monofilament testing for diabetics form to document a right foot ulcer and deformity with improperly fitted shoes and bilateral loss of sensation. This is the first test demonstrating loss of sensation by ADOC staff. The Charcot foot continued however to not be recognized. The degree of neuropathy was only documented as loss of protective sensation when in fact the patient had the highest degree of neuropathy which is Charcot foot.	This was not a competently completed assessment that placed the patient at risk for loss of limb.
6/10/2014	Patient found unresponsive with BS 30.	
6/19/2014	The patient placed a health request for a sore on his finger and a cold. The patient was charged $4 to see a nurse with referral to a provider.	
6/20/2014	A nurse saw the patient and noted the sore on the finger, leg and toe. The weight was listed as 205. The nurse referred to a provider for a chart review. The nurse provided antibiotic ointment.	
6/20/2014	A doctor noted that the patient had an episode of hypoglycemia with BS 29-30. Glucagon was given.	This was a severe hypoglycemic episode and the doctor should have reviewed the insulin regimen.

6/24/2014	A mid-level provider saw the patient for open wounds to his finger and toe. The patient's weight was 205. The patient was now gaining weight and had lost 37 pounds since his intake evaluation. The provider documented a healing abrasion to his leg with a chronic ulcer of his toe and a small paronychia of his finger. The diagnosis was a chronic ulcer of the toe. The only therapy was to continue current wound management which was inadequate.	The management of the chronic foot ulcer was below an acceptable standard of care.
6/24/2014	Patient experienced hypoglycemia with BS 30.	
7/2/2014	Patient experienced hypoglycemia with BS 39.	
8/9/2014	Emergently seen for BS 45.	
8/20/2014	A1c 7.8	
8/21/2014	Chronic illness visit by doctor. No history taken re hypoglycemia, medication management, other symptoms. No history taken with respect to chronic ulcer. A1c not documented. Weight now 209 but not addressed. The toe was not evaluated. The tibia wound was described as indurated. The wounds or neuropathy not listed as problems. The diabetes was listed in good control despite high A1c and hypoglycemia.	This was a poor evaluation. An A1c of 7.8 with multiple episodes of hypoglycemia is not good control. Multiple problems of the patient were not addressed.
8/25/2014	CXR no evidence of tuberculosis	
8/29/2014	Patient experienced hypoglycemia with BS 40. An LPN scheduled the patient for a nurse encounter which the patient refused. The nurse charged the patient $4	This is improper. A case could be made that the hypoglycemia resulted from poor physician insulin management yet the result of this was to charge the patient. Also, an LPN assessed the patient but the LPN is not trained to do this. A RN did not review the note.
9/2/2014	Patient experienced hypoglycemia with BS 45	
9/2/2014	Nurse noted 2 abrasions on top of L hand with drainage noted. The nurse cleaned the wound and put on a band aid.	The patient should have referred to a provider since the wound had drainage.
9/2/2014	70/30 changed from 36 to 32 units BID	The provider changed insulin without informing the patient
9/6/2014	The patient was seen for BS 36; glucagon was given	
9/17/2014	70/30 insulin changed to 34 units BID	The provider changed insulin without informing the patient
9/26/2014	70/30 insulin changed to 25 units BID	The provider changed insulin without informing the patient
9/29/2014	70/30 insulin changed to 28 units BID	The provider changed insulin without informing the patient

10/12/2014	The patient placed a health request stating he had a sore in his armpit.	
10/13/2014	An LPN saw the patient and noted several raised areas in the left axilla. The nurse referred to a provider.	RNs should perform assessments. This assessment was not signed as reviewed by an RN.
10/13/2014	A provider ordered Bactrim for 10 days. This was a telephone order documented by an LPN. There was no physical examination of the patient documented in the medical record.	It appeared that a provider ordered antibiotics based on an assessment of an LPN.
10/22/2014	An LPN saw the patient in FU of the wound and noted no drainage and a resolved skin infection. This was an LPN not licensed to perform assessments.	This is practicing out of the scope of a nurse license.
11/20/2014	A1c 8.5	The diabetes control was worsening.
11/25/2014	A1c 9.6	The diabetes control was worsening.
12/2/2014	70/30 changed to 30 units BID	The provider changed insulin without informing the patient
12/4/2014	A doctor saw the patient for chronic illness clinic. Virtually no history of the diabetes was taken except that the BS was uncontrolled and that this was inconsistent with diet. The A1c was noted as 9.6. Although the weight was now 202 it was not noted. The doctor documented fair diabetes control but made no changed to the diet. The doctor documented a normal extremity examination even though the patient had a significantly deformed right Charcot foot. The foot was not addressed. It was not clear whether the patient still had an ulcer. The doctor did not document a change in therapy.	The doctor did not adjust therapy despite uncontrolled diabetes. The document performed a careless examination documenting a normal extremity examination in a person with a deformed foot. The doctor failed to address the Charcot foot.
1/10/2015	Pt evaluated for hypoglycemia. BS 57	
1/12/2015	70/30 changed to 28 units BID	The provider changed insulin without informing the patient
1/13/2015	Chronic care visit. Little history was taken only that the patient had nocturia once. The doctor noted that the 70/30 was decreased. The examinations were listed as "WNL" even for the extremity with the foot deformity and chronic ulceration which had not been evaluated in a while. The doctor listed the diabetes in poor control but continued the present management.	This care is below acceptable standards. The doctor continued the same management for poorly controlled diabetes. Though the patient had significant foot deformity the doctor documented a normal foot examination. The Charcot foot was not evaluated and the patient was not sent to an orthopedic surgeon.
2/27/2015	A1c 9.4	The diabetes was in very poor control.
3/17/2015	The patient was evaluated for hypoglycemia with BS 41	
3/28/2015	The patient evaluated for hypoglycemia. BS 55	
3/30/2015	Apparently patient discharged.	

Patient 5

Date	Summary	Comment
12/8/2009	This chart did not contain the initial intake evaluation which by OHS policy is supposed to be in the current record.	
12/8/2008	The patient saw a cardiologist. The cardiologist noted that the patient had 2 prior stents and had another coronary artery occluded which was not stented. Because of angina symptoms, the cardiologist recommended another nuclear stress test with a follow-up after the stress test to determine if catheterization needed to be done. This test was ordered on 12/8/08 but not done. The cardiologist recommended follow-up in a year.	A recommended test was not done.
10/1/2009	Blood test showing uric acid of 7.6 (normal 2.4-7). No follow-up was noted.	This abnormal lab test wasn't noted or followed up.
12/17/2009	A nurse practitioner saw the patient for a 1 year follow-up. The NP stated that the cardiologist wanted a stress test 1 year after last follow-up which appears inaccurate. It appears that the cardiologist wanted the stress test the prior year because the patient was having symptoms. The patient still had chest pain 1-2 times a month. The NP ordered a follow-up with a physician and submitted a utilization management for stress testing.	This test was ordered a year late. Since the patient was still having chest pain the anti-angina medication should have been increased.
12/18/2009	Stress test approved by UM medical director.	
12/18/2009	The stress test was negative but the patient failed to reach 85% of maximal heart rate which limited the value of the test.	
12/28/2009	A cardiology note documented that the scan and stress test did not show evidence of ischemia. The cardiologist recommended aspirin, Niaspan, Toprol, simvastatin and isosorbide.	
1/1/2010	The January 2010 MAR does not document receipt of any of the patient's KOP medications.	Based on documentation in the MAR the patient did not receive needed medication.
1/12/2010	The inmate placed a health request stating that he hadn't received the isosorbide (Imdur). He also said he needed to see a nurse about follow-up of his blood tests.	This verifies that the patient failed to receive needed medication.
1/14/2010	A nurse documented to check the medication availability and refill if needed.	Apparently the patient hadn't received medication.
2/6/2010	A MAR for February documents receipt of all KOP medication including isosorbide.	

3/12/2010	March MAR shows delivery of KOP medications on 3/12/10 resulting in a gap of approximately 6 days without medication.	The patient failed to receive ordered medication.
4/11/2010	April MAR shows delivery of KOP medications on 4/11/10 roughly on time.	
5/12/2010	May MAR shows delivery of KOP medication on 5/12/10 roughly on time.	
6/11/2010	June MAR shows delivery of KOP medication on 6/11/10 roughly on time.	
8/14/2010	The August MAR documenting delivery of July medication on 7/11/10 and August medication on 8/14/10. The August MAR was late several days.	The patient failed to receive ordered medication.
9/17/2010	The September MAR documents delivery of KOP medication on 9/17/10 several days late.	The patient failed to receive ordered medication.
10/7/2010	An annual ADOC health evaluation is present which has a nurse signature on 10/7/10 and a provider signature on 2/9/11. This record documents a blood pressure of 136/90. The last cholesterol checked was in 2008. A provider documented that the patient had chest pain but there was no further history. Despite noting that the patient had hypertension, the provider took no action and made no comment on the elevated blood pressure. There was also no comment on the lack of cholesterol test.	The provider failed to address elevated hypertension on an annual review. The cholesterol should probably have been checked.
10/24/2010	The October MAR documents delivery of KOP medication approximately a week late.	The patient failed to receive ordered medication.
11/30/2010	November MAR documents delivery of KOP medication approximately a week late.	The patient failed to receive ordered medication.
12/31/2010	December MAR documents delivery of KOP medication approximately on time.	
1/29/2011	January MAR documents delivery of KOP medication approximately on time.	
2/10/2011	Lab tests show LDL = 49, creatinine 1.2, uric acid 6.9. The triglycerides were 217 which is high (nl < 150)	
2/28/2011	February MAR documents delivery of KOP medication approximately on time.	
3/31/2011	March MAR documents delivery of KOP medication 3 days late.	The patient failed to receive ordered medication.
4/29/2011	April MAR shows delivery of KOP medications on 4/29/11 roughly on time.	
5/30/2011	May MAR shows delivery of KOP medication on 5/30/11 roughly on time.	

6/28/2011	June MAR shows delivery of KOP medication on 6/28/11 roughly on time. In the prior year KOP medication was delivered on 6/11/10 indicating that the patient missed approximately 2.5 weeks of medication.	The patient failed to receive ordered medication.
8/1/2011	August MAR shows delivery of KOP medication on 8/1/11 a couple days late.	The patient failed to receive ordered medication.
8/17/2011	The patient wrote a grievance stating that he wanted to obtain niacin which he had previously taken for his high triglycerides. Apparently, his civilian cardiologist prescribed this for him. While it does not appear that a physician had evaluated the patient for over a year, the niacin was renewed on 8/17/11 without a physician evaluation. The patient lacks contact with a physician and needed to use the grievance process to obtain care. Even then a physician didn't assess the patient.	There was a lack of provider evaluation of this patient for chronic care needs.
9/1/2011	September MAR shows delivery of KOP medication approximately on time. Zocor is not listed on one of the 2 September MARs. The last delivery of Zocor was on 8/1/11. The second September MAR showed delivery of Zocor on 9/28/11 indicating a month of missing medication.	The patient failed to receive ordered medication.
9/13/2011	The patient filed a grievance that he had been out of his Zocor for 2 weeks.	The patient failed to receive ordered medication.
9/14/2011	A nurse wrote that the medication (presumably Zocor) was available at pill call. The MAR does not document delivery to the patient until 9/28/11. It appears that the patient missed a month of medication.	The patient failed to receive ordered medication.
9/28/2011	This September MAR shows delivery of Zocor and other KOP medications on 9/28/11.	
10/31/2011	October MAR documents delivery of KOP medication on 10/31/11 approximately 3 days late.	The patient failed to receive ordered medication.
11/30/2011	The November MAR documents delivery of KOP medication on 11/26/11 and/or 11/30/11 approximately on time.	
12/27/2011	The December MAR documents administration of KOP medication approximately on time.	
1/1/2012	A January MAR documents that the patient received no doses of aspirin, isosorbide, or Lisinopril. Nurses documented that the patient was absent for all doses.	Documentation failed to demonstrate why the patient did not receive ordered medication

1/4/2012	The January MAR documents delivery of metoprolol on 1/4/12 apparently on time.	
1/5/2012	Lab tests show a bilirubin of 1.4, LD of 244, and CO2 of 17 all of which are abnormal. There was no evidence a provider discussed whether any action needed to be done.	These lab tests were not reviewed
1/27/2012	The January MAR documents delivery of KOP medication on 1/27/12 apparently on time. A second MAR documents that the patient was absent and did not receive any doses of aspirin, isosorbide or Lisinopril. Another MAR documents the patient received this medication via KOP.	Documentation on the MAR was poor
2/26/2012	The February MAR documents delivery of KOP medication on 2/26/12 approximately on time.	
3/27/2012	The March MAR documents delivery of KOP medication approximately on time.	
4/27/2012	The March MAR documents delivery of KOP medication approximately on time.	
5/28/2012	The May MAR documents delivery of KOP medication approximately on time.	
6/27/2012	The June MAR documents delivery of medication approximately on time.	
7/16/2012	The uric acid was elevated at 7.4 (normal 3.4-7) LDL was 56 and triglycerides were 111.	These lab tests were not reviewed
7/27/2012	The July MAR documents delivery of KOP medication approximately on time.	
8/26/2012	The August MAR documents delivery of KOP medication approximately on time.	
9/5/2012	A doctor (apparently) documented discontinuation of omega 3 fatty acids because the drug was no longer a formulary medication.	
9/25/2012	The September MAR documents delivery of KOP medication approximately on time. Nitroglycerin was not included in these delivered medications.	The patient failed to receive ordered medication.
10/14/2012	The patient filed a grievance that he had not received his nitroglycerin during the month. He also complained of a hernia. He was given a truss which did not fit. He sought help for his hernia. There was no documentation in the record that this had been evaluated. The patient also complained about having his omega 3 medication discontinued.	Remarkably there were no provider notes for this patient for almost 3 years with the exception of prescriptions. The patient was addressing concerns through grievances.

10/17/2012	A nurse responded to the grievance of 10/14/12 stating that the nitroglycerin was available, that the omega 3 was discontinued and that if the truss didn't fit, the patient should sign up for sick call. There was no evidence that a physician had evaluated the patient for his multiple conditions for over a couple years.	The patient failed to receive ordered medication.
10/25/2012	The October MAR documents delivery of KOP medication approximately on time.	
11/29/2012	The November MAR documents delivery of most KOP medication approximately 4 days late. The November MAR documented that nitroglycerin was delivered 10/25/12 but this appears to be a postdated entry.	The patient failed to receive ordered medication.
12/13/2012	An LPN documented that the patient received a hernia truss. There was no provider evaluation associated with provision of this item.	It appears that the nurse was managing the patient's medical condition (presumed hernia) which is beyond the scope of her license.
12/26/2012	The December MAR documents administration of KOP medication including aspirin, metoprolol, simvastatin, and ranitidine on 12/26/12 approximately on time. Nitroglycerin, Lisinopril, niacin, Imdur were not apparently delivered to the patient.	The patient failed to receive ordered medication.
12/31/2012	The patient filed a grievance that he again had run out of his heart medication for 6 days. The patient implied that his medication was persistently delayed.	The patient's failure to receive medication was handled through the grievance process. There was no evidence of a provider evaluation.
1/1/2013	A MAR documents that the patient received Imdur, Lisinopril, niacin but not nitroglycerin.	The patient failed to receive ordered medication.
1/2/2013	A nurse responded to the grievance that the patient should check pill call on 1/4//13	
1/9/2013	A nurse chronic disease flow sheet documents a blood pressure of 142/96 which is high. There is no evidence of follow-up.	The patient should have been following with a physician
1/21/2013	The patient placed a health request stating that his left eye was swollen and pink. A nurse saw the patient and referred the patient to nurse sick call. This patient should have seen a physician.	
1/22/2013	A nurse evaluated the patient for a red swollen eye. The blood pressure was 180/80. The nurse referred the patient to a provider. There is no evidence in the medical record that the provider visit occurred.	The patient had a pink eye and elevated blood pressure but failed to see a physician. It appears that there were no physicians at this site as this patient hadn't seen one in years.
1/25/2013	A January MAR documents that the patient received KOP medications on 1/25/13 approximately on time. The patient did not receive nitroglycerin or Imdur.	The patient failed to receive ordered medication.

2/21/2013	The patient placed a health request to discuss his medication and diet. The nurse referred the patient to nurse sick call.	The patient continued to fail to see a physician.
4/18/2013	A nurse chronic disease flow sheet documents a blood pressure of 168/106 which is high and a deterioration of the blood pressure documented on 1/9/13.	The patient was at risk of harm due to failure to regularly see a physician.
7/15/2013	The patient filed a grievance that he had run out of medication and failed to receive renewals. A nurse responded that the medication was reordered. Notably, there is no evidence that a physician or other provider saw the patient for over 2 years. Also, there were no MAR records in the medical record so receipt of medication could not be verified.	The grievance process apparently has failed to ensure that the patient receive needed medication as the patient has repeatedly filed grievances to obtain medication.
12/19/2013	A December MAR documents receipt of aspirin, HCTZ, Imdur, Lisinopril, metoprolol, and niacin. But on 12/27/13 the patient filed a grievance that his aspirin dose was changed to 81 mg from 325 mg. A nurse responded on the grievance form that this was the recommended dose. There is no verification in the record that a physician discussed this change with a doctor. Also, the patient now appeared to be on HCTZ and antihypertensive medication but there is no verification that a physician saw the patient with respect to starting this medication. There was also no evidence in the medical record of a prescription for HCTZ.	Physicians apparently changed prescription medication without discussing with the patient. There was no evidence of a physician visit for years. Management appeared by remote control.
12/31/2013	The patient placed a health request asking to see a provider for his medical conditions. It does not appear that the patient had seen a provider for his chronic illnesses for a few years. The nurse charged the patient $4	Failure to see a provider placed the inmate at risk of harm.
1/2/2014	A nurse referred the patient to a provider based on the patient's request of 12/31/13.	
1/2/2014	An LPN evaluated the patient for his health request of 12/31/13. The nurse took a history that the patient said he was staggering and unable to work. The blood pressure was 130/90. The nurse gave the patient OTC medication based on a protocol which wasn't stipulated. Also, this note did not document referral to a provider although the nurse reviewing the health request of 12/31/13 did refer to a provider.	This was a serious symptom that required immediate attention. Yet the patient was only evaluated by an LPN who is not trained in nursing assessments.

1/7/2014	A provider documented a chronic care visit which was the first chronic care visit documented in the medical record and the first provider visit since 2009. The provider listed only 2 medical conditions hypertension and high blood lipids and did not address the coronary artery disease. The weight was 193 The provider documented that the patient complained of "staggering from side to side at times when walking". But except for documenting that the patient had no dizziness, no history was taken. The provider documented "WNL" for the physical examination but didn't document what examinations were performed. The complaint of staggering was not addressed. The coronary artery disease was not addressed. The provider did not address medication issues. The only plan was to order an electrocardiogram and raise the dose of aspirin.	This evaluation was a significant departure from standard of care as no history was taken relative to a serious medical complaint. Since the patient hadn't been evaluated in over 4 years, a thorough history and physical examination was indicated. It isn't clear what was actually examined by the provider. The patient's complaints were not all addressed. The patient's complaints were consistent with serious neurological problems that were not evaluated.
1/15/2014	The patient resubmitted the grievance stating that he believed that a cardiologist had previously recommended a higher dose of aspirin. A nurse documented on the same form that the higher dose of aspirin was ordered and would be available at pill call. The nurse did not refer to a physician.	The patient is again addressing medication concerns through the grievance process because they are not being addressed otherwise.
1/21/2014	The January MAR documented that the patient received HCTZ, Imdur, Lisinopril, Zantec, Zocor, and aspirin. Lisinopril was documented as having been given twice on the same day.	
2/20/2014	The February MAR documents delivery of KOP medication on 2/26/14 including aspirin, HCTZ, Imdur, Lisinopril, metoprolol, Zocor, ranitidine, and niacin. This did not include nitroglycerin.	The patient failed to receive ordered medication.
3/27/2014	The March MAR documents delivery of aspirin, HCTZ, Imdur, Lisinopril, metoprolol, Zocor, niacin and ranitidine but not nitroglycerin. This medication was received about a week late.	The patient failed to receive ordered medication.
4/25/2014	The April MAR documented receipt of aspirin, HCTZ, Imdur, Lisinopril, metoprolol, niacin, and Zocor but not nitroglycerin.	The patient failed to receive ordered medication.
4/27/2014	The patient filed a grievance wanting an upgrade of his medical status so he could return to work. A nurse documented that the hold could not be addressed at this time.	

5/13/2014	The patient filed another grievance asking for the medical hold to be discontinued. He complained that his medical hold status was determined without evaluation by a provider which appears to be accurate. A nurse responded that the patient had a medical classification due to his medical condition. There was no evidence in the record that this was addressed by a provider.	The failure to see a physician was affecting the ability to work and this had to be handled via a grievance process.
7/13/2014	The patient placed a health request but was not evaluated apparently because of a $4 co-pay requirement.	
7/15/2014	The patient placed another health request because of a painful throat.	
7/16/2014	An LPN saw the patient for his health request of a painful throat and referred the patient to a provider based on the patient's request apparently on 7/13/14. The patient wasn't evaluated for 2 weeks.	LPNs should not perform assessments as they have no training and it is out of the scope of their license. A RN did not review this work.
7/25/2014	Lab results showed a bilirubin high at 1.1 (normal 0.2-1), high triglycerides and high MCV. This indicates possible liver disease but there was no follow-up of this.	There was failure to follow up on abnormal lab tests.
8/1/2014	A provider saw the patient for follow-up of a sick call complaint of throat pain which was not in the medical record. The provider took a history of a sore throat for a month. The patient said he smoked for 40 years but quit about 8-9 years ago. The patient weighed 190 pounds. The patient had no adenopathy. The nurse practitioner started a trial of antibiotics and documented considering a referral to ENT if not better. A 10-day follow-up was ordered. The NP ordered an x-ray, thyroid panel, sedimentation rate and apparently an HIV test.	
8/6/2014	A provider ordered ASAP clinic to discuss the chest x-ray. This did not occur.	
8/6/2014	The chest x-ray showed bilateral interstitial markings indicative of possible pulmonary edema, atypical pneumonia or underexposed technique. This should have prompted an immediate repeat x-ray which was not done.	A potentially serious x-ray was not timely evaluated.
8/13/2014	The patient placed a sick call request complaining about his throat and because he was having a problem with his medication.	The prior NP visit of 8/1/14 documented a 10-day follow-up which did not occur. As a result the patient placed a request asking to be seen as well as to receive medication he was supposed to receive. The patient was being ignored.

8/19/2014	A provider saw the patient and documented cough and fever and noted the abnormal x-ray taken 13 days ago. The provider thought that the patient might have an abnormal lymph node on the left and that the patient might have pneumonia. The doctor ordered antibiotics and a repeat chest x-ray. A follow-up was ordered after the x-ray was done.	This evaluation took place 13 days after an abnormal x-ray was reported.
8/22/2014	Apparently the scheduled provider visit was cancelled because the x-ray wasn't done yet.	This delay in getting an x-ray for a patient with possible pneumonia is below standard of care. If the x-ray was unavailable the patient should have been sent to an emergency room for the x-ray.
8/23/2014	A repeat blood count, the thyroid studies, and CEA were normal.	
8/25/2014	A provider performed a chronic clinic visit but did not address the throat pain or abnormal x-ray. The provider took a history of shortness of breath when lying flat which is consistent with heart failure. The provider did not address the prior chest x-ray indicating possible heart failure. Only hypertension and high lipids were listed as problems. The patient's coronary artery disease, painful throat, abnormal x-ray, or potential for heart failure were not addressed. A 90-day follow-up was scheduled.	The NP did not evaluate all of the patient's problems. The patient had potential heart failure and should probably have had an echocardiogram. The failure to evaluate all of the patient's problems placed the patient at risk of harm.
9/3/2014	Lab test showed MCV elevated at 105.7. This can be indicative of liver disease.	There was no evaluation of this lab documented in progress notes.
9/8/2014	A provider ordered a thyroid panel, chest radiograph, blood count and x-ray of the neck with a return to clinic in 2-3 weeks.	
9/9/2014	A chest x-ray was reported normal.	
9/15/2014	A second chest x-ray reported right lobe atelectasis and cardiomegaly. The cardiomegaly is consistent with heart failure.	This result should have resulted in follow-up but it wasn't clear based on documentation that it was reviewed.
10/8/2014	A provider saw the patient and documented discussing the x-ray results with the patient. No specific follow-up was ordered. The provider did not ask whether the throat pain had resolved. Since there were two x-ray reports (9/9/14 and 9/15/14) one of which was abnormal, it is not clear what was discussed. The latest film was abnormal and should have prompted a follow-up possibly including an x-ray or CT scan.	Documentation of what x-ray was reviewed was poor.

11/25/2014	A nurse practitioner saw the patient for chronic care follow-up. The NP only addressed hypertension and high lipids and failed to address the patient's coronary artery disease or the abnormal chest x-ray of 9/15/14 which appears not to have been addressed. Recent abnormal lab test (MCV 105) was not addressed. Medication was not addressed. Aside from checked formatted history questions, no history was taken.	The NP did not evaluate all of the patient's problems. The patient had potential heart failure and should probably have had an echocardiogram. The failure to evaluate all of the patient's problems placed the patient at risk of harm.
2/13/2015	The patient filed a grievance stating he did not have an order for his niacin which had been prescribed previously for him to address his high blood lipids. The nurse responded that he did not have a current order for niacin and must place a sick call request. The niacin was not addressed by the NP at the latest chronic care visit in November including whether to continue or discontinue the medication. Notably, over the past year, MAR documents no longer verified receipt of medication. There are no documents in the medical record verifying receipt of medication. Only medication orders are present in the medical record.	The patient again needed to use the grievance process to obtain what he perceived as needed care.
2/19/2015	An NP saw the patient for chronic care but only documented hypertension and high blood lipids as problems. The most recent laboratory tests for lipids were not mentioned. The recent elevated MCV was not addressed. The patient complained of chest pain but his angina was not listed as a problem. The NP did not address the patient's grievance that he was no longer receiving niacin. A 90-day follow-up was ordered. The diastolic blood pressure was 90 which is high but there was no comment and the blood pressure was listed as in good control.	The NP did not evaluate all of the patient's problems. The patient had potential heart failure and should probably have had an echocardiogram. The failure to evaluate all of the patient's problems placed the patient at risk of harm.
3/4/2015	Lab tests showed a LD (lactate dehydrogenase) of 271 (normal 135-225), elevated triglycerides of 181 and MCV of 101.8 which may indicate liver disease. None of these were followed up on.	There was failure to follow up on abnormal lab tests.
5/13/2015	An NP saw the patient for chronic care but only documented hypertension and high blood lipids as problems. The abnormal lab tests of 3/4/15 were not addressed. Medications were not discussed. The comments under head and neck examination were illegible.	The NP did not evaluate all of the patient's problems. The patient had potential heart failure and should probably have had an echocardiogram. The failure to evaluate all of the patient's problems placed the patient at risk of harm.

5/28/2015	An LPN saw the patient for a sore on the right side of his face. The patient wanted to know what it was. Apparently the patient had the sore for 6 months yet this was not addressed at the 2 prior chronic illness clinics. The 2nd page of this note was missing so it wasn't clear what was done.	LPNs should not perform assessments as they have no training and it is out of the scope of their license. A RN did not review this work.
5/28/2015	The patient placed a health request for a sore on his face that wouldn't heal. The nurse referred to a medical provider. The nurse performing the assessment was an LPN. The patient was charged $4.	
5/29/2015	A provider saw the patient and noted a sore on the cheek present for 6 months. The provider noted that the patient had a prior actinic keratosis on a previous skin lesion and referred for a biopsy.	
6/11/2015	A skin biopsy of the face lesion was done.	
7/5/2015	Although the actual result was not in the medical record, a nurse practitioner documented that the biopsy showed solar keratosis.	
6/17/2015	The patient placed a health request complaining of shortness of breath at night and swollen feet. He also described chest pain with walking. A nurse did not evaluate the request stating that the patient left before being seen.	These symptoms are consistent with heart failure. The nurse should have called the patient back to be seen as this was an urgent type complaint.
7/6/2015	An NP apparently discussed the skin biopsy results with the patient but did not discuss the prior serious complaints of shortness of breath, chest pain and swollen feet. These complaints are consistent with heart failure.	The provider ignored serious medical issues
4/18/2013	Supplemental chart not provided until June 2016 right before report due. Chronic illness clinic. Provider noted that the patient wanted his niacin increased. Hypertension, high blood lipids and coronary artery disease were listed as problems but the provider took no history with respect to these conditions. The examination only documented "WNL". The blood pressure was 168/106 and the provider ordered a diuretic.	The provider took no history relevant to the patient's conditions.
4/10/2013	Supplemental chart not provided until June 2016 right before report due. The inmate placed a health request stating that staff were refusing to reorder one of his medications	The patient was not receiving ordered medication.
6/10/2013	Supplemental chart not provided until June 2016 right before report due. The inmate placed a health request stating that he was having problems with his medications.	The patient was not receiving ordered medication.

7/30/2013	Supplemental chart not provided until June 2016 right before report due. A provider saw the patient for chronic care. Only hypertension and lipid disorder were addressed. The history consisted of filling in the check box format of the chronic disease form. Medication problems were not addressed even though the patient had placed recent health requests stating that he was having problems with medication. Coronary artery disease was not listed as a problem.	The NP did not evaluate all of the patient's problems.

Patient 6

Date	Summary	Comments
4/2/2007	CT scan of the chest showed emphysema, but no evidence of the suspicious pulmonary nodule.	All patients suspicious for COPD should have spirometry and in this case full pulmonary function testing with blood gas testing, blood counts to assess for anemia, BNP with respect to assessment for heart failure, calcium and phosphorous and alpha-1 antitrypsin testing. Regular pulse oximetry should be done. ABGs should be done with low FEV1 (<50% predicted) which this patient had repeatedly, low oxygen saturation by pulse oximetry (<92 %), depressed consciousness, acute exacerbation of COPD, and assessment after initiation of oxygen in high risk patients. Chest x-ray and CT scan of chest are usually performed when cause of dyspnea is unclear and during acute exacerbations. This patient did not have recommended testing for his condition.
8/25/2009	AST 51 (<37) and ALT 70 (<40)	Providers did not appropriately assess or act on these abnormal laboratory results.
1/7/2010	T4 =15.4 (normal 4.5-12) free T4 1.81 (normal 0.93-1.7)	Providers did not appropriately assess or act on these abnormal laboratory results.
8/6/2010	An unknown writer documented that the patient was having trouble breathing. However, there were no other notes for that date and no evaluation of the patient.	
8/20/2010	A nurse practitioner saw the patient for follow-up. Virtually no history was taken. The patient had ronchi and an oxygen saturation of 94%. He was described as stable. Without an adequate history, it isn't clear how the NP came to this conclusion. The NP did not discuss medication use but renewed Advair.	The NP did not obtain a pertinent history and/or findings from examination. The NP did not establish an appropriate treatment plan for a defined problem or diagnosis which prompted this episode of care.

11/30/2010	On an annual nurse evaluation the patient had a weight of 110 and measured 5 foot 9 inches. His typical weight should have been approximately 161 pounds. So he was 50 pounds underweight. The patient reported to the nurse that he had a 20 year history of a growth on his anus. This combined with weight loss was a significant finding that required prompt work up with colonoscopy, stool guaiac and blood counts.	The nurse did not refer significant findings to a provider.
12/20/2010	An EKG documented right atrial enlargement, low voltage and septal infarct age indeterminate. This indicates that the patient might have cor pulmonale or right heart failure due to his emphysema.	A provider did not take action on this abnormal diagnostic test.
2/3/2011	A provider signed the nurse annual evaluation on 2/3/11 over 2 months after it occurred. On this day the provider documented that the patient had a sandpapery growth on the anus with 20 year history of intermittent bleeding. The growth was described as 1 cm with irregular shape. The provider diagnosed hemorrhoid vs. HPV. Given the significant low weight, it was an error not to consider cancer. Yet the NP documented that a physician also evaluated the patient and for unclear reasons the treatment was a high dose steroids which would have no effect on either HPV or hemorrhoids. Apparently, the prescription was for topical steroids which might have minimally helped hemorrhoids but might make HPV worse.	The provider did follow up to ensure that this problem resolved. Since the patient was underweight and had a suspicious lesion, he should have seen a gastroenterologist to evaluate for cancer. This was never evaluated further.
2/7/2011	A normal blood count with a high iron count was present.	
2/25/2011	An NP saw the patient in follow-up of the anal growth and noted that the patient didn't receive the Temovate (a topical steroid). The anal growth was unchanged. A 4-week follow-up was ordered. This follow-up apparently never occurred.	The NP did not order appropriate specialty consultation. The patient failed to receive ordered medication. The ADOC failed to ensure ordered follow-up occurred.
4/19/2011	A chest x-ray report indicated a mild left perihilar prominence with suboptimal lung detail.	There was no documentation of acting on this abnormal test but a repeat x-ray was done which was clear. The documentation was poor.
5/6/2011	An apparent repeat lung x-ray showed hyper-inflated lungs that were clear.	

5/12/2011	The patient was apparently asking to return to camp and was seen by an unidentified staff who noted that the patient was thin with COPD on Dulera and Atrovent and Albuterol 3 inhalers and intermittent Albuterol nebulization along with Theophylline an oral medication for severe COPD. This staff person documented that the patient could return to camp despite his COPD which had yet to be adequately classified.	The provider did not obtain pulmonary function tests/ blood gas to adequately assess the patient. The NP could have referred to a pulmonologist if he didn't know how to manage the patient.
5/20/2011	The patient was seen urgently for diarrhea but also complained of chest discomfort and said he couldn't catch his breath. The nurse practitioner documented that the patient said his inhalers were ineffective. The lung sounds were diminished. The patient was unable to lie flat without causing chest discomfort. The patient had no edema. The NP assessed COPD exacerbation and wrote to admit - but it wasn't clear where the patient was to be admitted to. The NP noted a persistent rectal lesion but did nothing about it.	The NP did not establish an appropriate treatment plan for the defined problems which prompted this episode of care. The NP didn't even obtain oxygen saturation. An echocardiogram and chest x-ray were indicated given symptoms consistent with heart failure. The NP ignored the rectal lesion. These all placed the patient at risk of harm.
5/23/2011	A chest x-ray showed bilateral pleural effusions with a metallic density in the mid lateral chest. There was atelectasis of the left	These abnormal results were not documented as followed up timely.
5/27/2011	A follow-up note for this patient was illegible. It appears that this patient had heart failure.	The illegible note made it not possible to evaluate the episode of care.
6/2/2011	A chest x-ray showed clear lungs with hyperinflation.	
7/26/2011	The lab reported a platelet count of 125 which is low. An ANA titer was high at 1:40 (normal < 1:40), the AST was high at 40 and the glucose was high at 101.	Providers did not appropriately assess or act on laboratory or imaging results.

7/28/2011	The patient was seen by an NP for FU of his COPD. The patient's weight was 126 or a gain of approximately 25 pounds. This was most likely fluid accumulation due to probable cor pulmonale. The history was poor and only documented that the patient "feels good". The NP did not note any of the abnormal labs and noted clear lungs, but did not address whether edema was present. The NP did not note the large increase in weight over a short period of time and diagnosed "stable" COPD. The NP indicated that a physician had cleared the patient to go back to camp even though he probably had active cor pulmonale.	The NP did not demonstrate that the patient was ready for discharge. The NP did not obtain pertinent history and/or findings from examination, didn't appear to make appropriate diagnoses and/or assessments, and didn't appear to develop an appropriate treatment plan.
1/10/2012	The patient had no further provider evaluations after the 7/28/11 evaluation until 1/10/12 when he placed a health request for a pain in his right lung. An LPN documented low PEFRs 270/290/300 and a weight of 115. The nurse referred to a mid-level provider.	Apparently the patient was lost to follow-up or wasn't seen for over 5 months with presumed severe COPD. The patient wasn't evaluated for over 2 weeks for this complaint which was a significant complaint. The nurse was an LPN who is not trained to perform assessments. A RN did not review the LPN note.
1/12/2012	A chest x-ray showed advanced emphysema but clear lungs	
1/25/2012	An NP saw the patient for follow-up of a chest x ray. The NP took no history except to state the patient had no complaints. The NP noted emphysema but did no other evaluation of the patient. The patient was not assessed for heart failure.	The NP did not obtain pertinent history. Although the patient had an x-ray showing emphysema, the NP did not evaluate the patient's stated problem with respect to the underlying condition.
3/21/2012	An NP saw the patient as an add-on for COPD. A nurse had seen the patient earlier and the PEFRs were 200/190/190 with a pulse of 101, weight of 115 and a respiratory rate of 24. The nurse noted use of axillary muscles to breathe. The patient described difficulty breathing and that the inhalers were ineffective but did not take a history appropriate for heart failure. The patient was described as restless and had wheezing. The NP documented that the patient had exacerbation of COPD but this diagnosis was made without any laboratory or radiographic diagnostic testing. The NP did not even document an oxygen saturation. The NP called a provider who ordered Solumedrol and oral prednisone but did so without diagnostic certainty of the patient's condition. This patient should have been sent for additional diagnostic testing.	The NP did not make appropriate diagnoses or assessments, did not obtain pertinent history and/or findings from examination, did not order appropriate diagnostic testing, and therefore did not establish and/or develop an appropriate treatment plan for the patient's problem. If immediate diagnostic testing was unavailable, the patient should have been transported to a hospital.

3/21/2012	A nursing note documented that the patient was on oxygen and had shallow breathing. The nurse noted COPD and wrote to continue monitoring. It appeared that the patient was on an infirmary or a monitored unit but there was no admission note, and no documentation of special housing.	Documentation was so poor that it was not possible to ascertain whether the patient was on a monitored unit. If the patient was on a monitored unit, providers failed to complete an admission note. If the patient was still in general population, he was inappropriately housed.
3/22/2012	An unidentified provider documented that the patient felt better but was coughing. Tachycardia was described but not quantified. The oxygen saturation was not documented or apparently done.	The patient's oxygenation is an important element of following someone with an exacerbation of COPD. The tachycardia was not addressed.
3/22/2012	A nurse documented that the patient still had problems breathing.	
3/22/2012	A provider ordered housing in MOU and discharge to camp on 3/24/12. Given the patient's condition the patient probably needed a monitored unit.	The provider did not demonstrate that the patient was ready for discharge.
3/23/2012	A doctor noted that the patient had exacerbation of COPD and was better on steroids. No history was taken. Except for listening to the lungs no examination occurred. The patient wasn't assessed for heart failure.	This was not a thorough evaluation.
3/23/2012	Chest x-ray report documents hyperinflation consistent with COPD otherwise clear.	
3/24/2012	The patient said he felt better and weighed 115 pounds. A nurse documented that the patient was being sent to camp. The nurse documented that the patient was instructed on use of KOP prednisone.	
3/24/2012	After a number of nursing notes, a nurse documented on 3/24/12 calling a physician on-call and informed to send the inmate to camp.	The patient should not have been discharged from a monitored unit unless a physician evaluated the patient face to face and ordered the discharge. The nurse appears to be discharging the patient from a monitored unit which is beyond the capabilities of a nurse.
4/12/2012	An LPN evaluated the patient for shortness of breath. The weight was 115 and oxygen saturation 94%. The nurse did not refer to a physician	Because of symptoms the nurse should have referred the patient to a provider. LPNs should not independently make assessments as this is beyond the scope of their license and training. A RN did not review the note.

9/21/2012	An LPN evaluated the patient for a presumed asthma attack, but the patient didn't have asthma. The nurse documented on a respiratory protocol that the patient had a cold and was coughing. The nurse documented that the patient was shivering "at this time". The nurse obtained a temperature of 102.7. The nurse, who was an LPN, documented giving the patient Tylenol, chlorpheniramine and guaifenesin and recommended sick call if no improvement. The nurse did not consult or refer to a physician even though a physician should have examined the patient. This examination was documented at 9:40 pm	The patient had a history of COPD and had coughing, chills, and a fever. A physician should have evaluated the patient. The nurse who evaluated the patient was an LPN. LPNs are not trained to assess patients and this is beyond the scope of their training. Notably the patient had not been evaluated by a physician in over 5 months. The patient had cough, respiratory symptoms and fever. Pneumonia should have been excluded but the patient didn't even see a provider. It appeared that there was no provider present. The patient should have been sent to a hospital. This action placed the patient at risk of harm.
9/22/2012	An RN saw the patient for shortness of breath. The nurse obtained an EKG and noted pulse of 116 and temperature of 101.1. The nurse started oxygen and consulted a physician. The plan was to transfer the patient to the MOU (presumably medical observation unit) and place on oxygen. This patient should have been sent to a hospital. The orders for the MOU were for observation, Solumedrol IM with a prednisone dose pack and oxygen. This patient had an infection. Blood cultures, blood counts, chest x-ray and antibiotics were indicated.	This patient's symptoms suggested pneumonia but there was no available physician to see the patient. The provider orders by phone were inadequate as a diagnostic evaluation. The patient was placed at risk of harm. Given the unavailability of a provider the patient should have been sent to a hospital.
9/22/2012	A nurse documented seeing the patient on the MOU (presumably the medical observation unit) and that the patient had fleeting chest pain and O2 sat 89-92% on 2 liters of oxygen. The patient had fever of 101.8 and respiratory rate of 24 with shortness of breath. The patient had productive cough. He should have been immediately hospitalized. The nurse continued to monitor the patient. A physician did not see the patient. The nurse contacted a provider by phone for orders for oxygen, an electrocardiogram, and medical observation housing.	This patient's symptoms suggested pneumonia but there was no available physician to see the patient. The provider orders by phone were inadequate as a diagnostic evaluation. The patient was placed at risk of harm. Given the unavailability of a provider the patient should have been sent to a hospital.
9/23/2012	A nurse documented that the patient was unable to walk out to the ER for assessment because he gets too short of breath with exertion.	Nurses were managing this patient who should have been hospitalized. There were no physician examinations. He should have been sent to a hospital.

9/23/2012	A provider documented that the patient had an exacerbation of COPD but took no other history except that the patient was better on steroids. The provider documented review of an x-ray that showed hyperinflation. However, there was no x-ray in the medical record.	The patient had symptoms of infection. There was no evidence of an x-ray in the medical record. But the patient certainly needed an x-ray.
9/23/2012	Another nurse note documented that the patient had a respiratory rate of 32 with a productive cough with a "bucket bottom full of fluid brownish sputum". The patient had chest pain but was afebrile. The patient should have been hospitalized.	Nurses were managing this patient who should have been hospitalized. There were no physician examinations. He should have been sent to a hospital.
9/24/2012	The patient was admitted to the infirmary. The admission note by a nurse practitioner documented diarrhea and said that the patient complained that it was hard to breathe. The NP ordered a stool specimen but did not start antibiotics, get a blood culture, blood count or blood gas. The examination did not include an oxygen saturation. The NP did not order a chest x-ray or laboratory tests indicated for his prior symptoms. The NPs history was poor and did not include information identified by nurses over the last few days.	The NP failed to take an adequate history, failed to complete an adequate examination, failed to order appropriate diagnostic tests and had a treatment plan that was not consistent with the patient's complaints for this episode of care and for his complaints over the last several days. The patient should have been sent to a hospital.
9/24/2012	An infirmary admission record recorded a pulse of 125 but a temperature of 98.7.	
9/24/2012	At 4 am a nurse documented that the patient complained of still being nauseated.	
9/24/2012	At 9:45 am a nurse recorded that the patient felt like he was going to faint. The pulse was 111 and oxygen saturation was 86% on room air. The nurse recorded shortness of breath with productive cough and use of accessory muscles to breathe. The nurse documented referral to a provider.	These are significant findings. The nurse properly referred to a provider
9/24/2012	At 9:50 am a nurse recorded a pulse of 111, an oxygen saturation of 86, PEFR of 160/170/130, respiratory rate of 26 and temperature of 98.8. An NP examined the patient as an add-on. The NP documented difficulty breathing. The NP ordered an orthostatic check, clear liquid diet, Imodium, oxygen, Hemocult, and Duoneb and continuation of prednisone along with 500 cc of intravenous fluid. This patient should have been sent to a hospital.	An NP should have sent the patient to a hospital because the vital signs including oxygen saturation indicated instability. Other diagnostic tests including blood count, blood culture, and metabolic panel should have been ordered. The patient may have needed antibiotics.

9/24/2012	At noon an RN saw the patient. The pulse was 125 and respiratory rate 26. The patient had productive cough and was using accessory muscles to breathe.	
9/25/2012	At 1:04 pm a nurse documented an oxygen saturation of 86% on room air with shortness of breath and abdominal cramping. The patient was speaking in a "pressured and scared tone". Based on the description of the patient, he should have been sent to a hospital.	The patient needed a higher level of management that was not occurring at the facility.
9/25/2012	The patient was sent to a hospital at 1:20 pm for COPD exacerbation and abdominal pain based on a nurse consultation with a physician.	The patient was on an observation unit for 3 days intermittently and inadequately evaluated by nurses and nurse practitioners without appropriate diagnostic testing. This placed the patient at significant risk of harm.
9/25/2012	At the hospital the patient had a WBC of 11.8, a pO2 of 76 with a pCO2 of 43 with a dense consolidation of the left upper lobe on chest x-ray. The sodium was 132. The patient was diagnosed with high risk respiratory failure and was admitted to the ICU. The patient was found to have a lung mass. This was consistent with pneumonia or cancer. The patient was noted to have malnutrition as well.	This patient was placed at significant risk of harm by this untimely admission to a hospital. The patient had malnutrition showing lack of attention. The patient had very infrequent provider evaluations at the prison and was not seen on two occasions for months despite having advanced COPD.
10/1/2012	The patient was discharged back to prison on antibiotics and oral steroids.	
10/1/2012	Upon return to the prison the patient was admitted to the infirmary by an RN at about 4:30 pm. The pulse was 120 and the weight 104. The patient received no nutritional supplementation.	
10/2/2012	A doctor wrote an infirmary admission note. The doctor noted that the patient was on oxygen but could come off the oxygen later. The doctor did not address the need for pulmonary function testing or blood gas testing when the patient was stable. The doctor did not address nutrition even though the patient was malnourished. COPD and post-sepsis with respiratory failure and pneumonia were the only diagnoses. The doctor wrote an order for tapering the oxygen and ultimately discontinuing after 2 days without any assessment of long-term need.	The doctor did not address all of the patient's complaints and the plan did not appropriately stage the patient's COPD disease including whether the patient needed long-term oxygen therapy. This placed the patient at risk of harm.

10/2/2012	At 3:45 pm almost 24 hours after admission, a nurse called a physician to ask about the antibiotic which apparently had not been yet given. The doctor recommended to obtain the medication from a local pharmacy.	This should have been addressed immediately upon arrival and placed the patient at risk of harm. This problem of not being able to obtain non-formulary medication is a systemic problem.
10/4/2012	A physician saw the patient and wrote an infirmary discharge note. The doctor noted that a follow-up chest x-ray needed to be checked (apparently the results were not back). The oxygen saturation was 94% on room air. The doctor documented that the onsite provider should get a CT scan when the patient arrived at his new facility and that chronic clinic follow-up should occur in 2-3 weeks. The patient was transferred back to Staton.	The provider should not have discharged the patient until the x-ray was completed.
10/5/2012	The patient was sent from Kilby to Staton. The transfer note did not document that the patient had just been hospitalized with exacerbation of COPD and pneumonia. During the infirmary stay a physician documented ordering a chest x-ray. The status of the patient's COPD was not documented. A provider ordered ensure for 2 weeks but did nothing to evaluate the low body weight and presumed malnutrition.	
10/5/2012	A provider ordered ensure BID for 14 days to be consumed in front of a nurse and a chest x-ray to be done on 10/15/12.	This is a cynical note. Why must the nutritional supplement be consumed in front of a nurse? The patient should probably have been on a medical observation unit so he could recover and receive appropriate nutritional support.
10/9/2012	The patient was discharged from the infirmary and sent back to camp.	
10/16/2012	A chest x-ray requested while on the infirmary wasn't done until 10/16/12. The lung fields were clear but showed hyperinflation.	
10/21/2012	The patient placed a health request stating only "COPD".	The 2-week appointment that was supposed to occur failed to occur and the inmate appeared to be reminding staff of a need to follow up.

10/23/2012	An NP saw the patient for follow-up on his respiratory status. Except to note that the patient was recently hospitalized, no history was taken except to note that the patient was weak and it was hard to get around. The NP assessed COPD but did not stage the patient's disease nor make note of the patient's progress. The NP did not note the x-ray results or note that a follow-up CT scan was recommended. The chronic clinic for this patient never occurred.	The evaluation was inadequate. Minimal history was taken. The NP did not order the follow-up x-ray, recommended CT scan, or order pulmonary function tests to stage the patient's COPD. This was a deviation from the standard of care.
11/5/2012	An NP saw the patient but except for noting that the patient's breathing was better took no history. The NP failed to check the x-ray or note the necessity of a CT scan. The weight wasn't assessed.	The NP failed to take an adequate history, failed to complete an adequate examination, failed to address the malnutrition and didn't properly stage the patient's COPD with pulmonary function tests.
11/7/2012	A nursing note documents that the patient stated he was "scared when I can't get my breath". This is a sign of severe disease and may have indicated need for continuous oxygen therapy for which the patient was not adequately assessed.	The nurse should have discussed this with a provider.
11/16/2012	A nurse saw the patient for difficulty breathing and increased coughing with sputum along with pain when he took a deep breath. Vitals were normal. The nurse referred to a provider.	
11/16/2012	An NP saw the patient for breathing difficulty and documented that the patient's breathing worsened necessitating an evaluation. The NP said that the patient had a breathing treatment earlier and felt better. A minimal examination was done. The NP ordered monitoring to the end of shift. This patient needed a more thorough assessment of his COPD including pulmonary function tests and a blood gas to assess whether continuous oxygen therapy was needed. The patient needed to have his COPD staged which had yet to be done while in prison. Also notably the low body weight was not assessed or addressed.	The evaluation of this patient was episodic and failed to address his long term chronic care needs.
11/19/2012	An NP saw the patient and took minimal history and performed minimal examination and assessed "stable" COPD but failed to actually thoroughly assess the patient.	There was virtually no history except that the patient felt better. It was difficult to determine on what basis the patient's COPD was stable as the provider had not established a baseline status for his condition.

11/24/2012	The patient placed a health request on this date stating "C.O.P.D." as his complaint. A nurse triaged the form on 11/25/12 and a nurse wrote a note on the health request form on 11/27/12 when the respiratory rate was 34 that the patient was sent to an emergency room. It wasn't clear if this was an off-site ER. It appears that it was the prison emergency evaluation area.	
11/25/2012	A nurse evaluated the patient for difficulty breathing. The respiratory rate was 32 and the pulse oximeter test was 97%; it isn't clear if this was on room air or not. After reassessment the respiratory rate was 26 and the oximeter was 98% on room air. The nurse called a physician who ordered Solumedrol IM. The nurse noted that the patient had audible wheezing with cough and sputum production and "active distress when breathing". This patient should have been sent to a hospital for a chest x-ray, blood work, and evaluation.	The patient needed additional diagnostic testing which was not ordered. If it was not possible to obtain these tests immediately, the patient should have been sent to a hospital.
11/27/2012	There was a physician order to admit the patient to a medical observation unit.	
11/28/2012	An NP admitted the patient to the infirmary for COPD exacerbation. The history was very poor and included no detail of his current status. The physical examination did not include oxygen saturation. The NP continued the current management.	The evaluation was inadequate.
11/28/2012	A nurse infirmary admission note documented that the patient was on Bactrim, Duonebs every 8 hours, and prednisone.	
11/28/2012	An NP note documents that a chest x-ray showed hyperinflation but the report was not in the medical record.	All records need to be filed in the medical record
11/28/2012	The patient was transferred from the infirmary to the MOU. O2 sat was 94%. The discharge medication was oral prednisone, Dulera, Atrovent MDI, Albuterol MDI and Zithromax. Dulera is Formoterol and Mometasone a long acting beta agonist and a steroid combined inhaler.	Because it wasn't clear what the patient's diagnosis was, it was unclear what the best management for the patient was. It appeared that the patient had COPD but a pulmonary function test had never been done. Therefore the stage of the patient's disease and status of the COPD if he had COPD was unknown.
1/3/2013	The patient placed a health request stating that he needed his KOP Ventolin inhaler.	The patient was not receiving needed medication

1/4/2013	A nurse used a respiratory nurse protocol to evaluate the patient for renewal of his inhaler. This should have been done in a chronic clinic encounter which had not occurred for months. The nurse referred the patient to a provider for renewal but stated that the patient was exhibiting use of accessory muscles apparently to breath. This indicated an emergency and the patient should have been seen urgently. The patient was not seen until 1/22/13 almost 3 weeks later.	The patient's chronic care follow-up hadn't occurred since the patient returned from Kilby in October of 2012. Medication renewal should occur in the process of chronic care not when the patient is suffering an exacerbation of his disease. Not immediately referring the patient placed the patient at risk of harm.
1/22/2013	An NP saw the patient and documented that a physician gave instructions to change the Dulera to QVAR. Dulera is a combination of a long acting beta agonist and steroid in an inhaler format. QVAR contains only steroid in an inhaler format. The NP documented that the patient was placed on Dulera after a hospitalization and documented referral to a physician and stated recommending that the patient remain on Dulera. This apparently is a formulary issue.	The NP took no history and did not ensure that the patient receive medication and also did not ensure that the patient was safe on the current regimen of medications.
1/25/2013	A physician did not evaluate the patient but wrote "will continue with Dulera". The lack of physician examination and evaluation was striking especially in light of the poor status of the patient. The patient had not had a chronic illness check recorded to date in the record. Providers appeared to evaluate the patient only when the patient deteriorated and then did not perform appropriate evaluations of his condition.	Without examining the patient a physician ordered medication. The patient had not had a chronic care visit in more than 2 years of medical records reviewed. Appropriate history was seldom taken, diagnostic evaluation was not performed and the patient experienced hospitalization and risk because of this lack of physician intervention.
2/5/2013	A nurse evaluated the patient for shortness of breath. The patient told the nurse he felt like he had pneumonia. Pulse was 104 and respirations 26 with a 94% saturation. The nurse documented that the patient did not have lung sounds that were clear but did not write any comment. The nurse did not refer to a provider.	This was dangerous. The patient should have been referred to a provider.
2/6/2013	The patient placed a health request stating "sick lungs" as his only comment. A triaging nurse wrote that the patient had shortness of breath when ambulating causing pain in lungs.	This request should have been immediately evaluated.

2/7/2013	A nurse evaluated the patient. The patient had temperature of 99.3 with respirations of 20. PEFRs were 200/180/220. The patient had productive cough. The nurse documented that the patient was worse and referred the patient to a provider.	
2/8/2013	An NP saw the patient. The NP took virtually no history and performed minimal examination. The NP arranged for a nebulization treatment but did not otherwise change therapy or do any other testing (e.g. chest x-ray, spirometry, blood counts, etc.)	The NP failed to take a proper history; failed to perform an adequate examination; and failed to develop an adequate treatment plan.
2/22/2013	A physician ordered a chronic clinic visit in a month and a chest x-ray for 2/25/13. The chronic clinic visit never occurred.	The patient had been incarcerated for years. Based on the chart sent to me there was not a single chronic care visit for this patient.
2/25/2013	A diet order was for an 1800 calorie diet with no snack yet the patient was significantly underweight and was described at a hospital as having malnutrition.	Providers never adequately assessed the patient's nutritional status.
2/27/2013	A chest x-ray showed emphysema.	
3/5/2013	The patient placed a health request for a rash on his foot.	
3/6/2013	A nurse evaluated the patient and described a swollen right foot with pitting edema to the ankle with tenderness to touch. The nurse referred to a provider.	
3/6/2013	A provider saw the patient for left ankle swelling and started antibiotics and ordered a blood count.	
3/8/2013	A physician saw the patient and noted that the swelling was nearly resolved and noted improved cellulitis.	
3/8/2013	The lab reported a normal blood count.	
3/11/2013	A physician ordered chronic clinic visit in a month. The chronic clinic visit never occurred.	Chronic care visits do not seem to occur at this facility (Staton).

3/14/2013	An NP documented admitting the patient apparently to an infirmary bed until seen by a physician. However, there were no physician notes in the record. Later that same day the NP documented speaking with the Regional Medical Director about the patient and said that there were further orders. Later still the same day the NP evaluated the patient and documented that the patient was breathing "OK". No history was taken and minimal physical examination was done. The plan was unclear. The initial provider orders for this date include a Duoneb treatment now with repeat PEFR testing. Later orders included changing Duoneb treatments to every 6 hours and starting Solumedrol along with Ciprofloxacin and oral prednisone on a tapering dosage. Later Theophylline was added along with 1 liter of oxygen. A chest x-ray was ordered stat.	Documentation was poor. It was not possible to determine what the providers were treating. It appeared that there was no physician at this site as the NP was communicating with the Regional Medical Director about care management.
3/15/2013	The patient was admitted to the infirmary for symptoms of COPD but the history was minimal and gave no information with respect to evolving symptoms. The only diagnosis was COPD and a plan was not documented. The provider title was not documented.	The history was poor and the provider admitting the patient documented no plan.
3/18/2013	A physician wrote a very brief note with almost no history except that the patient felt better. There was no examination except listening to the lungs. The diagnosis was advanced COPD.	This brief not was inadequate as it did not document the progress of the patient.
3/18/2013	A chest x-ray showed emphysema.	
3/20/2013	An NP saw the patient to renew an inhaler. Little history or examination occurred.	
3/21/2013	The patient was discharged from the infirmary by the Regional Medical Director's phone order. There were no thorough provider infirmary notes for this infirmary admission and a provider did not examine the patient to ensure that discharge was safe. It appeared that nurses were managing the patient because there were no physicians.	The lack of physician coverage was placing the patient's at risk of harm.

3/22/2013	Within a day of discharge from the infirmary, a nurse evaluated the patient emergently for shortness of breath. A nurse conducted a nursing evaluation for shortness of breath with coughing and labored breathing. The temperature was 100 and the pulse 108. Only the first page of this note was in the medical record. There are no provider entries for this date even though the patient should have been immediately evaluated because of elevated temperature and tachycardia. At 10:25 pm an LPN took a phone order for a blood count, blood cultures, Solumedrol, Duonebs, oxygen and Levaquin antibiotics. A physician was managing the patient remotely because there was no onsite physician.	The lack of physician coverage was placing the patient's at risk of harm.
3/23/2013	The provider infirmary admission note was written by a nurse and contained no history and no examination except that the patient was oriented and had a steady gait. The nurse called the Regional Medical Director for directions. This note was never signed by a doctor.	The nurse was acting out of the scope of her license. If the patient was unstable and there was no physician present the patient should have been sent to a hospital for physician evaluation. Instead, nurses evaluated the patient and consulted with a physician by phone. There appeared to be a lack of physician coverage at this facility.
3/25/2013	A provider apparently (note incomplete and not signed) wrote a brief note which contains no assessment or plan and virtually no history.	This was an inadequate note and may reflect lack of physician coverage.
3/25/2013	The Regional Medical Director wrote an infirmary discharge note without an examination. The doctor documented that the admission diagnosis was COPD exacerbation ruling out pneumonia and the discharge diagnosis was the same but there was no indication that an x-ray was done to rule out pneumonia. Also, The discharge orders included addition of Lasix as a stat only dose and a next available chest x-ray. The patient was on a tapering dose of oral prednisone. The indication for the Lasix was not included in the provider note and there was no examination indicating why this was necessary.	The doctor discharged the patient from the infirmary before the admitting condition had been thoroughly diagnosed. To order a diagnostic x-ray after discharge from the infirmary without an examination is poor care. The addition of the Lasix was presumably for heart failure which the doctor mentioned in his note. However, the patient needed an echocardiogram and pulmonary function tests to assist in diagnosing the patient's condition. The Regional Medical Director should have known this.
3/26/2013	The chest x-ray showed emphysema.	
3/29/2013	A provider prescribed dulera replacing QVAR.	

4/30/2013	A provider documented a note stating that the patient was still on tapering steroids. The note documented sending the patient to general population; it isn't clear that the patient was in higher level housing as there was no provider evaluation for over a month. The provider ordered hepatitis testing, blood count, chemistry panel, ferritin and ANA.	Provider visits were not consistent. Based on the provider notes, it was not clear where the patient was being housed.
5/17/2013	The ANA was positive with a titer of 1:320. The creatinine was low at 0.81 with a high LD of 247. Glucose was low at 55.	These abnormal results were not documented as followed up.
8/15/2013	A provider saw the patient and took virtually no history and performed only a brief examination. Severe COPD was the diagnosis. The patient had still not had a chronic illness visit, a PFT, or blood gas. Apparently, the patient was on long term oral steroids for his COPD and had been on steroids for months. The patient's weight was now 123 pounds so the patient had gained about 15 pounds yet the provider did not assess for long-term adverse effects of the steroids.	Lack of consistent provider coverage was resulting in harm to the patient who was on long term steroids for a condition that had not been definitively diagnosed. It was not clear that the patient needed long term steroids. The side effects of this medication were not being monitored.
8/1/2013	The patient placed a health request that stated only "C.O.P.D." An LPN evaluated the patient on 8/2/13 and noted that the patient had back pain when breathing and had productive cough with chest soreness. The nurse documented accessory muscle use.	He had not been followed in several months after discharge from a monitored unit and appeared to be asking for help. This demonstrates a lack of physician coverage. An LPN should not perform assessment examinations as they are not trained to do this. Although the LPN referred to a provider the patient wasn't seen for his complaint.
9/1/2013	An LPN saw the patient for shortness of breath. A nurse documented wheezing and use of abdominal muscles to breathe. The nurse documented use of Duonebulization but stated that they were out of albuterol which is a standard emergency medication. The patient's pulse was 118 with a respiratory rate of 24. The nurse contacted the Regional Medical Director who apparently was covering the facility. No physician referral was made.	LPNs should not make nursing assessments as they are not licensed or trained to do so. A RN did not review the LPN's note. There appeared to be no physician coverage and the Regional Medical Director phone management was inadequate for the patient. The patient should have been referred to a local hospital for evaluation since there was no physician on site. The patient had abnormal vitals and needed evaluation by a physician. This placed the patient at risk of harm.

9/3/2013	A nurse documented a note that the patient's breathing was worse and that he couldn't lie flat. These symptoms are consistent with heart failure yet the nurse did not refer to a physician. The blood pressure was very low at 86/58. The nurse documented rales in the lungs. The patient had shortness of breath with exertion. The nurse documented receiving physician orders for Solumedrol and antibiotics for 10 days. The antibiotics wasn't described and the subsequent provider note didn't document starting Solumedrol or antibiotics.	The patient's low blood pressure, abnormal breath sounds and symptoms of difficulty breathing necessitated immediate physician evaluation which did not occur. This placed the patient at risk of harm.
9/3/2013	A provider infirmary admission note by the Regional Medical Director included virtually no history except that the patient was short of breath but not coughing much. The examination included documentation of lower extremity edema but the provider did not include evaluation of heart failure and the provider didn't assess for side effects of long term prednisone use. The doctor noted that the patient was DNR status. The blood pressure was low at 86/58 but not mentioned as a problem. The doctor wrote that the patient was aware of his prognosis and didn't want life saving measures. However, it wasn't really clear what the prognosis of the patient was as so little diagnostic effort had been made that it wasn't clear that the patient's actual diagnosis was.	This was a poor evaluation. The patient should have had an echocardiogram to exclude heart failure. The long term steroid used should have been justified. There did not appear to be an adequate indication for such long term steroid use. The patient needed pulmonary function testing. If there was inadequate physician coverage, the patient should have been sent to a pulmonologist and cardiologist for definitive diagnoses. To declare that the prognosis was poor when the diagnosis wasn't clear was inappropriate and unethical.
9/4/2013	An NP saw the patient but only briefly and made no changes. The blood pressure was 84/50 with no comment. The patient's blood pressure was frequently low. The only history was the comment "doing OK". The NP documented a doctor would see the patient the next day.	This was inadequate history. A blood pressure of 85/50 is severe hypotension that needed evaluation. This was a significant departure from standard of care.
9/5/2013	The Regional Medical Director saw the patient briefly. The PEFRs were 150/200/150, weight was 118 and oxygen saturation 92%. The doctor assessed end-stage COPD yet the patient had yet to have a pulmonary function test or other assessment typical of COPD. The doctor ordered a chest x-ray.	The doctor failed to order indicated diagnostic testing to determine the accurate diagnosis of the patient.
9/5/2013	Chest x-ray reported emphysema with cystic bullous changes	

9/5/2013	The Regional Medical Director discharged the patient from the infirmary with a diagnosis of end-stage COPD. There was no physical examination. The doctor documented poor prognosis. If the patient had COPD, the stage of his COPD had not been documented by a pulmonary function test.	To document poor prognosis without ever staging the patient's COPD was inappropriate care. The patient should have seen a pulmonologist and been questioned with respect to exertional capacity. Given the lack of physician coverage at this facility, the patient should have been referred to a pulmonologist.
9/30/2013	The Regional Medical Director documented that the patient was discharged from the medical observation unit because "we do not have space for him in the MOU." There was no clinical note for this patient.	The Regional Medical Director had stated previously that the patient had a poor prognosis. If there was no room on the MOU at Staton, then he should have found room at another facility. This placed the patient at risk of harm since he would have to walk more than he was probably capable of doing.
12/28/2013	A nurse saw the patient for shortness of breath. The weight was 125. The pulse oximeter was 97%. The nurse seeing the patient was an LPN who is not trained to assess the patient. Apparently the doctor on call ordered Albuterol nebulization. According to the MARs the patient was still on oral steroids (10 mg a day).	
12/31/2013	The patient placed a health request stating that he had a cold and needed treatment. An LPN referred the patient to a provider and charged the patient $4	
1/2/2014	The patient was not seen between being on the MOU in September until 1/2/14 approximately 3 months later. An NP saw the patient, didn't note what medications the patient was using which is typical of their encounters. The patient complained of coughing up sputum and the NP documented considering antibiotics. Despite the weight gain the NP did not assess the fact that the patient had been on long-term oral steroids for almost a year. This is not a current recommended standard of care. This is particularly true as the patient had been inadequately evaluated and his COPD status was never determined. In fact the diagnosis was never clearly established.	This presumably DNR patient was not seen by a physician for over 3 months. Since the providers were treating the patient with long term steroid therapy, he was a high acuity patient but physicians did not regularly evaluate him. Long-term steroid use is questionable in persons with COPD. The patient could be expected to have more adverse consequences than benefits from the long term steroid use. If there were insufficient physicians the patient should have been sent to a pulmonologist for management.

1/2/2014	An LPN evaluated the patient using a nursing protocol. LPNs are generally not trained to make nursing assessments and should not perform nursing sick call. The patient had cough and congestion for 3-4 days coughing up yellow phlegm and was short of breath when walking. The nurse noted use of accessory muscles when breathing. The LPN noted that the patient had shortness of breath and COPD but did not document referral to a provider although it did appear that an NP saw the patient.	LPNs should not make nursing assessments as they are not licensed or trained to do so. A RN did not review the LPN's note.
1/2/2014	An NP saw the patient and noted cough. The examination was minimal. The NP ordered a chest x-ray and a "cold" protocol with a follow-up in a week and consider antibiotics.	
1/7/2014	A chest x-ray showed emphysema without significant change since September. The radiologist documented that there was either a bulla versus moderate loculated pneumothorax.	This x-ray should have been evaluated with a CT scan or consultation with a pulmonologist. Bulla that are large need to be evaluated. It is difficult to differentiate bulla from pneumothorax and CT scan may be indicated to differentiate these different conditions. Bulla that complicate COPD need to be evaluated by a pulmonologist to determine when the bulla needs surgical removal. This placed the patient at risk of harm.
1/15/2014	A provider saw the patient to follow up the cough and x-ray. The provider took no history except that the patient had no complaint. The provider did not review the x-ray but rescheduled a visit to follow up the x-ray. There was no plan.	This evaluation was poor. No history and little physical examination occurred. The provider didn't even review the x-ray that had been done a week previous.
1/17/2014	Lab tests showed a positive ANA test with a titer to 1:320. This test is associated with pulmonary fibrosis amongst other conditions which was consistent with the patient's symptoms. The patient never had a thorough diagnosis. Nothing was done to follow up on this test.	Medical staff ignored this important positive test result. This placed the patient at risk of harm.
2/4/2014	A nurse evaluated the patient who was brought to the health care unit on a stretcher with labored respiration. The pulse was 128 and pulse oximeter 96%. The nurse contacted a physician who ordered IM Solumedrol and started oxygen therapy.	There was no physician on site so care was being managed remotely. The patient should have been sent to a hospital for evaluation.
2/4/2014	An LPN noted that the patient had severe shortness of breath and was not able to talk except in short spurts. The patient was started on oxygen and the saturation was 97%. The pulse was 128 which is	LPNs should not perform independent nursing assessments as they have no training for this and it is beyond the scope of their license. A RN did not review the note.

	very high.	
2/5/2014	A physician saw the patient who complained of shortness of breath. The doctor noted shortness of breath was probably due to COPD. The O2 saturation was 96%. No change in therapy was made. The doctor did not note what medications the patient was taking. Though the MAR indicated that the patient was taking continual oral steroids the physician did not monitor for long-term effects. Also the physician did not follow up on the abnormal ANA test. The positive ANA test might have been indicative of pulmonary fibrosis, hepatitis, or other collagen vascular disease. The doctor reviewed the x-ray and documented that there were increased markings. The doctor failed to appreciate the bulla or loculated pneumothorax. The doctor, as usual, did not document whether the oxygen saturation was on room air or on oxygen. If it was on room air, the patient did not appear to have severe COPD and long term steroid use in this patient was likely harmful.	The evaluation was poor. The doctor failed to review all aspects of the chest x-ray, the ANA test result, and medication use. The patient had been on steroids continuously for about a year and the indication for this long term use was not present. The treatment was more likely causing harm than helping the patient. The patient needed evaluation by a pulmonologist as his condition was not being appropriately monitored at the facility.
2/5/2014	An EKG showed low voltage, right atrial enlargement with possible old septal infarct. The right atrial enlargement was consistent with right sided heart failure.	Although this EKG was signed as reviewed, the doctor did not perform a next obvious step which was an echocardiogram and pulmonary function test.
2/5/2014	A chest x-ray showed emphysema with bullae in the lung bases.	Bulla in the lungs needs to be evaluated if they are large. These bulla can rupture causing pneumothorax. The patient should have been sent to a pulmonologist as he probably needed a CT scan and pulmonary function testing.
2/5/2014	There was an initial nursing assessment for hospice for this patient but the date was not on the form. There were multiple illegible hospice forms in the record following this note.	The medical team was planning hospice for this patient without having established a definitive diagnosis. This is unethical as it is not clear whether the patient had a terminal disease.
2/7/2014	A nurse saw the patient who had "severe" shortness of breath while on oxygen. The patient had labored breathing. The saturation was 98% on oxygen. The patient said he felt worse with new medication being given to him. The nurse did not discuss which medication might be problematic.	The nurse failed to address the patient's concern about a medication that was resulting in increased shortness of breath.

2/7/2014	A nurse documented that the patient had obvious shortness of breath using accessory muscles and unable to speak. He had expiratory wheezing. Yet the oxygen saturation was 96% on oxygen. The respiratory rate was 26. A physician didn't see the patient.	The nurse should have discussed this with a provider.
2/9/2014	At 11:30 pm a nurse documented that the patient was severely short of breath and could barely talk. The patient said he was "not long for this world and I'm hurting so bad in my ribs, feet, head to toe all over". The nurse documented discussing hospice with the patient. This should have been done by a physician not a nurse. The nurse called the physician on call and the physician on call agreed with hospice management. Norco was started.	This is an unethical manner of instituting hospice management. This is not something that should be done over the phone and should be done when the patient is known to have a terminal condition. It isn't clear that the ADOC had established a clear diagnosis for the patient.
2/10/2014	A hospice note documented pain such that Norco (a narcotic) was started. The patient had never had a history of pain and was never evaluated for pain until he entered the hospice program. The pain was not described with respect to location and it wasn't clear what the cause of the pain was.	Either physicians had neglected to take a history of the patient's pain or the patient's pain was not significant. There was no obvious physical medical cause of pain. To start narcotics by phone order with a physician documentation of a pain syndrome is unethical.
2/10/2014	A doctor saw the patient. The pulse was 120 and oxygen was 92% on 2 liters of oxygen. The doctor took no history and performed almost no examination. The doctor noted that the patient was better since Norco was started. Narcotic medication is not known to improve COPD. The patient was on Norco presumably because he was in hospice. Since the patient did not have pain, there did not appear to be an indication for the narcotic. This could however, have an adverse effect by depressing respirations. The ANA wasn't evaluated. The doctor should have sent the patient to a higher level of care for a diagnosis.	The doctor was treating the patient with a narcotic without indication and without consideration for its potential adverse effect on his respiratory rate. The doctor's physical examination did not document a painful syndrome. Hydrocodone can cause respiratory depression which could cause death in a person with COPD. It was unethical to prescribe a narcotic to the patient without medical indication.
2/11/2014	A nurse evaluated the patient who appeared better. The oxygen saturation was 95% on 2 liters of oxygen.	
2/15/2014	Apparently the patient was in hospice and monitored only by nurses from 2/15/14 until 2/18/14	

2/18/2014	A physician saw the patient who had a pulse of 103 with an oxygen saturation of 97 on room air. The doctor wrote a very brief note stating that there was no significant change. Yet the patient was apparently not in distress and had a normal oxygen saturation on room air. This was inconsistent with severe COPD. The medications were not addressed. Pain was not addressed. The doctor did not address the patient's therapeutic plan.	The patient had a 97% oxygen saturation on room air, was on steroid medication without indication, was on narcotic medication without indication, did not have abnormal test results (ANA) reviewed, did not have a definitive status of his lung disease, and was placed in hospice when he apparently was not terminal. This is neglectful care.
2/25/2014	A nurse documented a hospice note and documented that the patient was only using oxygen at night. The patient never had an evaluation to determine if continuous oxygen was indicated. The patient did not appear to have an indication for continuous oxygen. The diagnosis may not have been correct.	
2/26/2014	A doctor saw the patient in hospice. The pulse was 82, PEFRs were better that they had been in a long time at 250/300/250 with an oxygen saturation of 93%. The patient said he felt better. The doctor took almost no history; did not address the ANA or improvement and continued DNR status.	The doctor still did not have a definitive status determined for his lung disease and did not adequately monitor the presumed COPD, long-term steroid use, narcotic use, abnormal test result (ANA). The patient should have been referred to someone who could manage the patient appropriately.
3/11/2014	A doctor again saw the patient who had normal vitals with a 98% saturation and felt "fine". Almost no history was taken with minimal physical examination. The doctor wrote that the patient was DNR even though the patient was clearly not terminal.	The doctor still did not have a definitive diagnosis of the patient's condition and did not adequately monitor the presumed COPD, long-term steroid use, narcotic use, abnormal test result (ANA). The patient should have been referred to someone who could manage the patient appropriately.
3/19/2014	A physician saw the patient in hospice the weight had increased to 127 while on continuous 10 mg of prednisone. PEFRs were 310/310/310 and saturation was 98% and the patient said he felt "OK". No history was taken. The indication for continued hospice was not clear. Minimal examination was done. Although the doctor documented that the patient was DNR the patient was clearly not terminal.	The doctor still did not have a definitive diagnosis of the patient's condition and did not adequately monitor the presumed COPD, long-term steroid use, narcotic use, abnormal test result (ANA). The patient should have been referred to someone who could manage the patient appropriately.

3/26/2014	The doctor noted weight up to 130, saturation of 98% with PEFR of 300. The doctor noted that the patient had a positive ANA and ordered a DS DNA test but instead the patient should have been referred to a rheumatologist and possibly a pulmonologist. A pulmonary function test was indicated to determine if the patient had pulmonary fibrosis.	The doctor still did not have a definitive status of the patient's lung condition and did not adequately monitor the presumed COPD, long-term steroid use, narcotic use, abnormal test result (ANA). Although the doctor acknowledged the positive ANA, the doctor did not document his reasoning why this test was abnormal. This test can be abnormal in hepatitis C, pulmonary fibrosis and other collagen vascular diseases. Which problem the patient had was not clear.
4/1/2014	A physician saw the patient who remained in hospice. PEFRs improved to 310/300/350 and saturation was 97%.	The doctor still did not have a definitive diagnosis of the patient's condition and did not adequately monitor the presumed COPD, long-term steroid use, narcotic use, abnormal test result (ANA). The patient should have been referred to someone who could manage the patient appropriately.
4/3/2014	Anti dsDNA was negative.	
4/28/2014	A doctor saw the patient with a weight of 127, saturation of 96%. The patient was short of breath. History and evaluation was minimal. The doctor did not follow up on the ds DNA and ordered routine follow-up. The patient was still in hospice but pain management and management of his illness was non-existent. The patient never was adequately diagnosed with respect to his lung disease yet was placed in hospice of end-stage COPD.	The doctor still did not have a definitive status of the patient's lung condition and did not adequately monitor the presumed COPD, long-term steroid use, narcotic use, abnormal test result (ANA). The patient should have been referred to someone who could manage the patient appropriately.
5/7/2014	A doctor saw the patient and took minimal history. The doctor noted that the ANA was positive but documented no diagnostic plan.	The doctor still did not have a definitive status of the patient's lung disease and did not adequately monitor the presumed COPD, long-term steroid use, narcotic use, abnormal test result (ANA). The patient should have been referred to someone who could manage the patient appropriately.
5/16/2014	A physician ordered a narcotic for 30 days but there was no pain evaluation of the patient. It appeared to be ordered only because the patient was in hospice but there did not appear to be an indication for a narcotic.	It is an ethical obligation of physicians to use narcotics appropriately. This requires that the narcotic use have an established indication, be used only when the net benefits outweigh the risks associated with narcotic use, respect for patient autonomy, and be fair. The respect for autonomy requires that interventions should not be imposed on any patient. Although parts of the hospice notes were illegible, it was not evident in the medical record that a physician ever had a discussion about pain with the patient and pain was not monitored on typical visits between the patient and physicians. To prescribe narcotics in this scenario is unethical.

5/30/2014	The patient placed a request asking for renewal of his pain medication.	Physician notes do not document a significant pain syndrome.
6/6/2014	The patient asked to rescind the DNR order.	
6/12/2014	The DNR status was discontinued	This calls into question the diagnostic status of the patient. Since the doctors had not definitively diagnosed the patient's conditions it was unclear what his status was. He should have been referred to outside consultants as he was not receiving a definitive diagnosis at the facility.
6/12/2014	Hydrocodone was prescribed for 2 months without indication or evaluation for a condition requiring chronic narcotics.	It is an ethical obligation of physicians to use narcotics appropriately. This requires that the narcotic use have an established indication, be used only when the net benefits outweigh the risks associated with narcotic use, respect for patient autonomy, and be fair. The respect for autonomy requires that interventions should not be imposed on any patient. Although parts of the hospice notes were illegible, it was not evident in the medical record that a physician ever had a discussion about pain with the patient and pain was not monitored on typical visits between the patient and physicians. To prescribe narcotics in this scenario is unethical.
6/16/2014	A doctor did no evaluation but wrote that the patient was being seen for chronic care evaluation. The patient was discharged to population. The chronic care note was not in the medical record.	It is not clear if a chronic care note was not done or if medical records were lost.
7/18/2014	The patient had a 3rd ANA test come back positive. The titer was high at 1:80; also the glucose was 135 and the patient was on long term steroids (10 mg prednisone daily) without good indication. Triglycerides were 211.	These results were not followed up.
7/24/2014	An A1c was ordered.	

7/24/2014	A provider saw the patient for chronic care clinic. This was the 1st chronic care visit in the record. The doctor noted hepatitis C, positive ANA and COPD as problems the weight was now 130; oxygen saturation 98%, triglycerides 217. The doctor noted that COPD was diagnosed in 1995 but PFT results were not documented. It is not clear that this was an accurate diagnosis. The doctor documented that the patient knew nothing about the positive ANA. The doctor ordered an A1c but had no therapeutic plan for the +ANA. The hepatitis C was also never evaluated. The doctor did not address medications yet the patient was continuously on oral steroids for almost a year which appeared to be raising the blood sugar. The doctor did not consider discontinuation of steroids. The indication for steroids was not clear. Long term corticosteroids are not recommended for COPD.	This was one of many different doctors evaluating the patient. Still the patient did not have a definitive status of the patient's lung condition. The ANA test was not evaluated, the patient never had a pulmonary function test, and the patient was on long term steroids without clear indication. The doctor should have referred to a pulmonologist and ordered a pulmonary function test. The etiology of the positive ANA test should have been worked up.
8/6/2014	A1c was 5.5	
8/7/2014	Chest x-ray showed changes consistent with emphysema.	
8/7/2014	A doctor saw the patient for productive cough. The doctor ordered a chest x-ray. No changes in therapy were ordered.	The history was poor.
8/26/2014	A doctor saw the patient for chronic care follow-up. PEFRs were 220/250/200. The weight was 126. The problems listed were hepatitis C, COPD, and positive ANA. The doctor listed the hepatitis C in fair control and the ANA in good control but did nothing to evaluate either of these conditions. The COPD was listed as in fair control but the condition had not been definitively staged based on information in the medical record. The doctor made no diagnostic effort to establish the status of the hepatitis C or + ANA test. Pain was not addressed although the patient appeared to still be on narcotic medication.	The doctor failed to follow all of the patient's conditions and abnormal labs. The patient still lacked a definitive status of his lung disease. The patient was still on steroids which are not recommended for long term use in COPD. The pain was not assessed even though the patient was on narcotics.

9/25/2014	A doctor saw the patient for chronic care follow-up but did no evaluation of the hepatitis C or + ANA. The doctor took no history with respect to COPD and yet diagnosed the COPD in fair control. The basis for fair control was unclear. The oxygen saturation was 98%. It was unclear if the patient was using oxygen. The doctor did not address what medications the patient was using and whether they were effective. The patient apparently remained on narcotics but pain management was not addressed and it was unclear why narcotics were being prescribed.	The doctor failed to follow all of the patient's conditions and abnormal labs. The patient still lacked a definitive status of his lung disease. The patient was still on steroids which are not recommended for long term use in COPD. The pain was not assessed even though the patient was on narcotics.
9/30/2014	Without any history or examination, a physician wrote that the patient was "advised no more Norco; start Tylenol #3".	There was no documentation with respect to an indication for any pain medication. The patient had been on narcotics for about 7 months related initially to his hospice placement. There had been no monitoring of this medication.
10/14/2014	A physician conducted chronic clinic for +ANA, hepatitis C, COPD, and narcotic use. The doctor took no history of why narcotic medication was indicated and the physical examination identified no painful conditions yet the patient was documented as in fair control with respect to narcotic use. It wasn't clear the basis for this assessment. The hepatitis C and + ANA were not evaluated or assessed. The reason for the + ANA had not been evaluated for over a year. The hepatitis C was never evaluated. The patient remained on oral steroids without clear indication and side effects were not evaluated.	The physician seemed to lack concern for that actual problems of the patient.
10/18/2014	A hepatitis C flow sheet listed AST of 27 with platelets of 177 thousand and ALT of 42. The ANA should have been evaluated to assess whether the patient had autoimmune hepatitis.	The physicians had failed to follow up on the ANA for over a year.
10/29/2014	A physician saw the patient for follow-up review of medication but the doctor without taking a history of why the patient might or might not need pain medication, assessed COPD, no painful condition and discontinued Tylenol #3. It appeared that the patient was inappropriately on narcotic medication for almost 9 months without evaluation. The ANA was not addressed.	Now that the patient had been on long term narcotics by physician prescription for an extended period of time, the patient may have become habituated to narcotics. The patient should have been tapered off these medications with use of medication for withdrawal because the physicians may have caused an addiction that could result in withdrawal.

11/23/2014	A provider was to perform a chronic clinic follow-up but the provider was unavailable and the visit was not conducted.	
12/29/2014	A doctor conducted a chronic clinic follow-up. A history with respect to COPD was not performed. The PEFRs were 160/160/150 oxygen saturation was 95%. COPD was listed as in good control and hepatitis C was in good control but the APRI indicated possible borderline fibrosis and not work up was done. The ANA continued to not be worked up. Medications were not evaluated. The patient remained on long-term steroids without monitoring.	The providers continued to fail to adequately follow all of the patient's conditions. The hepatitis C was documented as in good control when it may not have been. The positive ANA indicated possible autoimmune hepatitis.
1/23/2015	The patient placed a request stating he had something under his armpit.	
1/26/2015	An LPN evaluated the patient using a nursing skin protocol. The patient had temperature of 99.6 with redness and swelling under his arm. The LPN documented that the diameter was 2 by 2 but didn't describe the metric. The LPN documented that the patient was seen by a practitioner.	
1/26/2015	An NP saw the patient who had an abscess under his arm pit that was draining pus. The NP started an antibiotic.	
2/5/2015	A physician saw the patient. The blood pressure was now 184/80; oxygen saturation was 89% which was scratched out and 94% written in. The patient was short of breath but not coughing up sputum. The temperature was 99.1 and pulse 116. The doctor assessed stable COPD but the basis for this assessment was not clear as the saturation was lower than typical for this patient. It was not clear whether the patient was using oxygen. The doctor did not assess medication use including the long term steroid use.	The assessment was not consistent with findings. The doctor failed to assess the reason for elevated blood pressure and pulse.

1/29/2015	A physician saw the patient for chronic care follow-up. The doctor didn't document an adequate history for COPD. The saturation was 96%. COPD and ANA were listed as in fair control without a basis for giving this assessment. The physician failed again to conduct a diagnostic evaluation of the positive ANA. The hepatitis C was documented as in good control but there was no evidence that the patient was being monitored for this. The doctor noted an abscess but documented that the patient refused an incision and drainage. The doctor failed to monitor the indication for long term steroid use.	The doctor again failed to address all of the patient's problems and failed to address long term steroid use that was likely to harm the patient.
2/2/2015	A nurse noted that a physician gave orders for stat lab tests and blood cultures but stated being unable to obtain these without stating why. Solumedrol was given IM and the patient refused Duoneb. The orders were given by the Regional Medical Director because there was no physician available at the facility.	The patient should have been sent to an ER for evaluation if there were not physicians available on site. Remote control management by phone is inadequate care.
2/3/2015	A nurse documented that the patient had severe shortness of breath and was using the inhaler without improvement. The patient was on oxygen by nasal cannula. Vancomycin and Solumedrol were ordered but the physician note documenting this was not in the record.	The physician ordered medication by phone without evaluation of the patient. The lack of a physician meant that nurses were basically managing the patient.
2/3/2015	A nurse recorded that the patient had a saturation of 94% on 5 liters of oxygen which was probably too high if he had COPD. The patient was still short of breath. The pulse was 106. A physician should have seen the patient.	The lack of physician coverage was placing the patient's at risk of harm.
2/4/2015	The patient had a pulse of 102 with a respiratory rate of 26 and oxygen saturation of 94% on 5 liters of oxygen.	
2/4/2015	Levofloxacin was ordered. This would not be an appropriate medication for an abscess for which anti-MRSA treatment was indicated.	There was no evidence in the record indicating why this medication was ordered.
3/28/2015	Chronic clinic was not done because a provider wasn't available on site.	The lack of physician coverage was placing the patient's at risk of harm.

Patient 7

Date	Summary	Comment
1/10/2012	Uric acid 7.3 (normal 3.4-7); LDL 196	The elevated uric acid was not addressed.
1/30/2012	An NP saw the patient for chronic illness follow-up. Hyperlipidemia, GERD, and arthralgia were listed as chronic illnesses. There was no history with respect to GERD or arthralgia except that the patient wanted to continue NSAIDs for chronic knee pain. There was no examination of the knee. The medications were not listed as they never are. The NP documented that the patient received a food package in December which the NP attributed to the elevated LDL cholesterol which was 196. The NP documented that the patient was on HCTZ for swelling to the lower leg which had resolved since taking the medication. The etiology of the swelling was not discussed.	The LDL cholesterol test should be done as a fasting test. If the test is being done non-fasting the process should be changed.
3/17/2012	A nurse evaluated the patient for a swollen testicle. The patient had pain of 10 on a 10 point scale noted when he walked. Pain was improved with supporting the testicle. The temperature was 98.8. The nurse gave the patient ibuprofen by protocol but did not refer the patient to a provider.	This patient should have immediately been referred to a hospital. The nurse was an LPN. LPNs are not trained to perform assessments and are not licensed in most states to do assessments. This was a serious error as a swollen painful testicle can be torsion or infection which must be immediately addressed; instead an as-needed follow up was ordered if there was no resolution of symptoms. It is not unexpected that LPNs fail to adequately assess symptomatic patients as they are not trained in performing assessments.
3/19/2012	A doctor saw the patient for scrotal swelling. The doctor ordered an ultrasound of the scrotum, a blood count and bed rest. An ultrasound ordered at the facility was unlikely to be performed immediately.	Scrotal swelling is an urgent issue as testicular torsion or orchitis can result in loss of the testicle. The patient should have been immediately transferred to a hospital.
3/19/2012	WBC of 27 thousand indicating infection. Also the BUN was 50 with a creatinine of 6.3. This lab was collected and resulted (presumably reported) on 3/19/12 and the provider signed this as reviewed on 3/19/12. This patient should have immediately been sent to a hospital. There was no note related to the review of the lab.	Failure to immediately refer the patient to a hospital was a significant departure from standard of care. The lab values indicate life threatening values and based on these lab values the patient should have been admitted immediately to a hospital but admission does not appear to have occurred for a day
3/20/2012	The patient was admitted to the hospital.	

3/27/2012	The patient was discharged from the hospital. The patient had such a significant abscess that the penis was completely buried. The urethral meatus was not visible and the patient had developed urethral stricture making him unable to urinate. This resulted in renal failure and outlet obstruction. The patient had massive necrosis requiring orchiectomy and extensive debridement of necrotic tissue. The white count was over 19 thousand. The hospital physician instructed the prison to do daily dressing and debridement. The physician was worried about potential for infection and said re-admission might be necessary.	The failure to promptly hospitalize the patient for an emergency for 3 days resulted in loss of the patient's testicle.
3/27/2012	After discharge from the hospital, there were no infirmary, nursing or provider notes in the medical record. It was not possible to verify whether the patient was evaluated.	The patient was not evaluated appropriately at the facility. There appeared to be no medical director at this site and there appeared to be inadequate nurses on the infirmary. This placed the patient at risk of harm.
3/30/2012	An urologist saw the patient in FU. The wound was healing and the Foley was still in place. The patient had some swelling.	
4/1/2012	The patient returned to prison from the hospital. A nurse documented that he had 2 drains. The nurse documented that the patient was going to the infirmary.	
4/3/2012	A blood count documenting WBC of 13.1 indicating infection.	This was not followed up by providers covering the facility.
4/5/2012	A urology consultation report documented Foley catheter for urinary stricture and urinary retention and post orchiectomy due to an abscess. The urologist recommended continued antibiotics and daily dressing and packing and to leave the Foley in for the time being. A week follow-up was requested.	
4/5/2012	An NP requested a urology FU as requested for 1 week. This request was not reviewed.	There was a lack of physician coverage at the facility.

4/15/2012	The patient was admitted to the hospital for cellulitis of the surgical site. The surgeon's admission note documented that they "will try to control his diabetes". This had not been listed as a problem at the facility. A consultant during this hospitalization mentioned that during the prior admission in March the patient was treated for septic shock. The description of events then by the consultant included that the patient had pus from the abscess and "massive necrosis in the left scrotum extending to the phallus and up into the groin (there was no hernia)". The consultant mentioned that the patient had a hemoglobin of 7.3 with a hemoglobin A1c of 6.3. Apparently the patient was transfused. The 2nd surgery included debridement of necrotic tissue in the inguinal area. The infection during the 2nd hospitalization was with MRSA. The patient was discharged on HCTZ, vancomycin, Crestor, Naproxen, iron, Prilosec, and 81 mg of aspirin.	Because of lack of care of the patient, the patient developed an extensive, necrotic abscess that was life threatening. There was no documented nursing notes on the infirmary and no evidence that a provider evaluated the patient on the infirmary from the time of discharge from the hospital until this 2nd hospitalization. This is neglect. The patient needed a second surgery to debride the necrotic tissue. The lack of care harmed the patient.
4/15/2012	A nurse documented an emergency transfer because the patient had extensive cellulitis post orchiectomy 3/20/12. The nurse documented that the patient had lower extremity edema despite Lasix and had received the last dose of Levaquin that day. There was no evidence that a provider saw the patient.	
4/15/2012	An on-call provider checklist written by a nurse documented that the patient had orchiectomy and was on Lasix but still had increasing edema bilaterally.	
4/20/2012	A hospital physician (presumably the surgeon) prescribed vancomycin IVPB twice daily for 12 days	
4/20/2012	Genital culture positive for methicillin resistant staph aureus; resistance included clindamycin.	
4/23/2012	An NP referred the patient to the surgeon for follow-up indicating that the patient had acute infection. Part of the request appears redacted.	The follow-up after discharge from the hospital was also poor as there was no physician coverage.
5/11/2012	A surgeon saw the patient in follow-up of his abscess and documented that the wounds were healing and that wet to dry dressings should continue.	
5/19/2012	A catheter tip was culture positive for serratia marcescens resistant to cefazolin.	

6/4/2012	HGB 10.8	This anemia was not followed up.
6/13/2012	A provider documented that the patient was being seen for non-compliance with medications but noted that the patient was just recently discharged from the infirmary on 6/5/12 but had not received medications until 6/12/12. Presumably this was not non-compliance but failure to provide medication to the patient.	The patient failed to receive ordered medication. The system blamed the inmate for this.
7/25/2012	An NP saw the patient for chronic care follow-up and listed high blood lipids GERD, arthralgia, and s/p left orchiectomy as problems. The arthralgia and orchiectomy are probably not chronic illnesses as they may not reflect long term illness. The NP documented that the patient was taking a diuretic (HCTZ) for BP control and "mostly for swelling to lower extremity". The patient had gained 31 pounds over the past 6 months but this was not addressed. High blood pressure wasn't listed as a chronic illness and neither was chronic lymphedema. The LDL cholesterol was 72 and uric acid was listed as 9.3. The patient's medications were not listed. The patient had no edema on physical examination. The assessment included only high blood lipids documented as in good control and increased uric acid. The NP stopped the HCTZ and started aldactone. HCTZ can elevate the uric acid.	The patient's problems were not all covered during the chronic care episode. The weight gain was not evaluated.
7/25/2012	Uric acid 9.2; iron 30; LDL 72; HGB 12.2	
9/29/2012	The patient placed a health request stating that his legs, ankles and feet are swollen. He stated that since stopping HCTZ, the swelling started.	Given the patient's high blood pressure, heart failure should have been considered.
10/1/2012	A nurse wrote on the health request that the patient had just been started on aldactone but that it wasn't working. The nurse documented pitting edema to the L leg. The nurse consulted with an NP who started Lasix by phone and ordered a clinic follow-up in 2-3 weeks. The patient's weight was 293 pounds	The patient's symptom of leg swelling was being treated episodically instead of evaluating why it was occurring. The patient had indications for an echocardiogram and additional liver function tests. This response is below the standard of care.
10/2/2012	An NP started Lasix 40 mg a day for 180 days and renewed allopurinol.	

10/16/2012	An NP documented that the patient had less swelling. On examination no edema was noted. The assessment was bilateral lower extremity edema improving on Lasix.	The patient had no edema but the NP did not evaluate for the cause of the leg swelling.
11/13/2012	LDL 93; HGB 11.7; uric acid 5.6, triglycerides 172	The triglycerides were elevated.
11/19/2012	An NP ordered Crestor, increased iron to BID, aspirin, Colace, Lasix, Naprosyn, and Prilosec for 180 days.	
11/19/2012	An NP saw the patient in follow-up and noted that there was no swelling and documented that the lower extremity edema was resolving. Anemia from surgery was listed a problem and the NP increased the iron to BID but did not document a blood count.	
1/23/2013	Iron 34 (normal 45-160); LDL 99; HGB 12; uric acid 6.8 (8.6-10.2); triglycerides 244.	
1/28/2013	An NP ordered aldactone for 180 days	
1/29/2013	An NP saw the patient for chronic care and listed mixed dyslipidemia, hyperuricemia and anemia as chronic diseases. The blood pressure was borderline elevated hypertension at 120/90. No pertinent history was taken. The LDL cholesterol was listed as 99 with a triglycerides of 244.	
3/12/2013	The patient refused prostate, rectal, testicular exams as well as stool for occult blood.	
4/1/2013	An NP ordered allopurinol for 180 days	
4/24/2013	An NP ordered Colace, Crestor, aspirin, iron, Lasix and Prilosec for 180 days	

5/30/2013	The patient filed a pro se malpractice suit in circuit court of Limestone County against Corizon, et al. The claim was that on March 16, 2012 the patient noticed swelling in his groin and scrotum. The patient stated that on Saturday 3/16/13 the patient sought medical care by notifying the officer that he wanted to be seen in health care. The patient couldn't walk so he was placed on a wheelchair and taken to the health care unit. A nurse saw him. The patient alleges that there was no practitioner on duty and that the nurse accused him of waiting until the weekend so that he could expose himself to the nurse. The patient alleges that the nurse did not call a provider; instead gave him Tylenol and instructed him to ice the scrotum and that he would see a physician the following Monday. The patient alleges that the following Monday the doctor was not available in the morning. Later that day the doctor saw the patient who apparently had swelling in the groin area and scrotum. The patient said he wasn't able to urinate. The doctor placed the patient in the health care unit and ordered drinking water and ice on the scrotum. The patient then alleged that on Tuesday the doctor attempted at catheterize the bladder but was unsuccessful. The doctor then arranged to have the patient transferred to a hospital. The patient was told that he had gangrene of his scrotum which required surgery including removal of the left testicle. The patient alleges that follow-up care after hospitalization was poor resulting in an infection to his surgical site necessitating re-hospitalization and a second surgery. The patient alleged that failure to adequately change dressings resulted in the infection. After return to the prison, follow-up with the surgeon was allegedly prohibited. The patient apparently lost blood during the surgery but claims that no action was taken. Months later the patient claims that prison staff left packing inside his wound which he physically removed in June 2012.	This is the patient's version of events.
6/26/2013	An NP ordered aldactone for 180 days	
7/25/2013	An NP ordered Crestor for 180 days	
7/25/2013	LDL 155 TG 221; HGB 12.8; uric acid 6.3	The LDL cholesterol in again dramatically elevated.

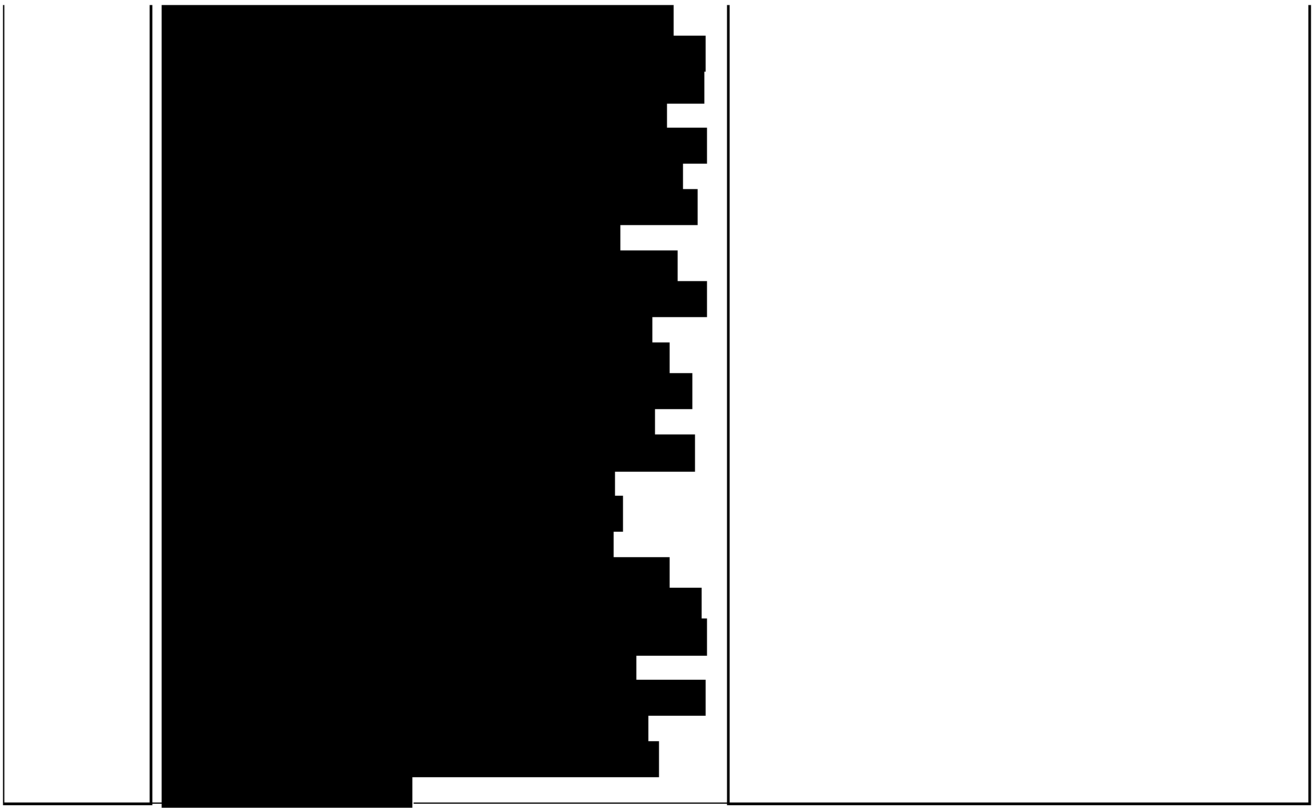
8/6/2013	An NP saw the patient in chronic care and documented that the patient was out of his anti-lipid medication for the prior 7-8 weeks. The NP documented that the original order was written on 4/24/13 and the inmate last received medication in May or June of 2013. The pharmacy apparently had no non-formulary order for Crestor which was written according to the NP on 7/25/13. The LDL was documented as 155. The unspecified anemia was listed as in good control but a blood count wasn't recorded. The uric acid was listed as in normal range but wasn't documented. The NP wrote to "once again" request medication. The NP documented that if the iron level was OK the next visit he/she would discontinue iron. But the etiology of the anemia wasn't specified.	The patient failed to receive ordered medication due to a non-formulary process error. This resulted in poor lipid control.
9/24/2013	An NP ordered allopurinol, aspirin, iron, Lasix Prilosec and Colace for 180 days.	
10/30/2013	LDL 104 TG 187; uric acid 5.8	
12/2/2013	An NP ordered aldactone for 180 days	
12/24/2013	A nurse practitioner saw the patient for chronic care follow-up. Hyperuricemia was documented as resolved. Anemia was listed as a chronic disease without any other qualifier. Mixed dyslipidemia was listed as another problem. The provider documented that the LDL decreased from 155 to 104 and the TG from 221 to 187. The hyperlipidemia was listed as in fair control but no change in therapy took place. The patient's risk factors were not listed. The blood pressure was 130/90.	The anemia was not a chronic illness. It was a result of blood loss after his past surgery.
12/24/2013	An NP ordered Naprosyn for 90 days, stopped iron and ordered Crestor for 180 days.	
1/10/2014	The patient filed a medical grievance stating that he had repeatedly tried to pick up his KOP medications but that they were repeatedly unavailable. A nurse wrote him back saying it would be resolved. MARs are not in the medical record only physician orders. Therefore it isn't possible to verify that patients receive their medications.	The patient failed to receive ordered medication and had to write a grievance to have it attended to.
2/27/2014	An NP ordered allopurinol, aspirin, Lasix, Prilosec and Colace for 180 days.	
5/2/2014	The patient refused prostate, rectal, testicular exams as well as stool for occult blood.	
6/13/2014	Lab results LDL 116; TG 230; glucose 101; HGB 13.9	The lipids (LDL cholesterol and triglycerides) were abnormal.

6/20/2014	A nurse evaluated the patient for abdominal pain. The nurse documented pain when trying to reduce the 4 by 5 cm hernia. The nurse referred the patient to a provider.	This hernia was not documented as a problem and not documented as a physical finding on the prior chronic illness evaluation. The abdominal examination was documented as normal.
6/24/2014	A nurse practitioner saw the patient on 6/24/14 for chronic care follow-up. The provider documented high blood lipids and resolved anemia as problems. The provider took no history. The BMI was 37.7 and the LDL cholesterol was 116 with an HDL of 41 and triglycerides of 230. On physical examination the provider identified umbilical hernia that was difficult to reduce. In the assessment an additional problem was documented; gout. The uric acid was documented as 6.4 but the date of the test wasn't included. Although the high blood lipids were listed as in fair control, no additional therapeutic action was taken. The provider documented submission of a request for surgical consultation.	
6/24/2014	The patient received an abdominal binder.	
6/24/2014	An NP requested a surgical consultation for an umbilical hernia causing frequent abdominal pain. The hernia was described as hard to reduce and getting worse. On 6/26/14 the request was denied with a comment to "manage on site". However, it was not clear how this was to be managed as this is a surgical condition.	There is not an alternative management strategy for a painful hernia than to surgically correct it.

Patient 8

Date	Summary	Comments
5/16/2014	An infirmary admission note at Hamilton stating that the patient was admitted after falling twice due to lightheadedness and lack of coordination. The sodium was 123. The doctor held the Lasix and ordered another metabolic panel.	
5/18/2014	A hospital note documented that the patient had diabetes and hypertension and hip fracture. The history was that the patient fell while in the shower.	The showers at Hamilton are not safe for the elderly. This fall demonstrates that inmates can be harmed as a result of the showering facilities.

5/23/2014	A doctor wrote a discharge note from the infirmary. The admitting diagnosis was marked hyponatremia and the discharge diagnosis was femoral head fracture and marked hyponatremia. The only problems listed were uncontrolled hypertension and orthostatic hypotension. The description of the infirmary course stated "In a second fall in infirmary he began to experience R hip pain and was unable to bear wt. stat x-ray recorded R hip fx transferred to [illegible] hospital. Not a candidate for ORIF, suggest weight bearing + conservative mgmt. If healing not successful will refer for hip replacement. Orthostasis has improved."	The patient had multiple falls. The facilities are not safe for the elderly.
5/24/2016	[redacted]	The medical record had none of the medical record documents referenced in the site medical director's narrative. The medical record was incomplete. There appeared to be significant problems with this patient's death but the medical record was incomplete.



Patient 9

Date	Summary	Comments
1/22/2008	The problem list documents that the patient was hepatitis C positive on this date.	
3/16/2009	A doctor saw the patient for chronic illness clinic. His only medical problem was hepatitis C. No laboratory tests were evaluated. Vaccinations were not checked. The stage of the patient's disease was not documented.	The doctor failed to properly assess the hepatitis C.
3/25/2010	The patient was evaluated by a PA for hepatitis C clinic. The patient was listed as in good control. The APRI was 1.46 which indicates possible significant fibrosis or cirrhosis. Nevertheless, no additional interventions were taken. The patient was not considered for treatment. Vaccination for hepatitis A was not offered.	The doctor should have vaccinated for hepatitis A, checked if patient was hepatitis B positive, and considered an ultrasound. Since the patient had a strong suggestion of fibrosis, treatment could have been considered.
12/19/2012	An NP evaluated the patient in hepatitis C clinic. The patient had slight swelling of his foot which was thought to be an ingrown toenail. The last APRI was 1.57 which is strongly suggestive of fibrosis and cirrhosis. Still there was no intervention.	The doctor should have vaccinated for hepatitis A, checked if patient was hepatitis B positive, and considered an ultrasound. Since the patient had a strong suggestion of fibrosis, treatment could have been considered.

3/2/2013	Lab tests show AST 97 and platelets 130K giving an APRI of 1.87 strongly suggestive of fibrosis and cirrhosis.	This indicated that the doctor should have considered ultrasound of the liver since the patient had swelling of the feet. He could have been considered for hepatitis C treatment.
3/21/2013	An NP evaluated the patient in hepatitis C clinic at Ventress. The patient had swelling of his lower extremities. The NP did not assess the APRI and diagnosed swelling and started a diuretic (HCTZ) without any diagnosis.	Lower extremity swelling in a person with no other medical conditions except hepatitis C should have resulted in a liver ultrasound and metabolic panel. Instead the provider merely treated the symptom without finding the cause. Also, the NP should have vaccinated for hepatitis A, and checked if patient was hepatitis B positive. Since the patient had a strong suggestion of fibrosis, treatment should have been considered.
6/2/2013	Labs around this time show platelets of 82 K and an AST of 80 giving an APRI of 2.2 which indicates likely cirrhosis. The patient should have been treated as if he had cirrhosis.	The patient should have had an ultrasound, upper endoscopy, evaluation for hepatitis C treatment, vaccination for hepatitis A and B, and placed on a prophylactic beta blocker.
6/2/2013	A nurse evaluated the patient for a pain in the right thigh with bruising and fever to 101.8. The nurse referred the patient to a doctor.	
6/2/2013	Without seeing the patient, the doctor ordered admission to the infirmary, blood count, sedimentation rate, metabolic panel, and blood cultures. He also ordered Zosyn and vancomycin antibiotics intravenously and a chest x-ray on the next day.	A doctor should have evaluated the patient. If a doctor wasn't available, the patient should have been sent to an emergency room.
6/2/2013	At 2 am the doctor ordered that the patient be sent to a local emergency room. There was no nursing or physician notes associated with this order.	Nurses need to document interventions when they occur.
6/3/2013	The patient was in the hospital. He had a thigh cellulitis. The hospitalist described the cellulitis as "remarkable cellulitis that is diffuse and has some seromas weeping from it, very tender exquisitely to palpation. Does have some superficial auto drain bulla away from this cellulitic and indurated area". Hospital notes were incomplete. The plan was to start Teflaro, an antibiotic, and consult a surgeon. It isn't clear if this occurred. The patient was discharged on 6/5/13 and arrived at the Kilby around 2 pm.	
6/5/2013	The patient arrived at Kilby and was started on Teflaro IV for 7 days with dressing changes. The patient was started on Lovenox for DVT prophylaxis along with Lasix.	

6/6/2013	The admission note to the Kilby infirmary was on 6/6/13. The admission diagnoses were cellulitis, hypertension, renal insufficiency, rule out hepatitis, and liver cirrhosis.	
6/7/2013	A doctor at Kilby documented that the patient had end-stage liver disease with cirrhosis and started lactulose. The doctor ordered no other interventions for ESLD including vaccination for hepatitis A or B; EGD, ultrasound to screen for hepatocellular cancer, beta blocker but did start lactulose.	The doctor identified cirrhosis but failed to initiate other treatment called for by OHS policy. Also, the provider did not discuss treatment options for his hepatitis C. The patient was now identified as cirrhosis but had not yet been offered treatment.
6/7/2013	BNP 325 (normal 0-100)	This test is used to identify heart failure. However, it only suggests heart failure. This person did not otherwise have enough evidence to suggest heart failure.
6/12/2013	The cellulitis was improving but there was significant swelling and erythema so the doctor continued the antibiotic for 5 more days. The plan was to transfer the patient back to Ventress.	
6/14/2013	The doctor documented that the cellulitis was resolving. The doctor also newly diagnosed heart failure on the basis only of the BNP. The patient probably didn't have heart failure as there were no other signs. To verify this the doctor should have ordered an echocardiogram. The doctor continued the antibiotic.	There is a reluctance to order diagnostic tests for diagnoses. Doctors presume patients have disease instead of performing diagnostic tests. This is below the standard of care.
6/24/2013	The patient was discharged from the infirmary.	
6/25/2013	The patient returned to Ventress. On the day of arrival at Ventress, the nurse at Ventress documented on the intra-system transfer form that the groin wound was still draining.	The wound was not healed and the patient should still have been on antibiotics.
7/1/2013	A doctor at Ventress evaluated the patient. The doctor noted that the wound was healing. There was still a "superficial wound". The doctor discharged the patient from the Ventress infirmary and sent the patient to his housing unit.	The wound had not completely healed. The antibiotics should have been continued and it appeared that the patient needed further diagnostic work up.

7/9/2013	A doctor evaluated the patient in chronic care clinic. The recent hospitalization was not commented on. The doctor described a 14 by 5 cm area of redness on the right thigh. This is a large area. The doctor diagnosed a healed abscess with redness. The hepatitis C was not addressed although at this time lab results at the recent hospitalization indicated an APRI of 2.2 which is likely cirrhosis. There was no intervention with respect to his hepatitis C. The patient was now being treated with Enalapril and furosemide on the basis of leg swelling and presumed heart failure. Isosorbide for unclear reasons and lactulose twice a day	The hepatitis C remained untreated. The wound did not appear healed.
11/28/2013	Platelets 111; AST 152; the APRI was now 3.4 which is consistent with likely cirrhosis.	
1/13/2014	The patient hadn't been seen by a physician since 7/9/13 almost 5 months ago. The patient now had lower leg edema. The only history the doctor took was that the patient had gained 5 pounds, didn't smoke and had a history of a groin abscess. The doctor checked a few of the formatted history boxes that were not pertinent to the patient's condition. The doctor identified 1+ edema and noted that the patient had elevated liver enzymes. The doctor also identified foot pain as a problem but there was no history associated with this problem and no examination for this problem except to note 1+ edema. The patient remained on Vasotec, Lasix, and aldactone.	There was no indication for the Vasotec as the patient did not have heart failure. It wasn't clear why the patient had edema but it was likely cirrhosis. However the patient had no verification of the cirrhosis except the APRI. An ultrasound of the liver was not done. Other interventions for someone with cirrhosis were not done either including vaccination for Hepatitis A and B; EGD, and use of a beta blocker.
1/16/2014	Platelets 79K; AST 151; bilirubin 1.4: APRI 4.78	The patient had likely cirrhosis but the providers still did not work the patient up with an ultrasound. The bilirubin was now becoming elevated indicating more advanced disease. No other interventions for hepatitis C were undertaken.
2/17/2014	A doctor saw the patient for chronic illness clinic. His only medical problem was hepatitis C. The doctor noted that the ammonia level was elevated at 161. The doctor restarted lactulose. The doctor initiated no other interventions for hepatitis C.	The doctor continued to fail to properly treat the patient's hepatitis C.
3/7/2014	AST 132; platelets 113; bilirubin 1.6; APRI 2.92	The patient continued to have likely cirrhosis.
3/11/2014	Chronic illness clinic. A doctor saw the patient and noted that the APRI was 3.07 but initiated no interventions. The doctor took no history except that the patient took lactulose on the weekends.	The doctor continued to fail to properly treat the patient's hepatitis C.

5/20/2014	The doctor saw the patient for chronic care. He took a history that the patient took lactulose on weekends and advised the patient not to use alcohol, drugs or have tattoos. The exam noted no edema. The doctor assessed hepatitis C with cirrhosis and decreased platelets. The doctor initiated no interventions for the cirrhosis.	The doctor continued to fail to properly treat the patient's hepatitis C.
6/16/2014	The doctor's only history was to note that the patient didn't smoke and "c/o joint pain". There was no other documented history. A few of the irrelevant check boxes were checked. The doctor noted pitting edema of the lower extremities. The only assessment was hepatitis C with increased liver function tests. The doctor initiated no interventions for the cirrhosis.	The doctor continued to fail to properly treat the patient's hepatitis C. The joint pain complaint was inadequately evaluated.
6/17/2014	AST 146; platelets 95K; bilirubin 1.6	The patient continued to have likely cirrhosis.
7/15/2014	A doctor saw the patient for chronic care. Except for checking irrelevant boxes on the form the doctor took no history. The blood pressure was now 160/100. The patient had 1-2+ edema. The doctor assessed hepatitis C in fair control and initiated no interventions to treat hepatitis C.	The elevated blood pressure was ignored. The doctor continued to fail to properly treat the patient's hepatitis C.
8/19/2014	A doctor saw the patient for chronic care. Except for checking irrelevant boxes on the form the doctor took no history except that the patient was not a smoker. The blood pressure was now 111/63. The patient had 1+ pitting edema. The doctor assessed hepatitis C with an APRI of 3.8 with decreased platelets and pitting edema. The doctor initiated no interventions to treat hepatitis C but did document that the patient would consider treatment for his hepatitis C.	The doctor didn't ask about hepatitis C treatment. The doctor continued to fail to properly treat the patient's hepatitis C.
9/16/2014	The doctor saw the patient for chronic care. He took no history except that the patient didn't smoke and checked a few of the formatted boxes with questions that were irrelevant to hepatitis C. The doctor noted trace edema and thought that there might be ascites. The doctor's assessment was hepatitis with APRI of 3.8 with ? ascites. The patient said he didn't want treatment or evaluation and would discuss it with his family. The exam noted no edema. The doctor assessed hepatitis C with cirrhosis.	The doctor failed to properly treat the patient's cirrhosis.

10/23/2014	A doctor admitted the patient to the infirmary for right leg swelling and pain. The doctor noted the prior history of right leg abscess. On exam the doctor obtained a difference in calf measurements but did not record a fever. The doctor's diagnosis was leg swelling and pain. He added that there was no evidence of DVT and cellulitis. Nevertheless, the doctor treated the patient with Zosyn and vancomycin, two intravenous antibiotics along with Lovenox and warfarin used to treat DVT. The following day the doctor added Ceftriaxone and a tapering dose of steroids. No	The doctor should have admitted the patient to a hospital. The doctor was unable to timely perform necessary diagnostic testing necessary to treat the patient. To give 3 antibiotics, steroids and anticoagulants without having a diagnosis was dangerous.
10/24/2014	The doctor admitted the patient to a hospital. The patient remained hospitalized for 3 days. The discharge diagnoses were severe cellulitis of the entire right leg; coagulopathy due to warfarin; chronic kidney disease; anemia and thrombocytopenia history of heart failure, hepatitis C and hypertension. Notably the heart failure was inaccurate. At the hospital the doctor's did a Doppler. There was no DVT so they stopped the warfarin and Lovenox. The patient had a severe cellulitis. The hospitalist documented that he received 3 calls from the site medical director at Ventress and another call by the Regional Medical Director asking to have the patient sent back to Kilby where he could be managed. The hospitalist documented that "I do not think he is ready to be discharged as he has severe cellulitis or the right lower extremity and might need infectious disease support and/or surgical support". Nevertheless, the hospitalist said "with much reluctance" "I will discharge him per the insistence of [redacted -Regional Medical Director] to Kilby Prison system." The patient's wound was described as severe swelling with ecchymosis on the right thigh with the right lower leg oozing terribly serous fluid. A CT scan of the lower extremity showed significant cellulitis.	It was inappropriate to take the patient back to the prison system as the prison did not have the capacity to support the needs of the patient. The placed the patient at significant risk of harm.

10/29/2014	A doctor performed an admission note to the infirmary at Kilby. The doctor documented that the patient had necrotizing cellulitis from Coumadin. The history was not thorough. The physical examination was the acronym WNL with an arrow through the entire examination section with the one comment "necrotizing cellulitis RLE". The doctor documented that the antibiotics would continue and he would watch for progression of fasciitis a serious deterioration of cellulitis. The doctor noted that if the patient didn't improve he would refer to surgery. The patient was on vancomycin and Cefepime along with prednisone, Vasotec, Lasix and spironolactone.	This was a dangerous situation. Kilby's infirmary is not equivalent to a hospital and it was dangerous to move the patient there. This appears to be an effort to save money at the expense of the patient's safety.
10/31/2014	The doctor described the leg as necrotizing cellulitis.	
11/7/2014	The patient had been on antibiotics for about 10 days. The right lower leg was still "weeping". There were still ulcerated areas with some open wounds on the lower right extremity. The description of this wound did not appear healed, yet the doctor stopped intravenous antibiotics and started Keflex.	This did not appear to be an appropriate choice. The doctor was not monitoring any lab test to ascertain whether the infection was improving. This did not appear to be an appropriate decision given the lack of diagnostic information reviewed.
11/13/2014	The doctor at Kilby discharged the patient from the infirmary and continued Keflex, an oral antibiotic. The doctor noted that the necrotizing cellulitis was "slowly resolving".	
11/19/2014	A wound nurse documented that the cellulitis was greatly improved but there was necrotic tissue on top of the foot and thigh.	Necrotic tissue indicates continued infection. The intravenous antibiotics should probably not have been discontinued. An ID specialist should have been consulted.
11/19/2014	The patient was transferred back to Ventress	
11/20/2014	The patient was admitted to the infirmary at Ventress. There was an order to use wound gel on necrotic areas with silvadene to other areas. The patient had a Foley catheter. There did not seem an indication for a Foley catheter except the convenience of staff. There was no provider note associated with these orders.	The patient should have been re-hospitalized. Keeping the Foley catheter in place placed the patient at risk of harm.
11/21/2014	An NP evaluated the patient and noted that the patient was on oral antibiotics. The patient complained of copious drainage from the wounds. The NP described 3-4+ pitting edema of both lower extremities with erythema of most of the right leg with weeping ulcerated necrotic areas on the right leg. The NP diagnosed necrotizing cellulitis.	The patient should have been re-hospitalized immediately. The care on the Ventress infirmary was not adequate. The patient appeared to need intravenous antibiotics.

11/24/2014	A doctor evaluated the patient and noted that he couldn't stand up. The nurses reported drainage. The doctor noted that his right leg was swollen and draining from ulcerated blisters. The ulcerated areas had necrotic tissue or eschars. The plan of the doctor was to consult with a wound care nurse.	The patient needed to be hospitalized immediately. This was a significant departure from standard of care.
11/25/2014	A doctor saw the patient again. The patient had 1-2 cm blister with cellulitis with ulceration and blisters.	This indicated deteriorating infection. The patient needed immediate hospitalization.
11/25/2014	BUN 42; creatinine 1.7; sodium 126; albumin 1.5; WBC 6.5; hemoglobin 8.8	These indicate significant anemia, early renal failure with hyponatremia. They were treating him with fairly large doses of Lasix and aldactone which could have caused the hyponatremia and dehydration. The albumin was very low and needed investigation as to whether it was related to liver or kidney disease or due to malnutrition or a combination. The patient needed hospitalization because the physicians at Ventress did not appear to be adequately treating the patient and the patient had a serious medical need.
11/26/2014	A doctor evaluated the patient. There was fluid oozing from the ulcerated wounds. Now the left leg had developed a blister. The doctor documented anasarca but didn't document more. There was no interventions made.	This indicated deteriorating infection. The patient needed immediate hospitalization.
12/1/2014	A doctor saw the patient for anasarca and increased edema. The doctor documented decreased urine output with anasarca and slight oozing from the leg ulcerations. The doctor diagnosed right leg cellulitis and anascara. He started intravenous Lasix twice a day. Antibiotics were not started.	This was incompetent care. The patient should have been immediately hospitalized for intravenous antibiotics as the patient's infection needed treatment. To diagnose infection (cellulitis) and not treat it with antibiotics is a significant departure from standard of care. The choice of intravenous Lasix was questionable. The patient appeared dehydrated. His edematous state was probably from his cirrhosis and adding aldactone would have been a better choice.
12/2/2014	WBC 5.1; hemoglobin 9.1; BUN 44; creatinine 1.7; sodium 129; albumin 1.6	The albumin was so low that it was probably causing the edema. To use Lasix was futile.
12/4/2014	BUN 38; creatinine 1.5; sodium 132; albumin 1.6; WBC 7.1; hemoglobin 10.1	These were all abnormal. The doctor did nothing to address the anemia, low albumin, abnormal kidney function.
12/4/2014	A wound nurse evaluated the patient. The nurse documented persistent necrotic tissue on two open areas of right leg. The wounds were described as friable with considerable edema that the nurse was "afraid" to remove the necrotic tissue.	

12/5/2014	A doctor saw the patient who still had edema. The doctor documented using silver nitrate on the leg ulcerations. The doctor diagnosed cellulitis of the right and possibly of the left leg as well. The doctor ordered a 24 hour urine test and resumed the intravenous Lasix and continued fluid restriction.	To diagnose cellulitis which is an infection and not start antibiotics is a significant departure from the standard of care.
12/5/2014	EKG accelerated junctional rhythm	This is a potentially dangerous cardiac arrhythmia.
12/5/2014	At 9 am a doctor ordered Azithromycin and at 3 pm he added Minocycline an oral antibiotic	
12/5/2014	At 12:40 pm a nurse apparently sent the patient to a hospital for hypotension and decreased urinary output.	
5/25/2016	[redacted]	There were several opportunities for improvement. (1) The treatment of the patient's hepatitis C was below the standard of care and below expectations of the OHS. The patient was never vaccinated for hepatitis A or B. The patient should have been considered for hepatitis C treatment early than when it was offered. The patient had indication for liver ultrasound in March of 2013 but he never had this test. Once cirrhosis was diagnosed, the patient never had an EGD, was not started on a beta blocker for variceal prophylaxis, and did not have screening for hepatocellular carcinoma. This should have brought into question the effectiveness of hepatitis C management in the state system. (2) The patient should never have been taken out of the hospital in November of 2014. He had serious medical needs that could not be accomplished at the prison. This contributed to his death. (3) The performance of the doctor at Ventress was below the standard of care. To diagnose an infection and not treat with antibiotics is below standard of care. The patient had signs for weeks that he needed hospitalization but he was kept at Ventress without antibiotics. This should have resulted in a peer review.

Patient 10

Date	Summary	Comments
2/3/2008	This is the first progress note of the medical record. It is a psychiatric progress note. There was no evidence of tuberculosis screening.	The medical record has no verification of tuberculosis screening on an annual basis.
1/7/2010	The patient placed a health request for hip and shoulder pain.	
1/8/2010	A nurse evaluated the patient and documented that the patient just wanted to get an egg crate mattress and referred the patient to a provider.	
1/14/2010	A provider evaluated the patient for hip pain. The patient weighed 244 pounds. A minimal examination was performed only of inspection and elicitation of range of motion of the hips. The patient had folliculitis. The provider ordered hip x-rays. There was no evidence of a hip x-ray or follow-up of the ordered x-ray in the medical record. The shoulder was not evaluated.	The provider did not adequately evaluate the patient's stated complaints from 1/7/10 of hip and shoulder pain. Ordered diagnostic testing was not apparently done.
1/28/2010	The patient placed a health request for abdominal discomfort and hip pain.	
2/1/2010	A nurse evaluated the patient and noted hip and abdominal pain and referred to a physician.	This evaluation was 3 days after the request.
2/3/2010	A provider [title not signed] saw the patient for abdominal and left leg cramping. The provider performed minimal history and examination and diagnosed gastroenteritis "recovering phase". Aside from recommending fluids, no other treatment plan was initiated. The hip x-rays ordered 1/14/10 were not checked and there is no evidence that they were done.	Ordered hip x-rays do not appear to have been completed. Inadequate evaluation occurred.
2/19/2010	HCTZ was discontinued	The patient's medication were apparently changed without discussion with the patient.
2/20/2010	The patient placed a health request asking to see a physician about his blood pressure and medication. The patient said that ordered medication was rejected by the pharmacy.	
2/23/2010	A nurse saw the patient whose blood pressure was 150/96. The nurse documented that the patient was placed on HCTZ but taken off the next day due to "sulfa in pill". It wasn't clear whether other medication was substituted for the HCTZ. The nurse referred the patient to a physician. There is no evidence in the medical record that this follow-up occurred.	The follow-up ordered failed to occur.
2/24/2010	Lisinopril was prescribed at 20 mg daily	It appeared that medication was started without seeing the patient and discussing the medication change with the patient.
2/25/2010	Lasix was started	

2/25/2010	A provider saw the patient. The blood pressure was 168/100. The provider documented that the patient didn't receive the HCTZ due to concerns regarding a sulfa component. The only examination consisted of noting the blood pressure and documenting "neurosurgery normal" which made no sense and was not pertinent to the patient's problems. The doctor noted poorly controlled hypertension and ordered intramuscular Lasix stat and oral Lasix thereafter. The intramuscular Lasix was a poor choice of medication.	The provider did not appropriately treat the patient's high blood pressure. Parenteral medication for moderately elevated blood pressure is not indicated.
4/2/2010	Lopressor was renewed for 180 days	
4/8/2010	Lasix was renewed for 60 days	
4/28/2010	An untitled provider saw the patient for elevated blood pressure. The patient had not taken his blood pressure medication for two days but the provider did not ascertain the reason for not taking the medication. The blood pressure was 155/110. The assessment was "passive aggressive manipulative, deceptive, argumentative, states he was anxious that his BP meds were not right for him". The provider started Lopressor for two doses and continuation of usual medications.	The provider appeared to make an assessment of the patient's intentions without any objective findings to substantiate his declarations. Because the blood pressure was elevated, the patient's concern may have been legitimate but appears to be dismissed by the provider. It wasn't clear what the therapeutic regimen was as the provider did not document what medications the patient was supposed to be taking. The patient did not appear to have been professionally treated and had out of control blood pressure that was not appropriately managed.
5/3/2010	Daily aspirin, slow release niacin 500 mg and Lisinopril 20 mg were prescribed.	
5/24/2010	The patient was evaluated in chronic care clinic for high lipids, hepatitis B, diabetes unspecified, and hypertension. The provider who did not document their title took no history with respect to diabetes. The provider also took no history with respect to compliance with medication and did not list what medications the patient was taking. The finger stick glucose values were 98-150 and the A1c was documented as 6.4 but the date of the test was not included. The LDL cholesterol wasn't documented yet the patient was listed in fair control. The blood pressure was 130/86 and listed as fair control. For a diabetic this was a blood pressure not in control; Lopressor was increased for headaches not for the blood pressure although it would help the blood pressure.	The history was inadequate. Medications were not listed and although the patient was listed as only in fair control for all diseases, there was not therapeutic change of plan. The provider did not appear to recognize that the blood pressure was abnormal for a person with diabetes and increased Lopressor for headaches not for blood pressure. The diabetes was not characterized. The lipid values weren't even listed yet the patient was listed as in fair control.
6/4/2010	Lasix was renewed for 60 days	

6/25/2010	An NP signed off on an annual health evaluation. The TB skin test was recorded as completed 6/11/10 and was negative.	
7/12/2010	The patient placed a health request asking why he had been taken off blood pressure medications. A nurse wrote that an appointment with a physician would be scheduled.	Patients should not have their medications changed without a discussion with the provider.
7/14/2010	Lopressor was renewed for 180 days	
7/29/2010	A provider ordered aspirin, Lasix, Lisinopril and niacin 500 mg daily. The type of niacin was not specified.	
8/9/2010	A1c= 6.4 (diabetes >= 6.5); LDL cholesterol 131 which is high for a person with hypertension and borderline diabetes. This was the first laboratory test in the record for some time	The LDL cholesterol was not at goal.
8/23/2010	A provider saw the patient for chronic illness clinic for diabetes, hypertension, high blood lipids and chronic headaches. Chronic headaches should be evaluated with a CT scan or MRI but this was not done. A specific diagnosis was not made for this complaint. The blood pressure was 118/80 and the weight 238. The headaches were not addressed in either the history or physical examination. The high blood lipids and diabetes were also not addressed at all; the last LDL-C or A1c were not documented. It was not clear what type of diabetes the patient had. The patient complained of diarrhea twice a day that initially was preceded by constipation. No other history was taken. The provider did not order fecal occult blood testing. The provider diagnosed acute diarrheal illness without being more specific and without ordering any evaluation except for an H pylori test which would not be responsible for a diarrheal illness. Based on this brief evaluation, the provider ordered Prilosec and metronidazole for 7 days.	The physician ordered metronidazole based on a presumptive diagnosis and without a more thorough evaluation of the patient. This medication is used for serious abdominal infections all of which should be verified by physician examination and other testing including possibly cultures, fecal occult testing, CT scan or other laboratory testing depending on the history and physical findings. None of these evaluations were done for this patient. The diabetes, elevated lipids, and chronic headaches were inadequately addressed.
8/31/2010	A nurse evaluated the patient for a month of mid lower crampy abdominal pain. The nurse documented that the patient had lost 15 pounds. The nurse documented that an anal examination was not applicable to the complaint which is inaccurate and that a fecal occult test was not indicated which is also inaccurate. The nurse consulted a physician and apparently gave the patient medication as recommended. On a separate order sheet a nurse took a phone order for metronidazole for 7 days.	The physician should not have re-ordered metronidazole without physically examining the patient. This medication is used for serious abdominal infections all of which should be verified by physician examination and other testing. Giving two consecutive doses of metronidazole without evaluation is unacceptable practice.

9/22/2010	A PA saw the patient because "need to have BP meds checked and adjusted". The blood pressure was 138/90 which is abnormal for a person with diabetes whose goal is 130/80. The PA documented that the patient stated he was taking several BP meds and wanted to have the number of pills decreased. This is reasonable. The PA did not document exactly what medications the patient was taking and there was no evidence in the medical record documenting medications. The PA documented in the assessment that the patient wanted a change of medications and documented consulting with the Regional Medical Director. The PA did not document the existing regimen but did document stopping a beta blocker and starting verapamil with follow-up in chronic care clinic.	The provider evaluated the patient for a medication concern but didn't even document what medications the patient was taking and the compliance with taking these medications. Because there were no MARs in the medical record, medication could not be verified. It was not clear from the medical record what blood pressure medication the patient was taking.
9/22/2010	A PA ordered discontinuation of Lopressor, starting Verapamil 120 mg daily	
10/13/2010	a PA ordered aspirin, Lasix, Lisinopril and niacin 500 Q Day	Regular niacin for use as an anti-lipid agent is prescribed at 1 to 6 grams a day and titrated from a small to a larger dose. Extended release niacin dosing is a 1/2 gram to 2 gram a day. Sustained release niacin dosing is between 250-750 mg once daily. It was unclear from the prescription which niacin the provider prescribed. There are serious concerns about safety and efficacy of this medication in combination with statins and as monotherapy. Up-To-Date does not recommend using niacin in patients using a statin drug and recommends niacin in patients who are unable to take other lipid lowering therapies and whose LDL-C is lowered by niacin. This patient is not apparently being appropriately managed. The order is only for niacin and does not specify if it is sustained release, extended release, or regular release product. Each of these products has different dosing schedules. The ACA recommends persons on niacin be monitored every 6 months with hepatic transaminases, fasting blood glucose or A1c and uric acid which was not ordered.
10/20/2010	The patient placed a health request for a variety of problems including pre-existing stomach problems.	

10/22/2010	A nurse evaluated the 10/20/10 health request and documented referral to a physician the same day.	
10/22/2010	A physician saw the patient and documented noncompliance without documenting verifying from the MAR. The doctor documented that the patient wanted to try dieting and salt avoidance to treat the hypertension. While the blood pressure was 136/88 on medication, the doctor discontinued Lasix, Lisinopril, niacin, and Verapamil stopping medication for hypertension and high blood lipids. This was not good judgment as the blood pressure was barely normal on 3 medications. The LDL cholesterol was not noted. The diet choices at the prison are not the same as in a community and since the patient was unable to lower the LDL-C on medication, he was unlikely to lower the LDL off medication. The doctor stopped the medication but only ordered a 3-month follow-up.	This appeared to be poor judgment on the part of the physician. The patient's blood pressure was abnormal for a person with diabetes and just barely normal for a person without diabetes. Yet the physician discontinued 3 blood pressure medications. This was poor judgment. The doctor also failed to address the elevated LDL cholesterol. The doctor appeared to discontinue the medication due to non-compliance but it did not appear that effective communication had been reached with the patient about compliance issues. It wasn't clear on what basis the doctor determined non-compliance.
11/5/2010	A physician saw the patient for chronic illness clinic including hypertension, chronic headaches, high blood lipids, hepatitis B and DAA as medical conditions. It is not clear what DAA meant. Except for asking about chest pain, the doctor took no history with respect to hypertension or high blood lipids. The patient's prior history of diabetes was not documented in this note. Except for taking a history that the patient had daily headaches for the last few years, the physician didn't take a thorough history of the patient's headaches. The only neurological examination documented was that there were no focal findings. Although the LDL cholesterol was documented as 125, the high blood lipids were not addressed. The blood pressure was 150/98 and the physician re-started Lisinopril at 20 mg a day for 30 days.	The history was inadequate. Medications were not listed. The high blood lipids were not addressed even though the LDL cholesterol was abnormal. The patient's headaches were not addressed. Chronic headaches for years should have prompted a more thorough examination and possibly brain imaging. The patient had previously diagnosed diabetes but this was not addressed.
12/23/2010	A nurse referred the patient to a provider because the patient was concerned about the change in color of a mole. Of note, the blood pressure was 142/98	The abnormal blood pressure should have been addressed but was not.
12/28/2010	A PA noted 3 suspicious moles and ordered a dermatology consultation.	
12/29/2010	Aspirin and Lisinopril were renewed.	

1/5/2011	A provider ordered a tapering dose of steroids starting at 40 mg prednisone tapering over a 12 day period. The provider also prescribed Clindamycin 300 mg BID for 10 days and Albuterol inhaler. The provider also discontinued the patient from the physician chronic care; presumably this meant that a mid-level provider would see the patient. The medical record does not appear to have a note for this date.	There is no note associated with significant orders. It appears that a medical record document is absent.
1/7/2011	The 12/28/10 PA request for a dermatology consult was denied stating that the provider should perform a biopsy onsite for any suspicious lesion.	There was no evidence in the available medical record that a skin biopsy was ever done. This placed the inmate at risk of harm.
1/20/2011	The patient complained of pain and numbness on his left side of his arm, leg, foot and chest. Also the patient complained of belching after eating. This was evaluated the next day.	
1/21/2011	A nurse evaluated the patient for chest pain. The nurse took a history of prior history of stable angina which was inconsistent with the patient's documented medical history. The blood pressure was 136/96 which is abnormally high. The nurse referred to a nurse practitioner. There was no evidence in the medical record of the patient being seen for this by a nurse practitioner.	The patient had a serious medical complaint (chest pain) which was not evaluated by a provider.
1/25/2011	A provider apparently saw the patient for L shoulder pain which he said he had for 4 years. The history and examination were minimal and the provider diagnosed L shoulder tendinitis and prescribed Tylenol and a shoulder injection of steroid medication. The provider appeared to fail to address the actual complaints of the patient on the 1/20/11 health request.	Generally, injection of the shoulder is reserved for certain conditions and only after a trial of non-steroidal medication, physical therapy and rest have been tried. Since this patient appears to have had years of shoulder pain that had not yet been adequately evaluated, it would have been appropriate for a proper diagnosis which didn't occur. If the provider wasn't familiar with shoulder disorders, referral to an orthopedic specialist was in order.
2/16/2011	The patient placed a health request stating that he had ongoing problems with headaches and a tickle in the back of his throat causing him to wake up gagging. This was evaluated by a nurse on 2/17/11 who referred to a provider	

2/21/2011	An NP saw the patient for headaches. The only history taken was that the patient had headaches not relieved by multiple medications. Aside from examining the eyes, the only documented examination was to state "neurologically intact" which is meaningless documentation. The assessment was headaches and GERD. The NP started Topamax a medication used to treat migraines. The NP also prescribed Motrin at 600 mg BID and Prilosec.	The NP failed to take adequate history or perform adequate examination for a person with long-standing headache. Long-term headache should have been evaluated with a CT scan or MRI of the brain.
3/10/2011	A provider saw the patient for abdominal and rib pain which had been present for about 6 months. The pain increased with breathing and palpation. The doctor diagnosed muscle strain. This group of symptoms suggests pleural disease or rib disease, yet the provider ordered x-rays of the abdomen which did not appear to be involved.	The choice of diagnostic test could have been better.
3/21/2011	A PA saw the patient for follow-up of headaches. The BP was 142/90 which is abnormal. The pulse was 110 which is abnormal. These were not addressed. The patient said that the headaches were different after starting Topamax but the difference wasn't elucidated. The PA diagnosed chronic headache and sinusitis but had not examined the sinuses and did not take any history of sinus related problems. The PA ordered Zyrtec and Topamax. The Topamax is for migraine headache and the Zyrtec is an antihistamine presumably used for nasal congestion.	The PA failed to take adequate history or perform adequate examination for the diagnoses made. The PA did not address the abnormal pulse or blood pressure.
3/23/2011	A provider ordered a chest x-ray and abdominal ultrasound.	
3/23/2011	A PA saw the patient for abdominal pain follow-up. The pulse was 102 which is abnormal. The PA stated that a chest x-ray and abdominal ultrasound were pending.	
3/28/2011	The patient requested to see the PA for more medication due to increased intensity of his headaches.	
3/29/2011	An abdominal ultrasound was approved.	
3/30/2011	The NP saw the patient for his headaches and documented that the patient had headaches for 2 years worse over the past 8-9 months. A better history was taken. The NP requested an MRI of the head and increased the Topamax.	This diagnostic test should have been done much earlier.
4/5/2011	The MRI of the head was approved.	

4/6/2011	The patient placed a health request for unspecified skin problems. Notably, the skin biopsy previously recommended as alternative treatment never occurred.	
4/7/2011	A nurse referred the patient to a provider for an ongoing skin rash.	
4/8/2011	A PA saw the patient for chronic illness clinic and documented high blood lipids, hepatitis B and non-insulin dependent diabetes as problems. The hypertension was no longer listed as a problem even though the patient was being treated with an antihypertensive drug (Lisinopril). The PA documented that the patient complained of headache yet took no history except that the patient was getting better on Topamax except for the last few days when the headaches were getting worse. The BP was 134/82 which is abnormal for a person with diabetes. The LDL cholesterol was 123 which is abnormal for a person with diabetes. The PA did not make an assessment of the status of the high blood pressure and documented that the high blood lipids were in fair control but did not modify treatment. The diabetes was listed as in good control but it wasn't clear that the patient actually had diabetes. The PA documented that the MRI of the head was pending. No mention was made of the abdominal ultrasound result. The PA ordered Excedrin migraine and ordered blood tests including a blood count, metabolic panel, lipids, hemoglobin A1c and micro albumin.	Not all problems were identified. Conditions not at goal (hypertension and high blood lipids) were not addressed. Hypertension was unrecognized.
4/13/2011	An NP saw the patient for a buttock rash. On exam the patient had a macular rash red in color diagnosed as acne.	Generally, macular rashes are not consistent with acne.
4/29/2011	A PA documented that the patient continued to have headache and was still awaiting an MRI. The PA listed problems as chronic headache, Hepatitis B and type 2 diabetes. The patient had no evidence of diabetes, but also had high blood lipids and hypertension.	Not all problems were listed.
5/5/2011	A provider documented that the ultrasound results were done but did not document the result and the result was not in the medical record. The provider documented a normal physical examination and ordered PRN follow-up.	The ultrasound results were not reviewed and the actual ultrasound results were not in the medical record so it wasn't clear that this test was done. All health record documents should be placed in the medical record.

5/18/2011	A provider documented that the MRI of the brain was normal. However the actual test result was not in the medical record. The provider documented that the patient had tension headaches but an appropriate history had not been taken to make this diagnosis. The patient was being treated as if he had cluster or migraine headaches with Topamax. The provider documented to continue Topamax and consider Toradol for breakthrough pain.	The treatment did not match the diagnosis of tension headache. All health record documents should be placed in the medical record.
5/19/2011	The patient placed a health request for headaches which he thought was due to light sensitivity. He wanted his eyes checked. A nurse referred the patient to a provider.	This appointment didn't seem to occur.
5/21/2011	The patient was transported back from Donaldson after an MRI of the head. Apparently the MRI was completed 5/4/11. The results of this test were not in the medical record.	
5/27/2011	The patient placed a health request for headache and a buttock rash that was bleeding and non-healing. The nurse referred the patient to a provider.	
6/1/2011	A provider saw the patient for persistent headache. The provider took a history of no visual changes even though the patient had recently wanted his eyes checked because he felt the headaches were due to light sensitivity. The provider failed to address the buttock rash. The provider tapered the Topamax and started Excedrin migraine.	The provider failed to address the patient's problems and appeared to document that the patient had no visual changes when he in fact did have visual complaints. The provider failed to evaluate the patient for his buttock rash which the patient described as bleeding.
6/27/2011	It appears that a normal TB skin test was performed. This was also negative on 6/27/12 but there was no skin test performed in 2013.	
7/3/2011	A provider saw the patient for persistent headache. The patient told the provider that his headaches were worse after reading. The patient wanted to discuss the MRI results which were done 3 months ago. The provider thought that the headaches were due to astigmatism. The patient also wanted to discuss his hepatitis B status and the provider documented that this was diagnosed in 2006 and would be followed up if any symptoms developed. However, the hepatitis B laboratory status (e.g. AB, Ag status) was not addressed. The provider referred the patient to an eye clinic.	Clearly, the facility providers had never discussed the MRI results with the patient causing him to worry.

7/18/2011	An eye clinic referral was denied; the Regional Medical Director said that the alternate plan was to manage the patient on site but what the management was to be was not specified. Apparently the patient was evaluated by optometry in 2010 when astigmatism was diagnosed. A new prescription didn't help the patient.	It is not clear what the alternative treatment plan should be. The referring provider was reasonably trying to eliminate eye conditions as a cause of the patient's headache.
7/28/2011	A PA saw the patient for chronic illness clinic. The only problems listed were high blood lipids, hepatitis B, and diabetes (diet controlled). The blood pressure was 130/80. The LDL-C was 129 and A1c was 5.9. The high blood lipids were documented as in good control which they were not. The patient's high blood pressure was no longer being documented as a problem even though apparently the patient was still on medication. Medications however were not listed.	This was a poor chronic clinic visit as the provider did not acknowledge all of the patient's problems and did not address all problems. The elevated lipids were not treated adequately.
7/29/2011	A nurse evaluated the patient for L ear pain. The nurse documented contacting a provider. An NP signed an order for Cortisporin otic drops without seeing the patient	It appears that Cortisporin otic was ordered but without provider evaluation. This isn't appropriate practice.
8/5/2011	An NP saw the patient for follow-up of ear pain. The NP continued Cortisporin eardrops which are for otitis externa; the NP documented that the patient had otitis media. The NP diagnosed and treated tinea cruris but did not document examination of the patient for this condition.	The NP was treating otitis media with a drug used for otitis externa. The NP treated a person for a condition without evaluation of the patient.
8/9/2011	The patient requested a blood test for hepatitis B. Apparently, even though the patient already had a diagnosis of hepatitis B, staff had either not diagnosed the condition or had not explained their diagnosis with the patient because on 8/15/11 another hepatitis A, B, and C test were ordered.	Communication with the patient was ineffective with respect to his prior positive hepatitis B test. Retesting the patient for hepatitis B a second time was unnecessary.
8/15/2011	A hepatitis A, B and C panel was ordered. Hydrochlorothiazide was started	
8/15/2011	A provider documented that the patient was being evaluated for lab results but the results were not in the medical record. The provider documented a history of hepatitis C even though the chronic illness visits documented history of hepatitis B. The blood pressure was 150/92 and the provider documented hypertension again which apparently had fallen off the problem list on recent chronic care visits. The provider did not document what medications the patient was on and started hydrochlorothiazide another blood pressure medication.	The system had lost track of the patient's medical conditions and failed to know what type of hepatitis the patient had or even whether he had hepatitis. There was no evidence that the hepatitis tests were done.

8/16/2011	A provider saw the patient for complaint of headache, foot pain and changes in bowel movements. The provider did not take a thorough history. Nevertheless the provider diagnosed irritable bowel syndrome, chronic tension headache and chronic foot pain and treated the patient with a nonsteroidal medication and fiber.	A neurology referral should have been undertaken as the patient had headache for over 2 years without improvement despite attempts at treatment.
9/25/2011	The patient placed a health request stating that he had severe headaches every day and thought that the headache might be from the Lisinopril.	
9/26/2011	A provider saw the patient for headache. The blood pressure was 142/92 which is high. The doctor diagnosed tension headache or intolerance to Lisinopril. The provider stopped the Lisinopril and started Norvasc 5 mg and started Toradol.	
10/24/2011	A PA saw the patient for chronic illness clinic the only problems listed were high blood lipids, hepatitis B and diabetes. The patient's hypertension was not listed as a problem even though the patient was on high blood pressure medication. The provider did seem to recognize that the patient had high blood pressure by discussing the change to Norvasc but it wasn't clear that the patient was being followed for this condition. The patient's LDL cholesterol was elevated but this was not addressed. It was not clear that the patient's hepatitis was accurately diagnosed and prior blood tests for hepatitis were not followed up on at this visit. Even though the patient's high blood lipids were listed as in only fair control, there was no modification of therapy. The medications the patient was taking were not listed, so it wasn't clear what medications the patient was being treated with.	This is a poor chronic clinic visit as the provider did not know or follow all of the patient's medical conditions. High blood lipids were not at goal yet there was no modification of therapy. The system did not appear to have an accurate diagnosis of the patient's hepatitis and previously ordered lab tests were not followed up on.
10/26/2011	A provider saw the patient in follow-up of changing blood pressure medication. The BP was 130/86 which is high for diabetes but normal for non-diabetics. The doctor diagnosed stable hypertension.	
11/9/2011	An abdominal ultrasound was re-ordered apparently had never been done.	

11/9/2011	A provider saw the patient for a rash in the groin area (the patient had run out of Lotrimin, an antifungal agent). The provider ordered hepatitis BsAG, BsAB, and B core antibody along with an abdominal ultrasound.	This was the second time that a provider ordered hepatitis tests. The prior order of hepatitis A, B and C tests was never done. Also the prior abdominal ultrasound ordered had been approved in March of 2011 about 8 months previous but apparently never completed. It wasn't clear what the reason for the current need for this test was as the provider made no diagnosis or assessment related to an abdominal complaint.
11/30/2011	A provider documented hepatitis BsAg negative but BsAB positive consistent with old hepatitis B.	This diagnosis should have been apparent in the medical record but the lab test values were not present in the record. Repeat testing indicated hepatitis B. This speaks to a very poor medical record system as test results are not filed in the record. Even though the provider documented the test results in his note, the actual test result was not in the medical record.
11/30/2011	An ultrasound showed a 2 cm right renal cyst. The liver appeared to show fatty infiltration.	There was no evaluation of the patient with respect to fatty liver.
12/20/2011	Norvasc was renewed for 6 months	
1/3/2012	A provider saw the patient for follow-up of the ultrasound. The provider ordered a repeat ultrasound in 3 months. The pulse was 106 and BP 142/88 but neither was addressed. The reason for requesting repeat of the ultrasound was not documented.	It isn't clear that the patient had an indication for the repeat ultrasound.
1/5/2012	A recommendation to repeat the ultrasound in a year was requested but denied with a comment to manage clinically as the cyst is of no consequence. It is not clear what "manage clinically" meant in this instance. Renal cysts are generally benign.	
1/23/2012	A provider saw the patient for chronic illness clinic for diabetes, high blood lipids and hepatitis B. Hypertension was not listed as a problem and not assessed. The patient complained of persistent headaches. Nothing was done with respect to the headaches. Hepatitis B, the lipid disorder and diabetes were all listed as in fair control but the lipids were not even documented and the patient had not had any evaluation of his liver function but did have a fatty liver on ultrasound. This may have been due to his diabetes.	The providers continue to fail to monitor all of the patient's chronic illnesses and failed to monitor laboratory testing necessary to monitor the chronic diseases under management.

2/12/2012	An NP saw the patient for chronic care for high blood lipids and diabetes. The NP documented that the patient was on Lopressor but there was no medical condition associated with this medication. This medication was started for headache but providers stopped following the patient for this condition. The diabetes history was listed as not applicable. The blood pressure was abnormal at 140/92 but was not addressed. The LDL cholesterol was abnormal at 128 and was documented as in fair control. The last A1c was documented as 6.3 but a date wasn't given. The only medications listed were aspirin, Lopressor and niacin. It does not appear that the patient was on diabetic medication and a hemoglobin A1c of 6.3 is not diagnostic of diabetes.	This is a poor chronic illness note. The history is inadequate for the patient's conditions. Not all of the patient's problems were addressed. It appears that the NP did not recognize or address the patient's hypertension which was not in good control. The elevated LDL cholesterol was not addressed. Because medications were not listed, it wasn't clear what the therapeutic plan for this patient was.
2/27/2012	A provider saw the patient for urinary urgency which was worse with Flomax. The provider stopped Flomax and ordered a metabolic panel and magnesium level.	
3/9/2012	A provider discontinued Norvasc and started atenolol.	
3/19/2012	A provider saw the patient for persistent headache. The blood pressure was 140/92. The metabolic panel was documented as normal but the results were not in the record. The doctor assessed persistent headache and hypertension, which was not being managed in chronic illness clinic. The provider stopped the Norvasc and started atenolol.	The patient was apparently already on Lopressor, another drug of the same class as atenolol.
4/12/2012	An optometrist documented that there was no ocular reason for the patient's headaches and recommended referral to a neurologist for evaluation. The vision was 20/20 bilateral	The optometrist recommendation for neurology referral was reasonable as the patient had almost 3 years of headache without a diagnosis and without local staff knowing what the patient's condition was.

4/23/2012	A provider saw the patient for chronic illness clinic. Again, the only problems listed were hepatitis B, diabetes and high blood lipids. The evaluation didn't include a lipid test which didn't appear to be done for over a year despite diabetes, hypertension and hyperlipidemia. Although the blood pressure was 132/84 (diabetics should be controlled to 130/80) the hypertension wasn't addressed. All the patient's problems were documented as in fair control but no additional steps were taken to obtain better control. The assessment of fair control of hepatitis made no sense. The patient's weight remained very high at 244 pounds but again was not addressed specifically.	Not all of the patient's problems were followed in chronic illness clinic and periodic laboratory testing (for lipids) did not appear to be done.
6/7/2013	A provider discontinued atenolol and started Cozaar 50 mg.	
6/7/2013	A PA saw the patient for chronic illness. The only diagnoses identified were high blood lipids and hypertension. The blood pressure was 140/88; the LDL cholesterol was 120 but was listed as in good control which is not accurate. The BP was in control but the patient complained that his blood pressure was high so the PA discontinued Atenolol and started Cozaar. The elevated lipids were not addressed. The PA did not list the patient's medications.	The PA did not list the patient's medications. Generally, one adds another drug rather than substituting one drug for another.
6/14/2013	A provider increased the Cozaar to 100 mg a day	
6/14/2013	The patient placed a health request stating that he wanted to see a physician because his blood pressure was 160/110 earlier in the day.	It does not appear that this was addressed.
6/26/2013	The patient placed a health request because of headaches and hip pain and a groin rash. A nurse took a blood pressure of 160/98 which is high.	
6/27/2013	A PA saw the patient for FU of BP. The BP was 146/100 which is high. The PA noted that the patient was now on Cozaar 100 mg a day. The PA noted that the "BP is OK today" which it was not. Nevertheless the PA added Norvasc 5 mg and a FU in 6 weeks.	

7/8/2013	A provider saw the patient for painful hip and headaches. The provider wrote that the patient had headache for 2 years but the patient had the headache for at least 3 years. Insufficient history was taken with respect to the headache. The blood pressure was 138/90 which is elevated. The provider documented well controlled hypertension. The provider did not investigate why the patient had headache.	The provider failed to address the patient's problems specifically the headaches. Although the blood pressure was minimally elevated the provider took no action.
7/12/2013	From 6/29 to 7/26 a nurse took blood pressure which was high on 22 of 27 episodes.	
7/22/2013	A provider saw the patient for an itchy groin. The blood pressure was 162/96 which is high. The weight was now 250. The provider diagnosed tinea cruris and prescribed Mycolog and Diflucan for 42 days. This seems a long period of time to treat tinea cruris. The provider did not address the high blood pressure.	Typically, Diflucan is used 2-4 weeks in extensive tinea cruris. Because fungal infections may be promoted by diabetes or maceration due to obesity, these should have been evaluated. The provider failed to address the high blood pressure.
7/24/2013	The patient placed a health request complaining of abdominal pain and asking to have a repeat ultrasound of his kidney to recheck the renal cyst.	
8/7/2013	Norvasc was increased to 10 mg daily and A1c was ordered for the next lab draw	This medication change was done without discussion with the patient.
8/17/2013	A PA saw the patient for chronic illness follow-up. Hypertension and high blood lipids were listed as problems. The patient was documented as being on Zyrtec, Norvasc, Cozaar, Prilosec and aspirin. The PA documented that the BP continued to be elevated and was 144/90 in the clinic. The LDL cholesterol was 120, but no laboratory values were in the record so it wasn't clear when this test was done. The provider documented that the high blood lipids were in good control which they were not. Also it wasn't clear whether the patient was on medication any longer for this condition as no MARS or medication history was available in the record. The PA increased the Norvasc to 10 mg and ordered a HGB A1c to the next labs.	The PA failed to adequately assess the high blood lipids or to treat the abnormal value. It appeared that the patient was receiving no treatment.
8/28/2013	A provider saw the patient for lower back pain. The provider noted that the groin rash was better on Diflucan but added Clindamycin for a skin infection on his back. Although the chart was somewhat difficult to read, it does not appear that a skin infection was diagnosed so it was not clear why the Clindamycin was started.	

9/5/2013	A provider saw the patient and documented MRSA lesion and continued Clindamycin but did not culture the lesion. The provider stopped Norvasc and started hydralazine 25 BID and ordered an A1c in 4 weeks.	
9/5/2013	A PA saw the patient for chronic illness clinic. The listed problems were hypertension and high blood lipids. The LDL cholesterol was 131 but was assessed as in good control which is inaccurate. The Hemoglobin A1c was not mentioned even though it was borderline for diabetes. The patient's BMI was 35 and weight was 245 which placed the patient at high risk for diabetes. There was no discussion with the patient. The blood pressure was 138/82 which is within normal range yet the PA stopped Norvasc (a medication which was helping the patient) and started low dose hydralazine without documenting why. The PA re-ordered the A1c apparently not seeing the lab result which was returned about a month previous.	This is a poor chronic clinic evaluation. The PA misinterpreted the LDL cholesterol value and thought it was good control when it needed treatment. The diabetes was borderline but was unrecognized. Blood pressure medication that was keeping the patient in control was discontinued and a new medication started without reason.
9/30/2013	Labs were repeated: Glucose was 113, TG 150; HGB A1c 6.2; ALT 47, LDL 111.	
10/17/2013	A PA saw the patient for chronic illness clinic for hypertension and high blood lipids. Although high blood lipids were a documented problem and the LDL cholesterol was still high at 111, the patient was on no medication yet this appeared to be unrecognized. The PA did not discuss the borderline A1c level with the patient even though the patient's weight was 246 pounds. The high blood lipids were listed as in good control with an LDL cholesterol of 111 which was inaccurate.	The patient's problems were not all addressed. Blood lipids continued to be untreated.
12/12/2013	Labs included cholesterol of 218, LDL-C of 132 and AST 49 and ALT of 56 all of which were abnormal. The HDL was 58. These labs as others were not addressed.	The AST and ALT abnormalities indicated liver disease which was possibly due to his hepatitis B infection or could have been due to fatty liver.
12/17/2013	A nutritionist documented a note stating that the patient wanted to lose weight due to health problems and wanted extra portions of vegetables and fruit and healthy snack choices instead of meat. The nutritionist said that she "explained to the inmate that DOC could not provide special requests to him due to policy; other inmates would perhaps expect special requests to be honored as a result. I explained to him that I had no authority as to what was offered for sale in the canteen but would pass along his requests for healthier choices to be provided to Warden Davenport.	The nutritionist documents a serious problem in that the diet of the prison was not amenable to choice that would benefit this obese patient.

1/17/2014	A PA saw the patient for chronic illness clinic. Hypertension, hyperlipidemia and hepatitis B were listed as problems. The LDL-C was 132. The blood pressure was 150/98. Each of these was documented as in fair control yet the hyperlipidemia was not treated. The PA added HCTZ to hypertension medication.	The PA again failed to treat high blood lipids and failed to recognize that this condition was not being treated.
1/27/2014	A nurse saw the patient for a blood pressure check and the blood pressure was 174/100. A PA was called and ordered a stat dose of Clonidine which is not an appropriate therapy.	The patient's blood pressure medication should have been adjusted instead of using a stat dose of Clonidine.
2/11/2014	A PA saw the patient for chronic illness clinic. Hypertension, hyperlipidemia and Hepatitis B were listed as problems. The BP was 122/80 but the pulse was 113. The tachycardia was not addressed. The LDL cholesterol of 132 was not addressed and was listed as in good control which it was not. The prior abnormal liver function tests were not addressed with respect to hepatitis B.	This was a poor visit. The PA failed to address tachycardia and elevated blood cholesterol and failed to understand that the hyperlipidemia was in need of treatment. Prior abnormal tests were not addressed.
2/11/2014	A nursing chronic disease flowsheet documented tachycardia of 113 on 2/11/14; 115 on 6/30/14; and 118 on 10/23/14 without any evaluation.	
2/18/2014	Labs glucose 212; A1c 6.2 LDL 107.	The glucose of 212 if symptoms were present (polyuria, polydipsia, nausea, etc.) would qualify for a diagnosis of diabetes.
2/20/2014	The patient requested to see a physician for headache and said that he would like the referral that the optometrist recommended.	
2/21/2014	A T-spot test was negative	
2/22/2014	A provider saw the patient for follow-up of hip and pelvis x-rays. The pelvis showed osteoarthritis	
2/26/2014	A doctor referred the patient to an ophthalmologist for decreased visual acuity of 20/200 in the left eye. There was no test verifying 20/200 vision in the record. The last visual acuity was in 2012 when it was 20/20 bilaterally. Sudden loss of vision is a medical emergency.	If this loss of vision was sudden, the patient should have been sent to an emergency room for evaluation.
2/26/2014	A doctor documented that the patient was still having headaches and would prescribe Imitrex.	
2/27/2014	A request for neurology for migraine headaches was denied. The recommendation was to try Triptin medication.	This was a reasonable request as the facility providers were unable to effectively manage his headache for over 3 years.
3/26/2014	Cholesterol 211; LDL 116, ALT 42	Despite elevation of transaminases on several occasions, the patient was not screened for hepatitis C or other liver disease.

4/3/2014	A PA saw the patient for chronic illness clinic for hypertension, high blood lipids and hepatitis B. Although the transaminases had been elevated, and the patient had fatty liver, the PA did not investigate this further. A hepatitis C test should have been ordered (in fact this was previously ordered but was not done). The LDL was 107 but was not treated. Blood pressure was 122/82. Blood lipids were listed as in good control which they were not.	All of the patient's problems were not addressed.
4/16/2014	A doctor saw the patient and the patient said that the Imitrex did not help his headaches. The patient had continued back pain. The doctor referred for an MRI of the lumbar spine; ordered medication for headache but the name of the medication was illegible.	
4/25/2014	An optometrist saw the patient for headaches but said that there was no ocular reason for the headache. The VA on the left was 20/200 but did not have a retinal problem identified.	20/200 vision is abnormal and qualifies for legal blindness. The patient should have been sent to a neurologist.
5/13/2014	A nurse saw the patient for suprapubic pain. There was blood in the urine by patient anecdote along with weight loss. The weight was 236 which did indicate weight loss of approximately 10 pounds. The blood pressure was 144/96 and the pulse was 132 which is very high. The urinalysis showed large blood, protein, and leukocytes. The nurse contacted a physician who recommended Ciprofloxacin and pyridium but did not evaluate the patient. No labs were ordered.	This was inadequate. A physician should have seen the patient as the pulse of 132 was significant. Labs should have been ordered including a blood count, urine culture, and metabolic panel.
5/23/2014	An NP saw the patient for follow-up of hip pain. The prior episode of hematuria was not noted. The pulse was now 68. The patient had a raised red rash in his groin. Tinea cruris was diagnosed and Diflucan was prescribed for 2 weeks. There was no follow-up of the prior hematuria.	The provider should have followed up on the prior problems of suprapubic pain.
6/6/2014	The patient's TB skin test was documented as 0 mm.	
6/9/2014	HCT 38 (normal 39-52); LDL 116	The anemia was not followed up on.
6/30/2014	A PA saw the patient for chronic illness clinic. Hypertension and high blood lipids and hepatitis B were listed as problems. The blood pressure was 132/86, the pulse was 115, and LDL cholesterol was listed as 116. The hyperlipidemia was listed as in fair control but no therapy was initiated.	The hyperlipidemia was not properly addressed.
7/2/2014	An NP saw the patient for a complaint of bumps on his penis. There were two bumps on the penis diagnosed as HSV.	

7/7/2014	Normal R hip x-ray	
7/10/2014	A herpes test of the penile lesions was positive for herpes	
7/17/2014	PA ordered spironolactone 25 mg daily	
7/26/2014	The patient placed a health request for daily headaches and a right sided abdominal swelling.	
7/30/2014	An NP saw the patient for a complaint of abdominal swelling. The pulse was 105. The NP did not identify an abdominal bulge on examination. The NP referred the patient to mental health for multiple sick call requests with "?somatic" complaints.	
7/30/2014	X-ray of chest and ribs show no abnormalities. The x-ray was over penetrated.	
8/4/2014	The inmate submitted a health request to obtain follow-up of the ultrasound and results of the rib x-ray	
8/5/2014	A mental health staff documented that the inmate was able to verbalize plausible explanations for submitting multiple sick call requests.	
8/6/2014	An NP ordered a urine culture including for chlamydia and gonorrhea	
8/6/2014	A nurse evaluated the patient for difficulty with urine stream and dysuria	
8/6/2014	The urine culture was negative and urinalysis was also negative	
8/14/2014	An NP saw the patient in FU of urinary symptoms with a chief complaint of hesitancy. The NP noted that urine culture including for chlamydia and GC were negative. The NP documented that she would talk to the doctor about ordering an abdominal ultrasound. Later this referral was made.	
8/15/2014	HGB A1c 6.5 which is diagnostic of diabetes.	
8/21/2014	The abdominal ultrasound which was previously denied was now approved.	
8/28/2014	The abdominal ultrasound demonstrated a 2 cm cyst of the right kidney and a 3 cm cyst of the left kidney. These cysts appeared benign.	
8/31/2014	The patient placed a health request complaining of dizziness and a feeling that he was going to pass out. He described his blood pressure as 180/88 in the morning.	
9/10/2014	A Dept. of Health TB screening form was completed. It was negative for symptoms of TB.	

9/11/2014	The patient complained of dizziness with palpitations for 4-5 months. Orthostatic BP was normal. He had a normal EKG. The patient appeared anxious. The ultrasound results were discussed with the patient.	
9/24/2014	An EKG showed sinus tachycardia	
9/30/2014	A nurse evaluated the patient for a complaint of palpitations described as heart flutters. The pulse was 95 and blood pressure was 130/90. The nurse referred to a provider on a routine basis. An EKG was normal.	The nurse should have consulted with a provider.
10/2/2014	A provider saw the patient for chest pain and dizziness. The provider mentioned that the patient had a history of panic attacks. The blood pressure was normal. The provider assessed panic attack and referred to psychiatry. The provider did not address the abnormal A1c diagnostic of diabetes.	The provider failed to follow up on abnormal laboratory values.
10/9/2014	The patient was evaluated in follow-up of dizziness. The pulse was 102. The NP stated that orthostatic blood pressures were normal.	
10/15/2014	HGB was now 39.8 which is normal. Transaminases were now normal.	
10/23/2014	A PA evaluated the patient in chronic illness clinic. The patient's problems were listed as hyperlipidemia, hypertension, hepatitis B, and diabetes. The PA documented that the patient had an episode of non-cardiac chest pain. The pulse was 112, BP 124/80, and A1c 6.5. Finger stick glucose values were 98-215 which include abnormal values. All conditions were listed as in good control which is inaccurate for his hyperlipidemia. There was no discussion about treatment of his diabetes. Although the blood pressure was normal, the PA added Carvedilol to the blood pressure regimen without giving a reason for doing so.	The PA established no plan for treatment of diabetes, did not address tachycardia, and again did not treat the patient's high blood lipids. The reason for adding another anti-hypertensive medication was not given as the patient was in good control. Medications were not listed.
11/4/2014	LDL cholesterol was 116, glucose 129 and total cholesterol 204	

11/20/2014	A PA saw the patient for chronic illness follow-up. Hyperlipidemia, hypertension, hepatitis B, and diabetes were listed as problems. The PA documented that the patient had no further chest pain while on Coreg. If this were true then there would be a high suspicion of angina which should have prompted a work up given the risk factors of the patient. The blood pressure was 122/82 and pulse was 94. The patient's weight was back up to 246 and the LDL was documented as 116. All of his conditions were listed as in good control. The PA without explanation increased the Carvedilol dose from 3.125 to 6.25.	The PA did not document a rationale for increasing the Coreg.
11/26/2014	A provider noted a tender nodule on the left breast and requested a mammogram along with pelvic and LS spine x-rays for back pain.	
12/1/2014	A hip x-ray showed narrowing of the articular space of the hips with spurring of the acetabulum consistent with degenerative arthritis of the hips. The LS spine also showed degenerative arthritis.	
12/2/2014	The request for mammogram was denied. The Regional Medical Director recommended surgical removal of the nodule for diagnosis.	
12/19/2014	A PA saw the patient for chronic illness follow-up. Hyperlipidemia, hypertension, hepatitis B, and diabetes were listed as problems. BP and pulse were normal. Although the A1c was documented as 6.5 no therapy was initiated. The LDL cholesterol was 116. The diabetes and hyperlipidemia were documented as in good control.	Medications were not listed. It was not possible to determine what medication the patient was on as no MAR records were in the medical file.
12/22/2014	Hydralazine 50 mg BID was started. The patient was additionally on Cozaar, aspirin and apparently Carvedilol and apresoline.	It wasn't clear why a new blood pressure medication was started.
1/7/2015	LDL cholesterol 126; glucose 128 and A1c 6.4	
8/1/2015	No records were found for August, Sept, or November of 2015	
1/13/2015	There were orders on the same day and time to both start and stop spironolactone. It wasn't clear whether the patient was still on this medication.	

1/22/2015	A PA evaluated the patient in chronic illness clinic. The patient's problems were listed as hyperlipidemia, hypertension, hepatitis B, and diabetes. The PA documented that the patient's dizziness improved on a lower dose of Coreg, but medications were not listed so it was not possible to determine what medications the patient was taking. The A1c was documented as 6.4; LDL as 125 and all conditions were listed as in good control. No change in therapy occurred. The PA did not discuss the patient's diabetes condition. The weight remained at 238. The patient was on a 2000 calorie "wellness" diet.	The cholesterol was not in good control.
3/18/2015	A PA saw the patient for chronic illness clinic for hyperlipidemia, hypertension, diabetes and hepatitis B. Although no new labs were done and no finger stick glucose values were taken, the PA documented that the diabetes was now downgraded to fair from good control. The PA documented that the patient's weight continued to rise despite diet control and that he would start metformin. The weight and A1c had not appreciably changed for years. It was not clear what prompted treatment. The PA did not list medications so it was not possible to determine from the record what medications the patient was on.	The documentation for care was poor. The lipids had not been in good control for years and yet remained untreated. The diabetes was in good control and probably did not need treatment.

Patient 11

Date	Summary	Comments
9/29/2011	AST-299; ALT 846. These are extremely high liver function tests but there were no associated medical notes. This might have been due to treatment with isoniazid for prophylaxis	
2/25/2012	PPD 12 mm; Apparently the tuberculin skin test was performed even though the patient was previously positive. The present weight was 172 pounds. The patient had no symptoms.	When a tuberculin skin test is positive, it should not be repeated.
2/25/2012	An intra-system transfer form documented that the patient was transferred to Draper. There was no medical evaluation of the patient upon transfer. Up to this date, there were no physician evaluations of the patient in the medical record provided.	

7/19/2012	The patient refused chronic care visits for hepatitis C and hypertension. The patient was not on medication for hypertension and blood pressure values on nursing notes during 2012 were normal.	The basis for hypertension was not clear.
9/12/2012	ALT 58 (normal <41); AST 33 (normal < 40); creatinine 0.74 (normal 0.9-1.30)	A liver function test was still abnormal
11/6/2012	Patient placed a health request stating that he had severe left hip pain	
11/7/2012	Patient placed another health request for severe back pain and requested to see a doctor.	
11/8/2012	A nurse saw the patient for pain. The nurse recorded no examination on the nursing protocol; the nurse assessed alteration in comfort and gave 5 days of ibuprofen by protocol.	
11/20/2012	The patient transferred from Draper to WDCF which is not an abbreviation of any Alabama correctional facility.	
1/8/2013	A urinalysis was negative for blood.	
4/8/2013	The patient placed a health request saying that his back hurt and his face was "broken out".	
4/9/2013	A nurse triaged the form on 4/9/13 and recommended only education.	
4/11/2013	A nurse saw the patient using an upper respiratory nursing protocol. It isn't clear why the nurse saw the patient. The chief complaint only documented "4 days". This was an LPN. Without any history the nurse documented giving over the counter medication but did not document what was given.	This was an inadequate nursing evaluation.
4/16/2013	The patient complained of headache, fever, and difficulty breathing.	

4/16/2013	A doctor saw the patient for chronic illness clinic for hepatitis C and hypertension. The patient did not appear to have hypertension. Except for asking about nausea, vomiting, abdominal pain or diarrhea, no history was taken. ALT of 58 was noted but no comment was made. The hepatitis C was noted to be in good control. The viral load for hepatitis C was not ordered. FU was ordered for 6 months. The doctor did not address the patient's complaint of headache, fever and difficulty breathing for which the patient had submitted a health request on the same day. The doctor ordered minocycline for 14 days but gave no indication in his note why he ordered this medication. The doctor documented that the hypertension was in good control but the patient was not taking medication for this condition. A urine test was ordered but the doctor gave no indication why he ordered this test.	The documentation for this episode of care was poor. The liver function test (ALT) was abnormal and hepatitis C was documented as in good control when there was no basis for this statement. The patient had complained of headache, fever and difficulty breathing on the same day but these complaints were not evaluated. There was no apparent indication for prescription of minocycline. The doctor did not indicate why he ordered a urine test.
4/18/2013	The patient refused sick call	
5/22/2013	The patient transferred from WDCF to Kilby.	
10/31/2013	The patient refused a physician visit to evaluate his hepatitis C.	
11/12/2013	A provider documented evaluation of the patient at 10 am for nausea, vomiting and flank pain. The blood pressure was now elevated at 152/98. The patient had left sided flank tenderness. The provider ordered a urine analysis, drug screen and encouraged fluid. The patient was given plain Tylenol and returned to the segregation unit.	The history and evaluation were inadequate for the patient's complaint.
11/12/2013	UA showed no blood but oxalates and moderate amounts of crystals. The urine drug screen was negative.	
11/12/2013	At 5:30 am a nurse evaluated the patient for chest pain but the patient was clutching his left side of his abdominal region. The patient had vomited. The nurse used a chest pain protocol but appears to have misinterpreted the patient's pain. The EKG was normal but the blood pressure was high. The nurse called a doctor who ordered cardiac troponin testing which was sent stat to a local hospital and was normal.	

11/15/2013	The patient was apparently sent to a local emergency room for a CT scan as recorded on a "Return from Offsite" form. An NP reviewed the patient post return on 11/19/13 and documented that the patient had a kidney stone. FU was recommended if the patient was unable to pass the stone but the patient had not been on an infirmary and the urine was not screened. The consultant recommended increased fluid, Macrobid, Flomax and Percocet but this was noted 4 days after the consultant evaluation. The NP consulted a physician who asked to have the dictated emergency room report along with the CT scan results and lab results.	The medication were apparently started on 11/16/13 when the patient returned from the hospital.
11/16/2013	A nurse noted that the patient had vomited 3 times and had chest pain. The nurse noted that an NP saw the patient for the same complaint on 11/12/13 and that cardiac enzymes were normal. The patient was sent to a hospital.	
11/16/2013	Vicodin, Flomax, and Macrobid were started 11/16/13	
11/16/2013	A nurse evaluated the patient on a "Body Chart" form and documented the patient asking for something for pain saying that his last dose of medication was 4 hours ago. The patient was apparently still in segregation.	The patient had a kidney stone and should have been housed on an infirmary unit not in segregation.
11/16/2013	The CT scan report recorded a 3 mm stone with mild hydronephrosis and possible ruptured fornix. The WBCs were 13.3 and the urine showed 1+ blood and the creatinine was 1.38. At the hospital, the patient gave a history of prior kidney stones.	
11/20/2013	An NP requested urology consultation stating that the stone was 3mm. The NP stated that the patient was still in pain and hadn't passed the stone. There was no examination connected to this request.	There was no evidence of an examination after return from the hospital for a kidney stone. The patient should have been on an infirmary unit and should have been evaluated by a provider.
11/22/2013	CO2 = 31 (normal 22-29), creatinine 0.97 Ca 9.5; WBC 5.81; urine negative for blood.	

11/25/2013	An NP saw the patient for "pain" management. There was no evidence that the patient had been examined since the ER visit on 11/16/13. The NP said that the patient remained in pain. The patient complained of a hard time urinated. The NP stated that the patient was on naproxen but on examination had marked tenderness. The NP stated to wait for the urology consult and continue the current pain medications which were not specified. A MAR showed that the patient was on Naproxen 500 BID, Flomax and Microbid. The Naproxen prescription was valid until 12/15/13.	The Naprosyn did not appear to be adequate pain management. .
12/9/2013	Naproxen was renewed until 1/8/13	
12/9/2013	On 12/9/13 an urologist saw the patient and documented that the patient was still having pain with hematuria. The urologist felt that the patient should be able to pass a 3 mm stone on Flomax and asked that the patient strain the urine and return in 3-4 weeks. The dose of Flomax was increased to 0.4 mg BID from daily.	
12/9/2013	An NP reviewed the urologist note and documented that the patient should strain the urine but he was not kept on an infirmary and it isn't clear how the patient was to do this.	The NP did not make an accommodation necessary for the patient to follow the specialist's instructions.
12/31/2013	The patient transferred from Kilby to SCCF. A check box for pending off-site consults was checked not applicable which was an error. The nurse documented that the patient was on no medication. Nephrolithiasis wasn't listed as a problem. The patient still had an active prescription for Naproxen.	This error was likely to result in a delay in seeing the specialist.
2/26/2014	The first provider visit at SCCF was by a PA on 2/26/14 when the PA saw the patient for chronic illness follow-up. The PA noted that the patient had a stone in November and the PA documented that he would order labs and refer the patient to an urologist urgently. The PA ordered Naproxen 375 and Flomax. The hepatitis C was documented as in good control. The PA did not take a history whether the stone had passed or whether the patient still had pain. The history of the patient's symptoms was absent except that irrelevant questions on the check box format chronic illness sheet about HIV, hypertension were checked normal.	The patient missed medication and his urology appointment due to an intra-system transfer problem. The history was inadequate.
2/26/2014	urinalysis showed negative for blood	

2/26/2014	Ca =9.5; AST= 77, ALT=141(normal 10-75)	The AST and ALT were abnormal liver function tests. This indicates chronic hepatitis C. The patient could have been assessed for treatment.
3/3/2014	An urologist saw the patient about 2 months late and documented that the left kidney had been obstructed for about 3 months and recommended laser surgery with a stent ASAP.	The delay in treatment and failure to provide needed medication resulted in harm to the patient (obstructed kidney and persistent stone with pain that was under-treated).
3/7/2014	The patient had lithotripsy with stent placement. The patient was discharged on Lortab 7.5 I-II prn Q4 hours for pain. This was changed at the facility to 2 nacre tabs TID for 5 days. Also, the patient left the hospital with instructions to pull the stent on 3/11/14.	
3/10/2014	An NP requested urology FU in 2 -4 weeks	
3/10/2014	Urinalysis had moderate to large blood	
3/10/2014	An NP saw the patient who still had pain since his surgery on 3/7/14. The NP admitted the patient to the infirmary for 23 hour observation. The NP ordered urology follow-up.	
3/11/2014	The stent was removed and shortly after that the patient was sent back to general population.	Continued infirmary care should have been considered.
3/12/2014	Norco was prescribed for 4 days 2 tabs TID	
3/18/2014	After discharge from the infirmary, the patient wasn't seen until 3/18, the patient now complained of a rash and had flank pain and had bleeding. There were multiple "sores" on his face mouth, arms, and shoulders without drainage. The sores weren't cultures and the NP started Keflex with a stat dose of Ciprofloxacin. The NP ordered a week FU.	The follow-up after discharge from the infirmary was poor.
3/19/2014	UA had small blood	
3/20/2014	The patient returned to urology and still had difficulty voiding. The urologist noted a rash on the upper extremities. The urologist recommended continuation of Flomax, and started pyridium. The urologist started hydrocortisone thinking that the rash was a latex allergy.	
3/20/2014	An NP noted the urology note and started pyridium and hydrocortisone.	
3/28/2014	A PA saw the patient for chronic care follow-up for hepatitis C. The NP noted that the patient did not have further pain. The hepatitis C was documented as in "good" control with an APRI of 0.97.	An APRI test of 0.97 suggested possible fibrosis and this was not in good control. The patient could have been referred for treatment.
4/14/2014	ALT =45; TG =303,	

4/19/2014	The patient placed a health request stating that he was in severe pain and couldn't urinate.	
4/21/2014	A PA saw the patient for chronic care follow-up for hepatitis C. The PA noted that the patient had low back pain (related to his sick call request on 4/19/). The PA did not ask about hematuria and didn't order urinalysis. The PA documented that the kidney stone "has passed" but the fact was that it was lysed via surgical laser therapy. The PA documented that the APRI was now 0.19 and that hepatitis C was in good control.	A repeat liver function test was indicated.
4/23/2014	Urinalysis negative for blood but positive for protein.	
4/23/2014	A nurse saw the patient for "urinary symptoms" without being more specific. The nurse referred the patient to a physician.	
4/25/2014	An NP saw the patient for FU of urinary symptoms and noted that the urinalysis was negative and chlamydia test was negative. The urine culture was pending. Notably, the patient's heart rate was 122 but was not addressed.	
4/29/2014	A nurse saw the patient urgently documenting on a "body chart" that the patient had multiple sores "all over body". The patient's pulse was 126. The weight was 169. The nurse didn't refer the patient.	The patient had an abnormal vital sign with a rash and should have been referred to a physician.
5/15/2014	The patient placed a health request complaining of back pain.	
5/16/2014	A urinalysis was positive for protein	
5/16/2014	A nurse evaluated the patient for back pain. The patient complained of occasional blood in his urine and painful urination.	The second page of the nurse's note was not present so it wasn't clear what the nurse did.
5/19/2014	The patient complained on a health request that he had blackouts and had passed out several times. The LPN scheduled the patient to see a nurse.	
5/20/2014	A RN saw the patient for blackouts and referred the patient to a physician.	This referral wasn't completed for 7 days but blacking out is an urgent issue.

5/27/2014	An NP saw the patient for passing out. The pulse was 86. The supine blood pressure was 98/64 which is very low and an upright blood pressure of 102/62, The weight was 150. The patient complained of feeling dizzy before passing out. The NP obtained a normal heart exam. The NP ordered an EKG, a metabolic panel and FU in a week. The NP failed to note that the patient was on Tamulosin, which is noted to cause hypotension.	The NP medication history was inadequate.
5/27/2015	The patient placed a health request complaining of back pain, dizziness, blackouts and weight loss to 150 pounds.	
5/29/2015	The EKG was normal sinus rhythm with a rate of 67.	
5/29/2015	A nurse evaluated the patient for back pain. The nurse referred the patient to a physician.	
5/29/2015	A drug screen was negative except for buprenorphine which is a semisynthetic opioid typically used for opioid addiction.	
6/3/2014	An NP saw the patient for follow-up of syncope. The weight was 152 and the pulse was 58. The NP noted that the EKG was normal and that the drug screen showed buprenorphine. The patient didn't want to discuss the "kidney pain". The patient became uncooperative and the NP asked to have the patient removed from the clinic.	
6/10/2015	Glucose was 63, phosphorus was 5 (normal 2.7-4.5) AST = 114; ALT =213; TG 227 and T3 204 (normal 80-200).	The liver function tests were abnormal indicating chronic hepatitis. The APRI score was over 1 suggesting possible fibrosis and possible cirrhosis. The patient could have been referred for treatment. An ultrasound might have been done.
6/13/2014	The patient placed a request saying that he continued to have blackouts and that he had a "spider bite" on the back of his leg that looked infected.	
6/13/2014	A nurse evaluated the patient for "spider bite". The temperature was 99 and the pulse 120. The weight was 169. The patient had an abscess on his buttock. The nurse referred to a practitioner on a routine basis.	An infection should result in an urgent referral.
6/17/2014	An NP evaluated the patient for the abscess. The patient said the abscess was draining. The pulse was 96 and temperature 98.2. The abscess was not draining according to the NP yet the NP ordered dressing changes and Clindamycin for 7 days and Bactrim for 10 days. A culture was not taken. The weight was 151.	Earlier treatment may have prevented the abscess from rupturing reducing the exposure of other inmates to possible MRSA. The patient's symptoms of blackouts was not evaluated.

6/24/2014	NP saw the patient in FU. The wound was erythematous and tender but no drainage. FU ordered for 7 days	
7/1/2014	An NP saw the patient in FU of the abscess. The pulse was 102. The wound was described as closed with no drainage. The NP diagnosed a resolved wound.	
6/24/2014	An NP saw the patient for chronic illness follow-up for hypertension and hepatitis C even though the patient did not have hypertension. The NP documented that the patient complained of syncope and noted that the blood pressure was low (106/78). The weight was 156. The liver enzymes were not noted although the recent enzymes on 6/10/14 were high. Despite the elevated enzymes the hepatitis C was assessed as in good control even though laboratory evidence supported chronic active hepatitis.	The NP failed to identify that the patient's hepatitis C was not in good control. The patient had chronic hepatitis and probable fibrosis. The NP failed to pursue the patient's syncope and did not even take a medication history. His dizziness may have been due to the medication he was on for stone disease (Tamulosin).

Patient 12

Date	Summary	Comments
8/19/2013	The inmate received an intake medical screening. The only identified problem was that the patient had hearing problems. However, the extent or reason for the problem was not identified. The patient was 36 years old.	
8/20/2013	The ALT=46 (normal < 41) and Calcium 10.3; cholesterol 204; TG 167; LDL 122	The abnormal liver function and lipids were not followed up and were not evaluated as part of the intake screening.
8/21/2013	The patient had a normal initial physical examination. The patient had no history of hepatitis. The hearing problem was not identified. The ear exam was documented as normal.	The patient had a significant hearing problem which was not identified during the initial intake physical examination implying that the provider did not speak with the patient much.
8/26/2013	A psychological evaluation identified that the patient was hearing impaired and needed translator services.	
9/30/2013	The patient transferred from Kilby to Decatur Work Release.	
9/30/2013	A kitchen worker screening identified that the patient had never been vaccinated for hepatitis A or B.	

10/10/2013	The patient was received at Limestone but the intra-system transfer form was not used; instead a nurse wrote a single line that the inmate was transferred. The nurse noted giving the inmate information on MRSA, HIV, Hepatitis, tattoos, sick call etc. but documented nothing else.	The transfer screening did not occur according to ADOC policy.
10/10/2013	A nurse wrote on an inmate checklist that verbal explanation was given regarding access to health services including sick call and the grievance procedure. The problem was that the patient couldn't hear. The nurse did not acknowledge this.	It is not clear if effective communication occurred.
10/10/2013	The inmate transferred from DWR to Limestone. The intra-system transfer form indicated that the inmate was hearing impaired but the nurse stated that the inmate could read lips but that he preferred written communication. No medical problems were identified even though the patient had prior abnormal lab tests.	Effective communication appeared difficult.
12/2/2013	The inmate placed a health request stating in writing that "I am deaf and I need a hearing aid. The ADA (Alabama Disability Advocate) has told my family I am entitled to a hearing aid and I need one."	
12/4/2013	A nurse saw the patient for the hearing aid issue. The nurse did not identify why the inmate was deaf but that he was deaf since childhood. The nurse referred to a provider.	
12/12/2013	An NP saw the patient for a hearing aid and documented she had to communicate with the inmate through writing. The NP documented that the patient was "totally deaf" and that he had had a hearing aide 2 years previous but had lost it. He wrote to the NP that he needed his hearing device to maintain his balance and that he had a hearing impairment since childhood. The NP documented that it was difficult to understand his responses. The ear examination was normal. The NP planned to refer for a hearing test in order to eventually obtain hearing aids for the patient.	
12/12/2013	An NP wrote a consultation referral for a hearing exam. On this referral the NP wrote that the tympanic membranes were opaque although in her exam on 12/2/13 the same NP wrote that the tympanic membranes were benign.	This appears to be in conjunction with the health request. This was an appropriate referral.

1/2/2014	The NP wrote that the ENT doctor saw the patient who recommended high powered hearing devices for profound sensorineural hearing loss which the NP submitted for UM approval.	
1/2/2014	An audiologist documented that due to a high fever at birth the patient had profound hearing loss. The patient was able to use sign language and written language to communicate. The audiologist recommended hearing aids for localization only as they will not make him hear.	
1/6/2014	The hearing aides were approved.	
2/6/2014	The NP saw the patient in follow-up and documented that the "State MD has not decided to approve high frequency hearing aids. Discussed situation with Dr. Hood. Dr. Hood wishes to talk to Ms. Naglich as to whether hearing aids can be paid for by state or thru Corizon contract, estimated cost $2000".	The denial was apparently a matter of cost. The patient needed hearing aids.
2/25/2014	The NP spoke with Dr. Hood who agreed to purchase standard hearing device. Apparently, this type of device would be unsatisfactory for balance which is why the patient needed the device.	The resolution was to give the patient a device unsatisfactory for his need.
3/19/2014	The NP documented that the contract hearing aid company did not want to dispense a standard hearing aid because of the patient's auditory examination results; they indicated that a high frequency hearing device was indicated. The NP documented that Dr. Hood was deferring high frequency aides or cochlear implants.	The civilian provider determined it was inappropriate to provide a device that would not benefit the patient.
4/7/2014	The NP documented speaking with Dr. Hood who suggested purchasing an amplifying device at a local store.	This pro forma resolution to the problem would not benefit the patient as he couldn't hear. The purpose of the hearing aids was to maintain balance to prevent falls and injuries.
4/9/2014	A nurse saw the patient for headache and referred the patient to a provider.	
4/13/2014	The patient placed a health request stating, "please take me test on CT scan because I had been getting migraine more often now which I been missed school".	The patient had a significant headache that disturbed his daily activity.
4/13/2014	The patient placed a 2nd health request asking when he would get his hearing aid because he was told 45 days ago that he would get it in 30 days. The nurse referred to the eye clinic.	

4/14/2014	The NP documented trying Target, HH Gregg, Walmart, and Best Buy but could not find an amplifying device that the patient could use. The NP documented finding a chargeable device at CVS and gave the information to an administrator to purchase.	The vendor wanted to give the appearance of obtaining a hearing aid when the device they were attempting to provide would be useless for the patient.
4/15/2014	A nurse evaluated the patient for headache and right eye pain and referred the patient to an optometrist.	
4/17/2014	An optometrist saw the patient and diagnosed a macular scar on the patient's right eye and a cataract on the left eye and said that these would need to be monitored.	
5/1/2014	The patient placed another health request asking about his hearing aid.	
5/5/2014	A nurse saw the patient who had questions about his care. The patient wanted to know what was the percentage hearing loss on his audiology test and what was wrong with his eyes based on the recent optometry visit. The nurse wrote that she "interpreted notes" for the inmate. It is clear that the patient did not understand the outcomes of his evaluations and was having trouble communicating.	Effective communication had not been achieved with the patient who did not understand what was wrong with him and the results of recent testing.
5/15/2014	The NP stated that the amplifying device required a charge and that the inmate was not able to keep a charged device on his person and that the device could not always have the device accessible from the health unit. The administrator was going to attempt again to get a device from the contract company.	
6/5/2014	The NP documented reminding the administrator about the hearing device.	
7/10/2014	The NP documented that she would re-submit a UM request for the device for the inmate.	This was appropriate.
7/10/2014	The NP re-submitted a request for the hearing aids stating "have exhausted efforts with local hearing contractor for alternate devices. Any other device other than above will not provide inmate with ability to balance".	This was correct.
7/10/2014	The doctor approved only one hearing aid despite prior information that the patient needed two devices for balance.	The Regional Medical Director did not appear to understand the reason for the request.
8/22/2014	AST and ALT were normal	
9/4/2014	The NP documented speaking again with the administrator about the hearing aides	Additional delays.

10/3/2014	An NP saw the patient for follow-up of knee pain. The patient had knee and facial pain. The facial pain was accompanied by photophobia. The NP did not document any facial abnormality but ordered facial x-rays to "R/O any sinusitis"	
10/7/2014	The facial x-ray showed a minimally displaced nasal fracture	
10/17/2014	A doctor saw the patient for follow-up of the x-ray. The doctor noted communicating by writing. The doctor noted that the nose was deviated but took no history and only evaluated the nose and somehow came to a conclusion that the nasal fracture was old and documented that no further treatment was needed.	The doctor failed to achieve effective communication with the patient. The patient's history was not taken with respect to an injury.
11/13/2014	The NP documented "sinus x-ray read as a trauma film has hx of old nasal fx". The radiologist did not read the film as an old nasal fracture. The NP should have assessed the patient about trauma and questioned him more thoroughly but did not. Communication may have been an issue.	The provider failed to achieve effective communication with the patient.
12/8/2014	An NP documented inquiring about the inmate's hearing devices. The administrator indicated that they were "still trying to get money to pre pay hearing devices. Current company who can mold structured hearing devices requires money up front before they will make devices".	
12/15/2014	The NP documented that the devices were paid for.	
12/17/2014	The NP documented that the patient had impressions for the hearing devices made but would need a follow-up for permanent fitting once the new devices come in.	
12/18/2014	A doctor referred the patient for final fitting for molds for his hearing device.	
1/14/2015	The patient was see for fitting the ear devices and received the devices.	It took almost a year and a half to obtain hearing devices. P
1/31/2015	The inmate was discharged from the ADOC.	

Patient 13

Date	Summary	Comments
3/22/07	patient had a positive TST of 22 mm listed on problem list	

8/20/10	Problem list documents on this date that the patient was "medication Noncompliance" with an arrow pointing to the positive TST.	The patient's non-compliance wasn't noted until more than 3 years later. This is a significant deficiency with respect to infection control.
9/28/11	First progress note describes placement of a splint on the right hand.	The complete record was not sent for this patient. The initial intake was not brought forward to this record.
10/28/11	Medical coding form completed by NP. The "critical non-compliance Rx issues" box was not checked implying that medication non-compliance was not considered an issue for this patient.	At the time, the non-compliance with TB preventive therapy was not considered a problem.
11/21/11	Medical coding form completed by NP. The "critical non-compliance Rx issues" box was not checked implying that medication non-compliance was not considered an issue for this patient.	At the time, the non-compliance with TB preventive therapy was not considered a problem.
1/2/12	An LPN completed a NET tool because the patient was coughing, vomiting and had a runny nose. An inadequate history was taken. The LPN did not document weight even though the patient complained of vomiting. The LPN assessed the patient with a common cold and a cough and gave the patient medication (sinus medication, Coricidin, and antacid) which were not medications authorized on the NET tool. This was not co-signed by an RN so the LPN was acting out of the scope of her license.	An LPN is not trained or licensed to perform assessments. There was no evidence of an RN review of this evaluation. The evaluation was inadequate and the cough and vomiting did not include adequate history. The patient should have been referred to a provider.
2/19/12	An RN evaluated the patient for nausea and vomiting. The nurse documented that the patient had no prior history of this problem which is inaccurate. The nurse took no history except to check the boxes on the NET tool which was insufficient history in that it did not address the patient's ability to eat, weight gain or loss, whether there was blood in the vomitus, etc. The nurse did not document a weight even though the patient's complaint was vomiting. The nurse wrote that the inmate denied nausea and vomiting when he didn't get something for a cold. The nurse wrote that the inmate refused "pepto tabs".	Without taking an adequate history the nurse presumed that the patient was faking his illness. This was a cynical evaluation that ignored significant problems.
8/21/12	A nurse completed a TB screening form indicating that the inmate had a positive TST on 3/14/07 and checked all symptom items as "no" including weight loss and productive cough.	
12/31/12	The inmate placed a health request complaining of chest pain and productive cough.	

1/1/13	An LPN evaluated the patient for complaints of a fever and a cough based on the health request. The temperature was documented as 100.8 and the pulse was 100. Weight was documented as 137 pounds. The LPN did not ask about weight loss even though this is a prompted question on the NET tool. The only history was to check boxes with formatted questions and the nurse checked as positive questions about productive cough and fever. The LPN referred to a provider. The date of referral wasn't included.	LPNs should perform independent assessments as they are not trained to do so. A RN did not review this evaluation. The patient had urgent issues (cough and fever) that should have prompted an immediate provider evaluation. But the patient was referred as a routine and the appointment didn't occur.
1/8/13	Allegedly the inmate refused to see a physician but a staff person signed the form with a notation that the inmate refused to sign. An officer witnessed the signature.	Given the nature of the symptom the patient should have been called back at another time.
1/16/13	The inmate placed a health request complaining of chest pain and productive cough. A nurse wrote a brief response on the health request documenting that she gave Coricidin and Motrin to the patient and referred to a mid-level provider.	
1/16/13	An LPN completed a NET tool for "respiratory" but failed to ask formatted questions about night sweats or weight loss. The weight was documented as "20" and it appeared that the nurse documented the respiratory rate in the wrong box and failed to take a weight.	The nurse failed to adequately assess the patient. LPNs should not perform independent assessments.
1/22/13	Amoxicillin and chest x-ray ordered	
1/23/13	An NP saw the patient for a "cold not responding to protocol". No other history was taken except that the patient "started feeling better then he started coughing up green phlegm and congestion started". This is inadequate history from a provider. The only examination was to listen to the lungs. The assessment was to rule out pneumonia. The provider ordered a chest x-ray, cough syrup, and Amoxicillin an antibiotic with follow-up in a week.	The history was inadequate.
1/23/13	A chest x-ray showed left upper and lower lobe pneumonia. This appeared to be signed as reviewed on 1/25/13.	This x-ray indicating pneumonia was also consistent with tuberculosis which given his 2 months history of coughing was likely.
1/25/13	A provider ordered Azithromycin, Albuterol/Atrovent nebulization, and discontinued Amoxicillin. This was done without examining the patient.	The patient never received the nebulization therapy. Treatment for pneumonia was made without evaluating the patient.

1/29/13	An NP saw the patient for "F/U Pneumonia". The history was documented in the objective findings section and documented that the patient still had cough and was now on Azithromycin but did not get the nebulizer. Except for listening to the lungs no other physical examination was done. The NP did not order a white count or electrolytes. The NP ordered a follow-up in a week.	The history and physical examination were inadequate for a person with two lobe pneumonia. Even though the patient was 36 years old at this time, a more thorough evaluation should be done for someone with infiltrates in two lobes. The follow-up never occurred. The patient wasn't seen for a year.
1/7/14	A RN evaluated the patient for a complaint of "trouble breathing" for 2-3 weeks. The nurse used an upper respiratory NET tool which had a line for last documented TB test date. On this line the nurse documented the she couldn't find the chart. The patient complained of weight loss and cough although the weight was not taken. The pulse was 131 and blood pressure 98/80, vital signs consistent with sepsis. The nurse also documented that the patient had abdominal pain but did not assess this complaint. The nurse contacted a physician who ordered a single dose of parenteral Rocephin (an antibiotic), followed by oral Levaquin for 10 days along with Albuterol nebulization.	It is a significant departure from standard of care for a provider to order antibiotics by phone for a patient with unstable vital signs and difficulty breathing. The patient should have been sent to a hospital for evaluation. The doctor did not order a white count or other laboratory tests and did not order a chest x-ray. Without a face-to-face evaluation the doctor couldn't determine the seriousness of the condition. This was dangerous for the patient.
1/8/14	A nurse saw the patient but did not document vital signs except to state "VSS". The nurse documented to continue current regimen but it wasn't clear what the regimen was. The patient was in M-cell.	The patient appeared to be in a single cell and was evaluated in the cell. Nurses did not document taking vital signs. To place a seriously ill patient in a single cell without having had a physician evaluation and without proper monitoring is a significant departure from standard of care.
1/8/14	The patient placed a health request stating "I have lost 30 pounds. I am very weak. I have no strength". This request was not evaluated until 1/10/14.	
1/9/14	A nurse saw the patient twice. Vital signs were documented on both occasions as "vital signs stable". The patient complained of pain and the nurse noted that PRN Lortab was given-Lortab is a narcotic medication. The patient was evaluated in M-cell.	The patient appeared to be in a single cell and was evaluated in the cell. Nurses did not document taking vital signs. To place a seriously ill patient in a single cell without having had a physician evaluation and without proper monitoring is a significant departure from standard of care.
1/10/14	Apparently the patient was placed on Rocephin but the order does not appear in the medical record. The order for Levofloxacin was dated 1/8/14.	The physician was treating a seriously ill patient without even evaluating the patient.

1/10/14	A nurse evaluated the complaint of 1/8/14 on 1/10/14. The patient was charged a co-pay for the evaluation. On the health request, the nurse documented that the weight was 110 pounds. The nurse documented that the weight on 2/22/13 was 135 pounds but because his height was 5 foot 6 inches his BMI was < 19. The nurse used an "abdominal pain" NET tool which was inappropriate for his complaint. The nurse documented the patient's complaint as extreme weight loss. The nurse documented that the patient said he was coughing so much that he vomited. The pulse was 123 and the weight was 110 pounds. The second page of this note was missing in the medical record.	The missing medical record document makes it difficult to assess the nurse's evaluation. All medical record documents should be filed in the record. To charge a patient for an emergency-like visit is inappropriate.
1/10/14	A doctor evaluated the patient. The only history consisted of two lines "c/o productive cough, green sputum x 10 d on Levaquin for 3 days". This history was below the standard of care given the patient's condition. The pulse was 123. The blood pressure was 118/68. The only examination was to listen to the heart and lungs and note that the abdomen was soft and non-tender with bowel sounds. The doctor's diagnosis was "suspect pneumonia RML" even though the prior chest x-ray showed left upper and lower lobe infiltrates. The doctor ordered a repeat chest x-ray on 1/13/14. The doctor didn't order any labs but ordered a liter of normal saline without giving an indication. The note has no documented indication for this therapy. The doctor also ordered a stat dose of Rocephin and to continue Levaquin. The doctor did not order a follow-up.	The patient had significant weight loss, tachycardia, and cough. Since the weight loss appeared to have occurred over an extended period of time, the physician failed to consider appropriate diagnoses. Failure to order lab tests for someone with weight loss, cough and tachycardia and failure to obtain an immediate x-ray and check oxygen capacity was a significant departure from standard of care. The patient should have had immediate lab and radiographic tests or been transferred to a hospital.
1/11/14	The patient was admitted to the infirmary for 23 hour observation for "possible pneumonia. There was no physician order or note associated with this admission. There was a brief nursing note but no admission note. The nurse documented vitals as pulse 125, BP 83/46. The nurse noted that there was no IV access.	This patient had severely abnormal vital signs indicating systemic infection. Combined with the abnormal chest x-ray the patient should have been hospitalized. Despite the seriousness of the patient's condition the patient wasn't evaluated daily. This is a significant departure from standard of care.

1/15/14	A repeat chest x-ray showed prominent interstitial markings with airspace consolidation present in the left lung. There was a large cavity in the left upper lung. The conclusion was pulmonary edema vs atypical pneumonia. The report also documented, "There appears to be a large cavitary lesion in the left upper lung. Consider TB and neoplasm. I recommend CT to further evaluate." A physician reviewed the report and wrote "Agree CT ordered". However there was not a date for the day of his review. However the CT scan was not ordered until 1/27/14 over a week later.	A physician did not review a critical x-ray for over a week resulting in additional exposure to inmates and staff from tuberculosis. Any x-ray suspicious for active tuberculosis requires immediate isolation in a negative pressure room which did not occur. The patient should have been hospitalized. If on-site management was desired, the CT scan should have been same day. This was a significant departure from standard of care.
1/17/14	A provider requested a CT scan of the chest for a large cavitary lesion in the left upper lung.	The provider knowing that the patient had a large cavitary lesion failed to isolate the patient or order this test as an emergency. The provider did not include whether this test was urgent or routine and so apparently it was done over 2 weeks later. This delay exposed many inmates and staff to tuberculosis.
1/27/14	A physician evaluated the patient. A provider hadn't documented a patient evaluation since 1/10/14. The doctor did not complete this note but the script is the same as the previous doctor note. The doctor noted that the patient had a history of tuberculosis 5 years ago and had 6 months of treatment. The doctor assessed that the patient might have tuberculosis and ordered a CT of the chest.	The patient based on weight loss, fever, tachycardia, and bilateral pneumonia with a large cavity wasn't evaluated by a physician for almost 2 weeks. If the doctor thought that the patient had active tuberculosis, immediate isolation was indicated. A CT scan was not necessary to suspect or preliminarily diagnose TB; there was no need to wait for a CT scan. By not isolating the patient, the doctor exposed many inmates and staff to tuberculosis. This was a significant departure from standard of care.
2/4/14	A nurse filled out a form that the patient was returning from an offsite appointment for a CT scan. The nurse documented that this occurred on 1/4/14 but the CT scan was done on 2/41/4 so the nurse misdated the form. The nurse documented that the patient was "reported to have TB". Despite the comment about having TB the nurse did not ensure that the patient was isolated. A physician signed this document on 2/5/14 documenting transfer to Donaldson for negative pressure room.	This test was apparently done on 2/4/14 so the nurse misdated the note. The nurse did not immediately notify a provider to isolate a patient with active tuberculosis. This resulted in unnecessary exposure of others to tuberculosis.

2/4/14	The CT scan result was not in the ADOC medical record but was on the Department of Public Health record, parts of which were present in the ADOC medical record. The DPH record documents that the CT scan showed a cavitation with fluid in the right upper lobe along with lower lobe consolidation with miliary nodularity of the right lung. There was adenopathy in the left hilum. The conclusion was "extensive pulmonary and mediastinal abnormalities represent tuberculosis until proven otherwise".	All medical record documents should be present in the medical record.
2/4/14	A DPH note present in the ADOC medical record documents that the patient was a past positive but non-compliant with therapy "per documentation". He completed 47 twice weekly doses.	
2/4/14	ADPH TB clinical record/correctional contact investigation form was in the record. It indicated that the patient had weight loss from 150 pounds to 116 pounds. The report documented "massive loculated cavitary infiltrate LUL w/ miliary dissemination LLL and throughout R lung".	To lose 34 pounds from tuberculosis means that the patient had this problem for an extended period of time. It is most likely that the patient at least had the condition in 2013 when he presented for presumed pneumonia.
2/5/14	A provider signed the MD review of the 2/4/14 offsite documenting transfer to Donaldson for negative pressure room. It appears that the offsite actually occurred on 2/4/14.	The patient had findings for which he should have been isolated a month previous to this date. The failure to isolate the patient resulted in many individuals being exposed to tuberculosis.
2/5/14	An ADPH note from the statewide TB manager for ADPH stated that, "This patient is extremely sick with multiple loculated cavities." "[names redacted-Regional Medical Directors] if you need to speak with [redacted- doctor at ADPH] at any time please let me know."	The patient should have been admitted to a hospital instead of an isolation room. Not sending the patient to a hospital placed the patient at risk of harm.
2/5/14	WBC 12.34; HGB 10.7; platelets 868,000; albumin 2.9, sodium 132, iron 35 (normal 45-160)	These are all abnormal values indicating systemic involvement.
2/6/14	Sputum collected on 2/6/14 was smear positive for tuberculosis. However, the providers caring for the patient at ADOC do not document the ADPH laboratory test results in their medical record documents.	The ADOC physicians were not documenting tuberculosis test information in their records. There was a disconnect between the ADOC and ADPH providers with respect to managing the patient.
2/6/14	The ADPH documented on their notes that [redacted –Regional Medical Director] gave verbal orders for nursing staff to begin the streptomycin and discontinue ethambutol per [redacted ADPH doctor] recommendation. It did not appear that a physician was personally evaluating the patient.	

2/6/14	A provider (apparently-note does not have title documented) admitted the patient to the infirmary. The note documents that the patient "has been ill for over a year". Virtually no other history was taken with respect to the patient's current condition. A brief physical examination was documented. The admitting diagnosis was cavitary tuberculosis. The abnormal laboratory results were not documented as problems. The pulse was 120 but the provider did not comment on that.	This was an inadequate evaluation as an admission note as it did not include an adequate history, failed to identify all of the patient's problems, and failed to address the severity of the patient's condition. This placed the patient at risk of harm.
2/6/14	A nurse infirmary admission note included vitals of BP 96/68, pulse 130 and temperature of 99.8. Since this evaluation was done on a pre-formatted form, the nurse didn't take additional pertinent history exclusive of the pre-formatted questions. The only problem listed was pulmonary tuberculosis.	The vital signs were not stable and indicated systemic risk.
2/6/14	A WEDCF Medical Referral Form dated 2/6/14 referred the patient to chronic care for active tuberculosis. The word "scheduled" was included on the form but the date wasn't provided.	
2/6/14	From 2/6/14 to 2/7/14 nurses documented brief notes on a progress note. None of the notes included vital signs even when the nurse noted abnormal vitals. For example, a nurse wrote decreased blood pressure and increase heart rate but failed to document what the vital signs were. On another note a nurse documented "temp slightly elevated" but failed to document the actual temperature. On another note a nurse wrote, "Dr. Hood notified of [increased] temp. No orders received" but the actual temperature was not documented.	This patient was very sick and needed daily physician visits and vital signs every shift. Not to perform vital signs on a patient this sick is below the standard of care. Based on tours I took, the negative pressure rooms were poorly designed and it is difficult to perform these evaluations which is way they are probably not done. This patient was not safely housed.
2/10/14	Nurses documented 5 brief notes between 2/10/14 to 2/11/14. It appeared that while in negative pressure housing a nurse would evaluate the patient. None of these notes included vital signs in the note even when the note documented an abnormal vital sign. It appeared that the patient was only being evaluated by nurses.	All patients in negative pressure rooms for tuberculosis should have daily vital signs. Not to perform vital signs is below the standard of care. Based on tours I took, the negative pressure rooms were poorly designed and it is difficult to perform these evaluations which is way they are probably not done. Physicians should have evaluated the patient on a daily basis but this was not done.
2/10/14	A doctor wrote an order to admit to infirmary "red station".	
2/12/14	A nurse took a verbal order from Dr. Hood for two liters of normal saline. A doctor signed the order 6 days later on 2/18/14.	It did not appear that there was a physician on site daily as the Regional Medical Director was managing care remotely. This patient should have

		been sent to a hospital for his safety.
2/12/14	A nurse documented a blood pressure of 80/51. The nurse documented that the patient drank about 350 ml of water without difficulty. The nurse discussed with the patient the need to drink fluid. But the patient was in a negative pressure cell. The nurse notified Dr. Hood of the blood pressure and he ordered intravenous fluid by phone order. Apparently the intravenous fluid was given in the isolation cell at 5:40 pm. A nurse checked the patient at 11 pm and the fluid was still infusing. By 2:30 am the patient was asking to have the intravenous line removed but a nurse noted that the fluid was still infusing.	This blood pressure is extremely low. A physician should have immediately evaluated the patient. Instead, a nurse called the Regional Medical Director for a phone consultation. This placed the patient at risk of harm. If there were insufficient physician staff, the patient should have been sent to a hospital so he could be properly cared for. To start intravenous fluid in this context without ordering laboratory tests (metabolic panel) was below the standard of care.
2/13/14	At 7:30 am the saline was still infusing. The intravenous line wasn't removed until 8 pm on 2/13/14 almost 24 hours from the start. This was a long time to infuse saline for the purpose of fluid replacement.	It did not appear that there was sufficient nursing staff to manage this patient. He should have been sent to a hospital.
2/13/14	Temperature was 100.8 on a graphic record. Blood pressure increased to 151/90 with a pulse of 104.	
2/14/14	An un-named staff documented a brief note stating, "tolerating TB meds T 100 appetite improving, snack ordered HS."	
2/17/14	The temperature was 101.2 on the graphic record with a pulse of 133.	These are significant abnormal values. A metabolic panel should have been ordered but a physician didn't even see the patient. He should have been hospitalized as there appeared to be were insufficient physicians and nurses at this facility. The patient required monitoring with laboratory testing and needed frequent physician and nurse interventions and should have been sent to a hospital.
2/18/14	DPH notes document that streptomycin would be continued because of the severity of the patient's disease.	
2/18/14	A nurse documented that the patient asked about pain medication and documented discussing with the doctor but did not document the contents of the discussion with the doctor.	Nurses should document the contents of their discussions with providers.
2/18/14	A nurse documented that a doctor ordered lab tests for 2/19/14. There was no documentation that the doctor saw the patient.	

2/18/14	Nurses obtained verbal orders for a change in tuberculosis medication via verbal order from Dr. Hood.	
2/18/14	On the graphic record the pulse was 125.	
2/18/14	A doctor evaluated the patient. This was the first evaluation since admission to isolation about 2 weeks ago. The doctor took only a brief history but did document pain with coughing, and some abdominal pain with vomiting. The doctor's assessment was "now on rifampin/INH/Pyrazinamide and vit B 6 and strept". This is not a diagnosis. The doctor did not document knowledge of tuberculosis screening tests for this patient. Another diagnosis was "low blood pressure + tachycardia somewhat bothersome but no other symptoms to suggest adrenal insufficiency". The doctor wrote to "consider Cortrosyn stress test if lab data suggestive of adrenal insufficiency". The Cortrosyn test along with a basal ACTH test are used in evaluation of adrenal insufficiency. It was possible that the patient had adrenal insufficiency from his tuberculosis. This was a common cause of adrenal insufficiency before tuberculosis medication became available and would have indicated advanced tuberculosis. The doctor ordered some blood tests.	The provider failed to identify results of tuberculosis testing. The provider failed to evaluate for why the patient had such a rapid pulse. Adrenal insufficiency was a possibility. If considered, it should have promptly been evaluated for by a CT scan of the adrenal gland and cortisol and ACTH stimulation tests. This evaluation was especially important as rifampin, one of his necessary tuberculosis drugs can cause acceleration of metabolism of cortisol exacerbating possible adrenal insufficiency. The provider noted the patient's pain but did not review pain medications or modify pain therapy. The doctor did appropriately order a blood count and metabolic panel.
2/19/14	WBC 15.8; HGB 11.2 (normal 11-14) HCT 33.7 (normal 35-48) and platelets 735,000 (normal 150-400,000); albumin 3 (normal 3.5-5); sodium 134 (normal 136-145), K 4.8 (normal 3.5-5.3)	
2/20/14	A nurse documented that normal saline was infusing intravenously, but the order in the chart was dated 2/21/14.	
2/21/14	A doctor saw the patient. The only history documented, "seems to be having [increased] respiratory difficulty". This is an inadequate history. The temperature was 102 and the pulse was 116 to 163. There was no physical examination except vital signs and documentation of consolidation on chest x-ray. The assessment was "suspect bacterial pneumonia superimposed on active TB. The presumed provider added Levaquin, ordered a sputum culture and a CBC and IV fluids. The doctor did not order an electrocardiogram.	This was an inadequate evaluation as it did not include an adequate history, failed to identify all of the patient's problems, and failed to address the severity of the patient's condition. The patient should have had blood cultures and closer attention than could be provided at this facility. The patient was very ill and should have been hospitalized. This placed the patient at significant risk of harm.
2/21/14	Temperature was 102.8 on graphic record with pulse of 163! The blood pressure was 108/80	The pulse was very high. An electrocardiogram should have been done.

2/21/14	A doctor ordered changing Levaquin to 500 mg from 250 mg and IV ringer's lactate at 83 cc /hour for 72 hours. Notably, a non-formulary request dated 2/21/14 documents an increase of Levaquin to 750 mg a day based on a phone order from Dr. Hood.	This degree of phone coverage strongly suggests that the patient should be hospitalized because there was insufficient coverage at the facility to care for the patient.
2/21/14	From 2/21/14 to 2/23/14 the graphic records show tachycardia with pulse varying from 103 to 133.	
2/21/14	Chest x-ray showed "widespread bilateral lung opacities" with a "large area of consolidation in the left lung"	
2/21/14	The patient placed a health request complaining that "I keep coughing up yellow stuff, having problem breathing, head and chest keep hurting". This wasn't evaluated until the next day.	The patient should have been monitored more closely including frequent oxygen saturation tests and even arterial blood testing. Oxygen therapy may have been indicated.
2/22/14	An LPN evaluated the patient complaint of 2/21/14 using a NET tool respiratory form. The LPN documented that the patient had productive cough, and "left chest wall pain". The LPN made additional comments that the patient had "c/o l chest wall pain. C/o chills, headache + night sweats". The LPN referred to a mid-level but did not indicate the urgency of the referral.	An LPN is not trained or licensed to perform assessments. There was no evidence of an RN review of this evaluation. These complaints were part of the patient's overall condition but the nurse treated this a routine. If the patient were monitored sufficiently while in negative pressure isolation, he would not have to place a health request to obtain care.
2/23/14	INH, rifampin, PZA, were placed on hold with a new order in place based on a MAR. These medications were documented on another MAR as given 2/25/14 to 2/28/14.	
2/24/14	The graphic record records a pulse of 153 with blood pressure of 105/75.	This pulse should have resulted in an electrocardiogram. The vital signs were so unstable that it was unsafe to house the patient in an isolated cell and not to continuously monitor the patient. He should have been hospitalized. This placed the patient at significant risk of harm.

2/24/14	A physician wrote 2 notes on the same day 30 minutes apart. On one note the doctor wrote "chest x-ray essentially unchanged". He indicated that the DPII test was ordered 2/18/14 but was not done. The doctor had wanted this test the next day. The doctor re-ordered the test and documented that Dr. Hood had ordered an echocardiogram but there was no prior note documenting a conversation with a nurse about this. On the following note the doctor documented a brief physical examination. The assessment was descriptive and stated, "since chest film is unchanged from 1/15 expect his fever, tachycardia, tachypnea etc. is from underlying pulmonary TB. Although bacterial superinfection a possibility - Is now on a respiratory quinolone" The doctor ordered a DPII test as stat which was not done. It is not clear what the doctor meant by DPII. I presume it means diagnostic panel II but am uncertain.	This patient was so ill he could not be safely managed in an isolated negative pressure cell. He should have been hospitalized.
2/24/14	A nurse documented talking to the ADPH TB control who apparently indicated that he would consult with a doctor from DPH about the addition of Levaquin. It appeared that the patient was being managed by phone consults from lay or nursing staff to remote physicians.	Care for this patient was disorganized and included infrequent onsite providers and two provider remotely managing by phone (the Regional Medical Director and the ADPH tuberculosis physician). The coordination was not good. The patient should have been hospitalized.
2/24/14	[Doctor name redacted] gave a verbal order for an urgent echocardiogram to rule out a pericardial effusion and to increase the Levaquin to 750 mg at 1 pm on 2/24/14.	If the doctor thought that the patient had pericardial effusion the patient should have been immediately admitted to a hospital for a stat echocardiogram. To manage this condition by phone with an elective echocardiogram placed the patient at significant risk of harm and was dangerous.
2/24/14	An EKG showed left atrial enlargement and left ventricular hypertrophy.	This indicated an enlarged heart.
2/24/14	WBC 14.2; HGB 11.4 (normal 13.8-17.2); platelets 709K; K 7.1; Na 130. On the report someone documented a call to Dr. Hood at 1:10 am with an order to repeat stat. The test was completed at 2/25/14 at just after midnight. Dr. Hood didn't give the order for repeat lab testing until 8 am.	To be placing phone calls at 1 am to manage the patient by phone is one more justification to admit the patient to a hospital. The serum sodium was low and indicative that the patient needed daily monitoring. The potassium level of 7.1 was a critical value and an immediate follow-up test was indicated.

2/24/14	[Doctor name redacted] gave a verbal order for a stat chemistry panel, and cortisol level with a stat dose of 125 mg of IV Solumedrol at 8 am.	The remote doctor was treating the patient for adrenal insufficiency by phone. This was dangerous. The patient should have been admitted to a hospital and this placed the patient at significant risk of harm. I could not find evidence that the patient received Solumedrol.
2/25/14	A MAR documents that Levaquin was given from 2/25/14 to 2/28/14 and Solumedrol was given as an intravenous stat dose on 2/25/14. Both were documented as being ordered by Dr. Hood.	Phone management of adrenal insufficiency was not safe.
2/25/14	A physician ordered 3 mg dexamethasone IV after drawing plasma ACTH and cortisol. The doctor also ordered that after drawing the ACTH and cortisol that the nurse was to give 0.25 mg Cortrosyn IV with phlebotomy for cortisol 30 and 60 minutes after Cortrosyn injection. This order was timed at 8:25 am. On the same day the physician submitted a non-formulary request for 0.25 mg of Cortrosyn which could not have arrived prior to the test. There was no evidence that the patient received this medication before the testing was done. The instructions for giving Cortrosyn IV were documented on the MAR but the administration was not documented. It does not appear on the MAR or in nursing notes to have been done.	Based on the DPH and ADOC notes the ADOC physicians did not communicate their concerns to DPH doctors about the potential for either adrenal insufficiency or pericardial effusion. A person presumed to have adrenal insufficiency is too sick to be housed in conditions at the prison and he should have been immediately hospitalized.
2/25/14	At 8 am a doctor documented a brief note stating that "his electrolytes are consistent with adrenal insufficiency other than he does not have azotemia. He vomited x 1 yesterday. Will treat with dexamethasone and await clearance of Solumedrol given last pm and then to Cortrosyn stimulation test".	
2/25/14	At noon a doctor documented that "Repeat electrolyte profile did not reveal hyperkalemia and his Na is only slightly low. BUN/Cr are normal on both panels. Therefore adrenal insufficiency less of a possibility and will not push dexamethasone other than one dose. ACTH stimulation test to be done tomorrow. Also EKG did not show tall T waves". There was no examination of the patient.	This is extremely cavalier management. The patient needed to be hospitalized.
2/25/14	A doctor ordered stat IV saline at 100 ml per hour for 10 hours.	
2/25/14	Just after midnight on 2/25/14 a nurse gave Solumedrol 125 mg IV push.	

2/25/14	At 9:10 pm dexamethasone IV push was given. An ACTH and random cortisol was collected at 9:38.	This test appeared to be affected by administration of parenteral steroids. It did not appear that the facility staff knew how to manage this condition which is why the patient should have been hospitalized.
2/25/14	A cortisol test returned with a value of 31.8 (normal 2.3-19.4). Adrenal insufficiency would have shown a very low level. A doctor wrote on this test that this was "evidence against adrenal insufficiency". But the Regional Medical Director had ordered a stat dose of Solumedrol IV at just after midnight on 2/14/14 so this test was possibly affected by administration of the corticosteroid.	
2/25/14	On the February MAR a nurse documented using a tuning fork every month to check hearing. This is an inadequate form of monitoring when using streptomycin.	Recommendations for monitoring for streptomycin include baseline and periodic audiograms along with routine BUN, creatinine and drug levels. These should be done in all patients on streptomycin. To test the hearing with a tuning fork by a nurse is not the standard of care and placed the patient at risk of harm. BUN and creatinine were not ordered as a routine. Neither were drug levels monitored. The patient never had an audiogram.
2/26/14	A nurse note describe the patient as diffusely sweating and documented that he was wiping moisture off his face. The nurse documented that a physician ordered 30 mg of prednisone.	
2/26/14	30 mg of prednisone was ordered stat and given at 5:50 pm.	

2/26/14	A second test was done to measure both ACTH and cortisol. This test is called an ACTH stimulation test. The test calls for administration of Cortrosyn IV and then at 30 and 60 minutes draw blood levels of ACTH and cortisol. However, Cortrosyn was requested on 2/25/14 and approved but the date of approval was not documented. There is no evidence in the MAR or medical record I reviewed that demonstrated that the patient received the Cortrosyn. Also only a 30 minute sample was done based on medical records I reviewed. The laboratory documented that the ACTH and cortisol levels were collected at 9:38 am only. A 60 minute test was not done. The cortisol was very low and the ACTH was minimally low. These are difficult to interpret because it is does not appear that the patient received Cortrosyn. The cortisol was low which suggests adrenal insufficiency but the ACTH was also low which does not suggest adrenal insufficiency.	The facility staff seldom if ever perform these tests and when adrenal insufficiency was suspected the patient should have immediately been hospitalized. The patient needed to be evaluated by an endocrinologist or have the test conducted in a facility with staff experienced in performing this test. It did not appear that the staff performed this test accurately.
2/26/14	The lab report showed a random cortisol of 4 (normal 2.5 to 25) and a low normal ACTH of 12 (normal 10-50). A low morning serum cortisol such as this patient has is strongly suggestive of adrenal insufficiency. This test was done about 9 hours after the patient was given dexamethasone	Cortisol is normally higher in the early morning. This test was done at 9:30 am and should be expected to be higher. A level this low suggested adrenal insufficiency. These tests are difficult to interpret and the facility should have consulted an endocrinologist.
2/25/14	Intravenous dexamethasone was given at 9:10 pm.	
2/26/14	The pulse was 139 on the graphic record with a temperature of 101.6	These indicate unstable vital signs. This patient should have been hospitalized.
2/26/14	A 3rd test of adrenal insufficiency was done on 2/26/14. This test was an am and pm cortisol test collected at 2:53 pm. It is not clear when the am value was drawn. However this test was not ordered and appeared to be the wrong test. The facility physician also was confused writing on the lab report that he was uncertain which the 30 minute was and which was the 60 minute test. Obviously the wrong test had been ordered. The patient had received dexamethasone at 9 pm the evening before. It is not clear how to interpret these tests.	The prison staff seldom if ever use this test. When the patient had appeared to have adrenal insufficiency, he should have been immediately sent to a hospital so he could be properly evaluated.

2/27/14	A physician documented that the Cortrosyn stimulation test was completed yesterday. He documented that a dose of prednisone was given yesterday. He stated, "cortisol values determine further management".	The tests did not appear to be accurately performed.
3/1/14	A MAR documents for a nurse to use a tuning fork to check hearing on first of each month. This was done because the patient was on streptomycin. The recommendation to monitor when this drug is used is to obtain baseline and periodic audiograms along with renal function tests and drug levels. This was not documented as done and gave no instructions on how to interpret the test or how to perform the test.	The prison staff were not following standard recommendations for monitoring use of streptomycin. It is not clear how they were interpreting use of the tuning fork. It is also unclear how a nurse untrained in monitoring streptomycin could interpret this testing.
3/3/14	At 10:20 pm a nurse documented calling the Regional Medical Director because the patient had an oral temperature of 104.6. He ordered stat blood cultures and sputum culture. He ordered Rocephin Q 12 for 10 days by phone without evaluation.	The patient was at significant risk of harm because the patient needed round the clock physician coverage which was unavailable at the prison. He needed to be hospitalized. A 104.6 fever is very high. Increased monitoring including physician intervention was indicated.
3/3/14	At 10:30 pm a nurse called a 2nd doctor who gave an order to give IV saline at 100 cc per hour via a large gauge needle. The order included that if the patient experienced hemoptysis or if "PCV" drops precipitously that the patient should be sent to an emergency room. It wasn't clear what PCV meant.	The patient was at significant risk of harm because the patient needed round the clock physician coverage which was unavailable at the prison. He needed to be hospitalized.
3/3/14	The lab sent a hematocrit result of 36.9 (normal 40.9-49.3). The lab noted that the specimen sent for the blood culture was contaminated with oropharyngeal bacteria and was unacceptable. They documented notifying the facility that the wrong specimen was collected and to repeat the specimen collection. The final result was usual respiratory flora. Apparently the blood cultures were not sent; only the hematocrit. The blood cultures were never sent.	Staff at the prison clearly were incapable of managing this acutely ill patient. He needed to be hospitalized.
3/3/14	On the graphic record the blood pressure was 80/60.	This is consistent with shock. The patient should have been sent to a hospital. The nurse did not call a physician.

3/3/14	The next morning a physician evaluated the patient. He noted that the Cortrosyn stimulation test was normal when it may have been done incorrectly. He failed to note that the patient had received corticosteroids on two occasions prior to the test. He documented that the patient had blood tinged sputum and said that the concern was breach of the pulmonary artery which was a serious concern. He failed to note multiple episodes of hypotension, tachycardia and fever present of the graphic record over the past two weeks. The only assessment was new onset hemoptysis. He ordered IV fluid and a stat hematocrit and wrote that if the hematocrit dropped significantly he would admit to a hospital. He did not note that the Regional Medical Director had recently ordered parenteral Rocephin for a fever of 104.6. This was gross lack of coordination of team management of the patient. He did not document the need to follow up on the blood cultures.	Coordination of care was a significant departure from standard of care. The patient should have been hospitalized.
3/4/14	On the graphic record the temperature was 102.8 and blood pressure was 90/52.	These vitals are consistent with sepsis or shock. The patient was not being appropriately managed.
3/5/14	A doctor wrote a very brief not only documenting vital signs which included a pulse of 138 and fever of 100.4. There was no physical examination of the patient. He documented that the patient had begun Rocephin due to a temperature spike but did not mention checking the blood cultures. It appeared that these had not been done.	This person had recent fever and abnormal vital signs suggestive of sepsis. The lack of coordination of care and completion of ordered tests verified that this patient could not be cared for at the prison. The patient needed hospitalization.
3/6/14	The glucose was 177 likely due to corticosteroids that the patient had received. The sodium was low at 132 but the potassium was 4. WBC was 15.5 and HGB was 11 (normal 12.3-17). Platelets were 833 K	These values are consistent with sepsis given the vital signs of the patient.
3/8/14	Pulse was 143 on 3/8 and 140 on 3/9.	This is an extremely high pulse consistent with instability.
3/10/14	Glucophage 500 Bid was ordered by phone by the Regional Medical Director.	Multiple physicians were managing the patient by phone without coordinating their actions was dangerous for the patient.

3/10/14	A physician hadn't evaluated the patient in 5 days. A physician wrote a 3 line note stating that the patient's TB organism was sensitive to current medication. He noted that the blood sugar was high and he added metformin. Two days later, he documented that the hemoglobin A1c was normal so he discontinued the metformin. The doctor didn't realize that another doctor gave a phone order for the same drug.	This extremely sick patient was not evaluated daily by a physician. He needed to be seen daily. The glucose might have been high due to high doses of steroids given to the patient or to use of IV fluid. Treatment with oral agents was not optimal. The physicians didn't even acknowledge the possibility of the side effect of a medication they were giving. The two physicians were not coordinating care well.
3/14/14	An ADOC infectious disease doctor evaluated the patient. He failed to address the potential for adrenal insufficiency not noting the past hypotension and tachycardia despite intravenous fluid therapy and occasional steroid administration. However, with continued anti-tuberculosis treatment the adrenal insufficiency was likely to improve.	
3/18/14	Pulse was 118 and blood pressure was 86/54 on graphic record.	These were very abnormal vitals demonstrating instability. There wasn't an attempt to determine why the patient had unstable vitals. Almost no laboratory testing was done.
3/19/14	The blood pressure was 90/58 with pulse of 116	These were very abnormal vitals demonstrating instability. There wasn't an attempt to determine why the patient had unstable vitals. Almost no laboratory testing was done.
3/21/14	A nurse practitioner evaluated the patient whose blood pressure was 91/66. The NP's only assessment was TB. The NP noted that the tachycardia was improving since the pulse was 95.	
3/26/14	Pulse 121 and blood pressure 88/65 on graphic record.	These were very abnormal vitals demonstrating instability. There wasn't an attempt to determine why the patient had unstable vitals. Almost no laboratory testing was done.
3/30/14	Pulse 134	This is a high pulse.
4/1/14	An unknown staff [title not documented in record] documented that the patient had no hearing deficits with air conduction > bone conduction. This method of assessing hearing is not the recommended test to monitor persons on streptomycin.	The standard recommendation is for audiograms.
4/2/14	A DPH note documents that the patient should receive a monthly hearing test while on streptomycin. The DPH nurse documented that hearing was checked but this was not by audiogram.	The standard recommendation is for audiograms.

4/4/14	A provider evaluated the patient and documented that the patient had no hearing deficits. The only examination was that the patient was gaining weight and had clear lung without chest pain.	This was an inadequate evaluation for this patient.
4/11/14	Albumin 3.3; glucose 129; HGB 11.2; platelets 602K; sodium 132; iron 33 (normal 45-160). This indicates iron deficiency anemia which the patient has had for at least 2 months without recognition. The patient possibly has adrenal insufficiency without being recognized due to testing inaccuracies. The facility should have referred the patient to a specialist.	These abnormal laboratory tests were not acknowledged by providers when they evaluated the patient.
4/11/14	An NP evaluated the patient and wrote an extremely brief note. There was no history and no physical examination except vital signs which included a low blood pressure of 90/64. The only assessment was cavitary tuberculosis. The anemia, hyponatremia and abnormal vitals on graphic records were not assessed.	The abnormal laboratory tests were not acknowledged by providers when they evaluated the patient.
4/16/14	The patient converted to negative smears per ADPH documentation.	This indicates improvement.
4/22/14	A nurse obtained a verbal order from the Regional Medical Director to change the acuity level to green who also ordered monthly blood tests and monthly hearing test without specifying what type of hearing test.	The doctor giving this order had not evaluated the patient.
5/9/14	HGB 11.8; platelets 628K; albumin 3.8; iron low at 36; uric acid high at 10.4; sodium was 136-the first normal value in several months; K was 4.6	
5/30/14	A provider [title not documented in the record] saw the patient for chronic illness clinic. No history was taken. The provider failed to document anything that the ADPH was doing for the patient or the progress of the patient's tuberculosis. Laboratory tests performed on 5/9/14 with multiple abnormalities were not addressed. The anemia, and high uric acid were not addressed. The BP was 107/83 and pulse 99.	This was an inadequate summary of the current status of the patient and a poor chronic disease evaluation.
6/3/14	The NP again saw the patient and again wrote a note without any history. The heart and lungs were examined. The only diagnosis was TB with management by ADPH. However, the ADPH management was not being summarized by ADOC providers.	The ADOC providers almost never acknowledge what ADPH doctors and nurses were doing for the patient.

6/17/14	A DPH representative wrote an email to the Regional Medical Director stating that based on negative culture results, [name redacted] could be released from isolation.	
7/2/14	The patient placed a health request stating that his feet were swelling.	
7/4/14	An LPN saw the patient for his 7/2/14 complaint. The LPN used a skin/nail problem NET form for the evaluation. The form was not the appropriate form to use for this evaluation. The pulse was 104 and BP100/68. The LPN noted slight swelling of both feet but made no assessment. The LPN did not refer to a physician but gave the patient a slip to have his feet measured.	LPNs should perform independent assessments as they are not trained to do so. A RN did not review this evaluation. The patient had a significant problem that a provider should have evaluated. The patient was charged for an inadequate evaluation by a nurse who was untrained to perform the evaluation.
7/8/14	HGB 11.9; iron 37 which is low; platelet count 675 K. The iron saturation was 19 (normal 20-55) and TIBC was 192 (normal 228-428) and the provider signed this as consistent with chronic disease. This appears to be iron deficiency anemia not anemia of chronic disease.	
7/18/14	An NP evaluated the patient for TB. The NP documented that the patient complained of feet swelling. He documented that the protein and albumin were acceptable. In the extremity physical examination box the NP wrote without "CCE". It isn't clear what that meant. Presumably it meant without edema but it is not clear as this abbreviation is not a standard one. Active TB was the only diagnosis even though the patient still had iron deficiency anemia.	The history for this patient's was inadequate for the problem.
7/21/14	A doctor saw the patient for a complaint of swelling of his ankles. The doctor noted that it hurt when the patient walked. The doctor did not identify edema. The patient denied trauma. The doctor did not identify edema and ordered ankle x-rays and follow-up in 2 weeks. The follow-up never occurred.	The follow-up of this problem did not occur.
7/23/14	Ankle x-rays showed no fractures of the ankle but there was a question of a distal fibular fracture. The report did not state whether this was right or left sided.	
7/24/14	A doctor ordered an MRI which was suggested by the radiologist.	
7/31/14	The ADPH notes document that the Donaldson DON reported that "they now have streptomycin in stock".	
8/15/14	MRI of ankle showed mild distal pretibial and post tibial edema with small tibiotalar	An MRI showed edema not identified by provider staff although the edema was mild.

	effusion.	
8/16/14	HGB 12.5 (normal 12.3-17); platelets 547 K; iron low at 37	
8/22/14	An NP saw the patient for chronic care. The NP did not evaluate the MRI results and only assessed TB. The iron deficiency anemia or ankle issue were not addressed.	The NP evaluating the patient in chronic care did not address all of the patient's problems.
9/16/14	T3 was 216 (normal 72-180); HCT 37 (normal 39.3-52.5); platelets 516 K	
9/22/14	An NP evaluated the patient for chronic care. The NP took virtually no history and did not note recent abnormal lab tests including iron deficiency anemia or elevated thyroid test. The only disease assessed was TB. The abnormal MRI of the ankle was not addressed and the NP did not ask the patient how his ankle felt.	The NP evaluating the patient in chronic care did not address all of the patient's problems.
10/1/14	A DPH note documented that the x-ray showed left lung fibrosis with volume loss and shift of the mediastinum to the left with a persistent large apex cavity.	This is significant lung damage due to the tuberculosis.
10/3/14	A chest x-ray concluded that there were prominent interstitial markings bilaterally consistent with pulmonary edema. A left pleural effusion was present with severe bullous disease of the left upper lung.	This is significant residual lung disease. The effusion and suggestion of pulmonary edema were significant. The patient's leg swelling may have been a result of the lung damage and subsequent right heart failure.
11/6/14	HCT 38.5 low; T3 186 (normal 72-180); high platelet 422.	
11/13/14	A doctor evaluated the patient who complained of swelling of his feet for about 2 months. The doctor examined the feet and found no edema. He did not evaluate the heart or lungs or review the MRI of the ankle. He did note that the chest x-ray "still" showed pleural effusion and he said he would discuss with a representative of the DPH TB coordinator. There was no follow-up of this and the next note was 4/27/15.	An echocardiogram and possibly CT scan were indicated. The doctor failed to appreciate the residual lung damage the patient sustained.
11/26/14	An NP evaluated the patient for chronic care but took no history. The NP noted a slight increase in eosinophils but none of the other abnormal labs including the anemia. The only diagnosis was active TB. The NP did not address the prior complaint of edema or note the abnormal x-rays.	The NP failed to evaluate the patient with respect to residual lung damage from tuberculosis during this tuberculosis chronic disease clinic. This was an inadequate evaluation. Pulmonary function testing and echocardiogram should have been considered.
1/7/15	A doctor from DPH ordered to discontinue streptomycin immediately.	

1/9/15	An ADOC NP re-ordered streptomycin on 1/9/15 for 4 months along with rifampin, isoniazid and rifampin. However, the DPH recommended stopping the streptomycin on 1/7/15 and the others were to discontinue on 2/5/15.	There was lack of coordination of ADOC with recommendations of the ADPH.
2/6/15	The Regional Medical Director stopped isoniazid on 2/6/15 and rifampin on 2/6/15. It isn't clear from documentation in the record whether the streptomycin was stopped timely.	This is a lack of coordination indicating that there was not consistent provider coverage at the facility.
2/20/15	An NP evaluated the patient for chronic care. He noted that the active TB was resolved and the patient was discharged from chronic clinic care. The anemia was never addressed. The volume loss of his lung was not evaluated with respect to long term consequences. Pulmonary function tests were not done.	Notably, the providers seemed unconcerned about the persistent complications of the patient. The patient had extensive fibrosis with continued cavities which had potential to affect the patient's lung function. This patient was at risk of future lung disability and had some risk for subsequent malignancy yet the provider felt that follow-up was no longer indicated. The DPH continued to request quarterly chest films most likely to continue to assess for potential subsequent lung deterioration as a result of the tuberculosis.
5/24/15	[redacted]	[redacted] This is a significant deficiency of the mortality review and sentinel event review. When a doctor reviews his/her own work, there is a higher probability that mistakes will be overlooked which occurred in this case. The doctor performing the review was the doctor who failed to immediately isolate the patient for tuberculosis in early January of 2014 when the patient had signs and symptoms of tuberculosis and a chest x-ray consistent with tuberculosis. This was a critical error showing significant clinical deficiency but was ignored by the reviewing physician, Regional Medical Director and sentinel event committee which appeared to consist of a single nurse. This mistake resulted in many individuals being exposed to tuberculosis. On multiple occasions in 2012 and 2013, nurses performed poor health request evaluations that may have identified tuberculosis. The lack of staffing appears to have contributed to having LPNs perform these evaluations when they are untrained to do so. Nurse assessment quality was deficient and should have been part of the corrective action. Quality of care of the providers in caring for the patient's pneumonia in 2013 was poor. Tuberculosis should have been considered.

[redacted]

Failure to successfully schedule the patient for follow-up after the first incident of pneumonia in early 2013 was a significant failure.

The care of the patient in the negative pressure room at Donaldson was also extremely deficient. There was inadequate physician coverage; necessary monitoring was not done; testing for adrenal insufficiency was improperly performed; risks to the patient were not all addressed. The sentinel event committee failed to address why the patient was not hospitalized. The sentinel event committee also didn't address the lack of physician and nurse staffing at Donaldson. These elements of care were not addressed in the sentinel event review.

Counseling of the physicians caring for the patient with respect to significant clinical errors did not take place. When this does not occur the system does not improve.

Lastly, the Centers for Disease Control has recommended since 2006 that treatment of latent tuberculosis be provided by directly observed therapy which was not done in ADOC. There is no evidence in the medical record that the patient received directly observed therapy. This was not part of the corrective action plan. The ADOC practice is deficient in this regard.

	[redacted]	

Patient 14

Date	Summary	Comments
9/30/2009	Positive TST 29 mm	
1/10/2012	A nurse saw the patient for a foot problem and the blood pressure was 150/84 and weight 260	
1/31/2012	Chronic illness clinic. BP 150/100 LDL C 101; HDL 59; weight 207; Hypertension listed in fair control DC hydralazine 25 and start 50 mg BID; Norvasc 10 daily and Coreg 12.5 BID clonidine 0.3 Bid 180 days and renew Lisinopril. The provider documented that the patient hadn't received his Lisinopril so it was re-ordered.	The patient failed to receive needed medication. The blood pressure was high but the patient hadn't received his medication.
2/14/2012	Chronic illness clinic. BP 150/100. Patient was compliant with medication. Minoxidil started at 2.5 daily	
3/27/2012	Chronic illness clinic. BP 180/110 weight 203. The patient hadn't received 4 medications in the am. It needed to be re-ordered. The provider ordered Clonidine 0.3 immediately and increase Minoxidil from 2.5 to 5	The patient didn't receive all of his medications.
4/2/2012	Hepatitis A, B, and C were all negative.	
4/3/2012	Chronic illness clinic. BP 150/90; the patient was still missing meds. The provider talked to the pharmacy nurse and the meds were re-ordered.	The patient was still not getting medication resulting in high blood pressure causing risk of harm. Problems like this should be studied in quality improvement.
4/23/2012	Chronic illness clinic. The patient was compliant with all of his medication yet the BP 160/100; weight 201. Minoxidil was increased to 7.5	
5/23/2012	The BP was 150/80 and even though the blood pressure was high the medications were not adjusted. The patient complained that he was unable to hear with the current hearing aid.	The high blood pressure medication should have been adjusted. The patient should have been referred for evaluation of his hearing device.

8/27/2012	Chronic illness follow-up. BP 170/105, NP did not discuss whether the patient was compliant. Clonidine was given stat but no adjustment made to his medication. The NP referred the patient for a renal ultrasound because of the resistant hypertension. This was an appropriate request but was denied. Dr. Hood gave an alternative treatment plan to manage on site but there was no alternative plan as the provider had been unable to bring the blood pressure under control for almost a year.	Stat doses of medication are inadequate for long-term blood pressure control. The NP should have increased medication. The patient needed a workup for secondary hypertension and the renal ultrasound was an appropriate first step. It isn't clear what the on-site management was supposed to be. This placed the patient at risk of harm.
10/2/2012	Urine test showed oxalate crystals moderate	The patient had oxalate crystals and was at risk for stone disease. This was an additional reason to perform the renal ultrasound.
10/5/2012	EKG left ventricular hypertrophy.	This indicates probable heart damage from hypertension. The patient should have had an echocardiogram and should have had his blood pressure medication increased and should have had the renal ultrasound.
10/30/2012	Chronic clinic visit. BP 140/100. The NP noted that the ultrasound was denied. He increased the Minoxidil to 10 mg. The NP seeing the patient documented referral to a physician.	The long standing hypertension was damaging the heart yet secondary hypertension evaluation was denied.
11/27/2012	Glucose 114, sodium 148; BUN 22; ALT 66; GGTP 210 (normal 10-71); LDL 105; platelet count 125K	Several tests (ALT, GGTP, and platelets) were abnormal indicating possible liver disease but these were not evaluated.
11/29/2012	A physician saw the patient for chronic care. The BP 164/110; The physician said that the BP was 134/90 without clothes on; but blood pressure shouldn't be taken with the clothes on the arm. The NP switched from Lisinopril to Losartan. The NP did not address the abnormal liver tests or glucose. The weight was 206	The switch of blood pressure medications were unlikely to affect the pressure because both medications were of the same class of drug. The patient needed a work up for secondary hypertension. Abnormal blood tests were ignored.
12/31/2012	A physician saw the patient for chronic care. BP 154/90; weight was 210. The patient had bronchitis and was treated with Augmentin but the blood pressure medication was not adjusted.	The patient should have had an increase of blood pressure medication and a work up for secondary hypertension was indicated. The patient should have had an A1c test for diabetes.
2/14/2013	The physician discharged the patient from the high acuity clinic and reassigned the patient to the hypertension chronic clinic.	The patient had a high acuity problem as the NP could not manage his blood pressure. The NP wanted to start a work up of secondary hypertension but this had been denied. The patient was placed at risk of harm and was denied access to an appropriate physician to care for him. If the facility providers were unable to care for the patient's hypertension, the providers should have referred to a higher level of care.

3/13/2013	LDL 106; BUN 26; alk pho 175 (normal 40-156); AST 48 (<40); ALT 99 (normal <41); TG 189	The patient may have had fatty liver and should have had an ultrasound and probably needed treatment for his high triglycerides. An A1c test was indicated. This placed the patient at risk of harm.
3/21/2013	Hepatitis A, B, and C were all negative.	
4/10/2013	An NP again started seeing the patient in chronic care. An ultrasound of the liver was ordered and approved. The BP was 150/95. The NP noted the high glucose from about 6 months previous. The patient had polyuria but was on Lasix twice a day. The weight was 216. The patient was communicating with sign language but it didn't appear that the NP could understand sign language. The NP increase Cozaar to 75 mg. and ordered a diagnostic A1c.	The patient had not had an evaluation of his hearing device for almost a year and couldn't hear making it difficult or impossible for the provider to understand. The patient should have had an evaluation for secondary hypertension.
5/1/2013	The date wasn't clear but appeared to be May. This was the high acuity clinic. The doctor wrote that the patient had shortness of breath with exertion. The doctor wrote that the patient hadn't been receiving Losartan for two weeks. The BP was 154/102 the doctor didn't check the A1c that had presumably been ordered. The weight was 207.	This is the third time that the patient was missing his medication with adverse effect. He failed to check on the A1c, but it appears that it was not done as it was not in the medical record. He didn't raise the medication for HTN, presumably because the patient hadn't received one of his medications. The patient had symptoms of heart failure but wasn't evaluated for this condition. The patient had EKG evidence of an enlarged heart on a previous EKG. This placed the patient at risk of harm.
4/26/2013	The patient had a normal ultrasound	
6/3/2013	The patient was seen for chronic clinic. The normal abdominal ultrasound was noted. BP 130/80- this was the first normal blood pressure in a year; A1c still not available since ordered 2 months earlier so the NP re-ordered the test.	The lab tests failed to get done.
8/5/2013	The blood test ordered on 6/3/13 were done 2 months later. The glucose was 171; ALT 43; GGTP 171; TG 158; LDL 90; platelets 142K. An oral glucose tolerance test was ordered but the specimen was hemolyzed so it couldn't be done.	
8/12/2013	The 2 hr. glucose tolerance test was 128 at 2 hours with no value above 200.	
8/12/2013	The 8/12/13 chronic clinic was rescheduled because the labs were not ready	This is the 2nd time that a lab test was not done
8/12/2013	The A1c was 6.9 which is diagnostic of diabetes.	
8/16/2013	The A1c was repeated and was 6.6	

8/22/2013	Chronic clinic visit. The NP discussed the lab results. The BP 140/98 which is high. The NP wrote "impaired fasting BS" but the patient had diabetes. The NP started Glucophage at 750 extended release. And ordered another A1c and a urine micro albumin and an EKG. The NP did not adjust the BP meds even though the BP was elevated	The blood pressure medication should have been adjusted as the patient's blood pressure remained high, particularly since the patient had diabetes. The blood pressure goal should now be 130/80.
11/13/2013	A nurse saw the patient for a "house arrest" and the BP was 160/100. The nurse did not refer the patient.	
12/30/2013	The patient was seen for chronic clinic. The BP was 150/88 which is high. The weight was 204. The TG were 158. The NP did not adjust the BP meds even though the patient's BP was not at goal. The NP also did not treat the TG which were high. The EKG ordered in August had still not been done and the urine micro albumin was also not done.	Multiple tests were not done (EKG, urine for micro albumin and another A1c) ordered on 8/22/13. The abnormal BP was not treated.
1/15/2014	A1c 6.6; ALT 66; GGTP 189; cholesterol 208 LDL 119; TG 121; urine micro albumin 19.5	The patient had liver function abnormalities with negative hepatitis tests and needed a work up. The elevated LDL cholesterol needed to be treated.
1/27/2014	Chronic clinic visit. BP 130/90 which is elevated blood pressure; weight 204; NP noted abnormal labs except for liver function tests. The EKG had still not been done and was re-ordered. The NP ordered another A1c for July. The NP did not adjust the BP meds even though the patient had elevated BP for a diabetic.	The EKG was not done for over 5 months. The abnormal BP was not treated. The elevated LDL cholesterol should have been treated.
2/15/2014	The EKG showed LVH with repolarization abnormalities. An echocardiogram should have been done. It appeared that the failure to control his BP was having an effect on his heart.	The failure to control blood pressure was undoubtedly contributing to causing deteriorating of heart function and placed the patient at risk for heart failure and myocardial infarction.
4/14/2014	Chronic clinic visit. The BP was 140/90 still elevated for a diabetic. The weight was 199. The Cozaar was increased to 100 daily and an A1 c was ordered. Medication sheets show that the patient was missing from 16-22 doses of 3 different hypertensive medications from January to February but this wasn't discussed with the patient. Very little history was taken. In a previous clinic the NP documented that the patient was deaf and unable to hear. So it is not clear if the NP was able to discuss this with the patient.	The patient still had not had his hearing device evaluated. The possibility of hearing difficulties affecting the patient's ability to receive medication was not considered. The patient needed an evaluation for secondary hypertension and needed to receive all of his ordered medication. This was harming the patient.
7/3/2014	A1c 6.7	This is still diagnostic of diabetes

8/12/2014	Chronic care follow-up. The BP was 180/100 and rechecked at 140/90. The LDL of 119 was noted but not treated. The NP increased the Carvedilol to 25 and Minoxidil to 10	The LDL cholesterol elevation should have been treated. The patient had uncontrolled blood pressure for at least 2 years and should have been referred to a physician who could better manage this disease as the uncontrolled blood pressure was harming the patient.
8/29/2014	The patient had a medication sheet for Minoxidil which showed that the patient missed 21 doses of Minoxidil from 1/2/14 through 2/25/14 and 16 doses of Carvedilol and 22 doses of Lasix over the same time period.	It may have been that the uncontrolled blood pressure was due to not receiving medication. Yet at chronic disease clinics medication was seldom addressed.
9/11/2014	Chronic clinic visit. The BP was 150/90; the BS was 142 and weight 200. The NP noted that the weekly blood sugar checks were 100-154. The NP did not treat the high LDL cholesterol, discuss medication with the patient and did not adjust the patient's medication even though the blood pressure was elevated. An A1c, urine micro albumin and metabolic panel was ordered. The NP checked the box that the patient was compliant with medication which is inconsistent with the 8/29/14 document. It wasn't clear whether the patient was or wasn't getting his medication. No effort was made to ensure that this happened even to the extent of discussing it with the patient.	The provider failed to evaluate the patient's medication regimen. The blood pressure was elevated and needed to be adjusted but wasn't.
12/2/2014	ALT 75; LDL 113; A1c 6.7; BUN 24; platelets 136; AST 49; micro albumin 386	These blood tests indicated that the patient had possible cirrhosis by APRI calculation. The patient should have had this evaluated but it was ignored.
12/18/2014	Chronic clinic. NP stated that the patient was non-compliant with evening pill call but didn't ask why. The patient had a thick greenish sputum from a productive cough. BP 160/110 which is very high. The patient was past positive PPD. The NP ordered sputum for TB and gave stat doses of Clonidine and Lasix and ordered a chest x-ray. The patient had proteinuria. The elevated LDL was still not recognized and treated.	The patient should have been treated for elevated LDL cholesterol. The proteinuria should have been documented as a problem. The abnormal liver function tests and low platelets indicating possible cirrhosis were unrecognized. The elevated blood pressure was only treated with a single stat dose of medication but required adjustment of long-term treatment. These caused harm to the patient.
12/19/2015	Sputum tests were negative for MTB and the chest x-ray was negative for tuberculosis.	
12/221/4	Sputum for MTB were negative.	
12/19/2014	T protein was low at 5.7 (normal 5.9-8.4); potassium was high at 5.5; platelet count was low at 138K	
12/23/2014	AFB were negative on sputum	

1/2/2015	The patient missed multiple doses of Carvedilol, Clonidine, furosemide and hydralazine during January, February, and march.	The patient failed to receive needed medication.
3/16/2015	The NP counseled the patient about missing his medication. The reasons for missing meds was not clear and not discussed.	
1/5/2015	Chronic clinic. BP 200/120; BS 113. The NP noted giving the pm doses of medication in the office but didn't discuss medication with the patient. The medications were not adjusted. A trial of infirmary care was not considered.	This blood pressure was a dangerously high level. The patient should have been placed on the infirmary to control the blood pressure. The no shows for medication should have been discussed with the patient to find out why he wasn't showing up. The patient consistently only missed the evening doses of medication. There may have been a legitimate reason for not showing up including security issues. Most of the patient's medications were twice a day so the patient was showing up for the morning dose. The provider could have used once a day dosing for many drugs. KOP medications should have been tried as well. The elevated cholesterol was still not treated. The abnormal liver tests were not evaluated.
1/20/2015	Chronic clinic. BP 160/100. The NP increased the Clonidine to 0.4 BID and the Lasix to 40 BID.	The provider continued to ignore the elevated lipids and liver tests. The patient's blood pressure hadn't been controlled for over a year. He should have been placed on the infirmary. The provider should have asked the patient why they weren't showing up only for the afternoon medication.
3/3/2015	A1c 6.7	Still diagnostic of diabetes at goal
3/16/2015	The NP stated that the inmate had multiple episodes of non-compliance with medication but was unable to hear. It is not clear if the medication administration is called out or whether the inmates know to go to the window. It wasn't clear whether the inmate understood this issue. The BP was 150/88. The NP documented that the inmate was educated on the risks associated with out of control hypertension but because the inmate couldn't hear it wasn't clear how this communication occurred. The NP did not adjust the medication or bring the patient into the infirmary. The NP referred the patient for a hearing aid stating that he was a "deaf mute" and that his hearing aid was not functioning.	I would have placed this patient on the infirmary to get the blood pressure under control. The elevated cholesterol should have been treated. The patient was selectively not showing up for only afternoon medication passages. The medication should have been switched to daily dosing or KOP meds. No one appeared to ask the patient why he wasn't receiving medication. The patient's hearing device hadn't been repaired for about 3 years.

Patient 15

Date	Summary	Comments
11/17/2011	A mental health note while the patient was on suicide watch shortly after transfer from a local county jail documents a history that the patient was unable to remember his medications, was unable to remember any president of the United States or Governor of Alabama, didn't know the name of the facility the facility he was in and said that his memory was bad since his stroke.	This information does not appear on any medical documents so it appears that they didn't even take that thorough a history to understand that the man had significant cognitive problems.
11/17/2011	An initial medical history and screening upon incarceration identified 2 strokes, diabetes, and stents for CAD, but did not identify hypertension or high blood lipids. The BP was 130/70.	This was an inaccurate history as it failed to identify his chronic kidney disease, dyslipidemia, GERD, prior throat cancer and paralysis. This was An LPN who probably should not be performing an intake screening assessment. This form is used as part of the history for the intake process as the NP does not perform a history. Having an LPN do this is inappropriate. The cognitive problem of the patient appeared unrecognized.
11/17/2011	The patient was on the following medication at intake: Metformin; HCTZ; Prilosec; Vasotec; Zocor; Zoloft; aspirin; 70/30 insulin 20 am 10 pm	
11/18/2011	His problem lists (there are several pages) include - PPD; hypertension; post stroke with residual L paresis- uses a cane (a different problem list states he uses a wheelchair); urinary incontinence from the stroke; dyslipidemia; type 1 diabetes (50 years) gastric ulcer with GERD and esophagitis; CRF; history of throat cancer; vascular dementia with depressed mood; CAD with stent in 2011; history of carotid endarterectomy;	

11/18/2011	A provider filled out a chronic disease clinic initial baseline medical data base and identified only hypertension, cardiovascular disease, dyslipidemia, and diabetes as diagnoses. The provider took a history of past stent placement and history of stroke and prior kidney disease but these do not appear in the assessment and diagnoses. On physical examination, the provider documented left hemiparesis but failed to specifically state what the findings were. The provider documented no gross deficits under neurology examination even though the patient had foot drop, partial paralysis, and dementia easily identified by a mental health staff by talking to the patient.	This was a poor initial chronic illness note. The physical examination was very poor and inconsistent with the history. The provider didn't properly evaluate the patient.
11/18/2011	An NP ordered a shower chair, a cane for ambulation and a wheelchair for use to get to the pill call line for 180 days.	
11/18/2011	Uric Acid 7.3; glucose 113; creatinine 1.81; BUN 30; TG 151; HCT 39; an LDL cholesterol wasn't done.	
11/19/2011	EKG NSR	
11/21/2011	An NP performed the intake physical assessment but took no history. There is no place to write a history on this form. The NP checked all physical examination boxes normal including neurological even though the inmate had hemiparesis with some degree of paralysis. The NP wrote that that "noted to be in W/C [wheelchair] normally ambulates with cane, 2nd stroke c/o l sided weakness". The NP wrote this history in the examination section but checked the box normal.	The examination was inaccurate and careless. This inmate had left sided weakness, and memory deficits identified by mental health but this examination had all boxes checked normal.
11/21/2011	LDL 107; HDL 32; TG 179; A1c 7.9	These were all abnormal values.
11/22/2011	chest x-ray normal	
11/28/2011	The patient was coded as a 1 and 6. 6 means that the person has a physical limitation related to ADLs and /or elderly.	
12/7/2011	The patient was transferred to Bullock; the patient was unable to read or write and couldn't sign the form. The patient was transferred to the RTU unit in Bullock.	The patient was on the RTU mental health unit because of a cognitive problem due to a stroke. Mental health housing forced the inmate to be housed with the mentally ill when he had a physical problem. This was not an appropriate housing location for the patient.
1/1/2012	HDL 35; BUN 21; uric acid 7.1; HGB 11.4; HCT 35; TSH 6.2; LDL 68	

1/12/2012	An NP saw the patient who complained of food getting stuck in his throat. He told the doctor that he had a history of esophageal stricture with a prior balloon procedure. The NP ordered old records and sent the patient to the doctor to evaluate.	
1/26/2012	The patient ate an apple and wasn't able to swallow it and it hurt. The patient had vomited. The LPN doing the evaluation contacted a provider who ordered sick call if the pain didn't improve.	
1/26/2012	An NP saw the patient and ordered a soft diet until the patient saw a gastroenterologist.	
1/30/2012	A provider ordered an EGD and the patient was referred to a prison physician who was also a gastroenterologist. This was approved on 2/13/12	
2/6/2012	A provider saw the patient for chronic illness visit. BP was 128/68. The GI consult was pending. There was no history about swallowing only the preformatted check boxes. All conditions were listed as in good control. But the provider had not evaluated abnormal labs- anemia and elevated uric acid. The provider wrote the TSH 6.2 but didn't comment on the abnormality.	The history was poor. The provider failed to address several abnormal lab results.
2/7/2012	TSH 5.19; uric acid 7.3; HGB 11.9; HCT 36.6	
3/8/2012	The EGD showed that the patient had gastritis and a hiatal hernia; the biopsy specimens of the stomach showed gastritis with intestinal metaplasia.	
5/2/2012	A psychiatric progress note documents that the patient needed help from other inmates with his ADLs	This patient should have been on a skilled nursing unit not a psychiatric unit.
5/10/2012	An NP saw the patient. The BP was 160/70 and the weight was 193. The NP noted that the TSH was 5.19. The NP reviewed blood pressures from nursing notes and stated that the patient's weight was the likely cause of his increased blood pressure. The NP did not change therapy. The patient was given a lay in for 180 days due to his disabilities	The blood pressure was elevated and therapy should have been modified. The NP did not document the plan for the elevated TSH.
6/20/2012	BUN 24; HDL 30; A1c 6.1; creatinine 1.53; uric acid 9.1; HGB 11.7; HCT 35.8; prolactin 28.3 (normal 4-15.2)	The patient has had anemia for about 6 months but no one has intervened. An abnormal prolactin was probably due to the psychotropic that the patient was taking but no one followed up on this abnormal test.

7/9/2012	The patient told a psychiatric NP that he was having hypoglycemia and was not eating all his meals.	
7/25/2012	Glucose 158; uric acid 9.1; TG 237; A1c 6.4; HDL 23; HGB 12.1; BUN 22; phosphorus 2.5 (normal 2.7-4.5); HCT 36.5; LDL 74	
8/27/2012	Chronic illness clinic. BP 140/69. LDL 64 A1c 6.4.	
8/29/2012	The inmate refused rectal exam for colon cancer screening.	
10/8/2012	The inmate placed a sick call request stating that his sugar has been high.	This did not appear to be evaluated.
11/2/2012	The inmate transferred to Kilby. The BP was 120/60.	
11/7/2012	The inmate placed a sick call request stating that his sugar has been in the 200 range. A nurse triaging the slip recorded a blood pressure of 170/90 which is high. The LPN referred to an NP.	
11/8/2012	An NP saw the patient. The patient hadn't received insulin, according to the NP, since 11/2/12. The blood pressure was 170/90 and the weight was 135. The NP documented that she would get the MAR and apparently ensure medication continuity.	The patient failed to receive medication after transfer to Kilby. Apparently the patient hadn't received medication.
12/5/2012	The inmate told a mental health staff member that he was frustrated because an officer gave him a hard time on second shift when he went to pill call.	
12/11/2012	The inmate placed a request to have his wheelchair checked because it was "beginning to fall apart".	
12/27/2012	An NP saw the patient and documented that the patient had hemiparesis and could only drag his left leg but had a history of falling due to instability. The NP noted that the wheels were loose on the wheel chair. The BP was 130/60. An NP wrote an order asking "can we replace wheelchair".	Notably it sounds like the inmate had a foot drop but he had never had a thorough examination since incarceration. Most examinations checked boxes as normal. Also the providers did not provide the patient with an ankle foot orthotic (AFO) to protect him against falls. The providers did not consider the risk of harm due to the patient's disabilities.
2/8/2013	Chronic illness clinic. BP 120/60. The neurological examination had an acronym OIT or GIT that was unrecognizable. The provider ordered a fasting lipid profile and A1c. There was no assessment of degree of control. The mild anemia was not assessed. The abnormal prior uric acid or abnormal liver functions were not addressed.	The provider documentation was poor. The provider did not assess the patient's problems or address prior abnormal lab results.
2/11/2013	HDL 32; A1c 5.9; LDL 62	

2/12/2013	The inmate wrote a grievance stating that he had taken "every step possible to get another wheel chair. Medical tells me it is DOC's responsibility and DOC captain Hicks tells me it is medical's responsibility. I have filled out sick call and request slips trying to get some help. I am sitting on the crossbar because the seat is torn badly. It is hurting my back and such because I am sitting on the crossbar."	
2/15/2013	A chest x ray showed modest cardiomegaly and mild interstitial infiltrates	This indicated possible heart failure. Given the history of hypertension, an echocardiogram was indicated.
2/18/2013	The inmate asked for a cushion for his wheelchair and the foot rest.	
3/1/2013	An LPN saw the patient and wrote that the supplier was ordering a wheelchair. The patient said he was sitting on metal.	
3/19/2013	A response was written stating, “I have been informed that a new wheelchair was ordered for you and that your received that chair on 3/12/13".	
5/24/2013	Chronic clinic visit. The BP was 150/52 which is elevated. A1c was not documented. Although the LDL was at goal with a value of 62 lipid therapy was listed as only fair control.	The provider did not adjust the blood pressure medication despite elevated blood pressure.
5/25/2013	The date on this chronic clinic visit was difficult to determine. The patient complained of urinary incontinence several times a day for a long time. The only history was "urinary leakage without pain or dysuria several times a day for a long time". This was insufficient history. This had not been previously uncovered in prior histories. BP 124/60, A1c 6.4. The doctor noted the hemiplegia but did not discuss whether the patient had a wheelchair or had difficulty with mobility. The doctor diagnosed stress incontinence and prescribed Ditropan. The doctor did not order a urine test and should have considered a PSA test.	Ditropan is not approved or recommended for stress incontinence. The doctor did not take sufficient history to make a diagnosis of stress incontinence. This was a careless and episodic evaluation. The doctor didn't order a urine test which is typically recommended for incontinence.
5/31/2013	The patient placed a health request stating that he was getting weaker and couldn't push himself around in a wheelchair.	
5/31/2013	An NP saw the patient and documented that the patient wanted a transfer to Hamilton. The NP continued current housing.	This patient had been on a mental health unit but had a cognitive disorder with urinary incontinence. Placement in a medical nursing home type arrangement was in his interest.
8/8/2013	A1c 6.6	

8/21/2013	Chronic illness clinic. BP 120/56; A1c 6.6. The doctor did not address the urinary incontinence and did not assess the control of the patient's problems. The weight was 171. The doctor documented a 30 pound non-intentional weight loss. The doctor ordered FOBT, PSA and CEA test to evaluate the weight loss. The patient's weight at intake was 158 pounds so it is not clear how the physician obtained values of a 30 pound weight loss.	
8/22/2013	EKG showed sinus bradycardia with low voltage and questionable anterior infarct age indeterminate but the QRS looked wide with an RSR prime.	
8/22/2013	Hemoglobin 11.6 (normal 12.3-17) CEA normal	
10/24/2013	The patient placed a health request stating that he had burning and hurting with urination.	This is consistent with a urinary tract infection.
10/25/2013	An NP evaluated the patient for the health request. His penis hurt when he urinated. He was having a difficult time getting to the dining hall and to pill call given his disability. The NP documented that the dysuria might be due to inability to get medication daily but didn't document if he was missing medication. The NP documented he would benefit from assistance with activities of daily living. The NP documented she would talk to the doctor. The NP didn't order a urine test or culture. The NP gave the Ditropan KOP even though the patient had a cognitive disorder.	The patient should have been in a nursing home type environment. He had a disability and was unable to fend in a prison environment. The NP didn't order a urine test or culture even though the patient had symptoms of a urinary tract infection. Persons with cognitive disorders shouldn't be given keep on person medication.
11/3/2013	A1c 6.4	
11/10/2013	The patient was evaluated emergently for nausea, vomiting with a fever of 102.9. He was sent to an emergency room. He apparently was treated for a urinary tract infection and cellulitis but the hospital discharge summary was not in the medical record.	All hospital discharge notes need to be in the medical record. Also, nurses sending the patient to the hospital and accepting the patient back need to write notes documenting what occurred.
11/11/2013	The patient had a CT of the abdomen showing enlarged prostate, a possible polyp in the duodenum vs stool and a small pericardial effusion.	
11/11/2013	Creatinine 1.34; potassium 3; sodium 135; urine trace protein, trace ketones, and trace blood. WBC 11.8	
11/12/2013	The patient was transferred to P ward at Kilby.	

11/13/2013	The patient was admitted to the infirmary when discharged from the hospital.	
11/18/2013	The patient was discharged from the infirmary. When the patient was discharged he was provided with a urinal to keep by his bed.	
11/19/2013	creatinine 1.37; A1c 6.5;	
1/21/2014	Chronic care. BP 90/50. The patient told the doctor that he had to pay someone to help him get to pill call because it was hard for him to manage the wheelchair. He had trace edema of the legs. The doctor noticed that lipids had not recently been drawn.	Hypertension was not listed as a problem but the patient was still on HCTZ and Lisinopril for HTN. The Tamulosin would also be expected to lower the blood pressure. His pressure was too low and placed him at risk for a fall. He needed to have his medication lowered. The patient needed placement in a nursing home type environment.
1/23/2014	A1c 6.8; LDL 76	
3/7/2014	Normal chest x-ray	
3/24/2014	Chronic illness clinic. The BP was 162/70. Except for "paraplegia" all physical examinations were documented as "WNL". There was no history except that the patient couldn't get to pill call because of shortness of breath and that he had dysphagia.	There was no plan for the dysphagia. The doctor wrote a special needs communication to allow the patient extra time to get to pill call. The elevated blood pressure wasn't addressed.
6/3/2014	Chronic illness clinic. The doctor performed a review of the patient's medications. The patient was on 15 medications. The doctor increased the glipizide and stopped insulin even though the current regimen was keeping the patient at goal with few side effects. The doctor stopped Oxybutynin, Flomax, and Doxysosin. The doctor decreased the Simvastatin.	The decisions to decrease medications was questionable. With respect to diabetes, the current regimen had the patient under good control. It was less clear with respect to medication for urinary symptoms.
6/24/2014	A doctor met with the patient about his "non-compliance" with medication. He used a wheelchair and had a difficult time getting to pill call. The doctor discussed with the patient whether he would agree with admission to the infirmary so it would be easier to obtain medication.	
6/25/2014	The patient was admitted to the infirmary. The patient's medication included Zocor, nitroglycerin, Glucotrol, Glucophage, Imdur, atenolol, aspirin, Colace, Mylanta, and lactulose.	

8/28/2014	Chronic care clinic. The doctor took no history. The BP was elevated at 190/90 and the A1c had risen to 8.1. Under physical examination, the doctor wrote “WNL” and drew arrows through the physical examination section. This included the neurological examination. The doctor was documenting that the neurological examination was normal when the patient was in a wheelchair for paraplegia. The doctor made no modifications to therapy or diabetes care even though both had deteriorated since discontinuing medications.	The doctor performed a careless evaluation not even recognizing that the patient had paraplegia. The diabetes care had deteriorated since stopping insulin. The blood pressure control had significantly deteriorated. The polypharmacy issue was not as much of an issue since the patient was on the infirmary.
9/18/2014	A doctor met with the patient to discuss significant non-compliance issues. The doctor documented that the patient had a problem getting up at 3 am to receive his medication. Since the patient was on the infirmary, it should have been possible to make an accommodation. Instead, the doctor merely advised the patient of the risk of non-compliance.	To make a partially paralyzed man with significant cognitive disorder wake up at 3 am to go to a pill line is unnecessary and cruel.
10/7/2014	LDL cholesterol 134;	The patient's cholesterol level was also deteriorating.
10/28/2014	A doctor again saw the patient again for chronic illness clinic. The doctor took no history except to say that the patient didn't have constipation and was non-compliant. The doctor's physical examination again was to write "WNL" and draw arrows through the entire examination section even the neurological examination despite the patient being partially paralyzed. The blood pressure was elevate at 180/90 and the A1c was not documented although it was deteriorating to 8.1. The lipids were not addressed, but the cholesterol was deteriorating. Hypertension, diabetes, and hyperlipidemia were all listed as in good control even though all 3 diseases were deteriorating and not in good control.	The doctor’s examination was careless. He did not even identify the patient's obvious paralysis. The doctor failed to identify the deterioration of all of the patient's conditions and failed to modify treatment to improve control. The doctor did nothing to address the difficulty of the patient receiving medication.
10/29/2014	A1c 8	
11/5/2014	A1c 8.1	
11/20/2014	The patient was transferred to Easterling	
12/3/2014	A special needs communication documented that the patient was to report to the health care unit at 5 am daily for 7 days to check his blood pressure and pulse.	This is uncaring. The patient had a difficult time with mobility. To make him go to the health care unit at 5 am for a blood pressure and pulse check was unnecessary. The nurse could have gone to the patient's housing unit to obtain the blood pressure if it was needed.

12/3/2014	Chronic care clinic. The BP was 160/80 which was high; LDL 134 which was high; A1c 8.1 which was high. The doctor started Lisinopril, changed one lipid drug for another, and increased the Imdur an anti-angina drug.	The doctor might have considered reverting to the medication dosage that had been used when the patient was in control.
1/25/2015	Chronic illness clinic. BP was 210/94; LDL 70; A1c 8.1. The cholesterol level was improved but the blood pressure had deteriorated. The doctor increased the Lisinopril for the blood pressure and increased Metformin for diabetes.	The doctor might have considered reverting to the medication dosage that had been used when the patient was in control.
2/5/2015	A1c 8.5	
2/26/2015	A physician at Easterling discussed an advanced directive and living will. The patient did not want to complete an advanced directive. This was documented by a nurse not the doctor.	The patient was not expected to die soon. It was not clear why this needed to be discussed at this time.

Patient 16

Date	Summary	Comments
2/27/2015	His problems on the problem list were given as DM/insulin; hypertension; and coronary artery disease (CAD).	
6/28/2014	He was admitted to a hospital. The patient was 71 years old. The hospital note documented CKD, type 2 DM, HTN, and HBL. He had slurred speech. CT scan did not show acute bleed but showed a suggestion of a dural venous malformation. He was noted to have chronic feet paresthesia secondary to diabetic neuropathy. He was taking Levemir, Lipitor, Neurontin, Novolog 30 U TID, Prozac, Lisinopril10, HCTZ 10. BP 147/84. Dysarthria was present. Notably the creatinine was 2.2 with glucose 235, hemoglobin 10.6 and A1c was 10. NIH stroke scale was 3. Echocardiogram showed EF 50% with mild concentric hypertrophy with trivial AI, MV regurgitation, enlarged left atrium,	This inmate had significant and multiple chronic illnesses.
2/26/2015	The patient arrived at Kilby and had an officer screening that had a straight line through all the questions with respect to any possible problem including the question "is the inmate carrying any medication or report that he is on any medication which must be continuously administered or available". The time was not indicated on this form	

2/26/2015	Presumably an intake nurse performed a monofilament testing form and noted that there was no loss of protective sensation and that everything was normal. The patient had a prior diagnosis of neuropathy.	It does not appear that diabetic neuropathy testing by nurses is appropriately performed.
2/26/2015	Presumably a nurse practitioner (title not signed and name illegible) performed the intake physical examination. The provider took no history. Everything was documented as normal. The provider noted that enrollment in diabetes, hypertension and CAD chronic clinics. The neuropathy was not noted. The NP did not note the patient's medications which included Neurontin and did not ask why the patient was on this medication which was presumably for neuropathy. The NP also did not question the patient why he was on Plavix. Notably, this note which constitutes the initial provider physical examination contains no history at all, no vital signs, and no documentation of understanding what medication the patient is taking.	Presumably the patient had a cerebrovascular diagnosis that was not identified but could have been identified by taking a thorough history including why he was taking Plavix. The diabetic neuropathy was also not identified related to also not taking a history. 6 months earlier the patient was in a hospital and had dysarthria (difficulty speaking) due to a stroke. This was not identified on the initial physical examination.
2/26/2015	An LPN used an intake current medication list and identified the patient's medications as ASA, Plavix 75, Prozac, Neurontin 600 mg, Lipitor 10, Lisinopril 40, Prilosec, chlorthalidone 25, Novolog 30 TID, Levemir insulin 50 QPM. On this form the LPN documented that the blood sugar was 224. The Novolog was documented as given TID. The dose of Plavix was 75 mg.	
2/26/2015	An LPN completed an intake screening form 2 which appears to be a nursing initial screening history and vital signs. The nurse asked and the patient responded yes to a question about having any medical problems or symptoms and the nurse wrote "DM" but nothing else. The nurse identified that the patient entered with no medical devices, had a negative TB screening form result, had no sign of infection, and required no accommodation or special housing.	LPNs should not be determining if a patient needs special housing or accommodation. The LPN history failed to identify the patient's problems.
2/26/2015	An LPN placed a TST and on 2/28/15 read the TST as 8 mm. This information was completed on a form that included vaccination update but these were not updated.	
2/27/2015	A nurse used an annual vaccination record to record that the inmate refused a pneumococcal vaccination.	

2/26/2015	An LPN completed a special needs communication form indicating that the patient needed no special housing work restrictions, or any special accommodation for medical reasons. The LPN apparently ordered blood sugar checks 2 times daily at 3 am and 3 pm for 180 days.	An LPN should not be filling this type of form out and making a decision with respect to medical housing.
2/26/2015	An LPN also ordered the therapeutic diet for the patient. This was a wellness diet of 2400 calories with an evening snack even though the patient was described on physical examination by the NP as obese with a weight of 240 pounds at a height of 5 foot 9 inches for a BMI of 35.4 which constitutes obesity.	This is the same LPN who completed all of the LPN intake records and presumably this is the intake nurse. This nurse should not order a therapeutic diet.
2/26/2015	Plavix 75, Lisinopril 40, HCTZ 25 were ordered to start 2/27/15 and Atorvastatin 10, and 30 units of 70/30 were ordered twice a day before meals but the meals weren't specified.	Since Levemir can be substituted on a 1:1 basis the patient had an initial reduction of his usual insulin dose by approximately 60%. Also the ordering provider did not specify which meals the inmate was to receive insulin. This plan would most certainly cause an increase in A1c level and worsen control. Also the patient's neuropathy was not identified and the Neurontin used apparently to treat it was not continued. The aspirin was not continued and based on documentation no one knew why the patient was taking Plavix, a medication that has serious potential side effects.
3/5/2015	A nurse presumably wrote a prescription for blood sugars BID for 180 days and a wellness diet with snacks for a year with a urine for micro albumin. This note was signed by a provider.	The nurse appears to be directing care. The calories of the wellness diet were not specified.
3/5/2015	A provider signed an order filled out by someone else for a metabolic panel, FLP, TSH, A1c, EKG, CXR, eye clinic referral and bottom bunk for duration of incarceration	
2/27/2015	The patient signed a refusal for a digital rectal examination.	This should have been done at the time of the evaluation which was on 2/26/15.
2/27/2015	A PA signed a bottom bunk form.	
2/27/2015	A dentist took a history from the patient on the intake dental screening and identified HTN, DM and kidney disease. The kidney disease had not been identified by medical staff.	This demonstrates the inadequacy of nurse only history at intake.
3//5/15	The lab reported intake screening tests: HIV and RPR were negative.	Not sure why RPR (test for syphilis) was indicated in a 71 year old without any symptoms of late stage syphilis.
2/27/2015	A chest x-ray was negative	
2/29/15	An EKG showed NSR with left anterior fascicular block and non-specific STT wave changes	This was signed as reviewed.

2/27/2015	An eye examination not signed by an optometrist documents 20/50 vision OU. This test was documented on an optometry form.	It isn't clear who performed this test. It appears that a nurse performs this Snellen test.
2/27/2015	As part of the intake evaluation, someone (staff did not sign sheet, title, name or date-presumably this is a nurse) filled out a "Diabetic Checklist" presumably an annual checklist. The list documented that the patient was a new intake and for 2015-16 was enrolled in chronic care, had a monofilament, had foot disorder treated, was given an appropriate diet, had regular glucose testing, was seen by dental had urine for micro albumin, was seen by a nurse and physician, had annual retinal exam ordered, and had an individual treatment plan.	Based on the documentation, the patient did not have an adequate history or physical examination, had an inappropriate diet ordered, had no evidence of education, and did not have an adequate treatment plan. His insulin was started at the wrong dose. His neuropathy was unrecognized. His chronic kidney disease was unrecognized. The reason for being on Plavix was unrecognized. His abnormal EKG findings were unrecognized. His care seemed to be managed by nurses.
2/27/2015	An LPN completed a Diabetic Intake Screening form. The CBG was now 270. The form requires repeating the value if > 200 but this was not done. The nurse documented that the patient had prior DKA, hypoglycemia occasionally, and history of neuropathy. The LPN drew a line through required testing indicating that all tests required were performed 2/27/15 including a funduscopic examination and peripheral pulses. The NP examination of 2/26/15 did not document a funduscopic examination or an evaluation for neuropathy. It isn't clear who performed the neuropathy examination because the photocopied record did not include the title and signature line. The nurse documented that there was an initial physician treatment plan and diabetic diet.	This was a poor intake evaluation for a person with diabetes.
2/27/2015	An LPN completed an intake screening form #3 documenting that instruction was given for access to health care, etc. The nurse documented the blood pressure as 160/90. The nurse documented that the TST was 0 mm even though it was previously documented as being 8 mm. This form is a check list to ensure that all required testing was done.	

2/27/2015	An Intake screening form #4 was completed but there is no signature line so it isn't clear who completed this form. This form assesses for childhood diseases, vaccination history, prior treatment for hepatitis C, and is a checklist inventory of about 70 conditions or problems. The unidentified person completing this form checked that the patient had a prior stroke, had high blood pressure, diabetes, and had kidney disease. The box on peak flow intended to have a numerical number for those tested had a check in the column where a typical "no" response should have been placed.	Even though the person filling out the form identified prior stroke and kidney disease, this was not identified to practitioners. .
3/1/2015	At midnight on 3/1/15 the patient experienced hypoglycemia with CBG to 49. He was evaluated by an LPN. The nurse documented sweating and dizziness. An hour later the CBG was 113. The nurse documented giving juice or glucose and a bag snack and sent the patient back to his housing unit.	With the patient's insulin change the patient started having hypoglycemia.
2/27/2015	K 5.6; A1c 8.7; WBC 5.6; MCV 101.7 but MCHC low at 28.4 (normal 29-35); BUN 32; creatinine 2.75; HGB 10.4 micro/alb ratio 38.9; LDL 66. The chlamydia and GC were negative. These were signed as reviewed 3/6/15	These were intake values but were not evaluated prior to intake history and physical examination. Why was chlamydia and gonorrhea done on a 72 year old man without symptoms? The labs show chronic kidney disease, anemia, and an elevated A1c indicating poor diabetes control. The 2.75 creatinine level in a person with diabetes warranted referral to a nephrologist.
3/4/2015	The patient placed a health request stating that he had a flu of a cold. This form was triaged on 3/4/15 with a checkbox checked stating that a nurse sick call was required.	
3/5/2015	Presumably an NP evaluated the patient at 1 pm for the health request referral from the LPN at 7 am and documented a history of cough fever and body aches for 2 days. The temperature was documented as101.9 at 6:50, and a repeat temp was 98.1, repeat pulse was 82 but the blood pressure was not taken the lungs were clear. The HEENT was documented as "benign". Even though the patient had hypotension (98/58) documented by the LPN, the provider didn't repeat the blood pressure. The NP ordered fluid, Tylenol 650 BID and guaifenesin 400 BID for 5 days. The provider did not order a follow-up.	This was a serious error. The patient with a history of hypertension (blood pressure was 160/90 at intake screening on form 3) now had hypotension along with fever and tachycardia. These are signs suggestive of sepsis. He needed to be hospitalized. In addition to fever, tachycardia, and hypotension the patient had significant risks for infection including age, diabetes and CKD. He should have had an immediate blood sugar, metabolic panel, and blood count to ensure that he did not have serious disease. Not sending this patient to the hospital placed the patient at significant risk of harm. Despite the seriousness of the patient's condition he was not evaluated by a provider for 4 days.

3/5/2015	An LPN saw the patient at 7 am in follow-up of the health request and used an upper respiratory form to evaluate. The LPN documented that the patient's TST was 8 mm previously, the temp 101.9 with pulse of 117 and BP of 98/58 and weight of 220. Though the LPN documented that urgent evaluation was not required and ordered a routine FU, a provider apparently saw the patient.	
3/6/2015	An NP filled out a health coding form indicating that the patient was a Health Code 4 which indicates that the patient may require prompt access to 24/7 health care staff and should be housed in a major institution or within close proximity to a major institution.	
3/8/2015	STAT blood tests show WBC 9.2; HGB 9.2 with MCV 93.8; glucose 582, sodium 125; K 5.3; CO2 17; creatinine 3.39. The lab indicated that the critical glucose was called to ebony McCord at 23:56 on 3/8/15	The glucose was very high and the sodium very low with acidosis. The patient might have had ketoacidosis. An urgent ketone check should have been done. These values were critical and the patient should have been admitted to a hospital. To not do so placed the patient in life-threatening risk of harm.
3/8/2015	An RN evaluated the patient at 9:15 pm for altered mental status. The patient was incontinent of bowel and urine and was confused with slow response. The temperature was 101 with pulse of 114 and blood pressure of 90/54. The blood sugar was "HI" and the nurse documented that the last insulin was 3/5/15 at 3 am about 3 days ago. The nurse was unable to obtain urine from the patient. The nurse documented urgent intervention was required and called a doctor who ordered a liter of IV normal saline with stat BMP and CBC and to hold in observation until the BMP was back. The nurse was to check the blood sugars every 15 minutes for 3 hours. The doctor ordered follow-up in sick call by a practitioner. The doctor ordered 20 units of insulin (type illegible) at 9:45 pm and 10 units of insulin (type illegible) at 11:40 pm.	The patient was probably in DKA and also had signs of septic shock. He needed immediate hospitalization. Instead he was kept at the facility and treated inadequately. This was a significant departure from standard of care on the part of the physician.
3/8/2015	At 10:45 pm a nurse started an IV. The nurse noted that the patient was confused and pausing in his conversation. The nurse noted an episode of incontinence of bowel and urine. The nurse notified a doctor of the altered mental status and elevated blood sugar	Altered mental status and fever with hypotension, tachycardia and incontinence are all significant signs of sepsis and septic shock in an elderly man. Given the extremely high blood sugar it was a significant departure from standard of care not to have admitted the patient immediately to a hospital.

3/8/2015	An LPN communicated with a doctor at 11:40 pm and obtained an order for additional insulin.	The patient should have been hospitalized. The patient required frequent monitoring that could not be done at the facility.
3/8/2015	An LPN obtained the critical glucose value of 582 at 11:55pm but did not call the doctor. Based on documentation the LPN had spoken with a doctor at 11:40 and received the critical lab 15 minutes later.	
3/9/2015	The nurse gave 10 units of regular insulin as ordered at 11:40 pm and documented that she would continue to monitor.	10 units of regular insulin for a person in probable diabetic ketoacidosis is insufficient and placed the patient in harm.
3/9/2015	A nurse documented vitals of BP 112/82; pulse 113, FBS 450 with shallow breathing.	
3/9/2015	A doctor at 6:30 am wrote his own order for stat BMP at 8, 12 and 4 and admission to the P ward. In addition he ordered 20 units of regular insulin state with fasting blood sugar every 2 hours along with a sliding scale insulin. At 7 am the doctor wrote another order to admit the patient to a hospital.	
3/9/2015	At 8:10 am nurse called the shift office reporting that the inmate was to be sent to Jackson Hospital. The order was written at 7 am. An ambulance arrived at 8:30 to remove the patient about an hour and a half from the order.	This appears to be a significant delay in transporting a critically ill patient to a hospital.
3/9/2015	A doctor completed part of an emergency department transfer form indicating that the 73 year old diabetic "has not taken his insulin" now having altered mental status and hyperglycemia. An LPN completed the remainder of the transfer form.	A provider at the facility altered his typical insulin at intake. The doctor appeared to be blaming the patient for his diabetic ketoacidosis. The doctor implied that the patient was refusing insulin which does not appear to be accurate. The patient had been noted to be confused. This was cynical.
3/9/2015	There are no further progress notes or hospital notes in the medical record.	

5/24/16	[redacted]	This mortality review was poor. [redacted] Physicians who participate in the care of the patient should not be the lead physicians in the mortality review because it is a bias. There were several problems with the care of this patient. (1) The intake evaluation of this patient was extremely poor. Providers failed to identify significant illness including chronic kidney disease, diabetic neuropathy, prior stroke, and prior vascular disease. (2) A provider changed the insulin dosage dramatically lowering the insulin from 50 units of a long-acting insulin (Levemir) and 30 units three times a day of a short acting insulin to 30 units twice a day of 70/30 insulin. This was a significant reduction in insulin dosage likely to result in increased blood glucose which happened to this patient. (3) On 3/5/15 the patient experienced cough, symptoms of upper respiratory infection, hypotension, fever, and tachycardia. These are signs suggestive of sepsis. He needed to be hospitalized. But instead was treated only with Tylenol and cough medication with a 5 day follow-up. The patient should have been hospitalized or had immediate blood tests to ensure he was not septic. This placed the patient at significant risk of harm. (4) The patient who had life-threatening vital signs was not evaluated in follow-up by a provider in 4 days. (5) 3 days later a nurse called a provider for critical blood glucose values (glucose 582). The patient still had signs of sepsis. The laboratory results indicated diabetic ketoacidosis and kidney failure. Despite these laboratory results a physician did not transfer the critically ill patient to a hospital. [redacted] (6) When the physician evaluated the patient the next day and sent the patient to a hospital, there was a delay of about an hour and a half in getting the patient out of the facility. This death was preventable. [redacted]

Patient 17

Date	Summary	Comments
1/11/2005	The BP on ALAT was 160/100	
11/11/2010	There were no problem lists or intake sheets in the medical record. OHS policy requires that all records include the intake sheets.	The medical records are not complete.
11/11/2010	An apparent annual health evaluation listed blood pressure as 164/90 and visual acuity as 20/200 both eyes. At this time the patient was a food service worker. On the same date the inmate was given education on food service worker guidelines.	Visual acuity of 20/200 is legally blind. It is unclear whether this was the best corrected visual acuity.
2/1/2013	February MAR shows that the patient received KOP (30 doses) for hydralazine, HCTZ, Losartan, and biscodyl on 2/4/13.	
3/1/2013	March MAR shows that the patient received KOP for hydralazine, HCTZ and Losartan on 3/2/13	This was timely.
4/1/2013	Two April MARs show that the patient received clonidine dose BID by dose on 4/25/13 through 4/30 but missed the 4/27 pm dose. The April MAR does not record giving hydralazine, HCTZ or Losartan but this was recorded as given and shown on the March MAR as given 3/27/13. No administration was shown for April even though the patient would have run out of medication on 4/30/13. Hydralazine and Losartan were prescribed 4/8/13 but apparently not given. The HCTZ was not documented as given either.	This patient did not receive timely medication. Also, he was on KOP but two year previous he was documented as having 20/200 vision in both eyes which legally constitutes blindness. He should have been in specialized housing and on DOT medication. It is not clear whether the visual acuity was the best corrected visual acuity.
4/8/2013	Provider ordered hydralazine 100 mg BID and Cozaar 100 mg BID for 180 days	
4/24/2013	The provider ordered CBC, metabolic panel, lipid panel, and BNP with a FU in the AM.	
4/25/2013	Progress notes begin for this patient in the record provided. Seen for FU of HTN. His BP was 166/92. The provider wrote that the patient hadn't received his am or pm doses of medication and hadn't received the last 2 doses of Clonidine. Based on the MAR the patient hadn't receive any of his Losartan, hydralazine, or HCTZ either. The provider documented poor control of hypertension and ordered Clonidine for 7 days and ordered a week follow-up.	The patient failed to receive necessary medication.
4/25/2013	K 3.2, LDL 104, lactate dehydrogenase 270	
4/29/2013	A provider ordered a repeat BMP with FU next Wednesday. The provider wrote for the inmate to bring all medication with him to clinic.	

5/1/2013	Seen in FU. BP 150/94. The provider discontinued Lopressor and hydralazine and started Coreg and a low dose of Minoxidil. The order was for DC Cozaar and hydralazine and start Coreg 25 mg BID and Minoxidil 2.5 mg daily. The Lopressor was not discontinued. The provider also noted he would need renal Doppler studies and to rule out pheo (meaning pheochromocytoma).	The provider hadn't determined that the patient was actually taking his medication. Since he was perhaps legally blind perhaps he couldn't see the labels, he might have trouble seeing the labels.
5/1/2013	May MAR shows Clonidine given 5/15; 5/16; and 5/17 am and 5/18 through 5/22 BID so he missed about 3 doses of medication. Lasix was given one dose on 5/22 and then again on 5/24 and 5/31. The patient was listed as absent for Lasix on 5/25 through 5/30. KCL was also listed as given 5/24 and 5/31 but absent for 5/25 through 5/30. There were no other medications documented as given in May so apparently the missed Minoxidil, Coreg, and HCTZ.	It appeared that the patient was not provided medication.
5/16/2013	A provider ordered Clonidine increased from 0.2 Bid to 0.3 BID for 7 days and a 24 hour urine for VMA, metanepherines, catecholamine, a CBC, metabolic panel, and TSH	These tests include tests for secondary causes of hypertension.
5/16/2013	FU by provider with BP 190/108. The history was that the patient was taking all medication although this is not what the MAR represents. The assessment was uncontrolled hypertension. A chest x ray, EKG, and labs were ordered. The labs included labs to rule out pheochromocytoma. The provider continued current therapy but wrote "added back Clonidine" although the patient was already on Clonidine. It doesn't appear any change to therapy occurred.	MARs were not consistent with medications the provider thought the patient was on.
5/22/2013	A nurse saw the patient at pill call and documented that the patient had swelling (3-4+ pitting edema) of the lower extremities with a blood pressure of 156/90... The nurse notified the Regional Medical Director of a medical observation unit placement with morning provider follow-up. Orders were given for an EKG and labs.	It appeared that there was no onsite physician. The patient's blood pressure was elevated and he had signs of heart failure and needed a physician evaluation.
5/22/2013	K 3.23 but the rest of the chemistry panel was normal. The HGB was 11.4 which was slightly low with MCV of 74, and microcytic indices	

5/23/2013	Seen by provider BP 148/88. On a nurse exam for the same day the weight was 244 pounds. The provider wrote that the inmate had bilateral ankle swelling. Heart and lung exams were normal. The provider diagnosed new onset of edema and increased blood pressure. But the provider did not list all of the patient's problems. The provider ordered an echocardiogram and Lasix with potassium for 180 days and ordered stool for occult blood and B12, folate, iron, ferritin, and TIBC. The HGB reported on 5/22/13 was normal at 13.4. It did not appear that the patient had anemia.	The echocardiogram was an appropriate test as the patient had signs of heart failure. Uncontrolled hypertension can result in heart failure.
5/23/2013	An echocardiogram ordered on 5/23/13 was not documented as reviewed by either the UM nurse or RMD,	It appeared that the echocardiogram was not done.
5/24/2013	A provider saw the patient. BP 142/84. "Mild" edema to the ankles was noted. The provider documented that the edema was resolving and the HTN was better controlled but did not address any other problems. Current medications were continued.	
5/24/2013	The patient was discharged to population.	
5/30/2013	A potassium of 3 was reported and "repeated" was written on the lab report but not signed or dated.	
5/31/2013	A provider saw the patient. BP 140/76 with decreasing edema. The weight was 245. The anemia was mentioned in the assessment with edema but no other medical problems. No additional plan was documented. The provider did not notice the potassium of 3 that was reported the day before. The provider ordered potassium and additional diuretic.	
6/1/2013	The June MAR documented receipt of Carvedilol and Minoxidil KOP on 6/6/13 and HCTZ, Lasix 20 mg and KCL on 6/1/13. These dates would mean that the patient missed most of May and part of June for Carvedilol and Minoxidil and all of May for HCTZ and Lasix. Also, having the patient on 2 diuretics is inappropriate.	The patient failed to receive necessary medication.
6/5/2013	The Regional Medical Director cancelled the echocardiogram, ordered a chest x-ray and ordered the patient to see the Regional Medical Director on 6/26/13 for chronic care.	This was inappropriate as the echocardiogram was indicated. The Regional Medical Director never evaluated the patient. The condition of the patient remained undiagnosed. This placed the patient at risk of harm.

6/5/2013	The patient was documented as being evaluated for FU of edema but was not seen. The blood pressure was 180/100 and the weight 238.	The patient's blood pressure was elevated and he needed to be seen.
6/7/2013	K was 3.53 (normal 3.5-5.1)	
6/7/2013	CXR showed no acute cardiopulmonary disease.	
6/8/2013	An unknown (title and signature illegible) wrote a note that the K was 3 and creatinine 1.6. A repeat lab was ordered	
7/1/2013	The July MAR showed that the patient received 5 mg Minoxidil on 7/19/13 2 days after ordering. Carvedilol, Lasix, Minoxidil and potassium were given KOP on 7/10/13. The Carvedilol and Minoxidil were 4 days late and the others were about 10 days late. The patient also received Naprosyn 500 BID.	The patient received medication late.
7/13/2013	A provider (signature illegible and no title) saw the patient because the patient tripped on a hose and injured his ankle which was swollen and painful. An x-ray was done and was negative for fracture. A 2-week follow-up was ordered.	
7/15/2013	Right ankle x-rays ordered and Naproxen 500 bid ordered	
7/17/2013	Minoxidil was increased to 5 mg	
7/23/2013	HGB 11.3 (normal 12.3-17) with microcytic indices.	
8/1/2013	August MAR shows Carvedilol, Lasix and potassium given on 8/11/13 approximately timely. There was no evidence that the patient received Minoxidil in July.	The patient failed to receive necessary medication.
8/13/2013	The patient was not evaluated since 5/31/13. The BP was 140/100. The provider was seeing the patient for follow-up of an ankle x-ray which had been ordered a month previously for an ankle injury. The provider didn't address the elevated blood pressure, and failure to get medications. The provider noted edema of the feet but didn't pursue evaluation for heart failure. The provider did not list the patient's chronic medical conditions. The provider ordered to increase the Lasix to 40 for 2 days and if not improvement to submit a health request.	The patient's blood pressure was elevated and he needed additional medication for hypertension. Instead the provider gave the patient 2 days of diuretic for his swollen feet. The swollen feet were probably a result of heart failure due to hypertension. Treating the hypertension with additional medication was very important.
9/1/2013	The patient received Carvedilol, furosemide, Minoxidil, potassium on 9/17/13. The Minoxidil was about 2 months late. The others were about 6 days late.	The patient failed to receive necessary medication.

10/1/2013	The October MAR showed that the patient received Lasix, potassium and Carvedilol on 10/17/13 approximately on time. The Minoxidil was given on 10/24/13 about a week late.	The patient failed to receive necessary medication.
10/11/2013	A provider ordered Carvedilol for 90 days	
10/17/2013	Patient placed a health request for fluid building up in his feet, ankles, legs, knees and thighs. This was associated with pain. This request was triaged on 10/17/13 and a nurse evaluation was required and the patient was charged $4 for being evaluated on 10/18/13	The patient shouldn't be charged because of the failure of the providers to treat and manage a complication of his chronic illness.
10/18/2013	An LPN evaluated the patient for fluid building up. The BP was 160/80 and the weight was 262 which was an 18 pound weight gain since 5/23/13. The LPN used a general sick call NET form. The LPN referred the patient to a provider. There was no evidence in the medical record of the provider visit occurring.	This patient appeared to have out of control heart failure given the weight gain. The appointment didn't occur for this urgent matter. It did not appear that there was adequate physician staffing at this facility.
11/1/2013	The November MAR documents delivery of Carvedilol, Lasix and potassium on 11/14/13. The Lasix dose had been increased to 40 mg and this dose was documented as given on 11/14/13. These were timely. The Minoxidil was delivered on 11/21/13 also timely.	
11/7/2013	A provider increased Lasix to 40 daily for 30 days, a BNP test and provider FU in 5 weeks	
11/7/2013	A provider apparently saw the patient as Lasix was increased and a BNP was ordered but there was no note for this event.	
11/15/2013	A provider ordered Carvedilol 25 BID, Minoxidil 5 mg, and potassium 20 meq for 90 days	
11/20/2013	The patient placed a health request because of continued swelling up to his thighs. The patient said that an NP saw him on 11/7/13 and increased Lasix and told him to place a health request if nothing changed. He wrote "please help me". The nurse did not charge the patient but only stated that an appointment had already been made.	The patient had no access to care. The health requests resulted in scheduled appointments that didn't occur. The complaint was consistent with heart failure.
11/21/2013	The patient refused a nurse evaluation. The documentation was that the patient already had an appointment scheduled for 12/12/13.	

12/1/2013	The December MAR documents that the patient received Carvedilol, Minoxidil and potassium on 12/26/13. The carvedilol and potassium were about 2 weeks late. The Minoxidil was about 5 days late. The 40 mg of Lasix was not documented as given. The patient also received Naprosyn for 30 days KOP even though this may have been harmful give potential for kidney disease.	The patient failed to receive necessary medication.
12/4/2013	A wrong tube was used to collect blood for the BNP so it couldn't be done.	Laboratory error resulted in failed diagnostic test.
12/6/2013	A provider ordered 40 mg of Lasix for 30 days but there was no evidence that it was given to the patient.	
12/12/2013	An NP saw the patient for follow-up. The weight was 252 and BP 150/90. The lungs were clear. The edema was up to the knees and the skin was described as tight. The NP attributed the knee swelling to an injury. The NP re-ordered the BNP which had been done as ordered 11/7/13. The NP ordered a 2-week follow-up. The NP ordered Naprosyn for a month at 500 BID, ordered x-rays of both knees. There was no note for the 2-week follow-up although the NP did write further orders on 12/20/13/	The NP believing that the patient had bilateral knee swelling gave Naprosyn. This could adversely affect his blood pressure. The NP failed to diagnose the cause of the patient's edematous state. The BNP was appropriate but nothing else was done. Additional blood pressure medication was indicated. A better option would have been to use more diuretic. The patient needed an echocardiogram and a chest x-ray as diagnostic tests.
12/14/2013	The sodium was 147 (normal 133-145) and the BUN was 22. Creatinine was 1.17. The BNP was in the wrong tube.	Again a lab error resulted in failed a diagnostic test.
12/18/2013	X-rays of the knees showed osteoarthritis with no joint effusion which meant that the edema was in the tissue not the joint.	
12/23/2013	The NP ordered a BNP and wrote to make sure that the correct tubes were used for the test.	
12/30/2013	The NP ordered a BNP and wrote to collect in the correct tube. The NP also ordered Naprosyn 500 BID for 30 days and Mobic 7.5 mg daily for 30 days.	The NP had made a diagnostic error. The patient did not have an arthritis.
12/30/2013	BNP was 189 (normal < 100)	This is consistent with heart failure.
1/1/2014	The January MAR shows the patient received Mobic, 40 mg of furosemide on 1/2/14. But the Carvedilol, Minoxidil, and potassium were not documented as given. The patient had received Carvedilol, Minoxidil and potassium on 12/26/13 so these should have been given again around 1/26/14 but weren't given until 2/6 about 10 days late. The Lasix wasn't documented as given in December and was last given on 11/14/13 so it was about 2 weeks late.	The patient failed to receive necessary medication.

1/5/2014	The wound nurse documented that the wounds were improving but didn't measure them.	
1/6/2014	It appears that the NP discontinued Naprosyn and Mobic but the writing was illegible enough to make it hard to read.	
1/7/2014	Lasix was ordered at 40 mg for 30 days.	
2/1/2014	February MAR shows the patient received Lasix 40, Mobic, Carvedilol, Minoxidil and potassium on 2/6/14 for a month. The Lasix was late a few days but the Mobic, Carvedilol, Minoxidil and potassium were late about 10 days.	The patient failed to receive necessary medication.
2/5/2014	Carvedilol, Lasix 40, Mobic 7.5, Minoxidil 2.5 and potassium were ordered for 90 days. The Minoxidil dose was in fact a lowering of the dose form 5.	
2/12/2014	The patient had 20/200 vision bilaterally that corrected with glasses to 20/40	This explains the earlier comments about the 20/200 vision.
2/18/2014	An NP ordered an EKG and CXR along with fasting lipid tests, TSH, a UA and A1c. A knee brace was also ordered.	
3/1/2014	The March MAR showed that the patient received Carvedilol and potassium on 3/13/14 about a week late. The furosemide and Mobic were received on 3/11/14 about on time and the Minoxidil was received 3/4/14 a couple days early.	The patient failed to receive necessary medication.
3/31/2014	The patient was seen by a practitioner in follow-up after an injury. The practitioner noted that the patient had right sided weakness causing him to fall and hit his mouth. The practitioner documented that the neurologic examination was "grossly normal" but it isn't clear what was evaluated. The weight was on the NET form of 223 was not noticed. The provider assessed right sided weakness with loss of consciousness. It appears that the patient was sent to a hospital but it is unclear. The vital signs were not assessed.	It appears that medical records are missing. The patient apparently had right sided weakness and fell. This is inconsistent with a “grossly normal” neurological examination.
3/31/2014	An LPN completed a skin/nail problem NET form because the patient fell when his leg gave out. The blood pressure was 200/110 and the weight was 223 which was almost a 20 pound weight loss from about 10 months ago. The bleeding was hard to control and the LPN referred the patient to Dr. Mendez.	The blood pressure was extremely high.

3/31/2014	Patient discharge instructions from the hospital were in the medical record but a discharge summary was not in the record. It is not clear what happened at the hospital. On the same day there was a form for release of records so that the hospital record could be obtained. This should be administratively handled so that medical record can be timely obtained.	Medical record documents are missing.
4/1/2014	The April MAR shows that the patient received Minoxidil, Mobic, potassium, Carvedilol, and Lasix on 4/15/14. The Minoxidil was about 2 weeks late, the Lasix and Mobic were a few days late and the Carvedilol and potassium were about on time. After this MAR the new eMAR system was put in place but no paper copy was placed in the medical record.	The patient failed to receive necessary medication.
4/2/2014	The doctor admitted the patient to P ward as acuity level red and reordered Carvedilol, Lasix, Mobic, Minoxidil and potassium. The Minoxidil was at 2.5 mg.	The patient had apparently recently been hospitalized and was sent to Kilby in follow-up. However the Kilby provider did not document why the patient was hospitalized.
4/3/2014	An order sending the patient back to population ECC (presumably Easterling Correctional Center) and a provider referral for 4/7/14	A provider never evaluated the patient at Kilby.
4/3/2014	BUN 23, creatinine 1.31 (normal .9-1.3) CO2 30 (normal 22-29). These tests were ordered from Kilby.	The renal function is now abnormal.
4/8/2014	The patient was seen at Elmore in follow-up after return from Kilby after a syncopal episode. The blood pressure was 160/90 and the weight 214. The assessment was resolved near syncope and the plan was to review the discharge summary. Apparently the patient was sent to a hospital but the hospital discharge summary was not in the record and the provider did not mention what occurred at the hospital.	None of the patient's problems were listed, the elevated blood pressure was not addressed. The hospital record was unavailable. The elevated blood pressure was not treated. This placed the patient at significant risk of harm.
6/25/2014	Orders for metabolic panel, PSA, lipids, A1c, TSH and micro albumin.	
7/31/2014	An order for blood cultures and vancomycin 1 gram Q 12 hr were canceled. This occurred at 11:31 pm	
7/31/2014	An order timed 3:45 pm was for NS 125 cc per hr. for 2 liters, a Foley catheter, and EKG, a stat CXR and CMP and notification of change in condition, admit to the MOU until pt. alert enough to eat, no routine meds until pt. alert enough to swallow, vital signs every shift.	

7/31/2014	A note by an NP at 6:30 am describing that the patient was brought in from Elmore unresponsive. The writer noted that a physician was present. A Foley was inserted and the patient was sent to Staton for observation per a doctor. No vital signs or examination was documented.	To transfer unresponsive patients between facilities is dangerous. It did not appear the unresponsive patient was transferred by ambulance. The patient should have been immediately hospitalized.
7/31/2014	Narcan was given and the patient was sent to an ER. No vitals were recorded. The patient was able to open eyes and a slight movement was noted. This note was timed by an RN at 12:20 pm.	
7/31/2014	At 1:45 pm a doctor wrote an infirmary admission note describing that the patient was being admitted for a "somewhat catatonic state". The doctor wrote "Was found to be unresponsive by ADOC around 4:35 am. Was felt to be not breathing and chest compressions were done. Then transferred to HCU". This indicates that CPR was initiated. The patient was being evaluated by the doctor almost 9 hours later. The patient was felt to not be breathing and chest compressions were done and he was then transferred to HCU where he was observed for the past 8 hours. Oxygen and fluids were given in the health care unit. On examination the patient was alert but not verbally responsive. The CBG was 125, pulse 76, and BP 140/98. The neck was supple, the eye exam as documented was illegible. The lungs were clear and heart was regular. The doctor diagnosed a catatonic episode, hypertension and something else that was illegible. The doctor wrote discussing the case with the Regional Medical Director and would continue to closely observe the patient. On the same note the doctor documented that the patient was hospitalized on 3/31/14 for a syncopal episode. The EKG was documented as NSR but the remainder of the EKG reading was illegible. The WBC was 10.6 and Potassium was 3.24 with glucose of 114 and Creatinine of 1.46.	This is a significant departure from the standard of care. The patient experience cardiac arrest yet after resuscitation was not sent to a hospital. The patient had experienced a massive stroke yet hospitalization was delayed for over 28 hours. The delay prevented the hospital from instituting de-clotting medication for stroke victims. Both the Regional Medical Director and the physician failed to send a patient who had cardiac arrest to a hospital. This failure to recognize the seriousness of the patient's obvious condition especially in light of the cardiac arrest was a significant departure from standard of care on the part of both the doctor at Staton and the Regional Medical Director.
8/1/2014	An order to transfer the patient via ambulance to Jackson Hospital at 8:45 am.	

8/1/2014	The doctor wrote a note that was not timed indicating that there was no improvement in the patient's responsiveness. The doctor noted "it would be wise to proceed at this point with further w/u CT/MRI head possible CP". She documented discussing the case with the Regional Medical Director. The BP was 172/96 and the temperature axillary was 99.9. The patient remained unresponsive although he opened his eyes. He made no movements. The patient's eyes were not reactive to light, he had a + gag reflex, lungs were clear, heart was regular, blood was present in urine with a Foley in place. The diagnosis was altered mental status and hypertension. The patient was sent to Jackson Hospital.	
8/1/2014	[redacted] a hospital admission note stating that the patient was "sent by state prison to the ER for 27 hour history of altered mental status. Patient has become unresponsive probably since that time."	This patient should have been hospitalized much sooner than occurred.
8/5/2014	[redacted] the hospital discharge summary documents that the discharge recommendations were to "continue physical therapy, speech therapy, and occupational therapy and keep tube feeding at Isosource soya 1.5 at 65 cc per hour".	The patient received no physical therapy, speech therapy or occupational therapy at the prison.
8/6/2014	The patient was placed in hospice care by a doctor at Kilby.	The patient was placed in hospice without an advanced directive and without any discussion with the family.
8/6/2014	A doctor ordered admission to the infirmary after return from the hospital. The patient was under DNR status. His medication changes were his antilipid medication was Zocor 40 mg and dipyridamole/aspirin was added. The patient was also on Catapres 0.1 mg BID. The patient was now taking medication by nasogastric tube. The initial acuity was red.	

8/6/2014	A doctor wrote an admission note to the infirmary. The patient returned from the hospital where he sustained a "severe acute multi-infarct dementia outside of t-PA window". The MRI showed prominent ischemia in distribution of bilateral anterior cerebral artery and complete occlusion of LACA with near complete occlusion of TACA. The patient had severe brain damage as a result of the stroke. He was decorticate indicating severe brain damage. The diagnoses were bilateral hemispheric stroke with marked metabolic encephalopathy; hypertension, dyslipidemia, and bilateral pleural effusions. The blood pressure was 164/100 with pulse of 100. The doctor documented that due to his severe disease and brain damage that "he is likely to remain in a vegetative state [with] extremely poor prognosis. Neurology consult @ JH confirmed that nothing further can be done for him and recommend palliative care. He will be made DNR. Placed in Hospice". The doctor did not order to turn the patient or include in the orders any directions on maintaining the completely vegetative patient in his bed. No specialized bed was ordered. Turning was not ordered. Raising the head was not ordered. Etc. etc. The doctor did not order the Foley catheter to be periodically changed. The only nutrition that the doctor ordered was a can of ensure three times a day with 40 cc of water.	The decision to make the patient DNR and place the patient in hospice without discussion with the family appears unethical. It was clear from the hospital summary that the delay at the prison appeared to harm the patient making a treatable stroke an untreatable stroke. The doctor failed to initiate appropriate treatment for a stroke victim including: physical, speech and occupational therapy; a specialized bed; and instructions for nursing care for an incapacitated patient.
8/7/2014	The patient's acuity was changed to yellow.	
8/7/2014	The doctor evaluated the patient whose blood pressure was 180/100. The patient was described as having agonal breathing. Despite just having had a stroke the doctor did not adjust hypertensive medication but only wrote to continue "supportive care, DNR/hospice".	The doctor appeared to stop intervening with the patient.
8/7/2014	The doctor documented on an Attending Physician's Do Not Resuscitate Order that the patient was in a terminal condition and that the patient was incapable of making an informed decision. The doctor gave direction to all medical personnel to withhold cardiopulmonary resuscitation, in the event of cardiac arrest. He also directed personnel to provide other medical interventions to provide comfort care or alleviate pain.	The family should have been contacted.
8/11/2014	An ASAP referral for a PEG tube was made by the doctor.	

8/11/2014	[redacted] The doctor placed a request for a PEG tube stating that the patient had "neurogenic dysphagia". This was done.	
8/13/2014	The patient was sent to the ER for reduction of a paraphimosis but the nasogastric tube was plugged and the doctor was going to attempt to unclog the tube. A PEG tube was pending. The blood pressure was 170/110 but no attempt was made to reduce it.	
8/15/2014	The doctor saw the patient who still had elevated BP 156/108. No change in status	The doctor made no attempt to lower the blood pressure.
8/15/2014	The doctor ordered for the patient to have heel protectors and to float the heels with bed rolls at all times. Granulex spray was ordered to both heels daily.	The patient had been on the infirmary for over a week. The doctor should have ordered the patient to be turned and obtained a specialized bed for the patient.
8/18/2014	Ensure was ordered at 480 ml TID.	
8/22/2014	The doctor saw the patient BP now 136/80; no change in plan.	
8/25/2014	The patient developed recurrent paraphimosis. A reduction was performed. A foul odor with purulent discharge was noted. Amoxicillin was ordered for 5 days.	
9/2/2014	The patient was moved from P-isolation #5 to P ward bed 29.	
9/4/2014	The doctor ordered to clean the left buttock with wound cleaner and apply dry dressing and turn Q 2 hours until healed. There had been no prior orders about turning the patient so presumably he was lying in the same position continuously since admission.	The patient had no orders to turn the patient for almost a month and developed decubiti ulcers. A specialized bed should have been obtained. This equipment should be part of every infirmary.
9/4/2014	Nurse wound Ongoing Assessment documented that the buttock wound was unchanged mostly from 9/4/14 to 9/22/14. On 9/10 a nurse documented that the wound was deteriorating.	A special bed should have been obtained.
9/23/2014	Nursing wound flow sheet dating from 9/23/14 to 10/5/14 document that the buttock wound was healing on 9/23/14 and 9/24/14; unchanged from 9/25/14 until 10/4/14. This is inconsistent with later findings.	
9/24/2014	A doctor saw the patient who had temperature of 100.3 with BP of 103/62. The doctor diagnosed fever of unclear etiology and ordered CBC, UA, and CMP. He did not make note of the low blood pressure.	Fever, low blood pressure and a source for infection suggest sepsis.
9/26/2014	A provider ordered a UA, CBC and CMP	

9/26/2014	The doctor documented that the patient developed respiratory difficulty the night before. The pulse was 108, BP 140/88. The Foley catheter was purulent. The doctor diagnosed UTI and started Augmentin and wrote again, "supportive care only"	The patient had a Foley catheter which apparently was not being monitored.
9/27/2014	Albumin 2.8; sodium 130; BUN 74; potassium > 7; creatinine 4.71; small blood in urine; high protein in urine; many bacteria in urine; leukocyte esterase large. There was insufficient blood to perform a CBC. These labs were not reviewed until 9/29/14	The patient had renal failure with an infection. Intravenous antibiotics were indicated.
9/29/2014	A provider ordered a stat BMP	
9/29/2014	The doctor wrote that the UTI was improving and that he was increasing the fluid but it was not clear what his order was. He wrote again "supportive care only".	
9/29/2014	Sodium 134; BUN 98; creatinine 3.16; potassium 4.7	
10/12/2014	Nurses documented a review of the patient on an Assisted Living Assessment Tool. This was the first one of these for this patient. The temperature was 100. Remarkably the nurse performing this assessment documented that there were no skin lesions even though the patient had an extensive decubitus on his buttock and on both heels.	Nursing documentation did not appear appropriate.
10/13/2014	A RN saw the patient for a coccyx pressure ulcer which by this time was stage 4 "with necrotic tissue over all strong odor but not much drainage". The RN said she would order an alternating pressure bed with instructions not to lie on his back but to switch side to side every 2 hours. The nurse gave would care orders. The wound measured 11 by 17 cm of eschar. There were also bilateral lateral heel pressure ulcers with dry eschar. Although not mentioned in this note, the patient was incontinent and wore a diaper. Since admission to the infirmary there were no routine nursing notes except notes about the ongoing wound assessment. It does not appear based on the documentation that nurses were providing much care. Nurses did not document a progress note when changing the patient's diaper, moving the patient, or otherwise caring for the patient. The MAR was incomplete and it could not be determined if the patient was receiving medication.	This bed should have been ordered over 2 months previous. The patient had a very large ulcer on his buttock and additional ulcers on his heels demonstrating very poor nursing care of the patient on the infirmary. The incontinence would likely contaminate the buttock ulcerations.

10/13/2014	The doctor ordered an alternating pressure mattress and wound care which did not include rotating the patient every two hours and keeping him off his back.	This order was over 2 months late.
10/15/2014	The doctor documented that nurses reported that the urine was cloudy and pus was noted on the decubiti. The temperature was 100.4, pulse 100. The doctor diagnosed UTI and decubitus ulcers and added Septra for 5 days. He did not order a CBC.	The patient needed intravenous antibiotics but was give oral antibiotics. The doctor needed to order tests to determine if the patient had infection.
10/15/2014	An LPN documented an Assisted Living Assessment Tool and noted temperature of 100.1 with skin lesions on the buttock and heels and referred to the wound ongoing treatment log.	
10/16/2014	An LPN documented an Assisted Living Assessment Tool and noted temperature of 99.8 and documented performing wound care. The nurse documented that lunch was 2 cans of ensure.	
10/17/2014	ALAT was done These ALATs do not document turning the patient or documenting care provided.	
10/18/2014	The doctor ordered by phone blood cultures times 2, CBC, UA and writes that it is OK to change the Foley catheter.	
10/18/2014	Blood cultures were reported 10/24/14 as no growth.	
10/18/2014	WBC 17.3 with HGB 6.2 with microcytic indices. The urine was consistent with infection. On 10/21/14 the lab reported pseudomonas growing in the urine susceptible to Cefepime, Ceftazidime, Ciprofloxacin, Imipenem, Levofloxacin, Piperacillin and Tobramycin	The white count indicated infection. The patient needed intravenous antibiotics.
10/18/2014	Nurses performed an ALAT documenting turning the patient every 2 hours. This is one of few ALATs that document turning the patient	
10/19/2014	An ALAT was done and again remarkably the box labeled "presence of skin lesions" was checked "none" the nurse did not document that the wound was cleaned.	It does not appear that nurses were performing adequately.
10/20/2014	The doctor noted that the decubitus was increasing in size. Temperature was 99.5. He noted that there was slow improvement. He added Augmentin.	The patient needed a more thorough evaluation of infection. Intravenous antibiotics were indicated.

10/20/2014	ALAT was done 10/20/14; 10/21/14; 10/22/14; 10/23/14; 10/24/14; 10/25/14; 10/27/14; 10/28/14; 10/29/14; 10/30/14; 10/31/14; 11/1/14 These did not document turning the patient. This form was a check box format and included vital signs, the complaint, onset of complaint, Pain on a 1-10 scale, type of pain, related symptoms, level of response (awake, drowsy, difficult to arouse, or unconscious; general appearance; skin assessment, presence of skin lesions; lungs sounds, abdomen and bowel sounds; last bowel movement; urine frequency; nutrition status with last food intake and fluid intake, recent weight change; difficulty in swallowing; feeding tube Y/N; activity level and medication compliance. Most of these forms list the patient's level of response as awake and in no distress which is inconsistent with the prior descriptions of the patient.	It did not appear that nurses were complying with physician orders to turn the patient.
10/21/2014	A doctor ordered not to allow the patient to lie on his back and to turn him side to side every two hours. Additional wound care using normal saline cleaning with dry gauze dressing.	
10/22/2014	The doctor documented that the patient still had fever but the temperature now was 98.8. He ordered CBC, CMP and UA and documented the examination as "NC" presumably not changed.	The doctor is not intervening by either performing physical examinations or by ordering tests to determine the seriousness of the patient's condition.
10/23/2014	Iron tablets were ordered.	
10/23/2014	The doctor documented foul smelling necrosis of the sacral decubitus with a 17 thousand white count and hemoglobin of 6.2. He only continued the antibiotic and started iron.	The patient had a life-threatening low hemoglobin and had serious infection with necrosis of a decubitus ulcer. Intravenous antibiotics were indicated. The prison was unable to care for the patient and he should have been sent to a skilled nursing facility or hospital.
10/24/2014	The patient had temperature of 100 when the doctor saw him. No change was initiated. He wrote that if there was no improvement with antibiotics he would consider further debridement.	
10/24/2014	From 10/24/14 until 11/4/14 the Wound Care Flowsheet documented that nurses assessed the wound as unchanged throughout the period of time.	
10/28/2014	WBC 51; HGB 5.5; BUN 26; Creatinine 1.15	The white count indicated serious infection. The hemoglobin was extremely low. The patient was placed at risk of death by not admitting him to a hospital.

10/31/2014	The doctor saw the patient whose blood pressure was 90/60. The wound culture was documented as growing bacillus fragillis, enterococcus, proteus and pseudomonas. Since the patient was incontinent it is likely that the wound was getting contaminated but this was not noted. The doctor added Flagyl and Zithromax and continued Ciprofloxacin and Septra. The patient needed intravenous antibiotics and should have been admitted for a transfusion and higher level of care. At a minimum the patient needed higher level of nursing care.	The patient should have been transferred to a skilled nursing unit or hospital where he could properly be cared for.
11/2/2014	A nurse performed an ALAT and noted that the patient was speaking more and speaking short phrases.	
11/3/2014	The doctor started Diflucan 150 mg stat. He wrote that the nurse could wait until the pill arrived from the pharmacy before giving.	
11/3/2014	The patient's status was changed to hospice. He was to be given 200 cc of water every 6 hours and to be given only comfort measures. He ordered a CBC and BMP for 11/6/14.	
11/3/2014	ALAT done again 11/3/14; 11/4/14; 11/5/14; 11/6/14; 11/7/14; 11/8/14; 11/9/14; 11/11/14; 11/12/14; not documenting turning patient. These are done once a day and nurses do not document other interventions so you can't tell if they are done or not done.	
11/3/2014	The doctor saw the patient who now had pressure ulcers forming on the right earlobe. The patient was developing pitting edema. He indicated that the wound nurse would check the wound. He wrote to continue antibiotics.	The lack of adequate nursing care was significant. To get pressure ulcers on the earlobes reflects a significant lack of nursing care.
11/3/2014	The doctor documented having a phone conference with the regional and assistant Regional Medical Directors after the white count of 51 thousand was identified with a HGB of 5.5. It was decided to manage the patient onsite and not send the patient to a hospital. The doctor's assessment was bacteremia secondary to infected decubitus. He ordered supportive care only and said "will manage on site as prognosis is extremely poor". He changed the antibiotics. The Regional Medical Directors agreed with his decision.	This was an ethical decision that was made without consultation with the patient's family.

11/3/2014	Piperacillin Tazobactam and Vancomycin was ordered IV but the nursing notes did not document placement of an IV line. Nursing notes did not document administration these antibiotics and did not even document that the patient had an IV.	
11/5/2014	The doctor ordered cleaning the wound with normal saline and covering with gauze. For the necrotic coccyx wound he ordered to apply gauze saturated with NS under the necrotic tissue and to cover with thin film. For the heels he ordered cleaning with NS and hydrogen peroxide and covering with gauze.	
11/5/2014	The doctor documented noting the wound care note. He wrote that the Regional Medical Office decided not to send to a hospital but to continue present management. He noted "massive feces in area of decubitus". He wrote "Try + keep off buttock, meticulous hygiene".	The regional office appeared to be directing this practice. The prison was clearly unable to care for the patient and even if they intended to allow the patient to die, the patient should not have been ignored and allowed to suffer. He should have been sent to a skilled nursing facility or hospital.
11/6/2014	WBC 13; HGB 5.8	
11/10/2014	The doctor wrote that the patient was eating a soft diet but continued to write "supportive care only".	The patient appeared to be improving.
11/10/2014	Vancomycin and Zosyn were discontinued. A mechanical soft diet was ordered.	
11/11/2014	The doctor wrote that yesterday the patient had a "lo grade fever". He mentioned that the patient was eating solid food. The blood pressure was 160/102. The doctor wrote "cont supportive care, DNR, [no] hospitalization".	The patient appeared to be improving.
11/12/2014	TSH CXR and lipid panel were ordered.	
11/12/2014	The ALAT showed a pulse of 110 but no action was taken.	
11/13/2014	LDL 56 and total cholesterol 120.	
11/14/2014	ALAT pulse 106 and BP 140/90	
11/15/2014	ALAT P 108 BP 160/80	
11/16/2014	ALAT BP 150/80	
11/17/2014	ALAT pulse 118	
11/19/2014	Septra started.	
11/19/2014	The wound nurse saw patient. She documented that the patient was talkative and smiling. She debrided the ulcers and performed hydrogel with thin film. There were big chunks of necrotic tissue removed from the coccyx wound. The necrotic tissue kept reforming probably because of lack of attention to the wound by nursing staff.	Nursing care remained inadequate.

11/19/2014	The patient said that he was "feeling pretty good today". The nurse did an ALAT. P was 110.	
11/20/2014	ALAT BP 142/98	
11/21/2014	ALAT 150/94	
11/24/2014	ALAT done	
11/25/2014	ALAT BP 120/90 P 104	
11/26/2014	ALAT P 100	
11/27/2014	ALAT P 100; BP 140/76	
11/28/2014	ALAT P 102	
11/29/2014	ALAT BP 140/90	
11/30/2014	ALAT BP 112/76	
12/3/2014	The wound nurse saw the patient and described a 14 by 12 by 5 cm wound with 4.5 undermining the coccyx wound. Trochanter wounds were 1.5 by 2.5 cm	This was a very large ulcer and reflects on nursing care.
12/10/2014	The patient pulled out the PEG tube. A nurse placed a Foley catheter in the PEG insertion site and taped in in place and notified the doctor.	
12/16/2014	The doctor documented that the patient pulled the PEG tube out. The BP was 144/98. He made no change to hypertension medication and noted that they were awaiting mesalt dressing change material for debridement.	
12/19/2014	Creatinine 0.58 (normal 0.7-1.3) suggesting that the patient was developing protein calorie malnutrition.	The provider failed to attend to the nutritional needs of the patient.
12/19/2014	BP on ALAT 156/100	
12/20/2014	ALAT BP 150/100; pulse 110	
12/22/2014	ALAT BP100/66 P 92 and nurse noted that the patient vomited.	
12/23/2014	ALAT temperature 100.3 and patient had difficulty swallowing and the doctor was notified.	The wound was again resulting in infection.
12/24/2014	Wound [from unspecified area] grew cornynebacterium, enterococcus, beta hemolytic strop and pseudomonas. The enterococcus was resistant to Erythromycin and Gentamycin	
12/28/2014	The doctor noted that the patient was "refusing" to swallow and was holding his meds in his mouth. The temperature was 100.3. He documented that he might have to re-insert the PEG tube if the patient continued to "refuse" medication. He wrote to continue Septra and noted that the patient had penile and scrotal swelling.	

12/29/2014	The doctor drained a pubic and penile abscess and placed a dressing.	The level of development of decubiti appeared to reflect neglect with respect to nursing care.
1/3/2015	ALAT A nurse noted that the patient was spoon fed with P 59 and BP 156/90	
1/3/2015	The medical record stops at 1/3/15 but the patient died on 3/14/15 from sepsis.	
1/20/2015	WBC was 16.18 with HGB of 7.1 and C difficile toxin A & B positive and C Difficile GDH +; this was in the SE file	
2/12/2015	Wound culture grew MRSA and enterococcus faecalis; both were multiply resistant organisms. This was in the SE file	
2/23/2015	Additional doctor record [redacted] with documentation of no change in status; no history, no examination except to state NC	These documents in the sentinel event file were not in the medical record demonstrating that not all documents are present in the medical record.
3/3/2015	The doctor documented a fever was reported but not documented, the pulse was 116 with BP 90/60 so patient is probably in septic shock. The patient had 1-2+ edema bilaterally and the doctor documented "pubis area wet, scrotum resting in feces". The doctor's plan was for "strict hygiene". The doctor noted that the patient had multiple courses of antibiotics resulting in MDR CDI or multi-drug resistant clostridia difficile. The doctor wrote "will continue with present course except CPR, hospitalizations, discussed with the Regional Medical Director and he agrees with DNAR, not eligible for medical furlough".	The level of neglect to allow a helpless patient to lie in a bed with his feces in his decubitus ulcer was a significant departure from nursing care.
3/4/2015	The doctor wrote a note without documenting an examination. He gave a history of the patient culminating now in extensive decubiti and MDR CDI with a waxing and waning mental status. He wrote "Due to his ominous prognosis and complications from repeated courses of antibiotics his prognosis is extremely poor and could take a downturn @ any time. Therefore, he will be made a DNAR".	

3/4/2015	The doctor and a 2nd physician wrote notes documenting a DNR order. This note verifies that the 2nd physician's DNR note was written at a later date. There are two photocopied documents of physician notes in [redacted] Each of them has an identical provider note on the top of the page but a different note on the bottom of the page. This indicates some manipulation of the medical record. There cannot be 2 notes with identical doctor #1 notes on the top of the page and 2 different notes by different providers on the bottom of the page.	This verifies very irregular and inappropriate documentation with respect to obtaining proper DNR status.
3/9/2015	The doctor documented that the inmate was in slow decline and had fecal and urine incontinence. Although the doctor listed current temperature as 99.2, he documented fever as a problem. He did not document changing or ordering antibiotics. The only antibiotics documented on the MAR for February and March were Vancomycin from 2/6-2/19; Ceftriaxone for 5 days 3/12/-3/16. The patient was given morphine 20 mg from 3/13-3/17 and a transdermal Fentanyl patch of 50 mcg on 3/13 @ 2 and 3/16 once.	
3/9/2015	A wound nurse documented that the patient had been on Flagyl for 3.5 weeks and now was on Vancomycin. His wounds were worse with necrotic tissue and a "big gob of slimy slough hanging out of his right hip wound and necrotic tissue on his L hop wound and right heel". The inmate also had abdomen and testicular swelling and "a clear liquid and then bloody fluid draining from his penis". Notably, the doctor's notes do not give this level of detail.	The patient received neglectful nursing care.
3/10/2015	The inmate had seizure like activity documented by a nurse but there was no note by the doctor evaluating the patient.	
3/12/2015	A nurse noted large amount of dark red stool with clots noted. The nurse documented that the doctor was aware, but the doctor wrote no note and did not evaluation. These clots were present on 3/13/15 as well. At the morning rounds a nurse documented noting dark stools while rounding with the doctor.	
3/14/2015	The patient expired	
12/27/2015	In the SE file there was a wound culture showing enterococcus faecalis and pseudomonas	

5/24/2016	[redacted]	This mortality review was inadequate. There were multiple opportunities for improvement that were not addressed. In part [redacted] it was biased. The doctor caring for the patient should not be the one to complete the review. The problems were: (1) Through 2013 and 2014 providers at Elmore failed to control the patient's blood pressure. He failed to consistently receive his medications and providers failed to adjust his medications. This probably resulted in the stroke that caused his death. (2) In 2014, the patient had a sudden collapse apparently at Elmore. He should immediately have been sent to a hospital. Instead, CPR was initiated, the patient was resuscitated following which the patient was transported, presumably by state vehicle, to another prison instead of to a hospital. This delayed hospitalization by 26 hours and prevented de-clotting his stroke and rendered the patient permanently brain damaged. (3) The application of DNR status for this patient appeared unethical. Even after the patient became conscious and was alert the doctors made no attempt for effective communication with either the patient or his family. After the doctors decided to apply DNR status they failed to intervene on behalf of the patient even though the patient was not near death. This is a serious ethical issue. (4) Nursing care on the Kilby infirmary was a substantial departure from the standard of care. The patient developed a massive decubiti on his buttock, heels, and even on his ear lobes. This reflects neglect. The lack of a specialized bed was notable. If care could not be provided the patient should have been sent to a skilled nursing facility. (5) Physician care was inappropriate. The doctor ordered no physical, occupational, or speech therapy; no specialized bed; no nursing care appropriate for the patient's condition and failed to appropriately manage the patient's condition. The patient lived for 8 months after his stroke but was not well cared for. This death was preventable if the patient had been timely transported to a hospital. There were multiple serious problems with care. [redacted] This committee does not appear to be effective.

Patient 18

Date	Summary	Comments
8/31/2009	This 41 year old man had a problem list documenting high blood lipids as his only medical problem	
2/9/2009	EKG shows sinus arrhythmia	
4/15/2013	Zocor started at 10 mg daily for 180 days	
12/13/2012	Zocor 20 mg discontinued and Zocor 10 mg started for 180 days	
11/29/2011	Zocor started at 20 mg daily for 180 days	
1/1/13	January 2013 MAR documents that the last Zocor was given 11/26/12	The patient failed to receive ordered medication.
2/2/2013	30 days of Zocor given. The patient had missed about a month and a week of medication	The patient failed to receive ordered medication.
2/19/2013	Patient transferred from Donaldson and Kilby. The patient was listed as on Zocor	
2/21/2013	Patient received Zocor which was a week early. MARS for March and April showed that the patient received no medication those months.	The patient failed to receive ordered medication.
4/12/2013	The patient was transferred from Kilby to Bibb and was listed as on medication; the nurse referred to the MAR.	
4/12/2013	The patient was referred to chronic clinic at Bibb	
4/17/2013	The first lab testing in the medical record showed a LDL cholesterol of 206 with a HDL of 37 which is low. Total cholesterol was 278	This is a very high LDL cholesterol.
4/29/2013	An NP saw the patient for chronic care. The NP documented that the patient was not "pursuing a cardiac prudent diet or taking medication". However it appeared that the patient never received medication. The NP documented that the patient had poor lipid control and didn't change medication or document a conversation with the patient about his medication except to check a box labeled medication management.	It isn't clear why the patient didn't get or take medication. The perspective of the patient was not documented.
8/1/2013	The chronic clinic did not occur.	It wasn't clear why the clinic visit didn't occur.
7/3/2014	The patient placed a sick call request for knee pain. He was charged $4.	It didn't appear that the patient was seen.
7/24/2014	A nurse documented that the patient was a no show for a scheduled doctor appointment. The nurse documented that the name with date and time is published in a newsletter.	It doesn't appear that the notification worked for the inmate.

8/3/2014	The patient placed another health request stating that he never saw the doctor and was still having knee pain.	Although documentation was that the inmate didn't show up for an appointment on 7/14/14, he appears to not have known he had a sick call appointment.
8/27/2014	The inmate showed up for a provider evaluation for his knee pain.	
12/9/2013	A provider ordered a clinic follow-up to discuss increase of lipids.	
11/20/2013	A provider ordered fasting lipids in the AM and to discontinue chronic care clinic noting "no meds in 3 months", Despite not having medication in 3 months and despite the most recent LDL cholesterol being very high, the patient was documented as in good control.	The patient wasn't in good control. It isn't clear why the patient didn't get or take medication. The perspective of the patient was not documented. The process of discontinuing chronic clinic should include a discussion with the patient documenting the patient's perspective.
4/24/2013	Chronic clinic was scheduled in late July and a fasting lipid panel in early July	
5/18/2013	Patient received Zocor on 5/18/13	
7/3/2013	LDL 173, glucose 121, HDL 34. Someone wrote "??fasting" on the lab	The LDL cholesterol is very high.
8/1/2013	A chronic care clinic had vital signs written on the clinic meaning that the patient showed up for clinic but the patient wasn't seen. There was no documentation on the note with respect to why the patient wasn't seen.	
8/1/2013	A doctor signed a medical coding assessment guide that the patient was a number 1 with respect to critical meds indicating that he was compliant with critical treatment and KOP consideration OK	This is confusing. On the classification coding form the patient is documented as compliant but in clinic he is documented as non-compliant.
5/14/2013	Zocor was stopped on 10/14/13	It wasn't clear why the medication was stopped.
11/20/2013	A provider saw the patient for chronic care. The provider took no history with respect to medication except a statement "no meds 3 months". It is not clear what discussion the provider had with the patient. The abnormal glucose was not addressed and the provider didn't document a discussion with the patient. The provider listed the patient as under good control for high blood lipids and discharged the patient from the chronic care clinic. The provider did check boxes that stated reviewed labs with patient and therapeutic plan changes discussed.	The patient's lipids were not in good control. The reason for discharging the patient from the clinic was not clear. The doctor did not document a discussion with the patient. To not see the patient in chronic care failed to give the patient access to a physician.
11/26/2013	LDL 164 and HDL 38	The LDL cholesterol is very high.

5/9/2015	The patient was brought to the health unit unresponsive with fixed eyes and gurgling. The LPN did not assess vital signs and instead tried to start an intravenous line. CPR was started a minute after arriving on the health unit but arrived unresponsive. The LPN received a phone call from custody 4 minutes before CPR was started stating they needed a wheelchair. An IV was started and CPR was started about 4 minutes after the first call from custody. EMS arrived at 13:45 about 30 minutes after the nurse first received the phone call from custody at 13:15. The patient was pronounced dead at the hospital at 13:52.	CPR appeared delayed.
5/24/2016	[redacted]	[redacted] Autopsy should be done for all deaths. In a 41 year old man with only high blood lipids an autopsy should have been done. If the patient died of coronary artery disease, the lack of treatment for his high blood lipids may have contributed to his death. The process of discharge from chronic clinics is not described in policy. This should have been discussed in the mortality review. The providers did not document a discussion with the patient or document the perspective of the patient with respect to attending chronic clinics or taking medication. The perspective of the patient needs to be known when discontinuing care. Also, there appeared to be a delay in starting CPR for this patient that may have contributed to his death. [redacted]

Patient 19

Date	Summary	Comments
5/23/2013	72 y/o man with HTN, CAD, dyslipidemia, history of 2 coronary stents on his problem list.	

5/22/2013	He had officer receiving screening at 9 am listing no problems. The officer checked the box "no" to the question "Is the inmate carrying any medication or report that he is on any medication which must be continuously administered or available?"	This is not a question that officers should be asking. The man has 3 chronic illnesses which require medication which must be continuously administered. It isn't clear what the question means to the officer, but on two separate patient I reviewed, the officers answered no when the patient was on medication for chronic illness. Does the officer believe that the inmate doesn't need to continuously take his anti-hypertension or anti-lipid medication?
5/22/2013	An LPN filled out Intake Screening Form 2 which appears to be the initial nurse screening form meant to pick up serious problems that need to be addressed immediately. The patient's weight was 184 and the CBG was 220 which is high and should have been brought to the attention of a provider. The only problem identified by the LPN was a heart problem. The LPN documented that the patient was not a known diabetic. The patient had known hypertension and high blood lipids and had been on medications for these conditions. These apparently were missed by the LPN.	The LPN did not take a good history as she failed to recognize hypertension and lipid disorder as active problems. The nurse did not identify that the patient had elevated glucose. The only medication the LPN wrote that the inmate took was aspirin. So the nurse did not ask the patient if he took medication for his diabetes, hypertension or lipid disorder, but then again the LPN didn't recognize these because the patient wasn't asked. Not having a staff trained and licensed to take a health history will result in this type of response.
5/22/2013	An NP filled out the Special Needs Communication Form and indicated that the patient needed blood sugar checks at 3 am.	There were 2 of these forms filled out. 3 am is an extremely early time to perform routine blood sugar checks.
5/23/2013	A visual acuity tests recorded the patient as being 20/40 bilateral. This result was recorded on an "Eye Examination Sheet" which contains a signature line for an optometrist. It appears however that a nurse or someone else performs a visual acuity and records it on this form.	
5/23/2013	A Chronic Care Clinic Referral Form was filled out by an unknown person. All documents should include the signature and title of the person filling out the form. The patient was enrolled in hypertension, CAD and dyslipidemia clinics. Medications were listed as HCTZ, metoprolol, ASA, and Zocor. Both the LPN doing the initial screening and the officer performing the Receiving Officer's Screening missed this. Apparently, the potential for diabetes was going to be left up to later.	
5/23/2013	HCTZ, metoprolol, aspirin and Zocor were ordered from intake for 180 days. But this was a day after the patient arrived meaning that the patient would have missed at least two days of medication.	It appeared that medication was not ordered until the initial physical examination was done which was several days after incarceration.

5/23/2013	Metabolic panel, FLP, A1c, EKG, CXR, eye clinic referral and bottom bunk profile were ordered along with chronic care appointment for hypertension only.	
5/23/2013	An NP and RN filled out a special needs communication form (the 2nd one) for a bottom bunk for the duration of stay because the inmate was over 65 years old.	
5/23/2013	A nurse filled out a ADOC Intake Current Medication List including HCTZ, metoprolol, aspirin, and Zocor	
5/23/2013	An RN filled out Intake Screening Form 4 which was the complete initial nurse screening form meant to take an immunization history, and a self-report inventory of about 60 some conditions. This patient gave a self-report history of hearing problems, heart condition, 2 heart attacks, high blood pressure, bronchitis, arthritis, back and neck pain, and hay fever. High blood lipids are not options on this check box format and there is no space for additional problems to be recorded. The nurse failed to answer the question as to whether the patient had diabetes.	This is the only intake history for the patient and it is inadequate. The nurse failed to document all of the patient's problems. The nurse failed to take a history of when the patient had heart attacks and what had occurred, the history of medication use, whether there were further symptoms or problems,
5/23/2013	An NP filled out New Arrival Intake Screening Form 5 which is a physical examination form. The NP did not perform a history and the nurse did an inadequate job. The only history documented by the NP was a brief comment that the patient had 2 coronary stents, inguinal hernia repair and prior surgery of his abdomen and L knee. At the end of intake the patient did not have an adequate history of his chronic illnesses. Although the patient had an elevated blood sugar it wasn't clear whether or not the patient had diabetes. Also, vital signs are not included on this form so the NP apparently does not evaluate the status and degree of control of hypertension, one of the patient's chronic illnesses. Under "rectal examination with stool for occult blood", the NP wrote "not clinically indicated". However, the USPSTF recommended that screening occur for all adults aged 50 through 75 years old. So this patient qualified for that screening.	The providers completing the physical examination of the patient should include a thorough history of the patient's current problems. The initial examination does not include review of laboratory results. Providers reviewing laboratory results do not consistently document abnormal findings.

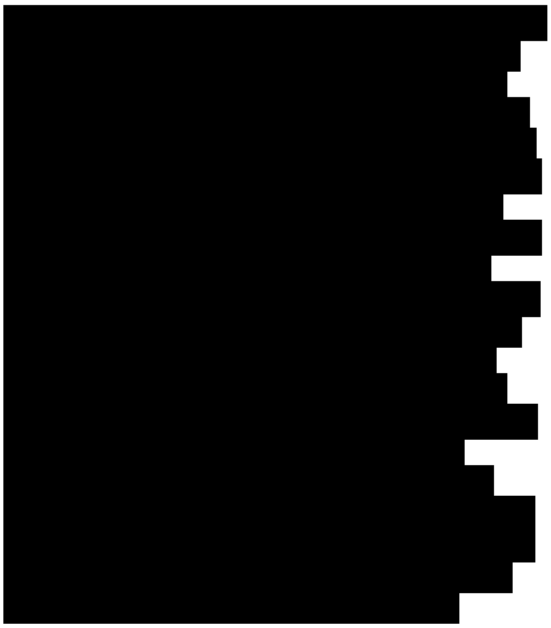
5/23/2013	Labs reported 5/24/13 included a glucose of 147 which is high and indicative of possible diabetes. Potassium of 3.1. This was not included in the intake evaluation. This lab result was signed as reviewed on 5/28/13.	Providers do not appear to review abnormal intake laboratory results. For abnormal test results the provider should document a brief note giving comments about therapeutic plan changes.
5/23/2013	An RN (apparently) filled out a New Arrival Intake Screening Form 3 that listed blood pressure as 138/60. This appears to be a checklist format of what tests need to be done in intake.	
5/24/2013	HIV, RPR and urine tests were negative as part of intake screening.	Is RPR necessary in a 72 year old man?
5/24/2013	Glucose was 147, potassium 3.1; creatinine 0.98; HDL was 32 which is very low and places the patient at high risk. LDL cholesterol was 44. The A1c value was 6.1 which is not diagnostic for diabetes but does identify pre-diabetes.	
5/26/2013	EKG showed non-specific STT wave changes	
5/27/2013	The patient placed a health request for swollen feet. He wrote that he had a "heart concern". This was appropriate as lower extremity edema may be indicative of heart failure which the patient was at risk for.	Lower extremity edema can be a sign of heart failure. Since the patient was older and had hypertension and heart disease, he should have had an echocardiogram.
5/28/2013	An NP saw the patient in sick call for swelling in his feet and ankles for a year. An LPN had evaluated the patient earlier. The NP examined the patient and found 1+ non-pitting edema which had not been picked up at intake screening 5 days previous. Since the patient had this problem for a year, neither the history nor intake physical examination picked up this problem. The BP was 120/72. Without ordering any diagnostic testing or reviewing tests done the prior week to determine the cause of the edema, the NP ordered HCTZ which the patient as already supposed to be on. The NP failed to take adequate history to exclude heart failure or other disease and failed to order tests (liver function tests) to exclude other conditions. The NP did not mention the kidney function test that had been done earlier in the week.	The NP failed to take an adequate history. The patient's comment that he had this problem for a year means that his condition was missed at intake. The NP should have reviewed the EKG, ordered a chest film and ordered an echocardiogram.

5/28/2013	An LPN evaluated the patient for swollen feet using a musculoskeletal NET form. This was an inappropriate form for this condition. The weight was 184 and BP 120/74. The NET questions are mostly related to injury and did not include appropriate questions for this man's condition. The LPN did not document referral and wrote that the patient was educated to contact medical if symptoms worsened. This patient could have had heart failure. Even though the LPN did not refer the patient, the patient did see an NP this day for this problem.	LPNs are not trained to perform assessments and the LPN should not have had this assignment. There was no evidence of an RN review. It appears that the LPN referred to a provider.
5/29/2013	A chest x-ray was normal.	
6/1/2013	There was no MAR for May so it is not clear that the patient received medication during May. For June the MAR indicates that the patient received all of his medication through the month of June.	
6/3/2013	A Medical Coding form was filled out and indicated that the patient was on prescription medication and was compliant with treatment and that he was OK for KOP meds.	
6/18/2013	The patient was transferred to Bibb from Kilby. Except for aspirin, his medications were listed on the transfer form. Under chronic care enrollment the nurse from Kilby wrote "N/A" but the patient had at least 3 chronic illnesses. The patient's weight at Bibb was 174. The patient had no special accommodation even though a low bunk had ordered. The Bibb staff did refer to the chronic care nurse.	Aspirin was not listed on the transfer form.
6/18/2013	A nurse filled out a chronic care referral form to enroll the patient in chronic clinic for HTN and dyslipidemia but not CAD.	
6/25/2013	A chronic clinic baseline medical data form was partially filled out that included vital signs but the form documented that the patient left without being seen. The patient was there long enough for obtaining vitals. It is not clear what occurred. The BP was 132/77.	
7/1/2013	The July MAR showed that the patient received aspirin, HCTZ, metoprolol, and Zocor throughout the entire month	
7/10/2013	HCTZ, metoprolol, aspirin and Zocor were ordered for 180 days.	
8/1/2013	The August MAR showed that the patient received aspirin, HCTZ, metoprolol and Zocor through the entire month. The patient was on DOT medication.	

9/1/2013	The September MAR showed that the patient received aspirin, HCTZ, metoprolol and Zocor through the entire month. The patient was on DOT medication.	
10/1/2013	The October MAR showed that the patient received aspirin, HCTZ, metoprolol and Zocor through the entire month except for missing 2 days of aspirin, HCTZ, and metoprolol and 1 day of Zocor. The patient was on DOT medication.	The patient missed a few days of medication.
11/1/2013	The November MAR showed that the patient received 6 days of all of his medication.	The patient appears to have missed medication for most of the month of November.
12/9/2013	The patient went to his first chronic clinic visit since being incarcerated about 7 months after incarceration. The NP identified HTN, CAD and dyslipidemia as chronic illness but did not identify diabetes. The patient's weight was 150 pounds which would mean that the patient had lost 34 pounds since intake. The provider noted that the patient had lost 24 pounds. The provider did not review the old labs showing that the patient had an A1c diagnostic of pre-diabetes. The BP was 124/78. The provider took no history with respect to the weight loss and checked all conditions as in good control. No evaluation or diagnostics were undertaken to determine the cause of the weight loss and the diabetes was not addressed.	The NP failed to take an adequate history with respect to weight loss. 24 pounds is a significant weight loss. The NP did not assess the possibility of diabetes.
12/26/2013	DPII and PSA blood tests were ordered along with a flu shot. DPII is probably a panel tests but it isn't clear.	
12/26/2013	The patient saw a provider for a boil on his back. No discharge was noted. The provider ordered antibiotics.	
12/29/2013	DPII, fasting lipid panel and screening AC tests were ordered and chronic care clinic was ordered for 3/14/14	
1/6/2014	Lactate dehydrogenase 124 (normal 135-225) HDL 39	
1/8/2014	A provider saw the patient for follow-up of the boil and continued the antibiotics.	
2/19/2014	HDL 35; glucose 79; LDL 36; A1c 5.4	These are normal laboratory results.
3/24/2014	An NP evaluated the patient in chronic care. BP was 148/72 and weight was 150. Minimal history was taken. All conditions had boxes checked as in good control even though the blood pressure was not at goal.	The NP took no history of the significant weight loss. The blood pressure was high. The NP did not acknowledge the elevated blood pressure and did not adjust therapy. The hypertension was listed in good control when it was not.

4/19/2014	An LPN evaluated the patient at about 6:30 pm for L chest pain for 10 minutes. The LPN checked that the pain was crushing, tight and nothing made it better or worse. The patient was a smoker, had hypertension, was an elderly male and had high blood lipids and low HDL all risks for coronary artery disease. The BP was 145/79. The LPN gave the patient Zantec and Mylanta by protocol and ordered a follow-up with a nurse but not a provider.	LPNs are not trained to perform assessments and the LPN should not have had this assignment. There was no evidence of an RN review. This evaluation by the LPN was a significant departure from the standard of care which should have been to obtain a better history, obtain an electrocardiogram, and contact a provider.
4/21/2014	A physician saw the patient in follow-up of the emergency evaluation of 4/19/14. He noted that the patient denied chest pain but had pain for 15 minutes over his left chest on Saturday with diaphoresis and described the pain as similar to when he had a "CVA" [apparently a stroke]. There was no nausea. This was the extent of the history. The doctor diagnosed atypical chest pain. The history of the LPN and physician was not consistent with atypical chest pain. This pain as described is typical of cardiac pain. The doctor wrote to return to the clinic if the patient had any problems and if that occurred to send to the ER or cardiology. An EKG ordered by the physician showed non-specific STT changes that were different from the prior EKG and consistent with possible cardiac ischemia. The EKG was not documented as reviewed.	The patient had typical chest pain with a changed electrocardiogram signifying possible coronary ischemia. The patient should have been sent to a hospital. At a minimum, anti-angina medication should have been added. This placed the patient at significant risk of harm.
5/19/2014	A RN documented that a stretcher was sent to a dorm for a "heart attack". This was at 12:03. At 12:05 am the stretcher and patient arrived in the ER and CPR was initiated. It appears that the patient was not receiving CPR prior to arrival in the HCU. The patient was unresponsive and died at the facility at 12:33 am.	
5/19/2014	An ambulance was ordered to take the patient to Bibb	

5/24/2016	[redacted]	This sentinel event review was not adequate. [redacted] RNs should perform independent assessments. When LPNs perform these assessments there is a greater probability that events such as this one will occur. In this case the nurse placed the inmate at risk of significant harm. The conclusion should have been that LPNs should not perform these assessments; only RNs should perform independent assessments. [redacted] The doctor who saw the patient on 4/21/14 failed to appreciate symptoms indicating typical versus atypical chest pain. Although this was recognized by the Regional Medical Director nothing was done about it. There was no peer review and no review of his credentials. The fact that the provider missed sending the patient for evaluation for typical chest pain and abnormal EKG was not addressed. At a minimum counseling and re-education was indicated with a review of his credentials. This episode should have been included in his peer review file with respect to subsequent re-credentialing decisions. This death was preventable.

Patient 20

Date	Summary	Comments
1/28/2013	Referred to GI for worsening dysphagia from scleromyxedema. The referring doctor wrote that the patient had been on IVIG but treatment was stopped due to "S/E". It isn't clear what S/E meant.	The patient's needed treatments were stopped for unclear reasons.
2/22/2013	The first group of orders in the chart received indicate that the patient was following with oncology.	
2/22/2013	A provider referred the patient to oncology FU stating that the patient had been on IVIG but this was stopped due to complications but since then the patient worsened with dysphagia. This wasn't approved until 3/4/13.	
3/8/2013	The patient returned from an offsite appointment and told a nurse that "They did chemo today".	

4/1/2013	The patient re-started on IVIG which he received daily for 4 days. No notes returned with the patient and it did not appear that providers saw the patient before or after treatment.	
4/26/2013	Pt seen for chronic care for hypothyroidism and scleromyxedema. The doctor checked all of the boxes "no" on the chronic care form but these questions were not quite pertinent to the patient's condition. The patient's skin wasn't examined and the NP did not ask about dysphagia, neurological problems and didn't note what had been happening at the oncology appointments. The NP didn't even note what chemotherapy the patient was getting. IVIG is a medication that can have serious consequences and the primary care provider should have followed the patient in anticipation of any adverse reactions. The NP listed the patient's hypothyroidism and scleromyxedema as in fair control but it wasn't clear what the basis for this was. The patient's last thyroid function wasn't mentioned. The provider didn't ask the patient about dysphagia for which a GI consult had been requested. There was no evidence that the GI consultation had occurred.	Patients with scleromyxedema have a chronic course. It is recommended to do a full skin examination once a month. Patients can have a variety of extracutaneous manifestations including neurologic, rheumatologic, cardiovascular, gastroenterologic, respiratory, renal, and ocular. For these reasons, UpTo Date recommends a multidisciplinary team manage the patient to include a dermatologist, hematologist, cardiologist, pulmonologist, gastroenterologist, and possible a hand surgeon. These specialist may be necessary when the patient's condition warrant. Because this was a rare disease, it was best that a specialist manage the patient. The facility provider did not appear to be capable of managing this condition or understand what needed to be followed with respect to chronic care visits.
4/29/2013	From 4/29/13 through 5/4/13 the patient received IVIG.	
5/1/2013	A provider wrote that the patient had received IVIG and was improved and that dysphagia improved. However the note was only five line long and did not include more of a history than mentioned and did not include a physical examination.	
5/6/2013	A provider documented ordering a consultation for EGD after recommended apparently by a gastroenterologist for esophageal dilation. The record does not have a complete dictated consultant note.	
5/17/2013	An oncology report states that the patient is swallowing better and that dilation was planned. The patient was receiving ongoing IVIG. At the oncologist metabolic panel and CBC was done. The creatinine was 0.9. The plan was to continue IVIG indefinitely and the oncologist was going to see the patient every 6 months. The patient received IVIG for 5 days.	The patient was receiving needed medication is an appropriate location.

5/30/2013	The patient placed a health request to get his hand creams renewed.	
5/31/2013	Eucerin hand cream prescribed with hydrocortisone cream and A & D ointment.	
6/3/2013	IVIG from 6/3/13; 6/4/13; 6/5/13; 6/6/13; 6/7/13 (the patient said he was not seen because his appointment was at 11:45 he didn't arrive until 1 pm and it was too late); 6/10/13	
6/20/2013	Seen by a physician for chronic care. The patient complained about dysphagia but noted no weight loss. The doctor did examine the skin. The doctor noted that an EGD was pending with dilation. He ordered CBC, CMP, thyroid profile and CRP and ESR with a FU in 30 days	
6/28/2013	The patient received EGD	
8/2/2013	An NP saw the patient for chronic care but took no history relevant to the patient's disease, did not note the prior consultations or note the progress or deterioration of the patient's condition. The provider documented that the patient was in fair control but it wasn't clear what the basis for this was. The provider didn't examine the skin or take a history for any of the complications of the disease. The NP documented that the patient needed esophageal dilation. A 90-day follow-up was scheduled. The last oncology visit was 5/17/13 and the patient hadn't been seen for his condition by anyone at the facility until this date. The NP did not evaluate or treat the patient.	This note exemplifies that this rare condition was not followed up as needed. The patient needed specialty care follow-up on a continuous basis but apparently wasn't receiving it.
10/16/2013	At 6 am an LPN evaluated the patient for pain and swelling in his joint. The patient had pruritus. The LPN referred the patient to an NP who saw the patient later that morning. The NP documented that it had been 8 months since the last oncology visit. The NP noted that the patient had recent esophageal dilation. The weight was 165 pounds. The NP apparently asked the scheduling clerk to move the appointment up as the patient was already scheduled. The NP did not add any treatment.	It was appropriate to refer to a specialist.

11/15/2013	The patient went back to his oncology appointment and told a nurse upon return that the oncologist straightened out appointments for treatment. The oncologist wrote on an offsite specialty report form that the patient requires IVIG every 28 days. He underlined every 28 days twice. He added, "He has not had treatment since June 2013 and is symptomatically much worse".	The result of not treating the patient resulted in worsening of his condition. The patient had missed 5 months of treatment.
11/18/2013	11/18-11/22 visits to oncology.	
12/10/2013	Went for IVIG at oncology on 12/10/13 and then again on 12/17-12/19 and then again on 12/23/13. The patient was supposed to go 5 consecutive days.	
1/14/2014	Went for IVIG from 1/14 to 1/17	
1/22/2014	A doctor evaluated the patient for chronic clinic and noted that the patient was having problems with swallowing since 9/13 and had an EGD scheduled but that it wasn't done. Food was getting stuck in his throat. The doctor ordered an EGD and scheduled a 90-day follow-up. The doctor did not comment on the oncology notes or IVIG therapy.	
2/6/2014	Patient went for endoscopy on 2/6/14. There was no stricture so the gastroenterologist thought that the patient's problem was a motility problem.	
2/17/2014	The patient had IVIG 2/17-2/21	
2/18/2014	The patient placed a health request asking for follow-up from the off-site visit.	
2/18/2014	The patient was examined in the oncologist office. The IVIG was continued. The NP noted that the patient had lost 8 pounds since his last visit and noted that the patient still had dysphagia.	
3/17/2014	The patient had IVIG 3/17/14 to 3/21/14	
4/14/2014	The patient had IVIG 4/14/14 to 4/18/14	
4/21/2014	A doctor saw the patient in chronic care clinic. He took no history with respect to the patient's scleromyxedema. The examination was minimal. The oxygen saturation was 84% which does not seem accurate but the doctor did not make any comment on it.	The provider note did not address the patient's problems.
5/12/2014	The patient placed a health request asking for follow-up from the off-site visit.	
5/12/2014	The patient had IVIG 5/12/14 to 5/16/14	

5/26/2014	A doctor saw the patient for chronic care clinic. No history was taken but the patient was examined including the skin. The provider, like all providers, failed to review the oncology notes.	Providers did not document review of the oncology notes so that they could be informed of the progress of the patient.
6/9/2014	The patient had IVIG from 6/9/14 to 6/13/14	
6/10/2014	An NP in the oncology office evaluated the patient. The patient was doing well on IVIG. His skin was becoming more flexible and his swallowing was improved. The recommendation was to continue IVIG and to give the patient an extra sandwich.	The patient was improving after return to the specialist.
7/7/2014	The patient had IVIG 7/7 to 7/11/14	
8/4/2014	The patient had IVIG from 8/4/14 to 8/8/14	
9/8/2014	the patient had IVIG from 9/8 to 9/12/14	
9/13/2014	The patient had chronic clinic with a PA. The PA mentioned that the patient was doing well on IVIG and had no new muscle aches since diagnosis. The PA did not evaluate the skin. No assessment was made of the patient's condition. A thyroid panel was ordered.	
10/6/2014	The patient had IVIG from 10/6 to 10/11/14	
10/6/2014	The patient saw an oncologist. The patient lost 6 pounds and weighed 170 pounds. Labs were done and were normal. The creatinine was 0.87	
11/3/2014	The patient had IVIG from 11/3 to 11/7/14	
12/1/2014	The patient had IVIG from 12/1/14 to 12/5/14	
12/17/2014	A doctor saw the patient in chronic care clinic. He documented that the skin was improved on IVIG. The examinations were documented as "WNL" for all boxes however the patient had significant skin abnormalities. This examination was not accurate. In the assessment, the doctor wrote, "will see about giving IVIG on site".	It was not an appropriate strategy to give IVIG on site. No one provider demonstrated knowledge or willingness to take a history and examine the patient required for this condition. Also, the staffing is not appropriate for administration of intravenous infusions that require intensive monitoring. ADOC nurses do not typically give infusion therapy and there would likely be a skills deficit. This placed the patient at risk of harm. Also, it was unclear if the providers at the facility had knowledge in the use of this medication that had serious potential side effects. The patient was given the infusions in the evening hours when a provider was unavailable on site. Nursing assessments were not consistently documented prior to starting the infusion.
12/22/2014	The doctor admitted the patient to P ward for IVIG for 5 days. This is the first IVIG the patient received at the prison.	
1/6/2015	The doctor ordered IVIG for 5 days each month for 3 months	

1/12/2015	The patient was admitted to P ward and received IVIG beginning at 5 pm until 11:30 pm. A pre-infusion of 500 cc was given. When the infusion concluded, the patient's BP was 150/88. The patient received infusion always on the evening shift on 11/13 (pre-infusion given); 11/14 (pre-infusion given); 11/15; and 11/16 had no pre-infusion. The notes by nurses giving the infusion were extremely brief and unlike the infusion center. On 11/16/15 the entirety of the infusion nurse note was "IVIG started dose #5 [no] NAD". This is poor documentation and indicates poor attention to details and may reflect lack of standardized procedure. Vital signs were not even done on 1/15 and 1/16. On 1/14 vitals were done only once.	Giving infusion therapy of a high risk medication during evening hours was a very poor idea. If a problem arose, no providers would be available. The nursing documentation did not verify that nurses were appropriately monitoring the infusions.
1/12/2015	The patient received IVIG on P ward. On 1/12 pre-infusion started at 7 pm and infusion ended at 11:30 pm. On 1/13 pre-infusion started at 7:30 and the infusion ended at 10:36. On 1/14 the pre-infusion started at 4 pm and the infusion ended at 8:50 pm. On 1/15 no pre-infusion was documented but infusion started at 4 pm and ended at 11:05. On 1/16 no pre-infusion was documented and only a 6 pm start time was documented.	Nurses documented no assessment of the patient before the infusion. Vital signs were documented. Only at the end of infusion did the nurse document mild itching. It did not appear that nurses were monitoring the infusions appropriately.
2/7/2015	The patient was admitted to P ward for 23 hour observation	
2/15/2015	The patient placed a health request on 2/15/15	
2/16/2015	An NP evaluated the patient for vomiting and diarrhea but only part of the note was in the medical record. The second page was not in the chart.	The vomiting and diarrhea would likely cause dehydration which would cause a problem with giving the infusion as patients needed to be well hydrated. An evaluation should have been more thorough and included laboratory tests to assess the renal function. Medical record documents appeared to be missing from the medical record.

2/16/2015	An LPN evaluated the patient at 10:30 am for "cold- diarrhea, vomiting, weakness +tiredness, dizzy x 3 d". The LPN used an upper respiratory NET form for purposes of the evaluation. But this form was not proper for the patient's set of symptoms. Formatted questions failed to take any history of the diarrhea, vomiting or weakness. The BP was 100/72 and pulse 96. The 96 pulse was scratched out and 80 was written in its place. The complete nursing NET tool was not in the medical record including the nursing assessment and plan.	LPNs are not trained or licensed to perform independent assessments. A RN didn't review the note. The entire evaluation document was not present in the medical record I reviewed so I couldn't determine what the LPN did.
2/17/2015	At 10:10 am the patient placed a health request stating that his stomach hurt, he had a sore throat and was dizzy. The patient wasn't seen.	
2/17/2015	A nursing rounding tool form a nurse documented on the night shift that the patient complained of feeling sick "on the stomach". The nurse did not take any other history. In the comments the nurse documented "no problems".	This was an inadequate history.
2/17/2015	At 10:10 am An LPN evaluated the patient for abdominal pain. The nurse documented that the patient's stomach hurt, he had a sore throat and was dizzy and felt nauseous. The pain was described as 8-9/10. The BP was 170/50. The history was poor. The LPN did not refer the patient to a provider but should have.	The patient had abnormal vital signs and had abdominal pain and nausea. The LPN should have consulted a provider but did not. LPNs are not trained to perform independent assessments.
2/17/2015	Nurses gave IVIG starting at 4:10 pm. the nurse did not document giving a pre-infusion. The IVIG infusion was started at 30 cc per hour and at 5:30 was increased to 120 cc per hour. Vitals weren't checked. The IVIG completed at 7:56. Which is a fast infusion. There were almost no notes for this patient. The nurse did not document giving any fluid infusion before giving the IVIG which is typical.	The nursing administration of the infusion was inadequate and included no monitoring. The pre-infusion wasn't given. The nurse did not assess the patient before administration of medication and failed to document any monitoring of the patient. Given the prior signs and symptoms of the patient, this placed the patient at significant risk of harm. Administration of this medication failed to adhere to the FDA boxed warnings. This infusion care appeared to be below the standard of care.

2/17/2015	At 9:29 pm an RN evaluated the patient because he didn't feel well and had nausea. The nurse noted that the patient had been symptomatic for 2 days. The nurse described the patient as "generally ill". BP was 120/70 with a pulse of 80 and temperature of 98.1. The nurse noted that the patient had unsteady gait. The nurse did not include a plan and it appeared that the assessment and plan page was missing. The assessment and plan pages for the prior two nursing notes also appears to be missing.	Patients with unsteady gait are generally not well. The RN described the patient as "generally ill". The medical record did not appear to be complete so it was unclear what the nurse did but the nurse should have referred the patient to a provider. Particularly, since the patient appeared unstable after an IVIG infusion, the patient should have been sent to a hospital.
2/17/2015	At 9 pm blood was drawn and reported at 11:55 pm. This appears to be drawn connected to the nursing evaluation at 9 pm. The WBC was 18.3 indicating a serious infection. The BUN was 60 and the creatinine was difficult to read but appeared to be 2.54. The sodium was 132. These values indicate new onset renal failure with hyponatremia, severe dehydration and infection. Given the patient's history, the patient should have been sent to a hospital. These labs were initialed as reviewed on 2/18/15. However, they were critical lab values especially for someone on IVIG.	These lab values are significantly abnormal, especially after IVIG infusion. The onset of renal failure with hyponatremia and dehydration with elevated white count should have prompted immediate hospitalization. For the provider to order labs and not check them until the next day in a sick patient with unsteady gait was below the standard of care. This was particularly true since the patient had just received IVIG.
2/17/2015	At 9:50 pm a doctor gave a phone order to admit the patient to P ward for 23 hour observation.	Given the recent IVIG infusion, the recent blood tests were critically abnormal. The doctor should have immediately hospitalized the patient. This placed the patient at significant risk of harm.
2/18/2015	At 6:20 am a nurse notified the doctor of the abnormal labs. He had no new orders and the nurse documented that he would assess the patient later.	Upon notice of the abnormal labs the doctor should have immediately referred the patient to a hospital.

2/18/2015	At 10 am the doctor admitted the patient to the infirmary. The admitting diagnosis was dehydration secondary to viral illness. His history was that the patient had been feeling ill with periumbilical pain. There was no further history with respect to the abdominal pain. The doctor did not note that the patient had diarrhea, had been vomiting and was nauseous and dizzy. He noted the BUN of 60 and creatinine of 2.5 with WBC of 18 thousand. He noted that the patient had IVIG the prior night despite being ill. The physical examination was had "WNL" written on top with a line through all elements of the examination despite the patient having a significant chronic illness involving his skin. The doctor made no connection with potential side effects of IVIG which include renal failure. He ordered a follow-up CBC and BMP the following day and encouraged oral fluids and did not order intravenous fluid resuscitation.	The doctor appeared to be unaware of the box warning for IVIG and should not have been administering this drug at the prison. It is not clear to what extent the renal failure was related to the IVIG, but new onset renal failure with signs of sepsis should have prompted hospitalization not an infirmary admission.
2/18/2015	A nurse infirmary admission form documented that the patient was being admitted to the infirmary for dehydration due to viral illness. The orders were intravenous fluid and Tylenol. The BP was 110/52 and pulse 110.	
2/18/2015	At 5 pm a nurse documented that the inmate "appeared generally ill". The nurse called the unit because the inmate had fallen when attempting to use the bathroom. The inmate was describe as confused, weak, and unable to sit erect. The doctor was notified. The temperature was 95, pulse 106 and BP 148/72.	The patient should have been immediately hospitalized. The doctor failed to appropriately monitor the potential side effects of IVIG which may have been responsible for the patient's condition. The patient apparently was going to receive another infusion of IVIG. The doctor failed to monitor infusion of IVIG.
2/18/2015	At 5:10 pm the nurse documented that the patient was moved to the ER. Warm saline was placed under each arm. The inmate was still confused and was incontinent of bowel.	The patient was critically ill.
2/18/2015	At 5:51 pm the doctor ordered transfer to an emergency room for confusion, hypothermia and elevated white count.	The lack of monitoring and recognition of potential adverse effects of a potentially dangerous drug placed the patient at risk of harm.
2/20/2015	The patient died apparently of sepsis with metabolic acidosis. There was no autopsy.	This death was preventable. The IVIG should not have been given at the prison because staff there did not appear to be aware of how to use the drug and monitoring of the infusions were poor.

5/24/2016	[redacted]	This death was preventable. [redacted] and arranged to have the IVIG infusions canceled at the infusion center and to perform them at the prison. [redacted], he may not have realized the potential problems with using IVIG. The failure to thoroughly investigate the death resulted in failing to identify potential problems with care. The problems with care were that the facility staff did not consistently understand the complications of the patient's rare disease. Expert outside help was indicated. The patient was receiving a medication with boxed warnings notifying the users that this medication could cause death. The prison medical staff appeared to give the medication in an inappropriate manner. The patient should have continued to receive the medication at an infusion center where the medication could be properly monitored. It is not clear the extent to which the IVIG caused the death but it appears likely that it contributed significantly to his death. An autopsy should have been done but apparently was not. The mortality review was not thorough.

Patient 21

Date	Summary	Comments
5/17/2007	This is the first date of the 1st problem list. There are 6 separate problem lists. All are different. None seem to detail all of his major medical conditions. The problem lists of this patient include the following problems: positive PPD, HTN, ?CVA, ANA 1:40; APRI score 0.5; severe stenosis of LAD; MI 2008; LV dysfunction; hepatitis C; CHF;	The number of problem lists were somewhat confusing.

7/13/2010	Received a health code of 1 which states that the patient is generally healthy and can be assigned to any facility. This is despite one of the problems on one of the 6 problem lists states that in 2008 the patient had 2 heart attacks in 2008 and then developed heart failure with an ejection fraction of 25% with a poor prognosis. The coding was filled out by a nurse practitioner.	This health coding places the patient at risk of harm by misclassifying the acuity of his illness.
7/7/2011	An LPN performed an inmate periodic health assessment Form E-4. The patient was listed as having no medical problems or symptoms (question 10) even though he had end-staged heart failure.	This was not accurately completed by an LPN who could not perform an adequate assessment.
7/12/2011	A provider signed a coding assessment but did not document what the code of the patient was.	
1/10/2012	Labs were reported including a normal albumin of 3.8; normal creatinine of 1.11; abnormal liver test AST of 106 (normal <40); and abnormal liver test ALT 90 (normal < 41). These indicate ongoing liver disease.	The patient did not appear to have a work up for these abnormalities.
3/7/2012	An NP saw the patient in chronic clinic and documented hepatitis C, hepatitis B, atopic dermatitis, and HTN with history of MI as problems all of which were listed in fair control. The NP documented discussing need for continued medical care after end of sentence which was due in 2 months. On 1/10/12 a staff also documented that the end of sentence was in 2 months. The medical staff did not appear to have a precise date for the end of sentence. The blood pressure was 130/80 and weight 210 with LDL of 72. The NP added an ACE inhibitor because of the prior history of MI even though the blood pressure was normal. The medications were not listed. The NP stated that the EKG showed marked bradycardia but the pulse at the visit was 80. Except for a history of itching no subjective history related to his heart failure or cardiac condition was taken. The NP ordered prednisone for the atopic dermatitis and Lisinopril with a 90-day follow-up.	The NP did not take an adequate history. Care might have been improved by determining the cause of the recent bradycardia. The NP did not list all of the patient's problems which included heart failure. The patient's hepatitis C included chronic active hepatitis which was not included either.

4/12/2012	An NP saw the patient for chronic care. Hepatitis B and C, HTN, MI, and allergies were listed as medical problems. Heart failure and chronic active hepatitis were not listed as problems even though the patient had these conditions. The NP stated that the patient was being seen in follow-up of an emergency visit to the HCU 4/7/12 for increased blood pressure and headache and was brought in for counseling for non-compliance. The NP, however, documented that the patient did not have his medication. Apparently the patient didn't know or follow the KOP rules. The NP increased the Lisinopril and ordered a 60-day follow-up but did not address the other problems.	The NP did not document all of the patient's problems.
9/20/2012	Labs reported AST 62, ALT 49 and platelets 130 indicating advancing liver disease.	The APRI score was 1.19 indicating significant fibrosis or cirrhosis was possible. This patient's liver disease was ignored.
9/21/2012	The CXR was normal	It appears that this was an intake screening diagnostic.
9/21/2012	A Kilby PA did a coding and assigned the patient to code 1 for chronic diseases which indicates stable condition, even though he was previously given a poor prognosis. It appeared that the patient was re-incarcerated.	The patient was re-incarcerated but was not given an appropriate coding. He actually had end-staged heart failure but it was unrecognized. This placed the patient at risk of harm.
10/11/2012	An unknown staff [staff name and title not on document] from **Bibb** performed a chronic disease initial baseline medical data form. High blood pressure was identified. The staff checked all symptoms of cardiovascular disease as negative. The only problems documented in the assessment were hypertension and hepatitis C.	The unknown staff member missed several of the patient's serious medical conditions (heart failure, prior heart attack and chronic active hepatitis).
10/22/2012	EKG showed anterolateral infarct age indeterminate with T wave abnormality-consider inferior ischemia. There was T wave inversion in the lateral leads and inferior leads with STT wave changes.	This indicates significant heart disease of unknown age. There was no follow-up of this abnormal EKG placing the patient at risk of harm.
12/18/2012	CXR was normal from Bibb	
12/19/2012	T4 level was 16.3 (normal 4.5-12) and T3 uptake 16.1 (normal 24-39); AST 75; ALT 65; TG 165; WBC 3.11; platelets 135 from Bibb	There were no progress notes for this time period. There were also no intake physical forms from the recent admission in September 2012. The abnormal labs were not addressed. The APRI was 1.39 indicating significant fibrosis or cirrhosis possible.
1/6/2013	Platelets 111; albumin 3.4 (normal 3.7-5.2); AST 135; ALT 107 from Bibb	The abnormal labs were not addressed. The APRI score was 3.04 indicating likely cirrhosis. This was never followed up.

1/8/2013	EKG sinus bradycardia rate 50 with old anterior infarct and STT wave changes	The EKG was not addressed.
1/11/2013	Ammonia 171 (normal 15-60) from Bibb	This indicates that the patient may have had hepatic encephalopathy. It was not addressed.
3/18/2013	AST 43; ALT 44; TG 194; WBC 3.21; T4 15.9; T3 uptake 18 from Bibb	
4/12/2013	A provider at Bibb saw the patient for chronic care and documented stopping all BP medication because the patient was non-compliant. The only problems listed were hypertension and hepatitis C. Heart failure was unrecognized since last incarceration. The doctor noted that the last ammonia was 171 so he documented that he would give lactulose. The provider did not document any discussion with the patient about his medication.	To give lactulose for a high ammonia implies that the provider knew that the patient might have encephalopathy. This condition causes altered mental status. To state that a patient with potential for altered mental status is non-compliant with medication ignores the possibility that the patient's mental status caused the non-compliance problem. The provider should have placed the patient on supervised medication administration particularly during a period of time when the ammonia was elevated. The provider also did not take a history relevant to encephalopathy and did not do a mental status evaluation. If the patient had encephalopathy he should have been evaluated for cirrhosis. To stop all medication in a patient with potential for encephalopathy shows either a lack of empathy or a failure to understand the complications of encephalopathy. Although the provider gave lactulose for a high ammonia, the provider did not diagnose encephalopathy or make any diagnosis. He did not evaluate for cirrhosis. The provider ordered a 6-month follow-up in chronic care. This was very poor care and showed a lack of concern.
7/1/2013	MAR present from Bibb does not document administration of any medication	The patient was at **Bibb**.
7/8/2013	A provider scheduled a patient for counseling for pattern of non-adherence to Norvasc, aspirin and lactulose.	It did not appear that this counseling took place.
8/1/2013	MAR from Bibb documents administration of Amlodipine, aspirin, and Lisinopril on 8/18/13. The last date of administration was listed as 5/28/13.	The patient had missed 2 months of medication, it part because it had been discontinued.
8/28/2013	The patient had HIV testing at Bibb which was negative	The patient hadn't been evaluated by a physician for 4 months.
10/29/2013	The patient received a reception mental health screening at Kilby.	It appeared that that patient was re-incarcerated but it wasn't clear.
10/30/2013	The patient signed a consent for a dental intake screening at Kilby.	It appeared that that patient was re-incarcerated but it wasn't clear. There was no medical screening for this patient.

10/30/2013	AST 81; ALT 55; TG 162; platelets 130. This was apparently another incarceration. These were at Kilby.	These abnormal labs indicating significant liver disease were not followed up on. APRI 1.56
11/11/2013	The patient had been re-incarcerated and a PA from Kilby did a medical coding assigning a code 1 "generally healthy" even though at a prior incarceration the patient had probable cirrhosis, encephalopathy, prior heart attacks, hypertension and heart failure.	This coding appears to be done only on a pro forma basis. There were no other intake documents for this individual and no progress notes during this time period. It appears that some medical record documents were missing.
1/1/2014	The MAR for January 2014 was from Elmore but showed no medications were administered.	It isn't clear when he transferred from Kilby to Elmore. But there was no intrasystem transfer form completed.
1/13/2014	An LPN took an order from a doctor to admit the patient to P ward for 23 hour observation. The P ward is at Kilby.	It wasn't clear why this was done. There appear to be parts of the medical record that are missing. Prior to the 2/20/14 admission to the hospital there do not appear to be any notes by providers documented that the patient was seen. It appears that either the medical record is missing documents or the patient wasn't see by a provider until he became so ill he needed hospitalization.
1/17/2014	Labs from Staton included LDL 120; A1c 6	It appeared that these were for the wrong patient as the patient did not have diabetes.
2/1/2014	The MAR for February was from Elmore and after 2/24/14 was from Kilby. Neither MARS show any administration of medication until after 2/24/14. The Kilby infirmary documents that after 2/24/14 administration of medication was "ND" or not documented.	It appeared that the patient received no medication in February until after hospitalization when he was on the Kilby infirmary and that at Kilby the administration of medication was not documented. So it wasn't clear if the patient received any of his medications.

2/20/2014	The patient was hospitalized on 2/20/14 until 2/24/14. The hospital face sheet indicates that the patient was hospitalized from the Elmore correctional facility. Echocardiogram results from an admission 2/20/14 show moderate dilated LV; severely dilated atrium; mild septal hypertrophy; ejection fraction 25% moderate mitral regurgitation, aortic insufficiency and tricuspid regurgitation. A CXR showed mild pulmonary edema. The hospital admission note states "known diffuse coronary artery disease especially the left anterior descending which as occluded in 2008 when he had anterior myocardial infarction x 2. He has not been seen by me since then. He states recently he has been having feeling of a knot in his chest with severe shortness of breath. He states he is taking no medicines. He states they would not give him his medicines because he would not take the pills". The patient was diagnosed with congestive heart failure with LV dysfunction and probable apical aneurysm. He was considered a poor candidate for catheterization due to severe diffuse disease. The doctor ordered Altace Coreg, Bumex and potassium. On discharge the labs were glucose 111, K 3.3	The previous echocardiogram was not in the medical record so it isn't clear whether there was deterioration or whether the patient's heart condition was unchanged. The patient had not received medications and wasn't being monitored at the prisons he was at and this resulted in a hospitalization.
2/23/2014	The patient apparently returned from the hospital and was admitted to the infirmary at Kilby. BP was 148/96.	
2/24/2014	On 2/24/14 a doctor changed the patient status to green and discharged him from the infirmary and then ordered medication including Zocor, aspirin, Altace, Coreg, Bumex, and KCL. The doctor's initial history and physical documented that the patient was discharged from the hospital for pulmonary edema and that he was stabilized and returned to the prison. He noted that the hospital records were pending. He noted that the EF was 20%. His examination was normal. He assessed the patient as having coronary artery disease and stable heart failure with resolved angina but didn't know what had occurred at the hospital because he hadn't yet read the report. The doctor ordered follow-up with MD at facility.	This patient was not well and should have been deemed stable before discharged. His health code was 1 so he could be sent anywhere. The doctor placed the inmate at risk of harm by transferring before the patient was deemed stable.
2/27/2014	Weight was 197	
3/1/2014	The MAR for March document that the patient received his medication March 1 through March 3 but not thereafter. There was no documentation at all on the MAR.	The patient was on significant medications which he needed. Failure to give the patient his medication placed the patient at risk of harm.

3/4/2014	A transfer summary form documented that the patient was transferred from Kilby by order of the ADOC. Apparently he moved back to Elmore. His PPD was listed a 0 mm on 10/31/13 although a problem list documented that on 5/17/07 the patient had a 20 mm PPD. The problem list from 2003 documented that the patient completed INH prophylactic treatment. TST from 2013 and 2015 were both recorded as 0. The medication summary on the transfer form noted "see MAR". But there is no evidence from the MAR that the patient received medication at the new facility.	Some TST tests appear to be inaccurate and appear to result from either being falsely recorded, not being done and recorded as negative or being incompetently performed. This kind of TST testing demonstrates why there are tuberculosis outbreaks. The transfer process is inadequate given that patients miss necessary medication. This placed the inmate at risk of harm.
3/4/2014	A provider note from Elmore documented that the patient was recently hospitalized and was being returned to Elmore.	
3/8/2014	At 10:05 am the patient was transferred to the hospital from Elmore for severe SOB and weakness. The blood pressure was 84/62 indicating severe hypotension.	The patient was transferred from Kilby to Elmore. There was no evidence of the patient receiving medication and the patient deteriorated and required hospitalization. This demonstrates extremely poor transfer procedures and very poor coordination between facilities.
3/10/2014	Medication orders for Simvastatin 40, Carvedilol, aspirin, Amlodipine, Lisinopril, and furosemide all for 6 months.	
3/10/2014	There was no record of the hospitalization in the record. On 3/10/14 a doctor re-admitted the patient to P ward on Simvastatin, Coreg, potassium, aspirin, Norvasc, Lisinopril and Lasix. But the patient wasn't evaluated.	All hospital discharge summaries, at a minimum, should be in the medical record.
3/12/2014	The TB screening form indicated that the TST was 15 mm	This indicates that TST screening is very poorly done. This inmate had 20 mm TST in 2007, 0 mm in 2013, 15 mm in 2014, and 0 mm in 2015. Something indicates a serious problem with respect to tuberculosis screening.
3/12/2014	A MAR from Elmore documents that the patient transferred in to Elmore of 3/12/14.	
3/18/2014	A provider from Elmore evaluated the patient for the first time since release from the hospital. The doctor took no history except noting that "I feel fine". The examination was minimal. The blood pressure was minimally elevated at 140/90. The assessment was heart failure and the plan was to follow up in chronic care. This patient's problems including HTN, CAD, and hepatitis C were ignored.	This was a very poor examination placing the patient at risk of harm. He wasn't seen for over a week after hospitalization and several serious medical conditions weren't addressed.

4/15/2014	A provider at Elmore saw the patient again and wrote in the history to "see nurses note" but this note is not in the record. The patient had been having shortness of breath. The doctor listened to the heart and lungs and assessed "SOB now resolved will return to pop return PRN".	The provider took virtually no history and did a poor assessment of the patient who had serious illness. It appeared that a nurse note was not in the medical record.
4/18/2014	On this date the patient transferred to Limestone and an LPN referred the patient to chronic care. The patient was now at Limestone CC but there was no transfer form in the record. There is no evidence in the medical record that the inmate was receiving his medication.	This is a significant breakdown in the intra-system transfer process. This inmate with serious illness was misclassified, remained misclassified and was sent to Limestone from Elmore from Kilby without notification or medical intra-system transfer information. The lack of intra-system transfer information already resulted in 2 hospitalizations causing harm to the patient.
4/25/2014	Labs reported AST 74 ALT 59 Hepatitis B & C positive; platelets low at 133; bilirubin 1.1; glucose 88 at Limestone	This is probable evidence that the labs done on 1/16/14 were probably from the wrong patient as the patient again demonstrated significant liver disease.
4/25/2014	An APRI score sheet documented that the patient had an APRI of 1.46 which indicated possible fibrosis and cirrhosis. The patient was a candidate for treatment but not referred for treatment. This was not addressed in subsequent chronic illness follow up.	The patient's hepatitis C disease and its consequences were ignored.
4/28/2014	An NP re-coded the patient as a 4 or critical unstable with non-compliance issues.	
5/1/2014	Someone at Limestone filled out a chronic disease clinic initial baseline medical data but did not sign their name or place their title on the document so it isn't clear who did this. The person documented that the patient had hypertension, obesity, alcoholism as risk factors had a stroke in 1985 and a prior heart attack and noted that the patient had heart failure with EF 25%. Hepatitis C and hepatitis B and CAD were listed as diagnoses but the extent of liver disease was not noted even though the patient had possible cirrhosis.	This is a poor evaluation. The patient was developing or had cirrhosis but this was unrecognized.
6/8/2014	Labs from a hospital emergency department: WBC 5.03; platelets 120; glucose 145; When the patient entered the hospital their knowledge of his medications were furosemide, Carvedilol and Simvastatin. At the hospital they diagnosed chest wall pain and prescribe Flexeril and Motrin.	

6/8/2014	An LPN documented ad emergency transfer form indicating that the patient had chest pain and fainting outside of chow hall and was sent to the hospital. The LPN listed his current medications as Simvastatin, Carvedilol and furosemide.	The patient's medications had changed since his last provider visit on 3/18/14 and it wasn't clear how this happened.
7/11/2014	A provider saw the patient whose weight was 193. The provider wrote "Pt has no complaints today. Was seen in ED-8th; no c/o CP or SOB He continues to smoke - needs to quit No DOE". That was the entire note. There was little pertinent history and no physical examination. The patient's problems including advancing cirrhosis and CAD were not addressed.	This was extremely inadequate note. The patient had not been adequately evaluated for almost 4 months and had recently been in the hospital. He should have had a thorough evaluation. The history needs to be probing with respect to the patient's conditions. That a patient has no complaints is insufficient as a history. The history needs to include questions pertinent with respect to the patient's conditions.
7/16/2014	The patient had an EKG showing bradycardia with 1st degree block, anteroseptal infarct age indeterminate, and STT wave abnormalities.	There was no follow-up of this abnormal EKG placing the patient at risk of harm.
8/17/2014	The inmate received a 30-day supply of medication for his end of sentence. His medications apparently given to the patient included Zocor, Coreg, Lasix, Norvasc, aspirin, Lisinopril and potassium	
12/23/2014	The patient was re-incarcerated and had another intake physical examination by an NP at Kilby. The NP took no history. The patient had 2 + pitting edema otherwise no abnormalities noted. The only assessment was hypertension 45 years ago. The NP didn't order medication for a week. The NP did not document vital signs.	This was an extremely poor examination. This patient had multiple incarcerations yet the staff appeared unable to obtain the prior records. The NP doing the intake physical failed to identify multiple serious illnesses including heart failure, prior heart attack, significant liver disease (probable cirrhosis) and hepatitis C. At a prior incarceration, the patient wasn't treated for his hepatitis C because he was being discharged. He should have been given an opportunity for treatment.
12/30/2014	Intake TST was 0 mm read on 1/1/15.	This indicates a very broken TB screening program as this person went from positive to negative to positive to negative over sequential incarcerations.
12/31/2014	The NP who did the intake physical ordered Lisinopril and aspirin as his only medications.	
12/31/2014	CXR showed cardiomegaly.	This did not appear to be followed up even though it was consistent with heart failure.

12/31/2014	an RN did a new arrival screening (form 4) identifying that the patient denied hepatitis C but identifying history of stroke, heart condition, high blood pressure, asthma and alcoholism. The nurse document PEFRs of 250/250/200. The RN did a better history than the NP on 12/23/14 even though it was partly inaccurate. There was no evidence for asthma or stroke. On a form 3 the same nurse on the same day documented that the patient had shortness of breath with a complaint of asthma and a problem with his left leg.	The shortness of breath may have been from heart failure but was not evaluated.
12/31/2014	An unknown staff member documented a hepatitis C flow sheet documenting that the patient had dementia, hepatitis C, CAD and heart failure. The column under "will patient consent to treatment" was blank and not filled out.	There had been no evaluation for dementia so this diagnosis was made without corroborating evidence. There was no history or physical examination to support or refute the diagnosis.
12/31/2014	CO2 21; AST 53, T4 17.5; creatinine 1.33, bilirubin 1.4 free t4 index 4.7 (normal 1.5-3.8); T3 217 (normal 72-180)	These abnormal labs indicating liver, thyroid, and kidney diseases were not followed up on.
1/4/2015	EKG PVCs LAD, inferior and anteroseptal infarcts age indeterminate.	This abnormal EKG was not followed up on
1/5/2015	A doctor admitted to P ward with acuity of yellow	
1/5/2015	A doctor admitted the patient to the infirmary. He was placed on the assisted living unit. The history was that the patient had been released from prison but was re-incarcerated due to vagrancy. He apparently had been short of breath for 3 days but had not reported it. There was no other history of his symptoms or his multiple conditions. The BP was 110/80. The physical exam section had the acronym "WNL" written with a line going through the entire examination indicating that the entire examination was normal. The doctor documented that the patient had slow mentation but did not make an attempt to determine why this was so. Notably despite a staff recording that the patient had dementia on the 12/31/14 hepatitis C flow sheet, the doctor took no history of this and appeared to not recognize whether there was any cognitive disorder. There was no assessment and the plan was admission for ADL assistance and medication compliance. Since there was no history and the examination was said to be WNL it isn't clear why the patient needed ADL assistance. The discharge goal was to maintain in sheltered housing unless his condition improved.	The doctor failed to perform an adequate history and failed to complete a thorough physical examination based on the patient's presentation. Although the patient was placed on an assisted living unit, there was no evidence either in the history or physical examination of a problem. Although the patient was determined to need assistance with activity of daily living the physical examination was documented as normal. Little prior history was noted. The patient's problems were not addressed. Abnormal labs from 12/31/14 including abnormal liver functions, renal function and thyroid function were not acknowledged or addressed. It seemed like the doctor didn't care.
1/5/2015	Atorvastatin was added	

1/6/2015	Furosemide was added.	
1/15/2015	Potassium was ordered and furosemide was increased to twice a day from once a day.	
1/15/2015	This is the first evaluation from the doctor since he admitted the patient to P ward 10 days previous. He noted that the weight was increasing but didn't document what the weight was. The BP was 160/100; the patient had 2-3+ edema of the extremities. The problems were listed as heart failure with coronary atherosclerotic disease, high blood lipids and dementia. The hepatitis C and hypertension were not noted. The doctor increased the Lasix. This is the first diagnosis of dementia on a doctor's note but there was no history or physical examination that documents the reasoning for the diagnosis. The doctor stated what the patient's diagnoses were without documenting an accompanying history or physical examination.	This is poor care. The doctor makes a diagnosis without taking a history or performing a physical examination required in order to make that diagnosis. The doctor also didn't determine why the patient was gaining weight. Notably, the doctor appears to fail to acknowledge the patient's hepatitis C and probable cirrhosis which could have caused the weight gain. The doctor should have ordered tests to evaluate why the patient had edema.
1/16/2015	Labs glucose 124; CO2 21	
1/20/2015	Daily weights were ordered.	
1/21/2015	WBC 4.92	
1/22/2015	The doctor evaluated the patient and documented no new complaints. The weight decreased from 226 to 220. The examination was documented only as not changed except for a decrease in edema with the phrase "not weeping anymore". Notably the doctor had never documented that the patient had weeping from his extremity edema. The electrolytes were noted. There was no change to the plan. Weeping edema would be significant edema that warranted investigation. It wasn't clear why the patient had edema. The doctor noted the abnormal glucose of 124 but did nothing.	This is another example of findings appearing that were not identified before but with documentation indicating that the finding had been present for a while. This is poor care. The doctor may have assumed that the heart failure was due to the patient's heart failure but he didn't say so. Since the edema could have been due to cirrhosis, additional evaluation was indicated (CXR, abdominal ultrasound to assess for cirrhosis). The doctor did not follow up on an abnormal glucose level.
1/22/2015	The doctor discontinued the patient from chronic clinic follow-up and stated in the order that he would follow up on the patient on P ward. However, the doctor was not following all of his conditions.	Apparently, the patient was assigned permanent P ward housing.
1/23/2015	The doctor ordered oxygen to maintain an oxygen saturation of 90%	It was not clear in the doctor's notes what the indication for the oxygen was. This was very poor documentation.
1/24/2015	A nurse documented on a weight flow sheet that the patient couldn't be weighed because he couldn't stand. On 1/20/15 the weight was 226 pounds.	This is a significant finding. From physical examinations, it isn't clear why the patient couldn't stand.
1/24/2015	Glucose 101; CO2 21; creatinine 1.45	The abnormal labs were not addressed.

1/25/2015	The doctor ordered the patient moved to an isolation bed on P ward.	It isn't clear from documentation why this was done.
1/25/2015	The doctor gave a phone order for Augmentin for ten days. There was no associated note.	This is poor care. If the doctor thought the patient had an infection, the patient should have been examined.
1/27/2015	A provider filled out a chronic disease clinic initial baseline medical data form. Hepatitis C, dementia, hypertension and cardiovascular disease are listed as problems. Shortness of breath, orthopnea, leg swelling, prior heart attack, dyslipidemia, weight gain, foot problems, nocturia and polyuria are all listed as symptoms or problems. The provider added cellulitis and diuretics as details to the symptoms. This type of history is unintelligible as cellulitis is a diagnosis and diuretics are a medication. 3 problems were listed: heart failure associated with atherosclerotic heart disease, high blood lipids and dementia.	The cirrhosis and hypertension and possible infection are not addressed. It is possible that the patient had anasarca from end stage cirrhosis which was unrecognized or from heart failure which was not being appropriately managed. The provider is a gastroenterologist; there was no excuse in not evaluating the patient's abnormal liver function tests.
1/28/2015	The patient complained to nurses that he had sores on his feet and his legs hurt. The nurse noted redness and blisters on bilateral lower extremities.	These symptoms and signs (pain and sores) are consistent with vascular insufficiency. A blistering lesion in an infected area portends a serious sign that is typically a medical emergency.
1/30/2015	Aspirin was ordered.	
2/1/2015	A nursing rounds form documented that the patient had painful legs with edema to feet and ankles. The nurse instructed the patient to use the oxygen when he was short of breath. This was not the order which was to maintain the O2 saturation to 90%. The nurse did not document the oxygen saturation.	If the patient had decreased oxygen saturation from heart failure he should have had an x-ray and further evaluation. Pain in the extremities at rest is a sign of advanced peripheral vascular disease which was not ever evaluated for. It did not appear that the doctor was reading the nursing notes.

2/2/2015	A doctor saw the patient and documented that the patient was found in his room filthy and not having taken a bath with urine on the floor and not using his oxygen. There was an order starting oxygen on 1/23/15 but there was no note documenting why he was starting oxygen. The O2 sat was 85% but increased to 98% on 2 liters. The doctor did no mental status evaluation. The extremities were noted to be warm with swelling and ulcers. The doctor did not even check the pulse of the foot. The doctor assessed "hypoxemia [secondary] to noncompliance" CAD with CHF, cellulitis of the lower extremity not resolving with Augmentin, high blood lipids and dementia. The doctor added Septra, and wrote an order to improve hygiene and ordered a CBC and BMP.	This falls below the standard of care. The patient has altered mental status [urine on the floor and not bathing] and the doctor blamed the patient for not using his oxygen and recommends better hygiene when obviously the patient couldn't care for himself. This is the first note indicating that the patient was being treated for cellulitis. Apparently there was a verbal order for the medication but no note was written. This is very poor care. The abnormal liver function was still not identified. If the doctor thought that the weeping legs were from infection a blood count should have been ordered well before this visit. Despite signs and symptoms of peripheral artery disease being present, the doctor never examined the patient for this including taking the pulse of his lower extremity which is a very simple examination to perform. The patient wasn't assessed for heart failure. The significant change in mental status along with the low oxygen saturation and signs of infection warranted hospitalization or at a minimum laboratory testing to assess the patient.
2/2/2015	An LPN documented on an assisted living assessment form a pulse of 102 and oxygen saturation of 85%. The nurse documented under "urine frequency" "no problem". The nurse's note appeared to indicate no problems with the patient except skin lesions on the feet. There was no documentation that the nurse called a physician or intervened with respect to oxygen therapy. Later the same day a note by the doctor indicated that the patient was found filthy with urine on the floor and not using his oxygen. The LPN's note appeared different from the presentation of the patient by different staff on the same day.	The nurse note that there were no problems with urination seem difficult to believe as on the same day the patient was urinating on the floor. The oxygen saturation of 85% is a life-threatening low level.
2/2/2015	A nurse documented on a wound care flow sheet that the patient had purulent drainage from lower extremity wounds from 2/2/15 to 2/8/15.	Purulent drainage is indicative of infection.
2/2/2015	The doctor evaluated the patient for "severe weeping" of his legs. The temp was 98.4. The patient had edema of his legs with an ulcer. The doctor diagnosed cellulitis, CAD with CHF, HLP, and dementia. He ordered to continue Septra and to start Dicloxicillin with dressing changes. He increased Lasix to 60 BID and ordered a CBC and CMP	Edema with ulcers are indicative of infection which the doctor diagnosed. The infection had been ongoing for over a week and appeared worsening. Given the low oxygen saturation and tachycardia, the patient should have been considered for admission to a hospital. A non-healing ulcer should have prompted evaluation for vascular insufficiency by at least taking a pulse of the foot.

2/3/2015	The doctor ordered to clean the wound with an antiseptic and then to put silvadene cream on it with a dry dressing and to elevate the feet.	
2/3/2015	Glucose 145; creatinine 1.18	
2/10/2015	The doctor documented no new complaints. The leg was still weeping. The doctor documented that weights were not being done. He made no change to the assessment or plan. He did not take note of the elevated glucose of 145. He didn't take a pulse of the foot.	The patient should have been considered for admission to a hospital.
2/15/2015	From 2/15 through 2/21 nurse wound flow sheet documents purulent drainage throughout this time period.	The patient should probably have been admitted to a hospital.
2/17/2015	A doctor saw the patient and documented no new complaints. There was decreased edema to trace edema but the ulcers were still present. The doctor said that the cellulitis had resolved. Doctor seemed to attribute the edema to CHF as he indicated in the assessment that the CHF had decreased. Stasis ulcer HLP, cellulitis and dementia were also diagnosed. He planned to continue diuresis.	The doctor failed to consider cirrhosis even though the patient had evidence of this disease. It was possible that the edema was from cirrhosis but this condition remained unrecognized because providers had ignored abnormal liver function tests.
2/24/2015	The doctor stated that the patient had increased energy and strength because he attempted to fight another inmate. He documented that the patient was picking sores on the lower extremity ulceration. There was no history, no physical examination except the words "N/C" or no change documented and the assessments and plan were documented "as above, CPM".	
2/26/2015	EKG shows PVCs with LAD, LAFB, and inferior and anterolateral infarcts age indeterminate.	
2/28/2015	A nurse on the wound care flow sheet documented notifying the doctor about a 1/2 cm open area on the right foot.	The patient had unremitting infections on his legs were not responding to outpatient management. He should have been hospitalized.
3/3/2015	The doctor ordered a mental health referral because he had "no desire to live". He also ordered TSH, T4, T3 CBC and CMP	

3/3/2015	A licensed counselor evaluated the patient as a mental health referral due to a statement by the inmate that he didn't want to live. The counselor documented that the inmate denied making that statement. He told the counselor that he was distressed from continued pain from diabetes and wanting to be back in the community. He said that he didn't have long to live and wanted to be released back to his community. The counselor noted "erratic breathing as if having difficulty catching his breath but regaining control when prompted to stop and take slow breaths". He was also inattentive during the interval "occasionally rubbing and shaking his legs with sighs of pain". The counselor found no mental health problems. Of note the patient seemed cognitively aware.	The patient's breathing difficulties and problems with his legs were evident to a non-medical person. This non-medical person noticed that the patient had pain in his legs, a symptom of vascular insufficiency. Yet the doctor never asked the patient this question even though the patient clearly had this symptom. Nurses had also documented on 1/28/15 and 2/1/15 that the patient had pain in his legs.
3/4/2015	Albumin 3.2; glucose 112; bilirubin 2.3. creatinine 1.38 AST 97; ALT 54; T4 16.7 (normal 4.9-12.9); T4 index 4.9 (1.5-3.8)	These indicate significant liver disease and thyroid disease but were not followed up on.
3/8/2015	Pulse 114	
3/9/2015	A nurse noted that the patient was incontinent.	This is a serious event and indicates significant mental deterioration. The mental status changes should have resulted in hospitalization.
3/10/2015	A nurse noted that the patient had bilateral leg lesions.	
3/10/2015	The doctor evaluated the patient and noted incontinence yesterday. His physical examination documented no edema with stasis ulcers described as dry. The weight was not taken. The only problems noted were atherosclerotic heart disease with heart failure, HLP, and dementia. The abnormal labs including signs of significant cirrhosis, elevated creatinine and elevated thyroid hormone were not documented or reviewed.	This physician ignored major laboratory findings and still lacked a diagnosis as to the reason for the development of the ulcers. The doctor continued not taking any history with respect to the patient's problems. He did not note the prior mental health evaluation. He did not evaluate why the patient was incontinent. He did no evaluation to determine why the patient had "dementia" and had not yet performed a physical examination or testing to determine whether this was an accurate diagnosis. To exclude new onset dementia a CT scan should have been done. The doctor failed to evaluate significant abnormal lab results. The patient had ulcerations on his feet for over 2 months. Yet the doctor did not evaluate for vascular insufficiency including not even taking a pulse of the foot or taking a history of leg pain. The doctor did not consider infection or the need for intravenous antibiotics which were indicated because the infections were not responding to oral antibiotics. The patient should have been sent to a hospital.

3/12/2015	A wound care flow sheet from 3/12/15 through 3/17/15 noted that the patient had serous purulent drainage and that the wound was unchanged.	This indicates that the patient should have been admitted to a hospital. The unremitting ulcerations were not healing and the doctor should have assessed the patient for vascular insufficiency.
3/14/2015	Pulse on nursing rounds of 123	This is a significant abnormality. The vital signs were becoming abnormal indicating more serious disease and possible sepsis.
3/17/2015	The doctor documented that the patient was non-compliant with medication and wanted out of prison. The doctor failed to address how it was that a patient with "dementia" was non-compliant. The patient's altered mental status had never been evaluated so it is difficult to ascribe it to dementia. It may have been due to his infections. The doctor failed to assess whether the patient's mental status affected his ability to take his medication. He took no history of the patient. He documented that he discussed the assessment and plan with the mental health team. He noted that the patient had expressed a desire to die "previously". He noted that the patient had previously not been capable of ADLs but was now doing better. He indicated that psychiatry would see the patient. He did not address the pulse of 123 on 3/14/15. He didn't document an examination only noted that there was no change.	The doctor's diagnosis of dementia was inconsistent with his statement that the patient was non-compliant. If the patient had dementia his cognitive function would be such that one would expect non-compliance due to his cognitive status. The doctor had not yet made an appropriate diagnosis with respect to the patient's altered mental status. The doctor documented no examination of the patient.
3/17/2015	A psychiatrist saw the patient and described him as clear and coherent and alert and oriented. He diagnosed depression and started medication. The psychiatrist stated that the patient was homeless and was repetitively incarcerated but wanted to go home.	This is inconsistent with the doctor's documentation.
3/24/2015	The doctor evaluated the patient. He noted that the patient was on a psychotropic medication and was more subdued. No assessment or plan was made. He noted that there was no edema but didn't examine the ulcers.	The doctor still had not evaluated the abnormal labs of 3/4/15
3/25/2015	The wound flow sheet from 3/25 through 3/30/15 document purulent drainage with eschar on the wound. This is the first time an eschar was described. Eschar is necrotic tissue.	An eschar indicates dead tissue which should have been evaluated. This indicates a serious infection and was consistent with end-stage vascular insufficiency and early gangrene.
3/26/2015	A mental health worker described the patient as short of breath during the interview.	This was not picked up by physician evaluations.

3/26/2015	The inmate fell and was evaluated by a nurse who noted 4 sores below both knees and on the right foot and left shin. The wound on the foot was open.	
3/26/2015	The doctor saw the patient and documented that the patient was short of breath. He took no other history. There was 1+ edema. He noted erythema but no increase in warmth or tenderness. Notably nurses on the flow sheets had been describing eschars which indicated necrotic tissue; this was either not noticed or ignored. Multiple nurses made this observation between 3/25-3/30. He increased the Lasix to 60 mg BID and documented no cellulitis. HLP and dementia were the only other diagnoses. He again did not address abnormal labs.	This evaluation was a departure from standard of care. It did not appear that the doctor was examining the patient carefully.
3/26/2015	A nurse saw the patient for wheezing at 4:20. The nurse noted a 0 mm TST, shortness of breath and a respiratory rate of 26. The patient was wheezing bilateral. The nurse called the doctor but didn't document the conversation. The nurse sent the patient back to his housing unit. The doctor stopped the 60 mg of Lasix BID and ordered a lower dose 40 mg BID. This was not documented on the nursing note but was on a prescription. It isn't clear whether this was a phone order. There was no evidence of a face to face visit by the doctor.	The patient should have been evaluated because of wheezing in a patient with heart failure. Also, it appears that an error was made in that the doctor ordered a lower dose of diuretic when the patient had worsening findings.
3/27/2015	Jackson hospital labs creatinine 1.3; sodium 135; WBC 7.3; BUN 21; troponin I= 0.43 (normal 0--.04); CK=MB 11.2 (normal 0-5). These tests were signed on 3/30/15. The tropinin test is typically used to evaluate for myocardial infarction. These were reported at 6/27/15 at 6:54 am.	It is not clear why these labs were ordered. The patient had elevated troponins which can be a result of a myocardial infarction but can also be a result of a number of different problems including being critically ill, sepsis, heart failure, renal failure, etc. In any case this abnormal test needed to be promptly evaluated. The patient should have been admitted to a hospital. Although the doctor documented some of these labs on his 3/27/15 note, he signed the labs as reviewed on 3/30/15. The troponins required prompt attention but this did not occur.

3/27/2015	The doctor evaluated the patient at 8.25 am and documented the "Pt appears to have fein illness yesterday" without explaining what he meant. He noted that the patient had a fall and said that the patient exaggerated trauma. He noted that the patient was short of breath. There was 1+ edema. The doctor noted some of the lab values but failed to note the abnormal liver function tests, abnormal thyroid tests, and most importantly the elevated troponin test. The test was reported to the facility only 2 hours earlier so it may not have been available. However it was a critical value. He made no assessment. He ordered a chest x-ray. He did not examine the ulcers.	The doctor was inferring that the patient was malingering when it appeared otherwise. The doctor continued to fail to take an adequate history. The failure to note the abnormal lab values may have been due to the test result just being reported 2 hours before the doctor saw the patient. The doctor continued to fail to realize that the patient had cirrhosis which may have been responsible for some of his symptoms. He did not address the mental status issues. This physician did nothing to evaluate the ongoing foot ulcers that had been present for months and hadn't even taken a pulse of the foot. At this point one should have considered osteomyelitis or vascular insufficiency.
3/27/2015	CXR bilateral interstitial markings indicating mild pulmonary edema or atypical pneumonia. The radiologist noted the film was worse that the film of 12/31/14.	
3/30/2015	The doctor saw the patient and noted the right foot pain but took no other history. He didn't examine the foot except to note no edema. The CXR showed increased interstitial markings. He noted that the Lasix had already been increased. He made not assessments and no changes to the plan.	To note that a patient has foot pain and to take no history of it and perform no physical examination of the foot shows a lack of concern for the patient. Nurses had been noting eschars on the foot. Eschars and foot pain suggest vascular insufficiency and early gangrene.
3/30/2015	The doctor ordered CBC, CMP, Cardiac enzymes and an EKG by phone.	The doctor had reviewed the labs reported 3/27/15 on 3/30/15 so it was just coming to his attention that the troponin was elevated. Instead of hospitalizing the patient or re-assessing the patient, the doctor re-ordered the lab. For the safety of the patient, the patient should have been hospitalized. This endangered the patient. The patient wasn't examined again for 3 days.
4/3/2015	The doctor evaluated the patient who complained of foot pain. The doctor examined the foot and noted a necrotic ulcer on the dorsum of the foot with the foot cool to touch. He diagnosed gangrene and cellulitis and sent the patient to a hospital.	The evidence for gangrene had been present for over a week. The patient had elevated troponin indicating a possible heart attack. Despite this the patient was not timely admitted to a hospital. This harmed the patient.

4/3/2015	A hospital admission note documents that the patient was a poor historian and was sent to the hospital for gangrene. The doctor noted that the prior history was CVA with dementia based on the records from the correctional facility. The doctor apparently was told that the patient had a wound that started about a week prior to hospitalization when in fact it started about 3-4 months before hospitalization. The patient complained of increasing pain in the foot, pus draining and blackish discoloration of the toes and foot which "started two days ago" He had multiple pustular drainage over the foot. It hurt to walk. While interviewing the patient, the doctor heard wheezing but thought it was from anxiety. He was afebrile. An x-ray of the foot showed subcutaneous gas in the soft tissue. There were no bony lesions. A chest x-ray showed enlarged heart, interstitial edema and small right pleural effusion. The admitting examination of the foot was: "2+ pitting edema in both the lower extremities and the right leg is much more swollen than the left. He has this blackish discoloration of the skin over all of his toes and also all over the foot area with a large ulcer over the dorsal aspect of the right foot with pustular foul-smelling wound base. He has also this pus drainage from the intertriginous area between the toes. He has erythema over the right leg area, tender to touch. Cannot palpate any pedal pulses on both sides but the left foot is warm to touch". The labs were troponin 0.39; BNP 2300; BUN 26; creatinine 1.3; AST 172; ALT 101; total bilirubin 8.2; INR 1.44; WBC 8.6; platelets 115. Right foot gangrene was diagnosed with acute heart failure, mild renal insufficiency, elevated transaminases. The Doppler study showed severe arterial insufficiency of the lower extremity. A thrombus in the left subclavian, cephalic and axillary and brachial veins. The patient had amputation of the right foot. The hospital discharge summary was not included.	The patient's condition was neglected at the prison. His vascular insufficiency was not attended to or evaluated even though the patient had ongoing symptoms (leg pain, non-healing ulcers). The gangrene was not identified for over a week. The initial hospital examination was a stark contrast to prior examinations at the prison demonstrating the deficiency of thorough physical examination.
4/9/2015	While at the hospital the patient had a left arm Doppler that verified a thrombus in the left subclavian, cephalic, axillary and brachial veins.	This required Coumadin therapy.

4/10/2015	The patient was returned to prison and admitted to P ward on Coumadin, Coreg, aspirin, Lovenox, Tylenol #3, Prilosec, Motrin, Lasix, Lipitor, and Lisinopril. INR was ordered every Tuesday and Thursday. There was no discharge summary in the medical record. The initial admission orders were not signed until 4/18/15 about 8 days after admission.	The doctor did not review and sign his phone orders admitting the patient for 8 days.
4/10/2015	The patient was returned to prison and admitted to P ward on Coumadin, Coreg, aspirin, Lovenox, Tylenol #3, Prilosec, Motrin, Lasix, Lipitor, and Lisinopril. INR was ordered every Tuesday and Thursday. The doctor performed the intake history and physical. The history noted severe PVD, CHF with atherosclerotic heart disease and psychosis. The reason for diagnosing psychosis was unclear as was the diagnosis of dementia. The doctor did not assess cirrhosis or liver disease even though there were indications that the patient might have this disease. The patient was diagnosed with pre-diabetes at the hospital and this was noted. The history included that the patient had a below knee amputation. The doctor noted that the patient was uncooperative with removing his pressure dressing but this was unclear. The pain was 7/10. The doctor wrote WNL and drew a line this statement through the entire physical examination with the exception of documenting that the patient had a pressure dressing on the RLE which was intact and that the patient had edema of the upper and lower extremity. The doctor did not note the INR but the doctor noted that the patient was on DVT prophylaxis. This was not correct as the hospital diagnosed multiple thromboses in the upper extremities. In the hospital the A1c was 6.2. It wasn't clear if the hospital discharge summary was available. The instructions were to continue Coumadin for 3 months and to stop Lovenox when the INR was 2. The surgeon recommended follow-up in a month.	The doctor didn't appear to know that the patient had deep vein thromboses of the arm veins; instead that doctor thought the patient was on DVT prophylaxis. The physical examination appeared careless and was not thorough. The physician failed to identify all of the patient's problems (cirrhosis and DVT).
4/11/2015	A RN noted increased edema of the L arm.	
4/12/2015	An LPN noted wheezing in the left lung and reported it to her supervisor. A doctor wasn't notified and vitals were not recorded.	Abnormal finding such as wheezing should be reported to a physician and vital signs should have been taken.

4/14/2015	At about 1 am an RN noted that the patient was restless and making grunting noises and "bothering" his stump dressing. A doctor was notified but no orders were received. The nurse did not perform vital signs. The nurse noted instructions to refer the patient to mental health in the morning.	The nurse should have performed vital signs. This was a poor emergency nurse evaluation.
4/14/2015	At about 1:30 am the doctor was called because of continued restlessness. The doctor instructed the nursing staff to talk to the inmate. The inmate was moved to a different bed with guard rails but shortly after moving the patient, the patient fell. The nurse did not assess the patient and had not performed vital signs. The inmate was moved back to the "ward". The inmate continued to sigh, grunt and make loud noises.	The nurse should have performed vital signs. This was a poor emergency nurse evaluation. Also the patient had new onset altered mental status. If he could not be immediately evaluated by a physician he should have been sent to a hospital.
4/15/2015	When the patient was referred to mental health. The reason was to re-evaluate for restarting Triavil. The altered mental status was not mentioned. The psychiatrist found no abnormalities and restarted the Triavil.	
4/15/2015	The doctor increased Lasix to 80 BID and started Spironolactone 25 daily.	
4/15/2015	A nurse noted at 12:40 pm that the stump wound was bleeding. The nurse didn't document calling a doctor but documented no new orders were received.	Although there was an order for INR to monitor anticoagulation, the doctor wasn't documenting these results. Bleeding in a person on anticoagulation should prompt an INR test.
4/15/2015	At 10:45 am the doctor evaluated the patient and documented no new complaints and noted that the patient was agitated the night before. No other history was taken to identify whether the patient had altered mental status. The doctor did not evaluate the mental status of the patient. He noted 2 + edema of the left upper extremity and noted left thigh edema. He noted that the dressing was intact but bloody. He increased Lasix to 80 mg and started Aldactone. He did not address the abnormal liver function tests and did not check the INR even though the wound was bleeding.	This was a poor evaluation. The anticoagulation status wasn't checked despite a bleeding episode. A new mental status change was not evaluated. The abnormal liver function tests were not evaluated. These deficiencies placed the patient at risk of harm.

4/16/2015	At 9:10 am the doctor evaluated the patient for significant bleeding from the stump from "persistent hanging leg down despite being repeatedly asked not to do that". The doctor seemed to blame the patient for bleeding when the patient was on multiple anticoagulants (Coumadin, Lovenox and aspirin). The doctor noted vital signs and noted hematoma of the stump with increased swelling and a bullae but intact staples. 3+ edema was noted on the left. The doctor held the Coumadin without even checking an INR and increased the Lasix to 120 mg. Then he noted he was sending the patient to the ER for wound complications.	The directions given to the patient were wrong. Patients with vascular insufficiency have increased pain when their leg is elevated due to poor blood flow. Patients with vascular insufficiency find that the pain is relieved by hanging their feet over the edge of the bed because of the gravitational effect on extremity perfusion. The doctor was giving the patient the wrong information and blaming the patient when the patient was attempting to relieve his pain. This was cruelty based on ignorance.
4/16/2015	At the hospital a CT scan showed bilateral pleural effusions with an enlarged heart. The liver was without focal abnormality. There was a 4.5 cm cyst on the right kidney. There was a probable post-operative hematoma at the operative site. Diffuse anasarca was noted worrisome for heart failure. A CT scan of the brain showed volume loss without hemorrhage suggestive of chronic ischemic insults. There was no deep vein thrombosis of the lower extremity. A culture of the wound identified staph. The albumin was 2.1; AST 92; ALT 50 and bilirubin 3.6.but was 8.2 on admission; INR on 4/16 was 1.54; on 4/16/15 the WBC was 10.9. The patient was discharged on 4/17 with diagnoses of L upper extremity DVT, BKA R, Left PVD; diabetes, CAD, HTN, high blood lipids, hepatitis C and PVD. Blood had been drawn at the prison prior to going to the hospital and the glucose was 155. The prison doctor had asked to have the patient be sent back to the prison. The patient still had an infected foot and was discharged on Zosyn but was sent back to the prison as requested.	The patient had infection of the opposite leg and was discharged on intravenous antibiotics. The patient was discharged prematurely from the hospital when the prison was not able to provide the necessary care.
4/17/2015	A nurse received phone orders for Augmentin Septra, INR Tuesday and Thursday, Coreg, Lovenox, Coumadin, Prilosec, Lisinopril, Lipitor potassium and Lasix 60 BID. The patient was discharged on Zosyn but oral antibiotics Augmentin and Septra were used instead. There was no reason why the IV antibiotics were not continued.	The patient needed intravenous antibiotics but oral antibiotics were given. This placed the patient at risk of harm. If the intravenous antibiotics couldn't be given the patient should have returned to the hospital.
4/18/2015	The doctor gave a phone order to hold Coumadin until the bleeding subsided. Lasix was increased to 100 mg BID with a stat dose of 40 mg.	This was done apparently without benefit of testing the INR for the degree of anticoagulation. Failure to give Coumadin placed the patient at risk for further clotting in his deep veins.

4/18/2015	The doctor ordered a surgical follow-up.	
4/18/2015	A nurse at night noted blood tinged urine and noted swollen penis, testicles and generalized edema. The nurse called the doctor about the swollen testicles and he increased the Lasix to 120 BID with 40 mg stat.	
4/19/2015	At 11 pm a nurse noted that the patient was found on the floor between the toilets. He was assisted back to bed by a nurse. The nurse did not perform orthostatic vital but the BP was 100/78 and pulse 77	This was a serious event. A doctor should have evaluated the patient.
4/20/2015	Even though the patient returned from the hospital on 4/17, the doctor didn't evaluate the patient until 4/20/15. He wrote almost no history with respect to testing done at the hospital and noted that the Coumadin was being held. He didn't document the INR. Apparently the patient was still on Lovenox. Again, he wrote WNL with an arrow through the entire formatted physical examination except to document anasarca and a dry dressing on the right leg stump. The left leg infection wasn't examined. He noted that an intravenous line couldn't be establish so oral antibiotics were being used while awaiting cultures. He restarted Coumadin and increased diuretics.	The patient has a swollen arm and heart failure and an infected left leg with peripheral vascular disease identified at the hospital and the doctor documented an exam WNL. He failed also to identify why the patient needed antibiotics but at the hospital the L foot was foul smelling. IV antibiotics should have been continued but the doctor brought the patient back to prison even though they couldn't properly care for him (i.e. give him his IV antibiotics). If they couldn't start an IV line the patient should have been re-hospitalized. This placed the patient at risk of harm.
4/20/2015	Warfarin was started at 7.5 mg and Lasix at 120 BID was ordered for 6 months.	
4/20/2015	BUN 30 creatinine 1.53	
4/22/2015	Glucose 104; BUN 22; creatinine 1.34; albumin 2.3; bilirubin 2.8; AST 111; ALT 58; creatinine kinase 1034 (normal 21-300); c reactive protein 16 (normal 0-1); WBC 7.3; platelets 238K	The c-reactive protein was markedly high and was highly suggestive of infection. The patient was not responding to oral antibiotics and needed intravenous antibiotics. He should have been hospitalized.
4/22/2015	The doctor saw the patient and took no history but stated that he wasn't sure if round orders were carried out. He noted anasarca but didn't weigh the patient. He noted blood on the dressing and blisters on the left lower extremity which was cool to touch. He noted diagnoses of R BKA with heart failure, RUE DVT and high anion gap metabolic acidosis. He suspected infection and ordered a number of tests. However, a blood gas is typically utilized to differentiate the various causes of this condition. Also, lactic acidosis can occur from tissue hypo perfusion and the left leg infection may have been the cause. He calculated that the anion gap was 18 which it was.	A cool to touch extremity with blisters indicate a medical emergency. The extremity had a high risk of vascular insufficiency. Since the patient had acidosis (indicative of systemic infection), the patient should have been sent to a hospital as the patient needed a higher level of care and IV antibiotics. The INR had not been checked since returning from the hospital. To keep the patient at the prison endangered the patient.

4/23/2015	The doctor saw the patient who had new blisters developing on the left leg. The temperature was 98. He noted the abnormal CK and abnormal labs. The anion gap was now 8 but he stated that the patient still had HAGMA. He suspected that the tissue ischemia was resulting in the elevated CK which is probably right. He noted that the anasarca was due to CHF or ESLD. For the first time he acknowledged probable cirrhosis. He did not change therapy. If the patient had ESLD and an ischemic leg the patient probably should be back at the hospital on IV antibiotics and may need a 2nd amputation as he had significant ischemia. The doctor stopped the Lovenox but had yet to check an INR since return from the hospital.	Not checking the INR, not sending the patient back to the hospital with signs (foot presentation and abnormal labs) placed the patient at significant risk of harm. He was probably going to lose his leg but he could lose his life. Not to check an INR placed the patient at risk of harm. To stop the Lovenox when the patient had a deep vein thrombosis risked additional life-threatening clotting. The patient was in danger and needed hospitalization.
4/23/2015	A nurse noted purulent drainage from the R stump. The nurse noted that the doctor evaluated the wound. The nurse noted that the left foot had serous drainage with multiple open areas and blisters. The leg was dark and cold to touch. The nurse noted that the doctor evaluated the leg.	The left leg had vascular insufficiency and both legs were infected. The patient needed to be hospitalized.
4/23/2015	The patient told the daytime nurse that he needed to go to the hospital. The nurse noted upper and lower extremity edema. The extremity was cool to touch.	The patient was right and needed to be hospitalized. The extremity being cold to touch was an ominous sign for the left leg which was also infected. The INR wasn't being monitored which placed the patient at risk of harm.
4/24/2015	Lovenox was discontinued.	
4/25/2015	The patient told the evening nurse that "I'm leaving here soon, see how swollen I am". The night nurse noted generalized edema and noted that the doctor was aware.	
4/26/2015	A nurse during daytime noted that the patient was sluggish. At night the patient was moaning and grunting. The vitals were 110/72; 82 pulse and 97.1 temp	

4/27/2015	The doctor evaluated the patient using a chronic disease form. The patient had shortness of breath and abdominal and ankle edema. The doctor took no additional history except for the check box format responses. He didn't ask the patient about bleeding, pain. He wrote WNL and an arrow through the head, heart lung and abdomen examinations. He wrote anasarca in the extremity examination. He only diagnosed heart failure, LLE ischemia with severe PVD, and LUE DVT. He did not assess all of the patient's problems. He did not document the progress of the left foot infection and ischemia even though it might need amputation. He did not check for infection even though prior lab tests indicated possible infection and sepsis (Increased c reactive protein with an infected appearance to the leg). He wrote that the patient would need a left foot amputation.	The patient should have been admitted to a hospital for evaluation for possible amputation and intravenous antibiotics. The patient needed more intensive monitoring than he was getting. The doctor failed to assess multiple problems including coagulation with an INR, diabetes, and liver disease. The assessment of the ischemic leg was inadequate. The doctor was placing the patient in significant risk of harm.
4/28/2015	The doctor ordered Augmentin and Septra, two oral antibiotics.	The patient was not responding to oral antibiotics. He needed intravenous antibiotics and needed to have his leg evaluated. The blistering was an ominous sign and was a medical emergency.
4/29/2015	The patient went for his follow-up vascular surgery appointment but was directly hospitalized apparently from the doctor's office. He had a chest x-ray at the hospital showing enlarged heart and an infiltrate in the right lower lung with an effusion. The vascular surgeon noted that the patient had been complaining about left leg pain for about two weeks and that the leg was red and swollen for about 2 weeks. The examination at the hospital showed multiple ulcerations of the left leg with extensive cellulitis extending from the foot to the mid-calf. The lactic acid was 2.8; BNP was 2468; d dimer 2.26; INR 1.96; WBC 14.8; platelets 288K, creatinine 1.34. He had right sided pneumonia and left leg cellulitis. He was put on broad spectrum antibiotics. They were going to try antibiotics but may need amputation. The patient was sent back to the facility on 5/4/15. The diagnoses were sepsis, gangrene of the left leg, cellulitis of the left leg. He required a BKA of the left leg. The patient was discharged on intravenous antibiotics. A doctor at the hospital noted necrotic margins of the right stump with an open ulcer overlying the knee. The left leg had multiple ulcerations of the leg, ankle and foot with	The presentation of the patient described by the doctor at the hospital was dramatically different from the prison doctor's physical examinations showing the deficiency of his evaluations. Not sending the patient to the hospital earlier placed the patient at risk from harm from the infected left leg and caused deterioration in the patient’s condition.

	bullous lesions on the foot. The leg was very tender. He was on discharged on vancomycin, Cefapime and metronidazole.	
5/4/2015	At 6 pm the patient returned from the hospital. He was supposed to be on Cefepime, Lovenox, furosemide 40 BID, insulin sliding scale, Duoneb hand held inhaler, metoclopramide, lorazepam as needed, metronidazole IV, morphine as needed, Zofran as needed, vancomycin IV, Carvedilol, Lipitor, Lisinopril, Albuterol, potassium and Protonix. The Coumadin had been discontinued. The hospital recommended that the prison physician see the patient within 24 hours. The patient left the hospital with a Foley catheter and had a PICC line. The prison doctor did not start insulin or continue the Cefepime and Albuterol. He did not indicate why he did not start these recommended medications.	Not starting one of the antibiotics possibly placed the patient at risk of harm.
5/5/2015	The doctor started warfarin at 5 mg even though the hospital stopped this medication as the patient was on a different anticoagulant Lovenox.	
5/6/2015	The doctor didn't see the patient for 2 days after hospitalization. He took no history or note what happened at the hospital. He did say that the inmate disturbed other patients during the night by moaning all night. He didn't attempt to find out why the patient was moaning. He didn't examine the patient except noting vitals. He noted continuing vancomycin and Flagyl but didn't say why he stopped Cefipime. He said he was restarting Coumadin and would get an INR in the morning. He didn't note the diagnoses made at the hospital. He didn't say why he was not continuing insulin or Albuterol. The patient had generalized edema but the doctor made no comment on it including why the patient was edematous.	The doctor failed to continue all hospital recommendations without documenting why. The doctor made no orders with respect to the Foley catheter. It should at a minimum have been inspected and changed periodically. The patient did not have an indication for the Foley catheter except the convenience of the staff. This placed the patient at significant risk of harm. The doctor failed to start antibiotics as recommended by the hospital specifically, he failed to start Cefepime, a broad spectrum antibiotic. He also failed to start insulin which had been started at the hospital when they diagnosed diabetes. These failures all placed the patient at risk of harm.
5/6/2015	Nurses were finding more on physical examination than the doctor on the same day. A nurse identified that the patient had edema of both arms on the same day that the doctor failed to thoroughly examine the patient. The left arm edema was 3+. This is significant arm edema.	The doctor's examinations appeared perfunctory and failed to evaluate areas of significant concern for the patient.

5/7/2015	Nurses on all shifts documented that the patient had 3+ edema over the entire body. At 1:30 pm a nurse notified a doctor that the patient still didn't have wound care orders 3 days after hospitalization. Nurses did not evaluate the Foley catheter except to say that it was patent and the urine was dark amber.	Not to have wound care orders for 3 days post hospitalization was not good care.
5/7/2015	The doctor increased Lasix to 80 mg BID	
5/8/2015	The doctor said that the patient was separated from other patients because he was making noise. But he made no attempt to find out why the patient was making noise. He said that there was no discharge from the stumps. He didn't evaluate the ulcer around the knee on the R found by the ID doctor at the hospital. The INR was 1.4 so he increased the Coumadin to 7.5. He ordered a BMP.	The doctor did not evaluate the Foley and appeared to not notice that the patient had a Foley catheter. He did not make any assessment of the abnormal liver function tests. He did not investigate why the patient's mental status was abnormal. He didn't evaluate the wounds. Care was inadequate.
5/8/2015	Nurses note that the urine was amber but the Foley wasn't examined.	
5/9/2015	A nurse checked the Foley which was patent with amber urine.	
5/10/2015	A night nurse noted that the patient had wheezing. A nurse noted that the urine was cloudy. The vancomycin trough order was not carried out. The vancomycin was also not given.	Cloudy urine indicates possible infection. The doctor should have been notified and a urine culture should have been done. The nurse and physician should have checked the Foley catheter. Wheezing in heart failure is a significant sign and should have been evaluated.
5/11/2015	The doctor saw the patient but took no history. He documented that the left leg was cool to touch with intact staples and without drainage. He said he would check the INR in the morning.	The doctor failed to evaluate all of the patient's problems.
5/11/2015	Nurses did vital signs only once a day. Vital signs should be done every shift but this doesn't consistently happen on this infirmary. The patient was on IV antibiotics and was recently septic and left the hospital early because presumably he was going to be cared for at the prison. Nurses did not document giving IV medications. Presumably this is on the MAR but the MAR isn't in the record.	It is not clear if the patient received his IV antibiotics. Monitoring by nurses was not up to infirmary care standards. Most nurses evaluating the patient were LPNs who are not trained to perform independent assessments.
5/12/2015	The nurse didn't check the Foley but noted that the urine was dark colored.	
5/13/2015	Nurses did not check the Foley catheter and didn't note the color or appearance of the urine	The Foley catheter had been in place for almost a month and at least should have been checked but was not. Nurse monitoring of this very ill patient was below standard of care.

5/14/2015	The Foley catheter wasn't checked.	The Foley catheter had been in place for almost a month and at least should have been checked but was not.
5/14/2015	Warfarin was decreased to 5 mg from 7.5	The doctor wrote no note with respect to the INR so it wasn't clear what the anticoagulation status was.
5/14/2015	Dressing changes were discontinued. CBC and CMP ordered, acuity changed to yellow.	
5/15/2015	The urine was amber and clear.	
5/16/2015	The Foley catheter wasn't checked.	The Foley catheter had been in place for almost a month and at least should have been checked but was not.
5/17/2015	The Foley catheter wasn't checked. There were no nursing notes for this day.	The Foley catheter had been in place for a month and at least should have been checked but was not.
5/18/2015	Stat CBC and CMP were ordered.	
5/18/2015	The patient developed fever to 102.4 with blood pressure 142/98. Stat labs at 10:25 included BUN 46; creatinine 2.21; with CO2 17; WBC 13.4; platelet count 336; test of urine was cloudy with 1+ leukocytes, 2 + protein and 3+ blood yet a provider didn't assess the patient. The vital signs were temperature 102.4; pulse 79; respiratory rate 24; blood pressure 142/98	Fever with the patient's underlying conditions (infected foot, indwelling Foley catheter, PICC line) is significant. Lab values were significant and indicated that the patient had renal failure, systemic infection, and urine infection. He needed immediate hospitalization. The Foley catheter should have been removed immediately and appropriate intravenous antibiotics started. Though the patient should have immediately been seen, a physician did not see the patient. The patient had several signs indicative of sepsis (fever, source of infection, elevated white count, elevated creatinine and elevated respiratory rate). Further blood testing should have been done. But with these values the patient should have been hospitalized.
5/19/2015	5/19/15 was a Tuesday and despite the fact that the patient had a fever the day before, had a Foley catheter and a PICC line a physician did not see the patient.	The patient was likely septic yet was not evaluated. This is irresponsible.
5/19/2015	At 11:45 pm the temperature was 101.6 and patient was drowsy, lethargic and breathing fast. The nurse call a doctor and the patient was sent to a hospital.	The continued febrile state with altered mental status and lethargy were significant. The patient was sent to a hospital almost 2 days after signs of sepsis were apparent. This placed the patient at significant risk of harm.

5/20/2015	The patient was admitted to the hospital. A CT scan of the abdomen and chest showed ascites, anasarca with pleural effusion, right base infiltrate with pleural effusions. When the patient arrived at the hospital he was in shock with acute renal failure, elevated liver function tests and an INR greater than 9. He had multiple organ failure. The patient was confused and lethargic. Upon arrival the blood pressure was 86/67. He had a holsystolic murmur with an S3 gallop. The glucose was 146 BUN was 90 and creatinine was 3.9; albumin 1.9; SGOT 1412; SGPT 443 and bilirubin 3.6. The troponin was 5.39 with BNP over 4500. Vancomycin and Zosyn were started. The urine was turbid with crusting around the catheter. The catheter was removed. On physical examination the patient was unresponsive. He had anasarca with weeping lymph. There was edema from the jawline down. There was 4+ weeping edema of all extremities. The patient was obtunded. There were areas of breakdown along the incision lines of the bilateral lower extremities. There was an ulcer on the left thigh as well as small open areas of the incision sites on both lower extremities. [Note: this is a very different examination than that which occurs at the facility]. He had septic shock with acute urinary tract infection, acute myocardial infarction, heart failure, acute renal failure. The patient remained hospitalized for 5 days and was sent back to prison on aspirin, Meropenem, Lovenox, Coreg, albumin 12.5 g IV, Lasix 60 every 8 hours, potassium and Prilosec. He was treated with Zosyn, vancomycin and Levaquin. The urine culture grew pseudomonas sensitive to Meropenem. The sepsis was due to the pseudomonas UTI. The anasarca was believed due to hypoalbuminemia from liver failure. The patient had hepatic encephalopathy. The discharge diagnoses were septic shock from pseudomonas UTI, acute heart failure, myocardial infarction, acute on chronic renal failure, anemia, liver failure, cirrhosis, anasarca, pulmonary edema.	Hospitalization was delayed until the patient was in septic shock with multi-organ failure. This resulted in a preventable heart attack as the heart attack was ascribed to the sepsis. The patient had signs of sepsis for 2 days prior to admission and should have been admitted at least 2 days before he was admitted. Also, the patient had no indication for a Foley catheter and the urosepsis, caused by the Foley caused the sepsis which resulted in a heart attack and ultimately resulted in the patient's death. Also, the patient's anticoagulation had not been monitored and was over 9 on admission which is a life-threatening value. This was preventable and care provided to the patient had resulted in harm to the patient.
5/26/2015	The patient was discharged back to prison. At 11 pm the patient's blood pressure was 110/64. The nurse notified the doctor and obtained orders. The patient was moved to isolation room on P ward and continuously monitored.	

5/26/2015	The doctor saw the patient and documented that the patient had cardiogenic shock, MI with heart failure, urosepsis, and renal failure. He failed to appreciate again that the patient had end-stage liver disease. He spoke with the cardiologist who apparently agreed with a DNR status. The prison doctor documented blood pressure of 84 over palpable. Again on the physical examination the doctor drew an arrow through all systems and wrote WNL except he wrote decreased bowel sounds, a systolic murmur, anasarca and bilateral amputations. The doctor noted that the patient didn't have an advanced directive. He noted that he spoke with the cardiologist who had signed off the case as there was nothing further to offer the patient. The doctor wrote that the cardiologist agreed with DNR so he made him DNR. Another physician on 5/27/15 wrote "I am familiar with Mr. [Patient 21] and his medical condition. He is pre-terminal with end stage CHF. Cardiology has determined that no further intervention would be helpful. In my medical opinion only comfort measures are indicated. I agree with DNR status."	The prison doctor continued to not monitor all of the patient's conditions. Without any discussion with the patient or attempt to contact the patient's family, the doctor decided to make the patient DNR. An attempt should have been made to discuss this with the patient.
5/27/2015	Only the evening nurse documented a note. The blood pressure was 114/84 and the heart rate 40. The nurse did not advise the physician.	
5/28/2015	The patient was improved. Although the doctor took no history, he wrote that the patient was alert today and oriented to person only. The examination was minimal. The doctor ordered no laboratory tests. He wrote that his plan was supportive care only and that the patient was DNR.	
6/1/2015	IV Lasix was stopped and oral Lasix started. An order to cleanse open areas of wound and to apply Duoderm weekly. The IV was to discontinue in 72 hours if the patient couldn't tolerate oral Lasix.	
6/11/2015	A potassium was ordered on 6/12/15	
6/12/2015	The doctor ordered to clean the skin breakdown on the thigh followed by Duoderm	

6/12/2015	A licensed counselor evaluated the inmate 2 weeks after hospitalization. The inmate was responsive and told the counselor that he eats his meals but was still losing weight. He said he was sleeping well and denied any mental health concerns. The mental health counselor asked him why he was looking down the hallway and he replied that he was just looking. The patient was using a wheelchair and had appropriate hygiene and was cooperative. His responses were described as coherent and rational.	The patient seemed to be improving but the doctor, except for continuing the patient's medication, stopped caring for the patient. He did not attempt to discuss advanced directives with the patient even though the patient was described as coherent by a counselor. This appears unethical. It is one thing to let a patient pass when they desire to die but in this case, the doctor had not discussed his decision to stop caring for the patient with the patient or the patient's family. The patient not the doctor should be making this type of decision. The patient at this point appeared to have adequate decision making capacity but was not allowed to make his own decision about living or dying. In particular, after the patient improved, a discussion about advanced directives should have occurred.
6/16/2015	The doctor evaluated the patient using a chronic disease form. He checked the boxes for the formatted questions but otherwise took no history and did not discuss with the patient his advanced directive decision made without informed consent of the patient. Remarkably, he checked the box asking about ankle edema "no" even though the patient had recent anasarca (which is edema throughout the body) and the patient had no ankles since he had bilateral amputations. He checked no under abdominal pain swelling even though the patient had ascites. The vital signs were normal with a blood pressure of 130/70. The doctor wrote WNL under head and neck, heart, lung and abdomen exams and 2+ edema of the lower extremities with BKA. He ordered no labs. His only diagnoses were heart failure and MI and dementia [which was not clear to what extent the patient had dementia]. He did not include any of the patient's other diagnoses. The only plan was to continue with the patient on P ward.	The doctor appeared to officially give up caring for the patient and failed to obtain an advance directive with informed consent. The doctor did not have the right to make this kind of decision particularly since the patient had been improving. The doctor should have discussed the DNR with the patient.
6/24/2015	Oral Lasix was discontinued and IV Lasix was started.	
6/25/2015	The patient fell out of bed and had a small raised area above the left eye. The nurse did not take vital signs.	
6/26/2015	The doctor stopped Duoderm and ordered cleaning the wound with Hibeclans with triple antibiotic ointment and non-adhesive dressing.	

6/30/2015	A nurse documented that the patient was less responsive but became normal. The respirations were irregular alternating with shallow breaths. The doctor was notified but he took no action.	
7/2/2015	The doctor ordered 2 cans of Ensure three times a day.	
7/4/2015	A nurse noted that the patient was not breathing. He was pronounced dead.	
5/24/2016	[redacted]	This was a deficient mortality review. This death was preventable. (1) There were many problems earlier in this inmate's incarceration related to intra-system transfer that should have been identified and corrected. (2) There were clear problems with tuberculin skin testing with the result being negative to positive to negative to positive. These inaccurate reading should have been evaluated as the system has significant issues with tuberculosis. (3) The medical record did not appear to be available when the patient was re-incarcerated. Therefore many previously identified problems were unrecognized. (4) The doctor at Kilby failed to timely identify peripheral vascular disease and failed to timely admit the patient to a hospital which may have contributed to loss of his right foot. (5) The doctor at Kilby asked to take the patient back from a hospitalization when the recommendation of the hospital for intravenous antibiotics could not be provided at the prison. This may have contributed to the loss of the patient's second foot. (6) The patient returned from the hospital after the 2nd amputation on 3 antibiotics but was only given 2. Also, the patient had a Foley catheter which the doctor did not appear to recognize. No orders were given for the care of this catheter. The patient developed a urinary tract infection because of the Foley and developed sepsis. The sepsis wasn't timely noticed by the doctor and the patient went into septic shock before being admitted again. As a result the patient sustained a heart attack and multi-organ system failure. (7) When the patient returned from the hospital the doctor placed the patient on DNR status even though within 2 weeks of return the patient was oriented and conversant. The doctor never documented talking with the patient about DNR status. This appeared unethical. The doctor withdrew medical interventions and the

	[redacted]	patient died. The sentinel event committee should have performed a careful peer review of the Kilby doctor. There were many other problems that should have resulted in root cause analysis with corrective action plans. [redacted]

Patient 22

Date	Summary	Comments
1/11/2013	A mental health staff saw the patient and noted that the patient had served 27 years of a life sentence. The diagnoses were listed as organic brain syndrome although the patient was described as oriented to person and place.	There were no medical notes for this patient.
1/22/2013	Psychiatrist saw the patient who was on remeron. The patient was conversant.	
2/25/2013	A doctor saw the patient for chronic illness clinic. DM, atrial fibrillation, hypertension, dyslipidemia, dementia and cardiomyopathy were listed as problems. BP was 142/78. Except for documenting periods of forgetfulness, the examination was documented as normal. All of his diseases were documented as in good control. A1c was 6.3 but the date wasn't on the note.	This patient had significant problems. Since he had organic brain syndrome he appeared to need nursing home like care. It appeared however that the patient was housed on a mental health unit which is not the appropriate placement for his condition.
3/22/2013	A doctor saw the patient for chronic illness clinic. All problems were listed in good control including the dementia. Almost no history was taken and the patient's cognitive status was not described. BP 120/60.	The provider failed to obtain a history from the patient. The patient had significant cognitive disorder but the provider didn't document this with respect to the history.
4/1/2013	Another inmate wrote a health request for Mr. Rice stating that for the past 2 days he was "freezing and sick, he is not eating". This was written by a hospice worker.	The nurse triaging the complaint wrote that due to cognitive deficits, she was unable to assess the patient. However, she wrote that the patient denied headache, stomach ache or cold. The patient said he could eat. The weight was 146 pounds. The patient couldn't even write his own health request. He needed housing in a nursing home type environment with assistance with daily living.
4/2/2013	An inmate worker told a nurse that the inmate was "not himself". The temperature was 99.4. Nothing additional was done.	The complaint appears to have been ignored.
4/3/2013	A psychiatrist wrote that the inmate had decreased appetite and weight loss.	

4/19/2013	The inmate was in an altercation with another inmate and was hit in the stomach. A nurse noted tenderness of the abdomen with the inmate holding his stomach.	
4/22/2013	A physician saw the patient. The abdomen was still tender. Other than examination the doctor ordered no tests.	It did not appear that an adequate evaluation was done.
4/27/2013	[redacted] An NP documented removal of the toenail due to injury.	All medical record documents should be in the medical record file.
5/1/2013	A provider ordered aspirin, Coreg, digoxin, Lasix, potassium and spironolactone.	
May-13	A mental health provider wrote a note stating that he was evaluating the patient because medical wanted mental health to rule out dementia. This is a medical diagnosis and should have been addressed by medical with a CT scan and other work up.	Mental health does not typically rule out dementia but diagnoses mental illness. The psychiatrist had already diagnosed that the patient had an organic brain syndrome.
5/19/2013	Nurses wrote notes on the MOU [? medical observation unit]. The patient was disoriented and confused and was not making sense. There was no evidence of a provider evaluation. The inmate was moved to a segregation cell at 3 am.	Disoriented and confused patients need medical evaluation not segregation. A provider should have been called.
5/22/2013	A provider wrote that the patient had prior prostate cancer with radiation. This problem was not on the problem list and not being followed in chronic clinic. The doctor documented that he would order labs and follow-up.	The provider history was poor.
5/22/2013	The patient was transferred to Bullock from Staton. On the transfer form, the Staton staff wrote under "current treatment" "*is a DNR*". Under diagnoses they listed HTN, DM, high blood lipids, atrial fibrillation, and prostate cancer. The patient was placed on an assisted living unit.	It isn't clear what DNR status means with respect to caring for the patient. It is also unclear how the DNR status was obtained since the patient had apparent organic brain syndrome.
5/22/2013	[redacted] A doctor saw the patient and noted that the patient was agitated and confused. The EKG showed atrial fibrillation. The doctor diagnosed DM, HTN, dementia, cardiomyopathy and atrial fibrillation. The doctor did not order laboratory tests. He wrote he would continue all meds and order a psych consult. He did not assess the status of the patient's chronic illnesses and did not even document vital signs.	The doctor ignored the patient's serious medical conditions. All medical records documents should be in the medical record.

5/22/2013	[redacted] The patient was admitted to assisted living but there were no daily nursing notes until January of 2015.	All medical record documents should be in the medical record.
5/23/2013	A doctor referred the patient to psychiatry for evaluation because the patient was not making sense and wasn't able to communicate. The doctor documented that the patient had a history of atrial fibrillation, heart failure, dilated cardiomyopathy, diabetes, hypertension, renal failure, hepatic insufficiency	The doctor should have also ordered evaluation for dementia including a brain CT scan or MRI.
5/23/2013	A psychiatrist saw the patient and diagnosed organic brain syndrome due to multiple etiologies but was not more specific. There was no evidence of a work up for this condition.	The different psychiatrist had already diagnosed this condition. The work up for organic brain syndrome is typically performed by primary care physicians but had not been done.
5/23/2013	[redacted] EKG atrial fibrillation with STT changes inferior leads.	The patient was not being monitored for his medical conditions. All medical record documents should be in the medical record.
5/24/2013	A CT of the brain was ordered because of altered mental status.	
5/26/2013	[redacted] A doctor documented that the patient was agitated and kicking the door. He ordered a milligram of Ativan. Later the same day the same doctor wrote that the patient was agitated and confused but did documented a heart exam although it is illegible. The doctor ordered haloperidol.	The doctor was sedating the patient but not addressing his medical conditions or behavioral problems except by sedation.

5/28/2013	[redacted] A psychiatrist wrote "I/M seen in infirmary following discussion w/ [site medical director name redacted] earlier today. Clinical picture is one of dementia starting around 2007-9 and progressing, possibly in step-wise fashion. Possible etiologies include vascular degeneration, Alzheimer's. He has high risk factors for vascular process. An MRI or CT could reveal if multi-infarct process is occurring. He is not able to converse coherently or participate in decision making now. He follows simple commands inconsistently. His speech pattern indicates a component of fluent aphasia and there may be a receptive deficit in his capacity to comprehend questions, etc. He needs 24/7 nursing home-level care, and this exceeds what is available in the RTU. Ham A & I is a consideration."	The patient should have been in a nursing home type environment. Instead his medical conditions were neglected. The primary care doctor should have conducted a work up of dementia. All medical record documents should be in the medical record.
5/28/2013	[redacted] A psychiatrist noted that the patient recently moved from Staton infirmary to Bullock infirmary and was confused, had impaired ADLs and was agitated. He had cognitive decline since 2007-9. The psychiatrist stated that the inmate was not oriented to place or time in 2010 and was not consistently following commands. He recommended a further and needed a CT or MRI and B 12. He said that his functioning was too limited for the RTU and he needed daily help with basic ADLs and he was not suitable for a dorm.	The patient needed a nursing home like housing. A proper dementia work up was indicated. All medical record documents should be in the medical record.
5/31/2013	The CT scan showed diffuse atrophy of the brain.	This is consistent with an organic brain syndrome of unknown etiology.
6/7/2013	A mental health worker noted that a trustee had been assigned to assist the inmate. The patient was not being logical.	The patient needed a nursing home like housing. The housing for this patient was inadequate.
6/7/2013	A nurse described that he was yelling and banging on the door most of the evening. Haldol was given and the patient became quieter. Later that day, the patient was found on the floor with his nose bleeding with a laceration. A doctor did not evaluate the patient.	It appears that the patient was neglected and sedated. The patient was injured and not evaluated.

6/17/2013	Nurses wrote mostly daily assisted living assessment tool notes on this patient. He required assistance with care but nurses did not document this care. Instead it appeared that inmate trustees cared for the patient. The nurse did not document administration of medication. It wasn't always clear that the patient was receiving his medication and it wasn't clear that the providers were re-ordering medication. Also, the patient had confusion and dementia. In April 2013 a nurse documented on a health request that the inmate couldn't give a history. Yet on these daily assisted living assessments nurses documented symptom screening as if the patient was communicating normally.	It appeared that the patient was neglected and left for other inmates to provide his care. Nursing documentation of care was below standard of care.
7/1/2013	A July MAR was in the record and documented that Carvedilol was discontinued 7/1/13 but that the patient was receiving aspirin, digoxin, Lasix, potassium, Mirtazapine,	There were no provider notes so it appeared that providers weren't even monitoring him. The patient appeared neglected.
7/1/2013	A nursing ALAT described excoriated areas to his forehead from banging his head on the door with bruises on his legs.	The patient was injured but was not evaluated. He appeared neglected.
7/2/2013	A psychiatrist documented that the patient was banging his head on the wall and picking at his skin and nails. The psychiatrist described sores on the inmate's body. The psychiatrist ordered a lipid profile and A1c since the patient was on Risperdal.	The patient appeared neglected.
7/2/2013	The nursing ALAT documented the skin as pink warm and normal and did not assess any skin lesions even though the psychiatrist on the same day described the patient as having sores on his skin from picking.	The ALAT assessments do not describe what is happening to the patient. It appeared that he was in a single cell and was banging his head on the door but this activity is not tracked at all.
7/3/2013	An ALAT form documents bruises on forehead, abrasion to the shoulder and bruises on his body. No action was taken.	The patient's injuries were neglected.
7/6/2013	A nurse documented that the patient vomited twice after eating. A nurse took a phone order for Phenergan but a provider didn't examine the patient.	The patient's condition was neglected by providers.
7/7/2013	ALAT documents normal skin.	
7/8/2013	ALAT documents bruise on arms, forehead and around nose.	It appeared that the patient was neglected.
7/9/2013	ALAT documents normal skin.	

7/18/2013	A nurse completed the first page of an abrasion and laceration NET tool assessment. The nurse noted that the toenail was cracked and bruised and that the patient had bleeding and pain. He was confused and disoriented concerning the injury. No provider notes were associated with this event. It isn't clear what the nursing plan was.	It appeared that the patient was neglected.
7/25/2013	The patient was transferred to the infirmary. A nurse completed an initial skin lesion form. The nurse documented 20 different bruises, or lesions on the patient some of which were extensive (23 by 10 cm was the largest)	There was no attempt during this period when the patient was engaged in self-harm that anyone on the medical staff or mental health staff intervened to try to ameliorate the patient's problem. Also, they did not attempt to ascertain whether the patient was in pain or was suffering in any way.
7/30/2013	An NP ordered A1c and fasting lipids for psychotropic medication screening.	
7/30/2013	Someone ordered bacitracin to his sores.	
7/30/2013	A psychiatrist saw the patient and noted that the patient was still banging his head on the door but less so since Risperdal started.	
7/30/2013	A nurse noted a 6 by 6 cm head wound with a 2 by 1 cm open area. The nurse dressed the wound but a physician didn't see the patient.	Medical staff ignored the patient.
8/1/2013	August MAR shows patient was on aspirin, digoxin, Lasix, lorazepam for part of the month, Mirtazapine, potassium, Risperidone, spironolactone, Ativan for part of the month, and Remeron.	
8/1/2013	[redacted] A1c 6.1; creatinine 1.32	The creatinine indicates early chronic kidney failure but there did not appear to be any follow-up of this lab. All medical record documents should be in the medical record.
8/1/2013	[redacted] EKG atrial fibrillation with STT changes inferior leads.	This is a serious medical condition that had been ignored by medical staff. All medical record documents should be in the medical record file.
8/13/2013	[redacted] The NP documented that the patient wasn't on any medication other than Ativan. The NP documented that the nursing staff held Lasix due to low blood pressure but there apparently was no order for this. The NP documented discussing BP meds with the site medical director but said there would be no changes. It isn't clear if medications were prescribed.	It appeared that nurses were acting out of the scope of their license by withholding a prescribed medication without an order from a provider. Providers were ignoring the patient's serious medical conditions. All medical record documents should be in the medical record.
8/14/2013	Mental health saw the patient.	
8/19/2013	From 8/19/13 to 8/31/13 nursing documentation was that the patient had no	

	skin lesions.	
8/21/2013	Risperdal and remeron were ordered.	
8/23/2013	Brief MH note	
8/30/2013	Brief MH note	
9/6/2013	Brief MH note	
9/13/2013	Brief MH note	
9/16/2013	Brief MH note	
9/20/2013	Nurses started writing weekly soap notes that were brief and did not describe his condition.	The patient appeared neglected.
9/25/2013	[redacted] An NP documented that nursing staff reported hesitation before urinating so she started ciprofloxacin without checking a urine culture.	The patient's medical conditions were not being monitored by medical staff.
10/2/2013	A provider ordered medical records from Jackson hospital and ordered echocardiogram and cardiac catheterization reports.	There was still no documented provider evaluation of the patient for his medical conditions.
10/2/2013	[redacted] A doctor ordered a barium swallow and an acute abdominal series and an ultrasound of the abdomen. The doctor also ordered his medical records from Jackson hospital and discharge summary and echocardiogram and cardiac catheterization reports.	There was no provider evaluation of the patient. It is not clear why the doctor was ordering the radiological studies. All medical records documents should be in the medical record.
10/3/2013	EKG showed atrial fibrillation with rate of 68	
10/5/2013	[redacted] The patient had 3 episodes of vomiting on 10/5/13; 10/7/13 and 11/8/13 documented by either a nurse or nurse practitioner. On 11/8/13 the NP started Rocephin for 3 doses but didn't specify why. There was no physical examination for any of these encounters. To start antibiotics without any physical examination and without checking any laboratory tests is below the standard of care. There was no evaluation of the patient.	The patient's serious medical conditions were being effectively ignored by medical staff. All medical records documents should be in the medical record.
10/7/2013	[redacted] The site medical director cancelled a barium swallow on 10/7/13 which was ordered 10/3/13. Apparently he had ordered this test because the patient couldn't swallow and vomited back up what he swallowed. This test was initially approved on 10/3/13.	The reasons for cancellation of the study were not documented. It appeared that the medical staff were ignoring the patient's problems. All medical records documents should be in the medical record.
10/8/2013	Creatinine 1.38, BUN 30; iron 22 (normal 45-160) HCT 38.98 (39.3-52)	The renal function was deteriorating.

10/9/2013	[redacted] Ultrasound of abdomen showed benign renal cyst; calcified granuloma of the lung; a shadow in the liver consistent with granuloma vs pneumobilia-malignant mass though unlikely. Recommended follow-up ultrasound in 6 months.	All medical records documents should be in the medical record.
10/11/2013	Brief MH note	
10/11/2013	Brief MH note	
10/26/2013	Brief MH note	
10/30/2013	An NP mental health note describing that the inmate kicked an officer and described as yelling and banging on the walls.	The NP did evaluate the patient's medical conditions.
10/31/2013	[redacted] A provider evaluated the patient and documented that the patient had dementia and end-stage cardiomyopathy and had developed dysphagia to even liquids. The only examination was that he was cachectic and non-cooperative; had an irregular heart and bowel sounds. The doctor noted speaking with the Regional Medical Director and documented their discussion as "no point in sending him to hospital w/u since comfort care"	This confirms that the patient's serious medical conditions were being ignored at the direction of medical leadership. DNR status applies to terminal events not to routine care for demented or disabled persons. This does not appear ethical. All medical records documents should be in the medical record.
11/1/2013	Brief MH note	
11/5/2013	An NP changed the Depakote order and increased Risperdal.	The NP did evaluate the patient's medical conditions.
11/5/2013	The NP wrote an addendum to the 10/30/13 note stating that there were further reports of agitation and aggression that were a safety concern; the NP increased the Risperdal and added Depakote.	The NP did evaluate the patient's medical conditions.
11/14/2013	Ruth Naglich writes an email to Lynn Brown stating "In addition, may what to look at AND/DNR status. It will have to be done by [names redacted- site and Regional Medical Directors]. I know he is not in an acute medical state at this time, but does have other chronic issues. I would rather be proactive than reactive". The response was "Great idea, will do".	This indicates that administrative leadership was initiating AND and DNR status not the clinical staff. This is a serious ethical concern. They are not the treating physicians and should not have been initiating an initiative to withhold care.
11/15/2013	Valproic acid level 26 (normal 50-100)	
12/1/2013	MAR documents patient still getting Ativan, potassium, risperidone, spironolactone, docusate, aspirin, digoxin, Depakote, Lasix, and Mirtazapine.	
12/17/2013	Counseling session	

12/17/2013	A treatment plan for mental health was written stating that MH would see patient monthly to allow a "safe place for ventilation and exploration of possible escalation of symptoms associated with dementia".	It appeared that the patient had an organic brain syndrome and needed a nursing home environment but instead was kept on a mental health unit where his medical conditions were ignored.
12/20/2013	A mental health note documented that a nurse informed him that the patient had trouble swallowing which "creates issues such as vomiting and not passing certain health tests".	The patient had a medical condition that was not evaluated.
1/1/2014	Still on all of his medications	
1/8/2014	Chest x-ray; cardiomegaly, hyperinflation	This is evidence for possible heart failure and emphysema. Additional tests may have been indicated.
1/8/2014	[redacted] EKG- atrial fibrillation with rate of 69 and STT wave changes with possible inferior ischemia.	The patient should have been evaluated. All medical records documents should be in the medical record.
1/16/2014	Depakote increased	
1/17/2014	Counseling session	
1/30/2014	Remeron decreased; lipids and A1c ordered;	
1/30/2014	NP for MH saw patient; patient weighed 133. Remeron decreased. Only MH issued addressed screening A1c and lipids ordered but the last screening tests were not done; this was not noted.	The patient's medical issues were not addressed by the mental health NP.
2/1/2014	Still on all of his medications	
2/3/2014	[redacted] A1c 5.5	All medical records documents should be in the medical record.
2/24/2014	The patient was at a local hospital for a facial laceration. There was no associated note at the facility and it does not appear he was even evaluated before or after this episode. The hospital noted the laceration and documented a periorbital hematoma from an old injury. This periorbital injury was not documented in the record. The hospital diagnosed a laceration, facial hematoma, orbital blowout fracture, maxillary fracture and facial fractures. The CT scan showed 2 small subarachnoid hemorrhage which were related to the trauma. The ER note stated that the patient "suffered a fall". The left maxilla was shattered with multiple displaced fractures.	The patient had a serious injury but was not evaluated prior to being sent to a hospital and the follow-up was extremely poor. The patient was ignored.

2/24/2014	A nurse documented a return from offsite report. The nurse noted that the patient was on antibiotics but did not document the diagnoses at the hospital. The nurse wrote "seen @ the ER @ Bullock for injuries of unknown origin". The patient wasn't seen by a provider after this episode and wasn't treated with any pain medication.	This was cruel. The patient most likely had pain from such serious injuries but wasn't appropriately treated or appropriately followed by medical staff.
2/24/2014	A tapering dose of steroids was prescribed along with 4 days of Keflex. The only pain medication was 2 plain Tylenol twice a day for 3 days. This was cruel.	There was no note associated with this prescription. It did not appear that a provider evaluated the patient after return from the hospital for serious injuries.
2/24/2014	[redacted] n NP wrote that the patient returned from the hospital and noted facial fractures and said she would discuss results with a medical doctor.	All medical records documents should be in the medical record.
2/25/2014	Counseling session	
2/25/2014	[redacted] A provider wrote that the patient sustained facial trauma 2/23/14 and was seen at the hospital and that the chart was reviewed. The provider noted a large hematoma around the eyes. The provider noted the problems as L orbital blow out fracture, maxillary fracture, cerebral contusion and ordered prednisone Keflex, and daily neuro checks for 7 days. The provider wrote that the patient would be evaluated in surgery and neurosurgery in the future. A second page of this note was missing.	These follow-ups with surgery and neurosurgery did not take place. It appeared that the patient's serious medical conditions were ignored. All medical records documents should be in the medical record.
2/27/2014	[redacted] A provider wrote a note which is partly illegible. The plan did not include surgical follow-up but continued prednisone, antibiotics and nasal spray. The doctor wrote to get the hospital records to determine if the patient received a tetanus shot. The doctor did not address what to do about the facial fractures.	The patient did not receive appropriate follow-up. All medical records documents should be in the medical record.
2/28/2014	Counseling session	
3/6/2014	Counseling session	
3/11/2014	NP mental health note documents that the patient was combative, yelling and banging on walls. The NP did not evaluate the facial wounds or try to assess for pain. The NP noted that the inmate was tearful.	The NP did evaluate the patient's medical conditions.
3/20/2014	[redacted] Platelets 128K, hemoglobin 11.2 Bun 28; creatinine 1.40	These abnormal labs were not addressed. All medical records documents should be in the medical record.

4/1/2014	Patient received medications based on MAR	
4/18/2014	Counseling session	
4/21/2014	[redacted] The site medical director ordered aspirin, digoxin, Lasix, Kdur and aldacone by telephone. The length of time was not specified.	
4/25/2014	[redacted] doctor wrote a brief note that the patient had a knot on his leg with surrounding cellulitis and was started on Bactrim.	Managing care over the phone is a poor practice. All medical records documents should be in the medical record.
4/27/2014	The MAR documents that the patient received Ancef IM 4/27 and 4/29 but the order was for every day for 3 days. There was no medical note or nursing note associated with prescription for this medication.	The patient failed to receive ordered medication and intravenous antibiotics were given without any apparent medical evaluation of the patient. This is inappropriate.
4/27/2014	[redacted] A doctor wrote a brief note describing that the patient had a tender oozing abscess and ordered Bactrim for 20 days.	The abscess should have been cultured and additional labs (blood count) ordered. All medical records documents should be in the medical record.
4/27/2014	[redacted] The site medical director ordered an intravenous antibiotic Ancef for 3 days, with daily dressings for 30 days, culture of the skin and a follow-up on 5/5/14 and 5/26/14	A blood count and culture of the abscess should have been ordered as the patient was not improving. All medical records documents should be in the medical record.
5/1/2014	MAR documents patient still getting Ativan, potassium, risperidone, spironolactone, docusate, aspirin, digoxin, Depakote, Lasix, Mirtazapine. But these medications were not documented as given after 5/22/14. It is not clear if they were discontinued or just not given. There were no MARs in the record until November of 2014.	
5/30/2014	Counseling session	
6/12/2014	A mental health treatment plan review notes that the patient requires daily living assistance which has been given by other inmates. The goal was to get the inmate to perform some activities of daily living.	The patient needed a nursing home like housing.
6/25/2014	NP for MH saw the patient and described a history as still combative, yelling and banging on walls. But the NP wrote that when reviewed the inmate was lying in bed asleep and couldn't be awakened.	The NP did evaluate the patient's medical conditions.
7/31/2014	Counseling session	

8/26/2014	[redacted] Digoxin 0.6 (normal 0.8-2); creatinine 1.48 platelets 133K	The renal function was deteriorating. This is a concern with digoxin as the dosage of digoxin may need to be adjusted for persons with renal failure. All medical records documents should be in the medical record.
8/28/2014	[redacted] An NP documented that the patient became unresponsive in the bathroom and chest compressions were done. An EKG was not done. The NP documented that the patient had normal vital signs. It isn't clear who did chest compressions and there is no note by anyone performing chest compressions. The NP documented that the patient became alert and verbal presumably after chest compressions but because of his dementia the NP was unable to take a history. Remarkably, the NP took no EKG despite documenting that the patient had atrial fibrillation and cardiomyopathy and had a pulse of 58 which may indicate digoxin toxicity.	This indicates significant problems with initiating CPR and may be due to significant lack of training. The patient had an apparent serious medical concern but it was ignored. There was no follow-up evaluation. A patient who apparently needed cardiopulmonary resuscitation was not sent to a hospital. This episode indicates significant issues with medical documentation. All medical records documents should be in the medical record.
9/5/2014	A nurse writing weekly charting noted that the inmate had slurred speech and had a bruise of his left arm. The nurse didn't refer to a provider.	Slurred speech is a sign of brain injury and possibly a stroke. The patient needed provider evaluation. The patient's serious medical condition was ignored.
9/12/2014	Counseling session	
9/15/2014	[redacted] The doctor ordered an EKG	All medical records documents should be in the medical record.
9/25/2014	MH NP note only MH issues addressed.	The NP did evaluate the patient's medical conditions.
10/3/2014	The inmate lacerated his toe but was only seen by a nurse. The nurse put gauze on the wound and sent the inmate back to housing.	His medical condition was ignored.
11/1/2014	The MAR for November shows that the patient received Remeron but did not receive aspirin, atenolol, Lasix, lorazepam, potassium, spironolactone, even though they were ordered. The digoxin appears to have been discontinued although there was no order for this.	There had not been an adequate provider evaluation of the patient's medical condition for over a year.
12/1/2014	MAR indicates that the patient received aspirin, atenolol, Lasix, lorazepam, potassium, and spironolactone. The digoxin was no longer being given.	

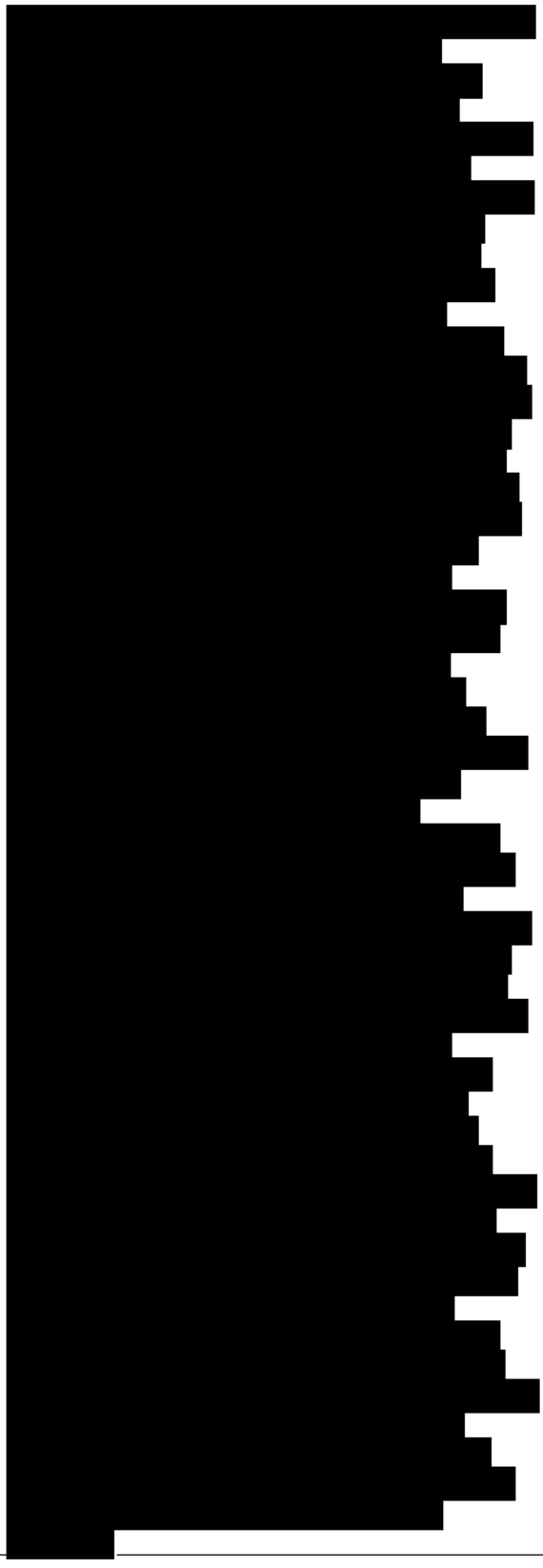
12/16/2014	[redacted]	The medical record did not contain multiple documents related to his chronic care. The 16 additional chronic care notes demonstrated poor quality including inaccurate physical examination (documenting normal heart rhythm when the patient had atrial fibrillation); poor history; not reviewing significant laboratory results; not adequately assessing the status of the patient's conditions; and not documenting how communication with the patient occurred. All medical records documents should be in the medical record.
12/19/2014	Counseling session	
1/12/2015	A1c 6.2; LDL cholesterol 69; WBC 12.23 with left shift; glucose 216; BUN 41; creatinine 1.8; AST 43; ALT 61	These laboratory results indicate infection (elevated white count), early renal failure, and abnormal liver function tests. There was no evidence that anyone took any action on these abnormal test results. It appeared that the patient's serious medical condition was ignored.
1/17/2015	[redacted] The inmate was walking around his cell and was alert "but confused". During this time period nurses were documenting a daily brief 3-5 line note. On 1/22/15 nurses documented several notes but mostly notes were daily with sometimes there being 2 notes a day.	The patient's serious medical condition was being ignored.
1/22/2015	[redacted] The inmate had taken the mattress off his bed and placed it on the floor and a nurse documented he was lying on this mattress in a fetal position.	All medical records documents should be in the medical record.
1/22/2015	[redacted] A doctor ordered a CBC and diagnostic 2 lab tests.	All medical records documents should be in the medical record.
1/23/2015	A nurse documented that the patient was lying on his bed with his eyes closed.	

1/24/2015	IV solutions were ordered on 1/24/15 for 3 days.	
1/25/2015	[redacted] A doctor wrote a note stating that the patient had been comatose and had not eaten in several days with hypernatremia on the Friday before and was started on D5 1/2 NS and had been on IV fluid ever since then. The patient was non-responsive. BP 92/42. The doctor assessed dementia, dehydration and hypernatremia, CHF and prostate cancer. The doctor wrote that the patient was in critical condition and that he would provide comfort care as he was DNR.	All medical records documents should be in the medical record.
1/25/2015	[redacted]. A doctor ordered that the patient is DNR but there was no DNR form in the record.	The DNR process is defective and does not protect patients. The interpretation of DNR by ADOC staff appears to be that routine medical care needed for serious medical conditions need not be provided as opposed to extraordinary efforts being provided to end-of-life situations. This is a serious ethical concern. All medical records documents should be in the medical record.
1/26/2015	[redacted] doctor wrote that the BP was palpable only and the patient was comatose. Later he recorded BP as 78/48 with a pulse of 48 and irregular. The doctor wrote renal failure, electrolyte imbalance and comatose and wrote that he would provide comfort care and IV fluid and IV antibiotics.	All medical records documents should be in the medical record.

5/24/2016	[redacted]	This mortality review was inadequate. There were a number of problems that were not identified. (1) The patient had an undiagnosed type of dementia. He needed nursing home type care but appeared to be housed in a mental health unit for long periods of time. When transferred to the infirmary at Bullock there was a significant lack of nursing documentation verifying that nurses were providing care for him. (2) The patient had a DNR status but the DNR documents were not in the medical record. It wasn't clear what DNR meant. Typically, DNR applies to extraordinary interventions at the end-of-life. In this case, the providers were applying the lack of intervention to routine medical interventions. This appears to be an ethical issue that is not addressed in policy or procedure and appears to be interpreted by each individual provider for each scenario. (3) In February of 2014, the patient sustained significant facial trauma. He did not have surgical or neurosurgical follow-up and was not even appropriately treated with pain medication despite a severe injury. (4) The OHS administrative leadership intervened in obtaining AND/DNR status when it should have been a clinical not an administrative matter. (5) The Regional Medical Director advised not to work up dysphagia since the patient was a DNR. This was not an end-of-life issue. These decisions should be guided by very clear policy and procedure that are reviewed carefully from an ethical perspective as they impact the life and death of a vulnerable population. (6) On 8/28/14 the patient appeared to experience cardiopulmonary arrest but was not sent to a hospital after the event. It appeared that the patient may have had an unrecognized stroke. [redacted] This was an inadequate mortality review. The death may have been preventable. The major issue however, is to what extent should the ADOC provide care to patients with cognitive disorder and whether these individuals should be allowed to die without intervening? This considerable ethical issue was ignored.

Patient 23

Date	Summary	Comments
5/10/2014	42 year old man placed a sick call request for upper abdominal pain and burning sensation with a bloated feeling for a week. The blood pressure was 140/92. He was evaluated by an LPN. The patient was given OTC by protocol and no referral. The nurse did not ask about chest pain.	An LPN is not licensed or trained to perform independent assessments. This LPN failed to identify elevated blood pressure. A better trained nurse might have asked the patient about chest pain. Upper abdominal pain can sometimes be cardiac in origin.
5/12/2014	An NP saw the patient for follow-up and noted that the patient complained of gas and bloating. The BP was 150/88. The NP started Prilosec and simethicone and advise to notify medical if pain worsened. The NP did not treat the elevated blood pressure.	The blood pressure was elevated and not noted. A better history might have included asking about chest pain.
8/30/2014	An LPN evaluated the patient emergently. The patient woke up sweating and felt nauseated with back pain. He vomited 3 times. The nurse took no other history. The nurse assessed possible acid reflux. The nurse documented that the patient was supposed to be on Prilosec but wasn't taking the medication. An EKG was done and the physician was notified. The EKG was consistent with anterolateral ischemia with sinus bradycardia. The EKG was faxed to the physician. The nurse documented that the doctor wanted the patient to see a nurse practitioner in the morning.	An LPN is not licensed or trained to perform independent assessments. The symptoms were consistent with cardiac pain but the nurse failed to identify this. A better trained nurse should have picked this up. The nurse did an EKG which was appropriate. The physician on call failed to send the patient to a hospital for an abnormal EKG and symptoms consistent with acute coronary syndrome. This placed the patient at risk of harm
9/2/2014	An NP evaluated the patient in follow-up of the 8/30/14 nurse evaluation. The NP took a very poor history. The NP documented that he sweat on one side of his body and had an episode of nausea and vomiting over the weekend that had since resolved. The NP documented that the patient had been dealing with sweating over the past 10 years. The NP did a brief examination and diagnosed resolved gastroenteritis. The NP did not review the EKG that showed ischemic changes.	This evaluation was below standard of care. The NP was asked to re-evaluate a patient after a nurse evaluation for chest pain. The NP failed to take an adequate cardiac history and failed to review the EKG.
9/7/2014	The patient was found on the floor vomiting and seen by a nurse at 9:38 am. The patient arrived at the hospital at 11:08 am and the admitting diagnosis was cardiac arrest.	There was no documentation of care for the patient between the time he was found and when he left the facility. It is not even clear if the patient had cardiac arrest at the facility. This documentation is a departure from standard of care.

5/24/2016		This mortality review was inadequate. There were several problems. (1) An LPN should not have been making independent assessments on 8/30/14. However the LPN did appropriately perform an EKG. (2) The provider had the EKG that documented anterolateral ischemia and was able to communicate with the patient by phone, if needed, for a better history. The doctor should have sent the patient to a hospital but did not. (3) The NP performing a follow-up evaluation on 9/2/14 performed an inadequate history and failed to review or misinterpreted the EKG and failed to initiate anti-angina therapy and refer the patient for higher level evaluation (stress test) with a cardiologist. This death was preventable. The actions of both the doctor and NP should have resulted in peer review and counseling.

Patient 24

This was a 69 year old man with a history of emphysema. He was housed at the Limestone facility from 12/18/00 until 1/18/11 when he transferred to Hamilton A & I where he was when he was hospitalized for chest pain. He had a prior positive tuberculin skin test in 1980 for which preventive therapy was completed. Department of Health records show that he had abnormal chest CT scans and x-rays beginning in February of 2010. These studies showed interstitial fibrotic changes but beginning in April of 2010 interstitial infiltrates began to appear. The patient apparently was not worked up for these pulmonary abnormalities until he was admitted to Brookwood Medical Center on 9/21/11 for chest pain. Hospital clinicians documented that the patient had over 100 pounds weight loss over a 4-5 year span of time. This would suggest long-standing tuberculosis. The patient underwent cardiac catheterization which showed multi-vessel coronary artery disease. The patient was not a candidate for stent placement and was considered a poor risk for bypass surgery. While hospitalized, a pulmonologist was consulted and hospital records document that the pulmonologist discussed follow-up with a provider at Hamilton A & I. On 9/22/11, tuberculosis smears were collected and reported as positive at the hospital at 5:29 pm on Friday 9/23/11. The hospital discharged the patient on 9/23/11 which was a Friday but the patient was not isolated at Kilby until Monday 9/26/11. Both his smear and culture results were positive for Mycobacterium Tuberculosis. He was in isolation at Kilby on 9/26/11 and died shortly after tuberculosis treatment was initiated. The Department of Public Health reported a positive probe for tuberculosis disease. While at Kilby in isolation the patient died on 10/8/11. This inmate's tuberculosis genotype was unique with respect to the other identified infections. This inmate was most likely contagious for a considerable period of time while at Hamilton A & I as well as at Limestone.	This review is from the Department of Health records. It demonstrates that the patient probably had long-standing tuberculosis at the Hamilton facility. This calls into question the ability of medical staff to identify active tuberculosis.

Patient 25

7/16/2007	Chest x-ray consistent with COPD was not followed up on.	Providers failed to follow up on an abnormal test result.
5/21/2008	Chest x-ray consistent with COPD was not followed up on.	Providers failed to follow up on an abnormal test result.
1/1/2011	The form E-4-a, the periodic health screening form which is supposed to be brought forward to the latest chart only had years 2011-2013. On those forms the patient did not show for the 2011 fecal occult blood test but the test was not done for 20112 and 2013 at Easterling.	The patient was over 75 so fecal occult blood screening is not recommended over 75.
9/19/2012	Lab reported hemoglobin of 12 (normal 12.3-17).	This anemia was not followed up.
1/4/2013	The patient placed a sick call request of "acid reflux" problem. He had this problem for some time.	The doctors didn't follow up diagnostically on a problem.
1/15/2013	An NP evaluated the patient for chronic care but did not take any history or evaluated the complaint of acid reflux.	The provider didn't follow up on a patient problem.
4/16/2013	An NP saw the patient for chronic care. The BP was 170/80 but was not addressed. The anemia was not addressed.	Providers failed to follow up on an abnormal test result.
10/25/2013	Lab reported hemoglobin of 10.9 and hematocrit of 33.7. No action was taken.	Providers failed to follow up on an abnormal test result.
10/29/2013	An NP saw the patient in chronic care. The NP failed to follow up on the significant anemia.	Providers failed to follow up on an abnormal test result.
1/28/2014	An NP saw the patient in chronic care. The NP failed to follow up on the significant anemia.	Providers failed to follow up on an abnormal test result.
7/23/2014	Lab reported a hemoglobin of 9.5 which is extremely low.	Providers failed to follow up on an abnormal test result.
7/27/2014	An NP saw the patient in chronic care. The NP failed to follow up on the significant anemia.	This was significant anemia but there was no follow-up.
7/29/2014	An NP noted the anemia on a chronic care visit and noted that Hemoccult tests were pending.	This was almost 2 years of anemia and almost a year with significant anemia.
8/19/2014	The lab reported a hemoglobin of 9 which was a significant anemia.	There should have been a more urgent follow-up.

11/4/2014	An NP saw the patient and documented that the patient had refused the Hemoccult test but re-ordered it. It isn't clear that the NP explained the purpose of the test to the patient.	The patient initially refused the test but then agreed. It wasn't clear if the patient initially understood the purpose of the test.
11/6/2014	An NP noted anemia and documented that occult blood was being tested for. The NP had noted the same about 2 months previous but apparently these tests were not done.	The patient initially refused the test but then agreed. It wasn't clear if the patient initially understood the purpose of the test.
11/6/2014	The lab reported a hemoglobin of 8 which is extremely low.	
11/7/2014	A doctor saw the patient and noted that 1 Hemoccult test was positive for blood. The patient had been on long-term prednisone for a rash and the doctor attributed the anemia and rectal bleeding to gastritis secondary to prednisone use.	
11/11/2014	The lab reported hemoglobin of 7.3 which is very low and was at a point for which transfusion was indicated.	The patient should probably have been admitted to a hospital for a work up and transfusion.
11/13/2014	A doctor wrote a referral for an EGD for iron deficiency anemia.	The provider didn't follow up on an abnormal test of almost 2 years.
11/14/2014	The patient initially refused an EGD to evaluate the anemia which he had had for over 2 years.	
11/22/2014	The Hemoccult test was positive for blood.	This indicated a gastrointestinal source of the blood loss.
11/23/2014	The Hemoccult test was again positive for blood.	
12/4/2014	The lab reported hemoglobin of 7.6.	
12/4/2014	The patient developed fever over 101 and the doctor placed the patient on the infirmary and started intravenous antibiotics without a diagnosis. A blood count showed a white count of 22 thousand which indicates systemic infection. The doctor ordered blood cultures.	The patient exhibited systemic signs and should have been hospitalized. Instead the doctor tried to manage the patient at the prison. He did not order a thorough work up initially but started antibiotics before ordering a thorough work up. This was an error.
12/8/2014	A repeat white blood count showed a white count of 19.9 thousand still showing significant systemic infection.	The patient should probably have been admitted to a hospital for a work up and transfusion.
12/8/2014	A doctor reviewed the blood count and documented that the patient had possible sepsis.	The patient should probably have been admitted to a hospital for a work up and transfusion.

12/10/2014	The white count was 21.5 thousand showing continued possibility of significant systemic disease. The doctor ordered more blood cultures (prior cultures were negative) and urine culture but the patient had been on antibiotics which would have unlikely yielded an organism.	The patient should probably have been admitted to a hospital for a work up and transfusion.
12/11/2014	Finally the doctor talked to the Corizon ID specialist who recommended a CT scan of the chest, abdomen and pelvis to search for a source of infection and to start a different antibiotic (Zosyn). The patient went to the hospital for the test and the abdominal CT scan showed a large metastatic liver lesion. These types of lesions are frequently from colon cancer.	The patient should probably have been admitted to a hospital for a work up and transfusion.
12/11/2014	The lab reported a hemoglobin of 6.7. The patient should have been referred for transfusion.	The patient should probably have been admitted to a hospital for a work up and transfusion.
12/12/2014	The doctor ordered a CEA test which is a proxy test for colon cancer.	
12/14/2014	The CEA test was 1038 (normal < 3.8). This was highly suggestive of colon cancer.	The patient should probably have been admitted to a hospital for a work up and transfusion.
12/14/2014	The doctor discontinued the antibiotic and stared Norco a narcotic medication indicating only supportive care would be given stating that the patient declined any further intervention. The date on this note was difficult to decipher.	
12/18/2014 2/19/2015	The doctor documented metastatic cancer. He had noted previously that this cancer was likely colorectal cancer. The doctor documented that only supportive care was going to be given. The patient expired at the prison.	

Patient 26

2/18/2012	The patient placed a health request stating that he had a cold. The blood pressure was 180/100.	The nurse did not address the elevated blood pressure.
2/21/2012	A nurse evaluated the patient 3 days after the health request and referred to a provider.	

2/22/2012	An obstetrician saw the patient who complained of fever, chills and productive cough. The patient had a history of COPD, diabetes, hypertension and coronary artery disease. The obstetrician ordered Solumedrol alone with no chest x-ray and no antibiotic.	The history was inadequate to determine the optimal treatment. The doctor didn't ask whether the shortness of breath was worse or whether the cough was worse and whether it was more purulent. For outpatient management oral steroids would have sufficed if indicated. Antibiotics may have been indicated but the history was too poor to make that determination. It did not appear that the obstetrician knew how to treat this presentation of fever with COPD.
2/28/2012	An NP evaluated the patient for cough and rattling in his chest. The NP ordered 3 antibiotics: Rocephin, Augmentin and Doxycycline.	The patient probably did not need 3 different antibiotics. One would have sufficed.
2/27/2012	The patient placed a health request about cough and rattling in his chest.	
3/15/2012	The patient placed a health request for shooting pain in his left foot from the foot to the knee. The pain started 3 months previous. The nurse evaluating the patient noted that the patient had left leg numbness for 2 years. The nurse referred to a provider.	
3/22/2012	A provider saw the patient and wrote an extremely brief note. The blood pressure was 158/100. The provider took no history. The physical examination of the leg was a single line that documented weak pulse and no wound on the left. The provider ignored the elevated blood pressure and had no diagnosis and wrote to continue the current treatment.	These symptoms are consistent with claudication. The patient should have had an ankle brachial index or arterial Doppler studies of the leg. This appeared to be a long standing problem. The patient also had lost his right leg but the reason for the loss of this leg wasn't addressed. The doctor also failed to address the patient's elevated blood pressure which is a risk factor for claudication and failed to make a diagnosis of the left leg pain. The provider developed no treatment plan for his claudication.
3/25/2012	The patient placed another health request for sharp pain in his left and right legs. A nurse referred him to a provider.	
3/26/2012	The patient placed another health request asking for an MRI of his left leg. A nurse saw him and referred him to a provider. The nurse noted that the pain occurred when walking. This type of pain is consistent with claudication.	
3/28/2012	The patient placed another health request stating that he wanted to be evaluated for left leg pain. He described the pain as 10 out of 10 and said he would rather have the leg amputated than endure the pain.	

3/29/2012	The patient places another health request complaining of numbness in his left foot. A nurse saw him the following day and referred to a provider. The nurse documented that the patient wanted his foot cut off.	
4/4//12	An NP evaluated the patient in chronic care. The only history was "numbness in left foot". There was no other history. The only examination was that the left foot color was normal and it was warm with capillary refill present. The NP made no diagnosis and added no treatment or additional plan.	After 4 health requests for left leg pain an NP failed to even take an adequate history of the problem. The examination did not include examination of the pulses. The left leg pain appeared to be ignored.
4/5/2012	The assistant Regional Medical Director evaluated the patient and diagnosed diabetic neuropathy and increased the Neurontin. The doctor took a very brief history.	The history was inadequate.
4/5/2012	The patient filed a grievance stating that he was not being attended to with respect to his left foot pain and wanted a second opinion about left and right leg pain. He stated that the Regional Medical Director had increased his pain medication but the pain wasn't resolving. The nurse responded by stating that the Neurontin was not for pain but for diabetic neuropathy. The nurse wrote to the patient that the Regional Medical Director would see him when he was next at the facility in about 3 weeks depending on what day he came that week.	The patient was correct with respect to the content of his grievance. His left leg issue was not being properly attended to.
4/15/2012	The patient placed a health request stating that he had pain in his left leg and right leg stump. The patient stated that he was placing the request just to document that he was complaining.	The patient was not getting his problem attended to.
4/16/2012	The patient filed a grievance stating that he wanted it on record that he was complaining about his left leg. He stated that he lost his right leg due to being on a list and not timely attended to and he didn't want that to happen again. A nurse responded that he would see the assistant Regional Medical Director today and needed to address the issue with the doctor.	The patient was correct with respect to the content of his grievance. His left leg issue was not being properly attended to.
4/16/2012	The patient wrote a health request stating that he wanted to see a specialist for his leg pains.	The patient was correct and should have been referred to a vascular surgeon.
4/17/2012	The patient wrote another grievance asking whether he had a right to a second opinion. The nurse responded that the assistant Regional Medical Director would determine whether he could see a specialist.	The patient was correct and should have been referred to a vascular surgeon.
4/17/2012	The patient wrote a health request asking whether he was on the list to be seen.	The patient's complaints were being ignored.

4/18/2012	The assistant Regional Medical Director wrote a very brief note. The history was extremely brief that the patient's pain was not responding to Neurontin. The doctor noted that the patient had no pulses on the left foot and diagnosed claudication and referred the patient for arterial Doppler studies.	This was an appropriate diagnostic test.
5/7/2012	An arterial Doppler study was done showing greater than 50% stenosis on the left leg.	This test result was never evaluated or addressed.
8/2/2012	The patient wasn't evaluated by a provider from 4/18/12 until 8/2/12. The NP saw the patient in chronic care and documented that she wanted the results of a Doppler done in May. The NP took no history of the progress of the patient's leg pain and made no diagnosis. Claudication was not listed as a problem.	The history was inadequate and the result of a diagnostic test was unavailable after almost 3 months. This follow-up was below standard of care.
8/16/2012	A doctor evaluated the patient who wanted to know about the Doppler study but the doctor didn't address it and apparently wasn't aware of the results. The doctor did document peripheral artery disease as a problem and added Pletal as therapy. He took no history with respect to whether the patient had ongoing pain.	The doctor needed to review the Doppler study and should have referred the patient to a vascular surgeon.
9/13/2012	A doctor evaluated the patient and described phantom limb pain in the right stump. The doctor documented no history about the pain. The pain likely stemmed from arterial disease in the right upper leg. The doctor failed to recognize the possibility of arterial disease in the remaining right stump. The doctor included peripheral arterial disease as a diagnosis but did not alter the plan and did not review the Doppler study. The patient had skin breakdown of the right stump and the doctor referred him to an orthotist.	The patient most likely did not have phantom limb pain but had peripheral vascular disease of the right leg stump. The patient should have been referred to a vascular surgeon.
10/25/2012	A doctor evaluated the patient for left leg swelling. The doctor took no follow-up history of the claudication and did not review the Doppler studies. The doctor did not take any history relevant to heart failure which the patient was at risk for (long-standing hypertension and with foot edema) and did not order an echocardiogram. Instead the doctor ordered a compression stocking and told the patient to elevate the leg. Elevation of the leg would make peripheral arterial disease worse.	The doctor failed to take an adequate history. The patient should have had a diagnostic echocardiogram and evaluation for heart failure which did not occur. The patient should have been referred to a vascular surgeon.
10/31/2012	An NP saw the patient for chronic care and took no history related to claudication, did not review the abnormal Doppler study and did not include claudication as a diagnosis.	The history, review of a past diagnostic study and diagnoses were all inadequate. The patient should have been referred to a vascular surgeon.

12/6/2012	Chest x-ray showed mild enlarged heart with interstitial prominence. This is consistent with heart failure and should have prompted an echocardiogram.	There was failure to follow up on this abnormal chest x-ray.
3/29/2013	A doctor saw the patient who had swelling of the left ankle. The doctor noted edema, decreased pulses and sensation and diagnosed dependent edema and internal ankle derangement. The doctor ordered ted hose and gave a tapering dose of prednisone. The Doppler study was not reviewed. The doctor didn't associate the edema with heart failure or associate the decreased pulse with peripheral vascular disease.	The treatment of a swollen ankle with prednisone without a diagnosis was inappropriate.
4/2/2013	An x-ray of the left ankle showed effusion but no fracture or derangement.	
6/11/2013	An NP evaluated the patient in chronic care. There was no history with respect to claudication. The NP did not review the Doppler study. Peripheral vascular disease was not listed as a problem.	The history and review of past findings was inadequate. The patient should have been referred to a vascular surgeon.
6/23/2013	Remarkably, a nurse on 6/23/13 performed a monofilament test on the inmate and documented no loss of protective sensation even though providers in the past had documented no sensation in the left foot and even though the patient had a diagnosis of diabetic neuropathy.	The failure of nurses to properly assess diabetic feet with respect to performance of the monofilament test was evident in a number of facilities. This means that nurses need significant training across multiple facilities. The patient had significant neuropathy and had loss of sensation in the foot yet was documented as having no loss of protective sensation.
9/1/2013	An NP evaluated the patient in chronic care. The date of the evaluation wasn't present but by the order of the document it appeared to be in September. The NP noted that the left leg hurt all the time but didn't take any further history of the leg pain. The examination documented 2+ edema with normal pulse and temperature. The Doppler wasn't addressed. Peripheral vascular disease wasn't diagnosed.	Both the history and assessment were inadequate.
12/17/2013	The patient was evaluated in chronic care by an NP. There was no history with respect to his claudication but the NP documented that there were no palpable pulses on the left foot. Nevertheless, peripheral vascular disease was not diagnosed, the arterial Doppler was not addressed and the claudication was not addressed. The right stump ulcer was not addressed.	The history was inadequate. The patient's problems were not addressed.

12/6/2013	A doctor evaluated the patient for complaints including that his left foot was cold and the right stump prosthesis was causing an ulcer. The doctor noted that the left pedal pulses were decreased and that the left leg Doppler was "monophasic", that the left leg was cold and that there was a 2.5 by 1.5 right stump ulcer. The doctor did nothing except to note that the patient had an appointment with the orthotist and would be followed in chronic care.	An ulcer on the stump should have been evaluated for the risk of osteomyelitis and should have been treated as if it were a diabetic foot ulcer. Antibiotics were indicated. The doctor appeared to ignore the problem.
1/31/2014	A doctor saw the patient who was concerned about the prosthesis causing an ulcer. The doctor did not evaluate the ulceration and referred the patient for follow-up in chronic care where his problems were not being addressed.	The doctor ignored the problem.
2/14/2014	The patient was evaluated by a doctor for an ulcer on his stump for over 2 months. The doctor did not take a history and only noted the ulcer. He ordered no laboratory tests and did not order antibiotics. He said the orthotist appointment was pending and the patient would be followed in chronic care.	The doctor ignored the problem.
3/3/2014	The patient placed a health request stating he wanted to know if he was diabetic because he was told he lost his right leg due to complications of diabetes. He asked to see a leg specialist.	The patient's request was correct. He should have been referred to a vascular surgeon.
3/6/2014	A doctor evaluated the patient and documented that the patient was a diet controlled diabetic. The doctor took no history with respect to his claudication or request to see a leg specialist.	The patient's problems were ignored.
3/19/2014	An NP saw the patient for chronic care and took no history related to claudication, did not review the abnormal Doppler study and did not include claudication as a diagnosis.	The NP took an inadequate history and failed to review the prior diagnostic test.
3/29/2014	The patient filed a grievance stating that it was his constitutional right to do so. He stated that he wanted a second opinion about his left leg which he felt was being ignored. He stated that if he had had a second opinion about his right leg he might not have lost it. A nurse responded that this was up to a provider.	The patient was correct. He should have been referred.
4/12/2014	A doctor saw the patient for ulceration of his right stump which was worsening. The doctor started rifampin and Bactrim but did not evaluate the claudication in the left leg or address the patient's concerns expressed in the grievance.	The provider should also have ordered an x-ray of the stump and checked a blood count and sedimentation rate to assess for osteomyelitis.

4/11/2014	The patient placed a health request complaining about a rash on the right stump and left foot problems. He was charged $4 for the evaluation which resulted in a provider visit the following day.	The patient was charged for a problem that was being mismanaged in chronic care.
6/15/2014	The patient placed a health request asking for help about his leg and neck.	
6/27/2014	A doctor saw the patient and noted that the patient lacked pulses in his left leg. He finally referred to a vascular surgeon.	The patient was referred finally for a problem that had existed for over 2 years.
7/7/2014	A different doctor saw the patient and documented that the patient had phantom limb pain in the right stump.	This physician did not competently assess the patient.
8/26/2014	This note was written 8/26 or 9/26/14. It was not clearly written. The physician documented that the patient had a stent placed in the left leg for vascular insufficiency and had bypass surgery scheduled for the left leg. This was almost 2 and a half years after the patient initially complained of this problem.	The patient finally had definitive treatment for a condition that had been ignored for over 2 years. This required the patient to file multiple health requests that were inadequately addressed and multiple grievances that needed to be filed before he was properly treated.

Appendix D: Curriculum Vitae and Fee Schedule

CURRICULUM VITAE

Michael Puisis
932 Wesley
Evanston, Illinois 60202

Home phone: 847-425-1270
Cell phone: 847-921-1270
Email: mpuisis@gmail.com

Personal Data:

Born: 6/28/50
Married, 1 child
Excellent health

Educational Experience:

Quigley North High School; graduated 1968
B.S. University of Illinois at Chicago 1978
Chicago College of Osteopathic Medicine 1982

Residency Training:

Internal Medicine, Cook County Hospital 1985

Board Certification:

Diplomate Internal Medicine, American Board of Internal Medicine 1985

Professional Activities:

National Health Service Corps Physician assigned as staff physician to Cermak Health Service (Cook County Jail), 1985-89.

Assistant Medical Director, Cermak Health Service, 1989 to 1991.

Medical Director, Cermak Health Services (Cook County Jail), 1991 to 1996.

Voluntary Attending Cook County Hospital, 1985 to 1996.

Advanced Cardiac Life Support Instructor at Cook County Hospital, 1985-89.

Director of Quality Assurance at Cermak Health Service, 1985-91.

Regional Medical Director, State of New Mexico for Correctional Medical Services, 1996 to 1999.

Corporate Medical Director, Correctional Division, Addus HealthCare, 1999 to 2004.

Consultant on correctional healthcare, 1988 to present.

Director of Research and Operations, Cermak Health Services, Cook County Jail, 2006-2007.

Medical Director, Illinois Department of Corrections, 2008.

Chief Operating Officer, Cermak Health Services, Cook County Jail May, 2009 to December, 2012.

Consultant Work:

Consultant to the U.S. Department of Justice 1989 to present on conditions at a variety of prisons and jails throughout the United States including reviews and/or monitoring of the follow programs:

- San Diego County Jail 1989
- Angola State Prison Louisiana 1992
- Simpson County Jail/ Sunflower County Jail and Jackson County Jail, Mississippi 1993
- Critteden County Jail 1994
- Gila County Jail 1994
- Maricopa County Jail 1994
- Cape Girardeau Jail 2000
- Montana State Prison 2004
- Wicomico County Jail 2004
- Baltimore City Jail 2005
- Cleveland City Jail 2005
- Augusta State Prison, Georgia, 2007
- Lake County Jail 2011
- Orange County Jail 2013

Consultant to the American Civil Liberties Union on the prison health system at the Indiana State Prison in Westville Indiana, 1988.

Consultant to the Legal Services Organization of Indianapolis regarding the prison health system at the Indiana State Prison in Michigan City and the Pendelton Reformatory in Indianapolis, 1988.

Consultant to the Indiana Civil Liberties Union reviewing Pendleton Correctional Facility, April 2000.

Member of the National Commission on Correctional Health Care Task Force for the revision of the *Standards for Health Services in Jails,* 1995.

Reviewer for the Centers for Disease Control for the *Prevention and Control of Tuberculosis in Correctional Facilities,* 1995.

Member of the Advisory Board for the "Evaluation of the Centers for Disease Control Guidelines for TB Control in Jails", 1999.

Clinical Reviews, grant review committee, Centers for Disease Control, 1999.

Member of the committee to revise the correctional health care standards for the American Public Health Association, 1999.

National Commission on Correctional Health Care's Physician Panel on Clinical Practice 1999.

Consultant to the United States Department of Justice to provide expert advice on the development of Standard Operating Procedures when federal inmates are confined in private prisons, September 2000.

Medical Expert for plaintiff in *Schilling v. Milwaukee County Jail*, 2001.

Expert witness for Southern Center for Human Rights in *Marshall,et al v. Whisante, et al* in review of conditions at the Madison County Jail in Madison County Alabama, 2002.

Expert witness for Legal Aid Society in *James Benjamin, et al.v. William Fraser, et al*. This resulted in a deposition in 2002 regarding medical complications in the utilization of shackles.

Expert consultant to the California Attorney General in *Plata v. Davis*, 2002.

Court appointed Medical Expert in Plata v. Davis, a consent decree regarding medical care in the California Department of Corrections, 2003 to present.

Expert consultant to the California Attorney General on medical care provided in the California

Youth Authority, 2003.

Committee member of the American Diabetes Association to revise the standard for diabetes care in correctional facilities, 2003.

Consultant to the Southern Poverty Law Center in assisting them in review of diabetes care for inmates in the Alabama Department of Corrections.

Medical Expert for Scott Ortiz plaintiff attorney in *Salvadore Lucido v. CMS*, 2005

Court appointed Medical Expert in *Laube et al v. Campbell* involving medical care at the Tutwiler women's prison in Alabama, 2004 to 2006.

Liason member representing the National Commission on Correctional Healthcare to the Advisory Committee for the Elimination of Tuberculosis (ACET), 2004 to 2007.

Medical Consultant to the Administration of Corrections in Puerto Rico via MGT of America in monitoring medical contract with Court Appointed medical corporation, 2005 to 2007.

Member of the Medical Oversight Committee, the monitoring body in a consent agreement covering the Ohio Department of Corrections and Rehabilitation, 2006 to 2007.

Medical Expert in monitoring Delaware Department of Corrections, 2006 to 2007.

Program Review of San Joaquin Juvenile Detention Center for San Joaquin County related to Walter Hixson et al v. Chris Hope, July-August 2007.

Monitor of Dallas County Jail in consent agreement between Dallas County and U.S. Department of Justice, 2007.

Medical Expert, review of Fresno County Jail, 2013.

Medical Expert, review of Monterey County Jail, 2013.

Medical Expert Consultant to Department of Homeland Security, 2013 to present.

Medical Monitor of Consent Decree Hall v. County of Fresno in regard to Fresno County Jail, 2015.

Consultant to Maryland Attorney General's Office with respect to *Duval et al v. Hogan et al* litigation, 2015.

Medical Monitor for medical provisions of *Duval et al v. Hogan* et al stipulated in the Settlement Agreement, filed 12/14/15.

Medical Consultant to the Southern Poverty Law Center with respect to *Dunn et al v. Dunn et al* with respect to the Alabama prison system medical program, 2015.

Medical Consultant to Promise of Justice Initiative, Advocacy Center of Louisiana, American Civil Liberties Union of Louisiana, and Cohen Milstein Sellers & Toll PLLC collectively with respect to the case *Lewis et al v. Cain et al* concerning medical care to prisoners at Louisiana State Prison, 2016.

Publications:

Radiographic Screening for Tuberculosis is a Large Urban Jail, Puisis M, Feinglass J, Lidow E, et al: *Public Health Reports* 111:330-334,1996.

Adding on Human Bites to Hepatitis B Prophylaxis; *Correct Care*, newsletter of the National Commission on Correctional Health Care, Vol.2, Issue 3, July 1988.

Editor, *Clinical Practice in Correctional Medicine,* Mosby, 1998.

Tuberculosis Screening, Overview of STDs in Correctional Facilities, & Chronic Care Management, Chapters in the textbook *Clinical Practice in Correctional Medicine,* Mosby, 1998.

Editor, *Clinical Practice in Correctional Medicine 2nd Edition,* Mosby/Elsevier, 2006.

Chronic Disease Management & Overview of Sexually Transmitted Disease, chapters in textbook *Clinical Practice in Correctional Medicine 2nd Edition, Mosby/Elsevier* 2006.

Deaths in the Cook County Jail: 10-Year Report, 1995-2004; Seijong Kim, Andrew Ting, Michael Puisis, et al; Journal of Urban Health 2006.

Risk Factors for Homelessness and Sex Trade Among Incarcerated Women:A Structural Equation Model; Seijong Kim, Timothy Johnson, Samir Goswami, Michael Puisis: Journal of International Women's Studies; 2011 January; 12(1):128-148.

Improving Health Care after Prison: Invited Commentary on Forced Smoking Abstinence: Not Enough for Smoking Cessation; *JAMA Intern Med* 2013; 173(9) 795-796.

Progress in Human Immunodeficiency Virus Care in Prisons: Still Room for Improvement? Invited Commentary, *JAMA Internal Medicine*, published online 2014 March 31, 2014 [Epublished ahead of print].

Improved Virologic Suppression With HIV Subspecialty Care in a Large Prison System Using Telemedicine: An Observational Study With Historic Controls: Jeremy Young, Mahesh Patel, Melissa Badowski, Mary Ellen Mackesy-Amiti, Pyrai Vaughn, Louis Shicker, Michael Puisis and

Lawrence Ouellet; Clinical Infectious Diseases, May 7, 2014 [Epublished ahead of print].

Awards

National Commission on Correctional Health Care Outstanding Correctional Health Care Publication of the Year for Clinical Practice in Correctional Medicine, November 1998.

National Commission on Correctional Health Care B. Jaye Anno Award of Excellence in Communication for Clinical Practice in Correctional Medicine, 2nd Edition, 2006.

2006 Armond Start Award of Excellence, from Society of Correctional Physicians.

Lectures:

Health Care: Correctional Medicine in the 90's
Illinois Correctional Association Fall Training Institute, October 22-23 1991.

Quality Improvement and Ethics, Who is the Customer, presentation at the University of Wisconsin, Madison, School of Medicine Second Annual Summer Forum, National Center for Correctional Healthcare Studies, July 1992.

Chest X-ray Screening for Tuberculosis in a Large Urban Jail, 16th National Conference on Correctional Health Care, September, 1992.

Overview of Tuberculosis as a Public Health Issue, National Association of Counties' public hearing of "County Government and Health Care Reform", October, 1992.

Screening for Tuberculosis, lecture at the Comprehensive AIDS Center, Northwestern University Medical School, August, 1993.

Management of Tuberculosis in Correctional Facilities, National Commission on Correctional Healthcare Roundtable, November, 1995.

Moderator: *Health Care Delivery in a Jails Setting,* at the 8th National Workshop on Adult and Juvenile Female Offenders, September, 1999, Chicago, Illinois.

Lecturer: Correctional Medical Services' Medical Director's Orientation, 1997-1999.

Satellite broadcast, "TB Control in Correctional Facilities", Texas Department of Health, February, 1999.

Presenter: *Chronic Care in Correctional Settings,* March, 2000, at a conference by Health and Medicine Policy Research Group, *Emerging Issues in Correctional Health.*

Presenter: *STD Screening, Treatment, and Early Intervention,* American Correctional Health Services Association's conference Public Health in Corrections co-sponsored by the Centers for Disease Control (CDC), March 2001.

Presenter: *Diabetes Cases in Corrections* Fall Conference 2003, National Commission on Correctional Health Care.

Presenter: *Contracting Out Medical Services* Spring Conference May, 2004, National Commission on Correctional Health Care.

Lecturer: Screening for STDs and HIV in Jails, 2005 National HIV Prevention Conference, Atlanta, Georgia.

Panel with Honorable Frank Easterbrook, Chief Judge, 7th Circuit and Ben Wolfe, ACLU at the John Marshall Law School American Constitution Society on inmate rights and access to health care, 2009.

Society and Organization Affiliations:

Society of Correctional Physicians

American College of Physicians

Fee Schedule

Consulting work: $250 per hour, $125 per hour travel time, and reasonable expenses

Deposition: $500 per hour

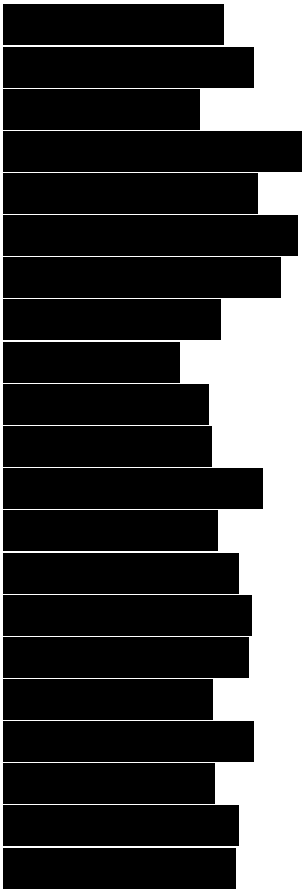
Appendix E: List of Documents Reviewed

Documents Reviewed through Discovery Process

1. ADOC Scabies Situation and ADPH Recommendations
2. Ventress Correctional Facility Continuous Quality Improvement Scabies 2013-2014
3. Corizon Reports
4. ADOC Audits
5. Corizon Monthly Client Reports
6. MAC Meeting Minutes
7. Credentialing file documents for physicians
8. Depositions
    a. Ruth Naglich
    b. Laura Ferrell
    c. Jeanette Dressel
    d. Vivian Odom
    e. Bobby Crocker
    f. Jim Mitchell
    g. Jane Haynes
    h. Marsha Patterson
    i. Marianne Baker
    j. Brandon Kinard
    k. Cindy Johnson
    l. Teresa Ergle
    m. Tahir Siddiq
    n. Jessica Duffell
    o. Anissa Thomas
    p. David Gams
    q. Jerry Lovelace
    r. Wilcotte Rahming
    s. Hugh Hood
    t. David Pavlakovic
    u. Domineek Guice
    v. Ken Dover
    w. Charles Hooper
9. Photos of facilities from site inspections
10. State of Alabama Department of Public Health subpoena response
11. Corizon Regional and Facility Specific Policies
12. Corizon Corporate Credentialing Policies

13. Healthcare Standard Operating Procedures for ADOC
14. Corizon ER and Hospital Reports
15. State of Alabama Administrative Regulation 700
16. Office of Health Services Division Manual of Policies and Procedures
17. Corizon Contract with ADOC
18. Corizon Infection Prevention Manual
19. Corizon Sentinel Event Process document
20. Alabama Department of Corrections Monthly Statistical Report for March 2016 National Commission on Correctional Health Care Standards for Health Services in Prisons 2014
21. Mortality review documents reviewed in Birmingham and in Chicago
22. Email from Ruth Naglich to Lynn Brown copied to Danny Gould and Martha Haynes sent 11/14/13
23. Alabama Department of Corrections, Institutional Vulnerability Analysis: St. Clair Correctional Facility
24. Email dated 09/26/2011 at 03:06 pm from Kimberly Taylor ADPH to Eric Morgan and Pam Barrett

Patient records reviewed in report:



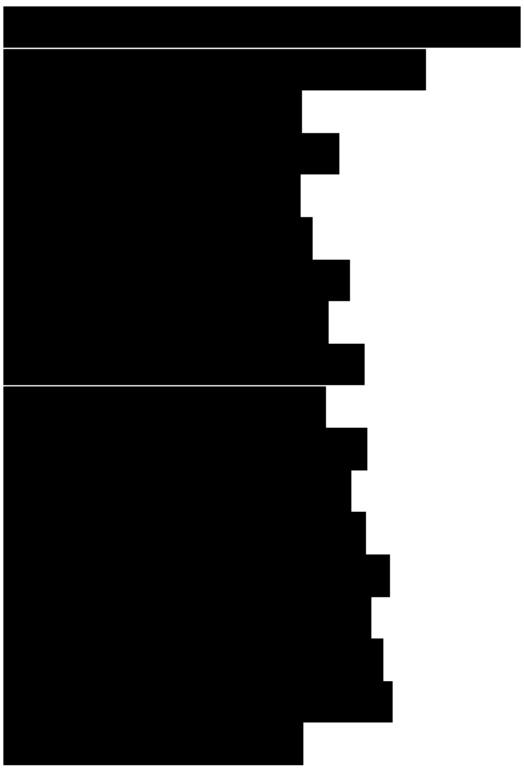
[redacted]

Additional charts reviewed:

[redacted]

Inmates interviewed during site inspections:

[redacted]



Additional documents and references

1. Quality Concerns Identified Through Quality Improvement Organization Medical Record Reviews; Department of Health and Human Services Office of Inspector General; May 2007 OEI-01-06-00170
2. E. Ann Carson, Prisoners in 2014; US Department of Justice, Bureau of Justice Statistics, September 2015, NCJ 248955
3. Alabama Department of Corrections website Facilities section under About ADOC tab found at http://www.doc.state.al.us/FacAddr.aspx
4. Alabama Board of Medical Examiners & Medical Licensure Commission of Alabama; Board ruling concerning medical records as found at http://www.albme.org/medrecrule.html
5. Catherine Knox and Steve Shelton; Sick Call chapter in Clinical Practice in Correctional Medicine, 2nd edition Mosby 2006 page 50
6. Position Statement: Charging Inmates a Fee for Health Care Services, National Commission on Correctional Health Care as found at http://www.ncchc.org/filebin/Positions/Charging_Inmates_a_Fee_for_Health_Care_Services.pdf
7. Guidance for Industry: Warnings and Precautions, Contraindications, and Boxed Warning Sections of Labeling for Human Prescription Drug and Biological Products – Content and Format published by the FDA (found at http://www.fda.gov/downloads/Drugs/.../Guidances/ucm075096.pdf)

8. Elizabeth Sazie, Mary Raines; Infirmary Care chapter in Clinical Practice in Correctional Medicine 2nd edition, Mosby 2006
9. To Err Is Human; Building a Safer Health System: Institute of Medicine, National Academy Press 2000
10. HCV Guidance: Recommendations for Testing, Managing, and Treating Hepatitis C; American Association for the Study of Liver Diseases and Infectious Disease Society of America, April 2016 version as found at http://hcvguidelines.org/full-report-view
11. Guide to the Application of Genotyping to Tuberculosis Prevention and Control, Handbook for TB Controllers, Epidemiologists, Laboratorians, and Other Program Staff, Prepared by the National Tuberculosis Controllers Association / Centers for Disease Control and Prevention, Advisory Group on Tuberculosis Genotyping June 2004 as found at http://www.cdc.gov/tb/programs/genotyping/images/tbgenotypingguide_june2004.pdf
12. For clinical reference I use UpToDate® an Internet based decision support resource.
13. Guideline for Prevention of Catheter-associated Urinary Tract Infections, 2009; Centers for Disease Control and Prevention, Healthcare Infection Control Practices Advisory Committee (HICPAC).
14. Altice F, Douglas B, Hepatitis C Virus Infection in United States Correctional Institutions, Current Hepatitis Reports- August 2004, 3:112-118
15. Moyer V; Screening for Hepatitis C Virus Infection in Adults: US Preventive Services Task Force Recommendation Statement; Annals of Internal Medicine September 2013; 159: 349-357 found at file:///C:/Users/mpuisis/Downloads/hepcfinalrs2%20(1).pdf
16. Evaluation and Management of Chronic Hepatitis C Virus (HCV) Infection, Federal Bureau of Prisons Clinical Practice Guidelines, April 2016 as found at https://www.bop.gov/resources/pdfs/hepatitis_c.pdf
17. PG-18-19: Space Planning Guide, March 2008, Revised October 01, 2015; Chapter 316: Dialysis Center as found at http://www.cfm.va.gov/til/space/SPchapter316.pdf
18. Prevention and Control of Tuberculosis in Correctional and Detention Facilities: Recommendations from CDC; MMWR 2006; 55 (No. RR-09, 1-44).
19. Rules of Alabama State Board of Health, Alabama Department of Public Health, Chapter 420-5-5; End Stage Renal Disease Treatment and Transplant Centers Amended December 18, 2007 as found at http://www.adph.org/HEALTHCAREFACILITIES/assets/ESRDrules.PDF