Audit health delivery Tulsa Co. Jail

12/26/11

Methodology: TCSO medical record audit 11/10/11 booking –

- 52 charts of 93 bookings.
- Excluded 29 of 39 released on booking date.
- All 19 federal inmates reviewed

Inmate booking –

If inmate is combative, intoxicated – they go to holding until calm before intake medical evaluation.
Risk of significant delirium, etc puts officer at risk w/o medical staff input.

Suggest: telemedicine - video in holding cell to allow medical to evaluate and initiate treatment prn

Pre-arrest Medications

There appears to be a gap in getting verification and initiating meds. CHC Clinical protocol L 12 appears to address this for psychiatric medications. The protocol discusses verification of current prescription [IV 1] however does not take into account the endemic process delays in obtaining such verification. There have been position by the DOJ regarding these delays as a serious deficiency [see Addendum 2].

Some meds are critical for medical health e.g. Synthroid 0154808 [if admitted to hospital would have these started w/o verification]

As many of these inmates have significant psych issues, one might anticipate an increase in negative incidents for these inmates who are off meds. Many withdrawal symptoms are consistent with worsening psychiatric condition [see addendum 1]. E.g. 1155634, 1204001, 156391, 0154808

Rec. – standing orders for initiating meds prior to verification if no contraindications – can use mental health telemedicine oversight.

Monitoring of Nursing primary care at sick call

#1195601
Nurse carries out protocol for ear complaint – does not follow it correctly – no notation that it was reviewed by provider. It was actually incorrect treatment – did not even comply with protocol.

No provider notation in EMR

Lag time inmate complaint until sick call

Generally 1-2 days for nurse triage then another 1-2 D for sick call visit. Some of these [# 1203989 eye, 156991 bite to groin, 1155634 SI] could have been more serious but screening leaves high potential for error.

Rec. – telemedicine

Medical complaints not evaluated prior to release

During the several day lag from inmate request to sick call, patient may be release. Potential for serious medical issue going unaddressed [e.g. 1536391 – chest pain significant high BP, released day after]

Liability issue if patient has ACS ??

Protocol Gaps

Protocol was not followed for #001719. Patient was reported to be intoxicated at booking and gave an intake history of excessive chronic alcohol use plus a history of withdrawal seizures. Protocol L04 is in place to address this high risk situation. It was not implemented. Of note is that patient was marked as suicidal risk on intake screening form but not so on intake history approximately 3 hrs later. Policy L13 requires suicide watch until patient no longer deemed to be at risk. There is no evidence of such precautions during the 3 and half hour interval between assessments. Also it would be prudent to consider addressing a disparity in detail when item such as suicidal ideation is at issue.

Even if followed, some protocols may be inadequate for standards medical of care. This allows lower level of care by nurse without proper oversight
e.g. Eye – no slit lamp 1203989 [Federal],
Headache – does not screen for sudden onset new headache 1134888 [Federal]

Rec. – Ongoing CQI with goal to have built in automatic flags that prevent deviation from proper protocol. Also overall protocol review for compliance with established medical standards of care.

Follow up missed sick call

As there may be multiple reasons for inmate missing sick call that might be out of his/her control – need follow up mechanism. E.g. 1204007
Rec – telemedicine

Incomplete Medical record

#1155634: Nurse notes an EKG was done p7 but physician note never comments on it and the EKG is not in the MR.

Summary

Although this was only 1 day of bookings and the number of cases would unlikely meet statistical standards confirming significance, the number of risk cases identified should raise enough concern to have these issues addressed promptly.

Addendum 1 Withdrawal symptoms psychiatric medications

SSRI discontinuation syndrome

Discontinuation symptoms typically arise within days after stopping the medication, particularly if it was stopped abruptly. Stopping a high dose of a relatively short-acting drug also can bring on symptoms. In addition to the previously-mentioned symptoms, "anxiety and depressed or irritable mood are common features that may make it hard to differentiate SSRI discontinuation syndrome from early return of symptoms of depression," Baldessarini said.

About 20 percent of people experience discontinuation symptoms, according to Dr. Michael D. Banov, medical director of Northwest Behavioral Medicine and Research Center in Atlanta, and author ofTaking Antidepressants: Your Comprehensive Guide To Starting, Staying On and Safely Quitting. About 15 percent experience mild to moderately bothersome symptoms while fewer than five percent experience more severe symptoms, he said.

However, the risk for discontinuation syndrome is generally greater with potent, short-acting SSRIs — particularly paroxetine (Paxil and others) and venlafaxine (Effexor and others), Baldessarini said.

Discontinuation symptoms can happen with any antidepressant, but seem to be more common with the following classes of drugs:

- **SSRIs**. These include citalopram (Celexa), escitalopram (Lexapro), fluoxetine (Prozac and others), fluvoxamine (Luvox), paroxetine (Paxil), and sertraline (Zoloft)
- **Inhibitors of inactivation of both norepinephrine and serotonin (SNRIs)**. These include chlompramine (Anafranil), venlafaxine (Effexor) and desvenlafaxine (Pristiq). Such drugs are prescribed more often for depression or severe anxiety disorders, so the withdrawal phenomenon is more common.

WELLBUTRIN Withdrawal Symptoms May Include:

aggression, anxiety, balance issues , blurred vision , brain zaps, concentration impairment, constipation, crying spells, depersonalization, diarrhea, dizziness. electric shock sensations, fatigue, flatulence, flu-like symptoms, hallucinations, hostility, highly emotional, indigestion, irritability, impaired speech, insomnia, jumpy nerves, lack of coordination, lethargy, migraine headaches / increased headaches, nausea, nervousness, over-reacting to situations, paranoia, repetitive thoughts or songs, sensory & sleep disturbances, severe internal restlessness (akathisia), stomach cramps, tremors, tinnitus (ear ringing or buzzing), tingling sensations, troubling thoughts, visual hallucinations / illusions, vivid dreams, speech visual changes, worsened depression.

Addendum 2 DOJ – delays in prescribed medications

http://www.justice.gov/crt/about/spl/documents/baltimore_findings_let.php

….findings of our investigation of conditions at the Baltimore City Detention Center ("BCDC"). On October 16, 2000, we notified you of our intent to investigate BCDC pursuant to the Civil Rights of Institutionalized Persons Act ("CRIPA"), 42 U.S.C. § 1997. In addition, 42 U.S.C. § 14141 provides us jurisdiction to investigate the conditions of confinement for juveniles at the facility. ……

Finally, inmates who come in to the facility on medications experience serious delays in restarting those medications, including medications needed to control asthma, seizures, mental

illness, HIV and blood clotting. In the meantime, they may experience withdrawal symptoms and/or re-experience the symptoms of their illnesses. The failure to provide medications in a timely manner is a serious deficiency in care at this facility