NCCHC™ Resources, Inc.

Technical Assistance Report

Washoe County Sheriff's Office

Reno, Nevada

This report details findings from a site visit to the Washoe County Sheriff's Office Jail and presents recommendations for quality improvement.

Developed by NCCHC Resources, Inc.

February 2017

TECHNICAL ASSISTANCE REPORT:
WASHOE COUNTY SHERIFF'S OFFICE

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INTRODUCTION

Origin of Project

The Washoe County Sheriff's Office presented a request for proposal and selected NCCHC Resources, Inc. (NRI), to improve cost effectiveness and system efficiencies while maintaining good patient outcomes in the correctional setting. This report presents the results of the technical assistance to help Washoe County Sheriff's Office accomplish this goal.

Plan of Action

NRI provided a team of correctional health care experts to review correctional health and mental health care services and policies for the Washoe County Sheriff's Office. The aim was for NRI to assess the health services policies and procedures at the Washoe County Sheriff's Office and recommend policy and procedure changes that can result in improved health care efficiency and effectiveness to meet current and future needs

Facility Visit

The objectives were met through a (4) four-day on-site visit and review of the Washoe County Sheriff's Office using the *Standards for Health Services in Jails (2014)* as a guide for the review. The team consisted of a lead consultant, a physician consultant, and a mental health professional.

The team conducted an inspection, interviewed facility staff, and assessed the medical and mental health workflow so that recommendations could be made for current and future needs.

Interviews with key medical and mental health personnel were conducted and a review of health policies and procedures were assessed to assist with department-wide assessments and evaluations against NCCHC Standards. During the on-site visit, the team observed the intake process, segregation, and general housing areas. They reviewed nursing protocols and examined equipment and supply needs for the medical unit. The team assessed the sick call process, intake screening process, management of communicable diseases, process for chronic disease management, and mental health services.

An oral conference was held at the conclusion of the visit and this written report is being presented for a full review of the on-site visit.

NCCHC Resources, Inc. Technical Assistance Report
Washoe County Sheriff's Office, Reno, Nevada
January 31 – February 3, 2017

The Washoe County Sheriff's Office Detention Center was opened in May of 1988 as a direct supervision jail. The original capacity was designed for a 499 bed facility, 8 housing units and an infirmary. There have been two major expansions in 1999 and 2008. The current capacity is 1,333 beds in 15 housing units plus 19 beds in medical. The average daily inmate population for the year of 2016 was 1,085.

The inmate population on the first day of the review was 1,025 including 825 adult males, 200 adult females, and no juveniles.

The focus of this report is on the operational flow and the efficiency and effectiveness of the provision of health care services at the Washoe County Detention Center. The report will present a summary of findings within the context of appropriate and effective health care services in correctional facilities as defined by NCCHC standards, along with other professional and clinical standards and expectations.

A team with NCCHC Resources, Inc. (NRI) reviewed all aspects of the health care operation over the course of a four (4) day site visit. They were tasked with assessing access to care, timeliness of care, and continuity of care throughout incarceration.

The process included a tour of:

- Intake/receiving/booking area
- Intake units for males and females
- Clinic areas
- Housing units: general population, segregation, disciplinary, mental health and medical which is referred to as the "infirmary"

A review of:

- Health care vendor policies/procedures
- Jail policies/procedures
- Staffing matrix
- Nursing protocols
- Minutes of administrative, staff, and committee meetings
- CQI reviews
- Statistical reports
- Health care records

Interviews with:

- Jail administrative staff
- Deputies
    - Intake

    - Housing units
    - Background investigation
    - Administrative support unit
- Health Services Administrator
- Director of Nursing
- Nursing supervisor
- Floor nurses
- Emergency medical technician
- Physician
- Nurse practitioner
- Dentist
- Psychiatrist
- Social worker
- Patients/Inmates
    - General population
    - Mental health unit
    - Segregation/lockdown
    - Intake/receiving
    - Clinic

Observations of daily activities:

- Deputy – patient/inmate encounters
- Health care staff – patient/inmate encounters
- Deputy – health care staff encounters
- Interactions between medical, mental health and dental staff
- Medication administration process
- Intake/receiving process
- Health assessments
- Sick call encounters
- Patient/inmate escort

The staffing plan that is called for in the current health care services contract: (FTEs)

Day Shift	
Health Services Administrator	1.0
Director of Nursing	1.0
Medical Director	1.0
Nurse Practitioner	1.4
Intake RNs	2.1
Intake EMTs	2.1
Charge Nurse	2.1
Registered Nurse (sick call)	1.0
LPN – AC-4	2.1

Social Worker	2.4
Discharge Planner	1.0
Psychiatrist	1.0
Administrative Assistant	2.0
Medical Assistant	1.4
Dentist	0.4
Dental Assistant	0.4
Medication nurse (LPN)	4.2
OB/GYN	0.1

Night Shift

Intake RN	2.1
Intake EMT	2.1
Charge Nurse – RN	2.1
Medication nurse (LPN)	4.2
LPN – AC-4	2.1

An effective health care program in jails requires a sufficient number of health care professionals of each indicated discipline, with adequate resources, who then design, implement, and operate efficient systems for the provision of care. The report of findings will identify general criteria for effective health care services in the Washoe County Sheriff's Office.

A comprehensive review of the various aspects of the medical, mental health, and dental care was completed during the four (4) day, on-site, review. The following health care service operations were identified as potential areas of workflow improvement.

INTAKE/RECEIVING PROCESS

Newly arrested individuals are met in the long hallway that connects the sallyport and the booking area. An EMT meets the arresting officer(s) and the arrestee at a workstation in that hallway. The arresting officer is required to complete a form to provide the EMT with a baseline medical and mental health status of the arrestee. The questionnaire is used to record the officer's observations regarding drug or alcohol intoxication, suicide potential, mental status, and obvious injuries and/or illness.

Finding: The EMT reviews the completed form prior to obtaining vital signs and asking the arrestee a series of health related questions. The answers to these questions, along with the information reported on the arresting officer's form, is used to assist the EMT in determining whether or not the arrestee will be accepted or denied entry into the jail.

Observations of the pre-screening process revealed that the EMT was asking the pre-screening questions that are on a designated form (titled Pre-Booking Triage), as well as many additional questions that were similar to a receiving screening process. This enhanced pre-screening process was observed on several occasions during the first two days of the review and interviews confirmed that EMTs were combining the pre-

screening and receiving screening processes. The pre-screening form had handwritten words in the margins that were reminders for the EMTs to make inquiries and observations that are beyond the categories on the pre-screening form.

Recommendation: The pre-screening and receiving screening processes should be handled separately. The proper sequence would be to complete the pre-screening upon arrival to determine whether or not the arrestee will be accepted into the facility. Once accepted, arrest paperwork should be given to a booking officer and the inmate booked into the jail management system. After this has been completed, the receiving screening process should be completed at the workstation that is setup for that purpose. A receiving screening process, based on memory and a few word reminders on the pre-screening form, leaves the system open to inconsistencies and omissions by the various EMTs. The receiving screening should be completed by the EMT at a computer station where a proper interview and observations can be documented. Each answer, and all observations, should be documented on the electronic form through the entire receiving screening process. It is not appropriate to complete the receiving screening form without the inmate present.

Finding: Health record reviews revealed that the electronic screening forms require "documentation by exception" which means that many of the fields on the screening form are left blank if there is no history, or the inmate denies a history of the particular health care issue. This leads to inadequate and incomplete screening. This results in a high percentage of the screening forms appearing to be incomplete.

Recommendation: The facility should use electronic forms that require complete documentation in all form fields.

ACCESS TO CARE

Inmates may request health care services by typing a request on a kiosk or by verbally asking a nurse, social worker, or officer. If the verbal request is determined to be non-emergent in nature, the inmate is directed to use the housing unit kiosk which is located in each unit.

Every inmate receives a unique PIN that enables them to electronically log into the kiosk system for the purpose of requesting health care services, ordering commissary, reviewing the jail rules and regulations, and for sending and receiving emails to individuals within the community.

Finding: There is no formal orientation to the kiosk system for newly arrived inmates. Staff members and inmates explained that inmates with communication barriers (e.g., non-English speaking, illiterate) are dependent on other inmates who are able to operate the kiosk to complete requests for medical, dental, or mental health care.

The evaluation team interviewed officers about the security of the system, specifically if inmates are able to manipulate those who require assistance out of money, goods or

services in exchange for using the kiosk. The evaluation team was assured that the security of the system is very good and internal and external controls are in place that prevents inmates from taking advantage of those who are unable to access the system.

Inmates who are in restrictive housing are only allowed out of the cell once every 48 hours. As a result, they do not have daily access to health care requests. It was reported that medical staff members, mental health staff members, and jail personnel are in the restrictive housing units multiple times per day. This gives inmates an opportunity to notify them of their health needs and to have those needs passed along to the appropriate health staff member(s). It is not appropriate for an inmate to have to express their medical or mental health concern to a jail staff member for non-emergency health care requests.

Recommendation: Every inmate should receive instruction on how to use the kiosks as part of the orientation process. Inmates who reside in housing units that do not allow daily, out-of-cell time, should, at a minimum, be granted time out of their cell at least once every 24 hours, and/or have access to a portable kiosk so they can make their health care requests confidentially.

Finding: When an inmate logs into the kiosk system and types a request for health care services, the request is reviewed in the infirmary by an LPN on night shift. A review of a random sample of health care requests showed that after reading the request, the LPN sends an electronic response to the inmate. The responses included the following:

- Whether or not the patient had already been to clinic for the problem
- Whether the patient had been scheduled to see a mental health counselor
- Whether the patient had been scheduled for dental clinic
- Whether the patient have been scheduled for sick call

We found that triaging of electronic health care requests is conducted in lieu of a face-to-face triage even when the requests contain clinical aspects. It was noted that there are times when a nurse does report to the appropriate housing unit to conduct patient triage. However, this does not always happen for mental health and dental requests.

There was an excessive amount of back and forth narrative between the nurse and the inmate that would have been more appropriately handled in a face-to-face discussion with the inmate.

Recommendation: Every written request for health care services that contains a clinical aspect in the narrative should require a face-to-face triage of the patient who submitted the request. The initial face-to-face triage can be conducted by a nurse even when the request is for a mental health or dental issue. The face-to-face encounter would also eliminate the back and forth electronic messaging between the nurse and the patient who has submitted the request for services.

Finding: Accessing mental health care can also be done through “appointments” or visits with mental health professionals. At present, there is one full-time and several PRN (as needed) mental health professionals available to respond to referrals and inmate requests for care. Due to the limited number of mental health professionals, it was reported by inmates and staff members that it typically takes a week or more for the mental health professional to respond to a request for care. Response to referrals is first given to those who are in crisis or urgent need of care followed by those who have been waiting the longest to see a mental health professional. Referrals made by officers or other health care staff are frequently responded to within 24 hours, depending on the urgency of the request.

Recommendation: It is recommended that the mental health professionals in the facility develop a system that is not crisis-based and that allows for timely access to care.

HEALTH ASSESSMENTS

Health assessments are completed by registered nurses in the booking area as a part of the intake process. The review team noted several concerns after observing the process and conducting interviews with health care staff, jail employees, and inmates

Finding: The health assessments are being conducted in an area that provides limited privacy for the patient who sits across a counter from a nurse. The two-seat workstation has a partition between the two inmate seats but the questions and answers can be overheard by other staff and inmates.

Recommendation: Either enclose the nursing workstation or relocate the health assessment process to another area that provides for patient privacy.

Finding: Nurses are required to lean over the workstation counter in order to obtain vital signs and there is no exam table available in the area if a more in-depth hands-on exam is required. The health assessment form includes additional hands-on components such as lung sounds, abdominal assessment, and palpation of hernia and/or masses that are not being addressed during the assessment process.

Recommendation: Provide an appropriate examination area that is adequately equipped with an exam table, adequate lighting, proper equipment, running water and the necessary medical supplies to complete a proper initial health assessment.

Finding: We received reports that some nurses are more efficient than others in completing initial health assessments. Variances in the timeliness of completing the health assessments combined with an annual book-in rate of over 20,000 inmates per year has been problematic. Inmates are required to remain in the booking area until the health assessment has been completed. The wait times range from two (2) to twenty (20) hours. Wait time has been a source of concern due to the number of inmates who

are staged in the receiving area at any given time. The greater number of inmates in the booking area proportionately raises the risk of security issues arising.

Recommendation: Consider relocating the health assessment stations to a location in or near the intake housing units or evaluate the option of delaying the initial health assessment to a more appropriate time. This can be done based on statistical analysis of releases that take place within the first several days following court arraignment.

There should also be a reassessment of the training given to the intake nurses, their proficiencies and the timeliness in completing the task. A CQI review that looks at the amount of time that inmates are kept in the booking area as a result of not having a completed health assessment would be advisable.

Finding: We reviewed the training program that must be completed by the intake nurses in order for them to complete the mental health portion of the health assessment. This is done as a part of the initial health assessment during the intake process. The training is adequate for screening purposes and for those with minor mental health difficulties. It is not sufficient for adequately assessing the complex mental health problems and mental illnesses that a substantial number of people who are incarcerated experience. Adequate and accurate assessment ensures accurate diagnosis and the development of an effective treatment plan.

Recommendation: Ideally it would be best to have mental health professionals complete the mental health screenings and assessments. This ensures that accurate identifications and diagnoses take place and that appropriate treatment plans can be generated. If the decision is made to continue the practice of having the registered nurses complete the screenings as a part of the health assessment, then a more robust training program on proper identification and referral of mental health care problems is a required. The training should be conducted by mental health professionals.

Finding: Professional standards and expectations require that a full mental health assessment be performed on inmates who have a screening that indicates the presence of mental health difficulties or mental illness. A total of 42 health records were reviewed. Twenty-one (21) of them had no mental health evaluation for the current incarceration. Two (2) health records indicated that individuals who had been in the facility for a significant period of time (a month or longer), had a screening that indicated the need for a mental health assessment. None had been completed as of the time of our review.

The mental health staff was aware that not everyone who required a full mental health assessment had received one and provided the following explanations for this finding:

- Inmates are not seen prior to being released. A significant number are released prior to the industry standard of completion within 14 days.
- Inmates who have had an evaluation or assessment in the past year do not require an additional assessment.

- Inmates can refuse assessments. When they do, the staff documents the refusal in a progress note. Health record review indicated four (4) of the twenty-one (21) who did not have a mental health assessment had refused it.
- Among those refusing the assessment included somebody who was:
    - "irritable and unkempt" (suggesting the need for a mental health assessment)
    - somebody who was currently "withdrawing" (suggesting the need for a mental health assessment)
    - somebody who "refused" (suggesting the need for a mental health assessment)

Recommendation: It is recommended that inmates participate in the mental health assessment. It is uncommon for inmates to refuse a mental health assessment, particularly when the need for it is explained and they are encouraged to participate. Even if an inmate has had an evaluation within the last three to six months, it is appropriate to at least do a brief assessment to ensure nothing has changed and that there are no current mental health issues with which the person may be struggling.

CONTINUITY AND UTILIZATION OF MENTAL HEALTH MEDICATIONS

It is common practice for jails in the United States to have a system in place to continue prescriptions for psychotropic medications, or an acceptable alternative that can be verified by a pharmacy or community medical or mental health provider upon admission. This ensures that the inmate does not experience an interruption in the administration of medication, especially psychotropic medication, which can lead to withdrawal effects and emotional and mental instability.

Finding: The practice at the Washoe County Detention Center is to electronically notify the psychiatrist that an individual has entered the jail with an active and verified prescription for psychotropic medication. At that point, the psychiatrist can electronically order the medication or decide that the inmate must first be seen before ordering the medication. The best-case scenario is that the inmate will receive the medication the following day. In many cases, the inmate is told it may take two to three days to receive the medication. Inmates report that it is not uncommon for it to take several weeks for them to begin receiving psychotropic medication for which they had an active prescription at the time of entry to the jail.

This is an ineffective system. Inmates who do not promptly receive psychotropic medication that they have been regularly taking are at risk of withdrawal symptoms, complications related to medication withdrawal, and are more vulnerable to the stress of incarceration.

Recommendation: It is recommended that the system be adjusted so that active, verified prescriptions can be continued within the first 24 hours of incarceration.

Finding: A primary method for prescribing and administering psychotropic medication to inmates is through inmate requests and triaging by the mental health professionals. The system involves having a mental health professional evaluate an inmate who has requested medication, who has submitted a request to see a mental health professional, or who has been referred by a jail or medical professional. The mental health professional makes a determination, and refers the inmate to the psychiatrist as deemed appropriate by the professional's clinical judgment and decision-making.

Unfortunately, because there are significant delays (often a week or more) between when an inmate requests medication and when seen by a mental health professional, there are delays in beginning the medication. It was difficult to determine the typical waiting time to see the psychiatrist, but inmates and jail employees reported that it often takes "weeks."

Recommendation: It is recommended that the facility develop a more effective triage and referral system so inmates can receive psychotropic medication in a timely manner.

Finding: A formulary is used to provide structure for which psychotropic medications may be prescribed. The formulary appears to be sufficient, but there are difficulties with the process and procedure for obtaining non-formulary medications or continuing non-formulary medications at the time of intake.

It was reported that most non-formulary medication requests are denied, and that a "fail first" process is utilized. This is defined as taking an inmate off a non-formulary medication at the time of intake, transitioning them to a formulary medication, then returning the inmate to a prescription for the non-formulary medicine only if they fail to receive benefit from the new formulary medication. In the worst-case scenario, this may consign an inmate to a prolonged period of instability as they try to adequately adjust to the new medication.

Inmates who are returned to the jail from the state mental hospital, or other facility after being restored to competency to stand trial, are automatically continued on the medication regimen that allowed them to achieve competence.

Recommendation: It is recommended that inmates who can document stability on a particular medication regimen be maintained on that regimen, even if it includes or consists of non-formulary medications. Additionally, it is recommended that all non-formulary requests be carefully reviewed and approved as appropriate.

Finding: The current use of psychotropic medication in the facility was reviewed, with the following outcome:

Type of Medication	Number of Prescriptions	Total Number of Active Psychotropic Prescriptions	Percentage of Active Psychotropic Prescriptions
SSRI/Antidepressant	8	122	8 %
Antipsychotic	108	122	90 %
Mood Stabilizer	6	122	2 %

This data indicates that antipsychotics are the most commonly prescribed type of medication by a wide margin. Included in this total are 30 prescriptions for Ziprasidone (Geodon) and 62 prescriptions for Olanzapine (Zyprexa). This is not what would be expected, since depressive disorders are much more common in the general and correctional populations than are psychotic disorders. It would be much more common to find 10 % or less of inmates diagnosed with a psychotic disorder and perhaps as many as 20-30 % of inmates diagnosed with a depressive and/or mood disorder.

Given the data presented above in the sections on intake and psychotropic medications, it is hypothesized that the model of first seeing inmates most in need of care, and then seeing those who are referred by jail employees, leads to a disproportionate amount of contact with inmates with more severe, potentially psychotic disorders. This in turn would lead to a disproportionately high number of prescriptions for antipsychotic medication. While it is important to see inmates with psychotic disorders, it is also important to see those with depressive disorders or other, less severe mental illness.

Recommendation: It is recommended that all inmates are seen in a timely manner, including those with depressive and other disorders that are not as severe as psychotic disorders. It would be beneficial to conduct a follow-up CQI study to determine if improving the system for seeing inmates in a timely manner has an effect on facility prescription practices.

MENTAL HEALTH TREATMENT

Large jails in the United States often provide both “outpatient” and “inpatient” mental health services. Outpatient services include individual counseling, group counseling, supportive interventions, segregation monitoring, suicide prevention and others. Inpatient services are for inmates with severe mental illness, and typically consist of careful monitoring, a treatment program or both types of service.

Finding: Washoe County Detention Center provides supportive interventions, segregation monitoring, and a suicide prevention program. The supportive interventions and segregation monitoring are conducted appropriately. Both staff and inmates report that these are helpful in meeting the mental health needs of inmates. Mental health staff members do not review inmates for contraindications to placement in restrictive housing. It was noted that they do monitor inmates in restricted housing units more frequently than is required by professional standards. Individual and group counseling is

provided in the jail by community agencies. The groups provided by community agencies include:

- Anger Management
- Relapse Prevention
- Domestic Violence
- NA/AA and other self-help groups
- Substance Abuse

The jail does have an inpatient mental health unit that is staffed by Crisis Intervention Team (CIT) trained officers and a social worker. The social worker sees all 50 inmates each day she is in the facility and provides case management and supportive interventions to them. She also participates in a treatment team meeting two times per week that includes the psychiatrist, officers and herself. There is an informal level system that inmates progress through prior to returning to general population. The lowest level requires that an inmate come out of the cell alone. The second lowest level allows an inmate to come out of the cell while other inmates are present. The third level allows them to have a cell mate. The fourth level allows them to "program," which means engage in activities outside of the cell. It was reported that approximately 25 % of inmates on this unit return to general population in any given week and that there is a 2-3 day waiting list to be housed on this unit.

There is no formal mental health programming on the unit. Instead, it functions primarily as a stabilization unit and a place where inmates can be monitored and stabilized so they become able to function in general population.

Recommendations: The inmates could benefit from more formal programming that would include symptom management, understanding mental illness, and maintaining appropriate behaviors. This would require additional professional staffing, but would help the inmates stabilize more quickly and become better able to manage their mental illnesses.

ADMINISTRATION OF MEDICATIONS

Licensed practical nurses complete medication administration rounds. The medications are delivered as stock blister cards and kept on one of several medication carts. Two LPNs administer medications in the main facility housing units while a third LPN administers medications in the seven housing units that are located in a facility that is accessible via an enclosed cinder block tunnel.

Finding: Nurses do not always arrive at the housing units at the same time or in the same sequential order of housing units. It was reported that some nurses take significantly more time in preparing for the medication round as well as notably more time in being able to complete the rounds. The variances from nurse to nurse create significant time differences in patients receiving their medications at consistent intervals from day to day. The inconsistent times are also problematic for the officers as they are not able to predict when they will have to be available for the medication rounds.

Recommendation: The medication administration training program for nurses should include topics that explain the need for consistency. There should be an active monitoring, review and re-training process implemented by the health services administrator to ensure the greatest degree of consistency. Both the patients and the housing unit officers will benefit from having more consistency in the timing of the medication rounds.

Finding: Some of the inconsistent performances between nurses can be attributed to the high percentage of per diem nurses that are used at the facility. Per Diem nurses may be less efficient since they do not consistently perform the tasks to which they are assigned.

The par levels of stock medication are maintained at levels that are too low for patient needs and workflow efficiency. It was reported that nurses periodically running out of an ordered medication during rounds. They must find one of the other medication carts to see if it has the required medication in stock. This is both inefficient and time consuming and further disrupts housing unit activities.

Recommendation: Re-assess the par levels for the stock medications. Empower the health services administrator with the authority to adjust par levels so that the needs of the patients are met on a consistent basis. There are variables such as increases or decreases in the number of incarcerated individuals, changes in patient acuity, and practitioner prescribing patterns that the nursing staff must adjust to in a timely manner.

SICK CALL PROCESS

The workflow issues with the sick call process stem from the lack of internal coordination and communication within the health care factions.

Finding: It was noted by various individuals that a significant source of frustration and disruption of housing unit functions is an inmate being called to the infirmary for nurse sick call, being returned to the housing unit and then called back to the infirmary within the hour for a dental clinic visit. This back and forth movement of inmates, especially those who are in restricted housing units, those on suicide watch, or who are an inmate worker disrupts the ongoing operations and security counts and is not an efficient use of time the health care staff. If the health care staff were aware of each other's clinic schedules and movement requirements then inmate movement could in some cases be consolidated and avoid the unnecessary movement from the housing units to the infirmary.

Recommendation: A review of clinic schedules should be completed with the intent of looking for ways in which to minimize inmate movement. An electronic spreadsheet or EHR cross-reference program would help keep inmate movement to a minimum and reduce the frustration created by excessive and repetitive traffic to and from the infirmary.

SUICIDE PREVENTION

Appropriate suicide prevention efforts in jails begin with training. It was reported that suicide prevention training for jail staff members has consisted of briefings at shift reports and has often consisted of approximately 30 minutes of training per year. Nevada reportedly requires “demonstrating proficiency” rather than specific amounts of training for jail employees.

Finding: The suicide prevention training for medical and mental health staff members is similar. It consists of an online class which is required for all staff members and is scheduled through an online training scheduling system. The training curriculum for health care staff was reviewed and consists of a Suicide Prevention course that is an hour in length. The course only contains ten slides that are specific to suicide prevention and consist of a basic overview of issues related to suicide in jails. There is an additional course, “Hot Topics in Suicide Prevention in Jails,” which is a two hour course, but again, only contains 10 slides that are specific to suicide prevention. The ten slides in this training present the data from Lindsey Hayes and his article on updating trends in suicide in jails in the United States (Hayes, 2012). Neither of these courses presents enough information to help officers, nurses, and mental health professionals adequately assess and intervene to prevent suicide.

Recommendation: It is recommended that all jail and health care employees receive a minimum of 4 hours per year of suicide prevention training and that the training for mental health staff members include information on how to diagnose suicide risk, risk factors that are specific to jails, how to develop a treatment plan related to suicide risk, and how to “step down” a person from suicide watch.

Suicide monitoring occurs in the “infirmary,” which is where medical services are provided and includes 19 cells that can be used for monitoring inmates who are suicidal. It was reported that the use of “constant watch” or “1:1 monitoring” is available, but that it occurs very rarely. The most common monitoring is in “approximately 15 minute, staggered intervals.” A review of the documentation indicated that there is some staggering of intervals of watch, which is required by professional standards, but that for the most part the monitoring of individuals on suicide watch occurs in almost exact 15 minute intervals. We found some documentation indicating intervals just short of or just longer than 15 minutes from the previous check on the inmate.

Recommendation: It is recommended that the facility increase the use of “constant watch” or “1:1 monitoring” for all those inmates who are judged to be acutely suicidal, meaning having a plan or intent to kill themselves or having recently attempted suicide or engaged in self-injurious behavior. It is further recommended that the facility continue to increase the frequency with which they complete checks at staggered times and that they are no greater than 15 minute intervals. This practice will help protect against genuinely suicidal inmates attempting to predict when they will next be monitored and then allow enough time for them to engage in behavior that will result in their death.

Finding: Any jail employee or health care employee can place an inmate on suicide watch, but only a mental health professional (including psychiatrist) can remove an inmate from suicide watch. This is a very appropriate practice. However, psychiatrists do not appear to have received sufficient training on suicide prevention in jails.

Our health record review indicated that a number of inmates had been taken off suicide watch despite clear evidence of ongoing risk factors or a recent history of attempt or significant suicidal ideation. The health record review further indicated that seven inmates had recent histories of suicide attempts, had violent thoughts of self-harm, had significant losses, or other suicide risk factors and either were not placed on suicide watch, were discharged from suicide watch, or not placed on an adequate level of watch.

Recommendation: It is recommended that all mental health professionals (including psychiatrists) receive adequate training on criteria for removing inmates from suicide watch, and suicide prevention practices in a jail.

Finding: In general, the jail facility is relatively safe. There are no bars on windows from which an inmate can hang themselves and there are no grates through which an inmate can attach a blanket or other item that can be used as a rope for hanging.

However, it was noted that most of the bunks in the facility are constructed in a way that presents a gap between the bunk and the wall. This provides an opportunity for somebody who wants to hang themselves to do so. In fact, at least one suicide in the last few years occurred by way of this method.

Recommendation: It is recommended that the bunks be reconfigured so the gap between the bunk and the wall is removed, thus removing an easily accessible means of suicide. The removal of the gap between the bed and the wall has occurred on at least one housing unit and it is recommended that the changes be made in all housing units in the jail.

Finding: Mental health staff members are not informed of suicide attempts or suicide completions that occur in the jail. Interviews with staff revealed that they were not aware that specific suicides had occurred, or of the suicide rate over the past few years.

Recommendation: It is recommended that mental health staff be informed of all suicides and attempted suicides. Mental health staff needs to be involved in the mortality review process following a suicide, the decision regarding the appropriate level of suicide watch, and need to be involved in the step-down process following attempts. It is also important to involve mental health staff members in assessing the impact of a suicide on inmates and other health care and corrections staff.

Finding: The suicide rate in the facility is dramatically higher than the national rate for jails. In 2015 there were 3 suicides in the facility resulting in a suicide rate of

300:100,000 (or nearly 10 times the national rate for jails) and in 2016 there were 2 suicides in the facility, resulting in a suicide rate of 200:100,000 (or more than five times the national rate for jails). This clearly indicates the need to implement the recommendations above in order to reduce the frequency of suicide and the level of suicide risk in the Washoe County Jail.

Recommendation: There was no evidence that the jail conducts psychological autopsies following inmate suicides. This is a professional standard, and should occur following any suicide in the jail. It helps determine if anything could have been done to prevent this specific suicide, and if there is a need to change or improve the suicide prevention program in the facility.

STAFFING CHALLENGES AND CONTRACT COMPLIANCE

The recruitment and retention of qualified health care staff has proven to be a significant challenge. The challenge has been heightened in the fact that there have been a total of three private health care contract vendors over the course of the past couple of years. Each major service provider change brings staffing and service consistency issues. Policies and procedures, protocols, employer performance mandates, wages, and employee benefits can vary greatly from one vendor to the next.

Findings: Interviews with both health care and jail staff revealed that the wages of the health care staff have gone down with each successive change of vendors. In many areas of the country it is tough enough to recruit qualified health care professionals let alone retain them as employees when their wages are reduced, their benefits changed and they are required to learn a whole new set of corporate directives.

Experienced providers are often lost in the transitions and reduced wages and benefits compound the recruitment challenges. The changeover of staff also damages, or at the very least diminishes, the teamwork network between health care and jail staff that had been established prior to the changeovers. The recruiting and retention challenges have resulted in a very high percentage of per diem staff (34% during the review). While many per diem staff is able to perform clinically, they tend to receive less orientation and are not trained as thoroughly as a full-time employee. There tends to be a greater degree of inconsistencies, less documentation and less commitment when only working periodic shifts.

It is imperative that the on-site health care administrative and supervisory staff have leadership skills and knowledge of the unique aspects of delivery constitutionally adequate health care within a correctional facility. The administrative and supervisory staff from both the health care and jail facets of the operation must have open and ongoing communication and present a unified front when it comes to supporting staff and providing for the safety, security and health care needs of the inmate population.

It is operationally essential that the allotted number of hours for each discipline is adhered to in order to effectively and efficiently complete the required medical, mental

health and dental services (e.g., physician hours covered by a physician, RN by an RN, EMT by an EMT, and social worker by a social worker).

Recommendation: It is recommended that the County add a contract monitor position for the ongoing review, analysis and reporting of contract compliance.

DOCUMENTATION/DATA ANALYSIS

During the course of the review, a discrepancy was discovered between the number of mental health contacts reported by mental health staff and indicated in recent CQI reports.

Finding: Mental health staff reported seeing as many as 800 inmates per month, while the official CQI or data report indicated that mental health had an average of 283 contacts per month for October through December, 2016. All jail administrators, deputies and health care staff reported that mental health staff are very busy and are "always on the units," indicating that they have a high number of contacts on a consistent basis, but it is not possible to determine the exact number of mental health contacts per week or month.

Recommendation: It is recommended that health administrators review the data that is collected and reported each month, to ensure its accuracy. This will benefit the health care providers and the jail administrators, as well as assist with planning for future health care services and needs.

SECURITY BACKGROUND CLEARANCES

An additional challenge to recruiting, staffing, and retaining health care professionals is the rather in-depth and lengthy security clearance process that is a requirement set by the Sheriff's Office.

Finding: The amount of time, effort, and man-hours that goes into completing the current criminal history checks and investigations may need to be re-evaluated. While the ultimate responsibility for safety and security lies with the Sheriff, it should be noted that the degree and depth of the current process is beyond what is in place at many correctional facilities across the country.

Recommendation: It is recommended that the Sheriff's Office investigation division take a detailed look at what level of background check and investigation is necessary. A review of other agency clearance processes would be advantageous and greatly assist the Sheriff's Office in determining an acceptable balance of security clearance of health care professionals and timely on boarding of new employees.

ADDITIONAL COMMENTS FOR REVIEW

1. The dentist is only on-site 16 hours per week. Wait times for dental care are not excessive, however additional dental hours would be recommended. Having an “extraction only” policy is not consistent with correctional health care standards.
2. Nurses are underutilizing the established nursing protocols. More comprehensive documentation of nursing encounters is recommended.
3. Intake nurses are not consistently completing and submitting the required Americans with Disabilities Act (ADA) forms that are used to properly classify inmates.
4. There are a couple prescription level medications in the nursing protocols that should be removed.
5. The health department provides services at the jail. They do not share documentation of their patient encounters with the jail health care staff. At the very least, the health department personnel should leave a summary of their encounters so that all parties are aware of all testing and care provided for every inmate.
6. The jail policies and procedures should be drafted without the names of specific vendors and personnel. Whenever specific names are incorporated into policy, they must be changed every time a particular vendor or individual is no longer working at the facility.
7. The medical director should remove the reference to the previously issued NCCHC chronic care guidelines and link the guidelines to other nationally recognized organizations/agencies.
8. Re-visit the conducting of patient encounters in the “lobby” area that is part of the common area just outside of housing units. The lobby area does not provide any privacy for the patients.
9. Work towards identifying additional space that could be used for the provision of inmate programs.
10. Review the processing and tracking of inmate grievances. Health care related grievances should be reviewed by the HSA or DON (never a per diem employee) and responses should be professional and appropriate for the situation. A review of grievances should be a part of the CQI committee function.

DISCLAIMER

Technical assistance by NCCHC Resources, Inc., is a professional activity that is completely separate from accreditation by the National Commission on Correctional Health Care and in no way guarantees accreditation, reaccreditation, or any other outcome of a survey.

ABOUT NCCHC RESOURCES, INC.

Leveraging NCCHC's expertise in correctional health care, NCCHC Resources, Inc., provides customized education and training, preparation for accreditation and professional certification, performance improvement initiatives and technical assistance to correctional facilities interested in health care quality improvement. NRI will put together a team of experts – clinicians, educators, administrators or other thought leaders – to address any sized project or challenge. A nonprofit organization, NRI works to strengthen NCCHC's mission: to improve the quality of health care in prisons, jails and juvenile detention and confinement facilities.

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