OCO INCIDENT REVIEW
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Summary of Complaint/Concern

On January 24, 2020, the Office of the Corrections Ombuds (OCO) received a complaint on behalf of an Incarcerated Individual, which alleged the following:

- The complainant alleged that the medical providers at Airway Heights Corrections Center (AHCC) were not providing this elderly patient with adequate medical care. The complainant stated that the Incarcerated Individual was experiencing pain and difficulty ambulating with a walker, but when he asked for a wheelchair he was told by staff that they would "infract him, spray pepper spray on him, or put him in 'the hole.'" The complainant stated that the Incarcerated Individual had tried to explain his symptoms to his providers several times, but his providers would not listen to him.
- The question was raised as to whether the Incarcerated Individual did not receive appropriate medical care because he is Black.

OCO Statutory Authority

- Per RCW 43.06C.005, OCO was created to assist in strengthening procedures and practices that lessen the possibility of actions occurring within DOC that may adversely impact the health, safety, welfare, and rehabilitation of incarcerated individuals, and that will effectively reduce the exposure of DOC to litigation.
- Per RCW 43.06C.040, OCO has the authority to receive, investigate, and resolve complaints related to incarcerated individuals' health, safety, welfare, and rights.

The OCO Incident Review Process

As part of this incident review, OCO reviewed the medical chart, DOC Policies 600.000 Health Services Management, 610.040 Health Screenings and Assessments, 610.650 Outpatient Services, 890.620 Emergency Medical Treatment, and the Offender Health Plan. Additional information was obtained from the Incarcerated Individual through conversations with his family member, and via communications with the physician, facility health services administration, and DOC headquarters.

Summary

This 65-year-old Incarcerated Individual entered AHCC as a Violator in December 2019. A little over three months prior to this incarceration, he developed an infection of his artificial hip joint and underwent a complex surgical resection of his prosthesis, debridement of soft tissue and bone,

and placement of a temporary antibiotic-loaded spacer (a device placed into the joint to maintain normal joint space and alignment while the infection is being treated). Upon entry into AHCC, it was noted that he needed assistance with activities of daily living due to his hip condition.

The records indicate that he began experiencing falls shortly after he became incarcerated; some falls resulted in visible injuries. Despite these numerous falls, he did not undergo a fall risk assessment, and was not given an appointment with a clinician for an appropriate evaluation of a geriatric patient with clear fall risk. In fact, the Incarcerated Individual sustained six falls and sent five medical Kites begging for help before he was finally seen by a physician.

Unfortunately, at that first appointment with the physician, a physical examination was not performed. Without performing a proper physical examination, the physician opined that the Incarcerated Individual did not medically need a wheelchair, and would receive an infraction for persistent use of the medical system for complaints that were not medically justifiable.

The interactions between the physician and patient deteriorated from that point. After yet another fall, he returned to the physician who reiterated she was not willing to order a wheelchair for him because it was not medically necessary – again without any physical examination. Still another fall occurred, prompting the Incarcerated Individual to declare a medical emergency; however, instead of examining the patient, the physician presented him with the choice of leaving the clinic or being infracted. The Incarcerated Individual left without receiving any sort of evaluation or treatment.

There are two additional physician encounters with either inadequate or absent physical examinations. At the request of a family member, OCO became involved and expressed concern to DOC Headquarters as to the lack of objective physical findings to support or refute whether the Incarcerated Individual indeed needed a wheelchair. The Incarcerated Individual subsequently received an x-ray – which revealed a broken wire in his right hip spacer. He finally received a wheelchair.

OCO concludes that the care the Incarcerated Individual received at AHCC did not follow the community standard of care given the lack of proper medical evaluation of a geriatric patient with a pre-existing hip abnormality and history of frequent falls. In addition, the care he received did not follow DOC Policy 610.650, which explicitly states that all incarcerated individuals have the right to declare a health care emergency, and that patients reporting a health emergency will not be denied access to health care.

Timeline

Pre-incarceration

8/27/2019 – 10/14/2019	Hospital records indicate that the patient presented with a two-week history of increasing falls and one week of right hip pain. On 8/29/2019, he underwent incision and drainage of a right hip/pelvic abscess as well as removal of a right hip arthroplasty with placement of a spacer. Multiple transfusions were required for

anemia. Hospitalization was complicated by acute kidney injury which resolved with intravenous hydration. Delirium and agitation improved with resolution of withdrawal. He underwent an additional incision and drainage of a right shoulder abscess at bedside on 10/13/2019. At discharge, he was to continue antibiotics until hip spacer revision was performed; physical therapy and occupational therapy were recommended.

11/19/2019 A note of the orthopedic surgeon reflects a 12-week post-operative visit. His surgery was described as a complex removal of his right total hip arthroplasty with placement of an articulating spacer, along with incision & drainage of a right pelvic abscess and debridement of his right iliac wing (hip bone). X-rays showed no evidence of hardware migration or failure. The patient was frustrated because he was no longer allowed to receive pain medication from that office; Mobic was prescribed, as well as Keflex for 90 days. He was to return in three months to discuss possibility of total hip arthroplasty.

Incarceration

12/17/2019 The Incarcerated Individual was remanded back to Airway Heights Corrections Center under Violator status. The Community Corrections Division Offender Arrest Screening document indicated that he needed assistance with activities of daily living due to a hip injury, and notified the facility of an upcoming appointment with a pain clinic on 1/8/2020.[1]

IPU notes from 12/17/2019 to 12/18/2019 documented symptoms related to detox such as lethargy, emesis, nasal discharge, and generalized pain. He was released to the Special Management Unit on 12/20/2019. During this period, he did not demonstrate any falls and was noted to be walking with a walker without difficulty.

12/20/2019 There is an Emergency Response Record which indicates that the Incarcerated Individual had sustained a fall.[2] Vital signs were recorded, but there is no other evaluation documented. The physician assistant was consulted, but no treatment plan was outlined. *There was no Fall Risk Assessment completed, and no follow-up appointment was made with a clinician for a formal evaluation post-fall.*

12/20/2019 The Incarcerated Individual sent a medical Kite stating that he had been in a lot of pain. He explained that he had methicillin-resistant staphylococcus aureus

[1] Although this 'Community Corrections Division Offender Arrest Screening" document was provided to OCO as part of a medical records request, the physician stated that there was nothing in the medical chart indicating the upcoming appointment on 1/8/2020.
[2] This is fall #1.

infection and needed antibiotics for 90 days per his surgeon. The physician responded on 12/31/2019, "Scheduled. Watch the callout."[3]

12/21/2019 During tier check, custody found the Incarcerated Individual on the floor. He stated that he was getting up to use the toilet and his walker brakes did not function properly; he fell[4] and could not get up. He complained of neck strain, left knee pain, and that he bumped his left temple. The nurse's exam described slight redness to left temple; there were no knee abnormalities, and neurological check was normal. He was given Tylenol. The brakes on the walker were found to be functioning correctly. *There was no Fall Risk Assessment completed, and no follow-up appointment was made with a clinician for a formal evaluation post-fall.*

12/23/2019 There was a "priority call" for an unresponsive patient; upon arrival, nursing found the patient on the floor[5] in front of the toilet with pants down. As custody entered the cell, the patient awoke and appeared disoriented. There was redness to the left forehead; the left eye was swollen with small abrasions. He was admitted to the IPU for neuro checks, which were all noted to be normal. He was discharged back to SMU. *There was no Fall Risk Assessment completed,[6] and no follow-up was made with a clinician for further evaluation and workup of his multiple falls.*

12/23/2019 The Incarcerated Individuals sent a Kite to medical asking to see a doctor to have his knee x-rayed; "in a lot of pain." The physician responded, "Scheduled. Watch the callout."

12/24/2019[7] The Incarcerated Individual was seen for right hand/forearm pain. He was observed to use both arms to push himself sitting on his walker. On exam, there was mild tenderness to palpation, and fingers were warm/mobile. He was diagnosed with a contusion of the right forearm, and was given Ibuprofen and an increased dose of acetaminophen. The plan was for x-ray in two days if there was no improvement.

12/26/2019 The Incarcerated Individual complained of constant pain in left wrist; complained of difficulty moving it. On exam, "able to move fingers, good circulation noted"; no exam of the wrist is performed. He requested x-ray to rule out fracture; this was reported to the physician, and x-ray was ordered for the left wrist and hand.

12/26/2019 The Incarcerated Individual sent a Kite to medical stating that he fell[8] and **"may have damaged the implant in my right hip."** He reported **"unbearable" pain** and **a "grinding noise"** which was not normal. He requested x-rays. The physician

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[3] The physician stated that the Incarcerated Individual was scheduled for a medical appointment three weeks after the kite date.
[4] This is fall #2.
[5] This is fall #3.
[6] The physician stated that a fall risk assessment was not done because the patient reported that he had fallen asleep on the toilet.
[7] The physician stated that prior to this assessment, the Incarcerated Individual had declared a medical emergency for left wrist pain and was given a compression wrap.
[8] This is fall #4.

responded, "Scheduled. Watch the callout." *However, no x-rays were ordered for the right hip.*[9]

12/27/2019 Left wrist and hand x-rays showed some osteoarthritis and a tiny radiopaque foreign body in the soft tissue of the palm at the base of the middle finger.

12/30/2019 The Incarcerated Individual sent a Kite to medical stating that he needed a wheelchair. The physician responded with "Scheduled. Watch the callout."

12/31/2019 There is an Emergency Response Record which indicates that the Incarcerated Individual fell[10] and hit his head. Vital signs were recorded, but no other evaluation is noted. The note indicates that the physician assistant was contacted by phone, and Tylenol was given. *There was no Fall Risk Assessment completed, and no follow-up was made with a clinician for further evaluation and workup of his multiple falls.*

1/1/2020 The Incarcerated Individual was evaluated by a provider for right hip and right knee pain, as well as tingling in the lower right extremity. *There is no physical examination documented,* yet the provider noted "all complain[t]s and condition chronic." He was given Toradol and educated regarding misuse of medical emergency resources.[11]

1/1/2020 The Incarcerated Individual sent a Kite to medical stating that he was supposed to have had a total hip replacement that month. He reported problems walking even with the walker; "every step I take hurts." He asked to be considered for a wheelchair at least until the winter season was over. The physician responded, "Scheduled. Watch the callout."

1/2/2020 The Incarcerated Individual declared a medical emergency for right hip pain and right knee pain; he stated that he needed a wheelchair, and was concerned that he would fall and sustain a head injury. He was seen by a nurse practitioner. *There was no physical examination documented in this clinic note.* He was told that he was not septic; "not clear what he need[s] today." Prescriptions for Meloxicam and Omeprazole were provided. He was to discuss his chronic medical conditions with the physician the following week.

1/8/2020 The Incarcerated Individual was brought to medical with the complaint of right knee pain after falling and twisting his knee. The nurse stated that he became argumentative and angry and left; he was observed to be walking with a slight limp, but ambulating without difficulty.

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[9] X-rays of the right hip were not performed until 3/31/2020, over three months later.
[10] This is fall #5.
[11] The physician stated that the incarcerated individual's complaint was "unclear," and there was no evidence to support pain that required attention, based on observations of the incarcerated individual using a walker without any disruption.

There is no record of DOC taking the Incarcerated Individual to his appointment with the pain clinic, which was scheduled prior to his incarceration.

1/10/2020 The Incarcerated Individual was seen by the physician. His main complaint is that he "keeps getting identified as a drug user and he has been clean for years." He wanted a wheelchair as well as Boost supplements to improve his nutrition in preparation for a hip replacement. He gave the physician permission to contact his orthopedic surgeon.

The physician contacted the orthopedic surgeon[12], whose medical assistant stated that the Incarcerated Individual had no physical restrictions, and was to perform weight-bearing as tolerated; the medical assistant did not advise the use of a wheelchair, stating it was not medically justifiable given his condition. The medical assistant planned to discuss the case with the orthopedic surgeon to determine the recommendation for follow-up. Keflex was resumed for infection prophylaxis.

The physician then noted that, based on discussion with other AHCC providers, the Incarcerated individual might be purposefully causing his falls. The physician's plan was to hold a case conference to discuss the Incarcerated Individual's "apparent manipulation."

There was no physical examination documented in this clinic note.[13] The physician informed the Incarcerated Individual that he did not medically need a wheelchair. He was also informed that he would receive an infraction for persistent use of the medical system for complaints that are not medically justifiable. He was told he would need updated laboratory tests "to be sure Boost is justified." Testing for Hepatitis C would also be repeated.

1/15/2020 The physician met with other DOC staff for a case conference regarding the Incarcerated Individual. They discussed a history of recurrent falls with joint injuries. The group consensus was that the Incarcerated Individual was "inappropriately using the urgent care and emergency services." The physician stated that she informed the Incarcerated Individual on 1/10/2020 that he did not need a wheelchair and was responsible for ensuring his own safety while ambulating. "He was advised that if he continues to access medical care for complaints that are not determined to be medically justifiable, he will be infracted."[14]

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[12] The orthopedic surgeon was reportedly being sued for malpractice by the Incarcerated Individual. On 1/11/2020, the orthopedic surgeon's office contacted DOC and stated that he was no longer managing the Incarcerated Individual, and that he needed to find a new orthopedic surgeon for additional questions or issues.

[13] The physician asserted that this visit was focused on establishing a provider/patient relationship, rather than on performing a physical exam. The physician stated that the plan was to bring the patient back for an assessment, but the office note does not reflect a follow-up appointment being ordered for this patient.

[14] The physician pointed to his refusal for mental health support, his alleged history of using one gram of heroin daily, and his positive urine toxicology at intake as rationale for this.

1/22/2020 The Incarcerated Individual declared a medical emergency because he had a cough and was unable to sleep. Lungs were reported to be clear, and he was "not coughing at all." Nursing notes indicate normal temperature and an oxygen saturation of 94% on room air. He was advised to see a provider the following day, or to sign up for sick call; however, he did not want to return the next day but wanted something to treat his cough that evening. He complained of how far he had to come to see his provider, only to learn that they did not believe him.

1/24/2020 The Incarcerated Individual gave a history of productive cough with brown phlegm and specks of blood, sore throat, malaise since Wednesday. He was now given antibiotics and an antitussive.

1/28/2020 The Incarcerated Individual brought his walker to the clinic for repair; he was issued a new one. He then declared a medical emergency stating he could not walk. The nurse noted that this was consistent with his previous request for a wheelchair; he also had multiple other concerns including HSR for a mechanical soft diet and re-evaluation of pain medications. He was placed on sick call for the following day.

1/29/2020 The Incarcerated Individual reported that his walker became caught on the carpet in the dayroom, causing him to fall.[15] The nurse indicates that he was not cooperative with exam of the right knee, with obvious tightening with attempts to evaluate range of motion; there was no new bruising or swelling. He was to be seen by his provider, but the appointment was cancelled due to the provider's illness. The nurse tied his shoe and reviewed the correct use of walker.

He was subsequently evaluated by a physician's assistant, who noted that he was able to bend his right knee to 90 degrees and there was no edema/effusion/bruising; however, he stood with all weight on his left leg. The assessment was chronic right hip & knee pain; Toradol was administered. He was to follow-up with his primary provider. He was observed to be ambulating with assistance from his walker and another incarcerated person.

1/30/2020 X-ray of right knee demonstrated sequela of prior trauma involving the proximal tibia, a healed fibular diaphysis with mild deformity, and evidence of prior femur fracture. He was placed on the sick call list to see the physician on 2/4/2020.

2/4/2020 The Incarcerated Individual presented to his appointment with the physician, who noted that he was almost 30 minutes late. When the physician told him his x-ray results were stable, he became upset and said could not walk anywhere. He stated that he was in pain, and his shoulder hurt. He wanted pain control but denied wanting narcotics. He wanted a wheelchair, but the physician was not willing to order one because it was not medically necessary. The physician reminded him he had to be off drugs for a hip replacement, and he denied being on them. The

[15] This is fall #6.

physician "told [patient] I wasn't willing to keep talking about this." The two appeared to argue for a few more minutes, and then the Incarcerated Individual left the room. The physician noted that he was walking down the hall "quite rapidly" and using his walker without difficulty. *There was no physical examination documented in this clinic note.*[16]

2/10/2020 The Incarcerated Individual declared a medical emergency. He reported that he could not walk; he fell[17] onto his right knee while going to the bathroom. He reported pain in the groin, and stated that his right knee was "locking up." Pain was 8/10, and he reported burning in the right leg from the ankle to the hip. *There was no physical examination documented in this clinic note.*[18] Instead, the physician reminded the Incarcerated individual of a prior conversation informing him that he would be infracted if he declared an emergency for chronic issues. The physician gave him the option of leaving or being infracted, basing this decision on a nurse report that he was stable. He reported that his walker was not working; the physician noted that he had had multiple walkers replaced and fixed, and advised him to kite another staff member. The physician told him that the next time he declared a medical emergency that was not substantiated, he would be infracted.

2/19/2020 The Incarcerated Individual sent a Kite to the facility medical director stating that his outside doctor recommended physical therapy, but he felt that his provider "seems to have her own agenda and my wellbeing doesn't appear to be part of her agenda." The physician responded on 2/20/2020 stating that she would discuss this at his next appointment.

2/29/2020 The Incarcerated Individual sent a Kite to the physician requesting a cortisone injection in the left shoulder and left knee, and a Toradol injection for right knee and hip pain. On 3/4/2020, the physician responded that cortisone injections might make arthritis worse, and that Toradol was generally not used for the control of chronic pain. Tylenol was suggested.

2/29/2020 The Incarcerated Individual sent a Kite to the physician requesting a personal care aide because of difficulty standing, and falling several times. He asked that the request be referred to the Care Review Committee along with a request for a wheelchair. The physician responded on 3/4/2020 that a wheelchair was not indicated based on his last assessment,[19] and refused to make a CRC referral until reassessed.

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[16] The physician explained that no further examination was done because the patient became upset and left the room. However, the notes do not indicate that a follow-up appointment was scheduled.

[17] This is fall #7.

[18] Although nursing documented no redness, swelling, or bruising of the right knee or shoulder, there is no practitioner examination documented. Note that this was his seventh fall, and at this point he still had never received a full physical examination to evaluate the reason for his multiple falls.

[19] There is no objective documentation of a previous physical assessment by the physician.

3/11/2020 The Incarcerated Individual sent a Kite to the facility medical director, reporting that he was having trouble using the walker because of numbness in both of his arms and hands. He asks, "Am I wasting my time requesting to be seen? I have requested to be looked at several times to no avail. Why?" The physician responded on 3/24/2020 that he was recently seen in sick call and had a scheduled appointment later that week.

3/12/2020 The Incarcerated Individual presented to the clinic complaining of left arm pain, with "tingles and pins" throughout the arm. He complained that it was not possible to walk and push his walker to main line and other activities. Although pulses were present, the left hand was noted to be purple and the nails were bluish; the color improved as he stayed in the room. He was instructed to return to discuss durable medical equipment with his provider. Although this presentation was reportedly discussed with the on-call provider, there is no documentation of any treatment or recommended follow-up evaluation.

3/13/2020 The Incarcerated Individual filed an emergency grievance. He reported that he could not use his hands and had difficulty ambulating long distances. He was observed pushing the walker with both hands, and able to remove jacket without difficulty. He was to be notified for sick call on Monday.

3/17/2020 The Incarcerated Individual was evaluated for his concern that he needed a wheelchair. He additionally had signed up for sick call regarding pain, numbness, and tingling of the left upper extremity. He complained that he was supposed to have been seen on Friday, but that his name had been "scratched off the list." *Physical exam is inadequate*; it states only that there was "minimal effort" when assessing lower extremity strength, and does not include a complete evaluation of the musculoskeletal or neurological systems.[20] Nevertheless, the physician stated that there was "adequate strength" in both lower extremities, and that she was unable to medically justify a wheelchair. The Incarcerated Individual became upset and intended not to show for future appointments. The physician did confirm that the Incarcerated Individual's name had been scratched off the call-out list for the prior Friday, but there is no additional information given.

3/26/2020 The Incarcerated Individual sent a Kite to the facility medical director, stating that he had been scheduled to meet with physical therapy but the physician "threw me out of medical because I didn't want to discuss my condition with her." The Incarcerated Individual planned to file a grievance because of her "unprofessional" conduct. The facility medical director responded on 3/30/2020 that "Your interpretation of the encounter is noted."

[20] Although not documented, the physician stated that a thorough exam was attempted but the incarcerated individual either actively resisted the exam or exaggerated his lack of strength by minimally exerting himself.

3/26/2020 There is a note by the facility medical director which appears to be a chart review. Recommendations included a physical therapy referral, laboratory tests, weekly weight monitoring, and a full musculoskeletal exam.

3/26/2020 Incarcerated Individual was seen by physician for a scheduled appointment. *There was no physical exam documented in this clinic note.* Initially, the Incarcerated Individual agreed to undergo lab draws, a musculoskeletal exam, and weekly weight monitoring. They discussed Toradol and the Incarcerated Individual reportedly gave conflicting information regarding how many NSAIDs he had taken that day; when told he had to be off NSAIDs for 24 hours prior to receiving an injection of Toradol, Incarcerated Individual reportedly stated that the physician "was trying to make him be in pain." When the physician began talking about risk of infection related to heroin use, Incarcerated Individual reportedly became very angry; he stated that he was clean, and had only taken oxycodone on the streets after he became addicted to Dilaudid during a hospitalization. He stated that he was going to refuse everything. He refused to leave the room, so the physician called custody; he left when custody arrived.[21]

3/31/2020 Incarcerated Individual presented for sick call visit due to right hip pain. The physician had a correctional officer serve as chaperone during exam. The note summarized his prior total hip arthroplasty with incision and drainage of a right pelvic abscess on 8/29/2019. He reported chronic pain since surgery, but experienced a new type of pain over the last week, "like a wire is floating in my hip joint." Aside from the description of a well-healed surgical site with no erythema, t*here was no physical examination documented in this clinic note.* X-ray demonstrated multiple findings including a broken cerclage wire at the proximal femur, with multiple wire fragments around the medial aspect of the proximal femur. Orthopedic consultation was recommended by the radiologist.

A request for an urgent orthopedic consult was submitted and a wheelchair was provided. The physician then spoke with the patient's former orthopedic surgeon[22] and read the x-ray report to him; without actually viewing the study, the orthopedic surgeon felt that the only new finding was the broken cerclage wire. He was felt to be an extremely poor surgical candidate with a very high mortality rate. The recommendation was to monitor him for infection.

4/5/2020 The Incarcerated Individual sent a Kite to medical, requesting to see a provider for severe pain in the right hip and leg. The physician responded on 4/8/2020 stating that he was scheduled to see her, and the x-ray findings would be discussed.

[21] The physician stated that no physical exam was done due to patient refusal.

[22] As previously noted, this orthopedic surgeon was being sued for malpractice by the Incarcerated Individual, and had already refused to be involved in the Incarcerated Individual's care.

4/6/2020 The Incarcerated Individual sent a Kite to the physician asking for the results of his right hip x-ray. The physician responded by instructing him to "please see other kite."

4/8/2020 Incarcerated Individual sent a Kite to the facility medical director stating that he was in a lot of pain. He additionally noted that he had been instructed to declare a medical emergency if someone from medical did not see him soon. The physician responded, notifying him that he had a pending appointment, and that his comment re: declaring a medical emergency was "noted."

4/8/2020[23] The physician spoke with nursing supervisor, facility medical director, and health services administrator. The group discussed observations of the Incarcerated Individual transferring and walking with his walker, with no complaints of pain. The physician stated that, "due to [patient's] behavioral issues I have been unable to assess him on my end for MAT." Outpatient referral was recommended.

4/19/2020 The Incarcerated Individual was released as part of the Rapid Reentry program.

Key Findings

- *Failure of communication with incarcerated individual*

  One of the most prominent findings in this case is the rapid deterioration in the quality of communication and interaction between the physician and the patient. The true reason for this is unclear, but it seems notable that at the first documented appointment on 1/10/2020, the physician already perceived the incarcerated individual to be manipulating the system. From that point onward, the physician-patient interactions involved repeated threats of infraction for declaring medical emergencies and ended in arguments. At one point, the physician had a custody officer serve as a chaperone during an appointment.

- *Delay in access to care*
  - The Incarcerated Individual already had an appointment scheduled with a pain clinic when he arrived to DOC as a Violator. Despite the struggle that the DOC providers had in managing his chronic pain complaints, he was not transported to this appointment.
  - The Incarcerated Individual submitted Kites asking to be seen by a physician for severe pain on 12/23/2019, 12/26/2019, 12/30/2019, and 1/1/2020; although the response was a stamped "Scheduled. Watch callout," he was not seen by the physician until 1/10/2020.[24]
  - The Incarcerated Individual submitted Kites reporting ongoing symptoms and difficulty ambulating on 2/19/2020, 2/29/2020, and 3/11/2020, but was not seen by

[23] This was the last medical record provided to the OCO before his release.
[24] The physician states that the patient was previously seen on 12/27/2019 while in x-ray, and was also seen several times "around the facility" prior to 1/10/2020. However, there is no objective documentation of a physical exam and/or an evaluation of his numerous falls and right hip complaints.

the physician until 3/17/2020 – and only after he filed an emergency grievance on 3/13/2020.
    - The Incarcerated Individual sustained multiple falls which were associated with declared medical emergencies. However, there was no follow-up appointment made for a comprehensive evaluation of a geriatric patient with a history of falls, which should include such components as postural vital signs, assessment of visual acuity and hearing, musculoskeletal function, neurologic examination, Timed Up and Go (TUG) Test, Berg Balance Scale, and others.
    - The Incarcerated Individual – who had a history of substance use disorder – requested medication-assisted treatment but was denied by the physician due to "behavioral issues." However, there is no documentation of any specific behavioral disorders; the records only reflect the Incarcerated Individual expressing frustration with not being properly assessed.

- *Failure to recognize, evaluate, and manage "red flags"*
    - The records reflect multiple falls, but the chart documents provided for OCO review do not include fall risk assessments. The providers also did not appear to recognize the concern associated with falls in a geriatric patient, since follow-up evaluations post-fall were not scheduled.
    - The records reflect symptoms of numbness in the upper extremities, which evidently affected the Incarcerated Individual's stability using a walker. However, the medical records do not include a sufficient neurological examination.

- *Failure to assume responsibility for the incarcerated individual's care*
    - Without performing an appropriate physical exam, the physician decided that the Incarcerated Individual was falsifying his complaints in order to manipulate his providers.
    - Without performing an appropriate physical exam, the physician somehow determined that there was no medical indication for a wheelchair, despite the history of falls and his recent complicated hip surgery. Ultimately, an x-ray was performed which revealed a broken wire in his hip spacer, and he finally received a wheelchair.

- *Failure to follow DOC policy*
    - At a 1/10/2020 clinic visit, the Incarcerated Individual was told he would receive an infraction for persistent use of the medical system for complaints that were not medically justifiable. However, this determination was made at the physician's first meeting with the Incarcerated Individual and without any physical examination – even though the Incarcerated Individual had experienced several falls, declared multiple medical emergencies, and sent several Kites expressing pain.[25]

[25] DOC 610.650 Outpatient Services, Section III. Emergency Health Care Services: A. 3. All incarcerated individuals have the right to declare a health care emergency. A. 4. A patient reporting a health emergency will not be denied access to health care, including evaluation and clinically indicated treatment, even when there is suspicion or history of abuse of the medical emergency

- On 2/10/2020, the Incarcerated Individual declared another medical emergency. However, instead of examining him and providing care, the physician reminded him that he would be infracted if he declared an emergency for chronic issues, and gave him the option of leaving or being infracted.[26]

- With regards to the question of whether the Incarcerated Individual did not receive appropriate medical care because he is Black, there was no specific allegation submitted to the OCO regarding inadequate care due to race. In addition, a review of the Incarcerated Individual's grievances found that none were related to racial inequity. DOC administration also was unable to find any information related to allegations of racism. Therefore, OCO was unable to substantiate that his care was affected by racial discrimination.

Recommendations

- **Employ an experienced patient advocate at every facility.** Effective provider-patient communication positively influences health outcomes by increasing the patient's comprehension of their diagnosis, contributing to better treatment adherence, and improving overall patient satisfaction. Aside from assisting patients with navigating DOC's complex health care system, a patient advocate could facilitate communication and strengthen provider-patient relationships before they deteriorate beyond repair.

- **Require a clinician evaluation after every declared medical emergency.** This has been a recommendation in several recent OCO investigations, since the lack of full evaluation following a declared medical emergency has led to negative outcomes, including death. DOC should implement a clear policy and procedure that requires a full evaluation by a physician or advanced practitioner after every declared medical emergency, to ensure that diagnoses do not get missed.

- **Educate medical providers on the components of a geriatric assessment, including how to assess for fall risk.** Falls in older persons are a common occurrence and often result in an injury. While these are usually minor soft tissue injuries, they can sometimes involve significant trauma such as fracture, head injury, or major lacerations.
  - Incorporate an assessment of fall risk into the intake history and physical examination of all incarcerated individuals age 50 or older[27]. A Timed Up and Go Test, as an example, can be performed in twelve seconds and therefore would not represent a significant increase in the time it takes to perform an intake physical.

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system. A. 4. a. Allegations of abuse of the medical emergency system will be referred to the Health Services Manager / Health Authority / designee after health care is provided.

[26] Ibid.

[27] National Institute of Corrections. What We Know about Elderly, Chronically Ill, and Terminally Ill Inmates. 2004 Edition. https://s3.amazonaws.com/static.nicic.gov/Library/018735.pdf

- Require a formal multifactorial fall risk assessment to ensure the safety of those who experience recurrent (two or more) falls, report difficulties with gait or balance, or seek medical attention or declare a medical emergency because of a fall.[28] DOC has provided training on the Hendrich II Fall Risk Model[29] in the past, but it does not appear to be routinely and consistently utilized.

- **Develop a formal protocol for determining when a geriatric patient needs a wheelchair to assist with daily activities.**
  - Support the justification for – or refute the need for – a wheelchair through a formal functional assessment of the patient, rather basing the decision on subjective opinion. For geriatric patients in the community, physicians collaborate with their physical therapy colleagues to make this determination.[30] Since DOC employs or contracts with its own physical therapist(s), such collaboration should be easy to implement.
  - Create a checklist which outlines the criteria that should be met to issue a wheelchair prescription, so that decisions are consistent throughout the system.
  - OCO consultation with two separate orthopedic surgeons[31] advised that patients with a history such as the Incarcerated Individual's are always maintained in either non-weight-bearing or "touch-down" weight bearing status[32] until re-implantation of the joint prosthesis, since bearing weight on the spacer could result in damage to or dislocation of the spacer, or could cause erosion and/or deformation of the remaining bone. Given that these expert opinions conflict with the information which DOC obtained in the course of the Incarcerated Individual's care, DOC should utilize the specialists available through their existing RubiconMD contract to assist with the final decision for wheelchair appropriateness by providing an external, unbiased community perspective.

- **Review DOC 610.650 with all medical staff,** particularly the section on Emergency Health Care Services. Remind all staff that the incarcerated individuals have the right to declare medical emergencies, and they should not be denied access to health care.

- **Develop a formal <u>administrative</u> procedure for determining when a patient has misused the medical emergency system.** Through the relationship between a provider and a patient, data is gathered, diagnoses are made, treatment plans are developed, treatment compliance is accomplished, and healing can occur.[33] Therefore, infractions

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[28] The American Geriatrics Society Clinical Practice Guideline: Prevention of falls in older persons (2010) http://www.americangeriatrics.org/health_care_professionals/clinical_practice/clinical_guidelines_recommendations/2010/

[29] Fall Risk Assessment for Older Adults: The Hendrich II Fall Risk Model https://hign.org/consultgeri/try-this-series/fall-risk-assessment-older-adults-hendrich-ii-fall-risk-model

[30] Per consultation with geriatricians at University of Washington Division of Gerontology and Geriatric Medicine.

[31] Per consultation with orthopedic surgeons at Rush University Medical Center in Illinois and University Clinic of Saarland in Germany.

[32] The foot or toes are permitted to touch the floor (such as to maintain balance) but should not support any weight.

[33] Delbanco TL. Enriching the doctor-patient relationship by inviting the patient's perspective. Ann Intern Med. 1992;116(5):414.

should not be issued by providers since this can damage the provider-patient relationship and negatively affect healthcare outcomes.
    - Assign the issuance of healthcare-related infractions to the facility's health services managers, although providers should offer relevant information for decision-making.
    - Include the facility's mental health provider(s) in the discussion, since misuse of the medical emergency system may signal an underlying mental health diagnosis that requires treatment.

- **Strengthen the process of determining who is eligible for medication-assisted treatment.** Denial of medication-assisted treatment for "behavioral issues" in a patient who would benefit from such treatment should require a mental health evaluation, rather than an opinion from a medical provider.

- **Permit Violator patients to keep healthcare appointments that were scheduled prior to incarceration,** provided that the care is consistent with the Washington DOC Health Plan / Offender Health Plan. This not only allows the patient to receive appropriate care without delay, but also helps keep the patient connected to a community provider so that care can continue upon release from DOC.