STATE OF WASHINGTON
DEPARTMENT OF CORRECTIONS
P.O. Box 41100 • Olympia, Washington 98504-1110

July 30, 2020

Joanna Carns
Office of Corrections Ombuds
PO Box 43113
Olympia, WA 98504

Dear Ms. Carns:

The Washington Department of Corrections appreciates the opportunity to respond to the OCO Report on the 'the OCO investigation into the suicide of an incarcerated individual at Monroe Correctional Complex' completed by the Office of Corrections Ombuds.

Recommendation	Response
Eliminate barriers to medical appointments. DOC should implement a clear policy and procedure that ensures an appointment for every patient who requests one.	The Department of Corrections is reviewing the triage appointment request process and will ensure that the process is being utilized effectively. The agency has a standing process in place where incarcerated individuals can sign up to be seen for walk-in services during sick call hours if an appointment was scheduled at a later date than desired. Additionally, mental health and medical staff are always available to respond to emergent situations upon notification of the situation.
Require an evaluation by a medical practitioner after every medical emergency. DOC should implement a clear policy and procedure that requires an evaluation by a physician or advanced practitioner within a week after a declared medical emergency, to ensure that adequate treatment has been provided and appropriate referrals have been made.	The Department of Corrections is continuing to work on nurse training to ensure that appropriate follow-up appointments are scheduled with a medical practitioner following a substantiated medical or urgent emergency.
Adopt a collaborative care approach for patients with medical and mental health diagnoses. DOC should require weekly multidisciplinary team meetings for these patients to ensure that their health needs are	The Department of Corrections began discussions pertaining to the coordination of care of the incarcerated population, to include seriously mentally ill and chronic care patients. These discussions will resume post

communicated and coordinated across disciplines**.**	COVID-19 response, as many of the individuals required to further these conversations are fully invested in the agency's current pandemic response.
Develop a process that ensures a follow-up appointment any time a medication is prescribed or dosage is adjusted. A follow-up after medication changes is simply good medicine. It enables the provider to assess for improvement or to make adjustments as needed.	The Department of Corrections mental health unit currently requires an evaluation every 90 days with patients prescribed psychiatric medications to evaluate their care, to include medications, and their mental health state. Psychiatric providers will schedule follow-up appointments if needed within the required 90 day time period.
Develop a process that ensures documentation in the chart is legible. Clear communication among all providers involved in a patient's care is imperative for good clinical outcomes. DOC should eliminate handwritten practitioner notes and require notes to be either dictation or typed. DOC should also ensure practitioner documentation quality via clinical oversight at appropriate intervals.	The Department of Corrections Health Services Administrator for Command B sent an email to all health services staff reminding them of the important of medical records and medical documentation being presented in a legible way for review of others who may need to evaluate the medical records. Additionally, Health Services will be conducting a cost benefit analysis to determine efficacy of providing clinical staff with a speech recognition program on their computers. Once this analysis is completed, Health Services leadership will determine next steps for the department. Please see the attachment A.
Ensure timeliness of Kite responses. In particular, DOC should implement a clear policy and procedure that requires response within 24 business hours for all Kites containing appointment requests.	The Department of Corrections is analyzing the current response time to kites, specifically health service related kites. Upon completion of the analysis and if the determination is made, the department will look to process improvements to ensure that kites are being responded to in an acceptable time frame. Additionally, at any time an incarcerated individual can declare a medical emergency through the grievance process.
Review with custody and medical staff the proper use of emergency restraint chairs. Patients who are found unconscious may be disoriented and instinctively defend themselves	Per policy 420.255 Emergency Restraint Chair, staff are now trained on the proper use of emergency restraint chairs, to include manufacturer's training, Department

when finally aroused; they should not be placed in restraint chairs, but instead should undergo a medical evaluation.	procedures and practical application.
Strengthen current policies and procedures so that rescue occurs promptly. A three-minute delay prior to rescue – such as that which occurred in Mr. Brown's case – is not likely to result in a life saved. In addition, accessibility to tools needed for rescue should be improved; this is particularly important in multi-tiered units, where precious minutes are lost while the officer is running back to the unit booth to find rescue tools.	Per policy 630.550 Suicide Prevention and Response, calls for assistance and lifesaving efforts are to be immediately made by responding staff.
Provide training on the manifestations and treatment of Parkinson's disease. DOC should extend this training to Medical, Mental Health, and Nursing providers. Consider including Custody staff on appropriate sections so they are familiar with the signs and symptoms of Parkinson's and other dementias, so as not to misread these symptoms as willful aggression.	At the Continuing Medical Education (CME) conference held in September 2019, attended by departmental health service providers, there was a specific course held titled "Older Incarcerated Individuals with Memory Loss and Dementia", along with other courses related to caring for geriatric incarcerated individuals. The department will continue to research, learn, and educate about signs and symptoms of dementia and other diseases. Please see Attachment B
Provide training on the evaluation and management of falls and syncope. DOC should extend this training to Medical, Mental Health, and Nursing providers.	At the Continuing Medical Education (CME) conference held in September 2019, attended by departmental health service providers, there was a keynote course held titled "Deprescribing to Reduce Fall Risk" followed by a course titled "Fall Risk Assessment". The department will continue to research, learn, and educate about evaluation and management of falls and syncope. Please see Attachment B
Provide training on the risk factors, evaluation, initial management, and follow-up of suicidal patients. DOC should extend	The Department of Health requires that all individuals who hold a medical license adhere to their requirement of completing a required number of suicide prevention continuing

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this training to Medical, Mental Health, and Nursing providers. DOC should also include refresher training on DOC Policy 630.550 Suicide Prevention and Response, the Suicide Risk Assessment Protocol, and the Suicide/Attempted Suicide Response Emergency Checklist, to ensure that these policies are followed.	education hours to remain in good status with their medical license. Additionally, the department's Training and Development Unit projects this curriculum specific to a prison setting could be incorporated in a year's time to future required annual in-service learning for health service professionals.
Assess whether the staff involved in the patient's care should be investigated for failure to provide care or appropriately respond in a timely manner.	Staff involved in the patient's care have been assessed and the case investigated. Action items suggested by the assessment and the investigation have been completed.
Provide better quality assurance for critical incident review reports and ensure better preservation of evidence.	DOC policy 400.110 Reporting and Reviewing Critical Incidents is scheduled for review. The Department has recently hired a new risk manager, who will consider increased quality assurance standards that may be incorporated into both the policy and practice of completing critical incident review reports.

The information provided by the OCO was useful to ensure the Department of Corrections is doing everything it can to ensure an incarcerated person's time in the agency's facilities is a fair and safe space for all incarcerated individuals.

We also appreciate your team's understanding of the unique processes across facilities and the addition of policies and procedures being put in place to address them. We are working towards proactivity and improving quality assurance processes throughout the department. Moving forward, Washington Department of Corrections will continue to collaborate with the Office of the Corrections Ombuds to implement additional policies, procedures, and security measures to continue to improve the facility operations.

Sincerely,

Steve Sinclair, Secretary
Washington Department of Corrections

From: Reninger, Kathleen J. "Kathy" (DOC)
To: DOC DL HS ALL STAFF
Cc: Russell, Scott J. (DOC); Perkinson, Paige T. (DOC); Barclay, Jeremy S. (DOC)
Subject: Medical Record Documentation
Date: Monday, July 20, 2020 12:51:31 PM

Good Afternoon,

I would like to address an issue that continues to plague health services – legible documentation and staff signatures in the medical record. This has long been an issue identified through CIR's, Investigations, Audits, Death Reviews, and OCO Investigations.

Medical records documentation must be legible so that staff may follow instructions for treatment for the current visit. Staff must also be able to refer to the patient history when the patient returns for future appointments. Documentation in the medical record must have meaning to all who read the record, in addition to the individual making the entry. Poorly kept or illegible medical records may be detrimental to patient care while also leaving medical providers and the department vulnerable to litigation. We work in an environment where a reliance on written documentation persists and contribute to clinical decision-making and outcomes. Because of our strict reliance on a paper medical record and written documentation, this standard must be met or exceeded on a consistent basis.

I know that some of you utilize staff, a dictation service or a speech recognition program to transcribe provider notes. Unfortunately, not all clinical staff are utilizing these options. Health Services will be conducting a cost benefit analysis to determine the efficacy of providing clinical staff with a speech recognition program on their computers. Once a determination has been made we will notify you of the results. Until this analysis is completed, I want to ask all of you to please take special care in how you are documenting in the medical record. Please make sure your documentation is legible so that all staff can understand what occurred at the appointment, what medications were ordered and the recommendations for follow-up.

Thank you,

Kathy

Kathy Reninger, MA

Health Services Administrator, Command B

WA Dept. of Corrections

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2019 FALL CME CONFERENCE AGENDA

CQIP Provider Education Workgroup: Trish David, Nancy Fernelius, Jon Neau, Bart Abplanalp

Dates: September 26th – 27th

Location: Tacoma Rhodes Center
949 Market Street, Tacoma WA 98402

Providing Quality Primary Care to Older Adults (Day 1)

08:00-08:15	Continental Breakfast / CMO Welcome
08:15-09:15	Assessment of the Geriatric Patient *Marissa Black, M.D.* *Geriatric Medicine Specialist, EvergreenHealth Geriatric Care*
09:15-09:45	Wound Care for the Older Adult *Alison S. Archer, R.N., C.W.C.N.* *RN Supervisor, Providence Wound Clinic* *Providence Regional Medical Center, Everett*
09:00-10:00	***Break***
10:00-11:00	Osteoporosis: Diagnosis and Management *Dr. Caitlin Kinahan, M.B.B.Ch.B* *Geriatrics & Gerontology Fellow, University of Washington*
11:00-12:00	Diabetes Management in the Elderly *G. Steven Hammond, Ph.D., M.D., M.H.A.*
12:00-12:15	CMO Awards Presentation *DOC Patient Safety Advocate of the Year* *DOC Community Partner of the Year*
12:15-1:30	***Lunch on your own***
1:30-2:30	Hypertension in Elderly Adults *Samantha Hersrud, M.D., Ph.D.* *Chief, University of Washington-Boise Internal Medicine Residency*
2:30-2:45	***Break***
2:45-3:30	Aging and Dental Health *Joy McDaniel, D.M.D.*
3:30-4:00	Physical Fitness for the Older Patient *Brent Carney, R.D.N., M.B.A. / Bryan Weston, D.P.T.*
4:00	***Adjourn***

Optional: 5:00pm Happy Hour gathering at Bar960 (inside Hotel Murano)

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Providing Quality Primary Care to Older Adults (Day 2)

8:00-8:15	Continental Breakfast and Networking
8:15-9:15	Keynote: Deprescribing to Reduce Fall Risk *Shelly L. Gray, Pharm.D., M.S.* *Professor, University of Washington Department of Pharmacy* *Director, Plein Center for Geriatric Pharmacy Research, Education, & Outreach*
9:15-9:45	Fall Risk Assessment *Ann Hendrich, Ph.D., R.N., F.A.A.N., and Dwana Murphy, VP Operations* *Hendrich II Fall Risk Model*
9:45-10:00	***Break***
10:00-11:00	Legal Aspects of End-of-Life Care *Marko L. Pavela, Assistant Attorney General* *Michelle M. Young, Assistant Attorney General*
11:00-11:45	Competency and Informed Consent *Bruce C. Gage, M.D.*
11:45-1:00	***Lunch on your own***
1:00-1:45	End-of-Life Care *Deborah J. Tonhofer, M.D.*
1:45-2:00	***Break***
2:00-3:00	Older Incarcerated Individuals with Memory Loss and Dementia *Lee H. (Tony) Rome, M.D.*
3:00	***Adjourn***

Save the Date: Spring 2020 CME Conference
Patient Safety in the Correctional Setting
March 26, 2020 (eastern WA) / March 27, 2020 (western WA)