# ARIZONA DEPARTMENT OF CORRECTIONS HEALTH SERVICES CONTRACT MONITORING BUREAU MEMORANDUM 

TO: Elsie Stowell Winslow Site Manager

## THROUGH:

FROM: John Mitchell Health Services Compliance Monitor
DATE: $\quad 3 / 22 / 13$
SUBJECT: Monitoring findings for March, 2013

This memorandum is intended to inform you, as the Facility Health Administrator for the Winslow complex, of the compliance issues that I have encountered during my monitoring activities during the month of March. As this is Corizon's first month under contract to provide healthcare to the inmates and a transition was required with a short turnaround, a formal corrective action plan will not be required. I do, however, believe that it is still very important that you are kept informed of my findings as many of them will continue to be an issue if they are not addressed. Many of these issues have been addressed with you and nursing as they were discovered and have been immediately corrected. Others will require more planning and time to remedy. Please be assured that my commitment to assisting you and your staff to attain and maintain compliance with NCCHC standards, ADOC policy, and compliance with the contract remains strong. I am committed to assisting your staff to acquire the knowledge and skills they need to be successful in providing healthcare to the inmate population as required by the contract.

Provider chart checks have not been completed in a timely manner. At times during the month the backlog has been over 150 charts and some of these charts have been sitting for well over a month. The one, part time, provider has been seeing 25-35 inmates a day on the days he is here. Patient care is rightfully being given priority but the backlog of chart checks needs to be addressed. Please keep me informed of progress towards hiring a Medical Director and a full time mid-level provider. Examples of consults that have not been signed off on by the provider within seven days as required are: ${ }^{\text {inmate }} \quad$ 2/28/13 consult not signed off on as of $3 / 11 / 13$, inmate ${ }^{\text {n }}$ ER consult from 12/21/13 not noted as of $3 / 11 / 13$, inmate $\quad 2 / 25 / 13$ consult not noted as of $3 / 11 / 13$, inmate Inmate ER notes from $1 / 17 / 13$ not noted as of $3 / 11 / 13$, inmate $\quad 2 / 28 / 13$ consult not noted as of $3 / 11 / 13$, ${ }^{\text {nimate }} \quad 2 / 6 / 13$ Optometry consult not signed as of $3 / 11 / 13$, and ${ }^{\text {nnmate }} \quad 2 / 25 / 13$ cardiac consult not noted as of $3 / 11 / 13$. In addition there are eight lab reports and an x-ray report that have not been noted by the provider some of which date back to Jan. These include


inmate

Return to custody inmates are not having a physical exam completed by day two of the intake process as required. ${ }^{\text {nnmate }}$ and ${ }^{\text {lnmate }}$ arrived on 2/7/13 and have not had a PE as of $3 / 18 / 13$. ${ }^{\text {inmate }}$ arrived $3 / 11 / 13$ and is still awaiting a PE as of $3 / 18 / 13$. inmate arrived 3/8/13 and did not have a PE until 3/14/13.

Inmates are not always seen within 24 hours of the HNR being triaged. Examples include ${ }^{\text {inmate }}$ Inmate HNR triaged 3/1/13 seen on nurse line 3/7/13, inmate $\quad$ HNR triaged 3/10/13 scheduled on $3 / 19 / 13^{\text {ninmate }} \quad$ HNR triaged on $2 / 27 / 13$ seen on nurse line $3 / 6 / 13$, ninmate $\quad$ HNR triaged on 2/13/13 seen on nurse line $2 / 20 / 13$, ${ }^{\text {nnmate }} \quad$ HNR triaged 3/7/13 scheduled 3/14/13, and ${ }^{\text {nnmate }} \quad$ HNR triaged $3 / 1 / 13$ seen on provider line $3 / 12 / 13$.

Vital signs are sometimes not being recorded during sick call. Examples include:
[nmate $\quad 3 / 5 / 13$

| ight, ${ }^{\text {inmate }}$ |
| :--- |
| without vital signs, |
| $3 / 7 / 13$ note without |
| $2 / 26 / 13$ note | note without vital signs, inmate $\quad 1 / 14 / 13$ note without a weight, inmate



Referrals to providers from nurse line are not being seen within seven days as required. Examples include $\qquad$ nurse line $3 / 7 / 13$ scheduled for provider line $3 / 26 / 13$ and 211211 nurse line $2 / 2 / 13$ provider line $2 / 12 / 13$. In addition the following charts were forwarded to the provider for review and not signed off on in a timely manner: 1/11/13,

Provider orders were not always noted daily. The following are examples:


You are well aware of the breakdown in the medication refill process and have been working diligently to correct the problem. I understand that Pharmacorr has agreed to auto-fill all the KOP medications so that you will have the stickers needed to start and maintain your tickler file for future refill needs. I have to commend the CRNS I for doing a great job of diagnosing and finding a cure to this problem. Please continue to monitor this issue as it will continue to be a point of emphasis in my monitoring effort. I have talked with the complex major of security and he has agreed to post the message that you requested to be posted regarding medication refills on the CCTV and on bulletin boards.

The requirement to have chronic care inmates seen on a regular basis has been met with a few exceptions. The HCP has done a remarkable job considering he has only been on-site every other week. Please continue to monitor this area as it also will remain a point of emphasis. Keep me informed of the progress towards hiring a full time Medical Director
and a full time Mid-level as I am sure that having these positions filled will greatly influence the ability to comply with this performance measure.

Please continue to communicate problems that you encounter to me. I can not assist with finding solutions if I am not aware of them. I remain committed, to assisting you in any way that I can, to insure that mandatory quality healtheare is provided to the inmate population. You are doing a good job considering the staffing issues and the short transition time. I expect that compliance will improve as positions are filled, staff is trained, and you have time to incorporate Corizon's policies and procedures.

Respectfully,
John Mitchell
Compliance Monitor I

