Final Report

September 27, 2023

Allegheny County Jail

TECHNICAL ASSISTANCE REPORT

This report details findings from a site visit conducted August 7, and 8, 2023.

SOLUTIONS FROM THE MOST TRUSTED NAME IN

CORRECTIONAL HEALTH CARE

Allegheny County Jail
Technical Assistance Report

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INTRODUCTION

At the request of the Allegheny County Manager, the NCCHC Resources team was on site at the Allegheny County Jail on August 7 and 8, 2023. The on-site team consisted of senior lead consultant Nancy Booth, RN, MSN, PHN, CCHP-RN, and Richard A. Forbus, Jr., CCHP. Richard Clarke, MD, CCHP-P, completed virtual health record reviews.

This visit was a follow-up to the visit on November 1, 2, and 3, 2022, when an NCCHC Resources team reviewed the in-custody deaths from January 2017 to October 2022. That study's results did not find malice, maleficence, or indifference, but did identify areas with a greater risk of potential critical outcomes. We included our recommendations for process changes in that study, and since that time, the health services administrator and staff have worked on making changes.

Visit objectives

- Interview medical and mental health personnel to assess the changes made since our prior visit.
- Review intake/receiving processes.
- Identify any operational gaps related to accepting, managing, treating, and housing incarcerated individuals with substance use disorders in the Allegheny County Jail and make recommendations to fill those gaps.
- Review health records and gain perspective on substance use disorder incidents and facility operations.
- Review the use and application of the Clinical Institute Withdrawal Assessments and Clinical Opiate Withdrawal Scale.
- Review the health records of a sample of patients on detoxification protocols to determine if treatment protocols align with best practices.
- Review staffing levels related to receiving and detoxification.
- Examine updated nursing protocols related to receiving and detoxification.
- Review the current training materials.
- Review the in-custody death packages of patients who were detoxifying and died in custody.
- Interview key jail personnel regarding the in-custody deaths of patients with substance use disorder.
- Interview key personnel to discuss receiving workflows related to substance use disorder and detoxification.

Abbreviations Used in this Report	
ACBOC	Allegheny County Bureau of Corrections
ACJ	Allegheny County Jail
ADON	assistant director of nursing
AED	automated external defibrillator
ASAP	Allegheny Standardized Arrest Program
CIWA-Ar	Clinical Institute Withdrawal Assessment for Alcohol
CIWA-B	Clinical Institute Withdrawal Assessment for Benzodiazepines
COWS	Clinical Opioid Withdrawal Scale
DON	director of nursing
QHP	qualified health care professional

Due to the complexity of the health conditions discussed herein, definitions have been provided.

Definitions

The **Clinical Institute Withdrawal Assessment for Alcohol** is a 10-item scale used in the assessment and management of alcohol withdrawal. The CIWA-Ar scale is the most sensitive tool for assessment of the patient experiencing alcohol withdrawal. Nursing assessment during alcohol withdrawal is vitally important. Early intervention for a CIWA-Ar score of 8 or greater provides the best opportunity to prevent the progression of withdrawal symptoms to dangerous levels.

The **Clinical Institute Withdrawal Assessment for Benzodiazepines** is a tool for assessing and monitoring the severity of benzodiazepine withdrawal.

The **Clinical Opioid Withdrawal Scale** quantifies the severity of opiate withdrawal and is used in the management of symptoms.

Detoxification is the first step in substance abuse treatment. Goals within the jail setting include initiating abstinence and reducing withdrawal symptoms and severe complications.

Fentanyl is a synthetic opioid 50 to 100 times stronger than morphine. Individuals addicted to opioids use fentanyl to increase the opioids' potency.

Intake/receiving (also referred to as receiving) refers to the initial entry point for arrestees in the ACJ. The receiving process consists of the initial arrival to the ACJ, initial search, entry into ASAP, a receiving screening, identification processes, and a pre-trial services interview. Once processed through receiving, arrestees are moved to pre-arraignment.

Medical clearance is the first encounter with the individual when they present to the jail. The objective of this process is to determine whether an individual is "fit for jail" or needs to be evaluated at the hospital before being booked into jail.

Narcan is the trade name of naloxone – a drug used in people of all ages that rapidly reverses the effects of opioids in the event of an overdose or possible overdose. It is meant to be used only in emergencies.

The **NCCHC Standards** provide a framework for quality health care for individuals incarcerated in jails, prisons, and juvenile facilities.

Opioid toxicity is life-threatening and requires immediate emergency attention. Symptoms include, but are not limited to, inability to awaken, slowed or absent breathing, and decreased or absent heartbeat.

Pre-arraignment is the area of the ground floor of the ACJ where arrestees are housed, awaiting their video arraignment appearance to determine if they will remain in the ACJ or be released without being processed into the facility.

Pre-trial services conducts interviews of arrestees before their arraignment. This process is typically used in county jails to gather information about an arrestee to determine risk or suitability to be released on their own recognizance. The term pre-trial also refers to one's status in the criminal justice system and is also known as a pre-trial detainee, meaning someone who has not been convicted of a crime but is held in jail pending a case disposition from a court of law.

Processing is the area of the ground floor of the ACJ where arrestees who are to remain in custody after arraignment are housed, pending movement to special housing or a classification pod within the ACJ. While in this area, individuals are entered into the offender management system, are asked a series of screening questions by ACJ officers, receive additional health screening from medical staff, and are given approximately 8 hours to arrange bail before being moved to a housing unit upstairs.

Promethazine is a medication used to manage and treat allergic conditions, nausea and vomiting, motion sickness, and sedation. It is also known to be abused in conjunction with opioids.

The **receiving screening** is a nursing assessment completed with vital signs, health issues, health history questions, medication verification, and initial treatment (if appropriate) before being transferred to a housing unit.

Stat is a word commonly used for urgent or rushed treatment.

TechCare is the ACJ's electronic health record software for patient data and documentation.

Xylazine is a non-opioid drug used for sedation, anesthesia, muscle relaxation, and pain relief in horses, cattle, and other non-human mammals. It may not be legally purchased without a veterinary license.

SITE VISIT OVERVIEW

Our team conducted an on-site visit to the Allegheny County Jail on August 7 and 8, 2023. An introductory meeting was conducted on the morning of August 7, 2023 with key personnel from medical services and custody. Our team received a thorough tour of the intake area and the units where patients are housed when they are placed on a detoxification protocol. We then conducted observations of operations in those areas, and interviewed personnel working in those areas throughout the time we were on site.

An exit meeting was conducted on the afternoon of August 8, 2023, where we presented our preliminary observations. After the site visit, we conducted a review of documents and data provided by health and custody staff as part of our analysis. We would like to thank the staff of the Allegheny County Jail health care and custody operations for providing the requested information promptly, and for their assistance in allowing our team to access the necessary areas of the facility to complete a thorough analysis of the intake and detoxification processes.

Interviews conducted

Custody

W Harper
DW Toma
MAJ Batykefer
CPT Merlino
CPT Frank
SGT Barker
SGT Gerber
SGT Greenawalt
OFC Poloff
OFC Renda
OFC Brown
Multiple housing unit officers in 4A, 1C, and intake/receiving

Nursing

Holly Martin, DON
Garett Wagner, ADON
Andrew Kuznetsov, ADON
Michael Elick, detoxification nurse
Tori Pipak, physician assistant
Robyn Smith, nursing educator
Ashley Plevlich, quality improvement manager

Administration

Ashley Brinkman, health services administrator
Mary Jeanne Serafin, project manager

Mental Health

Stuart Fisk, NP

Documents reviewed

- List of individuals seen in receiving who were sent to the emergency room
- List of individuals who required Narcan
- List of individuals testing positive for opiates at receiving
- List of individuals remaining in receiving for more than 12 hours
- List of individuals (including date and time of arrival and time of release) who were arraigned and not booked
- List of individuals with abnormal vital signs:
  - Blood pressure of 150/100 or greater
  - Pulse of 110 beats per minute or greater
  - Respiration rate of less than 12 per minute
- List of individuals with a Clinical Opioid Withdrawal Scale score of 25 or higher

- List of individuals with a Clinical Institute Withdrawal Assessment score of 15 or higher
- List of individuals listing medications at the time of receiving (during the past month)
- Policies and procedures related to:
    - Booking/receiving for initial arrestees
    - Detoxification protocol and management
    - Procedures for the intake/receiving housing unit within the jail
    - Special housing (mental health, detoxification, suicide risk, etc.)
- Documents reflecting:
    - Changes in policies and procedures for receiving and detoxification (custody and medical)
    - Changes in nursing protocols as they relate to detoxification care and treatment
    - Dates and training (either custody or medical) focused on detoxification or receiving
    - Custody lesson plans and course content for health-related training, including signs and symptoms of intoxication, withdrawal, and detoxification procedures
    - Health care lesson plans or course content on detoxification and signs and symptoms of intoxication and withdrawal

FACILITY OVERVIEW

Allegheny County Jail is a pre-trial and sentenced detention facility that houses male and female adult inmates and youth offenders under 18 years of age who are being tried as adults. The ACJ is a central booking facility, meaning multiple agencies bring arrestees to the facility straight from the community for new charges, warrants of arrest or bench warrants, and probation and parole violations. Individuals remanded into the facility's custody by a court of law may also be taken into custody at this facility.

As a central booking facility, individuals may present with acute medical conditions, significant injuries, or be under the influence of drugs or alcohol at receiving. A health care professional evaluates the individual and determines whether they are "fit for jail." Those not accepted are sent to a nearby emergency room for a more extensive evaluation before returning to be booked. Once accepted, individuals are moved through the pre-arraignment process and are formally arraigned when seen by a judge via video.

At their arraignment, the judge will determine whether the individual will remain in jail, which includes setting a bond, or if they are to be released from custody under terms determined by the court. If remaining in custody, arrestees are moved to the processing area and are given approximately 8 hours to post bail before they are assigned housing in a classification pod or, if applicable, assigned to special housing (medical, mental health, etc.).

Based on reports to the Jail Oversight Board, Allegheny Jail accepts an average of approximately 700 to 750 monthly commitments. It has been estimated by both custody and medical staff at ACJ that 40% of arrestees are released before being committed and processed into the facility. Based on recent data, the average daily population has been between 1,500 and 1,600.

CLINICAL MEDICAL AND MENTAL HEALTH FINDINGS

Intake/receiving process

We note significant concerns with how the health services operation is structured for the receipt of new arrestees, as well as how those arrestees are monitored, observed, and medically treated during the initial process of receiving, up to the processing stage of the operation. Further issues exist regarding how information is entered, maintained, and communicated across the receiving process. When considering the totality of the operation, there are several challenges for custody and health services.

The health services process is complicated to navigate because of the way it is implemented, and we noted multiple processes that must be addressed to improve the medical management of patients with acute health conditions, intoxication, and if applicable, withdrawal symptoms. These processes impact custody and health service delivery to new arrestees.

We also found inconsistent court arraignment processes and requirements that impact the time arrestees spend on the intake/receiving floor, as well as the ACJ's ability to track offenders, share information, and assign housing prior to an arrestee being committed to the facility. These factors ultimately create challenges in providing effective and efficient health care services. Given the current system, these processes are not within the control of the ACJ and effectively create a blind spot for offender management within the facility. Specifically, the current system for processing new arrestees limits options, impacts information management processes, and contributes to safety issues for arrestees.

The current system differentiates between simply being in custody and actually being committed to the facility. Importantly, there seems to be a difference in how arrestees are treated based on this status, as it affects how they are screened for health issues in receiving. In practice there is a shared mindset of waiting to see whether patients are being committed before completing the receiving screening. This delay seems to be an effort to cut down the number of receiving screenings by splitting the process between the arrival of arrestees and those committed to ACJ custody. These processes also drive culture within the ACJ.

The issue with the current mindset and process is that all arrestees are under the custody and care of the ACJ until they are released from custody, regardless of their status with the court, and all are equally at risk of adverse outcomes based on their individual characteristics and medical needs. Their status with the court is inconsequential when it comes to the facility's responsibility to maintain custody and care of its residents, and the current system creates unnecessary risk of an adverse outcome.

The current way of thinking minimizes the care of those who will not remain in custody and places this group of individuals at higher risk of an adverse health incident due to inadequate care. Although we appreciate that resources must be used efficiently, all arrestees are at an equal level of risk in the first 24 to 28 hours in custody and must thus be treated equally.

Receiving – medical clearance

The entire receiving process is completed incrementally; initially, everyone presenting to the jail is medically cleared. Medical screening includes brief questions, including illness and injuries, thoughts of suicide, orientation, and medication allergies. Additionally, vital signs are taken, and point-of-care testing is done for drugs, COVID, and pregnancy (for females). Medical clearance involves determining if the individual is fit for jail or needs to be referred to an emergency room for a more extensive

evaluation. Staff responsible for medical clearance can be a registered nurse, a licensed practical nurse, or a medical assistant.

Additionally, it was brought to our attention that custody staff are sometimes required to do the medical clearances. Systems in place need to consider the risk inherent in this practice. The assumption that less-trained staff can assess medical acuity is incorrect and ignores the risks the ACJ is taking by allowing this to take place. The importance of having an experienced registered nurse determining detainees' suitability for clearance cannot be overstated. While NCCHC standard J-E-02 allows for trained custody staff to conduct receiving screenings, this is only authorized in instances where no medical staff are on duty. It is expected that medical staff conduct initial screenings when staff are available at the facility, which is the case at ACJ.

We observed a qualified health staff member perform a medical clearance on a newly booked individual during our visit. The electronic health record was not accessed at the time of the encounter, and a short, paper-based version of the assessment was used (see Attachment A). According to the health services administrator this form was used in the past, but a more extensive medical clearance form has since been developed (see Attachment B). However, the shorter form continues to be used by staff. In reviewing this individual's health record after the staff member had entered it, the information was disconcerting as actions that had not been performed were documented. Additionally, not using the electronic health record prevented the health staff member from viewing historical information to assess the individual's health issues. This is a source of potential gaps in adequate care. When we were observing receiving and processing, we believed the health staff could handle all these processes and provide adequate and timely care, so we are unsure why the processes are not being followed.

Medical clearance and receiving screening policy

The progression of arrestees is captured within two policies; one for custody staff and one for medical staff. The progression of a new arrestee for custody staff is outlined within Policy 216 – Prisoner Admissions – Operations (see Attachment C). The progression of a new arrestee for medical staff is outlined within Policy 2501 – Medical Clearance and Receiving Screen. This policy is more extensive than the custody policy. However, several differences exist between the two policies. Custody and medical procedures must not conflict and must be reviewed to ensure they complement one another.

The medical policy addresses protocols when an individual is identified as having an emergent medical condition at the time of medical clearance. The intent of the policy is to communicate important information to all staff members encountering the individual throughout the booking process. Per policy, individuals with a medical condition must have a yellow wristband applied. This policy is not being followed, and when questioning a staff member on the protocol, her response was, "I don't do it; I wasn't trained." This attitude is discouraging and indicates a need for auditing, accountability, and leadership. Another staff member advised the team that the jail ran out of yellow wristbands. However, one of our team members found these yellow wristbands behind papers and files in the medical clearance area.

The medical policy creates additional questions about how receiving screenings are being conducted. A separation exists between "medical clearance" and receiving screening, differentiating between the initial arrival and the receiving screening process.

Additionally, both policies state they will be completed within 24 hours of arrival, which is too long of a time frame and allows for gaps in proactively preventing adverse outcomes.

Receiving to pre-arraignment

As mentioned above, ACJ custody and health staff have extensive issues with information management, largely due to being hampered by inconsistent court arraignment processes and the use of a separate computer system (ASAP) from the facility's offender management system. Having separate systems with no ability for them to interface negatively affects the ability to track the location of offenders, manage records, and ultimately creates the potential for an adverse outcome during the first 48 hours, as this period tends to be the highest-risk time period for individuals who are under the influence of or withdrawing from alcohol or narcotics.

The lack of health care oversight created by these disparate systems is problematic for several reasons. Individuals sometimes arrive at the jail intoxicated, and intoxication alone is not usually a reason to reject them for medical reasons. Health staff expressed frustration due to spending significant amounts of time trying to locate patients they need to see for detoxification checks, and when this is combined with other gaps in the receiving screening process, their ability to provide care is severely impacted.

Intoxicated individuals are undeniably at risk; according to the US Department of Justice, 15% of all jail deaths in 2019 were from alcohol or drug intoxication. Individuals presenting to jail withdrawing from substances can experience symptoms within 5 hours; well past the time they were first medically cleared, yet before they are provided with medical services by ACJ. For a list of time frames for withdrawal symptoms, see Attachment D.

While on site we observed an individual in pre-arraignment withdrawing from alcohol. This individual had an extensive record of previous incarcerations and emergency transfers due to seizures when withdrawing from alcohol. Staff were called to the pre-arraignment area and administered emergency care. The emergency equipment needed was not conveniently located and required staff to get supplies from another place.

In reviewing the emergency room send-outs we noted that some individuals have required emergency care that might have been averted if there was a health care presence in pre-arraignment. In the past 6 months, two individuals from this area had severe symptoms of alcohol withdrawal and were transferred to the nearest emergency facility. We are concerned about the lack of health care for people in this high-risk area.

The arraignment process seems to be very inconsistent and appears to contribute to the challenges and gaps we identified above. Aside from the limitations of the software applications and processes for determining whether someone is in custody or committed, our team also reviewed documentation revealing variances in the timeliness of arraignments that create challenges for the ACJ to manage their intake processes. Current procedures are driven by facilitating court processes, but negatively impact the ACJ's ability to manage their population and are a factor in the above-noted patient safety issues. Because arraignment drives the current processes and overlaps with the most dangerous period for new arrestees, the entire process will need to be examined to identify how it can be reworked to ensure information sharing and proper care.

Notably, once someone is committed after arraignment and moved to processing, the current procedure aligns with standard practices used nationwide.

Pre-arraignment to processing

Individuals who are committed are then moved to a large processing area. Upon transferring to processing, they are asked a series of questions by an officer, some of which are related to health. The custody policy and procedure indicate that critical health information must be shared with health staff. However, nurses we interviewed in processing stated that they have never been advised of an individual with emergent health issues. Reviewing data from the electronic record, we see that individuals can remain in processing for 48 hours without seeing a nurse.

Once custody has entered the individual into the offender management system (which we again note is different from ASAP, and the two programs do not communicate with one another), the nurses await notification through a card system to complete the receiving screening. It was unclear why the nurses needed to wait for this card to conduct the screening, and it appeared that this was not an efficient use of their time. The receiving screening includes vital signs, blood sugar checks (if applicable), TB skin tests, inquiries about current health issues, and a review of past health history. The nurse can also contact a provider for medication orders for acute issues, including treatment for substance withdrawal. This delay in nursing assessment and intervention is not a best practice. In one case we reviewed, an individual with Type I diabetes had not seen the nurse for more than 24 hours. This patient was not given insulin and had to be transported to the emergency room due to diabetic ketoacidosis – a life-threatening condition.

Matters of concern

- Staff not using the electronic health record to input patient information are at risk of gathering incomplete information and forgetting to enter gathered information.
- Staff other than registered nurses are doing medical clearances. Receiving screenings are intended to detect conditions requiring further medical care in an emergency room. Abnormal vital signs can be a precursor to many different conditions and require the knowledge base of a registered nurse to properly interpret. The total number of patients presenting to receiving with abnormal vital signs was 2,094 over the course of 7 months. This indicator alone is not cause to send a patient to the ER, but it does demonstrate the need for assessment by experienced health staff.
- The delays identified in the pre-arraignment process are problematic and cause delays in medical treatment.
- The delay in providing detoxification treatment places patients at risk and is an unacceptable practice. Deaths have occurred in the receiving area due to this practice, which needs to be changed.
- ACJ's written policies and procedures for custody do not always align with those of medical services.
- Custody staff are unable to manage detainee information. Because of the processes imposed by the county's criminal justice system, a DOC number is not generated or assigned immediately upon the arrival of a new arrestee. The initial data entry for each arrestee is done using the ASAP system, which does not communicate with the jail's offender management system.
- There is no ability to enter housing locations, informational reports, or other pertinent information into ASAP, and a significant amount of time is wasted trying to find patients in the receiving area to render care.
- With the recent nationwide trend of deaths occurring in the 8- to 48-hour window after arrest and with the median time of death being approximately 24 hours, this is the period during which new arrestees are at highest risk for an adverse incident.

Recommendations

- All inmates passing through pre-arraignment need to be observed by a nurse at least every 4 hours, or more often if clinically indicated.
- Staff should use the electronic health record to access valuable historical information.
- Staff should follow policies and procedures to avoid risking their licensure and keep patients safe.
- Custody should not be permitted to perform medical clearances.
- Allegheny custody administrators must work collaboratively with court services to identify ways to improve the pre-arraignment process.

Detoxification

After processing, detainees are moved from the ground floor to intake/receiving housing. Patients are usually housed in a designated area except for classification for security and safety reasons or acuity of withdrawal symptoms. Male detoxification inmates can be transferred to 4A, the housing unit for new arrivals pending classification, or 5B if they require additional medical care or observation. In 4A, detainees on a detoxification status are housed on the lower tier of the housing unit and assigned to lower bunks due to the possibility of injury from a fall from an elevated position.

Females are housed in 1C, and all the male and female detoxification units are extremely busy, with various residents of different statuses arriving at the jail and pending classification for final housing determinations. We observed that the room walkthroughs were done quickly, as we noted last time. However, with residents out in their free time, it was not clear which cells were occupied and unoccupied, so there could be an explanation for why some of the checks seemed hurried.

When completing the receiving screening, the nurse adds the individuals they identified as needing withdrawal treatment to a detoxification dashboard in TechCare. The detoxification nurse uses this dashboard to assist in reviewing the previous withdrawal assessment and as a method of patient management. The treatment protocols for withdrawal from opioids, alcohol, and benzodiazepines are determined by the symptoms observed. If the individual has a delay in withdrawal symptoms (due to their substance of abuse), their treatment may be delayed. Detoxification or withdrawal assessments are done daily by an RN or a provider for both males and females. This assessment occurs between 8:30 a.m. and 11:00 a.m. in the housing units. The COWS, CIWA-AR, or CIWA-B tools are weighted to evaluate the severity of the withdrawal symptoms. These tools include vital signs, assessment of symptoms, observations, and an encounter completed for each patient. (See Attachment E). Treatment is based on assessment scores, and additional treatment is provided if indicated.

As mentioned, the pharmacological treatment for withdrawal is based on the substance use history and differs if the patient admits to alcohol versus opioids. However, the loss of fluids from vomiting, diarrhea, and excessive sweating is common to many withdrawing patients, and dehydration can quickly ensue. Therefore, hydration is a critical part of treatment, and according to the World Health Organization, persons withdrawing from substances should drink between 2 and 3 liters of fluid daily to replace the fluids lost. It is unrealistic to rely on the individual withdrawing from alcohol or opioids to adequately hydrate with water they obtain from their sink. In the sample of emergency room send-outs, three individuals receiving detoxification treatment were transported for dehydration. The detoxification treatment plan should include supplemental, palatable fluids and electrolytes accessible by individuals in the housing areas.

Reviewing the medical services' policy for detoxification, the policy includes twice-daily assessment of vital signs but this is currently done only once daily. We completed a review of the past 6 months of

CIWA-Ar, COWS, and CIWA-B assessment scores ranging from mild to severe symptoms. These assessments are conducted during the receiving screening, and the individual could have been in custody for 12 to 48 hours before reaching that stage of processing. This is problematic as symptoms from alcohol, opioid, or benzodiazepine withdrawal can occur 5 to 8 hours after the last use. Additionally, when the nurse completes the substance abuse assessment during the receiving screening in TechCare, the electronic health record automatically scores the symptoms and based on those scores, indicates when the next assessment should be completed. This is problematic as best practice for the care of withdrawing patients requires frequent follow-up for up to 12 hours; currently, there is no process in place to support this frequency.

Matters of concern

- Waiting until an individual presents with withdrawal symptoms to treat is reactive and not proactive.
- Out of a sample of 40 patients sent to the ER over the past 7 months, 57% were undergoing detoxification treatment. This raises concerns about whether detoxification treatment at the jail is adequate.
- Currently, the medications used for withdrawal treatment are limited to twice daily, which could be insufficient to treat individuals with severe addictions or histories of seizures when withdrawing.
- Assigning the withdrawal assessment once per day is inadequate and risks complications.
- Hydration in processing is difficult as no drinking cups are available, and the only fluids available are in the vending machine.

Recommendations

- Medical policies and procedures need to be followed regarding twice-daily assessments.
- Provide patients with adequate quantities of more palatable fluid.

Use of Narcan

ACJ has implemented a policy and training to use Narcan when encountering an unresponsive individual. The rapid administration of Narcan when an overdose is suspected is essential to improving outcomes. Our data review discovered that many Narcan patients had no documented emergency room referral. We discussed this during the introductory meeting the day we arrived on site, and attendees agreed that anyone receiving Narcan should be transported to the emergency room for a more thorough evaluation. In situations where custody staff use Narcan before the arrival of medical personnel, the use must be reported to medical personnel. Medical personnel notified of such uses must record the use of Narcan in the appropriate area of the electronic health record so it can be appropriately tracked for statistics and effectiveness.

Data analysis related to detoxification

The data our team received and analyzed support the assertions from custody and health staff that there have been recent increases in emergency room transports. We requested information on the following events for analysis, with dates between January 1 and July 31, 2023:

- Abnormal vital signs
- Emergency room referrals
- Use of Narcan
- CIWA scores greater than or equal to 15
- COWS scores greater than or equal to 25

Abnormal vital signs comprised the largest list. We compiled the data from the other lists and compared it to the abnormal vital sign findings to determine if co-occurring factors were notable across these lists.

We identified the following trends through our analysis:

- Emergency room referrals have increased significantly in the last 4 to 6 months.
    - Quarter 1 2023 – 21 referrals
    - Quarter 2 2023 – 33 referrals (an increase of 57%)
    - Quarter 3 2023 (July only) – 14 referrals
- Narcan use has increased significantly since May 2023 but this could be due to the policy change requiring Narcan use for all man-down events.
    - Out of 30 individuals administered Narcan, 11 did not have an emergency room referral.
    - It was unknown if Narcan administered by custody staff was captured in the provided data.
- Abnormal vital signs were present for two of the three individuals who died, either while still in custody ( ), or after release ( ).
- Abnormal vital signs could be a possible predictor in some having co-occurring conditions on other lists, but not for all:
    - 14 of 30 who received Narcan had abnormal vital signs noted.
    - 1 of 5 on the COWS list had abnormal vital signs.
    - 24 of 63 on the CIWA list had abnormal vital signs.

Matters of concern

- Elevated vital signs can be a withdrawal symptom.
- Not everyone receiving Narcan is being transferred to the emergency room.

Recommendations

- Patients with elevated vital signs should be monitored more closely as the individual moves through receiving, pre-arraignment, and processing.
- All uses of Narcan should be documented in the health record; not just those administered by health staff.
- Everyone receiving Narcan should be transported to the emergency room.

Training

Staff knowledge of the signs and symptoms of detoxification, overdosing, and other emergent conditions is critical to patient safety. Officers, mental health, and ancillary staff are health care's eyes and ears and can provide valuable information. When one of our team members asked two of the mental health workers about the training they may have received for substance abuse, they responded that they "aren't nurses," clearly abdicating their responsibility for patients' care

The material developed by the nurse educator responsible for training was excellent; however, this material is directed toward health staff rather than custody staff. This creates the possibility of custody staff not recognizing when someone is exhibiting a progression in signs of withdrawal. This can result in missed or delayed opportunities to intervene early in the process and could result in adverse outcomes, including death. Materials (pamphlets) developed by outside entities are given to nurses and officers as a training method but are beyond the scope of knowledge of the non-health staff.

We spoke to custody officers and supervisors in housing areas 4A and 1C, and throughout the ground floor to discuss their level of training. While almost all senior staff referred to academy training and in-person training they once did, we noted a consistent theme of concern over the uptick in acuity of

detainees, especially in the context of opioid withdrawal. Supervisors we spoke to ranged in rank from sergeant to major. All expressed similar thoughts about the training element specific to withdrawal signs and symptoms. They were confident that senior staff had experience handling subjects during their work and that they could recognize issues. They also noted the higher acuity and risk of people coming in from the street and the impacts of fentanyl and xylazine on detainees.

Based on testing conducted at receiving, booking supervisors estimated as many as 80% of their arrestees come into custody with opioids, benzodiazepines, and/or alcohol in their system. Collectively, custody staff felt the number of medical emergencies, emergency room transports, and individuals requiring medical assistance has steadily increased since approximately March or April of 2023.

In speaking with the medical and custody administration, all agreed that enhanced training is needed for custody staff. However, there may be potential obstacles to providing this training in the most practical manner. There are union restrictions on who is entitled to attend training, so rather than being able to send all booking and detoxification housing personnel to training first, training must be offered on a seniority basis, which impedes the ability to provide specific training to those who need it in a timely manner.

Matters of Concern

- We noted a sense of complacency among some health staff regarding their role in caring for inmates.
- There needs to be more knowledge of the signs and symptoms of detoxification.

Medical services culture

While processes appear fragmented and need adjusting to provide efficient, effective care, some health staff seem to consider specific processes as optional, based on our observations and discussions with them. We identified instances where policy specifies processes intended to enhance or ensure patient safety that are not being used. It is unclear why policy and procedure are not being adhered to. Still, we witnessed and were told this on multiple occasions, giving the appearance of complacency or perhaps an emphasis on personal convenience rather than patient care. We observed this culture of noncompliance and pushback throughout our site visit. This culture directly impacts the safety of patients in the facility.

Examples we observed included staff openly stating “we don’t do that” when asked about multiple processes codified in policies and procedures or in the direction of administration and leadership. Despite clearly expressed policies and direction, compliance among health staff is, inexplicably, resisted. What concerned our team was the attitude of a few medical services staff members in crucial line positions, whose lack of adherence to direction and policy was shocking. Unfortunately, our team spoke to a newly hired employee handling receiving screenings who had a poor attitude and openly admitted to already not following policies.

Our team was also advised that staff are boycotting staff meetings. This is disconcerting as staff meetings are used to discuss patient care issues, changes in treatment, and policy changes. We observed a handful of individuals displaying an attitude of labor management and minimizing workloads for personal convenience over concerns for patient care. This presents a significant barrier to providing proper health care within the facility. These staff are insubordinate, exhibit manifest disrespect to their supervisors and administration, and even had a flippant attitude toward our team members while we were on site.

Some of the unionized health staff are making efforts to undermine leadership, specifically Dr. Brinkman, and such efforts are derailing the possibility of providing effective and efficient health care to patients. A specific individual interviewed by one of our team members openly exhibited these characteristics and admitted to insubordination, disrespect, and neglect-of-duty, directly to our team.

The same individual has had a litany of personal performance issues addressed through the labor-management processes by her chain of command with minimal accountability upheld by those in higher levels of the chain of command above the jail's medical administration.

Based on the totality of circumstances, it is reasonable to associate this specific individual with the prevailing attitude of other individuals in the health care system of the ACJ, since they are also in a top position in the labor-management association that represents health staff. Notably, this position was not disclosed to our team by this individual, who appeared to want to be perceived as an objective party looking at the facility. It appears to us that the complaints and attitude are intended to derail the administration's efforts to improve health care and even potentially derail accreditation efforts.

The lack of information sharing between the mental health and medical services is also noticeable. In reviewing one health record, an individual had admitted using fentanyl to the mental health clinician, but there was no indication that this information was shared. Subsequently, because the nurse was unaware of this, that individual was not entered into the detoxification dashboard. Another example was a seriously mentally ill individual who was decompensating. Although the clinician documented that they would discuss this with the medical provider, we saw no documentation of the discussion occurring. This siloed behavior serves no purpose; it must be corrected regardless of the cause.

The team reviewed health records and observed staff leaving areas of the health record form blank. Examples of incomplete questions included documenting receiving screening and mental health assessments. These essential questions have been developed to ensure thorough documentation and best practices.

Matters of concern

- The prevailing attitude of the health staff is disconcerting and unprofessional, placing patients at risk.
- Patient safety has taken a backseat for staff, and not documenting or sharing important information is negligent.
- Poor attitudes are contagious, and new hires are experiencing this negativity during their orientation period.

Positive changes

Notably, we did observe a change in the culture of custody during this visit. Many efforts have been made by custody to improve the safety of arrestees and staff, regardless of their progression through the receiving/intake process. An emphasis on care of those in custody was communicated by officers and supervisors we spoke to in the receiving, pre-arraignment, and processing areas. Custody staff have implemented several changes since the last visit to ACJ. Changes have been made to implement 15-minute checks on all holding cells and areas where detainees are housed within the ground floor operation. A roving officer also conducts additional 15-minute checks to supplement the checks being done in each area. The collaboration between custody and medical services appeared to be excellent based on our observation of their interactions.

The health care administration has also made changes, one example of which is a newly created assignment designed to have a roving nurse assessing individuals in booking/processing. This assignment has many tasks, but one of the primary roles is reviewing the booking queue, accessing TechCare to review past health and substance abuse history, rounding throughout the entire first-floor booking and processing area, and assessing potentially at-risk individuals. A licensed vocational nurse has been handpicked for this role and has previous experience in a treatment center. While on site, we observed her proactively obtaining orders for an individual at risk of serious withdrawal.

We identified the lack of medical leadership during our site visit in November. Since then, personnel changes have occurred, with several providers from Allegheny Health Network acting in the interim. Additionally, there are plans to assign one of the assistant directors of nursing to manage all processing areas. This will provide a manager’s presence to ensure policies and procedures are followed, adjust assignments when needed, and be present at all man-down events.

MEDICAL RECORD REVIEW

As mentioned earlier, we requested data before our site visit focused on individuals presenting to medical clearance with abnormal vital signs and patients placed on detoxification protocols with elevated COWS, CIWA-AR, and CIWA-B scores. Data regarding emergency care and send-outs for the past 6 months were also requested.

Dr. Richard Clarke reviewed 13 individuals identified from the abovementioned data – those with DOC identification numbers , , , , , , , , , , , , and

Dr. Clarke identified several common concerns, including delays in health evaluations and subsequent care, incomplete documentation of rationale for treatment and follow-up, the absence of a patient signatures on medical refusal forms, and failure to follow health care policies adopted by the Allegheny County Bureau of Corrections' Healthcare Services Department and signed by the warden.

We noted delays in appropriate health evaluations and subsequent care. Upon entering the jail, a medical clearance is completed. The objective of this initial medical clearance is to identify emergent conditions that cannot be handled safely in the facility. However, nonemergent health conditions and subsequent health care treatment plans must also be identified and assessed promptly. Examples of delayed care found during this review included:

- Individuals with a history of opioid abuse were not given an initial medical assessment for over 24 hours.
- Individuals who admitted to consuming daily substances of abuse (alcohol and/or opiates) were not assessed for over 24 hours.
- Individuals who admitted to a history of alcohol and fentanyl were not monitored (COWS, CIWA-AR, or CIWA-B assessment) for more than 24 hours.

Failure to follow medical policies and procedures for detoxification

Health care policies adopted by the ACBOC Healthcare Services Department and signed by the warden require COWS, CIWA-AR, and CIWA-B monitoring at least every 12 hours for patients undergoing detoxification; however, this monitoring occurs only once a day, regardless of the COWS/CIWA scores. It should be noted that the intent of the detoxification scoring is to treat based on the individual's presenting symptoms. Monitoring every 12 hours cannot adequately address an individual's needs; hence our concerns about current practice cannot be overstated, and revision of the policies and procedures needs to be considered.

- Out of all the records we reviewed, only one individual was reassessed sooner than 24 hours.
- Additional clonidine can be an adjunct to medication protocol for withdrawal. One record indicated additional clonidine, but the nurse's notes indicated that the clonidine was unavailable.

Medication refusals lacking an individual's signature

Staff are required to document a patient's signature acknowledging that they have been educated regarding the risks of refusal; the importance of this should not be minimized. Allegheny's health record has a checkbox for the nurse to indicate refusal and an area for the individual's signature. Merely checking the box and omitting a signature is a potential medical-legal issue. If a patient refuses to sign the refusal, there is an area to note their refusal on the form.

Lack of clinical Intervention

The minimal or absent documentation of nursing actions or clinical judgment taken once an individual has been assessed is concerning. This practice was particularly evident in medical clearance, intake/receiving screening, and detoxification treatment. Documenting the rationale of the nurse's or provider's observation and action provides a clearer picture and is an essential first step in a patient's treatment plan. In addition, the documentation of progress notes should be a part of medical screening, receiving, and physical assessment. This level of clinical knowledge requires a skillset that it is unrealistic to expect of a medical assistant or custody staff.

Examples include, but are not limited to, the following-

- An individual presenting to medical clearance with a blood pressure of 188/90 and a pulse of 102 beats per minute. Approximately 12 hours later he was seen for a receiving screening with a blood pressure of 205/96. He was seen for a physical assessment shortly after the screening, and there is no mention of hypertension or treatment.
- An individual was sent to the emergency room after a seizure at 11:00 p.m. However, there is a note that the individual had fallen at 6:00 p.m., and there is no documentation of assessment or disposition.

Emergency responses

Our review of the emergency care provided found it was appropriate, and the documentation of health care plans was also appropriate.

Below is Dr. Clarke's review of the in-custody deaths in 2023, with the most recent event occurring in July.

IN-CUSTODY DEATH REVIEW

Summary of 2023 Deaths and Comorbidities						
Gender	Booking Date	Date of Death	Housing Location	Was the Individual on a Detoxification Protocol?	Was Narcan Administered?	Cause of Death
Male	5/5/2023	5/7/2023	Receiving	Yes	Yes	Accidental blunt force trauma to head
Male	5/22/2023	5/25/2023	4A	Yes	No	Poisoning from a combination of fentanyl, promethazine, and hydroxyzine.
Male	1/11/2023	7/24/2023	5C	No	No	Accident

All three packages we were presented for review had consistent information and content. One package we reviewed was for an arrestee who had been housed on the intake/receiving floor at the time of the medical emergency leading to his death, and he had not been arraigned at the time of emergency transport. Two of the three were on a detoxification protocol. The third patient was being treated for mental health issues, and at the time of their death they were awaiting transport to the Torrance State Hospital for competency restoration.

Below are the details of the in-custody deaths we reviewed, in chronological order.

Age:	42
Booking Date	May 5, 2023
Date of Death	May 8, 2023
Housing Unit	Receiving
CPR:	Yes
AED:	Yes
Narcan:	One intramuscular injection and two doses by nasal administration
Staff Use of Force:	No
Cause of Death:	The Medical Examiner's report indicated the cause of death was an accident with blunt force trauma to the head.

Incident details

was medically screened and cleared on May 5, 2023, at 1:00 a.m., and his vital signs were within normal limits. His urine drug screening at entry was positive for suboxone and cocaine. He also had a history of hypertension and substance abuse and was enrolled in a medication-assisted treatment program. At the time of medical clearance, there was no mention of a head injury or accident.

During the receiving screening on May 7, 2023, at 12:30 a.m., mentioned that he only takes Suboxone once a week, had survived at least one overdose, and admitted to using four to five

bags of fentanyl intravenously, with the last use occurring the day of his arrest. Receiving noted an elevated blood pressure of 160/121. He remained in intake/receiving and was also given a physical assessment on May 7. He was prescribed Suboxone by a provider and received the dose at 1:20 a.m. Shortly after that was seen vomiting.

At 9:22 a.m. on the 8th, [redacted] was found unconscious; his Pulse was 120, his breathing was labored, and his pupils were unresponsive. He received one dose of intramuscular Narcan and two doses of nasal Narcan. At the scene, urine was collected for a second drug screening. It should be noted that the results of the second drug screening identified fentanyl, THC, and cocaine – different from the results 48 hours before and possibly indicating access to drugs while incarcerated.

[redacted]	[redacted]
Age:	60
Booking Date	May 22, 2023
Date of Death	May 25, 2023
Housing Unit	4A
CPR:	Yes
AED:	Placed, but no shock recommended.
Narcan:	No
Staff Use of Force:	No
Cause of Death:	Poisoning from a combination of fentanyl, promethazine, and hydroxyzine.

Incident details

[redacted] was screened for medical clearance at 5:36 p.m. His blood pressure was slightly elevated (141/95), and his pulse was elevated (122 beats per minute). His drug screening was positive for cocaine, THC, and fentanyl.

[redacted] was seen promptly in receiving by a medical assistant and admitted to being diagnosed with cardiac arrhythmia and bipolar disorder; however, no assessment or treatment plan was documented. At that time, he denied drug or alcohol abuse.

Health staff did not pass the drug screening results on to custody staff, and [redacted] was housed in the upper tier of housing. According to Allegheny's policy on housing, if custody had been aware that [redacted] was undergoing detoxification, he would have been housed on the unit's lower tier and a lower bunk. As it turned out, the housing on the upper tier did not impact visual check intervals by staff, nor did it contribute to his death. Medical records did not indicate the patient was placed on a COWS protocol. There is no evidence that a health care provider saw him after he had the physical assessment.

A qualified mental health professional completed a mental health assessment on [redacted] on May 22, where he had admitted to drug usage, and a provider conducted a physical assessment on May 23. At that time, he was started on a withdrawal protocol.

On May 25, he was found unresponsive in his cell and later transferred to the emergency room.

Recommendation

- Besides the manual process of marking his inmate card, he should have been placed on the "detox dashboard" to identify him as being on a detoxification protocol.

[redacted]	[redacted]
Age:	59
Booking Date	January 11, 2023
Date of Death	July 24, 2023
Housing Unit	5C
CPR:	Yes
AED:	Placed, but no shock warranted.
Narcan:	No
Staff Use of Force:	No
Cause of Death:	The medical examiner's report indicated the cause of death was an accident.

Incident details

[redacted] had a long history of mental illness (bipolar disorder with psychotic features) and was awaiting transfer to Torrance State Hospital. Provider records indicate that he began to decompensate in late June or early July. He was confused most of the time, was disheveled, did not speak, and could not follow directions. A mental health clinician noted on July 22 at 1:12 p.m. that multiple medical referrals had been made but the disposition of these referrals was not indicated.

In mid-July, [redacted] started defecating in his clothes, and feces could be seen in his sink and on the floor. He was admitted to the hospital and discharged before his death. This is notable because ACJ health staff felt there was an issue beyond their ability to provide care, yet the hospital sent the individual back quickly despite his multiple emergency room referrals and treatment history.

RECOMMENDATIONS

The NCCHC Standards have been developed to provide a framework to ensure systems, policies, and procedures are in place. We have identified priority recommendations immediately below, followed by a more complete analysis broken out by standard. The NCCHC Resources team appreciates the opportunity to provide feedback to the Allegheny County Jail administrators.

PRIORITY RECOMMENDATIONS

Priority One

- Reorganization of receiving. This was a priority in the past technical review. Although Allegheny has attempted to change the processes, many challenges remain.
  - This reorganization will require more global participation, including the creation of an interdisciplinary team that includes medical, mental health, custody, and administration.
    - A registered nurse must be placed at medical clearance immediately (within 60 days).
      - Using the form in TechCare will allow the nurse to determine risk and identify and apply wristbands to those individuals needing medical observation.
        - Once the patient has been assessed, the RN can contact the on-site provider to obtain stat detoxification treatment orders. The physician on our team recommends that individuals with a history of substance abuse, regardless of their withdrawal symptoms, be given the first dose of treatment by this RN. Given the historical and current waiting times for pre-arraignment, having a nurse begin withdrawal treatment immediately is a best practice. This nurse can also start treatment for other conditions requiring stat medication upon a provider's order. We have included a schematic of this process in Attachment F.
    - As mentioned in this document, cultural and communication barriers must be addressed collaboratively; all stakeholders should have a voice, and an unbiased mediator should also be considered.
    - Initiate an audit tool for detox treatment throughout receiving.
- Identify medical holding cells for all individuals with wristbands in pre-arraignment and processing (barring any security issues).
  - Implement rounding every 4 hours by an LPN or RN on all medical holding cells.
    - This would include vital signs, assessing symptoms, and contacting the provider if further treatment is required.
      - The nurse must complete these rounds at the beginning of their shift and every 4 hours or sooner.
- Implement a hydration program for those in detoxification housing areas.
- Equip pre-arraignment with emergency equipment.

Priority Two

- Transition from the two-step intake/receiving process to completing all receiving when an individual presents to the jail.
- Implement a hydration program in pre-arraignment and processing.
- Develop collaborative health training.
- Implement an audit tool for hospital send-outs from receiving.

Priority Three

- Identify a collaborative team to review all policies and procedures that encompass security and medical.
- Consider recommendations from an addiction consultant to:
    - Consider changing the detoxification protocol to a loading and fixed-dose treatment.
    - Consider additional treatment based on the CIWA AR, CIWA-B, or COWS score.
- Investigate additional TechCare upgrades to assist in receiving management.
- Research tracking systems for individuals being processed.

RECOMMENDATIONS BY STANDARD

J-A-05 – Policies and Procedures

This standard requires the responsible health authority to ensure that health care policies and procedures are developed, documented, and readily available. One compliance indicator requires that policies such as custody, kitchen, industry, health care vendor, or other contractors do not conflict with health care policies. This compliance indicator, and thus this standard, is not being met.

Recommendation

- Review all policies to ensure they do not conflict with, but rather complement, one another.

J-C-04 – Health Training for Correctional Officers

This standard requires that correctional officers are trained to recognize the need to refer an inmate to a qualified health care professional. Compliance indicators require that correctional officers who work with inmates must receive health-related training every 2 years, including intoxication and withdrawal. This standard is not being met.

Recommendations

- Consider collaborative training for all processing, detoxification, and infirmary staff.
- Training needs to be prioritized for officers assigned to critical areas where inmates on detoxification protocol are housed. Although we appreciate the intent of the seniority element for training purposes, it is critical for officers and supervisors assigned to high-risk areas to receive training that will help them recognize potential issues early on to prevent adverse outcomes. All officers should receive mandatory training on this subject; ideally annually, but at a minimum every 2 years, just as all health staff should receive it. Training should also include current trends and issues related to overdose and detoxification.
- Ensure training reminders are reviewed at briefings and staff meetings.
- The required number of man-down drills in processing, infirmary, and housing should be completed by all staff on every shift.

This is a patient safety issue as well as an officer safety issue, and it can protect officers from becoming involved in a predictable, preventable, critical incident. Collective bargaining associations should be approached about this as soon as possible, and we would be surprised if they did not recognize the critical need for this training for their members working in higher-risk areas of the ACJ. With the trends in Pennsylvania in particular, there has been no improvement in the challenges related to substance use disorders – particularly opioid use disorders.

J-E-02 – Receiving Screening

This standard requires screening of all inmates upon arrival at the intake facility to ensure that emergent and urgent health needs are met. Compliance indicators include conducting a receiving screening as soon as possible upon acceptance into custody, so this standard is not being met.

Recommendations

- Move all nursing assessment functions to the first stage (see Attachment G). This will require additional space, and we recommend moving the receiving screening portion of receiving to the room where fingerprints and pictures are taken. Dividing the space with a room divider would allow for privacy but provide additional space for completing the process.
- Initiate withdrawal protocols at the time of the receiving screening.
- Use a wristband system to identify medically and/or psychologically fragile individuals.
- House pre-arraignment individuals with these wristbands in designated housing cells.
- House booked individuals with these wristbands in designated housing cells.
- Implement an audit system for reviewing health records. Review them for completeness, compliance with wristbanding fragile individuals, and rounding every 2 to 4 hours in pre-arraignment.
- Equip pre-arraignment with emergency equipment.
- Research TechCare's capabilities to leverage any features available for automating processes. This should include evaluating which screening tools need to require mandatory entries to prevent accidental or neglectful data omissions.
- The ACJ is a central booking facility receiving new arrestees directly from the street so priority needs to be placed on the importance of the initial screening process.
- Policies and procedures for both medical and custody staff must accurately reflect the processing of new arrivals and the other associated processes carried out on the ground floor. Policy 216, Prisoner Admission – Operations, needs to be updated to reflect current practices. The same applies to related medical policies and procedures that outline processes on the ground floor.

J-F-03 – Mental Health Services

This standard requires that mental health services are available for all inmates who require them. One compliance indicator states that mental health, medical, and substance abuse services are sufficiently coordinated such that patient management is appropriately integrated, medical and mental health needs are met, and the impact of these conditions on each other is adequately addressed. However, this standard is not being met.

Recommendations

- The administration team needs to explore ways to integrate mental health into the health care process.
- Schedule collaborative meetings between medical and mental health staff.

J-F-04 – Medically Supervised Withdrawal and Treatment

This standard requires inmates who are intoxicated or undergoing withdrawal to be appropriately managed and treated. Compliance indicators for this standard require that individuals showing signs of intoxication or withdrawal be monitored by qualified health care professionals using protocols as clinically indicated until symptoms have resolved, and that medical supervision is implemented if the findings from patient monitoring meet the national guidelines to begin prescription medications. Thus, this standard is not being met.

Recommendations

- Implement a hydration program in the detoxification, pre-arraignment, and processing areas.
- Implement a second daily assessment for all individuals on detoxification floors.
- Consider changing your medication treatment for alcohol withdrawal to include a loading dose of a benzodiazepine.
- Consider starting all individuals with a history of substance abuse on a withdrawal protocol regardless of symptoms.
- Collaboratively audit Narcan usage and emergency room referrals.

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ATTACHMENT A

NAME:
DOB:
GENDER: M F T I

BP:	TEMP:
PULSE:	RR:
SPO2:	HT:
WT:	HCG: - / +
Suicidal? Y / N	Allergies:
Head Injury last 24?	
Hosp in last 72?	
Detox:	Injuries:
Diabetic? Y / N HTN? Y / N	
COVID Screen? Y / N	
UDS Complete? Y / N	
Meds: Y / N	Zip Code:

ATTACHMENT B

Updated April 2023

REMINDER- MEDICAL CLEARANCE, GENERAL INFORMED CONSENT, ACCESS TO CARE, REC. SCREENING all need done via the booking queue in the front of intake.

Date: Time:

Name: D.O.B:

Gender: Identify & Orientation: Male Female Transgender Intersex:

Interpreter need? # to call: 1-866-237-0173 code: 15208 or 1-877-229-8119 for sign language # 412-400-2021

VITAL Signs:

BP	Pulse	RR	SPO2	Temp	HT	WT

COVID SWAB result: Positive or Negative HCG: Positive or Negative UDS:+ for:

Mental Health Issues hx or current: Suicidal: SI/HI: (Call the ADON for 302-Do Not Medically Clear 302!)

Special Needs:

Head Injury: Other Injuries:

Mobility Issues: Assistive devices/DME needed: Hearing or Visual aids needed:

Recent Hospital Stay? (Last 72 hours):

Urgent Dental Needs:

Detox: From? ETOH or Drug: IV use: Last Use:

Pregnant & Detox: *Pregnant & Positive UDS(Call ADON x2277)

Previous Incarceration: ACJ or Other:

Any Chronic Health History: such as:

Diabetes-:

**Check Blood Sugar. If >400 test for ketones. Call HCP x1287 & ADON x2277. Obtain Orders for Blood glucose checks & Insulin.

HTN:

Asthma/COPD: CPAP needed?

Seizure:

Cancer:

Infectious Disease: such as... Hep C: STD

Transplant:

Chronic Pain:

Daily/Must Have Medications: Pharmacy used: Zip Code: (Sure Scripts)(ROI)(MAT)(Tadiso)

Vulnerable to: PREA/Sexual Assault or Physical Assault or other Violence: (Previously convicted of sex crime)

Military Service: Y/N Insurance---Medicaid / Medicare / Private Insurance Misc. Info:

TO BE USED BY THE STAFF AS A TOOL ONLY! NOT TO BECOME PART OF THE RECORD! NOTE TAKING ONLY!

ATTACHMENT C

Policies for Intake/Admissions of New Arrestees at ACJ ***(Medical Processes in Bold Italic)***

(The (entire) progression of a new arrestee is as follows within *Policy 216 – Prisoner Admissions – Operations* (See Attachment __)

- Arrestee arrives at the facility.
- Handcuffs removed.
- Searched for contraband/property.
- ***Medically screened for acceptance***
- If accepted, the Intake Desk Officer will apply a wristband to identify the arrestee.
- The assigned officer will enter the arrestee into *Allegheny Standardized Arrest Program* (ASAP) system.
- Arrestee is housed in a holding tank, pending fingerprint identification.
- Identification technicians notify desk/intake officers of those needing identification.
- ID tech will fingerprint, photograph, and run the arrestee for warrants.
- When completed, the Intake Floor Officer will escort the arrestee to Pre-Trial Services holding cell.
- Once interviewed by Pre-Trial Services, the arrestee will be moved to Pre-Arraignment holding area.
- When arraignment is scheduled, the arrestee will be moved to Video Arraignment.
- Judge will conduct a video arraignment.
- If staying in custody, arrestee and custody details will be logged and sent to Processing.
  - Those ordered released are sent to a separate area for release by Sheriff's Deputies
- Detainees will be sent to Processing. They are housed for 8 hours in this area to allow time to arrange bail.
- If bail is not arranged, Processing Officers will enter detainees into the OMS.
- ***An "in-depth" health screening*** is ***performed and recorded within <u>24 hours</u> of admission.***
  - ***A QHP will assess those not in good health within <u>24 hours</u>.***
  - ***A QHP will conduct a treatment intake screening.***
  - ***Determination of the need for special housing for medical/mental health needs***
  - ***Detoxification needs a red D marked on the inmate card.***
  - ***A medical history and physical will be performed within 14 days.***
- Once processed, detainees are moved to the shower area, searched, and given clothing/bedding by the Search and Escort Officer
- All personal property will be removed, and the Property Officer will provide a receipt.
- The Property Officer will take the detainee to the Movement Desk Officer.
- Detainees will be moved to the classification pod unless special housing is necessary.

ATTACHMENT D

Alcohol Withdrawal	
Symptoms	Onset
Tremor	6-36 hours
Anxiety	
Sweating	
Heart Palpitations	
GI upset	
Seizures	6-48 hours
Visual, tactile, and auditory hallucinations	12-48 hours
Delirium	48-96 hours
Agitation	
Elevated heart rate and blood pressure	
Sweating	

Heroin Withdrawal	
Symptoms	Onset
Aches and Pains	With shorter-acting opiates such as heroin, 5-12 hours with a peak of 48-72. With longer-acting such as Fentanyl, initial symptoms can be delayed up to 32 hours.
Muscle spasms	
Tremor	
Abdominal Cramps	
Nausea/vomiting/diarrhea	
Restlessness	
Insomnia	
Hot flashes/chills	
Sweating	
Runny nose	
Yawning	
Gooseflesh	

Benzodiazepine Withdrawal	
Symptoms	Onset
Increased heart rate, blood pressure, and temperature	Within 24 hours
Sweating	
Hand tremors	
Insomnia	
Nausea/vomiting	
Transient visual, tactile, or auditory hallucinations	
Anxiety	
Seizure	

*Information extrapolated from Up-to-Date, NCBI, American Addiction Centers

ATTACHMENT E

Clinical Opiate Withdrawal Scale (COWS)

Flow-sheet for measuring symptoms for opiate withdrawals over a period of time.

For each item, write in the number that best describes the patient's signs or symptom. Rate on just the apparent relationship to opiate withdrawal. For example, if heart rate is increased because the patient was jogging just prior to assessment, the increase pulse rate would not add to the score.

Patient's Name:_______________________ Date: ____________

Enter scores at time zero, 30min after first dose, 2 h after first dose, etc.

Times:	_____	_____	_____	_____
Resting Pulse Rate: (record beats per minute) *Measured after patient is sitting or lying for one minute* 0 pulse rate 80 or below 1 pulse rate 81-100 2 pulse rate 101-120 4 pulse rate greater than 120				
Sweating: *over past ½ hour not accounted for by room temperature or patient activity.* 0 no report of chills or flushing 1 subjective report of chills or flushing 2 flushed or observable moistness on face 3 beads of sweat on brow or face 4 sweat streaming off face				
Restlessness *Observation during assessment* 0 able to sit still 1 reports difficulty sitting still, but is able to do so 3 frequent shifting or extraneous movements of legs/arms 5 Unable to sit still for more than a few seconds				
Pupil size 0 pupils pinned or normal size for room light 1 pupils possibly larger than normal for room light 2 pupils moderately dilated 5 pupils so dilated that only the rim of the iris is visible				
Bone or Joint aches *If patient was having pain previously, only the additional component attributed to opiates withdrawal is scored* 0 not present 1 mild diffuse discomfort 2 patient reports severe diffuse aching of joints/ muscles 4 patient is rubbing joints or muscles and is unable to sit still because of discomfort				
Runny nose or tearing *Not accounted for by cold symptoms or allergies* 0 not present 1 nasal stuffiness or unusually moist eyes 2 nose running or tearing 4 nose constantly running or tears streaming down cheeks				

GI Upset: *over last ½ hour* 0 no GI symptoms 1 stomach cramps 2 nausea or loose stool 3 vomiting or diarrhea 5 Multiple episodes of diarrhea or vomiting				
Tremor *observation of outstretched hands* 0 No tremor 1 tremor can be felt, but not observed 2 slight tremor observable 4 gross tremor or muscle twitching				
Yawning *Observation during assessment* 0 no yawning 1 yawning once or twice during assessment 2 yawning three or more times during assessment 4 yawning several times/minute				
Anxiety or Irritability 0 none 1 patient reports increasing irritability or anxiousness 2 patient obviously irritable anxious 4 patient so irritable or anxious that participation in the assessment is difficult				
Gooseflesh skin 0 skin is smooth 3 piloerrection of skin can be felt or hairs standing up on arms 5 prominent piloerrection				
Total scores **with observer's initials**				

Score:
5-12 = mild;
13-24 = moderate;
25-36 = moderately severe;
more than 36 = severe withdrawal

Clinical Insitutue Withdrawal Assessment of Alcohol Scale, Revised (CIWA-Ar)

Patient:________________________ Date: ______________ Time: ____________ (24 hour clock, midnight = 00:00)

Pulse or heart rate, taken for one minute:________________________ Blood pressure:______________

NAUSEA AND VOMITING — Ask "Do you feel sick to your stomach? Have you vomited?" Observation.
0 no nausea and no vomiting
1 mild nausea with no vomiting
2
3
4 intermittent nausea with dry heaves
5
6
7 constant nausea, frequent dry heaves and vomiting

TREMOR — Arms extended and fingers spread apart. Observation.
0 no tremor
1 not visible, but can be felt fingertip to fingertip
2
3
4 moderate, with patient's arms extended
5
6
7 severe, even with arms not extended

PAROXYSMAL SWEATS — Observation.
0 no sweat visible
1 barely perceptible sweating, palms moist
2
3
4 beads of sweat obvious on forehead
5
6
7 drenching sweats

ANXIETY — Ask "Do you feel nervous?" Observation.
0 no anxiety, at ease
1 mild anxious
2
3
4 moderately anxious, or guarded, so anxiety is inferred
5
6
7 equivalent to acute panic states as seen in severe delirium or acute schizophrenic reactions

AGITATION — Observation.
0 normal activity
1 somewhat more than normal activity
2
3
4 moderately fidgety and restless
5
6
7 paces back and forth during most of the interview, or constantly thrashes about

TACTILE DISTURBANCES — Ask "Have you any itching, pins and needles sensations, any burning, any numbness, or do you feel bugs crawling on or under your skin?" Observation.
0 none
1 very mild itching, pins and needles, burning or numbness
2 mild itching, pins and needles, burning or numbness
3 moderate itching, pins and needles, burning ornumbness
4 moderately severe hallucinations
5 severe hallucinations
6 extremely severe hallucinations
7 continuous hallucinations

AUDITORY DISTURBANCES — Ask "Are you more aware of sounds around you? Are they harsh? Do they frighten you? Are you hearing anything that is disturbing to you? Are you hearing things you know are not there?" Observation.
0 not present
1 very mild harshness or ability to frighten
2 mild harshness or ability to frighten
3 moderate harshness or ability to frighten
4 moderately severe hallucinations
5 severe hallucinations
6 extremely severe hallucinations
7 continuous hallucinations

VISUAL DISTURBANCES — Ask "Does the light appear to be too bright? Is its color different? Does it hurt your eyes? Are you seeing anything that is disturbing to you? Are you seeing things you know are not there?" Observation.
0 not present
1 very mild sensitivity
2 mild sensitivity
3 moderate sensitivity
4 moderately severe hallucinations
5 severe hallucinations
6 extremely severe hallucinations
7 continuous hallucinations

HEADACHE, FULLNESS IN HEAD — Ask "Does your head feel different? Does it feel like there is a band around your head?" Do not rate for dizziness or lightheadedness. Otherwise, rate severity.
0 no present
1 very mild
2 mild
3 moderate
4 moderately severe
5 severe
6 very severe
7 extremely severe

ORIENTATION AND CLOUDING OF SENSORIUM — Ask "What day is this? Where are you? Who am I?"
0 oriented and can do serial additions
1 cannot do serial additions or is uncertain about date
2 disoriented for date by no more than 2 calendar days
3 disoriented for date by more than 2 calendar days
4 disoriented for place/or person

The CIWA-Ar is not copyrighted and may be reproduced freely.

Sullivan, J.T.; Sykora, K.; Schneiderman, J.; Naranjo, C.A.; and Sellers, E.M. Assessment of alcohol withdrawal: The revised Clinical Institute Withdrawal Assessment for Alcohol scale (CIWA-Ar). *British Journal of Addiction* 84:1353-1357, 1989.

Patients scoring less than 10 do not usually need additional medication for withdrawal.

Total CIWA-Ar Score ______

Rater's Initials ______

Maximum Possible Score 67

Clinical Institute Withdrawal Assessment – Benzodiazepine (CIWA-B)

Patient's full name: ______________________ **Date:** __________

Clinician's full name: ______________________

Client-reported Symptoms

Please select a number that best describes how you feel.

1. Do you feel irritable?

○0 Not at all ○1 A little ○2 Moderately ○3 Quite a bit ○4 Extremely

2. Do you feel fatigued?

○0 Not at all ○1 A little ○2 Moderately ○3 Quite a bit ○4 Extremely

3. Do you feel tense?

○0 Not at all ○1 A little ○2 Moderately ○3 Quite a bit ○4 Extremely

4. Do you have difficulties concentrating?

○0 Not at all ○1 A little ○2 Moderately ○3 Quite a bit ○4 Extremely

5. Do you have any loss of appetite?

○0 Not at all ○1 A little ○2 Moderately ○3 Quite a bit ○4 Extremely

6. Have you any numbness or burning on your face, hands or feet?

○0 Not at all ○1 A little ○2 Moderately ○3 Quite a bit ○4 Extremely

7. Do you feel your heart racing? (palpitations)?

○0 Not at all ○1 A little ○2 Moderately ○3 Quite a bit ○4 Extremely

8. Does your head feel full or achy?

○0 Not at all ○1 A little ○2 Moderately ○3 Quite a bit ○4 Extremely

9. Do you feel muscle aches or stiffness?

○0 Not at all ○1 A little ○2 Moderately ○3 Quite a bit ○4 Extremely

10. Do you feel anxious, nervous or jittery?

○0 Not at all ○1 A little ○2 Moderately ○3 Quite a bit ○4 Extremely

11. Do you feel upset?

○0 Not at all ○1 A little ○2 Moderately ○3 Quite a bit ○4 Extremely

12. How restful was your sleep last night?

○0 Not at all ○1 A little ○2 Moderately ○3 Quite a bit ○4 Extremely

13. Do you feel weak?

○0 Not at all ○1 A little ○2 Moderately ○3 Quite a bit ○4 Extremely

14. Do you think you didn't have enough sleep last night?

○0 Not at all ○1 A little ○2 Moderately ○3 Quite a bit ○4 Extremely

15. Do you have any visual disturbances (sensitivity to light, blurred vision)?

○0 Not at all ○1 A little ○2 Moderately ○3 Quite a bit ○4 Extremely

16. Are you fearful?

O 0 Not at all O 1 A little O 2 Moderately O 3 Quite a bit O 4 Extremely

17. Have you been worrying about possible misfortunes lately?

O 0 Not at all O 1 A little O 2 Moderately O 3 Quite a bit O 4 Extremely

Clinical Observations

18. Observe behaviour for sweating, restlessness & agitation:

O 0 None, normal activity O 1 O 2 Restless O 3 O 4 Paces back & forth; unable to sit still

19. Observe tremor

O 0 No tremor O 1 Not visible, can be felt in fingers O 2 Visible but mild O 3 Moderate with arms extended O 4 Severe, with arms not extended

20. Observe/feel palms

O 0 No sweating visible O 1 Barely perceptible sweating, palms moist O 2 Palms and forehead moist, reports armpit sweating O 3 Beads of sweat on forehead O 4 Severe drenching sweats

21. How many hours of sleep do you think you had last night? ______________ hours

22. How many minutes do you think it took you to fall asleep last night? ______________ minutes

TOTAL SCORE: [ ]

Scoring

Questions 1-11 and 13-17 are client-reported symptoms, with each scored on five-point scales from 0 = not at all to 4 = very much so.

Question 12 is also a client-reported item, but the 5 ratings are reversed, i.e., 0 = Very much so to 4 = Not at all.

Questions 18-20 are clinical observations, with all three scored on five-point scales (i.e. 0, 1, 2, 3 or 4).

The last two items (Question 21 and 22) are not scored, but they provide additional information regarding the benzodiazepine withdrawal.

A total score is obtained by summing questions 1-20. The minimum total score possible is 0, and the maximum total score possible is 80 (i.e., total score range: 0-80).

Here's how to interpret the results:

- 1 to 20 = Mild withdrawal
- 21 to 40 = Moderate withdrawal
- 41 to 60 = Severe withdrawal
- 61 to 80 = Very severe withdrawal

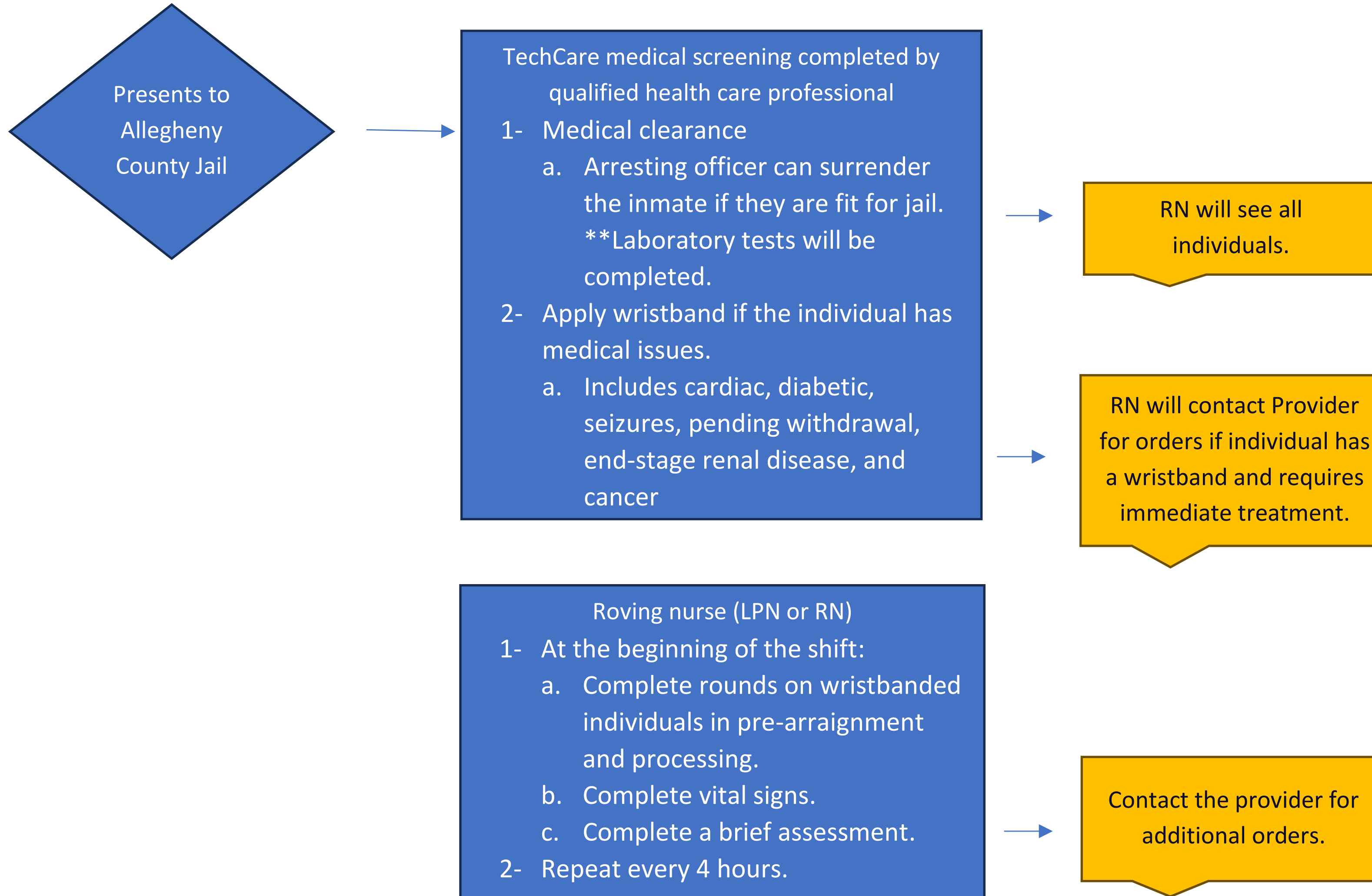
Source

Busto, U., Sykora, K. and Sellers, E. A clinical scale to assess benzodiazepine withdrawal. Journal of Clinical Psychopharmacology, 1989. 9(6): 412-416.

NCCHC RESOURCES

ATTACHMENT F

Proposed Medical Screening Process



ATTACHMENT G