IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF NEW MEXICO

JIMMY (BILLY) McCLENDON, *et al.*,

Plaintiffs,

v. **Civ. No. 95-0024 JB/KBM**

CITY OF ALBUQUERQUE, *et al.*,

Defendants,

v.

E.M., R.L., W.A., D.J., P.S., and, N.W.
on behalf of themselves and all others
similarly situated,

Plaintiff-Intervenors.

DECLARATION OF TAILEIGH SANCHEZ, R.N.

1. My name is Taileigh Sanchez. I am over eighteen years of age and am competent to testify to the information set out in this declaration.
2. I am a registered nurse. I obtained my nursing degree through PIMA Medical Institute in October 2011. Before that I was a licensed practical nurse (LPN) for ten years. I graduated from Trinidad State Junior College in 2001.
3. I have worked at the Metropolitan Detention Center (MDC) for eleven years.
4. I have worked for every medical vendor during this time period, including the methadone vendor, Recovery Services of New Mexico.
5. I am making this declaration because I am alarmed at the state of the medical program at MDC.
6. I care for our patients and I like our mission. I have had wonderful people to work with.
7. Now, I am worried for the safety of our patients, of our medical staff, and of security staff.
8. After the County awarded the medical vendor contract to Centurion in the middle of 2018, the medical program began to decline. It has only gotten worse since Corizon took over the medical vendor contract. Staffing numbers have decreased, and there seems to be no attempt to retain staff.
9. During my employment at MDC, I have worked primarily in Med 1.

10. Some of my duties as **Med 1** RN have included triaging patients, doing medication pass, responding to emergencies, caring for the higher acuity patients in the Sheltered Housing Unit (SHU), and oversight of the other departments.

11. In my early years at MDC, I did "float" and was cross trained for multiple positions. Until recently, I also worked part of the week as a methadone nurse.

Staffing is Critically Low

12. In my opinion, based on my experience at MDC and my education, training, and experience as a nurse, medical and mental health staffing is critically low right now. In my experience, what is occurring now is the worst medical care has ever been at MDC.

13. Not having enough staff affects our ability to treat our patients. It affects our ability to do intakes, detox, med pass, sick call, do history and physicals (H&Ps), and to respond to emergencies. It affects our ability to upload paperwork from hospitals into patient charts and to verify medications that patients report they are current on at intake. Current leadership has opted not to have a provider or RN review hospital paperwork received from intake, i.e, a patient was in the hospital and discharged to custody or was taken to the hospital prior to booking. This was said to be an "obsolete practice." There is no way for a provider or other nursing staff to know that a patient was taken to the hospital unless it is charted on intake (many times it is not).

14. There is currently no on-site medical director, no doctor, and only one nurse practitioner (NP). We do have one or two as needed (PRN) NPs that cover shifts sometimes. One has been more present recently. Recently there have been times where there is no provider on site, and no provider rounded on the SHU patients – these are the patients with highest acuity.

15. There are people's names on the staffing roster who are not working any hours.

16. We are two months into the Corizon contract, and people are quitting every week. In the last month the Director of Psychiatry has put in her notice, the most senior licensed counselor left, other counselors quit, and we have lost several nurses. Most shifts we do not have medical assistants. There are shifts where there are no mental health workers in the building. Staff are leaving at critical rates, and the positions are staying empty. PRN staff are brought in without adequate training.

17. On December 30, 2021, I arrived at the facility and was the only RN in the facility. Two LPNs from the day shift stayed until 9. Another RN came and joined shortly before they left. We usually have four nurses on grave shift.

18. In late November or early December 2021, we were so short staffed that I shut down admissions to the facility. This means I called security and law enforcement and told them MDC could not accept any new inmates until I had medical staff. I contacted my supervisor, and eventually staff arrived and I re-opened admissions. They did not arrive until around 9 PM, leaving arresting agencies waiting for medical staff.

19. I am assigned to **Med 1**, which is responsible for the handover of patients between shifts and has other duties as explained above.

20. Some of the other positions are Med 3 (intake), detoxification (detox), sick call, diabetics, and wound care. Currently, these positions are often left vacant, or people cover partial shifts and are allowed to leave without documenting patient information. This happens mostly in detox.

21. **Med 3**, which is intake, is the first point of contact at MDC. The nurse evaluates a patient to see whether they meet the admission criteria or need to be sent to the hospital. Med 3 is a critical position. Some of the things a Med 3 nurse does are take vitals, obtain a patient history, ask about current medications and treatment, evaluate substance use and whether someone is intoxicated and/or whether a provider needs to be contact for withdrawal treatment orders. They make referrals to providers for chronic care, wound care, or for follow-up by the Med 1 nurse if urgent issues are present. They also make referrals to PSU.

22. **Detox nurses** round on patients who are placed on detox. They assess vitals and the severity of a person's withdrawal symptoms. They contact providers for orders, and report to providers when a patient's vitals are unstable or their withdrawal symptoms are becoming more severe. They provide medication and hydration. Withdrawal can be life threatening and these nurses play a critical role in helping to keep people stable and take steps for more medical intervention when needed. With respect to detox, charting patient contact and vitals is very important as is following up if someone has abnormal vital signs. The administration has been notified that there is a lack of charting and follow-up for abnormal vital signs, and to my knowledge, nothing has been done thus far to remedy the situation. With the new electronic medical record (EMR) system multiple people who are on detox do not show up on the detox list. Charts are not being merged immediately at intake so medications may be missed. There is no cut-off for elevated BAC (blood alcohol content) per Corizon criteria. This means people with dangerous BACs may be admitted to the facility.

23. **Sick call nurses** respond to sick call requests. Patients place sick call requests on paper slips when the sick call nurses are out on the pods doing their rounds. These slips are taken back to medical and triaged. Right now there is a big backlog. Once they are triaged, the sick call nurse will go and see the patient regarding their compliant and refer to a provider or other nursing staff as needed. There have been days when no sick call has been done due to lack of staff.

24. **Wound care** nurses treat people who have wounds. Many of our patients arrive with wounds like abscesses, gunshot wounds, surgical sites, and lacerations. These wounds need regular care for things like changing dressings, debriding, and assessing for signs of infection. Due to shortage of staff, wound care isn't being done daily, and people in need of wound care are not always seen by the Med-1 nurse.

25. We are so short-staffed that there have been multiple times where one nurse has had to work multiple positions in one shift, or work a position they have not worked before, often without prior training on the positions or Corizon's protocols.

26. For example, there have been times where one nurse has run Med 1 and Med 3. That means, one nurse is responsible for both intake, responding to emergencies, and caring for patients in the SHU among other responsibilities. And recently, I learned that on the nights when there are no mental health counselors in the facility because the grave shift is not filled, I am also assigned to respond to mental health crises.

27. This is not possible and this is dangerous. For one thing, if there is a code – someone is having a medical emergency– both the Med 1 and Med 3 nurse are supposed to respond. Both the Med 1 and Med 3 nurse are needed if there is a medical emergency to take vitals, run the code, use the emergency medical equipment, and assess the patient. In the event I was covering both Med 1 and Med 3, I am the only person to respond to a code.

28. If there is a code where someone is suicidal, Med 1, Med 3, and the PSU counselor respond to that code. If I am covering all three positions, I am the only one to respond to that code. This is dangerous and it is impossible for me to do all three jobs.

29. There have been times where one nurse is covering Med 3, which is the intake unit, and detox. There have been times where the PSU nurse has had to cover PSU and Med 3.

30. It is critical to do a good intake. Intake is medical's first point of contact with a patient. Intake is where you gather information about the patient like their current medications and medical conditions they are being treated for. At intake, we assess a patient's vital signs and determine if they can be admitted to the facility or need to go to the hospital. We assess whether the patient is under the influence of a substance, is withdrawing, or will be withdrawing soon and in need of detox care. If a patient is coming in from a hospital, we receive their hospital paperwork. We assess patients for injuries or wounds that need treatment. We ask whether they have chronic conditions and then make the referral to chronic care. When things are missed at intake, or not properly documented, it can affect the whole course of patient care.

31. If a nurse is working Med 3 (intake) and detox, it is hard for them to do both jobs and puts patients at risk. If the Med 3 nurse is out on detox rounds, it means people are waiting for medical assessment and clearance before they can be admitted to the facility. Detox rounds are also very important and take a long time, usually hours. Patients on detox must have their vitals taken, their medications administered, and must be hydrated. It takes time to do each thing for each patient and make sure action is taken the patient needs more treatment.

32. These are two huge and critical jobs. It is not safe for a nurse to try to cover both positions.

33. It is also not safe for a nurse who has not worked one of those positions before to have to work one of those positions without adequate training. This is what nurses have been asked to do.

34. Another consequence of this staffing shortage is that some positions are not filled. For example, a nurse who usually works wound care has been working other positions – sometimes two at the same time. There has not been another nurse filling the wound care position. This means that our patients are not being seen, or not being seen timely for wound care. Wound care is very important too. Many of our clients arrive with injuries – anything from abscesses to gunshot wounds to lacerations. Many of our clients also have co-morbidities like diabetes that increase their risk of complications. Also, jails are known places for exposure to MRSA. Delaying wound care can lead to infection and hospitalizations. A patient needing more or longer wound care puts more strain on the medical staff. A patient needing to go to the hospital for an evaluation for treatment puts strain on security staff.

35. We do not have an infection control nurse.

36. Corrections is not for everyone and it is not easy work. We need MDC to do more to retain staff. There are too many gaps in the schedule.

37. Intake can be hectic. Past practice at MDC was to start having a nurse review intake documentation. We also had checklists of what to do if someone presented with a certain set of vital signs, or a certain disease. Corizon has discontinued this practice. This lack of additional review and/or oversight could result in documentation that misses something critical, including, for example, elevated blood pressures, antibiotic orders, chronic care medications, and follow-up off site appointments.

38. Before the change in vendors, MDC nurses who reviewed intake had a program called Dr. First available to verify patient medications. For some patients we still had to call the pharmacy or doctor to verify, but Dr. First worked for many patients. It saved a lot of time and let us verify a patient's medications and get an order to have them started. We do not have that program anymore, or any similar program. Because we are so short staffed, medications may be missed or delayed.

39. In my experience, right now hospital paperwork from intake often sits for days without any follow-up or provider review.

40. It has been said "a nurse is a nurse," and can cover any area, including intake, where so many things are critical. But you can't put a psych nurse in intake and expect them to know all the things they have to do – without any training. As an example, you wouldn't put a cardiac nurse on a labor and delivery unit.

41. If someone is withdrawing, and they are placed in a cell, they need an officer to watch them. Security staff is short and so many people do not have constant watch officers.

42. History and physicals (H&Ps) are exams that nurses or mid-level practitioners do. At an H&P you can take a more detailed history from someone than you might have gotten at intake. Patients can tell you if there are medical issues going on for them. At H&Ps we offer vaccines. H&Ps have not been getting done timely because we don't have enough staff. A nurse or provider assigned to do H&Ps will get pulled into another role. Corizon

is doing "blitzes" and bringing in outside people to get caught up, but this doesn't solve the staffing problems that make the backlog.

43. It is not safe practice, even if a nurse is cross trained, to make them work two critical positions at the same time. With no counselors in the building on some shifts this puts our already at risk population at even more risk.

44. This has been a great place to work. I want people to come and work here and be part of our team.

Documentation and procedures

45. Corizon brought a new electronic medical record. This has caused problems.

46. There are problems for at least two reasons. First, a lot of the important medical information about our patients from the last electronic medical record (Sapphire) is not in the new record. Second, in my opinion, it is a clunky system to use. The charting system in place now is outdated.

47. For example, in a typical or standard medical record there is something called a "Problems List" or "Diagnoses List." There was a problems list in the medical record system used by Centurion, known as Sapphire. It is important because it lets a nurse or doctor open the file and see all a patient's diagnoses. If someone has diabetes, hepatitis C, and asthma, that is all important information to have when treating that patient. The "Problems List" from Sapphire does not show up in the new medical record. There is a way for me to access it, but I have to open a different system. We have been told we have two months of access to Sapphire. I do not know what will happen after that or what the plan is for making a patient's historical chart available. Even now, if I am looking quickly at someone's record, the information about what they are being treated for may not be there.

48. The new medical record does not have forms that we need to document patient information or places to input all the information. If a person is arrested for DWI or appears intoxicated at intake, it is important to get their blood alcohol content (BAC) so that treatment decisions can be made. The new record does not have a place to input BAC.

49. Charting takes a long time. This is not just because the system is new to us. It is its structure. There has been at least one time where our charge nurse was working intake and went home without completing all of the charting. The health service administrator let her. Not having complete charts compromises patient care.

50. At intake, nurses used to be able to order lab work of blood pressure checks from intake. There were standard orders for someone who came in with hypertension, diabetes, hepatitis C, and other chronic conditions. Now, patients wait until they are seen in chronic care for labs to be ordered. The problem is that a provider seeing someone in chronic care often needs to have lab information to treat the patient.

51. People on detox are being missed. The new system doesn't transpose all the people that are on detox to the "schedule" that is printed out and used for round. If the nurse working detox is not diligent, patients may go without the proper detox meds that they need.

52. It is hard to find all our patients on detox. The medical record doesn't sync with the jails offender management system (OMS) and so the location is not always indicated on the record.

53. Charts are not getting connected. When someone comes in, they are now getting a new chart opened under a new identifier. With Corizon's system, a patient's file can't be accessed using their permanent jail ID number (their 100 number). A "T" number is created in the interim until the person is booked and then someone in medical records must manually merge the patient charts together. Until the charts are merged, it is like that person being booked, who may have 50 past bookings and a lot of medical history here, is a new person. This is a problem because this can cause delay in a patient care. For example, diabetic medication may have been ordered on the T number profile, and someone looks that up using their permanent 100 number and it will not show the medications that that person has been prescribed.

54. Having more than one chart can cause a lot of problems. If I look at one chart a patient has no medications. If I look at another for the same person, many medications are listed. This can lead to the patient not receiving their medications, or medications being ordered twice.

55. Corizon's formulary is different than Centurion's. What this means is that the medications it stocks are different from the ones that Centurion stocked. This is causing problems, particularly for diabetics. Medications that have been working to control someone's blood sugars are being changed and a hospital level of fast acting insulin is being used. This sliding scale insulin that is being used could cause a drop in blood sugars, and not all of the inmates that are diabetic are able to purchase commissary food to counteract this.

56. I do not know if it is because of staffing or new protocols, but there are important things that are not being done. Glucometer calibrations are not being done. Temperature checks and oxygen level checks are not always being done for COVID patients.

57. Maintaining the logs for CQI (quality assurance), call logs for CAPS (corrective action plans), and other important things are not being done. This concern has been brought to the site leaders' attention.

58. Some nurses aren't time stamping what they are doing, they aren't signing their name in the record. There are gaps in the charting. My supervisors have been made aware of this and to my knowledge nothing has been done to correct this problem.

The System is Down with the Ransomware Attack

59. I worked the grave shift on the night of January 5, 2022.

60. That was the first night after the ransomware attack on County.

61. It appeared that we did not have access to current medical records. The records we could access looked like they were backed up weeks before.

62. This means that we did not have access to current medication records for all patients, and so some patients may not have received their medications.

63. There was no way to properly chart medication administered or detox rounds conducted with the patient's symptoms. Detox could chart vital signs on the paper sheet.

64. As far as I know, and when I left work on the morning of January 6, 2022, our system was down and so we could not scan our paper documentation into the medical records.

65. There was no way to document our diabetic rounds, insulin given or blood sugars, we had no paper flow sheet to document that on and could not access the patient's electronic record.

Conclusion

66. I have told my supervisors and the County about my concerns.

67. I like my job and I feared retaliation for speaking out about the problems. After I raised concerns, I was excluded from emails sent to most of the other nurses about staffing gaps and open shifts.

68. Even though I like my job, and have even been here 11 years, I will be resigning my full-time position effective immediately due to the safety concerns I have for our clientele and our staff.

69. It is important for me to make this declaration because without change, I'm afraid something bad is going to happen.

I swear under penalty of perjury that foregoing is true and correct.

Executed January 6, 2022.

/s/ Taileigh Sanchez, RN

Taileigh Sanchez