Corcoran State Prison

Health Care Evaluation

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Introduction

In September 2012, the Federal Court, in Order Re: Receivership Transition Plan and Expert Evaluations, requested that the Court medical experts conduct evaluations at each CDCR prison to determine whether an institution is in substantial compliance. The Order contemplates that an institution "shall be deemed to be in substantial compliance, and therefore constitutionally adequate, if it receives an overall OIG score of at least 75% and an evaluation from at least two of the three court experts that the institution is providing adequate care."

To prepare for the prison health evaluations, in December 2012 the medical experts participated in a series of meetings with Clark Kelso, Receiver, California Correctional Health Care Services (CCHCS), and CDCR leadership to familiarize ourselves with structural changes that have occurred in the health care system since the beginning of the Receivership. Information gained from these meetings was invaluable to us in planning and performing the evaluations, and we express our appreciation to Mr. Kelso, CCHCS and CDCR.

In conducting the reviews, the medical experts evaluated essential components to an adequate health care system. These include organizational structure, health care infrastructure (e.g., clinical space, equipment, etc.), health care processes and the quality of care.

Methods of assessment included:

- Interviews with health care leadership and staff and custody staff;
- Tours and inspection of medical clinics, medical bed space (e.g. Outpatient Housing Units, Correctional Treatment Centers, etc.) and administrative segregation units;
- Review of the functionality of business processes essential to administer a health care system (e.g., budget, purchasing, human resources, etc.);
- Reviews of tracking logs and health records;
- Observation of health care processes (e.g. medication administration);
- Review of policies and procedures and disease treatment guidelines;
- Review of staffing patterns and professional licensure; and
- Interviews with inmates.

With respect to the assessment of compliance, the medical experts seek to determine whether any pattern or practice exists at an institution or system wide that presents a serious risk of harm to inmates that is not being adequately addressed.[1]

[1] Order re: Receivership Transition Plan and Expert Evaluations No. C01-1351 TEH, 9/5/12.

To evaluate whether there is any pattern or practice that presents a serious risk of harm to CDCR patients, our methodology includes review of health records of patients with serious medical conditions using a "tracer" methodology. Tracer methodology is a systems approach to evaluation that is used by the Joint Commission for Accreditation of Health Care Organizations. The reviewer traces the patient through the organization's entire health care process to identify whether there are performance issues in one or more steps of the process, or in the interfaces between processes.

The experts reviewed records using this methodology to assess whether patients were receiving timely and appropriate care, and if not, what factors contributed to deficiencies in care. Review of any given record may show performance issues with several health care processes (e.g., medical reception, chronic disease program, medication issues, etc.). Conversely, review of a particular record may demonstrate a well-coordinated and functioning health care system; as more records are reviewed, patterns of care emerge.

We selected records of patients with chronic diseases and other serious medical conditions because these are the patients at risk of harm and who use the health care system most regularly. The care documented in these records will demonstrate whether there is an adequate health care system.

The tracer methodology may also reflect whether any system wide issues exist. Our methodology includes a reassessment of the systemic issues that were described in the medical experts report to Judge Henderson in April 2006 at the time the system was found to be unconstitutional and whether those systemic issues have been adequately addressed.[2]

We are available to discuss any questions regarding our audit methodology.

[2] The Status of Health Care Delivery Services in CDCR Facilities. Court-Appointed Medical Experts Report. April 15, 2006.

Overall Finding

We find that Corcoran State Prison (Corcoran) is not providing adequate medical care to patients, and that there are systemic issues that present an on-going serious risk of harm to patients and result in preventable morbidity and mortality.

Executive Summary

On April 16-19, 2013, the Plata Court Medical Experts visited Corcoran State Prison to evaluate health care services. Our visit was in response to the OIG Medical Inspection Results Cycle 3 report showing that Corcoran scored 87.2% in September 2012. This report describes our findings and recommendations. We thank Warden Connie Gipson, Chief Executive Officer Teresa Macias and staff for their assistance and cooperation in conducting the review.

At Corcoran, we found serious problems related to access, timeliness, and quality of care. Clinical systems that we found to be deficient included the intrasystem transfer process, nursing sick call, chronic disease management, urgent/emergent care, specialty services, and medication administration. The lack of a fully engaged management team and the absence of effective clinical supervision of the physicians are major factors contributing to these problems.

We also have concerns related to the General Acute Care Hospital (GACH). According to GACH Bylaws, the Organized Medical Staff is to provide clinical oversight of the unit.[3] However, the Organized Medical Staff has been dormant and oversight committees are inactive. Therefore, there is no effective medical oversight of care of patients in the GACH. We found serious patient care issues related to medical and nursing practice for GACH patients. Nursing care on the GACH did not adequately address the needs of the patients. Patient monitoring (e.g. vital signs and symptom monitoring for medication reactions) was not performed in accordance with physician orders or as clinically indicated. Most troubling, however, is that there have been a high number of intravenous catheter and other infections, including bacteremia[4] that in some cases have led to sepsis.[5] These are potentially life-threatening infections are indicative of problems related to management of intravenous central lines, as well as lack of adequate hygiene, sanitation, and infection control activities in the unit. Hand washing observation studies conducted in April and May 2013 showed that none of the observed staff washed their hands before engaging in patient care.[6] Another contributing factor is inadequate custody staffing that prevents health care staff from having timely access to patients.[7]

[3] California State Prison Hospital, Corcoran Bylaws, Revision of February 2003

[4] Bacteremia is a condition in which bacteria are found in the blood. These are serious and potentially life-threatening infections.

[5] Sepsis is an inflammatory reaction of the body caused by infection that can lead to multiorgan failure and death.

[6] Corcoran April and May 2013 Infection Control Reports. Nursing leadership responded that none of the nurses were observed to wash their hands prior to putting on clean gloves before engaging in patient care. However, gloves are an adjunct to, but not a replacement for proper hand hygiene.

[7] It is notable that the patients housed in the GACH do not meet the clinical criteria for being in an acute care hospital. These patients could be appropriately placed in a well-run Correctional Treatment Center (CTC). Due to the expense of the licensing and staffing requirements for an acute care hospital, it is not cost effective to maintain a GACH at Corcoran.

When patients present urgently or emergently, prompt evaluation is critical in managing the patient. Delays in evaluation may result in deterioration of the patients' condition and can result in unnecessary hospitalization. We note that CCHCS quality data reports indicate that Corcoran had more than double the days of preventable hospitalization than other prison facilities. Our findings are consistent with their assessment. Corcoran leadership attributed these preventable hospitalizations to errors of judgment, delayed reports from specialty or hospital care, mental health overflow into medical beds, and inmate non-compliance. Based on our own chart reviews, preventable hospital days resulted primarily from problems with primary or urgent care evaluations and from deficiencies in care on the GACH, particularly nosocomial[8] infections.

We found serious problems with the intrasystem transfer process including lack of adequate communication and coordination of care from the transferring institution to Corcoran and medical errors by the transferring facility that were not noted upon arrival at Corcoran. In several cases this resulted in preventable hospitalization and deaths. We also found that patients did not receive continuity of essential medications (e.g. insulin), nurses did not refer high-risk patients in a timely manner, and providers did not thoroughly review the patient's previous medical history resulting in failure to follow-up previously abnormal diagnostic tests (e.g. CT scan) or obtaining missing hospital or diagnostic reports necessary for appropriate patient management.

There are problems with access to care, particularly in restricted housing units (e.g., SHU and ASU). Health care leadership reported that patient refusal rates were high; and we believe that some of the refusals are a result of custody practices that negatively affect access. When nurses do see patients, the quality of assessments is highly variable and, in several cases, nurses performed no assessment, but instead referred the patient directly to a provider. However, when these direct referrals were made, the provider often did not address the patient's concerns. There was lack of consistent providers taking care of patients, and care was fragmented.

We found significant problems with management of chronic disease patients related to the timeliness and quality of care. We also noted a high rate of patient refusals of chronic care visits, blood sugar monitoring and insulin administration. This was discussed with the medical staff, who acknowledged that the rate appeared to be around 40%, which is much higher than in other facilities and needs to be investigated.

We also found that inadequate custody staffing and/or cooperation adversely impacted timely medication administration in the SHU and Facility III general population. In the SHU, we observed, and staff reported, that custody does not provide escorts for nurses to administer medications in a timely manner. One patient refused his insulin because he said that nurses did not coordinate his insulin with meals. In general population housing units, custody did not

[8] Nosocomial refers to a hospital acquired condition.

permit inmates to come to a central medication window to receive medications in the evenings in accordance with policy, which resulted in nurses prepouring medications in violation of generally accepted nursing practice standards. At the time of our review, it did not appear that the medical leadership was effectively addressing these issues to custody leadership.[9]

We find that internal monitoring and quality improvement activities are not effectively focused on identifying and analyzing problems to determine their root causes and implement a corrective action plan that specifically targets the root causes. For example, infection control data shows a high number of health care associated infections in the GACH, but the response to this serious problem has been fragmented, less than thorough and has not included physician l leadership. According to the infection control nurse, there is no Infection Control Subcommittee; instead the infection control nurses provide reports to the Medical Subcommittee. However, in neither Quality Management Committee meeting minutes[10] nor in Medical Subcommittee Meeting minutes was this serious problem addressed.[11] Likewise, when staff hand washing observational studies revealed that none of the observed staff washed their hands before patient care, there was no discussion of the results of these studies, that they represent a serious problem, or plans to study and address the problem

Administratively, we found that health care operations are not well organized. Sanitation and disinfection activities do not reliably take place in all clinical areas. Clinical supplies are stored in areas where they are exposed and covered with dust and dirt. There is no effective periodic automatic replacement (PAR) system, and many of the clinical areas are cluttered with excess supplies. There is no effective system for tracking materials and supplies, which has resulted in a large excess inventory. Similarly, the facility does not have a system for inspecting and replacing equipment.

We also found problems, similar to the ones we found in other facilities, with the disciplinary process. Due to the length of time it takes to complete the process, there are a number of clinical staff working in non-clinical positions because their supervisors do not trust them to be involved in patient care activities. Not only is this wasteful; it prevents the manager from being able to hire someone else into the position. We also are concerned that the GACH Bylaws[12] are not consistent with the 2008 Court order on physician competency[13] and are concerned about the effect of this on potential physician discipline.

[9] Following our visit, Corcoran nursing leadership advised us that Health Care Access Teams from Sacramento instructed the Warden to have general population inmates come to the medication window.

[10] Quality Management Committee Meeting Minutes January 28, 2013; February 12, 2013; March 4, 2013; April 22, 2013; and May 20, 2013 as provided by Corcoran management

[11] Medical Program Subcommittee Meeting Minutes February 20, 2013; March 13, 2013; and April 10, 2013 provided by email on July 24, 2013.

[12] State of California, Department of Correction, CSP-Corcoran; California State Prison Hospital Corcoran Bylaws, Revision of February 2003 provided by Dr. Wang, CME, as the existing Bylaws of the Corcoran GACH.

[13] Plata v. Schwarzenegger Order Approving, With Modifications, Proposed Policies Regarding Physician Clinical Competency No. C01-1351 TEH.

Findings

Facility Description

Corcoran opened in February 1988 initially to house Level I minimum security inmates, Level III general population (GP), and security housing unit inmates. Since then Corcoran has evolved into a more complex, multi-mission institution comprised of the following facilities: Level I, Level III Special Needs Yard (SNY), Level IV SNY, Level IV General Population (GP), Administrative Segregation Unit (Ad-Seg), Security Housing Unit (SHU), Protective Housing Unit, Prison Industry Authority (PIA) and a fully licensed acute care hospital (GACH).

It also has an enhanced outpatient (EOP) treatment center. Construction of a multi-story EOP Administrative Segregation Treatment Clinic is underway and the unit is scheduled to open June 1, 2013.

The current population is 4,477, a decrease of 519 inmates from September 2011.[14] The design capacity of the facility is 3,116 inmates. It is currently 143.6% of design capacity.

Organizational Structure and Health Care Leadership

Methodology: We interviewed facility health care leadership and reviewed tables of organization, health care and custody meeting reports, and quality improvement reports.

Findings: Teresa Macias is the Chief Executive Officer (CEO) and has been in her position for three years. Ms. Macias has 30 years of experience in Federally Qualified Health Care organizations (FQHC). She was a chief operating officer for 20 years and chief executive for six years for Family Health, a FQHC in Tulare County. Jeffrey Wang MD is the Chief Medical Executive (CME). He has been at the facility since 2007 and was appointed Acting CME in June 2011. Since January 31, 2013, he has been permanent CME. Conall McCabe MD is the Chief Physician and Surgeon (CPS), and has been in his position since 2009. Laura Schaper RN is the Chief Nursing Executive (CNE) and has been in her position since June 2011. Joseph Obiza is the Chief Support Executive (CSE) and has been in his position since August 2011. Brian Miller is the Pharmacist-in-Charge (PIC), and has been in his position since August 16, 2011.

The Corcoran administrative table of organization is organized along functional lines of authority. The CEO indicated that she reports to Dr. Steve Tharratt for medical issues. She indicated that she collaborates with Regional Mental Health and Dental Directors but has no direct reporting relationship for these areas. As with other facilities, the CEO operates independently with minimal interactions with Central Office. There are quarterly Chief Executive Officer Meetings in Sacramento and periodic meetings with Chief Medical and Nursing Executives. There are also weekly conference calls for Chief Executive Officers. Central Office does not have regularly scheduled visits to the facility, but Dr. John Zweifler, the Regional

[14] April 3, 2013

Medical Director, comes to the facility at least quarterly and has seen patients during his visits at the facility.

The CEO participates in regular meetings with Warden Connie Gibson. Ms. Macias attends the daily Warden briefings. The Executive Leadership Team including the CEO, CME, CPS, and CNE meet daily. The Warden attends the weekly Executive Team Roundtable meetings. Captain Dennis Overly attends the Quality Management and Executive Team Roundtable meetings. Tim Press, the Deputy Warden, occasionally attends Quality Management and Executive Team Roundtable meetings.

Despite the length of time that Executive staff has been in place and the number of meetings that occur, the medical program is not being well-managed. We found that:

- Medical leadership does not provide effective supervision of medical providers or quality of medical care; either in the GACH or the facility as a whole;
- Provision of equipment and supplies is not standardized or well-managed;
- Health care sanitation is poor, especially on the GACH;
- Serious issues such as health care associated infections in the GACH and the high rate of patient refusals are not being effectively addressed through the quality improvement process;
- Custody issues that adversely affect patient care (such as patient access in the GACH and medication administration) are not being addressed to custody leadership in a manner that results in improved and timely clinical care.

Medical leadership at Corcoran is not effective in providing clinical supervision of staff physicians or clinical leadership to the medical program. The CPS focuses his attention primarily on responding to medical appeals.[15] The CPS also reviews non-formulary medication requests, addresses issues related to litigation, performs death reports and attends meeting. He chairs the Medical Subcommittee which is charged with monitoring, assessing and improving delivery of medical services.[16] While most of the time of the CPS is occupied with paperwork related to complaints, appeals and litigation, there was little evidence of meaningful clinical peer review of physicians as will be detailed later in the Peer Review section of this report. In addition, although the CPS chairs the Medical Subcommittee, meeting minutes identify no clinical concerns with corresponding recommendations and action plans to be implemented. [17] The Medical Subcommittee meeting minutes reflect an organization with no medical issues, which is clearly not the case.

Infection control on the GACH is an example of the lack of adequate oversight. Oversight of GACH medical care is to be provided by the Chief of Staff of the Organized Medical Staff. The Chief of Staff, who is a staff physician, is responsible for appointing the chairperson of multiple

[15] Staff reported that Corcoran had over 300 appeals in the last year.
[16] Local Operating Procedure1060 Health Care Quality Management Program revised 8/30/12
[17] Medical Program Subcommittee Meeting Minutes February 20, 2013, March 13, 2013, and April 10, 2013.

medical committees of the GACH, including the Infection Control Committee. However, according to the CME, the Organized Medical Staff is inactive, a Chairperson of the Infection Control Committee has not been appointed, and an Infection Control Committee has not been convened in years. Because there are no Infection Control Committee meetings, serious infection control problems are not being addressed by medical leadership.

Although there is no Infection Control Committee, GACH nursing leadership and public health nurses have been involved in surveillance of infections and development of infection control reports. The GACH Supervising Nurse and public health nurses also developed 2013 Infection Control Improvement Goals to address the increase in blood stream and PICC line infections. These reports are submitted to the Medical Subcommittee, a subcommittee of the Quality Management Committee. In this respect, the Medical Subcommittee is a proxy for the Infection Control Committee. However, review of Medical or Quality Improvement Meeting minutes shows that although infection control goals have been established, no meaningful discussion or action plan was developed and implemented to address infections. Regarding nosocomial (i.e., health care associated) infections on the GACH, the CPS said, "I also did not appreciate the frequency of PICC line infections; however these were not highlighted as issues of concern in the infection control reports presented to the Medical Subcommittee meetings and the issue was never presented to me by providers or nursing staff". We do not understand this comment, particularly since the Infection Control Reports include statistical data on infections on the unit were reported to the committee he chairs.

The CME stated that he lacks confidence in the CPS with respect to physician management skills.[18] Nevertheless, the current CME has not performed an annual performance evaluation of the CPS. The CPS believes he had a performance evaluation completed by an Interim CME a few years back. The CPS was unsure if he had seen his duty statement. We reviewed the CPS duty statement and found that it is dated and not descriptive of his current assignments.[19] Except for a custody orientation, the CPS does not recollect a definite orientation relative to duty expectations.[20]

In summary, it is our opinion that clinical supervision of providers and oversight of medical care at Corcoran is grossly inadequate and threatens patient safety. If the Organized Medical Staff does not provide medical leadership of the GACH, the CEO, CME, and CPS should consult with CCHCS central office and must make alternate arrangements to protect patients on the unit. The Medical Subcommittee must be re-evaluated and act in accordance with its stated mission. Duty expectations for the Chief Physician and Surgeon should be established, performance of those duties should be annually reviewed, and all Executives must be accountable for their performance. We note that these conditions are ultimately the responsibility of the CEO. With respect to operational management, it is our opinion that leadership is not sufficiently engaged in managing the operations of the medical program.

[18] Mike Puisis DO telephone interview with Jeffrey Wang MD July 24, 2013.
[19] Mike Puisis DO telephone interview with the Chief Physician and Surgeon on July 24, 2013.
[20] According to the CME the CPS came directly from a hospital faculty position and started directly as the Chief Physician and Surgeon without having had experience in correctional medicine.

Human Resources, Staffing and Budget

Methodology: We interviewed facility health care leadership and human resources staff. We reviewed current and Acuity Based Staffing Realignment (ABSR) plans, vacancy and fill rates and job descriptions. We also reviewed the process for credentialing and peer review.

Findings: The Acuity Based Staffing Realignment (ABSR) plan was placed into effect April 1, 2013. Prior to this, Corcoran had 380.8 employees. Under the ABSR plan, Corcoran has 389.7 employees, an addition of 8.9 employees. The major staffing changes include hiring an additional 2.7 pharmacy staff; eliminating 28.6 Registered Nurses; adding 21.6 Licensed Vocational Nurses; and adding 16.9 psychiatric technicians. For nursing, this is a net reduction of seven nursing position, all of which are registered nurses (RN). The changes in nurse staffing were designed to replace RNs with psychiatric technicians on the mental health unit and with licensed vocational nurses (LVNs) on the medical units of the GACH that previously consisted only of registered nurses.

The GACH staffing requirements are determined by Title 22, which states that the nurse-to-patient ratio will be 1:5, with LVNs not comprising more than 50% of nurses.[21] Nursing leadership believes that the new ABSR staffing patterns are insufficient to meet these requirements, particularly for registered nurses. Because the GACH is mostly used for CTC and OHU level of patients, we believe it would be most cost effective to change the unit to a CTC, thereby providing more flexibility to staffing patterns.

Corcoran management indicated that the ABSR plan[22] has resulted in 2.0 fewer RN positions than the Corcoran staffing plan and calls for the loss of a 0.6 supervisory nurse, while the Corcoran staffing plan calls for an additional supervisor. Management is concerned that these changes will result in an insufficient number of nursing supervisors and will adversely impact the health care program.

During this review, we noted that nursing tasks are not always completed on the GACH unit. It is unclear whether this is a result of lack of staff supervision, lack of staffing, or lack of nursing access to patients because of custody staffing patterns and/or practices. An evaluation of staffing, work assignments and productivity, and nurse access to patients needs to be performed.

Hiring a new employee takes about a month. Management does not feel that there have been problems or delays in bringing on new employees. However, there were issues related to the implementation of the ABSR plan in that initial projections of staffing positions contained errors that affected the number of employees who would be noticed that they were potentially losing their jobs. In addition, management was not informed which staff would receive notices before

[21] Conversation with Laura Schaper CNE.
[22] 94.60 RNs

employees began to receive letters. Corcoran leadership requested that they receive a list before the next round of notices was sent to employees; however, this did not occur.

Physicians receive training via mandatory webinars. Nurses receive annual training in a number of areas related to patient care, as well as training on physical assessment, urgent evaluations and sick call protocols. Nurses working on the GACH receive additional training on a variety of nursing functions related to specialized nursing care on that unit. Outlines for these trainings were reviewed and appear adequate. However, given the lack of documentation on the GACH and the number of infections on the GACH, we question the effectiveness of the existing training.

There is a nurse educator at the facility that has been in the position since March, although the position existed previously. He has a Master's degree in clinical nursing. He provides basic life support (BLS) training for all providers. He also provides 24 hours of mandatory training for RNs and 8 hours For LVNs and Psychiatry Technicians. Course material has been gathered over the years. The training manuals for RNs and LVNs were refreshed this past January and appear appropriate.

Credentialing and Peer Review

No credential files are maintained at Corcoran. Dr. Wang has not seen the credential files for the physicians and does not know whether any of the physicians has had a prior lawsuit or adverse action as registered in the National Practitioner Data Bank (NPDB). He knows their specialty but does not know whether physicians are Board Certified. While it is reasonable that the Central Office maintains credentialing, the CME at each facility needs to be aware of the credential status of each of the physicians working under their supervision.

The CME or designee is required by CCHCS policy[23] to perform an annual eUHR Clinical Appraisal (UCA) peer review for each medical provider and submit the review to the CCHCS Clinical Support Unit (CSU). At Corcoran, the practice is for the CPS to perform these evaluations. However, this is not written into the duty assignment of the CPS and appears to be an informally understood assignment. These UCA reviews are not up to date. The CPS completed only 5 of 12 (40%) required UCA evaluations in 2012. More importantly, after the CPS completed the UCA evaluations he did not discuss the results of the evaluation with the provider even when significant issues were uncovered in the reviews. As of April of 2013 only 2 of 12 (16%) UCA reviews for 2013 had been performed. Again, in neither of these reviews did the CPS discuss findings with the clinical provider. The Regional Medical Director recommended to the CPS repeatedly that he discuss the findings of the review with the provider but this has not occurred. This failure to effectively perform routine physician peer review contributes to lack of oversight of the clinical program.

[23] Inmate Medical Services Policies and Procedures Volume 3 Quality Management, Chapter 4B PCP Mentoring-Proctoring Program and Clinical Performance Appraisal Process Procedure found at the website http://www.cphcs.ca.gov/imspp.aspx

As noted earlier in this report, Corcoran has a GACH which is regulated by Title 22. Title 22 requires every acute care hospital to have an Organized Medical Staff.[24] The Bylaws of the Organized Medical Staff are to provide procedures to credential, assign clinical privileges, and means of enforcement of the Bylaws. The current Corcoran GACH Bylaws[25] were last revised in February of 2003 prior to initiation of the Medical Receiver. These Bylaws appear to contradict credentialing procedures of CCHCS. The Medical Executive Committee Action of the Bylaws also appear to create a parallel and contradictory procedure for discipline with respect to the 2008 Court Order on physician competency[26] and its associated policies[27] on physician discipline.[28] Although it does not appear that the Organized Medical Staff at Corcoran is effective or active, nevertheless, its Bylaws do currently appear to contradict existing Court ordered policy. Because the Organized Medical Staff is not carrying out its stated functions, this negatively affects clinical care on the GACH. CCHCS and medical leadership at Corcoran should confer to develop a solution to ensure that Bylaws at Corcoran required by Title 22 are consistent with the existing 2008 Court order and to ensure that the Bylaws adequately provide for clinical oversight of medical care on GACH.

Disciplinary Process

We continue to find problems with the disciplinary process. A regional Employee Relations Officer (ERO) provides assistance for discipline. She comes to the facility once a month and more often if necessary. The disciplinary process is similar to other facilities. Minor disciplinary action is immediately addressed without investigation. For serious matters all cases are referred to the OIA for investigation as the first part of the disciplinary process. After the OIA has completed its investigation, the hiring authority executes discipline which may include involvement of the Personnel Board. As with other facilities the OIA investigation may take up to 3 years. Follow up action by the hiring authority or Personnel Board can also be an extensive process and can extend the personnel action on completed OIA investigations. There were 15 employees involved in disciplinary actions at Corcoran from January 2012 until April 2013. Of these 15 disciplinary actions, 5 have been concluded. Of the remaining 10 actions, 1 employee is Absent Without Official Leave (AWOL). The Office of Internal Affairs (OIA) has completed investigations on 4 but personnel action has not yet been completed. The personnel action has been pending for 9 months in 2 cases and 4 months in 2 cases. In 5 remaining cases, the OIA has not completed the investigation.

[24] California Code of Regulations Title 22, Social Security volume 30 70703 Organized Medical Staff

[25] State of California, Department of Correction, CSP-Corcoran; California State Prison Hospital Corcoran Bylaws, Revision of February 2003 provided by Dr. Wang, CME, as the existing Bylaws of the Corcoran GACH.

[26] Plata v. Schwarzenegger Order Approving, With Modifications, Proposed Policies Regarding Physician Clinical Competency No. C01-1351 TEH

[27] Plata Physician Professional Clinical Practice Review, Hearing and Privileging Procedures, Pursuant to Order Approving, With Modifications, Proposed Policies Regarding Physician Clinical Competency, July 9, 2008; *Plata, et al. v. Arnold Schwarzenegger, et al.* Federal Court Case No. C01-1351

[28] Section 6.1-3 Investigation and section 6.1-4.

There are several employees working out of their job classification. There is one RN working at the warehouse. The allegation was a HIPAA issue; the nurse wrote detailed notes about patients on his public blog.

Another nurse assigned to nursing sick call is also working in the warehouse. He received discipline notices for poor performance and an adverse action was initiated. The nurse went out on mental health leave. A second adverse action was initiated because management found a large volume of health care request (7362) forms in a desk which should have been addressed by this employee. When the employee came back to work, he was reassigned to the warehouse. Shortly after reassignment, the employee went out on stress leave. This was November 2011. He has not yet returned to work. Furthermore, the nursing board has informed the facility that the nurse has been placed on probation by the nursing board due to an arrest for DUI and having drug paraphernalia in his vehicle. This nurse's position has been considered occupied since 2011 when he was placed on leave. Discipline has not yet been completed.

Another nurse also is on probation with the nursing board for having inappropriate relations with an underage client prior to employment at Corcoran. He started work at Corcoran before the probation was filed. The employee also had a second probation with the nursing board for an allegation of DUI and vandalism, which were criminal charges. The nurse did not report either of these probation episodes to management. Management discovered these probations because the nursing board called Corcoran about the infractions in October of 2012. At that point, management instituted disciplinary actions. Management sought termination but the final disciplinary disposition was that the employee obtained a 3-day suspension for not reporting his probation status. This employee is still working pending a decision by the nursing board regarding his license.

Another case is a psychiatry technician who was allegedly viewing pornography at the facility, which was identified by checking his computer. He is still performing patient care pending resolution by investigation.

These cases are all serious alleged infractions. Based on our experience in other systems, such employees would be suspended pending investigation. CCHCS management is unable to effectively remove these employees; therefore, employees with serious infractions are reassigned outside their job classification within the organization or continue in their assignments pending investigation. Because investigations can take a long time, these situations drag on, may result in patient safety concerns, and negatively affect staff morale.

AWOL terminations are another problem. If an employee fails to show up to work for an extended period of time, management must formally terminate the employee before another employee can be hired into the position. Because these termination proceedings take time, the position can remain open for extended periods. One example is a nurse who last worked 2/13/10. He had just started working two weeks before that but apparently decided not to continue working at the facility. He went AWOL. Although he was not getting paid, he

continued to occupy a position and management was unable to hire into the position until he was formally terminated. The formal termination did not occur until January 2013, so the position was vacant for almost three years.

Health Care Budget

In fiscal year 2010-2011, Corcoran had an initial budget allotment of $28.6 million, a final budget allotment of $52.8 million and had expenditures of $50.4 million. In fiscal year 2011-2012 Corcoran had an initial budget allotment of $46.2 million, a final budget allotment of $61.6 million, and had expenditures of $61.8 million. As with other facilities, expenditures exceed the allotment because the budget is not based on actual need.

Health Care Operations, Clinic Space and Sanitation

Methodology: We toured central and housing medical clinics, the GACH, Outpatient Housing Unit (OHU) and administrative and ancillary support areas. In addition, we interviewed staff involved in health care operations.

Findings: Health care operations are not well organized. Equipment management and supply chain are disorganized. Clinic and inpatient sanitation is poor and disinfection practices are inadequate.

Local operating procedure 1081, *Clinical Storerooms Supplies and Maintenance*, directs that each clinic storeroom shall be set up and maintained in a standardized fashion. All shelves are to be labeled with the item to be contained on the shelf. The LVN in the yard clinic is said to be responsible for maintaining each clinic storeroom. Each week the clinic LVN is required by the procedure to order supplies to bring them to periodic automatic replacement (PAR) levels. The supervising RN is to monitor this process weekly by filling out a designated form. This procedure is excellent but is not followed in any area we reviewed.

In practice, there is no PAR system in place. Any registered nurse can fill out a store order supply form. This is then signed by the supervisory nurse and given to the storeroom. The storeroom delivers supplies to the supply area. The actual placement of supplies is by clinic staff. Management acknowledged that PAR lists for clinical areas do not actually match the levels of supply in the respective clinical areas, which results in oversupply. For example, in Level 1 Facility, the doctor's examination room had dozens of wrist and knee splints and other supplies and equipment, which were not on the PAR list. Also, there were over 400 1 cc syringes that were not on the PAR list. These syringes are mostly used for placing Mantoux skin tests, which are performed annually. As there are only a couple hundred low security inmates in this area, the current supply exceeded approximately two years of prospective use. The LVN from the area agreed that this supply was seldom used and had been there for a while.

One section of the Triage and Treatment Area (TTA) had supplies in containers that were appropriately labeled and were neatly arranged. However, other areas of the TTA had supplies in a disorganized arrangement. Some cabinets in the TTA had labels on containers or on

cabinets that either had no supplies or had supplies different from the labels. Some drawers and cabinets had excessive supplies in disorganized arrangements. Another room used for TTA supplies had multiple cabinets with labels for various supplies but either had no supplies or supplies not corresponding to the label.

Management has not provided leadership on supply management. The issues noted above in the Level 1 Facility clinic and the TTA reveal that there is no standardized PAR system and that supplies are arranged in a disorganized fashion.

Corcoran has about 4500 inmates and could probably be serviced by a supply storage area of several hundred square feet of supplies, provided that a prime vendor was utilized for frequent deliveries. Instead, the program has a massive warehouse for storage of supplies. Several years ago, there was a separate storage area for medical supplies. At that time, the Warden changed the arrangement and required that the medical program share warehouse space with the institutional program. As a result, the medical program has an aisle in the institutional warehouse for disposable supplies that is approximately 100 yards long. It contains three levels of shelving reaching approximately twenty feet high and containing multiple skids of product. This area has an open bay door through which dirt, dust and debris are blown in by the wind. Many boxes in this aisle were open, and individual product, although covered in its wrapping, was exposed and covered with dust and dirt. Products included urinary catheters, intravenous line tubing and kits, anesthesia tubing, oxygen tubing and other similar items. Medical products should not be maintained in areas exposed to dust and debris, as the dust and debris may contaminate the product when opened.

In another room of the same warehouse, there was another aisle, about half the size of the first aisle used for medical supplies. This area was not exposed to dust blown in from the outside, as it was sheltered from the outside. Supplies in this area included office supplies and other disposable medical equipment. We could not be given an explanation why some equipment was in this area as opposed to the other area. Paper and office supplies and forms were locked up and protected from dust and dirt, but sterile medical disposable supplies were exposed to dirt and dust.

There was a third storage area in a locked room in the locked area. This room was large and contained syringes and certain surgical and dental equipment. This room was protected from debris and dust.

The warehouse space was enormous as compared to what is needed for storage of medical supplies. We asked for an inventory of supplies but none was provided. Inventory is based on the unit of measure in the Business Information System (BIS), which is not the same unit of measure that is used in the clinics. For example, the unit of use for gloves is a box containing 100 gloves. The unit of use for BIS is a carton of gloves which contains 10 boxes. When health care staff order a box of gloves they do not need a carton, so the system of ordering for clinic use does not match the BIS inventory system; tracking of use is therefore impossible using the BIS system. In other facilities we visited, they have created additional tracking spreadsheets in

an attempt to manage inventory, but this is not the case at Corcoran. As a result, the inventory in the warehouse is not evaluated in comparison to supplies used. This has resulted in a large excess inventory, which does not appear to be monitored. The warehouse manager acknowledged that many items in the warehouse are seldom used and have been on the shelves for years.

When physical plant items break, staff fills out a Plant Operations Work Request. These are signed off on by a supervisor and submitted to an office technician. The office technician is the work order coordinator. She enters the work order into a work order database, which is a shared database managed by CDCR. A number is assigned for each work order and when plant operations' personnel get the work order, an email confirmation returns to the work order coordinator. Since January 1, 2013, the work order coordinator has received 194 work orders. An opening presentation to us by leadership stated that staff ensures that work orders are closed out once repairs are complete. However, we could not verify this in practice. Staff could not show us the process to identify that a work order is completed. They also could not tell us the length of time it takes to complete a work order. The work order coordinator was unaware of timeliness tracking. We could also not verify that there is feedback to the medical program on outstanding orders. As a result, management does not know if the work order process is effective in repairing broken furnishings or fixtures such as sinks and toilets. On tour, we talked to staff who complained to us that broken items are not timely fixed. The current system does not provide a means to evaluate whether work orders are processed timely.

The facility does not use an inventory list of equipment matched against a preventive maintenance inspection report to assess adequacy of equipment. We could not verify from the list provided to us whether all equipment was inspected. For example, on tour we found three otoscopes or ophthalmoscopes that did not function in C yard clinic and one otoscope that did not function in the level 1 clinic. We asked for verification that equipment in those clinics was inspected, and mid-level management staff initially were unable to provide us either with an inventory list of equipment or with a report of inspection. After several requests, we were provided with a Preventive Maintenance Inspection report. This report did have an inventory of equipment with a comment section on it related to whether inventoried equipment was inspected. However, we could not find ophthalmoscopes or otoscopes on this report. We did find an item called charger base for otoscopes but could not verify whether this was for the charger base only or for the combination of the charger base, the otoscope and the ophthalmoscope. Management did not know how to verify whether the otoscopes had been evaluated. In addition, 60 (18%) of 325 line items on the Preventive Maintenance Inspection report were listed as either unavailable or could not be found. Management staff could not tell us what this meant. When we talked to the preventive maintenance vendor, he told us that this meant that the equipment was not in its proper location and he could not find it. He stated that staff moves equipment from its designated location and it becomes lost. Clearly, this report is not being effectively used, and almost 20% of all medical equipment was not in its designated location. In summary, we could not verify that equipment is in its correct location, is reported as broken, or that broken equipment is replaced or repaired.

All other facilities we visited utilized a spreadsheet listing all existing equipment with its location and most recent inspection date. This made verification easy and could be checked by inspecting certain areas and checking equipment in that area. It also was an easy way to verify that management was monitoring equipment adequately. We urge that this same system of equipment inventory and management be used at this facility.

We toured a couple of areas. The level 1 clinic was not well organized or clean. Clutter was evident in all rooms.

Civilian employees perform sanitation in the GACH. There are nine employees who report to a custodian supervisor who reports through the medical organizational structure. One registry staff employee cleans units 4A, 4B, 3A03, 3A04 and stand-alone Ad Seg using a schedule. Inmate porters clean other areas. Medical leadership did not know how many porters are assigned to medical. Inmate porters clean 3A, 3B and 3C and level 1. Health care management did not know the cleaning schedule of the inmate porters, and we were unable to verify how these units are sanitized.

The requirements for sanitizing patient rooms on the GACH as stipulated in the GACH Infection Control policy are not being adhered to.[29] This policy requires daily cleaning of patient rooms but the custodians clean the patient rooms only twice a week when inmates take showers. Each GACH unit take showers in rotation, so each unit gets to shower twice a week and, on that day, the custodians clean the rooms. In one unit, there were a number of persons with infections and draining wounds and in 5½ months there were multiple cases of bacteremia (systemic infections cultured from blood) or PICC line infections, which had developed in patients on the unit. On several occasions, bacteria were growing in the ice machine. Clearly, there are sanitation and infection control issues on this unit. A review of sanitation should be undertaken and sanitation standards should be maintained at the level of an acute care hospital. Custody must cooperate with the medical custodian staff in custodian efforts to sanitize rooms on a daily basis.

Policies and Procedures

Methodology: We interviewed health care leadership and staff and reviewed selected statewide and local policies and procedures to determine whether they were periodically reviewed and whether updated local policy was consistent with statewide policies.

Findings: We were provided the local operating procedures (LOPs) for review prior to our visit. There were 31 local operating procedures, excluding addendums and attachments, provided to us. All of these procedures have been reviewed and signed by March 2012. Many have been reviewed in 2013. Almost all significant areas of concern in our audits are covered by local operating procedures. Exceptions are that there are no local procedures on mortality review, credentialing, hiring, or admission to the GACH. Procedures were generally well written and comprehensive.

[29] CSP-Corcoran Hospital; Policy and Procedure Manual, Infection Control Revised September 7, 2012.

We have the following comments on specific local operating procedures. The Health Care Transfer Process procedure states that the eUHR shall accompany each inmate when transferring. This implies that the eUHR will be up-to-date at the time of transfer. However, if the inmate was in a GACH, CTC, or OHU, it is likely that the inpatient record will not have been scanned at the time of transfer. So the transfer of medical record information is not occurring as stipulated in the procedure, and an additional process needs to be established to ensure accurate transfer of medical information when patients transfer. For high acuity patients it is important to have physician-to-physician communication on transfers; however, there is no requirement in this policy for physician-to-physician communication when patients transfer between, to, or from higher levels of care. Nursing intrasystem procedures seem adequate. Also, the intrasystem transfer procedure requires potential high-risk patients to be seen by a provider within 30 days. This is too long of a time period to evaluate a medically high-risk patient. The policy also states that patients who have a scheduled specialty consult within the next two-week period, including specialty visits for chemotherapy or radiation therapy, can have the appointment rescheduled within 30 days of the inmate's arrival at the receiving institution. This may not be appropriate in certain cases, as a delay in chemotherapy, radiation therapy or other consultation may result in harm. In those situations, medical staff needs to institute a medical hold or confirm with the specialist that the delay is medically acceptable. Also, for high-risk patients, the CME or other physician is not required to document an endorsement by the receiving facility indicating that the receiving facility can manage the patient being transferred and provide continuity of care. A clinical endorsement between physicians needs to be documented in the eUHR. In addition, discussions between UM and the facility physician about patients returning from hospitals needs to be documented in the eUHR. There were several deaths that are illustrative of concerns with the intrasystem transfer process, and we recommend health care leadership review these cases in relation to this policy and procedure.

The procedure for Emergency Medical Response Documentation and Review includes a review of all emergencies and emergency off-site visits including hospitalization. These are performed by the supervising nurse but also need to include a review by physicians.

The procedure on Health Care Quality Management Program states that the Public Health/Infection report shall be sent to the Medical Program Subcommittee of the Quality Management Program, but the procedure has little detail on what the report consists of. At Corcoran we identified several health care associated infections in patients on the GACH including serious bacteremia requiring hospitalization. An infection control policy and procedure for facility wide use should be developed. The procedure for monitoring infection control issues needs to be improved. This should be through the Quality Management Program.

We note that in preparation for our visit we were only provided local operating procedures and assumed that these policies included all policies for the medical program. During interviews conducted after our tour related to infection control issues on the GACH, we discovered that there is a policy manual for the GACH, including infection control policies, which was not

provided to us in advance of our tour. GACH policies include a 232 page policy and procedure manual for infection control which was revised in September 2012. This policy details responsibilities of the Organized Medical Staff in establishing an Infection Control Committee and describes procedures for performing surveillance, cleaning, and other items related to infection control. None of the responsibilities of the Organized Medical Staff outlined in this policy are currently being performed. Also, even though this policy was recently revised, we recommend that the surveillance section be reviewed with respect to definitions of infections as these do not appear to be consistent with the CDC/NHSN surveillance definitions.[30] Instead of attempting to define surveillance criteria for infections on the GACH, it may be better to merely reference the CDC document and utilize their definitions to ensure uniformity in defining infections. Also, Section #10 on Cleaning/Disinfection of Patient Rooms should reference hospital standards with respect to cleaning. We note that cleaning regimens for the GACH required by this policy are not currently implemented.

The Organized Medical Staff play a major role in development of policies on the GACH and have a responsibility for clinical oversight of the GACH. Because we were not provided with any other GACH policies we did not have an opportunity to review the effect of the dormant Organized Medical Staff on existing policy and its effect on oversight of clinical care of this unit.

The Access to Primary Care procedure permits nursing assessments to occur in a holding cell in the rotunda of housing units if the inmate is "restricted." All assessments need to be conducted in a clinical area.[31]

We compliment the organization for their procedure on Clinical Storerooms Supplies and Maintenance. It attempts to standardize clinic supply provision. However, we note that it is not evidenced in practice.

Intrasystem Transfer

Methodology: We interviewed facility health care leadership and staff involved in intrasystem transfer and reviewed tracking logs, staffing and 16 health records of medium- to high-risk medical patients that transferred into Corcoran in the past year.

Intrasystem Transfers

Findings: We found that in each record reviewed the transferring facility staff completed a Health Care Transfer Information Form (CDCR 7371) and Corcoran staff medically screened the patient upon arrival. However, we found significant concerns with the intrasystem transfer

[30] Horan T, Andrus M, Dudeck M; CDC/NHSN surveillance definition of health care-associated infection and criteria for specific types of infections in the acute care setting; American Journal of Infection Control 2008; 36:309-32

[31] Corcoran staff responded that "*Per Local Operating Procedure 1068 it states…*In the GP facilities the inmate-patients shall be ducated to the facility clinic. In a restricted housing unit, the inmate-patient shall be escorted to the facility medical clinic for RN face-to-face triage Monday through Friday; 0700-1500…*Medical leadership does not condone conducting assessments in the rotunda for inmates in restricted housing units."*

process at both the sending and receiving facilities. In addition, we identified concerns related to utilization management of medical bed space.

We found:

- Medically high-risk patients that were scheduled for medical procedures or treatment immediately prior to transfer for whom a medical hold was not considered or implemented and that resulted in delayed access to care.
- Lack of continuity of critical medications. In one case, lack of continuity of a patient's glargine insulin contributed to his death shortly after his arrival.
- Lack of timely nurse referral to a provider for patients with urgent conditions.
- Lack of provider familiarity with the patient's medical history and need for follow-up and continuity of care.
- Inappropriate plans for medical interval follow-up (e.g., 150-180 days) for high-risk medical patients.

Examples are described below:

- On 3/29/13, a 49-year-old with a history of diabetes, hypertension and coronary artery disease with stent placement transferred from Folsom State Prison to Corcoran. Prior to transfer a cardiologist saw the patient for chest pain and recommended a stress thallium and echocardiogram that were scheduled for 4/3/13. On 3/26/13, the transferring nurse at Folsom completed a 7371 but there is no documentation that the nurse consulted with a provider to determine whether the patient should be placed on medical hold pending the procedures. Upon arrival at Corcoran, the nurse did not measure the patient's vital signs. The nurse scheduled a provider appointment for 4/4/13 but this appointment did not take place until 4/17/13. On 4/30/13 the patient underwent the previously recommended cardiac procedures. A medical provider saw the patient afterwards and planned to have him return to the clinic in 30 days. On 6/10/13 another provider saw the patient. The patient's diabetes was not at goal consistent with American Diabetes Association guidelines (7.8%, ADA goal=<7.0%).[32] He assessed his diabetes as being at goal and planned to see the patient in 150-180 days. This is not appropriate given the patient's high-risk medical acuity.[33]

- On 4/15/13, a 41-year-old patient with hypertension, latent TB infection and disseminated coccidioidomycosis transferred from Kern Valley State Prison (KVSP) to Corcoran. Upon arrival, the patient's hypertension was not well controlled (BP=156/101 mmHg and 146/97 mmHg) and he complained of two ingrown toenails that were painful

[32] The American Diabetes Association 2013 Guidelines notes that lowering hemoglobin A1C goal of <7% reduces microvascular complications of diabetes and implemented soon after diagnosis reduces macrovascular complications. Less stringent goals may be appropriate for patients with a history of severe hypoglycemia, limited life expectancy, however in the absence of these documented limitations, the recommended goals of <7% should be pursued to minimize diabetes complications.
.In some cases,

[33] Intrasystem Transfer/Nurse Sick Call Patient #1.

and red. The nurse did not refer the patient to a medical provider at that time. A week later the patient presented urgently to the TTA for surgical removal of his toenail plates. In addition, in November 2012, while he was at KVSP, the patient was hospitalized at San Joaquin General Hospital and diagnosed with disseminated cocci. A chest CT also showed a 10 mm nodule for which the physician recommended a repeat chest CT in 3 months. The CT was due in February 2013 but this recommendation was not addressed at KVSP or at Corcoran.[34] As of 7/27/13 the chest CT has not been performed.

- On 4/4/13, a 63-year-old with hypertension, hyperlipidemia, and severe cardiomyopathy with an ejection fraction of 20% transferred from CCI to Corcoran. In early March, he was hospitalized for treatment of his heart failure. Two weeks prior to transfer, a cardiologist recommended that spironolactone be added to his medication regimen and to return in 6-8 weeks as his prognosis was poor and medical management should be titrated to the maximum. This recommendation was not addressed at CCI. At the time of transfer he was housed in the OHU for uncontrolled hypertension. Neither the CCI nor Corcoran nurse noted on transfer forms that he had recently had a cardiology consultation. The Corcoran nurse also did not document the need for provider referral, and a provider did not see the patient until a month after his arrival. At that visit, the provider did not address the cardiologist's recommendation for spironolactone or note that his lipids were not at goal (LDL-C=139, goal=<70). On 5/16/13, the cardiologist saw the patient again, noting his very high mortality risk, and recommended adding nitrates; adding a statin since the patient's LDL was still high; and ordering a lab test (BNP) to evaluate the severity of his heart failure. The patient's shortness of breath has limited his activities to the extent that he is wheelchair bound. On 6/4/13, a Corcoran provider saw the patient and documented that although he had a cough, his heart disease was "well compensated" and that "I don't think he will die within 6 months. Will defer this issue to PCP." He did not order a nitrate; did not intensify his statin regimen; and did not order a BNP to evaluate the patient's heart failure in accordance with the cardiologist's recommendations. The provider then wrote an order for a chest x-ray and follow-up in 150-180 days. The providers' assessment of that his heart disease was "well compensated" not consistent with the patient's functional status (e.g., wheelchair bound due to shortness of breath) or the cardiologist' assessment of his high mortality risk. A follow-up interval of 5-6 months is inappropriate given this patient's high-risk status.[35]

- On 11/20/12, a 55-year-old with gigantism, acromegaly[36], pituitary tumor, schizophrenia, bipolar disorder, hyponatremia[37] secondary to psychogenic polydipsia[38], paroxysmal atrial fibrillation, recurrent syncope, left nephrectomy as an infant, colon cancer with right hemicolectomy, chronic deep vein thrombosis (DVT) with an IVC

[34] Intrasystem Transfer/Nurse Sick Call Patient #5.
[35] Intrasystem Transfer/Nurse Sick Call Patient #6.
[36] Acromegaly is a hormonal problem that results in increased bone size, including those of the hands, feet, and face.
[37] Hyponatremia is low serum sodium.
[38] Drinking excessive amounts of water.

filter[39], degenerative disk disease and left foot drop transferred to Corcoran. One week before transfer, the patient was hospitalized for right lower leg pain and edema. Upon arrival at Corcoran, the patient had a rapid pulse (pulse=139-147/bpm) and borderline low blood pressure (BP=102/68 mmHg). He had 3+ pitting edema (swelling) of his legs and reported pain 8 of 10 in severity. The nurse notified the ER and documented that the physician was "aware," but a medical provider did not see the patient and the nurse did not document another disposition. We did not find MARs in the record documenting that he received his diuretic (furosemide) used to treat his leg edema. On 11/26/12, at an undocumented time, a provider saw the patient and addressed some of his medical conditions but not his history of chronic DVT or hyponatremia. He documented that the patient has heart failure, but there is no objective data in the record to support this diagnosis. He did not reference the patient's hospitalization two weeks prior. Physical exam showed trace bilateral lower leg edema. His plan was to order labs and follow the patient in 60-90 days. The same day at an undocumented time, another provider saw the patient for chest pain and planned to send him to San Joaquin General Hospital (SJGH), but we find no documentation that this occurred.[40]

- On 8/23/12, a 56-year-old with diabetes, hypertension, chronic hepatitis C infection, gastric ulcer, internal hemorrhoids and severe anemia transferred from SVSP to Corcoran. The patient had a history of GI bleeding and severe anemia (hemoglobin= 6.4 gr., normal=14-16) in January 2012. The patient underwent endoscopy and colonoscopy and was found to have a healing gastric ulcer and severe internal hemorrhoids. Prior to transfer, in February 2012, a SVSP provider submitted a request for services for a general surgery consult for a hemorrhoidectomy. [Note: when the surgeon initially saw the patient, he recommended a laxative with follow-up in 4 weeks, not a hemorrhoidectomy]. The follow-up visit did not occur because the patient refused because he had not yet taken the laxative for four weeks as directed by the surgeon. However, at subsequent visits, the SVSP provider mistakenly documented that the patient had had the hemorrhoidectomy and took no action to have the patient sent back to the surgeon. At the time of transfer, the SVSP nurse checked with the provider to determine if he should be placed on medical hold. The provider indicated it was unnecessary and the patient was transferred. Upon arrival at Corcoran, the patient's hypertension was uncontrolled (BP=162/90 mmHg) and the nurse referred the patient to the provider in 4-6 weeks. We do not find August or September 2012 MARs to show the patient received his medications, except for lisinopril. On 9/11/12, a provider saw the patient as a new arrival and for chronic disease management. The physician did not perform a review of systems for each condition; did not explore the history of rectal bleeding; or perform a rectal examination. The physician did not document an assessment or plan. Two days later, the patient submitted a 7362 stating that the doctor told him to let him know when he started to seriously bleed, and that he was hemorrhaging like water. The nurse triaging the 7362 did not refer the patient urgently

[39] A mesh filter placed in the inferior venous cava to prevent blood clots in the leg from going to the lungs.
[40] Intrasystem Transfer/Nurse Sick Call Patient #12.

to the TTA. When a nurse saw the patient four days after he submitted his request, the nurse sent him to the TTA and he was immediately sent to San Joaquin General Hospital.[41]

Also, as described in the mortality section later in this report, there were three deaths in which problems with the intrasystem transfer process played a role. In two cases, medication continuity was not ensured. In another case, utilization management arranged for a patient transfer to Corcoran but critical specialty consultation was not arranged before transfer. The patient died, possibly as a result of failed access to care. These cases demonstrate a need for CCHCS leadership to review the statewide intrasystem transfer policy, especially in light of current utilization management practices of transferring patients into any open higher-level bed without ensuring clinical continuity of care; and for Corcoran leadership to review its own procedures.

We also found problems with care immediately following transfer. Of 16 intrasystem records reviewed, four patients were admitted to the GACH, and in two of four cases patients developed sepsis or a wound infection. Our review of care of patients in the GACH confirmed a serious problem with nosocomial infections (See GACH section). The two cases are noted below.

- On 3/21/13, a 39-year-old patient transferred from Pleasant Valley State Prison with coccidioidomycosis and admitted to the GACH treatment with a PICC line[42] for intravenous antibiotics. Ten days later, the patient developed a fever of 102°F and was diagnosed with Methicillin-Sensitive Staph Aureus (MSSA) sepsis. His PICC line was removed and a new one inserted.[43]
- On 4/9/13, a 65-year-old patient transferred from Mule Creek State Prison (MCSP) following open-heart surgery at UC Davis and was admitted to the GACH. While in the GACH, the patient developed a wound infection from his right upper thigh where saphenous veins were removed from his leg to perform bypass graft surgery. His infection was still being treated when he transferred back to MCSP on 5/9/13.[44]

Access to Care

Methodology: To evaluate access to care, we interviewed health care leadership and reviewed patient tracking and scheduling systems. We also reviewed 34 health services requests (CDCR Form 7362) in 15 records of patients with chronic diseases, including medium- and high-risk medical patients from different housing units including 3A, 3B, 3C, the SHU and ASU.

[41] Intrasystem Transfer/Nurse Sick Call Patient #14.
[42] A PICC line is a peripherally inserted central catheter. It is long, slender, small, flexible tube that is inserted into a peripheral vein, typically in the upper arm, and advanced until the catheter tip terminates in a large vein in the chest near the heart to provide intravenous access.
[43] Intrasystem Transfer/Nurse Sick Call Patient #2.
[44] Intrasystem Transfer/Nurse Sick Call Patient #3

Health Care Appointment Scheduling

Findings: We did not find any backlogs in patient appointments, but we did find that scheduled appointments did not take place due to reported patient refusals. However, in several cases we reviewed, there was no signed patient refusal, or one that was signed with a note from the patient saying "please reducat me," which indicates that the patient did not truly wish to refuse health care services.

Health care staff also reported that even although health care access data shows that custody escorts inmates to their appointments, custody escorts patients back to their housing units for count, whether or not the appointment has been completed; and custody may or may not bring the patient back to the clinic. Custody staff does not permit inmates to be "out counted" in the clinic as other institutions allow. This results not only in missed appointments but inefficient use of expensive provider time.

Nursing Sick Call (Face-to-Face Triage)

Findings: Our findings showed significant problems with timely access to care and are not consistent with the OIG Cycle 3 report score of 82.1% for Clinical Services or the Corcoran OIG and Dashboard Performance Trends that showed the quality of nursing assessments to be 91%.

Corcoran health care staff collects and triages medical health care request forms (CDCR 7362) in a timely manner. However, health care staff does not consistently date, time, and sign 7362s with dental or mental health complaints at the time of receipt or triage, document a triage disposition, or see the patient for potentially urgent dental and mental health complaints. Instead, staff typically forwards the forms directly to dental or mental health staff. We noted delays in access to care resulting from this process.

Moreover, we found that although 7362s with medical concerns are collected and triaged timely, nurses do not see patients in a timely manner, if at all, and the quality of nursing assessments is inadequate. In some cases, a nurse sees the patient, but instead of performing an assessment, refers the patient directly to a provider, and in some cases "piggybacks" the referral onto a previously scheduled appointment that may not occur for several weeks. In these cases, a nursing encounter amounts to no care at all. Moreover, record review shows that the provider appointment is often not timely and/or the provider does not address the reason the patient submitted the 7362. Thus, care is extremely fragmented, and patients repeatedly submit 7362s trying to get their medical concerns addressed.

This was particularly problematic for patients housed in the administrative segregation unit (ASU) and Special Housing Unit (SHU). In several cases, nurses administratively handled the 7362 without seeing the patient and without documenting any communication back to the patient.[45]

[45] Nursing leadership reported that the involved nurse in the SHU would be counseled regarding not seeing patients and performing appropriate assessments.

Health records also show that Ad-Seg and SHU patients frequently "refuse" appointments. In some cases we found this to be the case with signed refusals of treatment forms in the eUHR. In other records, health care staff documented refusal of appointments with no signed refusals in the record. We also found that patients signed the refusal form but also wrote "please reducat me," an indication that the refusal of the visit does not truly reflect intent to refuse medical care. Often there was a refusal form in the record, but it was not clear what service the patient was refusing.

Health care leadership is aware of the high rate of refusals but has not effectively addressed this through the quality improvement process. A nursing supervisor reported that inmates sometimes do not know when they are scheduled for their appointment and, when custody comes to escort them to the appointment, they are surprised and not ready. According to staff, custody won't wait for them and state that they are "refusing" their appointment. Staff also reported that inmates refuse appointments because it may conflict with recreation, which is the one opportunity to leave their cell each day. Staff also reported that when officers arrive to escort inmates to their appointments, their cellmate is required to stand up against the back wall of the cell until security procedures are completed. The supervisor stated that sometimes inmates do not want to inconvenience their cellmates. We did not independently confirm this and it requires further investigation. Health care leadership also communicated that lack of custody cooperation was an obstacle to patient access to care.

Examples of concerns related to access, timeliness or quality of care in the ASU or SHU include the following reviews:

- On 3/30/13, a 49-year-old patient with diabetes, hypertension, coronary artery disease and stent placement, and hypothyroidism submitted a 7362 requesting to see the doctor. On 4/2/13, a nurse documented "Ø (no) S/S (signs or symptoms)". There is no documentation of the nature of the patient's concerns in order to assess the urgency of the patient's complaint, and a disposition was not documented. On 4/17/13, a provider saw the patient who complained of chest pain and whose diabetes and hypertension were not at goal. This inmate was housed in the SHU.[46]
- On 5/4/13, a 58-year-old patient with hypertension, hepatitis C infection and neck pain following surgery with hemiparesis submitted a 7362 complaining of falling down secondary to needing a new left arm and knee brace. On 5/8/13, a nurse documented that the patient refused to see the RN for sick call. There is no signed refusal in the record showing that the patient refused the visit. This patient was housed in the ASU.[47]
- On 4/10/13, a 63-year-old patient with hypertension, hyperlipidemia, coronary artery disease, myocardial infarction and heart failure submitted a 7362 that requested several chrono items including a walker or cane. The nurse did not see the patient but documented that the provider saw the patient and "chrono issued." However the provider saw the patient for follow-up of gout and did not address the patient's chrono

[46] Intrasystem Transfer/Nursing Sick Call Patient #1.
[47] Intrasystem Transfer/Nursing Sick Call Patient #4.

request. Instead the provider wrote an order to "address the 7362 that was not addressed today," although it is not clear who this order was directed towards. This patient was housed in the SHU.[48]

- On 3/25/13, a 52-year-old patient with hypertension, epilepsy, chronic low back pain and mental health disorders submitted a 7362 complaining of dental pain. A nurse did not triage the form or assess the patient. Seven days later, on 4/2/13, a dentist signed the form and saw the patient the same day. The patient also submitted the following requests:
    - On 4/11/13, the patient submitted a 7362 complaining of back pain and constant urination that was uncontrollable. It was received and triaged the following day. On 4/12/13, the nurse documented that the nurse practitioner saw the patient. However, the nurse practitioner documented that the patient refused the visit, although there is no signed refusal in the record.
    - On 4/17/13, the patient submitted a 7362 complaining of neck, upper and lower back pain such that he was unable to sleep. It was received and triaged on 4/20/13. On 4/22/13, the nurse saw the patient and measured vital signs but did not perform an assessment or examination of any kind. The nurse did not address the patient's pain but referred him to a provider.
    - On 5/5/13, the patient submitted a 7362 complaining of difficulty urinating and being concerned about his prostate. It was received and triaged the following day. The nurse saw the patient and noted that the patient had been concerned about his prostate since watching a TV commercial, but aside from documenting frequency of urination did not perform a review of systems (e.g., painful urination, hematuria, urinary discharge, changes in force of stream, etc.) or perform a urinalysis. The nurse's assessment was that the patient was obsessing about his prostate and he referred the patient routinely to the provider.
    - On 5/19/13, the patient submitted a 7362 requesting to see the provider about his right shoulder and elbow and a chrono regarding waist chains. It was received and triaged the same day. The nurse did not see the patient but documented a referral to the provider.
    - On 5/30/13, a provider saw the patient for chronic disease management and evaluation of his shoulder and elbow pain. The provider documented "Limited range of motion examination was done secondary to Administrative Segregation status," suggesting that the provider did not request that the patient be uncuffed during the examination. The provider assessed him as having "chronic right elbow arthritis with limited range of motion." The provider did not address complaints in recently submitted 7362s including the patients back pain, urinary complaints or prostate concerns.[49]
- On 3/31/13, a 56-year-old with hypertension, gastric carcinoid tumor, dysphagia, latent TB and chronic hepatitis C infection submitted a 7362 stating he needed to see the doctor concerning his multiple medical issues and high-risk status. It was received and

[48] Intrasystem Transfer/Nursing Sick Call Patient #6.
[49] Intrasystem Transfer/Nursing Sick Call Patient #7.

triaged on 4/1/13. The nurse documented that the patient was a new arrival and the date of the appointment was TBA (to be announced). The nurse did not see the patient to find out the nature and urgency of the patient's concerns. The patient was housed in the SHU.

  - On 4/1/13, the patient submitted another 7362 stating that he had not been seen by mental health and his medications weren't working. It was date-stamped as being received on 4/2/13, but a nurse did not date, time, or sign when she saw or triaged the patient. The psychiatrist did not see the patient until 4/11/13.
  - On 4/11/13, a nurse practitioner saw the patient as a new arrival. The NP did not perform a review of systems for each chronic disease.
  - On 5/5/13, the patient submitted a 7362 requesting to see the psychiatrist because of his rage issues and he did not want to do something he regretted. It was received on 5/6/13, but there is no documentation that a nurse triaged the form, saw the patient to assess the urgency of his concerns, or communicated with mental health. On 5/13/13, the psychologist saw the patient.[50]

- On 3/10/13, a 56-year-old patient with a history of diabetes, hypertension, dyslipidemia, coronary artery disease and coronary artery bypass surgery, pacemaker, major depression, bipolar disorder and low back pain submitted a 7362 stating that he had burned his hand with hot water and needed to put something on it. The 7362 was received and triaged on 3/13/13. The nurse did not see the patient but documented that he forwarded the concern to the provider whom the patient was scheduled to see the same day. For reasons that are unclear, the patient refused the visit but stated "please reducat me." This case is a concern because of the risk of infection from burns of the hand.[51]

We also found issues for patients not housed in restricted housing units. Examples are noted below.

- On 1/27/13, the 55-year-old discussed above with acromegaly, gigantism, pituitary tumor, hyponatremia secondary to psychogenic polydipsia, colon cancer with hemicolectomy, schizophrenia and bipolar disorder submitted a 7362 complaining of constipation and diarrhea. It was triaged timely and a nurse saw the patient the same day. The nurse did not note the patient's history of colon cancer or other pertinent medical history, or obtain a complete abdominal ROS (e.g. abdominal pain, blood in stools, etc.). The nurse measured vital signs and performed a brief abdominal exam without palpation. The nurse's assessment was patient "knowledge deficit," and she encouraged the patient to increase fluids. Unfortunately, the patient had psychogenic polydipsia causing hyponatremia, and increased fluids were contraindicated for his condition. The following day, the

[50] Intrasystem Transfer/Nursing Sick Call Patient #8.
[51] Intrasystem Transfer/Nursing Sick Call Patient #10.

patient developed syncope, was hypotensive and hyponatremic and was sent out to the hospital. He was housed in 3C and later in the GACH.[52]

- On 8/30/12, a 55-year-old with diabetes, hypertension, chronic hepatitis C infection, gastric ulcer, severe anemia, hemorrhoids and an enlarged prostate submitted a 7362 complaining of peripheral neuropathy and needing a lower bunk. A nurse evaluated the patient the following day using the musculoskeletal assessment protocol. The nurse obtained a history but did not examine the patient's feet, including color, warmth, sensitivity, and pedal pulses. The nurse routinely referred the patient to a provider who saw him on 9/11/12. This patient is housed in 3C.
    - On 9/13/12, the patient submitted a 7362 stating that the provider told him to let him know when he started to have serious rectal bleeding and that it was hemorrhaging regularly like water every time he used the bathroom. He was supposed to have an operation at the last facility. It was received and triaged on 9/15/12, but the patient was not seen until 9/17/12. The nurse immediately sent him to the TTA. His hemoglobin had dropped from 11 to 9 and he was hospitalized for colonoscopy and further evaluation. He was diagnosed with diverticulosis, small internal hemorrhoids and end-stage liver disease. In this case, the nurse who triaged the 7362 on 9/15/12 should have arranged for the patient to be seen urgently.
    - On 10/23/12, the patient submitted a 7362 complaining of needing his omeprazole instead of ranitidine. It was received and triaged on 10/25/12. On 10/26/12, the nurse saw the patient and took a brief history, but did not ask him whether he had abdominal pain, rectal bleeding, or tarry stools. The nurse did not examine the patient's abdomen. The nurse educated the patient and told him to keep his scheduled 10/29/12 appointment with the provider. For unknown reasons, this visit did not take place.
    - On 11/1/12, the patient submitted a 7362 complaining of a change in his medication from omeprazole to ranitidine. It was received and triaged on 11/2/12. The nurse documented that the patient saw the provider the same day. However, on 11/2/12, the physician assistant saw the patient for chronic disease management but did not address the patient's concern regarding the change in medications and renewed the ranitidine.
    - On 11/5/12, the patient submitted a 7362 complaining of peripheral neuropathy. On 11/7/12, the nurse saw the patient and assessed him using the musculoskeletal protocol. This protocol is not adequately designed to guide the nurse in the assessment of the patient's complaint and as a result the quality of the assessment was inadequate. The nurse documented that the patient already had medication prescribed for his condition and made a routine referral to a provider. On 11/15/12, the provider saw him for his neuropathic pain but did not address his earlier concerns (7362 dated 11/1/12) regarding his GI medication.

[52] Intrasystem Transfer/Nursing Sick Call Patient #12.

- On 5/20/13, a 45-year-old with mood and seizure disorders, low back pain with sciatica, and chronic hepatitis C infection submitted a 7362 complaining of painful arthritis in his knee. It was received and triaged on 5/21/13. The nurse saw the patient that day. The quality of the nursing assessment was good. The nurse referred the patient to a provider. On 5/29/13, a physician saw the patient but did not address his knee pain. Instead the physician documented that the patient had an ingrown toenail and wanted a cane for chronic back pain. The physician did not perform any examination except "+ right ingrown toenail." He referred him to the procedure clinic and ordered Ibuprofen, physical therapy and activity modification. The patient is housed in 3B.
    - On 6/5/13, the patient submitted a 7362 complaining of his knee getting so bad he could not walk on it. On 6/6/13, the nurse assessed the patient using the musculoskeletal protocol noting bilateral knee pain 6 of 10 in severity without deformity, tenderness, or edema. The nurse did not refer the patient to a provider. This is not appropriate care.[53]

In summary, at Corcoran there are serious problems with both access to and quality of care, particularly in restricted housing units. As a result, patients submit multiple requests to try to get their health concerns addressed. This presents a serious risk of harm to patients.

Chronic Disease Management

Methodology: We interviewed facility health care leadership and staff involved in management of chronic disease patients. In addition, we reviewed the records of 30 patients with chronic diseases, including diabetes, hypertension, and clotting disorders, as well as other chronic illnesses. We assessed whether patients were seen in a timely manner in accordance with their disease control. At each visit, we evaluated the quality of provider evaluations and whether they were complete and appropriate (subjective, objective, current labs, assessment and treatment plan). We also evaluated whether the Problem List was updated and continuity of medications provided.

Findings: We found significant problems with management of chronic disease patients related to the timeliness and quality of care. Our findings are not consistent with the OIG's Cycle 3 report score of 86.8% for chronic disease management. However, our findings are more consistent with those noted in the CCHCS Dashboard. With respect to quality of care, according to the April 2013 Dashboard: Corcoran scored 79% for the management of diabetes and 73% for the management therapeutic anti-coagulation. Another concern is the rate of patient refusals of chronic care visits, blood sugar monitoring and insulin administration. This was discussed with the medical staff, who acknowledged that the rate appeared to be around 40%, which is much higher than in other facilities. The reason for such a high refusal rate needs to be investigated.

[53] Intrasystem Transfer/Sick Call Patient #20.

The following cases exemplify some of the problems we found:

- The patient is a 50-year-old man with diabetes and hypertension. On 12/21/12, his LDL cholesterol was elevated (LDL-C=132 mg/dl; the goal for diabetic patients is less than 100 mg/dl). He was seen by providers for other issues on 1/10/13 and 2/7/13. The providers did not address his high cholesterol on either of these occasions. The patient was next seen for chronic care on 2/26/13. The provider did not address his high cholesterol at that time either. On 3/21/13, the patient refused a clinic appointment. The provider noted that he would see the patient again in 3-5 months. A provider saw the patient for back pain on 4/16/13. The provider did not address the patient's elevated cholesterol.[54]

  Assessment
  There were problems related to quality and timeliness of care. The patient did not receive appropriate follow-up of his elevated cholesterol.

- The patient is a 58-year-old man with diabetes, hypertension, coronary artery disease with a history of bypass surgery in 1998 and a stent in 2005, and peripheral vascular disease with a femoral bypass in 2006. On 11/26/12, his LDL cholesterol was very elevated (LDL-C=170 mg/dl; the goal for patients with diabetes and coronary artery disease is less than 70). On 11/27/12, a provider notified the patient that he was being scheduled for a follow-up visit related to his laboratory tests. The patient was not seen until 1/4/13. The provider ordered a repeat blood test at that time. He did not adjust the patient's medications. On 1/9/13, the patient's LDL cholesterol was even higher (LDL-C=201 mg/dl). That day, a provider notified the patient that a follow-up visit was being scheduled to discuss his laboratory tests. On 1/10/13, a different physician notified him that his laboratory tests were within normal limits. The patient's very elevated LDL cholesterol was not addressed until 3/29/13 when a provider adjusted his medications.[55]

  Assessment
  There was a problem related to timeliness of care. The patient's very elevated LDL was not appropriately addressed for four months. (The CCHCS guideline on hyperlipidemia has an "alert" for patients with diabetes, coronary artery disease and an LDL greater than or equal to 100 mg/dl.)

- The patient is a 50-year-old man with diabetes, hypertension and hyperlipidemia. His LDL cholesterol was elevated (LDL-C=122 mg/dl, goal=<100) on 7/17/12. His medication was adjusted at a chronic care visit on 8/6/12. The patient refused a repeat blood test on 11/14/12 and refused a counseling visit with the provider on 11/29/12. The patient was not seen again for chronic care until 3/13/13. The provider ordered repeat blood

[54] Chronic Care Patient #3.
[55] Chronic Care Patient #4.

tests. They were performed on 3/26/13. The LDL cholesterol was 139 mg/dl. The patient has not been seen for follow-up since then.[56]

Assessment

There were problems related to quality and timeliness of care. The patient was not seen for over three months after he refused his appointment on 11/29/12. Furthermore, the patient has not been seen for his elevated LDL cholesterol on 3/26/13.

- The patient is a 66-year-old man with diabetes, hypertension, hyperlipidemia, coronary artery disease, aortic stenosis, aortic regurgitation, renal insufficiency and hepatitis C. He was seen for chronic care on 9/4/12. At that time, the provider noted that the patient's blood pressure was not at goal and ordered blood pressure monitoring one time per week. There is no documentation that this was done. The patient was next seen on 10/29/12 for chronic care. The provider noted that the patient's blood pressure was elevated (BP=145/95 mmHg; blood pressure goal for patients with diabetes is less than 140/80mmHg). The provider noted that the patient stated that he had forgotten to take his medication that day. The provider did not adjust the patient's medication. The patient was next seen on 12/3/12. His blood pressure at that time was again above goal (BP=137/87 mmHg). The provider noted that the patient's blood pressure was not at goal. He advised the patient to decrease salt intake and lose weight but did not adjust his medication. The provider also noted that the patient's hemoglobin A1C had been normal on 8/1/12 and that his blood sugar monitoring revealed that his morning blood sugars had ranged from 118 to 327 mg/dl[57] and that his afternoon blood sugars ranged from 103 to 410 mg/dl. Despite these elevated recent blood sugars, the provider documented that the patient's diabetes was at goal. The provider ordered follow-up in 8-10 weeks with laboratory tests. The patient was next seen for chronic care on 2/5/13. The clinician noted that the patient's blood pressure was 143/88 mmHg and that his recent morning blood sugars had ranged from 245 to 285 mg/dl and that his afternoon blood sugars range from 313 to 385 mg/dl. He noted that the patient's hypertension was not at goal but did not document an assessment for the patient's diabetes. He adjusted the patient's hypertension medication and ordered a repeat hemoglobin A1C. This was performed on 2/7/13 and was elevated (9.7%; goal is less than 7%). The patient was next seen on 3/19/13. The provider counseled the patient regarding his diet but did not adjust his diabetes medication.[58]

  Assessment

  There were problems related to quality of care. The patient did not receive appropriate care for his hypertension or his diabetes.

[56] Chronic Care Patient #8.
[57] Normal blood sugar is less than 105. While many diabetic patients have blood sugars that are routinely higher than this, values over 200-250 mg/dl are very high.
[58] Chronic Care Patient #17.

- The patient is a 51-year-old man with diabetes, hypertension, coronary artery disease with coronary bypass surgery in 2000 and stent placement on 8/9/12. On 9/5/12, he was found to have a thrombus in his heart and was started on warfarin. His INR (a blood test used to monitor patients on warfarin) was sub-therapeutic from that time until 12/26/12 (This was partly due to the patient's non-compliance but mostly related to lack of appropriate care and follow-up).[59]

  Assessment
  There were problems related to quality of care. The patient did not receive appropriate care related to his warfarin therapy.

- The patient is a 53-year-old man with atrial fibrillation for which he takes warfarin. On 1/23/13, his INR was very high (11.3 mg/dl, goal=2-3). The provider ordered a repeat INR the following day. On 1/24/13, the patient's INR was 15.8 mg/dl and the provider gave the patient 20 mg of vitamin K (vitamin K reverses the effects of warfarin). The following day, the patient's INR was therapeutic.[60]

  Assessment
  There was a problem related to quality of care. The patient did not receive appropriate care for his elevated INR. The CCHCS guidelines on anticoagulation specify that vitamin K (5 to 10 mg) be given when the INR is greater than 9.0 mg/dl. On 1/23/13, the provider should have given vitamin K to the patient when his INR was 11.3 mg/dl. On 1/24/13, the provider gave too high a dose of vitamin K. (The American College of Chest Physicians recommends only giving 2.5 to 5 mg of vitamin K when the INR is greater than 9.0 mg/dl.)

- The patient is a 49-year-old man with hypertension and a history of multiple deep vein thromboses for which he is receiving warfarin. On 2/6/13, a provider ordered a fasting lipid panel. It was obtained on 2/11/13. The patient's LDL cholesterol was elevated (163 mg/dl) and his HDL cholesterol was low (37 mg/dl, goal >= 40). He was subsequently seen by a provider on 4/25/13 and 5/7/13. The provider did not address his elevated LDL cholesterol at either visit.[61]

  Assessment
  There was a problem related to quality of care. The LDL cholesterol goal for a 49-year-old man with hypertension and low HDL cholesterol is 100 mg/dl.

- The patient is a 65-year-old man with diabetes, atrial fibrillation and hypertension. His hemoglobin A1C was 7.6% (normal=<7.0%) on 6/7/12. As of 5/15/13, it had not been repeated.[62]

[59] Chronic Care Patient #20.
[60] Chronic Care Patient #23.
[61] Chronic Care Patient #24.
[62] Chronic Care Patient #25.

Assessment
There was a problem related to quality of care. The CCHCS guidelines specify that the hemoglobin A1C needs to be monitored at least every six months.

- The patient is a 49-year-old man with diabetes and hypertension. Between 1/18/13 and 4/5/13, the patient had seen a provider on five occasions and his blood pressure was elevated at each visit. (The blood pressure goal of a patient with diabetes is less than 140/80 mmHg. The patient's blood pressures had been 126/85 mmHg, 135/87 mmHg, 133/84 mmHg, 130/87 mmHg and 136/93 mmHg.) None of the providers addressed his elevated blood pressure.[63]

  Assessment
  There was a problem related to quality of care. The patient's elevated blood pressure was not addressed.

- The patient is a 42-year-old man with a clotting disorder and recurrent deep vein thromboses for which he was taking warfarin. On 4/9/13, his INR was 4.0. The provider noted that the patient had been stable since July 2012. His plan was to repeat the INR. A repeat test was performed on 4/16/13 and was 5.0. The provider reviewed the result on 4/17/13 and wrote an order to hold the warfarin and to check the patient's INR daily beginning the next day. The INR was not repeated until 4/20/13, at which time it was therapeutic. At that time, the provider restarted the warfarin at a lower dose and ordered a repeat INR on 4/22/13. The INR was not repeated until 4/29/13, at which time it was still therapeutic. As of 5/15/13, the INR had not been repeated.[64]

  Assessment
  There was a problem related to quality of care. The patient did not receive appropriate management of his warfarin therapy. INRs were not performed in the timeframe ordered by the provider. In addition, the INR had not been checked for over two weeks. Since the dose of warfarin was decreased because the patient's INR was 5.0, the INR needed to be checked on a weekly basis until the INRs were stable for at least a few weeks.

Pharmacy and Medication Administration

Methodology: We interviewed Pharmacist-in-charge (PIC) Bryan Miller, nurses who administer nurse-administered and keep-on-person (KOP) medications, toured the pharmacy, clinic medication rooms and observed nurses administer medications and reviewed medication administration records (MARs) in clinics and in health records.

[63] Chronic Care Patient #26
[64] Chronic Care Patient #28.

Findings: Pharmacy services are adequate, but in need of improvement with respect to the security of dispensing containers for non-blisterpack or unit dose medications. Currently the pharmacy dispenses medications into plastic baggies that cannot be securely closed. We found that when nurses store medication bags in containers in the clinics, the baggies can easily open, spilling loose pills from the bag and contaminating the medication. This medication should be discarded, resulting in waste and shortages in the number of doses.[65] We also found that the pharmacy needs improvement with respect to sanitation and disinfection practices.

With respect to medication administration, we found concerns regarding lack of custody support for medication administration in the SHU and Facility III; in the latter case, this resulted in nursing departures from accepted standards of nursing practice for medication administration. These departures from standards of nursing practice likely contribute to medication errors, particularly in documentation.

We also note that there is an inadequate system for identifying, reporting and tracking medication errors in outpatient clinics. This is not surprising since the primary approach to these errors is progressive discipline. Although staff should be held accountable for their performance, medication error reporting should be encouraged and then studied under the auspices of the quality improvement program to determine whether system issues (e.g., how nurses are delivering medications, etc.) contributes to medication errors as opposed to individual performance issues, or both. Record review showed that medication administration records are not scanned into the eUHR in a timely manner. From our review, it was not possible to know whether patients consistently receive their medications in a timely manner. Quality improvement reports reflected that it takes an average of 4-6 weeks for MARs to be scanned into the record.[66] Our findings are discussed in greater detail below.

Pharmacy Services

Findings: The pharmacy is physically located in the General Acute Care Hospital (GACH) and provides both inpatient and outpatient pharmacy services. Pharmacy services operate under a hospital pharmacy license, a Drug Enforcement Agency (DEA) license, and a Sterile Compound license. All licenses are current.

The pharmacy physical plant is suboptimal. It appears to be of sufficient size but is cluttered and not clean. Floor tiles are missing. An accumulation of dust is noted on computers. The surfaces of medication exchange carts used in the GACH were dirty. The PIC indicated that during his previous employment in a hospital setting, housekeeping cleaned the pharmacy 2-3 times per day, but he feels fortunate if housekeeping services clean two to three times weekly. He reported that the pharmacy is the cleanest that it has ever been in the 18 months he has worked at the facility. Lack of adequate sanitation and disinfection is a major patient safety issue.

[65] We did not observe whether or not loose medications were discarded.
[66] Quality Improvement Meeting Minutes, 5/20/13.

The pharmacy operates Monday to Friday from 6 am to 4 pm, and on Saturday from 7 am to 3 pm for the hospital only. With respect to pharmacy staffing, there is currently one PIC and five state pharmacist positions and one contract pharmacist. There are also eight state pharmacy and two registry pharmacy technicians. The PIC believes this staffing pattern is adequate.

As at other facilities (e.g. CMC), prescription dispensing practices are not uniform and vary by location and security level. Pharmacy services process approximately 20,000 prescriptions per month through the in-house pharmacy and Central Fill Pharmacy in Sacramento. The pharmacy compounds approximately 800 intravenous (IV) bags per month.

The pharmacy processes all new prescriptions, ASU and SHU prescriptions, and provides medications to GACH patients through a medication cart exchange system. These prescriptions are typically filled through unit doses or loose pills in labeled baggies. One issue with dispensing loose pills into labeled baggies is that it difficult to keep them securely closed. When inspecting medication rooms in the yards we found that the bags easily opened and pills fell out into the storage bins or containers. This contaminates the medication which should be discarded and in these circumstances will result in shortages of medications. With respect to medication refills, Central Fill processes general population medication refills using blisterpack packaging.

Medication reconciliation reports show that when providers order medications, the pharmacy dispenses the medication in a timely manner. However, we found that MARs are not scanned into the record in a timely manner; and some have not been scanned at all.

With respect to medication error tracking systems, the PIC reported that a tracking system was in place. Review of the tracking log showed some medication errors identified in the GACH, but according to the Pharmacist in Charge, from January to April 2013, only one medication error had been reported or identified from the outpatient yard clinics. We reviewed MARs that showed blank spaces where nurses should have documented, but did not, the status of medication administration for a given dose. This is a missed dose, or error of omission, and should be reported as a medication error. Internal medication studies (e.g. AMAT) have also shown blanks spaces on MARs.[67] That no errors have been reported from facility clinics or from medication audit processes reflects lack of an adequate medication error reporting system and represents a patient safety issue.

Medication Management and Administration

Findings: We found significant issues related to medication administration at Corcoran. As noted in the intrasystem transfer section of this report, 5 (31%) of 16 records showed that when providers order medications, the MARs are not scanned into the eUHR to show whether or not the patient received continuity of medications upon arrival or even after residing at the facility for several months.[68]

[67] See Corcoran March 2013 internal medication audit reports.
[68] See Intrasystem Transfer/Nursing Sick Call Patients #1, #7, #12, #14, and #20.

We inspected the medication room in the Special Housing Unit (4B4). The room had adequate space and was clean except for the walls. However, there is no schedule of sanitation or disinfection activities for the clinic or logs showing that these activities have been completed. Staff reported that they sweep and mop the room daily as needed. There was an emergency response bag and automatic external defibrillator. The refrigerator was clean and we found no expired medications. The nurse indicated that there were issues with wastage of vials of injectable interferon because there was no refrigerator to store the medication in the area where pharmacy picks up returned medications. According to the nurse, each vial costs $6,000 and therefore any waste is costly. We recommend that this be addressed by health care leadership in the P & T Committee.

We reviewed medication administration records in the restricted, Special Needs Yards, and general population medication clinics that we found to be generally neat and legible. We noted blank spaces for some medication doses on some MARs reflecting that staff did not document administration of medication for those scheduled doses, which are errors of omission. In the SHU and 3B, we asked staff how these blank spaces are handled, and the nurses responded that they would call the nurse and tell them that they should fill in the blank the next time they came to work. One nurse stated that she would not report it as a medication error because she did not want to get the nurse in trouble. This is problematic because documentation of medications on the MARs days or weeks after the fact raises questions about the credibility of MARs. The nurses' concerns are supported by quality management committee meeting minutes that discussed April 2013 Medication Administration Process Improvement Plan (MAPIP) findings that identified missing documentation and blanks on the MARs in which the plan was to implement progressive discipline and in-service training.[69] The study also identified multiple MARs that were not scanned into the eUHR.

While it is important to hold staff accountable for their performance, there may be other systemic issues contributing to the lack of proper documentation that should be investigated. For example, during this visit we found that custody did not permit general population inmates to come to the medication window in Facility C. This resulted in nurses pre-pouring medications into improperly labeled envelopes and administering medications in the housing units without the MAR present. This is not in keeping with standards of nursing practice and could easily lead to both medication and documentation errors.

Medication Administration in the SHU

There are access to care issues related to the lack of custody support for medication administration in administrative segregation and SHU. We observed the noon medication administration in the SHU (4B4) during our site visit. After the nurse had received medications from the pharmacy and prepared the medication cart, she notified the control unit officer that she required custody escort to administer medications. The officer told her that there was no one available to escort her because officers were escorting inmates to and from recreation. The nursing supervisor accompanying us attempted to obtain the escort without success. We

[69] Quality Management Committee Meeting Minutes 5/20/13.

waited for approximately 30 minutes, and the nursing supervisor notified an officer in the chain of command that a Plata court expert was with the team, and then an officer appeared to escort the nurse. Nursing staff reported that it is a common occurrence and that they do not receive consistent custody support for medication administration.

This can have adverse clinical implications. For example, a 56-year-old with poorly controlled diabetes (HgbA1C=11.2%, goal=<7%) and heart disease repeatedly refused insulin doses. On 5/7/12, the patient told the physician that the reason he refuses insulin is that the nurses do not give the medication on time in relation to meals. His refusal of insulin was worsening his diabetes and increased his risk of cardiovascular events, and emphasizes the importance of medication administration taking place at appropriately scheduled times.[70] .

The nurse administered medications by pushing the medication cart to the cell front of each inmate scheduled for a medication dose. When the nurse administered medications in the SHU, the nurse did not consistently verbally and independently (e.g. ID badge) confirm the identity of each patient before administering the medication. The nurse passed the medication through the food port, and watched the inmate take the medication but did not consistently perform oral cavity checks. The nurse documented administration of medications onto the MAR at the time of administration which is the correct procedure.

Medication Administration in General Population Facilities

We found an issue on the main line yards with the evening medication administration. During the daytime medication administration, general population inmates are allowed to come to the medication window to receive their medications. However, custody staff does not allow general population inmates in facility 3A, 3B and 3C to come to the window for the evening medication administration. So the nurses pre-pour medications into coin envelopes that do not contain the same labeling that the pharmacy label contains. In the 3B medication room, a nurse used a coin envelope that had an inmate's last name, two inmate numbers on it, the location of the inmate, and that it was a pm dose. The envelope did not contain the name of the medication. The nurse then placed the coin envelopes into bags prior to transporting and administering the medications in the housing units. Nurses documented administration of medications when they returned to the medication room at the end of medication pass. These practices are not consistent with generally accepted standards of nursing practice and are error-prone.

Staff showed us a joint memorandum from Clark Kelso, Receiver, and Matt Cate, former Secretary of CDCR, which indicated that standard practice should be for general population inmates to come to a central window for medication administration. In addition, according to Operational Procedure 1050 Medication Administration that the CEO and Warden signed on 5/11/12, general population inmates are to come to a central administration window. Finally, Karen Rea, Statewide Chief Nurse Executive, has told facility leadership that facilities are not staffed for decentralization of medication administration for general population inmates.

[70] Intrasystem Transfer/Nurse Sick Call Patient #10.

Despite this, nurses were still administering medications in the housing units. We discussed this with nursing leadership who explained their numerous efforts to resolve this issue with custody leadership to no avail.[71] In this case, although lower level supervisory staff attempted to resolve the issue, we believe that the CEO should have taken this issue up the respective custody and medical chains of command given support at the highest levels of CDCR and the Receiver. It is our impression that health care leadership did not effectively address the issue.[72]

Laboratory/Radiology

Methodology: We interviewed laboratory and radiology staff, tracking systems and health care records.

Findings: Because Corcoran has a general acute care hospital it is required to have an on-site laboratory. It was very difficult to obtain accurate data from the laboratory. The supervisor provided one set of data for laboratory tests done in January of 2013 called a January 2013 Plata Report. This report documented 2797 tests done in January on 1893 specimens. The laboratory staff gave us a second report, called an Individual Test Tally Report, which documented that for January there were 2117 tests done. The supervisor was unable to explain the difference of 680 tests between the two reports. Routine tests are sent to an outside laboratory, and hospital tests and urgent tests are done on-site. The supervisor was not able to provide data for this area during our discussion. We asked for the data to be given to us prior to conclusion of the visit but we did not receive any.

We did not notice any problems with ordering or completion of laboratory tests. However, we noted issues with timely provider review, signing and dating of laboratory and diagnostic tests, and clinical follow-up of abnormal tests.

Health Records

Methodology: We toured the health records unit, interviewed health records staff, reviewed health records staffing and the health records (eUHR) for organization, ease of navigation, legibility and timeliness of scanning health documents into the health record.

Findings: As noted in previous reports, CDCR has migrated statewide from a paper record to an electronic Unit Health Record (eUHR). This has been described in previous reports and will not be duplicated in this report.[73] However, we continue to support the Receiver procuring a true electronic health record, which will dramatically improve communication between health care

[71] In early April 2013 SRNIII Vryhof met with Captain Gamboa of 3B facility to address the matter. This issue was referred to CDW Timothy Perez. SRN III Vryhof met with the facility Captains and the CDW on several occasions but to no avail. Custody held their position regarding no release of Close A, Close B inmates after 2000 to pill line despite the memo dated Aug 24, 2011 Pill Line Policy. In addition CEO Macias requested assistance from other CEOs who had encountered the same obstacle and CNE L. Schaper notified Statewide CNE Karen Rea. Medical leadership was actively discussing the issue with Custody leadership. Meetings continued with custody leadership subsequent to the Plata Expert visit.

[72] During a telephone conversation with nursing leadership following the audit, it was reported that a Health Care Access Team from Sacramento advised the Warden that general population inmates should be brought to the medication window for evening medication administration.

[73] Court Experts San Quentin report. March 2013.

staff, reduce opportunity for medical errors and improve the efficiency of health care service delivery.

At Corcoran we found several problems regarding the management of health records. Our findings are consistent with the OIG Cycle 3 report that scored Access to Health Information at 50%.

We did not find a backlog of health documents to be scanned at the time of our visit. In January 2013, reports showed that it was taking Corcoran staff on average 6.1 days from the date of a patient encounter until it was scanned into the health record, compared to 5.5 days statewide. We note, however, that April 2013 MAPIP studies showed that multiple MARs were not in the eUHR, and follow-up of these findings showed that some MARs were still missing and others were scanned but the average time frame was 4-6 weeks. Our review confirmed issues related to scanning of MARs into the eUHR (See intrasystem Transfer Section).

We also found the following issues:

- Hospitalization and diagnostic reports are not tracked, obtained, and scanned into the eUHR in a timely manner and some not at all.
- Medical providers do not consistently request medical records for care provided at a prior facility important to managing patients.
- There is no system to have medical providers review, date and legibly sign health documents such as diagnostic, specialty services or hospital reports prior to scanning them into the record.
- Health records has no system for tracking documents sent to staff for corrections (e.g., signatures, dates, etc.).
- In the GACH, a medical provider documents progress notes by cutting and pasting from previous notes, documenting the same history and clinical findings even though the patient's condition has changed, thus rendering clinical information inaccurate and unreliable.

Examples of these problems included the following cases:

- A 63-year-old with severe heart disease saw the cardiologist on 5/16/13. The cardiologist recommended adding nitrates, a statin and a lab test to evaluate the severity of the patient's heart failure. The report was printed on 5/17/13 and scanned into the record without being reviewed, signed and dated by a provider. The provider managing the patient did not implement the cardiologist's recommendations.[74]
- A 56-year-old with diabetes, hypertension, and coronary artery disease with heart surgery was sent out the hospital for chest pain on 11/15/12. At the hospital, diagnostic tests showed that he had severe left ventricular function and heart failure. At the time

[74] Intrasystem Transfer/Nursing Sick Call Patient #6.

of our visit in mid-April 2013, a medical provider had not signed and dated these reports as having been reviewed.[75]

- A 56-year-old with hepatitis C infection, gastrointestinal (GI) bleeding and severe anemia was hospitalized on 9/27/12 for GI bleeding. On 10/5/12, a medical provider saw him for follow-up noting that the results of his capsule endoscopy were not in the record. The provider planned to follow-up on these reports but as of June 5, the report was still not in the record.[76]
- A 39-year-old with diabetes and pulmonary coccidioidomycosis had chest CT for follow-up of a pulmonary nodule on 6/10/13. On 6/12/13, an ID consultant requested follow-up of the CT report, but as of 6/23/13 the report was not scanned into the record as having been reviewed by a primary care provider.[77]

Other medical record issues are noted in cases described in the GACH and mortality reviews.

Urgent/Emergent Care

Methodology: We interviewed health care leadership and staff involved in emergency response and toured the Triage and Treatment Area (TTA). We also reviewed 10 records of patients selected from the on-site urgent/emergent and off-site ED/hospitalization tracking log.

Emergency Department/Hospitalizations

Findings: When patients have urgent or emergency problems, prompt evaluation is critical in managing the patient. Delays in evaluation may result in deterioration of the clinical condition and can result in unnecessary hospitalization. For urgent care services, the OIG "addresses the care provided by the institution to inmates before and after they were sent to a community hospital."[78] Corcoran received an OIG score of 85.4% in this area. However, we found this area of care inadequate for reasons detailed below.

We note that CCHCS quality data reports indicate that Corcoran had more than double the days of preventable hospitalization than other prison facilities. Our findings are consistent with this assessment. Corcoran leadership provided us with a presentation at the start of our tour, and in that presentation, they addressed the issue of preventable hospital days. The facility attributes these preventable days to errors of judgment, delayed reports from specialty or hospital care, mental health overflows into medical beds, and inmate non-compliance. However, we were unable to verify inmate non-compliance as a reason for preventable hospital days. Based on our own chart reviews, preventable hospital days resulted primarily from problems with primary care or urgent care evaluations and also from deficiencies in care on the GACH. These and other problems with urgent care and care before and after hospitalization are detailed as follows.

[75] Intrasystem Transfer/Nursing Sick Call Patient #10.
[76] Intrasystem Transfer/Nursing Sick Call Patient #14.
[77] Intrasystem Transfer/Nursing Sick Call Patient #2.
[78] OIG *California State Prison, Corcoran, Medical Inspection Results, Cycle Three*, Executive Summary Table

- One patient was evaluated via a 7362 and was assessed by a nurse as having a swollen thumb which was draining pus. [79] The nurse's plan was to send the patient to the TTA, but the nurse documented that custody was unable to transport the patient to the TTA on an emergency basis. The next day, the patient was transported to the TTA and ultimately admitted to a local hospital for an infected thumb. The nurse evaluation was a routine evaluation but the referral to the TTA was for urgent care. It was delayed and this may have resulted in preventable hospitalization. This problem of urgent care resulted from custody's failure to transport an inmate for evaluation. Custody must not refuse to transport patients when medical staff advises them of the need for an urgent/emergent evaluation.

- Another patient saw a pulmonologist on 7/2/12 for asthma. [80] The consultant noted that during a recent hospitalization for an asthma exacerbation, the patient had an x-ray showing a possible pulmonary infiltrate. The consultant recommended a CT scan. The CT scan was done in about five weeks and showed consolidation in two lobes of the lung. The CT scan was signed as reviewed on 8/8/12. Even though the CT scan results indicated infectious disease and should have been acted on immediately, the patient was not promptly evaluated. The patient eventually had an urgent evaluation on 8/15/12 for breathing problems. The doctor did an x-ray but did not notice the previously positive CT scan results. The x-ray showed a left lower lobe infiltrate and the doctor prescribed antibiotics and prednisone with a 4-day follow up. Two days later, the CT scan results were identified and the patient was admitted to a local hospital. If the patient had been diagnosed earlier, hospitalization might have been prevented. The patient returned from the hospital 8/25/12, but wasn't seen until 8/29/12; when he was seen, the doctor noted that the hospital record was unavailable, so he did not know what had occurred in the hospital. Within six weeks, the patient was admitted to the GACH because his asthma was poorly controlled. The scanned GACH record is on three separate large PDF files that were not in chronological order and were disorganized and extremely difficult to read.

  For this patient, this kind of care continued. Over the period between 7/2/12 until 12/16/12, the patient was seen twice by pulmonary consultants via telemedicine, had two local area hospitalizations, was admitted to the GACH once, was seen in the TTA for exacerbations of asthma five times but was seen only twice in chronic care clinic. The chronic care visits were not of good quality and neither visit contained an adequate history of the patient's asthma. This is a failure of the chronic illness program in managing chronic illness and resulted in episodic management. When the episodes of urgent care are evaluated, each individually appears adequate, but evaluating care before and after hospitalization reveals significantly defective chronic care management resulting in preventable hospitalization.

[79] Hospital Patient #3.
[80] Hospital Patient #5.

- Another patient was seen in clinic urgently for buttock pain.[81] The history and physical examination was very poor and the doctor documented that the eUHR was not available. Almost no physical examination was done, and a muscle sprain was diagnosed. No follow-up occurred. Ten days later, the patient presented urgently for fever and an abscess of his hip with swelling of his leg and hip. The patient gave a history during the urgent care evaluation of having been ill for 2-3 weeks, had a fever, and said that he drained an abscess himself. He had a fever of 103.2°. Blood cultures were done in the TTA and the patient was admitted to the GACH on 12/13/11 for intravenous Vancomycin (an antibiotic used to treat staphylococcal (staph) infections). Vancomycin levels were not ordered (a routine method of monitoring antibiotic therapy). The patient's white blood cell count was high (WBC=23.9 K, normal=<10 K). Blood cultures were positive for penicillin-resistant staph but it was sensitive to oxacillin. The preliminary blood culture results were available on 12/15/11 but were unnoticed for two days while the patient was on the GACH. On 12/16/11, a physician did not see the patient. A physician recognized the positive blood cultures on 12/17/11, but the doctor did not document noticing that the patient had a 101.2° fever the evening before. On 12/18/11, the patient was admitted to a local hospital. Because Corcoran does not have capacity to do evaluations necessary to manage bacteremia with staphylococcus (performance of an echocardiogram), the patient should have been promptly sent to a local hospital.

  The patient spent nine days in the hospital. Upon his return to Corcoran, the patient was seen by a physician on 12/27/11, but from 12/28/11 until 1/2/12, the patient was not seen by a physician and the antibiotics were not monitored. On 12/31/11, the patient had a fever of 100.8°. However, the nurse who recorded the temperature wrote that the patient was afebrile, which is not accurate. The doctor was not notified. 12/31/11 and 1/1/12 were on a Saturday and Sunday and there were no physician notes on these days even though this is a GACH and the patient had an acute illness. On 1/2/12, the patient spiked a fever to 102.8° and his blood pressure was low (BP=94/54 mmHg) with a rapid heart rate (pulse=107 bpm). His creatinine was elevated, indicating decreased kidney function. His antibiotics were held because one of the side effects was kidney damage. The patient was sent back to the local hospital. This was a potentially preventable hospitalization, but the patient's creatinine was not monitored until he developed early renal failure. He remained at the hospital until 1/9/12 and was sent back to the prison on a different antibiotic. Upon return to the prison, the patient remained on the GACH until 3/15/12. A proper initial history and physical may have prevented the first hospitalization, and daily physician visits and attentive nursing care might have prevented the second hospitalization. This patient's hospitalization was in 2012, which resulted in our reviewing this case. We did review elements of care extending into 2011. We note however, that as with other patients reviewed, there were no differences in the overall patterns of care provided in 2011, 2012 or 2013.

[81] Hospital Patient #6.

We noticed on chart reviews that information obtained during offsite hospitalization was not consistently available for clinicians upon return from the hospital. This appears to be a major system problem at this facility and was seen on several chart reviews. The absence of data often resulted in guesses rather than informed clinical decisions.

- One patient was hospitalized for a deep-seated abscess and possible osteomyelitis.[82] Upon return from hospitalization, the patient had a telemedicine infectious disease consultation. At that consultation, the consultant did not have information in the eUHR on whether the patient's staph infection was Methicillin sensitive or resistant. Six weeks later, the patient was seen again by infectious disease and, although sensitivities were available, it was not specified whether culture results were taken intra-operatively or whether they were superficial cultures. This confusion altered antibiotic choices and may have affected care. Although this did not result in a preventable hospitalization, it indicates the type of process problem that exists.

- Another patient[83] had a history of mental illness, hypertension, coronary artery disease and a prior heart valve replacement. Apparently, this was a mechanical mitral valve for which he was receiving Coumadin. The patient was seen for chest pain in the TTA and sent to an outside emergency room. The patient was admitted to a local hospital where a myocardial infarction was diagnosed. His INR upon admission was sub-therapeutic and the hospital suggested that the infarction was due to an embolus from his mitral valve due to inadequate anti-coagulation.

  Upon discharge, the patient spent six days on the GACH because of suicidal thoughts and then was discharged to general population. He only saw a medical doctor on the day of admission even though he had just had a heart attack. A psychiatrist discharged him. Upon discharge to general population, he submitted a 7362 stating that he had missed several days of his anticoagulant. He had just had a myocardial infarction because of sub-therapeutic anti-coagulation. Review of the MAR verified that the patient did not get anti-coagulation upon discharge from the GACH. It took about 2 ½ weeks to obtain a therapeutic INR.

  For multiple visits, physicians documented confusion as to what type of heart valve replacement the patient had and when the valve replacement surgery was. This is important to know because valve failure depends on valve type. Antithrombotic therapy also varies with valve type and valve site. Doctors at the local hospital documented that the patient had a mitral valve replacement. A cardiology consultant via telemedicine documented that the patient had an aortic valve replacement with a pig valve in 2003. A physician at Corcoran noted that the valve was a mechanical aortic valve replaced in June 2011. This confusion was never cleared up in the record. In part, this resulted from

[82] Hospital Patient #4.
[83] Hospital Patient #9.

poor history. In part, it resulted from not obtaining old records and verifying exactly what surgery the patient had.

On 5/17/12, a doctor documented that the patient had three prior positive fecal occult blood tests. A digital rectal examination was not done. For five months, there was no follow up of this abnormal test. On 7/29/12, the patient had syncope and fell and had a large hematoma on his scalp. He was sent to a local hospital for a brain scan. At the hospital, an echocardiogram was done, indicating that the patient had a mechanical mitral valve. However, even after return from the hospital, Corcoran physicians documented that the patient had an aortic valve replacement. Upon return to the facility, the patient did not have a consistently therapeutic INR. At times, it was high and at times it was low. On 10/31/12, the patient reported urgently for nausea, vomiting and dizziness. His blood pressure was 84/40 mmHg and the pulse was 126/bpm. An INR test was done that day and it was 8.4 (INR goal=2.5-3.5) and the hemoglobin was 4.7. These critical laboratory tests were reported 10/31/12 late in the evening but were not acted on until 11/1/12. On 11/1/12, the laboratory tests were noted and the patient was admitted to a local hospital. At the hospital, the patient was diagnosed with gastritis and hemorrhoids. If the positive fecal occult blood tests from May had been investigated, this October hospitalization may have been prevented by treating the source of bleeding before it resulted in extreme anemia. This was a preventable hospitalization caused by failure to communicate a laboratory result and act on it timely.

- Another patient[84] was on the GACH for coccidioidomycosis. The care for this patient on the GACH was sub-standard. Monitoring of the patient was not thorough. In addition to his diagnosis of coccidioidomycosis, he also had a diagnosis of systemic lupus erythematosus (SLE). He had four separate episodes of bacteremia, ostensibly from PICC line infections being used to treat the patient for coccidioidomycosis. Three of these episodes of bacteremia resulted in hospitalization. All were potentially preventable. A medical provider did not see the patient between 10/23/12 and 11/1/12. Patients on a GACH should be seen daily. On 10/31/12, blood cultures were ordered, although no note was present in the eUHR. On 11/1/12, the blood cultures were preliminarily positive for gram-negative organisms. A doctor on call on the GACH prescribed clindamycin and ceftazidime by phone order. To start treatment for bacteremia without seeing the patient is not appropriate. On the same day, a different doctor started Vancomycin. Another doctor on the same day stopped the ceftazidime by verbal order. Oral Levaquin was then started. Later that day a different doctor gave a phone order to hold the Vancomycin. Three days later another physician stopped the clindamycin and Levaquin and started Bactrim for ten days. Later that day another physician wrote an order to discontinue the Bactrim and continue Levaquin for four more days. This bizarre sequence of antibiotic ordering for a very ill patient involved multiple doctors, none of whom documented the reasons for their prescriptions and changes to prescriptions. Many of these order changes occurred without seeing the patient and explaining to the

[84] Hospital Patient #10.

patient what the reason for the antibiotic change was. This epitomizes episodic medicine. During the entire sequence, there was no attempt to establish the source of the bacteremia. About five days later, the Levaquin prescription had run out and shortly thereafter, the patient spiked a fever to 102.6°. A doctor re-ordered Levaquin. About a week after the Levaquin ran out, the patient again spiked a fever and was hospitalized; he had bacteremia with Serratia. The catheter tip from the PICC line grew Serratia.

These examples demonstrate that communication errors affecting patient care, poor chronic care, and significant issues in care management on the GACH are resulting in preventable hospitalization.

Specialty Services/Consultations

Methodology: We interviewed staff involved in the review, approval and tracking of specialty services, OIG and other internal reports and reviewed health care records of 20 patients for whom services were requested.

Findings: There were delays in timeliness of specialty services in four (20%) of the cases we reviewed. This is in contrast to the findings of the OIG's Cycle 3 Inspection Report where they found that 100% of the specialty visits were timely. The cases we found are summarized below. In terms of primary care provider follow-up, we found that 90% of the patients were seen timely after their specialty care visits. This is slightly better than the 83.3% reported by the OIG.

- The patient is a 57-year-old-man. On 9/3/12, prior to his arrival at Corcoran, he had had surgery at a community hospital for a paraspinal abscess. At that time, he was also diagnosed with osteomyelitis (a bone infection) of his spine. On 9/13/12, he was transferred to the CTC at PVSP for completion of a six-week course of intravenous Vancomycin (an antibiotic commonly used to treat staphylococcal infections). He was readmitted to the community hospital on 9/17/12 for severe abdominal distention. He was discharged back to the PVSP CTC on 9/26/12, with an order for three more weeks of Vancomycin and follow-up in one week. Upon admission to the CTC, the physician noted that the cultures from the abscess had been negative for Methicillin-resistant staphylococcus and that the wound culture had been positive for Serratia (another type of bacteria). Despite this, he continued the Vancomycin. (Vancomycin is not used to treat Serratia.) On 10/1/12, the patient was transferred to the GACH at Corcoran because there was a lack of CTC beds at PVSP. The admitting physician ordered Vancomycin for three more weeks. On 10/16/12, the patient saw a neurosurgeon who noted that the patient stated he was doing well. The neurosurgeon's plan was for follow-up in three months or sooner if necessary.

  On 10/17/12, a blood test revealed that the level of Vancomycin was sub-therapeutic. A physician re-ordered the medication at a higher dose for thirty days. On 10/19/12, the level was still low and a physician increased the dose for twenty-one more days. On 11/20/12, a physician ordered a follow-up MRI. The neurosurgeon noted that he would

like the actual films mailed to his office as soon as possible for review so he could determine if the patient needed further surgery. On 12/13/12, the patient saw a neurosurgeon who recommended an MRI with and without contrast. On 12/17/12, the MRI originally ordered on 11/20/12 was done. On 12/28/12, the patient saw the neurosurgeon who again requested an MRI with contrast. The MRI was done on 1/14/13 and revealed that there had not been any improvement in the patient's condition. On 1/15/13, the GACH physician re-started the Vancomycin and ordered an urgent infectious disease consult.

An infectious disease consultant saw the patient via telemedicine on 1/25/13. He noted that another infectious disease consultant had seen the patient on 9/5/12 and had recommended treatment with Vancomycin for a spinal infection that the physician thought was most likely staphylococcal in origin. The consultant on 1/25/13 noted, however, that microbiological data from 9/12/12 indicated the presence of Serratia. He added, "As you are well aware, Vancomycin has no activity against Serratia." He further noted that an MRI on 1/4/13 indicated continued evidence of infection with spread to other areas of the spine. He stated, "My concern is that this patient has not been appropriately treated since September due to the choice of antibacterial therapy. At this time, I would strongly recommend discontinuation of Vancomycin and initiation of ceftriaxone [an antibiotic with activity against Serratia]. Furthermore, I would recommend neurosurgical consultation as the patient may need further surgical intervention…".[85]

Assessment

There were problems related to quality and timeliness of care. A CDCR physician did not adequately review the patient's medical records despite the fact that he was admitted to the CTC at PVSP on two occasions and had been housed in the GACH at Corcoran since 10/1/12. In addition, the MRIs ordered on 11/20/12 and 12/13/12 were not done in a timely manner. They should have been done on an urgent basis given the patient's history of a serious infection.

- The patient is a 34-year-old man with a history of pulmonary cocci in 2006 that was treated with one year of Diflucan. He was admitted to a community hospital on 10/9/12 for back pain. He was diagnosed with osteomyelitis of the spine and started on intravenous antibiotics. The hospital physician obtained a cocci titer that was weakly positive at a dilution of 1:4. The physician ordered Diflucan and noted that the patient should be on it indefinitely for treatment of cocci. On 10/16/12, the patient was transferred back to Corcoran and housed in the GACH for completion of six weeks of intravenous antibiotics. The admitting physician at the GACH noted that the patient had possible cocci and ordered an infectious disease consult. He also repeated the cocci titers and antibody tests. The tests were done, and the interpretation of the results was that there was no change from December 2010. On 11/27/12, the patient was

[85] Specialty Care Patient #11.

discharged to general population with follow-up ordered in 5-7 days. The patient had not seen an infectious disease consultant. The patient did not have follow-up with a primary care provider until 2/19/13. The provider did not address the question of whether the patient should be taking Diflucan. On 3/22/13, a provider submitted a request for infectious disease consultation stating, "Please enlighten if we need to continue the Diflucan indefinitely?" The infectious disease consultant saw the patient on 4/3/13 and noted that the cocci titer remained low and that there was no clinical evidence of relapse or active infection. He recommended stopping the Diflucan and repeating the titer in one month.[86]

Assessment

There were problems related to quality and timeliness of care. The patient did not receive timely or appropriate follow-up care for his cocci or for his osteomyelitis.

- The patient is a 35-year-old man who had nasal surgery on 7/26/12. He was seen for follow-up on 8/27/12. The surgeon noted that the patient was having some nasal obstruction and that his nose hurt when he moved. He also noted that the patient was complaining of numbness in his teeth and pain when chewing. The surgeon ordered a nasal spray and follow-up in one month. The patient was not seen for follow-up until 10/22/12. The surgeon noted that the patient stated that he was having electrical type shocks or pain in his nose and that he also felt that his two upper teeth were numb since the surgery. The surgeon ordered oral prednisone and follow-up in one month. The patient was not seen by a primary care provider for follow-up of this visit. The patient was not seen by the surgeon again until 1/28/13.[87]

  Assessment

  There were problems related to timeliness of care. The patient was not seen for follow-up after his appointment with the surgeon and did not have timely follow-up with the surgeon.

- The patient is a 45-year-old man who had an ultrasound for evaluation of a neck mass on 3/4/13. The ultrasound revealed that the mass was probably a lymph node. The patient was referred to an ENT physician for further evaluation. The ENT physician saw the patient on 3/25/13. The ENT physician recommended a biopsy and follow-up after the biopsy. The patient was not seen by a primary care provider for follow-up of this visit. Furthermore, the patient had not had the biopsy or follow-up as of 5/18/13.[88]

  Assessment

[86] Specialty Care Patient #17
[87] Specialty Care Patient #18
[88] Specialty Care Patient #20

There were problems related to timeliness of care. The patient was not seen by a provider for follow-up of his specialty visit and did not have a timely biopsy or follow-up with the ENT physician.

In addition to issues of timeliness, two of the above cases (the patient who was treated with the wrong antibiotic and the patient who was inappropriately treated with Diflucan) raise concerns about the thoroughness of care by the physicians. The following two cases raise similar concerns.

- The patient is a 54-year-old man who had three positive tests for fecal occult blood and was scheduled for a colonoscopy. He had refused the procedure in January, February and March 2013. There was no documentation that a provider had counseled the patient following any of these refusals.[89]

  Assessment
  There was a problem related to quality of care. Patients need to be counseled when they refuse important clinic visits, specialty consultations, tests or procedures.

- The patient is a 32-year-old man who submitted a health services request on 11/26/12 stating that he had an irregular bump on the side of his testicle. He added that upon self-examination, his testicles seemed asymmetrical. He requested to be tested for testicular cancer. A provider saw him on 12/14/12 and noted that his examination was within normal limits and that there were no masses. He ordered follow-up in 3-5 months. On 3/19/13, the patient submitted another healthcare services request stating that he was having a dull throbbing pain in his pelvic and testicular areas. He added that he was concerned that something was "out of the ordinary down there." The patient saw a provider that day, who noted that his testicle was enlarged and painful. The provider arranged for a urologist to see the patient the next day. The urologist saw the patient on 3/20/13. His assessment was that the patient possibly had testicular cancer and he scheduled the patient for surgery. On 4/15/3 an ultrasound was highly suspicious for neoplasm. On 5/28/13 the patient underwent left orchiectomy; pathology reports show a seminoma, a form of testicular cancer.[90]

  Assessment
  There was a problem related to timeliness and quality of care. There was a significant delay in the evaluation of the patient's testicular cancer.

[89] Specialty Care Patient #6.
[90] Specialty Care Patient #16.

General Acute Care Hospital (GACH) and Outpatient Housing Unit Care (OHU)

Methodology: We toured the GACH and OHU, interviewed health care and custody staff, and reviewed tracking logs and 10 patient health records.

Findings: Corcoran has both a GACH and an OHU. The GACH and the OHU are located in the same area. The GACH is on A and B units. The A unit has 24 beds separated into three corridors. The B unit has 26 beds separated into three corridors. All three units terminate in a central nursing station. The C unit is a 24-bed mental health unit with the same physical arrangements as the A and B units. The OHU is the D unit which is a 20-bed unit also with three corridors terminating in a central nursing station. The GACH, according to the information provided to us by the medical leadership, "has been providing 'step-down' services for all institutions to reduce Administrative Day costs in community hospitals."[91] As well, the GACH and OHU are used for housing patients who eventually will be sent to the new Stockton facility.

In evaluating patient charts, it appears that the GACH is not being used as an acute general hospital. It functions mostly as a Correctional Treatment Center (CTC). On the day of our visit, the GACH B unit had one empty bed and the A unit was filled. Seven of the 49 patients were on the unit for long-term treatment of disseminated cocci. Six patients had serious open wounds. Most of the patients on all units were chronically ill. Notably, three patients on the unit had recent PICC line infections. The OHU was completely filled. Patients on the OHU were mostly CTC type patients with disabling disorders. Few of these individuals would be able to provide the self-care required of OHU patients. Almost all of these patients will be transferred to the Stockton facility when it opens. Their disabling disorders include dementia, post-stroke, and end stages of various diseases.

Custody staffing on these units is inadequate and prevents medical staff from gaining access to patients as required for their physician ordered care. The lack of access may be one reason why many hospital-acquired infections are occurring. We were told that there were two officers on the third watch, three officers on the second watch and one officer on the first watch per hospital unit of 24-26 beds. On every watch, there are three RNs and two LVNs per unit. It is a rule that for any SHU or administrative segregation inmate, there must be two officers present to open the door and monitor the patient during any health care encounter. Staff estimated that 40% of inmates are SHU or administrative segregation. Given the amount of care that has to be provided, this number of officers is not able to provide sufficient staff access to the patients. At any one time, there may be as many as seven medical staff (five nursing, physician, physical therapist) but only two officers. As a result, necessary care is either delayed or not provided. Nursing leadership reported that they have proposed modifications to the GACH policy similar to those found at CMC, but to date no changes have been made that would increase access to patients.

[91] Health Care Services CSP-Corcoran; April 16, 2013 Powerpoint slideshow presented by Corcoran healthcare leadership team.

For example, on the A unit there are four patients with dementia or who otherwise require total care, 12 patients on intravenous antibiotics, and six patients who need serious attention to wounds or feeding. On second watch, there are five nursing staff, a physician and occasionally a physical therapist to care for these patients but only three officers to open the doors. If one of the patients is a SHU or administrative segregation inmate, both officers need to be present during the entire nursing or physician encounter regardless of the physical condition of the patient. In addition to nursing care, inmates are fed and are permitted a shower. Even though this unit is a hospital and patients have intravenous catheters and draining wounds, showers are permitted only twice a week. When showers occur, the officers are occupied in letting the inmates out of their rooms one by one to shower. For meals, officers participate in feeding inmates. Given the time it takes for showers and meals, officer are probably available to nurses about 6.5 hours a day; and, in practice, the availability is less than this since two officers are required to be present with SHU patients. For seven clinical staff this means that each clinical staff can have access to inmates less than three hours a day at best. For this reason, on the day of our visit, most nurses remained in the nursing station, not occupied in patient care activities. Based on our observations, it does not appear that nurses are adequately managing the patients' needs. This is especially problematic for those patients who require total care.

For example, one patient[92] was bedridden from severe late stage Huntington's chorea. He can no longer swallow and is at risk for aspiration. He cannot speak except in guttural tones yet he is documented as occasionally refusing vitals. He is a long time boarder and vitals are ordered three times daily. The need for vitals at this frequency is not clear and is probably unnecessary. The last physician note was a month prior to our visit. One of our monitoring team was on the unit from 11 A.M. until 4 P.M. and did not see a nurse enter his room. The patient needs assistance with his ADLs, including eating and getting to the toilet. Other than nurse feedings and toilet activity, the patient remains in bed continuously. This patient needs more human contact and should be engaged in some programming rather than having to lie in bed all day because of lack of staff/access.

The lack of access to inmates is evident in the failure of nursing staff to complete physician-ordered assignments. On multiple chart reviews, inmates had physician-ordered vital signs performed only about 40-50% of the time. Vital signs are almost never performed on the first watch when there is only one officer. This lack of performing vital signs is ascribed to patient refusals. These refusals seldom have patient-signed refusals. Refusals also occur for patients with dementia or other disorders which one would expect could not result in a refusal. For an acute care hospital, the degree of refusals of basic nursing tasks is unacceptable. This issue has not been raised in the quality improvement committee. Nursing notes are also not good. For example, patients on Amphotericin infusion may complain of rigors and shaking chills with the infusion or may have signs of phlebitis. When this occurs, these and other symptoms are often treated with medications including steroids. It is recommended that these medications be titrated to the symptoms the patient is having. However, on this unit, patients were given

[92] GACH Patient #8.

routine doses of these medications and, in many cases, we were unable to find documentation in the medical records that a nurse asked a patient about symptoms during the infusion. This culture of not engaging the patient may have developed in part as a result of lack of access to patients. This is detrimental to patient care.

Another aspect reflecting poor care on this unit is the management of health care associated infections. These infections may be related to lack of adequate nursing care, sanitation, and hygiene. Over the past year the supervising nurse of the GACH and the two infection control nurses have been attempting to institute hospital based infection control practices on the GACH unit. This has been made difficult because the two infection control nurses assigned to the hospital are public health nurses and have no specific training in hospital infection control. For this reason, they attended a 2 day surveillance reporting course and have been self-training on hospital infection control surveillance reporting so they can be consistent with Centers for Disease Control (CDC) and the National Healthcare Safety Network (NHSN) surveillance criteria.[93] Additionally, there is no central office guidance on hospital-based infection control. The manner of tracking data is not consistent or standardized and there has been no input from physician leadership or an expert in hospital infection control.

As an example, we reviewed a log of positive culture results for the institution provided to us by the infection control nurse. This log does not indicate if a patient has a reportable healthcare associated infection. It appears from the log that over a 5½ month period, there have been 13 episodes of either bacteremia or PICC line infection, almost 2.4 a month. These are serious life-threatening infections. However, the log does not classify the infection according to CDC/NHSN criteria; nurses keep this information in a separate folder. Also the log does not track infections diagnosed presumptively without a culture result.

Summary information on infections, including reportable healthcare associated (nosocomial) infections on the GACH unit is reported in a monthly Infection Control Report which is an official report of the infection control nurses. This monthly report is submitted to the Medical Subcommittee. To assess the validity of the report and data on the log we reviewed every positive culture entry on the log for the month of December in comparison with the Infection Control Report for December with an infection control nurse in an extensive interview. While reviewing the log the nurse told us that 4 blood stream infections (bacteremia) and one soft tissue infection of an arm listed on the log in December were nosocomial.[94] However, the actual December 2012 Infection Control Report lists only 3 nosocomial infections identified through cultures (there were 3 additional nosocomial infections due to empiric diagnoses). The number of cultures listed on the log did not correspond to reported nosocomial infections in the Infection Control Report of December 2012. The supervising nurse and the infection

[93] Horan TC, Andrus M, Dudeck MA; CDC/NHSN surveillance definition of health care-associated infection and criteria for specific types of infections in the acute care setting; American Journal of Infection Control 2008; 36: 309-32

[94] Nosocomial infections is an older term which has been supplanted by the term healthcare associated infections. Both terms refer to infections that are acquired in a health care setting and as a result of being in the healthcare setting. The Corcoran Infection Control Reports continue to use the term nosocomial to define these infections.

control nurses admit that infections are not always appropriately classified. The system of identification, classification and reporting of infections on the unit must be standardized.

Infection control efforts related to infections on the GACH are largely led by the supervising nurse on the GACH and the two infection control nurses but should include physician, environmental custodial staff, custody leadership and medical management input. There is no evidence of physician, custodial staff, or management involvement in this effort.

Custody staff controls access of nurses to patients and access of environmental custodial staff to patient rooms for cleaning. In addition, the frequency of showers is not determined by medical staff based on hygiene needs of the patients but is regulated by the availability of officers to transport inmates to the single shower on each unit. Because of the numbers of individuals with infections and draining wounds, it makes sense to increase the opportunities for inmates to be able to wash. The fact that inmates are only permitted to shower twice a week also affects hygiene on the unit. Custodians do not clean inmate rooms except when the inmate goes to the shower, so inmate rooms are not sanitized except twice a week on shower days. This may promote transmission of infection and may be contributing to the number of infections on the unit. The lack of hygiene on the unit is evident in cultures of the ice machine. The ice machine is regularly cultured as part of hospital regulations. Over the 5½ month period of data we were provided, ice machines on one or the other of the hospital wards grew bacteria or yeast on five occasions. When this happens, the machine is decommissioned and cleaned.

These issues of nurses' poor access to patients, of patients' insufficient access to showers, and of custodians' inability to adequately clean inmate rooms demonstrate a degree of custody control of the unit such that hospital functions cannot take place as needed. If custody cannot accommodate the medical needs of the hospital, the hospital should close. We did not get a sense from medical leadership or from Quality Improvement studies that these custody issues on the GACH unit have been communicated to custody. This demonstrates a lack of leadership on the part of the medical program.

Several other examples illustrate the inadequate care on this unit.

One patient[95] on the GACH had hemoptysis for several years at KVSP and ultimately was diagnosed with coccidioidomycosis in April of 2012. It appeared that diagnosis of his coccidioidomycosis was significantly delayed. After diagnosis with coalescing coccidioidomycosis, pulmonary cavities and involvement of his orbital bone, he was transferred to Corcoran's GACH on 5/8/12 for long-term Amphotericin infusions. Staff documented that he refused to have his vital signs taken 45% of the time but he never signed the refusals. During the infusions of Amphotericin, nurses did not document assessment of symptoms related to the Amphotericin infusions. Instead, they gave PRN (as needed) Demerol as a routine medication. Twice this medication was given because of fear of symptoms. Glucocorticoids were also used routinely with Amphotericin without assessment of symptoms. On 7/16/12, he developed

[95] GACH Patient #1

bacteremia from a PICC line infection and was admitted to a local hospital. This was a potentially preventable hospitalization. After return to the facility, the pattern of not performing vitals and not assessing for symptoms during infusions continued. As well, physician notes after the patient returned from the hospital were almost all cut and pasted and identical except occasionally for a modified assessment or plan. On 8/27/12, the PICC line was removed because a physician thought that the Amphotericin dose was complete. However, the patient actually needed a few more weeks of Amphotericin. A peripheral IV was started, but the physician continued to document in five subsequent notes the same cut and pasted physical examination stating that the "PICC line is clean dry, intact, no redness, warmth or tenderness." This underscores the lack of attention of the physician to the history and physical examination of the patient which was ongoing during the entire GACH stay of two months.

Another patient[96] developed an abscess at RJD after removal of orthopedic hardware in his leg. He was sent to Corcoran to complete his antibiotics. The patient was on the unit for about a month when the doctor ordered the wound VAC removed. On 6/25/12, the patient was lethargic. Instead of documenting a history and physical examination, the doctor wrote, "pt is lethargic refer to psychiatry." There was no examination. The patient was seen 6/26/12 and 6/27/12, but the notes were brief and did not include an adequate neurologic examination. On 6/29/12, the patient had a critically low white count of 1.9 but was not evaluated. On 6/30/12, which was a Saturday, a nurse documented that the patient was confused and disoriented; no physician referral occurred and the patient was not evaluated. Even though it was a weekend, because this is a hospital, physicians should be available continuously. On 7/1/12, a Sunday, a nurse documented again that the patient was confused and disoriented; again, no physician evaluation occurred. On 7/2/12, the patient spiked a fever to 101.2°. The doctor noted pain in the arm where the PICC line was. The line was removed and blood cultures were drawn. The patient was sent to a hospital where Klebsiella bacteremia was diagnosed.

Upon return from the hospital on 7/23/12, a physician saw the patient but the records from the hospital were not available. The patient was not seen again until 7/29/12. Subsequent physician notes were all copied and pasted and identical, with minor modifications to the plan. At times, these notes did not make sense. On one note 8/27/12, the doctor copied and pasted the words "Denies increase drainage from wound site, pain, redness." Yet in the assessment, the doctor wrote that the skin graft had failed and there was greenish drainage from the wound. These contradictory statements represent extremely poor documentation of clinical care. Also, this patient refused vitals 54% of the time and nursing notes seldom included an evaluation of the wound. Nurses frequently documented that the patient refused evaluation. Neither nurses nor doctors documented a reason for consistent refusals of vital signs or evaluations. Because the doctor's physical examinations were all copied and pasted, all physical examinations were identical for 2½ months. The wound was described identically over this 2½-month period of time and there was almost no nursing documentation of wound assessment. For the patient's entire GACH stay, it was therefore not possible to determine the progress of the wound.

[96] GACH Patient #2.

Another patient[97] was transferred from RJ Donovan (RJD) to Corcoran on 10/10/12. He had had a stroke in 2011. The initial nurse assessment at Corcoran documented expressive and receptive aphasia[98] and documented that RJD staff had recommended audiology and speech therapy. The first chronic visit was scheduled for 10/29/12, almost three weeks after transfer. This visit was subsequently cancelled because of provider reassignment. On 10/26/12, the patient was evaluated by a psychologist who documented a prior assessment performed at RJD on 9/24/12, indicating that the patient had cognitive impairments due to his prior stroke resulting in dementia. A single cell placement was recommended because of victimization concerns. The patient was admitted to the GACH in a mental health bed. Another note documented that the patient was referred due to custody and medical staff saying that he was not eating and showering without prompts. He was described as confused, nonsensical, and unable to identify his age or what year it was. When mental health staff asked the physician to evaluate the patient and include an EKG, the doctor documented that the patient denied any problems and wrote that there was no medical indication for an EKG unless mental health wanted a baseline. He then documented a normal neurological examination and concluded that the patient could return to general population. He gave mental health a list of tests to perform if they wanted a dementia work up. This was an irresponsible way to respond to a professional colleague's request for consultation. The patient remained on the GACH. It was documented that he refused almost all vital signs and assessments even though the patient had expressive, receptive aphasia and may have had dementia. Vital signs were performed three times during the month and on two occasions the blood pressure was elevated but not brought to the attention of a physician. A psychiatrist attempted to get the patient committed to a long-term mental health facility but the request was denied on the basis that the patient belonged in a medical facility.

The patient was ultimately transferred to the medical service on the GACH where speech and receptive aphasia were acknowledged; the doctor documented that the patient was developmentally disabled. The patient was seen several times in December 2012, but all notes were copied and pasted and identical except for different blood pressures. Pulse, respiratory rate and temperature were identical for three consecutive physician notes. Ultimately, the patient was transferred to CSP-SAC. He was diagnosed with severe dementia and was placed in the OHU secondary to "his IQ level." The patient never received brain imaging, nor did he receive occupational or speech therapy. Care for this patient was not professional, respectful or appropriate.

Another patient[99] was on the unit for recurrent coccidioidomycosis and had a PICC line to receive Amphotericin. His vitals were refused about half the time they were to be taken. On 4/8/13, he developed fever. Blood cultures were ordered and levofloxacin and Vancomycin were ordered. Later that day another doctor discontinued the PICC line. Nurses had a difficult time getting a peripheral IV. The line site was changed once because the site was reddened. The patient pulled the line out later that evening. Another line was started in the morning. On

[97] GACH Patient #5.
[98] The inability to communicate and understand.
[99] GACH Patient #6 .

4/11/13, Vancomycin was stopped and oxacillin was started, but there was no documented note by the physician explaining the rationale for the change in antibiotics. Later the same day, the oxacillin was stopped and clindamycin was started; again, there was no documented explanation. The following day, the doctor documented that the patient was refusing an IV so oral clindamycin was being used. The uninformed changes of antibiotics are problematic, as this practice can lead to resistance.

In summary, care on the hospital unit was below the standard of care because the physicians changed antibiotics without documenting a clinical rationale. Custody rules dominate the culture on this unit and medically ordered evaluations are not being carried out. Rates of refusals are significant and appear not to be related to actual patient refusals. Many adverse events (bacteremia) are occurring at rates higher than should be expected. It does not appear that severely disabled patients receive nursing services that are needed. The unit is not sanitized consistent with hospital sanitation. Patients do not have access to showers on a daily basis. Physician documentation utilized a cut and paste method which demonstrated a lack of concordance between documentation and the condition of the patient. Leadership did not identify these issues as problems and there was no plan of action for any of these items except for a nurse driven list of goals for reducing infections.

Corcoran does have a Quality Improvement Care Team for the GACH that meets twice a month to evaluate various patient care items. However, hygiene, failure to obtain vital signs, lack of access to patients, and PICC line infections were not items of discussion. The GACH Nursing Quality Improvement includes infection control in its areas of concern but for this item, it only monitors hand-washing compliance. We noted that in April and May 2013 none of the staff were observed to wash their hands prior to patient contact, but despite the frequency of nosocomial infections, this has not been noted as a problem or addressed in infection control or quality improvement meeting minutes.

Mortality Review

Methodology: We reviewed the CCHCS mortality reviews of the 23 deaths and performed record reviews for three patient deaths.

Findings: There were 23 deaths in calendar year 2012. The causes of death were mostly related to end-stage disease consistent with the use of the Corcoran GACH and OHU as long-term care placement units. We reviewed care for three deaths. All three of the deaths demonstrated significant problems with the intrasystem transfer process. In none of these deaths did the CCHCS mortality review conclude that there was a problem with the transfer process. Two of these deaths involved failure to inform the receiving institution of the patient's prescribed medication. For one patient, failure to provide that medication probably resulted in his death. In the other patient, failure to provide medication resulted in hospitalization and may have contributed to death. In the third death, the transfer of the patient was ill advised, in our opinion, because care the patient needed was not able to be provided at Corcoran and this may

have contributed to his death. We also note that Corcoran scored 100% for inmate transfers in the OIG Cycle 3 report. The question asked by the OIG for this item is:

> Focuses on inmates pending transfer to determine whether the sending institution documented medication and medical conditions to assist the receiving institution in providing continuity of care.[100]

The sending and receiving institutions failed to accomplish this in all three of these deaths. So while the OIG score was 100%, we found three patient deaths related to defective intrasystem transfers. Also, in these cases we found that the CCHCS mortality reviewers did not include as systemic problems those that involved Central Office, specifically utilization management, which plays a significant role in these transfers. CCHCS utilization management, in attempting to reduce hospital days, will arrange for transfer of inmates from hospitals to any open bed at a higher level of care facility. We have noticed that these transfers often occur with no information being provided to the CDCR facility receiving the patient. The 7371 form is not completely or correctly filled out because the patient is coming from the hospital, not the sending facility, and the sending facility may not know what medications the hospital physician prescribed at the time of discharge. Also, CCHCS utilization management does not ensure that needed specialty care follow-up appointments are arranged but expects the facility to arrange for this. In a number of cases this did not occur and the failure to do so contributed to the deaths of the patients. We continue to recommend that CCHCS review this process.

One death reviewed was a patient who was housed at Wasco State Prison (WSP).[101] He had diabetes, three prior cardiac stents, disease in two other coronary arteries, hypertension, hiatal hernia, esophageal strictures requiring dilation, and epilepsy. His diabetes was very poorly managed at WSP. He had five TTA visits and a hospitalization for poorly controlled diabetes before he had his first chronic clinic visit at WSP. The patient had episodes of confusion but had a normal CT scan. The reason for his intermittent confusion was not determined and the patient continued to have episodes of confusion. Ultimately, he was housed on the CTC unit where his diabetes continued to be ineffectively managed. Almost all of his physician notes were cut and pasted and are nearly identical except for some differing lab values. Because of the cut and paste notes, neither the history nor physical examination was meaningful. Because of the episodes of confusion, a neurology consultation was ordered but the neurologist could not identify a reason for the confusion. A referral was made to mental health. While at Wasco, the patient had nearly continuous intermittent nausea and vomiting. An EGD showed a hiatal hernia and chronic reflux with scar tissue at the gastroesophageal (GE) junction sufficient to require dilation.

At WSP, the patient was ultimately cleared for discharge from the CTC to general population but was transferred to Corcoran upon discharge from the CTC. How this happened is not evident from the record. It appears from the eUHR that the discharging physician documented

[100] OIG, California State Prison, COR; Medical Inspection Results Cycle 3, December 2012.
[101] Mortality Review Patient #1.

that the patient was on glargine insulin on his discharge note but he failed to renew the patient's glargine insulin on the prescription medication reconciliation form. When the patient arrived at Corcoran, he was not placed on glargine insulin. Corcoran staff might have identified the problem if they had the WSP CTC record in the eUHR, but these documents are paper and are not scanned until the CTC stay is complete. Since the patient's CTC stay was long, this was an extensive document. The CTC stay was contained in three separate PDF files containing 382 pages. An electronic medical record would have eliminated this error. Also, the problem of intermittent confusion and chronic gastric reflux were not noted when the patient arrived at Corcoran. The discharge note from WSP was not thorough and was based on cut and pasted notes that did not accurately describe the history of the patient's illness or its complicated course. The 7371 transfer note was also poor quality. It was not signed by Corcoran staff. It documented that the patient had an adjustment disorder and needed mental health follow up. It did not mention his significant medical problems. In effect, the providers at Corcoran had very little meaningful information regarding this patient and were not aware of his medical history.

After arrival at Corcoran, the patient was sent to general population. The patient's history of confusion was not noted and it is not clear what his mental status was and how it might have affected his decision-making capacity. Two days after arrival, the patient was seen in the TTA for chest pain. His oxygen saturation was low (87%). The patient was hospitalized. His blood sugar was very elevated (564 mg/dL). The patient returned to the facility from the hospital in three days. Myocardial infarction had been excluded and the patient was diagnosed with dehydration and elevated blood sugar. Providers at Corcoran did not evaluate his insulin regimen after return from the hospital even though he had just had extremely high blood sugar and dehydration. The patient was returned to general population housing still only on small doses of regular insulin. The day after return from the hospital, a nurse documented a blood sugar of 523 mg/dL. Additional regular insulin was given by a physician phone order. The patient was not referred to a physician. Regular insulin was refused on 10/2/12 and 10/3/12. There was no notification to a physician and there was no evaluation of his mental status. The following day the patient was found unresponsive. He was sent to a hospital where his blood sugar was 1087 mg/dL. The patient died in the intensive care unit the following day. This was a preventable death because, through a mistake, the patient failed to receive his glargine insulin, and he did not receive appropriate care for his diabetes at Corcoran.

The mortality review identified multiple clinical care issues including sending him to the wrong level of housing and nurses not referring the patient to a provider after refusing insulin. However, they did not identify that the glargine insulin was not renewed. They did not identify the problems with the intrasystem transfer process which permitted an unstable patient to be transferred and which resulted in the patient arriving on the wrong insulin dose and without medical information. They did not identify the failure of Corcoran staff to review the insulin orders after the patient was hospitalized with an extremely high blood sugar. They determined that this death was not preventable. We believe it was preventable. Problems we identified include a defective paper record system which may have resulted in this patient's death, a defective intrasystem transfer process which does not ensure continuity of medications, failure

to reassess the patient appropriately after his first hospitalization at Corcoran and failure to address refusals of insulin appropriately. There were also many problems with clinical care at WSP.

The second patient[102] had end-stage cirrhosis from hepatitis C, hypertension, coronary artery disease and knee prosthesis. His prosthetic knee became infected while he was housed at California Treatment Facility (CTF). This was treated at UCSF by operative debridement only. Typically, knee joints that become infected are removed and replaced either immediately or during a later surgery. In this case, we can only assume that this was not done because the patient was an extremely poor surgical candidate and might not have survived an extensive surgery. Despite having a complicated disease at end-stage and a serious infection, the patient was transferred to the Corcoran GACH, presumably by utilization management. Identification of a follow-up orthopedic consultant was not identified or arranged for prior to transfer.

The patient arrived at Corcoran on 4/25/12. On 5/7/12, he was transferred to a hospital for exacerbation of his knee infection. Of note, on 5/5/12 and 5/6/12, which were a Saturday and Sunday, a physician on the GACH at Corcoran did not see the patient. At the local area hospital, a physician was noted to say that the patient should be sent back to the hospital where he was operated on. The patient was returned to Corcoran on 5/11/12, and the next day was sent to another local hospital because of the knee infection. He remained hospitalized for two days. An acute gastrointestinal bleed was treated but, according to the mortality review, the infected knee apparently was not addressed. The patient returned to Corcoran on 5/14/12. An appointment with UCSF was secured, but on 5/18/12, when the patient's appointment was scheduled, a custody van was not operable and custody failed to transport the patient. An ambulance was not called. The patient's condition did not improve. Between 5/21/12 and 5/25/12, the patient's renal function deteriorated but the physicians did not document the progressive doubling of the creatinine level from 1.5 on 5/21/12 to 3.3 on 5/25/12. On 5/25/12 and 5/26/12, a provider did not examine the patient. On 5/27/12, the patient was confused and his Lactulose was increased. The following day, the patient was sent to a local hospital where he died with a diagnosis of septic shock.

We agree with most of the problems the CCHCS mortality review identified. Notably, they did cite a physician on 5/25/12 for having signed off on the creatinine of 3.3 but taking no action. They also cited the physician on 5/27/12 for not more aggressively managing a confused patient with deteriorating renal function. The mortality review did address the lack of transportation to a critical appointment but did not make suggestions. This is a serious issue and it is not clear how this problem will be followed up.

The mortality review did not address failure of physicians to examine the patient on the GACH on several occasions between 4/25/12 and 5/28/12. The lack of physician evaluation on the GACH is something we identified earlier in this report as possibly caused by a lack of access to patients on this unit. Most importantly, the mortality review did not identify how the

[102] Mortality Review Patient #2.

utilization process allowed this very ill patient to be sent to a facility without having secured the necessary follow-up consultation. Apparently, it is assumed that because of existing contracts, utilization is able to move patients to any facility where they have a contract and specialists will see the patient. In fact, this may not always be the prudent approach and this case demonstrates that. Transfer of clinically ill patients should include high-level physician review and acceptance by a consultant physician before the transfer. We believe this patient should have remained at CTF or a facility nearby so that appointments could have continued at UCSF. This calls for clinical expertise but it is not clear whether utilization decisions are made by higher-level clinicians.

The third mortality chart reviewed[103] involved a patient who was at Avenal State Prison (ASP) when he suffered a stroke. He was admitted directly to the ICU at Delano Regional Medical Center. During the hospitalization, the patient became hypotensive and was placed on a ventilator. He spent nine days in the ICU. A tracheostomy was necessary but was eventually removed. The patient needed speech therapy intervention to help him swallow. He was able to take small amounts of food by mouth but continued to have a PEG tube for feeding. The patient was discovered to have severe cardiomyopathy and had atrial flutter with a 3:1 block alternating with atrial fibrillation. On 9/21/11, the patient was transferred to a long-term care facility where he remained for almost four months until 1/13/12. The doctor at the long-term care facility wrote that he was told to discharge the patient and he talked to a doctor at ASP about arrangements for taking the patient back to the prison. Apparently, this was arranged by utilization management. The patient's prognosis was listed as guarded. The patient had seven major diagnoses and was on 16 different medications.

Instead of returning to ASP, the patient was sent to Corcoran. The 7371 transfer summary from ASP included only his pre-hospital diagnoses, which were four months old. Also, the 7371 mentioned that the receiving facility should check the Delano Hospital medication list. However, no list accompanied the patient to the facility.

Upon arrival, the admitting physician had no information on this patient and in his admission note he wrote:

> "A 63-year-old man who suffered a right-sided stroke in September 2011. Apparently, he was found unconscious, from what I can tell. He was taken to Delano Regional Medical Center where he was treated. I am handicapped by not having a History and Physical, a discharge summary, and I have not spoken to the attending physician. The attending physician was supposed to call me, but did not. I do have some notes and I have a whole bunch of medications, but I am not sure what he is taking…. On the record, they said he has congestive cardiomyopathy, however, there is no evidence of that and I do not see anything from his electronic unit health record (eUHR) when he was at a previous prison. He does have diabetes. He has been on Lantus. I do not have a

[103] Mortality Review Patient #3.

hemoglobin A1C. He has had a below the knee amputation of his right leg he says in the past from diabetes."

Importantly, the diagnosis of cardiomyopathy was documented in a different note by a physician as history "of cardiomyopathy without evidence." The patient was on 16 different medications at the long-term care facility but was only started on four medications upon arrival at Corcoran. The dose of warfarin at the long-term care facility was 1 mg of warfarin on Friday, Sunday and Wednesday and 2 mg of warfarin on Monday, Saturday and Thursday. This totals 9 mg a week or approximately 1.3 mg a day on average. Significantly, over the next two weeks no one from Corcoran's clinical staff attempted to contact the long-care facility to obtain the patient's medical information. As a result, the patient remained off his medication for heart failure. The dosages of his anticoagulant were incorrect also. These errors had clinical ramifications. The patient did not maintain a consistent therapeutic level of anticoagulation. More importantly, his heart failure was not treated and within two weeks the patient was in heart failure and needed to be hospitalized. This hospitalization was not mentioned as preventable by the mortality review.

At the long-term care hospital, they had established the status of his heart failure, but when the patient was re-hospitalized after coming to Corcoran, the hospital repeated many of the tests including cardiac catheterization, exposing the patient to unnecessary testing that put him at risk. The patient also received an implanted pacemaker. The patient was placed back on many of the medications he should have been on when he first came to Corcoran two weeks earlier.

Upon return to Corcoran, the patient had normal blood pressure. He returned on a Thursday night about 10:30 in the evening. Notably, the patient was started on 3 mg of warfarin upon return from the hospital, which was a 50% higher dose than the patient had needed to be therapeutic at the long-term care facility. Inexplicably, a physician at Corcoran increased the dose to 5 mg a day, which was 2 ½ times the dose the patient required for a therapeutic level at the long-term care facility. The doctor who did this did not document a reason, although he did note that the INR at the hospital was 1.7, which is sub-therapeutic. Additionally, the hospital re-started many of the medications that the patient had been on at the long-term care facility. Providers did not consider the effects these other drugs might have on the warfarin the patient was using for anticoagulation. One of the drugs, Amiodarone, carries a warning to use caution when initiating Amiodarone in patients on warfarin because cases of increased INR with or without bleeding have occurred in patients treated with warfarin. It calls for monitoring the INR closely after initiating Amiodarone in patients on warfarin. At the long-term care facility, the patient was on Amiodarone and his dose of warfarin was less than half the 5 mg dose he was on at Corcoran. Additionally, other drugs the patient was on including aspirin and omeprazole may also increase the INR or bleeding tendency in patients on warfarin. Thus, the patient was on three medications known to increase the anticoagulation effect of warfarin and he had his dose doubled from a dose known to produce a therapeutic INR at the long-term care facility.

On Saturday, two days after his return from the hospital, the patient's blood pressure was extremely low (BP=64/22 mmHg) and his urine output was extremely low. Without ordering

any laboratory testing to assess his hydration status, the doctor concluded, "this is probably end of life event. Death is imminent." Nothing was done for the patient. Even though the patient had signed a POLST that he did not want extreme measures performed, he did want ordinary medical care and the doctor did not even attempt to determine whether the patient would have improved with simple intravenous fluid. Nothing further was done, and the next day, the patient was in shock with a blood pressure of 55 systolic and no diastolic blood pressure. The staff could not start an intravenous catheter and the patient was transferred to the hospital. This patient should have had a more thorough evaluation as to why he was hypotensive.

At the hospital, the patient was discovered to have extremely low hemoglobin. It had been 14.1 at Corcoran on 2/3/12, but was 7.2 at the hospital. The patient was discovered to have had a massive retroperitoneal bleed. The initial INR at the hospital was 3.1 but it is not clear what it might have been when the bleed started and it was uncertain when the INR was taken relative to medication administration. Medication administration records were not in the eUHR. Warfarin was stopped and fresh frozen plasma was started. The patient died the following day of septic shock.

The initial and final mortality review found no departures from the standard of care by medical providers. The review identified that the patient's directives for end of life care resulted in unnecessary hospitalization. However, the POLST on record signed on 2/2/12 indicated that the patient wanted limited additional interventions. Included in this category was medical treatment, antibiotics, IV fluid, and non-invasive airway pressure. It indicates general avoidance of intensive care units. However, there were many medical interventions, including simple intravenous fluids, that may have helped this patient when he was initially hypotensive, (BP=64/22 mmHg). The mortality review did not mention the lack of transfer of the records to Corcoran, the failure to provide the patient with continuous critical medication from the nursing home, or the preventable hospitalization for heart failure. It was also not critical of cessation of care when the patient's blood pressure was 64/22 mmHg. These were all serious problems that should have been recognized. The mortality review recognized no systemic problems. We found significant problems with the intrasystem transfer process, failure to obtain necessary medical information from outside providers, failure to provide continuity of medication, failure to intervene appropriately for a distressed patient and failure to evaluate potential drug-drug interactions for a critical medication. Most serious of these problems, in our opinion, is the intrasystem transfer process which, if performed well, might have prevented this patient's death.

Internal Monitoring and Quality Improvement Activities

Methodology: We reviewed the Corcoran OIG report, facility Primary Care Assessment Tool, Performance Improvement Work Plan (PIWP), and internal monitoring and quality improvement meeting minutes for the past four months.

Findings: We find that although many meetings related to internal monitoring and quality improvement activities are occurring, they are lacking in focused problem identification,

developing a plan to study and identify root causes, and then developing and implementing strategies to correct root causes. After the corrective strategy has been implemented, the problem should be reevaluated to see if it has been corrected.

We reviewed Quality Improvement Meeting Minutes from 1/28/13 to 5/20/13. The minutes contain health care utilization data, but there is no discussion as to its significance. Many topics are briefly noted, but documentation of discussion is limited. If issues noted in QM meeting minutes were effectively described and addressed in subcommittee reports, it would at least provide documentation to support processes intended to improve services, but this is not the case.

As an example, infection control reports list nosocomial, or healthcare associated infections that occur in the GACH but there is no discussion of possible causes and how the infections can be reduced. We note with concern that staff hand washing observation studies in April and May 2013 showed that no staff was observed to wash their hands prior to patient contact, yet there is no discussion of these findings in infection control reports or Quality Management Meeting Minutes.

Review of Emergency Medical Response Review Committee Meeting minutes from 11/1/12 to 2/14/13 showed minimal documentation related to urgent events with no meaningful discussion of whether there are systemic issues to be addressed. The minutes are so scant that it is difficult to tell what transpired during EMRRC meetings.

Review of Pharmacy and Therapeutics Committee Meeting minutes from November 2011 to January 2013 showed that at several meetings key members whose attendance is required are absent.[104] Meeting minutes reflect data regarding pharmacy utilization but lack analysis and discussion intended to improve pharmacy services. Discussion of reported medication errors is limited to the type of error but does not include any root cause analysis or discussion of how these errors occurred or, more importantly, how they can be prevented in the future. There is no acknowledgment of sanitation issues or underreporting of medication errors.

In February 2011, a nurse was assigned to perform Medication Administration Process Improvement Plan (MAPIP) studies. According to nursing leadership, over a period of months the results of these studies were 100%. In March 2012, the PLO conducted a site visit and noted that their review of chronic disease medication management did not correlate with the high scores. We discussed this with nursing leadership, who reported that they performed a validation study of the nurse's work and found that she did not maintain any supporting documentation for the studies performed. When they attempted to replicate the study, it was determined that many of the patients included in the study were not eligible and in some cases

[104] For example, at the March 2012 P & T meeting, only four of ten required committee members were present. The meeting minutes were not approved until 10/23/12. In June 2012, only five of ten required committee members were present. Meeting minutes were approved on 9/6/12. In September 2012, six of ten required committee members were present. These minutes were approved on 1/8/13. In January 2013, most required members attended. The minutes were approved on 5/23/13.

never resided at the facility or had been released. In June 2012, the nurse was removed from this responsibility, and nursing leadership now monitors MAPIP studies more closely.

Recommendations

Organizational Structure, Facility Leadership and Custody Functions

1. CCHCS should assist Corcoran management in attempting to better organize its services.
2. CCHCS should meet with CDCR to address custody practices at this facility when these practices prevent appropriate medical care from being delivered. This effort should begin at the facility through the QMC but should escalate to a higher level if custody practices continue to prevent appropriate medical care.

Human Resources: Staffing and Facility Mission Hiring and Firing, Job Descriptions

1. As with other facilities, disciplinary procedures should be expedited.
2. The Chief Physician and Surgeon must engage in meaningful review of the clinical work of physicians. This should be clarified in a duty statement which is reviewed with the Chief Physician and Surgeon. Performance should be reviewed annually.
3. The process of hiring nurses should include a check of prior probations and sanctions by the nursing board prior to hiring.
4. Bylaws of the GACH should be revised so that they are consistent with the 2008 Court Order on physician competency and its related policies. If this is not possible due to Title 22 regulations, this issue should be brought to the Receiver's office for a resolution.

Operations: Budget, Equipment, Space, Supplies, Scheduling, Sanitation, Health Records, Laboratory, Radiology

1. Budgets should be based on actual need and should be actively managed.
2. Supply chain processes should be standardized and streamlined.
3. The use of the current warehouses should be re-evaluated. Under no circumstances should medical supplies be exposed to dirt, dust and debris.
4. The GACH inmate rooms should be sanitized daily.
5. Clinical areas sanitized by inmate porters should be cleaned in a standardized manner acceptable for health care facilities.
6. Equipment inventory should be standardized and maintained so management knows where equipment is located and is knowledgeable regarding maintenance of the equipment.
7. Work orders should be tracked so that management knows when work orders are completed.
8. Tracking of laboratory tests should be standardized.

Reception and Intrasystem Transfer

1. CCHCS should review and revise the intrasystem transfer policy to incorporate improved coordination and clinical oversight of transfers of complex CDCR patients from outside hospitals to CDCR higher levels of care; reevaluate criteria for medical holds or require provider review of high acuity patients to promote patient safety for patients being transferred; and require provider evaluation of high-risk patients within 7 to 14 days.

2. Utilization management should ensure that, prior to transfer of complex high-acuity patients between higher levels of care, specialty care services or other necessary medical care can be provided timely upon transfer of the patient.
3. Nurses should refer medically complex patients to a provider and document the time frames for provider referral on the 7277. There should be a mechanism to ensure that the time frames are met.
4. Medical providers should thoroughly review all intrasystem transfer patients' records with particular attention to outside hospitalization and diagnostic test reports, status of implementation of consultant recommendations, abnormal labs requiring monitoring, and control of chronic diseases management.
5. Sending and receiving institutions should coordinate continuity of critical medications with particular focus on insulin, anticoagulation, HIV and TB medications.

Access to Care: Nursing Sick Call

1. Health care leadership should conduct studies and root cause analysis regarding reasons for uncompleted health care appointments and develop targeted strategies to address root causes. Studies should focus on root causes of real and alleged patient refusals of health care appointments.
2. Nurses should triage all 7362 forms, including requests for dental and mental health treatment, and document name, credentials and date and time of triage. If the triage is urgent, the nurse should either see the patient or definitively arrange for the respective service to see the patient.
3. Nurses should see patients with symptoms within policy time frames in an adequately equipped and supplied examination room with auditory privacy. This particularly applies to restricted housing units where nursing assessments were generally inadequate.
4. Nurses should improve the quality of assessments by performing adequate review of systems related to a specific complaint and a pertinent physical assessment. Corcoran nursing leadership should provide ongoing feedback to nurses to improve their performance.
5. Nurses should refrain from "piggybacking" referrals onto future provider appointments unless there is communication with the provider so the patient's concerns are addressed.

Chronic Disease Management

1. Corcoran health care leadership should perform studies and a root cause analysis to identify the reasons for the lack of timely and appropriate chronic care.
2. The CME and/or the Chief Physician and Surgeon should provide more clinical oversight for the medical staff regarding patients with chronic illnesses.
3. Corcoran health care leadership should perform a quality improvement study to determine the reasons for the high rates of refusal of care. This may require assistance from Central Office staff.

Pharmacy and Medication Administration

1. Health care leadership should ensure that a strict schedule of sanitation and disinfection activities is implemented in the pharmacy.
3. Pharmacy should explore ways to ensure that prescription baggy containers can either be securely closed or consider other forms of packaging.
4. In general population housing units, nurses should administer medications from a centralized window using the MAR and administer medications from pharmacy dispensed, properly labeled containers. Nurses should document administration of medications at the time they are administered and, after each medication pass, document the status of medication doses that were not administered.
5. Custody should provide escorts to nurses administering medications based upon an established schedule. Particular attention should be focused on patients with time-sensitive medications such as diabetics taking insulin.
6. Health care leadership should conduct studies and root cause analysis of medication errors (e.g., missed medication doses, failure to document) to understand and address systemic versus individual performance issues.
7. Health care leadership should ensure that Medication Administration Records are scanned into the eUHR in a timely manner.

Specialty Consultations

1. Corcoran health care leadership should identify and address the issues related to lack of timely specialty care.
2. The CME and/or the Chief Physician and Surgeon should provide more clinical oversight for the medical staff regarding specialty care.

Specialized Medical Housing: OHU/CTC/GACH

1. CCHCS should re-evaluate the need for having a GACH at Corcoran. It is not functioning as a GACH and seriously ill patients might be better cared for at local hospitals. The Corcoran GACH would be best converted to a CTC. All the following recommendations would remain whether this facility had a GACH or a CTC.
2. Corcoran health care leadership should ensure that patients on the GACH have access to physician-ordered care. Adequate custody staff needs to be assigned to the unit so that health care staff can perform their assignments. To increase health care staff access to patients, establish GACH/OHU custody staffing based on a ratio of 1 custody staff for every 1.5 clinical staff. This can be modified during night shift. Another alternative, which is done in other systems, is to allow nursing staff to have keys to the rooms.
3. Corcoran health care leadership should work with custody to ensure that patients in the GACH are permitted to shower daily or as frequently as ordered by physicians.
4. Corcoran health care leadership should establish a special Quality Improvement Team (QIT) to improve the quality and timeliness of care on the GACH. The review should include investigation and root cause analysis of episodes of bacteremia and other nosocomial infections, failure to implement of physician orders and nursing care plans, and inmate refusals of medical and nursing care, as well as any other issues noted by staff.

5. Corcoran medical providers should review patient records thoroughly and request retrieval of relevant clinical information from hospitals or prior CDCR facilities to enable the provider to provide appropriate medical care.
6. Corcoran health care leadership should ensure that acutely ill patients on the GACH are examined daily and that these examinations are documented in the medical record.
7. Medical leadership at Corcoran and CCHCS central office should confer to develop a strategy to address the inaction of the Organized Medical Staff in providing medical oversight on the GACH. If it conforms to Title 22 regulation, it would be our recommendation that the Chief Physician and Surgeon should take responsibility for clinical care on the GACH. This would include development of policy and procedure, providing medical leadership on the unit, review of adverse events on this unit and planning for corrective action when problems are identified. Corcoran or CCHCS health care leadership needs to assess whether the current Chief Physician and Surgeon is capable of performing in this role.
8. CCHCS should ensure that infection control practices and sanitation standards on the Corcoran GACH are consistent with hospital based infection control practices and sanitation standards.

Mortality Review

1. The CCHCS mortality review process should include identification of systemic issues that may contribute to adverse patient outcomes.
2. Corcoran health care leadership should review as sentinel events all deaths or hospitalizations that occur within a month of an intrasystem transfer.
3. CCHCS should review the intrasystem transfer policy and procedure in light of the three deaths at Corcoran in which issues in the intrasystem transfer process were noted.

Internal Monitoring and Quality Improvement

1. Health care leadership should seek to have internal monitoring and quality improvement activities that are more meaningful in content, address actual problems, and are driven by data and root cause analysis. Minutes should adequately reflect these activities.