R.J. Donovan Correctional Facility

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 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, health care 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;
- Review of quality improvement and internal audit reports;
- 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]

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.

[1] Plata et al. v. Brown et al. Order re: Receivership Transition Plan and Expert Evaluations No. C01-1351 TEH, 9/5/12.
[2] The Status of Health Care Delivery Services in CDCR Facilities. Court-Appointed Medical Experts Report. April 15, 2006.

Overall Finding

We find that Richard J. Donovan Correctional Facility (RJD) is not providing adequate medical care, 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 February 4-8, 2013, the Plata Court Medical Experts visited RJD to evaluate health care services. This report describes our findings and recommendations. Our visit was in response to the Office of the Inspector General (OIG) Cycle 3 Report showing that RJD scored 87.3% in April 2012. We thank Warden Daniel Paramo, Chief Executive Officer Mary Ann Glynn, and their staff for their assistance and cooperation in conducting the review.

At RJD, 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, emergency response, and specialty services. We believe that in addition to system issues, medical provider staffing issues have negatively impacted care. There has been turnover in medical leadership positions in the past year, as well as physician vacancies that have resulted in provider appointments back logs.

RJD has undergone a change in medical mission in the past year. In August 2012 it ceased to be a reception center, converting 600 medical reception and 150 general population beds to a level III Sensitive Needs Yard. In addition, in October RJD was designated to be an Intermediate facility and began receiving inmates of higher medical acuity. According to the Chief Executive Officer as of March 2013, 80% of the population at RJD is in the chronic disease program; and the facility experienced a 34% increase in the number of chronic disease patients from February 2012 to February 2013.[3] In addition, 57% of the population is in the mental health program and these patients often present challenges in medical management.[4] If true, this is a dramatic increase in medical acuity that should have warranted increased provider staffing. However, implementation of the Acuity Based Staffing Realignment (ABSR) resulted in a loss of 1.5 providers. Given the findings of this report, we are concerned that loss of provider positions will result in further deterioration of care.

We found that RJD has not effectively incorporated the primary care model and that medical care is episodic, focused only on the immediate problem rather than being comprehensive.[5] Primary care providers do not adequately address each of the patient's chronic diseases or abnormal laboratory findings in a timely manner, resulting in preventable visits to the

[3] In comparison, 63% and 62% of the CMC and San Quentin populations, respectively, are in the chronic disease program.
[4] In comparison, 31% and 26% of the CMC and San Quentin populations respectively, are in the mental health program.
[5] The California Correctional Health Care Services (CCHCS) January 2013 Primary Care Model Domain Dashboard, which compares facility performance with respect to the primary care model, ranked RJD in low adherence for 6 of 8 indicators.

Treatment and Triage Area (TTA) and hospitalizations. We note with concern that RJD has the third highest rate of potentially avoidable hospitalizations of all CDCR facilities.[6]

We also found that RJD health care facilities are inadequate, but that the Receiver and CDCR have included RJD in the Health Care Facility Improvement Plan. We anticipate that medical clinical space will be adequate when the plan is completed. However, the plan does not address medical beds and RJD currently has insufficient numbers of Correctional Treatment Center (CTC) beds dedicated for medical patients. This is a concern as RJD is an Intermediate facility receiving increasing numbers of high acuity medical patients. It is also an Armstrong facility and receives disabled patients, some of whom are also medically complex.

We also found problems related to routine purchasing, maintenance and repair, and sanitation. For example, staff reported that new medication carts were purchased and delivered to the warehouse six months prior to our site visit, but repeated efforts to have the warehouse supervisor transport the medication carts to their locations have not been responded to. Similarly, work orders for nonfunctioning sinks and phones in disrepair have not been completed. These support functions, which are currently under CDCR's control, are essential to an adequate health care system and must be more responsive to the needs of the health care program.

These report findings raise questions regarding the OIG Cycle 3 report that reflected a score of 87.3%. The question is whether the score accurately reflected adequate care that has since deteriorated, or whether the OIG review failed to capture problems related to poorly functioning systems and quality of care issues. We note that RJD scored 68% and 73% in the OIG Cycle 1 and 2 reports, respectively, which is in the low adherence range, and then moved to high adherence with the Cycle 3 report. RJD is one of only two facilities that had two low adherence reviews and then scored in the high adherence range.

At the time of the OIG Cycle 3 report, RJD had full physician staffing, but since then has had turnover in medical leadership and provider vacancies. In addition, RJD's medical mission changed from a reception center to an Intermediate facility. Health care leadership believes that it was the combination of provider turnover and vacancies, combined with receiving increasing numbers of higher acuity patients in October 2012 that resulted in deterioration of services. A distinguishing characteristic between RJD and the other 3 facilities we have evaluated that scored >85% is that the population at RJD was 160.9% of design capacity at the time of our review, whereas the other 3 facilities ranged between 128 to almost 134% of design capacity.[7]

Although facility changes since the OIG Cycle 3 report may have negatively impacted care, the scope of our review includes care provided from late 2011 throughout 2012, including the

[6] RJD has 47 per 1,000 potentially avoidable hospitalizations, which is exceeded only by CMF (71) and SATF (57) and tied with COR (47). CCHCS Dashboard, January 2013.

[7] At the San Quentin, CMC and SCC evaluations the population was 128.3%, 132.9%, and 127.3% above design capacity, respectively.

period covered by the OIG Cycle 3 review. We did not find that care was adequate during the period of time that the facility was a reception center and had full provider staffing and then dramatically deteriorated. Our review found consistent issues throughout the period of review.

Findings

Facility Description

The primary mission of RJD is to provide housing and supervision for inmates classified as minimum to high custody. The facility is comprised of a Minimum Support Facility; two (2) level III Sensitive Needs Yards; a level III general population facility; and a level IV Sensitive Needs Yard. In addition, RJD has 1,989 mental health patients of which 589 are in the Enhanced Outpatient Program (EOP). The facility has a design capacity of 2,200 inmates, and during the week of our review the population was 3,540 or 160.9% of design capacity.[8]

RJD's medical mission has recently changed; it is no longer a reception center and has been designated as an Intermediate facility, meaning that RJD is receiving higher medical-acuity inmates. It currently has about 700 high-risk patients. RJD has a Correctional Treatment Center (CTC) which has 28 beds; about half of the beds are devoted to mental health and half to medical.

In addition, RJD is an Armstrong facility (accommodates persons with disabilities), a Clark facility (houses those with IQs less than 70), a special needs facility (protective custody, e.g. police officers, transgender inmates, etc.) and a mental health hub facility.

We note that patients with severe medical problems, such as severe chronic obstructive pulmonary disease (COPD), are being transferred to RJD as disabled because they use wheelchairs, but in fact, they are severely medically disabled and require specialized medical housing. RJD only has 12 dedicated medical CTC beds. As a result, high-risk medically disabled patients are being housed in general population where the support structure needed to care for them does not exist.

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: The RJD administrative table of organization is organized along functional lines of authority. The CEO reports to Clark Kelso for medical issues and to Diana Toche DDS, Undersecretary, Administration and Offender Services (Acting), for mental health and dental services. As with other facilities, the CEO operates independently with minimal interactions with CCHCS. 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. However, CCHCS does not have regularly scheduled visits to the facility. Physician staffing issues have recently surfaced as a major problem and although there has been communication between CCHCS and RJD, it does not appear that there has been optimal communication about the nature of the problem or a corresponding action plan to resolve the lack of adequate physician staffing.

[8] CDCR website, Weekly Report of Population as of Midnight February 6, 2013.

Administrative leadership has been stable at this facility. Mary Ann Glynn, the Chief Executive Officer of RJD, is an experienced health care executive. The Pharmacist-in-Charge has been in the position for about two years.

The medical program, however, does not have stable clinical leadership. The Chief Medical Executive and Chief Physician and Surgeon positions are currently vacant. Dr. Kyle Seeley is the Acting Chief Medical Executive and Dr. Robert Walker is the Acting Chief Physician and Surgeon. The former Chief Physician and Surgeon retired about seven months ago but had sufficient accrued benefit time that the position will not be available for hiring until March of 2013. The Chief Medical Executive left service seven months ago and his position has not been filled yet. These are critical positions in the management structure that need to be filled quickly. In addition, Dr. Seeley and Dr. Walker have vacated their clinical positions, resulting in two additional vacant staff physician positions. This is particularly problematic at this facility since approximately 40% of the staff physician positions are currently vacant.

In addition nursing leadership has also undergone transition. The Chief Nursing Executive, Regina Izu, who is new to corrections, assumed her position less than a year ago.

Daniel Paremo has been the Warden at RJD for two years. According to the CEO, there has been no interference from custody with respect to clinical decision making and medical autonomy. Relations with custody appear to be workable. The Warden and the CCHCS CEO meet weekly and any other time that collaboration between departments is needed. However, senior health care leadership does not attend the regularly scheduled meetings that the Warden has with his administrative staff. In other facilities, the CEO attends these meetings. Mr. Raymond Din is the Associate Warden for Health Care and is the liaison between the health program and custody. He attends weekly medical chief meetings, monthly quality improvement meetings and other medical meetings as they occur.

In the Acuity Based Staffing Realignment, the RJD management and staffing structure will not significantly change; however, the facility will lose one physician position and a half-time nurse practitioner position. Based upon our review, we believe that the loss of these medical provider positions will negatively impact the program.

Human Resources, Staffing and Budget

Methodology: We interviewed facility health care leadership and human resources staff. We reviewed current and planned Acuity Based Staffing Realignment plans, vacancy and fill rates. We also reviewed the process for credentialing, peer review and annual performance evaluations.

Findings: RJD has a budget authority for 245.0 positions, of which 209.8 are filled (86%). Under the Acuity Based Staffing Realignment there will be an increase of 26.7 positions.[9] There is a

[9] As of February 2012 per CCHCS

mix of deletions and additions in the staffing plan but, overall, mental health has the largest proportion of increased staff (about an 86% increase in psychiatric technicians, from 22 to 41 positions). There is a small increase in RN staff and almost a doubling of pharmacy staff from 9.47 to 15 positions.

The Acuity Based Staffing Realignment corrects for deficiencies in some areas of the existing staffing plan. In the last fiscal year, RJD utilized approximately $6.3 million in overtime and registry coverage. Overtime, extra staff, or registry coverage equivalent to approximately 20.8 positions was utilized for psychiatric technicians, and the equivalent of 20.2 positions was utilized for Certified Nurse Assistants. Most of these positions were needed for suicide watch. The Acuity Based Staffing Realignment will increase psychiatric technicians by 19 positions. This, accompanied by a significant drop in suicide watches, is expected to result in adequate staffing. Overtime and registry coverage in the last fiscal year for pharmacy staff was equivalent to 9.97 positions. In the Acuity Based Staffing Realignment, 5.53 positions will be added.[10]

We note that in the Acuity Based Staffing Realignment there has been a reduction in provider staff from 15.5 to 14.0.[11] Of the 14 positions, the Chief Medical Executive and Chief Physician and Surgeon positions are vacant, but filled on an acting level by two staff physicians. Two providers are on military leave, one is on sick leave and one is on stress leave after he was reassigned from the CTC to a facility medical clinic for productivity issues. Thus, of 14 positions, only 8 are filled, and only 6 are devoted to patient care. Currently, many patients are not being seen timely, and this can be attributed to the number of physician vacancies. Given existing coverage, there is only one physician assigned to yard clinics, which results in less than adequate coverage. Based on all of the expected evaluations which are required to occur (primary care clinic, five-day follow-up after hospitalization, abnormal lab follow-up, etc.) we calculate that the current number of physicians would not be able to see all patients unless they were seeing much higher than 20 patients a day. Currently, physicians only see approximately 12 patients a day due to the lack of adequate support, the cumbersome eUHR, and custody restrictions (counts, lock-downs, etc.).

While the proposed provider staffing plan may ultimately be adequate, provider vacancies and turnover are adversely affecting patient care. The situation will only get worse as RJD is assigned higher acuity patients consistent with its mission as an Intermediate facility. If the provider staffing is not brought up to full levels, the existing complement of physicians will continue to be unable to provide an adequate level of care to these high risk patients.

The Office of Inspector General Cycle 3 report staffing score was 100%. However, with respect to provider staffing, the only indicator was whether the institution had “a physician on-site, a physician on-call or a medical officer of the day available 24 hours a day, seven days a week, for

[10] Numbers based on average over utilization from the July ’11-June ’12 Position Management Reports
[11] A physician and 0.5 nurse practitioner positions are being deleted from the staffing plan.

the last 30 days." In order to evaluate adequate provider staffing, a more comprehensive analysis is required, including the acuity of the population and demand for services.

Every employee is supposed to have an annual performance review. There is no local policy or CCHCS policy which delineates how this is to be done. We were told that CDCR personnel provide a list of employees whose annual evaluations are due to the CEO. We were also told that local management performs and tracks performance reviews. About 86% of staff has their performance evaluations completed. We inspected several of these evaluations and both the positive and adverse evaluations are well done.

The Nurse Instructor offers weekly formalized training for nursing staff. Additionally, the CNE/DON reviews pertinent policies and procedures with the Supervising RNs who, in turn, review these with their nursing staff. There is an annual training from CCHCS, but this training is mostly on non-clinical matters such as use of force, key control, information technology issues, etc. Mandatory webinars do occur for physicians. Nurse Managers have informal training for staff weekly. Training for relevant policies needs to occur regularly as the policies change over time.

Credentialing and Peer Review

All credentialing is done through CCHCS. Local credentialing for the CTC is done through the Health Care Executive Committee. This facility believes that CCHCS does a good job of credentialing. Peer review is performed by CCHCS.

Hiring and Disciplinary Process

Human resource services are provided at RJD from a variety of sources. There are two regional staff members who assist in the human resource (HR) function. These analysts are assigned to the site but report regionally. They assist in human resource functions unrelated to hiring and discipline. Discipline is performed by regional Employee Relations Officers (EROs) who come to RJD a couple of days a month. Hiring is performed by Associate Government Program Analysts who are CCHCS regional staff. Local management staff performs interviews for all hires but the regional staff does the paperwork, posting, etc. Normally, it takes about two months to hire someone, although now practically all positions have been frozen for about a year due to realignment.

While the hiring process is adequate overall, one area in need of improvement is the screening of candidates by CCHCS. The search for candidates is not aggressive or thorough. For example, staff described interviews of candidates who were not qualified for the position for which they applied. As an example, a candidate for a nurse educator position had two solicitation arrests and convictions and had not been accepted by RJD management. The same person subsequently applied for a registered nurse position and CCHCS determined that the applicant was acceptable even though facility management had given CCHCS information about the candidate in the prior interview.

As was the case at the other facilities we visited, discipline is very problematic. Discipline at RJD is initiated by local management with regional support. Currently 16 people are in the process of serious discipline. The average time these 16 people have had their discipline pending is 12.8 months. This is much longer than San Quentin, where dedicated HR staff assisted in the disciplinary process. In 7 of these 16 cases, the Office of Internal Affairs (OIA) has not completed its evaluation. The average time these 7 cases have been pending is over 16 months. Historically, the longest disciplinary process involved a nurse and lasted approximately five years.

The length of the process results in some staff working out of their classification. Currently, there are two employees in this status because health care leadership will not use them in their clinical assignments due to patient safety concerns. One LVN is alleged to have engaged in over-familiarity with an inmate. It has been two years and a final discipline decision is still pending. This employee has been working in the mailroom for two years while occupying an LVN position. The second employee working out of classification is a pharmacist who is working as an office technician in mental health. This is the second adverse action for this employee. The first adverse action was in response to the employee losing two hundred morphine tablets. The CEO was told she could not terminate the employee because it was the employee's first offense. The second action was alleged clinical incompetency related to breaking a bottle of medication and attempting to reuse the liquid medication by pouring it into another bottle. The custody disciplinary matrix does not include medical adverse actions, and it appears that it is difficult for the OIA and personnel board to assign severity of adverse action. The other 14 people being disciplined have remained in their positions during the investigation.

Although the local management does not avoid discipline, they know it will take a long time to complete the process and there is a good chance that discipline will not be supported, even when it is warranted. This is both a morale issue and can become a staffing issue by virtue of employees working out of classification. We identified this as a serious issue in our 2006 report and it appears not to have substantially changed.[12]

Health Care Budget

As with other facilities, there is no fixed budget from which to manage. In fiscal year 2011-12, the initial budget allotment was approximately $39.7 million; the final allotment was $48.3 million; and final expenditures were $53.7 million. The expenditures in excess of allotment were provided through the Receiver. A budget process that is not based upon real operating costs does not assure that future budgets will be sufficient to provide adequate health care.

The budget allotment is insufficient for normal operations and an additional substantial sum is necessary to pay for existing operations. Because of the Receiver, facilities are able to spend what they need in order to operate, and the Receiver makes up the difference between expenditures and allocation by either moving money around within the Receiver's allocation or

[12] The Status of Health Care Delivery Services in CDCR Facilities. Court-Appointment Medical Experts Report. April 15, 2006, page 11.

petitioning the State legislature for additional funding. As with other facilities, tracking of the expenses is not standardized in a way that the CEOs find is practically useful.

Some normal operating costs, including overtime, registry use, equipment, and office supplies are not fully funded in the budget. These expenditures result in excess cost because there are either no or insufficient funds budgeted for these operating costs. Registry and overtime costs at RJD in 2011-12 were $6.3 million, yet nothing was budgeted for these expenses. Paper and other office supplies are supposed to be paid for by CDCR. However, because there was a budget crisis, CDCR stopped paying for these items and the Receivership bought these supplies. The costs in excess of budget are paid through the Receivership.

Although the Personal Services component of the budget posted a deficit of $2.96 million, Operating Expense and Equipment (which includes Registry Costs) posted a surplus of $3.98 million thereby providing a net surplus of $1.02 million.

We have the following concerns about the budget. One is that the additional expenditures required to operate may not be forthcoming when the operational control changes from the Receiver to CDCR. We understand that the health program's budget will be separate from CDCR's and that the two budgets cannot be comingled. However, the Receiver is a powerful advocate to the State legislature for additional funds. Because the typical allotments are not consistent with expenditures and because a real budget does not exist, we are concerned that when the Receivership terminates, appropriate funding will not be available. A second concern relates to routine operating costs associated with health care programs, such as overtime, registry, equipment costs, and office supplies that are not adequately budgeted. Because they are not budgeted as line items or are underfunded when the line item exists, they are considered extraordinary expenditures subject to higher level approval. While the Receivership is in place, these expenses have been covered, but it's not clear what will happen when CDCR assumes responsibility for the medical program. This issue needs to be resolved prior to the transition by establishing a predictable operating budget that reflects actual needs and operating expenses.

Health Care Operations, Clinic Space and Sanitation

Methodology: We reviewed the RJD Health Care Facility Improvement Plan and interviewed facility health care leadership regarding clinic space needs and operations. We toured clinical and medical housing areas to assess cleanliness, organization, and availability of medical equipment and supplies. We interviewed health care and custody staff and reviewed data regarding clinic operations and access to patients.

Findings: RJD clinic space does not provide an adequate environment to deliver health care. The RJD Health Care Facility Improvement Plan (HCFIP) identified medical space deficiencies related to the following operational areas:

- Medication Distribution

- Primary Care
- Specialty Care
- Administrative Segregation
- Pharmacy
- Health Care Administration

Our evaluation confirmed the findings of the RJD HCFIP that justify the need for structural medical space improvements. However, we also note that RJD has insufficient numbers of CTC medical beds for the size of the population and its designation as an Intermediate facility.

We anticipate that upon completion of the RJD HCFIP, RJD will have adequate clinic space. The HCFIP includes renovation of A, B, C and D facility clinics, new administrative segregation unit (ASU) primary care and mental health clinics, a new pharmacy and a new administration building. Although the plans have been developed, construction has not started. Until it is completed, we are concerned that the project will not be fully funded and implemented.

Facility Medical Clinics and Medication Rooms

Staff reported that the facility clinics were constructed in the mid-1970s. The floor plans of A, B, C, and D clinics are similar. There is no privacy in the examination rooms. In addition to accessing clinic rooms through a main corridor, three rooms are connected by open doorways between each room so that staff can access any of the three rooms during clinical examinations. This precludes privacy. The middle room has no sink, and the provider is unable to sanitize his/her hands except to go into another room which is being used by other staff.

The clinic rooms were cluttered in two of the four yards. Supplies were generally overstocked, not organized, and not in standardized locations. One clinic had a patient bathroom with an "out of order" sign on the door when in fact the toilet was functioning. In all of these clinics, the nurse performing face-to-face evaluations for health service requests[13] worked in a closet. In one clinic, the nurse was working inside a closet and the patient was sitting in a chair in the hall. This guarantees a lack of privacy and is inappropriate to perform clinical examinations. Ventilation vents had gerrymandered coverings over them. Medication rooms in clinics were small, cluttered, had poor lighting, no sinks, and are difficult to use because of space limitations. In addition, the equipment and furnishings are old and there is no replacement schedule. Items are replaced only when they break or can no longer be serviced.[14]

The situation in administrative segregation is particularly egregious. In building #6, the medical area is unfit for use. The nursing triage area was basically an examination table and a desk in an

[13] CDCR health service requests are submitted on Form 7362.

[14] The RJD HCFIP describes the same deficiencies in primary care clinics in Facilities A, B, C, and D in its section on existing conditions. They describe examination rooms without sinks, nurses using corridors for assessments due to lack of exam rooms, lack of data connectivity, shortage of storage space, no waiting area for inmate-patients, and lack of distribution windows in the medication rooms.

open area with some partitions. It does not provide visual privacy as staff and inmates on the upper tier can look directly into the area. There is no sink, no light, no privacy, and no fixed equipment.[15] This space should not be used in its current configuration for patient care activities. The medication room in this unit is small, cluttered, dark, and difficult to work in. Automatic external defibrillators (AEDs) are secured in the medication room that is locked when nurses are not present; therefore, officers do not have access to AEDs in the event that an inmate or staff experience cardiac arrest. We recognize that maintaining AEDs under the control of health care personnel is likely the practice at CDCR facilities. However, the likelihood of survival decreases 7-10% with every minute that passes without CPR and defibrillation. AEDs have been shown to increase survival 30-45% in cities where defibrillation is provided in 5-7 minutes.[16] Correctional officers play a vital role as first responders and enhanced access to AEDs increases the likelihood of survival for inmates and other staff.

In administrative segregation building #7, the area for the nurse to conduct sick call provided more privacy, but was similar in design to building #6. The medication room sink has been nonfunctional for two weeks and staff reported an odor coming from the sink that was so offensive that in the morning they cannot tolerate being in the medication room. Staff covered the drain of the sink so they could tolerate being in the room to perform their duties. Staff reported the nonfunctional sink to plant operations two weeks prior to our visit and was assured that it would be promptly repaired, but this has not taken place. Likewise, there is a telephone in the medication room that is falling apart. Staff made a request six months ago to have the phone replaced, but it has not taken place. Staff reported that this was not unusual.

The Triage and Treatment Area (TTA) was extremely cluttered with so many supplies that it looked like a storeroom. There was very little workspace. There is no reason for this area to be this cluttered as the supply storeroom is immediately down the hall. This unit needs to be better organized.[17] A room used for specialty and podiatry services was cluttered with inadequate work space for the providers to write notes.

Sanitation

Although clinic space was inadequate and cluttered, walls and counters were mostly clean. RJD has no budgeted janitorial staff, but uses five custodians obtained through a statewide contract that is funded through this year.

There are daily, weekly, monthly, and annual cleaning schedules. The schedules are bid in the custodian contract. The contract custodial service cleans clinic rooms according to the schedule. The contract company cleans the clinic exam rooms and the common areas of the CTC; they do not clean inmate rooms in the CTC, which poses an infection control issue.

[15] The RJD HCFIP makes similar observations noting that there is no dedicated health clinic to treat the ASU inmate-patients except for a small makeshift, unenclosed exam space on the dayroom floor which has no .sink or data connectivity. (Page 7)
[16] AED Usage: Statistics. Cardiac Science. www.cardiacscience.com
[17] We recommend a system called 5-S, which is a lean-manufacturing system of maintaining order in the workplace. The 5-Ss stand for sorting, straightening or setting in order, systematic cleaning, standardizing and sustaining the practice.

In addition to the contract custodians, CDCR attempts to make 15 inmate porters available to the medical program, but it cannot always identify, approve, and train 15 inmates to function as custodians because the inmates require training that is not always available. During lockdowns or when custody modifies the inmate schedules, the porters cannot work. Last year, there were no porters for a month due to inability to work. Maintenance mechanics supervise the porters but these positions are being eliminated. In the future, it is not clear who will supervise the porters. Formal environmental rounds do not occur on a regular basis. The lack of reliable clinic sanitation is consistent with our findings described in our 2006 report.

Maintenance and Repair

There is no one assigned from custody to address mechanical issues for the medical program. When a fixed structure is in need of repair, the health program submits work orders for repair. Management informed us that, on average, it takes two weeks to four months for these orders to be addressed. Over a 12-month period, there were an average of about seven work orders per month, ranging from no heat or air conditioning, to toilets and sinks not working, and even the phone used for 911 calls not working. Of concern was the fact that on multiple occasions there were complaints of no air conditioning or temperatures being too hot in the CTC. There were also reports of rooms in the CTC being too cold. Consistent temperatures are necessary in this unit because there are many mental health patients on the unit who may be on antipsychotic medication which could produce hyperthermia when ambient temperatures are high. We were unable to verify the average length of time it took to have items repaired, but time frames for repair have been excessive. As an example, an ice machine in the CTC was broken for four months. Staff reported that although the ICE machine was intermittently broken for a prolonged period of time, ice was brought from the main kitchen for patient use in a timely manner. This is a positive response to this particular situation; however there should be a system in place to provide timely and effective response to mechanical issues. Moreover, a schedule of equipment replacement would decrease situations in which a piece of equipment repeatedly breaks and requires frequent repair.

Equipment and Supplies

Purchasing of equipment and supplies is not standardized. Like other facilities, RJD does not use a single source supplier for purchasing supplies or equipment. The facilities must obtain three bids and then give them to CCHCS, which then purchases the necessary items. This results in a multiplicity of equipment models and supplies. In addition, state regulations require that certain equipment must be purchased through Prison Industry Authority (PIA) even when the equipment does not satisfy the needs of the health program and is often more expensive. As an example, all RJD clinic rooms have oversized wooden office desks that often take up needed space. Prison Industry Authority charges a higher price than for desks that can be purchased from outside vendors. This is wasteful and does not serve the needs of the program.

Even when staff successfully purchases medical equipment and supplies, they are not able to put them into service in a timely manner because warehouse staff does not deliver the equipment in a timey manner once it is received. For example, staff reported that new medication carts were purchased and delivered to the facility six months ago and are still sitting in the warehouse. Staff reported that the warehouse supervisor has been unable to devote the time to deliver the medication carts from the warehouse. In addition, the facility locksmith has to key the medication cart locks before they can be put into use, but staff reported that when they have needed the locksmith's services in the past, he can "*never be found.*" Staff reported that he avoids them and is not available to address the needs of the health care program.

RJD tracks the inventory of medical equipment and supplies through the CDCR Business Information System (BIS); however, there are problems using this system for inventory management and control. One issue is that BIS cannot track volumes of equipment or supplies. For example, BIS counts a carton of gloves as one item whereas the health program defines the carton as 24 boxes of gloves. Because of this, tracking the inventory of supplies is not done. At RJD, this results in excess supplies and in wasteful excess inventory. Another issue is that all equipment is listed by type, rather than by model. For example, electrocardiogram machines are listed as an electrocardiogram in BIS even if they are different models. This is not useful to the health program because maintenance and tracking requires knowing exactly what model of equipment is being used. To overcome this problem, the health program created their own tracking system to manage their equipment. This redundancy is inefficient. There is a par stock system, with each clinic having a separate par level.[18] Nurses are supposed to stock the clinics with supplies based on the par level. However, many of the clinics we visited were oversupplied and, as noted above, cluttered. In the TTA, there were 80 boxes of gloves under a counter. This is clearly more than can be used for months.

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 local policy was consistent with statewide policies.

Findings: There are 33 local operating procedures (LOPs) that were collaboratively developed by health care and custody. Some of these policies need to be revised so they address all of the issues relevant to the area covered by the policy. For example, the policy on the Health Care Access Unit primarily identifies who on the custody side is responsible for moving patients for their scheduled appointment. However, this policy needs to also address the timeliness and coordination of inmate movement related to scheduling activity by the medical program. The policy should address counts, lockdowns and other situations that need to be coordinated with health care staff to ensure that patients attend scheduled appointments.

[18] A PAR system means maintaining an average amount of supplies on hand, and neither overstocking or having so few supplies as to run out when they are needed.

There are no local operating procedures in major areas of service such as chronic disease management, the primary care model, health care access or emergent/urgent care. We were told that RJD utilizes CCHCS policies. In response to our request for local operating procedures, we were given a link to the CCHCS portal containing policies. It is RJD's position that since CCHCS develops policies, it is unnecessary to duplicate the effort and create a similar policy. However, the purpose of local procedures is to take CCHCS policies and make modifications to ensure effective implementation of statewide standards within their facility.

Management acknowledged that most staff would probably be unaware of most policy content. However, new and revised CCHCS policy and procedures are emailed to all staff. Staff is made aware to access local operating procedures through the shared file and the Public Information Officer sends an institution-wide email announcing new, revised, or deleted local operating procedures. However, particularly at this time, when a new primary care model and classification procedures are being implemented statewide, it is critical that management view staff training in these areas as a fundamental aspect of the medical program.

Intrasystem Transfer

Methodology: We toured the RJD receiving and release (R&R) area, interviewed facility health care leadership and staff involved in medical reception and/or intrasystem transfer, and reviewed tracking logs, staffing and 12 health records.

Findings: We found significant problems with the intrasystem transfer process. Typically, intrasystem transfers arrive on Tuesdays and Fridays, but primarily Fridays. Health care leadership reported that despite their requests, they are not provided lists of inmate transfers in advance of their arrival. RJD does not typically receive transfers on weekends unless they are a special transport. When medical transports occur, medical usually, but not always, receives advance notice.

Upon arrival at RJD, a nurse completes the health transfer receiving form in a timely manner. Our review showed that although nurses usually refer patients with acute or chronic conditions to a provider, referrals do not occur in a timely manner. There were multiple instances in which patients were scheduled to see a provider but the appointment was not completed. The following examples illustrate problems with continuity of care following intrasystem transfer.

- A 50 year-old patient with benign prostatic hypertrophy (BPH), hepatitis C and hyperlipidemia transferred to RJD on 10/5/12. He submitted four health service requests complaining of symptoms of urinary obstruction but nursing evaluations were inadequate and provider referrals did not occur as scheduled. A provider did not see the patient until 12/31/12, almost 3 months after he arrived at RJD. At that visit, the nurse practitioner did not perform an adequate physical examination, address his hyperlipidemia or hepatitis C infection, or address previous recommendations to refer the patient back to urology.[19]

[19] Intrasystem Transfer Patient #1

- A 48-year-old patient with hypertension, claudication, and severe peripheral artery disease transferred to RJD on 10/26/12. Upon arrival, a nurse referred the patient to a medical provider in one week. On 11/6/12, a provider saw the patient but did not perform any review of systems or examination related to his vascular disease. On 11/29/12 the patient underwent recanulization of his femoral artery and the consultant recommended repeat bilateral lower arterial Doppler in 3 months. A provider reviewed this report and saw the patient on 12/4/12, noting the recommendation for the Doppler and requested follow-up in two months. However, as of 2/8/13 we found no order for the requested Doppler.[20] We discussed this case with Dr. Seeley who reported that there was no reliable tracking system for these requests.[21]

- A 50-year-old patient with a history of pulmonary embolism who was taking a blood thinner transferred to RJD on 9/5/12. On 9/17/12 a provider saw the patient but did not reference the monthly blood test (INR) that reflects whether he was appropriately anticoagulated. (The usual therapeutic range for the INR is between 2.0 and 3.0.) On 9/22/12, a provider saw him for anticoagulation clinic and he was not seen again until 12/4/12. The following day his INR was subtherapeutic but a provider did not address this in accordance with CCHCS guidelines. On 12/27/27 his INR was therapeutic (INR=2.4), but as of 2/8/13, he had not had another INR.[22]

- A 30-year-old poorly controlled AIDS patient transferred to RJD on 9/13/12. He arrived after hours and a nurse contacted a medical provider to reorder his medications, however the medication reconciliation report in the medical record is not signed by a physician. The patient was apparently placed in administrative segregation and we find no September MARs in the eUHR to reflect that he was offered his HIV medications, reflecting medication discontinuity. RJD responded that his medications were administered via directly observed therapy and forwarded copies of October MARs that show he refused his medications, however, we were unable to locate the same MARs in the eUHR.[23]

Consistent with RJD's designation as an Intermediate facility, patients are being transferred because of their medical high-acuity status. Some of these patients are candidates for placement in the CTC but are being placed in general population due to the lack of CTC beds.

When patients do transfer to RJD for assignment to the CTC they sometimes arrive when there is no provider available to evaluate those who need to be seen. These are the sickest patients for whom it is most important that there be direct communication between medical providers

[20] Intrasystem Transfer Patient #8. In RJDs response to our report, it was indicated that the Doppler was ordered and a PCP evaluated the patient on 1/30/13. However, as of 3/17/13 we find no Doppler order or report indicating that it had been completed. Moreover, there 1/30/13 clinical visit was for public health and did not address the patients vascular status.
[21] We discussed this with the specialty services appointment scheduling staff who reported that, in fact, there is an RFS tracking system. It would only be an issue if the RFS was not completed and successfully forwarded to their office.
[22] Intrasystem Transfer Patient #3
[23] Intrasystem Transfer Patient #6

prior to transfer. Furthermore, when patients transfer directly from a higher level of care (OHU, CTC, or GACH) they may transfer without their inpatient medical records. In facilities we have evaluated with an OHU, CTC or GACH, staff documents on paper records that are not uniformly scanned into the eUHR until the patient is discharged from the unit. So, when patients are discharged from these units and immediately transferred, the receiving institution may not have the complete medical record. RJD providers reported that they are concerned that very sick patients are arriving at the facility, often without adequate documentation, at times when providers are not there to evaluate them. For these patients, there should be direct communication between providers prior to transfer, with timely provider evaluation following transfer to RJD. The following patient exemplifies this problem.

This 83-year old patient transferred from CTF to RJD on 12/16/11. His medical history included coronary artery disease, status post bypass surgery, advanced chronic obstructive pulmonary disease, heart failure, atrial fibrillation, hypertension, and hyperlipidemia. While at CTF, his medical classification was changed to totally disabled and high-risk.

On 12/14/11, CTF staff completed a transfer form noting that the patient would be transferred the next day. On 12/16/11 at 0715, an RJD nurse medically screened the patient. The patient's vital signs were grossly abnormal (BP=174/111 mm/hg, 163/97 mm/hg when repeated, and pulse=115/bpm). The nurse did not measure his respirations or temperature. His oxygen saturation was low (89%, normal 95-100%). His peak flow expiratory flow rate was 275. The nurse documented that he had not taken his medications that day.[24] The nurse administered some of his medications from the Triage and Treatment Area (Digoxin, Lasix, Carvedilol, and Xopenex).[25] The nurse also documented "Seen by PCP 2 weeks," presumably referring to the CTF provider that saw the patient on 12/5/11. Despite the patient's high-risk status and abnormal vital signs, the nurse's disposition was to explain the sick call process (7362) to the patient without making a PCP referral.

On 12/17/11, the patient submitted a health request noting that he had not received all his medications, including his potassium, blood pressure medications, and ibuprofen. He stated that he needed to sign a trust account form for a wheelchair because he could not walk far because of his chronic obstructive pulmonary disease. On 12/20/11, a nurse evaluated the patient who reported that he was unable to ambulate to the shower and chow hall. His blood pressure was elevated (BP=167/98 mm/hg) and oxygen saturation was low (85%) after walking from the bench to the nurse room, and improved with rest (91-93%). The patient had bilateral lower leg pitting edema (2+). The nurse discussed the patient with a physician who did not see the patient but increased his Lasix from 20 to 40 mg daily and ordered labs. The patient was provided a wheelchair and scheduled for follow-up in 2 days.

On 12/22/11, the provider saw the patient for the first time. The provider did not reference the patient's abnormal vital signs and low oxygen saturation upon arrival, nor obtain a history of the patient's exercise tolerance to determine whether it was improving, the same, or

[24] AT CTF, the patient's medications were last dispensed on 11/16/11, so presumably he was low or out of medication.
[25] A 12/19/11 reconciliation report showed that the pharmacy dispensed his medications on 12/16/11.

worsening. The patient's Peak Expiratory Flow Rate was 300; his oxygen saturation was not measured. The provider assessed his COPD and heart disease to be stable, even though his oxygen saturation had been 89% within the past week. The provider ordered additional labs, referred him to the Coumadin clinic, and planned to see the patient in 4 weeks or as needed. The following day the provider reviewed a lab test used to assess patients with heart failure and it was extremely abnormal (BNP[26]=765, normal <100), suggesting exacerbation of heart failure; however, the provider did not see the patient.

On 12/29/11 at approximately 0830, correctional officers found the patient was unresponsive and notified health care staff who responded to the patient's location and found him pulseless and without respirations. Health care staff implemented life support measures using an automatic external defibrillator (AED) and CPR, and successfully resuscitated the patient. During transport to the hospital, the patient arrested again and emergency medical services (EMS) successfully resuscitated him. The admitting hospital physician noted that he had exacerbation of his heart failure with elevated BNP levels and generalized edema, as well as suspected pneumonia and respiratory failure due to exacerbation of his COPD. He was later transferred to another hospital where his condition continued to deteriorate. He declined life-saving measures and died on 1/6/12. This case had multiple problems related to his care that began with the lack of physician evaluation at the time of arrival. Further problems are described in the mortality section of this report.

In summary, as RJD will continue to receive increasing numbers of high-risk patients, the intrasystem transfer process should be reassessed and a root cause analysis performed to identify and correct lapses in care.

Access to Care

Methodology: We interviewed health care leadership and reviewed patient tracking and scheduling systems. We toured the facility medical clinics and interviewed staff regarding timeliness of health care appointments. We also reviewed 45 health services requests in 15 records of patients with chronic diseases, including high-risk patients.

Health Care Appointment Scheduling

Findings: Staff uses the Inmate Scheduling and Tracking System (IMSATS) to schedule health care appointments. As of 2/8/13 staff reported that there were no backlogs of nursing sick call appointments but there were backlogs of medical provider appointments in several yard clinics. In facility B the next available provider appointment was 3/13/13, and in Ad-Seg the next provider appointment available was 3/11/13. For facility C, as of 2/7/13 the next routine provider appointment was available on 3/12/13, or in approximately 5 weeks.

[26] BNP (B-type natriuretic peptide) is a substance secreted from the heart that is increased in patients with heart failure.

Nursing Sick Call (Face to Face Triage)

Findings: Nursing staff collect and triage health care request forms and generally see patients in a timely manner (range=0-4 business days). Our findings are consistent with the RJD OIG Cycle 3 round scores for clinical services and RJD internal access to care audits.[27] However, the quality of nursing assessments varied significantly, and we found several cases in which the nurse's assessment and plan was inadequate. This is also consistent with the OIG report that scored nurses' subjective and objective examinations at 70% and 66.7%, respectively. To document the history of the patient's complaint, nurses use an algorithm called SAMPLEPAIN which does not result in an adequate history of the presenting complaint.[28]

We also found that nurses do not consistently refer patients to a provider when clinically indicated and that, when referrals are made, patients are not seen timely. Our findings were supported by RJD internal audits for the period of July 1 to December 31, 2012, which showed that nurses referred 15 of 64 (23%) patients that presented with symptoms. This number is extremely low given the high medical acuity of the population. Moreover, of the patients that were referred, only 7 of 15 (47%) were seen within the 14 days required by CCHCS policy. The combination of inadequate assessments, lack of referral, and untimely provider appointments constitutes inadequate access to care and increases the risk of serious harm to patients.

Our discussions with nursing staff led us to conclude that nurses were attempting to minimize referrals in a well-intended, but misguided, attempt to not increase the provider appointment backlog. Our review showed several cases in which nurses assessed a patient but did not treat the patient in accordance with a standardized nursing procedure or refer the patient to a provider. These nursing encounters, in effect, amounted to no treatment at all, and became a barrier to access to a health care professional that could diagnose and treat their condition in a timely manner. Examples are described below.

- On 10/7/12, a 50-year-old patient with a history of benign prostatic hypertrophy complained of severe difficulty urinating. The nurse did not adequately assess his urinary complaints, and the nurse's plan was for the patient to see the doctor "as scheduled," meaning the nurse would not refer the patient, but that he would be seen whenever his next provider appointment arose. (The patient was scheduled to be seen on 11/29/12.) The patient submitted two more health service requests over the next two weeks stating that he was still having problems but had not seen the doctor. Each time the nurse did not perform a meaningful assessment, only documenting that he was scheduled to see the doctor on 11/29/12. This appointment did not take place as scheduled. A provider did not see the patient until 12/31/12, almost 3 months after the patient's original request.[29]

[27] OIG Cycle 3 scores for timeliness of triage and face to face encounters were 100% and 93% respectively; and 94% for RJD Access Measure Audit Tool: Measure 1 & 2 Episodic Care for the period of July 1-December 31, 2012.

[28] We discussed this with Karen Rea, Statewide Chief Nurse Executive, who was in agreement and reported that she had previously given direction to nursing leadership to stop using this format. She addressed this topic again with nursing leadership during our visit.

[29] Nursing Sick Call Patient #1

- On 12/18/12, a 48-year-old patient with severe peripheral vascular disease submitted a request stating that the provider discontinued his pain medication and he had severe low back and right leg pain. The patient documented that the doctor told him that he "and others like me is the reason the state of California wastes millions of dollars a year and was sent here to cut off as many as she could". On 12/27/12, it was received and triaged. On 12/28/12, the nurse saw the patient noting that the patient had low back and right leg pain, 8 of 10 in severity. The nurse did not note the patient's history of severe vascular disease, recent vascular procedure, or perform a vascular assessment of the patient. The quality of the nursing assessment was inadequate. The nurse referred the patient to a provider but did not specify the urgency of the referral. As of 3/1/13 a medical provider has not evaluated the patient for his symptoms. [30]

- On 9/27/12, a 55-year old with multiple medical conditions submitted a request complaining of right shoulder pain stating that the doctor ordered an x-ray that had not been performed.[31] The nurse saw the patient who complained of pain, 7 of 10 in severity, but the nurse did not treat the patient's pain or refer the patient back to the provider. The x-ray was performed the following day, but the patient's pain was unaddressed by the nurse.[32]

- On 12/16/12, a 24-year-old with a history of abdominal pain, weight loss, and rash submitted a request stating that he had seen a doctor in October 2012 for a rash and was given a cream, but it was not working. He requested to see the doctor. On 12/18/12 a nurse saw the patient and made a routine referral to the physician. On 12/26/12, the patient submitted another request complaining that he was not receiving proper medical attention for his generalized body rash. He refused to see the nurse presumably because he was waiting for an appointment to see the provider. He was not seen.[33] This patient continued to submit health requests:

    - On 1/21/13, the patient submitted another request complaining of abdominal pain and allergy. On 1/23/13, a nurse appropriately assessed the patient's allergy symptoms but did not develop a plan for the patient's abdominal pain. The nurse did not refer the patient.

    - On 2/6/13, the patient submitted a request complaining that a pruritic rash was spreading all over his body and he needed to see a doctor. A nurse saw the patient, who reported that his previous treatment failed to improve his rash. On 2/15/13, a provider saw the patient and the plan was to *consider* changing to a different antifungal topical versus oral antifungal if the rash became symptomatic. The physician did not prescribe any treatment but planned to

[30] Nursing Sick Call Patient #8
[31] In his 9/19/12 note, the doctor also planned to treat the patient with Motrin, but did not order it.
[32] Nursing Sick Call Patient #11
[33] Nursing Sick Call Patient #12

> follow up with the patient in 2-4 weeks to reassess the rash. Given the patient's almost 5 month history of rash unresponsive to 2 courses of therapy, the plan to bring the patient back without further treatment is unresponsive to his condition. This patient should be referred to a dermatologist. In addition, we recommend that his abdominal pain and weight loss be reevaluated.[34]

These are examples in which although the nurse saw the patient in a timely manner, it did not result in an adequate assessment, an appropriate referral, or a timely one. In addition, it is apparent that the ongoing medical provider backlog has resulted in delays in evaluation, diagnosis and treatment of patients with significant pain and/or serious medical conditions. In some cases, we found that when the provider saw the patient, the treatment plan was unresponsive to the patient's condition.

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 38 patients with chronic diseases, including diabetes, hypertension, HIV disease 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 whether provider evaluations 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 87.1%.

However, our findings are consistent with those noted in the CCHCS Dashboard. With respect to timeliness, according to the January 2013 Dashboard, RJD scored 50% and 41%, respectively, for provider access and continuity of care for the most recent quarter, whereas the statewide averages were 82% and 73%, respectively. RJD's chronic care access reports for the period of July 1 to December 31, 2012 showed that in only 55% of cases did a provider see the patient within ordered time frames.[35] With respect to quality of care, the facility scored 74% for the management of diabetes and 63% for the management of therapeutic anticoagulation.

The following two cases are especially concerning in that they involved sentinel events: a hospitalization and a death. Both are HIV-infected transgendered patients under the care of an endocrinologist who treats the majority of CDCR transgendered patients.

[34] This patient's abdominal pain has been attributed to a history of abdominal stabbing and subsequent laparotomy; however his abdominal pain should be evaluated in the context of a history of decreased appetite, weight loss and low BMI.
[35] RJD Access Measure Audit Tool: Measure 3 Chronic Care, July 1, 2012, to December 31, 2012.

- The first case is a 44-year-old HIV infected transgendered patient who was hospitalized in December 2012 with severe electrolyte imbalance due to the syndrome of inappropriate antidiuretic hormone (ADH) caused by his medication regimen.[36] The patient had been complaining of gastrointestinal symptoms about ten days prior to his admission, but hospitalization only occurred after the lab notified staff of a critical lab (i.e., severe hyperkalemia and hyponatremia). The hospital physician then elucidated a four-day history of weakness, dizziness, feeling ill, nausea, vomiting, and lower abdominal pain. The hospital physician treated the patient with intravenous fluids and discontinued medications thought to contribute to his electrolyte abnormality. Upon return to the facility, the provider discontinued these medications. However the medication reconciliation report apparently was not faxed to the pharmacy and the patient's medications were continued. A few days later, the patient's labs showed continued hyperkalemia, and the medication error was noted and corrected.[37]

- The second case was a 47-year-old HIV-infected transgendered patient who died unexpectedly during the week of our visit. Review of his record showed that his medical history also included hypertension, hyperlipidemia and renal insufficiency. His medications included Epzicom, Darunavir, Ritonavir, Enalapril, Hydrochlorothiazide, Spironolactone (100 mg twice daily), Propanolol, Gemfibrozil and Estrogen. In August 2012, prior to his arrival at RJD, the patient had hyperkalemia and hyponatremia for which there were no provider notes reflecting that these labs were noted or addressed. The patient's labs subsequently normalized. In September 2012, the patient had very elevated estradiol (406, normal=<39), prolactin (128.5, normal=2-18) and triglyceride levels (541, normal=<150).

  Following arrival at RJD, on 12/18/12, the endocrinologist saw the patient and prescribed Aldactone 50 mg twice daily KOP and continued all the patient's medications at the current dosing. He also planned to obtain labs as soon as possible and see the patient in 3 weeks. On 1/7/13, the patient complained of nausea and abdominal pain, 8 of 10 in severity. The nurse who evaluated the patient did not refer him to a provider, but advised him to discuss his problems the next time he saw his provider and to submit another request if his symptoms worsened. On 1/16/13, a provider saw the patient for chronic care. He noted the patient's complaint of abdominal pain but did not explore the patient's history of abdominal pain, including onset of symptoms. The provider ordered a urinalysis and ranitidine and follow-up in six weeks. The patient had several more medical and dental encounters over the following weeks, none of which involved these symptoms.

  On 2/7/13, at 12:20 pm, staff responded to the patient's housing unit where the patient reported body aches, abdominal pain, and being unable to walk. The patient was

[36] His medications included Metformin, Spironolactone, hydrochlorothiazide, estradiol, medroxyprogesterone, and oxcarbazepine.
[37] Chronic Care Patient #36

agitated and flailing his arms. He yelled, "I can't move, I can't walk." Staff requested he move himself out of cell due to medical staff safety concerns and he scooted himself along the floor until he was outside his cell. The nurse notified a physician who did not see the patient but ordered follow-up with the primary care provider in one week. The nurse left as the patient continued to yell while sitting outside of his cell. At 9:15 pm, the patient was found in the dayroom unresponsive, pulseless and without respirations. Custody staff did not initiate CPR. The patient was transported to the TTA and staff initiated CPR and resuscitation measures that were unsuccessful. The patient was pronounced at 10:04 pm.[38]

This case is remarkable for nurses abandoning a patient in distress and the lack of physician evaluation when nurses notified the provider that the patient was agitated and complaining of body aches, abdominal pain, and inability to walk. In addition, health record documentation reflects that CPR was not initiated by correctional officers. When we discussed the case with the acting Chief Medical Executive, his initial response was that "inmates do cry wolf" rather than expression of concern that health care staff did not evaluate the patient.

Although the cause of death for this patient is not yet known, both of these patients had clinical symptoms compatible with severe electrolyte imbalance, raising questions about the management of HIV transgendered patients. We contacted Steven Tharratt MD, CCHCS Statewide Chief Medical Executive, and recommended peer review of these cases by a provider experienced in the treatment of transgendered patients. We also recommended review of both patients' medication regimens by a doctoral-level pharmacist for possible drug interactions.[39]

In addition, we found numerous cases that demonstrate serious problems related to the timeliness or quality of care for patients with chronic diseases. These cases are summarized below.

- This 55-year-old man transferred to RJD on 11/6/12. He has a history of diabetes, hypertension, hyperlipidemia, asthma and hepatitis C. On 11/17/12 and 11/18/12, a nurse contacted the TTA provider because the patient's blood sugar was very elevated (over 500). The patient was not seen by the primary care provider for his initial chronic care visit until two months later, on 1/18/13. The provider provided appropriate care for the patient's diabetes, but did not address his hepatitis C infection or gout.[40]

[38] Chronic Care Patient #37

[39] The medical experts are not experienced in the treatment of transgendered patients. We note, however, that both these patients were treated with Spironolactone, a potassium sparing diuretic. One of the side effects of this medication is gynecomastia (breast enlargement), which is likely to be desired by transgendered patients. It is a keep-on-person medication, and if taken in excess presents a potential for severe electrolyte abnormalities.

[40] Chronic Care Patient #1

Assessment
There were problems related to timeliness and quality of care. The patient was not seen timely for his initial chronic care visit. In addition, the provider did not address all of the patient's chronic medical problems at that time.

- The patient is a 65-year-old man who transferred to RJD on 10/3/12. He has a history of diabetes, hypertension, hepatitis C, asthma, hyperlipidemia and hemochromatosis. He has a permanent catheter for withdrawing blood when his iron level gets too high from his hemochromatosis. Prior to transfer, the patient had been referred for an abdominal sonogram because of an elevated alpha-fetoprotein (a blood marker for possible liver cancer). When he arrived at RJD, the patient was referred to see a primary care provider in one week. On 10/9/12, the patient refused his initial primary care visit at RJD. He wrote on the refusal form, "Please reschedule me." The patient was not seen for almost two months, until 11/26/12. (The provider noted that the patient was seen in clinic that day because he had been referred for refusal of medication.) At that time, the provider noted that the patient's diabetes was in poor control and increased his insulin. He also noted that the patient had not been taking his blood pressure medication due to side effects and changed his medication regimen. The provider noted that the patient had hepatitis C with an elevated alpha-fetoprotein but did not address this further and did not address the missed abdominal sonogram. Furthermore, the provider did not order iron studies to evaluate his hemochromatosis.[41]

  Assessment
  There were problems related to timeliness and quality of care. The patient's initial chronic care visit was not rescheduled in a timely manner. In addition, the provider did not appropriately address the patient's liver disease or hemochromatosis at the initial visit.

- The patient is a 46-year-old man with a history of diabetes, hypertension and hyperlipidemia. He had been seen for chronic care on 5/3/12 and 6/7/12. On both occasions, his diabetes and hypertension were not well controlled. On 6/7/12, the provider ordered follow-up in one month. On 7/5/12, the patient refused to see the provider. The patient was not seen again until 1/28/13.[42]

  Assessment
  There was a problem related to timeliness of care. The patient's chronic care visit was not rescheduled in a timely manner.

- The patient is a 52-year-old man with diabetes, hypertension, hyperlipidemia and chronic kidney disease. On 10/30/12, a provider saw the patient and increased his insulin. On 11/13/12, the provider saw the patient for follow-up, noting that his insulin

[41] Chronic Care Patient #3
[42] Chronic Care Patient #4

had recently been increased and his diabetes was not at goal. He did not adjust the patient's medication and ordered follow-up in 30 days. The patient was seen again two and a half months later on 1/29/13. The provider noted that the patient's diabetes was uncontrolled and increased his insulin at that time.[43]

Assessment
There was a problem related to timeliness of care. The provider ordered follow-up in 30 days but the patient was not seen for three months.

- The patient is a 58-year-old man with diabetes, hyperlipidemia, COPD, and coronary artery disease. His LDL cholesterol was not at goal (147) on 6/11/12 and on 7/16/12 (137). He was seen for chronic care on 8/7/12 and 10/23/12. His elevated LDL cholesterol was not addressed at either visit.[44]

  Assessment
  There was a problem related to quality of care. The patient's hyperlipidemia was not being appropriately managed. (In a patient with diabetes, the accepted standard is for the LDL cholesterol to be less than 100.)

- The patient is a 69-year-old man with diabetes, hyperlipidemia and hypertension who transferred to RJD on 10/24/12. Prior to his transfer to RJD, a provider saw the patient on 10/18/12 for chronic care. At that time, the primary care provider noted that the patient's diabetes was in poor control and that he was noncompliant with his medication. (10/16/12 hemoglobin A1C =10%, goal=<7%.) The provider referred the patient for a mental health evaluation due to his refusal of insulin and ordered follow-up in 2-4 weeks. Following transfer to RJD, the patient was not seen until 12/4/12. At that time, the primary care provider ordered laboratory tests and follow-up in one month. On 12/20/12, a provider saw the patient again for medical clearance for tooth extractions. The provider noted that the patient's diabetes was poorly controlled and increased his insulin. The provider noted that the patient's next visit was in early January; however, the patient was not seen again for another 7 weeks, despite the fact that on many occasions he had refused his morning insulin. On 2/12/13, the provider reviewed the patient's blood sugar log and noted that his diabetes appeared improved but that it was still not at goal. He increased the patient's insulin. He also counseled the patient regarding his non-compliance issues.[45]

  Assessment
  There were problems related to timeliness of care. The patient was not seen timely for his initial chronic care visit or his follow-up visit.

[43] Chronic Care Patient #5
[44] Chronic Care Patient #8
[45] Chronic Care Patient #9

- The patient is a 42-year-old man who transferred to RJD on 8/14/12. He has a history of diabetes, hypertension and hyperlipidemia. He saw a provider on the day of arrival who noted that his medical conditions were stable. The provider ordered laboratory tests and follow-up in one month. On 8/20/12, the patient's hemoglobin A1C was 6.7, indicating good control of his diabetes. On 9/14/12, the primary care provider saw the patient and adjusted his medication, including changing his NPH insulin to Lantus insulin and discontinuing his oral diabetes medication. The patient submitted a health request on 10/8/12 requesting that his insulin be changed back to NPH because his blood sugars were increasing with the Lantus. There was another request in the medical record from 11/13/12 in which the patient stated that this was his third request to change his insulin back to NPH because the Lantus was not working. He stated his blood sugars were running between 200 and 300 daily and he was always tired and sluggish. He further noted that he had had this problem with Lantus in the past. On 11/19/12, the provider saw the patient and noted that the patient's blood sugars were increasing, likely due to the discontinuation of the oral medication. He increased the dosage of the Lantus insulin. (There is no documentation that he discussed the patient's concerns regarding the Lantus.) A repeat hemoglobin A1C was 9.0% on 12/12/12, indicating that the patient's diabetes was no longer well-controlled.[46]

  Assessment

  There was a problem related to timeliness of care. The primary care provider did not see the patient in a timely manner in response to his healthcare request on 10/8/12.

- The patient is a 46-year-old man who transferred to RJD on 7/24/12. He has a history of diabetes, hypertension, asthma and a seizure disorder. On 3/26/12, prior to his transfer to RJD, a provider noted that his diabetes was not in good control. On 7/31/12, following his transfer, the patient refused his initial chronic care visit, and the primary care provider ordered follow-up in four months. On 9/19/12, the patient submitted a healthcare services request stating that he needed to see the doctor to have his diabetes medication increased. On 10/9/12, the patient submitted another request stating that he would like to have an "overall diabetic examination." The primary care physician saw the patient on 10/19/12 and noted that his diabetes was uncontrolled and adjusted his medication. He also noted that the patient's hypertension was not at goal and adjusted his medication. The provider did not address the patient's seizure disorder.[47]

  Assessment

  There were problems related to timeliness and quality of care. The patient's initial chronic care visit was not rescheduled in a timely manner. Four months is too long a time, especially given that the patient's diabetes was not well controlled at his prior facility. He was ultimately seen after he submitted two requests to be seen for his

[46] Chronic Care Patient #10
[47] Chronic care Patient #12

diabetes. In addition, the provider did not address the patient's seizure disorder at the time of the chronic care visit.

- The patient is a 53-year-old man with a history of diabetes, hypertension and hyperlipidemia. On 7/24/12, his LDL cholesterol was not at goal (116, goal=<100). He was subsequently seen for chronic care on 11/16/12, 11/27/12 and 1/4/13. The provider did not address his elevated LDL cholesterol at any of these visits.[48]

  Assessment
  There was a problem related to quality of care. The patient's hyperlipidemia was not appropriately managed.

- The patient is a 54-year-old man who transferred to RJD on 9/26/12. He has a history of diabetes, hypertension, hyperlipidemia, asthma and coronary artery disease with coronary artery bypass surgery in 2008. On 8/23/12, prior to his transfer to RJD, a provider at his prior facility saw him and noted that his diabetes was poorly controlled (hemoglobin A1C= >10%) due to poor compliance. The patient's hyperlipidemia was not at goal (5/7/12 LDL cholesterol=96). The accepted standard, noted in the CCHCS diabetes guideline, is that the LDL cholesterol should be less than 70 if the patient has overt cardiovascular disease. The provider adjusted the patient's diabetes medication, counseled him regarding his diet and ordered follow-up in 30 to 45 days. On 9/14/12, the patient refused his follow-up chronic care visit at his prior facility. Following his transfer to RJD, he was seen for his initial chronic care visit on 11/1/12. The primary care provider appropriately addressed the patient's diabetes and hypertension. He also noted the patient's history of cardiac surgery, but did not obtain a history related to current symptoms and did not obtain a history related to the patient's asthma. In addition, he did not address the patient's hyperlipidemia.[49]

  Assessment
  There were problems related to timeliness and quality of care. The patient was not seen in a timely manner for his initial chronic care visit given that his diabetes had been poorly controlled at his prior facility and the provider had recently adjusted his insulin. In addition, the provider did not obtain an adequate history related to the patient's chronic medical problems and did not appropriately address his hyperlipidemia at the time of his initial chronic care visit.

- The patient is a 48-year-old man with diabetes, diabetic retinopathy, hypertension and hyperlipidemia who transferred to RJD on 8/1/12. On 12/21/12, a provider saw him for chronic care, noting that his blood pressure was 127/92 mm/hg. The provider ordered blood pressure checks two times per month for two months and noted that he would consider adjusting the patient's blood pressure medications at the next visit if his blood

[48] Chronic Care Patient #14
[49] Chronic Care Patient #15

pressure was elevated. However, there was no documentation that the blood pressure checks had been done. The provider also ordered laboratory tests and follow-up in 2-3 months. The laboratory tests were done on 12/27/12 and revealed very elevated cholesterol (LDL =192, goal=<100). On 1/2/13, the provider notified the patient that a chronic care appointment had been scheduled to discuss his laboratory test results. As of 2/15/13 a provider had not seen the patient for follow-up.[50]

Assessment

There were problems related to timeliness of care and quality of care. A patient with elevated blood pressure and LDL cholesterol of 192 should be seen within one month. In addition, the blood pressure checks ordered by the physician were not done.

- The patient is a 50-year-old man who transferred to RJD on 6/15/12. He has a history of diabetes, hypertension and coronary artery disease, status post stent in 2009, hyperlipidemia and asthma. On 7/5/12, he was seen for his initial chronic care visit. The provider noted that the patient's diabetes and hypertension were in good control. Despite the patient's history of coronary artery disease and the fact that he had diabetes, hypertension and hyperlipidemia, the provider did not obtain a history related to chest pain, shortness of breath, or exercise tolerance. The provider ordered laboratory tests and follow-up in six weeks. On 7/12/12, the laboratory tests were done and showed that the patient's cholesterol was not at goal (LDL=104, given the patient's history of coronary artery disease, his LDL cholesterol target should have been less than 70). On 9/20/12, the provider saw the patient and noted that he would check a fasting lipid panel at the next visit. On 11/29/12, the provider saw the patient for follow-up and noted that he would continue the patient's current medications for hyperlipidemia. He did not order a repeat test. On 2/5/13, the patient completed the *Asthma Control Assessment Tool* form, stating that he felt that his asthma was "not so good", and the patient's score on the assessment tool indicated that his asthma was not in good control. The provider noted that the patient was using less than one inhaler per month. Other than that, he did not obtain any further history related to the patient's asthma. The provider did order a repeat fasting lipid panel that was performed on 2/7/13 and revealed that the patient's hyperlipidemia had worsened (LDL=127). As of 2/15/13, a provider has not seen the patient for follow-up.[51]

  Assessment

  There were problems related to quality of care. On 7/5/12, the provider did not obtain an adequate history related to the patient's coronary artery disease. On 2/5/13, the provider did not obtain an adequate history related to the patient's asthma. Furthermore, the patient did not receive appropriate care for his hyperlipidemia.

[50] Chronic Care Patient #17
[51] Chronic Care Patient #19

- The patient is a 41-year-old man who transferred to RJD on 9/11/12. He has a history of diabetes, hypertension, hepatitis C infection and peripheral vascular disease. At his prior facility, a provider saw him on 8/30/12 for chronic care. At that time, the provider noted that the patient's diabetes was not controlled (8/28/12 hemoglobin A1C=9.7%) and adjusted his insulin. When the patient arrived at RJD, the physician reviewed his medical record and ordered follow-up with the primary care physician in one week, but the patient was not seen for almost five weeks, on 10/15/12. At that time, the provider did not review the patient's blood sugars and, therefore, did not evaluate the degree of control of his diabetes. The provider ordered follow-up in 8-10 weeks.[52]

  Assessment
  There were problems related to timeliness and quality of care. The initial chronic care visit did not occur in a timely manner. In addition, when the provider saw the patient for his initial visit, the provider did not adequately evaluate the patient's diabetes and then did not order follow-up for another 8-10 weeks.

- The patient is a 59-year-old man who transferred to RJD on 11/30/12. On 1/3/13, his LDL cholesterol was 114. The primary care provider notified the patient that a chronic care visit had been scheduled to discuss the results of his blood tests. On 2/1/13 the primary care provider saw the patient for follow-up but did not address his elevated LDL cholesterol.

  Assessment
  There was a problem related to quality of care. The patient's elevated LDL cholesterol was not addressed.[53]

- The patient is a 50-year-old man who transferred to RJD on 8/29/12. He has a history of diabetes and hyperlipidemia. On 8/28/12, just prior to his transfer to RJD, a provider saw him for chronic care, noting that the patient's hyperlipidemia was not at goal (3/19/12 LDL=127) and that he was noncompliant with his medication. He documented that he discussed the need to take his medication and lifestyle changes with the patient. The provider further noted that the patient was due to be transferred the following day and that he would defer "to his new physician to adjust statin therapy." On 10/8/12, following transfer, a provider saw the patient for his initial chronic care visit and, noting the patient's prior LDL cholesterol, increased his medication for hyperlipidemia and ordered follow-up in 45 to 60 days. On 12/6/12, a primary care provider saw the patient for follow-up and planned to check a fasting lipid panel. On 12/11/12, his LDL cholesterol increased to 136. On 12/14/12, the provider notified the patient that a chronic care appointment had been scheduled to review the results of his laboratory test. However, as of 2/15/13, the patient had not been seen.[54]

[52] Chronic Care Patient #20
[53] Chronic Care Patient #21
[54] Chronic Care Patient #22

Assessment
There was a problem related to timeliness of care. The patient was not seen for follow-up in a timely manner.

- The patient is a 57-year-old man who transferred to RJD on 10/30/12. He has a history of recurrent deep vein thrombosis, for which he is receiving warfarin. On 1/24/13, his INR was sub therapeutic (1.7). On 1/29, the provider increased his dose of warfarin. As of 2/15, his INR had not been repeated.[55]

  Assessment
  There was a problem related to quality of care. The patient's anticoagulation therapy was not being appropriately managed. (According to the CCHCS guideline on anticoagulation, the INR needs to be checked seven to 10 days after a dose increase of warfarin.)

- The patient is a 50-year-old man with a history of protein S deficiency (a blood clotting disorder) for which he is receiving warfarin. Dr. Wilkinson, a hematologist, recommended an INR target range of 1.2 to 2.0. (The usual target range for a patient with a clotting disorder is 2.0 to 3.0.) Dr. Wilkinson's recommendation was noted on the problem list. Despite this, the patient was not receiving consistent care from the medical staff. Some providers were using a target range of 1.2 to 2.0, while others were using a target range of 2.0 to 3.0.[56]

  Assessment
  There was a problem related to quality of care. The patient's anticoagulation therapy was not being consistently managed.

- The patient is a 42-year-old man who transferred to RJD on 8/1/12. He has a history of ulcerative colitis and anemia that was diagnosed in June 2012 at another facility. He was being treated with Mercaptopurine and Mesalamine. On 8/10/12 and 10/15/12, a provider saw him for chronic care. On 10/15/12, the provider ordered follow-up in 8-10 weeks. However, as of 2/15/13, the patient had not been seen for follow-up.[57]

  Assessment
  There was a problem related to timeliness of care. Ordered follow-up did not occur in a timely manner.

- The patient is a 69-year-old man who transferred to RJD on 12/28/11. He has a history of diabetes, atrial fibrillation, kidney cancer, chronic kidney disease, hypertension,

[55] Chronic Care Patient #25
[56] Chronic Care Patient #27
[57] Chronic Care Patient #28

hyperlipidemia, hypothyroidism (the patient had been hyperthyroid in the past), cardiomyopathy with an ejection fraction of 20% and a pacemaker, aortic regurgitation, mitral regurgitation, and tricuspid regurgitation. Overall, his care was marked by the lack of a consistent and thorough treatment plan that addressed all of his problems. Multiple primary care providers and specialists saw the patient for his medical problems. This resulted in fragmented care as no one physician was responsible for managing all of this very complicated patient's medical problems.

The care of the patient's hyperthyroidism was particularly problematic. The patient was being treated with methimazole for hyperthyroidism. On 10/12/12, his TSH was high at 5.69 (normal=0.4-4.5) and the total T3 was low at 66 (normal=76-181). This is indicative of hypothyroidism is rather than hyperthyroidism. On 10/13/12, a primary care provider notified the patient that he would be scheduled for an appointment to discuss his laboratory tests, but did not see the patient until 11/19/12. The provider noted the TSH result of 5.69, but did not obtain a history or perform a physical examination related to signs/symptoms of thyroid disease. At that time, the patient was receiving the maximum recommended dose of methimazole. [Note: Patients should receive this dose of medication until the level of their thyroid hormone is in the normal range. At that point, the methimazole should be lowered to a maintenance dose.] The provider did not adjust the patient's medication. She ordered repeat laboratory tests and follow-up in six weeks. On 12/27/12, a repeat laboratory test revealed that the patient's TSH had increased to 131.57, indicating that the patient had severe hypothyroidism. The patient was not seen for eight days, despite this very high value. On 1/4/13, a provider stopped the methimazole and ordered repeat laboratory tests in 3-4 weeks. On 1/22/13, a provider ordered thyroid replacement therapy.[58]

Assessment

There were problems related to quality of care. The patient's care was fragmented. In particular, the treatment of his thyroid disease was inappropriate.

Pharmacy and Medication Administration

Methodology: We interviewed the Pharmacist-in-charge, nurses that administer nurse-administered medications and keep-on-person (KOP) medications, toured the pharmacy, clinic and KOP medication rooms, pharmacy inspection reports and reviewed medication administration records in each of the clinics and in health records. We also reviewed Medication Administration Process Improvement Reports (MAPIP) and other CCHCS internal audits.

Pharmacy Services

Findings: We reviewed RJD data and noted problems related to access to medications. The December 2012 CCHCS dashboard showed that, for October 2012, access to medications scored 62% compared to 85% statewide. We also note that there are issues related to chronic disease

[58] Chronic Care Patient #38

medication delivery, medication error reporting, and documentation of no shows/refusals (See Medication Administration).

At RJD, the pharmacy is located in the CTC and space is at a premium. Although staff has made an attempt to use the space to promote optimal use, the pharmacy is nonetheless cramped and difficult to keep clean. There are sheets of paper identifying pharmacy stations that are taped to the countertops, which make disinfection practices less effective.

The pharmacy provides coverage seven days a week. During the week, pharmacy hours are from 8 am to 6 pm; and weekend coverage is 9 am to 5 pm. The pharmacy dispenses an average of 800-900 prescriptions per day. Pharmacy staffing consists of five pharmacist positions; three pharmacists are full-time and two pharmacists are permanent intermittent employees (PIEs) that can work a maximum of 2000 hours per year. There are ten pharmacy technicians; four are full-time, one is a PIE, and five are registry. Weekend pharmacy staffing is through registry staff.

At RJD prescriptions are dispensed to patients through a combination of a licensed in-house pharmacy and Central Fill (30-40%) in Sacramento. This includes unit dose medications, blister packs and loose pills placed in a baggie with a pharmacy label. There is a limited amount of stock medications in the housing unit medication rooms.

Pharmacy staff conducts monthly inspections of medication rooms. Our review of pharmacy inspection reports from June to December 2012 show that pharmacy staff actively identifies and addresses deficiencies in medication rooms, such as removing expired medications, excess over-the-counter (OTC) medication supplies, and outdated open vials of medications.

New Prescriptions

For maintenance (e.g. chronic disease) medications, providers write prescriptions with durations of up to 12 months. To dispense new prescriptions, clinic nurses transcribe medication orders and scan them directly into a new prescription share folder on the computer. Pharmacy staff prints the order and scans the order into the pharmacy system.

Medication Refills

To ensure continuity of maintenance medications, the pharmacy auto-refills 80% of prescriptions 3 days in advance of the patient's last medication dose.[59] For the remaining 20% of refills, nurses can go into Guardian and click the refill request, submit a written request, or call the pharmacy. If an order has expired, a pharmacist emails the provider with a request to let the pharmacy know whether or not the medication needs to be renewed. For PRN (i.e., "as needed") medications, inmates are expected to submit written requests to refill the medication.

[59] Maintenance medications are essential medications (e.g., chronic disease) that should be continued.

Medication Renewals

To facilitate timely renewal of medication orders, every Monday the pharmacy prints out the medication reconciliation reports of medications that will expire in the next two weeks and delivers them to the medical providers. Providers are expected to review these medication reconciliation reports and renew or stop medications as necessary. The medication reconciliation reports are then scanned into the share folder for processing by pharmacy staff.

Medication Administration

Findings: The nurses generally adhere to proper nursing practice when administering medications. However, medication administration times are compressed and may lead to medication errors, side effects, or ineffective treatment.

RJD internal medication audits in October 2012 showed that 10 of 26 (38%) medication indicators scored >90%, and 18 of 26 (69%) scored >80%. However, of the remaining indicators, it is notable that chronic disease medication delivery scored 50%; medication error reporting scored 28%; and documentation of no shows and refusal scored 17%. In December 2012 internal audits show that chronic disease medication deliver had improved to 65%; medication error reporting to 85.71% and documentation of no shows and refusals to 23.81%. The scores for chronic disease medication delivery and medication error reporting are among the most important given the volume and medical acuity of the population.

Nurses administer medications via directly observed therapy (DOT), nurse-administered (NA) or keep-on-person (KOP). RJD has a mental health mission that increases the number of nurse-administered medications. Medication administration is conducted four times per day. However the times vary by facility and in some cases are compressed. For example, in Facility C, medication administration is from 7 am to 8:15 am; 11:30 to 12:00 pm; 3:30 to 4:30 pm; and 8 pm for hour-of-sleep medications. If a patient is prescribed medication three times daily (and not specifically at hour of sleep), the patient may receive these medications at 8 am, noon and 4 pm. This is a compressed dosing schedule (8 hours) for three times a day medications and may result in adverse side effects or ineffective treatment because serum drug levels may be too low for the remaining 16 hours of a 24 hour period.

We observed nurses administering medications to patients. In general, we found that nurses followed proper nursing practice. However, we noted that RJD procedure involves nurses using latex gloves to administer medications and staff reported that they are required to change gloves every fourth patient. This practice is largely ineffective because nurses can administer medications through aseptic technique (i.e. not touching the medication) whether they are wearing gloves or not. The important step is for the nurse to wash hands or use a hand-sanitizer before and periodically during medication administration. This is because the nurse is touching a number of objects (e.g., MARs, drawers, etc.) throughout the process. When nurses wear

gloves, they can also become contaminated, but nurses do not use hand-sanitizer because it makes the gloves sticky and interferes with medication administration. [60]

In administrative segregation, we did not observe medication administration, but asked nurses to demonstrate how they administer medications in the unit. The nurse demonstrated her practice, which was consistent with generally accepted nursing practice standards. Notably and correctly, the nurse did not describe that she removed medications from pharmacy dispensed, properly labeled containers and placed medications in improperly labeled coin envelopes, a practice we have observed at other facilities.

Review of MARs in the medication rooms and in the eUHR showed that they were generally neat, legible and contained few blank spaces.

Laboratory/Radiology

Methodology: We interviewed staff and reviewed reports and health care records related to management of laboratory and radiology services.

Findings: In general, RJD laboratory and radiology services are working well. Radiology services are provided on-site. In addition, mobile units provide magnetic resonance imaging (MRI), Computerized Tomography and ultrasound a minimum of twice monthly. Our review showed that radiology procedures were performed and reviewed in a timely manner.

Laboratory services are provided by Quest Laboratories. Record review showed that ordered labs were generally obtained, reviewed and scanned into the eUHR in a timely manner. However, we found that providers do not address abnormal laboratory reports in a timely manner, even with critical labs. One example is the 83-year-old patient discussed above whose lab tests indicated that his heart failure was poorly controlled. The provider signed the report the day after it was available but took no action to see the patient. One week later the patient went into cardiac arrest and subsequently died. Another example is the patient discussed above with a history of hyperthyroidism developed hypothyroidism by virtue of overtreatment with anti-thyroid medication; when his TSH increased to 5.69, a provider did not address the abnormal report. About 2 months later the TSH increased to 131.57 yet no one noticed the critical value for over a week. This patient had two episodes of failure to review labs and one episode of failure to review a critical lab.[61]

Health Records

Methodology: We toured the health records unit, interviewed the Medical Records Director and other health records staff, and 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.

[60] Staff reported that some mental health patients insist that nurses use gloves. The use of gloves should be determined by nursing and infection control standards, not patients. We discussed this with Karen Rea, Statewide Chief Nurse Executive who was in agreement and discussed this subject with RJD nursing leadership.
[61] Chronic Care Patient #38

Findings: As noted in our prior reports, CDCR has migrated statewide from a paper record to an electronic Unit Health Record (eUHR). This is not a true electronic health record in which information is entered directly into the record, but one in which staff completes paper documents or dictates clinical notes that are transcribed and scanned into the record. Although an improvement over a paper record, it has significant limitations (see San Quentin report).
Despite the limitations of the eUHR, we find that health records management is working well at RJD. The health records unit is of sufficient size to conduct operations but improvement is needed in sanitation. The area is undergoing transition as paper records are being shipped to the Health Records center in Sacramento. The area is to be renovated with paper record shelving removed, floors repaired and walls painted.

Staff reported that there would be no staffing changes as a result of the implementation of Acuity Based Staffing Realignment. Currently, there is a health record technician II position, and seven HRT I positions (one has been out on workers compensation for six months), and six office assistants (OAs). The facility averages approximately 15-22 inches of health records per day and 40-60 inches at the end of the month with receipt of Medication Administration Records. We found that there were no backlogs in scanning health records into the eUHR. However, providers reported that they have a difficult time obtaining hospital records upon discharge and this was evident in chart reviews (See Urgent/Emergent Care).

The Health Records Director has a quality improvement process to identify errors related to the timeliness and accuracy of health record scanning. She reported that sometimes the scanners are inoperable for a period of time.

Urgent/Emergent Care

Methodology: We interviewed health care leadership and staff involved in emergency response and toured the Triage and Treatment Areas (TTA). We assessed the availability and functionality of emergency equipment and supplies and reviewed the CCHCS Institutional Reports on potentially avoidable hospitalizations. We also reviewed 14 records of patients selected from the on-site urgent/emergent and off-site emergency room/hospitalization tracking log.

Findings: When patients have an urgent medical problem and require hospitalization, they are transferred timely to a hospital. However, based on chart reviews, it is apparent that the TTA is used in lieu of primary care management, and routine medical conditions become emergencies because patients do not have chronic illness follow-up in clinics. The primary care model is not effectively in place at RJD and the chronic care system is also not effective. Some patients reviewed had many more TTA visits than primary care visits. This was a pattern on multiple charts reviewed and unfortunately resulted in many potentially unnecessary and preventable hospitalizations that placed patients at serious risk of harm.

In one case, a patient had four TTA visits on an emergency basis, three specialty care visits and three hospitalizations before a primary care clinic occurred. This included an urgent care issue

that was dangerously trivialized. This patient had multiple episodes of hyperglycemia that were being managed in the TTA because of a lack of primary care management. At one point, his blood sugar was dangerously elevated (671) with a sodium of 132 and a bicarbonate of 20. These values are approaching diabetic ketoacidosis, a life-threatening medical emergency. A provider should have seen the patient immediately in the TTA and assessed further or admitted the patient to a hospital. Instead, the patient was not seen and this lab was signed off seven days later with a notation to follow-up in primary care clinic. This was a near-miss event and is unacceptable care. Furthermore, when a provider finally saw the patient for chronic care, the provider did not address all of his medical conditions. The patient was taking a blood thinner and was twice hospitalized for alarmingly elevated lab tests showing that he was at risk for life-threatening bleeding (INR values were 14.1 and 9.4). The second hospitalization was preventable because the warfarin dose was not adjusted after the first hospitalization and was not monitored. This episode was also a near miss because the patient had been hypotensive and fell. It was only then that the elevated INR was incidentally noted at the hospital. Falls in patients on warfarin are dangerous.[62]

Another example is that of a 53-year-old man who had seen his primary care physician on 8/6/12 for evaluation of a neck mass. During that visit, the provider noted that the patient was also complaining of intermittent swelling and pain of his left knee. The provider noted that his examination of the patient's knee did not reveal any abnormalities. He ordered an x-ray, lab studies, and follow-up in three months or as necessary. On 8/8/12, the x-ray was performed and revealed degenerative changes. On 8/14/12, laboratory tests were normal. On 8/17/12, the patient was seen in the TTA because he was complaining of knee pain and swelling that began that morning when he woke up. He stated that he was unable to flex or extend his leg due to the pain and swelling, and was unable to walk a long distance. The TTA nurse noted that, other than minimal swelling from the patient's thigh to his left foot, her examination of his leg was normal. She contacted the on-call physician, who ordered an ace bandage and ice. The physician also instructed the nurse to advise the patient to minimize his activity and ambulation and to continue with this current pain management (Tylenol that had been prescribed for low back pain). On 8/19/12, another nurse saw the patient in response to a health services request that he had submitted on 8/17/12 (the day he had been seen in the TTA). She noted that he was complaining of intermittent swelling of his knee. She further noted that the patient was walking with a limp and using a cane. She also noted the presence of swelling without any bruising or deformity. She discussed the case with a physician who recommended follow-up as had been ordered by the TTA physician. On 8/22/12, the patient submitted another healthcare services request complaining of knee pain. A nurse saw him that day and noted that he was ambulating with a limp and that there was swelling and tenderness to palpation. The nurse discussed the case with a physician who advised the use of crutches and follow-up with the primary care physician in one week. On 8/24/12, the patient was sent to the TTA due to a complaint of pain and swelling of his leg. His temperature at that time was 101°. His left knee was noted to be 4 cm bigger than his right knee. He was sent to an outside hospital where he

[62] Urgent/Emergent Care Patient #11

was admitted for an infected knee joint. In this case, the patient was seen multiple times by a nurse for a painful, swollen knee, before being evaluated by a physician. [63]

Medical care of patients following urgent events is poor because there is no effective primary care management at RJD. One patient[64] with severe emphysema was seen in primary care with an oxygen saturation of 83%, and the primary care doctor took no action. Two days later the patient submitted a health request (e.g. 7362) for shortness of breath, but the nurse did not see the patient urgently. Instead, the patient went to the TTA the next day for treatment. The following day a nurse triaged the health request but the nurse did not evaluate the patient because he had been seen in the TTA the previous day. The nurse ordered follow-up in 3-5 days with the primary care provider. The following day the patient was so short of breath, he could not speak and was hospitalized. His oxygen saturation was 73%, his PCO2 was 56 and he had pneumonia. This was a near-miss event. The failure to establish an adequate primary care program is resulting in episodic management through the TTA and unnecessary hospitalization with serious risk of harm to patients.

Follow-up after hospitalization is also poor. One patient developed a lesion and abscess on his scrotum that required surgical intervention with suture placement. He was discharged back to the facility and was not seen for 12 days. The sutures had not been removed and became infected, and the patient required rehospitalization. [65]

An additional serious problem was that doctors at RJD commented that they have a difficult time obtaining hospital records upon discharge. This was evident from the charts we reviewed.

Specialty 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 19 patients for whom services were requested.

Findings: With respect to timeliness, we note the OIG Cycle 3 report shows that specialty services were performed timely in just 66.7% of cases. In addition, the January 2013 CCHCS Dashboard shows that RJD scored 73% with respect to timely PCP appointments following specialty services. While in many cases the PCP is not seeing patients within the required time frames for follow-up of specialty care, the recommendations of the specialists are generally being addressed in a timely manner and the patients are receiving appropriate care. However, we did find that in 4 of 19 (21%) cases, there were serious problems with either timeliness of care (3) or quality of care (1). The cases we found are summarized below.

- The patient is a 57-year-old man with metastatic liver cancer for which he is receiving chemotherapy. On 12/26/12, the pain specialist saw the patient and recommended an increase in his pain medication. The patient was not seen by a primary care provider

[63] Urgent/Emergent Care Patient #15
[64] Urgent/Emergent Care Patient #8
[65] Urgent/Emergent Care Patient #9

following the appointment and his medication was not changed. On 1/29/13, a provider saw the patient and increased his pain medication.[66]

Assessment

There was a problem related to timeliness of care. The patient was not seen in a timely manner for follow-up of his specialty appointment. As a result, there was a delay in the implementation of the specialist's recommendation to increase his pain medication.

- The patient is a 53-year-old man with a neck mass. On 8/6/12, the primary care provider noted that the patient had a firm, fixed mass on the right side of his neck that the patient stated had been present for six months. The provider submitted a request for an ENT consultation and noted that it should be done ASAP. During the same time period, the patient was being evaluated and treated for a painful, swollen knee. On 8/24/12, the patient was admitted to a local hospital for treatment of an infected knee. He was subsequently transferred to Corcoran State Prison for six weeks of intravenous antibiotic therapy. His neck mass was not addressed either at RJD prior to his hospitalization or during the time he was at Corcoran State Prison.

  On 10/18/12, the patient returned to RJD and on 10/25/12, a provider ordered a CT scan to evaluate the neck mass. On 11/15/12, the CT scan revealed a mass that was suspicious for neoplasm and right-sided lymphadenopathy. On 11/20/12, the patient was referred to an ENT specialist on an urgent basis for an excisional biopsy of the neck mass. On 11/28/12, the ENT specialist saw the patient and biopsied the mass. He also ordered an MRI and follow-up in two weeks to discuss the results of the biopsy and MRI. Upon the patient's return to the facility, the TTA nurse referred him to the primary care physician for follow-up in three to five days.

  On 12/3/12, the pathology report was received and noted that the mass was suspicious for squamous cell carcinoma. On 12/5/12, the biopsy report was reviewed and signed by a physician. On 12/8/12, the patient submitted a health services request asking to know the results of the tests. He also stated that he was having pain and difficulty swallowing. The patient was seen in the TTA and the physician noted that he would check to see if the MRI and ENT follow-up had been ordered as requested. He also ordered follow-up with the primary care physician in five days. The patient was subsequently hospitalized from 12/10/12 until 12/12/12 for a knee injury that required surgery. On 12/19/12, the primary care provider saw the patient for follow-up of his hospitalization. The provider noted that the patient had a neck mass that was suspicious for cancer and referred him to an oncologist.

  On 12/28/12, the patient submitted another health services request complaining of difficulty swallowing. On 12/31/12, the patient submitted another health services request stating that he was having difficulty swallowing, his voice was changing and he

[66] Specialty Care Patient #6

was in pain. He stated, "I need help because I'm not able to eat very much." On 1/3/13, a provider saw the patient in response to his health services requests. The provider noted that the patient had pending appointments and that she contacted the specialty area but the scheduler was not there. On 1/16/13, the patient submitted another health services request stating, "This is about the fourth time I'm complaining about not being able to swallow food. I have a lump on the right side of my neck (squamous cell carcinoma.) I believe this is the cause. It is also starting to be very painful. I was supposed to have surgery to have it removed. Please help. Thank you." On 1/22/13, the patient submitted another health services request. On both of these occasions, a nurse told the patient that he had an appointment pending. On 1/24/13, the patient saw a provider who noted that he would follow up on the referral.

On 1/29/13, the patient finally saw the ENT specialist. The specialist noted that he would schedule surgery following the MRI. Upon the patient's return to the facility, a physician ordered follow-up with ENT and the primary care physician in two weeks. He did not address the need for the MRI. On 1/31/13, a physician submitted a request for surgical excision by the ENT specialist and an MRI. He ordered the MRI as urgent and added "prior to surgery within one week." The MRI was done on 2/12/13. The radiologist noted that there was enlarged adenopathy and increased enlargement of the tonsil. He advised biopsy, noting that this most likely represented tumor metastasis. The patient did not see the ENT specialist until 2/27/13. The ENT specialist scheduled the patient for surgical excision of the mass.[67]

Assessment

There were problems related to timeliness of care. There were multiple delays in the care of this patient that led to a six-month delay in the treatment of a life-threatening medical problem.

- The patient is a 63-year-old man who transferred to RJD on 7/13/12. He has a history of hypertension, congestive heart failure, diabetes, sick sinus syndrome for which he has had a pacemaker since 2004, atrial fibrillation for which he is on warfarin, hepatitis C infection and end-stage liver disease. The last time his pacemaker had been checked was in August 2011 at a prior facility. At intake, he was referred to see a primary care physician in two weeks. On 8/13/12, the primary care physician saw the patient for his initial chronic care visit. The provider noted that the patient was doing well and was compliant with his medications, and that the provider's review of systems was negative. He did not obtain any further history related to the patient's problems and did not address the fact that the patient had a pacemaker. He ordered follow-up 30 to 45 days. On 10/3/12, the provider saw the patient but did not address the patient's pacemaker at that time. He ordered follow up in 8-10 weeks. On 12/4/12, the provider saw the patient and, at that time, submitted a request for the patient to see a cardiologist for a

[67] Specialty Care Patient #8

pacemaker check. On 2/5/13, the patient saw the cardiologist. His pacemaker was functioning properly and the cardiologist ordered another check in three months.[68]

Assessment
There was a problem related to timeliness of care. When the patient arrived at RJD, his pacemaker had not been checked in approximately 11 months. He did not see a cardiologist and have the pacemaker checked for another seven months.

- The patient is a 42-year-old man who fractured his finger on 10/15/12. He received appropriate care. He was seen by the orthopedist for follow-up via telemedicine on 1/24/13. The orthopedist noted that the patient had stiffness and an inability to flex his finger more than 90° and recommended 2-3 weeks of hand physical therapy and encouraged full active and passive range of motion of the finger. On 1/29/13, the primary care physician saw the patient for follow up. He demonstrated exercises for the patient to do but did not address the orthopedist's recommendations for physical therapy.[69]

  Assessment
  There was a problem related to quality of care. The primary care provider did not address the recommendation for physical therapy.

Specialized Medical Housing: OHU/CTC

Methodology: We interviewed personnel working in the specialized medical housing units. We reviewed bed utilization reports and/or tracking logs of admissions to the specialized medical beds and reviewed records of patients admitted to the unit in the past six months.

Findings: RJD has a 28-bed CTC. Fourteen beds are dedicated for mental health patients, twelve beds to medical patients, and two beds are swing beds. Staff reported that the 12 medical beds are nearly continuously filled, and, on the week of our visit, all of the medical beds were filled. Twelve higher-level CTC beds are inadequate under current conditions for more than 3500 inmates. This is especially true because RJD is accepting an increasing number of high-acuity Intermediate patients.

At the time of our visit, the medical beds were occupied by five patients who were unable to care for themselves; five who were nursing home type patients; and two who were being cared for temporarily until placement could be arranged in an OHU. We reviewed all twelve patients on the CTC with the physician of the unit. All patients were appropriately assigned. Treatment plans were adequate.

[68] Specialty Care Patient #9
[69] Specialty Care Patient #10

The problem regarding specialized medical housing at RJD is not within the CTC unit. There are many general population patients who need CTC care but can not get into the CTC. Patients who were sent to RJD for higher levels of care are housed in general population because of lack of CTC beds. Keeping these patients in general population is not safe. We noted hospitalizations that we believe were due to the patient not being in the appropriate level of housing.

One patient transferred from CTF to RJD on 24 medications, had severe emphysema, diabetes mellitus, osteoarthritis, was on continuous oxygen therapy and was confined to a wheelchair because he could not walk 15 yards without shortness of breath. He was to be transferred to a higher level of care but was transferred to RJD as disabled and upon arrival was sent to general population. Upon arrival, he was not seen by primary care for a couple of weeks and, when seen, his care was not thorough. He spent about six months in general population before a bed opened up in the CTC, placing him at risk for a considerable length of time. [70] Another patient we reviewed had a stroke with hemiparesis and a foot drop. He had been on the CTC for rehabilitation and was discharged to general population. He had difficulty managing in general population and he fell twice; each fall required hospitalization. On the second fall, he broke his hip. He still resides in general population. [71] Another patient who was already identified as needing a higher level of care was housed in general population. He was unable to use a walker, unable to stand without dizziness, and got short of breath when he stood up. He was given a wheelchair but had significant difficulty in general population. He spent nine months in general population before being transferred to the CTC. [72] Yet another patient was transferred from CIM to a higher level of care at CMC, but because the patient did not need a GACH and was disabled, he was sent to RJD. He was in general population for about six months before he had a near-miss hospitalization due to emphysema and was transferred to the CTC. [73]

In part, the difficulty in placing patients in the CTC is related to the current shortage of beds for long-term skilled nursing patients in the CDCR. This will be ameliorated when the new California Health Care Facility (CHCF) opens in Stockton. While we recognize this future improvement, RJD must find a way to safely manage the current caseload of high-risk patients in general population who need a higher level of care. We suggest starting with a root cause and process analysis of problem patients identified in chart reviews and working from there to develop stopgap safety measures until CHCF opens.

In addition, in advance of CHCF opening, the CDCR and CCHCS have agreed on a strategy to house higher acuity medical patients in one of eleven Intermediate facilities. This strategy has already begun to be implemented. Medical classification information is provided to the CDCR via the medical chrono, and CDCR transfers inmates based upon an agreed medical classification matrix. However, in practice, this system is defective in that RJD is receiving patients classified only as disabled, but who are in need of a higher level of medical care that

[70] Specialized Medical Housing Patient #1
[71] Specialized Medical Housing Patient #2
[72] Specialized Medical Housing Patient #3
[73] Specialized Medical Housing Patient #5

RJD cannot accommodate due to woefully inadequate number of CTC beds. Consequently, these patients are assigned to general population, which is a patient safety issue.

Mortality Review

Methodology: We interviewed the Chief Medical Executive and staff responsible for Mortality reviews. We also reviewed CCHCS Death Review Summaries for deaths that occurred from 9/12/11 to 8/11/12. We reviewed 3 of 6 patient health records and compared our findings to the corresponding Death Review Summary. We also reviewed the health record of a patient that died on 2/7/13, during the week of our visit.

Findings: There were 15 deaths at RJD in 2012.[74] Of these, a Death Review Summary has been completed on 11 patients with 4 pending completion. Of the 11 Death Review Summaries available for review, causes of death were as follows: 2 were from suicide, 2 from drug overdose, 3 from cancer, 1 from sepsis, 1 from diabetic ketoacidosis, 1 from respiratory failure, and 1 from coronary artery disease. Of the four 2011 Death Review Summaries provided to us, causes of death included cardiomyopathy, respiratory failure, end-stage liver disease and suspected homicide.

We reviewed all of the CCHCS Death Review Summaries and reviewed four patient records to compare our findings with the CCHCS Death Review Summary. Our review showed significant lapses in care that were not identified in the CCHCS Death Summary. These cases are described below.

- In the case described in the Intrasystem Transfer section of this report, an 83-year-old medically complicated patient was acutely ill upon his arrival at RJD but the nurse did not refer the patient to a medical provider.[75] Although the patient's medications were reordered on the day of arrival, the patient reported that he did not receive several of his medications, notably Lasix, a diuretic that is a mainstay in treatment of heart failure, as well as potassium and nitroglycerin. The medication reconciliation report shows that the pharmacy refilled his medications on the day of his arrival, but we find no MARs that document that he received them. This occurred at a time when he complained of being unable to ambulate to the shower and chow hall due to shortness of breath.

  Four days after his arrival, when a nurse saw him for a health request stating that he did not receive his medications, his oxygen saturation was 85%, which is extremely low and a value supporting immediate medical evaluation. The nurse discussed his condition with a physician, who did not evaluate the patient but did increase his diuretic and order labs. The physician's failure to examine the patient was an extreme departure from the standard of care.

[74] RJD later stated that there were 14 deaths. The list given to us included 15 deaths from 1/6/12 to 12/14/12.
[75] The patient arrived at RJD on a Friday

Two days later, a provider saw the patient but did not take a history of his shortness of breath and exercise tolerance, which might have provided information about whether the patient's symptoms were more cardiac or pulmonary in nature, nor was the patient's oxygen saturation measured at the visit. Although the patient had a history of coronary artery disease and heart failure, the RJD provider did not prescribe an ACE inhibitor in accordance with current recommendations. When the provider reviewed a blood test (BNP=765, normal<100) the following day indicating exacerbation of his heart failure, the provider did not arrange to see the patient. A week later the patient had a cardiac arrest. Correctional officers found the patient unresponsive but did not assess the patient for life signs or initiate basic life support. Health care staff arrived and successfully resuscitated the patient, who was transported to the hospital, where the admitting physician noted that he had exacerbation of his heart failure with elevated BNP levels and generalized edema, as well as suspected pneumonia and respiratory failure due to exacerbation of his COPD. He was later transferred to another hospital where his condition continued to deteriorate. He declined life-saving measures and died on 1/6/12.

The CCHCS mortality review found that the death was not preventable. It found no departures from the standard of care except that the nurse failed to refer the patient to a provider at the time of arrival. It did not address lapses in medication continuity; provider failure to evaluate a patient with an oxygen saturation of 85; failure to address a laboratory report indicating worsening heart failure; or the failure of correctional staff to assess the patient for life signs and initiate CPR. Although the patient was elderly, it is our opinion that the lapses in care and lack of aggressive treatment of his heart failure may have led to premature death.[76]

- Another death involved a 69-year-old who arrived at CDCR on 10/05/10 and transferred from CIM to RJD on 5/27/11. His medical history included a myocardial infarction, coronary artery bypass surgery and atrial septal defect repair on 4/18/11, heart failure, paroxysmal atrial fibrillation, COPD, pulmonary fibrosis, leukemia and bone marrow transplant and suspected amyotrophic lateral sclerosis. At the time of transfer the patient was in a wheelchair.[77]

  Six weeks prior to transfer to RJD, the patient had a myocardial infarction, coronary artery bypass surgery and repair of a large atrial septal defect. On 6/10/11, a PCP saw the patient as a new arrival, submitted a request for cardiology consultation and planned to follow up with the patient in 30 days. Two weeks later, the patient was hospitalized for shortness of breath and a scrotal abscess. On 6/29/11, following discharge, a provider saw him as a hospital returnee. At that time, the patient reported difficulty breathing and that he needed an oxygen canister to help him breathe. The provider ordered Flovent and Atrovent and planned to see the patient in 30 days.

[76] Mortality Review #1

[77] Mortality Review #3. This review was limited due to all records not having been scanned into the eUHR. Some information was obtained from the CCHCS Death Summary.

On 7/20/11, the patient submitted a health request stating that he was having trouble breathing and needed his own tank of oxygen because it was an ongoing problem with no action taken. On 7/21/11 at 12:00 pm, during a lab draw, the patient was dizzy and short of breath. A nurse evaluated the patient, who was hypotensive (BP=80/52 mm/hg and 95/52 mm/hg repeated) and tachycardic (pulse=129/bpm initially and 158/bpm repeated). At 1:00 pm, a TTA provider evaluated him. His oxygen saturation was initially low (90% and 86%, then increased to 100% with oxygen). The provider ordered a portable oxygen concentrator, changed his chrono to high-risk status with limited duty, and sent the patient back to general population. Another provider saw the patient twice for Coumadin clinic but the patient was not taking his Coumadin and nurses had not advised the provider.

On 8/2/11, a provider saw the patient for his first chronic disease visit since his arrival on 5/27/11.[78] He did not obtain any history related to the patient's pulmonary fibrosis, atrial fibrillation or heart failure, including his recent urgent visit to the TTA. He also documented that he was on oxygen in his cell. He requested follow-up in 30 days.

On 8/10/11, the patient submitted a health request complaining of dizziness, shortness of breath, and 40 pounds of weight loss in a month. It was received and triaged the next day, but a nurse did not evaluate the patient until 8/12/11 at 11:45 am. At that time, his respiratory rate was 32-38 breaths per minute. A TTA provider saw the patient and sent him to the hospital.

Upon admission, the patient was initially treated for exacerbations of his interstitial lung disease and heart failure, but after developing hypercarbia, he was suspected of having a neuromuscular disease such as ALS (Lou Gehrig's disease). Despite treatment, his condition worsened, and he became dependent on a breathing machine.[79] The patient made a decision to become DNR and died on 9/12/11 of cardiac arrest.

In summary, a provider saw this medically complicated patient within two weeks of arrival. However, most of his care was episodic, fragmented, and occurred at the TTA. His primary care management was inadequate, and a provider did not thoroughly evaluate, document or manage all of the patient's medical conditions. The patient had a 40-pound weight loss that was not assessed or evaluated. The patient was not taking his Coumadin and his INRs were subtherapeutic, but nurses did not inform the provider he was not taking his medication. This patient required oxygen therapy and, due to his frequent episodes of shortness of breath, should have been housed in a higher level of care but was housed in general population.

[78] The provider noted he saw the patient on 6/29/11, but this was for a hospital return.
[79] BiPap machine.

The Death Review Summary did not identify any medical departures from the standard of care. The nurse review found that nurses did not notify the provider that the patient was not taking his Coumadin, and that a provider order for life sustaining treatment (POLST) was not discussed with the patient. Issues related to the 7/20/11 TTA visit, when the provider sent the patient back to general population after his grossly abnormal vital signs, were not addressed, nor was the issue of the patient's housing assignment discussed. Independent of whether the patient's death could have been prevented, the mortality review should have addressed these deficiencies.

- In another case, a 33-year-old was found unresponsive in the shower, and inmates carried him to the facility clinic, where a nurse found the patient to be unresponsive and pulseless. The clinic nurse and correctional officer initiated CPR but the patient died. The autopsy report found the patient died of an acute heroin overdose. Although the patient's death may not have been preventable, this case raises questions of the presence and role of correctional officers at the time the inmate was discovered in the shower; why correctional officers did not assess the patient for life signs and initiate CPR; and how the patient came to be transported to the clinic by inmates rather than health care staff summoned to the patient's location. These issues were not identified in the CCHCS mortality review.[80]

- With respect to the HIV transgendered patient described in the Chronic Disease section of this report, this case is remarkable for nurses abandoning a patient in distress and the lack of physician evaluation when nurses notified the provider that the patient was agitated and complaining of body aches, abdominal pain, and inability to walk. In addition, health record documentation reflects that CPR was not initiated by correctional officers. In our opinion, this patient's death was likely preventable.[81]

Internal Monitoring and Quality Improvement Activities

Methodology: We reviewed the 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 reviewed Emergency Response Review Committee, Infection Control and Pharmacy and Therapeutics Committee Meeting Minutes. With respect to ERRC Committee Meeting minutes, there is documentation of emergency response and areas requiring improvement. Infection Control Meeting Minutes primarily contain discussion of issues without any data regarding the incidence of infections. In fact, the June 2012 meeting meetings indicated that there had been no tracking for the last two years on communicable diseases. Pharmacy and Therapeutics Committee Minute Meetings contain useful information regarding pharmacy inspections and actions taken to correct deficiencies, but do not contain meaningful information regarding medication errors, analysis of root causes or corrective action plans.

[80] Mortality Review #4
[81] Chronic Care Patient #37

Recommendations

Organizational Structure, Facility Leadership and Custody Functions

1. Senior medical leadership should be hired as soon as possible.
2. Health care leadership should be represented at the Warden's meetings.

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

1. Physician staffing should be increased to full level staffing.
2. CCHCS should improve the hiring process by collaborative screening with the local facilities.
3. A program for training staff on pertinent policies and procedures should be instituted.

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

1. A 5-S lean process or similar process for organizing clinic space should be instituted.
2. CCHCS should continue with the plan to renovate clinic space at RJD.
3. CCHCS should ensure that a budget process is in place that accurately reflects health care operating expenditures.
4. Equipment and supplies should be standardized.
5. A replacement schedule for equipment should be instituted.
6. An alternate location for nurse triage in the segregation unit should be found until the planned renovation is complete.
7. Work orders for mechanical issues should be monitored for timeliness.
8. A process for reporting non-conformances with aggregate data being evaluated through the QI process should be instituted.

Policies and Procedures

1. Local operating procedures for major clinical processes should be developed.
2. Staff should be trained to these policies.

Reception and Intrasystem Transfer

1. A root cause and process analysis of the intrasystem transfer process should be performed in order to make it safe. This should include the time of transfers, the quality of clinical information handoff, the availability of medical records, the anticipated medical scheduled appointments or required appointments, and the timeliness and required content of initial physician evaluation at the receiving institution.

Access to Care: Nursing Sick Call

1. Health care leadership should review and provide feedback to nurses regarding their performance, including making appropriate provider referrals.
2. CCHCS and RJD Nursing leadership should provide training to nurses regarding obtaining a pertinent history of the presenting complaint and refrain from using the algorithm SAMPLEPAIN.

Chronic Disease Management

1. RJD Health care leadership should implement the Primary Care Model. This may require CCHCS support.
2. RJD health care leadership should perform studies and a root cause analysis to identify the reasons for the lack of timely and appropriate chronic care.

Pharmacy and Medication Administration

1. Nursing leadership should reevaluate the practice of using gloves during medication administration.
2. Nursing and pharmacy leadership should evaluate medication administration times to ensure an adequate interval between twice and three times daily dosing.
3. Nursing and pharmacy leadership should take measures to improve the reporting of medication errors and conduct a root cause analysis and develop corrective actions to address them.

Urgent Care/Emergent Care/Acute Hospital Care

1. The Quality Improvement program should perform root cause and process analysis on patients repeatedly admitted to hospitals or repeatedly managed in the TTA in order to improve the primary care program.
2. The Quality Improvement program should perform root cause analysis of failure to monitor critical lab values.

Specialty Consultations

1. RJD leadership should identify and address the issues related to lack of timely follow-up of specialty appointments.

Specialized Medical Housing: OHU/CTC/GACH

1. Until the CHCF opens, patients housed in general population who require a higher level of care should be separately tracked and managed as a special population of extremely high-risk patients.

Mortality Review

1. CCHCS should consider a change in policy requiring the facility to conduct an internal mortality review to identify deficiencies in care and that this be included in the CCHCS Death Review Summary.
2. CCHCS should reevaluate the Death Review Summary process to ensure that departures of care are adequately identified and addressed.
3. CDCR leadership should consider enhanced training for correctional officers to assess unresponsive patients for life signs and initiate basic life support measures. AEDs that may be used for inmates, staff and visitors, should be strategically placed around the facility.