

# **Sierra Conservation Center Health Care Evaluation**

March 26, 2013

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

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

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

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

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

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

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

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

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<sup>2</sup> The Status of Health Care Delivery Services in CDCR Facilities. Court-Appointed Medical Experts Report. April 15, 2006

## Overall Finding

We find that Sierra Conservation Center will be providing adequate medical care once health care physical plant issues are corrected.

## Executive Summary

On February 19-22, 2013, the Plata Court Medical Experts visited Sierra Conservation Center (SCC) to evaluate health care services. Our visit was in response to the OIG Medical Inspection Results Cycle 3 report showing that SCC scored 93.0% in September 2012. This report describes our findings and recommendations. We thank Warden Heidi Lackner, Chief Executive Officer Robert Duncan and their staff for their assistance and cooperation in conducting the review.

At SCC, we found an adequate health care delivery system that included:

- an appropriate medical organizational structure with competent leadership
- adequate health care staffing
- competent medical providers
- adequate custody to transport patients to on and off-site medical appointments
- timely initial access to care
- an adequate pharmaceutical system
- timely access to specialty services
- an adequate health records management system

We did, however, find opportunities for improvement. In some cases, the care of patients with chronic diseases was not timely and/or adequate. In addition, while providers review laboratory reports timely, they do not consistently address abnormal lab findings in a timely manner.

The facility medical physical plant is inadequate and in need of renovation. We believe that the SCC Health Care Facility Improvement Plan will significantly improve medical space. However, pending these improvements, clinical space needs to be better organized, standardized with respect to equipment and supplies, and sanitation maintained.

We commend SCC staff for improvements in the health care delivery system.

## Findings

### Facility Description

Sierra Conservation Center (SCC) is a minimum-medium facility that is one of two facilities that provide training and placement to inmates in the Conservation Camp Program. There are 19 camps serviced by SCC, located from central California to the Mexican border. The La Cima fire camp is located in Julian, California, about 480 miles away from SCC. This is an approximately eight-hour drive. Support for these facilities includes provision of routine medical care as well as medical support to the crews during actual fires.

The prison is separated into two dormitory-type facilities for minimum and low-custody inmates, and a separate high-medium custody facility. It has a level III Sensitive Needs Yard and approximately 350 correctional clinical case management (CCCMS) mental health patients. SCC also has an OHU of 13 beds. The design capacity of the facility is 3,736 and population at the time of our visit was 4,743, or 127% of capacity. This included 3,024 at the main facility and 1,719 at one of the 19 camps.<sup>3</sup>

SCC is a Basic CDCR institution. This means that the medical program mission at SCC is to provide medical care to inmates with uncomplicated medical problems.

### 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:** There is an adequate management structure at SCC. The senior management structure is shared between SCC and Deuel Vocational Institution (DVI), which is about 60 miles away. Mr. Robert Duncan, the CEO of both facilities, works one day a week at SCC. He has extensive experience in hospital administration, but has only a few months experience at SCC. Deborah Dietz, the Chief Support Executive, is at SCC approximately 2-3 days a week. She also has hospital management experience and has been at SCC for several years. Chief Nursing Executive Rebecca Potts is at SCC one day a week. In addition to the Chief Nursing Executive, SCC has a Director of Nursing (DON), Debra Jorge, who is full-time at SCC. Jack St. Clair MD, the Chief Medical Executive, is full-time at SCC. The senior managers attempt to stagger their days at SCC so that someone is continuously present, but if one of them is not present, Dr. St. Clair is the person in charge. The Chief Physician and Surgeon position is currently vacant and will not be filled in the new Acuity Based Staffing Realignment because the number of physicians is below 10, and a Chief Physician and Surgeon is not allocated when physician staffing falls below 10.

Mr. Duncan reports to the Receiver and Mr. Dave Runnels. According to Mr. Duncan, Mr. Runnels handles day-to-day operations. Mr. Duncan has a weekly call on Thursday with the

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<sup>3</sup> Institutional and Conservation Camp Count. February 19, 2013

Receiver's finance department. There is also a group CEO call every other week with the Receiver. CCHCS management does not visit SCC. However, CCHCS clinical leadership conducts frequent Webinars, which update staff on policy changes and management concerns.

Relationships with custody are very good, and there has been no interference by custody related to clinical decisions. Heidi Lackner was the Associate Warden at SCC before becoming Acting Warden. Her leadership has been a positive influence on the medical program. The position of Warden of Health Care Access has been eliminated. Currently, Joel Martinez, the Associate Warden of Central Services who manages the A and B yards, is the liaison to the medical program. The CEO and the DON go to the Warden's weekly meeting. If the CEO is unavailable, others can represent him. The Warden attends the Quality Management Committee along with the Associate Warden of Central Services. Therefore, there is a formal mechanism for the health program and custody to work on mutual problems and ample opportunity for sharing concerns.

### **Human Resources, Staffing and Budget**

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

**Findings:** SCC has 113.7 budgeted positions, of which 17.65 are vacant. This is a 16% vacancy rate. Under the Acuity Based Staffing Realignment, the medical program will lose approximately 2.7 positions. There have been minor adjustments to the staffing to address high levels of registry use. As noted above, the Chief Physician and Surgeon position was eliminated because there are only six physician positions at this facility. There is no anticipated problem with this reduction.

There is a personnel analyst who works at SCC but reports to CCHCS. This person processes documents for applications and expedites the hiring of employees. There is an Employee Relations Officer (ERO) assigned from CCHCS who is part-time and is shared between three institutions. This person assists in employee discipline. Additionally, SCC can make use of the Labor Relations Officer, who is a CDCR employee. This person can assist management with union issues.

CCHCS processes applications to hire new employees. Local management performs interviews and selects candidates while CCHCS completes the paperwork and processes the hiring. This process has worked well, and SCC management stated that it takes about six weeks to two months to hire a position. Currently there is a freeze, so hiring has not taken place for 4-6 months. The hiring process could be improved by closer collaboration with the facility in removing applicants from hiring lists who are found to be unqualified. Persons who apply for certain positions and are found unqualified or have insufficient experience are not removed from the hiring list by CCHCS.

SCC management did not propose a separate staffing plan beyond what was provided by CCHCS in the Acuity Based Staffing Realignment. This is due in part to the fact that SCC has not been able to create new job classifications to provide necessary services. As an example, SCC has been struggling to get the right mix of staff to put the primary care model requirements into place. The model requires development of a team to work together to provide chronic illness management. Licensed vocational nurses (LVNs) currently assist the providers when they are seeing patients in the clinic. Because LVNs have other responsibilities, mostly related to administration of medication, the full complement of assignments required by the primary care model has not been put in place. SCC would prefer to hire less expensive medical assistants to provide clinic support for the needs of the primary care model. This type of employee is now frequently used in community clinical settings for a similar purpose. However, the Medical Assistant job title does not exist and CCHCS has been struggling for about two years in attempts to create this position with the personnel board. The result is a less than adequate roll out of the primary care model and poor utilization of LVNs. If LVNs are fully utilized to support the primary care model, there may be insufficient LVNs to administer medication. Although this has not prevented SCC from initiating the primary care model, these bureaucratic barriers have slowed down progress considerably. According to CCHCS, some of the LVN positions will be reclassified to Medical Assistants once the job classification is established.<sup>4</sup>

One additional mission of the health program, which is unsupported by the staffing plan, is the Medical Emergency Response Team. This function is part of an agreement with Cal Fire. The agreement involves provision of medical care for inmates who fight fires. Cal Fire pays for these services, which are provided by SCC nurses and physicians. However, because the fires are unpredictable, SCC is unable to promptly bring on registry staff. The net result is that these events result in temporary reductions in health care staffing on an intermittent basis. There is no planning for this in the staffing model. Routine physician coverage for these 19 fire camps should be included in the CCHCS staffing plan.

### **Credentialing and Peer Review**

There is a local operating procedure for credentialing, and all clinical staff has credentials through CCHCS. Their credential review is excellent. However, the SCC facility credential files differ from the CCHCS credential files. The SCC credential files do not contain the National Practitioner Data Bank profile, litigation history, and details of any sanctions by the Medical Board. This is information that is obtained by the CCHCS credentials office but is not routinely shared with local facilities. The Chief Medical Executive should be informed on all these matters for all practitioners under his supervision. CCHCS does communicate to the Chief Medical Executive on problem physicians. However, the CCHCS credentials office should share the complete credential file with each Chief Medical Executive for all physicians under their supervision. This should be done in a manner to ensure integrity and privacy of the credential file.

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<sup>4</sup> Y. Mynhier



### **Disciplinary Process**

The problems with discipline are the same at SCC as at other facilities. SCC management does not have tracking information on the numbers of employees who are disciplined or the length of time it takes to accomplish discipline. However, they currently have a nurse who they allege was intoxicated, who refused a drug test and was initially sent home. That LVN is now working in the mailroom because they will have to go through the discipline process. Also, this facility had a physician who lost privileges and worked for four years at a physician's salary as an office technician until his case was adjudicated in his favor. He now has a limited scope of practice and is monitored daily by the Chief Medical Executive. His credential information was not available for our review.

### **Health Care Budget**

In fiscal year 2011-12, SCC had an initial budget allotment of \$15.8 million, a final budget allotment of \$18.7 million and expenditures of \$18.5 million. This difference of \$2.7 million between initial allotment and expenditures was 17% of the initial allotment, demonstrating that the allotment process does not accurately reflect operating expenditures. As with other facilities, capital expenditures are not included in the budget, and major expenditures like overtime and registry are minimally provided for in budget lines. This results in cost over-runs. Similar to other facilities reviewed, SCC management finds it difficult to utilize existing budget software (BIS), and they therefore utilize their own spreadsheet system to track expenses so that they can be more effective.

### **Health Care Operations, Clinic Space and Sanitation**

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

**Findings:** As currently configured, clinical space is inadequate. Physical plant structures and office layouts are poor and inadequate. Clinic examination space in this facility is old and poorly designed for efficient clinic operations. As an example, in the main clinic the physicians work in examination rooms that are on a long corridor. The LVN who triages patients for this clinic works near the waiting room, which is not close to where the physicians are working. This is a physical barrier to effective communication and promotes lack of contact between the nurse and physician treating the patient.

The clinics for yards A and B were built in 1965. The main health clinic was built in 1965. C yard clinic was constructed in 1990. The SCC Health Care Facility Improvement Plan includes plans to renovate existing clinic space, including the triage and treatment area (TTA), laboratory, pharmacy and medical records and to build a new administrative space, but it does not include renovation of the outpatient housing unit (OHU).

All clinical rooms in the main clinic, including the TTA, are cluttered. At one time, the clinic housed a surgical suite, and there are remnants of equipment such as autoclaves. The

physician and nurse examination rooms are very poorly laid out. The desks that are required to be purchased from the Prison Industry Authority (PIA) are so large that they take up a large portion of the room. They have drawers that are filled with clutter and odds and ends. There is a bookcase in each clinic room even though it is unnecessary for the work performed in the room. The examination tables are positioned with one end touching a wall in a manner that it is not possible for a six-foot tall person to lie flat without their head being off the table. In one room, a printer is precariously laid on the base of an examination table. Supplies are not readily available in the rooms, and it is extremely difficult to maneuver around the furnishings. None of the clinic examination rooms is adequately laid out and supplied. Even without expenditures of additional money, these rooms can be improved by removing anything that is not connected to the needs of the physical examination of patients. They could be further improved by purchase of standardized tables for the computer equipment so that the large over-sized desks can be removed. We note that this is not possible with existing requirements to purchase from Prison Industries because the PIA catalog does not have suitable clinic furnishings. The organization should not be required to purchase furnishings from PIA that inhibit adequate medical care.

The TTA is converted from an old procedure or operating room. The room is continuously open to a hall immediately adjacent to an officer station, and the officers store their personal effects and clothing in the TTA. On multiple occasions, the TTA appeared to be used as a social gathering place, which does not promote patient privacy. For example, on one visit to the room, there were four nurses and an officer in the room although only two nurses are assigned. On other occasions, staff was eating in the TTA when we were in the unit. There was an excessive amount of supplies on counters and shelves in the room. Periodic Automatic Replenishment (PAR) supply levels exist for some but not all items. There is no PAR level for gloves, as an example. There were 80 boxes of gloves on an overhead shelf in addition to numerous open boxes of gloves in the work area. There were two computer workstations that are gerrymandered spaces. Supplies in drawers appeared organized. Emergency response equipment was present and secured. Until the TTA renovation occurs, this area could be improved by a systematic cleaning and standardization of PAR supply.

The OHU is unacceptable from a clinical perspective and needs renovation. It is antiquated and, at the time of our visit, water was leaking from the OHU into the main hall. There is no call system for the OHU patient rooms, which is a patient safety issue. There are no clinical examination rooms in the OHU, and access to eUHR is poor. Renovation is not part of the Health Care Facility Improvement Plan. More comments are in the OHU section of this report.

Custody monitors sanitation of the health care unit. A sanitation schedule exists, but it only stipulates that the room is cleaned and does not indicate what cleaning the room means. A sanitation schedule needs to specify the cleaning procedure. This should conform to typical requirements of a health program. SCC management reported that custody uses three inmates in the cleaning program. When the inmate porters are not working, they sit at three chairs and a desk in a clinic hallway with cleaning supplies kept in the hallway as well. This contributes to

the clutter in the clinic. When inmate porters are not working, they should not be in clinical areas.

There is an inventory of all medical equipment. This inventory lists every item by location, serial number and item name. The program has a contract with a biomedical group that services the equipment. The facility provided evidence of maintenance of all equipment. Like other facilities, there is no replacement schedule for equipment. Equipment is replaced only when broken.

There is no standardized equipment list or PAR level of supplies for clinic examination rooms. As with other facilities, all furnishings must be purchased from PIA, even when the furnishings from PIA do not satisfy the needs of the facility. There is no prime vendor, and the facility stores excessive inventory and supplies.

There is no system for reporting non-conformances. For physical plant problems, staff can write a work order that is managed through custody. While the staff could not verify the time to fix problems with a log, there were no staff complaints about getting broken items fixed. However, staff had given up on long-standing problems deemed to be unsolvable. As an example, the water leak in the OHU has been ongoing for several years, but since the maintenance crew cannot fix it, it is no longer reported as a problem.

## **Policies and Procedures**

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

**Findings:** Local operating policies (LOP) and procedures were reviewed and are in line with statewide policies and procedures and appear adequate. LOPs were all reviewed within the past year and were up to date, including the primary care model procedures. The policies cover all major areas of service.

SCC has an adequate process of rolling out procedures. Every change of a local operating policy and procedure is provided to all staff, who sign that they reviewed the policy. There are also a variety of meetings in which training takes place. There are monthly nurse meetings that are attended by a nurse educator who goes over new processes or procedures or introduces new equipment. Doctors have a weekly meeting to talk over new processes. Also, SCC has a "Friday Pay Meeting," which is open to all staff, where new developments are discussed by management. These meetings address changes in policy.

## **Intrasystem Transfer**

**Methodology:** We toured the SCC receiving and release (R&R) area, interviewed facility health care leadership and staff involved in intrasystem transfer and reviewed tracking logs, staffing and 14 health records.

**Findings:** We found that, in general, the SCC intrasystem transfer process is working well. In each record reviewed, the sending facility completed a 7371 health transfer form noting pertinent health conditions; and upon arrival at SCC, nurses performed medical screening of the patient. With respect to timeliness, our findings were consistent with the OIG score of 100%.

Nurses noted whether medications transferred with the patient and facilitated renewal or refilling of medication orders at the time of arrival. However, we were not always able to confirm patient receipt of medications because some MARs were not scanned into the eUHR at the time of our review. Nurses appropriately referred patients with chronic diseases to a medical provider. While patients were generally seen by a provider in accordance with the timeframes of the nurse referral or in accordance with their disease control, this did not occur in 1 of the 14 cases we reviewed. (See Patient 1 below.) Of 14 records of patients with chronic diseases that we reviewed, the average time from transfer until a provider saw the patient was 17 days (range 4-56 days). This average time frame is acceptable as long as patients with poorly controlled chronic diseases are seen more timely. Our findings were not consistent with the OIG score of 100%.<sup>5</sup>

Although the intrasystem transfer process is working well, we reviewed two cases that were problematic, beginning with when the patient arrived at SCC. These cases are described below.

#### **Patient #1**

This 45-year-old patient arrived at WSP in April 2012 and transferred to SCC on 6/1/2012. His medical history included obesity, hypertension, asthma, seizure disorder and peptic ulcer disease. At the reception center, prior to transfer to SCC, his hypertension was poorly controlled (BP=159/112, 163/120, and 180/120 mm/hg)<sup>6</sup> on Lisinopril. The physician increased the Lisinopril and added Clonidine.

At the time of transfer, his blood pressure was not well controlled (BP=151/98 mm/hg). The nurse requested PCP follow-up in four weeks, but the patient was not seen in this time frame.

On 7/17/12, the dental staff saw the patient and referred him to medical for poorly controlled hypertension (BP=178/118 mm/hg). The TTA nurse rechecked the patient's blood pressure and it remained high (180/110 mm/hg). The nurse notified the physician, who ordered daily blood pressure checks and follow-up with the provider in two weeks. The patient's blood pressure was not treated at that time, nor was his baseline medication regimen changed. The nurse educated the patient to report to medical if he had headaches, dizziness or blurred vision.

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<sup>5</sup> The OIG Cycle 3 record sample for item 02.018 was comprised of just five records

<sup>6</sup> Normal blood pressure is 120/80 mm/hg

Blood pressure flow sheets show that from 7/20 to 7/24/12, his blood pressure was very elevated:

7/20/12	BP=174/103 mm/hg and 165/105 upon repeat
7/21/12	BP=183/120 mm/hg and 183/128 and 179/115 upon repeat
7/22/12	BP=162/104 mm/hg
7/23/12	BP=167/98 mm/hg
7/24/12	BP=156/101 mm/hg

Nurses did not notify the provider when the patient's blood pressure was >180/120 mm/hg. Seven weeks after arrival, on 7/26/12, the physician saw the patient for an initial visit. The provider added Amlodipine to the patient's medication regimen, ordered twice-weekly blood pressure monitoring, laboratory tests and follow-up in 60 days.

Staff continued to monitor his blood pressure daily through the end of July, and it continued to be elevated (BP=144-172/95-106 mm/hg). In August, his blood pressure was only checked on one occasion and was moderately elevated (8/1/12, BP=157/106 mm/hg). On 8/29/12, the physician saw him for medication nonadherence (Dilantin). At this visit, his hypertension was improved but still not controlled (BP=143/98 mm/hg). The physician did not change the patient's medication regimen at that time and planned to see him in a month.

On 9/5/12, labs showed the patient's fasting blood sugar (188, normal=<110) and cholesterol were elevated (LDL<sup>7</sup>=142). On 9/18/12, the physician saw him for follow-up of abnormal labs and wrote an excellent note. He addressed the patient's elevated glucose, lipids and poorly controlled hypertension, increased his Amlodipine and planned to order additional labs and see him in six weeks.

On 10/13/12, the patient's glucose was 264 and hemoglobin A1C was elevated (8%, goal=<7%), meeting the criteria for diabetes. A physician assistant reviewed and signed this report on 10/15/12. Blood pressure monitoring showed that his hypertension continued to be poorly controlled (BP=136-158/98-105 mm/hg).

On 10/18/12, a physician assistant saw the patient and addressed his hypertension, and although he had reviewed the lab report showing an elevated HbA1C, he did not inform the patient of his diabetes diagnosis and did not initiate treatment. The provider ordered daily blood pressure checks for four weeks and follow-up with a PCP in 3-4 weeks.

On 11/7/12, the physician saw the patient and discussed his newly diagnosed diabetes. His blood pressure was not at goal for diabetics (BP=138/89 mm/hg, goal=<130/80 mm/hg); however, the physician indicated that it was at goal. The physician's note was thorough and he planned to start the patient on low dose Metformin. He planned to follow-up the patient in 60 to 90 days.

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<sup>7</sup> The LDL goal for patients with diabetes is <100 and <70 for patients with coronary artery disease

On 12/21/12, laboratory tests showed that the patient's glucose (587) and HbA1C (14.7%) were very elevated; a provider reviewed the tests on 12/24/12. On 12/24/12 at 2:38 pm, without seeing the patient, a physician wrote orders to start twice daily Accuchecks and sliding scale insulin coverage in the morning, increased the patient's Metformin to 500 mg twice daily and requested follow-up in 1-2 weeks.<sup>8</sup> At 10:00 pm, the patient was seen in the TTA for reasons that are not documented. The nurse described the patient as lying on a gurney, and alert and oriented. His capillary blood glucose reading was too high to be measured. The patient stated that it must have been the two Pepsis he drank. The nurse contacted a provider, gave the patient 12 units of regular insulin and started an IV. At 2:00 am, the patient's capillary blood glucose was 291 mm/dL. The nurse discontinued the IV and released the patient to his housing unit to return in the morning. At 5:45 am, the patient's blood sugar was 192. The nurse gave the patient 2 units of regular insulin. A provider did not see the patient following this urgent event.

On 1/30/13, five weeks later, a provider saw the patient. The provider addressed all chronic diseases, noting that the patient's blood sugars were much improved and that he had required sliding scale insulin coverage only four times in the past month. He planned to obtain labs in late February and see the patient in early March.<sup>9</sup>

### Assessment

This record showed multiple lapses in care. The patient was not seen timely upon his arrival at the facility. He had hypertensive urgency but this was not addressed in a timely manner. Nurses monitoring the patient did not notify providers of extremely elevated blood pressure measurements. In October 2012, lab tests showed that he had newly diagnosed diabetes and there was a delay in informing the patient and initiating diabetes treatment. In November when the physician started Metformin, he did not plan to see him in a few weeks to evaluate how he was tolerating his medication, instead planning to see him in 60-90 days. Six weeks later, the patient's glucose was dangerously high (587) and his HbA1C showed his diabetes was poorly controlled; however, a provider did not see the patient the day the laboratory tests were reviewed but ordered sliding scale insulin. Later that evening, the patient was treated in the TTA for glucose levels too high for the glucometer to read. A physician did not see the patient for five weeks thereafter.

### Patient #2

This 49-year-old patient arrived at NKSP on 11/9/11, transferred to Ironwood in December 2011 and to SCC on 9/20/12. His medical history included diabetes, hypertension and hyperlipidemia. In September 2011, prior to arrival at CDCR, his diabetes was poorly controlled (HbA1C= 9.4%).

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<sup>8</sup>The physician did not discontinue the patient's previous order for Metformin 500 mg per day, and it continued to appear on his medication reconciliation report as an active medication along with the twice-daily dose until 12/28/12. At that time, the physician discontinued both previous orders and ordered Metformin 1000 mg twice daily as directly observed therapy for 90 days.

<sup>9</sup> Intrasystem Transfer Patient #3

Prior to transfer to SCC, a provider documented that he had been off medications for four months, had been exercising and that his diabetes was well controlled. In June 2012, laboratory tests obtained just following this visit showed his diabetes and hyperlipidemia were indeed well controlled (HbA1C = 6.9% and LDL=96).

On 9/20/12, he transferred to SCC and a nurse medically screened the patient upon arrival. The nurse documented that he had not taken any medications for six months and no medications were transferred with him. His blood pressure was elevated (BP=155/94 mm/hg). The nurse referred the patient to a provider.

On 10/1/12, a medical provider saw the patient, noting that he had taken Metformin and Glyburide for four years but had not taken medication for the past year. He noted the June laboratory tests that showed that the patient's diabetes and hyperlipidemia were well controlled. The patient's blood pressure was not at goal (BP=154/87, 152/92 mm/hg) and his body mass index was elevated (BMI=29). The provider ordered weekly blood pressure monitoring and follow-up in 30-45 days. The physician did not order laboratory tests at that time.

On 11/5/12, the medical provider saw the patient for follow-up. Blood pressure monitoring from 10/5/12 to 10/26/12 showed that the patient's blood pressure was poorly controlled (BP=s149-169/89-99 mm/hg). However, on the day of the visit, the patient's blood pressure was normal, so the physician assessed his blood pressure as being at goal. Laboratory tests had not been repeated since June 2012. He updated the patient's chrono, making him eligible for camp, and planned to see the patient in March 2013. Apparently the patient was later transferred to a camp.

On 12/12/12, laboratory tests reflected that the patient's diabetes was very poorly controlled (HbA1C=11.9%, goal<7.0%). A provider signed this report on 12/13/12, but did not write any orders. On 1/31/13, a physician wrote an order to transfer the patient from the camp to SCC due to uncontrolled diabetes.

On 2/5/13, prior to the patient's transfer back to SCC, the physician renewed the patient's Metformin, Lisinopril and aspirin. On 2/6/13, the patient transferred back to SCC and a nurse screened the patient. His blood pressure was elevated (158/108 mm/hg). The patient had not picked up his medications at that time.

On 2/11/13, the physician saw the patient for follow-up of his uncontrolled diabetes. The patient's blood pressure was 130/85 mm/hg, which the physician assessed as being at goal and there was no acknowledgement of the recent measurements reflecting poorly controlled hypertension. The patient declined insulin and fingerstick checks. The physician increased his Metformin to 1000 mg twice daily, ordered labs and planned to see him in 3-4 months.<sup>10</sup>

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<sup>10</sup> Intrasystem Transfer Patient #5

### Assessment

It appears that the patient's motivation for declining his chronic disease medications was to be eligible for camp. Initially, his diabetes and hyperlipidemia were well controlled with diet and exercise; however, from the time he arrived at SCC, blood pressure monitoring showed his hypertension was never well controlled. There is no documentation to reflect that the physician reviewed blood pressure monitoring flow sheets, and it appears that he relied only on blood pressure measurements the day of the chronic disease visit. Following December laboratory tests that showed the patient's diabetes was poorly controlled, another three weeks elapsed before the provider wrote orders to transfer the patient back to SCC. The physician has not reviewed recent blood pressure measurements reflecting poorly controlled hypertension and has incorrectly assessed him to be at goal.

### **Access to Care**

**Methodology:** To evaluate access to care, we interviewed health care leadership and reviewed patient tracking and scheduling systems. We also reviewed 25 health services requests (CDCR Form 7362) in 11 records of patients with chronic diseases, including high-risk patients.

### **Health Care Appointment Scheduling**

**Findings:** Until the week of our visit, staff used Inmate Statewide Appointment Tracking System (IMSATS). SCC was chosen to pilot implementation of the new medical scheduling program called MEDSATS. Unlike IMSATS, MEDSATS is more fully integrated with the Statewide Offender Management System (SOMS) and will enable staff to schedule appointments with awareness of the inmate's institutional schedule to minimize scheduling conflicts. It is an enterprise-wide system, which means that scheduled appointments will follow the patient when he or she is transferred to another facility. The features of MEDSATS are a significant improvement over IMSATS. As is often the case with rollout of a new system, staff was tracking and addressing glitches in the program in collaboration with CDCR/CCHCS IT staff.

At SCC, we found that there were no backlogs of either nurse or provider medical appointments. Nor were there any scheduling issues related to specialty services.

### **Nursing Sick Call (Face-to-Face Triage)**

**Findings:** SCC health care staff collects, triages and sees patients in a timely manner following submission of health service requests. This is consistent with the OIG Cycle 3 report score of 100% and SCC internal audits from July to December 2012.<sup>11</sup>

Patients with both routine and urgent medical complaints are seen in a timely manner. However, nurses who forwarded health service request forms directly to dental or mental health staff did not consistently date when the forms were received by health care staff. Dental and mental health staff documented when they triaged the form, but this may not correspond

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<sup>11</sup> SCC internal audits from June to December 2012 show that nurses saw patients who submitted health requests within one business day 97-100%.



with the day the form was collected by health care staff. Therefore, the timeliness of services from the time of receipt of the complaint could not always be measured. We recommend that nurses date-stamp all health requests before forwarding them to the respective service.

In general, the quality of nursing assessments was good. Our findings corresponded with the OIG Cycle 3 report that found that the scores related to the quality of nursing assessments ranged from 80-100%. The exception is that some nurses used an algorithm called SAMPLEPAIN to obtain the history of the chief complaint, which did not result in an adequate description of the patient's complaint. Triage dispositions were appropriate, and referrals to a provider occurred in a timely manner.

We did find some opportunities for improvement related to nurses' attention to findings incidental to the patient's primary complaint. For example, in December 2012, a nurse evaluated a patient for knee pain. His hypertension was poorly controlled (BP=164/99 mm/hg) but the nurse did not address this finding by inquiring whether the patient was compliant with his medication or arranging blood pressure monitoring. The nurse adequately assessed the patient's shoulder pain but did not address the patient's poorly controlled hypertension. The nurse did not refer the patient to a provider.<sup>12</sup>

In another case we reviewed, nursing triage occurred in a timely manner, but there was a problem related to provider-ordered follow-up. On 11/27/12, a 71-year-old man with a history of renal failure submitted a health services request complaining of painful urination. The request was received and triaged the following day by a nurse who saw the patient and referred him to a provider. The provider saw the patient the same day and treated him for early pyelonephritis and ordered follow-up in five days. This follow-up visit did not take place.<sup>13</sup>

## 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 19 patients with chronic diseases, including diabetes, hypertension, and clotting disorders, as well as other chronic illnesses. We assessed whether patients were seen in a timely manner in accordance with their disease control. At each visit, we evaluated the quality of provider evaluations and whether they were complete and appropriate (subjective, objective, current labs, assessment and treatment plan). We also evaluated whether the Problem List was updated and continuity of medications provided.

**Findings:** We found that when chronic disease patients transfer to SCC, they are generally seen in a timely manner for their initial chronic care visit. When patients are seen by the primary care providers for chronic care, the quality of provider evaluations is usually good and appropriate patient education is being provided. Provider orders and medication administration records show continuity of chronic disease medications. However, we did find a

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<sup>12</sup> Nursing Sick Call Patient #4

<sup>13</sup> Intrasystem Transfer Patient #14

number of cases where the care could have been improved. These cases are discussed below. Our findings demonstrate improvement compared to the OIG Cycle 3 Report in which chronic care scored 77.4%. They are more consistent with the most recent dashboard where PCP chronic care scored 82% and care for patients with diabetes scored 85%.

### **Patient #1**

The patient is a 55-year-old man with atrial fibrillation, diabetes, hypertension and COPD. The patient's blood pressure had been elevated (161/97 mm/hg) on 9/24/12. The provider increased his medication at that time. The provider saw the patient again on 10/16/12. The patient's blood pressure was improved but still elevated (145/81 mm/hg). The provider did not address the patient's blood pressure at that visit. He ordered follow-up in January. The patient was next seen on 2/11/13. His blood pressure was 145/94 mm/hg at that time. The provider noted that the patient's blood pressure was not quite at goal and would, therefore, have close follow-up. His plan was to order blood pressure checks with follow-up in 90-120 days. There was no documentation in the medical record that the provider ordered the blood pressure checks.<sup>14</sup>

### **Assessment**

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

### **Patient #2**

The patient is a 65-year-old man with a history of diabetes, hypertension, COPD and hyperlipidemia. The patient's HbA1C had been elevated (8.6%) in July 2012. On 11/26/12, it had increased to 9.3%. The provider saw the patient on 12/17/12 and noted that he was refusing to take insulin. The provider did not adjust the patient's oral medications. His plan was to continue with diet and lifestyle changes. He ordered follow-up in three months. On 12/24/12, the patient's HbA1C had increased to 10.2. As of 3/4/13, the patient had not been seen for follow-up.<sup>15</sup>

### **Assessment**

There were problems related to quality and timeliness of care. The provider did not appropriately manage the patient's diabetes and did not follow-up in a timely manner.

### **Patient #3**

The patient is a 56-year-old man who arrived at SCC on 11/16/12. He has a history of diabetes and hyperlipidemia. Prior to his arrival, on 10/22/12, his LDL cholesterol had been very elevated (195). On 10/31/12, a physician started the patient on medication for his hyperlipidemia. On 12/11/12, the patient was seen for his first chronic care visit at SCC. The provider noted the elevated LDL cholesterol. His plan was to consider adding another medication if the next blood test revealed that the patient had not responded well to his

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<sup>14</sup> Chronic Care Patient #1

<sup>15</sup> Chronic Care Patient #5

current medication. The provider ordered follow-up in 2-4 months. He did not order a repeat lipid panel.<sup>16</sup>

#### Assessment

There was a problem related to timeliness of care. The patient should have had a repeat lipid panel approximately 2 months after the medication had been started on 10/31/12.

#### Patient #4

The patient is a 68-year-old man with a history of diabetes and hypertension. A provider had ordered blood pressure checks in December 2012. All 12 of the readings were elevated, and 10 had systolic blood pressure over 150. The primary care provider saw the patient on 1/22/13. He did not check the patient's blood pressure at that time. In his assessment, he noted that the patient's hypertension was at goal and his plan was to continue his current medications.<sup>17</sup>

#### Assessment

There was a problem related to quality of care. The provider did not appropriately manage the patient's hypertension.

#### Patient #5

The patient is a 61-year-old man with a history of diabetes and hypertension transferred to SCC on 10/13/12. He was seen for his first chronic care visit on 10/23/12. The provider noted that the patient's most recent HbA1C had been 8.5% and that it was suggestive of poor diabetes control. His assessment was that the patient's diabetes was uncontrolled. His plan was to continue the patient on dietary and therapeutic lifestyle changes. He did not adjust the patient's medications. The patient was not seen again until 1/17/13. The provider noted that the patient's HbA1C had been 8.6% in November 2012. He also noted that the patient's blood pressure was elevated (154/77 mm/hg). His assessment was that the patient's diabetes and hypertension were not at goal. The provider did not adjust the patient's diabetes medications. His plan again was to continue therapeutic lifestyle changes and diet. He also ordered blood pressure monitoring and instructed the nurses to refer the patient if his systolic blood pressure was greater than 140. The patient's systolic blood pressure was 145 on 1/28/13 and 150 on 1/31/13. As of 3/5/13, the provider had not seen the patient again.<sup>18</sup>

#### Assessment

There were problems related to quality of care. The provider did not appropriately manage the patient's diabetes or hypertension.

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<sup>16</sup> Chronic Care Patient #7

<sup>17</sup> Chronic Care Patient #12

<sup>18</sup> Chronic Care Patient #14

## **Pharmacy and Medication Administration**

**Methodology:** We interviewed Greg Prior, Pharmacist-in-charge (PIC), nurses who administer nurse-administered medications and keep-on-person (KOP) medications, toured the pharmacy, clinic and KOP medication rooms and reviewed medication administration records in each of the clinics and in health records.

### **Pharmacy Services**

**Findings:** Pharmacy services at SCC appear to be working well. Record review showed that medical providers order and the pharmacy dispenses medications timely following the patient's arrival at the facility.

The pharmacy provides coverage 8:00 am to 5:00 pm, Monday through Friday, with no coverage on weekends. According to the PIC, the volume of medication orders is approximately 400 to 450 per day, with half of them filled at the in-house pharmacy and half by Central Fill in Sacramento. Turnaround time for dispensing medication orders is generally less than 24 hours.

With respect to staffing, the PIC reported that there is 7.0 pharmacy staff, including 1.5 pharmacists and 4.0 pharmacy technicians. With the implementation of the Acuity Based Staffing Realignment, there will be 2.0 pharmacists. The PIC believes that this staffing plan is adequate to meet the needs of the facility.

The pharmacy has a system for medication auto-refills and order renewal that is working well. In some cases, we were not able to confirm receipt of pharmacy-dispensed medications because the MAR had not yet been scanned into the eUHR.

The pharmacist explained that, in some cases, a TTA provider orders medications that the pharmacy dispenses while the patient is still in the TTA. This is very positive as it ensures timely treatment. However, in cases in which the pharmacy both dispenses and administers the medication, it is unclear where it is documented that the medication was administered to the patient. For example, we reviewed a record of a patient treated in the TTA for early pyelonephritis. The provider ordered antibiotics and documented on the medication reconciliation report that the patient was waiting for the prescription, and although a medication reconciliation report showed that the pharmacy dispensed the medication, there was no medication administration record (MAR) showing that the patient received the ordered medication.<sup>19</sup> If pharmacy staff both dispense and deliver medications to the patient, it should be documented on a MAR.

### **Medication Administration**

**Findings:** We observed nurses administer medications in Facility A (Calaveras) and Facility B (Mariposa). The Facility A medication room is actually a room in the gym that is the coach's office. Staff reported that during medication administration the coach usually leaves the room, but on this day he was in the room. This potentially raises issues of confidentiality as patients

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<sup>19</sup> Intrasystem Transfer Patient #14

ask nurses about their medications and sometimes their medical conditions. We did not observe a sink or hand-sanitizer in the room. Facility B medication room has an old desk and stained chair, and a cabinet that contained food. These are suboptimal conditions for administering medications.

Nurses generally adhered to proper medication procedures by having the patient identify himself by using his ID badge, reviewing the MAR, and documenting medication administration at the time it was given.

However, an area requiring improvement involves use of aseptic technique. Both nurses used latex gloves during medication administration. We observed one nurse reach into a pharmacy dispensed bag that contained loose pills with a gloved hand and then place the pill into a plastic cup and pour it into the patient's hand. The nurse reused the same plastic cup for each patient that came to the window. In between, the nurse then touched MARs, medication cart drawers, etc. that contaminated the gloves. If the nurse uses a gloved hand to reach into another medication container that has loose pills, this will contaminate the medication. The second nurse described that she usually pours medications into a cup except if it's a single pill, and that in some cases she places the pill onto her gloved hand and then onto the patient's hand. Neither of these practices is using aseptic technique.

Whether the nurse wears gloves or not, the nurse should not touch the actual medication. Secondly, nurses should pour the medication into a separate cup for each patient and not reuse the same cup. This preserves aseptic technique and also reduces the risk of the medication falling from the patient's hand onto the floor. Nurses should have hand sanitizer available during medication administration and periodically sanitize their hands as they are touching MARs, medication cart drawers and blister packs that have been touched by other nurses as well. The value of using gloves during medication administration is unclear, since using hand sanitizer makes the gloves sticky and difficult to use.

We reviewed MARs in each of the facility medication clinics as well as the eUHR. We found that the MARs were generally neat and legible, with very few blank spaces. The MARs of nurse-administered medications generally showed that patients received their medications, and in cases of refusals, nurses submitted a medication non-compliance form to the provider.

We also noted that one nurse documented administration of the medication on the MAR after the patient presented his identification badge but before the nurse determined that the medication was available in the medication cart and administered the medication to the patient. Nurses should document administration only after the patient has received and swallowed the medication.

We did not observe medication administration in administrative segregation, but the nurse has a medication cart that she is able to push to the cell front door to prepare and administer medications.

## **Laboratory/Radiology**

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

**Findings:** We found that laboratory and radiology services are working well at SCC.

With respect to laboratory services, there is a large room used to process and send out specimens. Staff currently uses IMSATS as their scheduling and tracking system for the completion of laboratory tests. We found that provider-ordered tests are obtained and reviewed in a timely manner. However, we also found cases in which providers did not address abnormal results in a timely manner.<sup>20</sup> We recommend that health care leadership conduct a quality improvement study examining the timeliness with which providers address abnormal labs.

With respect to radiology services, the volume of tests performed each month is relatively low. Staff has a tracking system for completion of ordered radiology procedures and reports. We found no delays in the performance of radiology procedures or review of radiology reports.

## **Health Records**

**Methodology:** We toured the health records unit, interviewed 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.

**Findings:** CDCR has migrated statewide from a paper record to an electronic Unit Health Record (eUHR). This has been described in previous reports and will not be duplicated in this report.<sup>21</sup> However, we continue to support the Receiver procuring a true electronic health record, which will dramatically improve communication between health care staff, reduce opportunity for medical errors and improve the efficiency of health care service delivery.

### **Health Records Space and Operations**

The area used to store health records is not optimal but is due to be renovated in the SCC Facility Improvement Plan. At SCC, management of health records is working well.

### **Timeliness of Scanning Health Documents**

There was no backlog of health documents to be scanned into the eUHR. On the day we toured health records, there were approximately 12 inches of documents to be scanned. Review of laboratory reports showed that providers review, date and sign the reports and staff scans them into the eUHR in a timely manner.

An area of concern is the timeliness of Health Records Center transcription of provider-dictated notes, provider authentication of the notes and scanning into the health record. We found that

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<sup>20</sup> See patient examples in the intrasystem transfer section of the report

<sup>21</sup> See Court Experts San Quentin report. March 2013

in the November 2012 to January 2013 timeframe, provider notes were not being transcribed and scanned into the record for up to three weeks. For example, in one record, the provider saw the patient and dictated a note on 12/14/12. This note was transcribed on 12/29/12, the provider authenticated it on 1/7/13, and health records received the document on 1/8/13.<sup>22</sup> In another case, the provider dictated a note on 11/6/12, it was transcribed on 11/13/12, authenticated on 11/15/12 and received by health records on 11/16/12.<sup>23</sup> We found other examples as well. It is our understanding that factors that contributed to transcription delays are primarily related to staffing reductions, vacancies and personnel furlough days at the Health Records Center in Sacramento. This is an area that needs to be addressed by CCHCS.<sup>24</sup>

### **Urgent/Emergent Care**

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

#### **Emergency Department/Hospitalizations**

**Findings:** There was ready access to hospitalization. Evaluation of patients with emergencies revealed that urgent care occurred promptly and there were no barriers to rapid transport to a hospital. There were no unnecessary hospitalizations. There were no identified incidents of harm as a result of untimely or unnecessary hospitalization. Follow-up care after hospitalization was good. There was one episode in which a patient's critical medication was delayed for three days after a hospitalization, but no harm occurred.

### **Specialty Services/Consultations**

**Methodology:** We reviewed the cases of 15 patients who had been referred for offsite specialty care. Most of these patients had been referred to and evaluated by multiple specialists.

**Findings:** Our review revealed that specialty services are available and are performed within appropriate time frames. The recommendations of the specialists are being addressed in a timely manner, and the patients are receiving appropriate care. Our findings are consistent with the third OIG Report in which specialty care scored 84.2% and the recent dashboard in which it scored 96%.

### **Outpatient Housing Unit Care (OHU)**

**Findings:** The OHU is a 13-bed unit. Three of the beds are in rooms that are in the medical clinic area. The remaining 10 beds are cells in a unit separated from the main clinic by a locked door. The OHU has a nurse stationed inside the unit, but it is not a formal nursing station. There are no patient alarms in the rooms. As a result, the higher-acuity patients are isolated behind two locked doors in rooms with no alarms. This is a patient safety issue. There are no

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<sup>22</sup> Intrasystem Transfer Patient #11

<sup>23</sup> Intrasystem Transfer Patient #9

<sup>24</sup> According to the CCHCS policy on medical transcription, medical progress notes are to be transcribed within 3 business days.

examination rooms in the OHU. Normally, the initial physical examination for patients going into the OHU is performed in the TTA. The cells have a bed that is not far from the floor so that if an examination is required in the supine position, the physician would have to kneel on the floor to accomplish the examination. Staff confirmed that this occurs on occasion. This discourages examination of the patient. Lighting in the patient rooms is dim and inadequate for physical examination. Movement to a clinic examination room in the main clinic down the hall would disrupt clinic services. There is a nursing station and nurses do circulate through the unit, but not having alarms in rooms with high acuity patients is not safe. Also, each patient cell has a Plexiglas shield over the bars so that sound is not easily transmitted. This unit is inadequate for a high level of care because of isolation of the patient from staff, lack of light, lack of patient alarms, lack of examination rooms and lack of access to the eUHR.

Additionally, the OHU is such an old physical structure that it cannot be easily renovated or maintained. As an example, on the day of our visit, water was leaking adjacent to a built-in lighting fixture so that a bucket had to be placed on the floor. We were told that this always occurs when it rains and that, because the roof has been replaced, no one is clear why the leak occurs.

Actual care on the OHU was adequate. A couple of areas could be improved. Nursing forms could be improved so that vital signs are recorded on the nursing OHU note. These are currently written on a flow sheet that is not consistently available in the eUHR. Also, some patients are admitted to the OHU because they have acute problems. When this occurs, the patients should have vital signs and physician visits based on their acuity, not on rules for an OHU.

Generally, patient assignments into the OHU were appropriate. Patients did receive an adequate assessment. It was not always clear what the nursing treatment plan for the patient was. One patient who was admitted because of an inability to eat did not have nutritional assessments done as part of his nursing care plan. This could be improved by including a discussion of all OHU patients in the daily morning huddle and improved specificity on physician orders.



## **Mortality Review**

**Methodology:** We reviewed 3 deaths at SCC in calendar year 2012 and one death that occurred in 2011.

**Findings:** The causes of death were suicide, hepatocellular cancer, metastatic lung cancer and bilateral acute bronchopneumonia and cerebral edema. We found a problem in the following cases.

### **Patient #1**

The patient was a 53-year-old man with a history of successfully treated hepatitis C infection and cirrhosis who died of hepatocellular carcinoma. Following his transfer to SCC in December 2010, a liver ultrasound was requested to screen the patient for hepatocellular carcinoma. The ultrasound was done in March of 2011 and showed a 1.8 by 1.4 cm liver mass. The patient did not see a specialist at the University of California Davis until October of 2011, when the lesion had grown to 8.5 by 6.7 cm. At this point, the UC Davis specialist said the tumor was too big to treat. Between March and October of 2011, the patient had a variety of delays, each of which independently is understandable; however, in aggregate, a delay of seven months to obtain an oncology consultation is too long. For this patient, the mortality review concluded that there were no departures from the standard of care. It is unreasonable to believe that, in a civilian setting, someone with a liver mass would wait seven months to see a specialist to evaluate for further treatment. The length of time from discovery of the liver mass to evaluation by an oncologist was too long. It is a systemic concern and may have contributed to an early death.<sup>25</sup>

### **Patient #2**

A second case was a 44-year-old patient who had been in CDCR since 1997 and transferred to SCC in 2007. He had no significant medical history and worked at the SCC fire camp. On 8/17/12, after coming off a 36-hour shift on an active fire line, he presented to a SCC medical emergency response nurse with complaints of nausea, vomiting, lightheadedness and headache. The nurse contacted the medical emergency response provider who ordered IV fluids and monitoring. The patient was monitored for 2 hours. When he was about to leave the fire line clinic, he vomited and continued to be weak. The nurse notified the physician who came to the fire line clinic and evaluated the patient. The physician treated the patient with Zofran<sup>26</sup> and allowed to return to his tent. The next morning custody found the patient unresponsive but with pulse and respirations. EMS was notified and he was transported to the hospital where he was found to have cerebral edema. He was placed on a ventilator, and on 8/19/12 the neurologist declared the patient brain dead, possibly due to carbon monoxide poisoning. An autopsy performed on 8/22/12 showed that the patient had bilateral acute bronchopneumonia, moderate pulmonary congestion and cerebral edema. The Death Review Summary found that the physician's care was adequate, there were no departures from the standard of care, and the death was not preventable. However, the cause of the patient's symptoms was not definitively diagnosed, and question is raised as to why this patient was not

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<sup>25</sup> Mortality Review Patient #1

<sup>26</sup> A medication to treat nausea and vomiting

sent to the local hospital for further medical evaluation, especially since he had been on the fire line and his symptoms were consistent with carbon monoxide poisoning.<sup>27</sup>

### **Internal Monitoring and Quality Improvement Activities**

**Methodology:** We reviewed the SCC 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:** SCC has an extensive internal monitoring process to measure their performance with respect to access to care measures.

OIG scores over the three cycles have, for the most part, shown improvement in many areas. However, there are key areas that have declined in performance over the three rounds. These include: TTA adequate primary care provider documentation and treatment; TTA nursing documentation; and adequacy of the quality of chronic disease management prior to a TTA visit. These are areas that need to be studied further and analyzed for root causes. Once the root causes are identified, corrective action plans can be developed to address them.

Emergency Response Review Committee (ERRC) Meeting minutes examine custody and medical responses to emergency events and analyze whether there are opportunities for improvement. The committee meetings focus on timeliness and appropriateness of response to the emergency event, including ambulance transport. The meetings do not focus on whether medical care provided prior to the urgent event contributed to or might have prevented the urgent event. This needs to be addressed through nursing and medical peer review.

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<sup>27</sup> Mortality Review Patient #2

## **Recommendations**

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

1. CCHCS should improve the hiring process by collaborative screening of candidates with the local facilities.

### **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 SCC.
3. The future use of the OHU should be evaluated in light of the inadequate OHU space. Accommodations for evaluation of inmates while they are on the unit should be made so that inmates are evaluated in appropriate clinic space.
4. The same budget recommendations as in prior reports should be addressed.
5. Equipment and supplies should be standardized.
6. CCHCS should institute a replacement schedule for equipment.
7. Health care and correctional staff should not eat in any clinical areas in accordance with OSHA regulations.
8. To ensure adequate visual and auditory privacy, correctional staff should not be posted at a desk in the TTA. Correctional staff should be in the TTA only when security is required (via custody level or when specifically requested by a provider).
9. A process of reporting non-conformances with aggregate data reported through the Quality Improvement program should be instituted.
10. CCHCS should continue to address the timeliness of transcription of provider-dictated progress notes.
11. Medical leadership should ensure that providers address abnormal labs in a timely manner.

### **Reception and Intrasystem Transfer**

1. Health care leadership should ensure that nurse referrals following arrival take place in a timely manner. High-risk patients should be seen by a provider within 14 days or sooner, if clinically indicated.

### **Access to Care: Nursing Sick Call**

1. The use of the SAMPLEPAIN algorithm should be discontinued. Nurses should be provided training regarding taking a history of the presenting complaint.

### **Chronic Disease Management**

1. Chronic illness processes should be reviewed and adjustments made so that communication between office support, clinic nursing staff and providers is improved during clinic sessions.
2. The quality and timeliness of chronic care should be evaluated through quality improvement and peer review.

### **Pharmacy and Medication Administration**

1. Nurses should use aseptic technique when administering medications.
2. Nurses should document administering medications only after the medication has been ingested by the patient.

### **Specialized Medical Housing: OHU**

1. The water leak into the OHU should be fixed.
2. Lighting in the OHU should be improved.
3. Patient alarms in inmate cells should be installed.
4. A procedure should be established about where inmates housed in the OHU are to be examined. This should be in a location with appropriate clinical space.

### **Mortality Review**

1. Health care leadership should review the case of the patient discussed above who died of liver cancer to determine if there are any systemic issues that contributed to the delay in his being seen at UC Davis.
2. CCHCS should review the second case again in light of the autopsy findings to determine what can be learned to prevent similar outcomes in future cases.