California State Prison at Sacramento (CSP-SAC)

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

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

Methods of assessment included:

- Interviews with health care leadership and staff and custody staff.
- Tours and inspection of medical clinics, medical bed space (e.g., Outpatient Housing Units, Correctional Treatment Centers, etc.) and administrative segregation (Ad-Seg) 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.
- Interviews with inmates.

Regarding 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 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

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

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 record may show performance issues with several health care processes (e.g., medical reception, chronic disease program, medication issues, etc.). Conversely, review of a 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 described in our report to Judge Henderson in April 2006 when the system was found to be unconstitutional and whether those systemic issues have been adequately addressed.[2]

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

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

Overall Finding

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

Executive Summary

On October 7-11, 2013, the Plata Court Medical Experts visited SAC to evaluate health care services. Our visit was in response to the OIG Medical Inspection Results Cycle 3 report showing CSP-SAC scored 79.2% in February 2012. This report describes our findings and recommendations. We thank Tim Virga, Warden, and Eureka Daye, Chief Executive Officer (CEO), and their staff for their assistance and cooperation in conducting the review.

Our review showed significant problems with intrasystem transfer, access to care, Outpatient Housing Unit (OHU), medication administration and continuity, chronic care management, specialty services, and health records. In addition, health care leadership needs to strengthen the quality management program.

SAC houses a high-security population with complicated medical and mental health disorders. This combination presents challenges to health care staff to provide adequate care and requires increased collaboration and cooperation between medical, mental health and custody staff.

A key finding is the lack of adequate nursing and medical evaluations. Record review shows that in many cases, nurses and providers do not perform an adequate history of the patient's complaint or perform adequate physical examinations, even when patients present with symptoms of serious medical conditions. We believe a contributing factor is that providers and nurses do not consistently evaluate patients in an examination room with adequate auditory and visual privacy. The standard practice during examinations is for patients to be handcuffed, placed in a cage and for correctional officers to remain in the room. We believe this arrangement interferes with the nurses' and providers' ability to obtain necessary clinical information, and perform adequate examinations, and contributes to patient refusals of examinations. Health care providers appear to have adapted to this custody-oriented culture and accept the arrangement as status quo. Moreover, in Enhanced Outpatient (EOP) I and A8 housing units, RNs conduct sick call in the dining hall.

We found serious problems with specialty care related to the timeliness and/or quality of care in 10 of the 17 patient records we reviewed. Many problems are related to provider failure to monitor and implement consultants' recommendations in a timely manner. Another contributing factor is a faulty system for tracking specialty services and hospital reports and timely provider review of these reports with appropriate action. Currently, health records staff scan off-site and hospital reports into the eUHR before providers review the reports. Therefore, in addition to providers not being aware that the reports have been received, providers do not date and sign the reports as having been reviewed, which does not provide medical-legal

documentation of when the provider became aware of the patient's condition. Moreover, although specialty services staff are very conscientious, we believe there is insufficient provider ownership of patients that lead to lapses of care.

We also found significant problems with management of chronic disease patients related to the timeliness and/or quality of care in 12 of the 24 patients we reviewed.

We also found significant problems with pharmacy and medication administration, including lack of continuity upon arrival, delayed refills of medications, lapses of medication orders, medication errors and delays of medication in urgent situations, such as dental abscesses. Nurses in segregation do not adhere to standards of nursing practice regarding medication administration.

Correctional Treatment Center (CTC) and OHU care quality of documentation was extremely poor. Provider copied and pasted notes resulted in inability to adequately assess quality, particularly on the OHU. CCHCS should prohibit physician copied and pasted notes.

Although many auditing activities are taking place, the Infection Control and Pharmacy & Therapeutics Committee Meeting minutes lack substance in content and need further development, and the Quality Management program needs to be strengthened.

Findings

Facility Description

SAC is a multi-mission institution. The institution houses maximum-security inmates serving long sentences or those that have proved to be management problems at other institutions. The institution also serves as a medical hub for Northern California with a Psychiatric Services Unit (PSU), Enhanced Outpatient (EOP) and EOP Ad-Seg levels of health care. The institution has an Outpatient Housing Unit (OHU) and Correctional Treatment Center (CTC) licensed in 2003.[3] The design capacity of the facility is 1,828 and current population is 2,168, or 118.6% of design capacity.[4]

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: We reviewed the SAC health care table of organization and found it was organized along functional lines of authority and internally consistent. SAC has had considerable turnover in key executive positions. At the time of our visit, five of eight executive staff were in an acting position. While the CEO has confidence in her senior management staff because of their prior experience at the facility in other management positions, a stable management team is a key component for a successful program. We recommend that CCHCS fill all management positions with permanent staff as soon as feasible.

Eureka Daye has been Chief Executive Officer (CEO) for two years. Prior to this position, she was CEO at a psychiatric hospital and has approximately 25 years of experience in private sector health care management. Ms. Daye has master's degrees in both clinical counseling and public health, giving her an excellent background for this facility. Dr. Preet Sahota is the Acting Chief Medical Executive (CME) and has been in that position for about two months. Prior to this assignment, Dr. Sahota was Chief Physician and Surgeon (CPS) at SAC for approximately six years. Dr. Vioug Duc is the Acting CPS and has been in that position approximately three weeks. Prior to this assignment, he was a staff physician at SAC. Rene Gutierrez is the Chief Support Executive (CSE) and has been at SAC since 4/12/13. Prior to that, he was Deputy Secretary for the State and Consumer Services Agency for five years. He has a master's in Economics and 27 years in state government. He is well qualified for his role. The Chief Nurse Executive (CNE) has been on an extended leave for over nine months and Tutu Oloyede is the Acting CNE. She has been in this position for approximately three months. She previously was the Director of Nursing (DON) for approximately a year, before which she was a Supervising Registered Nurse II (SRN II) at SAC. Jae Yang is the Acting DON for the past three months. Before this, Mr. Yang was an SRN II at SAC. The Pharmacist in Charge (PIC) is James Gallwey and has been in the position for approximately three years. The Acting Correctional Health Services Administrator II (CHSA II)

[3] CDCR Website. October 2013.
[4] CDCR Population Report. September 1, 2013.

is Rosa Quirate. She has been in the position for about four months. Prior to her current assignment, she worked as a Health Program Specialist at SAC.

Ms. Daye reports to Dr. Tharratt. She has a regional conference call once a month with Dr. Tharratt and CEOs from other regional facilities. Every Thursday, all CEOs have a conference call with Dr. Tharratt and Mitzi Higashidani.

The Warden is Tim Virga, who plans to retire in December. He has been Warden for four years. Anthony Jones is the Associate Warden (AW) of health care and retired the week of our visit. Bruce Forester is Captain of health care.

Communications and working arrangements between the medical leadership and custody leadership appear to be excellent. The CEO meets weekly with the Warden. They walk the facility together. The CEO attends the weekly Warden's meetings. The Warden attends the Quality Management meeting. The CEO meets with the AW of health care weekly.

Management has several administrative goals. One goal is to break down departmental silos. Management is attempting to create a program in which all staff sees themselves as part of a single team. As part of this effort, all senior management staff meets with the AW of health care three times a week in a "flash" meeting. At this meeting, management discusses all recent significant clinical events including hospitalizations, emergency room visits, and significant incidents. This is an excellent process.

Management has also utilized process flow modeling to describe and improve their workflows. Management provided examples of flow models for key processes. These are excellent tools. We recommend that management use this tool for modeling the specialty clinical care and medical care of persons with mental illness and behavior disorders, as these are areas with significant deficiencies. Process modeling of specialty care would include provider ordering, scheduling, review of reports and follow up of recommendations. All of these areas had serious deficiencies. Clinical staff, including one or more providers, would participate in this process.

Human Resources, Staffing and Budget

Methodology: We interviewed facility health care leadership and human resources staff. We reviewed current and planned acuity based staffing plans, vacancy and fill rates and job descriptions. We also reviewed the process for credentialing, peer review and annual performance evaluations.

Findings: Like other facilities, CCHCS manages most human resource functions. CCHCS posts positions and performs initial screening of candidates for vacant positions. SAC management interviews candidates, selects candidates to hire, and then provides names of selected candidates to CCHCS staff at SAC who complete the hiring process. (CCHCS assigns four human resource staff to SAC. Two staff provide services to the medical program and two provide services to the dental and mental health programs.) Staff reported that the hiring process takes

about two to three months. An Employee Relations Officer (ERO) is shared with two other facilities and assists in managing paperwork on disciplinary matters.

The 2013 position authority is 288.4. The position authority in 2012, prior to Acuity Based Staffing Realignment (ABSR), was 281.3. Under ABSR, SAC has added 7.1 positions. These are mostly licensed psychiatric technicians hired due to the opening of a new secure psychiatric unit, and that are included in the medical budget.

There are 66 (22.8%) vacant positions, a high vacancy rate that needs to be reduced. Management reported that they fill vacant positions with registry and overtime. Office technicians (OTs) have the highest vacancy rate. Of the 30.1 office technician positions, 16.1 (53%) are vacant.

All staff receives custody-oriented training provided by Institutional Services Training (IST). The training includes a medical component that addresses medical chronos, effective communication relative to Armstrong, and medical devices. We recommend that SAC staff modify training on effective communication in light of the significant numbers of persons with severe mental illness now housed there. Approximately 25% of the inmates are under court orders for forced medications. Training in effective communication needs to address effective communication with a patient who is psychotic or has significant behavioral disorders. In addition to IST, nurses receive health services training at orientation that includes policy review. Nurses are also provided annual training that includes refresher training on nursing skills and required competencies. Required competencies include emergency response, medication management and cardiopulmonary resuscitation. Providers attend webinars conducted on a regular basis.

Credentialing and Peer Review

The SAC CTC policy,[5] on credentialing and privileging is not consistent with the 2008 court order[6] or the physician privileging procedures[7] governing credentialing and privileging procedures statewide.

In practice, SAC does refer clinical performance issues to CCHCS Professional Practice Executive Committee (PPEC), but their policy does not reflect their practice. By CTC policy, the SAC PPEC is responsible for physician peer review and discipline. In practice, SAC refers provider clinical performance issues to CCHCS PPEC. SAC should modify their CTC policy to reflect actual practice, which is consistent with the 2008 Court Order.

The CPS performs timely peer review through Unified Health Record Clinical Appraisal (UCA) reviews for all providers. As described later, providers have a practice of copying and pasting

[5] SAC CTC policy Volume 1 Medical Staff Bylaws Revised July 2011.
[6] Order Approving With Modifications, Proposed Policies Regarding Physician Clinical Competency; July 9, 2008 *Plata, et al. v. Schwarzenegger, et al.* Federal Court Case No. C01-1351.
[7] *Plata* Physician Professional Clinical Practice Review, Hearing and Privileging Procedures, Pursuant to Order Approving With Modifications, Proposed Policies Regarding Physician Clinical Competency, published September 4, 2008.

progress notes in the Outpatient Housing Unit (OHU). Yet for the UCA reviews of these providers, the CPS graded providers' documentation as adequate to good, including a provider who consistently copied and pasted notes. This calls into question the effectiveness of the peer review process to detect and address significant problems.

In addition to the UCA process, the organized medical staff also performs a quarterly peer review of each provider.[8] Each provider reviews three patient records of a colleague and then discusses findings with the physician under review. The reviewer submits findings to the CPS. The CPS does not include these reviews in the credential file and does not retain the results.

Disciplinary Process

There are 14 individuals involved in ongoing discipline. Completion of disciplinary action takes 13.6 months on average with a range of three months to 24 months. Leadership has redirected one Office Technician to the mailroom for fighting with an officer. One nurse has been under disciplinary investigation for 20 months for alleged deviation from standard of care and failure to recognize symptoms of hypoglycemia and notify a provider. This nurse is still providing clinical care and, using union contract rules, bid on a position in the TTA. Management has refused to allow this to happen and is negotiating with the union. This same nurse was involved in another disciplinary action that recently concluded after approximately two years. The employee was given a 5% reduction in salary for three months for failing to remain with a patient who sustained a cardiac arrest. We strongly support management's ability to reassign employees when their practice may place patients in harm; however, as noted in previous reports, the disciplinary process for health care employees is performed using a custody model that is not appropriate, is not timely, and does not assure patient safety.

We continue to recommend that health care personnel adjudicate disciplinary actions of health care staff as opposed to the custody-staffed Office of Investigative Affairs (OIA).

Health Care Budget

Health care expenditures exceeded initial allocations for two consecutive years. For fiscal year 12/13, the initial allocation is below the prior year's expenditures. The Receiver obtains additional funding so that the programs can operate.

In fiscal year 10/11, the initial allocation was approximately $16 million, the final allocation was approximately $36.15 million and final expenditures were approximately $31.31 million. Final expenditures exceeded the initial allocation by $15.1 million (95%). That fiscal year, the Department of Finance reduced the correctional health care budget to be in line with an estimate of per inmate cost in other states.

In fiscal year 11/12, the initial allocation was approximately $29.97 million, the final allocation was approximately $44.4 million and final expenditures were approximately $42.71 million.

[8] The organized medical staff is defined by local operating procedures and bylaws of the institution. The organized medical staff is not related to the provider union agreement.

Final expenditures exceeded the initial allocation by $12.74 million (42%). Changes in this fiscal year included moving nursing mental health positions into the medical program.

In fiscal year 12/13, the initial allocation was approximately $39.63 million. This is 93% of the prior year's expenditures. In summary, the Department of Finance continues to underfund the CCHCS medical program, which is a concern when the Receivership is no longer in place.

SAC uses the Business Information System (BIS) for reporting expenditures, but does not use BIS for forecasting or for day-to-day management of the budget. We continue to recommend transitioning to a business information system that is useful for both managing and reporting budgetary items.

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. We interviewed staff involved in health care operations.

Findings: SAC uses Periodic Automated Replenishment (PAR) levels in clinics, consistent with a standardized process flow. The material and stores manager II (MSM II) sets PAR levels, reorder thresholds, and maintains inventory. Nurses order and manage all supplies in clinical areas. The MSM II reconciles the inventory monthly. Management does not use the BIS system to manage inventory.

Custody staff performs and tracks open and closed maintenance work orders.

Inmate porters perform sanitation services. There is a cleaning schedule. The medical program augments the inmate custodial service with a contract to provide custodian services for 32 hours a week. This contractor performs follow up cleaning after the porters for the CTC and administration offices. Most clinic spaces had clean floors and supplies were orderly; however, there was also clutter in these areas.

SAC has a major mental health mission. Sixty percent of inmates have a mental health condition. There are 456 (25%) patients on forced psychotropic medications for serious mental illness. Many of the mentally ill have level 4 classification and are housed in the PSU or Ad-Seg units. These units were not designed with adequate clinic examination space to treat this difficult population. Instead, much of the clinic space was modified from spaces built for purposes other than clinical care.

SAC is separated into three facilities, A, B and C. Facilities A and B have PSU, Ad-Seg units, Enhanced Outpatient units (EOP) and Secure Housing Units (SHU). Facility C is a general population unit. Facility A contains a Correctional Treatment Center (CTC) that has 13 mental health beds and only 2 medical beds. This unit has an extremely tiny nursing station with insufficient counter space. Keyboards used for the eUHR are in positions that are ergonomically inappropriate for routine use.

The medical examination room of Facility A is a converted inmate contraband cell. This is an inappropriate examination space. The restroom is used for storage and is cluttered. The clinic is a large space that has an examination table, a desk for a physician, and a cage approximately 4 feet by 4 feet and 6 feet high. The cage is placed in a corner so two sides abut walls. The other two sides of the cage are covered with Plexiglas except for about three feet on the bottom of one side. By custody procedure,[9] all PSU and Ad-Seg inmates housed in Facility A are brought to the examination room handcuffed with their hands behind their backs. At the discretion of custody, they may also be required to wear additional restraint devices. Examinations often take place while inmates wear handcuffs.

On the day of our visit, we observed a provider interviewing a patient. The patient was cuffed with hands behind his back and a nurse was attempting to take his blood pressure. An officer was standing next to the patient. The provider was sitting in a desk about 10 feet from the inmate with a second officer standing next to the provider's desk. This is not an appropriate arrangement. There is no privacy and health care staff cannot perform an appropriate clinical evaluation.

Custody procedure stipulates that medical staff can request removal of restraints. During health record reviews, we noted several instances when detainees were "cuffed up" during physical examination, including taking of blood pressure. In one case, the provider documented the patient's high blood pressure was due to being handcuffed, but did not request that custody remove the restraints to recheck his blood pressure. When we asked the AW of health care why handcuffs were not removed, he said the physician could order removal and the cuffs would be removed. We then spoke with a group of providers. Some stated that custody staff controls whether an inmate remains shackled during an evaluation, and others stated that they could order removal of the cuffs. However, there is no medical procedure for this and several staff stated they were more comfortable letting custody staff make the decision.

There was no procedure for use of the cage. Staff reported that if a patient required an examination out of handcuffs, custody placed the patient in the cage. Safety is a paramount concern for staff working at any facility. However, the lack of clear guidelines for use of restraint devices and cages during clinical encounters results in inadequate evaluations and increased risk of harm.

For example, we observed a physician clinically interviewing an inmate who was handcuffed behind his back in a cage with an officer standing next to the cage. The physician was sitting behind a desk from across the room. Staff reported that the purpose of this interaction was only patient interview. To hear the physician, the inmate had to bend over and place his ear near the area of the cage that did not have a Plexiglas covering. The patient was not psychotic or violent. Placing this inmate in a cage, handcuffed with a custody chaperone standing next to

[9] Chapter 5, Article 19, Section 52050.10-52550.21; Arrest, Search and Seizure, California Department of Corrections and Rehabilitation Operations Manual Supplement.

the cage appeared to be unnecessary. Placing the inmate in handcuffs and within a cage did not appear to enhance security, was unprofessional, and precluded privacy and confidentiality. SAC medical leadership should develop procedures for clinical evaluation of level four inmates incorporating staff concerns for safety and appropriateness of clinical evaluation.

We reviewed the Health Care Facility Improvement Program (HCFIP) architectural drawings of the new Facility A clinic and there is no space for a cage in clinical examination rooms. Procedures for clinical evaluation of level 4 PSU and Ad-Seg patients need to be developed in anticipation of the new clinic space.

Facility A also contains a second CTC unit. This is a new CTC built for mental health patients. It is clean, orderly, and contains an ample nursing station with sufficient space for nurses to work and document notes into electronic devices. Health care leadership should ensure similar work conditions for the medical CTC.

However, each PSU has a nurse examination room that was not designed to be examination space. In Facility A, the nurse examination room was previously a custody space with a large ceiling grate, which permits sound from the custody control station immediately above to pass into the room.

A 20 bed Outpatient Housing Unit (OHU) is also located in Facility A. This unit is similar in construction to a PSU. Nurses use a room near the unit to store medications and supplies. There is no examination room on this unit. Staff performs all dressing changes and examinations in the inmate cells. Since the OHU is used for high medical acuity patients and as a substitute for a CTC, this unit needs to be renovated to support management of these patients.

The main clinic in Facility B has an adjacent Treatment and Triage Area (TTA). Except for this area, all clinic examination space in Facility B was not originally built for its current use and is inadequate.

The Facility C provider examination room has an examination table placed in a corner so that patients cannot lie flat for an examination. One of the nurse examination rooms does not have an examination table and nurses evaluate patients in a chair. Facility C also has a TTA.

The stand-alone Ad-Seg unit in Facility C has a very small provider examination room. For evaluations, custody staff handcuff patients with their hands behind their backs and sit on a chair placed backwards. Officers stand next to the patient. This space is too small and does not permit proper examinations.

The HCFIP plans include building new clinics for facilities A, B and C, renovation of the pharmacy, and renovation of medication rooms. This construction should resolve clinic space issues at this facility except for the CTC and OHU. Health care and custody leadership should

reevaluate how high security, mentally ill patients are examined to provide privacy and permit adequate clinical evaluations. .

Policies and Procedures

Methodology: We interviewed health care leadership and staff and reviewed selected statewide and local policies and procedures to determine whether leadership periodically reviews and updates them and whether local policy follows statewide policies.

Findings: There are 26 local operating procedures. Of the 26 procedures, 13 address medication management issues. All local operating procedures were revised May 2013 but none of them had been signed as approved as of October 1, 2013.

The 26 local operating procedures address most major areas of service with several exceptions. There is no local operating procedure specifically addressing urgent and emergent services at SAC. Volume 4, Chapter 1, Medical Services Overview describes arrangements for how inmates will access emergency and urgent care but there is insufficient detail. There is also no local operating procedure specifically addressing the Outpatient Housing Unit (OHU) operations. Volume 4, Chapter 1 of the SAC local operating procedures, Medical Services Overview, describes admission procedures to the OHU but no other details regarding operations of this unit. In addition, there are no local operating procedures on credentialing, privileging or physician peer review except for procedures in the CTC policy manual discussed below.

Local operating procedure Preventive Clinical Services, Volume 4, Chapter 7 recommends providing preventive clinical services in accordance with the United States Preventive Services Task Force[10] (USPSTF). The USPSTF, which we agree with, recommends that clinicians screen for HIV infection in all adolescents and adults ages 15 to 65 years. The SAC local operating procedure does not make that recommendation even though it states it follows USPSTF recommendations. We recommend screening all inmates for HIV if they have not yet been screened. The USPSTF also recommends that clinicians screen all adults for lipid disorders based on age and sex; this should also be incorporated into this policy.

Excluding mental health and dental policies, there are 323 CTC policies. The last review for most of these policies was in August 2012. The pharmacy CTC policies were reviewed in May 2012. There was no approval page for Nursing CTC policies. We question whether it is necessary to have 323 medical policies to provide guidance in managing two medical CTC beds. Many of the nursing policies could be changed to guidelines. We recommend CCHCS review Title 22 CTC policy requirements to streamline these policies and assist facilities in crafting required standardized policies which can be used with minor modifications at all facilities with CTCs.

[10] Agency for Healthcare Research and Quality, Recommendations of the U.S. Preventive Services Task Force Guide to Clinical Preventive Services as found online at http://www.ahrq.gov/professionals/clinicians-providers/guidelines-recommendations/guide/abstract.html

Some CTC policies are outdated. The policy Medical Staff Bylaws, Volume 1 of the CTC policies, still describes the Governing Body as including the Director of CDCR, the CDCR Chief Deputy Director, the CDCR Deputy Director Institutions, the CDCR Deputy Director and CDCR Assistant Deputy Director. This organizational structure ended with the Receivership. SAC leadership needs to update this policy.

As noted above, some policies are inconsistent with the 2008 Court order[11] and statewide procedures[12] regarding physician privileging. The policy Medical Staff Bylaws, Volume 1 of the CTC policies, describes the Professional Practice Executive Committee (PPEC) as composed of officers of the local organized medical staff, the Medical Director, Chief Dentist, and Clinical Director of Psychiatry and Psychological service. In this policy, the SAC PPEC recommends clinical privileges. The policy also describes that the SAC PPEC undertakes personnel actions regarding providers at SAC. This contravenes court-ordered procedures.

The CTC Personnel policy, Volume 2, Chapter 1, addresses hiring and personnel procedures. This document gives direction on how to process personnel matters but does not refer to the 2008 court-ordered physician privileging procedures that include disciplinary and other personnel matters for physicians.

In summary, the local operating procedures need minor additions and revisions. The CTC policies need to be significantly streamlined and brought up to date.

Intrasystem Transfer

Methodology: We toured the CSP-SAC receiving and release (R&R) area, interviewed facility health care leadership and staff involved in intrasystem transfer and reviewed tracking logs, staffing and 15 health records from Facilities A, B, and C.

Intrasystem Transfers

Findings: Although nurses perform medical screening on newly arriving inmates in a timely manner, we found significant problems with the intrasystem transfer process. These problems included medication delays, discontinuity and errors in five[13] of 15 records, either upon or following transfer of the patient. Other problems included:

- Resubmission of a specialty service request to perform arthroscopy on the wrong knee that could have been avoided had providers examined the patient.
- Six-month delay in providing a C-PAP machine for a patient with sleep apnea.
- Failure to follow through on specialty service recommendations in a timely manner.

[11] Order Approving With Modifications, Proposed Policies Regarding Physician Clinical Competency; July 9, 2008 *Plata, et al. v. Schwarzenegger, et al.* Federal Court Case No. C01-1351.
[12] *Plata* Physician Professional Clinical Practice Review, Hearing and Privileging Procedures, Pursuant to Order Approving With Modifications, Proposed Policies Regarding Physician Clinical Competency, published September 4, 2008.
[13] In two of these five records, there was more than one example of delayed or lapsed medications.

- Failure to note and address all of the patient's medical conditions or diagnostic findings that warrant monitoring (e.g., history of stroke and myocardial infarction, mitral and tricuspid valve regurgitation, etc.).
- Delays in access to reports for services performed prior to or following transfer.
- Scheduled follow-up not occurring in a timely manner if at all.

We also noted that several records had health record documentation errors, such as patient documents being filed in the wrong record, records being misfiled in the wrong section, delayed access to specialty reports, and dictation errors (wrong date, wrong patient, etc.). These issues are further described in the Health Records section of this report.

Patient records that illustrate these findings are described below.

- This 42 year-old patient arrived in CDCR in 2009 at North Kern State Prison and transferred from Calipatria (CAL) to SAC on 11/7/12.[14] His medical history included obstructive sleep apnea and hypertension.

  Upon arrival in CDCR, the patient reported having a heart murmur. On 9/24/2010, an echocardiogram showed mild mitral and tricuspid regurgitation. Providers have not documented these findings on the eUHR or PHIP (Patient Health Information Portal) Problem List.

  On 11/2/12, Calipatria (CAL) staff completed a 7371 noting that the patient was overdue for a chronic disease visit; the patients' last chronic disease visit had been in March 2012 and he had been due for follow-up in July 2012. The nurse also noted he had a C-PAP machine and low bunk chrono.

  Upon his arrival at SAC, a nurse medically screened the patient. His blood pressure was normal (BP=133/80 mmHg) but his pulse was low (47/minute). The nurse did not repeat the patient's vital signs or ask the patient if he had symptoms of dizziness, shortness of breath, etc. The nurse did not document that the patient used a C-PAP machine or had a lower bunk chrono. The pharmacy refilled the patient's chronic disease medications and nurses delivered the medications to the patient the following day. The nurse referred the patient routinely to a provider.

  On 11/21/12, the provider saw the patient as a new arrival. He addressed the patient's obstructive sleep apnea but did not note his history of mitral and tricuspid valve regurgitation. The patient had not received a C-PAP machine since his arrival at SAC.

  On 1/24/13, the provider saw him for follow-up. The provider had not requested the C-PAP machine because he did not have the original sleep study report. The patient was scheduled for a sleep study on 1/22/13, but the patient reported he had not been notified of the

[14] Intrasystem Transfer/Sick Call Patient #14.

purpose of the appointment and refused it. Staff rescheduled the sleep study and it was performed on 2/19/13.

On 3/20/13, the provider saw the patient for follow-up, noting the sleep study had been performed but a report was not available in the health record. He planned to get the report and bring the patient back for discussion.

On 4/5/13, the provider saw the patient for follow-up and discussion of the sleep study results, which showed obstructive sleep apnea. Staff had already ordered the C-PAP machine but it had not yet arrived. On 4/29/13, staff issued the C-PAP machine to the patient. The provider requested that the patient return for follow-up in June or July; however, as of 10/31/13, the follow-up had not taken place.

Assessment

Issues related to intrasystem transfer were failure of the SAC nurse to note that the patient had a C-PAP machine and bottom bunk chrono, and to initiate and take action to facilitate continuity of care. Other system issues include lack of access to the previous sleep study report; not informing the patient of the need to repeat the sleep study in January 2013; and delays in obtaining the February 2013 sleep study report. These system issues resulted in the patient not receiving a C-PAP machine for almost six months after his arrival at SAC. Providers did not document the patient's September 2010 echocardiogram findings of mild mitral and tricuspid regurgitation on the patient's Problem List and the provider is unaware of the echocardiogram findings. The patient's pulse was abnormally low on two occasions but not repeated or addressed by a nurse; and an EKG has not been performed. The patient has not had timely follow-up for chronic disease management.

- This 50-year-old patient transferred from SVSP to SAC on 11/16/12.[15] His medical history included hypertension, hyperlipidemia, diabetes, coronary artery disease, stroke in 2004, myocardial infarction in 1999, blindness left eye, right knee medial meniscus tear, s/p arthroscopy February 2013, and bipolar disorder. He is taking multiple medications.

  On 10/9/12, while at SVSP, the patient's LDL cholesterol was high (LDL-C=134, goal=<70). Despite this abnormal report, the SVSP provider notified the patient that his results were essentially within normal limits. In 2011, a right knee MRI showed a meniscus tear, moderate effusion and Baker's cyst. A provider submitted a request for arthroscopic repair that was approved but did not take place due to refusals related to the patient's mental illness. In July 2012, the SVSP provider resubmitted a Request for Services (RFS) but noted that the patient had left knee meniscus tear instead of the right knee. In addition, the patient's medication orders for simvastatin, lisinopril and metformin expired in August and September 2012, respectively.

[15] Intrasystem Transfer/Sick Call Patient #17.

SVSP staff completed a 7371, noting that the patient had a history of a stroke and was pending arthroscopic repair of his left knee, rather than the right knee. Upon his arrival at SAC, a nurse medically screened the patient, noting his medical history and that some medications transferred with the patient. The nurse did not notice that that medication orders for simvastatin, lisinopril and metformin had expired. The patient reported hearing voices and had attempted suicide in July 2012 but denied current suicidal ideation. The nurse referred the patient to medical and mental health providers in 1-3 days and 14-21 days; however, the documentation did not clarify which referral was to occur in 1-3 days versus the latter timeframe. The patient was housed in the PSU.

On 11/21/12, a provider renewed the patient's simvastatin and lisinopril, but not his metformin and planned to see the patient in 30-45 days. In December 2012, laboratory tests show his diabetes control had worsened (HbA1c=6.9% in May 2012 to 7.7% in December 2012).

On 1/14/13, his hemoglobin A1C was 9.0%. On 1/24/13, the provider saw the patient and based upon his most recent laboratory tests, added metformin back to his regimen at a low dose (500 mg twice daily). On 1/28/13, his hemoglobin A1C was 9.7%. On 2/8/13, the provider saw the patient again and noted the 1/28/13 hemoglobin A1C of 9.7%. He added another medication (glipizide) and increased the patient's Lantus insulin, although this laboratory value reflected his glycemic control before the provider had added the metformin.[16]

On 2/22/13, his hemoglobin A1C was 10.4%. On 3/9/13, the patient refused his Lantus insulin, stating the doctor keeps changing his medication regimen without consulting him. He wanted to meet with the doctor to tell him how he was exercising and that he does not always eat everything on his tray. On 3/11/13, the provider saw the patient and reviewed his history of refusing insulin. The provider did not consider increasing the dosages of the oral hypoglycemic agents. At the same visit, the provider noted the patient's hyperlipidemia was not well controlled and he switched him from Simvastatin 80 mg to Atorvastatin 80 mg.

On 8/25/13, the patient submitted a 7362 requesting x-rays of his collarbone and left and right hands due to injuries. A nurse triaged it on 8/26/13. On 8/27/13, the nurse saw the patient using a musculoskeletal assessment form. The nurse did not perform an adequate assessment, noting that she was "UTA" range of motion. This abbreviation is unfamiliar to us but we presume it means "Unable To Assess," as the nurse did not document any meaningful assessment. The nurse did not document whether the patient was cuffed during the encounter. The nurse did not assess the patient's hand complaints. The nurse referred the patient to a provider.

On 8/30/13, mental health staff noted that the patient was losing weight through diet and exercise. On 9/3/13, there is an unsigned refusal of a provider appointment.

[16] The hemoglobin A1C reflects the degree of control for the prior 2-3 months.

Regarding the patient's knee problem, at the patient's new arrival visit on 11/21/12, the provider noted he had right knee pain and that he stated he was supposed to have knee surgery. The provider also noted the result of the abnormal MRI. However, he documented the patient's musculoskeletal examination as WNL (within normal limits). He did not refer the patient to orthopedics. On 1/9/13, the provider saw the patient and submitted a RFS for repair of a left knee torn meniscus. He documented the musculoskeletal examination was normal. The provider failed to note it was the right knee, not the left, which had the meniscal tear. The patient saw the orthopedic surgeon on 2/4/13. The surgeon noted the patient "denies any left knee pain, just right knee pain, which has always been the case." The surgeon scheduled the patient for surgery of his right knee, which was performed on 2/27/13. The surgeon saw the patient for follow-up on 3/14/13. He noted the patient was doing well and did not require follow up. The provider saw the patient for follow up of this visit on 3/20/13. On 5/28/13, another provider saw him for chronic disease management and again mistakenly documented that he had a left knee meniscal tear. She thought that the surgery was still pending, noting that she did not "have information on his upcoming surgery."

Assessment

This record shows multiple problems, beginning at SVSP where the patient's chronic disease medications (metformin, lisinopril and simvastatin) lapsed unnoticed and the request for arthroscopic repair was for the wrong knee. Since late 2011, the patient had been taking metformin 1000 mg twice daily and his diabetes was well controlled, with hemoglobin A1C of 6.9% in May 2012. However, because of the failure to renew his medications at SVSP and subsequent failure to re-order the metformin following transfer to SAC, the primary strategy used to control his diabetes was adjustments in insulin. The patient, however, refused his insulin, believing these changes were made without adequate communication and consultation with him. Moreover, laboratory tests and chronic disease visits were not well coordinated, and providers changed medication regimens before measuring the effect of the most recent change in medication regimen (see January and February 2013 notes). This does not promote trust between provider and patient and although the patient's diabetes had been well controlled on a different regimen, providers have labeled the patient as being non-compliant. Given his mental illness, this patient would benefit from medical and mental health case management, but we do not find documentation of communication between medical and mental health staff regarding management of the patient.

The error regarding which knee required arthroscopy was continued from SVSP to SAC and was likely due to the provider's failure to perform an adequate history and examination of the patient. On several occasions, providers documented the musculoskeletal examination as WNL, meaning "Within Normal Limits," which is not consistent with the patient's condition and raises the question of whether the provider examined the patient. As late as May 2013, three months after the patient had right knee arthroscopy, a provider documented that the patient was pending arthroscopy on his left knee, raising questions as to whether the provider interacts meaningfully with the patient.

- This 58-year-old patient transferred from Mule Creek State Prison (MCSP) to SAC on 4/8/13.[17] His medical history included HIV/AIDS diagnosed in 2010, chronic hepatitis C infection, Pulmonary TB in 2010 with a right lower lung wedge resection, a 2 cm left pulmonary nodule per CT in April 2012, COPD, hypertension, hyperlipidemia, basal cell cancer and depression. His medications are Atripla, atenolol, pravastatin, Prozac, hydroxyzine, Bactrim, and ibuprofen.

  On 4/5/13, MCSP staff completed a 7371 and documented his medical conditions. The nurse did not document the patient met Valley Fever elevated risk criteria. The nurse noted his chest x-ray was abnormal on 4/2/2012. The patient's CD4 cell count was low (206 cells/uL, normal=500-1500 cells/uL) and HIV viral load was undetectable on 3/13/13. The patient was due for a chronic disease visit on 4/12/13.

  On 4/8/13, a SAC nurse medically screened the patient measuring his blood pressure, pulse and weight and noting some chronic diseases. The nurse did not document his COPD, pulmonary nodule or basal cell carcinoma as medical conditions. The nurse noted the patient was due for dermatology follow-up on 8/20/13.

  The nurse documented on the medication reconciliation form that the patient transferred with three days of medications. All medications had refills except Prozac, which had none, and the medication was not renewed. On the medication reconciliation form under refills left, Simvastatin was noted to be a PRN (as needed) medication and it's unclear what this means regarding number of refills. The pharmacy refilled all medications for 30 days except Prozac and the patient received the medications the same day.

  The RN documented a referral to a primary care provider, the chronic disease program and mental health. The patient was housed in Ad-Seg. A provider did not see the patient for chronic disease management within the period requested by the previous provider (4/12/13). On 4/12/13, the psychologist saw the patient and noted his diagnosis of depression. The provider did not reference his taking Prozac and it was not renewed.

  On 5/6/13, the HIV provider saw the patient as a new intake and wrote a thorough note indicating that the patient ran out of his Prozac. The provider renewed his Atripla for one year, ordered labs, a psychiatry appointment and follow-up in two months. A psychiatrist renewed his Prozac and hydroxyzine on 5/13/13 for 90 days.

  On 5/21/13, a primary care provider saw him for chronic disease management. This visit was not in accordance with the transferring nurse's referral, but the patient was well controlled except for hypertriglyceridemia. On 6/17/13,[18] the provider saw the patient for HIV infection and dictated an excellent note addressing his HIV and hepatitis C infection. His CD4 count was 325 cells/uL. The physician noted that she discussed discontinuing the

[17] Intrasystem Transfer/Sick Call Patient #1.
[18] The provider dated the note 4/17/13; however, it appears that the patient was actually seen on 6/17/13 and the date on the note is apparently incorrect. This note was dictated on 6/17/13, transcribed on 6/19/13 and authenticated on 6/20/13.

Bactrim if the CD4 count remained greater than 200 cells/uL. (Bactrim is to prevent pneumonia in AIDS patients with a CD4 count less than 200 cells/uL.) The provider ordered repeat laboratory tests in 2 months.

A June 2013 MAR [showed the patient received Atripla, Bactrim, and atenolol but not simvastatin. A 7/2/13 MAR showed the patient's simvastatin had not been refilled since 5/7/13. On 7/5/13, the patient received 30 days of simvastatin.

On 7/16/13, a provider saw the patient, noting he had hypertriglyceridemia (TG=179, normal=<150). The provider did not document that there was a gap in refill of the patient's simvastatin. The provider changed his simvastatin to pravastatin. On 7/19/13, the patient received 30 days of pravastatin.

On 8/15/13, the patient refused the laboratory tests ordered by the HIV physician. On 9/4/13, a dermatologist saw the patient via telemedicine for evaluation of a scalp lesion and recommended a biopsy to rule out melanoma. On 9/11/13, a provider submitted a RFS for a surgical consult as soon as possible at San Joaquin General Hospital (SJGH) for the biopsy.

On 9/16/13, the HIV provider saw the patient and noted he was no longer taking his Bactrim because his refill was not continued and he had understood it was going to be stopped in the near future anyway. The provider did not address the patient's skin lesions or requested biopsy. The provider documented "No rashes." The patient agreed to have laboratory tests that day. The tests revealed that his CD4 count had dropped precipitously from 325 to 202cells/uL. A provider notified the patient his tests results were essentially unchanged and no follow-up visit was scheduled to discuss the tests.

On 9/17/13, a provider saw him and documented he was not receiving his blood pressure medications for reasons that were unclear. His blood pressure was elevated (BP=140/91 mmHg). The provider requested 90-day follow-up.

A punch biopsy of the patient's forehead lesion was performed on 10/21/13 and showed nodular basal cell carcinoma. The report was electronically signed on 10/24/13. Health records filed the report in the non-CDCR hospital reports instead of the pathology section of the eUHR. On 10/29/13, a provider saw the patient for follow-up but did not reference the pathology report. On 11/4/13, a dermatologist saw the patient and recommended a Moh's procedure. On 11/7/13, the provider saw the patient for follow-up and planned to schedule the procedure.

Assessment

This record showed three instances of medication discontinuity and an incorrect date of an encounter. Upon arrival, the patient's mental health medication (Prozac) was not renewed and not restarted until five weeks after his arrival. The patient has had interruption of his simvastatin that was noted to be a PRN (as needed) medication on his medication reconciliation report rather than for the pharmacy to refill it automatically. The provider

was not aware that he was taking his simvastatin when he ordered pravastatin. The patient's Bactrim order expired prior to his chronic disease visit and was not renewed because the provider anticipated it would not be necessary to continue the medication due to his CD4 count being well above 200. However, his CD4 count dropped precipitously to 202 and as of 11/11/13, he has had no HIV follow-up. The patient received a 30-day supply of two different statins in the same month and we do not find documentation of education advising the patient to discontinue the simvastatin when he began pravastatin.

- This 56-year-old patient transferred from the California Men's Facility (CMF) CTC to SAC on 10/31/12.[19] He was housed at SAC prior to transfer to the CMF CTC. His medical history included HIV/AIDS since 2010, pulmonary TB in 2010, hypertension, depression and right rotator cuff repair in February 2012.

  On 3/15/12, an orthopedic surgeon saw the patient following right rotator cuff surgery and noted he was doing well and should start physical therapy to improve his strength and return in three months. Three weeks later, the physical therapist saw the patient and documented that he was making slow progress and needed to be more aggressive. The physical therapist showed the patient exercises to do independently and discontinued formal physical therapy.

  On 6/18/12, the orthopedist saw the patient for follow-up. The patient reported severe pain. The orthopedist recommended pain management and resumption of normal activities. He also recommended an MRI and follow up in 2-3 months if the patient's pain was not improved.

  On 8/13/12 at 3:18 p.m., the patient was brought to the TTA following use of force that included OC spray. The patient complained of right shoulder pain (8-9 in severity). The patient's blood pressure and pulse were high (BP=162/111 mmHg, pulse=115, later BP=138/100 mm/Hg, pulse=95). The patient was admitted to the CTC for suicidal ideation. A provider did not evaluate the patient until the following day, noting he had pain upon mobilization (i.e. movement) of his right shoulder. He did not further examine the patient's shoulder or order imaging. The patient stated that he should have a waist chain chrono.

  On 10/19/12, the patient transferred to the CMF-CTC. He was discharged back to CSP-SAC on 10/31/12. A CMF nurse completed a 7371 and upon arrival at SAC, a nurse screened the patient. Nurses administered his medications via directly observed therapy. A provider wrote bridge orders for his mental health medications for 14 days and then another provider renewed all medications for 180 days. MARs show he has had continuity of medications at the time of transfer.

  On 11/14/12, a provider saw the patient for chronic disease follow-up and right shoulder pain. Over the past year, the patient has intermittently refused labs and medical

[19] Intrasystem Transfer/Sick Call Patient #2.

appointments. On 8/23/13, the provider saw him for chronic disease follow-up. The patient was requesting methadone for his shoulder. The provider did not examine the patient's shoulder. He denied him methadone and prescribed Naproxen.

Assessment

This AIDS patient had continuity of medications upon transfer but has not had timely evaluation and follow-up following his right rotator cuff injury. In June 2012, the orthopedist had recommended physical therapy and an MRI and return to the orthopedist if the patient continued to have pain. However, the physical therapist discontinued PT after a single visit and the patient did not have an MRI with follow-up as requested. Providers have not conducted adequate examinations of the patient's shoulder, possibly due to the patient being handcuffed.

- This 42-year-old patient transferred from California Correctional Institution (CCI) to SAC on 11/2/12.[20] His medical history included hypertension, psoriasis and chronic hepatitis C infection. His medication history include the following medications for psoriasis: Enbrel, Soriatane, hydrocortisone cream, coal tar, clobetasol, Triamcinolone cream, and vitamin A in petroleum. He had seen a dermatologist on 10/19/12 who had recommended follow-up for his psoriasis in 6 months. He is in Ad-Seg.

  At CCI, staff completed a 7371 noting the patient's current diagnoses and pending chronic disease follow-up. Upon his arrival at SAC, a nurse medically screened the patient. His medications arrived except for clobetasol and Triamcinolone. However, on the patient's medication reconciliation report the nurse documented that the patient's KOP and nurse administered medications arrived with the patient and his clobetasol and Triamcinolone were not refilled. The nurse referred the patient to a medical provider in 14-21 days.

  On 11/9/12, the patient refused his chronic care appointment, stating he had the flu. The nurse did not assess the patient. The physician wrote an order to reschedule the patient in 30 days. On 11/14/12, the patient submitted a 7362 stating he had not received his clobetasol since his transfer and he was having a painful breakout of psoriasis on his chest and stomach. The patient requested his medication refill. A nurse triaged it on 11/15/12. The nurse did not see the patient but requested refill of his medication. The pharmacy filled the prescription and a nurse administered it to the patient on 11/17/12.

  On 12/3/12, the provider saw the patient for chronic disease management. The patient's hypertension was well controlled and psoriasis was improving. The provider did not address his 7362 complaining of a painful rash on his chest and stomach, but documented a normal chest and abdominal examination. The provider planned to have the patient followed by dermatology as needed. He ordered follow-up in 90 days.

[20] Intrasystem Transfer/Sick Call Patient #5.

On 12/30/12, the clobetasol order expired and a provider did not renew it until 1/6/13. A January 2013 MAR showed that he did not receive his nurse-administered clobetasol on Wednesday 1/23/13.

On 2/14/13, the provider submitted a RFS for dermatology to evaluate the patient's severe psoriasis. On 3/25/13, a dermatologist saw the patient. Treatment options were somewhat limited due to the patient's chronic hepatitis C infection. The dermatologist recommended a course of Enbrel or topical coal tar 14%. A nurse wrote the recommendation for Enbrel and three-month follow-up on the RFS. On 4/5/13, the provider saw the patient and wrote a brief note regarding his psoriasis. He requested follow-up in 80-90 days.

On 6/11/13, a provider saw the patient for chronic disease management. The physician's note was brief and the ROS consisted of "denies chest pain and shortness of breath." There was no evaluation of the patient's psoriasis. He planned to have dermatology see the patient and follow-up in 90 days.

On 7/31/13, the dermatologist saw the patient for follow-up, noting he was improved but was having cutaneous side effects from the Soriatane. Due to these side effects and the patient's underlying liver disease, the dermatologist recommended discontinuing Soriatane and treating the patient with Enbrel alone and to see him for follow-up in one month. The telemedicine nurse wrote an order for follow-up with the dermatologist in one month, but also a conflicting statement that the PCP should decide follow-up at the 14-day follow-up. The one-month follow-up visit did not take place.

On 8/13/13, the provider saw the patient for chronic disease follow-up. The patient's blood pressure was low (BP=92/63 mmHg) and the provider attributed the hypotension to the patient's cirrhosis. The provider discontinued the Soriatane in accordance with the dermatologist's recommendation. The provider did not renew the patient's lisinopril or hydrochlorothiazide and the medication order expired. There was no plan to monitor the patient's blood pressure.

On 9/8/13, the patient submitted a 7362 stating he needed his medications refilled including hydrochlorothiazide and lisinopril and his skin creams. He also stated that since the Soriatane had been discontinued his psoriasis had worsened. He requested to see the provider. On 9/10/13, the nurse saw the patient. The quality of the nursing assessment was good. The nurse discussed the case and referred the patient to a provider.

On 9/11/13, the provider wrote an order to discontinue telemedicine dermatology for now. The next day the provider saw the patient, who reported his psoriasis was worse. The provider reordered the patient's Soriatane without consultation with the dermatologist, although the dermatologist discontinued the medication out of concerns regarding actual

and potential side effects (i.e., cutaneous reaction and underlying liver disease[21]). The pharmacy did not dispense the medication until 9/17/13.

On 9/24/13, the provider saw the patient for his medication refill requests and renewed the patient's psoriasis medications except for Coal Tar, which he discontinued. The patient's blood pressure was within normal limits but higher than at the previous visit (BP=131/78 mm/Hg). The provider did not address the patient's hypertension status or order blood pressure monitoring.

As of 11/1/13, the patient was still receiving the Soriatane and had not been referred back to the dermatologist.

We found numerous medical records problems in our review of this patient's eUHR.

- There was another inmate's consultation report scanned into this patient's record.
- There were no August MARs in the health record to show when the patient last received his hydrochlorothiazide and lisinopril.
- The 7/31/13 consultation report was filed in the outside hospital section of the eUHR, instead of the consultation section
- The 6/11/13 physician's progress note was labeled a nursing assessment protocol in the eUHR.
- On 4/8/13, the patient had an abdominal CT for follow-up of an abnormal ultrasound. On 4/18/13, the provider documented it showed a benign liver lesion and no follow-up was necessary. However, the CT report was not in the eUHR.

Assessment

The patient did not have continuity of his psoriasis medication, clobetasol, for two weeks following transfer and in late December, the order for his medication expired. The dermatologist discontinued the patient's Soriatane due to concerns about medication side effects and the patient did not receive recommended follow-up. The patient's psoriasis worsened and the provider resumed the patient's Soriatane without consulting the dermatologist. The patient also had discontinuity of his antihypertensive medication, but remains normotensive. The provider has not documented his thinking regarding the patient's hypertension and has not ordered blood pressure monitoring. There are numerous health record issues in this record, including the absence of an abdominal MRI report, another inmate's consultation scanned into the patient's record, and no August MARs scanned into the record.[22]

[21] Soriatane has been linked to serious liver problems and is generally contraindicated in patients with severe hepatic or dysfunction. It also has been linked to pancreatitis. UpToDate online medical reference. [www.UpToDate.com.]

[22] In response, SAC leadership disputed the findings of this case, but supporting documentation consisted of encounters that took place following our visit to SAC in October 2013.

- This 45 year-old patient transferred from CMC to CSP-SAC on 9/6/13.[23] His medical history included HIV/AIDS, peripheral neuropathy, hypothyroidism, hyperlipidemia, seizure disorder, adjustment disorder and asthma. His medications are Epzicom, Zidovudine, Raltegravir, Atazanavir, Ritonavir, amitriptyline, levothyroxine, gemfibrozil, Latanoprost, levalbuterol, levetiracetam, haloperidol and benztropine. On 9/26/12, prior to entry into the prison system, his CD4 count had been 552 cells/uL and his viral load undetectable.

  CMC staff completed a 7371. Upon his arrival, a SAC nurse medically screened the patient and performed a good assessment, noting medications transferred with the patient. The nurse referred the patient to a medical and mental health provider. His medication reconciliation form shows that all medication orders were current. His September MAR shows he received his medications timely.

  On 9/19/13, a provider saw the patient for chronic disease management. He noted the patient was taking multiple antiretroviral medications and that his most recent CD4 count was 745 cells/uL; however, the patient's CD4 count had actually been 475 cells/uL on 8/21/13.[24] The provider ordered an HIV viral load, but as of 11/1/13, there was no lab report in the eUHR.

  On 10/4/13, his CD4 count was 432 cells/uL. We did not find an HIV viral load in the eUHR record going back over a year. On 10/7/13, a provider saw the patient for chronic disease management and noted the 8/21/13 labs revealed that the patient's viral load was undetectable; however, we did not find an HIV viral load report in the eUHR. Health records staff did not scan the provider's note into the eUHR until 11/1/13.

  Assessment
  The patient's CD4 count has dropped from 550 to 432 in the past 20 months, but review of the eUHR shows that going back to May 2012 there is no HIV viral load report scanned into the eUHR. There is a delay in the review and scanning of the HIV provider's progress notes into the eUHR.

- This 66-year-old patient transferred from SAC to the CMF CTC on 9/4/13, then back to SAC on 9/13/13. His medical history included diabetes, hypertension, chronic kidney disease, hyperlipidemia, COPD, hospitalization for pneumonia in March 2013, chronic hepatitis C infection and paranoid schizophrenia. His medications are glargine and regular insulin, metformin, lisinopril, amlodipine, aspirin, simvastatin, dulera, levalbuterol, risperdone, terazosin, morphine and fluconazole.

  On 9/4/13, the patient transferred from SAC to CMF. The patient reported weakness and a nurse and provider evaluated the patient. The provider documented that the patient did

[23] Intrasystem Transfer/Sick Call Patient #8.
[24] It is possible the documentation error was due to transposed numbers.

not receive his medications or anything to eat before transfer. His blood sugar was 89 and BP was elevated (BP=146/87 mmHg).

On 9/13/13, CMF completed a 7371 and transferred the patient back to SAC. Staff admitted the patient directly to the OHU, apparently due to mobility issues. A provider renewed his medications on the day of arrival for 30 days and then renewed them again on 10/8/13 for an unspecified period. A provider performed a history and physical the following day.

Assessment

According to the eUHR, this high acuity medical patient did not receive a meal or medications prior to being transported to CMF.

- This 44-year-old patient transferred from Pelican Bay State Prison (PBSP) to SAC on 9/21/12.[25] His medical history included protein C and Protein S deficiency[26], chronic venous thromboembolism, placement of a Greenfield Filter[27] and bipolar disorder with suicide attempts. His medication is warfarin.

  On 9/14/12, PBSP staff completed a 7371. Upon his arrival at SAC, a nurse medically screened the patient, noting his medical history and that DOT (directly observed therapy) medications did not transfer with the patient. The nurse referred the patient to a medical and mental health provider in 1-3 days. The patient was in Ad-Seg. We did not find any September 2012 MARs for SAC showing the patient received warfarin following his arrival.

  Previous notes in the record indicate he is on lifelong anticoagulation with an INR goal of 2.5-3.5. On 9/28/12, a provider saw the patient for chronic disease management and renewed his warfarin for 180 days. His INR was 3.5 the same day. A provider reviewed this report the same day. Another provider reviewed the report on 10/1/12 and ordered the patient's warfarin be held for one day and that weekly INRs be done beginning 10/2/12.

  On 10/22/12, a provider saw the patient for follow-up, noting the 9/28/12 INR of 3.5. The patient had had no INRs measured since then. The provider did not address the fact that labs were not performed as ordered. We did not find refusals of care during this period.

  On 10/23/12, the patient refused labs and signed a refusal of treatment form, but neither a nurse nor provider documented counseling the inmate regarding risks of refusal. On 11/2/13, a provider noted that the patient refused Coumadin clinic and had been refusing lab testing. On 11/9/12, a provider saw the patient, noting he had refused Coumadin clinic but decided to come that day. He documented the INR goal was 2.5-3.5. On 11/30/12, his INR was 3.5. A provider did not review this report until 12/7/12.

[25] Intrasystem Transfer/Sick Call Patient #12.
[26] Deficiencies that can cause blood clots.
[27] A filter placed in the inferior vena cava to prevent blood clots from reaching the lungs.

On 3/12/13, his INR was 4.5. The following day his dose was held. An INR was not drawn again until 3/26/13 and was therapeutic (INR=3.2). No INRs were drawn from 5/7/13 until 8/6/13, a three-month period. On 9/24/13, his INR was supratherapeutic (INR=4.6). A provider reviewed this report the following day, held a dose and then lowered his warfarin dose with repeat INR in one week. On 10/16/13, a provider saw the patient and the patient denied bleeding symptoms. On 10/8/13 and 10/21/13, his INRs were INR=2.5 and 2.3 respectively.

Assessment

This is a challenging patient with a history of multiple pulmonary embolisms and deep vein thrombosis. He is not being clinically monitored in accordance with his medical acuity. We find no MARs showing he received continuity of medication following his arrival at SAC. He has gone through two extended periods of time in which INRs were not drawn as ordered (9/28/12 to 11/30/12 and 5/7/13 to 8/6/13); however, providers have not adequately documented counseling regarding the risks of refusal of monitoring. This is significant because the patient's INRs have at times been above the target goal and increased the patient's risk of bleeding. At these times, neither providers nor nurses interview the patient for symptoms of bleeding, a complication of warfarin therapy. This patient could benefit from case management.

- This 32-year-old patient transferred from LA County Sheriff's Department to SAC on 9/26/13.[28] His medical history included HIV infection and Idiopathic Thrombocytopenia (ITP)[29]) with a splenectomy in 2008. His medication is Atripla.

  This patient arrived in CDCR in 2003 and his HIV infection was diagnosed in 2005. He developed ITP and underwent splenectomy in 2008. Review of his record shows he has been assigned to SAC since at least 2011. However, on or about 9/14/13, he was transferred to LA County Sheriff's Department and transferred back to SAC on 9/26/13. There was no documentation that SAC staff completed a 7371 when the inmate transferred to LA County.

  Upon his return on 9/26/13, a nurse completed a 7277 noting medications did not transfer with the inmate, however continuity of medications was provided to the patient. The nurse referred the patient to a medical provider in 14 days; however, as of 10/31/13 the eUHR does not reflect this appointment took place.

  In June 2013, his CD4 count was drawn twice in three days and was 339 and 427 respectively, and his HIV viral load was undetectable.

  Assessment

  SAC staff did not complete a 7371 when the patient transferred to LA County. Upon his return to SAC, a provider did not see the patient consistent with the nurse referral. The

[28] Intrasystem Transfer/Sick Call Patient #13.
[29] A condition that can lead to excessive bleeding or bruising from low levels of platelets. One treatment option is splenectomy.

patient is due for HIV labs. Nursing documentation on some MARs is incomplete. We incidentally note that in June 2013, his CD4 count was drawn twice just days apart were discrepant by approximately 100 cells. His HIV labs need to be rechecked.

Access to Care

Methodology: To evaluate access to care, we interviewed health care leadership and reviewed patient tracking and scheduling systems. We also reviewed 35 health services requests (CDCR Form 7362) in 13 records of patients with chronic diseases, including high-risk patients.

Health Care Appointment Scheduling

Findings: We interviewed Office Technician (OT) schedulers for facilities A, B and C. Staff reported no significant backlogs for nurse or provider sick call.

Staff discussed the benefits and drawbacks of the MedSATS scheduling program. The primary frustrations are that the program forces staff to take extra steps to schedule appointments, but these added steps often results in inaccurate compliance data. For example, if an appointment is scheduled for a patient and custody transfers him to another facility housing unit, OTs record this appointment as "Not seen as scheduled," with the reason being due to custody. Staff must then create another appointment for the new location. Even if the patient is seen within policy, MedSATS data will reflect that two appointments were scheduled for the same reason, and for one he was not seen as scheduled and for the other he was seen as scheduled. Staff does not have the ability to go into the first appointment and simply change the location of the patient. This is very inefficient. Staff also reported that key demographic information is missing that is required for scheduling appointments. For example, at Facility C custody will not permit northern and southern Hispanics to be scheduled for appointments at the same time. However, ethnicity is not in the MedSATS database, which results in appointments being rescheduled, creating extra work and noncompliant appointments. Finally, staff expressed frustration with the inability to amend typographical errors. For example, if the provider requests follow-up in 45 days and the scheduler accidentally inputs 4 days and presses enter before the error is recognized, the program does not permit the scheduler to amend the error. Thus, the appointment has to be designated as "Not seen as scheduled" and the OT must create another appointment. As noted above, this is both inefficient and produces flawed data.

Nursing Sick Call (Face-to-Face Triage)

Findings: SAC health care staff collects and triages health care requests in a timely manner. However, there are systemic concerns regarding the lack of adequate nursing and medical evaluations and continuity of care, particularly for patients in restricted housing units such as EOP Ad-Seg, and the PSU.

Our findings reflect OIG Cycle 3 scores for access to care that show that nurses and providers see patients timely in 76% and 71% of cases, respectively. However, these scores do not reflect the quality of nursing and medical evaluations, which we often found to be poor. Record review shows that neither nurses nor providers obtain an adequate history of the patient's complaint

or perform adequate physical examinations, even when patients present with symptoms of serious medical conditions.

A contributing factor is the environment in which nurses and providers examine patients. Clinic space deficiencies are described earlier in this report. We also note that in Enhanced Outpatient (EOP) I and A8 housing units, nurses perform sick call in the dining hall.[30] When providers see patients, patients are handcuffed and correctional officers remain in the examination room. This practice does not allow for auditory or visual privacy for the patient. In some cases, this likely contributes to patient refusals. Health care providers appear to have adapted to this custody-oriented culture and accept the arrangement as status quo. The following cases are illustrative of these points.

- This 54-year-old patient transferred to SAC on 9/15/10.[31] His medical history included hypertension, hyperlipidemia and mood disorder. In August 2011, his weight was 212 pounds.

  On 8/16/12, the patient submitted a 7362 complaining of having an irregular bowel pattern with epigastric pain, incomplete evacuation, swelling and bleeding hemorrhoids. On 8/20/12, the nurse saw the patient, who reported a history of rectal itching, bleeding and burning, with blood on toilet tissue. The patient also reported a history of gastroesophageal reflux disease (GERD), colon polyps and prolapsed rectum. The nurse did not examine the patient but provided him hydrocortisone cream and referred him to the provider for evaluation. The following day, a provider did not see the patient but wrote an order for acetaminophen, omeprazole[32] 20 mg, and follow-up in 30 days.

  On 9/20/12, a provider saw the patient for hypertension follow-up but did not take a history of the patient's abdominal and rectal symptoms. The provider documented that the patient had a colonoscopy three years prior for a history of polyps that were "apparently normal." The patient had refused stool tests for blood (FOBT) but now agreed to it. The provider did not perform a rectal examination.

  On 10/16/12, labs showed the patient had thrombocytopenia (low platelets) (Platelets=118K, normal=140-400K). A provider did not notify and counsel the patient about this test result.

  On 10/30/12, the patient submitted a 7362 stating he had an appointment with the provider, but custody staff lied and said he refused the appointment. He requested to see the provider without custody interference. On 11/1/12, the nurse saw the patient. The quality of the nursing assessment was adequate. The nurse referred the patient to a provider; however, the appointment did not take place. (Review of the record shows that on 10/11/12 and on 10/30/12, the patient had several medical examinations but reportedly

[30] Clinic Operations Nursing Subcommittee Meeting minutes, June 2013.
[31] Intrasystem Transfer/Sick Call Patient #18.
[32] A medication for GERD.

refused them; however, the patient did not sign refusal forms.) On 11/1/12, his weight was 197 lbs.

On 11/19/12, the patient submitted a 7362 complaining of suffering from schizophrenia and panic attacks. He stated that a (mental health) provider conspired with custody to lock him in an interview room with his hands handcuffed behind his back without access to water or a bathroom. Now he felt paranoid and needed to speak with someone other than this provider. A nurse triaged it on 11/20/12. A nurse did not see the patient but apparently referred the request directly to mental health. On 12/3/12, the provider who the patient believed conspired against him saw the patient at cell side.

On 12/10/12, the patient submitted a 7362 requesting hydrocortisone cream because of rectal itching. On 12/12/12, the nurse saw the patient. The patient reported having a lump the size of a grape in or around his rectum that was bleeding. The nurse did not examine the patient but referred him to a provider.

On 12/26/12, the provider saw the patient, who reported a 5-6 year history of internal and external hemorrhoids. The provider quotes the patient as requesting renewal of hydrocortisone cream and asking why he had to see the provider for this request. The patient denied a rectal mass but reported an external "mound" since *illegible* x 5 years. He denied nausea, vomiting, abdominal pain and constipation. He had a history of colonoscopy in the past. The provider did not examine the patient and documented that the patient respectfully declined. The provider planned FOBT and possible endoscopy with follow-up in 4-6 weeks. The same day, the patient submitted another 7362 complaining of epigastric pain, IBS, GERD, peptic ulcer disease, rectal pain and bleeding hemorrhoids. He requested esophagoduodenoscopy (EGD) and colonoscopy. A nurse triaged it on 12/27/12. The nurse did not see the patient but scheduled him to see the provider on 1/3/13. On 12/31/12 his FOBT were negative. The provider did not see the patient on 1/3/13.

On 1/29/13, the provider saw the patient for hypertension follow-up but did not directly address the patient's abdominal complaints noted in the 7362 from 12/26/12. He documented that the patient denied fatigue, nausea, vomiting and abdominal pain. He did not inquire about rectal symptoms or the patients' GI history. His weight was 203 lbs. The provider noted FOBT were negative. He did not examine the patient's rectum.

On 2/19/13, the patient submitted a 7362 requesting a refill of his hydrocortisone cream. He stated, "I really need to see a gastroenterologist but the provider told him that was not going to happen, so please send the hydrocortisone cream." A nurse triaged it on 2/20/13. On 2/21/13, the nurse documented that the patient refused the nurse visit. The refusal form was unsigned by the patient.

On 2/24/13, the patient submitted a 7362 complaining of vomiting after meals for the past four days. A nurse triaged it on 2/25/13. On 2/27/13, the nurse saw the patient. The patient's weight was 195 pounds. His blood pressure was borderline high (BP=140/84

mmHg). The patient had lost eight pounds in one month but the nurse did not note this. The quality of the nursing assessment was poor in that the nurse did not document a physical examination of the patient but instead documented under HEENT, "no complaints of problems" and under cardiovascular documented "no SOB" which is a symptom, not an examination. The nurse referred the patient to a provider, who saw the patient on 3/12/13. The provider noted that the patient stated he had had nausea, vomiting and diarrhea two weeks ago but that the symptoms had resolved.

On 3/7/13, the patient submitted a 7362 stating his blood pressure was 152/94 mmHg and he needed to be back on the same blood pressure medication he was taking before the doctor recklessly discontinued the medication. On 3/11/13, the nurse documented that the patient refused nursing sick call.

On 6/19/13, the patient submitted a 7362 complaining of nausea and acid reflux. He requested refill of Mintox[33]. A nurse triaged it on 6/20/13. On 6/21/13, the nurse saw the patient and measured weight and vital signs but performed no additional assessment. The nurse forwarded the request for Mintox to the pharmacy.

On 7/2/13, the provider saw the patient for chronic disease follow-up. The provider did not address the patient's GI symptoms. The provider noted the patient's FOBT were negative x 3 in December 2012. The provider ordered hydrocortisone cream to hemorrhoidal area twice daily for three weeks only and return to the clinic in 120 days.

On 7/22/13, the patient submitted a 7362 complaining of chronic digestive problems and requested renewal of his Mintox. On 7/24/13, the nurse saw the patient, documenting that the patient had daily digestive problems and a history of GERD and esophageal and colonic polyps. The patient's vital signs were normal and weight was 190 pounds, a decrease of 22 pounds since August 2011. The nurse did not address the patient's weight loss and documented the patient's symptoms were controlled by Mintox and the medication was renewed the same day. The nurse did not refer the patient to a provider.

On 8/15/13, the provider saw the patient, who complained of a rectal mass protruding out of his anal canal for three months and that he had a history of hemorrhoids for 15 years. The patient reported bleeding and pain from the protrusion. The provider documented that the patient denied loss of appetite, nausea, vomiting, abdominal pain or weight loss. He noted the patient had "massive external and internal hemorrhoids and questionable ulcerated mass." His assessment was mass in the anal canal versus thrombosed hemorrhoids. On the Request for Services (RFS), the provider initially submitted an urgent request for colonoscopy, but changed the RFS to an urgent request for general surgery, documenting that the mass could be thrombosed hemorrhoids or cancer. On 8/29/13, general surgery saw the patient. There is no report in the record, but a handwritten note on the RFS recommended referral to GI for EGD and colonoscopy.

[33] A medication for GERD.

On 9/5/13, the provider saw the patient for follow-up. The patient's weight was 192 lbs. The provider planned to refer the patient to GI for ongoing epigastric pain and anal mass. He requested follow-up in 60 days. The provider wrote an order for an urgent referral to GI for EGD and colonoscopy. (Approval of this request was subsequently deferred because of questions regarding the need for the EGD. On 9/26/13, the provider re-submitted the requests as separate RFSs and the urgent status was changed to "routine ASAP

On 9/20/13, the patient submitted a 7362 complaining of becoming violently ill with chills, sweating, vomiting and diarrhea after eating a meal on 9/19/13. He requested emergency treatment. A nurse triaged it on 9/22/13. Before the nurse triaged the request, on 9/22/13 at 6:50 p.m., the patient presented urgently to the TTA with nausea, vomiting and diarrhea for two days. A nurse evaluated the patient, but did not perform an adequate assessment. The nurse did not contact a provider. She gave the patient Pepto-Bismol tablets and sent him back to his housing unit.

On 9/23/13, the nurse documented that the patient refused nursing sick call. The nurse documented that no reason was given and the patient did not sign the form. On 9/24/13, for reasons that are unclear, a provider ordered an HIV test, but there is no documentation that this was discussed with the patient.

On 9/30/13, the nurse documented that the patient refused FOBT. However, the patient did not refuse but stated, "I'm constipated for the past few days and had no bowel movement." On 10/3/13, the request for EGD was approved. The same day, nurses documented he refused an HIV test, stating it was "too early for labs." The patient did not sign the refusal.

On 10/17/13, the provider saw the patient for medication noncompliance. The patient reported he did not need Colace and fiber because he had bowel movements without them. The provider performed no physical examination. The provider documented no assessment or plan.

On 10/23/13 at 3:15 p.m., a nurse saw the patient, who reported having chest pain and always feeling nauseous. He was tired because he had been standing in a cage since early that morning and reported not receiving his medications. His last meal was at 6:00 a.m. because he had not received lunch. The nurse notified the provider and made a routine referral.

On 10/23/13, mental health staff saw the patient confidentially. He reported feeling overwhelmed and helpless because of harassment by custody staff following his filing a 602 appeal. The mental health provider documented his cell was ransacked due to a recent search and the patient was agitated, anxious and depressed. Mental health admitted him to the CTC for being a danger to self.

On 10/24/13, a medical provider performed an admission history and physical, noting his complaints of chest pain, and "prolapsed internal hemorrhoids" for which he was to have

colonoscopy. He did not perform an anal/rectal examination. The same day, a provider submitted an RFS for an exercise stress test. The patient was not weighed while in the CTC. On 11/5/13, the patient discharged from the CTC.

On 12/20/13, he underwent EGD and colonoscopy that revealed gastritis, a large polyp at the cecum, and an anal canal lesion/mass. The gastroenterologist removed the polyp by piecemeal polypectomy; and gastric mucosa, polyp and anal mass were biopsied. The gastroenterologist recommended treatment for h. pylori if gastric biopsies were positive, await other pathology reports; and follow-up colonoscopy in 2-3 months to ensure complete removal of the polyp; and surveillance colonoscopies every 2-3 years.

Assessment

Since August 2012, this 54-year-old patient has reported various GI symptoms including a rectal mass, pain and bleeding but neither nurses nor providers examine the patient for over a year after his initial complaint. Since August 2011, he has lost approximately 20 pounds (212→192 pounds on 9/5/13) that has gone unnoticed by providers and nurses. On multiple occasions, providers failed to explore and pursue the patient's history of GI complaints and "colonic polyps." Since 8/15/13, when the provider documented that the patient had an ulcerated anal mass and requested urgent colonoscopy, the patient has not received timely medical evaluation to rule out pathology, including GI malignancy, or anal condyloma. Health care staff has documented multiple patient refusals of medical care by the patient, including an HIV test, but most refusals have not been signed by the patient and there is minimal to no meaningful counseling regarding the risks of refusal. The patient has also alleged that custody has interfered with access to medical appointments by reporting he refuses medical appointments when he has not refused and has retaliated against him by making him wait handcuffed in interview rooms without access to water or a bathroom. There is no meaningful communication documented between medical and mental health providers regarding the patient's GI symptoms and pending work-up. We forwarded our concerns regarding this patient to CCHCS who arranged for a provider to examine the patient on 11/20/13. The provider did not perform a thorough medical history, and noted a small external hemorrhoid. EGD and colonoscopy performed on 12/20/13 revealed *h. pylori* gastritis; a large cecal tubular adenoma; anorectal hyperplastic polyp and moderate internal and external hemorrhoids. On 1/7/14, a provider ordered treatment for the patient's h. pylori infection. This patient did not have timely medical evaluation given the patient's history.

- This 53-year-old patient transferred to CSP-SAC on 1/20/10.[34] His medical history included hypertension and right shoulder avascular necrosis[35]. His medications are amlodipine, hydrochlorothiazide, aspirin, amitriptyline, methadone, olanzapine and sertraline.

[34] Intrasystem Transfer/Sick Call Patient #16.
[35] The death of bone tissue due to lack of blood supply.

On 6/28/13, the patient submitted a 7362 complaining of having a boil the size of a golf ball near his scrotum. A nurse triaged it on 6/29/13. The nurse saw the patient the same day and documented that he complained of a swollen scrotum and perineal[36] abscess that began three days prior. The pain was 10 of 10 in severity. The patient was febrile (Temp=99.9°F.) and tachycardic (pulse=110/minute). The nurse referred the patient to the provider, who had just arrived at the clinic.

The physician noted that the patient had perineal tenderness and induration with minor drainage and a small abscess on his right lower abdomen. The patient had scrotal warmth and edema and right inguinal lymphadenopathy. The provider diagnosed the patient with perineal abscess and right lower abdominal abscess. The provider instructed the patient to use warm compresses and prescribed clindamycin and Bactrim for 10 days and to return to the TTA the following day, and for provider follow-up in 3-5 days. The wound drainage was not cultured. The following day, a nurse saw the patient in the TTA and documented that the patient reported he had started his antibiotics, was using compresses; and that the "scrotal boil was draining well but the inguinal boil was not draining much." The nurse documented that a provider was present but the provider did not examine the patient. The nurse encouraged the patient to continue antibiotics and warm compresses and scheduled provider follow-up "as scheduled."

Three days later on 7/2/13, the provider saw the patient for follow-up. The patient had bilateral inguinal lymphadenopathy and a swollen perineum with an indurated abscess between the scrotum and anus. He noted the wound was draining pus and he ordered it cultured. The provider planned to continue antibiotics and warm compresses, follow up in a week, and consider a CT of the pelvis if the problem had not resolved. The culture grew Methicillin Resistant Staphylococcus Aureus (MRSA) that was sensitive to Bactrim.

On 7/11/13, the patient was apparently scheduled to see the provider but we find no provider progress note in the record for this date.[37] However, the same day a provider wrote an order for "follow-up in 60 days of right inguinal lymphadenopathy and perianal abscess." This did not take place and he had no further medical follow-up of his condition.

On 8/14/13 the patient submitted a 7362 complaining of something having bitten him and swelling on the back of his head. He stated he had pain on his backside. A nurse triaged this request on 8/16/13. On 8/19/13, he was noted to refuse his appointment but no reason was given.

On 9/9/13, a physician saw the patient for chronic disease management but did not address his recent perineal abscess.

[36] The area around the genitals and rectum.
[37] A scanned document was mislabeled as a primary care progress note for this date but in fact was a hunger strike observation sheet.

Assessment

This patient did not receive timely or appropriate care for his condition nor adequate follow-up. Since he was febrile, had a swollen perineum and bilateral lymphadenopathy, appropriate therapy would have been incision and drainage, and possible intravenous antibiotics.

- This 45-year-old patient transferred from CMC to CSP-SAC on 7/13/12.[38] His medical history included type I diabetes, hypertension, hyperlipidemia and asthma. He was housed in Ad-Seg.

  On 3/22/13, the patient submitted a 7362 complaining of needing an annual cleaning and a tooth that may need to be filled or extracted. A nurse triaged it on 3/23/12 and forwarded it to dental on 3/25/13. Dental staff did not see the patient.

  On 5/17/13, the patient submitted a 7362 complaining of extreme dental pain (10 of 10 in severity) and that he could not eat or sleep. On Saturday 5/18/13, the nurse saw the patient. The nurse noted that the patient complained of pain in the right lower gum area but did not take vital signs or examine the patient's oral cavity. His neck and cheek were slightly swollen. The nurse notified the dentist who ordered antibiotics for seven days and planned to see the patient on 5/22/13. The patient did not receive the medications until 5/20/13.

  On 5/22/13, the patient submitted another 7362 complaining of severe dental pain. The dentist saw the patient the same day and noted he had deep caries at the gum line and residual root of tooth #32. The dentist noted that the patient had five days left of Amoxicillin and advised him to complete the prescription before extraction.

  On Sunday 5/26/13, the patient was seen urgently for jaw pain and swelling and inability to open his mouth. The nurse called the dentist who ordered Clindamycin and Tylenol with codeine. The nurse gave the patient two days of Clindamycin KOP and one dose of Tylenol with codeine on 5/26/13. The dentist instructed the nurse to notify him if the pain was not improved. Three days later, on 5/29/13, the dentist saw the patient and extracted tooth #31. The patient received Tylenol with codeine three times daily over the next two days. On 5/30/13, the patient received the Clindamycin order 300 mg daily and Ibuprofen 800 mg three times daily.

  On 6/4/13, routine labs showed the patient had increased potassium (6.8, normal=3.5-5.3) and was in acute renal failure (creatinine 3.4, normal=<1.35). The report was printed at 10:30 p.m.

  Apparently, the lab notified TTA staff of these critical values. On 6/5/13 at just past midnight, a TTA nurse documented that the patient's potassium was 6.8 but did not

[38] Intrasystem Transfer/Sick Call Patient #7.

document the patient's elevated creatinine. The nurse notified the provider, who ordered an EKG and health assessment, and if everything was normal to repeat blood work in the morning. The nurse assessed the patient, who denied chest pain, palpitations, weakness or malaise. An EKG showed no changes compared to the previous one. The nurse discharged the patient back to his housing unit.

On 6/5/13, at 9:05 a.m., the dentist saw the patient for follow-up, noting he had minimal pain, limited ability to open his mouth and had had significant swelling after the extraction. The patient also stated that he was having difficulty eating. . His weight was 172 lbs., an 8 lbs. weight loss from 5/22/13. The dentist documented that no further treatment was needed at that time.

Later that day at 12:36 p.m., the provider saw the patient and sent him to the hospital where he was treated for acute renal failure and hyperkalemia (high potassium) secondary to dehydration from his inability to take in adequate fluids and nutrition due to his dental condition. He was noted to be taking enalapril and metformin and approximately 2500 mg per day of non-steroidal anti-inflammatory medications (NSAIDS), ibuprofen and naproxen for dental pain. He was treated with fluids, and medications causing renal injury were held (enalapril, Metformin, and NSAIDS[39]). The patient's labs normalized and on 6/6/13, he was discharged back to the facility. His potassium was 4.5 at discharge. A nurse saw the patient in the TTA upon his return and on 6/7/13, a provider saw the patient for follow-up.

On 6/12/13, the patient's potassium was elevated 5.8 and the provider ordered kayexalate[40].

A health records issue is that on 6/5/13 at 10:56 a.m., the same provider dictated two progress notes for the patient, but one progress note described another inmate with a different medical history and presenting complaint. We do not know if this was a provider or dictation error.

On 7/23/13, the patient submitted a 7362 requesting to see the provider because he needed his regular insulin every morning. He also wanted medication for his arthritis in his knees and shoulders. A nurse triaged it on 7/23/13. On 7/23/13, the nurse spoke with the patient, noting he had an appointment scheduled with the provider but the provider rescheduled the patient for the following week. On 7/29/13, at 11:55 a.m., a nurse responded to a man down situation. The patient was found unconscious on the toilet. His blood sugar was 40. The provider saw the patient and treated him for hypoglycemia.

On 8/21/13, the patient requested that the provider send him to an endocrinologist because his diabetes was not well controlled. His most recent HBA1C was 9.4%. On 9/3/13, his HBA1C was 8.6%.

[39] Medications such as ibuprofen and Naprosyn.
[40] A medication used to treat high potassium.

On 9/17/13 at 6:00 a.m., the patient was brought to the TTA for left hip pain. At approximately 3:30 a.m., the patient had fallen off his top bunk. At 7:00 a.m., x-rays revealed that he had a left hip fracture and he was sent to SJGH. The x-ray report was not in the eUHR. Local emergency medical responders arrived 70 minutes later at 8:10 a.m., and at 8:30 a.m., the patient was transported to the hospital, where he underwent hip surgery. He was subsequently transferred to CMF for post-operative care.

The endocrinologist saw the patient on 10/18/13 and recommended adjusting his insulin.

Assessment

This patient did not receive timely care for severe dental pain. He did not receive antibiotics on the day they were ordered or adequate pain management, which led to his inability to take adequate fluids and nutrition. When he was later treated with Clindamycin, he also had interruption in the prescription. He subsequently went into renal failure secondary to dehydration and was hospitalized. Given the severity of his pain and nutritional status, consideration should have been given to admitting him to the OHU over the weekend to ensure he received antibiotics, adequate pain management and nutrition. When the lab notified the TTA that the patient had critical labs, he was sent back to his housing unit instead of being monitored and/or sent immediately to the hospital for treatment of his renal failure. A medical records concern is that the provider dictated a note with this patient's name but that described another inmate and radiology report is not in the eUHR.

This type 1 diabetic had a low bunk profile, which raises the question of why he was in the top bunk when he allegedly fell and fractured his hip. Second, the eUHR documents that the incident occurred at approximately 3:30 a.m., but the patient was not transported to medical for approximately three hours. We requested a copy of the correctional officers' housing unit log to review correctional officer documentation, but it was not provided to us. Given the nature of the patient's injuries and delays in transport of this inmate, OIA needs to investigate this incident.

- This 56-year-old patient transferred from the CMF CTC to SAC on 10/31/12.[41] He had been housed at SAC prior to transfer to the CMF CTC. His medical history included HIV/AIDS since 2010, pulmonary TB in 2010, hypertension, depression and right rotator cuff repair in February 2012.

  On 9/5/13, the patient submitted a 7362 with several complaints, including having a bad cough. A nurse triaged it on 9/10/13. On 9/11/13, a nurse saw the patient. The quality of the nursing assessment was poor. The nurse did not note the patient's history of AIDS and pulmonary tuberculosis, measure the patient's vital signs and weight, or auscultate his lungs. The nurse referred the patient to a provider.

[41] Intrasystem Transfer Patient #2.

On 9/24/13, a provider saw the patient for a productive cough for three weeks and right shoulder pain. The patient denied fever, chills, chest pain, SOB, nausea and vomiting. The provider documented that the patient did not have a history of tuberculosis, which is not accurate. The provider documented the examination was "WNL." His diagnosis was chronic right shoulder pain and three-week cough. He ordered chest and right shoulder x-rays. At the time of our review the x-rays had not been performed.

Assessment

This patient has AIDS and a history of pulmonary TB and was not evaluated in an appropriate or timely manner. The nursing assessment was inadequate. The provider who saw the patient for a three-week cough incorrectly noted that the patient did not have a history of tuberculosis. Although his cough was productive, sputum for acid-fast bacilli (AFB) was not ordered. We reviewed this record on 10/9/13 and observed that the ordered chest x-ray had not been performed and alerted nursing leadership, who arranged for it to be done the same day. The chest x-ray was normal. However, given the patient's history, the chest x-ray needed to have been performed immediately.

- This 44-year-old patient transferred from Corcoran to SAC on 5/3/13.[42] His medical history included hypertension, hyperlipidemia and hypothyroidism. He is in Ad-Seg.

  On an undocumented date, the patient submitted a 7362 complaining of chest pain and vomiting for three days. The patient requested renewal of his ranitidine[43] or something stronger. A nurse triaged it on 8/10/13. The nurse assessed the patient using the Chest Pain Encounter Form. The patient reported "esophageal reflux pain, vomiting all day 3 days ago." The pain was 8 of 10 in severity. The nurse did not describe the onset of symptoms or quality of the pain. The nurse documented that the patient refused vital signs and the examination consisted of listening to the heart and lungs but no abdominal examination. The patient stated he submitted the 7362 form just to get his medication renewed. The nurse notified the physician, who did not examine the patient but renewed the patient's ranitidine.

  On 9/3/13, the provider saw the patient for follow-up. The provider documented a history related to cardiovascular and gastrointestinal symptoms. The patient's blood pressure was not at goal (BP=149/92 mmHg and 142/80 mm/Hg). The patient's weight was 230 pounds, an increase of 11 pounds since his arrival, but this was not addressed. The provider noted that neither the patient's blood pressure nor lipids were at goal. His plan was to monitor the patient's blood pressure and recheck a lipid panel in 10 weeks, although the patient's lipids had not been checked since 5/7/13 (LDL-C=121, triglycerides=201). On 10/31/13 the patient's blood tests showed that his lipids had worsened (LDL-C=156, triglycerides=226). On 11/19/13 the provider saw the patient and did not change the treatment plan to address his worsening lipids.

[42] Intrasystem Transfer Patient #4.
[43] A medication used to treat stomach ulcers and GERD.

Health records did not scan the patient's September MARs into the eUHR until 10/25/13. Another inmates MARs were also scanned into this patient's record.

Assessment

Neither the nurse nor provider performed an adequate assessment of the patient's symptoms that included chest pain and nausea for three days. The nurse referred the patent to a provider who did not see the patient, but treated him remotely. The patient was not receiving appropriate care for his hyperlipidemia. Per CCHCS guidelines, lipids are to be monitored every 3 months until the target LDL goal is reached. When the provider saw the patient for worsening lipids he did not change his treatment plan, which is not adequate care. Two health records issues are delayed scanning of September MARs and that another inmate's MARs were scanned into this patient's eUHR.

- This 53-year-old patient transferred to SAC on 7/25/12.[44] His medical history included hypertension, chronic kidney disease, myasthenia gravis[45] since 2010, left hip aseptic necrosis and major depression. His medications are pyridostigmine bromide[46], aspirin, tramadol and calcium carbonate.

  On 7/27/13, the patient submitted a 7362 complaining of muscle fatigue and weakness due to his myasthenia gravis. He was also concerned about difficulty eating. A nurse triaged it on 7/30/13. On 7/31/13, the nurse evaluated the patient using a musculoskeletal assessment form. His vital signs were normal. His weight was 140 pounds and body mass index BMI 23. The nurse observed that the patient moved all extremities but did not measure strength or sensation. The nurse did not refer the patient to a provider because he already had an upcoming appointment.

  Assessment

  The patient completed this 7362 on Saturday 7/27/13 but a nurse did not triage the patient's request until 7/30/13 and did not see the patient until 7/31/13. The nurse did not perform an adequate neurological assessment of this medically fragile patient whose treatment for myasthenia gravis was delayed. Due to the patient's difficulty with activities of daily living (ADLs), the nurse needed to arrange for his ADLs to be met. Although the provider indicated that the patient was stable, he had lost 10 pounds in four months, presumably due to difficulty with maintaining adequate nutrition. This case is further described in the Specialty Care section of this report.

- This 61-year-old patient transferred from MCSP to SAC on 8/12/13.[47] His medical history included HIV infection, hypertension, diabetes and DJD. The patient is in Ad-Seg.

[44] Intrasystem Transfer/Sick Call Patient #10.
[45] A neuromuscular condition characterized by weakness and rapid fatigue of voluntary muscle.
[46] Medication used to treat myasthenia gravis.
[47] Intrasystem Transfer/Sick Call Patient #11.

On 8/26/13, the patient submitted a 7362 complaining of severe back pain related to a fall and a wart on his left foot. On 8/28/13, the nurse evaluated the patient using the musculoskeletal and skin rash forms. The assessment of the patient's foot wart was appropriate but not assessment of his back pain. The musculoskeletal form does not adequately guide the nurse in evaluating back pain (i.e., there are no questions related to alarm symptoms, such as bowel or bladder incontinence). The physical assessment was also inadequate (i.e., there was no documentation of whether there was deformity or tenderness to palpation in the affected area). The nurse noted the results of a prior MRI, deferred treatment, and referred the patient to a provider, who saw the patient on 9/10/13. The provider documented that the patient had back pain for two months and denied injury. The provider did not document a musculoskeletal or neurological examination. The provider ordered x-rays and analgesia for the patient and planned to see him in 30 days. The patient's blood pressure was low for the patient (84/62 mm/Hg), but the provider did not address this. On 9/13/13, x-rays were performed and showed cervical and lumbar degenerative changes.

On 9/16/13, at 12:30 p.m., the patient was brought to the TTA because he fell in the shower. At 2:05 p.m., a nurse notified the physician who was present in the TTA but he did not examine the patient. The patient was discharged from the TTA at 3:30 p.m. without being examined by a provider.

Assessment

Neither the nurse nor provider performed an adequate assessment of the patient when he submitted his health request for back pain. Moreover, the provider did not examine the patient when he was brought urgently to the TTA following a fall in the shower. This patient is in Ad-Seg and based upon our observations that patients are placed in cages with handcuffs, it is not surprising that the medical examinations are inadequate.

- This 50-year-old patient transferred from SVSP to SAC on 11/16/12.[48] His medical history included hypertension, hyperlipidemia, diabetes, coronary artery disease, a stroke in 2004, myocardial infarction in 1999, left eye blindness, right knee medial meniscus tear with surgery in February 2013 and bipolar disorder. He is taking multiple medications.

  On 8/25/13, the patient submitted a 7362 requesting x-rays of his collarbone and left and right hands due to injuries. On 8/27/13, the nurse evaluated the patient, using a musculoskeletal assessment form. The nurse did not perform an adequate assessment, noting that she was "UTA" range of motion. This abbreviation is unfamiliar to us but we presume it means "Unable To Assess," but the nurse did not document the reason. The nurse did not assess the patient's hand complaints. The nurse did not document whether the patient was handcuffed during the encounter. The nurse referred the patient to a provider.

[48] Intrasystem Transfer/Sick Call Patient #17.

On 9/3/13, there is an unsigned refusal of treatment form for a provider appointment.

Assessment

The nurse conducted an inadequate assessment of the patient's right shoulder and we are concerned it was because the patient was cuffed, which is standard practice in the PSU. A properly completed refusal form is not in the eUHR for the 9/3/13 refusal.

Chronic Disease Management

Methodology: We interviewed facility health care leadership and staff involved in management of chronic disease patients. We reviewed the records of 24 patients with diabetes, hypertension, clotting disorders, and other chronic illnesses. We assessed whether providers saw patients 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 providers updated the Problem List and continuity of medications provided.

Findings: We found significant problems with management of chronic disease patients related to the timeliness and/or quality of care in 12 of the 24 patients we reviewed. Our findings are not consistent with the OIG's Cycle 3 report score of 76.2% for chronic disease management. However, our findings are more consistent with those noted in the CCHCS August Dashboard (the most recent one), in which PCP Chronic Care scored 61%.

The following cases exemplify some problems we found:

- The patient[49] is a 65-year-old-man with schizophrenia, diabetes, hypertension, hyperlipidemia, hepatitis C, coccidioidomycosis and chronic obstructive lung disease (COPD) who transferred from California Correctional Institution (CCI) to SAC on 11/28/12. Prior to his transfer, on 5/25/12, the patient's hemoglobin A1C was 7.4%. On 6/8/12, a provider at CCI discontinued the patient's insulin but there was no accompanying progress note explaining why this was done. A repeat hemoglobin A1C on 10/18/12 was 6.6%.

  A provider first saw the patient at SAC on 12/12/12. The patient was in a wheelchair. The provider described the patient as being unable to walk 100 yards. The provider did not take a more in-depth history of the patient's illnesses. The provider documented he would get the records regarding the patient's pulmonary coccidioidomycosis. It is not clear what this meant, as information regarding his diagnosis was in the eUHR. The provider ordered laboratory tests and a 30-day follow-up. The provider did not refer the patient to an infectious disease consultant to manage the coccidioidomycosis and did not evaluate the status of the patient's coccidioidomycosis.

  The 30-day follow-up did not occur, possibly because on 12/17/12, a psychiatrist admitted the patient to a mental health crisis bed for decompensated mental illness. The patient

[49] Chronic Care Patient #1.

remained in the crisis unit until 12/28/12. The patient refused an initial history and physical examination on the mental health crisis unit and medical staff did not evaluate him except once when a provider renewed his medication.

After discharge from the mental health crisis unit, a provider did not see the patient until 1/23/13, when a provider saw him to evaluate his request for a wheelchair. The provider noted that the patient reported he could not walk because he was having episodes of syncope (fainting). The provider noted that laboratory tests had been ordered but had not been done. The provider addressed none of the patient's chronic conditions. He ordered a wheelchair and laboratory tests, and reordered a Holter monitor[50] initially ordered while the patient had been at CCI. On 1/25/13, laboratory tests revealed that the patient's blood glucose (598 mg/dL) and hemoglobin A1C (14.5%) were very elevated. When the lab reported these tests to SAC at about midnight on 1/26/13, the patient was transported to the TTA. The nurse contacted the on-call physician, who ordered regular insulin. One hour later, the patient's blood sugar was 536 mg/dL and the physician ordered another dose of insulin. At approximately 2:30 a.m. on 1/26/13, the patient's blood sugar was 496 mg/dL. Despite this very high blood sugar, the patient was sent back to his cell. The following day, a nurse saw the patient in the TTA again because his blood sugar was 550 mg/dL. A provider did not evaluate the patient but gave phone orders for intravenous fluid and regular insulin. The physician also initiated therapy with long acting insulin. After the blood sugar decreased to 331, the patient stated he did not want any more care and wanted to return to his cell. This patient had extremely high blood sugars and needed to be monitored in a CTC or OHU, or sent to a hospital.

On 1/28/13, a provider evaluated the patient. The provider could not determine exactly when or why the patient's insulin had been discontinued at CCI. The provider documented that in June 2012, the patient had been taking 46 units of insulin at night and 52 units in the morning. The provider did not address the patient's coccidioidomycosis, hypertension, hepatitis C, COPD or hyperlipidemia. He ordered low dose insulin and glipizide (an oral medication for diabetes) and follow-up in 7-10 days.

The provider followed up with the patient on 1/31/13. Except for documenting high blood sugar results, the provider did not document a history. The provider did not perform a physical examination. The provider did not address the patient's hypertension, hyperlipidemia, COPD and coccidioidomycosis, even though the patient remained on medications for these conditions. The provider increased the patient's insulin and ordered a urine test for microalbumin (a test for increased protein in the urine), spirometry and a chest x-ray.

On 2/11/13, a chest x-ray report documented bilateral infiltrates. On the same day, a provider saw the patient but did not document a history or physical examination. The provider merely noted persistently elevated blood sugar. The provider increased the insulin.

[50] A device used for ambulatory monitoring of a patient's heart rate.

The provider did not review the abnormal chest x-ray report. On 2/20/13, a provider saw the patient for chronic care follow-up and addressed his diabetes, hypertension and hyperlipidemia. However, even though the patient was on fluconazole, the provider did not address his coccidioidomycosis or the abnormal chest x-ray. This was a serious lapse in care. On 2/25/13, the patient's hemoglobin A1C was still very elevated (12.4%).

A provider next saw the patient for chronic care on 3/11/13. The provider took a history based on the patient having asthma instead of COPD. Other than checking boxes in a pre-formatted history, the provider did not document a history related to the patient's diabetes. The provider did not address the coccidioidomycosis and still did not review the chest x-ray of 2/11/13 showing pulmonary infiltrates. This was again a serious lapse in care. Even though the patient remained on fluconazole for coccidioidomycosis, the provider did not address this condition or his abnormal chest x-ray taken on 2/11/13.

On 3/14/13, the patient was evaluated in the TTA for confusion, incontinence and facial drooping. The patient had a fever of 103.2°F. His blood sugar was 104 and his pulse was 138/minute. Staff sent the patient to a hospital. At the hospital, the patient had an elevated white blood count and pulmonary infiltrates and he was diagnosed with pneumonia. The x-rays at the hospital showed infiltrates in the right upper lobe and left base that were the same locations as the coccidioidomycosis. The hospital staff diagnosed community acquired pneumonia and treated the patient with several days of intravenous antibiotics. On 3/16/13, the patient was discharged on levofloxacin (an oral antibiotic). When the patient returned to SAC, the nurse noted the discharge orders for levofloxacin but did not order or facilitate ordering the medication. The nurse referred the patient to the primary care provider in five days.

On 3/19/13, a provider saw the patient and noted he was not receiving antibiotics. The provider stated:

> At this point, the patient is not on any antibiotic. I am not clear about it. I would want to put the patient on Cipro [an oral antibiotic of the same class as levofloxacin] for five days, since I feel probably the hospital would have discharged him with some medication, and there might be some confusion at this point since I do not have any record from the hospital in terms of the discharge orders as well as the complications that we have in terms of the confusion here.

He also stated:

> Review of the record shows that at some point all of his medications were discontinued and not renewed, though reviewing the record shows that he might be receiving medication. At this point, the pharmacy and the block are working on this issue.

The provider ordered antibiotics. He noted that the patient was hospitalized for a pulmonary infiltrate, but did not connect this with the patient's coccidioidomycosis. His diagnoses included community acquired pneumonia and diabetes, but noted none of the patient's other problems including his coccidioidomycosis. The provider did not order a follow-up chest x-ray. A follow-up white blood cell count was normal on 3/19/13.

A provider saw the patient for follow-up on 4/5/13, but only addressed diabetes, hypertension, dyslipidemia and hepatitis C. The provider took a brief history for asthma, even though the patient had COPD. He did not address coccidioidomycosis. The provider wrote that the patient was on fluconazole 200 mg twice a day for uncertain reasons, but did not document why the patient was taking this medication. The patient was actually on 400 mg twice a day. The provider did not order a follow-up chest x-ray after the hospitalization for pneumonia (which may have been coccidioidomycosis). Standard of care would be for the provider to have obtained a follow-up chest x-ray.

A provider saw the patient again on 5/15/13. The provider's history addressed the patient's diabetes but did not address his hypertension, COPD, hyperlipidemia, and still did not address the patient's coccidioidomycosis. The provider noted that the patient was on 17 medications but did not address why he was on all of these medications. The only problems assessed were diabetes, chronic liver disease, hypertension and diabetic neuropathy. The provider did not address the patient's COPD or coccidioidomycosis.

On 6/13/13, a provider saw the patient for chronic care follow-up. The provider did not address the patient's COPD, neuropathy or pulmonary coccidioidomycosis. A provider next saw the patient on 7/9/13 for chronic care follow-up. The provider noted that the patient was a poor historian. The patient noted he had fallen in the shower that day because his leg gave out. The provider noted that the patient had also fallen recently in the yard. The provider obtained no further history related to this event and did not document a physical examination related to possible injuries. He noted he would "discuss falling issue with nursing staff." There was no history related to the patient's other problems. This provider did note that the patient had pulmonary coccidioidomycosis and had not had a recent infectious disease consult. This recognition of the lack of care for the patient's coccidioidomycosis was approximately eight months after the patient arrived at SAC. In the interim, the patient had not received care for his coccidioidomycosis except to continue high dose fluconazole, which may or may not have been indicated. The provider's physical examination was minimal. The provider's assessment included only hypertension and diabetes, which were both listed as not at goal but improved. The provider did not change therapy. He ordered a cocci titer and a chest x-ray, but he did not note the previous abnormal x-rays or prior hospitalization. He ordered a 90-day follow-up. A 90-day follow-up for a patient not at goal for either diabetes or hypertension and without follow-up of his coccidioidomycosis for eight months is not adequate care.

On 7/12/13, an x-ray was performed and showed opacification of the right upper lung with mild diffuse chronic interstitial lung disease and cardiomegaly. The radiologist's impression

was the opacification was most likely scarring from old infection. On 7/17/13, the provider signed the x-ray as reviewed. The x-ray was abnormal and needed to be clinically correlated with the patient's condition, but the provider did not evaluate the patient.

On 8/22/13, a provider evaluated the patient because he was repeatedly falling. The patient had a rapid pulse (110/minute) and elevated blood pressure (152/97 mmHg). The provider noted that the patient had had "mobility impairment" for three months. The provider documented no further history related to the patient's falling. The provider noted that the patient was ataxic[51] and confused and was oriented only to his name. The only neurologic examination was to note that the patient had no rigidity and had decreased sensation in his feet. The provider thought that the patient had dehydration and ordered stat [immediate] blood tests, which were normal. The provider gave the patient a liter of fluid and noted he was more alert and able to walk with small steps after receiving the fluid. The provider consulted with a psychiatrist and documented that the patient needed OHU placement. This did not occur. The provider sent the patient back to his cell with a follow-up the next day. This was dangerous. The patient had altered mental status and ataxia (a sign of potential serious central nervous system disease) and needed a neurological evaluation and possibly brain imaging (CT scan or MRI). While it was possible that the patient's condition was due to his psychotropic medication, the provider's responsibility was to exclude serious neurological conditions. The provider also did not address the patient's elevated blood pressure.

Instead of a next day visit, a provider did not see the patient until 8/29/13, one week later. The history was inadequate. The provider noted that the patient was complaining of chronic dizziness and could not walk long distances, but did not obtain further history related to this or related to recent falls. The patient's blood pressure was mildly elevated (144/94 mmHg) and he had a rapid pulse (102/minute). On physical examination, the provider documented that the patient had an ataxic gait but did not document any further neurological examination. The provider increased the patient's blood pressure medication. The provider did not address the ataxia, diabetes, hepatitis C, COPD, coccidioidomycosis or blood lipids.

On 9/5/13, the patient transferred to CMF.

Assessment

The patient did not receive appropriate care for his chronic medical problems. The care related to his coccidioidomycosis was not adequate. The patient did not have a thorough evaluation for his coccidioidomycosis during his entire nine-month stay at SAC. He had been on treatment for 17 months, when the standard of care calls for 3-6 months of treatment and following the patient at 1-3 month intervals for one year or longer. Standard of care also includes interviews, physical examinations, serologic tests and radiographic examinations. While some of these interventions occurred, providers did not relate them to an evaluation of the patient's coccidioidomycosis. The patient needed to have been

[51] Ataxia describes a lack of muscle coordination during voluntary movements, such as walking or picking up objects.

followed regularly by a specialist. In addition, provider follow-up after his hospitalization for pneumonia and evaluation of his ataxia and altered mental status were not adequate.

- The patient[52] is a 49-year-old man with diabetes related to his psychiatric medications, hypertension and hyperlipidemia. The patient's LDL cholesterol was elevated on 2/11/13 (151 mg/dL; the LDL cholesterol goal of diabetic patients without coronary artery disease is <100 mg/dL). A provider notified him he increased his cholesterol-lowering medication and that he had scheduled him for a chronic care visit. However, the provider did not increase his medication and did not see the patient for chronic care until 6/3/13. At that time, the provider noted that the patient's LDL cholesterol had been elevated on 2/11/13. He also noted the patient's blood pressure was 134/94 mmHg (the blood pressure goal of patients' with diabetes is <140/80 mmHg). The provider's assessment was the patient's hypertension was not at goal, but that the patient was reluctant to take new medication. The provider noted he encouraged the patient to increase his physical activity and watch his diet. He further noted he would ask the nurse to monitor the patient's blood pressure twice a week for the next 2-3 weeks and that if his blood pressure remained elevated, he would consider adjusting the patient's medications. The provider ordered blood pressure checks two times per week for two weeks, increased the patient's cholesterol-lowering medication, and ordered chronic care follow-up in 5-6 months. The blood pressure checks were elevated (133/89, 146/120, 149/105, and 133/89 mmHg). On 6/25/13, the patient's LDL cholesterol was 154 mg/dL. On 7/11/13, a provider notified the patient that his laboratory tests were essentially within normal limits. As of 10/31/13, a provider has not seen the patient for follow-up of his hypertension or hyperlipidemia.

  Assessment
  The patient was not receiving timely or appropriate care for his hypertension or hyperlipidemia. Since these diseases were not within good control, the provider needed to see the patient for follow-up within 1-2 months.

- The patient[53] is a 50-year-old man with coronary artery disease with an MI in 1999, a history of a stroke, diabetes and hyperlipidemia. Prior stroke and myocardial infarction (MI) are on problem list but not addressed during chronic care visits. A provider saw the patient for chronic care on 5/28/13, 7/9/13 and 10/7/13 but did not address the patient's history of stroke and prior MI.

  Assessment
  The provider did not appropriately address the patient's chronic illnesses.

- The patient[54] is a 45-year-old man with diabetes, hypertension, hyperlipidemia, hepatitis C and a seizure disorder. On 4/17/13, his hemoglobin A1C was 7.1% (goal <7%) and on

[52] Chronic Care Patient #2.
[53] Chronic Care Patient #3.
[54] Chronic Care Patient #4.

12/26/12, his LDL-cholesterol had been 104 mg/dL. On 8/12/13, a provider discontinued his simvastatin (a cholesterol lowering medication) because of possible side effects. On 9/21/13, his hemoglobin A1C was 11.6% and his LDL cholesterol was 126 mg/dL. A provider saw him for follow up of his laboratory tests on 9/30/13. He noted the patient's diabetes was not at goal and initiated therapy with insulin. He did not address the elevated LDL cholesterol. The provider saw the patient for follow-up on 10/11/13 and noted his blood sugars were improving on the new regimen. The provider did not address the patient's elevated LDL cholesterol. He ordered follow-up in two months.

Assessment
The patient did not receive appropriate care for his hyperlipidemia.

- The patient[55] is a 42-year-old man with diabetes, hypertension, asthma and hyperlipidemia. His LDL cholesterol was 118 mg/dL on 5/31/13 and his hemoglobin A1C was 6.6%. A provider saw the patient on 7/19/13 and initiated therapy for hyperlipidemia with a "low dose" of simvastatin (5 mg). The provider ordered follow-up in 90 days. A provider next saw the patient on 8/15/13. The patient's blood pressure was 123/86 mmHg. The provider's assessment was that the patient's blood pressure was at goal (as noted above the blood pressure goal for patients with diabetes is <140/80). The provider next saw the patient for chronic care on 9/26/13 and noted his blood pressure was increased (133/89). He added lisinopril to the patient's medication regimen and ordered follow-up in six months. The provider did not address the patient's hyperlipidemia at that visit. As of 10/31/13, the provider has not addressed the patient's hyperlipidemia nor repeated his LDL cholesterol since 5/31/13.

  Assessment
  The patient was not receiving timely or appropriate care for his hyperlipidemia or hypertension. The normal starting dose of simvastatin is 10-20 mg per day. The provider documented no rationale for starting the patient on a lower dose. The patient did not receive timely follow-up for this problem. In addition, the provider's assessment of the patient's blood pressure being at goal on 8/15/13 was not correct. Finally, providers should see patients whose blood pressure is not at goal sooner than six months.

  - The patient[56] is a 55-year-old man with diabetes and coronary artery disease. His hemoglobin A1C was 8.8% on 7/9/13. A provider saw the patient on 9/10/13 and noted that neither his diabetes nor his blood pressure were at goal. The provider changed the patient's blood pressure medication, ordered blood pressure checks two times per week, fingerstick blood sugars three times per week, and follow-up in four weeks. The provider also noted he would repeat the patient's hemoglobin A1C in October. However, he did not write an order for this to be done. The blood pressure checks were not done. On 10/7/13, the provider saw the patient for follow-up and noted he had not

[55] Chronic Care Patient #8.
[56] Chronic Care Patient #11.

received the new blood pressure medication. The provider ordered blood pressure checks two times per week for three weeks and follow-up in 3-4 months. On 10/8/13, the provider ordered blood sugar checks two times per week for 90 days. They were not done. The blood pressure checks were only done on 10/10/13 and 10/11/13 (124/81 mmHg and 163/85 mmHg). As of 10/31/13, the hemoglobin A1C had not been done.

Assessment

The patient was not receiving appropriate care for his chronic illnesses. The patient did not receive the medication ordered by the provider and ordered monitoring did not occur.

- The patient[57] is a 47-year-old man with asthma and recently diagnosed diabetes and hyperlipidemia. On 5/23/13, blood tests performed revealed that the patient's hemoglobin A1C (8.1%) and his LDL cholesterol (146 mg/dL) were elevated. He did not have a prior history of diabetes. A provider notified him his laboratory tests were essentially within normal limits. A provider saw him for his asthma on 7/10/13. After the visit, the provider reviewed the patient's laboratory tests and noted he would have him return to clinic in a week or two to address his diabetes and hyperlipidemia. The provider did not see the patient until 8/22/13. The provider initiated appropriate therapy and the patient has received adequate care since then.

  Assessment

  The patient did not receive timely care for his diabetes and hyperlipidemia. The provider who reviewed his abnormal laboratory results from 5/23/13 did not note they were abnormal. In addition, follow up ordered for 1-2 weeks did not occur until six weeks later. Because of this, the provider did not address the patient's new onset diabetes and hyperlipidemia for three months.

- The patient[58] is a 37-year-old man with diabetes[59], hypertension and hyperlipidemia. On 2/5/13, the patient's LDL cholesterol was 125 mg/dL (goal < 100 mg/dL) and his hemoglobin A1C was 6%. On 2/6/13, a provider notified the patient that a chronic care appointment was being scheduled to discuss his laboratory results. A provider did not see him for this issue until 7/1/13. The provider noted the patient's hyperlipidemia was well controlled.

  Assessment

  The patient did not receive appropriate care for his hyperlipidemia. It took five months for a provider to see him for his elevated LDL cholesterol. When the provider did see the patient, the provider's assessment was that his hyperlipidemia was well controlled, when in fact it was elevated.

[57] Chronic Care Patient #14.
[58] Chronic Care Patient #16.
[59] The medical record for this patient is somewhat confusing in that providers sometimes state that he has pre-diabetes rather than diabetes. However, a chronic care progress note from 8/17/11 documents that the patient had had diabetes for at least two years and that he was being treated with metformin. The provider also documented that the patient had hyperlipidemia and was being treated with simvastatin 20 mg.

- The patient[60] is a 40-year-old man with diabetes, hypertension and hyperlipidemia. On 9/18/12, the patient's LDL cholesterol was 93 mg/dL. On 9/23/13, the patient's LDL cholesterol was 119 mg/dL. A provider notified the patient he was being scheduled for a chronic care appointment to discuss his laboratory tests. (As of 10/31/13, the provider had not seen the patient for follow-up.) On 10/9/13, the provider wrote an order for blood tests, including a lipid panel, to be done on the last week of 3/2013 [sic] and for chronic care follow-up in 5-6 months. (The provider had most recently seen the patient for chronic care on 5/31/13.)

  Assessment
  The patient was not receiving timely care for his hyperlipidemia. In addition, providers should see chronic care patients a minimum of every six months; however, the provider was not planning to see this patient until at least 10 months after his prior chronic care visit.

- The patient[61] is a 63-year-old man with diabetes, hyperlipidemia and hypertension. On 7/31/13, a provider saw the patient for chronic care and noted that the patient had stopped taking his cholesterol lowering medication. The provider counseled the patient, who agreed to re-start the medication. The provider ordered a repeat lipid panel and follow-up in October. On 8/6/13, the patient's LDL cholesterol was 123 mg/dL. As of 10/16/13, the provider has not seen the patient for follow-up and the lipid panel has not been repeated. On 10/16/13, the provider ordered a lipid panel for the first week of February 2014.

  Assessment
  The patient did not receive timely care for his hyperlipidemia.

- The patient[62] is a 25-year-old man with diabetes. On 6/1/13, his hemoglobin A1C was elevated (9.2%). On 7/29/13, the patient refused a repeat hemoglobin A1C test. A provider saw the patient on 8/14/13 and noted that the patient's blood sugars had been elevated, with many results in the 200s, but that it was difficult to treat the patient because he complained of slight shakiness whenever his blood sugar was 140-160 mg/dL. The provider increased his insulin and ordered follow-up in 5-6 months.

  Assessment
  The patient did not receive timely or appropriate care for his diabetes. The provider did not see him for 2½ months for his elevated hemoglobin A1C. In addition, the provider needed to order follow-up sooner than 5-6 months after increasing the patient's insulin.

- The patient[63] is a 44-year-old-man with protein C and S deficiencies[64] with multiple past deep vein thromboses and pulmonary emboli. He is being treated with warfarin with an INR

[60] Chronic Care Patient #17.
[61] Chronic Care Patient #18.
[62] Chronic Care Patient #19.
[63] Chronic Care Patient #25.

goal of 2.5-3.5. However, this is too high. The goal for this disorder is an INR of 2-3. On 9/24/13, his INR was 4.6. On 9/25/13, a provider decreased his warfarin dosage. The patient's INR was not re-checked until 10/8/13.

Assessment

The patient's warfarin therapy was not appropriately managed. The INR goal is too high, placing the patient at increased risk of bleeding.

Pharmacy and Medication Administration

Methodology: We interviewed James Gallwey, Pharmacist-in-charge (PIC), and nurses who administer nurse-administered and keep-on-person (KOP) medications. We inspected clinic and KOP medication rooms and reviewed medication administration records.

Pharmacy Services

Findings: We found problems with continuity of medications following arrival at SAC. As noted in the intrasystem transfer section of this report, in five of 15 records of we found examples of:

- Medications not renewed upon arrival.
- Medications not refilled timely following arrival.
- Medication orders that expired.
- Bridge orders not written for patients discharging from a CTC.
- Medication errors by nursing and pharmacy.
- Medication ordered urgently and not delivered to the patient timely.

In addition to cases described earlier in this report, we found the following case.

- This 61-year-old patient transferred from MCSP to SAC on 8/12/13.[65] His medical history included HIV infection, hypertension, diabetes and DJD. The patient is in Ad-Seg. At the time of transfer, the patient was prescribed glargine insulin 20 units every morning before breakfast and 6 units of regular insulin every evening before dinner. On 8/13/13, a nurse documented that the patient refused 20 units of glargine insulin in the morning and 6 units of glargine insulin in the evening. However, the prescribed evening insulin was regular not glargine insulin. On 8/14/13, nurses documented that the patient refused 20 units of glargine insulin in the morning and 20 units of glargine in the evening, but the patient was not prescribed 20 units of glargine in the evening.

  On Saturday 8/17/13, a provider saw the patient, who explained that unless he receives a diabetic snack twice daily he becomes hypoglycemic. The provider reduced his glargine insulin from 20 to 10 units daily, and his regular insulin from 6 units to 3 units. However, from 8/19 through 8/21/13 the patient continued to receive 20 units of glargine and 6 units

[64] Protein C and S deficiency is a blood coagulation disorder. Its chief characteristic is the predisposition to excessive blood clotting.

[65] Intrasystem Transfer/Sick Call Patient #11.

of regular insulin. Due to legibility issues, pharmacy staff interpreted the glargine insulin order for 10 units as 16 units of insulin. However, the patient never received this dosage. On 8/22/13, a provider saw the patient and noted that the patient was not refusing his insulin but was having frequent low blood sugars and requesting extra lunches. He decreased the patient's glargine insulin from 20 to 10 units every evening, and from fixed regular insulin to sliding scale insulin. On 8/22/13, the patient received two doses of glargine insulin, 20 units in the morning and 10 units in the evening. It is unclear whether he should have received both doses.

Pharmacy Operations and Staffing

The pharmacy operates from 8 a.m. to 4 p.m., Monday through Friday, and a pharmacist is on-call for weekends. Regarding staffing, besides the PIC there are four full-time pharmacists, all state positions, and 10 pharmacy technicians, six that are state and four that are contract positions.

We discussed the process for renewal of chronic disease and other essential medications. The PIC reported he is working with the providers to synchronize ordering of chronic disease medications but has not been entirely successful. Therefore, for a patient on five chronic disease medications, the expiration date for each medication may be different. This requires more pharmacy and provider surveillance than if all five medications were renewed at each chronic disease visit and increases the risk that medications will inadvertently be discontinued. The PIC reported he does not perform studies or have reports that show how often medications are inadvertently discontinued. Due to our findings during this review, we recommended he conduct such studies and perform root cause analyses of the medication issues we identified.

Medication Administration

Findings: The CCHCS Dashboard for July 2013 does not have a score for access to medications. We did not directly study the link between access to care and medication continuity; however, we note that the Dashboard also shows low scores for primary care provider (PCP) episodic care (71%), PCP chronic care (53%), and PCP specialty care follow-up (57%). We also note low scores for PCP continuity (50%). Lack of access and continuity may be factors contributing to the medication issues we found.

Our findings are not consistent with the Access Measures Audit Tool (AMAT) Summary Results from January through July 31, 2013 (except May) that show improving trends in medication continuity for chronic disease, return from higher-level care and intrasystem transfer.

We toured PSU 4. The room was not clean as no porters are allowed in this area. The cabinet drawers were dirty and in disrepair. We found loose pills and non-patient specific medications in the drawers. PSU nurses described that they pre-pour medications from a properly labeled pharmacy container into coin envelopes that do not contain identifying information regarding the patient and medications in the envelope. Nurses do not take patient medication administration records (MAR) with them during medication pass and therefore do not document medication administration when they give the medications to the patients. In

addition, nurses administer medications to patients through the food port instead of opening the door. This does not allow the nurse to perform an adequate oral cavity check, which is particularly important for mental health patients. These practices are not in accordance with standards of nursing practice. Furthermore, nurses do not crush medications in front of the patient per policy because of lack of a proper medication cart.[66]

We asked PSU nurses how they handle blank spaces on the MARs. They reported they notify the staff who failed to document administration of the medication so they can fill in the blanks when they return to the unit. As noted in other reports, for staff to return to the facility after the fact and document administration of a medication that may or may not have been given days or weeks prior to documentation raises serious questions about the credibility of the MARs. CCHCS and SAC health care leadership should prohibit this practice.

We reviewed MARs for nurse administered and keep on person (KOP) medications. The nurse-administered MARs were generally complete, neat and legible; however, the findings noted above regarding nurses filling in blank spaces days or weeks after the date raises issues regarding MAR credibility. Regarding KOP MARs, we found MARs in which the patient's signature and date was neither legible nor on the proper space on the MAR. We also found examples in which the nurse did not sign and date the MAR.

Laboratory/Radiology

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

Findings: The laboratory was clean, organized and of sufficient size for daily operations. Staff reported that laboratory orders that clinic staff fax to them by 10 a.m. are scheduled for the following day unless the order specifies otherwise. Quest laboratory reports are automatically printed, and lab staff calls the TTA nurse for notification of critical values. Review of laboratory reports showed that provider signatures are illegible and name stamps are not used.

Regarding radiology services, one concern is that, per policy, radiology reports are stored in RadNet, the on-line program for the vendor of radiology services, and are not scanned into the patient's health record. This is problematic, as the health record needs to contain documentation that provider-ordered procedures are implemented and reports received, reviewed and commented upon in a timely manner. If a radiology procedure was ordered but not performed, there is no information in the eUHR to know when it was scheduled, whether it was done, and, if done, what the result was.

Health Records

Methodology: We interviewed Barbara Shane, HPS 1, and Cynthia McCray, HRT II, and health records staff, toured health records, and reviewed health records staffing and the health

[66] Clinic Operations Nursing Subcommittee Executive Summary July 2013.

records (eUHR) for organization, ease of navigation, legibility and timeliness of scanning health documents into the health record.

Findings: At SAC, we found significant issues with health records. Issues found include misfiling of patient health documents into other patient records, mislabeling scanned documents, scanning documents into the wrong section of the health record, delays in transcribing and scanning provider notes into the record and failure to scan MARs into the record. We also noted a case in which a provider dictated two notes for the same patient but the medical history of one of the patients made it clear it was not the same patient. We do not know if this was a provider dictation error or a transcription error. Another concern is the failure to track and retrieve specialty services and hospital reports and ensure that a provider reviews and signs the reports prior to scanning them into the health record. This is also discussed in the specialty services section of this report.

Another serious issue is providers that copy and paste previous progress notes into current notes. In several cases, these progress notes contained the exact same clinical information, including examinations, when the record showed that the patient's condition had clearly changed. This is tantamount to falsification of the health record and warrants peer review. We discussed this with the Acting Chief Medical Executive (CNE).

Health Records Space and Staffing

The Health Records area is clean, well organized and of sufficient size for daily operations. With the implementation of Acuity Based Staffing Realignment (ABSR), the facility lost a SSMI position, Health Records Technician (HRT) II Supervisor, HRI I position and three office assistants.[67] This occurred at the same time the facility became the pilot institution for scanning inpatient records into the eUHR. ABSR did not result in loss of Office Technician scheduler positions.

Health Records Operations

Staff provided us the Daily Outpatient Scanning Report for the period of 7/8/13 to 10/5/13. In July and August, daily backlogs of documents to be scanned ranged from 2 to 20.5 inches. The volume of scanned documents increased during early September when inmates participating in a hunger strike were housed or transferred to SAC, but trended back down during early October. At the time of our visit, there was no significant backlog of scanned documents.

We discussed with staff the frequent occurrence of health record errors found during this review. Staff acknowledged they identified similar errors several months prior to our visit but believed they had corrected the errors. We recommend that health records leadership reevaluates the quality improvement process for the accuracy of health records scanning and perform a root cause analysis.

[67] The HPS I believes that three office assistant positions were eliminated, totaling six positions eliminated by ABSR; however, she was not certain of this number.

Urgent/Emergent Care

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

Emergency Department/Hospitalizations

Findings: Emergency services are inadequate due to significant delays in recognition, evaluation and treatment of emergent conditions. In addition, SAC patients do not consistently have ready access to tertiary care services when emergencies occur. SAC is an intermediate facility and therefore has higher acuity patients. Yet, SAC's main contract hospital, SJGH, is over an hour away in Stockton, California, and does not have several important services. For example, it does not have a full-time staff neurologist and is not capable of cardiac interventional surgery (coronary artery bypass graft or stent). This has presented barriers for urgent care and for specialty medical care, as described in the section on specialty care later in this report. SAC is near Sacramento and its location and access to tertiary medical care is one of the principal reasons it was chosen as an intermediate facility. In Sacramento, tertiary care is available but is either not accessible or not fully utilized. This adversely affects patient care.

SAC has a large population of patients with severe mental illness, addictions and behavioral disorders. Providing professional medical care to this population is difficult. At times, patients' attitudes and behavior may influence a provider's assessment of their medical problems. We recommend that medical leadership review ways that providers' and nursing skills in effective listening and communication with patients can be improved.

In addition, because SAC has a large mental health population, including very severe mental illness, medical physicians should work closely with mental health providers to co-manage medical conditions in patients with grave mental health disorders. Medical staff is invited to attend treatment team meetings for mental health patients. However, in record reviews we did not notice documentation of collaboration.

We also note that, for some patients, delayed diagnosis or delayed referral to a specialist resulted in delayed hospitalization and potential harm to the patient. We recommend that root cause analyses be performed for these cases to determine how clinical processes can be improved.

The following cases illustrate these points.

- One case[68] involved a 29-year-old patient who submitted a 7362 request on 1/22/13 complaining of "serious back pain" for a week, stating he could not sit up because of the pain. He asked to see a physician. A nurse performed an assessment on 1/24/13. The patient told the nurse the pain was such that he could not sit down. The nurse documented that the patient was having difficulty walking. The nurse gave the patient ibuprofen by

[68] Hospital Patient #3.

protocol and rescheduled the patient for a nurse follow-up. The next day, a nurse saw the patient. The nurse wrote that the patient was ambulating with a limp and "refuses to sit down." The term "refuses to sit down" assumes that that patient could but intentionally was unwilling to sit down. Perhaps the patient could not sit down because he had a physical problem. The choice of words displays an attitude toward that patient that is not sympathetic. The nurse referred the patient to see a provider the same day. The provider wrote that the patient was "ambulating well." The provider diagnosed musculoskeletal sprain, continued the ibuprofen, and ordered a muscle relaxant (Robaxin). The provider ordered a two-month follow-up.

On 2/4/13, a nurse saw the patient again because of back pain and that medication was not helping. The patient again stated that he could not sit down. The nurse referred the patient to a provider. The following day the nurse saw the patient again. The patient became angry and demanded something stronger for pain. The patient used profanity. The nurse discussed the case with a provider, who ordered Toradal[69] and Tylenol with codeine but did not examine the patient. The nurse scheduled the patient for a provider visit the following day. This is problematic because if a provider decides that a patient has pain severe enough to use a narcotic the provider needs to examine the patient.

On 2/6/13, a provider saw the patient. The patient came into the examination room in a wheelchair saying he could not walk. The patient refused examination but the provider documented that he elicited normal ankle reflexes. The provider wrote that the patient had normal bowel movements and no saddle numbness[70]. This reflects the provider was concerned about a spinal cord lesion. The provider ordered a spinal x-ray and next day follow up. On x-ray, the disc space between two of the vertebrae was narrowed but the discs were of normal height and bony structures were normal.

On 2/7/13, a different provider saw the patient. The provider documented a normal musculoskeletal and neurological examination. The provider wrote that there were no emergent neuromuscular deficits. He added morphine for a month to the pain regimen. The provider did not document the clinical decision behind this prescription. This raises the question that if the patient had a normal examination, what was the clinical rationale for treating the patient with morphine?

Four days later, on 2/11/13, the patient was brought to the clinic on a gurney complaining of low back pain. The provider noted the previous x-ray results. The patient was verbally abusive. The provider documented normal neurological examination and no tenderness in the low back. He wrote that the patient has an "expression of pain (20/10) out of proportion to physical exam." He added Toradal and Ativan for a month with a nurse follow up in 1-2 days.

[69] A non-narcotic analgesic.
[70] Numbness in the area of the groin.

On 2/13/13, the patient arrived in the clinic in a wheelchair for a follow-up. He described being only able to walk from his bunk bed to the door of the cell before getting pain. The patient complained that the pain now included his inner thigh and "private parts." This implies referred pain from nerve roots. The nurse consulted with a provider, who did not examine the patient but ordered Robaxin and an injection of Toradal. The referred pain signaled a potentially more serious problem, such as a tumor or infection, and the provider needed to examine the patient and consider an MRI.

On 2/16/13, the patient complained of pain preventing him from sleeping. He said he was unable to sit up or take a shower. On 2/19/13, a nurse evaluated the patient who reported that he had never had a pain like this before. He could not bend over and walked leaning to his right. The nurse gave the patient ibuprofen by protocol and rescheduled the patient for a two-week follow-up. The patient's history of significant disruption in his ability to carry on activity of daily living should have alerted the nurse to consult a physician.

On the same day, 2/16/13, the patient placed another 7362. The patient wrote, "I would please like/need an MRI done on my lower back. A provider ordered an x-ray, but it was not needed. This is my 5th slip I've turned in. I'm in serious pain and you're not taking me serious." A nurse triaged this complaint on 2/21/13. The nurse documented that a provider would see the patient on 2/22/13.

On 2/22/13, a provider saw the patient and noted that the patient had been on non-steroidal medication and narcotics for over a month without relief. The patient said he could not perform normal activities for over three weeks and that the pain was getting worse. The patient could not use crutches since the prior day but had no urinary or bowel symptoms. The doctor noted the prior x-ray results. The provider documented that on physical examination, the patient "overreacts to touch" but otherwise documented a normal examination. The provider ordered a routine MRI. Two weeks later, on 3/7/13, this request for an MRI was denied for not meeting criteria. The person denying the request did not sign their name or title and did not document the reason that the request did not meet criteria. We believe the patient and provider were correct that the patient needed an MRI.

On 2/27/13, the patient placed a 7362 asking for an evaluation for low back and groin pain. A nurse evaluated the patient on 3/1/13, two days after the patient wrote the complaint. The nurse documented that the patient had back pain radiating to his groin and right hip. The patient could not bend over, was limping and could not stand up straight. The nurse consulted a provider, who ordered Robaxin, Elavil and a nurse follow up if needed. The patient was sent back to his housing unit. Referred pain indicates potential for spinal disease, particularly given the severity of his pain. The provider needed to examine the patient. The provider did not follow up on the status of the MRI.

On 3/11/13, the patient placed another 7362 complaining of constant pain. A nurse evaluated the patient the same day. The nurse wrote that the patient had tenderness over both hips and that movement was painful. This is an additional factor suggesting a more

serious problem than musculoskeletal pain. The nurse referred the patient to see a provider and an appointment was scheduled for 3/18/13. The patient was sent back to his cell.

On 3/14/13, the patient placed another 7362 requesting pain medication because he could not sleep. A nurse wrote that a physician would see the patient on 3/18/13. On 3/18/13, the patient placed another 7362 requesting stronger pain medication because he could not sleep. A nurse wrote that the patient had a provider appointment.

On 3/18/13, a provider saw the patient and noted persistent and worsening pain. The patient complained that the pain was radiating down both legs. The provider documented 15 pounds of weight loss over the past four weeks. The provider wrote that the patient could not eat because of the pain. Significant weight loss is a sign of potentially serious disease. The patient denied incontinence. The provider noted limited range of motion with a positive straight leg-raising test[71]. The provider ordered immediate methadone and re-ordered an MRI. The provider initially ordered the study urgently, but someone scratched out urgent and circled routine. On 3/19/13, the MRI was approved. The provider ordered a 2-3 week follow-up. The provider did not evaluate for possible causes of weight loss except to note that the patient was not eating. The provider asked about incontinence, which is a symptom of spinal cord lesions, but did not probe deeper into this possibility. The provider thought that the patient had spinal stenosis. However, if a suspicion of cord disease existed, the provider needed to order an emergent MRI. The provider also needed to consider that the patient's weight loss might have been a sign of systemic disease.

On 3/20/13, the patient placed another 7362 about his pain. The nurse evaluated the patient on 3/22/13, gave him ibuprofen by protocol and sent him back to his housing unit. The same day, the patient placed another 7362 for pain and, on 3/23/13, a nurse evaluated the patient. The nurse discussed the case with a provider, who did not examine the patient but ordered 30 mg of morphine twice a day with no follow-up requested. Before ordering narcotic medication, the provider needed to evaluate the patient.

On 4/3/13, a provider saw the patient and documented that he walked and moved onto the examination table without difficulty and that the pain was well controlled. The provider noted that an MRI was pending and ordered follow up as needed. The provider should have scheduled a follow-up visit.

On 4/3/13, the MRI was performed. This study showed L5-S1 discitis (an infection of the lumbar spine). This extremely serious condition can cause permanent neurological impairment.

On 4/9/13, the radiologist read the study and documented that he notified SAC of the abnormal results on 4/9/13, at approximately 2:30 p.m. On 4/9/13, the patient placed a 7362 asking for results of the MRI. A nurse documented that the results were still pending

[71] A sign of spinal cord irritation.

and that the physician was aware. The Quality Management Committee needs to perform a root cause analysis of how the significantly abnormal MRI findings could be communicated to the facility and not be immediately acted on.

Three days later, on 4/12/13, staff brought the patient to the clinic on a gurney complaining of pain. The provider evaluated the patient, noted the abnormal MRI findings and sent the patient to the hospital. At the hospital, physicians diagnosed the patient with a spinal infection with spinal cord abscess. The patient admitted to intravenous drug use at the prison. The patient underwent surgery to drain the abscess and to remove infected bone and tissue. The patient also had a hip infection, which required drainage. On 4/18/13, the patient was discharged from the hospital on both intravenous and oral antibiotics. We did not find TTA notes in the eUHR when the patient returned. Staff did not address the patient's drug addiction when he returned to the prison.

Assessment

Spinal epidural abscess is an uncommon condition, is difficult to diagnose, and requires a thorough clinical examination and high index of suspicion. However, the patient submitted a dozen requests complaining of severe pain for approximately 10 weeks and did not receive an appropriate and timely evaluation. Providers saw the patient on eight occasions and prescribed narcotic medication at several of those visits. A provider also prescribed narcotic medication by verbal order without examination of the patient. On two occasions, the patient described referred pain, a sign of a potentially more serious problem. Frequently the patient described limitation of movement or inability to perform activities of daily living, but providers did not incorporate these symptoms into their diagnostic thinking. In general, the provider histories for this patient were not thorough. For some encounters, we question whether the provider was listening or taking the patient's complaint seriously. The radiologist informed SAC of the abnormal MRI demonstrating a spinal abscess but no action was taken for three days. This delay was dangerous for the patient and could have resulted in irreversible spinal cord damage.

- This is a 22-year-old patient[72] with a congenital heart condition called Tetralogy of Fallot. The patient had surgery to repair his cardiac defect as a child. As adults, patients with Tetralogy of Fallot are more likely to acquire adverse events related to the surgical repair. One possibility is supraventricular tachyarrhythmia[73].

  This patient arrived at SAC from San Quentin on 7/27/11. The 7277 transfer form noted this condition and documented that on 6/14/11; a cardiologist evaluated the patient and recommended a follow-up in one year. The reception nurse scheduled a primary care visit.

  A provider saw the patient on 8/9/11. The provider documented that the cardiologist who recently evaluated the patient in June 2011 recommended monitoring the patient. The

[72] Hospital Patient #7.
[73] A rapid, uncoordinated heart rate.

provider discharged the patient from chronic care clinic but did not document the rationale. The provider did not schedule a cardiology appointment as recommended. The provider needed to either follow the cardiologist's recommendation for follow-up or document his rationale for not doing so.

Over a year later, on 11/21/12, emergency responders evaluated the patient for dizziness, palpitations and chest pain with momentary numbness of his left hand. Palpitations are a common symptom of cardiac disease. Cardiac disease was likely, given the history of Tetralogy of Fallot. A provider evaluated the patient and decided that based on his history and physical examination, the chest pain was unlikely cardiac in origin. The provider did not provide clinical reasoning for this decision. The provider ordered an electrocardiogram and it showed a right bundle branch block, which is a common electrocardiogram pattern after surgery for Tetralogy of Fallot. The provider rescheduled the patient for several weeks and wrote that he might benefit from a cardiology consultation. Given his symptoms, the patient had a high risk of cardiac disease. The provider should have referred the patient to a cardiologist.

Within a few days, on 11/24/12, the patient submitted a 7362 complaining of chest pain. The patient wanted to see his civilian cardiologist and asked for his annual cardiology checkup. The patient asked for an echocardiogram. A nurse evaluated the patient for his complaint. The nurse scheduled the patient for a two-week follow-up with a provider and instructed the patient to return for any further chest pain. The nurse needed to consult with a physician because the patient had a heart condition and experienced chest pain.

On 12/10/12, a provider saw the patient. The provider documented that the patient had syncope and a history of Tetralogy of Fallot. The provider probed deeper about what had occurred two weeks previous and discovered that the patient had experienced palpitations and dizziness and subsequently fainted when he stood up. The provider assessed syncope and documented it was likely due to a lack of sleep. The provider did not document his reasoning. The patient had a cardiac condition that very likely contributed to his symptoms. The provider needed to recognize that the patient's symptoms were consistent with late complications of his cardiac condition and refer him to a consultant knowledgeable in Tetralogy of Fallot. The provider noted that the patient was asymptomatic. This was not correct unless the provider did not believe the patient. The patient had just told the provider his symptoms were palpitations, dizziness and fainting. The provider ordered follow-up in three months with a repeat electrocardiogram at that visit. The provider noted that the cardiologist had recommended an annual visit but documented that instead he would monitor the patient and submit a cardiology consult if the patient was symptomatic. It appeared the provider was denying that the patient's symptoms were real. The provider needed to refer the patient to a cardiologist.

On 12/25/12, the patient submitted a 7362 complaining of chest pain, stating he was told to let medical staff know if he had recurrent chest pain. The nurse documented a history that the pain radiated to his left shoulder; improved with rest, lasted 2-3 minutes; and was

associated with dizziness and diaphoresis. These are classic symptoms of cardiac pain. An electrocardiogram showed right bundle branch block. The nurse initially checked the box for a STAT referral but crossed this out. The nurse consulted with a nurse practitioner, who recommended a physician appointment in a week. In our opinion, the nurse was correct in initially recommending an immediate evaluation, and the nurse practitioner erred in judgment.

On 1/11/13, a provider saw the patient. The patient complained again about recent chest discomfort and dizziness with near syncope. As noted above, this combination of symptoms suggests serious cardiac abnormality. The provider documented that the patient was experiencing pre-syncope from his cardiac condition. We agree. The provider repeated an electrocardiogram, which again showed right bundle branch block. The doctor referred the patient to a cardiologist and requested an echocardiogram prior to that consultation. The provider recommended no strenuous exercise. The provider should also have considered a Holter monitor test.

On 1/12/13, a Saturday, at about 8:00 p.m., emergency responders evaluated the patient for another episode of chest pain and dizziness. The patient's heart rate was 186/minute with a blood pressure of 152/88 mmHg. Nurses called an on-call provider, who ordered the nurses to transfer the patient to the TTA for monitoring. It is not clear what the provider expected the nurses to monitor given the patient's rapid heart rate. Supraventricular tachycardia with a rate of 186/minute is not a condition to be monitored by nurses with remote provider consultation. This was dangerous for the patient. The provider needed to send the patient to a hospital emergently.

Staff transported the patient to the TTA. Nurses documented that while on the cardiac monitor, "the EKG machine will have sudden short tachy bursts- 110-140/min." Nurses called another provider. There was no documentation regarding the contents of that discussion. Eventually, the patient felt better and the heart rate subsided. A nurse documented that an electrocardiogram obtained at 9:35 p.m. was normal sinus rhythm. The nurse sent the patient back to his cell with a physician appointment the following week. This was extremely dangerous care. The patient had a life threatening cardiac episode. Nurses appropriately consulted a physician but the physician did not give appropriate advice on management.

On Monday, 1/14/13, a provider saw the patient and documented that the patient had palpitations and dizziness over the weekend, including a pulse over 180/minute. The doctor noted that the patient was still having recurrent palpitations. The provider requested a routine cardiology consultation and an urgent echocardiogram prior to the cardiology consultation and one week follow-up. On 1/14/13, both of these requests were approved. Because of the recent episode of tachycardia, the provider needed to call a cardiologist for advice that day.

On 1/18/13, a provider saw the patient. The patient was still experiencing dizziness and palpitations. The provider documented he would monitor the patient until the cardiology consultation occurred. He scheduled a one-week follow-up. The provider needed to consult promptly with a cardiologist for advice on a proper course of action.

On 1/21/13, a nurse saw the patient in the TTA for a complaint of chest pain and dizziness. The nurse performed an electrocardiogram, which showed sinus arrhythmia[74] with a heart rate of 67/minute and right bundle branch block. The nurse documented that the patient stated his heart "felt like flutter." The nurse consulted with a provider, who gave an order to schedule the patient for nurse sick call to follow up on the pending cardiology consult and echocardiogram. This was not appropriate. The provider needed to evaluate the patient for his dizziness and chest pain. Sending the patient back to his cell was dangerous.

On 1/17/13, prior to the TTA visit described above, the patient had submitted a 7362 for chest pain with associated diaphoresis, dizziness and shortness of breath. A nurse triaged this request on 1/18/13, but a face-to-face encounter did not take place until 1/22/13. Five days is not an appropriate timeframe for evaluation of chest pain. The patient complained about more frequent episodes of chest pain. The nurse obtained an electrocardiogram and documented it was normal. The electrocardiogram on this date was not normal; it showed sinus arrhythmia with right bundle branch block. A provider saw the patient the same day, 1/22/13, and noted that the patient had recurrent episodes of "fluttering of the heart" associated with dizziness and chest discomfort. The provider documented the urgent echocardiogram was still pending and that if the symptoms occurred more frequently he would send the patient to the OHU or CTC for closer observation. The provider scheduled a one-week follow-up. The provider should have consulted with a cardiologist.

A provider saw the patient on 1/28/13 and commented that the "urgent" echocardiogram had not been done. It had been two weeks since the urgent request for an echocardiogram. The provider noted that the patient was still symptomatic. The provider scheduled a one-week follow-up. This was another delay that placed the patient at risk.

On 1/29/13, the patient had an echocardiogram at San Joaquin General Hospital. On 2/1/13, the provider saw the patient in follow-up and documented that the results of the echocardiogram were unavailable. The provider scheduled a three-week follow-up. The cardiologist at San Joaquin General Hospital did not sign the dictation of the echocardiogram results until 2/14/13.

On 2/13/13, a cardiologist saw the patient almost three months after development of symptoms of an urgent nature. While in the clinic, the cardiologist diagnosed atrial flutter and admitted the patient directly to a hospital. A hospital physician agreed and recommended ablation therapy[75]. The patient was sent to UC Davis twice over the

[74] A variation of heart rate.

[75] A procedure that uses radiofrequency energy (similar to microwave heat) to destroy a small area of heart tissue that is causing rapid and irregular heart beats. Destroying this tissue helps restore the heart's regular rhythm.

following two weeks for this treatment that was not available at their community hospital. He had special electrophysiological studies and prescribed medication to control his heart rate.

Assessment
This patient's urgent, life-threatening medical problem took three months to evaluate and treat.

The next case illustrates problems co-managing patients with medical and mental health problems.

- This patient[76] had a history of hypertension, type 2 diabetes mellitus, hyperlipidemia, GERD, and chronic kidney disease. The patient also had a mental health condition and was not continuously cooperative with treatment.

  The patient experienced chest pain in March 2012, but refused a cardiac stress test. On 4/12/13, a provider saw the patient for chronic care follow-up. The provider took no history except to state that the patient had no complaints. The provider reviewed laboratory tests. Even though the patient had protein in his urine, chronic kidney disease and diabetes, the provider did not prescribe an ACE inhibitor[77], which is standard of care.

  On 5/4/12, a different provider saw the patient. The patient's blood pressure was 174/89 mmHg (goal <140/80). The provider ordered an ACE inhibitor and increased the patient's other antihypertensive medication. The provider ordered a renal ultrasound and rescheduled the patient for 1-2 weeks. The follow-up visit did not take place.

  Almost three months, later, on 7/23/12, a provider saw the patient. This was a failure to monitor the patient after his recent abnormal blood pressure. The patient's blood pressure was still elevated (153/78 mmHg). The provider did not perform a thorough history. The assessment did not include the status of the patient's problems. The provider added a diuretic and referred the patient to a nephrologist because of the proteinuria. The provider scheduled a 14-day follow up.

  On 8/6/13, a provider evaluated the patient. The patient's blood pressure was improved but still elevated (148/72 mmHg). The provider noted that the diuretic had not yet started. The provider did not document a history. The provider ordered a diuretic and wrote to add an ACE inhibitor, but the patient already had a prescription for an ACE inhibitor. The provider noted that the patient was often refusing treatment but did not probe to assess why the patient might have been non-compliant.

[76] Hospital Patient #8.
[77] A class of medications used to treat hypertension and to prevent progression of kidney disease.

On 8/29/13, a nephrologist evaluated the patient via telemedicine. The nephrologist documented that the patient reported he was getting conflicting messages from medical staff and did not believe what people were telling him. The nephrologist described paranoid delusions of the patient. The nephrologist also documented that the patient had stopped taking his blood pressure medications. The patient's blood pressure was 182/100 mmHg. The nephrologist described results of a renal ultrasound indicating one of the kidneys was small. The nephrologist thought this might result from renal artery stenosis and recommended a 24-hour urine for creatinine clearance, renal scan, and possibly a magnetic resonance angiogram (MRA). The nephrologist also recommended an ACE inhibitor and diuretic and to lower the blood pressure slowly to reduce adverse symptoms. The nephrologist made no recommendations regarding his mental health symptoms, but the patient's mental condition was a barrier to effective communication. Review of the nephrologist's note should have prompted a provider discussion with a psychiatrist on how to better manage this patient.

On 9/5/12, a provider saw the patient in follow-up of the nephrology consult. The patient's blood pressure was elevated (176/92 mmHg). The provider took no history except "No complaints. Remains psychotic. You people are doing malpractice. My BP is OK." The provider's assessment/plan was extremely brief and included all of the nephrologist's recommendations but did not include how to address the patient's psychosis and did not develop a plan to have a conference with mental health on how to treat this patient.

On the same day as the provider visit, 9/5/12, a psychologist completed a mental health chrono placing the patient in EOP with an alert that the patient was a danger to others and gravely disabled. Contemporaneous mental health notes do not mention the problems with managing the patient's chronic medical conditions. On this day, there was a PSU interdisciplinary treatment team note. No medical providers attended.

On 9/13/12, a provider saw the patient for chronic care. The provider did not document a history and wrote that the patient refused examination. The provider did not consider how the patient's mental health condition affected compliance with his medical regimen. The provider continued current therapy. This was indifferent, as the patient was not participating most likely due to his psychosis, and it needed to be addressed.

On 10/4/12, a clinical psychologist interviewed the patient. The psychologist noted: "He told this writer, 'I have the right to remain silent' and turned away from this writer and towards the booth door. (Note: 10/5/12 a colleague reported to this writer that the IP told him this writer wants to have sex with him but he won't because he is Christian.)" We note but cannot explain why the clinical psychologist wrote a note on 10/4/12 referring to an event occurring 10/5/12.

This patient was delusional and his medical management needed to be coordinated with the mental health team.

On 10/5/12, at 1:50 a.m., emergency responders evaluated the patient for a complaint of chest pain. The patient's blood pressure was elevated (170/90 mmHg). A nurse documented that the patient had epigastric-type chest pain, but it was not clear that this was the case. The nurse performed an electrocardiogram, which was normal, and sent the patient back to his unit. The nurse needed to consult a physician. The patient returned with the same complaint and the nurse gave the patient a medication for GI upset and sent the patient back to his cell telling him to rest and "don't be stress out." The nurse did not consult a provider but should have done so. This was an extremely poor evaluation that placed the patient at harm.

About noon the same day, 10/5/12, the patient complained of chest pain and requested nitrostat[78] and morphine. A TTA nurse evaluated the patient near the PSU and his blood pressure was dangerously high (207/100 mmHg). The nurse documented rapid, pressured speech. The patient told the nurse that blood pressure medication made his blood pressure higher. The patient refused evaluation or treatment. Custody officers escorted the patient to the Facility A TTA. The patient was grandiose and rambling. A nurse called a provider who ordered Labetalol, a blood pressure medication. The provider asked for a follow-up call. The patient refused medication. The patient told staff that medication made his blood pressure go up. The patient signed a refusal and returned to his cell. Due to the patient's dangerously high blood pressure, the medical provider should have admitted the patient to a medical bed for blood pressure monitoring and consulted a psychiatrist on a strategy for managing the patient or, alternatively, sent the patient to a hospital.

On 10/8/12, a psychiatrist evaluated the patient and wrote in the subjective portion of the note, "pt. is currently on no psych meds and stable without any further issues." We assume that by stable the psychiatrist was referring to the patient's mental health condition. This assessment was inconsistent with the mental status of the patient three days earlier.

On 10/11/12, a provider saw the patient for chronic care. The patient's blood pressure was elevated (152/88 mmHg). The provider described the patient as psychotic, rambling and refusing care. The provider documented that the patient refused all care and referred him for a mental health evaluation.

On 10/11/12, a psychologist evaluated the patient and documented that the patient was delusional and not on psychotropic medication. The psychologist documented that, "His toilet was filled to the brim with feces," and that the patient was smearing feces under the door. Custody reported to the psychologist that the patient was threatening staff and complaining staff was trying to poison him. The psychologist did not document awareness of the refusal of medical care. The psychologist ordered a psychiatric consultation.

On 10/16/12, a nurse evaluated the patient for constantly talking to himself and wanting to kill everyone. The patient was placed in a suicide watch cell. On 10/20/12, emergency

[78] A topical form of nitroglycerin used in the management of angina.

responders evaluated the patient for a complaint of chest pain. The patient's blood pressure was dangerously high (200/110 mmHg). The nurse obtained an EKG, which was normal. The nurse documented that the blood pressure dropped to 126/72 mmHg after three nitroglycerin tablets were given to the patient. It wasn't clear from nursing documentation why the nurse gave the patient nitroglycerin. The patient exhibited signs of psychosis and was uncooperative with staff. The nurse called a physician on call, who ordered medications for GI upset followed by hydroxyzine (for anxiety) and olanzapine (an anti-psychotic medication). After the patient was calmer, he returned to his cell. The provider ordered psychiatry follow up in the mental health unit for unresolved agitation.
On 10/30/12, a provider (physician assistant) ordered a stress echocardiogram, but there was no corresponding progress note referencing the recent episodes of chest pain that would support the rationale for the procedure.

On 11/1/12, a psychologist performed an evaluation related to a custody citation for disciplinary action for destruction of state property and refusing a direct order. The psychologist determined that the patient's mental health played a role in his actions. On 11/7/12, at a Keyhea hearing the patient was found gravely disabled and involuntary medication was ordered. In November, while in a mental health crisis bed there were several interdisciplinary treatment meetings on this patient, but no medical providers attended the meeting.

On 11/19/12, the patient was admitted to the CTC for schizophrenia and continued to refuse medication. Psychotropic medication was forced but the patient did not take his medical medications and his renal function and blood pressure subsequently deteriorated. On 12/10/12, the patient was sent to a hospital for hypertensive urgency. The hospital lowered the pressure immediately using a Clonidine patch. While hospitalized, the patient developed atrial flutter and refused several recommended therapies. The patient also developed sepsis secondary to Methicillin-Sensitive Staph Aureus (MSSA). On 12/17/12, the patient was discharged on intravenous antibiotics.

After return to the prison, the patient developed acute renal failure. On 1/2/13, he was re-hospitalized and diagnosed with post-infectious acute renal failure. On 1/6/13, he was discharged back to SAC.

Assessment

Early in this patient's care, mental health and medical staff needed to collaborate on the management of his medical issues and refusal of care. Staff needed to consider a Keyhea order for involuntary medication when the patient, because of his psychotic disorder, believed taking medication was harmful to him. Involuntary treatment of his serious mental health condition might have resulted in the patient accepting medical treatment for his hypertension. His paranoid delusions interfered with care of his poorly controlled hypertension and increased his risk of a cardiovascular event. Medical and mental health leadership need to develop procedures for collaborating when patients have co-morbid medical and mental health disorders.

Specialty Services/Consultations

Methodology: We met with telemedicine, on-site and off-site specialty services schedulers. We reviewed records of 17 patients referred for off-site specialty care. Most of these patients had been referred to and evaluated by multiple specialists.

Findings: We found serious problems with specialty care related to the timeliness and/or quality of care in 10 of the 17 records we reviewed. Many problems were related to the primary care provider's failure to implement the consultant's recommendations in a timely manner. In July 2013, only 70% of patients with approved high-priority RFSs saw a specialist within 14 days, and only 67% of them had provider follow-up within three days as required by CCHCS policy. Of patients with approved routine RFSs, 88% saw a specialist within 90 days, but only 68% had provider follow-up within 14 days as required by CCHCS policy.[79] These data are consistent with our findings and are concerning. Our findings are also consistent with the OIG score of 18.2% on the question of whether the PCP reviewed the specialist's report and saw the patient for follow-up in a timely manner.

The telemedicine coordinator is very conscientious. She presents the patient to the consultant, documents consultant recommendations onto a telemedicine form and, in some cases, writes orders onto a physician order form. She tracks handwritten and dictated consultant reports and personally takes them to the primary care provider for review, signature and physician orders. She then schedules ordered labs, procedures, etc., in MedSATS, including a return visit with the provider. She personally monitors each patient to ensure that ordered recommendations are implemented. This system appears to be working well, primarily because of the conscientiousness of the telemedicine nurse.

Staff report there are access issues for off-site specialty appointments. SAC is an intermediate facility. CCHCS policy[80] states that at intermediate facilities:

> Tertiary Care Consultations (oncology, endocrinology, neurology, neurosurgery, interventional cardiology, nephrology, cardio-thoracic surgery) are close and readily available.

Also, the Final Architectural Program[81] of the HCFIP states:

> SAC is one of eleven existing institutions designated as an intermediate institution based on an institution's ability to recruit and retain clinicians and its access to medical specialists and community medical centers of care.

Despite being an Intermediate institution with higher acuity patients, SAC does not have ready access to tertiary care consultative services. SAC contracts with SJGH through HealthNet for

[79] Access Measures Audit Tool (AMAT) Summary July 2013.
[80] Appendix II, California Prison Health Care Services Institutional Medical Groupings, policy Volume 4, Chapter 29.
[81] Page 2, Final Architectural Program September 12, 2013 Health Care Facilities Improvement Program, prepared by Lionakis for the California Department of Corrections and Rehabilitation.

specialty services. However, SJGH lacks several important specialty services, including readily available neurology (SJGH has a part time neurologist not readily available), interventional cardiology and radiation therapy amongst others. Imaging studies not available onsite or at SJGH are sent to Modesto, which is over a three-hour round trip. Based on record reviews, the lack of contracts providing readily available interventional cardiology and tertiary care surgical services resulted in transfers of patient to alternate hospitals. Sometimes, these transfers worked smoothly. Sometimes, the lack of available services resulted in delays in care. Lack of contracts for readily available neurology, neuro-ophthalmology and radiation therapy at SAC resulted in missed appointments, delayed care and harm to patients. If SAC remains an intermediate facility, CCHCS should reassess contracting for specialty services. UC Davis Medical Center, which is not part of HealthNet, is approximately 20 miles from SAC and staff reports it provides a broader array of services.

Based on record review, we found that ordering, reviewing, discussing and managing 7243 Health Care Services Physician Requests for Services is not functioning well. Communication between the specialty service staff and providers does not ensure that patients receive timely services and continuity of care. Providers make approximately 120 requests a month. Staff responding to these requests estimated that at least 50% of requests for service have insufficient information. This requires the staff to contact providers to get necessary information. Communication occurs by phone and email but does not appear to be effective. The scheduling office technician has an office in the mental health treatment center. Providers rarely come to this area, so personal communication is limited. This entire process needs to be mapped, streamlined and corrected to ensure timely care.

Initiation and follow-up of specialty care was inadequate. Providers did not consistently request necessary specialty care required for management of the patient's condition. Providers often documented in their notes that patients were scheduled for specialty services when the service had not been requested. For several patients this resulted in delayed care.

Providers did not consistently review consultant recommendations timely, resulting in delayed or failure to care for the patient. A contributing cause is that health records staff scans off-site specialty and hospital into the eUHR without providers' reviewing, dating and signing the report. Therefore, the provider does not know when the report is available and this often delays review of consultant findings and recommendations and development of timely treatment plans. If health records and/or specialty services staff closely track the receipt of reports and route them to the requesting provider, the provider can schedule the patient for timely follow-up. However, at SAC this system is faulty. Our review showed that in several cases, patients' serious medical conditions were not addressed for months or longer.

Refusals of off-site services are problematic. Because patients are prohibited from knowing when their specialty appointments are scheduled, they are sometimes unprepared and refuse to an officer. The officer is not in a position to properly counsel the patient regarding the consequences of refusal. Consequently, documentation in the health record regarding the reasons for refusal and counseling of the patient is often inadequate. We recommend that,

without communicating the precise date of the appointment, health care staff communicate with the patient as the appointment date approaches to ensure he understands and agrees to keep the appointment.

Several specific issues warrant mentioning. PICC lines[82] are often required for chemotherapy or long-term antibiotic therapy. At SAC, when a provider obtains approval for chemotherapy, the provider must also go through the process of obtaining approval for a PICC line. A reasonable case could be made to not require approval for PICC lines when chemotherapy is warranted. Once chemotherapy is approved, requiring another approval for a PICC line, which is necessary to provide chemotherapy can only delay the service. An example of this problem is described in a specialty care case below.[83] We recommend that CCHCS and/or SAC health care leadership reassess UM processes to ensure patients receive timely care.

Finally, many tests are cancelled because patients are improperly prepped. Twelve colonoscopies were cancelled over the past six months due to patients eating prior to the test. Twelve other tests were cancelled over the past three months due to patients eating before a test requiring a fasting state. This delays care. Currently, patients requiring preparation for tests are not placed in the CTC or OHU so that nurses can ensure adequate preparation. Instead, patients remain in their housing unit. Staff reported that they tape signs on the inmate's cell door notifying custody that the patient is not to eat after midnight. The frequency of cancelled and rescheduled procedures is an indication that the current practice is ineffective and wasteful of scarce resources. The process requires modification to ensure timely access to care.

In speaking with specialty services staff, we were impressed and commend specialty services staff on their efforts to ensure patient continuity of care. However, we find that in addition to system issues, providers are not assuming sufficient ownership of patient care and need to take more responsibility for patient monitoring than is currently taking place.

The following case reviews illustrate the problems with specialty care:

- The patient[84] is a 53-year-old man with myasthenia gravis,[85] hypertension, avascular necrosis[86] of his hip due to steroid use, and pre-diabetes. (Other aspects of his care are discussed under intra-system transfer.[87]) The patient began treatment with prednisone and pyridostigmine[88] for myasthenia gravis three years previous. The patient's condition caused him to have double vision, for which he periodically saw an ophthalmologist.

[82] A PICC line is a peripherally inserted central catheter. It is a long, slender, small, flexible tube that is inserted into a peripheral vein, typically in the upper arm, and advanced until the catheter tip terminates in a large vein in the chest near the heart to provide intravenous access.
[83] Specialty Care Patient #3.
[84] Specialty Care Patient #1.
[85] Myasthenia gravis is a neuromuscular disease characterized by weakness and rapid fatigue of any of the muscles under voluntary control. Common symptoms are weakness of arm or leg muscles, double vision, drooping eyelids, and difficulties with speech, chewing, swallowing and breathing. It can be life threatening if it affects the throat or respiratory muscles.
[86] Avascular necrosis is the death of bone tissue due to a lack of blood supply.
[87] Intrasystem Transfer/Sick Call Patient #10.
[88] A medication commonly used to treat myasthenia gravis.

An off-site neurologist saw the patient on 9/28/11, 4/11/12 and 5/15/12. During this time, the patient was prescribed prednisone. On 9/14/12, a different neurologist evaluated the patient via telemedicine. The neurologist recommended discontinuing the prednisone because it was causing destruction of the patient's hip. On 11/13/12, a neurologist evaluated the patient again by telemedicine and recommended a six-month follow-up and increasing his pyridostigmine if the patient developed double vision. A provider saw the patient in follow-up after the neurology consultation, but did not document the neurologist's recommendations in his note.

About two months later, on Friday 1/4/13, the patient submitted a 7362 stating he was experiencing double vision. A nurse evaluated the request on 1/5/13 and scheduled the patient for a provider visit the following Monday. On 1/7/13, a provider evaluated the patient and noted that the patient was having "worsening visual changes for 2 weeks." This provider was different from the one who evaluated the patient after the neurologist's consultation in November. The provider failed to note the last neurology note recommending increasing pyridostigmine for double vision. Instead of increasing the pyridostigmine, the provider gave the patient a dose of intravenous (IV) steroids and sent the patient to the emergency room at SJGH for an evaluation by a neurologist.

Following evaluation in the emergency room, the patient was sent back to SAC with a prescription of five days of high dose prednisone and a recommendation for an ophthalmology consultation. As noted above, SJGH does not have a full-time neurologist. As a result, the patient did not have the consultation that the SAC provider intended. If the provider had reviewed the last neurologist consultation note, it may have spared the patient an emergency room visit. If SAC had a contract with UC Davis, a neurologist likely would have been available to evaluate the patient.

On 1/9/13 a provider saw the patient for follow-up. He noted that the patient still had eyelid droop. He also noted that "unfortunately" a neurologist did not evaluate the patient at the hospital. The provider noted that the patient had avascular necrosis due to long-term steroid use. The provider failed to review the last neurologist's note. The provider continued the same medication, did not increase the pyridostigmine and noted the next neurology consultation was in May, five months away. The provider failed to acknowledge the hospital recommendation for an ophthalmology consultation.

On 2/25/13, the patient submitted another 7362 requesting to see an ophthalmologist. The nurse arranged for the patient to see a provider that day. The patient told the provider he had been advised he needed eye surgery to correct his double vision. The provider noted that the patient had avascular necrosis from chronic prednisone use and that the patient had double vision. The provider noted the patient stated he was scheduled to see an ophthalmologist to correct the double vision. The provider wrote, "Has not been seen yet." We could not locate an ophthalmology referral prior to this date in the eUHR. Instead of securing an ophthalmology appointment, the provider referred the patient to an optometrist who is not qualified to manage complications of myasthenia gravis. On 3/4/13,

a provider wrote a referral to an ophthalmologist, which was approved 3/6/13. There was no progress note accompanying this referral. On 3/5/13, an optometrist evaluated the patient and prescribed glasses. He did not address the patient's myasthenia gravis.

On 3/28/13, the patient saw an ophthalmologist. The ophthalmologist documented that the patient had ocular myasthenia gravis with worsening symptoms. The ophthalmologist wrote:

> I recommend immediate neurologic referral for this patient. Then I would consider increased pyridostigmine to 50 mg q.i.d. [4 times per day] and continue with long acting of 180 h.s. [at time of sleep] and monitor for any anticholinergic side effects. May also consider restarting a low dose of prednisone at 20 mg orally daily, but care by a neurologist is essential in this case and I would only recommend that the attending doctor on staff adjust these meds as he deems his comfort level by prior experience with treatment of myasthenia gravis and must stress that care under a neurologist is essential on this case.

The ophthalmologist's recommendation to increase the pyridostigmine was the same recommendation made by the neurologist on 11/13/12, which providers had not implemented at SAC. Following this appointment, the TTA nurse noted that the ophthalmologist recommended "prompt neurology evaluation". Under the item "medication orders," the nurse circled "NO," which was not consistent with the ophthalmologist recommendations. The nurse did not document consultation with a provider or address the recommendation to increase the patient's medication. The patient was sent back to his housing unit.

On 4/5/13, a provider saw the patient and noted that the ophthalmologist saw him on 3/28/13. The provider wrote that the ophthalmologist recommended topical prednisone and that the patient refused. The ophthalmologist did not recommend topical prednisone. The provider failed to document review or understanding of the recommendations of the ophthalmologist. The provider failed to assess the respiratory status of the patient; it was unclear how severe his myasthenia was. The provider failed to consider the medication recommendations of the ophthalmologist that included increasing pyridostigmine and restarting oral prednisone. The provider scheduled a six-week follow-up.

On 4/25/13, the patient submitted a 7362 stating he needed an eye examination for poor vision. The nurse triaged this request on 4/29/13, and without seeing the patient, referred the patient to optometry. The nurse did not acknowledge that the patient had myasthenia gravis or that he had recently seen an optometrist. This nurse failed to understand the nature of the patient's complaint because she did not associate it with myasthenia gravis.

On 5/4/13, the patient submitted a 7362 saying he was losing his grip, had weakness in his right arm, and needed to see his primary care provider and neurologist to get proper medication. On 5/7/13, a neurologist evaluated the patient via telemedicine. The patient

had weakness in his hands and arms. The neurologist increased the pyridostigmine to 60 mg every four hours (at least five doses during the daytime) with an additional half tablet for times of increased weakness. He told the patient to inform medical staff immediately of any shortness of breath. He also ordered pulmonary function tests. On 5/10/13, the pulmonary function tests were performed and showed severe restrictive lung disease[89] consistent with myasthenia gravis.

On 5/15/13, a provider saw the patient and documented that he was complaining of persistent weakness and that he had no respiratory or swallowing problems. The provider's physical examination noted only that the patient's strength was 3-4/5. The severe restrictive lung disease indicated that the patient was developing respiratory complications from his myasthenia gravis. Given the deteriorating status of the patient, the provider needed to perform a more complete physical examination. The provider noted the neurologist's recommendations and that there was a follow-up neurology appointment in three weeks.

On 5/24/13, a provider saw the patient because the pyridostigmine needed renewal. The provider did not ask questions about respiratory capacity or ability to breathe. The provider did not perform a physical examination except for checking the box for "general" as within normal limits and checking the "HEENT/neck" box as abnormal. There was no explanation regarding why the provider checked this box as abnormal. The provider did not assess whether the increased dose of medication was working or whether the patient's condition was stable or deteriorating.

On 6/4/13, a neurologist evaluated the patient by telemedicine and noted that the patient was not responding to the increased dose of medication and recommended another increase of the pyridostigmine, and intravenous immune globulin (IVIG) infusions monthly for 3-6 months with a follow-up after the infusions. A nurse wrote an order for the infusions, which a provider signed on the same day as the neurology consult. On 6/5/13, a provider submitted a referral, approved the following day, to send the patient to the local hospital for the IVIG. On 6/17/13, a provider saw the patient and noted the immune globulin was ordered. The provider rescheduled a follow-up visit in 30 days.

On 7/15/13, a provider saw the patient and noted that the patient was waiting for his IVIG and was threatening to sue over it. The provider documented that the patient was having trouble eating. After inquiring about the infusion, the provider discovered that that the patient needed a "face to face neurology appointment prior to IVIG infusion." Apparently, the scheduling staff attempted to obtain the infusion at UC Davis, but UC Davis required that a neurologist with privileges on their staff order the infusion. The provider placed a request for service for a "face to face" neurology consultation and ordered follow-up in 45

[89] Restrictive lung disease, a decrease in the total volume of air that the lungs are able to hold, is often caused by a problem related to the expansion of the chest wall during inhalation due to weakness of the respiratory muscles.

days. This follow-up interval was dangerous for the patient. He had a potentially life-threatening condition and the provider needed to have the patient closely monitored.

On 7/17/13, the patient filed a grievance because he had not received his immune globulin infusion that the neurologist had recommended. The provider wrote that a UC Davis neurology appointment was pending. The provider did not clinically evaluate the patient. On 7/25/13, the request for IVIG infusion at UC Davis was withdrawn. Handwriting on the request form stated that the patient was going to SJGH for the procedure.

On 7/27/13, the patient submitted a 7362 request complaining he was experiencing muscle fatigue along "with weakness in my core," a potentially dangerous symptom. On 7/31/13, the nurse who triaged the complaint documented that the patient had been examined by a provider on 7/16/13 and had a pending appointment at UC Davis on 8/12/13. This was not accurate; the patient did not have an appointment at UC Davis, as it had been cancelled on 7/25/13. The nurse failed to recognize a potentially life-threatening situation and did not respond appropriately. Given the patient's history and complaint, the nurse should have urgently referred the patient to a provider.

On 8/2/13, a provider saw the patient and documented that the patient had lost 10 pounds over the past four months. The provider documented that the patient was having difficulty eating due to weakness. This symptom approaches a myasthenia crisis. The provider documented: "Supposed to have IVIG infusion was originally referred to UCD [UC Davis] but was Δ'd [changed] back to SJGH. Some confusion over who will do procedure. Per consult desk has appt. in next couple of weeks."

Aside from documenting no shortness of breath, there was no history regarding respiratory complaints. The provider performed a minimal physical examination. The provider documented that the patient had a pending appointment for the IVIG infusion.

On 8/12/13, the patient was sent to SJGH, where a hospitalist (not a neurologist) evaluated the patient and approved the immune globulin as ordered by the neurologist (one infusion monthly for 3-6 months). On 8/22/13, a provider saw the patient for follow-up. The provider did not take a history of respiratory symptoms and, consistent with all of his prior notes, did not assess for side effects from the pyridostigmine. The provider performed a minimal examination. The provider noted the first infusion was planned at the SJGH infusion center but did not specify a date. The provider ordered follow-up in 90 days. Given that the patient had difficulty in getting specialty care and had symptoms that indicated his condition was deteriorating, a 90-day follow-up was dangerous.

On 9/5/13, a provider saw the patient in the TTA for lower extremity weakness. The provider noted that the patient was supposed to receive immune globulin the second week of August and attempted to clarify the appointment. He documented the appointment was "very soon per consult." The provider ordered intravenous (IV) steroids to be followed by oral steroids and a next day (Friday) nurse follow-up and follow up with a provider on the

following Monday. He noted he did not feel that the patient needed a higher level of care. Due to his potentially life-threatening condition, the patient required more frequent evaluation by a provider and needed to be housed in the CTC or OHU.

On 9/7/13, a TTA nurse saw the patient for progressive weakness. The nurse documented that the patient could not sit up because of weakness, was choking on water and had clear, but weak speech. The nurse said the patient had lost 9-10 pounds. The patient was transferred to SJGH, which, as noted above, does not have a full time neurologist.

At the hospital, staff gave the patient immune globulin. On 9/10/13, the patient was discharged from the hospital, apparently without neurology consultation. Upon his return to SAC, he was admitted to the OHU. The provider's admission history did not assess ability to eat, breathe or swallow. The provider noted that the patient could walk with a slow gait. The physical examination was adequate. The provider ordered follow-up neurology and ophthalmology consultations. The patient received a second dose of immune globulin on 10/7/13.

Assessment

The patient did not receive timely or appropriate care for his serious medical problems. The patient did not have access to appropriate neurology care. Subspecialty neurology care was inconsistent and not timely. Recommendations of the neurologist were not implemented timely. It had taken three months for the patient to receive an urgent intervention recommended by a neurologist. This resulted in harm to the patient and a preventable emergency room visit.

- The patient[90] is a 51-year-old-man with hypertension, hyperlipidemia and a mental health disorder that experienced deterioration of vision in March 2012. He was admitted to UC Davis Hospital on 3/7/12 and diagnosed with optic neuritis[91] due to chronic inflammatory demyelinating polyneuropathy (CIDP).[92] On 3/12/12 he returned from the hospital.[93] The hospital staff recommended neurology, ophthalmology and neuro-ophthalmology follow-up.

  A provider referred the patient for follow-up to neurology on 4/16/12 and to ophthalmology on 4/19/12. We could not locate a referral for a neuro-ophthalmology consultation as recommended by the hospital staff. On 5/16/12, a neurologist evaluated the patient at UC Davis. The neurologist recommended a five-month follow-up with neurology to evaluate whether the patient needed additional therapy, such as prednisone or IVIG

[90] Specialty Care Patient #2.
[91] Optic neuritis is an inflammation of the optic nerve, the bundle of nerve fibers that transmit visual information from the eyes to the brain. Pain and vision loss are possible symptoms of optic neuritis.
[92] CIDP is a neurological disorder is caused by damage to the myelin sheath (the fatty covering that wraps around and protects nerve fibers). It is extremely uncommon and has similarities with multiple sclerosis.
[93] This was difficult to determine because the nurse's hospital return note was mislabeled in the eUHR under the title "7230 MH Interdisciplinary Progress Note."

infusions. He also recommended follow-up with a neuro-ophthalmologist, which the providers at SAC had not yet initiated.

Four months later, on 9/24/12, a provider saw the patient for a rapid decline in his vision. The patient was sent to the UC Davis emergency room and received IV steroid medication. The hospital staff discharged the patient with recommendations for IV steroids for four more days. The UC Davis discharge disposition also documented that the patient needed to return to neurology clinic on 10/10/12 and needed to have an ophthalmology appointment. On 9/26/12, a provider ordered an urgent ophthalmology consultation and a routine neurology consultation at UC Davis.

On 10/8/12, a provider saw the patient in the OHU and documented his vision was 20/200. This is legal blindness. The provider documented this examination took place in the cell and it is not clear how the patient's visual acuity was tested in a cell. Typically, these tests are performed at 20 feet, but providers can use a small card that the patient can hold a small distance from their face. However, the test needs to be conducted under adequate light, which may be inadequate in a patient cell. The provider documented that the UC Davis ophthalmologist had seen the patient and would be seen for follow-up. The provider did not comment on the neurology appointment.

On 10/10/12, seven months after the initial recommendation in March 2012, neuro-ophthalmology saw the patient. The patient's visual acuity in the left eye was 20/100 and in the right eye the visual acuity could not be measured, but the patient could count fingers from three feet away. The consultant recommended IVIG because the patient was having progressive optic neuropathy despite the recent IV steroids.

On 10/12/12, an undated urgent request for service for IVIG infusion was approved. The provider who ordered the service did not specify the dose or duration of the infusion. That same day, the patient was seen in the TTA after he had collapsed in his cell The patient had dizziness, weakness and diaphoresis. His pulse was elevated (106). A provider referred the patient to a local hospital and was treated for dehydration and autonomic instability[94] from his neurological condition.

On 10/17/12, a neurologist at UC Davis saw the patient. The neurologist recommended IVIG, an ophthalmology consultation, and a neuro-ophthalmology consultation. On 10/18/12, the OHU provider saw the patient but did not document that he reviewed the UC Davis consult of 10/10/12 or 10/17/12. The provider wrote no orders. On 10/31/12, a provider documented that the patient was waiting for a neuro-ophthalmology appointment but did not document review of the 10/10/12 hospital records or the 10/17/12 neurology visit. The provider did not acknowledge the recommendations of consultants for IVIG infusion.

[94] Autonomic instability refers to dysfunction of the autonomic nervous system, which controls functions such as heart rate and blood pressure.

On 11/14/12, a neuro-ophthalmologist at UC Davis saw the patient. The consultant documented that the patient had received a two-day course of IVIG. We could not find records documenting IVIG infusion. The neurologist had recommended five days of IVIG monthly for six months. The neuro-ophthalmologist documented that the vision was improving. The visual loss was due to demyelination. The consultant said the patient's visual prognosis was guarded and he recommended more IVIG, a six-month follow-up, and advised the patient to notify his providers of any visual changes.

On 11/15/12, a provider saw the patient and copied and pasted a note from 10/31/12. Many parts of the 11/15/12 note were identical to the 10/31/12 note, including visual acuity examinations and histories. The provider documented that the patient had seen the neuro-ophthalmologist. The provider noted she would decide whether to send the patient back to see the neuro-ophthalmologist after the patient received the IVIG infusion. There was no mention about a follow-up with neurology.

On 11/29/12, a provider saw the patient and documented a note that appeared to be almost identically copied and pasted from the prior note. In the 11/15/12 note, the provider documented that the vision on the left improved about 30% and that the visual acuity was 20/50 on the left and less than 20/200 on the right. In the 11/29/12 note, the provider wrote that the visual acuity improved about 40% and that the visual acuity measured 20/50 on the left and less than 20/200 on the right. One sentence in the 11/29/12 note included the statement, "Seen in neuro ophthal in UCD yesterday." This visit had occurred about two weeks previous but the provider copied it identically from the prior note. This copied and pasted note is not credible, and it is not clear what amount of the note was accurate. The provider did not discuss when the neurology appointment would occur or when the IVIG infusion would start.

On 12/7/12, a provider submitted a request for the patient to go to SJGH for IVIG therapy as a routine visit but added that the visit should be as soon as possible (ASAP), which is confusing. The 12/7/12 request was poorly written, as it did not include the dose or the number of infusions required. The neurologist had recommended five infusions a month for six months.

On 12/13/12 and 12/27/12, a provider saw the patient for follow-up. The provider copied and pasted most of the note, including the statements that the neuro-ophthalmologist had seen the patient the day before and that the vision on the left was improved 40%, and the visual acuity results. Again, it is not possible to know what part of the provider's notes reflected an examination, if any, that occurred on the day of the note. There was no documented follow-up regarding the IVIG infusion.

On 1/9/13, a provider in the OHU documented a mostly copy and pasted note from 12/27/12. The provider documented that the vision had improved from 40 to 50% on the left but the visual acuity examination was copied and pasted from prior notes (20/50 on the left and less than 20/200 on the right). This did not make sense.

The patient did not return to UC Davis for ophthalmology follow-up. Instead on 1/22/13, the patient was sent to an SJGH ophthalmologist. The ophthalmologist documented that the patient had permanent damage to his right eye. The ophthalmologist also documented that the patient had received IVIG infusion treatment, but, as noted above, there is no documentation in the eUHR that this had occurred. The ophthalmologist recommended follow up with ophthalmology in four months and follow up with neurology.

On 1/23/13, a provider in the OHU again used a copied and pasted note to document a patient evaluation. This note included the identical assessment of the patient's optic neuritis that noted that the patient had "received SoluMedrol for another flare up 2 weeks ago." This is inaccurate and had been repeated on prior notes as well. The provider documented no acknowledgement of the ophthalmology appointment that occurred the prior day. The provider continued to comment, as in other copied and pasted notes, that the IVIG infusion was pending.

Eventually, the patient filed a grievance that he was not getting the infusions. Although the outcome of the grievance was not in the medical record, in February, the provider documented that the grievance was reviewed, and on 2/19/13, the provider documented that she contacted the consult desk to schedule the IVIG infusion. On 3/5/13, a provider documented that the request for IVIG infusion was approved and that the scheduler was waiting for an appointment from SJGH.

On 4/22/13, a provider wrote an RFS for IVIG on a routine ASAP basis because the "inmate missed his IVIG because of unknown reasons need to get IVIG ASAP." The provider did not specify the dosage, frequency or duration of the treatment. Someone wrote "SJGH or wherever that can be done" on the request.

The requested "ASAP" IVIG infusion took approximately seven weeks to complete. The patient received 30 grams of IVIG on 6/3/13 through 6/7/13 at UC Davis. We checked with the scheduling office technician, who told us there was no pending appointment for this patient; thus, it is not clear whether the patient will receive additional IVIG infusions as recommended.

On 6/21/13, an OHU follow-up note was scanned into the eUHR as a TTA MD visit. The provider wrote:

> The patient has had several steroid injections in the past without significant improvement of the vision. He has since received IV immunoglobulin with about 40% improvement of the vision in the left eye. He is being followed by the neuro-ophthalmologist at University of California, Davis (UCD)... At the present time, the specialist recommended that the patient continue on the same management with intermittent IV immunoglobulin.

This note appears to reflect the copied and pasted assessment of a prior provider and demonstrates how copied and pasted notes can cause errors due to transmission of inaccurate information.

Assessment

This review showed that the patient did not receive timely or appropriate care for his serious medical problems that resulted in harm to the patient. It was not one episode of bad care that may have affected the patient's vision, but rather repetitive mismanagement over a year and a half. Consultants' recommendations were not carried out. Follow-up with specialists did not occur timely or if at all. The patient received a potentially vision saving medication (IVIG infusion) eight months after it was recommended, and that occurred only because the patient filed a grievance. SAC staff failed to provide the patient with the recommended six monthly cycles of IVIG; the patient only received one cycle and that was eight months late. A provider on the OHU documented using copied and pasted notes whose accuracy was questionable. This reflected absence of care. This case reflects a breakdown of specialty care and near absence of care in the OHU.

- The patient[95] is a 58-year-old man with diabetes, hypertension, anemia of unknown etiology, cervical spine arthritis and hepatitis C, who submitted a 7362 on 3/23/13 complaining of "very bad" indigestion or "gallbladder" problem. A nurse did not evaluate the patient until 3/28/13. At that time, the patient complained of abdominal pain, nausea and white colored stool. The nurse notified a provider, who ordered a stat [immediate] hepatic panel and blood count, medication for nausea, and follow-up in four days. This was not appropriate care. A physician needed to see the patient the same day. His symptoms were consistent with acute hepatitis, which requires an immediate evaluation so appropriate infection control measures can be implemented if indicated.

  On 3/29/13, blood tests revealed that that the patient's liver function tests were elevated. On 4/2/13, the provider saw the patient. The patient weighed 204 pounds, a 46-pound weight loss in 18 months.[96] The provider noted that the patient complained of two weeks of epigastric pain and vomiting. The provider sent the patient to Methodist Hospital for possible cholecystitis but the patient was subsequently diagnosed with pancreatic cancer. The patient underwent surgery to resect the tumor and the patient had several post-operative complications, including atrial fibrillation and gastrointestinal infection. On 5/11/13, the patient was transferred to SJGH to establish a chemotherapy/radiation plan. On 5/15/13, the patient was discharged back to SAC. The SJGH discharge summary noted that on 5/25/13, the patient was scheduled for follow up with oncology for evaluation for adjuvant chemotherapy and radiation, and with the surgeon in two weeks. Upon his return to SAC, a provider admitted the patient to the OHU. The OHU provider noted that an oncology appointment had been scheduled. He did not address the recommendation for follow up with the surgeon. The provider did not write an order or submit a request for a

[95] Specialty Care Patient #3.
[96] On 9/23/11, at a chronic care visit, the patient weighed 250 pounds.

follow-up appointment and the patient was not taken to either his oncology or surgery appointments.

On 5/31/13, a provider ordered an urgent oncology evaluation, a routine radiation oncology evaluation, and routine surgery follow-up evaluation. These were approved the same day.

On 6/12/13, an oncologist at SJGH evaluated the patient. The oncologist noted that the patient would need adjuvant chemotherapy followed by radiation therapy and then another course of chemotherapy. He further noted that the patient needed to be clear of all infections prior to beginning chemotherapy. The oncologist further stated that the patient needed a Port-a-Cath[97] and a radiation oncology evaluation prior to the initiation of chemotherapy. The oncologist recommended follow-up in oncology clinic in 2-3 weeks and added, "Please follow this recommendation."

On 6/13/13, a provider saw the patient and noted the oncology recommendations, but did not order a Port-a-Cath and did not refer the patient to oncology and radiation therapy.

On 6/20/13, the surgeon who had performed the original surgery saw the patient for follow-up. She noted that the patient's wound was well-healed and that he was ready to start chemotherapy.

On 6/21/13, an OHU provider evaluated the patient and noted that the patient had seen the oncologist. He documented that the patient “might need also radiation therapy.” Radiation therapy was a clear recommendation. The provider did not document his plan to find out whether the patient required radiation therapy.[98]

On 6/25/13, the patient returned to the oncologist, who noted that radiation oncology and surgery[99] had not yet seen the patient. The oncologist requested another appointment in 2-3 weeks. On the same day, 6/25/13, a SAC provider ordered a routine radiation oncology consultation. On 6/27/13, a provider ordered an urgent oncology consultation that was approved the same day.

On 7/3/13, a provider submitted a surgery RFS for placement of the Port-a-Cath within 30 days. This was approved and scheduled for 7/29/13; however, the surgery was rescheduled for 8/14/13 because the patient had eaten prior to surgery. Chemotherapy started on 8/23/13, over three months after his discharge from the hospital.

Since SJGH does not have a radiation oncology service, a radiation oncology service had to be located. It took a considerable amount of time for scheduling staff to find a radiation oncologist. Schedulers finally arranged for radiation oncology at St. Joseph Hospital in

[97] A Port-a-Cath is a device for intravenous access in patients who require frequent or continuous administration of intravenous substances.
[98] This note was scanned as a TTA note.
[99] The surgery consultation was for placement of the Port-a-Cath.

Stockton. A provider had referred the patient for radiation oncology on 5/31/13. The first radiation oncology appointment was on 10/1/13, approximately four months from the time the oncologist first recommended the appointment. The radiation oncologist recommended daily treatments for five weeks, meaning that the patient would be shackled in transit for over two hours of travel a day to receive treatment.

Assessment

The patient did not receive timely care for his serous medical problem.

- The patient[100] is a 52-year-old man with glaucoma. On 5/17/12, an ophthalmologist saw the patient and recommended follow-up in three months. On 2/22/13, nine months later, a provider saw the patient for chronic care and noted that the recommended follow-up had not occurred. He wrote an order for the patient to be seen by the in-house ophthalmologist. On 8/5/13, the provider saw the patient for chronic care noting there was documentation in the eUHR that ophthalmology saw the patient in May but that the patient denied having seen the ophthalmologist. (We could not find any documentation of an ophthalmology visit in May 2013.) The provider further stated, "Either way, he needed to return to ophthalmology for a recheck because the last time when he was seen in ophthalmology by May [sic], ophthalmology recommended a three month follow-up." The provider submitted a request for services, noting that ophthalmology had last seen the patient on 5/17/12. On 9/24/13, an SJGH ophthalmologist saw the patient and recommended visual field testing and other tests. On 10/7/13, the primary care provider saw the patent for follow up of the 9/24/13 ophthalmology visit. The provider noted that because it took an hour and a half to go to the ophthalmologist, the patient refused to return to the ophthalmologist.

  Assessment

  There were problems related to timeliness of care and provider follow-up of specialty visits. On 5/17/12, an ophthalmologist recommended follow up for the patient's glaucoma in three months, but ophthalmology did not see the patient for almost 15 months. We note that the patient is refusing follow-up for his advanced glaucoma, in part due to the lengthy travel from SAC to SJGH.

- The patient[101] is a 61-year-old man with recently diagnosed kidney cancer. On 5/16/13, the patient had a chest x-ray for a chronic cough that revealed a lung mass. On 5/20/13, a provider saw the patient and ordered an urgent chest CT scan and follow-up in 14 days. On 6/3/13, the CT scan revealed possible lung malignancy and a large kidney mass. Two weeks later, on 6/19/13, the provider saw the patient for follow-up. At that time, he ordered an urgent CT scan of the abdomen and pelvis. On 7/5/13, the CT scan revealed a high possibility of kidney cancer. Ten days later, on 7/16/13, the provider saw the patient for follow-up, noting he would refer the patient to a urologist for surgery. On 7/24/13, another physician saw the patient and noted that the previous provider had not submitted an order

[100] Specialty Care Patient #5.
[101] Specialty Care Patient #7.

for the urology consult. He submitted an urgent referral that day. On 8/1/13, the urologist saw the patient and recommended a PET scan of the chest to rule out potential metastases and a 3-week return visit. On 8/6/13, a provider submitted urgent referrals for urology and a PET scan.

On 8/10/13, the patient was admitted to the OHU. On 8/15/13, the PET scan revealed a metastatic lung lesion. On 8/20/13, a provider noted the patient was anemic and was sent to SJGH for blood transfusion. On 8/26/13, a provider referred the patient to oncology urgently. There was no accompanying progress note related to this referral; however, on 9/6/13, a provider documented that the urologist had requested that oncology evaluate the patient prior to seeing him again.

On 9/5/13, the patient transferred from the OHU to the CTC. On 9/20/13, the oncologist saw the patient, noting the patient had a very poor prognosis and that his overall condition was deteriorating rapidly. He further noted that the patient wanted to go for all the treatment options. The oncologist recommended a bone scan or PET scan of the whole body as soon as possible and a CT scan of the brain to look for metastatic lesions. He added that given the appearance of the patient, everything should be done within the next week, and that if that could not be done as an outpatient, the patient needed to be admitted to the hospital. He also recommended evaluation by a urologist and a cardiothoracic surgeon for possible surgical excision of the lesions. On 9/27/13, the OHU provider noted that he had consulted with the oncology team and that they wanted the patient to be seen by urology to evaluate for possible surgery and after the surgery to get a CT scan of the brain and, if needed, radiation versus hospice care. On 10/9/13, the patient decided he only wanted comfort care.

Assessment

While the overall care for the patient was adequate, there were several problems we found that are similar to those found in other records. In two instances, follow-up of urgent tests (the 6/3/13 and 7/5/13 CT scans) did not occur in a timely manner. In addition, on 7/16/13, the provider failed to submit the necessary paperwork for the urology consult he stated he would order. Luckily, another provider caught the error in a timely manner.

- The patient[102] is a 35-year-old man referred to the neurosurgeon urgently on 8/19/13 for evaluation of severe back pain. On 9/3/13, the neurosurgeon saw the patient and recommended physical therapy and follow-up with him after therapy. On 9/9/13, the provider saw the patient for follow-up of the consult and submitted a request for physical therapy. Review of the eUHR revealed that while the provider wrote an order for physical therapy on the order sheet, there was no RFS l form in the eUHR. On 10/4/13, the provider submitted an urgent request for physical therapy. On 10/10/13 the physical therapist saw the patient.

[102] Specialty Care Patient #8.

Assessment
While the patient likely did not suffer harm from the delay in initiation of physical therapy, a provider failed to submit the paperwork for the service he was ordering.

- The patient[103] is a 54-year-old man with an 18-month history of GI and anorectal complaints referred urgently to a general surgeon on 8/15/13 for evaluation of an anal mass. On 8/29/13, the surgeon saw the patient but the surgeon's report is not in the eUHR. However, on the RFS, staff documented that the surgeon recommended referral to a gastroenterologist for esophagogastroduodenoscopy (EGD) and colonoscopy. On 9/5/13, the provider saw the patient for follow-up of this visit and wrote an order for the recommended studies but did not complete an RFS. On 9/26 and 9/27/13, the provider submitted the RFS for the EGD and colonoscopy, respectively. The colonoscopy was performed on 12/20/13.[104]

  Assessment
  There was a problem related to timeliness of care. The provider did not implement the surgeon's recommendation for EGD and colonoscopy because of a 30-day delay in submission of the paperwork. In addition, once approved, the procedures were not scheduled timely.

- The patient[105] is a 38-year-old man with significant heart disease. On 8/5/13, a UC Davis cardiologist saw the patient for follow-up of a recent hospitalization. In his report, the cardiologist noted he would "have some contact with you in regards to further evaluation given his severe right ventricular dysfunction; it might be worthwhile to proceed with right heart catheterization…" He added that he would contact the SAC provider by telephone within the next day or two, but there is no documentation in the eUHR that this occurred. On 8/9/13, a provider saw the patient for follow-up of the consult and noted that the records were not available. On 9/23/13, a provider saw the patient and reviewed the cardiology report. He did not address the cardiologist's recommendation regarding telephone communication. On 10/3/13, another cardiologist saw the patient for evaluation of his pacemaker. On 10/28/13, the patient transferred to MCSP. There is no documentation that a SAC provider contacted the cardiologist prior to the transfer regarding the possible catheterization.

  Assessment
  The patient did not receive appropriate follow-up of his cardiology consultation.

- The patient[106] is a 37-year-old man. On 6/10/13, a provider urgently referred him to the orthopedic surgeon for evaluation of a hand fracture. On 6/20/13, the surgeon saw the

[103] Specialty Care Patient #9.
[104] There are other issues involved in this case. See Intrasystem Transfer/Sick Call Patient #18 discussed in the Access to Care section of this report.
[105] Specialty Care Patient #10.
[106] Specialty Care Patient #12.

patient and noted in his dictated report that he scheduled the patient for surgery on 6/26/13. The dictated report was transcribed on 6/20/13, but health records staff did not date stamp the report indicating when it was received, and a provider has not signed and dated the report indicating when it was reviewed. On 6/21/13, the provider saw the patient for follow-up of this visit, but only had a copy of the surgeon's hand written note, which did not specify a date for the surgery. On 7/3/13, the provider saw the patient for follow-up and reviewed the orthopedists' dictated note, but the date for the surgery had already passed. On 7/10/13, health records staff scanned the 6/20/12 orthopedic report into the eUHR. The patient ultimately had the surgery on 7/24/13. The patient received appropriate postoperative care.

Assessment

There was a problem related to timeliness of care due to the lack of timely access and review of consultant reports. While the patient suffered no long-term harm, the case is concerning because it reflects problems noted in other cases with lack of appropriate follow-up and delays in care.

- The patient[107] is a 42-year-old man referred to the UC Davis ophthalmologist on 6/12/13 for emergent evaluation of an eye injury sustained during an altercation. The ophthalmologist diagnosed traumatic iritis and a subconjuntival hemorrhage. He ordered medications and follow-up on 6/18/13. At the scheduled follow-up, the ophthalmologist adjusted the patient's medication and ordered follow-up again on 6/27/13. On 6/27/13, the ophthalmologist again adjusted the patient's medication and ordered follow-up in two weeks, with intraocular pressure checks and gonioscopy.[108] When the patient returned to SAC, the TTA nurse noted that the patient needed to see the primary care provider in five days and follow-up with the ophthalmologist in two weeks. The nurse obtained a verbal order for the new medications. The provider did not see the patient for follow-up, and the follow-up appointment with the ophthalmologist was not scheduled. The provider saw the patient for chronic care on 8/1/13. He noted the 6/27/13 UC Davis ophthalmology recommendation to see the patient back in two weeks. Provider stated, "However, that appointment has never been scheduled somehow…" The provider ordered an ophthalmology consult. On 8/8/13, the ophthalmologist noted that the patient's problem had resolved.

  Assessment

  There were problems related to timeliness of care and lack of appropriate follow-up with the SAC provider. While the patient suffered no harm, the case is concerning because it reflects problems noted in other cases with lack of appropriate follow-up and delays in care.

[107] Specialty Care Patient #13.
[108] Intraocular pressure checks and gonioscopy are tests that are used in diagnosing and monitoring glaucoma.

Outpatient Housing Unit Care (OHU)

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

Findings: SAC is an intermediate facility. By definition[109], intermediate designations require ability for short and long-term placements into OHU and CTC units. SAC has insufficient CTC beds to carry an intermediate designation based on current arrangements. SAC has two CTC units; one unit containing 11 beds is dedicated solely to mental health. Another CTC has 15 beds, but only two of these are dedicated to medical. This is an insufficient number of CTC beds for a facility this size. Since SAC does not have sufficient medical CTC beds, the 20-bed OHU unit is used as a CTC. However, since the OHU is a converted Ad-Seg unit, it would probably not satisfy Title 22 requirements for a CTC.

Staff reported that patients with higher-acuity medical conditions do not always have access to a higher level of care because CTC and OHU beds are usually filled. During our tour, all CTC beds were occupied, and 13 of 20 OHU beds were occupied. One patient in the OHU had an acute medical problem (recent cellulitis) and two patients had acute surgical problems (recent jaw fractures). The remaining 10 patients had chronic medical conditions. Seven of these 10 patients had significant long-term high-acuity problems. Their care was disjointed and inadequate due to lack of adequate and timey evaluations, missed specialty appointments and serious deficiencies in provider documentation.

This facility has a large population of level 4 mental health patients, as well as problem patients with behavior disorders. Several patients on the OHU unit were habitually refusing care. Others were in contentious relations with provider staff regarding their care. Two patients on the unit had filed grievances for lack of care. In both cases, they had not received appropriate care and their grievances were sustained. Medical leadership needs to collaborate with mental health leadership to develop a training program on professional communication and management of patients at this facility.

There is an examination room adjacent to the OHU, but there is no examination room on the unit. Physicians evaluate patients in their cells and leave the unit to document their notes. This is not optimal. Nurses also do not have access to treatment room in which to perform patient assessments and treatments such as dressing changes. Staff reported that that nurses perform patient treatments in patient cells where lighting is poor. This impairs the nurse's ability to perform an adequate evaluation and provide adequate treatment. If this OHU will be used in lieu of a CTC, it needs to be rehabilitated under the HCFIP so it is appropriately configured for higher-level care.

It was difficult to evaluate physician practice on this unit because documentation of patient care was extremely poor. Documentation is so poor as to render care on this unit inadequate. Providers on this unit have a practice of copying and pasting notes from one visit to another.

[109] Appendix II, California Prison Health Care Services Institutional Medical Groupings, policy Volume 4, Chapter 29.

We illustrate this in several case reviews. This practice results in transmission of inaccurate information from visit to visit, and lack of reliability of the eUHR. For some patient records reviewed, we do not believe that the provider performed the evaluation documented in the eUHR. If providers' clinical evaluation is unreliable, this places patients at risk of harm. CCHCS and SAC health care leadership should stop this practice immediately.

SAC did not have an OHU local operating procedure available for review. SAC needs to develop a procedure for this unit.

The following cases illustrate the previous comments.

- This is a 63-year-old man[110] with hypertension, chronic kidney disease, hepatitis C, chronic obstructive lung disease, hyperlipidemia, migraine headaches, low platelets and mental health conditions. He also uses continuous oxygen therapy. He has been on the OHU for an extended period. On 4/7/11 and 4/17/11, his weight was documented as 208 and 205 pounds, respectively.

  On 10/11/12, a provider saw the patient for chronic care. There is a copied and pasted history stating: "No complaints. Denied CP, has SOB at baseline, denied N/V, abdominal pain, bladder, bowel complaints, bloody stools, black stools, headaches improved, no weakness, numbness. Denied fevers, chills, wt. loss."

  On 10/25/12 and 11/8/12, the provider documented the identical history. On 11/20/12, the history was modified slightly to include that the migraines were "intermittently far better on Topamax. In the last 2 weeks he had 5 episodes."

  On 12/3/12, a pulmonologist saw the patient and documented that the patient had advanced COPD and had been losing weight with decreased appetite. The pulmonologist noted that the patient had some "tumor markers" done, which were normal. The pulmonologist recommended a CT scan of the chest with a gastrografin swallow[111] to rule out an esophageal stricture. The RFS for the procedure noted that the patient had a 20-pound weight loss.

  On 12/4/12, a provider documented a note with the same copied and pasted history documenting no weight loss even though the pulmonologist documented that the patient had weight loss. The 12/4/12 history did not contain information documented by the pulmonologist but did note that the patient had seen a pulmonologist by telemedicine the previous day. The provider did not discuss or document the pulmonologist's recommendations.

[110] OHU patient #1.
[111] An x-ray study of the esophagus and stomach using contrast material that the patient swallows.

On 12/6/12, a provider placed an urgent request for a chest CT that was approved. On 12/17/12, a technologist documented that the CT scan was not performed because the patient ate and contrast could not be given.

On 12/18/12, the provider typed a note using the same copied and pasted history that included the statement that the patient had no weight loss despite just having had a CT of the chest ordered with gastrografin to rule out esophageal stricture for weight loss. The provider made no mention of the pulmonologist consultation or failed CT scan.

On 12/31/12, a provider entered another note including the same copied and pasted history, including the part about the patient not having weight loss. The physical examination did not include a weight. On 1/7/13, a local hospital performed a barium swallow (barium is often used in place of gastrografin) and noted a sliding hiatal hernia[112].

On 1/7/13, the report was transcribed, but the copy in the eUHR was not signed as reviewed. The provider ordered a gastrografin swallow, but the hospital used barium instead because they said it was a better contrast agent.

On 1/8/13, a provider saw the patient and documented that the patient had no new complaints. In provider notes from October 2012 to January 2013, there was no history of the patient's weight loss. The only history was the copied and pasted note stating that the patient had no weight loss. The 1/8/13 provider note documented that the patient had a barium swallow and results were pending. The provider also noted the CT scan was requested but the reason for ordering the CT scan was not documented. The notes do not accurately reflect the clinical problems of the patient.

On 1/10/13, a provider saw the patient and again used the identical copied and pasted history including the statement that the patient denied weight loss, even though the patient was undergoing an evaluation for 20-pound weight loss. In addition, the provider history included the statement, "In the last 2 weeks he had 5 episodes," referring to migraines. This statement about the number of migraines was identical to notes written on 12/31/12, 12/18/12, 12/4/12 and 11/20/12. In the assessment part of this note, the provider documented, "Got barium swallow study as part of dysphagia and weight loss work up, pending results."

The provider apparently did not notice the contradiction between the history documenting no weight loss and the assessment documenting a workup for weight loss.

On 1/16/13, the provider saw the patient again and documented the identical history. The provider documented that the results of the barium swallow were pending, even though on 1/7/13 the barium swallow report had been transcribed.

[112] A condition wherein the esophagus and stomach slide into the chest cavity through an opening in the diaphragm.

On 1/31/13, a provider saw the patient and, with minor revisions, the same history was copied and pasted. The provider again documented that the barium swallow results were still pending. Up to this date, providers had not documented weight loss as a problem in the provider assessment and plan. On 2/14/13, a provider saw the patient and documented the identical history from 1/31/13. At this visit, the provider noted the results of the barium swallow, about five weeks after the test. The provider also noted that the CT scan was cancelled and was being rescheduled.

On 2/25/13, the pulmonologist evaluated the patient. On a handwritten telemedicine note for this visit, separately scanned into the eUHR, a nurse documented the weight as 161 pounds. This would have indicated a weight loss of about 40 pounds. The pulmonologist noted the patient had abdominal pain and weight loss, as well as noting the results of a recently completed esophagram as part of a weight loss evaluation. The pulmonologist also noted that the CT scan of the chest he had requested had not been completed. He suggested a GI referral for evaluation of abdominal pain and weight loss. His plan was to see the patient again in two months with the result of the CT scan.

On 2/27/13, the provider saw the patient and used the same copied and pasted note documenting that the patient had no weight loss despite writing in the assessment under COPD that the patient had a barium swallow as part of a weight loss workup. The provider did not acknowledge the pulmonologist's note of 2/25/13 and did not note the recommendation for a gastroenterologist workup.

On 3/7/13, an abdominal CT scan was normal except for a cyst on the dome of the liver. A provider did not date and sign this report indicating that the provider reviewed the report. On 3/8/13, a provider saw the patient for follow up of the CT scan, documenting a handwritten note. The provider documented in the assessment that the patient had a 30-pound weight loss. This was the first SAC provider to document weight loss in the assessment and as a problem. This occurred three months after the pulmonologist noted the patient's weight loss. The provider noted the CT scan was normal. The provider did not order a gastrointestinal workup or describe a differential diagnosis for the weight loss.

On 3/13/13, a provider saw the patient and documented a slightly modified history from the copied and pasted version that included the statement of the patient denying weight loss. The provider noted that the patient saw the pulmonary consultant and noted the CT scan results. However, weight loss was not included as a problem and the pulmonologist's recommendation for a gastroenterology workup was not acknowledged or addressed.

On 3/19/13, a provider saw the patient and documented a handwritten note. The provider acknowledged the weight loss, noted the previous normal tests and ordered a colonoscopy and a CT of the abdomen and pelvis. On 3/26/13, a blood count showed a mild anemia. On 3/27/13, a provider saw the patient and used the same copied and pasted history documenting no weight loss. The problem list and assessment was also cut and pasted from

a prior note and did not include weight loss as a problem or acknowledge the workup initiated by the provider on 3/19/13.

On 4/4/13, a gastroenterologist saw the patient and documented that the patient had lost 40 pounds in six months and for the prior month was having dysphagia[113] to solids with nausea and vomiting. The consultant recommended an upper endoscopy and colonoscopy. He noted the patient was at high risk from conscious sedation and recommended a consultation with anesthesia. The history of dysphagia, nausea and vomiting was not present in any of the histories of the providers at SAC.

On 4/5/13, a provider saw the patient and documented a note with a slightly different version of the copied and pasted history. This history did not include reference to the gastroenterologist's note or include a history of dysphagia, nausea or vomiting. Ironically, the provider did not include weight loss as a problem in the assessment but documented that the patient had seen a gastroenterologist who had recommended endoscopy and colonoscopy for evaluation of weight loss.

On 5/9/13, the patient underwent endoscopy and colonoscopy under sedation. He sustained a perforated colon that was surgically repaired. No lesions were detected on either study.

Assessment

The clinical reason for the patient's severe weight loss has not yet been established. The provider copied and pasted notes makes the eUHR unreliable to accurately follow care for this patient. Specialty consultants were the primary sources of information and drivers of care decisions. The providers were passive in managing a patient, as reflected, in part, by the poor quality of medical record documentation.

- Another case[114] involved a patient with a history of gastric polyps that were resected in 1986. He subsequently had surgery to relieve symptoms of gastrointestinal reflux disease but without relief. The patient continued to have mild reflux esophagitis.

  We could not determine the patient's exact condition from review of the eUHR. This patient was admitted to the CTC from 8/11/10 until 7/5/12. There were 43 separate PDF files in the eUHR containing 3889 pages representing the medical care provided on the CTC. None of the PDF files were labeled other than with the name "CTC." It would be unreasonable to expect clinicians to pore through almost 4000 pages of PDF records attempting to find notes related to care to yield a summary of care for the patient. However, a provider should have done this at least once to summarize the patient's medical conditions and treatment plan so that the information would be available to other health care providers. This problem should be corrected with an electronic health record.

[113] Difficulty swallowing.
[114] OHU patient #4.

On 8/16/11, a surgeon saw the patient and recommended a CT of the abdomen and pelvis, a barium swallow, a helicobacter pylori test and a follow-up appointment when the tests were completed. After completion of the tests, on 1/30/12, the patient signed a refusal to see the surgeon, telling the nurse, "I don't do last minute things." A provider did not see the patient again until 5/4/12. The provider said the patient refused to talk to him and to be examined. The patient wanted pain medication for his migraine headaches and threatened to sue the provider. The provider summarized the problems and rescheduled an appointment for two weeks.

On 5/30/12, a provider documented that the patient had prior Barrett's esophagus, which is a precursor to esophageal cancer. This condition is not documented on the patient's problem list and is not addressed in progress notes in the eUHR.

On 7/5/12, the patient transferred to MCSP, where he remained until 7/10/12. On 7/10/12, the patient transferred to High Desert State Prison (HDSP) "due to bed changes at CSP-SAC." The initial history at HDSP included assessments of chronic dumping syndrome[115], hepatitis C, increased blood pressure not treated, and a history of prior nephrectomy. On 7/16/12 an occult blood test was reported as positive. On 7/26/12, the patient transferred back to SAC.

On 7/26/12, the patient transferred back to SAC, the nurse completed a 7277 form that included his history of dumping syndrome, refractory GERD and Hepatitis C infection. The transfer intake history and physical documented his prior surgical history prior but did not indicate why the operations were done. The problems were listed as dumping syndrome, migraines, GERD and GI bleed.

On 7/27/12, the patient was admitted to the OHU because he required a hospital bed under a court order so the head of his bed could be elevated. A provider performed a history and physical examination and described a history of refractory GERD with partial gastrectomy for a benign gastric tumor. This differed from the prior provider note of 5/30/12 in which a provider documented prior history of Barrett's esophagus. Barrett's esophagus may require surveillance depending on the status; a resected benign gastric tumor does not. The provider did not assess the patient's pain even though the patient was on 180 mg of morphine a day. Providers told us that this patient had won a court settlement that included pain management. The result was that providers prescribed high doses of morphine to the patient without performing any pain assessments. This is not medically appropriate and indicates a lack of clinical oversight.

On 8/10/12, a provider saw the patient and documented refractory GERD and hepatitis C as problems. The provider noted that the patient refused a previously offered upper endoscopy and wanted medical management instead of further surgery. The Barrett's esophagus was not mentioned.

[115] A group of symptoms, including abdominal cramps, nausea, and diarrhea that are likely to develop if all or part of the stomach is removed. They result from food moving too rapidly from the stomach to the small bowel.

Providers continued to evaluate the patient about once every month while on the OHU and mostly documented hepatitis C, migraines and refractory GERD as problems. Barrett's esophagus was not mentioned. The patient continued to receive 180 mg of morphine a day without having evaluations of his pain.

On 10/4/12, a new provider began seeing the patient on the OHU. This provider typed his notes. This provider's history consisted of the following:

> No complaints. Denied CP, SOB, N/V, abdominal pain, bladder, bowel complaints, bloody stools, black stools, headaches, +weakness at base line, +numbness on right side, Denied fever, chills, wt. loss.

The assessment of this provider was refractory GERD, chronic pain from adhesions, hepatitis C, knee pain and migraines. However, the history was unrelated to the patient's problem list. The provider did not mention Barrett's esophagus or address whether surveillance was indicated. The provider did not appropriately address the patient's pain with respect to the morphine. The assessment on this point was, "Chronic pain from adhesions related to prior surgeries; on huge doses of narcotics. Pt. is aware of risks, complications involved in this." Although the provider documented "no complaints" and no abdominal pain on the typed note history, the patient was ostensibly on 180 mg of morphine for chronic abdominal pain. This does not make sense.

From 10/4/12 to 12/13/12, a provider saw the patient six times and the history and assessment were with minor variations, almost identical copied and pasted notes. The same assessment of pain occurred throughout these notes, indicating that there was no new assessment of the patient's pain syndrome.

On 1/8/13, a provider attempted to evaluate the patient but the patient refused so the provider documented an assessment that was nearly identical to previous notes. The assessment under hepatitis C was identical to the assessment on 12/27/12, which stated:

> Has elevated transaminases. He got liver biopsy in 1995 and in 2001. Reviewed the treatment options, complications and cure rate. Initially, he said, he will think about it, now he requests more time to think about it. Referred to Hep C clinic. NP [name be redacted for privacy] saw him. Inmate reported he does not want treatment now.

The provider repeated this same copied and pasted assessment four times after 11/15/12. One can only conjecture whether the nurse practitioner saw the patient repeatedly and whether the provider asked the patient at each visit whether the patient wanted treatment for his hepatitis C. With minor variations, these copied and pasted notes continued. On 1/21/13, the patient had chills and cough but refused vital signs. On 1/22/13, a provider was scheduled to see the patient, who had a fever of 101.3°F. The provider documented that the patient refused evaluation. Nevertheless, the provider ordered a chest x-ray, which

the patient refused but then said he would do the following day. Despite not having evaluated the patient, the provider's assessment and plan were mostly copied and pasted from prior notes.

On 1/23/13, the x-ray showed the patient had left lower lobe pneumonia. The radiologist dictated the report on 1/25/13 and on 1/28/13; a provider reviewed and signed the x-ray report. The provider did not evaluate or treat the patient following review of the x-ray report. On 1/29/13, the provider ordered a metabolic panel and a blood count, but there was no clinical evaluation or note associated with the order. On 1/30/13, the blood count showed a normal white blood count but a mild anemia. The provider did not follow up on either of these tests.

On 2/5/13, a provider saw the patient. The history was copied and pasted but modified to say: "Headaches better, denied CP, SOB, N/V, abdominal pain, bladder, bowel complaints, bloody stools, and black stools. Denied weakness and numbness. Denied fevers, chills, wt. loss."

The assessment and plan were also copied and pasted but included a line that stated, "Abnormal CXR, with LLL infiltrate, Pt. has no sxs (symptoms). Will repeat CXR today." Basically, the patient had untreated pneumonia and it appeared to be resolving. The repeat chest x-ray showed diminished left lobe pneumonia. Fortunately, this patient's pneumonia resolved without treatment, but the failure follow up on the abnormal chest x-ray for 2 weeks was an extreme departure from the standard of care and placed the patient at risk of harm.

The providers' copied and pasted notes regarding migraines also caused confusion. The assessment for this was "On triptain, refused propranolol, added Topamax." Providers repeated this identical statement eight times from 11/15/12 to 3/19/13.

Due to the copied and pasted notes, it is not possible to determine the course of the clinical care of this patient over a six-month period. Obviously, the provider did not add Topamax on eight separate occasions.

Assessment

This patient's care demonstrates the problems with using copied and pasted notes. The documentation of the patient's actual prior history was not clear in the existing eUHR. The documentation in the eUHR does not verify that the provider actually provided care to the patient. The patient had fever and an abnormal chest x-ray. Provider notes do not reflect knowledge of the patient having a fever, and a provider did not evaluate the patient following the abnormal chest x-ray for 2 weeks. CCHCS and local health care leadership need to evaluate practices and quality of care on this unit, and, as noted above, prohibit providers from copying and pasting clinical evaluations.

- Another case[116] involves a patient with depression. No medical conditions were documented in the problem list.

  On 8/20/13, emergency responders evaluated the patient and documented the patient's complaint as dehydration and right lower leg pain. The patient was febrile (temperature= 102.5°F) and tachycardic (pulse=143/minute). The nurse evaluating the patient noted that the patient had a history of hypertension but was not on treatment; hyperlipidemia; and GERD. The nurse's note was not clear about communication with a provider, but the nurse obtained orders to send the patient to the hospital.

  On 8/26/13, the patient was discharged from the hospital with diagnoses of sepsis secondary to cellulitis (deep vein thrombosis was ruled out), hypertension, hyperlipidemia, GERD and a mental health disorder. His discharge medications included ciprofloxacin, clindamycin and multiple psychotropics. At 3:30 p.m. on 8/26/13, a nurse documented a provider telephone order for ciprofloxacin and clindamycin for five days. At about 10 p.m. on 8/26/13 a nurse in the TTA evaluated the patient upon return from the hospital. The medication administration records scanned to the eUHR indicate that the patient received the newly ordered medications the evening of 8/27/13. The patient was apparently sent back to the EOP unit where he had been housed.

  On 9/4/13, a provider saw the patient for the first time following hospitalization, over a week after his return to SAC. The provider noted that the patient had worsening of lower leg edema. The leg was "markedly" swollen, red and warm. The patient's pulse was rapid (118). The physician sent the patient back to the hospital. This patient should have been referred to a monitored unit after hospitalization or followed at a shorter interval, but instead was not seen for a week.

  On 9/6/13, the patient was discharged from the hospital. Blood cultures were negative and a CT scan did not demonstrate an abscess. A PICC line was placed in the hospital and intravenous Vancomycin was started with a recommendation to continue it for five days at the prison. On 9/7/13, an OHU provider saw the patient on the unit. The provider documented a reasonable evaluation and ordered the Vancomycin as recommended. A Vancomycin level was initially low, and the dose was increased. A follow-up level was adequate. On 9/12/13, nurses removed the PICC line.

  Almost two weeks later, on 9/19/13, a provider evaluated the patient. The patient still had edema of the leg. As of our visit the week of October 7, 2013, the patient remained on the OHU. A provider had not seen the patient since 9/19/13.

  <u>Assessment</u>
  The patient did not receive appropriate care following his hospitalizations. The patient was admitted to the OHU for cellulitis and had only two provider evaluations from 9/6/13 to

[116] OHU Patient #2.

10/7/13, despite being on intravenous antibiotics. Even though it appears that the patient's infection was resolving, the time interval between evaluations was too long and is not appropriate standard of care for follow-up of an acute infection.

Mortality Review

Methodology: There were five deaths in 2012 and six deaths in 2013. Of these 11 deaths, one patient died of a ruptured aneurysm during our visit, one patient died of rectal cancer, one patient died of scleroderma (an uncommon disease of connective tissue), and another patient died of a drug overdose.

All remaining seven deaths involved persons with serious mental illness or involved a death with mental illness as a complicating condition. Two of these seven patients died of suicide. In one of the suicides, the CCHCS review concluded that lack of communication between medical and mental health staff was a contributing factor in his suicide.[117]

One patient was murdered. However, mental health staff at Salinas Valley State Prison noted he was a vulnerable patient and at high risk of abuse in part due to his mental illness. When he transferred to SAC, he was housed in a level 4 administrative high security unit with another inmate who murdered him. Mental health leadership did not collaborate on this mortality review. Whether he was properly housed was not identified as an issue in his death. His death was described as not preventable. However, a mental health evaluation of his housing relative to his vulnerable status might determine this was a preventable death. Mental health staff needed to routinely participate in mortality review.

Another patient, whose case is reviewed below, had hyponatremia from psychogenic polydipsia that was not included in the transfer summary. The failure to include this in the transfer summary resulted in failure to identify the problem. The patient died from this problem. Mental health staff needed to participate in this mortality review.

Another patient with serious mental health and behavior problems continuously refused treatment and experienced sudden death. Refusals of care are common in this complex population of patients with mental illness and behavioral disorders. We question whether there is effective communication with this difficult population of persons with mental illness regarding refusals of care. The Quality Management Committee should use this case to perform a root cause analysis of communication with this difficult population. This death was reported as not preventable. However, in the Combined Death Reviews presented to us, mental health management did not participate in the mortality review. Combined mental health and medical management might have improved the patient's compliance with therapy. As noted above, since this facility has a large mental health population, the mortality review committee needs to include a representative of the mental health program. This has not been done, even when mental health issues were a major factor in the patient's death.

[117] Mortality Review #4.

In three cases, there was either delayed detection that the patient was dead, as evidenced by the patient's body being cold and/or failure to initiate CPR in a timely manner.[118] Two of the three cases were PSU patients.

We reviewed two deaths, one involving hyponatremia and one case involving a PSU patient whose death was questionable and warrants further investigation.

- The first case[119] involved a patient who had a problem list that documented schizophrenia, chronic hepatitis C and thrombocytopenia. This patient had other medical conditions, such as hypertension and hypothyroidism that providers did not document on the problem list. The lack of a consistent problem list and summary of problems remains a persistent problem within CCHCS facilities. He also had a history of psychogenic polydipsia and hyponatremia. Polydipsia is a condition of excessive water ingestion. Psychogenic polydipsia is a condition usually affecting patients with mental health disorders. Mental health patients are often treated with drugs (e.g., chlorpromazine) which cause dry mouth. Patients may increase fluid intake to alter the sensation of dry mouth. They may drink excessive fluids because of their mental health condition.

  At the time of his death, this patient was on the following medications: chlorpromazine, olanzapine, venlafaxine, risperidone, hydroxyzine, levothyroxine, divalproex, docusate, acetaminophen and diphenhydramine.

  This patient was at the Department of Mental Health (DMH) at CMF for suicide intentions and schizophrenia beginning in May 2012 until he transferred to SAC on 1/25/13. During the first month at CMF, the patient was on a mental health crisis unit. While on that unit, on 5/19/12, the patient had hyponatremia (low serum sodium) from polydipsia. Hyponatremia can be life threatening.

  The discharge summary from the DMH to SAC included a medical history of hypertension, hypothyroidism and hepatitis C. On the fourth page of the 33-page discharge summary, it was noted that, as late as 12/22/12, the patient had hyponatremia with a sodium as low as 125 mEq/L (normal range=135-145 mEq/L) and needed water restriction. This was not included in the summary of his medical conditions. This is a system defect. The medical conditions in the discharge summary did not document the patient's psychogenic polydipsia and hyponatremia. Because of staff failure to identify the problem, the patient engaged in unrecognized polydipsia resulting in hyponatremia resulting in the patient's death.

  On 1/25/13, the day of transfer, nurses at SAC documented that the patient had schizophrenia, hypertension, hypothyroidism, and hepatitis C, but did not document that the patient had psychogenic polydipsia. The first mental health progress note did not document psychogenic polydipsia. This was a serious lapse in transfer of this patient.

[118] Mortality Review Patients #1, #2, #3.
[119] Mortality Review Patient #1.

On 1/31/13, a provider saw the patient for chronic care follow up. The patient was not on medication for either hypothyroidism or hypertension. The patient's blood pressure was normal. The provider took minimal history, did not document review of the old record and performed an examination. The provider ordered a TSH test and scheduled a 3-6 month follow-up.

On 2/12/13, custody notified a provider to respond to the TTA for an unresponsive patient. Upon arrival, the provider determined that the patient was without pulse or respirations. It was not clear whether custody staff recognized that the patient was unresponsive. CPR was unsuccessful. On autopsy, the coroner discovered pulmonary edema, bilateral pleural effusions, pericardial effusion, ascites and dependent edema, and a vitreous[120] sodium of 113. The cause of death is likely hyponatremia, most likely from psychogenic polydipsia. The final coroner's report is pending.

Assessment

The Combined Death Review deferred an opinion regarding whether this death was preventable until the autopsy report was obtained. In our opinion, the death was preventable. The patient had a history of low sodium from polydipsia. This information was provided to SAC but was not documented in the problem list on the transfer summary. The patient died with low blood sodium. We agree with most of the Combined Death Review evaluation.

This case is another example of a failed transfer process. We continue to recommend a root cause analysis of the transfer process to identify ways to ensure adequate transfer of medical information.

- This 51-year-old patient arrived at CDCR in 1987 with three paroles and returns.[121] He had four Department of Mental Health (DMH) admissions in 2004 and transferred to SAC on 1/26/08. He died on 8/15/12 in EOP Ad-Seg. His medical history included head trauma secondary to gunshot wound, seizure disorder, hyperlipidemia, coronary artery disease, myocardial infarction, GERD, BPH, sinusitis, right eye blindness, psychosis, antisocial personality. His medications were levetiracetam, phenytoin, simvastatin, aspirin, ranitidine, risperidone and Cogentin.

  Review of his record shows that a provider saw the patient for chronic disease management on 11/22/11, 12/13/11, 12/27/11, 3/23/12 and 6/20/12. On 11/22/11, his phenytoin level was toxic (28.5, normal=10-20 mg). However, a provider did not sign this report, and it was not until 12/13/11 that, when seen for chronic disease follow-up, a provider ordered the nurses to hold his phenytoin. A repeat level the same day was 19.7.

  Over the next nine months, routine serum phenytoin and levetiracetam levels were therapeutic and the patient reported no seizure activity.

[120] Fluid in the eye.
[121] Mortality Review Patient #2.

On 5/3/12, a TTA nurse saw the patient for having blood in his urine and his boxer shorts. The nurse noted blood stains in his right leg jumpsuit. The nurse did inquire into the onset or source of the blood. The patient stated he had normal bowel movements and denied insertion of foreign bodies into his penis or rectum. The nurse documented no signs of injury to his genitalia. A urine dipstick was negative for blood. Staff returned the patient to his housing unit with plans to follow up with a nurse in the morning. On 5/4/12, a nurse saw the patient, who said he was doing better. A medical provider did not evaluate the patient.

On 7/25/12, an RN saw the patient and documented he had superficial scratches to his right facial area. He denied pain. The nurse did not directly ask the patient how the scratches occurred.

On 8/1/12, mental health staff saw the patient and deemed him a low suicide risk. On 8/4/12, mental health staff evaluated the patient for placement in Ad-Seg for allegedly throwing coffee at an officer through a food port. The patient was alert and oriented. On 8/9/12, mental health staff saw the patient, who reported that officers were constantly harassing him. He denied suicidal ideation, homicidal ideation, or violent ideation. He did report occasional paranoid ideation, agitation, mild depression and anxiety, and aggressive behavior. He claimed to be refusing medications due to side effects, but MARs show that nurses documented administering his medications.

On 8/13/12, a psychologist evaluated the patient to determine whether his mental health disorder was severe enough to impair his awareness of the nature and quality of his actions. The inmate reported being nervous and going to bed by 8 or 9 p.m. He stated, “I’m not a PC dropout. Some want to hold it against me.” The psychologist’s opinion was that the patient’s mental health disorder did not impair his judgment and should not be considered at his hearing. The same day, a psych technician documented that the patient complied with his evening medication but refused his morning medications.

On 8/15/12, at approximately 7:05 a.m., nursing and custody staff found the patient in his cell lying prone on the floor, unresponsive, without vital signs and with livor mortis. Cardiopulmonary resuscitation was not performed.

The CCHCS Combined Death Review Summary found the death was natural and unexpected and not preventable. On 1/16/13, the Death Review Committee found there was insufficient information to determine a cause of death. The Committee requested that the physician contact the Coroner’s office to obtain a preliminary cause of death. The Committee discussed the lack of communication between medical and mental health providers and that, when the death occurred, staff was unable to contact the on-call medical and nursing staff. On 5/22/13, the Committee reconvened and discussed the autopsy report, which noted that the cause of death was a probable seizure, and the case was closed.

Assessment

This mortality raises several questions. From November 2011 until the patient's death, he reported no seizure activity and his serum phenytoin and levetiracetam levels were therapeutic. In May and July, he was seen urgently for blood on his clothes and facial scratches but no medical or mental health provider asked him direct questions regarding the causes of the injuries. From our observation of patient encounters, custody staff is virtually always present and there is no auditory privacy. Just prior to the patient's death, he acted aggressively towards officers, reporting they were harassing him, but mental health did not assess him to be overtly psychotic. On the morning of his death, staff found him in his EOP Ad-Seg cell unresponsive, cold and in livor mortis. This raises questions about the frequency of custody rounds and thoroughness of assessments that patients are alive and safe. The CCHCS mortality review explored none of these questions. Given this patient's unexpected death, an independent investigation needed to be conducted. We did not review the autopsy report, but given the patient's history, we question the basis for the coroner's conclusion that the patient died of a seizure.

Internal Monitoring and Quality Improvement Activities

Methodology: We reviewed the SAC 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 Infection Control Meeting Minutes for January and June 2013. We find the meetings to be skeletal with minimal substance. The minutes do not contain information about infection rates for communicable diseases (e.g., MRSA) in outpatient and inpatient settings or tuberculin infection rates in the population and the results of annual skin testing that would reveal skin test converters. The minutes also lack action plans for identified projects. In the 1/22/13 minutes, there is the following statement: "There is a new Inmate Varicella Program policy that HQ would like us to move forward within the near future; there will be testing of inmates soon." However, there is no discussion of what the policy involves, a timetable for planning the program and who is responsible for coordinating implementation of the policy. Likewise, the minutes indicate that the 2012-2013 rate of influenza vaccination was 53% at SAC, yet there is no discussion of the meaning of these results, whether they are low or high, or discussion of what could be done for the next influenza season to increase compliance rates. Finally, the minutes state that "CTC infections are down and everything looking well," with no data regarding infection rates. The next meeting was held six months later and lacked meaningful content. This program needs substantial development.

We reviewed Pharmacy and Therapeutics Committee Meeting Minutes from January to August 2013. Often, representatives of major disciplines (e.g., nursing, mental health and dental) were absent. In August, only medicine and pharmacy were represented at that meeting. At most meetings, few medication errors are reported (e.g., three in May 2013) and there is no data or discussion regarding the types of errors or how they might be prevented. Given our findings, it suggests there is no effective process for identifying, reporting and studying medication errors. We recommend a quorum of members be required to attend to conduct a meeting, and that

the content of P&T Committee meetings include presentation and discussion of data-driven studies so they are more meaningful.

We reviewed Quality Management Meeting Minutes from April through July 2013. The content of these meetings is substantive with monitoring of action items from previous meetings. The content of the minutes could be strengthened by interpreting the meaning of data presented and what actions will be taken for performance falling below expectations. In the July 2013 meeting, MAPIP results for section 2A showed Plata 59% compliance and Coleman 61% compliance, but there was no discussion of what these scores mean and what action will be taken to improve performance. This indicator involves evaluation of whether sending institutions forward medications with inmates transferring to SAC. There is no discussion of whether any action is taken to notify the sending institution when there is a lapse in compliance with policy. The same principle applies to internal studies that show performance falling below expectations. The data needs to be interpreted and a root cause analysis performed to develop strategies that will be effective in improving performance.

Recommendations

Organizational Structure, Facility Leadership and Custody Functions

1. CCHCS and SAC health care leadership, in collaboration with the Warden, should reassess policies and practices related to health care assessments of inmate-patients that ensure that health care personnel are able to perform adequate clinical evaluations that provide auditory and visual privacy.
2. Following changes in the above policies and procedures, CCHCS Regional staff and SAC leadership should perform observational studies to ensure that patients receive adequate evaluations.
3. SAC should develop procedures for interdisciplinary treatment team management for patients with complex medical and mental health disorders. This will require interdisciplinary collaboration with mental health staff.

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

1. CCHCS should fill vacant health care leadership positions.
2. SAC should work to reduce its vacancy rate of 22%.
3. CCHCS should modify statewide policy to include Court-ordered physician clinical competency policies[122] and to incorporate those policies into existing practices.
4. CCHCS-appointed staff should investigate personnel issues instead of OIA.
5. CCHCS should institute training of clinical staff at SAC on developing effective communication with patients who have severe behavior disorders and psychotic disorders.

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

1. Health care leadership should conduct a study and root cause analysis to develop effective strategies to address health record errors noted in this report.
2. The process for tracking, retrieving, reviewing and scanning off-site specialty services reports should be reevaluated. All laboratory, radiology, specialty service and hospital reports should be routed to the primary provider for review and signature prior to scanning into the health record.
3. Budgets should be based on actual need and should be actively managed.
4. HCFIP should move forward with their construction plans.
5. CTC policies should be brought up to date.
6. CCHCS should address scheduling issues during the development of the electronic health record and should seek to make the scheduling process efficient and reliable. [
7. CCHCS should prohibit providers from the practice of copied and pasted notes.

[122] Plata Physician Professional Clinical Practice Review, Hearing and Privileging Procedures; Pursuant to Order Approving, With Modifications, Proposed Policies Regarding Physician Clinical Competency, July 9, 2008.

Intrasystem Transfer

1. Medical and nursing leadership should ensure that health records of transferring inmates are more thoroughly reviewed to provide adequate continuity of care.

Access to Care: Nursing Sick Call

1. Nurses and providers should examine patients in medically equipped examination rooms with auditory and visual privacy.

Chronic Disease Management

1. SAC health care leadership should perform studies and a root cause analysis to identify the reasons for the lack of timely and appropriate chronic care.
2. The SAC CME and/or the Chief Physician and Surgeon should provide more clinical oversight for the medical staff regarding patients with chronic illnesses.

Pharmacy and Medication Administration

1. Pharmacy and nursing leadership should develop a more robust system for identifying, reporting and studying medication errors to identify and correct root causes.
2. CCHCS Statewide Nursing leadership should address the issue of nurses filling in blank spaces on MARs days or weeks after the fact, and instead should treat these blanks as errors of omission to be studied under the auspices of the quality improvement committee.

Specialty Services/Consultations

1. SAC health care leadership should address the issues related to timeliness and quality of specialty care by expanding the network of providers.

Specialized Medical Housing: OHU/CTC/GACH

1. CCHCS should assign more CTC beds to the medical service or rehabilitate the OHU so it can serve as a CTC.

Quality Improvement/Mortality Review

1. Health care leadership should work with the health care disciplines to develop the infection control and pharmacy & therapeutics programs. These programs should include data-driven studies of problem areas to identify and address root causes.
2. CCHCS should include mental health leadership for all mortality reviews involving mental health patients.