Central California Women's Facility (CCWF)

Health Care Evaluation

December 11, 2013

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Introduction

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

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

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

Methods of assessment included:

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

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

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

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

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

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

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

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

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

Overall Finding

We find that the Central California Women's Facility (CCWF) is not providing adequate medical care, and that there are systemic issues resulting in preventable morbidity and mortality and that present an on-going serious risk of harm to patients.

Executive Summary

On July 8-12, 2013, the Plata Court Medical Experts visited the Central California Women's Facility (CCWF) to evaluate health care services. Our visit was in response to the OIG Medical Inspection Results Cycle 3 report showing that CCWF scored 90.7% in July 2012. This report describes our findings and recommendations. We thank Warden Deborah K. Johnson and Tim Neal, Chief Executive Officer, and their staff for their assistance and cooperation in conducting the review. During this review, Christine Berthold, Senior Deputy Inspector General, Office of the Inspector General (OIG), and members of the OIG Medical Inspection Team joined us to observe and discuss the experts' methodology for conducting health care evaluations.[3]

At CCWF, we found that some elements of the health care delivery system are working well. These include:

- A stable health care leadership team
- Timely initial access to health care
- Timely access to specialty services
- Timely medical intake and intrasystem transfer screening
- Medication administration procedures that meet standards of nursing practice
- An effective sanitation program

However, we found significant problems related to timeliness and quality of care in several systems, resulting in an assessment of inadequate care at CCWF. We believe that the majority of problems are attributable to overcrowding, insufficient health care staffing, and inadequate medical bed space.

Over the past year, CDCR realignment resulted in Valley State Prison (VSP) being converted from a female prison to a male prison. The VSP female population was transferred to either CCWF or California Institution for Women (CIW), the only two remaining major CDCR women's facilities. Since July 2012, CCWF's population rose from 2,696[4] to 3,525[5], approximately 830 inmates. This is a 30% increase in population and an increase from 134.5% to 175.9% of CCWF's design capacity. During this same period, the Acuity Based Staffing Realignment (ABSR) plan

[3] In order to accommodate the OIG team and allocate sufficient time for observations, joint record review and discussion, the experts deferred a portion of record reviews until after the evaluation.
[4] CDCR June 30, 2012 CCWF Population report.
[5] CDCR June 30, 2013 CCWF Population report.

was implemented, resulting in health care staffing reductions including a 21% reduction in medical provider staffing.[6]

We also note that CCWF has been designated as a Basic rather than an Intermediate Facility, even though it has a Skilled Nursing Facility (SNF). But, as noted above, there are only two women's facilities remaining, and the overall medical acuity of the population at CCWF has dramatically increased. There are insufficient beds in the Skilled Nursing Facility to accommodate patients requiring admission. This sometimes results in patients being sent back to the housing units or premature discharge from the SNF with subsequent preventable hospitalization. We understand that the mission of the new California Health Care Facility (CHCF) in Stockton does not include treatment of female inmates, and so aging and high medical acuity female patients will continue to accumulate at CCWF and CIW.

The systems that we found to be problematic include medical intake, chronic care, the skilled nursing unit, and health records. We also found issues with the quality of medical and nursing evaluations documented in the health record.

With respect to medical intake, we found that the process is fragmented and does not result in the timely identification and treatment of serious medical conditions. There is no standardization to laboratory tests ordered for newly arriving inmates; instead, nurses independently order laboratory tests without a physician order. Providers do not write medication orders, but sign the sending jail facility's medication profile without designating the duration of the medication order. We believe that these practices reflect workarounds because of inadequate provider staffing. In addition, the initial history and physical examination is not performed timely and providers do not adequately document history and physical findings. Providers do not consistently initiate a Problem List that notes all serious medical conditions.[7]

Although initial access to care (i.e., a registered nurse) is timely, there are increasing backlogs for provider referrals. This is exacerbated by problems with MedSATS, the new patient scheduling system. Staff reported that MedSATS is more labor intensive than previous systems,[8] but CCWF now has fewer staff for scheduling and other administrative functions. Nurses do not perform adequate evaluations and when nurses refer patients, providers do not consistently address the reason for the referral.

With respect to chronic care, in more than half of the cases reviewed, we found problems with timeliness and quality of care. Medical providers did not address abnormal lab findings that reflected poorly controlled chronic diseases (e.g., hyperlipidemia, diabetes, anticoagulation

[6] Similar reductions were planned for nurse staffing but were amended so that although CCWF did not lose positions, they did not gain any positions. Office technician (OT) staffing was also significantly reduced.

[7] We have noted in several prison health care evaluations that providers do not consistently update either the electronic Patient Health Information Portal (PHIP) or eUHR Problem List. This appears to be a worsening problem. Staff reported that they have been told to document medical conditions only on the PHIP and not the eUHR; however, neither is adequately taking place.

[8] Inmate Scheduling and Tracking System (IMSATS) and Strategic Offender Management System (SOMS).

etc.), change medication and/or treatment regimens timely, or monitor patients with poorly controlled chronic diseases at appropriate intervals.

With respect to the Skilled Nursing Facility, due to staffing reductions, there is no medical provider assigned to the SNF on a regular basis and therefore no real ownership of this complex patient population. Medical providers rotate every three months, and just as providers become familiar with patients, they transfer to another assignment. Review of records showed that care was episodic and providers did not address all the patients' medical conditions.

Health Records staffing was reduced from 15 to 6 staff at the same time the population dramatically increased and current staff is unable to scan records contemporaneously. Medication Administration Records are not scanned timely, preventing providers from timely evaluation of patient medication adherence.

With respect to pharmacy services, internal audits show lapses in continuity of chronic disease medications. We also found concerns related to expiration of chronic disease medication orders. We noted medication errors by pharmacy and/or nursing. As noted above, because MARs not being scanned into the eUHR in a timely manner, this limited our assessment of timeliness and continuity of medications.

Review of internal monitoring and quality improvement reports showed that emergency medical response review is very effective, but pharmacy and therapeutics and infection control programs need to be strengthened.

In summary, we believe that systemic issues at CCWF are related to overcrowding of the facility, reductions in health care staffing, and inadequate medical bed space for a high acuity female population. We also attribute some issues to lack of adequate systems (e.g., medical intake) and inadequate medical provider and nursing evaluations.

We are impressed with CCWF health care leadership and believe that with adequate health care staffing, medical bed space, improved medical and nursing evaluations, and support from CCHCS, improvement at CCWF will likely follow.

Findings

Facility Description

CCWF is located in Chowchilla, CA and is the largest female institution in the state. Its primary mission is to process, rehabilitate, and incarcerate California's female offenders in a secure, safe, disciplined and ethical institutional setting. It houses approximately 20 condemned inmates. The design capacity of the facility is 2,004 inmates and as of 6/30/2013 the population was 3,525 or 175.9% of design capacity.[9]

With respect to medical missions, the facility is a reception center and has a licensed skilled nursing facility (SNF). It also provides mental health services.

Organizational Structure and Health Care Leadership

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

Findings: The executive team at CCWF provides stable and positive leadership to the medical program despite the challenges of increases in population and staffing decreases. Most of the executive staff has been in their positions for several years, which has created a stable environment. The CCWF administrative table of organization is organized along functional lines of authority. Tim Neal is the Chief Executive Officer (CEO). He has been in his position for three years. Prior to this engagement, he was regional Vice President for Kindred Health Care for three years. He has been a health care executive for over 20 years and brings considerable experience and maturity to the program. Mr. Neal reports to Dr. Steve Tharratt for medical program issues and to Diana Toche DDS, Undersecretary, Administration and Offender Services (Acting), for mental health and dental services.

Dr. Pal Virk has been in his position of Chief Medical Executive (CME) for three years. He is a Board Certified Internist. Dr. Virk was Health Care Manager at Valley State Prison prior to his current position.

Dr. Robert Mitchell is Chief Physician and Surgeon (CPS) and has been in his position for two years. Dr. Mitchell is a Board Certified Family Practitioner. Prior to this current position, Dr. Mitchell was a staff physician at CCWF.

Sarbjeet Kaur is the Chief Nurse Executive (CNE). Ms. Kaur is a Nurse Practitioner. She was the Director of Nursing at Corcoran three years ago. She has been in her position for one year.

Corryn Pierini is the Chief Support Executive (CSE). She started in her current position a year ago as an interim and became the permanent CSE three months ago. She has three years prior

[9] CDCR Website. September 2013.

experience as a health program manager. She also worked in medical administration at Valley State Prison for 15 years.

The Pharmacist-in-Charge (PIC) is Curtis Peterson, who has been in his position for one month. This is a temporary assignment. Frank Lopez is the PIC at Valley State Prison (VSP). Mr. Lopez had been the PIC at CCWF for over four years and is on temporary assignment at VSP and will return to CCWF when his temporary assignment is completed.

With the exception of the PIC, all of the senior executives cover both VSP and CCWF. Valley State Prison is across the street, about 0.7 miles from CCWF. Nevertheless, the arrangement does result in executives only being able to dedicate half time to the program.

Human Resources, Staffing and Budget

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

Findings: The process of hiring staff is similar to other facilities and works well. There is no impediment to hiring. As with other facilities, Central Office posts positions and performs initial screening. Local leadership interviews and makes final hiring decisions.

The current budget authority for staffing is for 227.6 positions, of which 174.3 (76%) are filled. The high vacancy rate relates to a recent increase in staffing, readjusting for the increase in population due to closure of the women's facility at Valley State Prison for Women (VSPW) as explained below. These positions were recently posted and are expected to be hired soon. The current ABSR includes 13.5 additional staff as compared to the budget authority prior to 3/31/13. The largest change in staffing is in pharmacy, where there will be a gain of 9.3 pharmacy technicians and 2.1 pharmacists.

The initial ABSR budget authority staffing was developed some time around September 2012, when the population of CCWF was approximately 2,700. As a result of the ABSR analysis, approximately 25 nursing positions and 2.9 provider positions (1.9 physicians and 1 nurse practitioner) were designated for elimination. Some of these nursing and provider positions were vacant, but the ABSR did result in some layoffs.

After ABSR was enacted, Valley State Prison for Women (VSPW) closed as a female facility in January of 2013 and reopened as a male facility. From June 30, 2012, to June 30, 2013, the population at CCWF increased from approximately 2,700 to approximately 3,500, a 30% increase. Despite this increase in population, planned layoffs for ABSR took place on 3/29/13. After these layoffs, the medical program was unable to perform required services without utilizing staff from Valley State Prison and instituting weekend clinics.

Because of the increase in population, the executive leadership appealed to CCHCS that additional staffing was necessary. Subsequently, nurse staffing was readjusted in May 2013.

This adjustment merely reinstituted the prior budget authority number of nursing positions that existed prior to ABSR, when the population was approximately 2,700. The adjustment amounted to approximately 17 licensed vocational nurses and 8 registered nurses. These positions are currently in the process of being hired.

However, no corresponding adjustment was made to medical provider staffing. Although the facility had a 30% increase in population to 175.9% of design capacity, it now operates with 2.9 (21%) less providers than it had before the population transfer from VSP.

This is a concern because the facility serves a female population and has several medical and mental health missions including being an intake center and having a Skilled Nursing Facility (SNF). The mission of the California Health Care Facility (CHCF) in Stockton does not include providing health care to female patients; therefore, CCWF must retain high acuity disabled patients in the SNF. Because it is an intake center, a small but continual number of patients who are pregnant or on dialysis remain at the facility until they can be transferred to the California Institution for Women (CIW).

With the reduction in staff, there are insufficient numbers of providers to assign regular coverage to the SNF. This problem is exacerbated when providers take vacations. Providers rotate on the SNF unit on a three-month basis, resulting in no single provider taking ownership for care on the unit. Provider care on this unit was not good, as noted in patient case reviews presented in the SNF section of this report. Staffing may be the reason for this discrepancy. We also note that unlike most other facilities, the CPS allocates about 15% of his time in direct clinical care to assist in providing care on the unit. We believe provider staff levels at this facility needs to be reexamined and increased to match the acuity of the population.

ABSR does not include relief time for provider staff. The following statement describes the rationale for this:

> "There is no approved relief factor for PCPs; therefore, there is no relief factor for PCPs included in the staffing realignment. The staffing realignment was based on 'total utilization,' which includes relief of PCPs, so relief is indirectly built into staffing realignment."[10]

Total utilization was not defined in their methodology statement, but it appears to us that the practical effect of this methodology is that each facility must make do with the number of providers assigned to that facility.

In summary, the combination of a significant increase of a female population with corresponding increase in medical acuity, along with medical missions such as medical reception, skilled nursing facility, and housing long-term care patients not eligible for transfer

[10] CCHCS Staffing Realignment Methodology 1.0 Final Version, sent to Court Experts via email by Jared Goldman on 12/31/12.

to CHCF, warrants reevaluation of medical, nursing and ancillary staffing patterns. The analysis should take into consideration a relief factor for medical providers.

With respect to staff training, all new nurses receive an initial orientation training which is offered monthly. Annual training for nurses consists of a series of training topics which are anticipated to be needed over the upcoming year. This list is provided to supervisors who are to provide the training. An annual training calendar is developed from the list of topics for the upcoming year. Providers receive training via mandatory webinars in addition to topical instruction at periodic provider meetings.

Credentialing and Peer Review

As with other facilities, CCHCS performs all credentialing and maintains all credential files. CCHCS sends an electronic copy of approval of credentials to the CME. CCHCS sends these notification letters after initial credential approval and every two years thereafter after re-credentialing. CCWF maintains these approval letters in a provider file. These files were reviewed. Credential notification letters were present for all providers.

We evaluated the eUHR Clinical Appraisal (UCA) files for practitioners. Of the current 10.6 provider positions, only six providers had a UCA file and, of these, only three were up to date. Every provider is supposed to have an annual UCA peer review, which is not evident in files examined at CCWF. After our review, we were told that 10 UCA files were completed but were not on file or provided to us in our document request. We did not have an opportunity to verify this.

There were two providers involved in discipline at CCWF. One provider was being disciplined for non-clinical reasons. This provider was using state property for his personal business. He was referred to the Office of Internal Affairs (OIA), which was appropriate because his alleged infraction was non-clinical. A second provider was referred to OIA for patient abandonment. Allegedly, this provider walked out without assisting other staff in the midst of a patient having a cardiac arrest. This appears to us either to be a failure to perform required standard of care or unethical conduct. This allegation should have been referred to the Professional Practices Executive Committee (PPEC) in accordance with the 2008 court ordered physician privileging procedures.[11] Instead, this clinical issue was referred to the Employee Relations Officer (ERO) for investigation by the OIA through the routine discipline process. We learned that the CEO was not aware of the 2008 Court Order on physician competency or the physician competency policy and procedure related to the Court Order. He believed he was correct in following existing CDCR personnel rules, as there is no CCHCS policy stating otherwise. CCHCS needs to develop a policy that corresponds to the Court Order and ensure that all facilities are adhering to the policy.

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

Training for providers occurs by way of webinars with occasional regional wide CME. At the time of our visit, the Regional Deputy Medical Executive was John Zweifler, who came to CCWF about every three months. Training for providers occurs by way of webinars with occasional regional wide continuing medical education programs. At the time of our visit, the Regional Medical Director was John Zweifler, who came to CCWF about every three months. Dr. Zweifler has since left CDCR. Dr. Robert Chapnick is currently the Regional Deputy Medical Executive with responsibility for CCWF.

Disciplinary Process

There are eight individuals at this facility who were involved in the disciplinary process during 2012. Two individuals resigned before completion of the discipline process. Two additional individuals have discipline pending; one has been pending for 14 months and another has been pending for 10 months. Four other individuals had discipline completed in 2012. The length of time it took to complete the discipline process averaged 12 months and ranged from three to 22 months. No one has been redirected as a result of discipline. We continue to recommend an expedited disciplinary process which is separate from custody investigation.

Health Care Budget

For several years at CCWF, California State government allocated funding to the correctional medical program at significantly lower levels than it takes to operate the programs. The Receiver continues to negotiate annually in order to obtain additional funding at the end of the fiscal year to operate programs at existing levels. This continues to cause concern with respect to the transition from Receivership to CDCR control.

Health care funding for fiscal year 2010-2011 included an initial allocation of approximately $19.16 million, a final allocation of approximately $37.25 million, and a final expenditure of approximately $39.23 million. The final expenditure was more than double the initial allocation. The 2010-2011 fiscal year initial allocation was initially based on a decision by the Department of Finance to compare costs with other state correctional medical programs and to reduce the allocation to those levels. The allocation ultimately had to be significantly increased to maintain normal operations.

In fiscal year 2011-2012, the initial allocation was $32.12 million, the final allocation was $38.08 million, and final expenditures were $40.91 million. The difference between initial allocation and final expenditures was $8.79 million, or a 27% increase from the initial allocation. In fiscal year 2011 to 2012, CCHCS took responsibility for mental health nursing positions, but funding for these positions was not provided until late in the year.

In fiscal year 2012-2013, both the initial allocation of $33.75 million and the final allocation of $35.69 million are at least 10% lower than operating expenses for prior years.

Health Care Operations, Clinic Space and Sanitation

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

Findings: Health care operations at this facility are generally adequate. Equipment is inventoried and is calibrated and serviced annually. This is tracked in a spreadsheet format. The storeroom is modestly stocked. The storeroom manager does not maintain an inventory count of supplies. Nevertheless, there are only a modest amount of supplies in clinical areas and in the warehouse as compared to other facilities. Storeroom staff orders supplies by inspection and estimation of supply shelves. Supplies are stored in four bunkers and two conex storage containers. Bunkers are approximately 200 square feet of storage in shelters similar to an outside tool shed. Conex storage containers are approximately 30 by 8 foot metal containers similar to a railroad car. These storage spaces are located outside. They have no lights and have no temperature control. As a result, they are extremely hot in the summer and have to be used in daylight hours or require a flashlight. One bunker has climate control and is used for perishable product. Pharmacy product is stored in the pharmacy. There needs to be a reasonable storage space for medical product which is protected from outside conditions.

All clinical areas utilize a Periodic Automated Replacement (PAR) system. Staff is not precise in use of the PAR system. Nevertheless, all clinical areas had limited and appropriate amounts of supplies. As a result, there was very little clutter in clinical areas. We were impressed with the lack of clutter in the clinics.

Clinical space at this facility is poorly designed, has inadequate space for the expected use, lacks universal hand washing availability, lacks sufficient electronic devices on the SNF to document clinical encounters, lacks ergonomic arrangements for electronic devices, and is not set up for female clinical examinations. Most of the space issues we identified will be addressed by the Health Care Facility Improvement Plan[12] (HCFIP). Some issues do not appear to be addressed by that plan and CCHCS needs to re-evaluate the plan based on the change in mission and demographics at this facility.

Because the California Health Care Facility (CHCF) in Stockton will not house female patients, high-risk patients and disabled patients can only be distributed between CIW and CCWF. The current SNF nursing stations are not well sized or configured for the expected use. The HCFIP for CCWF was developed for a population of approximately 2,000 inmates, but since the closure of VSPW the population is now approximately 3,500 inmates. Additionally, since females will not be sent to CHCF and the SNF unit will house disabled females, the nursing staff ratios will be expected to be at the level of a CTC or higher. No improvements were scheduled for the SNF, even though the nursing stations do not now adequately accommodate the number of nurses

[12]Health Care Facility Improvement Plan, Central California Women's Facility, May 2013 AB 900 Project Authorization, Vanir Construction Management, Inc.

required to work there. In particular, there is insufficient space for staff to work and for required electronic devices necessary to complete assignments.

Also, Building 505 was built as an OHU but is no longer used for this purpose. Given the increase in population and expected increase in higher acuity patients due to the change in mission for VSP, consideration needs to be given to re-opening this unit as an OHU. Clinic plans may be adequate but need to be re-evaluated given the population increase and the expectation that there may be a larger number of high-risk patients. The HCFIP construction for CCWF is scheduled to start on 2/16/15, and construction is scheduled for completion by 3/2/16. Because construction will be almost 3 years into the future, facility leadership needs to refurnish clinics with proper examination tables and desks to improve the ability of clinicians to provide adequate care.

One area of deficiency was fixed equipment. Every clinic area had a different configuration of furnishings. The furnishings were not designed to be used in the designated space. Many furnishings were delaminating or deteriorated. As with other facilities, almost every clinic examination room had large oversized office desks in provider examination rooms. Many times, the room was adequately sized at about 100 square feet but the office desk for the provider was so large that it occupied a significant portion of the room. As with other facilities, this occurs because CCHCS is required to purchase equipment from the California Prison Industry Authority (PIA), even when the equipment is not appropriate for its intended purpose. These purchases from PIA are also much more expensive than if appropriate equipment were purchased in the open market.

CCWF is a women's facility and every examination room needs to have an examination table capable of gynecological examination. Yet only about half the examination tables we saw in multiple clinical areas had tables with stirrups so that gynecological examinations could be performed. As a result, many providers lacked the ability to perform these examinations in clinics.

In addition, for those examination rooms that had adequate gynecological examination tables, many had extremely large desks. Because the desk occupied most of the room, the examination table was placed in a corner or in a space which prevented the use of stirrups for a proper gynecological examination. Providers we spoke with told us they had to move equipment and furnishings around in order to examine the patient. This discourages proper examination of the patient. The configuration of furniture and equipment must permit adequate examination.

As an example, in the room where intake physical examinations are performed, the examination table is in the corner of the room so that the provider can barely sit in a proper location to perform a reasonable physical examination. Papanicolaou tests for cervical cancer require use of an assistant and a tray on which necessary supplies are placed. This room does not have sufficient space to conduct these evaluations. This room needs to be reconfigured or a larger room needs to be used.

In addition, because this is a women's facility there is a need to perform wet mount examinations to test for yeast and other types of vaginal infections. Wet mount examinations are smears of specimens on a glass slide which are then viewed under a microscope. Despite this need, there are no microscopes in the prison. Every clinic with an expectation of evaluating females for vaginal discharge needs to include a microscope and equipment to perform a wet mount.

The room used for nurse reception screening is too small for its required purpose. This room needs to have an examination table but does not. All screening evaluations are performed with the patient sitting in a chair. As noted above, there is no Doppler equipment to assess fetal heart tones of pregnant females. This room needs to be configured similar to a clinic examination room. This nurse reception room was one of the few cluttered and disorganized rooms in the facility, and administration needs to work to improve the presentation of this room.

This facility has an administrative segregation unit and a condemned unit in the same building in the A yard. Because inmates seldom leave the building, a clinic space has been configured for their routine care in the building. This clinic is not appropriately furnished and equipped. The clinic is cleaned only twice a week. The examination table is not equipped to perform a gynecological examination. The cabinetry is broken. It was hot in the clinic on the day of our visit. There was a second examination room for provider use, but this room was so small that the placement of the examination table made the existing arrangement difficult to perform a gynecological examination. If this area is to be used for clinical care, it must be appropriately sized, equipped, furnished, and sanitized consistent with medical clinics in other areas of the prison.

Persons with disabilities are housed in the A yard. We watched a female patient from A yard in a wheelchair attempting to access the examination room. The patient could not wheel the chair into the room in a manner that permitted a reasonable examination. All clinical areas housing disabled patients must have examination rooms that accommodate their necessary equipment consistent with the American for Disabilities Act.

CCWF has four yards, each with a medical clinic. In each of these four clinics, there are two nurse examination rooms and two provider examination rooms. In every yard, one of the nurse examination rooms does not have a sink. We did not note whether there was an alcohol based cleansing solution in the examination room.

We did not examine the patient waiting areas in every yard, but in B yard inmates wait outside. There is an awning under which patients sit, but this is not adequate. Waiting areas for patients need to be indoors so that inmates wait for their appointment in a properly heated and cooled space protected from wind, rain and other weather elements.

We were extremely impressed with sanitation at this facility. With a few exceptions, all clinical areas generally contained sufficient but minimal supplies and were appropriately sanitized. The

Skilled Nursing Facility, main clinic area and the health unit in building 505 are cleaned by 16 inmate porters supervised by a single state custodian, Mr. Mendoza. Ten porters work day shift and six porters work evening shift. All other medical clinical areas are cleaned by inmate porters under custody supervision.

We were particularly impressed with the main clinic and SNF unit. All areas, including patient rooms, were well sanitized. There was no clutter. All floors including patient rooms were waxed and buffed. Remarkably, this effort is attained with a single custodian employed by CCHCS who supervises 16 inmate porters. Although we have recommended not using inmate porters, this facility is an example of how using inmate porters can work, provided that training and appropriate supervision is provided. The custodian supervisor is trained in custodial work. He trains the porters with both videos and other instructional material so that they are knowledgeable and utilize appropriate sanitation techniques in their work.

The benchmark for sanitation at CCWF is hospital hygiene, and the instructional videos are geared toward that goal. Instructional videos include topics such as stripping and waxing floors, safety for healthcare housekeepers, cleaning the occupied patient unit, universal precautions, etc. In total, there are 12 instructional videos used along with other instructional material. Each porter-custodian receives an orientation with training, followed by a monthly review. During lockdowns, a skeletal porter crew of 3-4 individuals is permitted to work. All floors are waxed every 3-6 months, with buffing weekly to biweekly. Floor waxing is scheduled in the evening when there is less patient care activity. The cleaning schedule of work for the porters is clear and understandable. A checklist format is used for the porters so that the supervisor can monitor their work. This is, to date, the most impressive sanitation program we have seen in the CDCR, demonstrating the capacity to perform given the right support and supervision. This program is especially valuable in that the inmate porters receive hospital standard of care training for cleaning in a health care setting. The porters at CCWF working under custody supervision do not receive this training, and we recommend that all porters at CCWF providing sanitation services for health care units receive this training. We also suggest that CCHCS utilize this program as a center of excellence which can be duplicated at other facilities. This would require CDCR support and cooperation.

Policies and Procedures

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

Findings: There are 52 Local Operating Procedures at CCWF. These have been reviewed and signed within the past year. All major areas of service are covered. The Warden cosigns policies when custody staff is part of the procedure. These interagency type procedures are generally of good quality.

In addition to Local Operating Procedures, there are 165 Skilled Nursing Facility (SNF) non-nursing policies and there are 141 SNF nursing policies and/or procedures. The 141 nursing SNF

policies contain 395 pages of material. All of these have been recently signed. However, we note that this is an extraordinary amount of policy information. Most of the SNF nursing policies and procedures relate to task-oriented procedures such as how to irrigate an ear, how to perform an electrocardiogram, care of an eye prosthesis, how to perform fecal occult blood testing, etc., which are more properly contained in guidelines. We recommend that task-oriented procedures be replaced by guidelines instead of utilizing policies. Since guidelines would only have to be modified when there is a change in technique or equipment, the frequency of review could be less.

The 165 SNF non-nursing policies and procedures contain many policies which appear to be unnecessary. For example, there is a policy on what is to occur if a patient has an avulsed tooth. This also may be useful information for staff, but we recommend placing this information in a guideline instead of in a policy. Guidelines require revision only when the information changes. There are many other examples of similar policies that need to be converted to guidelines.

In general, SNF policies need to be reviewed for redundancy and necessity. This could significantly streamline the policy manual so that it describes essential processes rather than a wide range of practices on the unit.

Medical Reception/Intrasystem Transfer

Methodology: We toured the CCWF receiving and release (R&R) area, interviewed facility health care leadership and staff involved in medical reception and intrasystem transfer, and reviewed health records.

Findings: We found problems with the medical reception process. First, the room in which health care staff performs the reception screening process is inadequate. It is small, cluttered and dirty. Three staff are crammed into this small room that also has a chair for the inmate to sit in.

Review of health records shows that medical reception process is a nurse-driven process in which the nurse performs a health screening, measures weight and vital signs, orders laboratory tests, and determines whether essential medications (e.g., chronic disease, psychotropic, etc.) have transferred with the patient.

To renew medications, medical providers do not write medication orders on a physician order or medication reconciliation form; instead, a nurse forwards the jail medication profile form to the medical and mental health providers, who simply sign the form to indicate renewal of all medications. However, this is insufficient direction to pharmacy regarding reordering of the medications because the provider does not specify which medications should be continued and the duration of medication orders. This is important because it may not be clinically appropriate to continue all medications and each medication may warrant a different duration. Providers should indicate which medications are to be continued and the duration for which they are to be renewed (e.g., 14, 30 days, etc.). Since we had not observed this practice at previous facilities, we discussed it with staff, who reported that this system was developed because of

concerns about the timely provision of medication continuity upon arrival and to avoid having nurses or providers rewrite medication orders. We believe that to some extent this is a workaround due to insufficient medical providers.

We note that the intake nurse documents a plan on the health screening form (i.e., 7277) that includes laboratory tests and referrals to providers and/or the public health nurse. However, nurses do not document laboratory test orders on a physician order form that is cosigned by a provider; this exceeds nursing scope of practice. Moreover, nurses do not adequately document the type of tests are being ordered. For example, a nurse may order an "HIV test;" that could be an HIV antibody or HIV viral load test. Likewise, nurses order a "hepatitis screening" that presumably is for a hepatitis immunity panel that will indicate which patients require hepatitis vaccination. However, instead of ordering a hepatitis immunity panel, nurses order an acute hepatitis panel that is to determine if a patient is currently infected with hepatitis A, B, or C. This does not provide information regarding hepatitis immunity that guides vaccination orders.

Health care leadership showed us a draft standardized order form for newly arriving patients that includes laboratory tests for chronic disease patients. We support ordering standardized tests upon arrival for patients with chronic diseases so that laboratory tests are available to the provider at the time of the physical examination. However, the standardized form is so limited that the only chronic diseases it includes are patients being anticoagulated and mental health patients taking Clozaril. If the facility desires to develop a standardized set of medical orders for newly arriving inmates, we recommend that the form include all required medical reception and/or intrasystem transfer procedures (e.g., health history, vital signs, pregnancy screening, tuberculin skin testing, etc.) and have a section for optional laboratory testing based upon the medical history of the patient. For example, the form may include laboratory testing for patients with chronic diseases that includes the most common tests ordered (e.g., serum chemistry, CBC, urinalysis, hemoglobin A1C, fasting lipids, etc.).

When patients report abnormal findings upon arrival, the nurse does not necessarily address the complaint. For example, one patient complained of dysuria (pain upon urination) but the nurse did not perform a dipstick urinalysis or refer the patient.[13]

According to CCHCS policy, medical reception history and physical examination are to take place within seven days, but at CCWF these examinations do not occur timely. In addition, the examinations are not complete and do not identify or address all medical conditions. Examples are described below.

- A 55-year-old woman arrived at CCWF on 6/19/13.[14] Her medical history included HIV/AIDS and resolved hepatitis C infection, hyperlipidemia, seizure, bipolar disorder and a hysterectomy in 1999. Her physical examination was not completed within seven

[13] Medical Reception/Intrasystem Transfer Patient #1.
[14] Medical Reception/Intrasystem Transfer Patient #1.

days of arrival. Medical providers did not perform a comprehensive medical history, and although the patient reported a history of myocardial infarction to nursing and dental staff, this has not been addressed by a medical provider.[15] An HIV viral load was not ordered upon arrival, and pertinent laboratory tests were not available at the time of her physical examination. Her LDL cholesterol was high and given her HIV history and possible history of coronary artery disease and/or myocardial infarction, the patient's hyperlipidemia needs to be addressed. Nursing staff read her tuberculin skin test (TST) as negative but her QuantiFERON[16] test was positive. Staff has not addressed the discrepancy in the tests or ordered a chest x-ray to rule out active tuberculosis. The patient had a history of urinary incontinence but did not have a urinalysis upon arrival.

Assessment

The patient has not received an adequate medical evaluation and treatment plan for each of her serious medical conditions, including a reported history of myocardial infarction. The patient has not been adequately evaluated to rule out active tuberculosis, for which she is at increased risk due to her HIV infection.

- A 33-year-old patient arrived at CCWF from the LA County Jail on 6/18/13.[17] Her medical history included HIV and chronic HCV infection, asthma, bipolar and schizoaffective disorder. Upon her arrival, the reception nurse did not address a pending ENT appointment noted on the jail transfer form. The patient's history and physical was not performed within seven days of arrival but instead the patient had a series of episodic visits. On 6/26/13, the HIV provider saw the patient and performed a brief HIV history. The provider reordered HIV medications for two months and ordered a chest x-ray and laboratory tests, but did not include an HIV viral load or urinalysis. On 7/8/13, another provider saw the patient and assessed the patient's HIV and hepatitis C infection to be in control without the benefit of any laboratory tests. The provider assessed the patient as having bilateral axillary folliculitis and ordered sulfamethoxazole for seven days. The next day, a nurse practitioner performed a history and physical examination, noting that the patient had a 2.5 x 2 cm left axillary abscess. The NP addressed available laboratory tests but not the lack of a chest x-ray. The NP's clinical description of the patient's axillary lesions (abscess) differed significantly from the physician's description (folliculitis) and warranted referral to the TTA for consideration of incision and drainage.

  Assessment

  At the conclusion of the medical reception process, although the patient had been seen by several providers, her pending ENT consult had not been addressed, key laboratory tests and diagnostic tests (e.g., chest x-ray) had not been performed, and a Problem List had not been established with a plan for each problem. This is fragmented care.

[15] As noted in previous reports, dental staff are the only providers to perform a complete medical history including review of systems. Medical staff should obtain the same information upon arrival.
[16] QuantiFERON is a diagnostic tool for tuberculosis infection.
[17] Medical Reception/Intrasystem Transfer Patient #2.

- A 28-year-old patient arrived at CCWF on 6/13/13.[18] Her medical history included type 1 diabetes. The nurse ordered laboratory tests (e.g., CBC, chemistry panel, lipid panel, LFTs, urine for microalbumin) without a provider order or protocol and referred the patient to the chronic disease program. The patient's blood sugar was high (351) but the nurse did not notify or refer the patient to a provider. The following day, laboratory tests showed that the patient's diabetes was poorly controlled (Hemoglobin A1C=11.0%, ADA[19] goal=<7%). A provider did not complete a history and physical within seven days of arrival. On 6/25/13, a provider saw the patient, addressing her diabetes, but did not document a review of systems or physical examination aside from WNL (within normal limits). The provider noted that the patient's diabetes was poorly controlled and added "sliding scale with low dose regimen." On 7/3/13, 20 days after her arrival, a nurse practitioner performed a history and physical and performed a review of systems for diabetes. The patient's past medical history was noted to be "within normal limits," but it is unclear what this means, because there was no documentation of what questions were asked about the patient's past medical history. On 7/19/13, the patient's urinalysis was abnormal, showing bilirubin, leukocytes and proteinuria. The report was signed by a nurse but not a provider, and has not been addressed as of 8/18/13.

  Assessment

  The reception nurse ordered laboratory tests without a physician order or according to a medical reception protocol. The history and physical were not performed within CCHCS policy, and abnormal laboratory tests were not addressed. Documentation of physical findings as being "within normal limits" does not describe the extent of the examination and does not provide a baseline evaluation from which to compare future changes in the patient's medical condition. There is no Problem List noting her medical diagnoses.

- This 42-year-old patient arrived at CCWF on 5/13/13.[20] Her medical history included injection drug use, HIV/AIDS since 1992, peripheral neuropathy, hyperlipidemia and questionable TB infection. Jail transfer information indicated that the patient had a previously positive tuberculin skin test (TST) and a January 2013 chest x-ray was normal. On the day of arrival, a nurse performed a tuberculosis symptom screen and retested the patient. Her TST was read as negative (0 mm). MARs show that the patient received her HIV and other medications timely. On 5/21/13, the HIV physician saw the patient and performed an assessment, ordering laboratory tests but not an HIV viral load (the physician orders by test number) and renewed her HIV medications for six months. On 5/23/13, a NP performed a history and physical examination. Under past medical history, the NP did not note her history of peripheral neuropathy.

[18] Medical Reception/Intrasystem Transfer Patient #3.
[19] American Diabetes Association
[20] Medical Reception/Intrasystem Transfer Patient #5.

Assessment

In summary, this AIDS patient has been at CCWF since 5/13/13 but as of 8/18/13 has not had an HIV viral load test to assess virologic HIV disease control. Her physical examination was not performed within CCHCS policy. The jail provided documentation suggesting that she has a history of TB infection but she was TST negative at CCWF, and neither nurses nor clinicians have addressed the discrepancy in her history. This is important because if not previously treated for TB infection, she needs to be to reduce her risk of active tuberculosis. Neither the eUHR nor the electronic Patient Health Information Portal (PHIP) Problem List notes her major medical diagnoses.

CCWF has received a large volume of transfers since VSP converted from a female to male facility. Although both VSP and CCWF completed the necessary forms in a timely manner, we found problems with continuity of care. Examples are described below.

- This 58-year-old patient transferred from VSPW to CCWF on 10/5/12.[21] Her medical history included morbid obesity, obstructive sleep apnea, diabetes, hypertension, hyperlipidemia, peripheral artery disease, two strokes, chronic DVT and pulmonary embolism, seizure disorder, hepatitis C infection, asthma and depression.

  VSPW staff completed a 7371 at the time of transfer, noting pertinent health information. A CCWF nurse completed a 7277 upon her arrival, measuring vital signs, weight and noting that medications transferred with the patient. The nurse referred the patient to a provider in seven days and a mental health provider in two weeks. The day of transfer, a VSPW nurse documented that the patient's INR was supratherapeutic (INR=4.3, goal=2-3) and a provider ordered that the evening warfarin dose be held and restarted the following day at 9 mg daily. The nurse faxed the orders to CCWF; however, that evening a nurse administered warfarin to the patient. All other KOP and nurse administered medications were delivered the day of arrival.

  Assessment

  The VSPW provider ordered that the patient's warfarin be held and the order was transmitted to CCWF; however, the evening nurse gave the warfarin to the patient. This was a medication error.

- A 52-year-old patient transferred from VSPW to CCWF on 11/24/12.[22] Her medical history included depression, substance abuse, chronic hepatitis C infection genotype 3A, thrombocytopenia and cirrhosis, esophageal varicies s/p banding in 9/2010. Her PHIP Problem List notes pancytopenia, hepatitis C infection and cirrhosis and was last updated in March 2012. Her eUHR Problem List is blank. The patient is housed in ad-seg.

[21] Medical Reception/Intrasystem Transfer Patient #11.
[22] Medical Reception/Intrasystem Transfer Patient #6.

Prior to transfer from VSPW to CCWF, in May 2010, a UCSF GI consultant saw the patient via telemedicine and recommended HCV treatment for the patient because she had genotype 3A for which treatment success rates are higher and had well compensated liver disease. The patient had thrombocytopenia that was a contraindication to treatment and the consultant recommended urgent referral to a hematologist for treatment of the patient's thrombocytopenia followed by hepatitis C treatment given her genotype. She also recommended ultrasound screening for hepatocellular carcinoma (HCC). In June 2010 a hematologist saw the patient to evaluate the patient's thrombocytopenia and noted that the patient's lab values were stable and discussed available information regarding the use of Promacta in conjunction with HCV treatment. The hematologist did not make a specific recommendation other than to avoid iron supplements and return as needed. In June 2010 the UCSF consultant recommended starting HCV treatment for six months. In August 2010 another UCSF hepatologist recommended HCV treatment for six months. In September 2010 the patient had an endoscopy for banding of esophageal varicies. In November 2010 the primary care provider did not reference the consultants' recommendations but noted that the patient had poor long term prognosis.

The patient was not seen again until the end of June 2011. On 10/19/11, the GI consultant saw the patient again, noting that she had hepatitis C, genotype 3, cirrhosis complicated by a mild degree of esophageal varicies and thrombocytopenia with hypersplenism. He documented that the patient "had not started therapy for hepatitis C despite my recommendation because the facility is not comfortable giving her therapy due to low platelet count." His only other recommendation was to wait until new medications became available that do not reduce platelet count to such a significant degree. The other radical alternative is splenectomy. He also recommended in lieu of propranolol, due to patient side effects, to perform upper endoscopy with variceal band litigation every 12 months. The report is not documented as having been reviewed by a provider. On 11/1/11, a provider addressed the recommendation to discontinue propranolol but not the other recommendations.

On 11/24/12, VSPW staff completed a 7371. On 11/24/12, CCWF staff completed a 7277 noting that the patient had liver cancer, pancreatitis, thrombocytopenia, splenomegaly and asthma. The patient was pending an MRI, laboratory tests and 90-day follow-up. The nurse ordered laboratory tests and follow-up with the provider on 11/26/12 per sending facility recommendation, and chronic care and mental health follow-up in two weeks.

On 1/29/2013 the patient was scheduled for chronic care but according to the provider note refused the visit. The provider requested four week follow-up but this did not take place. On 6/27/13, a provider saw the patient for chronic disease management, noting that she had chronic hepatitis C infection and cirrhosis, and seizure disorder. The provider did not document any history or review of systems (ROS) regarding her cirrhosis or address the nurse's documentation that she had liver cancer. The provider

planned to get a GI consult and see the patient in a month. This did not occur. In March 2013 the patient refused a chronic disease visit.

On 6/27/13, laboratory tests were drawn. Her alpha-fetoprotein was high (31.1, normal =<6.1). She also had thrombocytopenia (45K, normal=>140-400K). A provider signed the laboratory tests on 7/2/13. On 7/31/13, the patient underwent endoscopy and no esophageal varicies were noted.

Assessment

In 2010 and 2011 several GI consultants recommended treatment for her hepatitis C, given the high treatment success rate for genotype 3A, but this has not taken place. The patient is at increased risk for HCC and has an abnormal AFP and has not had a recent abdominal ultrasound to rule out HCC. We recommend reconsideration of treatment of her thrombocytopenia given the consultants recommendations and hepatitis C infection treatment given her genotype, potential success rate, and high risk of liver decompensation and liver cancer.

Access to Care

Methodology: To evaluate access to care, we interviewed health care leadership and reviewed patient tracking and scheduling systems. We also reviewed 28 health services requests (CDCR Form 7362) in 13 records of patients with chronic diseases, including high-risk patients.

Health Care Appointment Scheduling

Findings: CDCR women's facilities migrated from the inmate scheduling and tracking system (IMSATS) to the Strategic Offender Management System (SOMS) about two and half years ago and then to MedSATS in March 2013.[23] Staff reported that with IMSATS they could easily sort patients who had existing appointments and combine them to make them more efficient.

The transition to MedSATS has been problematic. The system has gone down several times, and the week before our visit, the program was down for three days. When this occurs, staff enters appointments directly into SOMS. When MedSATS runs correctly, it communicates with SOMS, which prints ducats for inmates to be informed of and access health care appointments. However, sometimes MedSATS does not communicate with SOMS, and staff is unaware of this until the daily ducats do not print and patients do not come to their appointments. Staff then uses SOMS but when MedSATS becomes functional, staff must reenter the appointments into MedSATS so CCHCS can collect appointment data. The time involved in duplicating entries into MedSATS and determining which patients missed appointment detracts from staff staying current on scheduling new appointments and rearranging existing ones to meet compliance dates. Staff reported that grievances related to access to care are increasing.

[23] At that time, the facilities included Valley State Prison for Women (VSPW), California Institute for Women (CIW) and Central California Women's Facility (CCWF). VSPW has been converted into a male facility, and there are now only two CDCR facilities for women.

Another issue with scheduling is that when appointment information in MedSATS interfaces with SOMS, SOMS may establish a placeholder appointment time, such as midnight or 1 a.m. and not the actual appointment time, as in MedSATS. As a result, unless staff changes the appointment time in SOMS, the inmate has two appointments for the same encounter. This distorts data regarding the number of appointments and the number of patients seen as scheduled.

Another disadvantage of MedSATS is that when patients move within the facility, SOMS does not automatically update the new location of the inmate in MedSATS. Staff has to open the MedSATS appointment and document that the patient was not seen as scheduled, even if the scheduled date has not yet occurred. Then, staff must close the appointment and create a new one with the patient's new location. MedSATS statistics then reflect that the patient was not seen as scheduled (even though the patient may eventually be seen within required time frames) when all that has occurred was that the patient moved to a new housing unit. In IMSATS, staff could open the existing appointment and change the inmate's location and appointment date if it was still within the compliance date, but in MedSATS they have to close the appointment and create a new appointment. This is remarkably inefficient.

Another feature of MedSATS is that staff must close a completed appointment in order to send electronic reminders to schedule new appointments (e.g., x-rays, specialty services, etc.,) in accordance with physician orders that are generated from the patient encounter. If for any reason the office technician does not close the appointment in MedSATS, the orders generated from the encounter will not be electronically sent to the respective service.

This is important because as the workload for MedSATS has increased as compared to IMSATS/SOMS, the ABSR plan resulted in a 50% reduction of office technicians (OT).[24] Staff reported that they have fallen approximately two weeks behind in closing appointments that generate reminders to schedule provider ordered care. This is particularly problematic for providers who request that patients return in 3-5 days because by the time staff close the original appointment, the time period for the new appointment has lapsed. It is less problematic for laboratory tests, as providers enter the order for the laboratory test directly into the laboratory program (i.e., Care 360), and requests for specialty services forms (RFS) are forwarded directly to UM so at least they are aware of the request.

If a provider clinic is canceled for any reason, staff has difficulty keeping up with rescheduling appointments because the appointments must be closed as not having been seen and a new appointment scheduled.

When OTs cannot keep up with closing appointments in MedSATS, medical orders associated with those appointments build up in the queue. Services (e.g. laboratory, radiology) are waiting for OTs to close out appointments that generate appointment reminders so the service can then schedule the appointment. As a workaround, staff creates their own appointments in

[24] Previously, there were two OTs per yard and now there is one OT and a floater.

MedSATS, which then generates duplicate appointments. For example, a provider may enter an order for laboratory tests directly in Care 360; laboratory staff notes this order and await notification from MedSATS to schedule an appointment to draw the ordered laboratory tests. However, if there is a delay in closing the MedSATS encounter, laboratory staff, having seen the order in Care 360, will create its own appointment for the laboratory tests, but when an OT eventually closes the MedSATS encounter, a notification will be sent for a laboratory test that may have already been scheduled and drawn, but the lab staff have to make sure that it's not a separate appointment. This creates confusion and duplication of effort.

With respect to the efficiency of MedSATS, staff reported that they cannot easily find patients with multiple appointments, as they have to go into each individual screen instead of being able to sort patient appointments by name. Staff is unable to bundle separate appointments into one appointment. If there is a TTA follow-up, Specialty Service follow-up and chronic disease follow-up, they have to be scheduled as three appointments.

Staff reported that MedSATS produces many reports, but only four of 63 reports are accurate, and the remaining reports do not reflect accurate utilization data.

As of the date of our visit, staff reported that they were 7-10 days behind in closing out appointments. As noted above, if they are not closed, future provider orders may not be implemented timely, if at all. Although there is workaround for laboratory and specialty services, there is not one for provider follow-up appointments. Staff reported that duplicate appointments may be made, thus creating a vicious cycle and inaccurate data.

Nursing Sick Call (Face-to-Face Triage)

Findings: CCWF health care staff collects triages and sees patients in a timely manner following submission of health service requests. This is consistent with the OIG Cycle 3 report score of 88.1%.

However, although initial access is generally timely, we found that there are increasing backlogs of referrals to providers such that, as of 7/9/2013, the next routine provider appointment available in Facilities A-D was in approximately three weeks. Although this timeframe may not initially appear to be excessive, it is being exacerbated by problems with the new MedSATS scheduling system; the increase in population; and the ABSR reduction from 13 to 10.6 providers. Moreover, although CCWF is classified as a Basic versus Intermediate medical facility, the fact that CDCR now has only two women's facilities has resulted in increasing numbers of high medical acuity patients.

With respect to record review, we found that the quality of nursing evaluations is variable and in some cases reflects deficiencies in the nursing protocol forms that do not adequately guide the nurse in the assessment process. Other issues are related to providers not seeing patients urgently even when notified by a nurse, and/or seeing the patient timely but not addressing the reason the patient was referred. Examples are described below.

- A 45-year-old patient transferred from VSPW to CCWF on 10/9/12.[25] She was a medically complicated patient, and her medical history included sarcoidosis[26] since 1997, diabetes, hypertension, hyperlipidemia, rheumatoid arthritis, epilepsy and chronic hepatitis C infection. On 12/6/12, she had a chest CT with contrast to evaluate pulmonary sarcoidosis. On 12/7/12, the patient submitted a 7362 complaining of having an allergic reaction and hives all over her body, including her mouth. On Friday 12/7/12, the nurse saw the patient but failed to note that the patient had a CT with contrast the day prior to her symptoms. The nurse notified the physician on a stat basis, who gave verbal orders for diphenhydramine 25 mg three times daily. The provider did not evaluate the patient or refer the patient to the TTA for evaluation of hives and did not note the possibility of a possible allergic reaction to contrast dye.

  The patient potentially had a severe allergic reaction to contrast dye, but the nurse failed to note that the patient had a CT with contrast dye the day prior to her symptoms. A provider did not evaluate this medically complicated patient to perform an independent evaluation of the patient's symptoms. This patient is at potential risk of a severe allergic reaction if she receives contrast dye in the future.

- A 55-year-old patient arrived at CCWF on 6/19/13.[27] Her medical history included HIV/AIDS and resolved hepatitis C infection, hyperlipidemia, seizure, bipolar disorder and a hysterectomy in 1999. On 6/21/13, the patient submitted a 7362 complaining of a painful cyst on her wrist. On 6/24/13, the nurse saw the patient and performed an appropriate assessment using the musculoskeletal protocol. The nurse routinely referred the patient to a provider, who saw the patient on 6/25/13 for an initial visit, but did not address the patient's painful cyst.
  - On 6/26/13 and 7/1/13, the same patient submitted 7362s complaining of severe dental pain. They were received and triaged on 6/28/13 and 7/2/13, respectively. A nurse did not see the patient. On 7/3/13 five days after the initial complaint, the dentist saw the patient and performed a medical and dental history, noting the patient had AIDS and a heart attack. Dental staff extracted two teeth. Because the patient complained of severe pain on 6/26/13, a nurse and/or dental staff should have seen the patient the day the complaint was received and triaged.
  - On 6/30/13, the patient submitted a 7362 stating that she had had a heart attack four years ago, had full-blown AIDS since 2005, that her heart has been fluttering for three days, and that she had a headache. She was frightened and requested to be seen as soon as possible. It was received and triaged on 7/1/13. On 7/2/13, the nurse saw the patient and documented that the patient had no shortness of breath or chest pain, but it was unclear from the note whether the patient was denying she ever had the symptoms or just not at that time. The nurse did not refer the patient. In addition, the patient has reported a history of a heart attack

[25] Intrasystem Transfer/Sick Call Patient #13.
[26] Sarcoidosis is a disease in which inflammation occurs in the lymph nodes, lungs, liver, eyes, skin or other tissues.
[27] Intrasystem Transfer/Sick Call Patient #1.

to both nursing and dental staff, but medical providers have not noted or addressed this history.

- A 28-year-old patient arrived at CCWF on 6/13/13.[28] Her medical history included type 1 diabetes and hyperlipidemia. On 7/5/13, the patient submitted a 7362 complaining of having diabetes and two loose teeth. It was received and triaged on 7/6/13. A nurse did not see the patient. On 7/10/13, five days later, dental staff saw the patient.

- A 46-year-old patient transferred from VSPW to CCWF on 10/5/12.[29] Her medical history included diabetes, hypertension, asthma, GERD, and migraine headache, and s/p hysterectomy. On 11/2/12, the patient submitted a 7362 complaining of having had a hysterectomy and having vaginal odor and a history of a bladder tumor. She requested to see the urologist. It was received and triaged on 11/3/12. On 11/5/12, a male nurse saw the patient and used the genitourinary protocol. The nurse addressed the yeast infection but not the history of the bladder tumor. He performed no review of systems related to urinary symptoms. The nurse did not perform a dipstick urinalysis. The nurse treated the patient with Miconazole and referred the patient to a provider. The referral did not take place. On 11/23/12, the patient submitted another 7362 for the same complaints. The nurse referred the patient to a provider, who saw her on 11/29/12. The provider evaluated the patient for a urinary tract infection but not the history of bladder tumor or vaginal odor.

- A 42-year-old patient arrived at CCWF on 5/13/13.[30] Her medical history included injection drug use, HIV/AIDS since 1992, peripheral neuropathy, hyperlipidemia and questionable TB infection. Her PHIP Problem List is blank and the one in her eUHR included only neuropathy. On 6/21/13, the patient submitted a 7362 stating that she had a mole she wanted examined; requesting that her medications be renewed; and complaining that her throat was scratchy and she was short of breath. On 6/25/13, the nurse saw the patient. The quality of the nursing assessment was good for the patient's URI symptoms but the nurse did not describe the size, color and edges (round, irregular) of the mole. The nurse treated the patient symptomatically and told the patient not to scratch the mole. The nurse did not make a referral for evaluation of the mole.

- A 60-year-old patient transferred to CCWF on 8/15/2012.[31] Her medical history included diabetes, hypertension, hyperlipidemia, hypothyroidism, hearing impairment, and a left kidney stone. She was taking clopidogrel (Plavix) but the clinical indications for this blood thinner were not well documented. On 3/13/13, the patient submitted a 7362 complaining of painful bruising in her private parts. It was received and triaged on 3/14/13. On 3/15/13, the nurse saw the patient, noting that the patient complained of

[28] Intrasystem Transfer/Sick Call Patient #3.
[29] Intrasystem Transfer/Sick Call Patient #4.
[30] Intrasystem Transfer/Sick Call Patient #5.
[31] Intrasystem Transfer/Sick Call Patient #8.

vaginal discharge, pain, frequency, dysuria[32] and hematuria[33]. The nurse did not examine the patient's genital area for bruising. A dipstick urinalysis was normal and the nurse routinely referred the patient to a provider.

- On 3/20/13, a provider saw the patient as a walk-in. The patient reported that she had been out of her Plavix for a month and that she had taken it for a history of a stroke with left-sided weakness, which had since resolved. The provider did not address her history of bruising and did not examine the patient other than to note the patient was obese and her neurological examination was "WNL." The provider planned to see the patient in 8-10 weeks. The provider did not perform an adequate evaluation of the patient.

- A 51-year-old patient, discussed above, transferred to CCWF in 2009.[34] Her medical history included obesity, HIV infection, chronic hepatitis C infection that was stage 3-4/4 per liver biopsy in August 2011, asthma, diabetes, hypertension, hyperlipidemia, irritable bowel syndrome (IBS), and surgery for a left hip fracture from a motorcycle accident in 2009 with residual left-sided weakness. She uses a wheelchair because of left-leg weakness. On 11/4/12, the patient submitted a 7362 complaining of hemorrhoids. On 11/6/12, the nurse saw the patient. The quality of the nursing assessment was inadequate. The patient reported pain that was 10 of 10 in severity. The nurse documented that the patient was "unable to stand." It is unclear whether the nurse performed a visual examination of the patient's anus, but the nurse checked that the patient had anal redness, edema and hemorrhoids. The nurse referred the patient routinely to a provider. On 11/16/12, the provider saw the patient but did not perform an examination. The provider ordered hydrocortisone cream and advised the patient to follow-up with the nurse.
  - On 12/19/12, the patient submitted a 7362 complaining of severe low back pain that was 10 of 10 in severity. On 12/21/12, the nurse saw the patient. The quality of the nursing assessment was inadequate. The patient described the pain as being continually present for a week and worsening. The nurse did not adequately describe the location of the pain, degree of tenderness to palpation, or inquire about alarm symptoms (e.g., incontinence of bowel or bladder). The nurse notified a provider, who ordered a single injection of Toradal[35]. The provider did not request that the patient be referred to her for examination, and no follow-up was requested. The patient was simply instructed to submit another 7362 in 72 hours if the pain continued.
  - On 1/15/13, the patient submitted a 7362 complaining of persistent severe back pain and swelling of her hands, face and arms. On 1/17/13, the nurse saw the patient. The quality of the nursing assessment was inadequate. The nurse did not inquire about alarm symptoms (e.g. incontinence of bowel or bladder, etc.)

[32] Painful urination.
[33] Blood in the urine.
[34] Intrasystem Transfer/Sick Call Patient #10.
[35] A pain medication.

or obtain a urinalysis, which was warranted since the patient's back pain had persisted. The nurse referred the patient routinely to a provider.

- On 1/24/13, a provider saw the patient. The history consisted of "Patient here c/o (complaining of) stiffness in the back. No fall/trauma. No lifting heavy object." The provider did not obtain any review of systems related to constitutional (e.g., fever, chill, weight loss, etc.) or urinary symptoms. The examination consisted of "obese, wheelchair bound, able to get on exam table, SLRT (straight leg raise test) negative, gait only transfer *illegible* in W/C (wheelchair)." The diagnosis was back sprain. The provider prescribed Robaxin.
- On 4/4/13, the patient submitted a 7362 complaining of body aches, sore throat and a productive cough. It was received on 4/5/13 and triaged on 4/9/13. On 4/10/13, the nurse saw the patient. The quality of the nursing assessment was adequate. The patient complained of a productive cough of green sputum x 1.5 weeks. The nurse did not refer the patient, which was not appropriate given the patient's complex medical history and the duration of symptoms.
- On 7/1/13, the patient submitted a 7362 complaining of a rash under her left breast that burned. On 7/3/13, the nurse saw the patient. The nurse did not note the patient's medical history of HIV infection and diabetes. The nurse described the rash as being vesicular and excoriated from scratching. There was no description of the size or distribution of the rash. The nurse assessed the patient as having a fungal infection and treated the patient with antifungal cream. This assessment is not consistent with the presentation of a vesicular rash, which may have been from herpes zoster (shingles). The nurse did not refer the patient.

In summary, the patients submitting health requests are seen in a timely manner but nurses do not always perform adequate assessments or appropriately refer patients. Provider evaluations do not consistently or adequately address the reason the patient was referred.

Chronic Disease Management

Methodology: We interviewed facility health care leadership and staff involved in management of chronic disease patients. In addition, we reviewed the records of 24 patients with chronic diseases, including diabetes, hypertension, HIV infection, and clotting disorders, as well as other chronic illnesses. We assessed whether patients were seen in a timely manner in accordance with their disease control. At each visit, we evaluated whether provider evaluations were complete and appropriate (subjective, objective, current laboratory tests, assessment and treatment plan). We also evaluated whether the Problem List was updated and continuity of medications provided.

Findings: We found significant problems with management of chronic disease patients related to the timeliness and quality of care in over half of the cases we reviewed. Our findings are not consistent with the OIG's Cycle 3 report score of 91.4% for chronic care or with the June CCHCS Dashboard score of 79% for PCP Chronic Care. In addition, our findings are not consistent with scores noted in the CCHCS Dashboard. With respect to quality of care, according to the June

2013 Dashboard; CCWF scored 76% for the management of diabetes and 83% for the management therapeutic anti-coagulation.

The following cases exemplify some of the problems we found:

- The patient is a 46-year-old woman with asthma, diabetes, hypertension, sarcoidosis, hyperlipidemia and hepatitis C. On 10/22/12, her LDL cholesterol was 121 mg/dL (goal < 100 mg/dL). She saw a provider on 12/7/13 who noted the elevated LDL cholesterol level. The provider's plan was to continue the patient's current medications and repeat a lipid panel. The lipid panel was not repeated until 2/21/13, at which time her LDL cholesterol was 123 mg/dL. Her elevated cholesterol had not been addressed as of 7/26/13.[36]

Assessment
The patient did not receive timely or appropriate care for her hyperlipidemia.

- The patient is a 58-year-old woman with asthma, diabetes, hypertension, hyperlipidemia, recurrent deep vein thrombosis for which she is receiving long-term warfarin, and a history of a prior stroke. A provider saw the patient on 11/21/12 and noted that her blood pressure was elevated. He added another blood pressure medication to her regimen and ordered blood pressure checks two times per week for three weeks. The blood pressure checks were performed as ordered and revealed that her blood pressure remained elevated. A provider saw her for chronic care on 1/15/13 and provided appropriate care. The provider ordered follow-up in 60 days. On 2/25/13, a different provider saw the patient for another issue and noted that her blood pressure was elevated. The provider increased the patient's medication, changed it from self- to nurse-administered, and ordered follow-up at the next scheduled chronic care visit. The provider saw the patient on 3/14/13 for another issue. Her blood pressure was elevated (130/88 mmHg) at that time. The provider did not address the elevated blood pressure. A different provider saw the patient on 4/5/13 for another problem. The patient's blood pressure was 144/89 mmHg at that time. The provider did not address her elevated blood pressure. The patient's most recent blood pressure was 160/93 mmHg on 6/26/13 when she was seen in anticoagulation clinic. The provider noted that the patient's most recent chronic care visit had been on 1/13/13 and that the primary care provider had ordered follow-up in 60 days at that time. The provider in anticoagulation clinic ordered a chronic care visit within 30 days. As of 7/26/13, the patient had not been seen for chronic care or for follow-up of her elevated blood pressure.[37]

Assessment
The patient did not receive timely or appropriate care for her hypertension.

- The patient is a 48-year-old woman with diabetes, hyperlipidemia and asthma who arrived at CCWF from Riverside County on 10/31/12. On 11/1/12, the patient's hemoglobin A1C

[36] Chronic Care Patient #2.
[37] Chronic Care Patient #3.

(8.8%) and LDL cholesterol (148) were elevated. A provider saw her for her initial chronic care visit on 11/15/12. The provider noted that the patient refused to take simvastatin for her high cholesterol, stating that she would only take the medication that her physician had prescribed in the past. The provider also noted that the patient's diabetes was not at goal. Despite this, the provider lowered the dosage of the patient's insulin. The provider also noted that she would request the patient's old medical records from her physician. The provider ordered a hemoglobin A1C for 2/15/13 and chronic care follow-up in 60 days. On 1/10/13, a provider saw the patient for chronic care. The provider noted that the patient's diabetes, hyperlipidemia and hypertension were not at goal, and that the patient refused to change her medications. The provider ordered follow-up in 30 days. The patient saw a provider on 1/25/13 after she had submitted a health care request asking for nitroglycerin for chest pain. The provider provided appropriate care, ordered blood tests, including a lipid panel. The provider ordered chronic care follow-up in 60 to 70 days. The lipid panel was performed on 2/11/13 and revealed elevated LDL cholesterol (134 mg/dL). On 2/25/13, a provider ordered a hemoglobin A1C. It was done on 3/13/13 and was elevated (9.4%). On 7/11/13, the patient refused her chronic care visit. As of 7/26/13, there was no documentation that a provider ordered a follow-up appointment.[38]

Assessment

The patient did not receive timely or appropriate care. The patient's chronic illnesses were not well controlled and she was refusing to accept the provider's recommended care. It is therefore important that the provider see the patient at shorter intervals in order to monitor changes in the patient's condition, provide counseling, and to attempt to establish a trusting relationship with the patient. It appears that the provider who saw the patient on 1/10/13 and ordered follow-up in 30 days may have understood this. However, the follow-up did not occur as ordered. Furthermore, the follow-up ordered by the provider on 1/25/13 did not occur in a timely manner. Moreover, even though the patient refused her appointment on 7/11/13, it does not invalidate the fact that the appointment was not scheduled in a timely manner. In addition, the provider who saw the patient on 11/15/12 lowered her insulin despite the fact that her diabetes was not controlled.

- The patient is a 56-year-old woman with diabetes and hyperlipidemia who arrived at CCWF on 4/11/13 from the Fresno County Jail. Laboratory tests were done on 4/18/13, and revealed that her hemoglobin A1C (11.9%) and LDL cholesterol (131 mg/dL) were very elevated. A provider saw her for her intake history and physical examination on 4/22/13, and noted that her diabetes and hyperlipidemia were not at goal. The provider noted that he would increase her insulin and order medication for her hyperlipidemia. However, instead of increasing the patient's dosage of insulin, he reordered the same dosage that the patient had been taking. In addition, the provider did not order the cholesterol lowering medication. Another provider saw the patient on 5/8/13 for her initial chronic care visit and increased the dosage of insulin and ordered Simvastatin for her hyperlipidemia.[39]

[38] Chronic Care Patient #4.
[39] Chronic Care Patient #6.

Assessment

The provider who saw the patient on 4/22/13 failed to order the medications he had documented in his plan. While another provider ordered the medications approximately two weeks later, this case reveals a failure to provide adequate care on the part of the first provider.

- The patient is a 69-year-old woman with diabetes, hypertension, hyperlipidemia, peripheral arterial disease, hypothyroidism, congestive heart failure, chronic renal disease and coronary artery disease with a history of heart attacks in September 2012 and April 2013. A provider saw the patient on 1/4/13, and noted that her diabetes was not controlled (her most recent hemoglobin A1C had been 9% on 8/12/12) and that she had refused to take insulin in the past. The provider discussed insulin with the patient and she agreed to take it once per day. The provider ordered follow-up in 2-3 weeks. The provider saw the patient on 1/9/13 for follow-up of a hospital admission due to a cardiac arrhythmia. The provider noted that the patient was refusing to take insulin, discontinued the insulin, re-ordered oral medication and ordered follow-up in 10-14 days. Providers had seen the patient multiple times since that visit for other issues but did not address her diabetes on these occasions. The patient was not seen again for her diabetes until 5/24/13. The provider noted that the patient was not at goal and re-ordered insulin after discussing this with the patient. The provider ordered follow-up in 90-100 days.[40]

Assessment

The patient did not receive timely care for her diabetes. The provider on 1/9/13 ordered follow-up within two weeks and the patient was not seen for approximately four and a half months. In addition, the provider who saw the patient on 5/24/13 needed to see her back in 4-6 weeks, rather than three months, since her diabetes was not adequately controlled and he was changing her medications.

- The patient is a 41-year-old woman with diabetes, asthma and hyperlipidemia. Her hemoglobin A1C was 6.2% and her LDL cholesterol was very elevated (168) on 7/20/12. On 8/1/12, her cholesterol medication was increased from simvastatin 20 mg to 40 mg. She was next seen on 10/4/12 for chronic care. The provider noted that her cholesterol medication had been increased but did not order a repeat lipid panel. The patient was next seen for chronic care on 2/4/13. The provider ordered a hemoglobin A1C and a lipid panel. The tests were done on 2/13/13. The patient's LDL-cholesterol was 127 mg/dL and her hemoglobin A1C was 6.1%. A provider did not see the patient again for chronic care until 5/21/13. He added gemfibrozil[41] to the patient's medication regimen and ordered follow-up in 90 days.[42]

Assessment

[40] Chronic Care Patient #8.
[41] Gemfibrozil is a lipid lowering medication. It is most effective in lowering triglycerides but does have a modest effect in lowering LDL cholesterol.
[42] Chronic Care Patient #11.

The patient did not receive timely or appropriate care for her hyperlipidemia. The CCHCS guidelines state that patients with hyperlipidemia need to be seen and have their lipid panels monitored at three month intervals until their target LDL is reached. In this case, the patient did not have her lipid panel re-checked for over six months and did not have her medication adjusted for almost 10 months. In addition, the accepted standard of care would have been to increase the patient's simvastatin or to change to a different medication of the same class rather than adding gemfibrozil.

- The patient is a 55-year-old woman with diabetes, hypertension and hyperlipidemia who arrived at CCWF from Valley State Prison (VSP) on 11/30/12. A provider at VSP had seen the patient for chronic care on 11/8/12. The provider noted that her diabetes, hypertension and hyperlipidemia were not at goal. The patient's most recent hemoglobin A1C had been 10.7% and her LDL cholesterol had been 107 mg/dL. The provider ordered medications for her diabetes and hypertension to her regimen and counseled the patient about compliance with her medications. The provider ordered follow-up for chronic care in 30 days, noting that the patient was high risk. Following her transfer to CCWF, the patient saw a provider on 12/7/12. The provider listed the patient's chronic medical problems, but did not document a history, physical examination, assessment or plan related to them. The provider ordered follow-up for chronic care in 80-100 days. On 12/12/12, laboratory tests revealed that her hemoglobin A1C continued to be very elevated (10.4%). On 12/17/12, a provider saw the patient because her blood sugars had been "ranging at about 455." The provider also noted that her hemoglobin A1C was over 10%. The provider's assessment was that the patient's diabetes was not controlled but that he would not adjust her medications since "the patient recently had a change of medication which was given by Dr. Romero who will note the changes on her next Chronic Care Program (CCP)." There was, however, no documentation that the patient's medications have been adjusted since her arrival at CCWF. In addition, the patient's blood pressure was elevated (139/93 mmHg) at the time of the visit, and the provider did not addresses this. The provider ordered follow-up in 120-130 days for chronic care. On 2/19/13, the patient's hemoglobin A1C (11%) and LDL cholesterol (109 mg/dL) were elevated. A provider notified her that a visit was being scheduled to discuss the results of her laboratory tests. Review of the patient's blood sugars from February revealed that they also remained elevated, with most results in the 200-300 mg/dL range and a few in the 400s. There is no documentation that a provider was notified of these very high readings. On 3/11/13, a provider saw the patient for follow-up of her laboratory tests. The provider documented that the patient had refused to accept an 1800-calorie diet, noting that she stated that she was always hungry. The patient's blood pressure was elevated at that visit (135/94 mmHg). The provider's assessment was that the patient's diabetes was not in control and that she was noncompliant with her diet. The provider did not change the patient's diabetes medication. In addition, the provider did not address the patient's hypertension or hyperlipidemia. He ordered follow-up in 90-100 days. A provider saw the patient on 4/15/13 for evaluation of pain in her feet. The provider's assessment was that the pain was probably due to diabetic neuropathy. The provider also noted that the patient's blood sugars remained elevated and that she was noncompliant with her diet. The provider ordered medication for diabetic neuropathy but did not adjust the patient's

diabetes medication. On 5/23/13, a provider changed the patient's medications from self- to nurse-administered at the patient's request. On 6/11/13, a provider saw the patient for chronic care follow-up. Her blood pressure was within normal limits at that time. The provider documented that the patient was compliant with her diet, exercise and medication, except for simvastatin, which was prescribed for hyperlipidemia. The provider noted that the patient stated that she never took the simvastatin because it made her nauseous. The provider's assessment was that the patient's diabetes was not at goal and changed her medication from Glyburide 10 mg to glipizide 10 mg. In addition, the provider discontinued the simvastatin, noting that her LDL-cholesterol had been close to goal in October 2012. The provider ordered follow-up in 90-120 days.[43]

Assessment

The patient did not receive timely or appropriate care for her chronic illnesses. Most significantly, her diabetes medications were not adjusted for almost six and a half months following her arrived at CCWF, despite the fact that her diabetes was in poor control. In addition, her hemoglobin A1C had not been monitored for almost five months. (CCHCS guidelines state that the hemoglobin A1C needs to be monitored every three months if the patient is not at goal.) Moreover, glipizide and Glyburide are the same class of medication and 10 mg of glipizide has the same potency as 5 mg of Glyburide. Therefore, the provider effectively decreased the dosage of the patient's medication on 6/11/13. Furthermore, after changing the patient's medications, the provider did not order follow-up until 90-120 days later.

- The patient is a 53-year-old woman with diabetes, hypertension, chronic lung disease and hyperlipidemia. She arrived at CCWF from VSP on 10/16/12. On 10/3/12, her LDL cholesterol had been 129 mg/dL. On 10/25/12, a provider at CCWF saw the patient for her initial chronic care visit. The provider noted that the patient's hyperlipidemia was not at goal but did not further address this. On 1/15/13, a provider saw the patient for chronic care follow-up and did not address her hyperlipidemia. On 2/25/13, the patient's cholesterol lowering medication was changed from self to nurse-administered when 77 tablets were found in her locker. The patient was next seen for chronic care on 4/2/13. The provider ordered a repeat hemoglobin A1C and a lipid panel. The tests were done on 4/16/13 and revealed a hemoglobin A1C of 6.2% and a total cholesterol of 132 mg/dL (normal=125-200 mg/dL). LDL cholesterol was not reported. The patient had not been seen for follow-up as of 7/26/13.[44]

Assessment

The patient did not receive timely care for her hyperlipidemia. Her elevated LDL cholesterol was not addressed for four months.

[43] Chronic Care Patient #12.
[44] Chronic Care Patient #13.

- The patient is a 63-year-old woman with hypertension, asthma, hypothyroidism, hyperlipidemia, paroxysmal atrial tachycardia and a history of a stroke in 2001 from which she had fully recovered. A provider saw her for chronic care on 1/28/13. Her prior chronic care visit has been on 3/12/12. At the 1/28/13 visit, the provider noted that the patient's hyperlipidemia was not at goal. (Her LDL cholesterol had been 143 mg/dL on 1/4/13.) The provider counseled the patient regarding medication adherence and ordered a repeat lipid panel on 5/20/13. He also ordered follow-up in 120-150 days. On 5/17/13, the patient's LDL cholesterol was very elevated (174 mg/dL). A provider saw her for chronic care on 5/28/13 and mistakenly noted that the patient's LDL cholesterol was 143. He noted that there may be compliance issues with her cholesterol-lowering medication because she was concerned about the side effects. The provider counseled the patient and increased the dosage of the medication. The provider ordered follow-up in 120-150 days. He did not order a repeat lipid panel.[45]

Assessment

The patient did not receive timely care for her hyperlipidemia.

- The patient is a 35-year-old woman with diabetes, asthma and hyperlipidemia who arrived at CCWF from the Los Angeles County Jail on 8/28/12. Her transfer summary from the jail noted that she was allergic to atorvastatin[46] and gemfibrozil. On 9/4/12, her LDL cholesterol was elevated (138 mg/dL). A provider saw her on 9/11/12 for her initial chronic care visit. The provider noted that the patient stated that cholesterol-lowering medications caused rashes and blisters. The provider noted that he would try to obtain prior records related to the allergies and ordered a repeat lipid panel in three months. The provider ordered follow-up in 110 days. There was no documentation that the provider actually wrote an order to obtain the records or that a release of information was obtained from the patient. (Moreover, the records were not in the eUHR as of 7/26/13.) On 12/20/12, the patient's repeat LDL cholesterol was 144 mg/dL. A provider saw her on 1/23/13, and ordered atorvastatin for hyperlipidemia and follow-up in 90 days. There is no documentation that the provider addressed the allergy history. In addition, the provider did not order a repeat lipid test. The patient was next seen for chronic care on 4/10/13. There is no documentation that the provider addressed the issue of rashes or other potential side effects from the Lipitor. The provider ordered a lipid panel in one month. The test had not been done as of 7/26/13.[47]

Assessment

The patient's hyperlipidemia was not addressed in a timely manner. The provider who saw her for her initial chronic care visit did not address her hyperlipidemia, other than to order a repeat test in three months. Furthermore, it is not clear whether her old medical records were ever ordered. Following this initial visit, the patient was not seen for four and a half months. In

[45] Chronic Care Patient #15.
[46] Atorvastatin is a cholesterol lowering medication of the same class as simvastatin.
[47] Chronic Care Patient #16.

addition, the issue of her stated allergy to atorvastatin was not addressed. Finally, the lipid panel ordered for 5/10/13 had not been done as of 7/26/13.

- The patient is a 49-year-old woman with diabetes and hyperlipidemia. A provider saw her for chronic care on 5/28/13. The provider noted that her diabetes was not at goal and ordered insulin. The provider also noted that the patient's LDL cholesterol was 129 mg/dL. Despite the fact that the LDL cholesterol goal for patients with diabetes is <100, the provider noted that the patient's LDL-cholesterol was at goal "per care guidelines." The provider ordered follow-up for the patient's diabetes in 30 days. On 6/14/13, the patient's hemoglobin A1C was elevated (10.6%). The provider saw her for follow-up of her laboratory tests on 7/16/13. The provider noted that the patient's recent fingerstick blood sugars had been very elevated and that her hemoglobin A1C was elevated. The provider also noted that the patient was noncompliant with diet and exercise and that he discussed increasing her insulin with her. He further noted that the previous chronic care note in which it was stated that her LDL cholesterol was at goal was an error. The provider discussed use of cholesterol-lowering medication. The provider did not, however, adjust the patient's insulin or order cholesterol-lowering medication.[48]

Assessment

The patient did not receive timely or appropriate care for her hyperlipidemia or diabetes.

- The patient is a 43-year-old woman with diabetes and hepatitis C. She saw a liver specialist via telemedicine on 6/11/13. The specialist recommended checking an alpha-fetoprotein level.[49] A provider ordered the test on 6/17/13. The test was done on 6/24/13 and revealed that the alpha-fetoprotein was elevated (17.8 ng/mL; normal<6.1 ng/mL). On 7/1/13, the provider notified the patient that she was being scheduled for a follow-up medical appointment in 1-2 weeks to discuss her laboratory tests. The provider saw the patient on 7/9/13 for chronic care. The provider noted the results of some of her laboratory tests from 6/24/13, but did not address the elevated alpha-fetoprotein.[50]

Assessment

The patient did not receive follow-up for her elevated alpha-fetoprotein level.

- The patient is a 48-year-old woman with a history of multiple strokes and Moyamoya disease[51] for which she is receiving long-term anticoagulation with warfarin. She is being followed in the CCWF anticoagulation clinic with an INR target range of 2.8-3.8. A neurologist saw the patient on 1/25/13 and noted that the INR needs to be between 2 and 3. The primary care provider saw the patient for follow-up of this visit on 1/28/13, but did not address this recommendation. On 2/13/13, the case management nurse noted that the

[48] Chronic Care Patient #17.
[49] Alpha-fetoprotein is a blood test that is used to screen for liver and other cancers.
[50] Chronic Care Patient #18.
[51] Moyamoya disease is a rare, progressive cerebrovascular disorder caused by blocked arteries at the base of the brain. It can cause multiple strokes.

INR range was supposed to be 2-3; despite this, the providers continued to use a therapeutic range of 2.8-3.8. On 2/13/13, a blood test for an INR was drawn. According to the documentation from the laboratory, the result of 4.5 was reported to the facility on 2/14/13 at 1:35 a.m. A provider did not address the elevated result until the following day, 2/15/13. On 6/14/13, the INR was again found to be elevated (4.5). The result was reported to the facility the following day, 6/15/13, at 1:06 a.m. A provider did not address the elevated result until 6/17/13.[52]

Assessment

The patient was not receiving appropriate or timely care related to her anticoagulation therapy. The target range for her INR was too high, increasing the risk of a life-threatening bleed. In addition, on the two occasions when her INR was very high, the provider did not lower the dose until a day after the result had been sent to the facility. In addition, the CCHCS anticoagulation guidelines state that the warfarin needs to be held for 24 hours if the INR is 4.5. This was not done on either occasion. Moreover, according to the online medical journal UptoDate, "In adults, hemorrhage is the predominant manifestation of Moyamoya, and anticoagulation is generally not indicated."[53] The disorder is often treated surgically. It is not clear from the documentation that was available in the eUHR whether surgery has been considered for this patient. We recommend that staff obtain the patient's stored medical records and determine if there is a reason the patient would not be a surgical candidate. If such documentation does not exist, the patient needs to be referred for a surgical evaluation.

- The patient is a 54-year-old woman with hypertension, hyperlipidemia, hypothyroidism for which she is receiving thyroid replacement medication, and atrial fibrillation for which she is receiving long-term anticoagulation. On 6/25/13, her TSH (thyroid stimulating hormone) was low (0.05 mIU/L; normal range=0.4-4.50 mIU/L), indicating that her dosage of thyroid replacement medication was too high. On 6/26/13, a provider notified the patient that an appointment was being scheduled to discuss her laboratory tests. The provider saw the patient on 6/28 and 7/5/13 for her anticoagulation. The provider did not address the low TSH. As of 7/26/13, a provider had not addressed this issue.[54]

Assessment

The patient did not receive timely care for her thyroid disease. This is of special concern in this patient as high levels of thyroid medication can exacerbate her atrial fibrillation. The patient needed to be seen within two weeks.

- The patient is a 60-year-old woman with diabetes, hypertension, hypothyroidism and recurrent deep vein thrombosis for which she is on long-term anticoagulation. On 6/5/13, her INR was elevated (4.1). A physician reviewed the result on 6/6/13, but did not take

[52] Chronic Care Patient #19.
[53] Nijasri Charnnarong Suwanwela, MD, Moyamoya disease: Prognosis and Treatment, UptoDate, April 2013.
[54] Chronic Care Patient #20.

action until 6/7/13, when he held the warfarin for one day and decreased the dosage beginning the following day.[55]

Assessment

The patient did not receive timely care related to her anticoagulation.

- This 51-year-old patient transferred to CCWF in 2009.[56] Due to the complexity of her medical conditions, we reviewed her care for continuity over time. Her medical history included obesity, HIV infection, chronic hepatitis C infection, asthma, diabetes, hypertension, hyperlipidemia, irritable bowel syndrome (IBS), and surgical repair of a left hip fracture from a motorcycle accident in 2009 with residual left-sided weakness. She uses a wheelchair because of left-leg weakness. On 8/22/11, the patient had a negative bilateral mammogram. The radiologist recommended repeating the mammogram in approximately one year. This has not taken place. Another concern is that in August 2012 she had an elevated alpha-fetoprotein (AFP=11 ng/mL, normal=<6) but has not had an abdominal ultrasound since 2011 to screen for hepatocellular cancer (HCC). Although medical providers have followed the patient routinely, the patient's care is fragmented and potentially serious medical findings have not been addressed. The patient has been in a wheelchair since her incarceration but the clinical reason for the wheelchair is unclear and providers have not documented any musculoskeletal or neurological evaluations to speak of. The patient has also complained of persistent low back pain for which a provider ordered a lumbar and pelvic x-ray that were not performed or refused, and for which ordered follow-up did not take place. The patient has been monitored routinely for HIV infection with current laboratory tests in the record, but with respect to her diabetes, the patient has not had a repeat hemoglobin A1C for over six months, since 11/30/12, yet providers documented that the patient's diabetes is at goal at each chronic disease visit.

Assessment

This patient needs an adequate evaluation to assess why she is wheelchair bound and a determination made whether physical therapy or other treatments may provide improved mobility for her, including elimination of wheelchair use. She also needs an adequate evaluation of her chronic hepatitis C infection and screening for hepatocellular carcinoma and an evaluation of her low back/pelvic pain to rule out a serious medical condition.

Prenatal Care

Findings: CCWF has an obstetrician/gynecologist on staff. This is extremely helpful. This is an intake facility, so pregnant females are incarcerated and remain at CCWF until they can be transferred to California Institute for Women (CIW). Nevertheless, they may remain at CCWF for several months. Prenatal care was reviewed and is excellent. Documentation of pregnancy care is on a formatted flow sheet, but these are not consistently scanned to the eUHR when the

[55] Chronic Care Patient #21.
[56] Medical Reception/Intrasystem Transfer Patient #10.

obstetrician sees the patient. Prenatal care included all necessary laboratory testing. All prenatal care was timely and occurred at appropriate intervals.

Pharmacy and Medication Administration

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

Pharmacy Services

Findings: We noted that an internal audit did not find systemic lapses in pharmacy services. Our review, however, did identify issues related to renewal of medications at intake and health records in which patient's chronic disease medications expired. We also found records with medication errors. Some MARs are not scanned into the eUHR in a timely manner and we were unable to measure timeliness and continuity of medications (See Health Records).

The pharmacy is licensed and the current license expires on 11/1/2013. Its Drug Enforcement Agency (DEA) license expires 8/18/2013.

The pharmacy physical plant is cramped and inadequate for the volume of work at CCWF. The pharmacy is not sufficiently clean. The pharmacy is operational 7 a.m. to 5 p.m., Monday through Friday. On the weekends, there is an on-call pharmacist, and nurses have access to a Documed[57] that enables nurses to provide prescribed medications until the pharmacy opens.

Staffing consists of a PIC (Pharmacist 2) and six pharmacist positions, four of which are filled (three state and one contract) and two that are vacant. There are 12 pharmacy technician positions, all of which are state positions and one that is vacant.

As noted in the Medical Reception/Intrasystem Transfer section of this report, chronic disease and psychotropic medications for newly arriving inmates are renewed by having a medical provider sign the medication profile from the sending facility. However, the provider does not indicate the duration of the order. The form is forwarded to the pharmacy that uses it for the purposes of medication renewal. Review of these forms shows that provider signatures are often illegible and name stamps are not used.

Medication Errors

We reviewed records involving medication errors or lacking documentation of medication dosage changes. In one case, discussed above, a patient taking a blood thinner was transferred from VSPW to CCWF.[58] On the day of transfer, the VSPW provider ordered that the blood thinner be held because the patient's INR was elevated (INR=4.3, goal=2-3) and although the order to hold the blood thinner was faxed to CCWF, the evening nurse gave the blood thinner

[57] A machine for dispensing medications.
[58] Medical Reception/Intrasystem Transfer Patient #11.

to the patient. For this same patient, on 10/12/12, a provider saw the patient for Coumadin (warfarin) clinic and documented a plan to decrease the patient's dose from 9 mg to 8 mg daily with plans to obtain an INR in five days. We did not find a medication reconciliation report ordering the change in dosage.

In November 2012, a rheumatologist saw a patient with sarcoidosis and prescribed Imuran 100 mg daily for the patient; however, the December 2012 MAR showed that the patient was receiving 50 mg per day. This appears to have been a pharmacy error.[59] The same patient was ordered azathioprine 75 mg each morning and requested that it be changed to the evening. The provider did so but on 3/1/13, the nurse administered the medication to the patient in the morning and evening. This appears to have been a nursing error.

We found cases in which the patient's chronic disease medication orders expired, including anticoagulants (e.g., clopidogrel), cholesterol and antihypertensive medications.[60] In other records we were unable to evaluate medication continuity because MARs were not scanned into the record at the time of our review.

Medication Administration

Findings: We found that the medication administration process is working well. We inspected medication rooms and observed nurses administering medications. We found medication rooms to be clean and well-organized. Narcotics were counted each shift and a random check showed that counts were correct. Medications stored in the medication carts and refrigerators were current and none were expired.

We observed nurses administering medications and found that they each followed proper procedures and documented administration using the Medication Administration Record (MAR) at the time medication was prepared and administered to the patient.

Review of MAR records showed that they were neat, legible and complete.

Health Records

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

Findings: CDCR has migrated statewide from a paper record to an electronic Unit Health Record (eUHR). This is not a true electronic health record in which information is entered directly into the record, but one in which staff completes paper documents or dictates clinical notes that are transcribed and scanned into the record. Although an improvement over a paper record, it has significant limitations. Most importantly, each encounter is filed as a PDF file that must be opened individually. Because of this, review of a medical record is a very time consuming

[59] Medical Reception/Intrasystem Transfer Patient #13.
[60] Medical Reception/Intrasystem Transfer Patient #8, and #5.

process, and important clinical information can be missed when providers are seeing many patients during a clinic session. In addition, the eUHR does not directly interface with the pharmacy information system (Guardian), laboratory (Quest) information systems, or the CCHCS Health Information Portal. It has limited interface with the Strategic Offender Management System (SOMS). This makes the record inefficient in accessing clinically relevant data such as the ability to know the patient's current medications without exiting the eUHR. The Receiver is in process of procuring a true electronic health record, which will dramatically improve communication between health care staff, reduce opportunity for medical errors, and improve the efficiency of health care service delivery.

Health Records Space and Operations

Health records space is of adequate size and is generally well organized. The flow of health record documents appears to work well.

Timeliness of Scanning Health Documents

We found that that current staffing is unable to keep up with scanning health record documents into the eUHR. As noted in earlier reports, ABSR was implemented prior to the designated change in institutional medical missions as either Basic or Intermediate. In March 2013, the health records staffing was reduced by eight positions. The facility had both day and evening coverage prior to the staffing reductions, but now has a day shift only. Since the reductions, staff has not been scanning MARs on a daily basis. Moreover, the CCHCS Health Records Center in Sacramento no longer provides assistance in scanning MARS. At the time of our site visit, there were approximately sixty inches of documents to be scanned into the eUHR. This is one of the downsides of not having an electronic health record in the midst of downsizing.

Although CCWF was designated to be a Basic facility, the reduction in the number of CDCR women's facilities from three to two places increased pressure on the remaining two facilities to manage high acuity medical and mental health patients. The presence of the skilled nursing facility in and of itself will draw higher acuity patients. In our opinion, for all intents and purposes, CCWF functions as an Intermediate facility. Yet health record staffing was reduced from 15 positions to six positions and, based upon the current backlog, may not have appropriate health records staffing. Although health care leadership is authorizing overtime to try to catch up, CCHCS needs to monitor the situation and adjust staffing as necessary to enable the facility to contemporaneously scan health documents.

We also found that while there is a system for providers to sign and date review of laboratory tests, there is no system in place to ensure that providers sign and date review of specialty services and hospital reports. Our review showed that providers generally do not sign and date dictated consultant and biopsy reports. This is both a medical and legal issue that presents a risk that important clinical findings will not be addressed.

Urgent/Emergent Care

Methodology: We interviewed health care leadership and staff involved in emergency response and toured the Triage and Treatment Areas (TTA). We reviewed the CCHCS Institutional Reports on potentially avoidable hospitalizations. 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: There were no impediments with respect to access to emergency care. There were several problems with quality of chronic and urgent care that resulted in hospitalization and increased risk of harm.

Problems with care included the following. One patient[61] with significant sickle cell disease had a gluteal abscess for which antibiotics were prescribed. Two days later the abscess was indurated and a provider sent the patient to the TTA for incision and drainage. The patient had fever and tachycardia, which indicated systemic infection and warranted a higher level of observation (SNF unit observation) and possibly intravenous antibiotics. The provider did not document incision and drainage of the abscess; instead, the patient was sent back to the yard on oral antibiotics. Three days later, the wound began to drain pus. A provider was not consulted and the nurse did not document placement of a dressing. The patient needed, at a minimum, to have been housed on the SNF unit. There was no documentation indicating why the provider in the TTA did not incise and drain the abscess.

Several patients did not have adequate medication management. One was the same patient with sickle cell disease referenced above.[62] This patient had severe sickle cell disease with avascular necrosis of her hip.[63] This patient did not have a clear pain medication management plan in her record. She also had episodes of care during which pain medication was changed without documentation of adequate history or physical examination of pain. Over a period of two months, the patient had two hospitalizations for pain control which could have been managed at the prison if an adequate pain management plan was in place.

Another patient[64] demonstrating medication management and chronic care problems was a patient post bypass surgery for coronary heart disease, diabetes, hypertension, hyperlipidemia, peripheral artery disease, hypothyroidism, heart failure, bilateral carotid artery disease and chronic kidney disease. This patient was on Plavix and a beta-agonist inhaler, but the reasons for being on Plavix or the inhaler were not documented in the record. The patient had a hematoma (a bleeding episode) which may have been a complication of the Plavix. This patient also had a positive occult blood test on 3/6/12 which was never followed up. This patient subsequently was admitted twice to a hospital in May 2013 with respective hemoglobin tests of 9.4 and 7. She refused colonoscopy during her hospital admission, but the positive occult blood

[61] Hospital Record Patient #1.
[62] Hospital Record Patient #1.
[63] A destruction of the hip joint often seen in patients with sickle disease.
[64] Hospital Record Patient #3 .

had not been worked up for 14 months and it was the hospital, not the chronic care program that identified the problem.

From September 2012 until May 2013, the patient had uncontrolled blood pressure and diabetes. The patient had two hospitalizations, multiple specialty visits with a cardiologist but only two chronic care visits eight months apart. The patient's chronic care was managed by specialists and hospitalists. Twice the cardiologist recommended increased blood pressure medication. The primary care provider did not follow up on one of those recommendations. The primary care provider did not adequately manage the patient's blood pressure or diabetes. On 4/29/13, the patient experienced a rapid pulse to 150 with atrial fibrillation. The patient was admitted to a hospital where she was treated for heart failure. The patient returned to the prison on 5/2/13 and was sent back to general population. She probably needed to be housed on the SNF unit. This patient had a history of refusing medication and after a serious illness, general population housing was not prudent.

On 5/4/13, the patient complained of difficulty swallowing her food. A nurse evaluated the patient in the TTA. The nurse did not take a thorough history. The patient was fed, and when observed to have eaten without difficulty, the nurse obtained a provider order to refer to mental health. However, the following day the patient developed shortness of breath and a rapid pulse to 135. She was hospitalized and diagnosed with a myocardial infarction and decompensated heart failure. The uncontrolled diabetes and hypertension likely contributed to her myocardial infarction and heart failure.

Upon return to prison on 5/7/13, the patient was on a diuretic (furosemide) in addition to her other medications. Her first provider visit was 5/9/13. The patient's weight was 117. The provider noted the hospital diagnosis of non-ST elevation myocardial infarction (NSTEMI) (heart attack) and noted that the patient did not want interventional management. The patient refused physical examination. The provider only noted three diagnoses: NSTEMI, anemia and atrial fibrillation. This was again episodic and did not consider all of the patient's conditions. Although this patient frequently refused care, her chronic care notes were not thorough and did not address all of her problems. Medication management was poor. Her occult bleeding was not addressed at the prison despite being on Plavix. This was poor care management.

Coordination of care with the mental health staff also appeared to be problematic. One patient[65] had four life-threatening episodes of low serum sodium resulting in two hospitalizations. Her low serum sodium was a result of drinking excessive water, probably as a result of a mental health condition. Nevertheless, there was no attempt, despite repeated life-threatening events, to coordinate a treatment plan with mental health to manage this patient. This patient probably needed to be housed on the SNF unit for observation and management. During one episode of low sodium, the sodium level was 112, which is a life-threatening level. The patient was confused earlier in the day as a result of the sodium level. The medical staff in the TTA attempted an intravenous line to treat the patient with sodium, but the line could not

[65] Hospital Record Patient #2.

be started. The patient was sent back to her housing unit with salt tablets. This was dangerous. Since the patient had confusion earlier in the day, she could not have been expected to reliably take her medication, salt tablets, or report symptoms. This patient needs to have been sent to a hospital or kept on the SNF for observation.

There were occasional cases where providers made poor clinical decisions that ultimately resulted in hospitalization. One case[66]involved a 62-year-old woman with hypertension and hepatitis C infection. The patient was followed appropriately in chronic clinic. On 2/20/13, the patient was evaluated for chest pain. The EKG demonstrated lateral T wave inversion which could have been consistent with ischemia. The patient needs to have been admitted to a hospital to evaluate for myocardial infarction. Instead, she was returned to general population with a proton pump inhibitor.[67] Four days later on 2/24/13, the patient returned urgently with complaints of chest pain, shortness of breath, and palpitations. Another EKG showed lateral T wave inversion and the patient was admitted to a local hospital. Studies were negative for myocardial infarction but the patient was diagnosed with dilated cardiomyopathy and hypertension. She returned to prison and was seen on 2/27/13; the provider noted the hospital diagnoses. The provider ordered a cardiology follow up. On 3/4/13, the patient collapsed and died. Although the provider made a diagnostic error on 2/20/13, it did not appear to contribute to the patient's death, which does not appear to have been preventable.

We did review several hospitalizations for term pregnancy. In all cases, appropriate prenatal care was provided. Labor was recognized and the mother was timely transported to the hospital for delivery.

Specialty Services/Consultations

Methodology: We interviewed staff involved in the review, approval and tracking of specialty services, OIG and other internal reports and reviewed health care records of 12 patients for whom services were requested.

Findings: We did not find any problems related to specialty care or the follow-up by the primary care physicians. This is better than the findings of the OIG's Cycle 3 Inspection Report where they found that, overall, specialty services scored 90.7%. Our findings are consistent with the June 2013 Dashboard findings of 100% for Specialty Consultation and 94% for PCP Specialty Follow-up. However, we did find that there is no system in place for providers to sign and date when consultant, diagnostic, and hospital reports are reviewed.

Skilled Nursing Facility (SNF)

Methodology: We toured the SNF, interviewed SNF health care and custodial staff, and reviewed SNF tracking logs and five patient health records.

[66] Hospital Record Patient #6.
[67] A medication used to treat reflux and/or ulcer disease.

Findings: CCWF is the only state prison in California to have a Skilled Nursing Facility (SNF). A SNF is defined by State of California Title 22 regulations as a "health facility or a distinct part of a hospital which provides continuous skilled nursing care and supportive care to patients whose primary need is for availability of skilled nursing care on an extended basis." A SNF and a Correctional Treatment Center (CTC) are for practical purposes identical with respect to the level of acuity of patients and the types of services which can be provided. Intravenous antibiotics can be provided at both types of facilities and this is the highest level of medical procedure employed at both facilities in the CDCR system. Except for historical reasons, we could not identify a reason why this particular facility has a SNF as opposed to a CTC. There was no adverse effect on patient care by virtue of having a SNF license as opposed to a CTC license.

The SNF unit at CCWF has 39 licensed beds, but only 37 of these are considered active; two of the beds are not utilized. Of the 37 usable beds, 25 are used for medical patients and 12 are used for mental health. On the day of our visit, there were 28 patients on the unit. Twenty-three of these were medical patients and five were mental health patients. Almost all of the 23 medical patients were long-term care patients. Except for two patients (one with a recent lung abscess and another with exposure to chicken pox), the 21 other patients had significant physical disabilities and required long-term nursing care. Most patients were complex patients with multiple medical conditions.

Although there were 9 vacant beds during our visit, 23 of 25 medical beds were filled, and leadership reported that the SNF unit was almost always filled to capacity. This is problematic for several reasons. There are now only two female facilities in CDCR: CCWF and CIW. Females will not be permitted in the new CHCF in Stockton and therefore all females will need to be cared for at CCWF and CIW. This means that the SNF at CCWF and CTC at CIW will be used to house disabled and long-term care patients in addition to providing short-term care for acutely ill patients or for patients who need closer monitoring of their illness. Based on record reviews already described,[68] it was clear that several patients needed to have been housed on the SNF but were instead housed in general population because there were no beds on the SNF. This adversely affected care and is dangerous. Given that CHCF will be unavailable for females, there will be insufficient higher acuity bed space for females. One option is to open the OHU at CCWF to unburden the SNF.

The SNF unit does not have a regularly assigned provider but is managed by rotating coverage. Providers rotate on this unit every three months. Given the complexity of patients on this unit, it takes some time to become acquainted with patients' problems. By the time providers are comfortable knowing the patients, it is time to rotate off the unit. This appeared to us to result in inadequate care on this unit.

An example of a patient who needed to have been housed on the SNF is provided below. This patient[69] was transferred to CCWF when VSP changed to a male facility in January 2013. She

[68] Hospital Record Patient #1, #2, and #3 in the Urgent Care/ Hospitalization section of this report.
[69] SNF Patient #4.

had chronic obstructive pulmonary disease (COPD)/asthma with prior intubation, hypertension and GERD. Her COPD was very severe and required long-term steroid therapy. On the day of transfer, the patient had very low PEFR[70] values of 215 to 320. She had expiratory wheezing on the day of transfer. The nurse administered a nebulizer treatment and scheduled a three-day provider follow-up. Due to the condition of the patient, the provider appointment needed to have been the same day instead of three days later. The patient had a history of not taking her medication, but this was not recorded on the transfer screening form and the patient remained on keep on person medication.

On 1/13/13, before the 72-hour appointment occurred, the patient was seen emergently because she said she could not breathe. Her blood pressure was 180/102 mmHg, pulse 90 and respiratory rate was 24 (normal rate is 12-20). The nurse provided a nebulizer treatment with medications based on a standing order; a provider was not consulted. The patient improved and was returned to housing with a PRN (as needed) follow-up. She needed to have seen a provider and should probably have been placed on the SNF unit for observation.

A provider saw the patient on 1/14/13 and noted that the patient had COPD and asthma. The provider noted that the patient had an exacerbation of COPD on 1/3/13 prior to transfer. The patient had moon facies (a condition indicating long-term steroid use and reflecting severe emphysema or asthma), a peak flow of 340 and had scattered rhonchi and no rales. The provider ordered a next day visit. A provider saw the patient the following day on 1/15/13 and the provider started steroids on a tapering dose. A chest film needed to have been considered. This was a 58-year-old female with significant COPD requiring steroids. The provider needed to have excluded infection.

On 1/16/13, the patient had another exacerbation of COPD. A provider ordered SoluMedrol (a steroid that is administered intravenously or intramuscularly) and a chest x-ray. The provider sent the patient back to her cell. However, the provider needed to have admitted the patient to the SNF. The provider started Levaquin (an antibiotic). The patient continued receiving KOP medication. On 1/17/13, a provider saw the patient again urgently in the TTA for COPD. The provider continued existing medications as KOP medication even though the patient had a history of non-compliance with medication

On 1/18/13, a provider saw the patient, who was not improved. The provider started medications as directly observed therapy. This was appropriate and needed to have been done from intake based on her history at the prior facility. If the patient were on the SNF, medication would have automatically been directly observed. On 1/22/13, the patient did not improve and the provider discussed the case with the Chief Physician and Surgeon, who recommended

[70] PEFR (Peak Expiratory Flow Rate) measures a person's maximum speed of expiration and is used to determine the degree of obstruction in patients with asthma.

placing the patient on the SNF. Since there was no available bed, the patient was placed in unit 505[71] for closer observation until a bed opened up in the SNF.

By 1/23/13, the patient was still in general population because no bed was available. She was improving somewhat because she was taking her medication. On 1/28/13, the patient experienced another exacerbation of COPD and was sent to a hospital for further evaluation. She was diagnosed with right lower lobe pneumonia and COPD exacerbation, but was not kept in the hospital. She returned to CCWF that day.

On 2/8/13, the patient saw the pulmonologist in his office and from there was sent directly to a hospital for exacerbation of asthma. At the hospital, the patient was treated for an acute exacerbation of bronchial asthma.

The patient was hospitalized again for an acute asthma exacerbation on 5/2/13 and remained in the hospital until 5/7/13. Upon arrival at the hospital, her potassium was very low (2.8 mEq/L, normal range 3.7-5. mEq/L), assumed to be from being on furosemide (a diuretic). The patient was found to have a Candida infection (a fungal infection) due to broad-spectrum antibiotics and long-term prednisone use and was treated with Ketoconazole (an anti-fungal medication). When the patient was discharged from the hospital she was finally admitted to the SNF. The admission history was extremely brief and did not describe the prior asthma history or the recent hospital status. The physical examination was good except it did not include a PEFR. The assessment and plan included all problems and was adequate. The reason for admission was not given. This patient had two hospitalizations that may have been prevented if closer observation on the SNF were available.

The first provider note after discharge from the hospital was 5/10/13. The provider noted that the patient still had cough and on physical examination wheezes were noted. Steroid medication was increased. The patient was seen weekly, even though due to her condition and symptoms she probably needed to have been evaluated daily.

Currently, all acute and chronic illness patients in need of higher-level housing are not receiving appropriate housing. Opening unit 505 as an OHU may relieve bed space on the SNF.

The SNF has four corridors of patient rooms arranged spoke-like around a central nursing station. Between two of these four corridors, there is another span of patient rooms immediately across from the nursing station. The nursing station is extremely small. Although this area is clean, there was insufficient room to work. There are currently 7-9 nursing staff during days and six staff on nights; the unit utilizes 12-hour shifts. However, the nursing station had only two eUHR terminals and the keyboards for the terminals could not be ergonomically used because there was insufficient space on the counters. Keyboards were placed at the very

[71] Previously, CCWF had an OHU in addition to the SNF. This unit is not currently used as an OHU even though the call system is still in working order. This unit is called unit 505, and providers at CCWF still use it to house sicker patients, although it is not staffed or equipped as an OHU.

edge of the counter. Of the nine daytime nursing staff, 4-5 are Registered Nurses who have significant nurse charting requirements. The nursing station did not have sufficient space for five Registered Nurses to work. With the approaching installation of an electronic record, units like this will require re-configuration to accommodate appropriate number and placement of electronic devices so that all staff is able to access the devices to complete their assignments. As well, nurses bring their medication carts into the nursing station to prepare medication administration and it is extremely crowded.

The nurses have complete access to patients by virtue of having door keys on their person. There were no difficulties with respect to access to patients for performance of nursing duties. When nurses anticipate difficulties with a violent or difficult patient, they ask and receive custody assistance. This system works very well. The unit appeared quiet and well managed. We were told that there are no security issues. Patients were clean, beds were made, there was no clutter, and nurses, based on observation, appeared to spend considerable time with patients. We note that the rates of refusal of vital signs and other nursing tasks is very low (estimated at less than 5%) on this unit as opposed to a GACH we recently visited, where the refusal rate was approximately 50%. A major difference between these two facilities is the access of nurses to patients. We commend CCWF for the relationship between custody and medical on the SNF unit related to nurse access to patients.

There is no examination room on this unit, so all nursing and provider evaluations must be performed bedside even when two patients share a room. There are occasions when private examinations are required. While portable curtains can be used, it would be better if there were an examination room on this unit for assessments that require privacy.

We toured the unit and were impressed by the excellent sanitary conditions. Corridors, work areas, and patient rooms were not cluttered, were clean and the floors of all rooms, including patient rooms, are regularly waxed and buffed. We commend the facility for this effort.

The unit is supervised by Lorraine Vance, an SRN II. Staffing on this unit is similar to a CTC unit in terms of Title 22 requirements of 3.2 nursing hours per patient day. This unit has a population of very sick and disabled patients and the acuity level requires additional staffing above Title 22 requirements. One RN position for this unit was lost in realignment, but that loss did not affect ability to staff the unit. Staffing is currently managed on a 12-hour shift basis. On the day shift, there are three or four RNs and four Certified Nurse Assistants (CNAs). On evening shift, there are three RNs and three CNAs. These staffing numbers are in place seven days a week.

Nursing care on this unit was good. Based on charts reviewed, physician ordered care was provided to patients, and patients on the unit appeared well cared for. As with other facilities, there is an excessive amount of required nursing documentation that is redundant and not geared toward specific patient needs. While patients appeared to be cared for, the nursing documentation did not always represent a treatment plan specific for the patient. At this facility, nursing leadership has attempted to make nursing care more specific to the needs of

the patients by utilizing 30 preformatted nurse treatment plans. In addition, specific patient care instructions are kept on either an individual care plan or on other documents, such as skin profile (for decubiti), which has documentation of daily skin care similar to a MAR. Still, there was much redundant and unnecessary documentation which was unrelated to patient specific care needs.

There were problems with provider clinical management on the unit. Providers provided episodic care on the unit instead of identifying all patient problems and developing a treatment plan for each problem. There were several examples of this. One patient[72] had diabetes, hyperlipidemia, osteoporosis, and a history of previous breast cancer. The admission history did not provide a reason for admission to the SNF or a history of the breast cancer. There was no history provided for each of the patient's problems, and the assessment did not include the current status of the patient. Medication management was not addressed. From October 2012 until May 2013, her diabetes was not in control (HgbA1C around 9%). Although the provider described the patient as having frequent hypoglycemia, we could only identify four episodes of hypoglycemia in provider notes. The patient did not appear to have an adequate treatment plan for her diabetes and it was not clear why she was being housed on the SNF. Provider notes are required weekly on the SNF, but it appears that between October 2012 and April 2013, many provider notes were either missing or not done, and existing progress notes were not in chronologic order.

Another patient[73] had multiple sclerosis, hypertension, degenerative arthritis, blindness, hypothyroidism, GERD and hyperlipidemia. Because of provider rotation through this unit, the care provided to this patient was provider specific. One provider wrote careful and thorough notes documenting each problem and creating a care plan for each problem. Another provider documented only episodic care and did not consistently document all problems with a treatment plan. These types of issues need to be addressed in UCA reviews, and require consistent provider staffing and adequate documentation.

Another patient[74] had a coronary stent placed 7/10/11 with a recommendation to continue aspirin and Plavix for 18 months. The Plavix was to be stopped in January 2013, but appeared to have continued indefinitely. This was unrecognized. Later, this patient fell on the SNF unit and was more susceptible to bleeding because she was on Plavix. This medication with serious side effects was unnecessary.

The patient had no Problem List in the eUHR. Her admission physical examination to the SNF on 6/2/13 was after hospitalization for a COPD exacerbation, but contained virtually no history of her existing medical problems or of her recent hospitalization. The hospital summary was not yet scanned to the eUHR as of 7/12/13, but a brief hospital discharge summary of only one paragraph was in the paper record. In the eUHR Problem List, no problems were listed. The 6/2/13 admission note to the SNF documented that the patient was hospitalized for

[72] SNF Patient #1.
[73] SNF Patient #2.
[74] SNF Patient #5.

exacerbation of COPD, but there was no summary of what occurred at the hospital or how long she was hospitalized. When the patient returned to CCWF, there was no TTA note in the eUHR documenting her return. All patients returning from the hospital are to go through the TTA and need to have a note documented in the chart.

There were three pages of admission orders to the SNF dated 6/1/13, including about 30 medications. The 6/2/13 admission note to the SNF included the following problems: coronary artery disease, seizure disorder, chronic kidney disease on dialysis, hypertension, anemia, hyperlipidemia, COPD, cerebrovascular accident, and hypothyroidism. No further definition of these problems was provided. On a 7/2/13 provider order, the following diagnoses were also listed: pulmonary embolism, history of subarachnoid hemorrhage and a psychiatric disorder. This was not adequate documentation or evaluation.

On 6/4/13, there was a telephone order for oxygen at 2 liters by nasal canula, yet it was not clear that there was evidence of the patient requiring continuous oxygen therapy. The patient had not yet seen a provider. There was no provider note accompanying this order.

The first note on 6/5/13 had a history negative for shortness of breath, paroxysmal nocturnal dyspnea[75] or orthopnea[76], and assessed only resolved pulmonary edema and a healing decubitus ulcer. The decubitus ulcer was described in the physical examination. None of the patient's other nine problems was assessed. The note implied that the patient was recently admitted to the hospital for pulmonary edema, but heart failure was not a listed diagnosis and it was not clear exactly why the patient was hospitalized.

When the patient was admitted to the SNF, a nurse obtained provider phone orders for the following medications: Azithromycin, Tylenol, Singulair, albuterol by nebulizer prn, amlodipine, aspirin, calcium acetate, Sensipar, Clonidine, clopidogrel, B12, enalapril, iron, folate, hydralazine, Atrovent, ipratropium, Xopenex, levetiracetam, levothyroxine, nitroglycerin, phenytoin, risperidone, simvastatin, Hydroxyzine, bisacodyl, Colace, metoprolol, Minoxidil, omeprazole, and Renagel. The reason for being on all these medications was not addressed in the first note and it was not clear what the medication management plan was. Based on an earlier hospital note, it appears that the Plavix was no longer indicated; this was important because the patient had subsequent falls and this could be a safety issue.

A hospital list of medical diagnoses included prior myocardial infarction with coronary stent, COPD, hypertension, diabetes, polycystic kidney disease, prior cerebrovascular accident, pulmonary embolism, heart failure, hyperlipidemia, asthma, arthritis, coronary artery disease, anemia, seizure disorder, psychiatric conditions, pressure ulcer, and history of subarachnoid hemorrhage. Exacerbation of COPD with heart failure was documented as the reason for admission. A hospital summary was in the paper record but not scanned to the eUHR. The list of hospital diagnoses did not match the CCWF Problem List, admission assessment list, or list of

[75] Paroxysmal nocturnal dyspnea is a sensation of shortness of breath that awakens the patient from sleep.
[76] Orthopnea is the sensation of breathlessness in the recumbent position, relieved by sitting or standing.

problems being managed by the SNF provider. This can result in harm to the patient by missing needed therapy.

On 6/10/13, a fairly thorough physical examination was performed. The patient had an episode of hypotension with systolic blood pressures in the 90s during the morning. The provider noted that on multiple tests the patient's systolic blood pressure was in the 90s. The provider noted a weight gain of four pounds in five days. The care reflected in this note was episodic and the provider discussed only the hypotension and potential fluid overload. The patient's multiple problems were not assessed and it was not clear what the plan was for any of the patient's problems. The provider ordered blood pressure medication to be held if the systolic pressure was less than 100. However, the patient was taking six medications for hypertension and there was no review of the multitude of medications to assess whether any one of them or combination of them might have resulted in low systolic blood pressure. The effect of stopping or holding all antihypertensive medications was not considered; some of these were probably also being used to treat heart failure. An "all or none" approach with respect to holding blood pressure medication was potentially dangerous given the patient's conditions.

On 6/11/13 at 5 a.m., a nurse took a phone order to reduce the enalapril, hydralazine, and Clonidine and to discontinue the metoprolol and Minoxidil. There was no note associated with this change of therapy and no rationale given for the therapeutic change. While a reduction in blood pressure medication was clinically indicated, the provider needed to have documented the rationale in a note. Because the patient had heart failure, the provider needed to have considered continuing metoprolol and discontinuing Clonidine.

The provider note later that day on 6/11/13 did not document recognition that a provider, by telephone order, had changed blood pressure medication the night before. The blood pressure during the provider visit was 155/67 mmHg and the patient had increased (2+) leg edema. The patient's B-type natriuretic peptide (BNP)[77] was 1228 pg/mL, indicating possible heart failure. The provider noted that the chest x-ray demonstrated a small left sided pleural effusion. Pleural effusion was not previously listed as a problem and because the hospital stay was not summarized, it was not clear whether the patient had a pleural effusion in the hospital. There were two assessments: hypertension and increased BNP. The assessment of hypertension was listed as "improved" because the patient had an episode of hypotension the day before. However, the blood pressure with a systolic blood pressure of 155 was not normal and the phone order discontinuing blood pressure medication was not documented as known. The provider assessed that the prior day's low blood pressure was due to her edematous state. The assessment of increased BNP was accompanied by a statement that the patient had no signs of heart failure and that a chest x-ray of 6/10/13 noted a small pleural effusion but no pulmonary edema. The remainder of the patient's problems were not assessed. This was episodic care.

[77] BNP is a substance secreted from the heart in response to changes in pressure that occur when heart failure develops or worsens. BNP levels above 100-300 pg/mL suggest heart failure is present.

On 6/12/13, no problems were noted in the assessment. The blood pressure was 109/64 mmHg, but there was no comment on the variability of blood pressure readings. A reasonable physical examination occurred, but none of the patient's other medical conditions evidenced being addressed except for heart failure. Even though it appeared that heart failure was being followed, this diagnosis was not listed in the problem list.

On 6/18/13, laboratory tests were reviewed which had been reported on 6/12/13. These included an elevated glucose of 156 mg/dL and low hemoglobin of 8.6 gm/dL (normal range 12.1-15.1 gm/dL). The creatinine (4.0 mg/dL; normal range 0.6-1.1 mg/dL) was also elevated and the GFR[78] (12 mL/min/1.73 m^2; normal range 90 - 120 mL/min/1.73 m^2) was low, indicating renal failure. The provider notes did not document whether the patient was receiving dialysis, even though it was listed as a condition on the SNF admission note. Liver function tests were documented as normal but the alkaline phosphatase[79] was elevated 395 IU/L (normal range 20-10 IU/L). The only assessments were pulmonary edema and hypertension. The abnormal lab results were not assessed. There was no update on the continuous oxygen therapy and, with respect to the patient's COPD, there was no documentation of the patient's baseline status. The provider documented that with respect to pulmonary edema, the patient gained 3 kg over two days but that the patient had no symptoms of heart failure. The blood pressure was elevated at 164/74 mmHg but was not noted as abnormal. The only plan was to restrict fluid intake to a liter a day for three days. For the assessment of hypertension, the provider documented that the blood pressure was improved even though the blood pressure was 164/74 mmHg. It was not clear the provider knew that antihypertensive medication had been discontinued by phone order previously because the provider did not document this incident. The high blood sugar was not evaluated relative to whether this was new diabetes and whether the patient needed treatment. There were many careless omissions evident in this note.

On 6/19/13, the provider documented a patient fall while going to the commode. The blood pressure was 115/65 mmHg. Since blood pressure medication had not changed and since the day before the blood pressure was 164/74 mmHg, it was not clear why there was such a variation in blood pressure. The history did not include review of medication, relationship of the fall to dialysis and compliance with anti-hypertensive medication, use of nitrates, etc. This was important to eliminate any adverse drug action as a cause of the fall because the patient was on Plavix which placed the patient at increased risk for bleeding. As noted above, the Plavix may not have been indicated. None of the patient's problems was documented in the assessment. The assessment did include that the patient was scheduled for an echocardiogram but had refused. The provider ordered that the test be rescheduled.

On 6/26/13, the provider noted echocardiogram results as diastolic dysfunction and right ventricular systolic pressure elevation consistent with pulmonary hypertension which was attributed to her COPD. None of the patient's multitude of problems was documented in the

[78] GFR or glomerular filtration rate is a test used to check kidney function.
[79] Alkaline phosphatase is an enzyme that is often elevated in liver disease.

assessment and, for the entire SNF stay up to 6/26/13, it was not clear what the therapeutic plan was for each of the problems.

Through the remainder of the notes until 6/26/13 (the last note before our visit), there was no evidence that all of the patient's problems were being monitored. There was no summary of the hospital stay in the provider's note, but the provider was only monitoring the patient for the acute problem for which the patient was hospitalized in May. The patient was on almost 30 medications. These were not detailed in any provider note and it was not clear that the patient was being monitored for side effects. The hypotensive episode might have been due to one of her several blood pressure medications, but this was not assessed. When an on-call provider changed the prescription of five anti-hypertensive drugs, there was no comment in the chart. While the anemia might have been due to the chronic renal failure, there was no evidence of a discussion of why the patient had anemia. If it was due to renal disease there was no discussion of why erythropoietin[80] was not used. It was not even clear from the notes whether the patient was receiving dialysis or not. If the patient was not receiving dialysis and given that the creatinine was above 4.0 mg/dL, the use of enalapril was probably not safe and the patient needed to have seen a nephrologist. The patient was on Plavix, and it appears from a prior hospital note that the indication for this medication had expired. Keeping someone on Plavix unnecessarily who is at risk for falls and who had previously fallen is dangerous. There was no attempt to consolidate the patient's medications. The patient had elevated blood pressure one day and low blood pressure the next day for several days. There was no attempt to discern whether this was medication related.

Internal Monitoring and Quality Improvement Activities

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

We reviewed Emergency Medical Response Review Committee Meeting Minutes (January to April 2013), Pharmacy and Therapeutics Committee Meeting Minutes (June to December 2012) and Infection Control Committee Quarterly Meeting Minutes.

EMRRC Committee Meeting Minutes described the chronology of emergency response and was effective in identifying opportunities for improvement for both health care and custody staff. There was good documentation of follow up of problems, including completion of training.

With respect to Pharmacy & Therapeutics Committee Meeting Minutes, we found these to be lacking in meaningful content and discussion. The number of medication errors reported was extraordinarily low, suggesting that the system for identifying and reporting medication errors is lacking.

[80] Erythropoietin is a medication that increases red blood cells and is used to treat anemia in patients with chronic renal disease.

Infection Control Meeting Minutes contained data regarding the number and types of reportable diseases as well as nosocomial and community acquired infections. There is limited analysis of nosocomial infections and whether there is any relationship between infections. In the December 2012 meeting minutes, it was reported that the acceptance rate for flu vaccine was that 59% accepted and 43% declined; however, there was no discussion of whether this was an acceptable acceptance rate and what might be done to improve acceptance rates for the next influenza season.

Mortality Review

Methodology: We reviewed mortality review documents for 2012 and performed one record review.

Findings: There were six deaths at CCWF in 2012. Five deaths were due to terminal cancer and one death was due to complications of end-stage liver disease. There were three deaths so far in 2013. For five deaths, we reviewed the CCHCS Combined Death Review Summary and agreed with their findings. We performed a chart review for the one other death in 2012.

Overall, these mortality reviews did not demonstrate a consistent pattern of poor care contributing to the death. However, in one death there were several problems. This patient[81] who had cancer died of sepsis. She had a history of stage III colon cancer and hypothyroidism. She had a central catheter that was no longer used for chemotherapy but apparently was kept in place for ease of phlebotomy. Chemotherapy was last given 1/18/12 and the catheter was still in place on 9/13/12.

On 9/13/12, the patient complained of being sick, having chest pain and complained that her central line port was painful, red, and swollen. These are signs of infection. A nurse saw her for this on 9/13/12. The patient's temperature was 99.4°. The nurse noted that the catheter port was red, warm and raised. The patient complained of fever and chills and tenderness to palpation over the chest. The lung sounds were not assessed because the patient said she could not take a deep breath. The evaluation was consistent with infection. The nurse assessed a risk for bacterial infection because of a red and warm port of unknown etiology. The nurse called a provider who recommended no new orders except a follow up with a provider. Given all the findings of the nurse, and assuming the nurse communicated these to the provider, the provider needed to have had the nurse send the patient for a provider evaluation. This was also identified as a problem by the Combined Death Review.

The following day, a nurse saw the patient. The patient complained of an infected port and shortness of breath. The patient was sent to the TTA. In the TTA, the nurse evaluated the patient and documented redness around the port. A provider was notified. The provider ordered blood cultures, but the nurse was unable to obtain blood from the port although the nurse was able to flush the port. A laboratory technician drew peripheral blood for cultures. A

[81] Mortality Review #1.

provider saw the patient and documented no fever or chills but noted redness, pain, and swelling of the central line site. The provider assessed cellulitis versus an infected port. The provider ordered oral antibiotics and documented that if the infection was not improved or worse, the line needed to be removed. Because the catheter was not needed, if the provider suspected an infected catheter or cellulitis, the catheter needed to have been removed immediately. The conclusion of the Combined Mortality Review did not include this criticism. Moreover, perhaps the most important point we identify that was not identified by the Combined Mortality Review is that if the catheter was unnecessary, it needed to have been removed nine months earlier. Why place a patient at risk in order to make phlebotomy easier?

The following day a nurse evaluated the patient emergently for difficulty breathing. The patient had an increased pulse rate (142/bpm). The patient was evaluated in the TTA. The provider evaluated the patient and sent her to the hospital to rule out a pulmonary embolism. Blood collected on 9/14/13 was tested and reported 9/17/13. The white count was 23.2 and the blood culture grew staphylococcus aureus. On 9/20/13, the patient died in the hospital from complications of sepsis.

This case needs to result in a general discussion of management and indications of central venous catheters with the medical staff.

Recommendations

Organizational Structure, Facility Leadership, and Custody Functions

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

1. Due to the increase in population and resulting higher acuity, CCWF should be designated as an Intermediate Facility, and staffing, especially medical provider staffing, should be increased.
2. UCA provider reviews should be completed as required.
3. Local operating procedures on physician referral to PPEC consistent with the 2008 Court order on physician competency should be developed and put into effect at this facility.

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

1. The allocation for health care should match expected expenses.
2. Pending the implementation of the HCFIP, health care clinical areas should be re-designed and re-furnished so that providers can adequately evaluate patients.
3. The HCFIP should be re-evaluated due to the increased population, closure of VSPW, lack of ability to house females at Stockton, and increased burden on the SNF.
4. Re-opening unit 505 as an OHU should be considered if females will not be sent to Stockton.
5. The intake screening room should be re-configured or relocated so that examinations can take place if necessary and so that privacy is ensured.
6. All examination tables should be equipped for gynecological examination as this is a female facility.
7. Doppler units for assessing fetal heart tones should be available in every unit in which a pregnant female is expected to be cared for. Clinical care should include evaluation of the fetus for pregnant females.
8. Yard clinics and the gynecology office should include a microscope to perform wet mount evaluations.
9. The SNF nursing station should be re-designed and refurbished so that all nurses have access to ergonomically placed keyboards and terminals for documenting notes.
10. Examination rooms in yards that house disabled patients on wheelchairs should have examination rooms that accommodate disabled patients in wheelchairs. This should be consistent with the Americans with Disabilities Act.
11. The clinic in the administrative segregation unit in A yard should be refurbished so that it is appropriate for clinical evaluation of patients.
12. Equipment for emergency delivery should be available in the TTA.

Policies and Procedures

1. SNF policies and procedures should be re-evaluated. Redundant policies should be eliminated. Nursing policies that consist mostly of care guidelines should be re-formatted as guidelines as opposed to policies.

Reception and Intrasystem Transfer

1. Local policy and procedure should be revised to ensure that there is standardization to the medical intake process, including all processes such as screening, laboratory tests, tuberculin skin testing and timing of the physical examination.
2. The history and physical examination should be performed within seven days, in accordance with CCHCS policy. Optimally, appropriate laboratory tests would be ordered at intake and available to the provider at the time of the physical examination to assess disease control timely and formulate an appropriate treatment plan.
3. Providers should document a more adequate history and physical examination, including a more adequate past medical history, review of systems, and documenting normal and abnormal findings.
4. Providers should initiate and/or update the Problem List in the eUHR.

Access to Care: Nursing Sick Call

1. Health care leadership should review and provide feedback to nurses regarding their performance, including making appropriate provider referrals.
2. Health care leadership should analyze root causes of problems related to providers not addressing reasons for nursing referrals.

Chronic Disease Management

1. CCWF 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 CCWF 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. Health care leadership should reevaluate the system for renewing medications for newly arriving inmates. Providers should ensure that medication orders include all elements of a legal order.
2. Health care leadership should perform studies of pharmacy and medication errors and develop corrective strategies to address root causes.

Specialized Medical Housing: SNF

1. At least one full time provider should be assigned to the SNF as a regular assignment.

Mortality Review

1. Indications for maintaining and removing central line catheters should be reviewed with clinical staff.