San Quentin State Prison

Health Care Evaluation

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Introduction

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

To prepare for the prison health evaluations, in December 2012 the medical experts participated in a series of meetings with Clark Kelso, Receiver, California Correctional Health Care Services (CCHCS) and CDCR leadership and staff 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 and CDCR.

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

Methods of assessment included:

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

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

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

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

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

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

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

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

Overall Finding

We find that San Quentin State Prison will be providing adequate medical care once the significant problems in medical reception, health care staff access to OHU patients, and first responder initiation of CPR are corrected.

Executive Summary

On January 7-11, 2013, the Plata Court Medical Experts visited San Quentin State Prison to evaluate health care services. Our visit was in response to the OIG Medical Inspection Results Cycle 3 report showing that San Quentin scored 90.4% in April 2012. This report describes our findings and recommendations. We thank Warden Kevin Chappell, Chief Executive Officer Andy Deems, and their staff for their assistance and cooperation in conducting the review.

Since our last visit in 2006, significant improvements have been made in the health care delivery system to San Quentin. These improvements include:

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

We found that when patients were seen by medical providers, the quality of care was good. However, we found three significant barriers to health care access that present a serious risk of harm to patients. These are found in the areas of medical reception, health care staff access to OHU patients, and first responder initiation of cardiopulmonary resuscitation. We believe, however, that the deficiencies in these areas can be corrected in the relatively near future, and therefore we find San Quentin will be providing adequate care as soon as these deficiencies are corrected.

With respect to medical reception, we found that newly arriving patients with serious medical conditions do not receive an evaluation by a medical provider within seven days as required by the CCHCS policies and procedures. Some medical reception patients are not evaluated by a medical provider for over a month and some do not receive a physical examination by a medical provider at all. This presents a serious risk that newly arriving patients will not be diagnosed and treated in a timely manner. In addition, medical reception forms in use do not include an adequate medical history and review of systems, which are necessary to perform an adequate medical evaluation.

With respect to the Outpatient Housing Unit (OHU), we found that during the past six months, custody staffing has been reduced, so that, as a practical matter, there is only one officer assigned to the OHU to provide health care staff access to 34 OHU patients, including several that require complete care. As a result, we found patients who developed intravenous access infections that required hospitalization. One incontinent inmate had a diaper and nurses changed the diaper only once a shift. There was an odor of feces when passing the room and it was clear that this inmate needed greater attention than once a shift.

In addition, 10 of the 34 OHU beds are being transitioned to mental health beds, leaving 24 OHU medical beds for a projected population of 4,000 inmates. We are concerned that this is insufficient for a population of 4,000 that includes 690 condemned inmates. Moreover, staff reported that, except for an occasional inmate-patient, the majority of condemned inmate-patients must remain at San Quentin, even if their medical needs exceed what can be provided in the OHU. However, their security classification should not override the serious medical needs of the population. We recommend that consideration be given to dedicating medical beds for this population at the California Health Care Facility in Stockton.

With respect to emergency response, we noted two cases in which custody first responders failed to initiate CPR. Timely response by health care staff becomes moot if correctional officers do not assess unresponsive patients for signs of life and initiate CPR. This was consistent with the OIG Medical Inspection Results Cycle 3 report showing that first responders initiated CPR 60% of the time.

This review showed other clinical issues that require focused attention. This includes systemic delays in provider follow-up of chronic disease patients, due in part to limitations in the Inmate Appointment and Scheduling System (IMSATS) and the electronic Unit Health Record (eUHR). San Quentin staff has attempted to mitigate the problem by developing workarounds; they have developed an Access database that they use to track the highest risk patients. It is used as a communication tool between providers to promote continuity of care. Normally this would be accomplished through a true electronic health record; however, this is not yet in place. The San Quentin staff is to be commended for developing strategies to mitigate the limitations of the scheduling system and health record. However, despite their efforts, there continue to be delays in care for patients with poorly controlled chronic diseases. Moreover, this system exists solely due to commitment of the San Quentin medical leadership and is not part of the overall health care system.

We note that San Quentin is undergoing a medical mission change with its designation as an Intermediate facility. At the same time, implementation of the Acuity Based Staffing Realignment has resulted in an 18% reduction in health care staffing at the facility. We are concerned about the potential for this staffing reduction to negatively impact San Quentin's ability to sustain improvements in health care, and we recommend that staffing be reevaluated 6 months after the completion of the reassignment of higher acuity inmates to Intermediate facilities.

We congratulate the San Quentin leadership and staff on the improvements in health care delivery at San Quentin. We attribute this success to at least three factors that have played a major role in the improvements at San Quentin.

The first reason is the Court's Order that established a framework to hire competent physicians.[3] This Order resulted in a major overhaul of the medical staff in CDCR that culminated in the kind of quality medical staff we reviewed at San Quentin. A competent medical staff is the foundation of a sound medical program. Continuation of the spirit and terms of this Order will be instrumental in maintaining the foundation of the medical program. In addition, the Receiver's Plan of Action has resulted in increases in other health staff at San Quentin that has also had a dramatic effect on the medical program.

The second reason that care has improved is that the physical plant improvements initiated under the Receiver have resulted in significant gains and will ultimately result in adequate clinical space at San Quentin upon completion of the few remaining facility upgrades planned by CDCR. Adequate clinical space is a second fundamental part of delivering adequate health care. We are pleased in seeing competent physicians working in improved conditions.

The third reason for improvements in health care at San Quentin is that the Receiver, through the California Correctional Health Care Services (CCHCS) program, assumed operational control of many health care business functions, including development of a statewide network of health care providers, timely execution of business contracts and invoice payments, development of an electronic Unit Health Record (eUHR), an appointment scheduling system, provision of funding to supplement insufficient budgetary allotments and a statewide pharmaceutical operation. The Receiver has made many positive changes in allied support operations, but significant system challenges remain in this area, including purchase and installation of an electronic health record and a more functional appointment scheduling system. The remaining systemic operational challenges are discussed in the applicable sections of the report.

The Court's Order includes a process for the Receiver to transition responsibility for the health care system back to the State to "demonstrate their ability to maintain a constitutionally adequate system of inmate medical care…," while remaining under Court oversight until such time that the State has demonstrated the "will, capacity and leadership" to maintain a system of providing constitutionally adequate medical care. However, at the time of our visit to San Quentin State Prison, the Receivership had delegated authority to CDCR limited to activation of the California Health Care Facility, DeWitt Nelson Facility and Health Care Facility Improvement Program and Health Care Access Units. Therefore, to a large extent, this report reflects the state of health care at San Quentin State Prison under the oversight of the Federal Court. In order to evaluate the performance of CDCR in managing the health care system, we recommend that the Receiver accelerate delegation to CDCR while maintaining oversight of the

[3] Order re Quality of Patient Care and Staffing.

health care system until the State demonstrates that it can establish and sustain a constitutionally adequate health care system.

In order to maintain adequate conditions at San Quentin, it is our belief that CDCR must institutionalize and maintain operational changes established during the Receivership regarding the level of compensation and the contract process. In addition, the Receiver must secure appropriate revisions or additions to state law and CDCR's Operations Manual to minimize the need for any waivers of state law following termination of the Receivership.[4] We find that the areas likely to need such revisions include the CDCR health care organizational structure, creation of new job titles, hiring and progressive discipline.

[4] Plata et al. v. Brown et al. Order Re: Receivership Transition Plan and Experts Evaluations, No. C01-1351 TEH, 9/5/12. Page 7.

Findings

Facility Description

San Quentin is CDCR's oldest facility. Facility missions include a reception center for new commitments, a parole violator unit, general population and a minimum-security work crew unit. All CDCR male condemned inmates are housed at San Quentin. On the day of our visit the population of San Quentin was 3,955 inmates, or 128.3% of design capacity.

With respect to health care missions, San Quentin is a medical reception center, and has a 34 bed outpatient housing unit (OHU) for complex medical patients, and an 18 bed Correctional Treatment Center (CTC) dedicated for mental health patients. It also provides an array of on-site specialty services.

San Quentin is currently undergoing changes in its medical mission and population. CDCR is undergoing realignment and has designated 11 of its 33 prisons as Intermediate facilities. Intermediate facilities will have a higher medical acuity population. San Quentin has been designated to be an Intermediate facility and is in process of receiving higher acuity inmate-patients.

Currently there are approximately 12,000 CDCR inmates designated to be assigned to Intermediate facilities. As of the time of our visit, the process of assigning and transferring eligible inmate-patients to an Intermediate facility was not completed. However, in anticipation of mission and population changes, the health services program has realigned staffing to match the medical acuity and clinical needs of the patients. We note that San Quentin is receiving higher acuity inmate-patients, and medical staffing is being reduced by 18%. Because the mission and staffing changes are in process, the impact of these changes on the health care program cannot yet be fully assessed.

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: Health care delivery at San Quentin is a system of shared governance. Some functions are under the control of the Receivership (e.g., medical services, Receiver's Turnaround Plan) and some are under the control of CDCR (e.g. assignment of inmates to facilities, mental health and dental services). In addition, some business (e.g. purchasing), human resources processes (e.g., disciplinary investigations) and operations (Health Access Teams) are under control of CDCR. This creates less than clear areas of responsibility and authority for local management.

The California Correctional Health Care Services (CCHCS) program is a system in transition. While the Receiver exerts control over the Receiver's Plan of Action, each local facility, like San Quentin, operates somewhat independently. Mr. Deems, Chief Executive Officer, reports to the Receiver, Mr. Clark Kelso for medical issues and to Diana Toche DDS, Undersecretary,

Administration and Offender Services (Acting), on dental and mental health issues. Mr. Kelso has biweekly conference calls with the CEOs. Central office also hosts quarterly meetings with all the CEOs, periodic meetings with the Chief Medical Executives (CMEs) and Chief Nurse Executives (CNEs), and utilization management training for individual institution executive staff on an as needed basis. There are occasional visits by CCHCS staff to the facility, usually related to specific topics, but no routine CCHCS staff visits or participation in committee meetings (e.g., Quality Improvement meetings). While we believe that this is a less than optimal system for Central Office to provide needed leadership, assistance and guidance to the facilities, it is an acceptable model.

We reviewed the San Quentin Administrative, Nursing and Support Operations' tables of organization and found that they are organized along functional lines of authority and internally consistent.[5] The medical program has stable and capable leadership. All senior management positions, except the Chief Support Executive, are filled.

With respect to policies and procedures, CCHCS produces centralized policies and procedures and each facility develops local operating procedures that provide operational detail to enable staff to adhere to the CCHCS policy. Currently, the local policy and procedures at San Quentin are more updated than CCHCS policy.

With respect to medical autonomy and collaboration with custody, we found that health care leadership has autonomy, in that medical staff is able to make medical decisions without interference from the custody. The CEO reported that he has a good rapport with the Warden and attends his daily meetings. The Warden meets weekly with the CEO to discuss issues related to health care. In addition, representatives from custody attend the medical Quality Improvement meetings; usually this is the Associate Warden and the Captain for Health Services.

Human Resources, Staffing and Budget

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

Findings: San Quentin currently has adequate health care staffing. As noted above, the facility has been designated as an Intermediate facility and is receiving higher acuity medical patients. Under the Acuity Based Staffing Realignment, health care positions will be reduced 18%.[6] Because the facility is in the process of receiving higher acuity patients and staffing is being reduced, it is not possible to assess whether the future staffing pattern will be adequate to meet the needs of the population.

[5] San Quentin State Prison, dated January 3, 2013.

[6] CCHCS Acuity Based Staffing Realignment. The plan was designed to appropriately distribute staff based upon the acuity of patient-inmates and on basic staffing needs not tied to patient acuity.

San Quentin has 318.2 positions of which 259.9 (82%) are filled, 53.3 (18%) are vacant, and 5 (1.5%) are hired outside of budget authority. Vacancies have not been filled due to the pending implementation of the Acuity Based Staffing Realignment. The proposed lay-offs include both clinical and support staff.

While the CEO and CME do not think that the reduction in clinical staff will have a significant impact, they believe that the reductions in support staff, particularly in management and office technician staff will be a detriment to the program. There were discussions between management and Central Office on issues of clinical staffing, but decisions on reductions in non-clinical staff were largely made without input from local management. Furthermore, it is our understanding that the CEOs have no authority to modify the staffing plan, even if the modification is budget neutral or more cost-effective.

Scheduling and office tasks associated with the primary care model are heavily dependent on having sufficient support staff because automated scheduling and the electronic health record are not yet available. Even then, the concept of keeping one office technician in the primary care team will be jeopardized by these reductions. The facility is not sure how to manage the support of this function. Scheduling, in particular, is very labor intensive and requires manual input. Despite current efforts, scheduling remains a major deficiency at this facility. In addition to these positions, the program is losing its labor relations and employee relations staff. These two positions will become regional positions and no longer work at the site (see Disciplinary Process).

We discussed the nursing staffing plan with the Chief Nurse Executive. The current staffing plan for RNs, LVNs, and CNAs is similar to the proposed Acuity Based Staffing Realignment and is adequate to address the medical needs of the existing population.

The impact of the new staffing model cannot be fully assessed until the new Stockton facility has been completed and occupied. Following the opening of the Stockton facility and reassignment of inmates based on medical acuity, we recommend that the model be reevaluated and staffing adjustments be made as necessary. We believe that the acuity-based staffing model would be improved by discussion with local management so that they can communicate the specific needs of their facilities. There should be flexibility of local leadership to adjust the plan, especially if it is more cost-effective or budget neutral.

Credentialing and Peer Review

Credentialing, peer review and annual performance reviews are performed by Central Office. The CEO sees the credentialing information and performance reviews for direct reports. There is a report showing performance evaluations which are coming due. We did not review credentialing for this facility because material was unavailable during our visit. Performance evaluations are done annually. These are reviewed with the employee by the supervisor.

Disciplinary Process

One of the major issues identified in our 2006 Report was CDCR's lack of an effective disciplinary process. Although some improvement has been made for peer review and discipline of physicians, the progressive discipline process is largely unchanged for other CDCR staff. The current system is an impediment to effective management and detracts from morale.

Discipline adheres to the CDCR procedures as stipulated in CDCR's Operations Manual. In many cases, it requires an internal affairs investigation managed by the Office of Internal Affairs (OIA), which is a custody function. The hiring authority (in this case the CEO of the health unit) is responsible for logging allegations, requesting adverse action, reviewing investigative reports and imposing discipline. But ultimately, the Personnel Board is in charge of determining penalties if the hiring authority's disciplinary decision is appealed by the employee.

After the hiring authority requests an investigation, the OIA makes a determination within 30 days whether an investigation is warranted. An investigative officer, who is a custody officer, is assigned within 10 days. Investigation types include:

- Criminal
- Administrative
- Retaliation
- Workman's Comp
- Deadly Force

This process was not designed with considerations of professional practice standards and patient safety in mind. The rules embedded in the Operation's Manual and the types of investigations mostly pertain to law enforcement discipline.

It is the responsibility of the CEO at each facility to prepare documentation for the OIA to review in the investigation. San Quentin is the only CDCR institution to have an Employee Relations Officer (ERO) collect and prepare all data to give to OIA in preparation for a disciplinary review. In the future, this position will be regionalized and local management feels that less attention will be focused on this effort. San Quentin management feels that the ERO is a major asset in its ability to present properly completed paperwork to the investigator in order to discipline staff. This is particularly important because if paperwork is not properly submitted, staff cannot be effectively disciplined in a timely manner, if at all.

OIA investigators have a dual time frame for the completion of investigations. For custody employees, the OIA investigator must complete their investigation within a year. For non-custody employees the OIA must complete investigations within three years. The hearing and adjudication process is bureaucratic and replete with various types of hearings after the investigation is completed. The fact that discipline investigations may take as long as three years is a barrier to effective discipline and adds a Kafkaesque quality to the procedure. If management's disciplinary decision is appealed by the employee, lawyers from the Personnel

Board adjudicate the matter, sometimes reversing management decisions. As noted in our 2006 report, this discourages managers from effective supervision and discipline.

San Quentin has a management philosophy of undertaking discipline as needed, and they are aided by the fact that they have an ERO to prepare the documents properly for the OIA to move proceedings along. Even with this support, discipline takes an extraordinarily long time. Without this support, it may become discouraging to attempt discipline.

Nineteen employees have had disciplinary charges made against them over a several year period. One employee subsequently transferred to Pelican Bay. Of the remaining 18 cases, 15 cases have been accepted for investigation by OIA. The average time to accept an investigation for these 15 cases is 72 days even though 30 days is the proscribed limit. The remaining three cases have not yet been accepted by OIA for investigation. The average time these cases were submitted is over 50 days. The average time to complete the entire discipline process is 157 days with a range of 62 to 560 days. Only 5 of 18 staff (27%) had an adverse action taken to date. Three were dismissed and two were suspended. Two employees voluntarily resigned or left. If the staff who resigned is included in the numbers with an adverse action taken, only 38% of discipline staff had a completed adverse action. Of course, every case of discipline does not require or deserve an adverse action. However, when the person investigating the employee is a custody staff and is not part of the health program, there is less likelihood of the Investigator understanding the meaning and consequences of the employee's action and whether discipline is warranted.

Employees are not being disciplined for trivial matters. Most of the allegations, if substantiated, would warrant dismissal in non-CDCR health programs. Nevertheless, it is extremely cumbersome to discipline staff. There are cases at San Quentin in which the OIA investigator did not sustain the charges and because of patient safety issues, health care management would not reassign the individual staff to their usual role. One case involves a nurse alleged to have issued medication without a physician order. That nurse is now working in a secretarial role. Management is placed in an uncomfortable and potentially dangerous position of retaining individuals who they deem are dangerous to patients. Reassignment to alternate duties becomes wasteful and effectively reduces staff available for work.

A further problem with the discipline process is the adverse action template that is used in disciplinary cases. The CDCR operations manual has a matrix for disciplinary action which was not developed for a health program. Causes for adverse action include 24 items which mostly pertain to custody functions such as use of force and failure to secure an environment. The process of investigation, especially of violations of professional practice standards and patient safety, needs to be managed by health program staff, who understand the issues being investigated and who have an interest in promoting the quality of the program. For the protection of patients, the process should be expedited and resemble discipline in non-CDCR settings.

Health Care Budget

Having sufficient operating funds in a budget is a matter that is currently protected by the Receiver. Notwithstanding the Receivership, CCHCS still receives its funding through the same California State budget process as all other state departments and agencies.[7] When the budget is passed the State legislature approves an initial allotment for each agency including CCHCS. Appropriations are made to the extent that is fiscally possible.[8] The allotment is modified over the ensuing 6-8 months of the fiscal year and sometime around January a final allotment is settled upon. The allotment modifications are based on changes to statewide funding needs or changes in statewide revenue.[9] Almost all of CCHCS's appropriation comes from the State's general fund which is the funding source most impacted during times of declining revenue.[10]

Over the past two fiscal years the initial allotments for San Quentin bore little resemblance to the actual expenditures of the facility. As example, the initial allotment for San Quentin medical program including pharmacy in fiscal year 2010-2011 was $24,951,906; the final allotment was $44,395,272 and actual expenses were $47,888,057. In fiscal year 2011-2012 the initial allotment was $39,449,850; the final allotment was $48,262,148; and expenses were $54,236,355. The allotments varied widely even though the there was not much difference in the operational needs of the medical program during these two years. From the perspective of the San Quentin management, the differences between the allotment and expenditures at San Quentin can mostly be accounted for because the allotment provided almost no funding for overtime, equipment, or registry. In addition, the allotment funded salaries and wages at mid-point ranges, rather than at actual costs. The health care budget should reflect actual operational and personnel expenditures, so the true costs of a constitutionally adequate health care program can be defined and sustained.

The fact that the allotment may change year to year irrespective of expenditures, however, gives us concern. Expenditures in excess of allotment are not permitted. In these situations, the Receiver must move funding around internally or ask the legislature for more funding. The Receiver has been a buffer in this process ensuring that the health programs have had sufficient funds to operate.

A positive development is that the allotment for the health program is now separate from the CDCR allotment. This gives some protection because by state regulation the health program allotment cannot be comingled with the CDCR allotment even though it is anticipated that the CCHCS Agency Director will report to the Director of CDCR.

Capital expenditures are also affected by this allotment process. In the normal course of events, equipment breaks and must be replaced. Most health care organizations plan for obsolescence by including replacement costs for capital equipment on a scheduled basis based on the typical obsolescence factor for each type of equipment. In CCHCS, equipment is replaced

[7] Budget Process Explained; Mitzi Higashidani, 2/13/13
[8] Budget Process Explained; Mitzi Higashidani, 2/13/13
[9] Budget Process Explained; Mitzi Higashidani, 2/13/13
[10] Budget Process Explained; Mitzi Higashidani, 2/13/13

when it breaks. When equipment breaks or is no longer functional, local management can request funding from the Receiver. A planned replacement of equipment has not been a standard practice in creating allotments. Currently, because of the Receiver's ability to reallocate funding within CCHCS or go to the legislature, this has not affected operations. How this will work after the Receivership is not clear.

In our opinion, the real issue is whether the medical program has sufficient funding to provide necessary services. Currently, under the Receiver, the San Quentin program has had sufficient funds to operate. However, in order to attain sustainability we recommend having a budget that displays the costs of care in a line item manner that is reflective of anticipated expenditures and that is matched by an allotment in line with the budget developed for the site. The current system of allotment budgeting is different, and is not real in the sense that the allotment does not conform to anticipated expenditures; may vary dramatically year to year; and is subject to political competition in the budget process.[11] The allotment gives targets based on State fiscal decisions that may or may not actually provide sufficient funding for operations.

Under the current system of allotment budgeting, we are concerned about what would happen if San Quentin were required to adhere to an allotment that was set too low as in 2010-2011. We are also concerned about what will happen when the CDCR health leadership, instead of the Receiver, has to approach the legislature for necessary funding and whether competing interests within CDCR will adversely affect funding for the medical program.

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: Since our last review in 2006, the Receivership made dramatic improvements in construction of medical clinics and bed space and in health care operations.

San Quentin has undergone major renovation, most of which, was completed early in the Receivership. A Central Health Services Center was constructed that includes clinics for primary care providers and specialty services, a Triage and Treatment Area (TTA), Reception and Receiving area, Correctional Treatment Center (CTC), Outpatient Housing Unit (OHU) and administrative offices space. This area was clean, organized and well maintained.

Medical clinics in the housing areas were either refurbished or newly constructed and clinic space is now more appropriate. Planned construction of new medication rooms for North Block and South Block, included in the San Quentin Health Care Facility Improvement Plan, has not yet begun. With minor exceptions, each of the clinics was appropriately medically equipped and supplied. However, we did find opportunities for improvement. For example, in each of the

[11] Budget Process Explained; Mitzi Higashidani, 2/13/13

housing unit clinics, staff reported that there were no schedules for routine sanitation and infection control duties. During inspection, two clinic rooms in West block that are medically-equipped but rarely used were not clean.[12] The medication room counters were cluttered, making disinfection more difficult to maintain. Lack of adequate sanitation and disinfection is a patient safety issue.

In East block where condemned inmates are housed, new clinic space was built that includes four rooms, a significant improvement from our visit in 2006. Each clinic room was equipped with an oto/ophthalmoscope; however, the LVNs do not use this equipment and there was no power cord. This is expensive equipment that should either be maintained fully functional or removed. The two nurses' rooms were cramped and cluttered. There also was no schedule for sanitation and disinfection in the units.

H-unit clinic space was somewhat cramped but well organized and clean, except in the hallway near the medication room. The North Segregation clinic room was acceptably clean and organized. The Adjustment Center clinic is located in the old kitchen and is the least optimal space, as it was formerly the kitchen for the housing unit.

San Quentin has an inventory of medical equipment and a maintenance contract for periodic inspection and repair of broken equipment. There is, however, no replacement schedule based on an obsolescence factor. The equipment inventory was reviewed and inspection dates were present. It appears that routine maintenance of equipment is appropriate; however, a replacement process should be put in place.

There is no formal system to report non-conformances or problems with equipment, clinic space or processes. This is important so that the organization knows when a problem occurs and is able to fix it. Summary data from such reporting can be reported to the quality improvement (QI) Committee so that root cause analysis can be performed on frequent and problem prone areas. If staff does not have a formal mechanism to report such occurrences, reporting will not systematically take place and problems will persist. For example, during our tours we found three oto/ophthalmoscopes had no power cords, rendering them inoperable. Even though there was a semiannual inspection of the equipment, this problem went unrecognized for months.

For the most part, clinical staff has necessary medical supplies. A par level is established for each clinic, but according to staff, excess supplies are stored in the clinics. San Quentin has a warehouse for storing medical supplies. Typically, if a prime vendor were available, a facility of San Quentin's size would require a much smaller storeroom for supplies and the prime vendor would essentially serve as the warehouse. The warehouse workers estimated that inventory in the warehouse turns over every six months to a year. This is a long time. To modify the current

[12] These rooms were formerly used by medical providers that now conduct clinics in the new building. If these rooms are going to be maintained for use in emergencies, they should be adequately supplied and kept clean. If there are no plans to use the rooms, the equipment should be removed.

process would require reliable and prompt vendor payment. If this is indeed possible, use of a prime vendor would improve supply management for this facility.

Twenty-three inmate porters clean the health units throughout San Quentin. A cleaning schedule exists for the main clinic, which delineates the cleaning requirements for each clinical area. The schedule is appropriate for central clinical areas; hygiene was adequate in all areas we visited. However, staff in the housing unit clinics did not have a sanitation and disinfection schedule and the clinics were not consistently clean.

The custodian supervisor makes rounds daily. The vocational instructor makes rounds weekly. Quarterly rounds are made in the CTC. A checklist of these environmental rounds is used by the custodial staff. We would recommend that a report from these environmental rounds be incorporated into the Quality Improvement meeting minutes on a quarterly basis. In that way, the leadership can be formally informed of hygiene issues as they arise.

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: Overall, we found policies and procedures to be adequate, but there are opportunities for improvement. A local operating policy and procedure (LOP) manual is in place; however, not all local operating procedures have been reviewed within the past year. Two policies have not been reviewed since 2010 and the others were reviewed in 2011 or 2012. Notably, there are no consolidated policies on chronic care or appointment scheduling, which are two major program areas. For scheduling, we found that staff has developed a significant number of workarounds. Staff reported that scheduling guidance is offered in individual policies reflecting the type of scheduled appointment, such as specialty, TTA, and medications refusals.

In some cases, there were significant inconsistencies between policy and actual practice. The LOP for the OHU differs from statewide policy and needs to be clarified. The San Quentin LOP specifies that inmates who require activity of daily living assistance can be housed in the OHU for no longer than 30 days. This would require transfer of a significant number of patients on the current unit. A higher level of care is provided on this unit than is described in the policy and the practice should be consistent with the policy or the policy should be modified. Also, pharmacy policy indicates that default length of prescriptions is 180 days. However, we were advised and record review showed that physicians routinely order chronic disease medications up to one year.

With respect to the medical reception process, our review showed that San Quentin's LOP is not in compliance with CCHCS policies and procedures to perform a complete history and physical examination by a medical provider within seven days of arrival. According to the LOP, some inmate-patients do not receive a history and physical by a physician for up 30 days after

arrival, and others do not receive one at all. Actual practice showed that the time frame for completing a history and physical by a physician exceeds 30 days.

Training for staff is less than optimal. There is a new employee orientation and all staff has to sign off that they have read and understand policies. Nursing conducts initial and annual training of: (a) 23 urgent/emergent and sick call protocols according to Headquarters requirements; (b) annual training of CTC staff which meets licensing standards; (c) specific functions such as Wound Vac and PICC line care; and (d) the nurse trainer reviews all statewide and local operating policy revisions to train nursing personnel against those changes. However, annual training is not completely defined or implemented, and training, other than orientation, is sporadic. This needs to be improved.

Medical Reception/Intrasystem Transfer

Methodology: We toured the San Quentin receiving and release (R&R) area, interviewed facility health care leadership and staff involved in medical reception and/or intrasystem transfer, and reviewed tracking logs, staffing and 21 health records.

Medical Reception

Findings: San Quentin's local policies and procedures (LOP) and actual practice are not in compliance with CCHCS policies and procedures to perform a complete history and physical examination for newly arriving inmates within seven days of arrival, and actual practice shows that inmates with serious medical conditions do not receive a history and physical by a medical provider timely, often not for more than a month.

We note that newly arriving inmates, whether reception or intrasystem transfers, are typically managed in the same manner. All are processed through the Receiving and Release area of the institution, where a nurse performs a medical screening.[13] If the nurse does not identify any health problems the nurse educates the patient regarding sick call with no referral to a medical provider for a history and physical examination, even if he is new to CDCR.

If the patient has acute or chronic health conditions the nurse is to refer the patient to a medical provider in the Triage and Treatment Area (TTA). However, records show that when referred, a provider does not see all patients at the time of arrival. This is particularly true if the transferring bus arrives late in the afternoon and nurses have not screened all patients by the time the physicians leave at 7 pm, but its also true if the patient arrives during business hours. If a provider does not see the patient, the nurse calls a medical provider to order medications and then places patient health screening forms in the provider's box to be reviewed the next day. Our review showed that providers may order labs, x-rays, blood pressure checks and follow-up with the primary care provider in time frames that range from 2-12 weeks. Therefore, chronic disease patients who are referred but not successfully seen on the day of arrival will not receive a history and physical by a medical provider within seven days and in many cases not for over a

[13] Form 7277 Initial Health Screening.

month after their arrival, increasing the risk of harm through lack of timely diagnosis and/or treatment.

If a medical provider does see the patient upon arrival, evaluations range from a brief assessment to a complete dictated medical history and physical examination. There is no standardization to this process. Components of a comprehensive history and physical include a personal medical history and review of systems (ROS); however, aside from the initial health screening form, neither nurses nor medical providers complete a standardized personal medical history and review of systems for each patient, and practice and quality vary depending on the provider. Ironically, the only CDCR form that includes this complete medical history information and review of systems is a dental history form.[14] The medical reception evaluation should include the same information as is contained in this dental form and should be completed for every new arrival.

The origins of this departure from the statewide policy and procedure date back several years to when San Quentin was inundated with parole revocators that had recently been released from CDCR. In an effort to focus scarce health care resources on the highest acuity patients, the first Receiver implemented a pilot program that resulted in the current San Quentin local operating policy and procedure. Staff reported that since then the volume of parole revocators has significantly declined and the pilot no longer exists; however, medical reception practices are unchanged and are not in compliance with current CCHCS policy.[15]

We found several examples of chronic disease patients who were not seen upon arrival following nurse referral to the TTA. One patient was a 62-year-old patient with a history of hypertension that was poorly controlled on arrival (BP=160/96 mm/hg). A nurse referred him to a medical provider during business hours, but the provider did not see the patient and instead ordered medications and 4-6 week follow-up with a primary care provider. The patient did not have an initial history and physical examination for more than 30 days after his arrival.[16]

In another case, a 61-year-old medically complicated patient with extensive cardiovascular disease arrived at San Quentin with hypertensive urgency (BP=200/100 mm/hg). Instead of referring the patient upon arrival, the nurse ordered blood pressure monitoring for seven days and referred the patient to his primary care provider in 14 days. We found no documentation that blood pressure monitoring was performed. Two weeks later, a medical provider saw the patient for an initial visit. This patient was at risk for a heart attack or stroke and was not evaluated in a timely manner.[17]

[14] Dental Health History Record (CDCR 7433 Revised 08/10)
[15] The decline in parole revocators is attributed to implementation of AB109.
[16] Medical Reception/Transfer Patient #7.
[17] Medical Reception/Intrasystem Patient #20

Another example is a 50-year-old patient with sickle cell disease and hypertension. A medical provider did not see him on the day of arrival; instead, the provider reviewed the patient's record, ordered medications and ordered PCP follow-up in 3-4 weeks.[18]

For these patients, not being seen by a medical provider within seven days of arrival creates a risk that serious medical conditions will not be treated in a timely manner, particularly because nurses only perform a health screening and not a complete medical history or review of systems.[19] Moreover, nurses are supposed to complete a physical assessment on all newly arriving patients, but instead of examining the patient and describing physical findings, in most records we reviewed, the nurse simply asked the patient if he had any problems for each anatomical area. Overall, the quality of the nurses' physical assessments was poor.

Alternately, we also found cases in which chronic disease patients received an adequate evaluation by a medical provider at intake but the scheduled follow-up interval with the primary care provider was delayed. For example, a 35-year-old with a history of non-Hodgkin's lymphoma, hypothyroidism and hepatitis C infection arrived at San Quentin on 10/9/12. A provider saw him upon arrival, ordered medications, labs and follow-up with a primary care provider in 10-12 weeks; however, 12 weeks later he still had not yet been seen.[20]

In summary, our review showed that there is no standardization to the medical reception process, and newly arriving patients do not receive a history and physical examination by a medical provider in accordance with CCHCS policy and procedure. Many patients are not seen timely in accordance with the requested follow-up by the medical provider. This places patients at risk of harm.

Intrasystem Transfers

Findings: As noted above, intrasystem transfers arriving at San Quentin are essentially treated in the same manner as medical reception inmates, including having medical reception laboratory tests performed (e.g. syphilis, HIV, and STD testing). In most cases, this is not medically indicated and incurs unnecessary cost. We discussed this with Dr. Pratt, who agreed that routine testing on intrasystem transfers was medically unnecessary and stated that she would address it.[21]

With respect to the transfer of patients from San Quentin, staff reported that each Thursday, custody provides a list of inmates that are scheduled to transfer the following week. Registered nurses complete an intrasystem transfer form and, just prior to transfer, arrange for health records and medications to be transported with the inmate-patient. Medical providers place inmate-patients on medical hold if they are in the midst of an evaluation or treatment for a serious medical condition that would be disrupted if transferred. Intrasystem transfers occur Monday through Friday with the bulk of transfers occurring Tuesday-Thursday.

[18] Medical Reception/Intrasystem Transfer Patient #6.
[19] The only health care form that includes a complete medical history and review of systems is the Dental 4344/43.
[20] Medical Reception/Intrasystem Transfer Patient #4.
[21] Per policy, medical reception lab testing is not to be done on intrasystem transfer patients.

We found cases in which patients transferring into San Quentin were not seen in accordance with the requested or clinically indicated follow-up. This included patients with elevated blood pressure and poorly controlled diabetes.[22]

Access to Care

Methodology: To evaluate access to care, we interviewed health care leadership and reviewed patient tracking and scheduling systems. We also reviewed 35 health services requests (CDCR Form 7362) in 22 records of patients with chronic diseases, including high-risk patients. We also included a sample of records from maximum-security housing units including East block and Adjustment Center.

Health Care Appointment Scheduling

Findings: The current scheduling system is inadequate and poses a potential risk of harm due the possibility that needed appointments will not occur within clinically necessary time frames.

The current patient statewide scheduling system is the Inmate Statewide Appointment Tracking System (IMSATS). It is populated by the Strategic Offender Management System (SOMS) but has no interface with the electronic Unit Health Record (eUHR). There is no means for nurses and clinicians to determine from the eUHR when patients are scheduled for appointments and if appointments did not occur, why they did not take place.

Health care leadership reported significant problems related to appointment scheduling. Due to the demand for health care services, on any given day there may be 185 patients on a housing unit scheduled to see a provider who has 15 available appointment slots (e.g. North and West blocks). These appointments are for a variety of reasons (e.g. chronic care, sick call, emergency or specialty services follow-up, etc.). In order to manage this situation, each day the provider reviews the list of patients scheduled and chooses which patients she or he will see. The rest of the patients are rescheduled. This results in continuous bumping of patients.

To try to ensure that providers see the patients with the highest medical acuity, the San Quentin staff has created an Encounter Log used by the medical providers. This is an Access database system that is pre-populated with all inmates at San Quentin. Medical providers use the database to track important clinical information. Dr. Pratt, the Chief Physician and Surgeon, advised us that it was her practice to focus on the highest acuity patients. If one of the providers is out on vacation and another provider sees a high-risk patient, the covering provider can look at the Encounter Log and can become familiarized with the patient and his highest priority medical needs that are not readily apparent due to the limitations of the eUHR.

The Encounter Log also enables staff to track overdue appointments. Dr. Pratt showed us a report of all patients who are 30 days overdue for their appointments on H-unit. This report

[22] Medical Reception Patients #15, #17, and #18.

showed 102 patients who were overdue for appointments ranging from 1 to 623 days. Noting that some patients were overdue by more than a year, we inquired how the log was being used. Dr. Pratt advised us that H unit had the more healthy population at San Quentin and that there had been a change in physicians. Apparently, the new physician was not using the report to find overdue patients and reschedule them. It is also possible that some patients were no longer at San Quentin. We turned this list over to Anthony Laureano, CNE to research the status of each patient and learned that in fact, many had been seen but some were still overdue, including patients with chronic diseases.

The description of the scheduling process explains both our findings and that of the OIG reports, that patients with chronic diseases and those who require follow-up for specialty services are not seen in a timely manner. The delays in care are mitigated by the development of the Encounter Log that medical providers use to identify the needs of the highest acuity patients and to ensure continuity of care. At a statewide level, the master CDCR Registry is intended to serve the same function, but according to San Quentin staff some patients noted on the registry do not in fact have the illnesses that are listed. However, the master CDCR registry also does not allow for the types of detailed information that the San Quentin Encounter Log provides. These issues can be significantly remediated by implementation of a true electronic medical record.

Once patient appointments are scheduled in IMSATS, they must be communicated to custody so they can print appointment notices (Ducats) that are used to notify and enable patients to attend health appointments. Due to limitations in the current eUHR and IMSATS scheduling system, dental and mental health staff forward lists of appointments in a Word document that health records staff inputs into an Access database. This database is then exported to custody staff so that they can print the ducats. This database was internally developed at San Quentin and the Medical Records Director expressed concern that there is no Information Technology (IT) support for the program and if it were to crash, it would significantly impact the ability of custody to notify inmates of their appointments and adversely affect access to care. Staff advised us that a new scheduling system, Med-SATS, is to be rolled out in the near future.

Nursing Sick Call (Face to Face Triage)

Findings: Access to care has significantly improved since we last toured San Quentin in 2006. We found that when inmates submit health services request forms, the forms are collected and triaged in a timely manner. We also found that nursing triage decisions regarding urgency of the need for health care were generally appropriate.

A striking observation about the 35 health service request forms was that many were related to minor health problems and requests for over-the-counter medications or dental and mental health complaints. Others were related to acute conditions such as skin or upper respiratory infections and chronic pain. We generally did not find complaints that were linked to poorly-controlled chronic diseases. The majority of these patients were being routinely seen by their primary care providers for management of their chronic diseases. These chronic disease visit

notes are notable for providers consistently addressing each chronic condition at every visit.[23] As a result of appropriate treatment for chronic diseases, it appears that patients are appropriately using the sick call system to address minor and/or acute medical, dental and mental health issues.

When nurses performed patient assessments they usually selected a nursing protocol to complete the assessment which resulted in good assessments. In some cases, however, nurses did not use the protocols and the evaluations were not as thorough. Furthermore, when patients presented for evaluations, nurses did not consistently address incidental findings of abnormal vital signs (usually elevated blood pressures). And, although nursing triage and treatment decisions were usually appropriate, there were exceptions. In addition, one of the nursing protocols does not provide nurses adequate treatment guidance.[24]

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 47 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 the quality of provider evaluations were complete and appropriate (subjective, objective, current labs, assessment and treatment plan). We also evaluated whether the Problem List was updated and continuity of medications provided.

Findings: As previously noted in this report, some chronic disease patients are not seen in a timely manner by a medical provider. When patients are seen by the primary care providers for chronic care, the quality of provider evaluations is good and appropriate patient education is being provided. Provider orders and medication administration records show continuity of chronic disease medications. However, follow-up visits do not consistently occur as clinically indicated in accordance with the degree of disease control.

In one case, on 10/15/12, the primary care provider ordered four to six week follow-up of a patient with poorly controlled diabetes. The patient had not been seen as of 1/7/13. The case was discussed with the medical staff and the patient was seen on 1/9/13.[25]

In another case, on 8/3/12, the primary care provider ordered follow-up in two months for a patient with hypertension and hyperlipidemia. The patient had not been seen as of 1/7/13. The case was discussed with the medical staff and the patient was seen on 1/30/13.[26]

[23] If time prohibits the provider from addressing all chronic diseases, this is noted as well, with a plan to address it at the next visit.
[24] The protocol for allergic and viral rhinitis, and pharyngitis did not have a treatment section for patients with pharyngitis.
[25] Chronic Care Patient #7.
[26] Chronic Care Patient #14.

A third example involved a patient with hypertension whose blood pressure was not controlled. On 4/6/12, the primary care provider saw the patient and ordered blood pressure checks. The provider noted that he would make adjustments to the patient's medication based on the results of those visits and ordered follow-up in four months. Review of the patient's blood pressures revealed that they continued to be elevated on numerous occasions. The patient had not been seen since 4/6/12 and did not have a pending appointment. The case was discussed with the medical staff and the patient was seen on 2/8/13.[27]

These cases were discussed with the medical staff. For other examples, see Chronic Care patients 1, 2, 5, 9, 10, 22, and 31. Our findings are consistent with the OIG third round report finding that 48% of chronic disease patients were seen in accordance with the patient's degree of control at the prior visit.

The lack of timely follow-up appears to be primarily related to problems with the scheduling system but there may be other contributing factors that were not apparent during our visit. The CEO, CME and Chief Physician all stated that this problem would be resolved with the implementation of the new medical scheduling system that was expected to occur within the next few months. Another problem is that the log for finger stick blood sugar (FSBS) monitoring is often not available when the providers are seeing patients with diabetes. This is due to the fact that the results of the testing are documented on the medication administration record (MAR) forms and these forms are only to be scanned into the eUHR at the beginning of each month. Compounding this problem is the fact that the nursing supervisors do not send the MARs for scanning in a timely manner because they retain them in order to perform audits. Both the CEO and CMO assured us that this problem would be resolved. In addition to the above issues, the problem list is often not being updated as new problems are identified and some patients noted on the registry do not in fact have the illnesses that are listed.

Despite these concerns, we found that when providers see patients, the quality of care being provided to patients with chronic illnesses at San Quentin is very good. The problem with scheduling is a systemic issue that, as noted above, should be resolved with the implementation of the new medical scheduling system. We will continue to monitor the implementation of the new scheduling system during our future site visits at the other institutions. In addition, the medical administration at San Quentin is aware of the problem related to the MARs and plans to implement changes in the procedure so that providers will have the necessary clinical information when they see patients with diabetes.

Pharmacy and Medication Administration

Methodology: We interviewed Ms. Meredee Crutcher, Pharmacist-in-charge, nurses that 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.

[27] Chronic Care Patient #15.

Pharmacy Services

Findings: Pharmacy services at San Quentin appear to be working well. Record review showed that medical providers order and patients receive medications timely following their arrival at the facility. The pharmacy has a system for medication refills and order renewal that is working well. However, our ability to accurately measure medication continuity and compliance was limited by the fact that medication administration records (MARs) are not scanned into the record in a timely manner.

We reviewed medication reconciliation reports and noted that they may contain active prescriptions for two drugs in the same class when it is not the intention of the clinician for the patient to take both drugs. The pharmacy staff stated that if an inmate does not request a refill of both medications, the pharmacy permits active prescriptions of drugs of the same class. Thus, an inmate can have multiple drugs active of the same class. This is a potentially serious patient safety and polypharmacy issue. This process should be reviewed by the Pharmacy and Therapeutics Committee.

The Receivership purchases pharmaceuticals statewide through AmerisourceBergen. At San Quentin, medications are dispensed to patients through a combination of a licensed in-house pharmacy and Central Fill in Sacramento. The pharmacy is located in the new building and is clean, well organized and sufficiently large to securely store pharmaceuticals and perform pharmacy operations.

Medication Administration

Findings: Medications are administered through directly observed therapy (DOT), nurse administered (NA) and keep-on-person (KOP). We found several problems with the medication administration process and documentation of medication administration.

The primary issues are in segregation, where nurses take medications from pharmacy dispensed, properly labeled containers, and place them in repeatedly used envelopes with only the inmates name and ID number before delivering the medications to the patients. In addition, often there is more than one medication in the envelope, and if one falls out or is dropped by the patient, the nurse cannot be certain which medication was not given. We discussed our concerns with Tony Laureano, RN, CNE.

Review of MARs showed that they were neat, legible and contained nursing signatures. The time of administration, however, was not consistently documented. Nurses administer medications, both NA and KOP, on the tiers and then return to the medication room and document the administration of the medications. This does not meet generally accepted nursing practice standards to document administration of medication at the time they are given. In addition, nurse-administered medications are typically administered twice daily; however, in several clinics the MARs have no time of administration documented for morning and evening medication passes. Instead, nurses use yellow and red highlighters to differentiate between the morning and evening medication passes. This does not provide the medical-legal

documentation of the time of administration. Nursing practice standards and patient safety concerns require that a medication is administered one hour before or after a designated time; thus, it is important to document the time of administration on the MAR.

We also noted that there is no administration code on the MAR to indicate whether the medication was administered, the patient refused, the patient was at the hospital, etc. Furthermore, the MARS often show blank spaces, indicating errors of omission in administering medications. Discussions with staff reveal that these are not consistently reported as medication errors. These are errors of omission, and should be reported as medication errors to study under the auspices of the Continuous Quality Improvement (CQI) committee. While some medication errors reflect human error, they can also reflect process issues. For example, in East Block, we reviewed over 30 MARs for which there was no documentation of medication administration the evening of 1/8/2013. It is conceivable that the nurse administered the medications and failed to document administration, or alternately, that the medications were not administered that evening for security, staffing or other reasons.

Finally, we note at H-unit, inmate-patients must line up at the medication window that has no protection from the elements. Thus, if there is a torrential downpour, inmates must either stand in line and become drenched, or decide that they are not going to take their medication. This does not promote medication adherence and is not consistent with an adequate health care delivery system. It is not in compliance with medication audit indicator 9C requiring that "Shade and shelter from inclement weather is provided at medication delivery". (Custodial Measure). We discussed the above concerns with Tony Laureano, RN CNE.

Laboratory/Radiology

Methodology: We interviewed Mr. Angel Llano, Health Program Manager III and reviewed reports and health care records.

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

Laboratory services are provided by Quest Laboratories. Record review showed that ordered labs were generally obtained, reviewed and scanned into the eUHR in a timely manner.

Health Records

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

Despite the limitations of the eUHR, we find that health records management is working well at San Quentin. The health records unit is clean and well organized. Staff scans received health documents timely into the electronic Unit Health Record (eUHR) and there is no backlog of documents to be scanned into health records.

Although staff timely scans health documents once received, we found recent but systemic delays (14 to 21 days or longer) in the transcription of dictated physician progress notes that have resulted in delayed scanning of primary care, chronic disease, and urgent care progress notes into the eUHR. We also found that medication administration records (MARs) are not forwarded from the housing unit health clinics to health records in a timely manner. This includes MARs that also contain daily finger stick blood sugar (FSBS) results that providers use to assess and treat diabetic patients. The delay in forwarding these MARs to health records adversely affects medical providers' ability to assess and treat poorly controlled diabetics in a timely manner (See Chronic Disease Management). In addition, it negatively impacts medical providers' ability to assess medication compliance and its effect upon the patient's disease control and subsequent treatment plan.

Health records staffing will be reduced from 27 to 14 positions with the implementation of acuity based staffing patterns. The Medical Records Director believes the new staffing pattern will be adequate to manage health records. This reflects efficiencies gained from migration to the eUHR. We anticipate further efficiencies once a true electronic health record is implemented.

Health Records Space and Operations

The health records unit is located in the new health services building. The area was clean, well organized and sufficiently large to manage health records. The daily processes of health record management include document collection, date stamping, sorting, prepping and scanning into

the health record. Staff also performs quality improvement activities following scanning to ensure that documents are scanned into the correct file in the right location.

Timeliness of Scanning Health Documents

Staff receives and scans an average of 3000 health documents per day into the eUHR.

We noted that some records are filed in the eUHR in sections other than those specified in the eUHR Organization (Version 10.0) documentation. Management should continue to regularly monitor scanning of documents to ensure correct filing of records. If documents are not filed consistently throughout the system, it is more difficult for staff at other facilities to review the records.

Review of health records showed that that Medication Administration Records (MARs) are not scanned into the record in a timely manner because they are not forwarded to health records in a timely manner. In West clinic we found MARs of diabetics on sliding scale insulin from November and December 2012 in the MAR books. These MARs also contain daily fingerstick blood sugar checks that medical providers need to have access to during chronic disease visits. Since the MARs are not available, the providers do not have this important information when seeing the patients (See Chronic Disease Management). In North Segregation, we found a MAR from December that the nurse kept in the MAR book as a reminder to give the patient an injection the following month.

Another reason for delayed scanning of MARs into the eUHR is that Supervising Registered Nurses (SRNs) hold MARs at the end of the month to perform their medication audits prior to sending them to health records. The lack of timely scanning and access to MARs adversely impacts providers' ability to assess patient medication adherence and continuity, as well as diabetes control. All documents need to be scanned into the eUHR as soon as practical.

San Quentin management told us that all OHU paper records are scanned into the eUHR with the exception of nursing care plans. However during our audit we were not able to locate all paper records in the eUHR even with the assistance of staff. Staff on the OHU unit use paper records and did not find the eUHR reliable. This has the potential for error and is a potential patient safety issue because providers and nurses in locations other than the OHU may be unaware of important clinical information contained in the paper record. We recommend that San Quentin management review this process and make any necessary changes.

Urgent/Emergent Care

Methodology: We interviewed health care leadership and staff involved in emergency response and toured the Triage and Treatment Areas (TTA). We assessed the availability and functionality of emergency equipment and supplies and reviewed the CCHCS Institutional Reports on potentially avoidable hospitalizations. We also reviewed 12 records of patients selected from the on-site urgent/emergent and off-site ED/hospitalization tracking log.

On Site Urgent/Emergent Care

Findings: Overall, San Quentin health care staff responds timely and appropriately to patients with urgent health conditions. The triage and treatment area (TTA) is a state of the art emergency room that was clean, organized, and adequately equipped and supplied. Medical clinics located in the housing units were also equipped with automatic external defibrillators (AED) and emergency response bags that staff checks daily.

San Quentin has a multidisciplinary Emergency Response Review Committee (ERRC) that reviews institutional staff response to on-site emergencies. This is an excellent quality improvement process. Review of ERRC minutes shows that the committee effectively identifies areas requiring improvement.

One significant area of concern involves instances in which custody staff did not assess the patient and initiate cardiopulmonary resuscitation (CPR) when necessary, and delays in health care access to patients with life threatening conditions, particularly in condemned housing units.[28] These areas will require continued collaboration and coordination of efforts to ensure inmate-patients receive appropriate and timely emergency response. This finding was consistent with the OIG report that first responder initiated CPR only 60% of the time.

Given the age of the institution and physical plant issues and security procedures involving this population, we recommend that custody staff is trained and has access to automatic external defibrillators.

Although overall this area is working well, our record review showed opportunities for improvement. We found some cases where there were problems with the quality of nursing assessments, lack of wound care and clinical follow-up of patients. In one case, a patient with a known history of cholelithiasis (gallstones) presented with burning chest pain that he attributed to his gallstones. The nurse assessed him as having chest wall pain and referred him to a medical provider; however, this visit did not take place.[29] In another case, a nurse assessed a patient who had experienced a seizure as having 'status epilepticus' or continued seizures, which was inaccurate.[30]

Other issues involve failure to implement physician orders or lack clinical follow-up. In one case, a provider saw a patient for an abscess of his right forearm and performed incision and drainage (I&D). The physician ordered antibiotics and wound care for seven days, but did not request clinical follow-up. There was no documentation that nurses performed the ordered wound care and three weeks later the patient returned to the TTA with a fluctuant abscess that had to be incised and drained a second time.[31] The patient received appropriate follow-up following the recurrent abscess.

[28] See August 27, 2012, September 10, 2012 ERRC Meeting Minutes.
[29] Urgent Care Patient #1.
[30] Urgent Care Patient #2.
[31] Urgent Care Patient #4.

Another serious case involved a delay in sending a high-risk patient to an outside hospital. A 61-year-old patient presented with chest pain, hypertensive urgency and EKG changes. He was kept in the TTA for approximately three hours before being sent to the emergency room. Documentation shows that his blood pressure was not adequately monitored and treated, and by the time he was sent out his blood pressure remained dangerously high (BP= 219/98 mm/hg). At the hospital he was diagnosed with myocardial infarction and underwent angioplasty with stent placement.[32] We discussed this case with medical staff.

Emergency Department/Hospitalizations

Findings: Access of patients to outside hospital care was good. Arrangements with local hospitals are in place and appear to serve the needs of the facility. Hospital reports were found in all records reviewed, so it is clear that clinical communication is good.

There were no identified cases where a patient needed hospital care and did not get it. There was one case of a patient with asthma who had a preventable hospitalization because of problems with care at the facility.[33] In this case, the patient care would have been improved if managed in an OHU or CTC. This patient had repeated hospitalizations for asthma and was not appropriately managed in general population as was clinically indicated. While the facility staff believe that management should have been better in general population, it is our opinion that more complicated patients are better managed in a nursing unit with 24 hour coverage. There is some reluctance to place individuals into the OHU because the restrictive environment on that unit is something patients dislike. When custody staffing is low on the OHU, as it is currently, inmates seldom leave their rooms and the OHU essentially becomes similar to segregation. For that reason, patients object to going to the OHU. Patient resistance to placement in the OHU increases the likelihood that patients will be misassigned to general population. There were some nursing issues involving central lines that resulted in hospitalization on two occasions.[34] This area could be improved by having the OHU physician see the patient upon hospital return as well as training of nurses in management of central lines.

Specialty Services/Consultations

Methodology: We interviewed staff involved in the review, approval and tracking of specialty services and reviewed health care records of 16 patients for whom services were requested.

Findings: Specialty services are available and, in most cases, are performed within appropriate time frames. While in many cases the PCP is not seeing patients within the required time frames for follow-up of specialty care, the recommendations of the specialists are being addressed in a timely manner and the patients are receiving appropriate care. Our findings are consistent with OIG reports that scored San Quentin 55% with respect to timely follow-up following specialty services appointments.

[32] Urgent Care Patient #3
[33] OHU Patient #7.
[34] OHU Patient #3.

Outpatient Housing Unit Care (OHU)

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

Findings: There is lack of health care staff access to patients which is due to reduced custody staffing and lack of adequate number of medical OHU beds. This is a significant issue.

With a projected population of 4,000 inmates and 500 high-risk patients, San Quentin has 34 OHU beds and 18 CTC beds for medical and mental health patients, respectively. OHU beds are managed by both San Quentin medical providers and the CCHCS Utilization Management program that assigns patients from other facilities to empty CTC and OHU beds. While the concept of a centralized bed management program is good, San Quentin medical providers need to have sufficient control over medical/mental health beds to manage the needs of its own population and to ensure that patients do not exceed the medical criteria appropriate for an OHU. Central Office Utilization Management needs to work closely with the San Quentin medical staff to ensure that there is sufficient bed capacity for the needs of the San Quentin population.

The 34 OHU beds are almost always at capacity. Staff reported that a decision has been made to rededicate 10 OHU medical beds to mental health. This will require blocking oxygen and suction at the wall and remodeling the rooms to be suicide preventive. This will reduce the OHU capacity from 34 to 24 medical beds. This is a ratio of six OHU beds per thousand inmates, which is low given the medical mission of the facility. This was supported by our finding of general population patients whose medical needs warranted OHU placement. Therefore, we believe the reduction in OHU medical bed capacity is inappropriate.

The problem is compounded because San Quentin houses approximately 690 condemned inmates that are anticipated to age and die at the facility. Currently, except for the occasional patient, when these inmates become disabled or seriously ill, they remain at San Quentin even if they require a higher level of care, which is not medically appropriate. For patients whose medical care exceeds the capacity of San Quentin to appropriately care for them, we recommend that medical beds be designated for this population at the California Correctional Health Care Facility (CHCF).

The California Penal Code, Section 3600 states:

> "An inmate whose medical or mental health needs are so critical as to endanger the inmate or others may, pursuant to regulations established by the Department of Corrections, be housed at the California Medical Facility or other appropriate institution for medical or mental health treatment. The inmate shall be returned to the institution from which the inmate was transferred when the condition has been adequately treated or is in remission."

Based on this, it is our opinion that this portion of state code should be standardized into a procedure that results in severely disabled condemned patient-inmates being transferred to appropriate levels of care, to include the new CDCR health care facility in Stockton, rather than remain at San Quentin regardless of their medical condition.

Our review of the OHU census showed that patient medical acuity is quite high. At least three of the 34 inmates were total or nearly total care patients. More than half of the patients are disabled and have difficulty walking. San Quentin local operating procedure states that one criterion for OHU placement is for patients needing temporary assistance with activities of daily living (ADLs) and that if the inmate-patient requires assistance longer than 30 days, the patient shall be referred to a higher level of care. The 30-day time restriction is not present in the State-wide policies and procedures. However, clearly the facility is not placing patients on the unit in accordance with its own procedures because there are numerous inmates with ADL problems who are essentially living in the OHU. Based on record reviews, it appears that CTC patients are being transferred from other facilities to San Quentin because of quality of care issues.

Custody Staffing Resulting in Lack of Access to Patients

Despite the high level of medical acuity and although the medical staffing currently is at the level of a CTC, the staff have difficulty seeing patients because there are insufficient officers available to open doors and accompany staff when they are seeing a patient. The existing rule is that all doors must remain locked and custody staff must be present when medical staff is seeing a patient, even if the patient is totally disabled and bedridden.

Currently, health care staffing is 2 RNs, 1 LVN, 1 Nurse Assistant, 1.5 medical providers and physical therapy as needed, or approximately seven clinical staff. During the week of our review, there was one correctional officer to open OHU doors to provide health care access and escort inmates to the dayroom. Depending on the shift, there are 7 or 8 officers assigned to the 4th floor; only 1 of them is consistently assigned to the medical OHU. The remaining officers are assigned to the mental health unit or have other assignments.[35] As a result, health care staff is not able to complete all necessary work during their shift. During our visit, a nurse waited 25 minutes for an officer to open a door for a clinical need. One incontinent inmate had a diaper and nurses changed the diaper once a shift. There was an odor of feces when passing the room and it was clear that this inmate needed greater attention than once a shift. This is a serious access issue.

[35] After our San Quentin visit, we were advised that Custody staffing for the Fourth Floor in the Central Health Building at SQ is not divided between the OHU and the MHCB. On second watch, there are seven inpatient officers and one sergeant assigned to the entire floor; on third watch there are six officers and one sergeant. During the week of our visit San Quentin failed to fill one post for the inpatient area at different times. On Monday and Friday, one third watch post was left vacant. On Saturday and Sunday, one second watch and one third watch post was left vacant. All the posts were filled Tuesday through Thursday. The Health Care Access supervisors are responsible for ensuring the custody officers are deployed appropriately. However, we also note that staff reported that Custody staffing was reduced in the past six months, and that the week of our visit was not atypical.

In addition, physician notes on the unit are mostly every two weeks even when it is clinically indicated to see patients at more frequent intervals. Patients admitted to the unit are not always seen within 72 hours or as ordered by the intake physician and timely care does not always occur.

Custody staff needs to be reallocated to the OHU to permit health care staff greater access to patients. A reasonable recommendation is one officer for every 1.5 clinical staff. With that ratio, clinical staff would have adequate access to patients. Staff reported that at one time they had more officers in the OHU but that Headquarters health care access teams recommended a decrease in custody staffing.

The inmates who live in the OHU maintain food amidst their personal property. Because some inmates are long-term borders on this unit and because the unit houses high acuity medical patients, management should consider development of some rules on hygiene in inmate rooms, in particular as it relates to storage of food items.

Nursing Care Issues

With respect to quality of care, we found that nursing care plans are inadequate. The proscribed method of documenting a nursing care plan is to utilize a paper Kardex. This form is embedded in a binder which is kept in the nursing station. These nursing care plans are poorly maintained and instead of using the nursing care plan, most nurses use an informal system of tracking care items on an Excel spreadsheet which is used to maintain census information. In a comment section, nurses will write their care plan for the day. Many nurses we spoke with do not use the Kardex at all; some use both the Kardex and the census sheet. This parallel process diminishes the probability that an accurate care plan will be developed and implemented, and may result in patients not receiving physician ordered care. Nursing care plans need to be standardized made simple for nurses to use, and accurately reflect the needs of the patient consistent with physician orders.

OHU Patients Require a Greater Level of Care than what is being provided

Review of patient charts on the OHU reflected patients housed on this unit require a level of care greater than an OHU. [36] These patients require a skilled nursing unit or a nursing home environment. Several patients did not have timely testing or follow up.[37] It was not clear whether this was because by definition OHU patients are seen only every two weeks, because of lack of access to the patients due to insufficient custody staff, or for some other reason. In any case, patients need to be evaluated timely based on their clinical condition. In some patients, nursing care plans did not accurately reflect physician orders or were inadequate for the patient.[38] While we could not identify explicit harm to the patients because of these deficiencies, continuation of these problems may result in harm to patients and therefore need to be corrected.

[36] OHU Patients #2 and #8.
[37] OHU Patients #1, #3, #4, #6, and #9.
[38] OHU Patients #2 and #8.

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.

San Quentin leadership has instituted several processes related to quality improvement. These include the Quality Management Committee, Emergency Response Review Committee, Morbidity and Mortality Review Committee and Institutional Utilization Management Review Committee.

Review of the QMC committee meeting minutes from July to November 2012 showed that the minutes are essentially an outline of topics that were discussed with reference to subcommittee report handouts. These handouts were not provided to us for review. Moreover, there is no documentation of group discussion regarding the content of the handouts. Thus the meeting minutes are not useful in describing committee activities and progress made in resolving identified problems.

We reviewed Emergency Response Review Committee (ERRC) minutes from June to November 2012. We found the minutes to be very useful in describing the timeliness and quality of emergency response by custody first responders and health care staff. Review of the minutes showed that health care response was generally timely and appropriate. There were instances, however, of failure of custody staff to assess the patient for life signs and initiate cardiopulmonary resuscitation (CPR) when indicated and/or delays in access to the patient by health care staff.[39] We incidentally note a downward trend in attendance from June to December 2012 by committee members.

[39] August 27, 2012, September 10, 2012 ERRC Meeting Minutes.

Recommendations

Organizational Structure, Facility Leadership, and Custody Functions

1. CCHCS staff should regularly visit every site. Optimally, this should be at an annual QI meeting in which Central Office would hear and understand the major problems at each facility and get a better sense of operational difficulties.
2. There should be an interagency policy on acuity based classification between CDCR and CCHCS. In a procedure or appendix, there should be reference on how to make classification assignments which are consistent with definitions of Intermediate housing.
3. Prior to finalizing the budget and staffing for a facility, fiscal and operational managers from CCHCS should meet with the facility senior management to discuss the proposed budget and rationale for staffing and budget changes.

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

1. CCHCS should review the existing Acuity Based Staffing changes with San Quentin health care management following the completion of the classification based reassignment to ensure that staffing types and numbers are appropriate to the new mission.
2. Before reduction of office staffing who perform scheduling, CCHCS should ensure an adequate scheduling system is in place.
3. In keeping with the powers granted by the Transition Plan Order of 9/5/12, the Receiver should secure appropriate revisions to state law and regulations to modify discipline procedures so that:
    a. Investigation of health care staff is under direction and supervision of Health Services
    b. The matrix of discipline is modified to conform to a health care system, not a custody one.
    c. The disciplinary process is initiated and completed in a timely manner, and no greater than 60 days.
4. Health Services management should perform a root cause analysis and process analysis of the discipline process relative to its capacity to effectively discipline staff. This should be reported to QI and to Central Office.
5. Adverse actions should be consistent with health care standards, not custody standards.
6. Regular annual training should be incorporated into the program, especially for nursing.

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

1. All budget lines should be clearly understood and all expenses incurred by the facility should be accounted for by the facility. Annual budget reviews with each facility should be implemented.
2. A replacement schedule for capital items should be developed. The American Hospital Association has a book detailing a depreciated schedule for various assets which could be used as a resource (Estimated Useful Lives of Depreciable Hospital Assets). This can be modified for existing capital resources within the health system.

3. A system of reporting non-conformances should be developed. This should be an offshoot of the QI committee.
4. Inventory turns should be increased to reduce costs. A prime vendor might be helpful.
5. Environmental rounds should be reported to QI on a quarterly basis.

Policies and Procedures

1. All Local Operating Procedures should be reviewed and signed as reviewed annually.
2. The OHU policy should be reviewed in light of current practice and the policy and practice should be consistent.
3. The medical reception policy should be revised to conform to the Statewide policy.
4. The medication prescription policy should be revised to ensure consistent practice in terms of default length of prescription medication.
5. A policy and procedure should be developed on reporting non-conformances.
6. A policy on Self-Monitoring Quality Improvement, Routine Audits, Identification and Resolution of Problems, OIG Reports and CCHCS dashboards should be developed.

Reception and Intrasystem Transfer

1. Health care leadership should revise the medical reception policy and procedure to be consistent with the statewide policy and ensure that all newly arriving inmates receive a history and physical examination within 7 days.
2. The medical evaluation should be standardized to include a more complete personal history and review of systems, similar to that found in the Dental Health History Record (CDCR 7433).

Access to Care: Nursing Sick Call

1. Health care leadership should continue to review nursing assessments and provide feedback to nurses to improve performance.

Chronic Disease Management

1. Health care leadership should identify and address issues contributing to the lack of timely follow-up care.
2. Blood sugar monitoring logs should be available when providers see diabetic patients in chronic care.
3. The Problem List should be updated with new diagnoses.

Pharmacy and Medication Administration

1. Medication administration practices in segregation should be changed so that nurses adhere to generally recognized standards of nursing practice.
2. Nurses should forward MARs to health records in a timely manner.

Urgent/Emergent Care

1. Correctional staff should be provided additional training regarding assessing patients for life-signs and initiation of CPR.
2. Conduct more frequent emergency response drills for using cardiac arrest as the medical event.
3. Consideration should be given to the strategic deployment of Automatic External Defibrillators (AEDs) in selected areas of the facility that are accessible to custody and other non-health care staff in the event of cardiac arrest of an inmate, staff or visitor. This is particularly applicable to maximum security housing units where logistics may delay access of health care staff to the patient or staff member.

Specialty Consultations

1. Health care leadership should identify and address issues contributing to lack of timely PCP follow-up care.

Specialized Medical Housing: OHU/CTC/GACH

1. Due to San Quentin's size, facility medical mission and location of the condemned population, we recommend maintaining the current level of OHU medical beds.
2. Patients requiring a higher level of care, including condemned inmate-patients, should be transferred to a facility capable of providing the needed medical care.
3. To increase health care staff access to patients, establish OHU custody staffing based on a ratio of 1 custody staff for every 1.5 to 1.75 clinical staff. This can be modified during night shift. Another alternative, which is done in other systems, is to allow nursing staff to have keys to the rooms.
4. Review and revise nurse documentation procedures on the OHU. One way to accomplish this is performance of a process flow of documentation with subsequent standardization of nurse care plan development and management.