

# **California Men's Colony 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 Medical Inspection Results report 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.<sup>1</sup>

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

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

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

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

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

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

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

## Overall Finding

We find that California Men's Colony (CMC) will be providing adequate medical care once the significant problems in pharmacy services, medication administration, and the health care physical plant are corrected.

## Executive Summary

On January 22-25, 2013, the Plata Court Medical Experts visited CMC to evaluate health care services. Our visit was in response to the OIG Medical Inspection Results Cycle 3 report showing that CMC scored 85.4% in March 2012. This report describes our findings and recommendations. We thank Warden Elvin Valenzuela, Chief Executive Officer Ted Fox, and their staff for their assistance and cooperation in conducting the review.

This is our first visit to CMC, and we found that many elements of the health care delivery system are working well. These include:

- an appropriate medical organizational structure with competent leadership
- adequate health care staffing
- competent medical providers
- custody collaboration and support
- timely intrasystem transfer screening
- timely initial access to health care
- timely access to specialty services
- timely radiology services
- a health records management system
- an active quality improvement program

We found that other systems are generally working well but require focused improvement. With respect to chronic disease management, we found that when patients were seen by medical providers, the quality of care at visits was good; however, providers do not consistently monitor patients in accordance with their disease control, which increases risk of harm to patients. The quality of care for patients in the general acute care hospital is also good but the physical plant is problematic. CMC staff is to be congratulated on the many improvements to the health care delivery system.

As noted above, there are two areas that pose a serious risk of harm to patients. The first is that approximately 35% of all medication orders, averaging 600 per day, are dispensed to patients by having nurses administer dose-by-dose medications from stock bottles stored in the medication rooms. This is done without the pharmacy safeguards that are in place for pharmacy-dispensed prescriptions to ensure that nurses administer the right drug, at the right dose, to the right patient. In addition, nurses pre-pour and repackage dangerous drugs from pharmacy dispensed containers into improperly labeled, repeatedly used coin envelopes which

are not sanitary. These practices are not found in any hospital or retail pharmacy and pose a high risk of medication error and harm to patients. We understand that contributing factors to these practices are the lack of sufficient pharmacy space and staff to dispense all prescriptions in patient-specific, pharmacy labeled containers. In addition, medication clinics are not of sufficient size to store the volume of pharmacy dispensed and Central Fill medications. Nevertheless, this is a dangerous practice and we recommend that CCHCS immediately address this situation. We recommend increased use of Central Fill Pharmacy dispensed prescriptions to the extent feasible, and removal of stock supplies of the most dangerous drugs.

Secondly, CMC health care facilities are inadequate. The Receivership, in coordination with CDCR has included CMC in the Health Care Facility Improvement Program pursuant to the authority provided by AB 900. AB 900 authorizes CDCR to design and construct new buildings, renovate existing buildings, and make ancillary improvements at facilities under the jurisdiction of the Department to provide medical, dental and mental health treatment.<sup>3</sup>

We have reviewed the CMC Health Care Facility Improvement Plan and believe that it will address the majority of medical physical plant deficiencies. However we note that it does not include improvements to the general acute care hospital (GACH) that also has serious physical plant problems, including a roof that continues to leak despite having been replaced, resulting in evacuation of patient rooms during heavy rains. This and other GACH physical plant issues need to be corrected.<sup>4</sup>

We note that CMC has been designated as an Intermediate facility and is in process of receiving a higher acuity medical population at the same time staffing is being reduced. We recommend that following the implementation of Intermediate facilities and Acuity Based Staffing Realignment, the Receivership, in collaboration with CDCR reevaluate staffing to ensure that adequate care is being provided.

As noted in previous reports, in order to maintain adequate conditions at CMC, we recommend that the Receiver institutionalize operational changes already established in the Receivership regarding salaries and contracting. In addition, we recommend that the Receiver 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.<sup>5</sup> 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.

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<sup>3</sup> Health Care Facility Improvement Program. California Men's Colony. February 2013. Page 2.

<sup>4</sup> This is true whether this inpatient area continues as a licensed GACH, a Correctional Treatment Center (CTC), or Outpatient Housing Unit (OHU).

<sup>5</sup> 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**

CMC has two physically separate facilities, designated as East and West facilities. The Level III East Facility, which houses medium security inmates, is divided into four quadrangles. Each quadrangle has its own dining room, classrooms, athletic fields, and two three-story housing units. The East Facility has a licensed general acute care hospital. The facility also provides mental health care through Enhanced Outpatient Program (EOP) and outpatient treatment for inmates assigned to the Correctional Clinical Case Management System, as well as a mental health crisis bed Unit.

The Level I and II West Facility houses minimum security inmates in dormitory settings. In addition to the three general population housing units, the West Facility contains a Level I camp program for fire suppression, conservation and other community service work. At the time of our review the population of CMC was 5,141 inmates or 133.9% of design capacity.

CMC 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. CMC has been designated to be an Intermediate facility and is in the process of receiving higher acuity inmate-patients.

Due to its location, CMC is able to attract qualified professional staff and is in close proximity to hospital and specialized consultative care in the surrounding community. This makes it an excellent choice for an Intermediate facility. However, due to its lack of structures that are ADA accessible (there are stairs throughout the facility), disabled inmates, inmates who need wheelchairs, and those who otherwise cannot walk up stairs cannot be housed at the facility. This limits the types of Intermediate patients who can be housed at CMC.

### **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:** As noted in previous reports, health care delivery at CMC is a system of shared governance with some functions under the control of the Receivership and some functions under the control of CDCR.

We reviewed the CMC health care table of organization and found that it was organized along functional lines of authority and internally consistent.<sup>6</sup> All senior management positions are filled.

CMC has stable and capable senior management. Ted Fox, the Chief Executive Officer, has been at CMC for three years. He has 30 years of experience in hospital and health

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<sup>6</sup> CMC, untitled document dated January 14, 2013.

administration, of which 20 years were as a CEO of a hospital. All remaining senior staff has been in place at least for two years. Dr. David Ralston is the Chief Medical Executive, Dr. Christine Barber is the Chief Physician and Surgeon, Rick Mott is the Chief Nursing Executive, Martha Wallace is the Chief Support Executive and Lauren Krup is the Pharmacist-in-Charge. There is no anticipated change to management in the Acuity Based staffing model.

Mr. Fox reports to the Receiver and to Diana Toche DDS, Undersecretary, Administration and Offender Services (Acting), on dental and mental health issues. He communicates with Mr. Kelso on a group conference call, every other week. There is no participation by Central Office on a routine basis at the site, although Central Office does review their Process Improvement Plan.

Management at CMC stated that custody staff does not interfere with medical autonomy or clinical decision making. When problems arise, management believes it has good relations with custody and ample opportunity to discuss problems when they arise. Mr. Fox attends the Warden's Executive Staff meeting twice a week. The Health Care Leadership Council meets weekly and the Associate Warden is always present. Mr. Fox has lunch with the Warden every month. The only impediment to delivery of medical care is that custody staff has not completed fit testing of the N-95 masks so that patients with potentially infectious pulmonary disease cannot utilize the negative pressure rooms. As described below, we observed officers standing in doorways or in clinical examination rooms compromising privacy. We also saw officers assisting nurses in taking weights. These minor deficiencies can be easily corrected.

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

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

**Findings:** Staffing is adequate for the hospital and appears to be adequate for an Intermediate facility. CMC has 369.18 budgeted positions with 41.28 vacancies (11%). Vacancies are roughly equally distributed amongst supervisory, clinical, and administrative support positions. CMC medical staffing will be reduced by 18 positions under acuity based staffing.<sup>7</sup> As in other Intermediate facilities, the Acuity Based Staffing Realignment will result in more complex and higher acuity patients at the same time that the medical program will have a 5% staff reduction. According to management, this will most likely not adversely affect patient care. In preparation for these cuts, CMC management had several discussions with Central Office on staffing, but without discernable impact, according to CMC management. These staff reductions were made by a working group, utilizing a mathematical model, at the Central Office level. The CEO of the facility should participate in all staffing reduction plans.

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<sup>7</sup> CMC will receive an additional 60 positions to staff a new mental health unit.



The number of budgeted positions does not entirely reflect the staffing needs. Over time, work processes change, the mission of the facility changes, and technology improves. Under these conditions, some positions can be eliminated and new types of positions are required. In this area, the CEO is hampered by an inflexible and extremely bureaucratic position control process. Only the Department of Personnel can formally create a new position and authenticate a job description. Local management can attempt to create positions but it takes years to do so. The CEO at CMC is attempting to create a Chief Quality Officer position but it has been two years and he has not yet been able to create this position. Such a position would be in line with quality improvement requirements of Central Office. With changes in automation, there is less need for clerical staff, but increased need for data resource staff and people who can utilize existing databases to improve workflow. However, neither job deletions nor job additions can be made by local management, even if the net cost is zero or more cost effective. Local management ends up using existing staff to perform duties that were not intended by virtue of their job descriptions. As a result, some individuals find themselves working out of their classification. This can result in labor relation problems, occasionally higher costs, and less productivity. This inflexible situation makes it difficult to manage. There needs to be a way for local management, with appropriate direction and approval from Central Office, to modify staffing to improve services.

The time to hire depends on the type of position. We were told that, in general, it takes approximately 6-8 weeks to hire staff, which is satisfactory from our perspective. Currently positions are frozen during the Acuity Based Staffing Realignment. Entry-level clerical staff, custodians, laboratory scientists, and LVNs are difficult to recruit because the local cost of living is higher than many people can afford given the salaries for these positions.

### **Credentialing and Peer Review**

Since CMC has a GACH, credentialing is required for purposes of Title 22 licensing requirements. Central Office maintains the credential files. Peer review is performed by Central Office. National Practitioner Databank and litigation information is available in the credential files and is available to CMC management.

### **Disciplinary Process**

CMC has Regional human resource support for purposes of discipline and hiring. CMC also uses two local positions (a Plata analyst and a Coleman/Perez analyst) for human resources issues and for assistance with interpretation of work rules and the functioning of the CDCR personnel system. These individuals are not intended to be human resource staff but assist in that function.

CMC management finds the personnel system extremely bureaucratic, cumbersome, and so complex that it is hard to understand and manage. There is no specific policy or procedure defining how to hire staff. Neither is there a written procedure in CCHCS on discipline. As in other facilities disciplinary procedures are part of custody operations and are present in the CDCR Operations Manual.

At CMC, discipline of health care employees is problematic. This is because the medical program may have to wait for an office of internal affairs (OIA) investigation, legal review or a personnel board review of management decision on discipline. For patient safety reasons, health care management will not reassign an employee who is thought to be a danger to patients even when the custody investigator or the personnel board do not recommend discipline. In these cases the CEO will typically reassign the employee to another position, usually a lower level of assignment.

One example is that a nurse, on multiple occasions, gave the wrong medication to patients. The OIA investigation was adequately performed; however, the attorneys assigned to the matter were unwilling to recommend discipline. The nurse in question has been on special assignment for about six months and not allowed to see patients. CMC's unique approach, as occurred in this case, is to place nursing staff in extended orientation in which they are not engaged in direct patient care. In another case, another nurse allegedly made a serious medication error which may have resulted in a patient death. The investigation and legal review lasted about two and a half years. Ultimately, upon recommendation from attorneys assigned to the matter, disciplinary action was not pursued. During the investigatory and legal review, the nurse was reassigned to extended orientation rather than allowing the nurse to see patients again. Shortly after starting back at work the nurse left on medical leave. The Nursing Board is currently investigating this case.

We agree with the position of not allowing problematic employees to engage in work that may create patient safety problems. However, we do not agree with an approach that retains problematic employees in positions that reduce budgeted positions by having them work in a job out of their classification. This reduces the authority of the CEO and demoralizes good employees. We recommend that a more prudent discipline process, in line with health care and distinct from custody operations, be put in place for CCHCS.

### **Health Care Budget**

As in other facilities, the allotment, which is equated with a budget, does not match expenditures. CMC spends more than is budgeted in the allotment. Based on information from the CEO, the initial allotment for CMC was approximately \$47 million. Based on information from the Budget Office the final allotment was \$55,439,881 and final expenditures were \$63,406,926. This indicates that the initial and final budgets as provided by State government are insufficient to operate the program and intervention by the Receiver was necessary in order to obtain sufficient funds.

The CEO estimates that approximately 95% of the budget allotment is for personnel items. According to the CEO, a contributing factor to the mismatch between allotment and expenditures is that all staff is budgeted at the mid-level salary range rather than at their actual salary. If staff have been in their positions for a long period of time (which is the case for many of the staff at CMC), then the amount budgeted for their position is too low and expenses will exceed the allotment. Another issue is that the budget does not include a relief factor for some positions. As a result, when a position without a budgeted relief factor is vacant,

overtime is used to backfill the position. Overtime costs are expected to be obtained from unspent allotment for vacant positions. But when the amount of overtime exceeds the funding available for vacant positions, overtime costs will accumulate as an unfunded expense. Additionally, if money for vacant positions is used for overtime costs, then the vacant position cannot be filled because the funding is being used for other purposes. This is a barrier to hiring.

The CEOs do not participate in the budget process so those making the allotment do not get input from CMC local management on appropriate allocations. Some line items required for operation are not provided for in the allotment. Supplies, as an example, come from the Warden's budget. Staff reported that they were told that there was no money for paper or minor office supplies. Local management typically goes to the Receiver or Central Office for problems like this to ensure that the program has necessary supplies and equipment.

For managing the budget, CMC leadership does not use CDCR's budget software because from the perspective of the CEO the software does not make expense tracking easy nor does it provide for comparisons of expenses against budget. CDCR uses BIS (Business Information System) as the system which is used to manage the budget. The CEO does not use BIS because it does not provide information that can be used by him in a practical manner. Instead, he uses a spreadsheet format, created by another CEO, as a matrix to track expenses. While this gives the CEO and management a tool to see how their expenses line up with their allotment, it creates a parallel system of bookkeeping that can be confusing. We experienced that confusion first hand in attempting to obtain allotment and expense numbers from CEOs and Central Office budget staff as budget numbers did not correspond. From an operational perspective it would be better to make modifications to the BIS software so that it satisfied the manager's needs to track expenses rather than to maintain separate business software programs.

As noted in our report on San Quentin, we are concerned that once CDCR assumes control of CCHCS and the Receiver is no longer able to augment budget deficits, individual facilities may have a harder time getting resources to maintain services at adequate levels. We continue to recommend that the budget process be made rational and transparent with all budget lines accounted for on an expected cost basis. Facility staff must also be given the tools to effectively manage their budgets.

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

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

**Findings:** Medical clinical space is a major problem at CMC. The CMC Health Care Facility Improvement Plan identified medical space deficiencies related to the following operational areas:

- Medication Distribution

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

Our evaluation confirmed the findings of the CMC HCFIP that justify the need for structural medical space improvements. However, we note that the facility improvement plan does not address medical plant deficiencies in the general acute care hospital.

#### Central Health Services Building

The Central Health Services Building, located in Building C was built in 1962. It contains the primary care and dental clinics, an emergency room, a surgery suite, radiology, health records, pharmacy, laboratory and health care administrative staff. These functions serve the entire population, including those housed at West Facility with the exception of West facility health records and primary care services. It also houses public health and HIV clinics. The GACH is located on the upper floor.<sup>8</sup>

The Central Health Services Building has inadequate space. There is no indoor waiting room for patients and on the day of our visit, it was raining. Patients waiting for medical appointments are required to sit on outdoor benches. A large blanket was placed on the floor to absorb rain and water dripping from people coming into the clinic. The open door made the interior clinic feel like it was outdoors. Patients reported being required to sit outdoors even when the weather is cold or inclement, sometimes for several hours. This is not appropriate for any patient, much less a medically fragile population.

Upon entering the main clinic through which one must pass to access other areas of the building, there is desk where a nurse checks patients into the clinic. This is a public area and although we were told that no medical history is taken in this area, we observed this to be the case. The lack of privacy is evident. There are no toilets in the immediate area for patients or staff. Staff has to leave the clinic and walk down the hall to an administrative area to use the restroom. There is no ready access to hand-washing in this area. We note that in the CMC OIG Medical Inspection Results Cycle 3 report that only 50% of staff was observed to wash their hands between patients.

The open area results in the mixing of custody and medical functions and on multiple occasions we saw custody officers either performing medical tasks (weighing patients or cleaning patients after EKG testing) or standing in the doorway during a physical encounter between a provider and a patient. There is a room that is equipped and supplied as an emergency room and that

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<sup>8</sup> CMC Health Care Facility Improvement Plan. February 2013.

provides adequate privacy, but staff reported that this room is not routinely used. Instead, patients are examined in the large open room which does not provide adequate privacy. We inquired why this is occurring and staff reported it was because it worked better for the correctional officers.

Although many clinical functions, including emergency care, occur in this area, we observed custody and health care staff eating food in this area, with food stored on top of medication carts. This is not in compliance with OSHA bloodborne pathogens standards prohibiting consumption of food and drink in areas in which potential exposure to blood or other potentially infectious material takes place.<sup>9</sup> Clutter is in evidence throughout the clinic.

There are several medical provider clinic rooms, but they are not standardized with respect to medical equipment and supplies. Most equipment is of different size and shape and most of it is old and obsolete. Examination tables are non-standard and appear homemade. They are 20 inches wide which is not sufficiently sized for even normal people. This places the patient in danger of falling and does not promote thorough patient examinations

There was no standardization of equipment and supplies in the clinics. There is a par level which is replenished by nurses but standard supplies were not evident. There is an equipment line in the budget but the allotment does not include funding for this line. Any equipment over \$5000 must be approved by Central Office. For the most part, equipment is only replaced when broken. All of the examination tables at CMC need to be replaced and other equipment, like the optometry equipment, is so old that parts are not always possible to find. There is an inventory of medical equipment but it is impractical to use. There is a contract for the servicing of equipment, but no systematic way of reviewing whether all equipment has been appropriately maintained. As a result, it requires a great deal of effort to determine whether the equipment is in need of servicing. Standardizing this process across facilities would be an improvement. Central Office and/or the facility would be able to track equipment and identify when items needed to be serviced or replaced.

Regarding sanitation, there is a janitorial staff of two that supervise 14 inmate custodians. When there is a lockdown, the custodians are available to clean. There is a cleaning schedule that is monitored by the custodian supervisor. The sanitation schedule is not specific and only states that the room should be cleaned. The program needs a sanitation schedule in a checklist format that custodians can follow in their daily routine. The checklist for each day can be monitored and monthly reports sent to the QI committee.

Environmental inspections are only done in the hospital by the Standards Compliance officer and by plant operations (custody). Formal inspections are not done in the Quadrangle clinics or office areas. This should be done optimally using a checklist format. During our tour of the facility, we identified many areas that were cluttered with broken equipment and obsolete equipment. These items should be identified and repaired or replaced. There are newly

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<sup>9</sup> Occupational Health and Safety Administration (OSHA) 29 CFR 1910.1030 (d) (2) (ix).

created patient safety rounds. Staff performing these rounds could incorporate an environmental inspection as part of their responsibilities.

#### General Acute Care Hospital (GACH)

The GACH is a 37-bed facility. In the past, there had been discussion of turning the unit into a Correctional Treatment Center. However, by transitioning to a CTC, state regulations would require significant renovation because the unit does not meet current regulations for structural requirements of a CTC. Therefore, it continues to be used as a general acute hospital and is “grandfathered” in under the current regulations. This unit is unacceptable as an acute care hospital or as a CTC because of its configuration and physical plant. As an example of its structural problems, when it rains, four of the single bed patient rooms leak and the patients need to be evacuated. This has occurred on a consistent basis for years, despite the roof being replaced.<sup>10</sup>

The hospital consists of two large dormitories and several single beds at the end of a long corridor. The rooms are clean and have new hospital beds that were purchased under the Receivership. There are several additional single or two patient rooms on the opposite end of the corridor. There are no examination rooms or nursing treatment rooms in the hospital so all exams and treatments are done bedside. Privacy examinations are basically not possible because the hospital is in a dormitory arrangement. Portable curtains can be moved into the room and made to surround the patient’s bed, but this still does not offer much privacy and does not offer sound privacy. There is no sound privacy on the unit except for the few single rooms.

In the center of the hospital unit there is an extremely small nursing station. There is insufficient working space for nurses. The nursing station only has four nursing work areas and terminals to review the eUHR and the same number of chairs with very limited counter space. On the day of our visit, eight nurses were on duty. As well, there is another small room on the opposite end of the corridor but this room has one terminal and counter space for only one person. The physician and other clinical staff also use this nursing station to document their notes which makes it extremely crowded.

Office space is minimal. The Nursing Supervisor’s office is extremely narrow and looks like a closet or storage space. The physician’s office is extremely tiny and has a desk that is so small it does not accommodate an open medical chart.

This unit has inadequate plumbing. There are no sinks in the dormitories for employees to wash their hands after patient contact. There are a couple of hand-washing sinks on the unit but they are not in proximity to patient rooms. There are only two hand sanitizers on the unit: one near the elevator and one at the far end of the long corridor where the single patient rooms are located. To maintain proper hygiene, nurses and other clinical staff would have to

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<sup>10</sup> Staff reported that since the roof has already been replaced, there are no other plans to correct this long-standing problem.

walk half the entire length of the unit to wash hands or sanitize their hands after each patient encounter. Effectively, there is no good place to wash hands in this hospital setting. This discourages proper hygiene and promotes hospital-acquired infections. As well, there are two negative pressure rooms for use for isolation of persons with contagious diseases such as tuberculosis which are not useable because custody staff hasn't been fit-tested with N-95 masks. As a result the rooms cannot be used for their intended purpose and anyone requiring negative pressure is sent out to a local hospital.

If CMC continues to be an Intermediate facility, a major strategic decision remains as to how CMC will continue to care for acute and higher-level acuity patients who require a higher level of care than can be provided in general population.

#### East Facility Clinics

We toured East facility yard clinics in A-D Quads. In facility A the nurses' clinic used to be the coach's room. It is small, cramped and the furniture is old. It is adequately equipped and supplied. We note that the oto-ophthalmoscope is located on the opposite wall from the exam table. The room is difficult to keep clean due to dust storms, and sanitation was suboptimal.

The facility B 112 yard clinic had no toilet in the clinic. Staff has to leave the premises to use the restroom and there is no restroom for patients. There were two exam rooms. One of them was so small that the examination table didn't fit in the room and the patient chair was in the doorway. Lack of visual privacy was guaranteed. We also saw an officer standing in a doorway listening to an appeal interview, evidence that there is no privacy. Lack of standardization of clinic exam rooms was similar to that in the East clinic. There was no space in the examination rooms for storage of supplies. The providers used the examination table for storage and told us that they move the stored items to examine patients.

Quad B contains a 200 bed administrative segregation (ad-seg) unit. The room used by medical providers is also used by the classification committee and is inadequate. There is basic medical equipment (e.g., exam table, oto/ophthalmoscope, etc.) that is collectively pushed up against the wall and presumably is rearranged each time a clinic is conducted. A portable sink is inoperable. The room was filthy. Staff reported that inmate porters are not permitted anywhere in the Ad-Seg building for security reasons, and correctional officers and nurses are expected to provide adequate sanitation. This obviously is not occurring. We found similar findings in both ad-seg medication rooms. In addition to not being clean, there is no temperature and humidity control in these rooms where stock medications are stored. (See medication administration). The standards of cleanliness and disinfection that apply to the hospital also apply to these satellite health clinics, but are essentially no different than findings prior to the Receivership.

## West Facility Clinics

The West Clinic was built about 70 years ago and is unacceptable for patient care. It needs major renovation or needs to be rebuilt. It has an outdoor patient waiting area that is unacceptable. A couple of years ago, medical staff arranged for a tin shed cover to be placed over the benches outside the West clinic. However, if there is wind, the rain blows across and under the shed roof. On the day of our visit, it was drizzly and cool in the morning (we estimated between 45-55 degrees F). While clinic wait times can be short, we talked to some inmate-patients who said that they can wait up to 3-4 hours in cold conditions for their appointment. As noted earlier in this report, this is unacceptable under all circumstances but especially since CMC is an Intermediate facility with high-risk patients.

There is essentially no separation of custody and medical functions in the clinic and this encourages lack of privacy. The nursing evaluation areas lack privacy and separation from custody staff. Equipment, including examination tables and furnishings, is all obsolete and all needs replacement. West yard nurse triage clinics varied in their adequacy, but nurses work in isolation in these clinics. This does not facilitate communication with medical providers.

We note that the OIG audit tool does not adequately assess the adequacy of medical space, which is a fundamental requirement of an adequate health care delivery system. The OIG section relating to Clinic Operations has three questions marginally related to the issue of physical plant. One question is whether the floors, waiting room chairs, and equipment are cleaned daily. Another question asks whether staff wash hands between seeing patients.<sup>11</sup> The other question is related to whether patients are provided audio and visual privacy. These questions alone are insufficient to evaluate clinic space. Moreover, with respect to privacy, we note that the OIG Medical Inspection Results Cycle 3 report provided a score of 100% for the question addressing audio and visual privacy<sup>12</sup>, whereas we found major deficiencies in this area.

We recommend that future revisions to the OIG audit tool separate clinic operations from medical clinic and bed space and include elements contained in the Health Care Facility Improvement Plan and in this report. Moreover, the evaluation of the adequacy of medical space should include all inpatient beds (e.g. GACH, CTC and OHU beds).

In conclusion, it is our opinion that medical clinic and inpatient bed space at CMC are inadequate. With the completion of the CMC HCFIP and correction of the inpatient bed physical plant deficiencies, we anticipate that this area would be compliant with the requirements of an adequate health care delivery system.

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<sup>11</sup> This scored 50% for two of four staff evaluated.

<sup>12</sup> OIG indicator 14.164



## **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:** CMC has a major problem concerning local operating procedures. There are 33 electronic folders of local policies at this site comprising somewhere between 1000 and 1500 policies. Management staff is not completely aware of the contents of many of these policies. Many of these policies are related to the GACH and are required for licensing purposes. This is an inherited problem that is extremely dysfunctional. For example, there are ninety policies related to laboratory services. Almost all, by virtue of their title, were related to laboratory services required for the GACH. As noted below, the laboratory performs approximately 4-5 tests per day. Although we acknowledge that the policies may be a licensure requirement, considerable staff time and energy is required to review and update so many policies for such a small number of tests.

There are local operating procedures matching some of the key statewide policies, such as Access to Care, Urgent and Emergent services, Intrasystem Transfers, and Nursing Sick Call. However, given the large number of policies, we did not have time to determine whether the Local Operating Policies conformed to statewide policies. Title 22 requires that the local operating procedures are reviewed every two years. However, many policies were old and, according to management, had not been reviewed for years. We were not able to obtain accurate information regarding the number of policies which had been reviewed in the past year.

Several important areas that require a policy did not have one. These areas include chronic care management, procedures for practitioners in admitting patients to the hospital, medical autonomy, employee hiring and discipline, maintaining supplies and equipment, scanning medical records, quality improvement, medication storage in nursing areas, nursing medication administration, ordering and reporting laboratory tests, specialty consultation and mortality review. In addition, it appeared that many existing policies were unnecessary.

While management provides training when new policies are implemented, they acknowledged that staff training has not occurred for many of the existing policies. Staff sign off that they have reviewed local operating procedures but it is not clear that they have actually read all of the 1000 to 1500 policies. Management did not feel that employees were aware of all the policies even those in their area of responsibility.

Management has recognized that the current status of the policies is problematic and is undertaking corrective action and developing a set of key policies. Within their quality group, they are mapping selected important processes and are creating flow maps out of which they intend to develop standardized procedures. This is an excellent idea. We reviewed a flow map of specialty care and believe the process they have undertaken is the correct one. However, the existing policy situation is deficient and will take a year or more to resolve.

## **Intrasystem Transfer**

**Methodology:** We interviewed facility health care leadership and staff involved in intrasystem transfer, and reviewed 12 health records of medium to high risk, chronic disease patients that transferred to CMC since April 2012.

**Findings:** Our review showed that nurses evaluate newly arriving inmate-patients in a timely manner and that, with exceptions, medications are generally refilled or renewed in a timely manner. Focused attention is needed for timeliness of referral for high-risk patients.

In all records reviewed, sending facility nurses completed a 7371 transfer form at the time of inmate-patient transfer. This is consistent with the OIG Medical Inspection Results Cycle 3 report score of 100% for this area. The Health Screening section of the report measures the receiving facility's performance and CMC scored 82.6% for this area. One area of concern is that when nurses referred patients to a medical provider, in only 25% of cases did a provider see the patient in a timely manner.

Upon arrival at CMC, nursing staff completes a medical screening, noting whether the patient has any acute problems and whether chronic disease medications arrived with the patient, or required refill or renewal. We found examples of medication discontinuity. In one case, medication discontinuity for a patient with end-stage liver disease may have contributed to hospitalization for edema.<sup>13</sup> In another case, a nurse noted that a patient with multiple chronic diseases including diabetes, hypertension and hypothyroidism arrived without his medications but they were not renewed upon arrival.<sup>14</sup> Another high-risk patient with severe heart disease, cardiomyopathy and an internal defibrillator arrived at CMC with only 1-4 days left of two heart and blood pressure medications. The nurse documented referral to a provider but this did not occur and his medications were not renewed until a week later.<sup>15</sup>

Nurses referred newly arriving patients to a physician within 1-14 days, in accordance with nursing judgment regarding the urgency of the patient's condition. The referrals generally took place as requested but there were exceptions. The high-risk cardiac patient described above advised the nurse that he had used his nitroglycerin tablets five times the day prior to his arrival. The nurse referred him to the physician early the following week, but the visit did not take place for almost two weeks. Due to his high-risk cardiac status and frequent chest pain, the nurse should have arranged for the patient to be seen within 24 hours.

In another case, a 60-year-old patient diagnosed as bipolar disorder with psychotic features, coronary artery disease and poorly controlled diabetes and hyperlipidemia transferred to CMC in December 2012. Upon his arrival, the patient was refusing his "medical" medications and the nurse referred him to see a provider within 14 days. However, two days after arrival he

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<sup>13</sup> Intrasystem Transfer Patient #1

<sup>14</sup> Intrasystem Transfer Patient #5

<sup>15</sup> Intrasystem Transfer Patient #8

threatened to hurt himself and he was placed on suicide precautions. A week later he was scheduled to see a physician but documentation reflected that staff was notified that the patient “refused” the visit. It is not clear that health care staff knew that he was under mental health observation or whether he was mentally competent to refuse. The patient’s triglycerides are extremely elevated (>600, normal=<150), increasing his risk of a cardiovascular event, but the patient is refusing his cholesterol medications due to medication side effects. Nurses have documented his medication refusals but have not notified the physician that the patient is experiencing side effects. As of the time of our review in late January, this patient had not yet been seen by a primary care physician.<sup>16</sup> We discussed this case with Dr. Ralston.

These cases illustrate that although the intrasystem transfer process itself is generally occurring timely, focused attention is needed on high-risk patients to ensure they receive timely and appropriate medical care. Once primary care providers see the patients the quality of care is excellent.

Medication audits performed in the past year shows that CMC staff identified issues related to medication discontinuity within the facility. In June 2012, internal audits showed scores of 45% and 52% for intrasystem medication continuity indicators and in September 2012 a performance improvement work plan was developed to address the issues.

Subsequently, a CMC internal audit for the period of October 1-December 31, 2012 indicated that continuity of medications for internal transfers was 85%. However, this was based upon data showing that 12 (60%) of 20 patients received medications within required time frames following their arrival at the facility. In five of the eight remaining cases in which patients did not receive their medications timely, nurses properly followed policy to document missed or discontinued medications and these records were counted as compliant records, resulting in overall compliance of 85%. This data is misleading regarding the number of patients that actually received continuity of medications.<sup>17</sup> A threshold of 60% for continuity of medications is not an acceptable compliance threshold.

## **Access to Care**

### **Appointment Scheduling and Tracking**

**Findings:** With respect to initial access to care through nursing sick call, we toured each of the housing yard health care clinics and reviewed lists of patients scheduled to see the nurse following submissions of a health services request form (7362). We also reviewed health service requests that were pending being scheduled.

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<sup>16</sup> Intrasystem Transfer Patient #11

<sup>17</sup> This is a design flaw in the instrument, rather than with how CMC staff conducted the study. We later discussed this with Karen Rea, Chief Nurse Executive, CCHCS.

Our review showed that there was no backlog of patients scheduled to see the nurse. In several yard clinics, the numbers of patients to see the nurse were typically less than ten, and many were for minor complaints. Reviews of pending request forms showed that all were submitted within the previous 48 hours and were collected and triaged in a timely manner.

With respect to scheduling physician appointments, staff reported that several months ago, there was a significant backlog of medical provider, chronic disease, and specialty follow-up appointments. Facility leadership convened a Quality Improvement Team (QIT) to study the issue and develop a corrective plan. One strategy involved having the providers specify a range of time for follow-up (e.g., 2-4 weeks), instead of a single point in time (e.g., 4 weeks). Office Technicians (OT) scheduled the patients earlier in the time frame which provided leeway if the appointment did not occur for any reason.

Although this successfully eliminated the backlog, a concern is that record review showed that providers have lengthened the time interval between some chronic disease appointments, even if the patient's chronic diseases were not well-controlled (See Chronic Disease). Indeed, CMC's internal audit showed that only 67% of chronic disease patients were seen timely in accordance with the provider's orders.

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

**Methodology:** We interviewed health care leadership and reviewed patient tracking and scheduling systems, and the responses to 25 health services request forms in 16 patient records.

**Findings:** Our review showed that access to care through nursing sick call is working well. When inmate-patients submit health services request forms, health care staff collects and triages them in a timely and appropriate manner. With some exceptions, nurses see patients with urgent complaints the same day.<sup>18</sup>

The quality of nursing assessments is good, particularly when nurses use the appropriate protocol. Health record documentation showed that communication between the nurses and physicians was good. However, we found cases in which nurses independently managed patients that should have been evaluated by a physician. One case involved a 48-year-old AIDS patient who presented with severe headache, sore throat, nausea and vomiting. The nurse treated the patient for a cold, which was not consistent with the patient's clinical symptoms. The nurse also did not refer the patient to a physician, which should have occurred given his severe immunosuppression.<sup>19</sup>

Another case involved a newly arrived 57-year-old high-risk patient with diabetes, severe heart disease and chronic obstructive pulmonary disease (COPD). The patient presented with a 3-4

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<sup>18</sup> This is consistent with the OIG Medical Inspection Results Cycle 3 report score for timeliness of access.

<sup>19</sup> Nursing Sick Call Patient #3

day history of cough, productive of green sputum. The nurse treated the patient symptomatically without referral. Due to his high-risk status, this patient should have been referred to a physician for evaluation.<sup>20</sup>

Another case involved a 27-year-old who complained of severe ear pain and requested immediate treatment. Despite the reported severity of pain, a nurse did not see the patient urgently. When the nurse saw the patient he reported that he cleaned his ear with a Q-tip and noted drainage. The nurse noted purulent drainage in his right ear canal but was unable to visualize his tympanic membrane.<sup>21</sup> The nurse diagnosed the patient with right otitis media (inner ear infection) and notified the physician, who did not see the patient but gave orders to treat him for an external ear infection and for the nurse to see him in 48 hours. This did not occur. Four days later, the nurse saw the patient, who reported less right ear pain but decreased hearing. In this case, the nurse made a medical diagnosis of an internal ear infection that was not supported by the clinical findings; the physician should have examined the patient. In addition, since the patient may have perforated his eardrum when cleaning it with a Q-tip, the nurse should not have flushed his ears until it was determined that his eardrum was intact, as bacteria may be forced further into the inner ear.<sup>22</sup>

In another example, a 48-year-old taking a blood thinner complained of badly bleeding gums for four months. The nurse did not see the patient but instead informed the patient that he had an appointment with the physician in two weeks. The nurse should have assessed the patient to determine the severity of the bleeding and whether it required immediate referral, as it may have signaled that the patient's level of anticoagulation was too high with an accompanying risk of serious bleeding that may have required holding the medication or decreasing the dosage.<sup>23</sup>

These cases reflect a need for nursing referral to a physician, and may indirectly reflect insufficient physician availability at the facility; however, this requires further evaluation. Health care leadership should focus on the appropriateness and timeliness of nursing referrals to a provider. Despite these cases, we found that overall, patients are receiving timely and appropriate care.

### **Chronic Disease Management**

**Methodology:** We interviewed facility health care leadership and staff involved in management of chronic disease patients. In addition, we reviewed the records of 38 patients with chronic diseases, including diabetes, hypertension, HIV infection, and clotting disorders, as well as other chronic illnesses. We assessed whether patients were seen in a timely manner in accordance with their disease control. At each visit we evaluated whether provider evaluations were complete and appropriate (subjective, objective, current labs, assessment and treatment plan).

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<sup>20</sup> Nursing Sick Call Patient #13

<sup>21</sup> The tympanic membrane is the eardrum.

<sup>22</sup> Nursing Sick Call Patient #14

<sup>23</sup> Nursing Sick Call Patient #6

We also evaluated whether the Problem List was updated and continuity of medications provided.

**Findings:** In most cases, patients are being evaluated in a timely manner following arrival at the facility. When patients are seen by the primary care providers for chronic care, the quality of provider evaluations is mostly very good (subjective, objective, labs current, assessment of disease control and treatment plan) and appropriate patient education is being provided. Provider orders and medication administration records show continuity of chronic disease medications.

In some cases, the physicians failed to see patients whose disease was not well controlled in a timely manner for follow-up.<sup>24</sup> Our findings are consistent with the OIG Medical Inspection Results Cycle 3 report finding that only 44% of chronic disease patients were seen in accordance with the patient's degree of control at the prior visit. Another issue was that the physicians often did not address blood tests (INRs) used to monitor patients being anticoagulated in a timely manner. We recommend that CDCR implement point of care testing so that physicians can have the INR results readily available when they are seeing patients who are taking warfarin. In another case, a patient with AIDS and end-stage liver disease, lapses in a potent diuretic contributed to a 20 pound weight gain and worsening edema, but this was identified and corrected, and he is currently being appropriately monitored.<sup>25</sup>

CMC has implemented a "Gold Coat" program in which inmate helpers shadow at risk inmate-patients and assist them with their day to day activities. We reviewed the medical records of 5 inmate-patients<sup>26</sup> who had been assigned Gold Coats. Overall, the program appeared to be working well. However, we did find 2 cases where care would have benefited if the Gold Coat had received training in medication issues. In one case, a patient with a Gold Coat missed multiple doses of medication.<sup>27</sup> In another case, a nurse documented that the Gold Coat didn't know where the medication line was and apparently was not always taking the patient.<sup>28</sup>

Despite these concerns, we found that the care being provided to patients with chronic illnesses at CMC is adequate.

### **Pharmacy Services and Medication Administration**

**Methodology:** We interviewed Lauren Krup, Pharmacist-in-Charge (PIC), nurses that administer nurse-administered and keep-on-person (KOP) medications, toured the pharmacy and yard medication rooms including administrative segregation, observed medication administration, reviewed health records and interviewed patients.

<sup>24</sup> Chronic Care Patients #s 5, 6, 7, 10, 14, 16, 17, 19 and 20.

<sup>25</sup> Chronic Care Patient #29

<sup>26</sup> Chronic Care Patients #s 30 to 34

<sup>27</sup> Chronic Care Patient #30

<sup>28</sup> Chronic Care Patient #34

**Findings:** We found that CMC pharmacy and medication administration practices are unsafe and present an unacceptable risk of harm to patients. We also found significant issues with medication continuity. Our findings are not consistent with the OIG score of 100% for pharmacy services.

### **Pharmacy Services**

**Findings:** At CMC, the pharmacy operates under a hospital pharmacy license. It is located in the East clinic with a satellite pharmacy in the General Acute Care Hospital (GACH). There is a pharmacy warehouse in an adjacent building that we did not tour.

The pharmacy physical plant is suboptimal. It is small, cramped and the floors are not clean. As part of the Health Care Facility Improvement Plan (HCFIP) there are plans to construct a health services building that will include a new pharmacy.

The pharmacy operates Monday to Friday from 7 am to 7 pm. With respect to pharmacy staffing, there is currently one PIC and five pharmacist positions (one position will be dedicated to the mental health crisis unit that opens in July 2013). There are also eight pharmacy technicians; however, due to the volume of prescriptions, CMC actually utilizes 11 pharmacy technician positions.<sup>29</sup> When the acuity-based staff plan is fully implemented there will be 12.5 pharmacy technician positions. The PIC believes this staffing pattern will be adequate.

CDCR purchases pharmaceuticals from AmeriSource, and Guardian is the pharmacy software program. The PIC expressed concerns regarding Guardian software, stating that when it goes down, there is no back up. She reported that this occurred two months ago and staff were handwriting prescription labels. This increases the risk of medication lapses and errors.

At CMC, prescription dispensing practices are not uniform. The pharmacy receives an average of 1200 new orders each day. Approximately 50% of these prescriptions are filled directly by the CMC or Central Fill Pharmacy with patient-specific, pharmacy labeled prescriptions. For each of these patient-specific medications, a pharmacist double checks the medication container and label to ensure that the medication order was correctly filled and has the right medication in the right dosage for the right patient.

The other 50% of patient prescriptions are dispensed by nurses from stock bottles or unit dose containers kept in the East and West yard medication rooms, including administrative segregation (See medication administration). On a daily basis, nurses and pharmacy techs dispense and administer thousands of doses of medications from stock or unit-dose containers to patients without any pharmacy safeguards in place.

We reviewed a list of 113 dangerous drugs that are maintained as stock in the medication rooms and dispensed dose by dose by nursing staff. The list includes drugs such as warfarin, Amiodarone, Plavix, levothyroxine, gabapentin and HIV medications. Some of the stock bottle

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<sup>29</sup> The other three positions were unfunded.

medications are different doses of the same medication; for example, levothyroxine comes in doses of 50, 75, 100 and 125 micrograms.

Having nurses administer dangerous drugs from stock bottles to hundreds of patients each day creates significant risks of medication errors. It is counter to the culture of safety and would not be found in any hospital or retail pharmacy setting in the community. We spoke with the PIC, who understood the inherent risks of these practices and did not disagree with our concerns. However, she indicated that the pharmacy currently does not have the capacity to dispense all prescriptions in patient specific containers.

#### New Prescriptions

Providers write prescriptions for chronic medications with durations of up to 12 months. This is not consistent with the local policy for maximum prescription duration of six months.

To dispense new medications, clinic nurses transcribe medication orders and fax them to the pharmacy, where technicians enter the medication order into order entry stations.<sup>30</sup> These orders are reviewed, authorized by a pharmacist, and automatically enter a batch label queue from which the dispensing labels are printed. Pharmacy techs fill and barcode the order and the prescription is rechecked by the pharmacist before final dispensing. Pharmacy techs then create a manifest of medications by housing location. Nurses picking up medications check the manifest against the prescriptions. Nurses then take the medications to the yard medication rooms for delivery to patients.

#### Medication Refills

To ensure continuity of maintenance medications, the pharmacy auto-refills prescriptions 5-7 days in advance of the patient's last medication dose.<sup>31</sup> There are exceptions, however, in that the pharmacy does not auto-refill medications such as inhalers. This is a reasonable approach.

For "as needed" medications, patients are expected to submit written requests and place them in medication refill boxes on the yards. We inspected these boxes and found that they are locked, but have a large hole in the side of the box into which we were able to reach in and pull out medication refill requests. Obviously this is not a secure arrangement.

#### Medication Renewals

To facilitate timely renewal of medication orders, each week the pharmacy sends medical providers lists of medications that will expire within the following two weeks. Providers are expected to review these medication reconciliation reports and renew or stop medications as clinically indicated.

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<sup>30</sup> Faxing is not as reliable as scanning the order and sending it via email as is done at San Quentin, but the pharmacy does not have scanners to establish this business practice.

<sup>31</sup> Maintenance medications are essential medications (e.g., chronic disease, mental health) that should be continued.



### **Medication Management and Administration**

**Findings:** We toured the housing yard medication rooms and found significant issues with pharmaceutical storage and medication administration processes.

The OIG audit does not evaluate medication administration as an independent area, but we found significant problems with medication management and administration.

As of December 2012, CMC audits showed ongoing problems with continuity of medications. For example, CMC internal audits from October 1 to December 31, 2012, revealed that only 6 (28%) of 23 patients with chronic diseases received continuity of essential medications.

When inmates transfer from one housing unit to another, only 12 (60%) of 20 patients received continuity of medications.<sup>32</sup> For Administrative Segregation Unit (ASU) patients, 14 (70%) of 20 had continuity of medications upon transfer from the ASU.

The audit tool for medication continuity for patients returning from higher level care showed that in December 2012 that 9 of 9 (100%) of patients received continuity of care, but patients admitted to a GACH, CTC or OHU, who are likely to have a higher medical acuity, are excluded from the sample. Our findings are described below.

### **West Yard**

West Facility has a design capacity of 1,413 inmates and currently has approximately 2,500 inmates housed in four quads containing army barrack style housing units. It has a central health clinic and medication room where nurses deliver all medications for the population. Nurses administer medications via directly observed therapy (DOT), nurse-administered (NA) or keep-on-person (KOP).

In the medication room, there is a cabinet containing multiple stock bottles of dangerous drugs including warfarin, Amiodarone, and HIV medications (e.g., Atripla, Reyataz). Several unlocked drawers contained gabapentin, carbamazepine and phenytoin. The same drugs were also stored in open containers placed on the countertops near medication windows. A pharmacist comes to the clinic monthly to check par levels, but there is no accountability system for these medications and they are subject to diversion.

In West Yard, medications are administered three times daily.<sup>33</sup> We noted that nurses pre-pour some medications by placing a pill or unit dose into a coin envelope that is not labeled with the patient's name or medication. The envelope is then placed into a plastic sleeve in a binder that also contains the patient's MAR. The practice of nurses taking medication from a properly labeled container and placing it in an unmarked envelope increases the risk of medication

<sup>32</sup> Medication Administration Process Improvement Program Studies

<sup>33</sup> Medications are administered 7:30-9:30 am, 12-1 pm and 5:00-7:30 pm. There is no hour of sleep (HS) medication administration.

errors and is unsafe. In addition, it's possible for the nurse to place the unmarked envelope in the wrong MAR sleeve. The repeated reuse of coin envelopes is unsanitary.

The West Yard medication room had two windows from which nurses administer medications to patients. We did not observe medication administration, but noted that one window has an overhang that protects patients standing in line from the elements. The other line has no protection from inclement weather, thus when it rains, patients must choose between standing in the rain and missing their medications. 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)."

Review of West Yard medication administration records showed that they were generally neat, legible and contained nursing signatures. However, the times of medication administration are not documented on the MAR. The only designations are AM, NOON and PM. The lack of specified times increases the risk that patients will receive doses too close together. For example, a patient might receive a three time a day antibiotic at 9:30 am and then at 12:00 pm which is an insufficient interval between dosing.

Nursing practice standards generally require that nurses administer medications an hour before or after a designated time. So, if nurses administer morning medications from 7:30 to 9:30 am, a designation of 8:30 am on the MAR would meet the standard. The medication administration schedule should be reevaluated to ensure that medications ordered three times daily have a sufficient interval between doses. From a medical-legal perspective, it is important to document the time that patients receive medications onto the MAR.

Some MARs contained blank spaces indicating that the nurse did not document whether the medication was administered or not. On one MAR, we noted a blank space that occurred several weeks prior and asked a nurse how these blank spaces are addressed. He responded by attempting to determine whether he had worked that day, with the intention of filling in the space, until he realized that he had not worked that day. This is problematic because nurses should document administration at the time it occurs, and reconciliation of the MARs (i.e., determining who did not appear for their medications) should also occur the same day. Documenting administration of medications weeks or even a day after the fact is inappropriate and raises questions about the credibility of MAR documentation.<sup>34</sup> Blank spaces should be treated as errors of omission, and should be reported as medication errors to study under the auspices of the quality management committee.

#### East Yard

We toured medication rooms in East clinic and B, C and D Quads. The East clinic medication room is immediately adjacent to the pharmacy in the East clinic and provides medications to general population inmate-patients in A and B Quads. Like the pharmacy, the area is small and

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<sup>34</sup> Health care personnel can document a late-entry in the record if properly documented, but this must be done timely.

cramped for its purpose. We noted that nurses had pre-poured medications into repeatedly used coin envelopes and placed them into a plastic sleeve that also contained the MAR. We inspected an envelope that contained a loose pill. The envelope was not labeled with the patient's name but someone had written 'Prezista' on the envelope with no dosing information. Prezista is an HIV medication; however, the nurse told us that the medication in the envelope was actually Naproxen, an anti-inflammatory medication. This is both a dangerous and an unsanitary practice.

Quad B has an administrative segregation unit housing approximately 200 inmates. There is a medication room on the second and third floors. Each medication room contains a cabinet with stock bottles and blister packs of dangerous drugs. Staff reported that the pharmacist conducts monthly visits to inspect the medications.

The medication room on the second floor was small, cramped and unsanitary. The refrigerator was also dirty. Staff reported that the medication room roof leaks. There were towels in the windowsills and nurses reported that sometimes the room "sweats" and needs to be wiped down, suggesting high humidity in the room. There are no custodians assigned to clean the medication room and the nurses are expected to perform sanitation duties. The furniture and medication carts were old. Staff reported that their request for new medication carts was denied because "there is no money."

We again observed that nurses pre-pour medications by placing unit dose or loose medications in a repeatedly used envelope that is not properly labeled with the patient's name, medication name, dosages or administration directions. The nurses take these envelopes out into the unit to deliver to patients and then return to document medication administration. This practice does not meet generally accepted nursing practice standards to prepare, administer and document medications at the time of administration. Moreover, a nurse stated that there are times when custody rushes them or is not cooperative when they are administering medications to patients.

The third floor medication room was constructed from two inmate cells. It is smaller than the second floor medication room and has inadequate workspace for the nurses. It is also not cleaned on a regular basis. Nurses also administer medications from stock bottles and unit doses.

In both medication rooms, nurses count narcotics at the change of shift and a random inspection showed that all narcotics are accounted for.

C Quad houses a large number of mental health patients. The medication room is an adequate sized room with two medication windows. The room was generally well-organized but there is no custodian assigned to this area and routine sanitation of the floors does not take place. Like other medication rooms, it contained large quantities of dangerous drugs in stock bottles or unit dose packaging. Narcotics were counted each shift and accounted for.

On the day we toured, it was staffed by two nurses and two pharmacy technicians. We observed staff pre-pouring medications just prior to the noon medication pass. One staff member poured two HIV medications from a stock bottle into an unlabeled cup and set it on the counter.

To receive medications, patients line up in the quad in an area that provides no protection from the elements. We inquired about this and staff reported that patients have learned that they can miss doses of medications without being considered non-compliant, so some patients do not come for their medications when it rains. We spoke to approximately six patients who were waiting in line or had just received their medication, and they reported that when it rains, they get wet. Some reported that regardless of the weather they come to get their medication, and others reported that they miss doses especially during heavy downpours.<sup>35</sup> It's important for the institution and health care system to support patient medication adherence under any circumstance, but particularly for mental health patients whose behaviors related to poorly controlled disease may result in altercations with other inmates or staff. Requiring patients to stand in the rain to receive their medications is not acceptable nor in compliance with the health care program's own requirements to provide shelter from the elements.

Once medication administration began, we noted that two patients approach each window at the same time to receive their medication. Having four patients at the medication windows at the same time presents an opportunity for confusion and medication errors and is unsafe. In addition, it also presents an opportunity for patients potentially to exchange medication.

D Quad medication room was large and generally well-organized, but cabinet drawers containing medications were broken and in disrepair. As with the other medication rooms we inspected, it also contained large quantities of stock medications.

Nurses administer medications to patients from two windows and we observed a medication pass in progress. We observed no significant issues with medication administration, and at the completion of the medication pass, one nurse sanitized the countertops in her area and washed her hands.

Review of MARs showed several with blank spaces. We spoke to a nurse about the procedure for addressing blank spaces. She told us that normally she reconciles MARs at the end of each medication pass, but sometimes doesn't get a chance to do by the end of the shift. She says that sometimes she does it the following day. Thus, it appears that there is no consistent procedure to reconcile MARs and address missed medication doses.

We performed a random review of narcotics and found that the count for Tylenol with codeine was not correct. Staff reported that a nurse had not signed out two doses at the time they were removed from the supply, but the issue was not yet resolved at the time we left the medication room.

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<sup>35</sup> Inmates reported that rain jackets were no longer being issued to inmates, but we were not able to confirm this.

## **Laboratory**

**Methodology:** To assess this area, we interviewed Martha Wallace, Chief Support Executive, and health records staff and reviewed health care records.

**Findings:** In general, we found that laboratory and radiology services are working well, although we identified opportunities for improvement.

The facility has a licensed general acute care hospital (GACH) and is therefore required by Title 22 to have an on-site laboratory. Staffing for the lab consists of a Senior Laboratory Technologist, two Clinical Laboratory Technologists and two Laboratory Assistants. This staff is involved in scheduling and tracking lab tests, performing phlebotomy and on-site lab tests, and maintaining laboratory equipment, including quality controls. The laboratory in the GACH only performs approximately 4-5 in-house laboratory tests a day. The laboratory is of adequate size, but remarkably cluttered given the small volume of labs performed each day. The remaining laboratory tests are sent out to a reference laboratory. The volume of on-site labs does not justify the expense of an on-site laboratory. The cost effectiveness of having the laboratory must be weighed against the alternative of closing the GACH, which is the only higher-level housing for patients at CMC.

We reviewed the tracking logs in which staff document when laboratory tests are scheduled and completed, and when reports are received from the reference laboratory. In reviewing the logs, we noted that in late December 2012 there were a number of labs for which no report was noted as being received. We discussed this with the Senior Laboratory Technologist who was surprised and planned to investigate the reasons for the lack of completed entries. Record review showed that ordered laboratory tests were generally performed and the results reviewed and scanned into the eUHR in a timely manner.

With respect to radiology services, we reviewed radiology and ultrasound data for the period of October 1 to December 31, 2012. During this period, the facility averaged 329 radiology and 18 ultrasound procedures per month. This averages approximately 16 radiology and 1 ultrasound procedures per day. A mobile unit comes to the prison weekly to provide magnetic resonance imaging (MRI) and computerized tomography (CT), averaging 36 procedures per month.

There is a system for scheduling and tracking procedures and reports that appears to be working well. Radiology reports are produced, reviewed and scanned into the eUHR in a timely manner. In April 2013, the radiology services are scheduled to become digitalized through the Health Records Center.

Current radiology staffing is a Senior Radiology Technology Specialist and three radiology technicians. When the acuity-based staffing plan is implemented, staffing will be reduced from four to two positions, which appears to be appropriate based upon the volume of services.

## **Health Records**

**Methodology:** We toured the health records unit and interviewed Martha Wallace, Chief Support Executive, Christine Alderete, Correctional Health Services Administrator (CHSA) I, and other health records staff. We 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:** In general, we find that the health records system is working well and are consistent with the OIG Medical Inspection Results Cycle 3 report score of 82.4%. As noted in the San Quentin report, CCHCS/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. It is very time consuming to review a record as each note is stored as an individual PDF file. The eUHR does not directly interface with the pharmacy (Maxor/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 CMC. The health records unit is a large room that is clean and well organized. Staff is in process of shipping paper health records to the Health Records Center in Sacramento for storage.

Staff scans received health documents timely into the electronic Unit Health Record (eUHR) and there is no meaningful backlog of documents to be scanned into health records. Neither did we find backlogs of health records in the outlying clinics. However, we did find that health record documents were misfiled into the wrong health record. In one record, we found that the health records of two different patients were misfiled into the patient's record. We referred this record to the Chief Medical Executive so it could be corrected.

Current health records staffing consists of approximately 23 positions: the Medical Records Director, 5 Health Record Technician II Supervisors, and 17 health record technicians 1 (HRT 1).<sup>36</sup> When the acuity based staffing plan is implemented, there will be 15 positions. With the transition from a paper record to the eUHR, this staffing reduction appears appropriate. Moreover, we anticipate further efficiencies when CCHCS/CDCR transitions to a true electronic health record.

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<sup>36</sup> The current staffing number is 16.72 health record technicians I.

## **Specialty Consultations**

**Methodology:** We interviewed staff involved in specialty services tracking and scheduling, reviewed 15 health records of patients who had been referred for off-site specialty care. Most of these patients had been referred to and evaluated by multiple specialists.

**Findings:** Our review revealed that there is a functional tracking and scheduling system. The review showed that approximately 50% of pending appointments do not have scheduled appointments, but most are still within policy timeframes for completion.

Review of off-site services (e.g., cardiology, oncology, etc.) reports showed that for 136 pending requests 67 (49%) had confirmed appointments and 69 (51%) were awaiting appointments.

Of those with scheduled appointments, approximately 20% of appointments exceeded CDCR policy timeframes. The longest period of time for completion of scheduled specialty service was expected to be 195 days (an orthopedic consultation).

Of those without a scheduled appointment, the longest elapsed time since the request was approved was 81 days (oncology). Eight (10%) of 69 have been pending for 50 or more days without an appointment; and the remaining 61 (88%) have been pending less than 50 days.

For on-site general surgery, the aging reports showed that 15 (20%) of 76 pending requests had scheduled appointments. For those with confirmed appointments the time frame from the approval until the appointment date ranged from 2-51 days. Of 61 (80%) pending without a scheduled appointment, the longest elapsed time since the approval was 57 days, with most pending less than 30 days.

For on-site specialty services (e.g. podiatry, physical therapy, etc.) an aging report showed that of 386 routine requests only 1 was greater than 90 days. For six pending on-site urgent requests, none was greater than 14 days.

Record review showed that for completed services, providers implement the recommendations of the specialists in a timely manner and the patients are receiving appropriate care. We find that the specialty care at CMC is adequate.

## **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 6 records of patients selected from the on-site urgent/emergent and off-site ED/hospitalization tracking log.

**Findings:** Urgent/emergent care was appropriate. Clinics had appropriate emergency response bags and automated external defibrillators that are checked daily. Hospitalization, when necessary, was timely and appropriate and the care prior to hospitalization was adequate. We found no unnecessary or preventable hospitalizations. If the GACH were equivalent to an acute care hospital, one of the patients with encephalopathy<sup>37</sup> and another with infection<sup>38</sup> might have been cared for at the GACH instead of sending them to outside hospitals. However, the support services and physician coverage in the GACH is not consistent with an acute care hospital. Under the circumstances, clinicians made appropriate judgments and patients were sent offsite to community hospitals and were consistently appropriately cared for.

There were problems with auditing documentation of follow up care because GACH records are not scanned to the eUHR. If a patient had returned to the facility and was housed in the GACH, records from the outside hospital would not be readily available when reviewing the eUHR.

### **General Acute Care Hospital Care**

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

**Findings:** Most of the patients in the GACH unit are not acutely ill. There were 29 patients in the GACH on the day of our visit. Of these, only four were acute care patients who had been recently admitted. Nineteen were skilled nursing patients, one was receiving rehabilitation services, two were admitted for psychiatric issues (foreign body ingestion), and three were inappropriate transfers. (See below.) Most people on the unit were on the unit for a year or more. Clearly, this unit is functioning as a CTC not a GACH.

Each nurse cares for five patients and administers medications for each of their patients. Each nurse keeps MARs in a separate binder. The pharmacy on the unit fills medications daily on a cart fill basis. Nurses maintain an up-to-date patient care plan for each of their patients, which is found in the paper record. We examined several of these. Because there are multiple orders, which are changing frequently, multiple versions of the care plan accumulate. One patient we reviewed had 18 care plans with active items on each one. This makes it very difficult to use as a practical document and promotes missed assignments. An electronic version would significantly improve the ability to have real time modifications without potential loss of information. Care plan documentation should be standardized statewide.

Dr. Amato, the doctor on the unit, is board certified in medicine and nephrology. His care was excellent. We reviewed all 29 patients currently housed in the GACH with him. Treatment plans were appropriate for all patients. In review of the patient charts, we noted one patient was sent to CMC for management who had not been managed well at the sending institution.<sup>39</sup> This was a patient who had a long-standing fever which was inaccurately diagnosed. At one

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<sup>37</sup> Urgent/emergent Patient #5

<sup>38</sup> Urgent/emergent Patient #2

<sup>39</sup> GACH Patient #1



point, while at the prior facility, the patient, who already had two weeks of fever, was seen and had a chest x-ray ordered. It took about ten days for the patient to receive an x-ray and have it reviewed. The x-ray showed a cavitory lesion which requires mandatory isolation in the event tuberculosis is present. Instead the doctor ordered additional tests and sent the patient to general population. Almost two weeks after the x-ray and about 4 weeks after the fever started, the patient was hospitalized. This is an unacceptable delay. The hospital diagnosis was coccidioidomycosis. It wasn't until the patient was transferred to CMC that Dr. Armato diagnosed endocarditis. This required re-hospitalization for treatment.

Nursing care of patients in the GACH appeared appropriate. We note that in part this is due to the complete access nurses had to patients. Patients from security levels 1-4 are housed in the GACH. However, except for administrative segregation, doors on all patient rooms are kept open and nurses and other staff have complete access to patients. There have been no security issues. This is very positive, as it resembles a hospital setting. The nurse access is excellent.

Three patients in the GACH on the day of our visit were inappropriate transfers from other facilities. Two of these patients were disabled and one was blind. Because CMC has no accommodation for these types of patients in general population areas, they remain in the GACH until the Health Care Population Management Unit arranges for transfer. Whether this is the result of inaccurately filled out medical Chronos, mistakes by the Health Care Population Management Unit, or mistakes by CDCR is unclear. According to staff, this occurs frequently and results in misallocation of bed space.

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

**Methodology:** We interviewed health care leadership and staff involved in quality improvement activities; the OIG report, Primary Care Assessment Tool, Performance Improvement Work Plan (PIWP), internal monitoring and quality improvement meeting minutes for the past 12 months.

**Findings:** We found that CMC has internal monitoring and quality improvement processes that have been successfully implemented to improve health care services.

## **Recommendations**

### **Organizational Structure, Facility Leadership, and Custody Functions**

1. Central Office staff should participate in an annual CQI meeting in order to better understand problems at the facility.
2. Custody staff should be fit-tested for N-95 respirators so that negative pressure rooms can be utilized in the GACH.
3. Custody and Medical leadership should develop a procedure for conduct of officers during clinical encounters to ensure privacy.

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

1. Local management should participate in personnel planning for their facility.
2. CCHCS/CDCR should have a procedure for creating new job titles in order to make job titles contemporary.
3. Standardized hiring and discipline procedures should be developed specifically for CCHCS/CDCR which are consistent with contemporary and safe health care operations.

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

1. The CMC Health Care Facility Improvement Plan should be fully implemented. In addition, the future mission of medical bed space at CMC needs to be established. If it is to remain a hospital, CTC or OHU, it needs to be refurbished or rebuilt according to its mission and according to contemporary standards and regulations.
2. Pending implementation of the HCFIP, health care leadership should reassess interim steps to ensure that existing clinic areas are organized, clean and in compliance with OSHA regulations.
3. Sanitation in yard clinics should be improved, particularly in administrative segregation medication administration rooms and medical provider areas. Sanitation schedules should be more specific and include a checklist for porters.
4. Environmental rounds should be conducted in clinic areas and identified problems corrected in a timely manner.
5. All clinical staff should have easy and ready access to soap and water or hand sanitizers in order to wash hands between patients.
6. Patients should have indoor waiting space when they attend clinics. Shelter from rain should be provided to patients waiting to receive medications.
7. Equipment inventories at facilities should be standardized so that it is clear when equipment is serviced and if and when equipment is obsolete or broken.
8. Clinic supplies and equipment needs should be standardized.
9. Facility budgets should be transparent and include all operating needs.

### **Policies and Procedures**

1. Policies and procedures should be simplified and unnecessary policies eliminated. Policy development should be prioritized to important aspects of care.
2. Regular training on policies should be instituted for all staff relative to their particular job duties.

### **Pharmacy and Medication Administration**

1. As soon as feasible, CMC should administer medications to patients via patient-specific blister pack or unit dose medication. Consider expanded use of Central Fill to meet this need.
2. The practices of having nurses dispense dangerous drugs from stock bottles or loose unit dose should be discontinued. High-risk medications like warfarin and Amiodarone should never be dispensed from stock bottles, and should be immediately removed from medication rooms.
3. Dangerous drugs should not be stored in unlocked drawers or in open containers on countertops. The pharmacy should develop an accountability system for all dangerous drugs to prevent or minimize the risk of diversion.
4. Medication rooms in administrative segregation should be reconstructed to provide adequate space, furniture and cabinetry, sanitation, repair of ceiling leaks and adequate temperature and humidity control. If this cannot be accomplished, these rooms should not be used, and another strategy should be developed.
5. All medication rooms should be terminally cleaned and cabinets and furniture repaired or replaced. The rooms should be organized in a manner that enables disinfection activities to take place daily (i.e., countertops free of unnecessary clutter). If rooms cannot be adequately and routinely cleaned or ceiling leaks cannot be repaired, the rooms should not be used to store medications.
6. Medication administration times should be documented on MARs, rather than the current practice of documenting am, noon and pm.
7. Nurses should prepare and document medication administration at the time of administration. Nurses should not take medications from properly dispensed and labeled containers and place them into repeatedly used and unlabeled coin envelopes.

### **Chronic Disease Management**

1. Medical providers should monitor patients in accordance with their disease control.

### **Intrasystem Transfer**

1. Health care leadership should focus on continuity of medications for newly arriving patients and timeliness of provider referrals.
2. Health care leadership should analyze root causes of intra-housing unit medication discontinuity and develop strategies to address root causes.
3. Consider amending the OIG audit tool to reflect performance of the receiving facility, not the sending facility.