California Institution for Men (CIM)

Health Care Evaluation

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Contents

Introduction

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

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

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

Methods of assessment included:

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

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

To evaluate whether there is any pattern or practice that presents a serious risk of harm to CDCR patients, our methodology includes review of health records of patients with serious medical conditions using a "tracer" methodology. Tracer methodology is a systems approach to

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

evaluation that is used by the Joint Commission for Accreditation of Health Care Organizations. The reviewer traces the patient through the organization's entire health care process to identify whether there are performance issues in one or more steps of the process, or in the interfaces between processes.

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

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

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

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

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

Overall Finding

We find that the California Institution for Men (CIM) is not providing adequate medical care to patients, and that there are systemic issues that present an on-going serious risk of harm to patients and result in preventable morbidity and mortality.

Executive Summary

On August 5-9, 2013, the Plata Court Medical Experts visited the California Institution for Men (CIM) to evaluate health care services. Our visit was in response to the OIG Medical Inspection Results Cycle 3 report showing that CIM scored 89.6% in February 2013. This report describes our findings and recommendations. We thank Warden Brenda Cash, Chief Executive Officer (CEO) Robert Herrick and staff for their assistance and cooperation in conducting the review.

With respect to its medical mission, CIM has undergone a major change in the past year. Once a reception center, it has been designated as an Intermediate Facility and has accumulated increased numbers of inmates with serious medical conditions. Health care leadership advised us that approximately 70% of the population has one or more chronic illnesses and 30% of the population is medically high risk. With the increased medical acuity of the population there has been a corresponding increase in the demand for health care services; however, the Acuity Based Staffing Realignment (ABSR) has reduced health care staffing. Since ABSR was implemented in March 2013, use of overtime and registry staff has increased 50%. In addition, although the population has declined in recent years, the current population is 162.8% of design capacity.

Our review suggests that CIM is approaching, if it has not already reached, its capacity to manage inmates with high medical acuity. For example, in Facility A, which is designated to house inmates of higher medical acuity, the number of inmates requiring bottom bunks has exceeded the number of available lower bunks. Officers we interviewed make a decision as to who gets the lower bunk based upon their perception of who needs it more. This reflects deficiencies in the CIM classification system and results in some inmates not receiving prescribed accommodations for their medical impairments (e.g., low bunk).

We also found significant problems related to the management of patients with chronic diseases, both in terms of the timeliness and the quality of care, in 19 of the 25 cases we reviewed. Primary care providers do not adequately address each of the patient's chronic diseases or abnormal laboratory findings in a timely or appropriate manner.

With respect to medical reception/intrasystem transfer, nurses do not perform medical screening in a clinical setting, but instead in a "confessional booth," as was done when we made our last site visit in 2006. Review of records showed problems with medical reception and the intrasystem transfer process that include transfer of seriously ill inmate/patients without

direct provider-to-provider communication; transfer of inmate/patients pending specialty services scheduled on or around the day of transfer; untimely medical reception history and physical examinations; and lack of timely follow-up of abnormal laboratory tests at the previous facility. Issues related to intrasystem/medical reception processes contributed to preventable deaths and delayed diagnosis and treatment of serious medical conditions.

With respect to access to care, CIM health care staff collects and triages health request forms (7362) in a timely manner following submission of health service requests. However, nurses did not consistently see patients in a timely manner and/or effectively address their health concerns, including urgent dental and mental health complaints.[3] Nursing evaluations were inadequate, often due to deficiencies in nursing protocols that do not provide adequate guidance to the nurse. When primary care provider (PCP) referrals were made, the provider referrals did not occur timely and providers did not consistently address the reason for the referral. Our findings were consistent with CIM internal audit reports that showed that nurses saw patients submitting health requests containing symptoms timely in 74% of cases; routine provider referrals took place timely in 58% of cases; and urgent provider referrals took place within policy time frames in 63% cases.[4] These delays in access occurred after the implementation of ABSR staffing reductions.

A related concern is that the CDCR Health Care Access Team in headquarters reduced correctional officers' posts assigned to health care operations. For example, staff reported that in Facility C, an evening shift correctional officer post was eliminated, so that there is no officer in the clinic with the nurse when inmates are sent to the clinic. This is an access issue as well as a safety issue for health care personnel.

Review of specialty services showed problems related to timeliness in seven (35%) of the 20 records, including two cases which involved delayed evaluation and treatment for malignancies.

Mortality review showed serious systemic issues and lapses in care. We reviewed deaths that we believe were preventable and that are described in this report. These cases involved the following issues:

- Deficiencies in the intrasystem transfer and medical reception process
- Failure in two deaths to identify serious illness and take action to treat
- Failure to examine a critically ill patient on the OHU for five days
- Failure of providers to examine patients when clinically indicated (e.g. following trauma, altered mental status, etc.)

[3] In these cases, dental and mental health staff did not see the patient timely.
[4] CIM access to care data from 5/1/2013 to 7/15/2013.

- Failure of a mental health provider to report a patient reporting sexual abuse and failure of custody to protect the inmate following known assault
- Failure to have an adequate policy regarding amitriptyline

Review of internal monitoring reports show lack of substantive discussion of issues that includes data and root cause analysis, corrective action plans or follow-up studies to demonstrate whether problems have been resolved. Although some communicable disease reporting takes place, there is not a functional infection control program to monitor surveillance of tuberculosis screening and other infections, which is a serious patient safety issue, particularly at an intake facility.

We found that health care leadership has not written local operating procedures that provide operational detail to implement the CCHCS statewide policies and procedures. As noted in previous reports, issues related to the budget process, discipline of health care professionals and inadequate clinic space, sanitation and privacy are found at CIM as well.

In summary, we found significant problems with the reception/intrasystem transfer process, chronic care program, access to care, timeliness of specialty services, mortality review, and the adequacy of clinic space that could cause or contribute to harm to patients with serious medical problems. The change in CIM's medical mission with the resultant increase of medically vulnerable patients with concurrent staffing reductions has significantly contributed to the problems in clinical care. We recommend that CCHCS/CDCR evaluate CIM's capacity from a classification perspective to ensure that the facility has sufficient resources to provider timely and appropriate medical care.

Findings

Facility Description

CIM opened in 1941 on 2,500 acres of land. It is a large complex consisting of four separate facilities under the administration of one Warden. The design capacity of the facility is 2,976. The current population is 4,845[5] or 162.8% of design capacity.

Facility A has a population of approximately 960 medium security Sensitive Needs Yard (SNY) inmates. The facility consists of eight dormitory housing units, and each unit has a capacity of approximately 140 inmates. One housing unit, Mariposa Hall, is currently vacant and being used for inmate programming.

Facility B has an inmate population of approximately 946 medium/maximum security inmates and serves as a male reception center, receiving and processing newly committed inmates. In addition to a reception center, Facility B includes Palm and Cypress Halls, which are designated as administrative segregation (Ad-Seg) units. These units receive inmates from CIM, CRC, local CDCR/Cal Fire Camps, and inmates serving a SHU term en route to other CDCR Institutions.

Facility C was converted in December 2011 from a Reception Center and currently houses an inmate population of approximately 760 medium/maximum Sensitive Needs Yard (SNY) inmates, many of whom are serving life sentences. The facility is located approximately two miles east of CIM's main complex.

Facility D, a secure level I facility, has a population of approximately 2500 inmates housed in open dormitories. Minimum level inmates can be housed and work outside the secure perimeter. Inmates with medium custody are housed and work inside the secure perimeter, but can live in a dormitory environment.

Organizational Structure and Health Care Leadership

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

Findings: The current executive team at CIM has been in place for three years and provides excellent leadership. The CIM administrative table of organization is organized along functional lines of authority. Robert Herrick has been the CEO at CIM for three years. Prior to that, he was involved in private sector hospital administration for over 30 years. Part of that time had been as a hospital CEO. This is his first prison system job.

[5] CDCR Weekly Report of Population. CIM. July 31, 2013.

Dr. Muhammad Farooq, the Chief Medical Executive (CME), has been in the system for approximately seven years and in his current position for three years. Dr. Tom Le is the Chief Physician and Surgeon (CPS). He has been at CIM in his current position approximately seven years. The Pharmacist in Charge (PIC) is Kerim Bangou. He has been at CIM approximately seven years. The Chief Nurse Executive (CNE) is Jorge Gomez and he has been at CIM for approximately eight years. This leadership team appears to work together well.

The Warden at the time of our visit was Brenda Cash. Since our visit, she has retired and Tim Perez is the acting Warden. There have been five Wardens over the past 19 months. The Assistant Warden (AW) position for health care has been vacant since 7/3/13. The health care Captain is Jesse Tolvert. Mr. Herrick attends the daily Warden briefing and meets with the Warden as needed. The AW and Captain attend the bimonthly Quality Management Committee (QMC) meetings. The AW and Captain also attend medical services meetings, medication management meetings, Emergency Response and Death Review Program Subcommittee meetings, and the medical chief's meeting every Tuesday.

Mr. Herrick reports to Dr. Tharratt. He also reports to Dr. Mort Rosenberg for dental issues and to Tim Belavich for mental health issues. There are group CEO meetings three times a year. In addition to these meetings, Mr. Herrick communicates with Dr. Tharratt as needed.

Human Resources, Staffing and Budget

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

Findings: As with other facilities, CCHCS posts all positions and performs initial screening of employee candidates. CCHCS then provides a list of candidates to the facility and CIM leadership re-screens candidates, interviews and completes the hiring process. It takes about two months to hire a candidate. The CEO feels that the hiring process works well.

CIM had 375.4 staff positions and lost 30.2 positions in the March 2013 Acuity Based Staffing Realignment (ABSR). CIM currently has 345.2 positions, of which 27.1 (7.8%) are vacant. The major changes as a result of ABSR were a loss of 13.4 office staff, 14.9 Registered Nurses and 4 Supervising Nurse II positions. There were deletions and additions of one or two positions in other areas.

Leadership at CIM believes that the loss of office technicians and nurses will be problematic. The population went from 6,104[6] to 4,845[7] under ABSR. This is a 25% reduction in population.

[6] CDCR Weekly Report of Population. January 2, 2008.

However, under ABSR, CIM became an Intermediate Facility. This has resulted in a significant increase of high-risk patients assigned to CIM. As of the day of our visit, the high-risk population at CIM had increased from approximately 900 individuals to 1,355. The high-risk population is expected to increase to 1,400, a 55% increase from baseline. CIM also has housing for the disabled and those who are developmentally delayed, as well as an Outpatient Housing Unit (OHU).[8] In addition, CIM continues to be a reception center, taking in approximately 120 new inmates each week.

Beginning in March with the reductions in staffing, overtime and registry use increased approximately 50%. The total of registry and overtime expenditures is equivalent to 50 full time equivalent (FTE) staff. The use of 50 FTE staff in overtime and registry exceeds the 30.2 positions deleted in the ABSR. Registry and overtime costs for the four months since the inception of ABSR was $178,096 per month as opposed to $99,655 for the four months before ABSR started. This is a 78% increase in overtime and registry cost. Given the changes in medical acuity of the population, CCHCS needs to re-evaluate staffing at this facility.

Credentialing and Peer Review

CCHCS performs all credentialing for CIM. CCHCS sends letters to CIM announcing initial credentialing and biennial renewal. The CIM leadership keeps these letters on a hard drive accessible to the CME and CPS. CIM maintains no other credentialing information on-site. The CME maintains a list of every credential decision on a log with the date of credentialing and the expiration date of the credentials.

With respect to peer review, CIM keeps an electronic file for each provider. The CME and CPS have an electronic file of all eUHR Clinical Appraisals (UCAs). Each provider receives a UCA annual performance evaluation from the CPS. Of the 17 providers who have been on staff over the past year, all 17 had a UCA on file. All but one of these UCA reviews has been done within the past year. No significant problems have been identified. However, the CPS documented a discussion of the review with the provider in only five of 17 cases. This needs to be done for every review. In addition to the UCA reviews, Dr. Le and Dr. Farooq perform random record reviews of patients whose chronic illness is not in control as identified from patients in the chronic illness registry. They do not document the results of these record reviews.

We asked leadership at this facility how they would address discipline for a physician who committed a serious clinical error. The response was that they would refer the doctor to the Office of Investigative Affairs (OIA) for investigation. They were not familiar with the 2008

[7] CDCR Weekly Report of Population. July 31, 2013.
[8] The OHU consists of 44 medical and 36 mental health beds. While classified as an OHU, it is used similarly to a CTC.)

policies[9] on physician clinical competency. CCHCS needs to ensure that all leadership staff are aware of these Court ordered policies.

The CME and CPS meet every morning with all providers to discuss patients who had returned from the hospital, on-call problems and problem patients. This is an excellent vehicle to communicate problems and to discuss management issues as a group. After this morning report, providers return to their yard clinics and attend a morning "huddle" with the other clinic staff during which similar issues are discussed.

Training for providers consists of webinars and didactic discussions conducted in the morning report. These are discussions of patient cases. There are 16 providers and all are Board Certified. Eight are Board Certified in Family Practice and eight are Board Certified in Internal Medicine. Most providers have been at the facility for more than four years.

Disciplinary Process

Ten disciplinary actions are pending as of 7/15/13. These have been pending, on average, for 6.6 months each. The range is 1 month to 11 months. One new employee was found allegedly diverting narcotics and has been reassigned to housekeeping duties outside of the perimeter of the prison pending investigation. No other employees are reassigned. We continue to recommend that CCHCS assign the investigators for the initial disciplinary investigation of CCHCS employees.

Health Care Budget

In FY 2010/2011, the initial budget allocation was approximately $27.86 million, the final allocation was approximately $53.68 million and final expenditures were approximately $62.96 million. Final expenditures exceeded the initial allocation by $35.1 million (126%). In this fiscal year, the Department of Finance reduced the correctional health care budget to be in line with an estimate of per inmate cost in other states.

In FY 2011/2012, the initial allocation was approximately $46.75 million, the final allocation was approximately $55.55 million and final expenditures were approximately $68.20 million. Final expenditures exceeded the initial allocation by $21.45 million (46%). Changes in this fiscal year included moving nursing mental health positions into the medical program.

In FY 2012/2013, the initial allocation was approximately $58.93 million. This was only 86% of the prior year's expenditures.

The Department of Finance continues to significantly underfund CCHCS medical programs.

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

Health care expenditures exceeded initial allocations for two consecutive years. And in fiscal year 2012 to 2013, the initial allocation is below the prior year's expenditures. The Receiver provides additional funding so that the programs can operate; however, this process does not assure an adequate and sustainable health care budget once the Receivership ends.

Health Care Operations, Clinic Space and Sanitation

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

Findings: While CIM does not currently have a Periodic Automatic Replacement (PAR) system, they are in the process of developing one. CIM has a warehouse for medical supplies which is 2000-3000 square feet. They have no prime vendor. Mr. Maldonado, who maintains the supplies and equipment, provided The Medical Equipment Quarterly Preventive Maintenance Inspection Service Report. All the equipment had been documented as calibrated and maintained within the past quarter. However, as noted below, we found numerous oto-ophthalmoscopes that did not have working bulbs, were not properly mounted or were not operating. The inspection report listed only one oto-ophthalmoscope as not working. This discrepancy needs to be reviewed by leadership.

CIM has not been able to use the CDCR Business Inventory System (BIS) for all supply items, so they have to maintain two inventories; one inventory is of items that are in BIS and one inventory is of items that are not in BIS. The two inventories are not reconciled. As a result, a complete current inventory was not available.

The clinic space at CIM is inadequate. Many clinics are not adequately sized or designed. For example, Facility A nurse triage and assessment area is shared by three nurses and several office staff, and thus lacks privacy. We were told that privacy is assured by talking softly. Facility C nurse triage and assessment is also shared by both nursing and office staff and lacks privacy.

Clutter is everywhere in all clinics. For example, in Facility C, one of the provider examination rooms had wheelchairs and a box of opened floor buffing pads stored at the end of the examination table so that the foot extender could not extend. Clearly, a patient would not be able to lie down for a proper examination. Examination tables in several areas are used as storage shelves. In the C clinic, the provider stores her supplies on the foot extension of the examination table. Because there are no break rooms, staff eats in clinical areas, which violates OHSA regulations. Microwaves, coffee pots and toasters are kept in clinical areas.

Many clinical examination spaces are makeshift. For example, Facility A recently had a large influx of high-risk patients and another provider was added. That provider works in an old office

previously used by the supervising nurse. He performs patient examinations with the patient in a chair. No sink is available. Also in Facility A, another provider examination room was formerly a storage room. When the door opens, it butts up against the examination table. It is not possible for a patient to lie flat on the table or to extend the foot support of the table.

Some rooms did not have oto-ophthalmoscopes. One room had an oto-ophthalmoscope unit that was built to be mounted on a wall. It was not mounted on a wall but was lying on a shelf so far from the examination table that it could not be used. We note that several other oto-ophthalmoscopes were not mounted in correct locations. We were told that CCHCS no longer provides maintenance of fixed medical equipment. This is now provided by CDCR plant operations. There have been delays in getting work orders completed. Additionally, because the walls may have lead paint or asbestos, drilling holes requires a study to determine if the drilling will result in hazardous exposure. We were told that this is a barrier to timely installation of equipment. Multiple rooms had oto-ophthalmoscopes that had nonfunctioning light bulbs. Some rooms did not have sinks.

CIM is an intake facility. The nurse reception screening area consists of two rooms. Each is a 5-foot by 4-foot booth sealed with Plexiglas with a small opening to ask the patient questions. The patient stands outside the room. The nurse performs vital signs, a tuberculin skin test and completes a questionnaire through the small porthole. The lower wall is solid material. It is difficult to hear and see the patient. This room is unacceptable for its intended purpose and needs to be changed as soon as possible. Some of the problems described with medical reception screening may be a direct result of this inadequate arrangement.

In Facility A, inmates wait for clinic visits outside on bleachers. In Facility C, there is a small bench inside the clinic that seats approximately three people and another bench outside that also seats about three people. Patients must be able to wait indoors for their clinic appointments.

The OHU is an 80-bed unit separated into four wings. There are two nursing stations, each of which serves two wings. The nursing stations are small and do not have sufficient counter space for every staff member to have a workspace to type a note into the eUHR. All keyboards and terminals for the eUHR are located on the counter edge making them extremely difficult to use. The providers have no workspace, so they see patients and walk back to an office in another area of the building to write their notes. As noted in the OHU section of this report, this resulted in patient safety issues.

The Health Care Facility Improvement Plan (HCFIP) includes a schedule to start construction at CIM on 9/10/14. Construction will be completed by 9/16/16. The HCFIP will correct almost all of the deficiencies we noted. One exception is the OHU. Renovation plans for the OHU include repair of vinyl tile in several inmate rooms with an epoxy material for purposes of improved

sanitation. The HCFIP does not include renovation of the two nursing stations. These nursing stations are inadequate. They lack sufficient workspace; they do not have appropriate space for terminals for the eUHR, and are poorly designed for nursing workflow.

Sanitation of clinic space is not consistent. Some clinics and the OHU were clean. Others were not clean. All clinics were cluttered. Four civil servant janitors (one supervisor and three janitors) clean Facility D and supervise inmate porters who also clean Facility D. Inmate porters supervised by a custody sergeant clean Facilities A, B and C. The civil service staff and inmate porters clean the pharmacy under the supervision of pharmacy staff. There is a cleaning schedule; all clinics are cleaned five days a week and the OHU seven days a week.

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: CIM has used the CCHCS Inmate Medical Services Policies & Procedures (IMSPP) as a template for their local operating procedures (LOPs).[10] This saves time and ensures standardization of procedure and generally is a good idea. However, the CIM LOPs are almost all verbatim copies of the equivalent IMSPP. The local procedures have insufficient CIM specific information to guide staff. Verbatim substitutions used at CIM often do not make sense or are unclear. LOPs need to clearly identify implementation steps as they are to occur at CIM.

For example, item 9 in the LOP on Healthcare Transfer Process (Volume 4, Chapter 3) contains the statement, "The CIM Supervising Registered Nurse shall ensure the health care staff includes copies from the eUHR of all active CDCR Form 7221s in the transfer envelope." There are 3 SRN III positions and 12 SRN II positions on staff. The local operating procedure does not make clear which of these supervising nurses is assigned to this duty.

Item 11 of the LOP on Access to Primary Care (Volume 4, Chapter 4) states:

> The facility is responsible for developing a system to ensure that the CDCR Form 7362 and associated Nurse Encounter information is available to the PCP at the time of scheduled appointment with the inmate-patient.

This is taken verbatim from the IMSPP, but does not clarify who at CIM is responsible for making these forms available to the provider. In other sections of the same policy, there are references to a "designated RN" without being more specific. These are confusing instructions.

[10] Inmate Medical Services Policies & Procedures found at the website www.cphcs.ca.gov/imspp.aspx.

The LOP on Overview of Health Care Services (Volume 1, Chapter 3) is a verbatim replication of the IMSPP, stating that the facility is to deliver medically necessary services. However, it does not specifically address the arrangements at CIM to accomplish this. For example, what local hospitals, specialists and radiology services are used?

While it is time saving to mimic the IMSPP, procedural instructions need to be specific enough so that it is clear who is to perform the procedure, what they are to do, where they are to do it, when the procedure is to be done and how the procedure is to be done.

At times, the verbatim replication of IMSPP results in having a procedure that is unnecessary. For example, the LOP on Credentialing (Volume 1, Chapter 9) provides policy on credentials, including the manner of credentialing in General Acute Care Hospitals, Correctional Treatment Centers, and Skilled Nursing Facility, none of which are present at CIM.

Furthermore, verbatim replication of IMSPP can result in LOPs that are confusing. For example, the LOP on Professional Clinical Staff (Volume 1, Chapter 5) states:

> Where there is an organized Clinical Staff, the following is the officer of the Clinical Staff
>
> - Chief of Staff
>
> The Chief of Staff is appointed by Executive Clinical Staff for a two-year term. Where there is no organized Clinical Staff, the Chief Medical Executive (CME) shall provide official leadership for the Medical Staff as long as they retain their respective positions.

There is no organized medical staff at CIM. This LOP is confusing. Instead, CIM needs to have a procedure that clarifies how the CME and CPS supervise and direct providers and how they perform their annual peer review evaluations. This section needs to include a statement about how peer review is managed and must reference the 2008 Court order[11] regarding provider clinical competency and its associated policy.[12] Another example is the LOP on Reception Health Care Procedure (Chapter 4, Volume 4.2.2). It is identical to the IMSPP to the extent that it contains directions for forms to use to screen female patients. There are no female inmates at CIM.

While using IMSPP as a template is useful, CIM must revise the IMSPP so that it accurately reflects expected procedures at CIM.

One LOP is missing. There is no procedure for the Outpatient Housing Unit. There is a LOP entitled Correctional Treatment Center (Volume 4, Chapter 15) which consists of one

[11] Order Approving, with Modifications, Proposed Policies Regarding Provider Clinical Competency; NO. C01-1351 TEH Document 1302 filed 07/09/2008.

[12] Plata Provider Professional Clinical Practice Review, Hearing and Privileging Procedures Pursuant to Order Approving with Modifications, Proposed Policies Regarding Provider Clinical Competency, July 9, 2008.

paragraph, stating that CIM is not licensed to operate a CTC and instead operates an Outpatient Housing Unit (OHU). However, there is no policy or procedure for the OHU. This needs to be developed.

With the exception of the OHU, all major areas of service are covered by LOPs.

Medical Reception/Intrasystem Transfer

Methodology: We toured the receiving and release (R&R) area in Facility B, interviewed facility health care leadership and staff involved in intrasystem transfer and reviewed tracking logs, staffing and 22 health records.

Intrasystem Transfers

Findings: As noted above, CIM's medical mission has changed from primarily a medical reception facility to an Intermediate Facility that includes a medical reception component. Staff reported that prior to the change in mission the facility used to receive approximately 100 inmates per day, but this has decreased to approximately 20-25 per day. Counties transfer inmates on Tuesdays and Thursdays. The facility also receives transfers from other CDCR facilities. There is no regular schedule for these transfers.

While health care staff screens newly arriving inmates in a timely manner, the screening is not performed in an appropriate clinical setting that permits the nurse to perform an adequate assessment. In fact, the conditions of health care screening are unchanged from those described in our 2006 report. Nurses conduct screening in what amounts to a "confessional booth" where the nurse sits on one side of the booth separated from the inmate by Plexiglas and a metal grate that has a small 4" x 6" opening for the nurse to speak to the inmate. The inmate must stand throughout the process because there is no seating on that side of the booth. We stepped into the booth and had a staff member step into the other side to evaluate the ability to see and hear the inmate. We found that lighting was poor and negatively impacted the nurse's ability to observe the person's expression and color. The arrangement did not permit the nurse to observe the patient below the waist.[13] The Plexiglas and metal grate combined with the small opening made it difficult to hear the other person. Ironically, the medical clinic for Facility B is directly across the hall and could easily be utilized for medical screening of new arrivals.

Review of records showed several problems with medical reception and the intrasystem transfer process. These include transfer of seriously ill inmates without direct provider-to-provider communication; transfer of inmates pending specialty services scheduled on the day of transfer; untimely medical reception history and physical examinations; and lack of timely follow-up of abnormal laboratory and diagnostic tests at the previous facility. Two cases

[13] This does not permit the nurse to observe patient's lower extremities.

involved delays in diagnosis and treatment for malignancies and are described in the Specialty Services section of this report.[14] Our review also revealed cases in which medical providers did not perform and document clinical evaluations of patients when medically indicated. Examples are described below.

- This 29-year-old patient with a medical history that included newly diagnosed AIDS, disseminated MAC[15] and renal disease transferred from Avenal State Prison (ASP) to CIM on 10/5/12.[16] At ASP, in August 2012, the patient complained of weight loss, diarrhea and painful feet. He also had severe anemia.[17] On 9/9/12, the patient was sent to the TTA urgently with high fever (Temp=102.6°F), tachycardia (pulse=132/bpm), 25 lbs. weight loss and leg pain. The ASP provider ordered intravenous (IV) fluids, Tylenol, antibiotics, laboratory tests and a chest x-ray to be obtained the following day, and sent the patient back to his housing in Ad-Seg. Three days later, the patient was admitted to a local hospital with newly diagnosed AIDS (CD4[18] count=5, normal >500 cells) and esophageal candidiasis.[19] On 9/20/12, he was discharged and housed in the ASP OHU and arrangements were made to transfer him from the cocci hyperendemic area. On 9/28/12, his blood count showed an elevated white blood cell count (WBC=17, normal=4-10) suggesting systemic infection, but the lab did not report this result for a week (10/4/12) and a provider did not review it until 10/6/12. On 10/5/12, an ASP OHU nurse completed a transfer form that did not adequately describe the severity of the patient's illness (e.g., 50 lbs. weight loss since his arrival in CDCR in April 2011). Upon arrival at CIM, a nurse notified a provider of the patient's condition but a provider did not see the patient. The following morning a provider did not document a clinical evaluation but completed a Request for Services (RFS) to transport the patient to the local hospital where he was admitted for fever, cough and tachycardia. He was subsequently diagnosed with MAC. Over the following months, he was treated by two infectious disease (ID) physicians and a primary care provider and the patient's care became fragmented. For example, in February 2013, the ID physician treating the patient for MAC advised the primary care provider that his treatment regimen did not meet the standard of care and that his antiretroviral regimen was not appropriate for the patient due to his renal disease. The primary care provider doubted the patient had MAC and did not address the consultant's recommendations, which created a risk of harm to the patient. In March and May, the ID consultant again raised concerns regarding the patient's treatment plan and it was not until late May 2013 that the recommendations were adequately addressed.

[14] Specialty Services Patient #8 and #15.
[15] Mycobacterium Avium Complex, an infection found in patients with compromised immune systems.
[16] Intrasystem Transfer/Sick Call Patient #3.
[17] This 9/6/12 abnormal lab report was not reviewed by a provider until 9/20/12.
[18] A type of white blood cell that is decreased in HIV-infected patients.
[19] A fungal infection that is typically found in patients with compromised immune systems.

Assessment

There were both system and quality of care issues at ASP related to timely receipt and review of abnormal labs and sending an acutely ill patient to administrative segregation instead of admitting him to a medical bed. Intrasystem transfer issues include lack of provider-to-provider communication between ASP and CIM and lack of provider evaluation on the day of transfer. Following transfer, the CIM provider did not follow ID consultant recommendations in a timely manner, resulting in delayed provision of the standard of care.

- This 31-year-old patient arrived at Wasco State Prison (WSP) on 4/23/13 and transferred to CIM on 7/25/13.[20] His medical history included HIV infection/AIDS, syphilis, MAC, peripheral neuropathy, a bowel obstruction for which he had surgery in 2011, chronic coccidioidomycosis, deep vein thrombosis and depression. The patient had been treated for syphilis in the past and his last known titer was 1:2 in 2011. At Wasco, the patient's syphilis test was positive with an increased titer of 1:16, suggesting treatment failure or new infection. Wasco providers did not obtain a sexual history or review of systems related to syphilis, but planned to obtain previous medical records; this did not occur. A repeat RPR titer was 1:8 and the provider planned to follow the patient, but did not order repeat titers. Also, on 5/31/13, while still at WSP the patient presented to a nurse with bilateral lower leg edema and leg discoloration for five weeks. The nurse notified the provider, who did not see the patient but ordered a diuretic and potassium, and follow-up in 14 days. On 6/6/13, the patient submitted a 7362 stating that his legs were still painful and swollen. A provider did not document an examination but completed a RFS and sent the patient to San Joaquin General Hospital (SJGH) for a lower extremity ultrasound. We did not find the report in the record. On 7/24/13, the patient transferred to CIM. Since his arrival at CIM, the patient's ultrasound report is still not in the record. Apparently, the patient is being anticoagulated for deep vein thrombosis. We also found no documentation of the patient's onset of his symptoms or planned duration of therapy. In August and September his INRs have been either subtherapeutic or supratherapeutic.

  Assessment

  There was a delay in evaluation and treatment of the patient's elevated syphilis titer and inadequate documentation related to the patient's history and treatment plan for his DVT. We discussed this case with the CME prior to leaving the facility and thereafter the patient was evaluated for neurosyphilis and treated for latent syphilis.

- This 62-year-old patient transferred from Mule Creek State Prison (MCSP) to CIM on 12/29/11 and died on 1/24/12.[21] His medical history included gastric bypass surgery, benign prostatic hypertrophy, prostatitis, transurethral resection of the prostate (TURP) in 2008,

[20] Medical Reception/Intrasystem Transfer Patient #1.
[21] Medical Reception/Intrasystem Transfer Patient #11.

low back pain, glaucoma and gastroesophageal reflux disease (GERD). At MCSP, on 11/14/11, the patient had urinary hesitancy and was sent out to the hospital, where he was diagnosed with bladder outlet obstruction due to benign prostatic hypertrophy (BPH). The urologist inserted a Foley catheter and requested follow-up in his office for cystoscopy with transrectal ultrasound to evaluate the patient's prostate. The urologist also requested a renal ultrasound to evaluate the status of the patient's kidneys, a chemistry panel and PSA. Upon his return to MCSP, a nurse saw the patient and scheduled him to follow-up in 14 days. On 11/23/11, the MCSP provider requested the renal ultrasound and cystoscopy. The patient's PSA was mildly elevated (PSA=7.6, normal=<4.0). Approximately two weeks later on 12/8/11, the request for renal ultrasound was approved and scheduled for 12/29/11. On 12/16/11, the request for cystoscopy was approved but there is no date documented as to when it was scheduled. On 12/27/11, a MCSP nurse completed a 7371 noting that the patient had a pending chronic disease appointment for BPH, but did not note that the patient had a Foley catheter or pending procedures. The patient was scheduled for a renal ultrasound on 12/29/11, but this was not completed due to his transfer to CIM and on 12/29/11, a nurse documented that per provider a medical hold was not necessary. On 12/29/11, CIM staff completed a 7277, noting that the patient had a Foley catheter. The nurse did not document a complete set of vital signs (no temperature or respirations). The nurse made a routine referral to a provider. On 1/10/12, at 8:30 p.m., the patient was at pill line and told the nurse that his Foley catheter was leaking all over his underpants and asked if he could get a new one, stating it was last changed 2-3 months ago. The nurse changed the patient's catheter. His vital signs, except blood pressure (that was not measured), were normal. The following day, the patient was admitted to Chino Valley Medical Center, apparently with complaints of dizziness, weakness and altered mental status. (We did not find nursing or provider documentation of his condition prior to being sent to the hospital). Upon arrival at the hospital, he was hypotensive requiring vasopressors.[22] He subsequently went into respiratory distress and was intubated. His condition progressively worsened and he died on 1/24/12 of complications from urosepsis.[23]

Assessment

System issues related to this case include lack of coordination of care between the MCSP primary care provider and urologist, delayed request, approval, and scheduling of his cystoscopy and renal ultrasound. The patient was transferred on the day of a scheduled medical procedure, which was not appropriate. We reviewed the Combined Death Review Summary for this patient and noted that the patient's death was determined to be "Natural and Expected" and "Definitely Preventable." Based on the patient's baseline medical condition, we do not agree that the patient's death was natural and expected because his underlying condition was benign prostatic hypertrophy with urinary retention and is not a

[22] Medications used to increase blood pressure.
[23] A severe illness that occurs when an infection starts in the urinary tract and spreads into the bloodstream.

terminal condition. His death was due to urosepsis secondary to a medical device (i.e., Foley catheter). The Death Review Summary appropriately identified lack of a clear plan by the urologist and primary care provider regarding continued need for a Foley catheter as contributing factors, prescribing of a medication known to cause urinary retention (Hydroxyzine), as well as systemic issues related to the transfer of the patient with pending medical tests. In addition to the findings noted in the Death Review Summary, there was also no documentation of the patient's condition and treatment on 1/11/12 when the patient was sent to the hospital.

- This 68-year-old patient arrived at CIM from Vista Detention Facility on 9/24/2012.[24] Upon arrival, a nurse completed a 7277 noting that the patient had chronic neck pain secondary to an old injury. His medication was Naproxen. The nurse did not measure the patient's vital signs. There were no admission orders for laboratory testing. The nurse scheduled the patient to see a provider routinely but did not specify a time frame. On 9/28/12, officers noted the patient had facial injuries and referred him to medical for evaluation. The nurse performed a brief assessment and notified a provider who ordered facial x-rays without seeing the patient. Mental health staff saw the patient, and noted that the patient reported that his cellmate was trying to be sexual with him. The mental health staff questioned the patient's version of events and did not refer him for medical evaluation. The patient did not receive an intake history and physical evaluation within seven days of arrival. On 10/3/12, at approximately 3:40 p.m., the patient was sent to the TTA for mental health evaluation for urinating and defecating in his underwear. At 8:36 p.m., he was sent to the emergency room for head trauma and altered level of consciousness. No nursing or medical evaluation is documented supporting the need to send the patient to the TTA or hospitalize the patient. At the hospital, he reported being raped by his cellmate and was found to have perforation of his rectum due to assault with a foreign object. He was taken to surgery and found to have an abscess and necrotizing fasciitis[25] involving his buttocks and upper thigh. Following debridement, he was sent back to CIM pending surgery for a muscle flap to his buttocks. Documentation shows that he did not receive appropriate care and he was sent back to the hospital. His course was complicated and he died seven months later on 5/13/13.

  Assessment

  This case reveals several quality and systemic problems and is further described in the mortality review section of this report. However, with respect to the medical reception process, this patient did not receive a history and physical examination and laboratory

[24] Intrasystem Transfer/Sick Call Patient #22/Mortality Review Patient #1.
[25] Necrotizing fasciitis is a fulminant infection causing significant soft tissue destruction and sepsis. Mortality is high in this condition.

testing within seven days of arrival as required by CCHCS policy.[26] Importantly, the physician who was notified that the patient had facial injuries did not evaluate the patient. Timely medical evaluation following the assault by his cellmate or timely medical reception evaluation would have presented an earlier opportunity to identify and treat his head and rectal injuries. When the patient presented with facial injuries on Friday morning of 9/28/12, and with incontinence and altered level of consciousness on Wednesday afternoon of 10/3/12, there is no documentation that a nurse or medical provider saw the patient.

- This 51-year-old patient arrived at CIM on 7/18/13.[27] His medical history included hypertension, diabetes, hyperlipidemia, coronary artery disease with multiple stents, a myocardial infarction on 2/13/13 and peripheral vascular disease with bilateral iliac stents.

  Upon his arrival at CIM, a nurse medically screened the patient. The nurse did not document any medical history except that the patient had chest pains off and on and had 11 stents in five years. The patient's blood pressure was severely elevated (BP=198/101 mmHg) but the nurse did not repeat the patient's blood pressure or refer him to a provider.

  On 7/24/13, the physician performed a history and physical examination. He did not document an adequate cardiovascular history or perform a cardiovascular examination including heart sounds, murmurs or bruits, or peripheral pulses. The physician ordered laboratory tests and requested previous medical records. He increased the patient's blood pressure medication and stopped the patient's nitroglycerin. He requested follow-up in 21-30 days.

  There is no Problem List in the record documenting the patient's history in either the eUHR or PHIP.

  <u>Assessment</u>
  The screening nurse did not refer the patient when his blood pressure was severely elevated. The quality of the provider physical examination was poor and the provider discontinued the patient's nitroglycerin tablets when he has a significant history of coronary artery disease. The patient has an extensive cardiovascular history but providers have not documented his medical conditions on the Problem List.

- This 42-year-old patient arrived at CIM from a jail on 10/29/12.[28] His medical history included HIV/AIDS since 2004, bilateral inguinal lymphadenopathy, hypertension, chronic renal insufficiency and anemia. At the time of arrival at CIM, the patient was severely

[26] CCHCS Policy and Procedure Manual. Volume 4, Chapter 2. Reception Health Care Policy and Procedure Revised October 2012.
[27] Medical Reception/Intrasystem Transfer Patient #8.
[28] Medical Reception/Intrasystem Transfer Patient #14.

immunosuppressed (CD4=70 cells; normal ≥500). The sending facility provided a report of a 10/22/12 inguinal ultrasound that showed extensive lymphadenopathy.[29]

On 10/29/12, a CIM nurse completed a 7277 noting his diagnoses and that medications had transferred with the patient. The nurse documented the patient's vital signs and weight and that he was asymptomatic. The patient's medications were ordered the same day and received timely. The nurse referred the patient to a provider routinely.

On 11/6/12, the HIV provider saw the patient. He documented that he did not know what the patient's labs were, indicating that the provider did not review the jail transfer information. He documented that the patient had bilateral small inguinal hernias that were easily reducible.[30] He ordered comprehensive labs.

On 11/7/12, another provider performed a history and physical and noted that the patient had enlarged inguinal lymph nodes (not inguinal hernias) and referred the patient for lymph node biopsy. He documented his skin as normal.

The laboratory tests from 11/6/12 revealed that the patient's current CD4 count was low (125). The HIV viral load was not measured (mistakenly a hepatitis B viral load was performed instead). Other labs showed that the patient was anemic and thrombocytopenic (low platelets).

On 12/11/12, the HIV provider saw the patient for follow-up. It was a thorough note; however, the provider documented that the patient had *"no abnormal lymph nodes palpated"* which is not consistent with the jail ultrasound report and medical reception physical examination performed a month prior. There is no documentation showing the provider was aware that a surgical consult for lymph node biopsy had been requested. The patient was significantly anemic and thrombocytopenic but the provider did not address his anemia or initiate an evaluation for GI bleeding (a common cause of anemia).

On 12/11/12, a repeat blood count showed his hemoglobin had increased but was still low. The patient's HIV viral load was almost undetectable (HIV viral load=56 copies/mL) indicating that the patient's HIV disease was well controlled.

On 12/12/12, a primary care provider saw the patient for chronic disease management, noting that he had a pending biopsy of his inguinal lymph nodes. He noted that the patient had no significant skin lesions.

[29] The report showed multiple enlarged lymph nodes measuring 2.4 x 0.8 cm, 1.2 x 0.6, 1.0 x 0.8 cm and a complex mass or lymph node measuring 2.0 x 1.5 cm. In the left groin there is a complex mass measuring 5.4 x 1.5 x 2.0 with Doppler flow inside. Other lymph nodes are seen measuring 1.0 x 0.6 x 1.8 x 0.8 cm."

[30] A hernia with a bulge that flattens out when the provider gently pushes against it.

On 12/18/12, the HIV provider saw the patient and documented that he palpated no abnormal lymph nodes and his skin was normal. He documented that he did not believe the patient's anemia was related to GI bleeding but did not order fecal occult blood testing.

On 12/28/12, a surgeon biopsied the patient's inguinal lymph nodes and a large skin lesion on his back. The pathology report was faxed to CIM on 1/8/13 and signed off by one of the providers on 1/9/13. The pathology report noted that the skin lesion was suggestive of cutaneous mycosis fungoides[31] and that although the lymph node biopsy appeared to be benign, lymphoma needed to be ruled out. Both specimens were sent for further testing and the pathologist noted that there would be an addendum to the report with the results of these tests.

Further testing revealed that the skin lesion was highly suggestive of a T-cell lymphoproliferative disorder/mycosis fungoides and that the lymph node was suspicious for T-cell lymphoma. However, a definitive diagnosis required further testing (T-cell gene rearrangement) and the lab requested to be contacted if the provider wanted the lab to perform this testing. The pathologist noted on the report that a verbal report was attempted on 1/10/13. There is no documentation that staff at CIM received this report. (The faxed report is stamped as being received at CIM on 1/23/13.)

On 1/15/13, the patient had follow-up with the surgeon, who reviewed the pathology report and documented that the patient had T-cell lymphoma and recommended referral to oncology. A nurse documented this information on the patient's return to CIM. The report was signed by a physician on 1/17/13.

On 1/23/13, a provider saw the patient and noted that the patient had had the biopsy of his inguinal lymph node and upper back lesion. The provider further noted that, "per Dr. Y. the lesion was noncancerous and inflammatory, and lymph node shows no evidence of cancer." However, the final pathology report was not in the record and the provider planned to get the official biopsy report. On 1/25/13, another provider signed final biopsy report; however, there is no documentation that additional testing needed to confirm the diagnosis of T-cell lymphoma/mycosis fungoides was ordered or requested from the lab.

On 1/29/13, the HIV provider saw the patient and documented that his skin was normal and that he had no palpable nodes. It appears that the provider was unaware of the procedures that the patient had undergone or the biopsy reports.

On 4/3/13, another primary care provider saw the patient, and it does not appear that the physician was aware of the patient's medical evaluations in progress.

[31] Rare types of lymphoma that primarily develop in the skin.

On 5/16/13, the patient was sent back to the surgeon, who again noted that the patient's biopsy was suggestive of T-cell lymphoma and recommended oncology referral. On 5/20/13, this was reviewed by another provider, who ordered the oncology referral.

On 6/12/13, the oncologist saw the patient, noting the biopsy report and questioning whether the T-cell gene rearrangement study was ever performed. He described a 10 cm wide skin abnormality between the scapula and extending to the dorsal spine. His impression was that the patient possibly had mycosis fungoides. The oncologist planned to contact Integrated Oncology or Riverside Hospital to see if the rearrangement study could be performed. If the patient is shown to have mycosis fungoides or T-cell non-Hodgkin's lymphoma, he will require further staging, including possible bone marrow studies, further blood tests, and CT scans of the chest, abdomen and pelvis. On 6/18/13, the HIV telemedicine provider reviewed the report.

On 7/10/13, the oncologist saw the patient and indicated that the T-cell rearrangement study did not show T-cell lymphoma or mycosis fungoides. He recommended that CIM staff monitor the patient's skin and, if the lesions were persistent, to have the patient return in 3-4 months to consider rebiopsy. This report was reviewed on 7/15/13.

Assessment

This record showed multiple lapses in care. Multiple providers saw the patient, but it is unclear who, if anyone, was coordinating the patient's care. The HIV provider documented that the patient had bilateral inguinal hernias that were easily reducible and documented no palpable lymph nodes, when both ultrasound and examinations by other providers showed that the patient had bilateral inguinal lymphadenopathy raising the question of lymphoma or infection. A lymph node and skin biopsy suggested lymphoma and although it is an AIDS-defining illness, the HIV provider appeared to be unaware of the work-up in progress. In addition, all providers documented the patient's skin as being normal, and it was not until the surgeon saw the patient to biopsy his lymph nodes that a 10 cm x 10 cm skin lesion was found on his back and biopsied with a suspicion for cutaneous lymphoma. The discrepancy in documented physical examination findings between providers and consultants suggests that some CIM providers do not perform adequate physical examinations. In January 2013, the lymph node and skin pathology reports suggested lymphoma, and additional testing was recommended to confirm the diagnosis, but the provider reviewing the report did not request the testing. In January 2013, the surgeon documented that the patient had lymphoma and needed be referred to an oncologist, but it was not until May, after the surgeon repeated his recommendation, that a CIM provider addressed this and referred the patient to oncology. It was not until July 2013 that lymphoma was ruled out.

Access to Care

Methodology: To evaluate access to care, we interviewed health care leadership and reviewed patient tracking and scheduling systems. We also reviewed 25 health services requests (CDCR Form 7362) in 15 records of patients with chronic diseases, including high-risk patients.

Health Care Appointment Scheduling

Findings: We interviewed staff involved in scheduling nursing and provider appointments as well as on and off-site specialty services. Staff expressed frustration that the new MedSATS scheduling system automatically scheduled appointments that were medically unnecessary (e.g., a provider appointment following each physical therapy session, etc.). Staff explained that this is a result of how MedSATS is programmed. This programming takes discretion regarding appointment scheduling away from staff using the program.

Nursing Sick Call (Face-to-Face Triage)

Findings: CIM health care staff collects and triages health request forms (7362) in a timely manner following submission of health service requests. However, nurses did not consistently see patients in a timely manner and/or effectively address their health concerns, including dental and mental health complaints. Nursing evaluations were sometimes inadequate due to deficiencies in nursing protocols that do not provide adequate guidance to the nurse. When PCP referrals were made, the provider did not consistently address the reason for the referral. Our findings were consistent with CIM internal audit reports that showed that nurses saw patients submitting health requests containing symptoms within policy time frames only 74% of the time between 5/1/13 and 7/15/13.[32] During the same time frame, CIM internal studies showed that routine nurse to PCP referrals took place within policy time frames in 64 (58%) of 110 of records, and urgent nurse to PCP referrals took place within policy time frames in 7 (63%) of 11 records. However, these data were not consistent with Access to Care Measures (AMAT) reports for January to June 2013 that showed higher compliance rates. Our findings and internal CIM report data are not consistent with the OIG Cycle 3 report score of 89.6%.[33]

Examples of case reviews are noted below.

- On 8/14/13, a 53-year-old patient with HIV infection submitted a 7362 complaining of needing to have warts taken off.[34] On 8/16/13, the nurse saw the patient, who requested referral to dermatology. The nurse noted the patient's medical history, including HIV infection and COPD, and noted that the patient had "quite a few warts in his genital area," but did not describe their specific location or size. The nurse noted that there was no

[32] CIM Completed FTF triage percentage 5/1/13 to 7/15/13. In this report, 2012 of 2776 (73.56%) of patients submitting 7362's with symptoms were seen within CCHCS time frames.
[33] The Medical Experts have identified concerns regarding the accuracy of data extracted from the new MedSATS medical scheduling system and it is unknown whether it is reliable.
[34] Intrasystem Transfer/Sick Call Patient #2.

drainage or redness. The nurse discussed that the physician would need to refer the patient to a dermatologist, but did not document a referral to a provider. On 8/21/13, the HIV provider saw the patient but did not obtain a history or examine the patient for genital warts.

Assessment

The nurse did not adequately describe the location, extent and severity of the patient's genital warts and the provider did not address the patient's concerns. It appears there was lack of communication between the nurse and provider.

- A 56-year-old patient with diabetes, hypertension, hyperlipidemia, hypothyroidism, degenerative joint disease, depression, latent TB infection and chronic hepatitis C infection transferred to CIM on 7/19/13.[35] His mental health medication (Prozac) was not renewed upon arrival. On 8/3/13, the patient submitted a 7362 asking to know why his Prozac was discontinued. A nurse received and triaged it on 8/3/13. The nurse did not see the patient and referred the 7362 to psychiatry. Mental health staff received it on 8/5/13 and wrote a note that the patient was scheduled to see the psychiatrist on 8/7/13. There was no documentation that a psychiatrist saw the patient on 8/7/13, but the psychiatrist wrote an order for Prozac for 90 days.

  Assessment

  This case represented system issues with intrasystem transfer and nursing sick call. Mental health staff did not renew the patient's medications upon arrival. Upon receipt of his request, nursing staff did not review the patient's eUHR and contact on-call mental health staff to facilitate the timely renewal of his mental health medication.

- A 60-year-old patient transferred from Avenal State Prison (ASP) to CIM on 7/24/13.[36] His medical history included hypertension, chronic hepatitis C infection, thrombocytopenia, deep vein thrombosis in 2008 and 2012, and latent TB infection diagnosed on 4/29/13.

  In January 2013, prior to the transfer to CIM, the patient developed an ulcer on his right ankle for which he was treated with Clindamycin. Over the next six months, the ulcer increased in size and began draining serosanguinous fluid.[37] Just prior to transfer he was admitted to the ASP OHU for wound care for his leg ulcer.

  On 7/26/13, following his transfer to CIM, the patient submitted a 7362 complaining of having a leg ulcer that was draining and painful (10 of 10 in severity) making it difficult for him to walk and sleep at night. It was received and triaged, and the nurse saw the patient

[35] Intrasystem Transfer/Sick Call Patient #4.
[36] Intrasystem Transfer/Sick Call Patient #7.
[37] Fluid containing both blood and the liquid part of blood (serum).

the same day. The nurse noted that he was a new arrival and had hypertension and was taking hydrochlorothiazide, but did not measure his blood pressure. The nurse observed that he had an ulcer on right ankle that showed no signs of infection. The nurse provided wound care and indicated that the patient would see the provider as scheduled.

On 8/6/13, a physician saw him and documented a thorough note indicating that the patient's right lower leg ulcer was 1 cm x 2 cm and showed no signs of infection. The provider ordered wound care. Over the next several weeks, nurses providing daily wound care did not document a description of the wound. On 9/18/13, the patient complained of having a wound infection and a nurse noted that the patient was having purulent (pus) drainage. A provider saw the patient and ordered wound culture, antibiotics, and a leg x-ray.

On 9/26/13, a provider saw him for follow-up, noting that his culture grew gram-negative anaerobes. He put the patient on Clindamycin. On 9/30/13, a provider saw him for chronic disease follow-up and noted that his right leg ulcer was diminishing in size and improving. Although there is no radiology report scanned into the record, the provider noted that his right leg x-ray showed no abnormalities, including osteomyelitis. On 10/8/13, a provider saw the patient and documented that his leg wound was 3 cm x 4 cm with good granulation.

Assessment

This patient has had a right lower leg ulcer for 10 months. At CIM, nursing documentation of the wound at daily dressing changes is inadequate, failing to note the size and condition of the wound. Provider documentation of the wound has been inconsistent. The failure of the wound to heal raises questions about undiagnosed vascular disease, diabetes and osteomyelitis. Although the patient's x-ray was not suggestive of osteomyelitis, radiographs are not as sensitive compared to other imaging techniques (e.g., MRI, CT, bone scan). If the patient's ulcer fails to heal despite good wound care, further investigation is warranted. Currently the wound has good granulation but if purulent drainage recurs, given the patient's recently converted his tuberculin skin test, wound culture for TB might be considered.

- This 42-year-old AIDS patient arrived at CIM on 10/29/12. On 4/4/13, the patient submitted a 7362 complaining of severe dental pain x 2 days.[38] It was received and triaged the following day. A nurse did not see the patient. On 4/12/13, the patient refused a dental appointment due to education testing. He was instructed to resubmit his request.

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

Assessment

This patient complained of severe dental pain but the nurse did not evaluate the patient and dental staff did not schedule the patient in accordance with the urgency of his complaint. Given the patient's complaint of severe pain, a nurse or dental staff should have scheduled the patient to be seen within 24 hours of receipt of his complaint. If the patient refused the appointment in person and signed a refusal of treatment form following counseling regarding the risks of refusal, the standard of care would be met.

- This 48-year-old patient transferred from North Kern State Prison (NKSP) to CIM on 12/8/2011.[39] His medical history included transgender status, HIV/AIDS, TB and hepatitis C infection, gonorrhea and depression. On 7/21/13, the patient submitted a 7362 requesting to see the doctor about his hormones. It was received and triaged on 7/22/13. On 7/23/13, the nurse interviewed the patient, who was in no acute distress. The nurse discussed his future appointments with the patient. An order was written to follow up with the PCP in 2-4 weeks. On 9/3/13, the HIV provider saw the patient, who reported decreased appetite with a documented eight pound weight loss in three months. The HIV provider deferred to the PCP in addressing hormone therapy. However, as of 10/26/13, a primary care provider has not seen the patient and he has had no further follow-up.

  Assessment

  This HIV transgendered patient's request for hormone therapy made two months ago has not been addressed. In addition, this AIDS patient has had a documented eight-pound weight loss in three months and has not had timely follow-up.

- This 54-year-old patient transferred from ASP to CIM on 4/10/13.[40] His medical history included chronic ischemic heart disease, cardiomyopathy with internal defibrillator, sick sinus syndrome, epilepsy, BPH, low back pain, L5-SI central and right-sided disk protrusion and foraminal narrowing, and depression.

  On 4/28/13, the patient submitted a 7362 complaining of back pain. On 4/30/13, the nurse saw the patient. The nurse documented that the patient's back was pink with full range of motion. The nurse did not document the presence or absence of tenderness. The nurse noted the patient was taking Naproxen and acetaminophen and instructed the patient to submit another 7362 if his symptoms worsened. On 5/9/13, the patient was scheduled for follow-up with the provider, but became disruptive and the visit was terminated. The provider planned to see him in 1-2 months.

[39] Intrasystem Transfer/Sick Call Patient #15.
[40] Intrasystem Transfer/Sick Call Patient #19.

On 5/15/13, the patient submitted a 7362 stating that he needed to see mental health because he was mentally stressed out and not being properly medicated. It was received and triaged on 5/16/13. A nurse did not see the patient. On 5/23/13, mental health staff saw the patient, who reported being depressed and not sleeping for six days. The mental health provider planned to refer him for medication evaluation [but did not?].

On 6/23/13, the patient submitted a 7362 complaining of worsening back pain. A nurse saw the patient on 6/25/13. The examination was not appropriate for the nature of his complaint. The nurse documented that the provider had evaluated the patient and counseled the patient on pain management. The nurse did not refer the patient to a provider. On 6/27/13, mental health saw the patient.

Assessment

This is a challenging case involving a patient with chronic low back pain. Neither the nurse nor mental health saw the patient in a timely manner following submission of his 5/15/13 health request. In addition, the nursing evaluations on 4/30/13 and 6/25/13 were not adequate.

- This 64-year-old patient transferred to CIM on 10/4/12.[41] His medical history included hypertension, hyperlipidemia, coronary artery disease, with by-pass surgery in 2008 and GERD.

  On 11/15/12, the patient submitted a 7362 complaining of dental pain. It was received and triaged on 11/16/12. A nurse did not see the patient. On 11/21/12, the dentist saw the patient, who reported severe dental pain for two weeks. The dentist found irreversible pulpitis[42] in one of his teeth and extracted the tooth.

  On 3/18/13, the patient submitted a 7362 complaining of a rash on his penis. On 3/20/13, the nurse saw the patient. The quality of the nursing assessment was inadequate. The nurse did not describe the onset of the patient's symptoms, describe the type of rash or interview the patient regarding sexual activity. The nurse documented that the provider was consulted, who ordered Clotrimazole for two weeks. The provider did not perform an examination.

  On 8/27/13, the patient submitted a 7362 complaining of right leg pain 6 of 10 in severity that radiated to his foot. On 8/29/13, the nurse evaluated the patient using the musculoskeletal protocol but did not examine the patient's right leg for warmth, tenderness pulses, reflexes, etc. The nurse did not refer the patient.

[41] Intrasystem Transfer/Sick Call Patient #21.
[42] Inflammation of dental pulp tissue, which contains the blood vessels, nerves and connective tissue inside a tooth.

On 9/18/13, the patient submitted another 7362 with the same complaint, stating it was worse. On 9/20/13, the nurse saw the patient and performed an inadequate evaluation and still did not refer the patient. As of 10/28/13, a provider had not seen the patient.

Assessment

Neither nursing nor dental staff saw this patient in a timely manner for his severe dental pain. The patient was not adequately evaluated for his penile rash. The nurse did not adequately evaluate or appropriately refer this patient to a provider, and he had not been adequately evaluated and treated for his leg pain.

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 25 patients with chronic diseases, including diabetes, hypertension, HIV disease 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). We also evaluated whether the Problem List was updated and continuity of medications provided.

Findings: There were significant problems related to the management of patients with chronic diseases, both in terms of the timeliness and the quality of care, in 19 of the 25 cases we reviewed. Primary care providers do not adequately address each of the patient's chronic diseases or abnormal laboratory findings in a timely or appropriate manner. While in many of these cases there were no direct adverse consequences to the patients, these problems reflect a dysfunctional chronic care system that places patients at risk of harm. Our findings are not consistent with the OIG's Cycle 3 report score of 87.5% for chronic care.

The following cases demonstrate some of the serious problems related to the timeliness and/or quality of care for patients with chronic diseases that we found.

- The patient[43] is a 37-year-old man with diabetes, hypertension and hyperlipidemia who arrived at CIM from Wasco State Prison (WSP) on 4/12/12. On 9/26/12, his hemoglobin A1C had been 6.5%. A provider had seen the patient for chronic care on 12/20/12. He noted that the patient's diabetes was at goal. Per the patient's request, the provider decreased the dosage of the patient's Glyburide. The provider ordered a repeat hemoglobin A1C in four months and follow-up for chronic care in 4½ to 5 months or sooner if necessary. On 1/16/13, the provider decreased the dosage of the patient's metformin without any documentation as to why he was doing so. On 1/17/13, the provider saw the patient again

[43] Chronic Care Patient #1.

for chronic care. The provider noted that the patient had been taking his metformin as directed and that, "[P]er the medication reconciliation, it says 1000 mg but the patient actually was prescribed 500 mg and has been taking only 500 mg." (The Medication Administration Records, however, revealed that the patient had been receiving metformin 1000 mg at WSP and that it had been ordered and given to the patient since his arrival at CIM.) The provider changed the order for metformin to 500 mg and ordered follow-up in 2-3 months. The patient's hemoglobin A1C was repeated on 2/15/13 and was elevated (8.8%). On 2/19/13, the provider notified the patient that he was being scheduled for a medical appointment to discuss his laboratory results. On 3/1/13, the provider saw the patient for follow-up of an orthopedic visit. The provider did not address the patient's diabetes at that time, noting that the patient would follow up in the chronic care program as scheduled or as necessary. A provider saw the patient for chronic care on 4/10/13. He noted that the patient decided that he would prefer to attempt to control his diabetes with lifestyle changes rather than increasing the dosage of his medication. On 4/23/13, the patient's hemoglobin A1C was 10.6%. The provider saw him for chronic care on 6/20/13. The provider discussed initiating therapy with insulin; the patient stated that he had been doing well on a higher dose of metformin and preferred increasing his metformin dosage to taking insulin. The provider increased the dosage of the patient's metformin to 1000 mg. On 6/26/13, the patient's hemoglobin A1C was 11.3%. The provider reviewed the results on 7/3/13 and ordered follow-up for chronic care in 7-10 days. On 8/1/13, the patient's hemoglobin A1C was still very elevated (10.3%). The patient had not been seen for follow-up as of 8/16/13. In addition, on 6/20/13, the patient's blood pressure was 130/84 mmHg. The provider did not address the patient's elevated blood pressure (blood pressure goal is < 140/80) in his assessment. The patient was not seen for follow-up until 8/22/13.

Assessment

The patient had not received timely care for his diabetes. The patient's hemoglobin A1C was very elevated on 4/20/13 and on 6/26/13. He was not seen for approximately two months on both occasions.

- The patient[44] is a 66-year-old man with diabetes, hypertension, dyslipidemia, chronic anticoagulation therapy for an aortic valve replacement, a pacemaker and chronic kidney disease who arrived at CIM from Avenal State Prison (ASP) on 9/20/12. The patient also had a history of coccidioidomycosis in 2010 for which he was still being treated with fluconazole. A provider saw him for his initial chronic care visit on 9/28/12. The provider noted that he had a pacemaker and a mechanical aortic valve for which he was on anticoagulation with a target INR range between 2.5 and 3.5.

[44] Chronic Care Patient #2.

Review of the patient's INRs revealed that, since January 2013, most had been sub-therapeutic. The primary care provider noted that the patient was being followed in anti-coagulation clinic. There was, however, no documentation that the patient was ever seen in this clinic. On 1/2/13, the patient's INR was 1.6. On 1/9/13, the provider notified the patient that he was being scheduled for a follow-up medical appointment to discuss his laboratory test results. On 1/11/13, the INR was repeated and was found to be 1.6. On 1/15/13, the provider wrote an order to change the patient's warfarin from self- to nurse-administered without seeing the patient. On 1/16/13, the provider notified the patient that he was being scheduled for a follow-up appointment to discuss his laboratory results. On 1/22/13, the patient's INR was still subtherapeutic (2.2). On 1/24/13, the provider notified the patient that he was being scheduled for a follow-up medical appointment to discuss the results. On 1/25/13, the provider saw the patient for chronic care. He noted that the patient's INR was subtherapeutic but that he would continue the current warfarin dose per anti-coagulation clinic. On 2/4/13, the patient's INR was 2.1 and on 2/20/13, it was 2.2. On both occasions the provider notified the patient that the results were essentially within normal limits and that no follow-up was necessary. A cardiologist saw the patient for a pacemaker check on 2/25/13, nine months after his last check. On 3/13/13, the patient's INR was 2.1 and the provider notified him that he was being scheduled for a follow-up medical appointment to discuss his laboratory results. On 3/21/13, there is a note in the patient's medical record from the provider that the patient had been ducated in error, that all his medications were up to date, and that he would be followed up in the chronic care program as scheduled. On 4/15/13, the patient's INR was 2.4. On 4/16/13, the provider changed the patient's warfarin from nurse- to self-administered without seeing the patient. On 5/1/13, the patient's INR was therapeutic. On 5/23/13 and 6/20/13, the patient's INR was subtherapeutic (2.3). On both occasions, the provider notified the patient that his laboratory tests were essentially within normal limits and that no follow-up was required. The provider saw the patient for chronic care on 7/1/13. The provider noted that the patient's INR had been 2.3. His assessment was that the INR was at goal, noting that the patient's range was between 2 and 3. On 7/17/13, the patient's INR was elevated (5.0). On 7/18/13, a provider wrote an order to hold the warfarin. On 7/22/13, the patient's INR was subtherapeutic (1.7) and a provider re-started the warfarin. On 7/29/12, the patient's INR was 1.4 and the provider increased the dosage of warfarin. There is no documentation that a provider met with the patient to discuss compliance or diet (which can affect the INR) over the entire period of time from 7/18/13 to 7/29/13.

At the time the patient arrived at CIM, his pacemaker had most recently been checked while he was at ASP on 5/30/12. His pacemaker needed to be checked by a cardiologist every six months. Following his arrival at CIM, the patient was not referred to a cardiologist until 1/25/13. The cardiologist saw the patient on 2/25/13, nine months after his prior pacemaker check.

On 10/11/12 and 3/12/13, the patient's Coccidioides antibody titers were 1:4. Despite this, the patient was still on treatment, years after the initial diagnosis. (When treated, the duration of uncomplicated infection is usually 3-6 months.) When the patient saw the cardiologist on 2/25/13, he recommended that the patient be referred to an infectious disease specialist to determine if he still required treatment. As of 8/16/13, this has not occurred.

Assessment

The patient has not received timely or appropriate care related to his anticoagulation therapy, his pacemaker or his coccidioidomycosis infection.

- The patient[45] is a 65-year-old man with hypertension, diabetes, hyperlipidemia and non-Hodgkin's lymphoma who arrived at CIM on 4/10/13 from California Substance Abuse Treatment Facility (SATF). His LDL-cholesterol had been elevated (129 mg/dL) on 11/21/12. This was not addressed while he was at SATF. He was seen for his initial chronic care visit at CIM on 4/22/13. The provider provided appropriate care. He ordered laboratory tests, including a lipid panel and follow-up in 2-3 months. The laboratory tests were done on 4/24/13 and revealed that the LDL-cholesterol was still elevated (130 mg/dL). The provider saw the patient for chronic care follow-up on 8/7/13. He noted that the patient's LDL cholesterol was not at goal and changed his medication.

  Assessment

  The patient did not have timely follow-up of his elevated LDL-cholesterol at SATF or CIM. He was at CIM for four months before his elevated LDL-cholesterol was addressed.

- The patient[46] is a 66-year-old man with diabetes, hypertension and hyperlipidemia who arrived at CIM from North Kern State Prison on 5/3/13. The provider saw him for his initial chronic care visit on 5/13/13. The provider noted that the patient's chronic problems were all well controlled. He ordered laboratory tests and follow-up in 2½ to 3 months or sooner if necessary. The laboratory tests were performed on 5/17/13 and revealed that the patient's hemoglobin A1C (9.4%), LDL-cholesterol (123 mg/dL), and urinary microalbumin (a test for early kidney disease) were elevated. The provider next saw the patient on 7/22/13 and appropriately increased his diabetic and cholesterol lowering medications. However, he incorrectly stated that the patient did not have any evidence of microalbuminuria. The patient was already ordered lisinopril for his hypertension (which is the treatment for increased urinary protein) so this error did not impact the patient's care. The provider ordered repeat laboratory tests, including a hemoglobin A1C in two months and chronic care follow-up in three months.

[45] Chronic Care Patient #3.
[46] Chronic Care Patient #4.

Assessment

The provider failed to recognize that the patient's urinary protein was elevated. While the patient did not suffer any harm from this error, it does indicate a possible problem with the provider's knowledge and assessment skills.

- The patient[47] is a 38-year-old man with diabetes, hypertension and hyperlipidemia who arrived at CIM on 3/11/13 from the San Diego County jail. A provider saw him for chronic care on 4/8/13. The provider provided appropriate care at that time. He ordered laboratory tests and follow-up in three months. The provider next saw the patient on 5/24/13 and noted that he was complaining of symptoms that were consistent with hypoglycemia. The provider decreased the patient's diabetes medication. He noted that the patient was scheduled to have blood tests and that he would see the patient for follow-up one week after the tests were drawn. The laboratory tests were done on 7/19/13. The provider did not see the patient for follow-up until 9/20/13. The provider did not document any history related to hypoglycemia.

  Assessment

  Ordered follow-up was not timely or appropriate.

- The patient[48] is a 77-year-old man with a history of diabetes, hypertension, hyperlipidemia, coronary artery disease with an angioplasty, and a pacemaker. Since the patient has a history of diabetes and coronary artery disease, his LDL-cholesterol goal is 70 or less. On 11/9/12, the primary care provider saw the patient for chronic care and noted that his LDL-cholesterol was not at goal (111 mg/dL). The physician increased the patient's atorvastatin from 40 mg to 80 mg/day and ordered a repeat fasting lipid panel in three months. Despite this, the patient continued to receive atorvastatin 40 mg/day as documented on future MARs and providers' progress notes. On 3/11/13, the patient's LDL-cholesterol was 96 mg/dL. The provider did not address this, despite the fact that it was still not at goal. On 5/6/13, the patient's LDL-cholesterol was 176. The provider saw the patient on 5/23/13 and increased his atorvastatin to 80 mg/day and noted that he would check a fasting lipid panel in 3-4 weeks. On 6/25/13, the provider ordered another lipid panel to be done in 4-5 weeks. The lipid panel ordered on 5/23/13 was done on 6/26/13 and revealed that the LDL-cholesterol was 132. The provider saw the patient for follow-up on 7/18/13. He noted that the patient's LDL-cholesterol was elevated, but incorrectly stated that his cholesterol lowering medication had been increased on 6/10/13 by the cardiologist and that the repeat LDL-cholesterol from 6/26/13 had been obtained too soon to expect that the cholesterol would have responded. (As noted above, the provider had increased the dosage on 5/23/13.) He noted that he would follow up with the patient in 6-8 weeks to review the

[47] Chronic Care Patient #5.
[48] Chronic Care Patient #6.

results of the laboratory tests that he had ordered to be done in 4-5 weeks from 6/25/13. The provider saw the patient for follow-up of other problems on 8/12/13, but did not address his hyperlipidemia. The lipid panel had not been done as of 11/19/13.

The patient had also been having chronic swelling and pain of his right ankle for several months. On 6/10/13, a cardiologist saw the patient for follow-up related to his coronary artery disease and his pacemaker. The cardiologist noted that the patient's main concern was extreme pain and swelling of his right ankle. The cardiologist's assessment was that the pain and swelling could be due to gout. He recommended checking the patient's uric acid level and a trial administration of anti-inflammatory medication specifically directed at gout. He further recommended starting colchicine. He added that he would leave the treatment of the right ankle swelling to the discretion of the cardiologist's primary care physician. There is no documentation that a provider addressed the cardiologist's recommendations.

Assessment

The patient did not receive timely or appropriate care for his hyperlipidemia. In addition, the recommendations of the cardiologist concerning the patient's painful, swollen ankle were not addressed.

- The patient[49] is a 34-year-old man with diabetes, hypertension, hyperlipidemia, glaucoma and gout. The patient's hemoglobin A1C was very elevated (11%) on 2/20/13. A provider saw him for chronic care on 3/14/13. The provider's assessment was that the patient was not at goal and worsening. His plan was to change the patient's insulin regimen. He ordered follow-up in 3½ to 4 months. Review of the patient's fingerstick blood sugars revealed that his blood sugar remained high, with many results in the high 100s and 200s. The patient had not been seen for follow-up as of 8/16/13.

  Assessment

  The patient was not receiving timely care for his diabetes. Patients in poor control need to be seen in approximately one month for follow-up.

- The patient[50] is a 68-year-old man with diabetes, hypertension and coronary artery disease with by-pass surgery in November 2010. The patient's LDL-cholesterol was 107 mg/dL on 3/3/13. (The patient's goal was <70 mg/dL since he had coronary artery disease.) A provider saw him for chronic care on 3/28/13. The provider noted that the patient's LDL-cholesterol was not at goal and changed his cholesterol lowering medication. The provider ordered a repeat lipid panel in three months. The patient's LDL-cholesterol was 160 on 6/28/13. On 7/11/13, a provider notified the patient that he was being scheduled for a medical

[49] Chronic Care Patient #7
[50] Chronic Care Patient #8.

appointment to discuss his laboratory tests. The patient paroled on 8/8/13 without being seen by a provider.

Assessment

The patient did not receive timely care for his elevated LDL-cholesterol.

- The patient[51] is a 37-year-old man with Type 1 diabetes, hypertension and hyperlipidemia who arrived at CIM on 12/13/12 from WSP. The patient was often non-compliant with his care. On 4/25/13, the patient's hemoglobin A1C (8.4%) and LDL-cholesterol (151 mg/dL) were elevated. The provider saw the patient for chronic care on 5/16/13 and noted that the patient's diabetes was not at goal. He adjusted the patient's insulin and noted that he would review the patient's fingerstick blood sugars every week and adjust the insulin as clinically indicated. The provider also noted that the patient's hyperlipidemia was not at goal. He further noted that the patient had recently been started on medication and that he would repeat the fasting lipid panel at the next chronic care visit. Review of the patient's medical record, however, revealed that the patient had been receiving the cholesterol-lowering medication since November 2012. The provider ordered chronic care follow-up in 5-6 months. The provider saw the patient again on 5/22/13 and noted that 5-6 months was too long an interval for the chronic care visit. He ordered laboratory tests to be done in three months and follow-up in 3½ to 4 months. On 7/25/13, the provider saw the patient because he was requesting a low bunk due to his diabetes. The provider noted that the patient's recent blood sugars had displayed wide variation with "numbers somewhere from 80s to 100s, 150 occasionally 250 to 300." (The fingerstick blood sugar results from July 2013 were not in the eUHR at the time of our visit.) The provider did not document an assessment or plan other than to note that he would follow up with the patient as scheduled.

  Assessment

  The patient was not receiving timely or appropriate care for his diabetes or hyperlipidemia.

- The patient[52] is a 46-year-old man with diabetes and hypertension. He arrived at CIM on 3/4/13 from San Diego County. At the time of his arrival, the patient was only receiving oral medications for his diabetes. On 3/12/13, his hemoglobin A1C was elevated (8.5%). On 3/21/13, a provider ordered sliding scale insulin three times per day. There was no documentation from the provider as to why he was doing this. In addition, there was no documentation that the provider discussed the initiation of insulin therapy with the patient. Another provider saw the patient for his initial chronic care visit on 4/9/13. The provider noted the patient's hemoglobin A1C of 8.5% and also noted that his recent fingerstick blood

[51] Chronic Care Patient #9.
[52] Chronic Care Patient #11.

sugars had been more than 200 mg/dL. The provider did not assess the degree of control of the patient's diabetes and did not adjust his medications. He ordered follow-up for chronic care in three months. The provider saw the patient again on 4/25/13. The provider noted that the patient was "supposedly" there in regards to a Chrono related to a foot problem. The provider noted, however, that "[T]he only thing the patient is interested in is to make sure that he has a glucose check before his meals three times per day for a couple or three weeks as was given to him before, which custody did not allow him to have. He said they only did p.r.n. [as needed] once daily and he does not think that is enough." Review of the fingerstick blood sugars revealed that they were only being done one time per day as the patient stated and that they were very elevated, with readings in the high 200s to 300s. The provider's plan was to have the patient's glucose checked three times daily for three weeks and for the patient to follow up in four weeks. The provider did not address the patient's elevated blood sugars. Review of the MARs revealed that the fingerstick blood sugars were, for the most part, performed as ordered. The patient's blood sugars remained elevated. The patient was seen by another provider on 5/24/13, 6/20/13 and 7/9/13. He received appropriate care for his diabetes.

Assessment

The patient did not initially receive appropriate care for his diabetes.

- The patient[53] is a 53-year-old man with diabetes, hypertension and hyperlipidemia. He is receiving long-acting insulin as well as sliding scale insulin for his diabetes. The patient was seen for chronic care on 12/27/12. The provider noted that the patient's hemoglobin A1C had been 7.4% on 9/19/12 and that he reviewed the patient's fingerstick blood sugars with him. The provider's assessment was that the patient's diabetes was at goal. Our review of the fingerstick blood sugars revealed, however, that his blood sugars were mostly elevated and that his diabetes was not well controlled. The provider saw the patient next for chronic care on 2/27/13. At that time, he noted that the patient's fingerstick blood sugars had been elevated and increased the dosage of his long-acting insulin. The provider saw the patient for follow-up chronic care on 4/23/13. The provider noted that the patient's hemoglobin A1C had been 7.5% on 3/27/13. The provider did not, however, review the patient's fingerstick blood sugars. Our review of the blood sugars revealed many readings in the high 200s and 300s mg/dL and one of 423 mg/dL. The provider's plan was to continue the patient's current medications, obtain laboratory tests in mid-August, and follow-up in 5-6 months or sooner if indicated. Review of his fingerstick blood sugars from May to August revealed that his blood sugars remained elevated. The provider saw the patient for follow-up on 8/26/13 and noted that his "recent" hemoglobin A1C had been at goal (7.5% on 3/27/13). The provider did not review the patient's finger stick blood sugars. The provider did not adjust the patient's medications. He noted that he would repeat the hemoglobin

[53] Chronic Care Patient #13.

A1C. He did not, however, order the test. The provider next saw the patient on 10/9/13. He noted that the patient was "at least at goal as of March 2013." He noted that the patient stated that his blood sugars had been improved but did not review the results himself. (Our review revealed that the patient's recent blood sugars were not well controlled, with many afternoon readings in the 200s.) The provider ordered a repeat hemoglobin A1C. On 11/8/13, the patient's hemoglobin A1C was 8.1%. The patient had not had a repeat hemoglobin A1C as of 10/1/13.

Assessment

The patient was not receiving timely or adequate care for his diabetes. Despite the fact that his hemoglobin A1C was close to goal in 3/2013, his fingerstick blood sugars revealed that his diabetes was not well controlled and that his insulin required further adjustment. His hemoglobin A1C was not repeated for seven months. While the CCHCS guidelines state that the hemoglobin A1C goal is 8%, the American Diabetes Association guidelines state that the goal is 7% unless the patient has a reason, which this patient did not, for it to be higher. Furthermore, the patient's fingerstick blood sugars documented that his blood sugar was, in fact, not well controlled. In addition, his hemoglobin A1C had been less than 8 in the past. A goal of 8% in this patient is below the accepted standard of care.

- The patient[54] is a 53-year-old man with diabetes, hypertension and hyperlipidemia who arrived at CIM from California Men's Colony (CMC) on 2/15/13. The patient's diabetes was being treated with oral medications and sliding scale insulin two times per day. A provider saw him for his initial chronic care visit at CIM on 3/4/13. The provider noted that the patient's hemoglobin A1C was 9.9%. His assessment was that even though the hemoglobin A1C was not within the therapeutic goal, the patient's fingerstick blood sugars showed better control. He noted that this may have been due to the fact that the patient's psychiatric medication had been changed. The provider's plan was to discontinue the fingerstick blood sugar monitoring and sliding scale and to obtain a repeat hemoglobin A1C in approximately two months. The patient saw a different provider on 5/2/13 for another problem. The provider noted that the patient's hemoglobin A1C had been "very high in the past." The provider ordered a hemoglobin A1C and follow-up in 4-8 weeks. On 5/3/13, the patient's hemoglobin A1C was 11.6%. The provider saw the patient for follow-up on 6/3/13. The provider documented that he discussed the patient's request for a low bunk at that time. The provider also noted that the patient's blood pressure was elevated and increased his medication. The provider did not address the patient's diabetes or his elevated hemoglobin A1C. On 7/12/13, a nurse saw the patient for evaluation of injuries sustained during an altercation. The nurse noted that the patient's fingerstick blood sugar was very elevated (310 mg/dL). The nurse contacted a provider, who gave a telephone order for a one-time dose of insulin "if wanted by inmate." The patient subsequently refused the

[54] Chronic Care Patient #14.

insulin. The provider referred the patient for follow-up in three days. Another provider saw the patient on 7/15/13 for follow-up of his injuries but did not address his diabetes. The patient saw a provider on 7/29/13 for another problem. The provider did not address the patient's diabetes. The patient transferred to a different facility on 7/30/13.

Assessment
The patient did not receive timely or appropriate care for his diabetes.

- The patient[55] is a 49-year-old man with diabetes, hypertension and hyperlipidemia. The patient's LDL-cholesterol was elevated (108 mg/dL) on 10/26/12. On 12/26/12, a provider saw the patient for chronic care and changed his cholesterol-lowering medication. The provider ordered follow-up in 2-4 months. On 2/26/13, the patient's LDL-cholesterol was 142 mg/dL. On 5/7/13, the provider saw the patient for chronic care and increased the dosage of his cholesterol-lowering medication. His plan was to re-check a fasting lipid panel in three months. The provider saw the patient on 8/7/13 "to follow-up laboratory, right knee effusion (swelling) issues and diabetes." The provider did not address the patient's hyperlipidemia. Results of the repeat lipid panel were not in the eUHR as of 10/1/13.

  Assessment
  The patient did not receive timely care for his hyperlipidemia. The CCHCS guidelines state that patients are to be seen every three months until the target LDL goal is reached.

- The patient[56] is a 42-year-old man with diabetes, hypertension and hyperlipidemia. The patient's LDL-cholesterol was 120 mg/dL on 1/29/13. The provider saw the patient for chronic care on 3/5/13 and increased the dose of his cholesterol-lowering medication. The patient's repeat LDL-cholesterol was 149 mg/dL on 6/11/13. On 6/13/13, the provider notified the patient that he was being scheduled for follow-up medical appointment to discuss his laboratory results. The patient had not been seen for follow-up of his high cholesterol as of 10/1/13. Furthermore, the provider noted that the patient's blood pressure was 124/86 mmHg when he saw the patient on 3/5/13. His assessment was that the patient's blood pressure was within the therapeutic goal of 130/80. The patient's blood pressures have continued to be mildly elevated 140/87 (5/24/13), 123/84 (6/4/13), 128/82 (7/9/13), and 125/87 (8/7/13). This has not been addressed.

  In addition, when the provider saw the patient for chronic care on 3/5/13, he noted that the patient had anemia of uncertain etiology. The provider noted that he would order blood tests and check stool for occult blood. The blood test were done on 4/5/13 and revealed that the patient was still anemic. On 4/10/13, the provider notified the patient that he was

[55] Chronic Care Patient #15.
[56] Chronic Care Patient #16.

being scheduled for an appointment to discuss his laboratory results. As of 10/1/13, the patient had not had the stool tests and had not been seen for follow-up of his anemia.

Assessment
The patient was not receiving timely care for his hyperlipidemia or anemia.

- The patient[57] is a 27-year-old man with diabetes, hypertension and asthma who arrived at CIM from WSP on 5/23/13. A provider had seen him most recently at WSP on 4/16/13. At that time, the provider noted that the patient's diabetes was not controlled and increased his insulin. He ordered follow-up in 30 days. A provider at CIM saw the patient for chronic care on 6/3/13. The provider noted that the results of the patient's fingerstick blood sugar monitoring were not available. His plan was to continue the patient's current insulin regimen and reassess the patient at the next visit. (Our review of the medication administration records from 5/28/13 to 6/2/13 revealed that the patient's blood sugars were not controlled, especially at noon, when his blood sugars were in the high 200s and 300s.) The provider saw the patient on 7/3/13 following a podiatry consultation. The provider noted that the patient had diabetic neuropathy. The provider did not review the patient's fingerstick blood sugar monitoring and did not address the patient's blood sugar control. (Our review of the patient's blood sugar monitoring revealed that his diabetes remained uncontrolled.) On 7/17/13, the patient's hemoglobin A1C was 9.9%. A provider reviewed the result on 7/19/13. As of 8/16/13, the patient had not had follow-up for his diabetes.

  Assessment
  The patient was not receiving timely or appropriate care for his diabetes.

- The patient[58] is a 48-year-old man with newly diagnosed diabetes, hepatitis C with end-stage liver disease, and asthma. The patient had a blood test on 2/26/13 which revealed blood glucose of 151 mg/dL (normal range 65 to 99 mg/dL). On 3/1/13, the provider notified him that a medical appointment would be scheduled to discuss his laboratory tests. On 4/11/13, another provider saw the patient for follow-up of laboratory tests. The provider noted that the patient thought that the tests had been done approximately 2-3 weeks before. The provider further noted that there were no recent laboratory tests except for 2/26/13. The provider did not address the results of those tests. Another provider next saw the patient on 5/30/13. The provider noted that the patient's blood glucose had been elevated and ordered further tests. The provider did not obtain a history from the patient related to signs/symptoms of diabetes. On 6/4/13, the patient's blood glucose was 206 mg/dL and his hemoglobin A1C was 9.9%. The provider saw the patient for follow-up on

[57] Chronic Care Patient #17.
[58] Chronic Care Patient #21.

6/18/13 and noted that he had new onset diabetes. The provider did not obtain a history related to signs/symptoms of diabetes. The provider ordered long acting and sliding scale insulin and noted that he would repeat the hemoglobin A1C in approximately one month. The patient's hemoglobin A1C on 7/15/13 was 9.7%. The provider saw the patient for follow-up on 7/30/13. The patient's recent fingerstick blood sugars had been variable, with many morning blood sugars in the high 100s to 200s and many afternoon blood sugars in the 200s. The provider increased the patient's insulin. He noted that he would repeat the hemoglobin A1C approximately 9/9/13 and ordered follow-up in 2-3 months.

Assessment

The patient did not receive timely care for his elevated blood sugar. It took 5½ months from the time the patient's blood sugar was initially elevated until he was diagnosed with diabetes. In addition, his follow-up visits were not timely. Newly diagnosed diabetic patients, especially those who are prescribed insulin, need to be seen at least monthly for the first few months. Furthermore, standard of care is to initiate treatment for type II diabetes with oral medications, not insulin. The CCHCS diabetes guideline states that insulin is generally recommended after failure to respond to oral medications. The provider did not document any reason as to why he decided to start the patient on insulin.

- The patient[59] is a 64-year-old man with diabetes, hypertension and hyperlipidemia. The patient's hemoglobin A1C had been 7.2% on 10/23/12. A provider saw him for chronic care on 2/13/13 and noted that his diabetes was at goal and that he would repeat the hemoglobin A1C. The provider ordered follow-up in 4-5 months. On 7/9/13, the patient's hemoglobin A1C was elevated (8.5%). The provider saw the patient on 7/19/13 and changed the patient's medications.

  Assessment

  The patient did not receive timely care for his diabetes. The hemoglobin A1C needs to be repeated every 3-6 months. The patient had not had his hemoglobin A1C checked for nine months.

- The patient[60] is a 35-year-old man with diabetes, hypertension and hyperlipidemia who arrived at CIM from Ironwood State Prison on 6/24/13. A provider saw him for his first chronic care visit on 6/27/13. The provider noted that the patient's diabetes and hypertension were at goal and ordered laboratory tests. On 7/2/13, the patient's hemoglobin A1C (9.2%) was elevated. Another hemoglobin A1C was done on 7/16/13 and was 9.7%. The provider saw the patient for follow-up on 8/8/13. The provider initiated

[59] Chronic Care Patient #23.
[60] Chronic Care Patient #24.

treatment with long acting insulin and sliding scale insulin two times per day. The provider ordered follow-up around 12/27/13.

Assessment

The provider did not order timely follow-up. A patient whose diabetes is not controlled and is started on insulin needs to be seen for follow-up within 2-4 weeks.

- The patient[61] is a 36-year-old man with hypertension, asthma, hyperlipidemia, coronary artery disease, congestive heart failure, a cardiac pacemaker, a history of stroke, and recurrent deep vein thrombosis for which he is receiving long-term anticoagulation. He arrived at CIM from North Kern State Prison on 6/18/13. Recent INRs had been therapeutic on a dose of 4.5 mg of warfarin per day. On 6/21/13, he was admitted to an outside hospital for evaluation of chest pain. His INR was noted to be therapeutic at that time. He was discharged on 6/22/13 after having been ruled out for a heart attack. In error, his discharge medications included warfarin at a dose of 2 mg per day. This lower dose of warfarin was continued when the patient returned to CIM. (The provider did note that there had been a dose change at the time he ordered the warfarin.) On 6/24/13, the patient's INR was subtherapeutic (1.4). On 6/25/13, a provider increased the dosage of warfarin to 4 mg. A repeat INR on 6/27/13 was still sub-therapeutic (1.4). There is an informational chrono in the eUHR noting that on 6/29/13, a provider sent the patient back to the hospital for another episode of chest pain via code 3 ambulance. There is no other documentation related to this episode and there are no records from the outside hospital. On 7/2/13, a provider saw the patient for follow-up of the hospital visit. The provider noted that the workup for chest pain had been negative. The provider did not address the patient's subtherapeutic INR. On 7/9/13, the patient was sent to the outside hospital for evaluation of numbness and weakness. He was admitted for a possible stroke or transient ischemic attack (TIA). Upon admission to the hospital, his INR was 1.2. The doctor at the hospital increased the patient's warfarin dose to 6 mg and initiated therapy with Enoxaparin. The patient returned to CIM on 7/12/13. (It is not clear what the final diagnosis was.) Upon the patient's return, a provider ordered 6 mg of warfarin and Enoxaparin for one week. He also ordered an INR for the next day and then daily for five days. On 7/13/13, a provider saw the patient in the TTA for evaluation of chest pain. At that time, the provider noted that the patient stated he had not been given his self-administered medications when he had returned from his most recent hospital admission. The provider noted that he would change the medication to nurse-administered. However, when he ordered the medications, he ordered the warfarin at a dosage of 4 mg instead of 6 mg.

  A provider next saw the patient on 7/15/13 and noted that the patient's INR had been reported to be 1.0 (there was no documentation in the eUHR of this lab result). The

[61] Chronic Care Patient #25.

provider increased the patient's warfarin to 6 mg. He noted that the patient's INR needed to be rechecked in approximately three days to determine if he still needed to be receiving Enoxaparin. On 7/18/13, an INR was drawn early in the morning. Later that day, a provider ordered a "stat" (to be done immediately) INR for 7/19/13 and noted that he needed to be called with the results. The INR done on 7/18/13 was subtherapeutic (1.1). A provider reviewed the result on 7/19/13 but did not address it. The INR ordered to be done on 7/19/13 was not done. An INR was next done on 7/23/13 and was still subtherapeutic. On 7/24/13, a provider increased the dosage of the patient's warfarin. A repeat INR on 7/29/13 was still subtherapeutic (1.2). A provider increased the dosage of warfarin and noted that he would follow up in two weeks. The provider saw the patient on 8/7/13 for multiple issues, noting that the patient was scheduled as an add-on because he was very non-compliant with medications or doctors' orders. There were, however, no nursing notes documenting that the patient was refusing his nurse administered warfarin or that he was found to be diverting his medication. In addition, the provider noted that the patient denied ever "cheeking" or not taking his medication. The provider's plan was to continue the Enoxaparin until the patient's INR was therapeutic. He noted that the patient stated he would be compliant with his medications. The provider did not adjust the dosage of warfarin and ordered follow-up in three months. He did not order a repeat INR.

Assessment

The patient did not receive timely or appropriate management of his anticoagulation. In addition, there were problems related to lack of documentation.

Infection Control

While there is no official infection control program at CIM, there is a process for tracking reportable diseases. A public health nurse ensures that reportable diseases are reported to the local public health department in conformity with Title 17. The public health nurse also tracks the number of patients who have a positive skin test for tuberculosis and the number of patients on treatment for latent tuberculosis infections. The public health nurse provides data for the Data Collection Summary. This report is given to the monthly Medical Program Subcommittee Meeting. This report includes the number of new cases of hepatitis C, HIV, syphilis, gonorrhea and Chlamydia. The public health nurse obtains this information from laboratory reports. The public health nurse also reports new cases of these diseases to the San Bernardino Health Department.

The public health nurse also tracks the number of inmates coming through reception screening who have a positive tuberculin skin test (TST) for tuberculosis. If the TST is positive, the inmate is determined to have latent tuberculosis infection and is offered preventive treatment. This screening program appears to be ineffective. For the nine months from July 2012 to March 2013, there was an average of approximately 12 inmates coming in through reception

screening a month who had a positive TST. Since there are approximately 480 new inmates arriving at CIM a month, the rate of skin test positivity is about 2.6%. This is low for a correctional facility. In 2000, the estimated prevalence of latent tuberculosis infection in the U.S. was 4.2%.[62] It would be unusual for the prevalence of latent tuberculosis infection in CIM to be less than the prevalence of latent tuberculosis in the general U.S. population.

In April 2013, the public health nurse reported that 66 inmates had a positive skin test for tuberculosis. This was approximately five times the monthly average number of positive skin tests. The reason for the sudden rise in the number of positive tests was that April is the month when annual skin testing is performed on inmates in the facility. Inmates who previously tested negative are annually re-tested to assess whether they have recently acquired tuberculosis infection. Inmates who have already tested positive for latent tuberculosis infection are not re-tested. If an inmate has a positive skin test on annual screening, it means that they acquired tuberculosis within the prison during the prior year. These inmates are described as convertors. A large number of convertors in a prison is usually a sign that someone with active tuberculosis was infecting inmates within the prison during the past year. However, the public health nurse believed that the reason for the increased number of convertors was that inmates are mistakenly screened as negative at intake when they are actually positive. This produces more positive test results on the annual screening and accounts for the large rise in the month during which annual screenings occur. From a public health perspective, based on the data for the month of April, one cannot be certain whether the reception screening for latent tuberculosis is ineffective or whether there are one or more cases of unidentified active tuberculosis within the prison. CIM needs to review the intake screening procedures for tuberculosis.

The reception nurses who apply the TST work in a small 5 by 4 foot booth with a small opening through which inmates place their arm for the nurse to apply the skin test. This is an inappropriate arrangement and may account for the poor results. (As noted above, the reception booth is an extremely difficult location to obtain a health history.) A recent national shortage of Tubersol, a purified protein derivative (PPD) used in performing the TST led to use of Aplisol, an alternate method of performing a TST. The public health nurse believed that this product change caused differences in positivity rates. However, it has been reported that there is no statistical difference between these two products.[63] The following case is an example of ineffective screening.

[62] Bennett, DE, Courval JM, Onorato I, et al.; Prevalence of Tuberculosis Infection in the United States Population: The National Health and Nutrition Examination Survey, 1999-2000 American Journal of Respiratory and Critical Care Medicine Volume 177, Issue 3, February 1, 2008.

[63] Guidelines for Preventing the Transmission of Mycobacterium Tuberculosis in Health-Care Settings, 2005; MMWR December 30, 2005, Volume 54, No.RR-17.

- The patient[64] was incarcerated on 6/6/13. Nurses performed his intake health reception screening and did a tuberculosis evaluation that documented no symptoms, no prior tuberculosis and no prior TST. A TST was applied to the right forearm. It was read on 6/8/13 and was positive, indicating prior TB infection. The nurse who read the skin test took further history that in 2009-10, the patient had been in airborne isolation for one and a half months and took medication for a year at the University of California San Diego Hospital. A nurse later verified with the San Diego Health Department that the patient had prior active tuberculosis with positive smears and had completed nine months of treatment. The reception tuberculosis screening failed to accurately identify this individual's prior tuberculosis history. Also, despite the history of prior treatment for active tuberculosis, on 6/11/13, a nurse offered the patient preventive tuberculosis treatment, which was unnecessary and should not have been offered. The patient fortunately refused.

  The patient had a right upper lobe infiltrate with hilar adenopathy, but the infiltrate may have been old disease with fibrosis. Nevertheless, the patient was placed in airborne isolation until tuberculosis could be ruled out. On 8/5/13, the patient was still in isolation, when a provider recognized that culture results for tuberculosis had not been sent and these were reordered. Apparently, tuberculosis smears were ordered, but this order does not automatically result in orders for a tuberculosis culture, which is typically done. As of 8/16/13, acid-fast smear results for tuberculosis were negative, but culture results are still pending. The patient remains in negative pressure isolation pending culture results.

  Assessment

  The nurse performing the reception screening questionnaire did a poor job. A nurse subsequently offered preventive therapy to a patient who had already been treated for TB. This could have harmed the patient if he had reactivation of his tuberculosis as it could lead to drug-resistant TB. The sputum testing for tuberculosis did not include automatic cultures for tuberculosis which is necessary to confirm the diagnosis.

We also noted that Methicillin resistant staph aureus (MRSA) infections are not reported on the Data Collection Summary. MRSA is a very common and serious infection in correctional facilities. The public health nurse stated that MRSA is not reported because it is not a reportable disease under Title 17. Regardless of whether MRSA is a reportable disease, it is a condition that can cause serious harm to both inmates and employees. Tracking MRSA is important. Tracking MRSA cases can result in identification of hygiene or other environmental problems that are correctable. Tracking of MRSA needs to be done and needs to include both culture positive cases and presumptive MRSA cases.

[64] OHU Record Review #1.

The public health nurse also has no responsibilities to provide surveillance for nosocomial (hospital-acquired) infections in the OHU/infirmary. There is no program to provide this service at the facility. This needs to be done.

Pharmacy and Medication Administration

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

Pharmacy Services

Findings: The Pharmacist in Charge has been at the facility approximately three years. The pharmacy switched from bulk medications to patient specific medications in December 2012. Currently, the pharmacy dispenses approximately 21,000 to 24,000 prescriptions per month. This is the same volume as when there were 7,000 inmates, and they now have 4,800 inmates. This likely reflects the increasing medical acuity of the population, particularly in A Yard, that has 900 elderly lifers.

Pharmacy services are provided Monday through Friday from 8:00 a.m. to 4:30 p.m. The PIC has added a Saturday shift 8:00 a.m. to 4:30 p.m. with registry staff. He currently has 3.9 FTE civil service pharmacist positions and 5.1 FTE contract pharmacists. CIM lost 2.0 positions in the ABSR, and in addition is down 1.5 FTEs due to maternity leave and long-term illness (> 1 year). The facility is using registry expenditures to fund 8-9 pharmacists. Pharmacy staffing also includes 12 pharmacy techs comprised of six civil service and six registry positions. Central Pharmacy refills KOP medications.

For CDCR intrasystem transfers, nurses visually check an envelope containing the inmate's medications to determine if all medications were successfully transferred. However, staff reported that inmates' medications are sometimes packed with their property that is not necessarily transported on the bus with the inmate. Moreover, according to pharmacy staff, even when their property is transported on the same bus, custody may not deliver it to inmates for 2-3 days. These medications are considered "lost" and pharmacy refills the prescription if it is current. The June 2013 Medication Administration Audit Summary showed that medication continuity was provided in 18 of 20 (90%) of records reviewed. However, January to June AMAT studies show that compliance with continuity of medications was 85% or below in four of six months.

The PIC carefully tracks and reports lost medications. The previous month, there were over 900 lost medications and the cost to refill them was $40,000. He stated that Receiving and Release (R&R) staff emails sending facilities to let them know what medications did not arrive at the

time of transfer. A related issue is that inmates may transfer frequently in a short period of time (e.g., three times in 30 days), resulting in multiple medication refills in a short period of time. If the pharmacist at each prison refills the medication orders, all the refills may have been used by time the inmate arrives at his final destination, even if the prescription date has not expired.[65]

Staff reported that sometimes a bus arrives late Friday when pharmacy staff is at the end of their shift or have left. The medication Night Locker supply has a limited supply of medications (approximately 40 drugs) and pharmacy staff comes in on Saturday to fill prescriptions. The PIC recommended that Pyxis machines[66] be installed at medical reception centers.

With respect to transfers out of the facility, each Monday, custody staff provides health care staff an inmate transfer list for the week. However, the transfer list often changes from day to day. On any given day, custody may notify staff at 2 p.m. that an inmate is to be transferred the next morning. By the time nurses complete the transfer form, pharmacy staff may no longer be at the facility to prepare medications to transfer with the inmate.

The PIC reported that there are conflicts between the statewide policies on intrasystem transfer, medication management and pharmacy policy with respect to whether the sending facility needs to send a 3-day medication supply.

With respect to medication refills, every two weeks the pharmacy emails a list to providers and nurses of medication orders that will expire in 14 days. The nurses print the medication reconciliation reports for providers to facilitate the renewal of medications.

With respect to quality improvement, we reviewed Medication Management Meeting Minutes from December 2012 to May 2013. We found that the minutes generally lacked substantive discussion, analysis, and follow through of identified problems (See Internal Monitoring Section).

Medication Administration

Findings: We found varying practices in medication administration at CIM, some that do not conform to generally accepted standards of nursing practice.

In Facility A, the medication room was organized as well as could be expected given the space; however, the room is cramped, with large bags of medications on the floors. We observed nurses administering medications and all followed proper procedure. However, CIM Medication Management Meeting minutes note that medication errors in A yard were due to

[65] Prescriptions are valid for a certain number of doses. If a prescription is refilled more frequently than monthly, it may shorten the period in which the prescription is valid.
[66] Medication dispensing machines.

documentation delays, not clinical practices; however, the extent of the problem was not quantified.[67] This suggests that some nurses document administration of medications after the fact, which is not in compliance with nursing practice standards.

In Facility B, medication administration is decentralized. Five nurses transport five medication carts to the dormitories to administer medications, and nurses reported that it takes approximately one to two hours at a given medication administration. Staff reported that medication administration revolves around other custody activities such as meals, and if a meal is delayed, medication administration is delayed.

As noted at other facilities, in segregation housing units, nurses pre-pour medications from pharmacy dispensed packaging into coin envelopes that do not have the same pharmacy labeling and are repeatedly reused. This method of administering medication increases the risk of medication error, is unsanitary, and not in conformance with standards of nursing practice.

In Facility C, medications are administered centrally from a medication room located in the yard. The room is clean and very well organized. We observed three nurses administering medications to inmates lined up at three windows. In general, nurses adhered to standards of nursing practice by requesting inmate identification badges and using the MAR to prepare the medication; however, a concern is that correctional officers had the IDs of inmates going to the canteen, and they were unable to receive their medication during the time we observed medication administration. It appeared that the inmates had to choose between losing their place in the canteen line and receiving their medications or vice versa. Another concern is that oral cavity checks were cursory, if performed at all. In addition, only one of three nurses signed out controlled substances at the time the medication was removed from secure storage.

Laboratory/Radiology

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

Findings: We did not find any significant issues with timeliness of laboratory and radiology services. Laboratory and specialty services reports are placed in a file folder in Facility D. Each day, providers are expected to review, date and sign these reports and take appropriate clinical action. However, as noted in case reviews in this report, we found cases in which there were delays in addressing abnormal laboratory or diagnostic reports.

In addition, patients on warfarin are being managed by a pharmacist. Pharmacy notes do not consistently include clinical indication and duration of treatment. In cases in which INR values

[67] Medication Management Meeting Minutes, May 2013.

are supratherapeutic, there is no documentation to demonstrate that patients are interviewed for complications of warfarin therapy (i.e., bleeding).

Health Records

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

Findings: CDCR has migrated statewide from a paper record to an electronic Unit Health Record (eUHR). This has been described in previous reports and will not be duplicated in this report.[68] It is our understanding that the Receiver has purchased an electronic health record (EHR) and that plans are underway to implement the new EHR.

Health Records Space and Operations

Health records are managed in two separate facility buildings, Facility B and Facility D. The ABSR has resulted in reduced health record staffing and a reduction from two shifts to one shift per day. CIM is using overtime to maintain current scanning of health records. This is not surprising, as the designation of CIM as an Intermediate Facility with a population of increasing medical acuity would be expected to increase the volume of health records to be scanned.

Timeliness of Scanning Health Documents

We found no significant backlog of health records to be scanned except that staff does not scan OHU records until the patient is discharged. This delays the availability of important clinical information and may have an adverse impact on patient care.

Urgent/Emergent Care

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

Emergency Department/Hospitalizations

Findings: Overall, emergency care was adequate. The provider evaluations were generally appropriate and thorough, and there were no barriers preventing patients from being transported to local hospitals. However, we reviewed records in which there was no documentation of either nursing or medical evaluations of patients prior to being sent to the hospital.[69] In addition, record reviews revealed the following problems:

[68] See Court Experts San Quentin report. March 2013.
[69] Intrasystem Transfer/Sick Call Patient #11 and #22.

- Nurses managed a patient[70] with a serious soft tissue infection by phone consultation with providers. Instead, a provider needed to evaluate the patient in person. On 1/31/13, the patient placed a 7362 for right calf swelling. The patient complained of a red swollen calf and had loss of appetite and vomiting, diarrhea and fever, indicating possible systemic infection. A nurse evaluated the request on the day it was delivered. The nurse documented that the patient had no fever, but did have a swollen and red leg that was painful. The nurse called a provider, who ordered antibiotics. A provider needed to have examined and followed up with the patient.

  On 2/7/13, a nurse saw the patient, who said his leg was not getting better. The nurse noted continued redness of the leg. The nurse called a provider, who admitted the patient to a local hospital for cellulitis. The patient was treated in the hospital with intravenous antibiotics and returned to the prison on 2/14/13.

  Assessment
  The patient never saw a provider during the week that he had the leg infection at the prison. If a provider had seen the patient earlier, it is possible the hospitalization might have been avoided. His infection could have been treated in the OHU.

- Another patient[71] had a calcified brain lesion from a prior toxoplasmosis infection[72] as a result of HIV infection. Neurology and neurosurgery were following the patient. The patient had refused recommended neurosurgery to remove the lesion. The brain lesion contributed to temporal lobe epilepsy, which resulted in spells during which the patient was confused. The patient had repetitive seizures that often resulted in hospitalization. As part of his epilepsy syndrome, the patient had confusion. Because of this, the patient needed to receive his medications via nurse-administered instead of keep on person (KOP).

  On 2/16/13, an on-call provider conducted a telephone consultation for the patient. The patient apparently was found walking around with altered mental status, not listening to custody. His pulse was 115 in the TTA. Initially, the provider intended to transfer the patient to a hospital, but the patient said he did not want to go to the hospital, so the provider sent him back to population with a 4-7 day follow-up.

  Assessment
  The patient needed to have been admitted to the OHU for observation.

[70] Hospital Record Review #3.
[71] Hospital Record Review #5.
[72] A fungal infection.

We identified a case of hospitalization due to injection drug use. We also note that there have been other cases in CDCR of injection drug use resulting in hospitalization and death.[73]

- One example is a patient[74] who was being followed for hypertension and hyperlipidemia. On 4/23/13, a provider saw the patient urgently for chest pain and a pustule with a hive like rash on his torso. The patient complained of fever. He admitted to using illicit intravenous drugs several days previous. After labs were done, the vitals were rechecked and the blood pressure had dropped from 103/60 mmHg to 92/55 mmHg. His pulse was 100. His white blood count was very elevated and he had blood in his urine. The patient was diagnosed with sepsis and sent to a local hospital. The patient had MRSA sepsis with pneumonia. These were ascribed to his injection drug use. The patient developed renal failure requiring dialysis, was gravely ill and remained hospitalized for just over two weeks. When the patient returned to the prison, his drug use was not addressed as a problem and the patient was not offered drug treatment. CCHCS should work with CDCR and develop a harm reduction strategy.

Specialty Services/Consultations

Methodology: We interviewed staff involved in the review, approval and tracking of specialty services, OIG and other internal reports and reviewed health care records of 20 patients for whom services were requested. Many of these patients had been referred to multiple specialists.

Findings: There were problems related to timeliness in seven (35%) of the 20 records we reviewed for specialty care, two of which involved delayed evaluation and treatment for malignancy. Our findings are not consistent with the OIG Cycle 3 report, which showed that CIM scored 93.7% overall for specialty care. The problems we found are discussed in the cases below.

- The patient[75] is a 34-year-old man with diabetes, hypertension, hyperlipidemia and uncontrolled glaucoma. The patient saw an off-site ophthalmologist on 6/3/13. The ophthalmologist examined the patient and ordered follow-up in one month for visual field testing and in two months for intraocular pressure check and review of the results of the visual field testing. The primary care provider saw the patient for follow-up on 6/13/13. The patient saw an ophthalmologist via telemedicine on 8/8/13, who noted that the patient's intraocular pressure was "much too high" and that he had "far advanced" disease. He referred the patient back to the off-site ophthalmologist on an urgent basis.

[73] SVSP Mortality Review Patient #1 and SVSP Mortality Review Patient #2.
[74] Hospital Record Review #6.
[75] Specialty Care Patient #2.

Assessment

The patient's specialty follow-up care with the off-site ophthalmologist did not occur in a timely manner.

- The patient[76] is a 42-year-old man with diabetes, hypertension and hyperlipidemia. He underwent a two-day cardiac stress test on 1/9/13 and 1/10/13. The provider saw the patient for chronic care on 1/17/13 and noted that the visit was also follow-up for the cardiac scan. The provider further noted that the results were not yet available and that he would discuss the results at the next chronic care visit. The primary care provider saw the patient for chronic care on 3/5/13 and 6/4/13. He did not discuss the results of the scan at either visit. Furthermore, as of 8/16/13, the results of the myocardial perfusion scan were not in the medical record.

  Assessment

  The patient did not receive timely primary care provider follow-up of his specialty visit.

- The patient[77] is a 54-year-old man who underwent a urological procedure on 6/28/13 to dilate his urethra. The patient returned to the facility with a Foley catheter in place. The urologist noted that the catheter needed to be removed in one week and that the patient needed to follow up with him in one week. On 7/1/13, a provider wrote an order for follow-up with the urologist in one week. The patient did not return to the urologist until 7/11/13, at which time the catheter was removed.

  Assessment

  The patient did not receive timely specialty follow-up care. The urologist recommended removal of the catheter in one week, but the patient did not see the urologist for removal of the catheter for 2 weeks. A catheter needs to be removed as soon as possible in order to reduce the risk of infection. In addition, the catheter is very uncomfortable and should be removed as soon as possible.

- The patient[78] is a 70-year-old man with a history of recently diagnosed prostate cancer and squamous cell skin cancer six years ago. On 10/2/12, while the patient was at the Substance Abuse Treatment Facility, a primary care provider noted that the patient was complaining of swelling in his neck that "comes and goes." The provider noted that the patient had a hard lymph node, for which he ordered five days of antibiotics. He also noted that the patient might need a biopsy if the swelling did not subside. The provider saw the patient on 10/10/12, and noted that the lymph node was still present. He did not address this in his

[76] Specialty Care Patient #3.
[77] Specialty Care Patient #7.
[78] Specialty Care Patient #8.

assessment or plan. The provider saw the patient on multiple other occasions for his prostate cancer but did not address the lymph node. The patient was subsequently transferred to CIM in December 2012. A primary care provider saw the patient on 12/24/12 and noted the history of the lymph node. The provider ordered a biopsy on a routine basis. A surgeon saw the patient on 3/14/13. He noted that he discussed options with the patient and that the patient wished an ultrasound guided biopsy. On 3/20/13, a CIM provider referred the patient to interventional radiology for the biopsy. The biopsy was done on 6/6/13. The initial pathology report noted scattered clusters of atypical cells favor neoplastic. The pathologist added that "[A]ppropriate material has been forwarded to Integrated Oncology for immunohistochemical analysis. An addendum will follow." The primary care provider saw the patient for follow-up of the biopsy on 6/19/13. The provider noted that he would follow-up on the immunohistochemical analysis pathology report. He also referred the patient to oncology on a routine basis. Another provider reviewed the final pathology report on 6/20/13. The report noted that the biopsy revealed metastatic squamous cell carcinoma. The provider noted that the patient had been seen on 6/19/13 and took no further action. The patient's primary care provider saw the patient for follow-up on 7/24/13. He noted that the oncology referral was pending and that he had consulted off-site services, who would schedule the patient to be seen. The provider saw the patient again on 7/31/13 and noted that the oncology consult was still pending and that he had contacted Utilization Management. The patient has not been seen by the oncologist as of 8/16/13.

Assessment

The patient did not receive timely specialty care for his malignancy.

- The patient[79] is a 64-year-old man with newly diagnosed diabetes, who underwent coronary artery bypass surgery and an aortic valve replacement on 5/28/13, following an extensive myocardial infarction. While in the hospital, he was also diagnosed with diabetes. He was discharged from the hospital on 6/6/13, and saw the cardiologist for follow-up on 6/18/13. The cardiologist recommended increasing the patient's pain medications, monitoring his blood sugar two times per day, noting that "the sternum does not heal well with high blood sugars," and increasing the patient's ambulation to 30 minutes per day. He ordered follow-up in two weeks. The patient refused his follow-up appointment on 7/1/13 and signed a refusal form. A CIM provider saw the patient for follow-up on 7/3/13. He noted that the patient was asymptomatic and was taking his medications as directed. He did not address the patient's refusal and did not order any follow-up with the cardiologist. Review of the patient's July fingerstick blood sugar results revealed that his blood sugars were not optimally controlled, with many morning results in the high 100s and 200s. As of 8/16/13,

[79] Specialty Care Patient #14.

the patient had not been seen by a CIM provider for follow-up of his diabetes or cardiac condition since 7/3/13.

Assessment

The patient did not receive appropriate follow-up care from the CIM provider. The patient had recently had a myocardial infarction and the cardiologist had recommended a follow-up visit. The standard of care in such a case is for the provider to counsel the patient about his refusal and re-refer him if the patient agrees to go. If the provider did not think the patient needed to see the cardiologist, he needed to document a reason for not following the cardiologist's recommendation. In addition, the patient was not being seen timely for his diabetes or cardiac condition.

- The patient[80] is a 52-year-old man with multiple chronic medical problems who arrived at CIM from NKSP on 12/11/12. He had originally arrived at NKSP on 10/2/12 from San Bernardino County. Prior to his arrival at NKSP, the patient had had a biopsy of a cervical lymph node, which was positive for carcinoma, possibly squamous. It appears that copies of the report arrived at NKSP on or about 10/4/12. A provider saw the patient on 10/4/12 and noted that he had had a lymph node biopsy prior to his arrival and that the results of the biopsy were pending. The provider saw the patient again on 10/24/13 for other issues and did not address the biopsy. The physician saw the patient next on 11/28/12 for follow-up of a neurology consult. He noted that he would obtain the results of the biopsy from 9/18/12 at that time. The patient transferred to CIM on 12/11/12. Right cervical lymph nodes were listed as one of his problems on both the transfer form and the initial health screening form. A provider saw him for his initial chronic care visit on 12/20/12. He did not address the lymph node biopsy. The provider next saw the patient on 1/29/13. He documented that the patient "mentions that he forgot to tell me about a neck mass that he has had now for approximately six months or so or almost eight months." The provider noted that he would request the results of the biopsy and order laboratory tests. The provider must have found the biopsy results in the medical record because on 1/31/13, the provider referred the patient to ENT for further evaluation of the mass, noting that the biopsy had been positive for metastatic cancer. The provider also ordered a chest CT scan, which was done on 2/14/13. On 2/15/13, the patient saw an ENT surgeon who recommended a neck CT scan followed by surgical biopsies and a possible neck dissection on 3/4/13. The patient was ultimately diagnosed with metastatic cancer of the tongue and is being treated with radiation and chemotherapy.

  Assessment

  The patient did not receive timely follow-up of his biopsy results at either NKSP or upon arrival at CIM.

[80] Specialty Care Patient #15.

- The patient[81] is a 55-year-old man with diabetes, hypertension, hyperlipidemia and cardiomyopathy, for which he has a pacemaker. He arrived at CIM from Avenal State Prison (ASP) on 12/18/12. His most recent pacemaker check had been on 10/18/12. At that time, the cardiologist stated that the patient needed his pacemaker checked in three months. Following his arrival at CIM, a provider saw the patient for his initial chronic care visit on 1/4/13. The provider noted the pending cardiology referral and ordered a telemedicine cardiology consult. The provider next saw the patient on 4/11/13 and noted that the patient had not been seen by cardiology. He checked with the Telemedicine Clinic and was informed that the patient would need to be seen at an outside facility for a pacemaker check. The patient saw a cardiologist on 5/6/13, approximately four months after his pacemaker check was due.

  Assessment
  The patient did not receive timely specialty care.

Outpatient Housing Unit Care (OHU)

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

Findings: Provider clinical care and nursing care on the OHU are adequate, but support services, particularly medical records, are inadequate. We continue to find the intrasystem transfer process inadequate and potentially harmful to patients. The CIM OHU is also referred to as an infirmary. This unit has four wings that contain a total of 80 beds. Two wings are dedicated to mental health and two wings are dedicated to medical. Because of the increased number and acuity of medical patients, some of the mental health beds are occupied by medical patients. On the day of our visit, there were 48 medical patients in the OHU. One patient was housed in the OHU because there was no electric outlet available in any general population area so he needed to be in the OHU to use his continuous positive airway pressure (CPAP) machine. Twenty of the 48 patients were long-term skilled nursing type patients. Even though this is an OHU unit, it is housing CTC and skilled nursing type patients.

Nurse staffing consists of two registered nurses and one nurse assistant for each medical unit on the day and evening shifts. At night, there is one registered nurse and one nurse assistant for each medical unit. There are only two nursing stations for the OHU. Because there are only two nursing stations, the number of nurses exceeds the available workstations. There is insufficient counter space for documenting notes. There is also insufficient space for keyboards and electronic devices for the eUHR. We note that the HCFIP includes renovations of several

[81] Specialty Care Patient #19.

inmate cells in the OHU, but there is no renovation scheduled for the nursing station. This unit needs to be remodeled so that every staff member has appropriate space to work.
During the daytime shift, two officers are assigned to each wing, except for one of the wings which has only one officer. In addition, there are two escort officers. All doors are locked and officers must open all doors. Two officers must be present when a staff member goes into a room of an administrative segregation patient. Patients shower three times a week. Three of the units have showers. Two inmates shower at a time, except for administrative segregation inmates, who shower singly. There are times when clinical staff competes to have officers open the doors. Because nearly half the patients are long-term care patients requiring considerable nursing assistance, an additional officer may be needed so that access is adequate.

Nursing care on this unit was generally good. The nursing program has developed checklists for assisting in care of patients. This is an excellent method to ensure care is being performed. There is a total care checklist and an activity of daily living (ADL) checklist. Nurses use these checklists for patients who have hygiene issues. When a patient has dementia or is unable to care for himself, the nurse develops a total care checklist and an ADL assist list for the patient. These lists guide the nursing assistant in providing hygiene for the patient. Nursing documentation is generally good. There is one area of concern. On the graphic record, nurses document the temperature and pulse oximeter reading in the same section. These are both numbers and at times, we could not distinguish which number was the temperature and which number was the pulse oximeter value. This is a patient safety issue.

Health records on the OHU are inadequate. For this unit, the official health record is a paper record contained in a hard-backed binder. However, provider notes and other documents are occasionally scanned into the eUHR and are not present in the paper record. Hospital records are not consistently in the eUHR or available on the unit. One provider uses cut and pasted notes that are not accurate. Pharmacy notes, reflecting management of anticoagulation, are not present in the medical record. Each of these issues is discussed below.

There is no workspace in the OHU nursing station for the providers to write a note. Therefore, the providers see one patient at a time and then leave the unit to write their notes in an office outside of the unit. This often results in notes getting misplaced. Some provider notes are scanned into the eUHR and are not in the paper record. Other provider notes are in the paper record but are not in the eUHR. Still other provider notes are in both locations. This is dangerous because important information can be missed. During our record reviews on the OHU, a hospital record was not available in the eUHR or paper record. A nurse spent part of a morning attempting to locate the record, which was eventually found in an office space off the unit.

Also, one provider types notes. These typed notes include improperly used cut and pasted items. For example, one patient we reviewed[82] had an infection and had completed antibiotics several days prior to our review. Yet the provider cut and pasted sections of the record from about two weeks previous. On 7/15/13, a provider used cut and pasted notes documenting that the patient needed six more days of an antibiotic that was scheduled to expire on 7/3/13. These notes were written on 7/15/13, but do not make sense because the dates given for expiration of the antibiotic had passed. This resulted in confusion and is unsafe.

Our record reviews of OHU patients revealed the following problems:

- This patient[83] was at California Correctional Institution (CCI) when he was hospitalized from 8/18/12 to 8/28/12 for respiratory failure with pericardial effusions[84] requiring a pericardial window.[85] The pericardial effusion was a complication of prior coronary artery bypass surgery. He had a history of COPD, diabetes, hyperlipidemia and coronary artery disease. When the patient was hospitalized on 8/18/12, he had pneumonia. He developed severe hypoxemia[86] requiring intubation after undergoing the pericardial window procedure. The patient returned to the prison with a chest tube for drainage. When the patient returned to CCI from the hospital, he was housed on the OHU. On 9/10/12, a provider discharged the patient from the OHU to general population. On the day of discharge from the OHU, the patient received a chest x-ray that showed left lower lung infiltrate with pleural effusion. This was signed as reviewed on 9/13/12, but there was no action taken regarding the abnormal x-ray. The following day, a provider in the yard wrote a note stating that the patient still had pain with deep breaths. There was no follow-up of this film and there were no further provider notes at CCI.

  On 10/1/12, the patient was transferred from CCI to CIM. The 7371 transfer form did not note that the patient had COPD. The note documented a thoracotomy and "open heart surgery," but did not document the reason for the surgery. The initial health screening form at CIM only documented COPD, diabetes requiring insulin, hyperlipidemia and a recent CABG as problems. It did not list his recent pericardial window surgery. Furthermore, the nurse who performed the screening did not note that this patient had an abnormal x-ray that had not been followed up at CCI. This history was poor and significantly underrepresented the actual condition of the patient. The patient was not listed as needing immediate attention. The CCI nurse documented that the patient needed chronic care follow-up 12/5/12, two months after transfer. This patient had just been discharged from a hospital for a serious procedure and needed to have had an earlier appointment. This

[82] OHU Record Review #7.
[83] OHU Record Review #2.
[84] Fluid surrounding the heart.
[85] A surgical procedure to drain pericardial fluid.
[86] Low blood oxygen levels.

transfer placed the patient at risk of significant harm by failing to recognize his actual conditions.

Fortunately, despite the 12/5/12 chronic care scheduled appointment, a provider saw the patient on 10/9/12. The provider identified most of the patient's problems, except for the outstanding abnormal chest x-ray, hyperlipidemia and hypertension. The timeframe of the recent pericardial window was not documented and the recent abnormal x-ray was not noted. The provider noted that the patient had recently seen cardiology. The patient denied symptoms. The patient was on 17 medications. The provider ordered a lipid panel, digoxin level and several other blood tests. The problem list did not include a problem for which digoxin was indicated.

During subsequent visits, providers did not consistently list the patient's medications. Providers did not document why the patient was on digoxin.

On 7/9/13, nine months after transfer from CCI, a provider saw the patient urgently for respiratory distress. His oxygen saturation was 80% and the patient had tachycardia. He was sent to a local hospital. He remained in the hospital until 8/2/13.

Upon his return to CIM, the patient was admitted directly to the OHU and placed in airborne isolation with diagnoses of community-acquired pneumonia, possible Mycobacterium avium complex (MAC)[87] and coccidioidomycosis. Nine months previous, the patient transferred from CCI to CIM with an unidentified abnormal chest x-ray. The location of the infiltrate on 9/10/12 was similar to the location of the infiltrate on the July 2013 hospital admission. It is possible that the patient had an unidentified abnormality for nine months.

The provider's admission note to the OHU included a very brief history. The provider's history did not document what tests for MAC and coccidioidomycosis had been performed at the hospital or whether these conditions had been definitively diagnosed. The hospital record was not available on the unit and was not scanned into the eUHR. Therefore, although the patient had been on the unit for five days, the precise status of his condition was not clear. A Tuberculosis Patient Plan (form 7405) was in the eUHR but not in the paper record. This document indicated that the patient had positive acid-fast bacillus smears[88] and that the hospital was waiting for cultures to identify whether this was Mycobacterium avium or Mycobacterium tuberculosis. This was not documented in the initial history and was not present in the paper record. The status of the patient could not be established by review of the medical record on the unit.

[87] A type of infection caused by an organism that is similar to the organism that causes TB. It is not, however, spread by person-to-person contact.
[88] A test to detect the infections caused by mycobacterium. The test does not differentiate between TB and MAC.

When the hospital records were located, additional information was available. Fungal cultures were highly suspicious for coccidioidomycosis, although titers for coccidioidomycosis were negative. Although acid-fast bacilli were also identified, the QuantiFERON[89] and TST were negative. MAC was the probable diagnosis, but the hospital elected not to initiate treatment for either MAC or pulmonary TB until the results of the cultures were available. The patient was started on fluconazole and the x-ray was improving after treatment, indicating that the patient likely had cocci infection.

Assessment

There were problems with the intrasystem transfer process that resulted in delayed care. The abnormal x-ray from CCI had not been addressed either at CCI or at CIM. As noted above, the x-rays in the hospital showed a left basilar infiltrate in the same area as was affected based on the x-ray at CCI in September 2012.

- We noted another patient on the OHU who had problems with the transfer process. This patient[90] was at Wasco State Prison (WSP) where he was being followed for hypertension, benign prostatic hypertrophy and recurrent chest pain with a negative echocardiogram and cardiac angiogram. While at Wasco on 4/30/13, the patient complained of difficulty in urinating and a provider ordered an indwelling Foley catheter by phone. On 5/2/13, a provider saw the patient for follow-up and ordered a routine urology consult. Also, the patient was on four blood pressure medications (HCTZ, carvedilol, lisinopril, and Norvasc), but had repeatedly low blood pressure. The blood pressure was 90/60 mmHg on 5/2/13, but the provider ordered only a slight reduction of HCTZ from 25 to 12.5 mg. The blood pressure was 97/64 on 5/6/13, and no change in therapy occurred.

  On 5/8/13, the patient transferred to CIM. The 7371 health care transfer information note did not indicate that the patient had a Foley catheter or that the patient had a pending urology appointment. The 7277 initial health screening form noted that the patient had a Foley catheter but did not identify the reason for the catheter and did not identify the pending urology consult. There was no evidence that the patient's Foley catheter was inspected upon transfer. This is a transfer problem and a patient safety issue.

  The baseline provider chronic care visit took place on 5/15/13. The provider noted that the patient had a Foley catheter and documented a detailed and thorough history. The patient's blood pressure was 94/64 mmHg so the provider stopped the HCTZ and ordered continued monitoring. The doctor ordered a routine urology referral.

[89] A blood test for TB infection.
[90] OHU Record Review #4.

On 5/24/13, the patient developed a fever to 103° and pulse of 110/minute. A provider saw the patient in the TTA and sent him to a hospital. The patient was diagnosed with a catheter-associated infection with E. coli and pseudomonas. A hospital physician started medication to relieve the urinary obstruction and the Foley catheter was removed. Prostatitis was the initial impression of the hospital physician. The hospital discharge summary documented that the patient had a CT of the abdomen that showed that his kidneys were normal. The CT scan also noted an adrenal adenoma (tumor). The patient returned to prison on 5/28/13. A provider saw the patient in follow-up on 6/3/13. The provider addressed the post-hospital issues but did not document that a urology referral was pending and did not note that the patient had an adrenal adenoma.

A provider saw the patient on 7/12/13. The blood pressure was 99/69 and the lisinopril was decreased from 40 to 20 mg.

On 7/18/13, a urologist saw the patient via telemedicine. He noted the adrenal adenoma that was on the CT scan from 5/24/13. The urologist recommended cystoscopy for the patient's prostatitis, but did not make a recommendation regarding the adrenal adenoma. On 7/22/13, a provider requested a cystoscopy. There was no provider follow-up of the consultation and the adrenal adenoma has not been addressed.

Assessment

This patient was transferred with a Foley catheter, but the transfer summary incompletely summarized his condition. The intrasystem transfer process did not work well. The status of the patient's hypertension was also not documented in the transfer information. CIM providers did not address the patient's adrenal adenoma identified at the hospital.

- We identified a third patient[91] on OHU record review who had problems with respect to the transfer process, along with other problems. This patient is a 56-year-old man who was housed at Avenal State Prison (ASP) with diagnoses of diabetes mellitus with amputation of his left toe for dry gangrene, hypothyroidism, hypertension and atrial fibrillation on anticoagulation. His last INR at ASP had been 3.6 (goal=2-3), but the transfer summary did not indicate that the INR was supratherapeutic. Within a week of arriving at CIM, the first INR was 5.3 and the patient had an episode of rectal bleeding resulting in a preventable hospitalization. Use of checklists in transfers would help to alleviate transferring patients with poorly controlled problems.

  The patient returned to CIM from the hospital but developed Clostridia difficile infection[92] and was re-hospitalized. During this hospitalization, he was found to have decreased blood

[91] OHU Record Review #7.
[92] A bacterial infection that affects the colon, commonly causing diarrhea.

flow to his foot and underwent surgery to widen his tibial artery. Part of the evaluation of persons with diabetic foot ulcers includes evaluation of their peripheral blood flow. This needed to have been done at ASP prior to transfer.

Another problem is that the patient had been on the OHU at CIM for about a month but his INR had not been therapeutic. The provider documented on multiple notes that the patient's anticoagulation was being monitored by a pharmacist. However, there were no pharmacist notes in the record. The facility utilizes a pharmacist to manage anticoagulation, which is a useful adjunct. The pharmacist told us that he gives his notes to the medical records staff for filing. However, we found no notes from the pharmacist in the eUHR or in the OHU paper record. We reviewed the entire record with the pharmacist and could find none of his notes in the record. Also, because the pharmacist was managing the anticoagulation, the provider did not document a note indicating knowledge of the sub-therapeutic INR. This was not good care. If the pharmacist manages the care, he needs to document his care in the medical record. The provider needs to review and oversee that care.

Assessment

There were problems related to the patient's anticoagulation therapy.

Mortality Review

Methodology: We reviewed all 27 CCHCS Combined Death Review Summaries since 2012. Twenty of the deaths occurred in 2012; seven occurred in 2013. We also reviewed selected medical records.

Findings: Nine patients died from end-stage liver disease (ESLD) or a complication of ESLD. Four patients died of cancer, three patients died of myocardial infarction and two patients died of pulmonary fibrosis. The remaining nine patients died of various causes. Not all patients had autopsies, even when the cause of death was not completely certain. This is a large number of deaths and is reflective of the high acuity at this facility.

We identified several serious problems in these death reviews, including:

- Failure to examine a critically ill patient on the OHU for five days
- Failure of a mental health provider to communicate significant findings to medical staff and failure of custody to protect an inmate known to have been physically assaulted
- Failure to have adequate policy regarding amitriptyline[93]
- Failure in two deaths to identify serious illness and take action to treat.

We selected several records for review and identified the following problems:

[93] A medication used to treat depression. It is also effective in treating chronic pain in some patients.

- The patient was a 68-year-old man[94] who died of a rectal abscess with necrotizing fasciitis. He was incarcerated on 9/24/12. He had no identified medical problems except for chronic neck pain due to an old injury. The intake health screening had all boxes checked normal related to mental illness or to the question of whether the inmate appeared disoriented. On 9/24/12, the mental health screener cleared the patient for general population. On 9/26/12, the patient placed a 7362 stating:

  > I repeat stories over and over again and told my cellie that I walked from Blythe CA to San Diego CA. I also need to see the provider for a fractured disk in my upper back, close to the C6 vertebra.

  The nurse reviewing this request referred the patient to mental health. On 9/28/12, a psychologist saw the patient for this request and wrote the following:

  > I/P reported 'My cellie has been smacking me in the eyes and nose, punching me a lot since he arrived. He's been wanting me to be sexual with him. He was washing my face with a washcloth and pushed his thumb hard into my eye. He accused me of ripping up my medication bag and throwing my Naproxene (sic) into the toilet. I need my Naproxene for my back pain. I think my cellie stole my meds. I want a cell change.' He reported he is incarcerated for not reporting to his probation officer. He stated custody staff drove him from Chuckawalla Prison and dropped him off at a bridge in Chula Vista. He said the custody staff took his $200 gate money and only gave him $20 before leaving.
  >
  > Appearance: looks his stated age. Right eye is red and swollen. Thought content: account of event and accusations against cellie are questionable; account of custody staff taking him to San Diego is questionable. Thought Process: nonlinear regarding events leading to assault as well as his release from prison.
  >
  > A: Inmate's account of events leading to his assault is questionable. Cellie's version is markedly different from inmate's, in which cellie reports inmate was urinating on the floor, waking him up several times at night, and flushing his medication in the toilet. Inmate may need further evaluation.
  >
  > P: Notify RC ASU MH staff of further MH evaluation. Custody staff plans to separate him from his cellmate. 115 to be written. He remains GP; continues in RC ASU.

[94] Death Record Review #1.

The mortality reviewer documented that custody did not provide an immediate cell change. A nurse also saw the patient on 9/28/12 because custody referred the patient for injuries. The nurse noted swelling and bruising surrounding the patient's eyes. The patient had no nausea or dizziness or blurry vision. The nurse documented that the patient was oriented to person and place, but it is not clear if the inmate was oriented to time. The nurse documented that she would notify the provider and told the patient to return if he had nausea, blurry vision or headache. A provider did not see the patient, but ordered a facial x-ray. This x-ray was performed 10/3/12 and showed soft tissue swelling and near complete opacification of the left maxillary sinus, which was never followed up. (Opacification is indicative of fluid in the sinus. This can be due to a number of conditions, such as infection or trauma.)

There were no further clinical encounter notes. The patient was incarcerated for 10 days and did not see a provider for an intake history and physical and did not see a psychiatrist despite bizarre affect and being beaten.

On 10/3/12, a nurse obtained a telephone order from a provider to admit the patient to a mental health crisis bed because the inmate was defecating and urinating on himself and appeared confused. This was a clinical error. The provider needed to have immediately evaluated the patient or referred him to a hospital for evaluation. The order was written at 3:40 p.m. Later, at 8:36 p.m., a nurse wrote an order to transfer the patient to a local hospital for "slow onset dementia & hx [history] of head trauma." The patient was subsequently admitted to a local hospital. It appears that the patient had not been evaluated at CIM prior to transfer to the hospital.

A physician in the hospital described the patient as:

> A 68 year old inmate with no past medical history brought in with confusion and fecal incontinence. Apparently, about a week ago he was involved in an altercation with another inmate in which he was hit with a cord. He denies any intervening complaints or pain. Apparently, they noticed that he was more confused, was unsteady on his feet and had fecal incontinence, all of which were different from his baseline. Upon arrival to the TCMC ED he also noted a history of anal rape during the incident a week ago, though he did not offer this information freely.

The patient was delirious while hospitalized and had necrotizing fasciitis of his buttock with rectal perforation. Surgeons performed significant debridement of the wound. He needed a wound VAC.[95] He remained disoriented and the hospital diagnosed mild dementia. A neurologist saw the patient and felt he was delirious due to sedating medication. A CT of

[95] A vacuum dressing that promotes wound healing.

the brain showed no active hemorrhage or masses, but did show tiny subdural hematomas[96] or hygromas.[97]

The patient was transferred back to CIM on 10/18/12 with a scheduled appointment for surgery to close his buttock wound with a skin flap on 10/29/12. A provider wrote an OHU admission note on 10/19/12, the day after the patient arrived from the hospital. The note was very thorough. The provider documented that the patient had mild to moderate dementia diagnosed at the hospital. The provider noted that the dementia and confusion was "delirium and benign prognosis." However, the provider's evaluation was not consistent with the hospital diagnosis of benign dementia. The provider described the patient in his OHU admission note as:

> Very confused and not able to identify himself, place, time of day or date, and was not able to give an appropriate history. Even on being questioned positively whether he was at the acute care facility, he was not sure. He even did not remember that he had the surgery or that he does have an active open wound on his lower back and thigh. Repeated questioning about his past medical history, social history, family history and review of systems did not yield any significant information. He even did not respond with 'I do not know' but simply remained blank with an empty gaze.

The patient had a Foley catheter, had anal incontinence, and a large buttock wound. This was an extremely complex and difficult patient. Even the provider noted, "With all of these components combined, he requires a higher level of intensive nursing care for his wound." We agree. It was not appropriate for the provider to accept this patient back to CIM. If the provider believed that the patient required a higher level of care, we question why the patient was accepted back to CIM.

From the time of admission to the OHU, the patient was confused and incontinent. He was unable to sign his signature to the OHU admission note. The initial nurse note on 10/18/12 described the patient as oriented only to person. On 10/19/12, a nurse note documented the patient alert and oriented x 3. The same day another nurse documented that the patient was oriented only to himself. The patient removed his wound VAC on 10/20/12 and was found on the floor. He refused to shower and was agitated and combative. The patient continued to pull off his dressings. He remained disoriented. The provider discharge summary of 10/24/12 documented that the patient had attempted to eat his own excrement. Aside from the OHU admission note on 10/19/12 and the discharge note on 10/24/12, providers did not evaluate the patient on the OHU. This patient needed to have been seen daily.

[96] A collection of blood on the surface of the brain.
[97] A collection of fluid on the surface of the brain.

The patient remained confused at the hospital. He developed MRSA pneumonia and acute respiratory failure. The patient was ultimately transferred to a long-term care facility where he remained unresponsive for months. After multiple complications at the long-term care facility, the patient died on 5/13/13.

The CIM staff was not able to adequately care for this patient's wound and did not have the resources to diagnose the reason for his continued confusion and ultimately sent the patient back to the hospital. It was not appropriate for this patient to be housed in the OHU, as he needed a higher level of care. In our opinion, the failure of providers to evaluate the patient on a daily basis contributed to a delay in sending this patient to a higher level of care.

Assessment

A reviewer completed the Combined Death Review Summary, but the Death Committee had not yet reviewed this case. We agreed with many of the reviewer's findings. The reviewer found that the 9/28/12 nurse telephone consultation with the provider was not thorough and suggested that the provider failed to ask the nurse sufficient questions about the patient. The reviewer stated that this was a missed opportunity to identify the patient's problem. We agree, but also believe that the provider should have evaluated the patient when informed of his injuries.

The reviewer also was critical of the nurse for not taking a more thorough history when the patient reported for evaluation on 9/28/12 with facial injuries. We agree.

The reviewer also reported a systemic concern that the patient required a higher level of care than was provided on the OHU. We agree. CCHCS needs to perform a root cause analysis on the issue of failure to provide an appropriate level of care.

The reviewer was critical of the mental health professional who did not advocate for the patient when the patient alleged sexual harassment. We agree, but also believe that this episode demonstrates a greater problem with communication between mental health staff and medical staff on significant patient care issues. The mental health professional did not communicate with medical staff significant information about the inmate's complaint of sexual harassment and altered mental status. We believe the psychologist needed to communicate his findings to medical staff. If this had occurred, the patient would probably have been referred to a higher level of care in a timelier manner.

The reviewer was critical of custody for not providing the inmate with an immediate cell change. We agree.

The reviewer was critical of a provider for approving admission to a mental health crisis bed because the patient was defecating and urinating on himself and appeared confused without a medical assessment. We agree.

The primary cause of death was listed as complications from a rectal abscess. However, the patient's primary cause of death appeared to us to be complications of rape with rectal abscess as a contributing cause of death. The death may have been a homicide. The death was ruled not preventable. We disagree. Our opinion is that it was possibly preventable.

We also note several other problems not mentioned by the reviewer. There was no collaboration with custody in this review. Custody needed to participate in an investigation as to why the patient was not provided an immediate cell change in order to protect the patient. Also, the reviewer did not comment on the lack of provider evaluation on the OHU between 10/19/12 and 10/24/12. During this time, the patient was critically ill, confused, combative, and nurses could not manage his wound. Yet there were no provider evaluations. Providers needed to have seen the patient daily.

- Another patient[98] was a 67-year-old man with a history of hypertension, hyperlipidemia, hepatitis C, gout and sciatica. On 11/2/11, the patient placed a 7362 request specifically to obtain amitriptyline, which he related had helped with his leg pain. A nurse evaluated the patient and assessed low back pain radiating to his hip and leg. The nurse obtained a phone order for amitriptyline as a keep on person medication. A provider did not evaluate the patient. Amitriptyline is known to cause cardiac conduction changes and is recognized in correctional medicine for its overdose potential. For this reason, many correctional systems restrict this medication and use it only as directly observed therapy. This patient requested the medication, was prescribed the medication without a provider evaluation and was given the medication keep on person. This was not safe care.

  At a later chronic care visit on 12/20/11, a provider did evaluate the patient with respect to use of the amitriptyline. However, the provider continued the medicine as keep on person. On 10/27/12, medical staff found the patient unresponsive in his cell. He was dead. The initial mortality reviewer's opinion was that the death was not preventable. He identified no problems. The Death Review Committee requested autopsy results, which confirmed that the patient died of a lethal level of amitriptyline. The Death Review Committee notified the CEO and recommended that he discuss with the PIC that amitriptyline not be a keep on person medication.

[98] Death Record Review #2.

Assessment

The Death Review Committee did not rule whether this death was preventable. We believe it was preventable.

We identified several problems. Potentially dangerous medications must not be given by phone orders without provider evaluation. There would have been no problem with waiting to start this medication until the provider could have seen the patient. There needs to be a statewide policy that amitriptyline be restricted to dose-by-dose medication only. It cannot be left up to individual facilities to do this. Finally, this death emphasizes the importance of autopsy. This serious problem would not have been identified without an autopsy.

- Another patient was a 69-year-old man[99] with a history of asthma, epilepsy, hypertension and prior stroke. On 9/13/11, he developed fever, headache, flank pain and nausea and was seen in the TTA at ASP. Initially, he was treated with an antibiotic for a kidney infection. However, the following day, on 9/14/11, a provider saw the patient in follow-up in the TTA. The provider documented a history of cough and chest pain and ordered an x-ray, which showed left lower lobe pneumonia. The provider ordered antibiotics and serology for coccidioidomycosis, which was positive. The provider diagnosed the patient with primary coccidioidomycosis infection and placed the patient on fluconazole. A follow-up x-ray on 10/28/11, after starting fluconazole, was unchanged.

  On 11/1/11, the patient submitted a 7362 complaining of headache, but apparently refused to see a nurse for the complaint. On 11/22/11, a provider saw the patient and documented that the patient denied fever or headache, even though the patient placed a 7362 complaining of headache three weeks previous. On 12/5/11, a provider saw the patient again, but this time documented that the patient "continues to have mild cough and mild headache." The provider documented the head and neck examination as "essentially normal." The provider documented that there were no meningeal signs.[100] On 12/29/11, a provider again saw the patient, who complained of occasional headache. There were no meningeal signs. On 1/18/12, a provider saw the patient again and the patient had no headaches. On 3/14/12, a provider saw the patient again and documented that the patient "has nuchal [in the area of the neck] headache, marginal appetite, myalgia, anorexia, fatigue that are persistent." The patient remained on 400 mg of fluconazole.

  On 4/20/12, the patient placed a 7362 stating that he was confused and could not think clearly. The nurse referred him to mental health. He was not referred to a provider. On 5/15/12, the patient placed another 7362 for problems sleeping, loss of appetite and

[99] Death Record Review #3.
[100] Physical examination findings, such as a stiff neck, that are concerning for meningitis.

concentration. The nurse referred him to mental health. On 6/6/12, a provider saw the patient but did not ask about headache.

On 6/20/12, the patient transferred to CIM. He was still on 400 mg of fluconazole. The ASP provider treatment plan for coccidioidomycosis was not clear. The provider at Avenal did not refer the patient to see an infectious disease specialist.

On 7/11/12, a nurse saw the patient for a headache and dizziness. The nurse scheduled a follow-up with a provider in 7-10 days. On 7/18/12, a provider saw the patient, but failed to ask the patient about his headaches.

On 8/23/12, the patient placed a 7362 for "feeling off balance and as though one might collapse or faint." When a nurse saw the patient on 8/28/12, the nurse documented that the patient did not have a headache. The patient was not referred to a provider.

On 10/3/12, a nurse saw the patient urgently for a headache. The nurse documented that the headache was present for seven days. The headache was a 7 on a pain scale of 1-10. There was a provider telephone note in the eUHR documenting that the patient needed to be seen in the morning. A provider did not see the patient the following day. Instead, a nurse saw the patient. The nurse documented that the headache was better and that the patient should continue Tylenol.

On 11/9/12, the patient had a pulsating headache with dizziness and blurry vision. He had fallen and sustained bruises and abrasions. This was a problem because he was on Plavix, an anticoagulant for his prior stroke. A provider saw the patient and noted that the patient had a fever to 101°F. and had been febrile for a few days. The provider documented that the patient had a headache. The patient was transported to a local hospital. The hospital record was not available in the eUHR.

On 11/10/12, the patient returned from the hospital and was admitted to the OHU. The provider documented that the patient had been recently hospitalized and discharged from the emergency room at a local hospital with syncope and closed head trauma. The provider documented that a CT of the brain was "unremarkable." The provider documented that the patient was not febrile at the emergency room in the hospital, even though prior to transfer to the hospital the patient had a fever as high as 102°F. The provider did a thorough evaluation but did not investigate the headache and fever with respect to the coccidioidomycosis infection. When the provider saw the patient again on 11/14/12, the patient told the provider that he did not have a headache.

On 11/19/12, a provider documented that nurses placed the inmate's mattress on the floor because the patient was climbing out of bed. Custody was concerned because the patient was frequently getting out of bed and was unsteady on his feet. The patient denied having a headache. The provider noted that the patient had a broad based gait and was ataxic and that he might have normal pressure hydrocephalus.[101] Although the provider noted that the patient had coccidioidomycosis infection, he did not include that as a reason for the patient's fever, headaches and altered mental status. If hydrocephalus was a consideration, the provider needed to send the patient to a hospital.

On 11/21/12, a provider documented that the patient needed assistance to eat, had urinary incontinence, had fallen and had a broad based gait. He ordered an MRI to evaluate these problems. By then, the provider noted that the patient's presentation was consistent with coccidioidomycosis meningitis. He intended to perform a lumbar puncture, but when he attempted to discuss this with the patient, the patient could not speak. The patient was not able to intelligibly communicate with the provider. In his assessment, the provider concluded that the patient might have coccidioidomycosis meningitis and sent the patient to an outside hospital for evaluation. The patient had an MRI consistent with hydrocephalus and a lumbar puncture confirmed coccidioidal meningitis. The patient died 12/16/12 of coccidioidomycosis meningitis.

Assessment

The Death Review Committee concluded that the death was not preventable. We felt that the death was possibly preventable. The reviewer found that medical standard of care was met with one exception, when medications for hypertension, epilepsy and lipid disorder were altered without a timely follow-up. The Mortality Review Subcommittee additionally was critical of the local hospital on 11/9/12 for not performing a lumbar puncture. The Mortality Review Subcommittee also recommended that a case conference for all providers be conducted on overall care and management of coccidioidomycosis, because there was a possible delay in the patient's diagnosis.

We do not completely agree with these findings. This patient complained of headache on eight separate occasions dating from September 2011 until his final admission in November 2012. Providers never performed a reasonable history regarding these headaches. Furthermore, providers did not draw a conclusion that the persistence of the headache over a year might be associated with coccidioidomycosis. The patient also had three other complaints of confusion or problems thinking in April, May and August 2012. Nurses referred the patient to mental health on two occasions, and in August a nurse did not refer the patient to a provider. Providers at both ASP and CIM failed to follow up on headache

[101] An abnormal buildup of cerebrospinal fluid in the brain's ventricles, or cavities.

symptoms. Evidence of central nervous system involvement was present for over a year. Multiple providers were involved.

We do agree with the recommendation of the Mortality Review Subcommittee to provide training to providers on overall care management of coccidioidomycosis. In addition, we add a recommendation that all patients with coccidioidomycosis see an infectious disease specialist initially and that infectious disease specialists continuously manage complex coccidioidomycosis cases. As this case demonstrates, multiple physicians failed to recognize symptoms referable to coccidioidomycosis until the patient was critically ill. It appears to us that the level of expertise of staff physicians is insufficient to manage this disease. Although this patient was on fluconazole, which is frequently prescribed for coccidioidomycosis meningitis, he clearly was failing on this antifungal agent and needed additional therapy. A specialist needed to be involved in the management of this patient.

- Another patient was a 66-year-old man[102] who had a history of prostate cancer and hyperlipidemia. On 1/27/12, a provider noted LDL cholesterol of 124 but did not initiate treatment. Instead, the provider recommended dietary changes and a three-month follow up. A provider saw the patient next on 5/8/12 and ordered another LDL cholesterol level. The follow up LDL cholesterol was elevated (128). On 6/5/12, a provider noted LDL cholesterol of 128 and started a low dose of Lipitor but did not assess cardiac risk factors. The patient was rescheduled for 30-60 days.

  On 11/2/12, the patient submitted a 7362 complaining of shortness of breath while walking. A nurse evaluated this complaint on 11/3/12. The history was not thorough. The nurse documented that there were no provider orders. It was not clear from the note whether the nurse had a conversation with a provider about the patient. No follow-up was scheduled. An electrocardiogram was not done. Shortness of breath can be a symptom of myocardial ischemia. The patient needed an immediate evaluation.

  On 11/19/12, the patient submitted a 7362 for shortness of breath and chest pain. A nurse evaluated the patient the following morning and documented that the patient complained of shortness of breath and chest pain with exercise and when walking. The nurse noted that the provider wanted the patient to be seen on a routine basis. This was a clinical error. The patient had possible coronary ischemia. The patient needed an immediate evaluation of his chest pain and referral to a higher level of care for evaluation for new-onset angina.

  On the morning of 11/26/12, a nurse again saw the patient for a complaint of chest pain. The patient gave a history of chest pain on and off for two months. The patient described mid-chest pain with a sensation of burning and feeling like indigestion. It was better with

[102] Death Record Review #4.

changing position but was worse with exertion. The pain was accompanied by nausea. The nurse checked the box that stipulated that the nurse was to refer the patient to a provider stat [immediately] if the patient was older than 35 or had a history of high blood lipids, which was the case for this patient. The nurse discussed the case with a provider, who recommended a 2-4 week follow-up. The provider did not order an electrocardiogram. This was another error of clinical judgment. The patient had classical symptoms of angina. The provider needed to evaluate the patient immediately and refer the patient to a higher level of care for evaluation for new-onset angina.

On 11/28/12, the patient arrived in the clinic urgently for shortness of breath. A provider saw the patient, who described shortness of breath when walking as little as one block. He also described mid-epigastric pain, which the patient described as heartburn. The provider did not document cardiac risk factors or order an electrocardiogram. The patient's pulse was initially 112, but dropped to 84 after five minutes. The provider ascribed the chest pain to gastroesophageal reflux or chronic obstructive pulmonary disease and gave a trial of an inhaler. He also ordered antacids. The provider ordered a 1-2 week follow-up. This was another clinical error. The patient had symptoms consistent with new-onset angina. The provider needed to document a better history, including cardiac risk factors. The provider needed to order an electrocardiogram. The patient needed referral to a higher level of care.

Later the same day at 8:50 p.m., a nurse evaluated the patient urgently for difficulty breathing. The nurse was unable to obtain a blood pressure. The patient was sent to a local hospital, where he died.

Assessment

The Mortality Review Subcommittee concluded that this death was possibly preventable. We believe it was preventable. The reviewer of this case for the Combined Death Review concluded that the patient received overall good care with one departure from the standard of care. The departure of care consisted of two episodes when the provider did not consider acute coronary syndrome when a nurse called the provider on 11/20/12 regarding exertional chest pain and when a provider saw the patient on 11/28/12 for mid-sternal chest pain. The reviewer correctly noted that the provider treated the patient with antacids without sending the patient to a higher level of care. We agree with these comments. We identify four episodes (11/2/12, 11/19/12, 11/26/12 and the early afternoon of 11/28/12) when the patient complained of symptoms related to acute coronary syndrome. The patient was 66 years old and had high blood lipids. He needed to have had a full evaluation, including an electrocardiogram, at each of these encounters. Moreover, since his symptoms were consistent with new-onset angina, he needed to be sent for a higher-level evaluation. These were serious errors. We agree with the Mortality Review Subcommittee's referral of this case to the Peer Review Subcommittee.

- Another patient[103] was incarcerated on 11/26/12 at Wasco State Prison (WSP). On 11/27/12, a nurse practitioner evaluated the patient urgently in the TTA for shortness of breath and cough. On examination, the nurse practitioner noted expiratory wheezing with a pulse oximeter reading of 95%. The nurse practitioner reviewed the chest x-ray results and consulted with a physician. The nurse practitioner ordered prednisone, Spiriva and antibiotics. The nurse practitioner also ordered coccidioidomycosis titers.

  A provider saw this patient on 11/30/12 in follow-up from the TTA visit. The provider documented that the patient had chronic obstructive lung disease (COPD), hypertension, heart failure and coronary artery disease. The provider noted that the TTA visit was for an exacerbation of COPD for which the patient received steroids and antibiotics. The provider did not document the patient's oxygen saturation. The patient told the provider that he felt better. The provider ordered follow-up in 180 days. This was not good care. This patient was not well and had a recent exacerbation of a serious disease. A chronic illness follow-up of 180 days was inappropriate.

  A positive coccidioidomycosis titer was reported on 12/1/12. A provider completed the initial history and physical on 12/3/12 and identified a 25-year history of COPD, heart failure, gout, hypertension and hepatitis C infection. The provider documented that the patient could only walk a few feet due to his COPD and ordered a wheelchair. The provider documented that the patient used oxygen intermittently in the community. An initial screening chest x-ray showed thickening of a minor fissure and prominence of lung markings with evidence of emphysema. The provider did not note the positive coccidioidomycosis test.

  On 1/10/13, a provider saw the patient and noted that the coccidioidomycosis titer was 1:4 and started fluconazole. The provider did not document the rationale for treatment with fluconazole. The provider documented a normal physical examination. The provider did not document a history of symptoms for coccidioidomycosis or assess for risk factors. (Most patients with cocci get better without treatment.) The provider discontinued the wheelchair, ordered Bactrim for bronchitis and started 400 mg of fluconazole for three months with a follow-up of 180 days. The provider did not document why he discontinued the wheelchair, as this patient could not walk far without shortness of breath. The provider also did not assess whether the patient needed continuous oxygen. A six-month follow-up was not appropriate because the patient had serious poorly controlled COPD and had recently been started on fluconazole for coccidioidomycosis.

  The patient transferred to CIM from WSP on 1/29/13. The 7371 transfer information form did not include coccidioidomycosis as a problem, but did document that the patient was at

[103] Death Record Review #5.

elevated risk for valley fever. The nurse noted that the patient had a chronic clinic visit scheduled for 7/10/13, almost six months from the date of transfer. The 7277 initial health screening included gout, heart failure, hypertension, hepatitis C and COPD as problems. Coccidioidomycosis was not identified as a problem, even though the patient was still on fluconazole. A six-month appointment for a patient with these problems was inappropriate. WSP staff needed to have documented that this patient needed an expedited appointment.

Within two days of transfer, on 2/1/13, the patient placed a 7362 for shortness of breath and chest tightness. A provider evaluated the patient. The patient had a productive cough but no fever. He could only walk half a block before developing shortness of breath. The provider documented that the patient had coccidioidomycosis, but took no history of the illness and did not document the indication for the fluconazole or the expected duration of therapy. The provider adjusted the patient's medications, and ordered antibiotics and steroids. The provider needed to consider placement on the OHU because of the patient's condition.

A provider saw the patient briefly for follow-up on 2/7/13. The patient had shortness of breath after exertion. The provider sent the patient to a hospital emergency room to get a blood gas. When the patient arrived at the hospital, the patient was diagnosed with pneumonia and placed on prednisone and antibiotics, which the patient was already taking. After return from the hospital, the patient was admitted to the OHU and discharged in two days back to general population.

A provider saw the patient on 2/12/13 for an initial chronic care visit, almost two weeks after transfer. There had been two urgent care visits and a hospital emergency room visit before this first chronic care visit. The provider noted that the patient was on fluconazole, but took no history of coccidioidomycosis symptoms. The provider also did not identify risk factors for coccidioidomycosis. Although the patient described shortness of breath walking a short distance, he had no other abnormal symptoms. The provider noted that the patient had recently been in the hospital. The provider noted oxygen saturation was 94% on room air. The provider was going to see the patient again in 1-2 weeks. With respect to the positive coccidioidomycosis titers, the provider noted this and referred the patient to an infectious disease specialist for advice on whether to continue to treat the patient.

On 2/15/13, a nurse urgently evaluated the patient for coughing and sweating. The patient was wheezing and complained of chills and chest pain. A provider saw the patient and took a very thorough history and performed a thorough physical examination. The provider diagnosed exacerbation of COPD but did not believe the patient needed either OHU placement or hospitalization. We disagree with the judgment of this provider. For a patient with frequent exacerbations of COPD who is having difficulty walking, OHU placement is the best strategy to monitor the patient.

On 2/20/13, a provider saw the patient on an emergent basis. The patient had a pulse of 102 and an oxygen saturation of 88% on room air with a respiratory rate of 24 with jugular venous distention,[104] rales[105] and wheezing. He was sent to a local hospital. While at the hospital the patient deteriorated, developed complications including an ileus,[106] and eventually died on 3/10/13. The cause of death was not known because an autopsy was not performed.

Assessment

The Combined Death Review Summary noted two deficiencies. Both involved scheduling of 180-day appointments for a patient who had serious uncontrolled chronic illness. We agree with these comments. The Mortality Review Subcommittee concluded that the death was not preventable. We agree.

However, we noted multiple other problems with patient care, mostly at WSP. A provider started the patient on treatment for coccidioidomycosis without clear indication. The patient never saw a specialist for this illness. A CIM provider eventually referred the patient to an infectious disease specialist, but the patient died before this occurred. The WSP provider's treatment goals for this condition were not clear. Also, this patient had an exacerbation of COPD just prior to transfer to CIM and within two days of transfer, the patient had another emergency related to his COPD. WSP did not appropriately transfer this patient. There was no documented physician-to-physician communication about a very sick patient. The transfer summary was incomplete; it did not include information about coccidioidomycosis and did not describe the severity of the patient's COPD. The transfer summary also did not include that the patient had a recent exacerbation. This put the patient at risk.

This patient also, in our opinion, needed to be housed in a higher level of care. He could not walk more than a block and had frequent exacerbations resulting in hospitalization. He had multiple emergency evaluations while housed in general population. His condition did not improve while in general population. He needed closer observation.

Lastly, an infectious disease specialist needed to be involved in the management of this patient's coccidioidomycosis. This patient had significant risk for disseminated coccidioidomycosis because of his COPD and because he was frequently on steroid therapy for his uncontrolled COPD. The providers at CIM were confused as to whether treatment needed to continue. The WSP providers needed to request infectious disease consultation

[104] A finding usually associated with heart failure.
[105] An abnormal coarse crackling sound heard on auscultation of the chest, usually caused by the accumulation of fluid in the lungs.
[106] A blockage of the intestines caused by a lack of peristalsis, the pumping action of the intestines

> early in the course of this man's illness because he was a complicated patient. Whether coccidioidomycosis contributed to his death was not clear because an autopsy was not performed.

Internal Monitoring and Quality Improvement Activities

Methodology: We reviewed the OIG report, and internal monitoring and quality improvement meeting minutes.

Findings: We were provided Emergency Medical Response Review Committee Meeting minutes for January to June 2013; Medication Management Committee Meeting Minutes from December 2012 to May 2013; Morbidity and Mortality Review Committee Meeting Minutes for June and July 2013; and Access to Care Measures (AMAT) Reports for January to June 2013. There is no formal Infection Control Program per se. This is a patient safety issue, as this program should monitor nosocomial infections.

With respect to EMRRC meeting minutes, we note that they generally include a description of the emergency event with related timelines. There is limited documentation of opportunities for improvement. In the June 2013 minutes, the following statement was documented regarding a problematic case:

> Nurse Assistant documented abnormal vital signs and notified the RN. The RN failed to notify the physician, and therefore progressive discipline was initiated. We also noted that vital signs in the OHU are completed once every 24 hours unless there are triggering issues. We noticed that vital signs are completed more frequently than indicated and nursing supervisors are correcting this problem.

This statement identifies vital signs measured more frequently than per policy as a problem, with nursing supervisors taking action to correct it. We do not understand the rationale for identifying more frequent vital signs as problematic.

Also in the June 2013 EMRRC minutes, the two code II's were identified as delayed longer than 45 minutes but not affecting the outcome of the patient care. However, there is no discussion or analysis of the reasons for the delay and any action taken to prevent such delays in the future.

Medication Management Committee Meeting minutes are skeletal and contain no meaningful discussion or root cause analysis of identified pharmacy and medication problems such as warfarin errors and lost medications. For minutes that documented the start and adjournment time, the meetings lasted approximately 45 minutes, which is insufficient time to address the identified issues and expect meaningful progress. There is no list of attendees for the meeting.

Recommendations

Organizational Structure, Facility Leadership and Custody Functions
Human Resources: Staffing and Facility Mission Hiring and Firing, Job Descriptions

1. CCHCS should re-evaluate staffing at CIM in light of the increase in high-acuity patients at this site.
2. CCHCS should evaluate CIM's capacity with respect to treating inmates with chronic diseases and other conditions requiring medical accommodations and collaborate with CDCR to ensure that CIM does not receive inmates requiring accommodation beyond its capacity.
3. CCHCS should modify statewide policy to include the Court-ordered physician clinical competency policies and to incorporate those policies into existing practices.
4. CCHCS-appointed staff should investigate personnel issues instead of OIA.

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

1. Budgets should be based on actual need and should be actively managed.
2. Staff responsible for the HCFIP should evaluate the OHU nursing station and expand renovations to include that unit.
3. Staff responsible for the HCFIP should move forward with their construction plans.
4. A 5-S[107] method of standardizing clinics and removing clutter should be instituted at this facility.

Policies and Procedures

1. CIM medical leadership should revise local operating procedures to be specific to CIM.
2. CIM medical leadership should develop an OHU local operating procedure.

Reception and Intrasystem Transfer

1. CIM health care leadership should stop the practice of performing health screening in the booth and conduct screenings in the medical clinic across the hall.
2. CIM health care leadership should ensure that medical reception history and physical examinations are completed within seven days of arrival. Optimally, laboratory testing based upon the patient's medical history should be ordered and performed so that results are available at the time of the physical examination.
3. CCHCS should conduct a root cause analysis of transfers of patients who are hospitalized within a month of transfer to discover whether there are patient safety concerns in these transfers.

[107] 5 S is the name of a workplace organization method used in lean manufacturing methods. The 5 S phases consist of sorting, set in order, systematic cleaning, standardizing and sustaining.

4. Nurses and providers should completely review health records at the time of arrival to determine what continuity of care is required for the patient.

Access to Care

1. Nurses should see patients with symptoms, including patients with urgent dental and mental health complaints, unless the respective disciplines can see the patient in the same time frame.
2. Nurses and providers should document all clinical examinations in the health record.
3. Providers and nurses should improve the quality of the medical history, review of systems and physical examinations. Providers should document the details of their clinical findings and refrain from using "WNL" (within normal limits) as it provides insufficient information about the extent, thoroughness and quality of the examination.

Infection Control

1. CIM should develop an infection control program with regular meetings. CCHCS and CIM should evaluate the role of the CCHCS public health nurse. The public health nurse should provide a greater role in infection control activities at the facility, including managing MRSA surveillance and infections on the OHU.
2. CIM medical leadership should review tuberculosis surveillance and screening procedures to ensure that they are adequate.

Chronic Disease Management

1. CIM health care leadership should develop a corrective action plan to address the problems identified with the management of patients with chronic illnesses.
2. The pharmacist assisting in anticoagulation management should write a clinical note for all encounters including interviewing patients for complications of warfarin therapy. These should be filed in the medical record.
3. CCHCS should reconsider the time intervals of INR testing for patients with subtherapeutic INR.
4. CIM should consider addition of point-of-care testing of INR in anticoagulation management.

Pharmacy and Medication Administration

1. Intrasystem Transfer issues related to medications is a statewide issue that CCHCS should study under the auspices of quality improvement to identify root causes and develop effective remedial strategies.
2. CIM health care leadership should ensure that nurses adhere to standards of nursing practice with respect to medication administration. Nurses should refrain from the practice of pre-pouring medications into improperly labeled envelopes.

Specialty Services/Consultations

1. CIM health care leadership should identify and correct the issues related to timeliness of specialty care.

Specialized Medical Housing: OHU/CTC/GACH

1. CIM medical leadership should correct medical record deficiencies on the OHU. All documents should be filed in the medical record and be available to providers and nursing staff.
2. CIM nursing leadership should correct documentation problems on the graphic record with respect to temperature and pulse oximeter readings.
3. The CME should ensure that patients on the OHU who are acutely ill are seen as often as necessary, even if the interval is daily.
4. CCHCS and CIM medical leadership should conduct root cause analysis to evaluate why patients on the OHU unit are not provided a higher level of care when necessary.

Mortality Review

1. CCHCS should undertake a review of the mortality review process. Court Experts would like to participate in an evaluation of the review process. Review of the process should result in:
    a. Involvement of local institutional leadership in performing the initial mortality review or collaborating in a meaningful way on mortality review.
    b. Integration of the corrective action plan into the Quality Improvement program at the institutional level.
    c. Establishment of procedures for follow-up of corrective action plans.
    d. Identification of responsible Central Office staff for ownership of CCHCS system wide identified problems and a mechanism to report on progress of corrective action.
    e. Incorporation of professional practice issues into staff training and continuing education.
    f. Custody staff should participate in mortality review when there is custody involvement in a patient's death.