First Monitoring Report of the Medical Consent Decree

Mays et al. v. County of Sacramento

Case No. 2:18-cv--02081

Submitted
January 20, 2021

Submitted by
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Contents

Introduction

On July 31, 2018, Plaintiffs Lorenzo Mays, Ricky Richardson, Jennifer Bothun, Leertese Beirge, and Cody Garland filed a federal class-action complaint[1] alleging that Defendants: failed to provide minimally adequate medical and mental health care to incarcerated persons in its jails; imposed harmful and excessive use of solitary confinement in violation of the Eighth and Fourteenth Amendments to the US Constitution; and discriminated against individuals with disabilities in violation of the American with Disabilities Act (ADA) and section 504 of the Rehabilitation Act.

On October 18, 2018 the parties entered into a Consent Decree and Defendants agreed to implement measures set forth in a Remedial Plan, to be monitored by court-appointed Court Experts.[2] Within 180 days after approval of the Consent Decree, Defendants are to provide Plaintiffs' counsel and Court Experts a Status Report which includes a description of steps taken by Defendant to implement each provision set forth in the Remedial Plan and specifies provisions of the Remedial Plan which have not yet been implemented. With respect to the provisions of the Remedial Plan not yet implemented, Defendant's Status Report needs to: describe all steps taken by Defendant toward implementation; set forth with as much specificity as possible those factors contributing to non-implementation; set forth a projected timeline for anticipated implementation based upon the best information available to Defendant. Every 180 days thereafter, Defendants are to provide Plaintiff's counsel and Court Experts an updated Status Report addressing each item of the Remedial Plan and shall specify a compliance assessment for each provision of the Remedial Plan.[3]

Within 180 days of the Consent Decree, Court Experts are to conduct monitoring site visits and produce compliance reports for their respective areas. Due to the impact of the COVID-19 pandemic, in April 2020, the parties agreed to postpone on-site visits. In July 2020, the parties requested the Medical Court Experts[4] to conduct an evaluation of the County's response to COVID-19. The Court Experts conducted an evaluation and submitted a report to the parties on October 26, 2020.

This first monitoring report was limited by the lack of ability to conduct an on-site visit due to COVID-19 and lack of timely document production by the County. Following my draft report, on 1/12/2021 the County produced the Mays Second Status Report and provided updated policies and procedures. I used these documents to update the draft report findings, recommendations and compliance assessments. I thank Sandy Damiano Ph.D., Deputy Director of the Department of Health Services, Primary Health Division, Deputy Chief Santos Ramos, Sacramento Sheriff's Office, and their staff for their assistance and cooperation in completing this review.

[1] Mays et al. v. County of Sacramento, Case No: 2:18-cv-02081-TLN-KJN.

[2] Court Experts are Lindsay M. Hayes, suicide prevention expert and Mary Perrien LCSW, mental health expert.

[3] On 6/19/2019, the Consent Decree was filed with the Court.

[4] Michael Rowe MD was a Court Expert at the time of the request, but resigned prior to completion of the report.

Compliance Definitions

The Consent Decree offers limited guidance to the court-appointed experts regarding the measurement of compliance with the remedial plan, simply stating that the Defendants are in substantial compliance or not in substantial compliance with an individual provision. The term "substantial compliance" was not defined. The Consent Decree, however, does state that the "Defendant may, after conferring with Plaintiffs' counsel, request a finding by the Court that the Defendant is in substantial compliance with one or more components of the Remedial Plan and has maintained such substantial compliance for a period of at least 12 months."[5] In an effort to more accurately measure compliance with the provisions of this Consent Decree, as well as to provide guidance to the parties, the court-appointed experts subsequently decided to create a three-tier system for the measurement of compliance. Each of the experts have utilized such a system in prior federal court monitoring assignments. As such, the court-appointed experts agreed to the following definitions for compliance measurement for each of the provisions in this Remedial Plan:

Substantial Compliance: Defendants have achieved compliance with most or all components of the relevant provision of the Consent Decree for both the quantitative (e.g., 90% performance measure) and qualitative (e.g., consistent with the larger purpose of the Decree) measures. If an individual compliance measure necessitates either a lower or higher percentage to achieve substantial compliance, it will be so noted by the expert. Compliance has been sustained for a period of at least 12 months.

Partial Compliance: Defendants have achieved compliance on some of the components of the relevant provision of the Consent Decree, but significant work remains. A minimum requirement is that for each provision, relevant policies and procedures must be compliant with Remedial Plan requirements, contain adequate operational detail for staff to implement the policy, staff are trained, and the County has begun implementation of the policy.

Non-Compliance: Defendants have not yet addressed the requirements of a provision of the Consent Decree or have not made substantive progress.

[5] Mays Consent Decree. Page 11.

Facility Description

The Sacramento County Jail is comprised of two adult jails, the Main Jail (MJ) and Rio Cosumnes Correctional Center (RCCC), also known as Branch Jail.

The Main Jail is a multistory building built in 1989 with an original rated capacity of 1,250 that was later increased to 2,380. It is the primary intake center for the jail and houses individuals of varying custody levels. Housing unit design is primarily single and double cells with solid doors.

RCCC is located in Elk Grove and constructed as an Air Force base, which was deeded to the County in 1947, and converted to a jail around 1960. It is the primary custody facility for detainees sentenced to County Jail from the Sacramento County Courts. An increasing percentage of the detainees are pre-sentence detainees housed at RCCC to keep the population at the Main Jail below the limit set by Federal decree. In addition, RCCD houses detainees enroute to other jurisdictions, federal prisoners under a contract with the Federal Bureau of Prisons, and reciprocal prisoners from other counties. RCCC is the primary reception center for parole violators who are being held pending revocation hearings and the central transportation point for all defendants sentenced to State Prison. Housing units are a combination of single and double cells as well as open barracks or dormitories. It has a current rated capacity of 1,625 detainees. The rated capacity of both jails combined is 4,005 detainees. As of 1/13/2021 the population of both jails was 3,166 or 79% of rated capacity.

The Sacramento Sheriff's Office (SSO) has overall responsibility for management of the jails. Adult Correctional Health (ACH), a program in the Department of Health Services (DHS) Primary Health Division, provides health care services and physical/behavioral health services through county and contracted staff working in partnership with SSO.

Due to the age of the jails, they were not designed for health care and are not compliant with the American with Disabilities Act (ADA) or Health Insurance Portability and Accountability Act (HIPAA) which were enacted at later dates. Construction of an Annex is planned to facilitate compliance with ADA and HIPAA requirements.[6]

[6] Remedial Plan Status Report. Adult Correctional Health. July 10, 2020.

Executive Summary

The COVID-19 pandemic has negatively impacted implementation of the Remedial Plan

At the outset, it is important to acknowledge the impact of the COVID-19 pandemic on the County's implementation of the Remedial Plan. In early 2020, the County began implementing Remedial Plan requirements such as revising policies and hiring new staff. When the pandemic arrived, the County's attention and resources were focused on prevention of COVID-19 in the jail. Through intake testing and quarantine, the County was initially successful at preventing COVID-19 outbreaks. In July 2020, the parties requested an investigation and report regarding management of COVID-19 at the jail, which was submitted to the Court in October 2020.[7] While recognizing the success of the County in preventing transmission of COVID-19, the report identified practices that increased the risk of COVID-19 outbreaks at the jail and recommended improved coordination, screening and management operations.[8] These included the need for Sacramento County Sheriff's Office (SSO) to develop policies and procedures for custodial operations needed to prevent disease transmission, improve staff training, and monitor compliance with COVID-19 guidance documents.[9] This review showed that staff did not consistently adhere to COVID-19 procedures. At the end of December 2020, a significant COVID-19 outbreak occurred with transmission occurring both at Main Jail and RCCC, and which is still evolving at the time of this report.[10]

The prevention and management of COVID-19 has imposed new demands upon the County related to development of COVID-19 protocols, and detainee screening, testing, quarantine, monitoring and now disease outbreak management. These demands are imposed upon existing resources, with concurrent staff shortages due to quarantine requirements and family leave. The pandemic has negatively affected the County's ability to hire and retain staff. These factors have diverted resources and focus from implementation of Remedial Plan requirements.

Health care organizational structure, leadership and staff vacancies negatively impact implementation of the Remedial Plan

The COVID-19 pandemic is not the only factor negatively affecting the implementation of the Remedial Plan. There has been turnover in key health care leadership positions at the jail, including the Medical Director and the Mental Health Director. There are excessive physician vacancies such that the County has not timely implemented key Remedial Plan requirements such as providing continuity of essential medications and implementing the chronic disease program.

[7] Report on Prevention, Screening and Management of COVID-19 at Sacramento County Jail. Madeleine LaMarre FNP-BC. October 26, 2020. Mays at ECF No. 129-1. Page 10.
[8] COVID-19 Report. Page 10.
[9] COVID-19 Report. Pages 14-15.
[10] As of 1/11/2021, 270 cases of COVID-19 have been identified

The current health care organizational structure does not facilitate compliance with the Remedial Plan, and likely represents an obstacle to compliance. The Medical, Mental Health, Dental and Pharmacy Directors report to the Division Manager, who reports to the Deputy Director. However, the Nursing Director reports directly to the Deputy Director, not to the Division Manager. This effectively elevates nursing services above other health disciplines. It has resulted in poor communication and collaboration, and dysfunctional relationships between the health disciplines. In addition, the Nursing Director has dual responsibilities for the Sacramento County Jail and the Juvenile Detention Facility which prevents her from devoting her full attention to the needs of the jail. Given the challenges to implement the Remedial Plan and address the COVID-19 pandemic, I believe that the organizational structure should be realigned.

Moreover, understanding that the County has provided additional funding for positions at the jail, I believe that the County has insufficient resources to support and oversee the implementation of the Consent Decree. This is evidenced by the First and Second Mays Status Reports that do not address the requirements of the Consent Decree to conduct a self-assessment for each Remedial Plan provision, identify barriers to implementation, and describe actions taken to achieve compliance.[11] Understanding that current health care and custody leadership and staff are working diligently to address daily operations in the midst of a pandemic, this suggests that additional resources are needed to support the implementation of the Remedial Plan.

There are serious and systemic issues resulting in harm to patients, including hospitalizations and death

There was no medical expert report produced for purposes of negotiating the Consent Decree and resulting Remedial Plan, therefore I am unable to assess progress or lack thereof as compared to conditions that existed at the time of the agreement. However, this review shows there are serious and systemic issues causing harm to patients.

These serious systemic issues are related to: inadequate policies and standardized nursing procedures; lack of adequate health care staffing; faulty process design and implementation; electronic health record configuration that is not aligned with health care processes; lack of communication and collaboration between medical and mental health; leadership turnover; and poor nursing and medical quality of care. Review of health records shows health care is delivered via remote control, in which nurses and providers review the record and order care without seeing the patient. This results in lack of adequate evaluations, treatment plans, and communication with the patient. Health record review also shows problems with custody escorts and cooperation.

[11] For the Medical Remedial Plan, areas not addressed include Chronic Care, Medication Administration and Training, Clinic Space and Medical Placements, Health Care Records, Reproductive and Pregnancy Care, Transgender Care, Detoxification Protocols and Nursing Protocols.

Intake screening is a high-risk process, as the failure to identify and treat patients with serious medical needs may result in adverse patient outcomes. This review showed that intake screening is timely, but nurses do not adequately perform substance abuse evaluations. Neither do they review previous medical records to identify patients at risk of withdrawal, needing essential medications, or provider referrals.

Nurses do not order withdrawal monitoring or essential medications at intake when the need is identified, but instead enter an order in the electronic health record (EHR) for a future appointment. The EHR appointment results in nurse or provider record review to initiate withdrawal monitoring, essential medications, and medical or mental health appointments. However, this multiple step process results in delays in care. In addition, intake nurses do not consistently make referrals to medical providers for patients with serious medical conditions. When provider referrals are made some referrals do not timely take place.

Alcohol, benzodiazepine and opiate withdrawal monitoring does not timely occur following the patient's arrival and is not occurring twice daily for a minimum of 5 days as required by the Remedial Plan. This is in part due to standardized nurse procedures that are not consistent with the Remedial Plan. When nurses do monitor patients, they do not notify a medical provider when the patient is not responding to the detox protocol. For example, this resulted in a likely preventable hospitalization of a patient for dehydration due to severe withdrawal.[12] For patients with a history of severe withdrawal, consideration should be given to initiating fixed dose detox regimens at intake, rather than symptom-based detox protocols.[13]

In regards to COVID-19, staff do not consistently comply with policies such as monitoring patients in quarantine for symptoms. Another concern is that in early December 2020, a patient tested positive for COVID-19 on the same day he was transferred to CDCR.[14] He transferred back to the jail the following day, but there was no documentation that staff were aware that he had tested positive or any contact tracing measures taken as a result of the transfer.

The sick call system does not provide timely access to care.

It appears that health requests are timely collected by a certified nurse assistant (CNA), however a registered nurse does not immediately triage these requests for emergent or urgent complaints. Instead, the CNA enters a nurse triage appointment into the EHR, and a nurse typically reviews the nurse triage request the following day. Then, the triage nurse enters an order into the EHR for a nurse sick call appointment, which may or may not take place.

[12] Patient #2.
[13] This should be done pending the County being able to perform timely withdrawal monitoring assessments.
[14] Patient #4.

There are systemic medication issues that result in medication discontinuity and lack of timely administration

In addition to delays in medication continuity at intake, medical providers do not consistently order all essential medications. A contributing factor is that medical providers are sometimes unaware of all essential medications needed to treat the patient. They do not see the patient in person to conduct a medical evaluation and discuss medications with the patient. Medication administration records show that nurses administer the 7 pm dose of medication as late as 1 am or 2 am, and document that patients refuse their medications without obtaining a patient signature. Another concern is that registered nurses enter medication orders for chronic diseases and detox regimens that are not reviewed or cosigned by a medical provider. This has resulted in medication errors.

There are excessive delays in transporting patient to the hospital

A review of hospitalized patients revealed delays in sending patients to the hospital. In one case, a patient in drug withdrawal complained of chest pain and it took 4 hours from the initial complaint until an EKG was performed. Following the abnormal EKG, it took an additional hour for the medical provider to order the patient to be transported to the hospital. Once the ambulance arrived, there were further delays before the patient was transported to the hospital.[15] In another case, a patient was transported from the jail to the hospital but there was no documentation of the events that led to the patient being sent to the hospital. [16]

There are serious nursing and medical quality of care issues

With regard to quality of care, an alarming finding is that nurses do not notify physicians when a patient's condition is clearly deteriorating, which has resulted in hospitalizations and deaths. In one case, a patient on 2M who had been languishing for weeks was hospitalized with starvation ketoacidosis.[17] In another case, a patient with heart failure and previous pulmonary embolism screamed that he couldn't breathe, but the nurse did not notify a medical provider. The patient was found unresponsive and died the following day.[18] Unfortunately, record review shows that in these same cases, physicians also minimized patient clinical findings and failed to adequately treat their underlying chronic medical conditions. These cases may reflect a wider cultural issue at the jail in how health care personnel view their obligations to provide timely, appropriate and compassionate care to patients.

[15] Patient #10.
[16] Patient #17
[17] Patient #17.
[18] Patient #10.

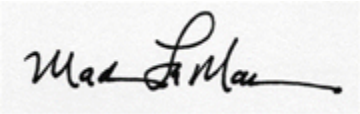
Conclusion

Understanding that all Remedial Plan provisions need to be timely implemented, given the current challenges, I support the prioritization of Remedial Plan requirements. However, this should be done in the context of an overarching master plan to implement all the Remedial Plan requirements. For the next monitoring period, I recommend the County assure adequate infrastructure to implement the Remedial Plan based on the priorities set forth below:

1. Health Care Organizational Structure
2. Staffing
3. Intake Screening
4. Alcohol and Drug Withdrawal Assessment, Treatment and Monitoring
5. Chronic Disease Management Program
6. Specialty Services
7. Electronic Health Record
8. Reproductive and Pregnancy Related Care
9. Continuous Quality Improvement (CQI) Program

Although the findings of this report are deeply concerning, these issues are all correctable. More detailed findings and recommendations are contained in the body of this report, as well as medical record reviews attached as an appendix providing supporting documentation for my findings and recommendations. I am available to assist the County and look forward to working with health care leadership and their staff to improve health care systems and achieve Remedial Plan compliance. Below is a summary of compliance for the Remedial Plan. A more detailed table of compliance is found at the end of this report.

Respectfully Submitted,



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Summary of Medical Remedial Plan Compliance

Substantive Area	Total Provisions	Substantial Compliance		Partial Compliance		Non-Compliance		Not Evaluated	
		#	%	#	%	#	%	#	%
Medical	**75**	**4**	**5%**	**15**	**20**	**39**	**52%**	**17**	**23%**

Findings

A. Staffing

1. The County shall maintain sufficient medical, mental health and custody staffing to meet professional standards of care to execute the requirements of this remedial plan, including clinical staff, office and technological support, QA/QI units and custody staff for escorts and transportation.
2. Provider quality shall be evaluated regularly to ensure that relevant quality of care standards is maintained. This review shall be in addition to peer review and quality improvement processes described in this plan. The parties shall meet and confer regarding any deficiencies identified in the evaluation. Should the parties disagree regarding matters of provider quality, the Court Expert shall evaluate the quality of provider care and to complete a written report.

Methodology: Compliance measures include:

- The monitoring process shows that the County has sufficient resources to meet the requirements of the Remedial Plan.
- The Medical Director performs regular reviews to evaluate the quality of medical care provided to the population, including, but not limited to: intake history and physicals, chronic disease care, specialty services, emergency care, etc.

Findings: To assess staffing, I reviewed the County's Mays Remedial Plan Status Reports dated July 10, 2020 and January 5, 2021, and updates provided by Adult Correctional Health leadership.

Beginning in fiscal year 2018/2019, the County began implementation of a multi-year phase in plan to add clinical and ancillary staff at Sacramento County Jail. This included 12 FTE's[19] in fiscal year 2018/2019 and 12 FTE's in fiscal year 2019/2020.

On September 10, 2020, the Board of Supervisors approved a Revised Recommended Budget for fiscal year 2020/2021 that included approximately $1.8 million in growth for Adult Correctional Health that provides for 12 FTEs and an augmentation for the University of California (UC) Davis contract. These include:

- 2 FTE Physicians-midyear January 2021
- 5 FTE Registered Nurses (3 Sick Call, 1 Discharge Planning, 1 Chronic Care)
- 1 FTE Dental Hygienist (replaces registry staff)
- 1 FTE Pharmacist
- 1 FTE Pharmacy Technician
- 1 FET Administrative Services officer 3 (Electronic Health Record)

[19] Full time Equivalent.

- 1 FTE Administrative Services Officer 2 (Contracts)

Augmentation of the UC Davis Behavioral Health Services (BHS) Contract provides for Enhanced Outpatient Mental Health Services for the Outpatient Psychiatric Pod. This includes mental health services, medication evaluation and monitoring, case management and discharge planning. This is intended to serve approximately 200 patients at any given time.

Thus, over 3 fiscal year cycles, Sacramento County has added 36 health care positions and augmented mental health programming demonstrating a commitment to increase staffing. However, the COVID-19 pandemic has presented challenges to staff recruitment and retention and resulted in staff leaves due to exposure to COVID-19 and Families First Coronavirus Response Act (FFCRA). According to ACH leadership, this has had a major negative impact on staffing.

ACH has 158.5 FTE permanent positions. As of 12/29/2020 133 positions were filled and 25.5 FTEs were vacant for an overall vacancy rate of 16%.[20] Permanent position vacancies include:

- 6.5 FTE Physician
- 1.0 FTE Supervising Nurse
- 11.0 FTE Registered Nurse
- 3.0 FTE Medical Assistant
- 1.0 FTE Office Assistant
- 2.0 FTE Administrative Services Officers

The lack of filled physician positions is particularly concerning, and is reflected in the health records that demonstrate lack of timely access to a medical provider. Filling these positions will be key to implementing the requirements of the Remedial Plan.

With respect to health care leadership, there has been turnover in key positions, including the Medical Director and Mental Health Program Director. As of 12/30/2020 the Medical Director position has been filled and is onboarding into the position. Stable health care leadership is key to Remedial Plan implementation and sustainability.

Compliance Assessment:
A.1=Partial Compliance
A.2=Noncompliance

Recommendations:

1. Fill key health care leadership positions.
2. Continue to fill budgeted positions.
3. Periodically conduct staffing assessment needs as health care system processes change.
4. Conduct provider quality studies related to health care systems, such as intake, chronic care, etc.

[20] Second Mays Status Report. January 5, 2021. Page 5.

B. Intake

1. All prisoners who are to be housed shall be screened upon arrival in custody by Registered Nurses (RNs). RN screening shall take place prior to placement in jail housing.
2. Health Care intake screening shall take place in a setting that ensures confidentiality of communications between nurses and individual patients. Custody staff may maintain visual communication, unless security concerns based upon an individualized determination of risk that includes a consideration of requests by the health care staff that custody staff be closer at hand. There shall be visual and auditory privacy from other prisoners.
3. The County shall, in consultation with Plaintiffs, revise the content of its intake screening, medical intake screening, and special needs documentation to reflect community standards and ensure proper identification of medical and disability related concerns.
4. Nurses who perform intake screening shall consult any available electronic health care records from prior incarcerations or other county agencies. The form shall include a check box to confirm that such a review was done.
5. The County shall make best efforts to verify a patient's prescribed medications and current treatment needs at intake, including outreach to pharmacies and community providers to request prescriptions and other health records related to ongoing care needs. The policy shall ensure that any ongoing medication, or clinically appropriate alternative, shall be provided within 48 hours of verification or from a determination by a physician that the medication is medically necessary. Any orders that cannot be reconciled or verified, such as those with conflicting prescriptions from multiple providers, shall be referred to a health care provider for reconciliation or verification the next clinic day after booking.
6. The County shall follow a triage process in which intake nurses schedule patients for follow-up appointments based upon their medical needs and acuity at intake and shall not rely solely on patients to submit Health Services Requests once housed. The policy shall, in consultation with Plaintiff's counsel, establish clear protocols that include appropriate intervals of care based on clinical guidelines, and that intake nurses shall schedule follow-up appointments at the time of intake based upon those protocols.
7. All nurses who perform intake screenings will be trained annually on how to perform that function.

Methodology: Compliance measures include:

- Review of Intake policies and procedures and standardized nursing procedures show they are compliant with Remedial Plan requirements and contain sufficient operational guidance to implement the policy. The policies have been implemented.
- Inspection shows that intake areas are clean and staff have access to equipment and supplies to perform the intake process.
- Observation shows that patients are provided auditory privacy.
- Registered nurses perform intake screening and have real time access to the electronic health record.

- COVID-19 prevention measures are implemented, including masking of arrestees, arresting officers and staff, and social distancing measures among detainees and staff are enforced and disinfection practices are performed.
- Record review showed:
    - The nurse completed the intake form, including COVID-19 screening prior to placement in a housing unit.
    - The nurse performed a Fitness for confinement screen and referred acutely ill patients to a provider or hospital as clinically indicated.
    - The nurse measured height, weight, vital signs including pulse oximetry.
    - The nurse assessed the patient for risk of hepatitis C infection. If risk factors were present, the nurse offered the patient opt-out HCV testing.
    - The nurse assessed the patient for alcohol and drug use and risk of withdrawal, performed baseline CIWA and COWS assessments and referred the patient for withdrawal monitoring in accordance with protocols.
    - The nurse verified medications or referred the patient to a provider the next calendar day.
    - The nurse performed a tuberculin skin test (TST) per policy. A nurse read the TST within 48-72 hours and recorded the result in the EHR.
    - The nurse performed pregnancy screening for female patients.
    - The nurse obtained a signed release of information (ROI) from the patient for pertinent medical/mental health information.
    - The nurse performed an ADA assessment and durable medical equipment and/or medical profile was issued in accordance with policy and/or provider consultation.
    - Medication records show that medications were continued within 48 hours or as ordered by a provider (critical medications within 24 hours).
    - The nurse referred the patient to a provider in accordance with the patient's clinical condition and risk of alcohol/drug withdrawal.
        - A provider shall see high acuity patients on the day of arrival.
        - A provider shall see chronic disease patients within 30 days of arrival (with pertinent labs available prior to the visit).
        - The record shows the referral took place as planned.

Findings: I reviewed the intake related policies and procedures including: Nurse Intake[21], Medical Scheduling[22], and Alcohol, Benzodiazepine, and Opiate Withdrawal Standardized Nursing Procedures and patient medical records. Overall, I found serious and systemic issues related to the intake screening and related processes. My findings are discussed below.

Intake Polices and Nursing Standardized Procedures

Review of the Nurse Intake policy shows that it does not provide sufficient operational guidance on all aspects of the intake process such as determining fitness for confinement, screening and

[21] Nurse Intake. Policy 05-05. Revised 06/05/2020.
[22] Medical Scheduling. Policy 04-07, Revised 02/07/2020.

management of COVID-19, and tuberculin skin testing etc. The policy states that a registered nurse will make a medical provider referral when a patient shows signs and symptoms of acute intoxication or withdrawal symptoms, has been transferred or released from a hospital, or has clinically significant findings that have changed since the last incarceration, however this policy is in conflict with the Medical Scheduling policy which refers such patients to a registered nurse, not a medical provider.

The Medical Scheduling policy is a new policy to be phased in over time. It references a Nurse Intake Assessment that is to occur following Intake Screening for patients with serious medical conditions.[23] However, many of the conditions for which patients are to be referred for a Nurse Intake Assessment are beyond the education, training, and scope of practice for a registered nurse to evaluate and treat. These conditions include hypertensive patients with systolic blood pressure >180 mm Hg, heart rate >120/minute, current daily alcohol, methadone, or suboxone use with signs and symptoms of withdrawal, severe dementia, and patients who are gravely disabled and unable to provide an adequate history. It is critical that patients with acute medical and mental health conditions are evaluated by a medical or mental health provider licensed to diagnose and treat their serious conditions as soon as possible. This policy does not facilitate timely access to a medical and mental health provider.

Review of Standardized Nursing Procedure (SNP) regarding alcohol, benzodiazepine, and opiate withdrawal are not compliant with the Remedial Plan and do not ensure that patients at risk of withdrawal are timely identified, monitored, and treated. Record review shows that this led to a likely preventable hospitalization and contributed to a death. The substance use disorder withdrawal standardized nursing procedures are further described in the Detoxification Protocols section of this report.

Medical Record Review

I reviewed 24 intake screenings in 15 medical records. Review of medical records showed that a registered nurse performed intake screening on all newly arrested detainee except in one case, in which an LVN conducted the screening.[24]

With respect to the completeness and quality of assessments, nurses performed intake assessments inconsistently. Information contained in a template sometimes conflicted with free texted information. For example, information contained in template may state the patient has no underlying medical conditions, but the nurse may free text that the patient has diabetes and heart failure.

Nurses do not consistently review the patient's medical history to verify current information. The intake screening form does not have a radial button that the nurse can click yes or no, to demonstrate that the nurse has performed medical record review as required by the Remedial Plan.

[23] This policy is to be phased in over time.
[24] Patient #9.

With respect to COVID-19 screening, the screening process has evolved over time as policy changes have been made. Some nurses perform abbreviated assessments (e.g., measure temperature, and a symptom review for cough, SOB and difficulty breathing), and other nurses perform more thorough review of systems (ROS). Nurses do not routinely document whether patients are masked at the time of the screening. Following baseline COVID-19 screening, records showed that nurses do not daily perform COVID-19 health checks. Nurses screen all patients for tuberculosis symptoms. Ordered Tuberculin skin testing is not always completed.

Nurses do not consistently perform adequate substance use disorder (SUD) histories that include the type, amount, frequency, duration and last use, or include the patient's history of severe withdrawal that would inform the nurse about the need for withdrawal monitoring and treatment. Nurses do not ask about a history of endocarditis, HIV, hepatitis or cirrhosis as required by standardized nurse procedures.[25] In some cases, patients are under the influence and not able to provide a good history, however nurses do not review the medical record for previous admissions which document the patient's substance use disorder and withdrawal history. In some records, the nurse documented that the patient does not appear to be under the influence of alcohol or drugs, but later in the note, free texts that the patient appears to be under the influence.[26] Nurses do not consistently perform urine drug screens or document the reasons they were not performed. Patients are placed in the "sobering cell" in booking and are not adequately monitored, which is dangerous as these patients may have medical and mental health comorbidities requiring immediate medical or mental health evaluation and treatment. Nurses do not consistently perform baseline COWS and CIWA assessments for patients presenting a risk of withdrawal.

A key finding is that intake nurses do not enter orders into the electronic health record (EHR) specifically for alcohol and drug withdrawal monitoring. Instead, nurses enter a nonspecific order for a Priority Flex Nurse (PFN) appointment which may apply to other tasks.[27] Record review showed extended lapses in time (13 to 22 hours) before nurses performed post-intake CIWA or COWS monitoring, which in some cases resulted in adverse patient outcomes. Not all medical orders initiated at intake are carried out, including lab orders.

With respect to continuity of essential medications, some nurses attempted to verify medications but often did not review previous admissions in which the medication information was readily available. Unfortunately, the process for providing medication continuity builds in a delay and results in lapses of essential medications. Records show that intake nurses verified the patient medications, but instead of notifying a provider immediately to reorder medications, the nurse entered an Essential Medication Review order. Provider review of essential medications did not routinely occur on the day of arrival but the following day, and

[25] Opiate Withdrawal Treatment. Revised 05-04-20.
[26] Patient #4.
[27] This may be because Centricity is not configured for specific types of monitoring orders, with corresponding time frames and alerts.

sometimes not at all, which resulted in lapses of essential medical and mental health medications. For example, a patient with severe heart failure was discharged from the hospital to the jail on several medications, including a diuretic. This information was known to the intake nurse who entered a provider order for essential medication review. The physician reviewed the patient's medications the next day, but by that time, the patient had missed the morning dose of his diuretic. This patient later died at the jail of poorly controlled heart failure.[28]

This process of next day essential medication review might be understandable if the patient's medication could not be verified on the day of admission, but in many cases, the intake nurse had the information immediately available, and could notify a provider immediately for a bridge order. The County reports that they do not have enough physicians to timely renew essential medications.

Medical providers do not adequately review the patient's record and review all essential medications. In one case, a 71-year-old patient with severe cardiovascular disease was admitted to the jail directly from the hospital where he was treated for chest pain. He was discharged on a diuretic, blood thinner, antiseizure and nitroglycerin tablets. The physician ordered the diuretic and seizure medication but not the blood thinner or nitroglycerin tablets.[29] In another case, a NP conducted an essential medication review but did not order a hydrocortisone-based cream for a with lichen simplex chronicus, a chronic skin condition characterized by severe itching, scaling and plaques. The information was in the record from a previous admission. The patient submitted several sick call requests before the medication was ordered.[30] The County responded that this was a clinical decision not to renew the medication, but this decision was made without a clinical evaluation of the patient and without reviewing previous admissions supporting the need to continue the medication.[31]

With respect to medical and mental health referrals, record review showed that nurses did not consistently make referrals to a medical and mental health provider when indicated. For example, one patient provided a history of cirrhosis, but the nurse did not refer the patient to a medical provider.[32] She later submitted multiple sick call requests stating she needed to see a doctor due to her cirrhosis. In another case a nurse did not refer a trangendered patient with a history of seizure disorder and taking levothyroxine.[33]

In reviewing patient medical records, a striking observation is the lack of physician involvement in patient care for chronic disease patients who are poorly controlled. Health care leadership reports that this is due to physician vacancies at the jail.[34]

[28] Patient #10.
[29] Patient #10.
[30] Patient #3.
[31] County Response to Patient Reviews. 12/30/2020.
[32] Patient #5.
[33] Patient #15.
[34] Currently there are 6.5 FTE physician vacancies. Second Mays Status Report. January 5, 2022.

Compliance Assessment:

- B.1=Substantial Compliance
- B.2=Not Evaluated
- B.3=Partial Compliance
- B.4=Noncompliance
- B.5=Partial Compliance
- B.6=Partial Compliance
- B.7=Not Evaluated

Recommendations:

1. Health care leadership should conduct a process review and redesign of the Intake Process to ensure that patients receive timely care for their serious medical conditions. Policies and procedures and standardized nursing procedures should be revised.[35]
2. Processes to be reviewed include:
    a. Standardizing COVID-19 symptom screening and prevention measures (e.g., patient masking, and patient education regarding COVID-19)
    b. Review of previous admissions for past medical history with particular attention to substance use history, chronic diseases, mental health conditions, and essential medications.
    c. Substance use disorder histories (type, amount, frequency, duration and withdrawal history).
    d. Ordering withdrawal monitoring at intake to be performed within 4-6 hours of arrival.
    e. Ordering verified essential medications at intake.
    f. Nurse to provider referral criteria and time frames.
3. Require medical provider evaluation of patients with chronic diseases and in moderate-severe withdrawal within 24 hours.
4. The electronic health record should be reconfigured to:
    a. Streamline the nurse intake form to eliminate duplicate information.
    b. Insert radial button that the RN can check following review of previous admissions. It should be Yes/No.
    c. Create orders and alerts for nurse and medical provider referrals based upon the urgency of the referral.
    d. Creating intake, substance use withdrawal, and chronic disease order sets.
5. Establish an Intake team, consisting of a physician, registered nurse, LVN, infection control coordinator and administrative support to track and monitor that all intake activities and related referrals are timely performed, and quality of care is appropriate.[36]

[35] The County responded that review and revision of the intake process was begun in October and is ongoing. Changes to the HER are underway staff have targeted completion and testing in January 2021.

[36] ACH responds that they have insufficient physician staffing to assign a physician to intake due to volume. However, this is a high-risk area and there needs to be a plan to address lack of timely access to a medical provider for patients that need immediate medical evaluation and/or essential medication review.

C. Access to Care

1. The County shall ensure that Health Service Requests (HSRs) are readily available to all prisoners, including those in segregation housing, from nurses and custody officers.
2. The County shall provide patients with a mechanism for submitting HSRs that does not require them to share confidential information with custody staff. The county shall install lockboxes or other secure physical or electronic mechanism for the submission of HSRs (as well as health care grievances) in every housing unit. Designated staff shall collect (if submitted physically) or review (if submitted electronically) HSR's at least two times per day in order to ensure that CHS receives critical health information in a timely manner. Designated health care staff shall also collect HSRs during pill call and go door to door in all restricted housing units at least once a day to collect HSRs. HSRs and health care grievances will be promptly date- and time stamped. The county may implement an accessible electronic solution for secure and confidential submission of HSRs and grievances.
3. The County shall establish clear time frames to respond to HSRs:
    a. All patients whose HSRs raise emergent concerns shall be seen by the RN immediately upon receipt of the HSR. For all others, a triage RN shall, within 24 hours of receipt of the form (for urgent concerns) or 72 hours of receipt of the form (for routine concerns).
        i. Conduct a brief face-to-face visit with the patient in a confidential clinical setting.
        ii. Take a full set of vital signs, if appropriate.
        iii. Conduct a physical exam, if appropriate.
        iv. Assign a triage level for a provider appointment of emergent, urgent, routine or written response only.
        v. Inform the patient of his or her triage level and response time frames.
        vi. Provide over-the-counter medications pursuant to protocols; and
        vii. Consult with providers regarding patient care pursuant to protocols, as appropriate.
    b. If the triage nurse determines that the patient should be seen by a provider:
        i. Patients with emergent conditions shall be treated or sent out for emergency treatment immediately.
        ii. Patients with urgent conditions shall be seen within 24 hours of the RN face-to-face; and
        iii. Patients with only routine concerns shall be seen within two weeks of the RN face-to-face.
    c. Patients whose requests do not require formal clinical assessment or intervention shall be issued a written response, with steps taken to ensure effective communication, within two weeks of receipt of the form. (Not evaluated)
    d. The County shall permit patients, including those that are illiterate, non-English speaking, or otherwise unable to submit verbal or electronic HSR's to verbally request care. Such verbal requests shall immediately be documented by the staff member who receives the request on an appropriate form and transmitted to a

qualified medical professional for response in the same priority as those HSRs received in writing.

4. The County shall designate and make available custody escorts for medical staff in order to facilitate timely and confidential clinical contacts or treatment-related events.
5. The County shall track and regularly review response times to ensure that the above timelines are met.
6. The County shall discontinue its policy of prohibiting patients from reporting or inquiring about multiple medical needs in the same appointment.
7. When a patient refuses a medical evaluation or appointment, such refusal will not indicate a waiver of subsequent health care.
   a. When a patient refuses a service that was ordered by medical staff based on an identified clinical need, medical staff will follow up to ensure that the patient understands any adverse health consequences and to address individual issues that caused the patient to refuse a service.
   b. Any such refusal will be documented by medical staff and must include (1) a description of the nature of the service being refused, (2) confirmation that the patient was made aware of and understands any adverse health consequences by medical staff, and (3) the signature of the patient, and (4) the signature of the medical staff. In the event the signature of the patient is not possible, the staff will document the circumstances.

Methodology: Compliance measure include:

- Review of access to care policies and procedures demonstrate they are compliant with Remedial Plan requirements.
- Inspection of inmate housing units and inmate interviews demonstrate that officers have an adequate supply of HSRs that are provided to inmates upon request.
- Locked boxes accessible only by health care staff have been installed in inmate housing units for detainees to submit health services requests. The boxes should be separate from boxes for grievances.
- Inmates have daily access to sick call boxes (or kiosks have been installed in housing units that inmates have ready access to submit health requests).
- Staff and patient interviews show that health care staff collect HSRs twice daily.
- Staff date and time-stamp the HSRs and grievances upon receipt.
- Review of health records show:
  - A registered nurse triages HSR within 2 hours of receipt and schedules the patient to be seen in accordance with the urgency of the complaint (emergent=immediate, urgent=<24 hours and routine=<3 days).
  - Nurses conduct clinical assessments in an adequately equipped and supplied examination room that provides auditory and visual privacy.
  - Nurses conduct clinically appropriate assessments with vital signs, provide treatment and referrals in accordance with nurse protocols.
  - Nurse-to-provider referrals take place in accordance with the urgency of the referral (Emergent=Immediate, Urgent=<24 hours, routine=<14 days).

  - Nurses provide patients not requiring a clinical assessment a written response within 14 days of receipt.
- The County permits inmates to submit verbal requests for care which staff immediately document on an appropriate form (HSR) and transmit to health care staff.
- Staffing documents show that custody posts are established for medical appointment escorts.
- Sick Call tracking systems or CQI studies show appointments are not rescheduled or cancelled due to lack of custody escorts.
- CQI studies show that nurses timely collect and triage health care request forms, schedule and see patients in accordance to triage decisions; and provider referrals timely take place.
- Review of health records show that nursing assessments are in accordance with nurse protocols or generally accepted standards of care.
- Review of health records demonstrate that provider assessments are clinically appropriate and consistent with generally accepted standards of care.
- Health records show that when patient refuse medical care, nurses counsel the patient regarding any adverse health consequences and patients and nurses sign the refusal form.

Findings: Record review shows that the current system does not provide patients timely access to health care services. My findings are described below.

Access to Care Policies and Procedures

I reviewed the draft Access to Care[37] and Medical Scheduling policy procedure.[38] These policies do not describe the routine access to care system (i.e., sick call); do not provide sufficient operational guidance to staff regarding access to care procedures; and are not compliant with Remedial Plan requirements.

Medical Record Review

The system is not designed to timely triage and schedule patients to be seen. My review showed the following:

1. Some patients submit health requests on a generic Correctional Services Message Request and some patients submit a Health Services Kite. This raises a question as to whether there are sufficient numbers of Health Requests Kites available to patients.
2. The forms contain a signature and date line for staff who collects the form. This is typically a Certified Nurse Assistant (CNA). The form does not contain space for a Registered Nurse to document a triage disposition (emergent, urgent, routine) and a line to document signature, credentials, the date and time.
3. A CNA usually timely collected health requests on the same or following day. There were some exceptions.

[37] Access to Care. Policy No: 01-12. Revision date: 09-04-2020

[38] The corresponding NCCHC policy is Non-Emergency Health Requests and Services. J-E-07.

4. Following collection of the forms, the CNA enters the complaint into the electronic health record (EHR) and creates an order for RN Triage. This creates an automatic delay in triaging health requests and presents a risk that patients with urgent conditions will not be timely evaluated.
5. The Medical Scheduling policy states that a Supervising Registered Nurse (SRN) will triage Health Services Requests, however many health requests were not timely triaged, if at all. When triage did take place, it appears to be performed by many different nurses, not just an SRN. This is not necessarily an issue, but the policy should reflect what is intended to take place.
6. Following RN triage of the request a RN enters an order for Nurse Sick Call into the EHR. For many encounters, a RN neither triaged the request nor assessed the patient.
7. In some cases, nurses assessed patients in the housing units rather than a properly equipped examination room that provides privacy. In these cases, the quality of assessments was often inadequate. It's unclear whether this practice is due to movement restrictions due to COVID-19, lack of adequate clinic space for the nurse to examine the patient, or lack of custody escorts.
8. When a patient refuses treatment, nurses do not counsel patients regarding the risks of refusal and on the majority of refusal forms no patient signature was found.

Examples found in the medical record are as follows:

- A 35-year-old woman with a history of substance use disorder and cirrhosis submitted a HSR on 11/3/2020 stating "I need a doctor! Cirrhosis to the liver, in pain!" On 11/3/2020 a CNA collected the form and entered an order for Nurse Triage into the EHR. A RN did not triage the request or assess the patient. [39]
- A 44-year-old man with a history of substance abuse disorder, esophageal ulcer, GI bleeding and anemia submitted a HSR on 8/16/2020 reporting that his doctor stopped his water pill and now his legs were swollen. It was received on 8/18/2020. A CNA ordered Nurse Triage. A RN did not triage the request or see the patient.[40]
- On 8/18/2020 the same patient submitted a request to obtain an eyeglass prescription so his wife could obtain new glasses for him. On 8/19/2020 a CNA entered an order for Nurse Triage. A RN did not triage the request or see the patient.
- On 8/27/2020 the same patient requested a printout of his medications. On 8/28/2020 a CNA ordered Nurse Triage. On 8/30/2020 a RN ordered a nurse sick call appointment but its unclear whether it was for the 8/16, 8/18 or 8/27/2020 request.

While none of these cases resulted in a serious outcome for the patient, they illustrate that the current system does not ensure timely access to care.

Compliance Assessment:

- C.1=Noncompliance
- C.2=Partial Compliance

[39] Patient #5.
[40] Patient #6.

- C.3=Noncompliance
- C.4=Noncompliance
- C.5=Noncompliance
- C.6=Noncompliance
- C.7.a=Noncompliance
- C.7.b=Noncompliance

Recommendations:

1. Health care leadership should develop a policy that is consistent with Remedial Plan requirements and NCCHC policy (Non-Emergency Health Requests and Services).
2. The County needs to revise its Health Services Request (HSR) form to include check boxes for RN triage dispositions (emergent, urgent, routine) and line for the RN to document signature, credential and date and time.
3. Develop an accountability system for ensuring each housing unit has an adequate supply of HSRs and for the daily collection of HSRs.
4. Following collection of HSRs, the CNA should immediately deliver them to a RN who will triage each request and document a triage disposition for a nurse sick call assessment. The RN will arrange for any patient with a potentially emergent complaint to be seen immediately (e.g., chest pain, shortness of breath) and document the intervention in the EHR.
5. The RN returns the HSRs to the CNA who will order a nurse sick call appointment based upon the urgency of the triage disposition by the RN.
6. The EHR should be reconfigured to permit ordering Nurse Sick Call appointments based upon the urgency of the complaint (urgent=within 24 hours, and routine=within 72 hours). It should be noted that NCCHC standards require a RN to assess patients the following day, unless they should be seen sooner based upon the urgency of the patient's condition.
7. Nurses should conduct patient assessments in an adequately equipped and supplied examination room. If due to COVID-19, assessments are conducted on the housing units, an area should be set aside for the nurse to conduct interviews with auditory privacy, vital signs and limited examinations.
8. The EHR should be reconfigured to permit ordering Medical Provider appointments based upon the urgency of the complaint (emergently=Now, urgent=within 24 hours, and routine=within 14 days). Nursing documentation should reflect the urgency of provider referrals.
9. Health care leadership should conduct CQI studies regarding compliance with Remedial Plan requirements, quality of nursing assessments and appropriateness of nurse to provider referrals.

D. Chronic Care

1. Within three months of the date the Remedial plan is issued by the Court, the County shall, in consultation with Plaintiffs' counsel, develop and implement a chronic disease management program that is consistent with national clinical practice guidelines. The

chronic disease program will include procedure for the identification and monitoring of such patients and the establishment and implementation of individualized treatment plans consistent with national clinical practice guidelines.

a. The chronic disease management program shall ensure that patients with chronic illness shall be identified and seen after intake based upon acuity (on the day of arrival for patients with high acuity and not to exceed 30 days for all others). The County will timely provide clinically indicated diagnostic testing and treatment, including prior to this post-intake appointment. Follow-up appointments will be provided in intervals that do not exceed 90 days unless patients are clinically stable on at least two consecutive encounters, in which case, follow-up appointment intervals will not exceed 365 days (and sooner if clinically indicated), subject to a chart review every 6 months.
b. The chronic disease management program shall ensure patients are screened for hepatitis C at intake. If medical staff recommend Hepatitis testing based upon screening results, such testing shall be offered on an "opt-out" basis for those individuals who remain in custody long enough to receive a housing assignment. If the patient declines testing the refusal shall be documented in the health record. Patients found to have hepatitis C shall be offered immunizations against hepatitis A and B.
c. The chronic disease management program shall include a comprehensive diabetic management program consistent with the American Diabetes Association (ADA) Diabetes Management in Correctional Institutions. The protocol shall be developed in coordination with custody administration to address normal circadian rhythms, food consumption times and insulin dosing times.
d. The chronic disease management program shall ensure that patients who take medications for their chronic conditions shall have the medications automatically renewed unless the provider determines that it is necessary to see the patient before renewing the medication. In that case, the patient shall be scheduled to be seen in a reasonable time period to ensure medication continuity.

2. The County shall track compliance with the chronic disease management program requirements for timely provision of appointments, procedures and medications. The County shall ensure that its electronic medical record system is adequate to support these critical functions.
3. The County shall review its infection control policies and procedures for dialysis treatment to ensure that appropriate precautions are taken to minimize the risk of transmission of blood-borne pathogens, given the proximity of HCV+ and HCV- patients receiving dialysis in the same room.

Methodology: Compliance assessment includes:

1. Review of the County's applicable policies and procedures demonstrate compliance with Remedial Plan requirements for enrollment, monitoring and treatment.
2. Review of the County's clinical practice guidelines show they are consistent with national practice guidelines.

3. The County has a chronic disease tracking system that includes date of arrival at the jail, date of enrollment in the CDP, date of initial appointment, date of scheduled labs or diagnostic tests, date of next appointment, dates of pertinent examinations (e.g., foot, eye, etc.).
4. Review of intake policies and actual practice shows that patients were screened and offered hepatitis C testing, if warranted by screening results. Patients for whom testing was ordered received testing if still in the facility after 72 hours. Patients refusing testing signed a refusal form.
5. There is a functional system for automatic renewal of medications.
6. Review of medication administration records shows that patients received essential (chronic disease) medications without interruption.
7. Review of records demonstrates with timeliness of clinical monitoring and adherence to clinical practice guidelines.
8. The County has implemented a system to track compliance with Remedial Plan requirements for provision of timely appointments, procedures and medications.
9. Review of infection control policies and procedures, observation of dialysis treatment and interview with nurses demonstrate adherence to infection control infection control principles.
10. Self-audit/CQI reports show that the County monitors performance with Remedial Plan requirements and develops corrective action plans as indicated.

Findings: According to the County, program and policy development on chronic care was delayed by the prior Medical Director due to COVID-19 and provider shortages. A revised draft of the Chronic Disease Management Policy and Procedure was revised on 11/27/2020.[41] The number of diseases included for treatment based upon national guidelines is limited and does not include other common chronic diseases such as chronic obstructive pulmonary disease (COPD), thyroid disorders (hyper- and hypothyroidism), chronic gastrointestinal disorders (inflammatory bowel disease) and seizure disorders. The policy appropriately requires that intake registered nurses refer patients with chronic diseases to a clinician according to their medical acuity (Urgent within 24 hours and routine within 14 days), however the chronic disease program has not been implemented due to a shortage of medical providers. The Second Mays Status report does not address Chronic Care with respect to action items in the next 180 days to achieve compliance.

Record review shows that nurses did not consistently refer patients with chronic diseases to a provider and essential medications were sometimes delayed. Patients are not screened for hepatitis C and offered opt-out testing. Providers do not order necessary testing, such as INR's for a patient on warfarin, or microalbumin for diabetics.

Compliance Assessment:

- D.1=Noncompliance
- D.1.a=Noncompliance

[41] Chronic Disease Management. No. 05-xx. Effective 04-20. Revised 11/27/2020.

- D.1.b=Noncompliance
- D.1.c=Noncompliance
- D.1.d=Noncompliance
- D.2=Noncompliance
- D.3=Noncompliance

Recommendations:

1. The County should prioritize completion of chronic diseases policies and procedures and clinical practice guidelines.
2. Ensure that intake nurses refer chronic disease patients to a medical provider to be seen based upon their medical acuity, and in accordance with policy and procedures.
3. Develop an electronic tracking system for chronic disease patients to include:
    a. Date of arrival
    b. Dates of initial chronic disease visit
    c. Dates of labs to be performed prior to the next chronic disease visit
    d. Dates of follow-up visits
4. When labs are indicated, schedule them to be performed in advance of clinic visits, so that pertinent clinical information is available to assess disease control (e.g., hemoglobin A1C, INRs, etc.)
5. Perform CQI studies to assess timeliness of referral from intake to a medical provider and that medical providers comply with nationally recognized clinical practice guideline for treatment of chronic diseases.

E. Specialty Services

1. The County shall develop and implement policies regarding specialty referrals using an algorithm with evidence-based referral criteria and guidelines.
2. Within 3 months of the date the Remedial plan is issued by the Court, the County shall develop and implement policies and procedures to ensure that emergency consultations and diagnostic treatment procedures, as determined by the medical provider; are provided immediately; high priority consultations and procedures, as determined by the medical provider are seen within 14 days of the date of the referral; and routine consultations and procedures, as determined by the provider are seen within 90 days of the date of the referral.
3. Patients whose routine specialty consultation or procedure do not take place within 90 calendar days from the date of the referral shall be examined by a clinician monthly and evaluated to determine if urgent specialty care is indicated.
4. Within 5 days of the completion of a high priority specialty consultation or procedure, or within 14 days of a routine specialty consultation or procedure, patients returning to the Sacramento County Jail shall have their specialty reports and follow-up recommendations reviewed by a jail nurse practitioner, physician assistant or physician.
5. Specialty care consultations and outside diagnostic and treatment procedures shall be tracked in a log that identifies:
    a. The date of the referral request

b. The date the request is sent to UM
c. The date of UM notification of approval or denial
d. The date the referral was sent to the specialty care provider
e. The date of the consultation or procedure appointment
f. The date the consultation or procedure took place
g. If cancelled or rescheduled, the reason for the cancellation/rescheduling
h. The date the appointment was rescheduled.

6. Requests for specialty consultations and outside diagnostic and treatment procedures shall be tracked to determine the length of time it takes to grant or deny requests and the circumstances or reasons for denials (Note: date of approval should be on specialty services tracking log, see above).
7. At least twice a year, the County shall conduct an audit of specialty care referral logs described in subsections (5) and (6), above, and complete a report as to whether each category of specialty care is completed in a reasonable time frame, consistent with established time frames. If any specialty care area has a record of untimely appointments as determined by the Correctional Health Service Continuous Quality Improvement (CQI) Committee, the County shall report to Plaintiffs and the parties shall meet and confer to take prompt steps to address the issue. The County will provide Plaintiffs access to the specialty care referral logs and audit reports periodically and upon written request. The parties will work to resolve issues with untimely specialty care in individual patient cases and with respect to systemic trends, including through the dispute resolution process.
8. The County shall consider implementing an e-referral system to reduce delays and facilitate communication between specialists and primary care providers, as well as reducing unnecessary transportation costs and unnecessary specialist appointments by ensuring that the specialist has all the information he or she needs before an appointment takes place.
9. The County shall ensure that utilization management and/or scheduling staff provides notification of whether a patient's specialty care appointment is scheduled to occur within the timeline pursuant to the referral and/or clinical recommendation, including as follows:
    a. Medical staff may request and obtain information as to whether any patient's specialty care appointment is scheduled, and as to the general timing of the appointment (e.g., within a one-week date range).
    b. If a specialty care appointment is denied or is not scheduled to occur within the timeline pursuant to the referral and/or clinical recommendation, such information will be affirmatively provided to the treatment team and to the patient.
    c. If a previously scheduled specialty care appointment is postponed to a date that is outside the timeline pursuant to the referral and/or clinical recommendation, such information will be affirmatively provided to the treatment team and to the patient.
10. The County shall consider creating a physical therapy clinic at the jail to more efficiently meet the demand for service at the jail.

Methodology: Compliance measures include:

- Review of Specialty Services policies and procedures show they are compliant with Remedial Plan requirements.
- The County has implemented algorithms for referral based upon evidenced based criteria.
- Review of contracts shows broad access to specialty services, including physical therapy for onsite services.
- Review of Specialty Services tracking log shows it is contemporaneously maintained and compliant with Remedial Plan requirements for 12 months.
- Tracking logs and medical records show that patients receive specialty services in accordance with the urgency of the request and/or clinical need.
- Review of health records show that clinicians timely monitor patients to ensure the treatment plan has been implemented and that the patient's condition meets desired clinical outcomes.

Findings: Subsequent to the draft report, the County provided the Second Mays Status report and policies and Specialty Referrals policy and procedure[42] which were reviewed and incorporated into this report.

The Specialty Referrals policy is not compliant with Remedial Plan requirements, including: timeframes for completion of urgent specialty services (21 versus 14 days); and requirement to monitor patients pending specialty services beyond 90 days on a monthly basis, etc. There are no designated time frames for completion of the initial utilization management review and authorization of specialty services requests, etc.

The County has executed several contracts related to specialty services, including RubiconMD and eConsult platform which enables primary care clinicians an electronic consult with over 120 specialty providers. Clinician and case management training utilizing RubiconMD is in process. The County has also purchased an evidence-based software, InterQual, and staff training has been completed but an implementation plan is needed. The County has been challenged with initiating specialty services contracts due to specialists' concerns regarding COVID-19. The County has contracted with American Correctional Solutions to recruit a physical therapist.

The Second Mays Status report does not address Specialty Services in its action plan.

Compliance Assessment:
E.1=Noncompliance
E.2=Noncompliance
E.3=Noncompliance
E.4=Not Evaluated
E.5=Not Evaluated
E.6=Not Evaluated

[42] Specialty Referrals. No. 04.08. Effective 02/20/2020.

E.7=Not Evaluated
E.8=Not Evaluated
E.9=Not Evaluated
E.10=Partial Compliance

Recommendations:

1. The County should implement InterQual criteria for utilization management decisions regarding specialty services.
2. Revise the Specialty Services policy and procedure to include all Remedial Plan requirements, including timeframes for access to specialty services appointments and provider follow-up appointments.
3. Implement specialty services tracking log in accordance with Remedial Plan requirements.
4. Assign staff responsibility to maintain and monitor the tracking log and to notify clinicians when specialty services appointments are not in compliance with provider orders and/or Remedial Plan requirements.
5. Continue to seek on-site physical therapy services.

F. Medication Administration and Monitoring

1. The County shall develop and implement policies and procedures to ensure that all medications are appropriately prescribed, stored, controlled, dispensed, and administered in accordance with all applicable laws through the following:
    a. Ensuring that initial doses of prescribed medications are delivered to patients within 48 hours of the prescription, unless it is clinically required to deliver the medication sooner.
    b. Ensure that medical staff who administer medications to patients document in the patient's Medication Administration Record (1) name and dosage of each dispensed medication, (2) each date and time medication is administered, (3) the date and time for any refusal of medication, and (4) in the event of patient refusal, documentation that the prisoner was made aware of and understands any adverse health consequences by medical staff.
2. The County shall provide sufficient nursing and custody staffing to ensure timely delivery and administration of medication.
3. The County shall provide pill call twice a day in each housing unit, at regular times that are consistent from day to day, except as may be required by non-routine facility security concerns. The County shall develop and implement policies and procedures to ensure that prescribed medications are provided at therapeutically appropriate times as determined by the ordering physician. Any patient who requires administration of medications at times outside the regular pill call shall be provided that medication at the times determined by the ordering physician.
4. The County shall develop and implement policies and procedures to ensure that patients are provided medications at therapeutically appropriate times when out to court, in transit to and from any outside appointment, or being transferred between

facilities. If administration times occurs when a patient is in court, in transit, or at an outside appointment, medication will be administered as close as possible to the regular administration time.

5. The County shall develop policies and procedures to ensure that medication efficacy and side effects are monitored by staff and reviewed by appropriate clinicians at appropriate levels.
6. The County shall explore the expansion of its Keep-on-Person medication program, (especially for inhalers and medications that are available over-the-counter in the community) and to facilitate provision of medications for people who are out to court, in transit, or at an outside appointment.

Methodology: Compliance measures include:

- County policies and procedures meet Remedial plan requirements.
- Inspection of pharmacy and medication storage areas show that medications, including controlled substances are properly stored, controlled, dispensed and disposed of in accordance with pharmacy board requirements.
- Medication administration schedules, medication records and patient interviews demonstrate show that nurses administer medications twice daily, or as required per provider orders (e.g., three times daily).
- Meals and insulin administration schedules show they are coordinated to reduce risk of hypoglycemia.
- Medication administration records contain legally required information (e.g., name, dose, frequency, duration, etc.) and that that medications are administered within 48 hours of prescribing or sooner if clinically required.
- Observation of medication administration shows that there are sufficient numbers of deputies to accompany nurses and ensure timely medication administration at a consistent time each day.
- Observation of medication administration shows that nurses administer medications hygienically, adhere to the “five rights” (e.g., right patient, right medication, right dose, right route, and right time), and document administration at the time medication was given to the patient.
- Observation of medication administration shows that nurses perform oral cavity checks for clinical reasons, and custody performs oral cavity checks for custody reasons (e.g., hoarding, diversion).
- Review of medication administration records (MARs) show that nurses document the administration status for each dose of medication.
- Review of MARs and health records show that nurses document patient refusals of medications and counsel the patient regarding the risk of refusals (Note: No shows are not to be considered refusals of medications).
- Review of pharmacy policies, practices, and health records show that pharmacy staff refill chronic disease and other essential medications automatically, without relying on patients to submit sick call requests (from section D. Chronic Care).

- Review of MARs show no disruptions in renewal of chronic disease or other essential medication prescriptions.
- Review of pharmacy and therapeutics/CQI meeting minutes show that the County tracks and addresses medication adverse outcome reports, medication errors (e.g., wrong patient, wrong mediation, missed medication, etc.) data and addresses root causes of medication errors.
- Self-audit/CQI reports show that County monitors performance with Remedial Plan requirements and develops corrective action plans as indicated.

Findings: This was a limited review and included review of selected medication policies and procedures, medication orders, and medication administration records, and the Second Mays Status Report.

The County has developed draft policies and procedures related to medication administration, Pill Call, and other pharmacy and medication related areas. While generally comprehensive, the medication administration policies do not describe administration times at the jails, including insulin administration and coordination with meals. The policies do not describe the procedure for providing medications for detainees going out to court or who would otherwise not be present when nurses administer medications in the housing unit. Regarding refusals, the policy states that the nurse will document that the patient was made aware of and understands the adverse consequences of refusal of medications, but record review shows that this is not occurring. Moreover, it is an unrealistic expectation that nurses counsel patients regarding risks of refusal for each and every dose of medication.

Medical record review showed significant problems with medications including:

- Lack of timely essential medication review and continuity at intake due to insufficient provider staffing;
- Nurses independently ordering legend medications without provider review and signature;
- Nurses making medication errors when ordering legend medications, such as ordering a but not discontinuing a previous medication order for the same drug; and ordering an opiate withdrawal protocol and omitting a protocol medication (e.g., clonidine);
- Lack of timely medication administration, particularly for the evening (1900) dose of medications that often are not administered until 1 or 2 am.
- Nurses document that patients refuse medications but refusal of treatment forms do not include counseling of the patient (there is no space for this on the form) and patient signatures are not found on refusal forms;
- Nurses document administering medications and then changing administration status that the medication was not given;
- Nurses document in a progress note that they were unable to administer the patient medication but the medication administration record indicates the medication was given;
- Nurses document administering medications after a patient has been released.

- No provision to provide medications for patients going out to court. A nurse informed a patient who was not given his morning medication that it was his responsibility to request medications 24-48 hours in advance of going to court.[43]

Other findings include:

- The County has initiated providing discharge medications to sentenced population but not the presentenced population due to pharmacy software implementation and provider shortage.
- A budget request proposal resulted in 8 Deputy Sheriff positions added (2 for each shift) to Main Jail to escort nurses for medication administration.

Compliance Assessment:

- F.1.a=Substantial Compliance
- F.1.b=Substantial Compliance
- F.2=Noncompliance
- F.3=Noncompliance
- F.4=Noncompliance
- F.5=Noncompliance
- F.6=Partial Compliance

Recommendations:

1. The County should revise medication related policies and procedures to include administration times at each of the jails and procedures for providing medications for detainees going out to court.
2. The County needs to ensure that adequate medical provider resources are dedicated to review of essential medications upon arrival, timely renew of chronic disease medications, review of nursing ordered medications, and discharge medications.
3. The County should ensure adequate nurse and custody staff assigned to medication administration to ensure that medications are administered within a 2-hour time frame (one hour before and one hour after a designated time). For example, for a designated administration time of 1900, medications can be given from a 2-hour window of 1800 to 2000.
4. Medical providers should timely cosign nurse ordered medications in accordance with policy and procedure.
5. Health care leadership should study documentation issues such as documenting medications as given then changing to not given, documenting administration of medications after the patient has been released, etc.
6. Consider amending the Remedial Plan to require that nurses document counseling of risks of medication refusal for critical medications only, and refer patients refusing non-essential medications to a provider after they have refused a threshold of doses (e.g., 50% of medications within a 7-day period, etc.).

[43] Patient #8.

G. Clinic Space and Medical Placements

1. The County shall provide adequate space in every facility to support clinical operations while also securing appropriate privacy for patients. Adequate clinical space includes visual and auditory privacy from prisoners, and auditory privacy from staff, the space needed reasonably to perform clinical functions as well as an examination table, sink, proper lighting, proper equipment, and access to health records.
2. The County shall ensure that any negative pressure isolation rooms meet community standards, including an antechamber to ensure that the room remains airtight, appropriate pressure gauges, and regular documented checks of the pressure gauges.
3. The County shall ensure that absent individualized, documented safety and security concerns, patients in acute medical or quarantine placements shall be allowed property and privileges equivalent to what they would receive in general population based upon their classification levels. The County shall ensure that patients in medical placements are not forced to sleep on the floor, including providing beds with rails or other features appropriate for patients' clinical needs and any risk of falling.
4. The County shall not discriminate against patients in medical placements solely because of their need for C-Pap machines, but instead shall provide access to programs and services in accordance with their classification level, as set forth in the ADA remedial plan.

Methodology: Compliance measures include:

- Review of County clinic space, medical housing, infection control and related policies show that they adhere to Remedial plan requirements.
- Inspection of examination rooms show that each is of adequate size for its purpose with proper lighting, functional sink, proper equipment and supplies, including an exam table and access to the electronic health record.
- Inspection of respiratory isolation rooms show they have an antechamber and properly working negative air flow. Tracking logs show staff check the functionality of the rooms daily.
- Inspection of medical housing units show that all patients have an appropriate bed for their medical condition and medically indicated durable medical equipment (DME).
- Review of policy and patient interviews show that patients requiring C-Pap machines in medical housing are offered programming in accordance with their classification level.
- Self-audit/CQI reports show that the County monitors performance with Remedial Plan requirements and develops corrective action plans as indicated.

Findings: The Second Mays Status Report indicates that inmates in medical quarantine are allowed to keep personal property with them and participate in programs that do not interfere with safety and security concerns. With respect to inmates on C-Pap machines, at RCCC there are no outlets in inmate sleeping areas, except the Medical Housing Unit (MHU). Inmates in the MHU are able to participate in programming consistent with their security classification.[44] The

[44] I was unable to confirm these findings due to the lack of onsite visit. I will review during a future onsite visit.

County reports that all inmates have a bed and none sleep on the floor. Respiratory isolation rooms at Main Jail do not have an anteroom.

Currently, there are insufficient examination rooms at Main Jail. It has been reported that there is only one examination room on each floor that is shared by medical, nursing and mental health staff. Nurses perform assessments in the housing pods that results in inadequate assessments and privacy. This led to the proposal for a new Annex to provide additional clinical space.

In response, the County has engaged in planning for facility improvements to meet the needs of the Consent Decree including Americans with Disabilities Act (ADA) standards, patient privacy and sufficient space for medical and mental health services. The project consists of design and construction of a new building of the existing Main Jail facility. The construction will include a new Intake/Booking area, additional medical, mental health, education and program space and be compliant with ADA and the Health Insurance Portability and Accountability Act (HIPPA). This planning is currently underway.

The RCCC facility requires modifications to be responsive to the Consent Decree. However, in September 2020 the County Board of Supervisors declined funding for the project and there are no further updates at this time.[45]

There are no policies and procedures related to clinic space, equipment and supplies, patient privacy, or infirmary care/medical observation or medical housing.

Compliance Assessment:

- G.1=Partial Compliance
- G.2=Not Evaluated
- G.3=Not Evaluated
- G.4=Not Evaluated

Recommendations:

1. New construction needs to ensure that clinic space is adequate to meet the service demands of population, including nursing, medical, mental health, dental and laboratory services.
2. To the extent possible, rooms should be configured to offer multipurpose use, each room could be used as an examination or interview room.
3. The County should determine whether the respiratory isolation rooms at Main Jail meet current regulations and standards for use with having an anteroom.[46]
4. Develop policies and procedures related to clinic space, equipment and supplies that are consistent with NCCHC standards.[47]

[45] Second Mays Status Report. January 5, 2021. Pages 15-16.
[46] Standards for Health Services in Jails. 2018. National Commission on Correctional Health Care. J-B-02.
[47] Standards for Health Services in Jails. 2018. National Commission on Correctional Health Care. J-D-03.

H. Patient Privacy

1. The County shall develop and implement policies and procedures to ensure that appropriate confidentiality is maintained for health care services. The policies shall ensure confidentiality for clinical encounters, including health care screening, pill call, nursing and provider appointments, and mental health treatment. The policies shall also ensure confidentiality for written health care documents, such as health care needs requests and grievances raising medical care or mental health concerns, which shall not be collected by custody staff.
2. The County shall provide adequate clinical space in each jail to support clinical operations while securing appropriate privacy for patients, including visual and auditory privacy from prisoners and auditory privacy from staff.
3. All clinical interactions shall be private and confidential absent a specific, current risk that necessitates the presence of custody staff. In making such a determination, custody and clinical staff shall confer and review individual case factors, including the patient's current behavior and functioning and any other security concerns necessary to ensure the safety of medical staff. Such determinations shall not be made based upon housing placement or custodial classification. The issuance of pills does not constitute a clinical interaction.
    a. For any determination that a clinician interaction with a patient requires the presence of custody staff, staff shall document the specific reasons for the determination. Such decisions shall be reviewed through the Quality Assurance process.
    b. If the presence of a correctional officer is determined to be necessary to ensure the safety of staff for any clinical encounter, steps shall be taken to ensure auditory privacy of the encounter.
    c. The County's patient privacy policies, as described in this section, shall apply to contacts between patients and all staff who provide health-related services on site at the jail.
4. Jail policies that mandate custody staff to be present for any medical treatment in such a way that disrupts confidentiality shall be revised to reflect the individualized process set forth above. Custody and medical staff shall be trained accordingly.

Methodology: Compliance measures include:

- Review of County medical, mental health and custody policies show they are in compliance with Remedial plan Requirements.
- Observation of clinical encounters with patients demonstrates that patients are provided auditory and visual privacy from other inmates, and auditory privacy from custody staff.
- Observation of clinical encounters provided by outside medical providers demonstrates compliance with the Remedial plan requirement.
- CQI reports track and monitor cases in which health care staff request custody staff to be present during the clinical encounter, or custody determines they must be in the room during the clinical encounter.

- Self-audit/CQI reports show that the County monitors compliance with Remedial Plan requirements and develops corrective action plans as indicated**.**

Findings: There is no policy on privacy of care. The Second Mays Status Report indicates that all Main Jail and RCCC medical and psychiatric offices provide visual and auditory confidentiality. However, due to inadequate clinical exam space and COVID-19, nurses conduct assessments cell-side which does not permit adequate examinations and privacy.

A significant privacy concern is that when patients are transported to the hospital, transporting deputies are given a form to provide the hospital that contains Health Protected Information (HPI) for which the officer does not have a need to know. The deputy sees this information because the deputy must sign and document the time of departure from the jail on the form.

Compliance Assessment:

- H.1=Noncompliance
- H.2=Partial Compliance
- H.3=Not Evaluated
- H.4=Noncompliance

Recommendations:

1. The County needs to develop a policy on privacy of care that is consistent with the Remedial Plan and NCCHC Standards.[48]
2. Nurses should conduct assessments in adequately equipped exam rooms that provide privacy. If an exam room is not available, establish areas on housing units with privacy screens where nurses can conduct assessments.
3. While non-health care staff should be provided information necessary for safety, they should not be provided protected health information (HPI). HPI should be separated from any forms that require officer review and signature.
4. Transfer information containing medical information should be placed in sealed envelope.

I. Health Care Records

1. The County shall develop and implement a fully integrated electronic health care record system that includes medical, psychiatric, and dental records and allows mental health and medical staff to view the medical and mental health information about each patient in a single record. This shall be accomplished within 12 months of the date the Remedial plan is issued by the Court.
2. Until such a system is implemented, the County shall develop and implement policies and procedures to ensure that medical staff have access to mental health information and mental health staff have access to medical information, as needed to perform their

[48] Standards for Health Services in Jails. 2018. National Commission on Correctional Health Care. J-A-07.

clinical duties. This information shall include all intake records. Medical and mental health staff shall be trained in these policies and procedures within one month of the date the Remedial plan is issued by the Court.

3. The County shall develop and implement policies and procedures to monitor the deployment of the CHS Electronic Health Record (EHR) to ensure the records system is modified, maintained and improved as needed on an ongoing basis, including ongoing information technology support for the network infrastructure and end users.

Methodology: Compliance measures include:

- Review of health records policies and procedures show they are consistent with Remedial Plan requirements and actual practice.
- Review the operational capabilities of the electronic health record shows that it is a fully integrated system with clinical information available to medical, mental health and dental disciplines.
- Staff interviews reflect that staff have appropriate access to medical, mental health and dental information.

Findings: The County has developed health record policies and procedures including: Release of Protected Health Information, Safeguarding Protected Health Information, Standard Abbreviations and Records Retention. There are no policies to monitor the deployment of the electronic health record.

According to the County, staff transitioned from a home grown electronic medical record to the Fusion/Centricity product in April 2018. The transition was accomplished very quickly with little transition, configuration or training.[49] The electronic medical record is extremely challenging and does not meet workforce needs for data tracking and reporting. Key interfaces remain incomplete, Staff have decided that the current electronic health record will not meet program needs and are in the early phases of developing next steps. [50] A Centricity Steering Committee has been established and a new IT position has been funded but not yet filled.

With regard to specific EHR templates and forms, the intake form is not well organized, is cumbersome and contains duplicative information leading to conflicting clinical information. The form does not contain a radial button for the nurse to indicate review of previous admissions as required by the Remedial Plan.

The EHR has a function for ordering tasks and future appointments but does not permit ordering them in accordance to the urgency to which they should be performed. For example, intake nurses order a priority flex nurse appointment for alcohol or drug withdrawal monitoring and essential medication review, but the review showed that these appointments/tasks are not timely performed, sometimes leading to adverse patient outcomes, such as hospitalization due

[49] First Mays Status Report. July 15, 2020. Page 1.
[50] Second Mays Status Report. January 5, 2021. Page 2-3.

to severe drug withdrawal. The same is true for provider essential medication review, although lack of timely essential medication review is also due to inadequate provider staffing.

Compliance Assessment:

- I.1=Substantial Compliance
- I.2=Partial Compliance
- I.3=Noncompliance

Recommendations:

1. The EHR should be configured to align with health care processes.
2. The Nurse Intake form should be reconfigured and streamlined to reduce duplicate information and better organize clinical information.
3. Insert a radial button for the nurse to check yes/no to reviewing medical and mental health information from previous admissions.
4. The nursing and medical directors need to develop procedures to ensure that nurses timely perform intake tasks and medical providers timely perform essential medication review.
5. If the current EHR is unable to meet clinical needs, pursue purchasing and installation of a new record.

J. Utilization Management

1. The County shall revise its utilization management (UM) system to ensure that critical health decisions about patients' access to care are made with sufficient input from providers and a thorough review of health care records.
2. The County shall ensure that decisions about a patient's access to, timing of or need for health care are made by a physician, with documented reference to the patient's medical record. Nurses may gather information and coordinate the UM process, so long as it does not interfere with that requirement. All decisions by the UM committee shall be documented, including the clinical justification for the decision.
3. The UM system shall ensure that providers and patients are promptly informed about decisions made by the UM committee, including denial of a specialist referral request. (Not evaluated)
4. The UM system shall include an appeal process to enable patients and providers to appeal a decision denying a referral request.

Methodology: Compliance measures include:

1. Review of the County's UM policies and procedures show they address and are compliant with the Remedial plan. The policies include an appeal process for patients and providers.
2. Review of health records of patients with specialty services/diagnostic procedure requests show that:
    a. UM review adequately reviews all pertinent clinical information.

b. UM personnel inform providers regarding the UM decision within 48 hours of the submission for urgent requests and 5 calendar days of submission for routine requests.
c. A provider informs the patient of denial of the specialty services request within 5 calendar days and documents an alternate treatment plan.
d. There is a meaningful appeals process.
e. UM decisions are documented on the provider request form and specialty services tracking log.

3. Interviews with providers demonstrate that they are aware of an appeal process for specialty services denials.
4. Self-audit/CQI reports show that SCJ/CHS monitors performance with Remedial Plan requirements and develops corrective action plans as indicated.

Findings: The County has developed a policy on Specialty Referrals that includes the Utilization Management Review process. The policy does not include timeframes for UM staff to notify providers of UM decisions. The policy does not include time frames for providers to notify the patient of UM decisions. The policy does not address the procedure for appeal of denied specialty services.

Compliance Assessments:

- J.1=Partial Compliance
- J.2=Partial Compliance
- J.3=Noncompliance
- J.4=Noncompliance

Recommendations:

1. Ensure that Specialty Services policy and procedure addresses all aspects of the Remedial plan.
2. Ensure that the policy provides operational guidance as to who is responsible for maintaining and monitoring the Specialty Services Tracking Log, including oversight by the Medical Director or designee for monitoring timeliness of completion of specialty services.

K. Sanitation

1. The County shall consult with an Environment of Care expert to evaluate facilities where patients are housed and/or receive clinical treatment, and to make written recommendations to address issues of cleanliness and sanitation that may adversely impact health.

Methodology: Compliance measures include:

1. Documentation that the County has consulted with an Environment of Care expert who has evaluated facilities where patients are housed and/or receive treatment and issue written recommendations.

2. Documentation shows that the County has addressed the Environment of Care expert and routinely monitors sanitation and disinfection of housing units and clinical areas.

Findings: This provision was not addressed in the First or Second Mays Monitoring Report. The Infection Prevention and Control Program policy and procedure[51] briefly addresses Environmental Inspections but there is no operational detail regarding what areas are to be inspected and whether health care staff participate in any inspections.

Compliance Assessment:

- K.1=Noncompliance

L. Reproductive and Pregnancy Related Care

1. The County shall ensure that pregnant patients receive timely and appropriate pre-natal care, specialized obstetric services when indicated, and post-partum care (including mental health services).
2. The County will provide pregnant patients with comprehensive counseling and timely assistance in accordance with their expressed desires regarding their pregnancies, whether they elect to keep the child, use adoptive services, or have an abortion.
3. The County will provide non-directive counseling about contraception to female prisoners, shall allow female prisoners to continue an appropriate method of birth control, shall provide access to emergency or other contraception when appropriate.

Methodology: Compliance measures include:

1. The County has developed, implemented and trained staff regarding Reproductive Health/Pregnancy Related Care policies that are compliant with the Remedial Plan.
2. The County has developed clinical guidelines for management of pregnancy that are compliant with national guidelines (e.g., American College of Obstetricians and Gynecologists (ACOG).
3. The County has established a contract for obstetric/gynecological services.
4. Review of health records shows that women are provided timely and appropriate obstetric/post-partum/gynecological care, including:
    a. Women are screened for pregnancy at intake, including urine pregnancy test.
    b. Nurses refer pregnant patients to a medical provider on the day of arrival for evaluation and risk assessment.
    c. Providers counsel patients regarding their pregnancy options in accordance with the Remedial Plan.
    d. Providers monitor pregnant women in accordance with ACOG guidelines.
5. Review of health records show that women are provided contraception counseling if desired, and birth control methods based upon preference.
6. Self-audit/CQI reports show that SCJ/CHS monitors performance with Remedial Plan requirements and develops corrective action plans as indicated.

[51] Infection Prevention and Control Program. No. 02-02. Effective date 7/24/2020. 01/20/2021

Findings: The County has developed policy regarding Female Reproductive Services that address the requirements of the Remedial Plan. [52]

I reviewed two records of pregnant women. Both women had confirmed urine pregnancy screens. In one case, the patient was severely mentally ill and had a delayed referral to mental health. She is refusing prenatal labs and psychotropic medication. There has been no collaboration between obstetrics and mental health regarding patient refusal of labs. A mental health provider initiated and discontinued the patient's psychotropic medication without ever seeing the patient. [53] The other patient had timely obstetric care.

Compliance Assessment:

- L1=Partial Compliance
- L.2=Partial Compliance
- L.3=Partial Compliance

Recommendations:

1. Medical and mental health staff should collaborate regarding management of patients with medical and mental health conditions who are unable to comply with the treatment program.

M. Transgender and Non-Conforming Health Care

1. The County shall implement policies and procedures to provide transgender and intersex prisoners with care based upon an individualized assessment of the patient's medical needs in accordance with accepted standards of care and prevailing legal and constitutional requirements, including, as appropriate:
    a. Hormone Therapy
    b. Surgical Care
    c. Access to gender-affirming clothing
    d. Access to gender affirming commissary items, make-up, and other property items
2. The County shall ensure that medical and mental health staff have specific knowledge of and training on the WPATH Standards of Care.

Methodology: Compliance measures include:

- The County's Transgender policies and procedures meet Remedial Plan requirements to include access to gender-affirming clothing and commissary items.
- The County's Transgender policies and procedures and clinical treatment guidelines meet Remedial Plan requirements and address the provision of hormone therapy and surgical care.

[52] Female Reproductive Services. No. -2-03. Revision date 10/16/20.
[53] Patient #11.

- County training records that show staff has been trained on WPATH.
- Health records demonstrate that patients are timely referred to a medical provider for medical evaluation and treatment at intake, or when a patient declares transgender or non-conforming status.
- Health records of transgendered/non-conforming patients demonstrate compliance with clinical treatment guidelines.
- Self-audit/CQI reports show that the County monitors performance with Remedial Plan requirements and develops corrective action plans as indicated.

Findings: The First and Second Mays Status Reports do not address each element of the Remedial Plan. The County has developed a draft policy regarding Transgender and Gender Nonconforming Health Care.[54] It has not been implemented.

I reviewed the record of one of two transgendered patients housed at SCJ. The patient was not referred to a physician for management of transgender care and other chronic diseases.[55]

Compliance Assessment:

- M.1=Noncompliance
- M.2=Noncompliance

Recommendations:

1. Finalize and implement the policy and procedure regarding transgender and nonconforming health care.
2. Ensure that transgendered patients are timely referred to a physician and specialist as necessary for care.
3. Provide continuity of care for hormone therapy.

N. Detoxification Protocols

1. Within three months of the date the Remedial plan is issued by the Court, the County shall develop and implement protocols for assessment, treatment, and medication interventions for alcohol, opiate and benzodiazepine withdrawal that are consistent with community standards.
2. The protocols shall include the requirements that:
   (i) nursing assessments of people experiencing detoxification shall be done at least twice a day for five days and reviewed by a physician.
   (ii) nursing assessments shall include both physical findings, including a full set of vital signs, as well as psychiatric findings.
   (iii) medication interventions shall be updated to treat withdrawal syndromes to provide evidenced-based medication in sufficient doses to be efficacious.

[54] Transgender and Gender Nonconforming Health Care. No.05-xx. Draft 04/10/2020.
[55] Patient #15.

(iv) the County shall provide specific guidelines to the nurses for intervention and escalation of care when patients do not respond to initial therapy; and

(v) patients experiencing severe-life threatening intoxication (an overdose), or withdrawal shall be immediately transferred under appropriate security conditions to a facility where specialized care is available.

Methodology: Compliance measures include:

- Review of County policies and procedures show they are compliant with Remedial Plan requirements and provide sufficient operational guidance to staff to implement the policy.
- Review of alcohol and drug withdrawal clinical treatment guidelines are consistent with national clinical practice guidelines (e.g., UpToDate, American Academy of Family Physicians, etc.).
- Record review shows compliance with policies and procedures and clinical practice guidelines.

Findings: The First and Second Mays Status Report do not address Detoxification Protocols. The County developed Standardized Nursing Procedures (SNPs) for alcohol, benzodiazepine, and opiate withdrawal within 3 months of the date the Remedial Plan was finalized by the Court. However, the SNPs are not compliant with remedial plan requirements nor with nationally recognized clinical treatment guidelines. In addition, NCCHC Standards for Medically Supervised Withdrawal and Treatment requires that medically supervised withdrawal is performed under physician supervision, which is not taking place. Moreover, record review shows that the County is not complying with their own Withdrawal Treatment Standardized Nursing Procedure (SNP) requirements. A review of the Standardized Nursing Procedures and medical record review findings are described below.

<u>Opiate Withdrawal Treatment SNP</u>

The Opiate Withdrawal Treatment SNP was revised 5/4/2020. Review of the SNP shows that it does not include:

- Direction to nurses on the time frame for initiating Clinical Opiate Withdrawal Scale (COWS) assessments following intake (e.g., within 4-6 hours depending on baseline COWS assessment scores).
- Direction to nurses regarding referral of patients with medical and mental health comorbidities to physicians for immediate or urgent evaluation (e.g., signs and symptoms of cellulitis, endocarditis, and other complications of opioid use).
- Frequency of COWS monitoring, including the Remedial Plan requirement that nursing assessments are performed at <u>least</u> twice daily for 5 days (and more frequently as clinically indicated), and that assessments are timely reviewed by a physician.
- The requirement for psychiatric symptoms in the nursing assessment.

- Adjustment of clonidine dosing based upon COWS assessment scores or patient weight in accordance with national treatment guidelines.[56]
- Clinical guidance to nurses for intervention and escalation of care when patients do not respond to treatment regimens, including housing in a medically supervised environment (e.g., 2 Medical, detoxification unit, etc.)
- Patients experiencing severe-life threatening intoxication (an overdose), or withdrawal will be immediately transferred under appropriate security conditions to a facility where specialized care is available.

In addition, for patients with long-time opioid use and predictable withdrawal syndrome, consider initiating the treatment protocol at lower COWS assessment thresholds (COWS=>8) to prevent escalation of symptoms and avoidable suffering. Prevention of symptom escalation may prevent the need for intensified monitoring.

Alcohol Withdrawal Treatment Syndrome

The Alcohol Withdrawal Treatment Syndrome SNP was revised on 4/21/2020. The SNP provides more specific guidance for initiating and intensifying monitoring based upon the patient's response to treatment. The SNP treatment and monitoring criteria are based on risk assessments for alcohol withdrawal (e.g., low, high) which may not be readily ascertained by the intake nurse and for which Centricity is not configured to designate risk of alcohol withdrawal for monitoring purposes and treatment purposes.

Review of the SNP shows that it does not include:

- Direction to Intake nurses regarding referral of patients with history of severe alcohol withdrawal and/or medical comorbidities (e.g., cirrhosis, gastrointestinal bleeding, other poorly controlled chronic diseases) to a physician for medical evaluation within 24 hours or sooner, as clinically indicated.
- Adequate frequency of clinical monitoring of patients placed in a sobering cell.
- Nursing CIWA assessments to be performed a minimum of twice daily for 5 days.
- Alcohol treatment regimens that are consistent with the risk or severity of alcohol withdrawal and which taper too rapidly.[57]
- Immediate notification of physicians for any patient in moderate to severe alcohol withdrawal.
- Placement in medically supervised housing for pregnant and non-pregnant women with a history of severe alcohol withdrawal.
- Requirement to notify a medical provider of patients whose symptoms are escalating on treatment.

[56] For COWS score of 8 to 12, give Clonidine 0.1 mg and for COWS over 12, give 0.2 mg and for COWS exceeding 24, change strategy to buprenorphine/naloxone or methadone. For patients over 200 lbs. the doses of clonidine can be raised by 0.1 mg. Medically Supervised Opioid Withdrawal During Treatment for Addiction. UpToDate. 12/15/2020.

[57] ASAM Clinical Practice Guidelines on Alcohol Withdrawal Management. January 23, 2020.

The current Alcohol Standardized Nursing Procedure permits discontinuation of CIWA after 2 CIWA assessments. This does not take into consideration that some patients may provide incomplete historical information about alcohol use and withdrawal syndrome due to intoxication or serious mental illness (and that alcohol related withdrawal seizures may occur 24-36 hours after alcohol cessation.)

With respect to where patients are to be housed while being monitored, males are to be monitored on 2E and in the medical housing unit (MHU) at RCCC, while females are only to be monitored in general population at Main Jail and RCCC. Any patient with moderate to severe alcohol withdrawal should be housed in a medical environment where their symptoms of withdrawal can be closely monitored and treated.

During this era of COVID-19, where new inmates are placed in quarantine pods for 7-14 days, it provides the opportunity to consolidate monitoring of patients at risk of withdrawal. Post-COVID-19, health care and SSO leadership should give strong consideration to establishing a detoxification unit which would enable more effective and efficient monitoring of patients at risk of withdrawal syndrome.

Benzodiazepine Withdrawal Treatment SNP

The Benzodiazepine Withdrawal Treatment SNP was revised on 4/21/2020.

Review of the SNP shows that it does not include:

- Direction to Intake nurses regarding referral of patients with history of severe benzodiazepine withdrawal and/or medical comorbidities (e.g., poorly controlled chronic diseases) to a physician for medical evaluation within 24 hours or sooner, as clinically indicated.
- Adequate frequency of clinical monitoring of patients placed in a sobering cell for benzodiazepine poisoning or withdrawal.
- Nursing CIWA assessments to be performed a minimum of twice daily for 5 days.
- Immediate notification of physicians for any patient in moderate to severe benzodiazepine withdrawal.
- Requirement to notify a medical provider of patients whose symptoms are escalating on treatment.
- Placement in medically supervised housing for patients (male or female) with a history of severe benzodiazepine withdrawal.

The current SNP does not provide adequate monitoring intervals following initiation of treatment. The SNP states to schedule a Priority Flex Visit at 24 and 48 hours to follow-up on symptoms and monitoring is not based upon the severity of withdrawal at the time treatment is started.

Medical Record Review

I review health records of detainees admitted to SCJ from March to mid-November 2020. I found that that patients at risk of alcohol, benzodiazepine and opiate withdrawal are not adequately evaluated during the nurse intake screening and are not monitored in accordance with the Remedial Plan, ACH Standardized Nursing Procedures, or nationally recognized clinical practice guidelines. failure to order withdrawal monitoring at intake, failure to timely monitor

My specific findings include the following.

- Intake nurses do not consistently perform adequate substance use histories, particularly if the patient reports using more than one substance.
- Nurses do not consistently perform urine drug screens as required by SNPs.
- Intake nurses do not specifically order CIWA and/or COWS monitoring at the intake screening process. Instead, nurses order a generic Priority Flex Nurse (PFN) Appointment.
- Nurses do not perform timely and appropriate CIWA and COWS monitoring.
- Nurses do not notify physicians of patients with severe withdrawal or whose symptoms are worsening.
- Nurses do not refer patients to a substance abuse counselor per intake policy.

These problems were exemplified in the following records:

Patient #2

A detainee was admitted to the jail in September 2020 with a history of substance use disorder with alcohol, benzodiazepines, heroin, and methamphetamine. In 2019 during a previous jail admission, he reported history of alcohol, benzodiazepine and methadone use and was treated for alcohol/benzodiazepine withdrawal with valium.

Upon arrival a RN performed intake screening noting his substance abuse history. The nurse obtained a history of amount, frequency and last use of heroin, but did not obtain a positive or negative history for alcohol, benzodiazepine and methamphetamine use. The nurse did not inquire about HIV, hepatitis, cirrhosis, or endocarditis as required by the standardized nurse procedure. The nurse did not perform a urine drug screen. The nurse ordered an immediate nurse assessment, for a nurse to reevaluate the patient for substance use withdrawal. The nurse did not refer the patient to a substance use disorder (SUD) counselor.

Twelve hours after arrival, a nurse was called to the patient's housing unit for a man-down. The nurse observed the patient to be diaphoretic and yawning. He complained of body aches, nausea, and vomiting. He was able to walk from his cell door to downstairs and then moved to a wheelchair and transported to 2M. COWS score=13. BP=171/93 mm Hg. A nurse did not contact a physician regarding the patient's withdrawal symptoms or high blood pressure. The nurses' plan was to initiate opiate protocol per a standardized nursing procedure (SNP) and schedule the patient for a *48-hour detox check* and continue to monitor. The nurse ordered

Loperamide and Ondansetron, but not Clonidine. These orders were not cosigned by a medical provider.

Over the next 48 hours, nurses did not perform timely COWS assessments but when performed, documented that the patient's withdrawal symptoms escalated, with persistent nausea and vomiting, unrelieved by medications. Nurses did not notify a physician for orders that might have included intramuscular anti-nausea medications to relieve his symptoms.

Approximately, 56 hours after arrival, a physician evaluated the patient due for lethargy, inability to get out of bed, abdominal and chest pain. The patient was hospitalized and treated for toxic encephalopathy, substance abuse and withdrawal.

Summary: This patient was not timely evaluated, monitored and treated for heroin and possibly other substance use withdrawal that resulted in a likely preventable hospitalization. The nurse ordered part of the opiate withdrawal protocol but not Clonidine and there was no review of the nurse's orders by a medical provider. Nurses did not report the patient's unrelieved symptoms to a medical provider Although substance use withdrawal should be medically monitored, in this case, a physician was not involved until the patient had deteriorated to the point of requiring hospitalization.

Patient #16

A detainee was admitted in July 2020 and died 11 days after arrival at the jail. His medical history included substance use disorder involving benzodiazepines and heroin and left arm abscess. The patient had a previous admission on 1/26/2018[58] and 12/8/2019.

Upon arrival a RN conducted intake screening. The patient reported heroin and benzodiazepine use. The nurse did not take a history of amount, frequency, duration or last use of each substance and did not perform a urine drug screen. He denied mental health conditions. The patient had a left arm abscess that the nurse cleaned and dressed. COWS=3, CIWA=not performed. The nurse ordered Essential Medication Review, Priority Flex Nurse (PFN) Appointments x 2 and MD Sick Call x 2, MH referral, SARS CoV-2 and tuberculin skin testing. The nurse did not refer the patient to a substance use disorder (SUD) counselor.

A nurse did not perform substance use withdrawal monitoring (e.g., COWS or CIWA) the remainder of the day or the following day.

Approximately 56 hours after his arrival a nurse practitioner (NP) saw the patient for follow-up of his left arm abscess. The NP noted the patient appeared to be detoxing with elevated BP and pulse. The patient using other drugs and denied nausea, vomiting and diarrhea. Temp=99° F, BP=181/85 mm Hg, pulse=137/minute, resp=16/minute, oxygen saturation=100%. The NP did not perform a COWS or CIWA assessment, order a urine drug screen, address the patient's

[58] I am unable to open documents from the January 2018 admission.

abnormal vital signs, order vital sign monitoring, or opiate and/or benzodiazepine withdrawal medications.

Approximately 60 hours after arrival a RN assessed the patient for substance use withdrawal, noting that he complained of hot/cold flashes, nausea, vomiting and diarrhea. The patient reported smoking 2 points of heroin per day. Has used daily for 2 years. COWS=9. A urine drug screen was positive for methamphetamine, opiates, MDMA and THC and negative for benzodiazepine. The nurse noted that the patient's COWS score did not warrant medication. The RN encouraged patient to hydrate.

No further COWS or CIWA assessments were performed. Nine days after arrival a telephone referral form notes that custody made an urgent JPS referral because the patient was extremely paranoid, had irrational thoughts and had pressured speech. A RN entered a JPS Must See order into the EHR. This did not immediately occur and a RN entered another order for JPS must see noting the patient was irritable, disruptive and not able to follow directions. A LCSW saw the patient who was anxious and "freaking out", afraid of other inmates. The LCSW ordered a welfare check. The next day a LCSW saw the patient and observed him talking to an unseen person and entered a diagnosis of bipolar disorder into the EHR.

Ten days after the patient's arrival a CNA approached a Supervising Registered Nurse regarding how to handle a telephone call she received from JPS staff who was concerned about a patient with possible detox symptoms. The CNA had referred the call to another RN who initially refused to accept the message but told her that "if it was truly urgent, they will bring him down to be checked". The SRN and CNA contacted the Flex RN who reported that the patient was past the detox monitoring period. The SRN instructed the RN to see the patient and check his vital signs and document the results of her assessment.[59] This did not occur.

Eleven days after his arrival a nurse saw the patient for evaluation of detox medications. The patient was rambling with compressed speech. The nurse did not refer the patient to a physician. Two hours later a nurse responded to a man down at the patients housing location. The patient was without respirations or pulse. CPR started and AED applied. No shock advised. The patient expired. An autopsy report was not available for review, but County health care leadership reported that the patient died of "ruptured acute myocardial infarction and severe drug abuse history".

Summary: This case exemplifies the structural and systemic process issues described in this report, such as failure to take an adequate substance abuse history, failure to monitor and initiate treatment and lack of medically supervised withdrawal. This case demonstrates lack of cooperation between medical and mental health staff and indifference by two nursing staff to this patient with serious medical needs. This may reflect a wider cultural issue at the jail in how health care personnel view their obligations to provide timely, appropriate and compassionate care to patients.

[59] Patient #16 Incident Report. 8/4/2020.

Compliance Assessment:

- N.1=Noncompliance
- N.2=Noncompliance

Recommendations:

1. The County needs to develop a Medically Supervised Withdrawal and Treatment policy and procedure that is consistent with NCCHC standards.
2. The County need to implement nationally recognized clinical practice guidelines regarding substance abuse withdrawal, incorporating the guidelines into expected physician practice standards at Sacramento County Jail.
3. The County's medical leadership should ensure increased medical supervision of patients undergoing substance use disorder monitoring and treatment.
4. Consider implementing fixed dose treatment regimens (as opposed to symptom triggered treatment) to prevent escalation of withdrawal syndromes.
5. The County needs to revise its Substance Abuse Disorder Standardized Nursing Procedures to be consistent with the Remedial Plan and nationally recognized clinical practice guidelines.
6. Centricity should be reconfigured to create order sets and alerts for physician referral timeliness, frequency of monitoring, medication regimens, physician review of CIWA/COWS assessments based upon the risk of, or symptoms of SUD withdrawal.
7. The Intake Nurse should enter orders for SUD withdrawal monitoring and treatment that that creates an alert for nurses to complete COWS or CIWA assessments no later than 6 hours after arrival.
8. The County should develop a tracking system to ensure that all patients being monitored for substance use withdrawal receive timely assessments.
9. To the extent feasible, designate housing units for the purposes of detox monitoring.
10. Provide training to health care staff regarding revised policies, standardized nursing procedures and clinical practice guidelines
11. The County should implement CQI studies of performance to track compliance with policies and procedures.

O. Nursing Protocols

1. Nurses shall not act outside their scope of practice.
2. To that end, the County shall revise its nursing standardized protocols to include assessment protocols that are sorted, based on symptoms, into low, medium and high-risk categories.
    a. Low risk protocols would allow registered nurses to manage straightforward symptoms with over-the-counter medications;
    b. Medium-risk protocols would require a consultation with a provider prior to treatment; and
    c. High-risk protocols would facilitate emergency stabilization while awaiting transfer to a higher level of care.

Methodology: Compliance measures include:

- Health care policies and procedures, practices, staff interviews and health records demonstrate that nurse's practice within their legal scope of practice.
- The review shows that the County has revised its nursing standardized protocols that are based upon symptoms, into low medium and high-risk categories.
- Health record review shows that nurses complied with nursing protocols including timely referral to a medical, dental or mental health provider (See access to care record review).
- Self-audit/CQI reports show that the County monitors its performance with Remedial Plan requirements and develops corrective action plans as indicated.

Findings: A review of health records shows that nurses do not consistently refer patients with serious medical needs to a medical provider and instead, plan to monitor the patient themselves. This exceeds their scope of practice. The County has not developed nursing standardized procedures for commonly occurring conditions that are stratified by low, medium and high-risk protocols, except for substance use disorder protocols. The Second Mays Report does not address Nursing Protocols.

Compliance Assessment:

- N.1=Noncompliance
- N.2=Noncompliance

Recommendations:

1. Nursing leadership should develop Nursing protocols consistent with Remedial Plan requirements and ensure that nurses do not exceed their scope of practice.

P. Review in Custody Deaths

1. Preliminary reviews of in-custody deaths shall take place within 30 days of the death and shall include a written report of the circumstances of the events leading to the death, with the goal to identify and remedy preventable causes of death and any other potentially systemic problems.
2. Mortality reviews shall include an investigation of the events occurring prior to the death, an analysis of any acts or omissions by any staff or prisoners which may have contributed to the death, and the identification of problems for which corrective action should be undertaken.

Methodology: Compliance measures include:

- Mortality Review policies and procedures show they are compliant with Remedial Plan requirements.
- Preliminary mortality reviews are conducted within 30 days and identify immediate individual or systemic issues that need to be addressed to prevent future harm, including death.

- The County conducts a thorough mortality review within 45 days to evaluate the timeliness and appropriateness of care, including:
    - Identifying acts or omissions that may have contributed to the death.
    - Identifying specific or systemic problems for which corrective action should be taken.
    - Identifying opportunities for improvement health care systems or quality of care.
- Documentation shows that the County timely develops and implements a corrective action plan with assigned responsibilities, time frames for completion, and reevaluation of progress.

Findings: In the past 12 months, there were 5 reported deaths at Sacramento County Jail.

Medical Review of In-Custody Deaths Policy and Procedure
The policy on Medical Review of In-Custody Deaths was developed on 10/10/2019. It requires that clinical and psychiatric leadership conduct an assessment of care provided within 30 days of the death. The policy does not establish time frames for administrative review that includes correctional and emergency response. The policy is compliant with Remedial Plan requirements.

Review of Mortality Reviews and Related Documents
I requested incident reports, mortality reviews and corrective action plans for each respective death. I was provided incident reports for 3 of 5 deaths. However, I was not provided any mortality reviews reflecting that in-custody deaths were reviewed within 30 days and analysis of the care provided.

I was also provided a Nursing Corrective Action Plan dated 10/20/2020 for an Emergency Medical Response involving a death that occurred in December 2019. The Nursing Corrective Action Plan reflects that on 12/9/2019, a serious incident involving a nurse occurred. On 12/12/2019, an Emergency Meeting was called for medical, nursing and custody leadership to review video. On 12/12/2019 leadership reviewed the video with the Supervising Nurse who responded. Problems and corrective actions were identified. From January to October 2020, the Corrective Action Plan reflects actions taken in response to the December 2019 incident.

Medical Record Reviews
I reviewed the medical records of 2 of 5 deaths that occurred in 2020. Review of these records showed systemic issues that are described in Intake Screening and Detoxification Protocols Sections of this report.

Compliance Assessment:
- P.1=Noncompliance
- P.2=Noncompliance

Recommendations:

1. Health care leadership should ensure timely initial and subsequent reviews of deaths to identify problems, root causes and develop a corrective action plan.

Q. Reentry Services

1. The County shall provide a 30-day supply of current medications to patients who have been sentenced and have a scheduled release date, immediately upon release.
2. Within 24 hours of release of any patient who receives prescription medications while in custody and is classified as presentence, the County shall transmit to a designated County facility a prescription for a 30-day supply of the patient's current prescription medications.
3. The County, in consultation with Plaintiffs, shall develop and implement a reentry services policy governing the provision of assistance to chronic care patients, including outpatient referrals and appointments, public benefits, inpatient treatment, and other appropriate reentry services.

Methodology: Compliance measures include:

- The County has developed and implemented reentry policies and procedures that comply with Remedial Plan Requirements.
- The County demonstrates that through policy and practice it:
    - Provides a 30-day supply of each medication to eligible inmates (i.e., sentenced with a release date) immediately upon release; and
    - Within 24 hours of release of pre-sentenced inmates, transmits a prescription for 30 days of medication to a county facility.
- Self-audit/CQI reports show that the County monitors performance with Remedial Plan requirements and develops corrective action plans as indicated.

Findings: The County developed a Discharge Medication policy in February 2020. The second Mays Status Report indicates that the County began providing medications to sentenced inmates being released in December 2019. From July to November 2020 the percentage of inmates receiving medications ranged from 65-88%. The denominators for these compliance rates are small, ranging from 81 to 120 inmates. The County is not yet providing medications to presentenced inmates.

Compliance Assessment:

- Q.1=Partial Compliance
- Q.2=Noncompliance
- Q.3=Noncompliance

Recommendations:

1. The County should perform CQI studies to determine whether current policies and actual practices capture all sentenced inmates eligible for discharge medications.
2. Initiate discharge medications for presentenced inmates as soon as feasible.

3. Develop and implement a Reentry Services Policy that is compliant with Remedial Plan Requirements.

R. Training

1. The County shall develop and implement, in collaboration with Plaintiff' counsel, training curricula and schedules in accordance with the following:
    a. All jail custody staff shall receive formal training in medical needs, which shall encompass medical treatment, critical incident response, crisis intervention techniques, recognizing different types of medical emergencies, and acute medical needs, appropriate referral practices, relevant bias and cultural competency issues, and confidentiality standards. Training shall be at a minimum every two years.

Methodology: Compliance measures include:

- Training records demonstrate that all jail custody staff receive formal training in medical areas identified in the Remedial Plan.
- Training records show that the training is performed every 2 years.

Findings: This provision was not evaluated for this monitoring report.

Compliance Assessment:

- R.1=Not Evaluated

Recommendations:

1. The County should develop curricula and implement training for each of the areas identified in the Remedial Plan.
2. The County should maintain centralized records and tracking system of staff training.
3. The County needs to ensure that training is performed and documented every two years.

Medical Remedial Plan Compliance Summary

	Paragraph	Substantial Compliance	Partial Compliance	Noncompliance	Not Evaluated
1.	A.1.		01/21/2021		
2.	A.2.			01/20/2021	
3.	B.1.	1/20/2021			
4.	B.2.				01/20/2021
5.	B.3.		01/20/2021		
6.	B.4.			01/21/2021	
7.	B.5.		01/20/2021		
8.	B.6.		01/20/2021		
9.	B.7.				01/20/2021
10.	C.1.			01/20/2021	
11.	C.2.		01/20/2021		
12.	C.3.a			01/20/2021	
13.	C.3.b			01/20/2021	
14.	C.3.c			01/20/2021	
15.	C.3.d			01/20/2021	
16.	C.4.			01/20/2021	
17.	C.5			01/20/2021	
18.	C.6.			01/20/2021	
19.	C.7.a			01/20/2021	
20.	C.7.b			01/20/2021	
21.	D.1.			01/20/2021	
22.	D.1.a			01/20/2021	
23.	D.1.b			01/20/2021	
24.	D.1.c			01/20/2021	
25.	D.1.d			01/20/2021	
26.	D.2.			01/20/2021	
27.	D.3			01/20/2021	
28.	E.1.				01/20/2021
29.	E.2.				01/20/2021
30.	E.3.				01/20/2021
31.	E.4.				01/20/2021
32.	E.5				01/20/2021
33.	E.6.				01/20/2021
34.	E.7.				01/20/2021
35.	E.8.				01/20/2021
36.	E.9				01/20/2021
37.	E.10.				01/20/2021
38.	F.1.a	01/20/2021			

	Paragraph	Substantial Compliance	Partial Compliance	Noncompliance	Not Evaluated
39.	F.1.b	01/20/2021			
40.	F.2.			01/20/2021	
41.	F.3.			01/20/2021	
42.	F.4.			01/20/2021	
43.	F.5.			01/20/2021	
44.	F.6.		01/20/2021		
45.	G.1.		01/20/2021		
46.	G.2.				01/20/2021
47.	G.3.				01/20/2021
48.	G.4				01/20/2021
49.	H.1.			01/20/2021	
50.	H.2.		01/20/2021		
51.	H.3.				01/20/2021
52.	H.4.			01/20/2021	
53.	I.1.	01/20/2021			
54.	I.2.		01/20/2021		
55.	I.3			01/20/2021	
56.	J.1.		01/20/2021		
57.	J.2.		01/20/2021		
58.	J.3.			01/20/2021	
59.	J.4			01/20/2021	
60.	K.1			01/20/2021	
61.	L.1.		01/20/2021		
62.	L.2.		01/20/2021		
63.	L.3.		01/20/2021		
64.	M.1.			01/20/2021	
65.	M.2.			01/20/2021	
66.	N.1.			01/20/2021	
67.	N.2.			01/20/2021	
68.	O.1.			01/20/2021	
69.	O.2.			01/20/2021	
70.	P.1.			01/20/2021	
71.	P.2.			01/20/2021	
72.	Q.1.		01/20/2021		
73.	Q.2.			01/20/2021	
74.	Q.3.			01/20/2021	
75.	R.1.				01/20/2021
	Total	**4 (5%)**	**15 (20%)**	**39 (52%)**	**17 (23%)**