Seventh Monitoring Report of the Mays Medical Consent Decree

Mays et al. v. County of Sacramento

Case No. 2:18-cv--02081

FINAL

Submitted
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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 the Defendants agreed to implement the measures set forth in a Remedial Plan, to be monitored by court-appointed Experts.[2] On January 13, 2020, the federal court approved the Consent Decree. Among other things, the Consent Decree requires Defendants to issue periodic status reports describing the steps taken to implement each provision set forth in the Remedial Plan and identifying 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 Reports must describe all steps taken 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 the Defendant. The Consent Decree also requires that court-appointed neutral experts report periodically on Defendant's compliance with the Remedial Plan in publicly filed reports. This report is responsive to that requirement.

We thank Tianna Hammock, Health Services Administrator, Sacramento Sheriff's Office (SSO), Captain Mark Cherry, Captain Mark Limbird, and their staffs 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 (E.D. Cal.).

[2] Angela Goehring RN, MSA, CCHP and Sylvia McQueen, MD are the Medical Experts. Mary Perrien is the Mental Health Expert. Lindsay Hayes is the Suicide Prevention Expert. Madeline LaMarre, MN, FNP-BC was a member of the monitoring team. She retired March 31, 2025.

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 experts should determine whether the Defendants are in substantial compliance or not in "substantial compliance" with an individual provision. 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 created a three-tier system for the measurement of compliance. Each of the experts has 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 measures (e.g., consistent with the larger purpose of the Decree). 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.

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 "the Branch."

The Main Jail is a multistory building built in 1989 with an original rated capacity of 1,250, which was later increased to 2,380. It is the primary intake center for the jails and houses individuals of varying custody levels. Housing unit design is primarily single and double cells with solid doors. As December 2024, Main Jail population was 1,737. This is 73% of the officially rated capacity, but near 100% of functional capacity.

RCCC is in Elk Grove and was originally 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 by the Sacramento County Courts. An increasing percentage of the detainees housed at RCCC are pre-sentence detainees, to keep the population levels down at the Main Jail. 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. As of December 2024, the RCCC population was 1,440, or 88% of rated capacity.

The Sacramento Sheriff's Office (SSO) has overall responsibility for the 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 Americans with Disabilities Act (ADA) or Health Insurance Portability and Accountability Act (HIPAA), which were enacted at later dates. The County has represented that it plans to renovate the Main Jail to provide a new acute psychiatric unit, and to construct an Intake and Health Services Facility (IHSF) medical building to become compliant with the Consent Decree.[3]

[3] Remedial Plan Status Report. Adult Correctional Health. January 7, 2025.

Glossary

ACH	Adult Correctional Health Care
ADA	Americans With Disabilities Act
APU	Acute Psychiatric Unit
AED	Automatic External Defibrillator
ATIMS	Automated Information Technology Management System
AUD	Alcohol Use Disorder
BAC/BAL	Blood Alcohol Content/Blood Alcohol Level
BUD	Benzodiazepine Use Disorder
CalAIM	California Advancing & Innovation Medi-Cal
CIPS	Center for Innovative Pharmacy Solutions
CM	Case Management
CAP	Corrective Action Plan
CNA	Certified Nurse Assistant
CDCR	California Department of Corrections and Rehabilitation
CIWA-Ar	Clinical Institute Withdrawal Assessment-Alcohol
CIWA-B	Clinical Institute Withdrawal Assessment-Benzodiazepine
COWS	Clinical Opiate Withdrawal Scale
CPR	Cardiopulmonary Resuscitation
CT	Computed Tomography
CD	Consent Decree
DDS	Doctor of Dental Surgery
DGS	Department of General Services
DON	Director of Nursing
DT	Delirium Tremens
ED	Emergency Department
EDD	Estimated Due Date
EGD	Esophagogastroduodenoscopy
EHR	Electronic Health Record
EKG/ECG	Electrocardiogram
EMS	Emergency Medical Services
EMG	Electromyography
eMAR	Electronic Medication Administration Record
EOP	Enhanced Outpatient Program
FSBS	Finger Stick Blood Sugar
FTE	Full Time Equivalent
HSR	Health Services Requests
HUSC	Hospital Unit Services Coordinator
IHSF	Intake Health Services Facility

KOP	Keep on Person
LCSW	Licensed Clinical Social Worker
LMFT	Licensed Marriage and Family Therapist
LOC	Level of Consciousness
LVN	Licensed Vocational Nurse
MA	Medical Assistant
MD	Medical Doctor
MAT	Medication Assisted Treatment
MH	Mental Health
MHA	Mental Health Assessment
IT	Information Technology
MJ	Main Jail
MRI	Magnetic Resonance Imaging
MRSA	Methicillin-Resistant *Staphylococcus Aureus*
MR	Mortality Review
MRT	Magnetic Resonance Tomography
MUD	Methamphetamine Use Disorder
NCCHC	National Commission on Correctional Healthcare
NP	Nurse Practitioner
OB/GYN	Obstetrician/Gynecologist
OUD	Opioid Use Disorder
PAWSS	Prediction of Alcohol Withdrawal Severity Scale
PEFR	Peak Expiratory Flow Rate
PharmD	Clinical pharmacist/Doctor of Pharmacy
RCCC	Rio Cosumnes Correctional Center
RDA	Registered Dental Assistant
RN	Registered Nurse
ROI	Release of Information
QI/QA	Quality Improvement/Quality Assurance
SCJ	Sacramento County Jail
SMI	Serious Mental Illness
SrHPM	Senior Health Program Manager
SRN	Supervising Registered Nurse
SSO	Sacramento Sheriff's Office
STI	Sexually Transmitted Infection
SNP	Standardized Nurse Procedures
SUD	Substance Use Disorder
SW1	Social Worker 1
TBI	Traumatic Brain Injury
UM	Utilization Management

Executive Summary

The Medical Experts thank Tianna Hammock, Captain Mark Cherry, Captain Mark Limbird, and their staff for their assistance in conducting the site visit. Everyone was extremely cooperative and helpful to us. We specifically thank Compliance Lieutenants Aaron Decanio and Darron Epperson, as well as Compliance Manager Michael Kotara, for their assistance during the site visit.

During the site visit, we toured both facilities, reviewed documents, and interviewed healthcare and custody leadership, as well as line staff. We also interviewed inmates selected from medical records reviews, and at the request of the class counsel. Following our site visit, we reviewed additional medical records and documents. We thank the health care and custody leadership for providing additional information and clarification following the site visit.

Summary of Medical Remedial Plan Compliance

Substantive Area	Total Provisions	Substantial Compliance		Partial Compliance		Non-Compliance		Not Evaluated	
Medical	**80**	**14**	**18 %**	**47**	**59 %**	**18**	**22 %**	**1**	**1 %**

This monitoring cycle, from 9/23/24 to 3/21/25, showed some progress in compliance with the Consent Decree. Compliance assessments increased for eleven provisions, remained the same for sixty-two provisions, declined for seven provisions, and one provision was not evaluated.

Key Consent Decree components that did not improve or declined include provider staffing and medical leadership, chronic disease management, infirmary care, monitoring of patients requiring sobering and experiencing substance abuse withdrawal, access to specialty services, use of standardized nursing protocols, access to programs and services for patients housed in medical units, review of in-custody deaths, and the evaluation of health care quality.

Key components of the Consent Decree that were improved included patient confidentiality during the intake screening process, the availability and collection of health service requests, utilization management reviews, provider decision-making, and training.

Patient access to Health Services Requests (HSRs) forms and the collection of the requests improved. The County provides adequate supplies and reasonable access to health service requests (HSRs) and grievance forms. At RCCC, inmates report that their completed HSRs are placed in the collection box without interference from other inmates or are accepted directly by health staff. They report that the practice of other inmates collecting the written request and impeding their access to care no longer occurs.

Patient confidentiality during the intake screening in the booking suite has improved. The remodeling of the unit and the training of custody and healthcare staff on the requirements of

patient privacy and confidentiality had a significantly positive impact. There remain challenges with managing the patient queue and overall supervision of health staff that require continuous focus in the service delivery area.

Another area of notable focus and improvement during this monitoring cycle is the Specialty Services referral process. The addition of Case Management nurses and dedicated physicians to complete patient case reviews has improved the authorization process, resulting in the more efficient approval of medically necessary specialty referrals and a reduction in requests that are more elective in nature.

The County added a Health Program Manager position as a second Director of Nursing (DON) position to oversee all nursing operations at RCCC. An additional Nurse Educator position was also added to enhance clinical onboarding and training of nursing staff. The County is commended for allocating resources for these important additions.

A significant concern is the lack of medical leadership in overall health services. The Medical Director accepted a new position with an outside agency and resigned from ACH in mid-February. Although a new physician has been appointed, onboarding is pending. The full-time Assistant Medical Director position was converted to two part-time positions, one of which has been filled. The lack of consistent and comprehensive physician leadership is palpable in several areas of service delivery. A stable, joint leadership team comprising the Health Services Administrator, Medical Director, Director of Nursing, and Dental and Behavioral Health Director is required to consistently advance the health services program, meet the needs of the patient population, and fulfill the requirements of the Consent Decree.

The improvements in the provision of private clinical exam rooms in the booking area and the purchase of modular exam booths in the housing units are laudable. However, an inadequate number of clinical examination rooms that provide both auditory and visual privacy during healthcare encounters remains. The insufficient amount of clinical space at the Main Jail and at RCCC results in an ongoing pattern of seeing patients in cell-side areas, in housing unit dayrooms, in front of cells occupied by other inmates, and in front of custody staff. Despite the best efforts of custody staff to maintain auditory distance, the physical plant does not provide adequate privacy. The County's report that the Board of Supervisors recommended sourcing another feasibility study for the planned fiscal plant improvement project is concerning, as it further delays addressing this critical issue.

There has been no significant change in patients' access to care during this monitoring period. Challenges persist in accurately and timely triaging requests for medical, dental, and behavioral health services. Although there has been a slight improvement in the number of pending provider appointments, an ongoing backlog persists, resulting in delayed care and treatment of serious medical conditions. The backlogs persist due to provider productivity and a lack of sufficient custody escorts.

Challenges in the care and treatment of patients under the influence and at risk of withdrawal from alcohol and drugs remain. There is a lack of appropriate intake referrals for Obstetrics and Addiction Medicine. Nursing withdrawal monitoring is not timely and is often not done at all. Staff do not recognize patients experiencing severe and potentially life-threatening intoxication and therefore do not timely transfer them to a higher level of care. Patients determined to be fit for confinement who require sobering are placed on the floor, in a cell, in the booking suite, and are not consistently monitored by nursing staff. Patients who are intoxicated and those at risk for withdrawal from alcohol and drugs require appropriate medical placement, monitoring, and treatment.

The County has still not implemented a chronic disease program that provides patients with timely and appropriate care, meets the nationally published clinical guidelines, or the requirements of the Consent Decree. A tracking system, either manual or electronic, is required to ensure that all patients with chronic diseases are identified and monitored in a timely manner.

The County has not conducted regular evaluations of provider quality, resulting in care that does not meet generally accepted standards of care or meet current medical care guidelines. The lack of a comprehensive credentialing program, inadequate oversight by a Medical Director, failure to develop and implement chronic disease guidelines, and failure to conduct comprehensive clinical qualitative and quantitative improvement studies that identify systemic and individual performance issues will continue to result in the delivery of care that falls below the standard.

There was a change in leadership in the Quality Improvement program during this monitoring cycle. There were critical service delivery areas that were not studied, such as chronic disease management, prescriptive practices, medication verification, medication errors, patient refusals, and coordination between custody and medical staff in access to care. There was no significant progress in completing the established corrective action plans, which are a critical component of the QI process.

An effective QI program provides a solid foundation for measuring critical components of service delivery in the healthcare delivery system. To adequately measure the overall effectiveness of the delivery system and compliance with the Consent Decree, each program component must be assessed at least annually, and critical and deficient components must be assessed more frequently. Given the progress toward compliance with the Consent Decree, it is vital that the QI program is adequately staffed, completes critical service delivery area studies, and provides leadership with meaningful, accurate, and validated data that facilitates measuring compliance, developing mitigation strategies to avoid patient harm, operational inefficiencies and waste, and promotes progressive improvements that are sustainable.

The review of in-custody deaths is conducted within thirty days of the event; however, it does not adequately correlate the clinical practice, deficient processes, systems, and professional performances that directly contribute to the clinical outcomes. The goals for the County should be to quickly identify opportunities for improvement and to adjust the care accordingly to prevent further and avoidable harm. Healthcare systems, processes, policies, procedures, as well

as clinical guidelines, quality improvement activities, and clinical competencies, must all align to mitigate patient harm, maintain patient health, and improve clinical outcomes. The County is still evolving to accomplish these alignments.

This review revealed mixed progress in compliance with the Consent Decree. There was improvement in some provisions and a decline in others. In our last report, we recommended that the County establish a multidisciplinary internal Consent Decree Strike Team. We strongly recommend that leaders in each discipline implement mitigation steps to support the various corrective action plans. Serious consideration should be given to sourcing external correctional healthcare experts who can provide the necessary expertise in implementing proven best practices in the carceral setting and moving the program toward compliance.

Respectfully submitted,

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Sylvia McQueen, MD, MBA, FACP, CCHP

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.

Findings: To determine if adequate personnel resources are available, the County needs to assess if they have sufficient numbers and types of medical, mental health, ancillary, and custody staffing to meet professional standards of care and to execute the requirements of this remedial plan. The assessment should include clinical staff, the office, technological support, the quality improvement unit staff, and custody staff responsible for escorts and transportation. In November 2024, the County started the contracting process to complete the required analysis. However, it was determined that the County needed to conduct a needs assessment before the staffing analysis. The vendor is updating the scope and cost of the project, and the County hopes to have a contract by the next monitoring period[4](VI. A.1).

The County has increased Adult Correctional Health Care (ACH) Medical and Administrative FTEs by adding three Registered Nurses and three Supervising Registered Nurses (SRNs). Two SRNs will be assigned to oversee nursing intake operations on the night shift, and the third will oversee the grievance process. [5]

The County has also added a Health Program Manager position as a second Director of Nursing (DON) position to oversee all nursing operations at RCCC.[6] The County has created and filled a Supervising Nurse Educator position who will oversee onboarding and training of new nursing staff, ensuring compliance with mandatory staff training requirements, and training all staff on new and existing policies and procedures.[7]

[4] 10th Sacramento County Remedial Plan Status Report. January 7, 2025, page 96.
[5] 10th Sacramento County Remedial Plan Status Report. January 7, 2025, page 7.
[6] With two Director of Nursing positions, the County needs to determine who has final authority over nursing policy, protocol, and nursing resource utilization.
[7] 10th Sacramento County Remedial Plan Status Report. January 7, 2025, page 7.

The Medical Director resigned in mid-February 2025, and the newly hired physician is pending onboarding. The full-time Assistant Medical Director position has been converted to two part-time positions. One of the positions has been filled, and the County is currently recruiting and advertising for the second position. There is a lead physician at both the Main Jail and RCCC. However, both physicians report that their positions do not include supervision. *Thus, there is no effective medical supervision on a day-to-day basis at the jails.* ACH clinical leadership daily huddles are not being conducted at the Main Jail to assess the clinical workload and to make adjustments in resources as needed. During the monitoring visit, a single provider was assigned to 2M, but the volume of work resulted in an inability to meet the clinical workload, leading to frustration and concern about not being able to meet the patients' needs.

The County has expanded on-site medical provider coverage to seven days per week, including evening hours. This includes both primary care and MAT providers. The County provides 24/7 physician on-call coverage.[8]

Provider productivity issues and provider clinic backlogs remain, although improved from the prior monitoring report. The County reported conducting "blitzes" to reduce the number of delinquent appointments; however, backlogs remain. At the time of the tour, there was a backlog of 190 patient encounters at RCCC. Of the 190 appointments, only one was delinquent beyond 30 days, fourteen were delinquent beyond fourteen days, and the remainder were within fourteen days. Similar data for the Main jail was not provided to the monitors.

SSO custody FTEs have increased from 650 pre-Consent Decree to a total of 809 permanent allocated FTEs. The number of deputy escorts devoted each day for health care appointments varies but has significantly increased since the last review period. At the Main Jail, the number of deputy escorts ranged from three to twelve each day,[9] averaging six to ten deputies per day each week. At RCCC, deputy escorts ranged from three to eight daily.[10]

As noted in the previous report, SSO was allocated four additional Deputy Sheriff positions responsible for escorting to and from medical appointments, escorting nursing staff during medication administration, and facilitating other medical and mental health appointments. System-wide, SSO averages eight medical escorts from Monday to Friday and four escorts on weekends.

SSO is to be commended for increasing the number of deputy medical escorts. However, until a needs analysis and staffing study is conducted, it is unclear whether there are adequate custody escorts, including specialty services appointments and hospital send-outs.

[8] 10th Sacramento County Remedial Plan Status Report. January 7, 2025, page 96.
[9] Dedicated Medical Escort Reports. 9/19/24 and 12/4/24.
[10] Dedicated Medical Escorts Report. 12/6/24 and 8/8/24.

V.I.A. 2 requires that: Provider quality shall be evaluated regularly to ensure that relevant quality of care standards are 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 complete a written report.

The County reported that the previous Medical Director, Assistant Medical Director, and lead physicians initiated medical record reviews to conduct peer review. A physician consultant created a standardized form that is being utilized. Feedback is being provided to providers, which may include progressive discipline.

Peer review is a key component in identifying and addressing practice issues to improve medical care; however, this provision focuses on evaluating medical care quality to ensure that relevant standards are maintained. An evaluation of medical quality requires a review of providers' performance. Multiple clinical summaries that demonstrate the importance of evaluating the medical quality of care are discussed in Section D, Chronic Care, of this report, along with concerns and recommendations (VI.A.2).

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

Recommendations:

1. Complete a staffing analysis that includes clinical staff, office, technological support, QA/QI units, and custody staff escorts and transportation.
2. Evaluate and clarify the roles and responsibilities of the Lead Physicians and determine direct lines of authority and supervision.
3. Ensure every Nurse Practitioner and Physician Assistant has a qualified physician assigned as their supervisor. Even if California does not require this oversight of these positions for licensure, it is best practice to keep patients safe and identify areas in need of development.
4. Evaluate current providers' credentials and determine if the appropriate skill set is available to meet the clinical demands and complexities of patients.
5. Develop a program that evaluates medical provider quality, peer review, and meaningful audits that measure compliance with medical standards of care and meet the requirements of the Consent Decree.
6. Conduct an adequate peer review, by a qualified reviewer, on each provider to establish if each is performing according to evidence-based medicine and the standard of care. If not, implement a provider-specific developmental program that will demonstrate necessary improvement.
7. Develop a provider appointment scheduling process that prioritizes patients by acuity and ensures scheduling within timeframes required by ACH policy and the Consent Decree.

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.

Findings: Registered Nurses medically screen patients upon arrival to the jail and prior to placement in jail housing (VI. B.1.).

The County has modified medical screening to include a two-phased process. Phase 1 is to determine the arrestees' fitness for confinement to the jail. Phase 2 is to identify the patient's medical, dental, and mental health needs for housing, referrals, monitoring, and treatment. Following Phase 1, if the patient is found to be fit for confinement, the RN places a wristband on the patient to reflect patient acuity and priority for completing Phase 2. Patients may be declared unfit for confinement upon completion of the Phase 2 assessment. Patient acuity levels are as follows:

- Red: The patient needs expedited medical screening for urgent medical needs (e.g., substance use disorders, poorly controlled chronic diseases, dental (e.g., moderate to severe pain and/or infection), and mental health needs (e.g., agitated, actively psychotic, suicidal, etc.).
- Yellow: The patient has chronic medical and/or mental health conditions.
- Green: The patient has no significant medical, dental, or mental health conditions.

The County provides auditory privacy in the booking suite
Nurses conduct screening in examination rooms that provide privacy from custody staff and other arrestees (V1. B.2). Each examination room has a door with a window so that arresting officers or designees can observe the arrestee and nurse during the screening process for safety reasons.

There is no reliable tracking system to ensure that patients are timely seen in accordance with their medical acuity and duration in the booking suite.
Nurses completing the Phase 2 screening are left to guess about clinical priority within each color category. ACH reports that an electronic board is on order to track patients in the queue and will provide staff with a better understanding of which patients are next in line. Unfortunately, the board does not track the acuity of patients placed in observation, safety, or segregation cells, requiring ACH to track these patients through the electronic health record. Record review showed several concerns:

- Nurses and medical providers did not declare patients unfit for confinement when medically necessary.[11]
- Nurses did not make necessary referrals to a medical provider for the treatment of chronic diseases.[12] Some patients with chronic diseases were not seen for two months following their arrival at the jail.
- Medical providers conducting essential medication review did not review previous admissions to note chronic diseases requiring renewal of prescription medications (e.g., glaucoma eye drops, etc.). [13]
- At the initial visit, medical providers did not address each of the patient's chronic diseases and order appropriate follow-up.

The following cases are examples:

Patient #2
This 58-year-old male arrived at SCJ on 10/28/24 and was released on 10/30/24. His medical history includes hypertension. Medications were Amlodipine and Lisinopril.

Summary: This patient was at the jail for almost 72 hours. Upon arrival, he was having a hypertensive emergency (BP=221/132 mmHg). The patient was not declared unfit for

[11] Patient #2.
[12] Patient #7
[13] Patient #7.

confinement. The patient's blood pressure continued to be uncontrolled (BP=221/142 mm Hg) and he developed a "migraine headache," and his EKGs, on two consecutive days, were abnormal and showing ischemia and an anteroseptal/septal infarct. Nurses did not timely monitor the patient's blood pressure. Due to EKG changes showing ischemia and possible infarction, the patient needed to be treated for acute coronary syndrome (e.g., aspirin, nitroglycerin, oxygen) and transported to the Emergency Department (ED) via Emergency Medical Services (EMS) ambulance services. An RN did not reassess the patient or check his vital signs for six hours. Failure to declare the patient unfit for confinement upon arrival, and the attempt to manage the patient's hypertensive emergency at the jail resulted in significant delay in care and possible irreversible and preventable damage to his heart. (VI.B.6)

Patient #7

This 56-year-old female arrived at SCJ on 11/22/24 and was released on 2/6/25. Her medical history includes obesity, obstructive sleep apnea, asthma/COPD, diabetes, hypertension, hypertriglyceridemia, bilateral glaucoma, visual impairment, migraine aura without headache, seizure disorder, complex tear and derangement of the right knee medial meniscus, and bipolar disorder. Her current medications are Latanoprost eye drops, Montelukast, Fluticasone-Salmeterol inhaler, vitamin D, Risperidone, Buspirone and Prazosin.

The patient had previous admissions to the jail in 2023 and 2024. In November 2023, the patient was diagnosed with primary open-angle glaucoma and classic optic disc atrophy. She was prescribed Latanoprost 0.005% eye drops every evening. A provider recommended follow-up at UCD Ophthalmology service. The patient was also prescribed Lisinopril, Fluticasone-Salmeterol for asthma/COPD, Buspirone, Geodon, and Depakene.

Summary: This review showed several system and individual performance issues.

Medical Access to Care and Provider Quality Concerns

- The intake RN did not review the patient's complete medical history including medical conditions noted on the patient's Problem List. This included obstructive sleep apnea, bilateral acute angle glaucoma, vision impairment, migraine aura with or without headaches, right knee derangement with torn meniscus and severe osteoarthritis. The RN noted the patient's hypertension but did not list Lisinopril as a medication to be renewed, and did not refer the patient to a medical provider.
- A provider conducted an essential medication review but did not note all the patient's diagnoses and renew key medications for the patient. This included Latanoprost eye drops for bilateral glaucoma, Lisinopril for hypertension, and Imitrex for migraine headaches.
- A medical provider saw the patient 17 days after arrival for a referral from nurse's sick call. The medical provider did not review and address all chronic medical conditions on the problem list, including obstructive sleep apnea, bilateral glaucoma, seizure disorder, migraine aura, headaches, and hypertension. The patient reported the need to use a rescue inhaler several times a day and nighttime symptoms, but the provider did not

order a rescue inhaler KOP, instead the provider ordered Albuterol nebulizer treatments that would require the patient to go to 2M several times a day. This presents a risk to the patient lack of timely access to Albuterol treatment for wheezing and shortness of breath.

- The medical provider did not order a follow-up chronic disease visit, so most of her chronic diseases were not evaluated during her 2.5-month detention, and there was no follow-up of the patient's poorly controlled asthma/COPD.
- The medical provider ordered labs, and the patient's triglycerides were elevated (TG=324, normal<150). The provider wrote that she notified the patient and recommended diet and exercise, but this was not an in-person visit and therefore the patient could not ask questions (e.g., what are triglycerides and what do they mean). During the 12/17/24 chronic care visit, a jail panel was ordered. The value of 324 was resulted on 12/9/24. The patient submitted 11 medical HSRs related to migraine headaches, glaucoma, and repeated falls. The patient was not adequately evaluated for these complaints, which resulted in multiple resubmissions of HSRs, resulting in increased nursing workload.

Mental Health Access to Care Concerns

- Following intake, a social worker noted that the patient had an urgent mental health referral for a history of bipolar disorder, depression, anxiety and inpatient hospitalizations.
- Custody staff contacted mental health staff three times over a period of days due to the patient crying and requesting to see mental health; and the patient submitted eight mental health services requests for medications and/or to see mental health. Each time, mental health staff noted that the patient was pending a mental health assessment (MHA), but did not go see the patient to determine the severity of her condition.
- The mental health assessment and MH provider encounter took place 13 and 14 days, respectively following a court referral
- Of the eight mental health HSRs or Correctional Services Message Requests, none were triaged by an RN. Mental HSRs are triaged by mental health staff. The mental health triage is often untimely secondary to the current process. There were consistent delays in forwarding and/or triaging of MH request forms. None of the forms were complete with legible staff signature and credentials, date and time of triage, and the mental health triage disposition. This process contributes to consistent delays in access to mental health care.

Dental Access to Care Concerns

- On 11/24/24, she submitted a dental HSR, but an RN did not triage the form or assess the patient for pain and infection. The HSR was forwarded to dental. Two days later, on 11/26/24 at noon, dental received the HSR, but did not triage the form until the following day, when a dental sick call appointment was scheduled.
- On 11/28/24, the patient submitted another HSR for dental services reporting a toothache in her front tooth, and that her fillings fell out. The HSR is stamped as being received on 11/30/24 at 19:07. A RN did not triage the form however, a registered dental

assistant did. On 12/2/24 at 07:02, the form is dated stamped as being received by dental. On 12/2/24 at 08:03, a staff person initialed the form without credentials stating that the patient was pending dental sick call.

- On 11/29/24, the patient complained of jaw pain and being unable to open her mouth. She reported that her pain began upon arrest. A dentist saw the patient and took Pano x-rays that showed a mandibular fracture due to trauma at the time of arrest. The patient was sent to UC Davis Medical Center where a fractured jaw was ruled out via CT scan. This raises questions about the accuracy of the interpretation of Pano x-ray.
- On 11/30/24 the patient filed a dental grievance. Dental did not timely address the grievance or see the patient for definitive treatment for five weeks, until 1/1/25.
- 12/6/24: The patient submitted a Correctional Services Message Request (CSMR) stating that she had a toothache and needed fillings. It was stamped as received on 12/11/24. The HSR was not triaged by a nurse. On 12/11/24, a dental staff member documented illegible initials. No patient disposition was documented.
- On 1/2/25, the dentist saw the patient for a grievance and, noting that the patient had been treated the day before, documented that the grievance was resolved and withdrawn. The grievance was not timely investigated and addressed, and only after the patient received dental treatment the day prior. The grievance was *warranted* with respect to a delay in dental treatment and should not have been withdrawn because the delay in access to care was indeed a problem. A plan needed to be made as to how delays in access to dental care can be reduced in the future.
- The access to care concerns is further discussed in Section C of this report.

Intake Medical Screening Concerns (VI.B.4)

- On 2/13/25 the patient was readmitted to jail. The RN did not note the patient's medical history that included obesity, hypertriglyceridemia, hyperglycemia, asthma/COPD, bilateral glaucoma, obstructive sleep apnea, seizure disorder, hypertension, migraine aura, headaches, right knee injury with severe osteoarthritis.
- The nurse did not refer to a medical provider.
- On 2/14/25, the patient was released.
- On 3/10/25 the patient was re-admitted to jail and is still in custody.

Patient #25 (V1.B.3 and B.5)
This is a 60-year-old male with significant medical conditions and congenital deafness.

Summary: Unfortunately, his disability and chronic illnesses were woefully mismanaged and fell below the standard of care.

- The record shows that a single chronic care visit occurred nine months after the booking date and the assessment was inadequate. This patient requires a seasoned provider to manage his complexities and there is no evidence that his acuity was ever appreciated. Diabetes, renal insufficiency and left ventricular hypertrophy all pose a risk of sudden cardiac death. The use of long-term NSAIDs is not recommended in any patient and

especially not in patients with renal compromise. The patient's upper GI symptoms could have been related to the chronic use of Naprosyn, but this did not appear to be considered. The patient was placed on Famotidine instead of discontinuing the NSAID. This patient requires nephrology evaluation, given the rate of his renal function decline. There needs to be a low threshold to conduct upper and lower endoscopies for this patient to make sure he does not have cancer. A cardiac stress test and current 2D echocardiogram should have been done, given his collective cardiac risk factors.

- A special needs program serves a broad range of health conditions that encompass physical and mental disabilities. Patients with special needs must be identified during the intake screening process so that an individualized treatment plan can be developed to reduce the effects of the impairment. On 6/26/24, during the intake screening, the nurse identified that he was deaf and used sign language. The attempted use of the language line was unsuccessful as the limit for use had been reached. The nurse communicated with the patient by writing notes back and forth. Given this patient's cognitive disability, it is unclear how effectively he can communicate in writing. A provider saw the patient on 7/1/24 and utilized the language line and sign language services. Multiple staff, including nursing, dental, and optometry, saw the patient and did not access sign language interpretation services, and communicated with the patient by writing notes.
- Another inmate reported concerns to Prison Law office staff, about his care, potential cognitive deficits, and failure to provide disability accommodation. The Prison Law Office subsequently conducted a legal call with the patient and raised these and additional concerns with ACH . On 4/22/25, an alert was placed in the health record directing staff to access sign language interpretation services with every encounter. A mental health professional evaluated him and found that he had a mild cognitive impairment. On 4/23/25, the nurse manager at RCCC met with the patient, utilized the sign language interpretation services, and evaluated his understanding and knowledge on how to access medical services and the chow line. His eating patterns were also discussed. The nursing plan of care included consulting the provider and establishing ongoing wellness checks to ensure his disabilities were being adequately accommodated. This case underscores the need to maintain a list of all special needs patients and to ensure their disabilities are adequately accommodated and their well-being is routinely monitored.

Compliance Assessment:

- B.1=Substantial Compliance
- B.2=Substantial Compliance↑
- B.3=Partial Compliance
- B.4=Partial Compliance
- B.5=Partial Compliance
- B.6=Partial Compliance
- B.7=Partial Compliance

Recommendations:

1. Conduct daily review of newly arriving patients' medical records to ensure that all appropriate referrals have been made.
2. Conduct daily review of newly arriving patients to ensure all active and essential medications are acknowledged and ordered.
3. Ensure all patients with language barriers of any type have timely access to interpreters and equipment/aides required to effectively communicate their care needs and allow staff to conduct adequate assessments.
4. Establish a high-acuity program to ensure that patients with complex medical conditions are identified early and have a treatment plan developed by a qualified provider.
5. Establish and maintain a list of all special needs patients to ensure their disabilities are adequately accommodated and their well-being is routinely monitored.
6. Establish an efficient and effective chronic care program that includes the pertinent clinical components of each known disease and proper follow-up.
7. Consider adding an EHR note type specifically for providers who assess patients in Intake and add the forcing function to attest reviewing of the problem list, previous detox history, active and previous medication orders and allergies.
8. Conduct an audit of Phase I documentation on a random sample of five charts per day until a compliance of >= 90% is accomplished for three consecutive weeks and then move to ten random charts weekly.
9. Complete the planned installation of an electronic tracking system that will accurately correspond to the clinical priority of each new intake. Implement a triage tracking system within each color code. The tracking system must be visible to all booking staff.
10. Providers should speak directly with patients about initiation and modification of medication. It is not appropriate to delegate this primary responsibility to a nurse.
11. The DON must ensure that there is adequate supervision of the Intake suite and performance of the Nurse Manager
12. Retrain nursing staff on the requirement to review previous jail admissions and medical records to identify medical, dental, and mental health conditions that require further care. Nurses should not check the box on the form indicating that previous records were reviewed unless the nurse actually performed the review.
13. Develop staff training and orientation programs that provide proctored training, opportunities for questions, a review of potential situations, and a discussion of recommended steps the nurse should take.

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) HSRs 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.
    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.

Findings: There has been no significant change in patients' access to care during this monitoring period. There continues to be substantial delays in access to care, resulting in preventable pain and suffering due to a lack of timely diagnosis and treatment.

The monitors found that health service request (HSR) forms are available in the housing units, and patients interviewed by the monitors reported no barriers to submitting their completed requests by either placing them in the locked boxes in their housing unit or by handing them directly to the nurse during medication administration (IV. C.1). The HSRs are collected twice daily during medication administration times and include ensuring patients in segregation cells have the opportunity to submit them to nursing staff.

Nursing staff collect the HSRs and return them to the medical units at both facilities, where they are electronically dated and time stamped as received. Multiple examples of HSRs are cited in the case reviews included in this report, where the stamp is so light that it is not legible. This is caused when the ink in the machine is depleted and not promptly replaced. When the date and time of the receipt of the health services request, and the date and time of the triage are not clear and legible, tracking compliance with the triage's timeliness is impossible (IV. C.2). Review of health records also found delays in transcribing the health service request into the health record, often beyond the time allowed by policy timeframes, related to acuity, e.g., 24 hours and 48 hours.

ACH recently hired a nurse manager to coordinate the grievance process, including tracking and reporting compliance with a timely response. The County is applauded for this addition, as many

patients utilize the paper grievance form to request health services, and a timely response is critical. This process will be examined during the next monitoring period.

Challenges with accurate triaging of the health service requests remain. Nurses do not document the date and time of the triage and often select more than one disposition, e.g., emergent and urgent. Staff also write "duplicate" on health service requests written in sequence, when the request is not a duplicate but a continuation of unresolved symptoms that require an assessment (IV. C.3). Nursing staff often fail to conduct the nursing sick call encounter in a clinical setting and they perform inadequate assessments that do not comply with the approved Standardized Nursing Procedures. Nurses often select authorized over-the-counter medications from protocols, without methodically following the protocol, and documenting the required subjective and objective data (VI. C.3.a.).

ACH reporting and review of health records demonstrate an ongoing backlog of provider appointments, resulting in delayed care and treatment of serious medical conditions. (VI. C.3.b) These delays cause harm to patients, including unnecessary pain and suffering. The chronic delays also result in patients writing multiple health service requests for the same issue, often on the same day.

The County provided Morning Huddle Dashboards that report the number of pending patient appointments. On March 20, 2025, there were 679 pending provider appointments and 114 urgent appointments pending at the Main jail. RCCC had 206 pending provider appointments and ten pending urgent appointments. This report lacks an aging component, rendering it impossible to measure the depth of appointment delinquency and non-compliance with the Consent Decree.

Other reports provided to the monitors include an "ACH Access to Care" report from 9/2024 through 2/2025. This report is an Excel spreadsheet of more than 4,300 entries, listing why patients' appointments were not completed. The spreadsheet lists the appointment type, staff discipline, and reason for canceling the appointment. It lacks any meaningful data analysis.

Another report provided was a list of completed nursing encounters, arranged by month and facility. The report includes verbal requests for health services from custody staff and patients (IV. C.3.d). The report also lacks data analysis and does not include nursing encounters that should have been scheduled but were not, as well as pending nursing sick call encounters. Generally, these reports are backward-focused and provide little real-time support for overseeing and managing the various health service delivery areas. They also do not track, evaluate, and demonstrate compliance with required response times (IV. C.5).

A similar challenge is tracking custody escorts for medical staff to facilitate timely and confidential clinical encounters and treatments. The County provides a daily report showing the number of dedicated escort deputies assigned. The report does not demonstrate the number of escorts required each day to accomplish the pending appointments, nor the number of encounters that were not completed secondary to insufficient medical escort availability. The

monitors' review of health records finds that lack of custody escorts remains a barrier to patient access to care and completion of clinical encounters in a confidential, clinical setting (IV. C.4).

Another practice that negatively impacts the timeliness of access to care is the failure to stage patients in a queue to facilitate uninterrupted clinic flow. Patients continue to be escorted by custody staff one patient at a time, resulting in significant waiting time between patients for health staff. Efficiencies in nursing and provider services cannot be maximized until a staging process is developed and implemented. Uninterrupted patient flow will be paramount in resolving the significant backlog and maintaining clinic services within timelines allowed by the Consent Decree and ACH policy.

The County discontinued the policy of prohibiting patients from making multiple requests during the same HSR; however, because there is no comprehensive tracking system with associated data analysis, monitoring whether the patient was timely responded to by each applicable discipline, e.g., medical, dental, and mental health, and duplicate complaints, is not possible (VI. C.6).

Patients are frequently documented as refusing based on reports from security or “refused to come out of cell” without health staff attempting to determine the validity of the reported refusal, investigate the cause of the refusal, encourage the patient to accept care, or educate and counsel the patient. At RCCC, the monitors observed nurses and custody staff assigned to medication administration working together and requiring the patient to state their refusal in person to the nurse, such that patient education could be provided. Although this is an improvement, the process should be expanded in all clinical service delivery areas (VI. C.7.a, and VI. C.7.b).

Examples of these concerns about a lack of timely access to care are included in the case reviews below.

As documented in Section B, Intake, patient #7 is 56-year-old female who presented to SCJ with a complex medical history that required accelerated access to medical providers to determine her medical stability and to establish a treatment plan, commiserate with her multiple chronic illnesses. The triaging of all patients starts at intake screening. If this is not done properly, then there is a risk of not identifying a condition that requires access to a particular clinical service. As mentioned, this patient did not have timely access to medical, dental, or mental health care. The intake RN did not review the patient’s medical record from previous incarcerations, which would have revealed multiple diagnoses. The RN did recognize hypertension but still did not refer the patient to a provider. A provider conducted an essential medication review and did not order all the appropriate chronic care medications, and did not recognize this was a high acuity patient who should be seen urgently. When a provider saw the patient seventeen days after arrival, they did not address all the patient’s chronic illnesses either. The patient reported the need to use a rescue inhaler several times a day, and she had night symptoms. Access to a keep-on person albuterol inhaler was not ordered. The frequency of these symptoms correlates with moderate to severe lung disease that the provider failed to recognize. Getting a patient in front of a provider is certainly the first step to timely access to care. However, if that provider does not

complete an adequate and competent evaluation, the access is ineffective and futile. There was no follow-up chronic care visit ordered, and therefore, no plan for future access to this complex patient. There was no access to a provider to discuss treatment plans.

The patient submitted multiple HSRs that were not adequately addressed. She submitted eight mental health requests and never saw a mental health provider to address her mental health conditions and acute episodes of crying.

Another 30-year-old female[14] arrived at SCJ on 11/21/24 and was released on 1/21/25. Her medical history includes polysubstance use disorder, including Fentanyl, pregnancy, abnormal Pap smear, bipolar disorder, and poor dental health. Her medications were Methadone, prenatal vitamins, and Ondansetron. She had three admissions during this review period.

The first admission was from 9/22/24 to 9/23/24. During this brief admission, the patient was noted to have opioid use disorder with Fentanyl, was 19 weeks pregnant, and reported suicidal thoughts. She had no prenatal care. She was declared unfit for confinement and taken to a hospital. She did not return to the jail.

The second admission was from 10/11/24 to 10/12/24. During this brief admission, the patient was declared unfit for confinement due to pregnancy and opioid use disorder. She still had no prenatal care. The patient was sent to Sutter Medical Center and treated for a urinary tract infection. She was not sent to UCD Maternal Fetal Medicine for admission, prenatal care, or induction on medication-assisted treatment (MAT). On 10/12/24, when she returned from Sutter Medical Center to jail, a nurse did not notify the OB/GYN provider regarding the patient's arrival and whether to immediately send the patient to UCD. On 10/12/24 at 08:22, she was evaluated by the MAT provider and noted to be at 19 weeks gestation with a high risk pregnancy, but was not prescribed medication. She was released from custody on 10/12/24 at 09:10. This case demonstrates a lack of appropriate orders for Obstetrics and Addiction Medicine Referrals (VI. C.3.b).

The third admission was from 11/21/24 to 1/25/25. On 11/21/24, the patient was arrested and taken to Mercy Hospital in Folsom where she was noted to be 27 weeks pregnant and had opioid use disorder. The ED provider treated her for a urinary tract infection but did not address her opioid use disorder. The arresting officer brought the patient to jail. On 11/21/24 at 18:24, A nurse conducted Phase 1 screening. Although the patient was pregnant and in active withdrawal, the patient was declared fit for confinement. The intake nurse contacted a provider about the patient's urinary tract infection but did not call an OB/GYN provider regarding the patient's pregnancy and withdrawal symptoms. The nurse also did not order an Addiction Treatment Provider referral, MAT Induction Housing, MAT RN referral, and low-tier and low-bunk, prenatal vitamins, and a health snack. There was a lack of appropriate intake orders for Obstetrics and Addiction Medicine Referrals. This requires providers to be notified directly and not depend on a referral process to accomplish.

[14] Patient #4

On 11/22/24 at 09:00, the OB/GYN provider was notified and immediately sent the patient to UCD where she was admitted for five days for prenatal care and methadone induction. This is a significant delay in referral to obstetrics and Methadone induction.

Upon her return to jail, the patient was under the care of both obstetrics and an addiction medicine specialist who, in coordination with the CORE program, adjusted the patient's Methadone dose over the next two months. A concern is that the addiction specialist and other providers documented that the patient was having significant withdrawal symptoms requiring Methadone dosing adjustment, but the nurses' COWS assessment scores were low and resulted in discontinuation of COWS monitoring until the providers reordered the assessments. Methadone morning dosing was from 08:30 to 09:00, and afternoon at 15:00 to 16:00. This is a dosing interval of six to eight hours, which resulted in the patient not being treated for 16 to 18 hours. This prolonged dosing interval resulted in the patient having recurrent withdrawal symptoms in the evening or early in the morning, subjecting the patient and her fetus to withdrawal symptoms. Twice daily medication dosing intervals need to be at least eight hours apart, and withdrawal medications need to be closer to ten to twelve hours to provide continuous coverage, minimize symptoms, and mitigate the need for increasing doses. Inconsistent and extended Methadone dosing intervals result in predictable withdrawal symptoms and inaccurate COWS assessment scores.

The patient was timely referred to the CORE outpatient drug treatment program and the patient was enrolled into the program prior to discharge. Although the patient was initially not provided with timely access to opioid use disorder treatment, once enrolled, the medical providers closely monitored the patient and adjusted treatment.

After the patient was released from UCD Medical Center back to jail, the patient received timely and appropriate obstetrical care. OB/GYN providers ordered labs that were performed timely, as well as anatomy and growth ultrasounds that were also performed timely. Case Management documented the status of the review and scheduling of the ultrasounds. This is a significant improvement from the last review period. However, a concern is that the patient was scheduled for an anatomy ultrasound that was to be completed before 12/20/24, per OB orders. The day the appointment was scheduled, a medical assistant (MA) documented that the patient refused the appointment through the intercom and signed a refusal form and patient had been counseled regarding the risks of an unspecified appointment/procedure. A medical assistant is not trained and qualified to counsel the patient regarding the risks of refusal of an anatomy ultrasound (VI.C.7). The patient needed to be escorted to 2M where a medical provider could explain the risks of refusal of the ultrasound. This was not an informed refusal. Fortunately, Case Management immediately rescheduled the appointment, which took place timely.

At the time of release, the patient was seven months pregnant but there was no documentation of birth control counseling following the pregnancy. Overall, the patient received timely and appropriate prenatal care.

There were incidental but important findings noted in the care of the patient.

- On one occasion, custody denied the patient access to an obstetrical appointment because something was "going on in the pod". This should never occur and may pose greater delays in access to care because the OB/GYN providers come on site once a week, and the patient was a high-risk obstetrical patient (VI.C.4).
- The patient reported to a provider that she missed two doses of Methadone because a Deputy would not escort her to 2 Medical to receive her medication (VI.C.4). The patient missed one dose on 12/19/24 upon her return from an outside medical appointment.
- A medical provider treated the patient for a urinary tract infection (UTI) based upon symptoms, but the urinalysis did not show evidence of UTI, and the provider did not order a urine culture to verify the infection, organism, and drug sensitivities.
- Providers did not consistently review lab reports in a timely manner. In one case, an abnormal Pap smear report was not reviewed for three weeks. All lab reports need to be reviewed within three business days of being reported.

D*ental Access to Care Concerns*

On 11/24/24, a patient[15] submitted a dental health services request (HSR), but an RN did not triage the form or assess the patient for pain and infection. The HSR was forwarded to dental. Two days later, on 11/26/24 at noon, dental received the HSR, but did not triage the form until the following day, on 11/2724. A dental sick call appointment was scheduled.

On 11/28/24, the patient submitted another HSR for dental services, reporting a "toothache of her front tooth, fillings fell out." The HSR is stamped as received on 11/30/24 at 19:07. A RN did not triage the form. A RN saw the patient for knee pain, and she reported that during her arrest, an officer threw her to the ground, and she struck her jaw and front teeth. The nurse ordered a dental referral.

On 11/29/24, the patient complained of jaw pain and being unable to open her mouth. A dentist saw the patient, took panoramic X-rays that showed a mandibular fracture due to trauma at the time of arrest. The patient was sent to UCD, where a fractured jaw was ruled out via CT scan. This raises questions about the accuracy of interpreting the Pano X-ray.

On 12/2/24 at 07:02, the HSR initially submitted on 11/28/24 was dated and stamped as received by dental. On 12/2/24 at 08:03, a staff person initialed the form without credentials, stating that the patient was pending dental sick call. Had the health record been reviewed during the triage, staff would have recognized that the dentist had seen her for this complaint.

On 11/30/24, the patient filed a dental grievance. Dental did not address the grievance promptly or see the patient for definitive treatment for five weeks until 1/1/25.

[15] Patient #7

On 12/6/24, the patient submitted a Correctional Services Message Request (CSMR) stating that she had a toothache and needed fillings. It was date-stamped as received on 12/11/24. A nurse did not triage the HSR. On 12/11/24, a dental staff member documented illegible initials or a signature, and no patient disposition was documented.

On 1/2/25, the dentist saw the patient to address the grievance, noting that the patient had been treated the day before. The dentist documented that the grievance was resolved and withdrawn. The grievance was not investigated and addressed in a timely manner, and only after the patient received dental treatment the day prior. Although the patient received care, it was after the grievance was authored and the care was delayed, which indicates the grievance was *warranted* with respect to the delay in dental treatment and should not have been withdrawn, as the delay in access to care was indeed a problem. A plan needed to be made as to how delays in access to dental care can be reduced in the future.

Additional patient case reviews found concerns about nursing access to care and custody interference with access to care.

On 10/26/24 at 05:48, a 42-year-old male[16] with a history of type 2 diabetes, hypertension, and kidney stones was brought by a deputy to the medical unit. He was seen in the lobby as a confidential space was unavailable. The patient was complaining of abdominal pain, nausea, and reported vomiting seven to eight times and having seven to eight watery stools that morning. His vital signs were within normal limits; however, the nurse documented that he appeared "sick-looking." The nurse contacted the provider who ordered Zofran, housing in medical observation, and scheduling of an urgent provider encounter. The nurse ordered Imodium and Pepto-Bismol per the standardized nursing protocol and placed him on a liquid diet for 24 hours. Imodium should never be given for diarrhea without a known etiology. A provider should order it only after completing an adequate assessment. When patients are admitted by the provider for medical observation, and a plan of care is ordered, nursing staff should not initiate medication orders from standardized nursing protocols.

At 08:02, the provider evaluated the patient who reported two days of watery, non-bloody diarrhea and denied current nausea and vomiting. The diagnosis was acute viral gastroenteritis versus irritable bowel syndrome. He was discharged from the medical housing unit, ordered a regular diet, and decreased the duration of the Imodium to 2 mg twice daily to daily.

On 10/28/24, he authored a request for health services, writing, "Man down asap. I in pain [sic] I think I have food poisoning. I keep throwing [sic] up, and also have the runs. My pain is a 8." The request was received on 10/28/24 at 10:12 and was triaged as emergent and urgent at 13:15. There should be a single triage decision, e.g., urgent or emergent, but not both. Given that the patient had been admitted for medical observation two days prior, for the same complaint, this patient should have been triaged as emergent.

[16] Patient #24

The patient was not emergently seen as triaged. More than twelve hours later, on 10/29/24 at 00:01, the nurse completed a chart review and documented "Custody referral: c/o food poisoning. Per chart, seen by MD for abd pain/diarrhea 10/26; uNSC appt scheduled and custody advised. Per custody, unable to bring inmate to MHU at this time, no escort available per Dep Nefedov". Escalation to a custody supervisor should occur anytime a patient needs to be emergently or urgently seen, and an escort is unavailable. Given the persistent abdominal symptoms, a provider should have been directly notified for proper disposition.

On 10/29/24 at 00:32, the nurse saw the patient in an interview room in the J Barracks. He complained of diarrhea for two to three days, accompanied by some back pain. His abdomen was documented as soft, non-tender, and with hyperactive bowel sounds. The nurse ordered acetaminophen 1000 mg twice daily and loperamide 2 mg twice daily for three days. Nursing sick call services should be conducted in a clinical setting. Given the patient's history, a provider should have been notified.

On 10/30/24, the patient authored another health service request writing, "Man down". It was received on 10/31/24 at 10:10. It was not triaged, and "Duplicate" was written in the margin. This was not a duplicate, as the original HSR was authored on 10/28/24. The next day, on 10/31/24, the patient authored three health service requests that were received on 10/31/24 at 10:09. On the first request he wrote, "Man down. I very sick. How long its (sic) going to take." This request was triaged as both urgent and routine on 10/31/24 at 10:52. The second request read, "I need help please." It was not triaged, and "Duplicate" was written in the margin. The third request read, "I'm sick, need help ASAP. Man down. Please help me." It was also not triaged, and "Duplicate" was written in the margin. The mishandling of the health service requests blocked the patient's access to care and led to delays in treatment. The nurse should have reviewed the patient's health record, seen him emergently, and notified a provider.

On 10/31/24 at 08:30, custody called the MHU and reported having a man down. The nurse saw the patient, documenting the location as "J Barracks floor". When the nurse arrived, the patient was sitting on the floor with his back resting on the wall. The nurse documented that vital signs were taken but were not recorded in the health record. The patient complained of having nausea, vomiting, headache, and diarrhea for five to six days. He reported vomiting more than fifteen times through the night and having two loose stools. He complained of mild upper abdominal pain. The nurse practitioner also responded to the call and evaluated the patient. The NP documented that the patient complained of feeling weak and reported vomiting five times and had fifteen diarrheal episodes, which raises the question of the accuracy of the documentation. He was taken to the MHU for observation, and Loperamide, Ondansetron IM, and IV fluids were ordered. A rapid COVID-19 test was also ordered. The patient improved and was discharged at 15:05. Given the persistence of the abdominal signs and symptoms, the provider should have ordered labs to check for electrolyte imbalance and orthostats to assess for dehydration. The patient was released from jail on 11/6/24.

Another 23-year-old male[17] arrived at the jail on 8/19/24 and is still in custody. His medical history includes alcohol, benzodiazepine, and opioid disorders, sexually transmitted infections, priapism, and erectile dysfunction following priapism, adjustment disorder with mixed anxiety and depressed mood. His medications are suboxone and mirtazapine. This case was referred to the monitors by class counsel, and the monitors interviewed him during the tour.

He authored a health service request on 10/17/24, writing "I have a bump on my private part, I need to see a nurse. I am very worried. Get back to me please and thank you". The date and time stamp on the request is too faint to read. It was triaged on 10/17/24 as routine. However, the time of the triage was not documented. An LPN completed a chart review at 14:56 on 10/17/24, with no additional documentation noted.

The patient reported being housed on the 8th floor of the Main Jail on 10/17/24, telling the deputy that he needed to be seen by the nurse. He reported the deputy's response was, "Okay, we'll tell them". He reported continuing to tell the deputies that he needed medical attention throughout the day.

At 21:30, on 10/17/24, the nurse documented "The patient is a walk-in reporting an abscess inside their penis. The patient reported having a small hard bump on their penis that started two days ago. The patient reported they have pain, and it hurts when they walk and when they pee." The nurse wrote, "The penis was observed and there was a 3.5 x 2 cm bump on the pts. penis." The nurse documented, "Dr. Patniak was contacted and informed about the situation with the patient. Dr. Patniak ordered medications for the pt. and an urgent MDSC for the pt." The provider ordered acetaminophen, and he was sent back to his cell. During the interview, the patient described having an unresolvable, erect penis at the time the nurse assessed him. The nurse did not document this specific symptom, nor was it documented as being reported to the on-call provider. The patient reported to the monitors that he told the nurse his condition was painful and not resolving. The nurse failed to recognize the signs and symptoms of a priapism.[18]

The patient reported that the following day, he was moved to a segregation cell, secondary to participating in a fight on 10/14/25. He reported telling the officers in the segregation unit that he was in pain and needed to see a doctor. He describes pushing the emergency call button "at least every hour". He also describes "going into panic mode", crying, and "begging the officers" to let him see a doctor. Reportedly, a Sergeant came to his cell and asked him what his specific problem was. He explained that he had a painful erection that would not resolve. He recalled the Sergeant responding, "That's not a situation you need to go to medical for".

On 10/21/24, the patient authored a Correctional Service Message Request, with "EMERGENCY" written in two places and "PLEASE CALL MEDICAL I'M IN PAIN" on the form's header. He wrote, "I have been putting medical kites in for the last 4 days, saying that I've had a bump on my private

[17] Patient #5

[18] Priapism is a persistent, painful erection that lasts more than 4 hours and is not related to sexual stimulation. It can be caused by certain medical conditions, medications and trauma. Immediate medical attention is required.

area and need to see a doctor, and now there are red bumps on top of the bump that was already there. It hurts very bad can I please see medical!!!". "Please call medical I'm scared it's something serious!!!". The form was triaged as routine on 10/21/24 at 09:20 by "Trish". The form was scanned into the health record on 10/21/24 at 12:00 am. This health service request required a face-to-face triage by the nurse to obtain additional history and information. Triaging this complaint as routine allowed 48 hours for the nursing sick call encounter, which was far too long for a painful priapism.

On 10/21/24, the patient authored a second Correctional Services Message Request, dated 10/22/24, writing "EMERGENCY" in three different places. He also wrote, "Can a depoty [sic] please call medical for me I am throwing up everything I eat and I have a fever. I feel very sick, also I am having a herpe [sic] outbreak on my private area and it's very painful. Please I need medical." The form is not dated as to when it was received. "Seen for complaint" was written in the margin and unsigned by the author. The form was scanned into the health record on 10/21/24 at 12:00 am. Health service requests written on Correctional Services Message Request forms, or any other type of form, should be processed in the same manner as the HSR, with the date and time stamped upon receipt, and documentation of the date and time of the triage, disposition, and signature with credentials of the nurse completing the triage.

During the monitor's interview with the patient, he acknowledged falsifying his medical complaint by including that he was vomiting and had a fever. He described being in a state of desperation after multiple attempts at pushing the emergency button, submitting requests for help, and asking custody staff for help all failed. Other inmates coached him to write that he was vomiting blood or had a fever to access care successfully.

On 10/21/24, at 10:56, an RN in the 2M medical unit saw the patient. Nursing documentation included, "pt. endorses pain level 8/10 to the penis. Pt. states he had pumps [sic] on his penis and painful urination. Pt. also endorsed fever, nausea." The nurse referred the patient to the provider, who examined him. The provider documented that the onset of partial erection occurred 4-5 days ago, after a fight with another inmate. "He is not sure if the penis was injured at all then. Penis has been enlarged ever since. He feels like there is a ball or enlargement inside the mid penis. There is dysuria. He was seen 2 days ago after about 2 days of persistent erection, and a urine dipstick was negative. His penis was semierect, firm, some bulge on the right midshaft." The diagnosis was priapism. The plan was, "needs eval by urologist ASAP; unfortunately, much time has already passed. Will send out to UCD by van".

The ED physician's diagnosis was nonischemic priapism, and the patient was treated with a lidocaine penile block. He was returned to the jail, and a referral for provider follow-up in one week was ordered. On 10/23/24, upon returning from the emergency department, a provider saw the patient. A urology follow-up was not considered at that time. The provider's plan included a follow-up in two days. The ordered follow-up visit did not occur. On 10/29/24, a provider documented that the patient reported "priapism had resolved", but there was no physical exam documented.

On 11/22/24, the patient authored another Correctional Service Message request writing that he needed to see the doctor as soon as possible because he was having sharp pain in his penis. The request was triaged on 11/22/24 by the SRN; however, there was no documentation of the triage level assigned or the time the triage was completed. The patient authored another request on 11/23/24, writing "Can I please see a doctor, I am having pain inside my penis and I'm getting worried. Please this is very serious". The SRN triaged the form on 11/24/24 but did not document the triage level or the time the triage was completed.

On 11/26/24, the provider saw the patient who complained of erectile dysfunction. A Rubicon Urology consultation was submitted. However, the Rubicon consultation results were not documented, and a medical follow-up was not ordered.

After reviewing the health record and completing an interview with the patient, the monitors referred this patient's case to ACH.

On 3/14/25 and 3/18/25, the patient complained of "groin pain," and it took several days for the nurse to respond to the sick call. This is significant because of this patient's known history. This patient should be on the special needs, high acuity list, and all should be aware of the urgency to refer to a provider for any groin or genital complaints.

On 3/18/25, the Rubicon Urology consultation response was entered into the health record, almost four months after the consultation was submitted and completed. The Urologist recommended further workup, including penile Doppler Ultrasound. Dr. Ma acknowledged the recommendations but referred to a primary care provider for further workup. This was not necessary and would have created a delay in care, if not for Dr. Pillay's intervention on 3/20/25 (described below) to order the urgent Urology consult properly.

On 3/19/25, Dr. Reyes submitted additional questions to the Rubicon Urologist, asking if he could recommend further workup to perform while he awaits a urology consult. If there was a response from the Rubicon Urologist, it is not documented in the health record. The urgent referral should have been submitted.

Dr. Pillay submitted the urgent referral on 3/20/25. This referral was significantly delayed from the original Rubicon consultation completed on 11/15/24. The referral has been sent to the custody transportation unit for scheduling, and the appointment is pending.

The following findings reflect ongoing challenges with access to care:

- The patient submitted several HSRs for which he was not seen by an RN or provider. The patient complained of submitting multiple HSRs regarding his priapism and penile pain, but it appears that some were not collected, triaged, and scanned into the EHR.
- Provider's decision to refer the patient back to a primary care provider when specialist care was required.
- The significant delay for the Urology referral recommendation on 11/15/24 that did not occur until 3/18/25.

Another example of custody interference with access to care includes a pregnant patient[19] who on one occasion, was denied access to an obstetrical appointment by custody staff because something was "going on in the pod." This should never occur, and it becomes more significant because the OB/GYN providers come only on Fridays, and the patient was a high-risk obstetrical patient. This patient reported to a provider that she missed two doses of Methadone because a deputy would not escort her to the 2 Medical unit to receive her medication.

Another patient, brought to the attention of the monitors by Class Counsel, is a 60-year-old male with significant medical conditions and congenital deafness.[20] This case was also discussed in Section VI. B of this report. Unfortunately, his disability and chronic illnesses were woefully mismanaged and fell below the standard of care (VI.C.3.d). The record reflects a single chronic care visit that occurred nine months after the booking date, and the assessment was inadequate. This patient requires a seasoned provider to manage his complexities, and there is no evidence that his acuity was ever appreciated. Diabetes, renal insufficiency, and left ventricular hypertrophy all pose a risk of sudden cardiac death. The use of long-term NSAIDs is not recommended in any patient, and especially not in patients with renal compromise. The patient's upper GI symptoms could have been related to the chronic use of Naprosyn, but this did not appear to be considered. The patient was placed on Famotidine instead of discontinuing the NSAID. This patient required nephrology evaluation, given the rate of his renal function decline. There needed to be a low threshold to conduct upper and lower endoscopies for this patient to make sure he does not have cancer. A cardiac stress test and current 2D echocardiogram should have been done, given his collective cardiac risk factors.

A special needs program serves a broad range of health conditions that encompass physical and mental disabilities. Patients with special needs must be identified during the intake screening process so that an individualized treatment plan can be developed to reduce the effects of the impairment. On 6/26/24, during the intake screening, the nurse identified that he was deaf and that he communicated in American Sign Language. The attempt to use the language line was unsuccessful as the limit for use had been reached. The nurse communicated with the patient by writing notes back and forth. A provider saw the patient on 7/1/24 and utilized the language line and sign language services. Multiple staff, including nursing, dental, and optometry, saw the patient and did not access sign language interpretation services, and communicated with the patient by writing notes.

Another inmate reported concerns about the patient to class counsel. The concerns about his care, potential cognitive deficits, and failure to provide disability accommodation were brought to the attention of ACH by class counsel. On 4/22/25, an alert was placed on the health record directing staff to access sign language interpretation services with every encounter. A mental health professional evaluated him and found that he had a mild cognitive impairment. On

[19] Patient #4
[20] Patient #25

4/23/25, the nurse manager at RCCC met with the patient, utilized the sign language interpretation services, and evaluated his understanding and knowledge on how to access medical services and the chow line. His eating patterns were also discussed. The nursing plan of care included consulting the provider and establishing ongoing wellness checks to ensure his disabilities were being adequately accommodated. This case underscores the need to maintain a list of all special needs patients and to ensure their disabilities are adequately accommodated and their well-being is routinely monitored.

Compliance Assessment:

- C.1=Substantial Compliance↑
- C.2=Partial Compliance
- C.3.a=Noncompliance
- C.3.b=Noncompliance
- C.3.c=Partial Compliance
- C.3.d=Partial Compliance
- C.4=Partial Compliance
- C.5=Noncompliance
- C.6=Substantial Compliance
- C.7.a=Noncompliance
- C.7.b=Noncompliance

Recommendations:

1. Ensure date and time stamp machines have sufficient ink required for legible stamps to facilitate tracking of the timeliness of response.
2. Health Service Requests should be scanned into the patient's electronic health record upon receipt. This will reflect an accurate time.
3. Retrain nursing staff on the triage process, including selection of a single triage acuity level and legible documentation that includes the nurse's date, time, name, and credentials determining the triage decision.
4. Triage nurses should be required to review the medical record during the triage process to ensure the complaint is a true duplication, and not a condition that has been treated but remains unresolved.
5. Nursing sick call encounters should be conducted in a clinical setting.
6. Require nurses to follow the approved standardized nursing procedures, document the completion of each component of assessment needed, and order only medications authorized by the protocol.
7. Imodium should be removed from the standardized nursing procedure. It should never be given for diarrhea without a known etiology. A provider should order the medication after an adequate assessment.
8. The County needs to eliminate provider backlogs and ensure that medical providers see patients in compliance with Consent Decree time frames.

9. The County should staff sufficient custody escorts to ensure timely access to all clinical encounters.
10. Implement a staging process to ensure an ongoing patient flow during nursing and provider clinics, avoiding wait times between patients.
11. Nurses, medical and dental providers should verify that patients refuse appointments or care by observing and speaking with the patient, encouraging patient compliance, and obtaining an informed, signed refusal.
12. Ensure all patients with language barriers of any type have timely access to interpreters and equipment/aides required to effectively communicate their care needs and allow staff to conduct adequate assessments.
13. Require intake nursing staff to review the patient's medical history, including the problem list, to facilitate a comprehensive care plan.
14. Require providers ordering essential medications to review the patient's problem list and a comprehensive list of medications, including medications ordered during previous jail stays.
15. Health care staff should deliver normal and abnormal diagnostic test results, reports, treatment recommendations, and grievance responses *directly to the patient* and not send them through the jail's inmate mail system.
16. Develop a system for timely triage of mental health and dental health service requests.
17. Prohibit the use of standardized nursing protocols for patients admitted to the infirmary and require nursing staff to communicate with the provider for necessary plan of care changes.
18. Require escalation to a supervisor when access to care is denied by custody staff.
19. Prohibit custody staff from denying access to care and investigate all reports of denial of access to health care services, including refusals related to using the emergency button.
20. Develop and implement a standardized genitourinary nursing procedure that includes a plan of care to address the signs and symptoms of emergent urologic conditions, including priapism.
21. Develop a system that tracks all special needs patients so that all health care staff immediately recognize their unique needs and ensure timely access to a provider. This system should be part of the electronic health record system so that staff are immediately aware of their unique health care needs.
22. Ensure the case management system includes monitoring and confirmation that all Rubicon consultation requests and responses are timely received, recorded in the patients' health record, and reviewed by the provider with documentation of the care plan.
23. When providers deviate from the specialty provider's recommendations, documentation of the justification for prescribing an alternative care plan should be entered into the health record.
24. Evaluate the grievance response practices and avoid categorizing grievances as unwarranted and/or withdrawn when corrective action is taken after the date the grievance was authored.

25. Conduct data analysis and reporting of findings, trends, and non-compliance with timeframes required by policy and the Consent Decree for all reports, e.g., Morning Huddle Dashboard, Access to Care, Health Service Requests, and Custody Escorts.

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.

Findings: The County has not implemented a chronic disease program that provides patients with timely and appropriate care that meets nationally published clinical guidelines and the requirements of the Consent Decree (VI. D.1). Currently, not all chronic disease patients have been identified and enrolled into the chronic disease program and/or are being timely seen in accordance with their disease acuity.

The County has not developed an electronic or manual chronic disease tracking system that ensures that all patients with chronic diseases have been identified and are being monitored (VI. D.5). The current electronic health record (EHR) does not have the capability to produce a tracking system. The County intended to rely on the acquisition of a new EHR to develop such a tracking system, but this was deferred until health care processes at the jail were established.

The County is making changes to chronic disease processes, including planned modifications to the electronic health record (EHR) to facilitate enrollment into the chronic disease program when patients are readmitted to jail, and development of chronic disease templates and encounter forms that will provide data to populate chronic disease dashboards and tracking systems.

Record reviews show that nurses do not consistently refer patients with chronic diseases to a medical provider.

Medical providers do not timely address all the patient's chronic diseases and in some cases not at all.

The County reports that there is a "chronic conditions report" that has been developed and is available to staff. It includes diagnoses, degree of control, last provider's visit details, recent lab reports, and future appointment dates. We were provided with an excel spreadsheet for chronic disease encounters that include patient appointment dates, responsible providers, and patient location. It does not include types of chronic diseases for every patient, lab results, patient disease control, and future visits. We note that many providers schedule sick call encounters to follow patients for their chronic diseases, instead of ordering chronic disease follow-up appointments. This tracking system does not ensure that all patients with chronic diseases are captured. The lack of a reliable system has resulted in patients not being timely seen, and some patients are lost to follow-up. The County can no longer defer the development of a reliable chronic disease tracking system pending the arrival of a new EHR. Recognition, stabilization and maintenance of chronic illnesses are critical to the overall health and safety of the applicable inmate-patient. The lack of a reliable tracking system and monitoring program pose a perpetual risk of harm to the patient.

For those chronic care templates currently in use, the medical providers are prompted to conduct evaluations consistent with chronic disease treatment guidelines. This includes a review of systems, pertinent physical examination, and labs that support the provider's assessment of the patient's disease control. Record reviews show that some providers document thorough patient assessments and appropriate care plans that meet current guidelines. However, record review also shows that some evaluations are incomplete, assessments of disease control are inaccurate,

and follow-up intervals are not in accordance with recognized guidelines and the Consent Decree. This practice results in a lack of timely follow-up for patients whose chronic diseases are not at goal. The adoption, training, and implementation of missing chronic disease guidelines would bring more consistency to the quality of medical care provided to patients.

The Chronic Disease Management policy states that the Medical Director will develop chronic disease guidelines for the following conditions:

- Diabetes
- Asthma
- COPD
- Seizure Disorder
- Cancer
- Autoimmune Disease
- Hyperlipidemia
- Hypertension
- Coronary Artery Disease
- Hepatitis C
- Psychotic Disorders/Mood Disorders

The previous Medical Director developed guidelines for asthma, diabetes, and hypertension that met national chronic disease guidelines. The County has not adopted or developed guidelines for other chronic diseases such as dyslipidemia, heart failure, or hepatitis C. The County presented the Bureau of Prison Guidelines for HIV treatment as the resource in use by the dedicated HIV provider, and this is acceptable. The lack of readily accessible clinical guidelines for providers continues to hinder some patients from receiving the standard of care (VI. D.1).

The following cases exemplify patients that are not being monitored in accordance with their disease control and not receiving care consistent with national guidelines or community standards.

Patient #1

This is a 39-year-old female who had four admissions to the jail from 4/30/24 through 10/19/24. She is homeless with a medical history of hypertension with medication noncompliance, opioid and methamphetamine use.

Summary: During her admission from 4/30/24 to 4/30/24 (prior to the current reporting period) her blood pressure was severely elevated (200/114 mm Hg). The nurse notified the provider who ordered Clonidine 0.1 mg, stat. The nurse noted a plan to recheck blood pressure in three hours. The patient was an asymptomatic known hypertensive patient and should not have received Clonidine and especially not as the only treatment. Her blood pressure should have also been rechecked 30 minutes to an hour after administration. She was released the same day.

During the second admission from 7/11/24 to 7/14/24, the patient endorsed hypertension and depression, but denied alcohol, opioids, benzodiazepines, and methamphetamine use. The

patient was still homeless, and blood pressure was elevated (185/94 mm Hg) and heart rhythm irregular at a rate of 82 per minute. The RN ordered all appropriate labs and tests, blood pressure checks twice weekly, urgent provider H&P, mental health referral, discharge planning, and lower bunk. The nurse contacted a medical provider who ordered a stat dose of lisinopril, but the patient refused. The provider also ordered lisinopril 20 mg and hydrochlorothiazide 25 mg daily. Given the patient's irregular heart rhythm, an EKG should have been obtained. Unless the provider knew what the home regimen was and this was not documented, two medications at such doses are not routinely initiated and require close observation to monitor for precipitous reduction in blood pressure. The RN did not review the previous admission in April 2024, when the patient reported daily opioid and methamphetamine use. The patient's Avatar showed no mental health history. The patient received her first dose of medication within 48 hours, and she was released on 7/14/24.

During the third admission from 8/28/24 to 8/30/24, the patient reported Hypertension and medication noncompliance. She also admitted to substance use but then denied specific substance use. The intake BP was elevated (170/90 mm Hg) and heart rhythm regular. All routine intake tests were completed, except pregnancy. Blood pressure checks twice weekly, urgent medical provider H&P, and discharge planning were ordered. The nurse contacted a medical provider who ordered lisinopril 20 mg and hydrochlorothiazide 25 mg daily. Once again, the RN did not review the patient's previous admission information that showed the patient had opioid and methamphetamine use disorders. The patient received the first dose of antihypertensive medications within 24 hours. Follow-up blood pressure on 8/29/24, at 09:38 was 154/89 mm Hg. The social worker assessed the patient on 8/29/24 and captured the substance use history and detox assessments ensued. Over the next two days, the patient's COWS score maxed at eight and her vital signs remained stable with a maximum blood pressure of 154/89 mm Hg. While on detox treatment, the nurse made appropriate calls to the provider to address withdrawal symptoms. The patient was referred to MAT induction and Suboxone was initiated. Her drug screen showed positive for Fentanyl, amphetamines, and methamphetamines, and a pregnancy test negative. The patient did well clinically and was released from jail on 8/30/24 at 16:51.

During the fourth admission period from 10/19/24 to 10/29/24, several system and care issues were identified, including:

- RNs not conducting adequate withdrawal monitoring, including determining whether the patient was alive when she was repeatedly "unresponsive" to staff.
- A medical provider did not conduct an objective evaluation of the patient after her report that she was struck by a vehicle and hit her head three days prior to admission to the jail, and then reported severe headache, neck and chest pain upon arrival at the jail. Given the expected exposure to Fentanyl and the new onset of chest pain, this patient required intervention for possible acute coronary syndrome.
- The provider did not renew the patient's antihypertensive medications, address each of the patient's chronic diseases or order appropriate follow-up at that initial visit.
- The RN did not timely monitor the patient's blood pressure during and following hypertensive emergencies.

- After the patient was sent to Mercy General Hospital ED for hypertensive emergency, she was transferred to UC Davis for concern of a dissecting celiac artery aneurysm. UC Davis ruled out a celiac and aortic aneurysm, but the patient was given discharge papers for a dissecting aortic aneurysm and her medical records were not retrieved and timely scanned into the EHR. This resulted in medical providers being unaware that a dissecting aortic aneurysm (AA) had been ruled out. She was subsequently sent out two more times in 24 hours to two different emergency departments. At the last visit, the ED physician was upset that the jail providers were unaware that AA had been ruled out and the patient had been sent to three different hospital systems to evaluate the patient (in an approximately 72-hour period).
- Providers did not address abnormal labs, including the patient's low serum potassium (3.5) when the patient was prescribed a potassium depleting diuretic (i.e., hydrochlorothiazide).
- Nurses did not immediately assess the patient when she complained of bloody stools.
- The patient was not given discharge medications for hypertension, Suboxone, nor levofloxacin for urinary tract infection.
- Given the patient's history of being struck by a vehicle and complaints of worsening headache, neck and chest pain, further investigation was warranted to rule out internal pathology (e.g., bleeding, fractures).
- The provider did not order the patient's antihypertensive medications despite the patient's severe hypertension.
- During detox management, the blood pressure ranged from 182/106 mm Hg to 200/112 mm Hg. The provider ordered stat hydrochlorothiazide, labetalol, and lisinopril. The patient's blood pressure was not repeated before or after the patient was given stat doses of medications.
- On 10/25/24, the elevated heart rate of 112 per minute was not reported to the provider.

The above patient's review was shared with ACH, and they provided responses to inquiries. They acknowledged and agreed with the monitor's comments regarding blood pressure monitoring, urinary drug testing (UTD), RNs reviewing problem list, and modifying the Unfit for incarceration criteria. They will address these areas going forward. ACH agrees that providers must complete adequate examinations, timely diagnostics and documentation. Peer reviews will be conducted on applicable providers.

ACH informed the monitors that gaining access to medical information at UCD is a challenge. However, we feel it is imperative that accurate clinical reports are obtained timely and that the County has to work with community partners to rectify this barrier to information. RNs not properly triaging and referring patients to a higher level is still a challenge in the intake area and ACH agrees this needs to be addressed. The monitors disagree that prior nursing documentation is not expected to be reviewed by nurses during subsequent clinical encounters. Review of previous documentation is the standard of care.

Patient #2
This 58-year-old male was presented in detail in Section B, Intake. This patient had severely uncontrolled blood pressure associated with abnormal EKG and headaches. The nurses and providers did not recognize the seriousness of this patient's condition and therefore he did not receive care consistent with standards or evidence-based medicine..

Patient #3
This 52-year-old female arrived at SCJ on 9/25/24 and was released on 11/1/24. Her medical history includes methamphetamine use disorder, hypertension, chronic hepatitis C infection without treatment, and poor oral health. Medications were amlodipine-valsartan.

Summary: This patient was in jail for five weeks. The patient was hypertensive upon arrival and was timely treated at intake. Her history and physical took place 19 days after arrival. The provider addressed the patient's hypertension and hepatitis C infection and ordered appropriate labs, but did not order a chronic disease follow-up visit. On 10/30/24, the patient complained of chest pain; the patient's blood pressure was mildly elevated, and the EKG was normal. The nurse appropriately notified a provider who ordered the patient sent to the ED to rule out acute coronary syndrome (ACS) due to cardiac risk factors. The patient was not initially treated at the jail for ACS with aspirin, nitroglycerin, and oxygen. The provider ordered the patient to be sent via custody van which departed the jail approximately 90 minutes later. It is dangerous to transport a patient with suspected ACS, via custody van, due to lack of advanced cardiac life support capability. Emergency department records were not obtained and scanned into the record, so staff were unaware of what transpired at the ED and the recommendations. There is no documentation that the patient received discharge medications.

Patient #6
This 39-year-old male arrived at SCJ on 10/10/24 and is still at the jail. His medical history includes type 2 diabetes, alcohol and methamphetamine use disorders, and serious mental illness. His medications are metformin, glipizide, olanzapine (Zyprexa), buspirone and sertraline.

The patient had several previous admissions to SCJ in 2021 and March 2022. Upon release in March 2022, the patient was prescribed olanzapine.

Summary: This patient was declared unfit for confinement upon arrival with elevated blood sugars in the 400's. Following his return to jail, a medical provider did not see him but ordered medications and labsThere was an encounter scheduled for 10/14/24, and the patient refused. On 10/17/24, the patient had a highly abnormal HbA1c of 14.7%, reflecting poor diabetes control, but this result was not reported or noted by a medical provider. A medical provider did not see the patient for two months after his arrival. During that visit, the provider did not perform a diabetes review of systems or conduct a pertinent examination, including the heart, lungs, pulses, and feet. The provider did not order a follow-up visit, and none is scheduled. The patient's medication adherence has been excellent, and his diabetes has improved. He has had an eye exam but no foot examination. It is important to monitor diabetics on atypical antipsychotics

closely. Olanzapine can exacerbate this illness. Patients with significant abnormalities and who repeatedly refuse care should be scheduled to be seen more often, and some may require admission to the infirmary for close monitoring.

The following concerns were noted in the care of this patient:

- The Sutter records are primarily labs and contain no medical history or physical examination. The patient's weight was documented as 215 pounds, discrepant from the jail weight of 144 pounds.
- During the Phase 2 assessment, the RN did not note that the patient had been declared unfit for confinement earlier that day and was being readmitted.
- The RN did not note that per the patient's problem list, he had a history of alcohol, cocaine, and methamphetamine use.
- On 10/11/24, at 16:48, when the patient reportedly refused to come out of his cell for a blood sugar check and Humalog insulin, the RN completed a Refusal of Treatment form, but the patient did not sign it. Therefore, this is not an informed refusal. The RN did not engage the patient to assess whether he was awake and had the capacity to refuse treatment.
- Neither the medical order for sliding scale Humalog insulin nor the eMAR includes instructions as to how much Insulin is to be given to the patient based upon the blood glucose.
- Nurses document the administration of insulin without documenting the corresponding blood glucose.
- On 10/14/24, a medical provider assessed the patient and ordered diabetic treatment and follow-up in two to three days. The next visit did not occur until two months later.
- On 12/11/24, at 09:22, a medical provider saw the patient for chronic disease management. The provider did not perform a diabetes pertinent examination of the heart, lungs, pulses, and foot exam, note the previous HbA1c of 14.7, or order a follow-up chronic disease appointment, and there is no appointment scheduled. The patient is lost to follow-up.
- The mental health nurse practitioner who saw the patient on 10/26/24 should have noted the elevated HbA1c before starting the patient on Zyprexa.

Patient #7

Sections B (Intake) and Section C (Access to Care) provide thorough details on the global mismanagement of this patient's chronic care conditions. The deficiencies ranged from failure to acknowledge all chronic illnesses to failure to evaluate and establish control status of each, to inadequate medication treatment. This description applies to her physical and mental health.

Patient #25

This is a 60-year-old male with significant medical conditions and congenital deafness who was presented in detail in Section B, Intake. The management of his chronic illnesses fell well below

the standard of care. He was seen once for his illnesses, and this was seven months after his booking date. His conditions collectively put him at risk for sudden cardiac death

Patient # 26

This is a 70-year-old female who presented to the jail on 3/30/23 with a complex medical profile inclusive of chronic pain associated with chronic kidney stones and degenerative arthritis of cervical and lumbar spine; right breast mass associated with right axillary adenopathy and trace cardiac pleural effusion that was not appropriately investigated before release from jail; fluctuation in renal function indices, as can be expected in xanthogranulomatous pyelonephritis, but not adequately acknowledged; COPD that was inadequately assessed; iron deficiency anemia that was never investigated; polypharmacy and use of Ditropan without a clear documented indication and possible experience of dizziness as a side effect. The patient's dizziness was never considered as a side effect of medication and moreover, meclizine was added to treat the symptom and erroneously diagnosed as vertigo. Hyperthyroidism appeared to be a new onset, based on lab values. From the time of diagnosis, the patient appeared to respond to treatment. However, on 1/5/25, the provider indicated the patient's thyroid function had been over-suppressed, but no lab work was found to support this assertion. The provider discontinued the pm dose of 5 mg and ordered a three-month follow-up. This would be too long to reassess a patient with this clinical scenario. The administration of methimazole reflected at least two separate medication errors (4/24/24, doses administered too close together; 11/27/24, 15 mg "administered", but no corresponding order). The eMAR reflects administered and KOP for the same medication.

Summary: There were 154 chronic care note types documented throughout the incarcerated period of this patient. Although several providers engaged her, none of them fully addressed the collective chronic illnesses. This demonstrates a complete lack of patient care focus. The vast medication profile suggests symptom management versus investigation for etiology. The care for this patient was woefully inadequate and did not meet the standard of care. The patient's insulin regimen varied frequently and did not correspond to diet times or normal circadian rhythm, as required in the Consent Decree (VI.D.1.c.).

The lack of required core biopsies for her breast mass and axillary adenopathy is the most concerning. If this patient has cancer, the failure to follow-through on her breast mass would equate to deliberate indifference. On 11/22/24, the Nephrologist saw the patient for kidney stone and recommended Urology consults. The Urology request was sent to the US Marshall for approval, as the patient was a Federal inmate. On 12/27/24, the Urologist request was "denied", but no reason documented.

Systemic and Quality of Care Concerns

- Significant delay in response to the Urologist referral from the Federal Prison.
- Poly Pharmacy (duloxetine and Neurontin (for pain?); duloxetine and Trazadone (for depression?).
- Medication Errors.
- Discrepancy in documentation of "administered and KOP" on the eMAR.

- Prescribing of meclizine without supporting clinical justification and not stopping after recommendation to do so.
- Failure to follow through on positive findings in right breast and axillary images, especially with small pericardial effusion.
- Lack of supervision of the Nurse Practitioner while managing complex patients.
- No clear admission, concurrent care or discharge notes while the patient was housed on 2M.
- Failure to investigate the etiology of iron deficiency anemia (in this case, kidney disease could have been the culprit, but a GI cancer must be ruled out).

Patient #28
This is a 34-year-old female with an established history of Type I diabetes who submitted a complaint regarding her Insulin regimen and concern that ACH was not equipped to manage her condition. As a result of her concern, she threatened to harm herself by refusing to eat or take insulin. She was appropriately referred to mental health and during the mental health assessment the patient denounced the desire to kill herself and endorsed the wish to live and become a lawyer. Her false claim to self-harm appeared to be related to her frustration with her diabetic care and distrust for ACH.

Summary: The review of the medical record indicates that the diabetic care was erratic throughout the entire incarceration. The doses of insulin administered were inconsistent with orders and the patient's glucose levels widely varied day after day. The patient was instrumental in the amount of pre-meal coverage for anticipated carbohydrate ingestion, but it was clear that the patient was not capable of determining this and there was no documented correlation of meals received. The record indicates that Lantus was not given on each day and when it was, it did not always match the order. There were several discrepancies between the glucose values attained by staff (manual) and those attained by the keep on person monitor (CGM). The staff appropriately offered to replace the self-monitor, but the patient declined. The patient reported a very high glucose level (371), via the intercom, and the nurse did not assess the patient.

The evidence of care documented in the medical record supports the concerns expressed by the patient. The patient was correctly housed in the infirmary, but did not receive the appropriate frequency of clinical encounters required for her instability. The medical staff appeared to be task focused and not care focused. There were several critical vital signs unaddressed by the nursing staff, primary care provider and gastroenterologist. The patient exhibited several episodes of high blood pressure that may have been an indication of new onset hypertension or a cardiac event. The episodic fast heart rates could have been a sign of dehydration, silent ischemia which is a well-known phenomenon in diabetics, or metabolic derangement resulting from the wide swings of glucose values or electrolyte imbalance. An EKG should have been obtained during the elevated heart rate episodes to determine the rhythm. The ACH provider and the gastroenterologist erroneously recorded "RRR" for their cardiac exam. Diabetic ketoacidosis is a common occurrence in patients with Type 1 diabetes, and this can occur when the sugars are normal or high. None of these possible clinical entities was considered in this case. IV hydration is a staple in the management of uncontrolled diabetes, and this patient should have been

offered intravenous fluids and assessment for urine ketones. There was a drastic drop in the systolic blood pressure, without a compensatory increase in the heart rate on 4/1/25, at 09:19, and this was not recognized.

Patients with Type I diabetes can be a challenge to manage, and sometimes meticulous care is required to maintain steady glucose readings before meals and at bedtime. As mentioned by the patient, unpredictable mealtimes made it impossible to effectively care for her illness. Around-the-clock consistency in meals and medication is imperative to establish and maintain control. Many medications were administered too soon, and this may have been the cause of her frequent complaints of nausea, which were never adequately assessed. Nausea can also be a symptom of unstable angina, especially in patients with diabetes. The overall management of this patient's clinical presentation grossly fell below the standard of care. The *ADA's Standards of Care in Detention Settings* publication provides a useful guide for complex cases like this one.

Systemic and Quality of Care Concerns

- On 3/16/25, the provider indicated in their note that Zofran and Hyoscyamine were discontinued and replaced by promethazine. This did not occur.
- The provider appeared to close the notes out late.
- The ACH provider abdicated the responsibility to inform the patient of medication changes and initiation of Vistaril.
- Several medications were administered too soon throughout the patient's care.
- NSAID was added to the medication list from nursing protocol. NSAID and prednisone together increase the risk for GI Bleed, and it does not appear this was considered in this patient.
- Abnormal vitals were not addressed.
- Nursing documentation is lacking and/or conflicting.
- Nurses failed to notify the provider about significant abnormal vital signs and physical symptoms.
- The exact time documents are scanned to the record is not documented.
- Staff demonstrated overall inflexibility with Insulin and medication administration.
- Nurses document "administered" for medication that was provided KOP.

Compliance Assessment:

- D.1=Noncompliance
- D.1.a=Partial Compliance
- D.1.b=Partial Compliance
- D.1.c=Noncompliance
- D.1.d=Partial Compliance
- D.2=Noncompliance

- D.3=Substantial Compliance

Recommendations:

1. Consider having a provider endorse outside medical records before scanning. This will mitigate records being filed and a provider being unaware.
2. Nurses should document every patient encounter, including communication prior to and after administering prn medications.
3. Develop and implement a policy requiring staff to notify a physician of all glucose results outside a specified range, as determined by the treating physician.
4. Work with Pharmacy Director to correct the documentation discrepancy regarding "administered" and KOP".
5. Ensure medication errors are quickly identified, investigated and measures are instituted to prevent them in the future.
6. Staff should go to the patient and shake them to make sure they are responsive and confirm that care is not needed.
7. Training on management of HTN with a focus on the appropriate use and side effects of Clonidine.
8. Training for proper assessment and timely diagnostics for patients with head injuries. Trending blood pressure and pulse can help assess the possibility of evolving increased cranial pressure.
9. Nurse or provider should assess patients who report "bloody stools" to help develop a differential diagnosis.
10. If a patient is actively demonstrating aggressive behavior when custody or medical staff attempt to assess, then the necessary steps should be taken to stabilize the patient to provide necessary care. An attempt to provide necessary care should not be predicated on an assumption that the patient might be aggressive.
11. Medical Providers, not nurses, should maintain and update the Problem List to ensure accuracy.
12. Providers should speak directly with patients about initiation and modification of medication. It is not appropriate to delegate this primary responsibility to a nurse.
13. Ensure all patients with language barriers of any type have timely access to interpreters and equipment/aides required to effectively communicate their care needs and allow staff to conduct adequate assessments.
14. Establish and maintain a list of all special needs patients and to ensure their disabilities are adequately accommodated and their well-being is routinely monitored.
15. Establish a High Acuity program to ensure patients with complex medical conditions are identified early and have a treatment plan developed by a qualified provider.
16. Establish and maintain a list of all special needs patients and to ensure their disabilities are adequately accommodated and their well-being is routinely monitored.
17. Establish an efficient and effective chronic care program that includes the pertinent clinical components of each known disease and proper follow-up.

18. Complete implementation of the VA chronic care guidelines, provide a copy of the guidelines and documentation of provider training to the monitors.
19. Implement a CQI monthly audit of a random selection (30 charts) of chronic care encounters to collect, analyze, and trend data.

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 Plaintiff's 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.

Findings: Please note that this section will overlap and reiterate some or similar comments made by the monitors in the Utilization Management (UM) section of this report. ACH has secured two dedicated physicians to oversee its specialty referral process. Dedicated Case Management (CM) nurses have enhanced the processing of requests and scheduling of appointments. The dedicated physician review has improved the authorization of medically necessary referrals and reduced those that are more elective in nature. This effort has helped to mitigate the wasteful consumption of available appointment slots in the community.

However, the process is still very convoluted in that a significant amount of information must be gathered before the provider can request an appointment, the CM nurse must still share the clinical information and urgency of the providers' requests with Custody Medical Transport (CMT) to secure the appointment. The monitors positively recognize the County's progress on increasing the number of transport vehicles to accommodate the offsite demand but wish to reiterate the previous recommendation to remove the CMT from this process, we believe it is a direct violation of HIPAA and an unnecessary exposure of protected health information (PHI).

InterQual was previously used as a resource to support decisions for specialty services, but this was aborted due to the excessive "denial" dispositions. The County is reconsidering an agreement with InterQual to help meet the Consent Decree's requirement to "use an algorithm with evidence-based referral criteria and guidelines" (VI.E.1).

In the meantime, the County's dedicated physician determines the authorization of referrals based on the use of medical references of their choice and, at times, with the support of Rubicon. Rubicon is a well-recognized and acceptable consultation resource to assist providers in determining appropriate interventions and management of clinical cases.

The UM physician reports steady improvement in meeting the fourteen-day and ninety-day requirements for applicable appointments (VI.E.2). However, the UM physician also reports that communication with the providers about the status of their specialty request varies, and confirmation of their awareness is currently not possible. The UM physician stated that standardizing the communication practice will be a focus of the new operating procedure (VI.E.3, VI.E.9). The monitors will review the compliance of the appropriate appointment times and the proposed new practice for notification of noncompliant appointments during the next monitoring cycle. Effective notification of the providers is paramount to ensure patients are properly monitored for decompensation while waiting for an appointment.

The County is doing better at having patients evaluated post-offsite care. The case studies below reflect this, but the practice is not consistent, as another case review will reflect (VI.E.4). There is a tracking log in use, but it needs to be improved to include the tracking of the entire process from the inception of the CM nurse receiving the request through the acknowledgement of the specialist's recommendation. The monitors wish to stress the importance of tracking each offsite visit to its completion to avoid missing critical continuity of care (VI.E.5, VI.E.6). ACH is currently working on developing the auditing system to measure the effectiveness of its specialty referral process (VI.E.7). The County has maintained the e-referral system for specialty referrals and remains in substantial compliance for VI.E.8. Onsite Physical Therapy is provided by the County. However, it is insufficient to meet the clinical demands (VI.E.10).

The patient reviews below support the above findings:

Patient #29
Summary: This is a 52-year-old male who presented to the jail in October 2021 with chronic back and knee pain. He continued to experience these discomforts throughout his incarceration and received appropriate care for both. He presented with a testicular mass in August of 2024, for the first time, and this clinical finding was appropriately addressed, and the patient was diagnosed with testicular cancer. The patient received appropriate specialty evaluations (Oncology and Urology). The patient declined further treatment interventions (Chemotherapy), after receiving adequate education on the risks of not accepting recommended treatment. The patient offered the potential negative outcome of his criminal charges as his main reason for not moving forward with treatment at this time. ACH managed this patient timely and appropriately, with a few exceptions in provider follow-up orders. In addition, a patient with this type of clinical diagnosis and refusing recommended treatment should be assessed more frequently than every three months. This will allow for early detection of acute changes or decompensation.

The patient also demonstrated decreasing kidney function while receiving medications that compromise kidney function (8/9/24: GFR 85 and Cr 1.06; 12/6/24: GFR-78 and Cr 1.14) The changes in the kidney function, along with the elevation in the patient's blood count (9/10/24: HCT 54.9) suggested dehydration that was never recognized and addressed. The combination of dehydration and chronic use of NSAIDS (anti-inflammatory pain meds) can cause acute kidney injury. The patient was prescribed a second medication to address the stomach side effects from the NSAID. NSAID medication causes acid to burn the chest, and acid blockers are prescribed to

neutralize the acid. These are called proton pump inhibitors (PPI) and H2 blockers. A better approach would have been to change to Tylenol and avoid stomach upset, the need for another medication, and kidney compromise.

Pulmonary Function Tests (PFT) were recommended for this patient, but he declined. However, another patient's PFT results were found in this patient's medical record, and ACH was informed of this so they could rectify.

Findings:

- Protracted use of NSAID and H2 Blockers/PPI.
- Decreasing Renal function, while on chronic NSAID medication.
- Increased Hematocrit suggestive of volume depletion and need for hydration.
- Miss filing of another patient's PFT results.

Patient #5

This 23-year-old male, described in detail in Section C of this report, arrived at SCJ on 8/19/24 and is still at the jail. His medical history includes alcohol, benzodiazepine, and opioid use disorders, sexually transmitted infections, priapism (prolonged erection) and consequential erectile dysfunction, adjustment disorder with mixed anxiety and depressed mood. Medications are Suboxone and mirtazapine.

Summary: The monitors receive this patient for review by class counsel. This 23-year-old man was booked-into jail on 8/19/24 with a history of polysubstance use disorder and active treatment with Suboxone. His blood pressure and heart rate were elevated, 151/91 mm Hg and 116 per minute, respectively. His urinary drug screen was positive for Suboxone, and oxycodone and his initial COWS score was two. The patient was declared fit for incarceration. The RN called a medical provider for a Suboxone order. The RN ordered a COVID-19 vaccination check, tuberculosis skin test, intake dental assessment, and discharge planning. The intake RN did not refer the patient to a medical provider for a history and physical, a MAT provider, a MAT RN, a SUD counselor, or MAT housing. The patient is not under the care of an addiction medicine specialist. and his prescriptions for Suboxone are automatically renewed.

On 10/17/24, the patient presented as a 2 medical walk in for what the patient described as an "abscess on his penis." An RN documented a 3.5 x 2 cm bump on patient's penis and contacted a medical provider who ordered acetaminophen (Tylenol) and an urgent medical provider visit, but the patient was not seen by a medical provider for four days. On 10/21/24, a medical provider saw the patient for the first time since his arrival two months prior. The patient presented with dysuria, priapism, and minimally raised nodules on the shaft of his penis. The provider sent the patient to UC Davis Medical Center's ED where the patient was diagnosed with nonischemic priapism and given a penile block with Lidocaine. Discharge instructions were to return to the clinic, if the erection does not resolve or intensifies.

On 10/23/24, a provider saw the patient post ED visit and determined that a urology follow-up was not warranted at that time. The provider's plan indicated a follow-up in two days. This follow-up visit did not occur. On 10/29/24, a provider documented that the patient reported "priapism had resolved", but there was no physical exam documented. A month later, on 11/21/24, the patient submitted multiple HSRs (some of which are not scanned into the EHR), complaining of severe penile pain (VI.C.2). Four days later, on 11/25/24, a provider saw the patient who complained of erectile dysfunction. The provider submitted a Rubicon urology consult and added the diagnosis to the Problem List, but did not order any medical follow-up and did not document the results of the Rubicon referral. As of 3/5/25, the patient had not been seen for this persistent problem. Four days later, on 11/25/24, a provider saw the patient who complained of erectile dysfunction. The provider submitted a Rubicon Urology consult and added the diagnosis to the Problem List, but did not order any medical follow-up and did not document the results of the Rubicon referral. As of 3/5/25, the patient has not been seen for this problem again. However, the patient's family has reached out to class counsel to say that the patient faces "permanent damage" and has not had access to a Urologist.

On 3/14/24 and 3/18/24, the patient complained of "groin pain" and it took several days for the nurse to respond to the sick call. This is significant because of this patient's known history. This patient should be on the high acuity list and all should be aware of the urgency to refer to a provider for any groin or genital complaints.

The Urologist consult that was originally made on 11/25/24 did not occur until 3/18/25. The Urologist recommended further work up, including penile Doppler Ultrasound. A medical provider acknowledged the recommendations but elected to refer the patient back to a primary care provider for further work-up. This was not necessary and would have created a delay in care, if not for another provider's intervention on 3/20/25 to properly order the urgent Urology consultation.

Findings:

- Provider's incorrect decision to refer the patient back to a primary care provider when specialist care was required.
- The significant delay of the Urology visit that was requested on 11/15/24 but did not occur until 3/18/25.

Patient #30

This patient was booked into jail on 8/11/21 and remains incarcerated. The monitors received this patient for review by class counsel.

Summary: This is a 49-year-old male who presented to the jail with chronic shoulder pain related to old injuries. The image of the right shoulder on 3/22/25 revealed old surgery with retained hardware and no acute findings. Therefore, there is no indication that the patient has an active problem with his right shoulder that requires further intervention. The patient underwent a total left shoulder arthroplasty on 7/17/24. The staff is commended on getting this done in a reasonable time, based on the imaging report and positive physical findings, between May and

June 2024. The Orthopedic surgeon requested physical therapy (PT) and a follow-up in three to four months after surgery. Unfortunately, the patient did not receive the required post op PT, and this created a less-than-optimal recovery of his shoulder and did not meet the standard of care (VI.E.3., E.4., E.5., E.10).

The patient did have an orthopedic follow-up on October 15, 2024, and he informed the surgeon that he had not received physical therapy. The physical exam of the patient during this visit was consistent with the lack of rehabilitation that should have occurred. The patient had reduced range of motion and pain, limiting manual manipulation by the Orthopedist. The Orthopedist ordered the PT again. This time, the patient did receive PT, on average, once a week for a total of nine out of twelve visits. The patient refused one visit, and two visits were not completed because of "time constraints." It is not clear what the time constraints were, and this should be investigated and explained by ACH, as this could be another example of access to care issues. PT was finalized on 3/17/25, and the patient was released with a home exercise program. The record shows the patient was happy with the progress made with PT. The monitors submit that weekly PT visits, post-surgery are not sufficient, and this patient had a significant delay in continuity of care.

The patient has a long history of fat containing tumor (lipoma) on his left lower leg and it has been determined to be benign. Routinely, this type of finding is not life or limb threatening and would be considered an elective surgical procedure. He reports daily discomfort with the mass when he sits. Assessment of compromise to the patient's ability to carry out activities of daily function should be considered in determining if this elective procedure should be authorized. The patient has a chronic (1/28/2022) lump in the tail of his right epididymis (scrotum). The monitor could not find evidence that he has acute issues with either scrotum that requires immediate attention.

Compliance Assessment:

- E.1=Partial Compliance↑
- E.2=Partial Compliance↑
- E.3=Noncompliance
- E.4=Partial Compliance
- E.5=Partial Compliance
- E.6=Partial Compliance
- E.7=Noncompliance
- E.8=Substantial Compliance
- E.9=Noncompliance
- E.10=Partial Compliance↓

Recommendations:

1. Enhance the current offsite tracking tool to capture the status of each request from the original request date to the acknowledgement of the specialist's recommendation and discharge of information by a provider.

2. Improve access to Physical Therapy to ensure appropriate patients receive adequate number of sessions within a reasonable timeframe.
3. ACH should investigate and identify the root cause of the “time constraints” that prevent patients from getting scheduled specialty care and implement mitigation strategies.
4. ACH should develop an auditing tool of its Specialty Referral system to demonstrate compliance with the Consent Decree.
5. Develop a training module on the indication and proper treatment of GERD and use of Proton Pump Inhibitors (PPI).
6. Develop a training module on the use of Nonsteroidals (NSAID) in patients with decreasing renal function
7. Develop a standard communication procedure for notifying the provider of delayed Specialty appointments and audit the compliance.

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.

Findings: The County has established policies and procedures specific to the procurement, storage, control, and administration of medications, which were reviewed and approved by the monitors. The practice of medication administration, however, continues to present challenges (VI.F.1.).

The County reports that audits completed during 2022, 2023, and 2024 find that initial doses of prescribed medications are delivered to patients within 48 hours of the prescription 96%-100%

of the time.[21] Review of patient records find that the initial doses of prescribed medications are usually administered to patients within 48 hours of the prescription. However, they are often delayed. The delays occur for a variety of reasons, including transfer of the patient and lack of staffing/custody escorts. Additional medical escorts are required for ACH to consistently meet this Consent Decree requirement (VI. F.1.a, VI. F.1.b, and V1. F2).

Timely administration of scheduled medications.
Standards of nursing practice require the prescribed medication to be administered up to one hour before and one hour after the scheduled administration time. Nursing staff contemporaneously document the administration of medication, and a review of records reveals that administration times are often earlier or later than those allowed by nursing standards. For example, a patient prescribed an antibiotic for the treatment of balanoposthitis[22], an inflammation of the glans penis, timely received seven of fourteen (50%) of the prescribed doses. The remaining seven doses were given up to one hour early and up to one hour and forty-three minutes after the scheduled time. Another patient was prescribed daily Suboxone, scheduled for administration at 07:30.[23] From January 4 through January 9, none of the seven doses (0%) were timely administered. On January 10, the scheduled medication administration time was changed from 07:30 to 09:30. From January 10 through January 15, 86% of the seven scheduled doses were timely administered.

Inconsistent and extended methadone dosing Intervals result in predictable withdrawal symptoms and inaccurate COWS assessment scores.
Patient #4 is a pregnant woman with opioid use disorder who was inducted on methadone. The addiction specialist and other providers documented that the patient was having significant withdrawal symptoms requiring methadone dosing adjustment. Methadone morning dosing was at 08:30 to 09:00, and afternoon at 15:00 to 16:00. This is a dosing interval of six to eight hours, which resulted in the patient not being dosed again for sixteen to eighteen hours. This prolonged dosing interval resulted in the patient having recurrent withdrawal symptoms in the evening or early in the morning, subjecting the patient and her fetus to withdrawal symptoms. Twice daily medication dosing intervals need to be at least eight hours, and for withdrawal medication, need to be closer to ten to twelve hours to provide continuous coverage and prevent symptoms and the need for increasing doses. In addition, while the patient was reporting increasing symptoms to a medical provider, the nurses' COWS assessment scores were low, resulting in the discontinuation of COWS monitoring until the providers reordered the assessments. Positively, the patient was timely referred to the CORE outpatient drug treatment program, and the patient was enrolled into the program prior to discharge. Although the patient was not initially provided with timely access to opioid use disorder treatment, once enrolled, medical providers closely monitored the patient and adjusted treatment.[24]

[21] 10th Sacramento County Remedial Plan Status Report. January 7, 2025. Page 100.
[22] Patient #18
[23] Patient #19
[24] Patient #4

Nurses are not administering medications three times daily as ordered by a medical provider.
This pregnant patient had a urinary tract infection and was ordered Keflex 500 mg three times daily. The patient was not administered the evening dose of Keflex on November 22, 23, and 24, 2024. An untreated or undertreated bladder urinary tract infection during pregnancy can lead to serious complications for both the baby and mother, including a kidney infection (pyelonephritis). When medical providers order medications three times daily, pharmacy staff must determine whether the medication dosage can be adjusted to safely administer it twice daily (VI. F.3).

Court Medication Administration
Effective November 2024, a new court medication process was implemented at Main Jail. Through collaboration with custody, pharmacy, and nursing staff, a new method was developed for daily court notification, medication preparation, and administration prior to patients leaving for court in the morning.[25]

The monitors observed medication administration at both facilities, in multiple housing units. At RCCC, the officers were observed to have good control of the unit and the queue, resulting in a quiet, orderly process. The officer allowed the nurse to engage each patient and did not interfere with the process. Nursing staff consistently used multiple patient identifiers to ensure the correct medication was administered to the right patient, engaged with patients who declined their medication, and provided excellent education on the importance of compliance. Custody staff enforced the completion of mouth checks and used illumination to adequately visualize each patient's mouth. It was apparent that this process had become routine, as most patients automatically presented their open mouths for inspection without prompting.

At the Main jail, observation by the monitors found challenges that remain. Wi-Fi connectivity issues in the housing unit precluded the nurse from accessing the electronic health record. The patient's profile picture was not available to the nurse, and multiple patients presented for medication without having a wristband. The nurse asked the patient their name and "xref" number and administered the medication. This is problematic as inmates often easily memorize the names of other inmates and their corresponding "xref" numbers. When photo identification or a wristband is not available, in addition to name and number, nursing staff must utilize additional unique patient identifiers, such as date of birth and/or social security number. In some jurisdictions, the security staff maintain an identification card that includes a photograph for each inmate in the unit. When the electronic system is down, both the officer and the nurse can rely on the identification card for positive identification of each patient.

The officer completed mouth checks through the door window; however, inmates were allowed to drink from opaque, Styrofoam-type cups, which allowed them to divert the medication into the cup without being detected by the officer. Another observed practice that was concerning was custody staff taking the lead in the medication administration process by asking each patient, "Do you want your medication"? Because inmates typically view custody staff as law enforcement, they often will refuse to take medication in order to demonstrate control and

[25] 10th Sacramento County Remedial Plan Status Report. January 7, 2025. Page 9.

resistance. The nurse should take the lead in the therapeutic medication process, giving soft commands such as, "Mr. Jones, it's time to take your medication. Please come to the door with your cup of water." Patients have a right to refuse. However, the nurse should engage the patient, explore the reasons for their refusal, and educate them on the importance of medication compliance. Custody staff should limit their involvement to maintaining a safe environment, accessing the cell, and, if a patient refuses to present to the door, command the patient to step forward and speak with the nurse.

Lack of continuity of the medication regimen when patients are transferred.
On January 14, a patient transferred from the Main jail to RCCC.[26] He did not receive his scheduled Suboxone until 21:08, twelve hours after it was scheduled. He also did not receive his other ordered medications, which included Lopressor, his medication ordered for the treatment of hypertension. The nurse documented that they were not given secondary to his transfer. The same patient did not receive his Lopressor on January 23, 2025, with the nurse documenting that he was at work. Processes should be established to ensure the transfer of patients' medications when the patient is transferred between the two jails. A process to ensure patients on work details receive their scheduled medications is also required. There are several process options, including having the nurse report to the work detail or packaging the scheduled dose for consumption at the scheduled time and providing it to the patient prior to their departure for work (VI. F.4).

Non-compliant patients are not routinely referred for compliance counseling.
This same patient refused six of his fourteen (43%) scheduled doses from January 10 through January 16, 2024. One dose was missed because the patient was transferred, and another dose was not documented, raising questions about whether it was actually offered. There was no referral to the provider to address his non-compliance. Nurses need to make the referrals in a timely manner, and the provider and/or the clinical pharmacists should schedule the patient for counseling (VI. F.1.b).

The County is to develop policies and procedures to ensure that that medication efficacy and side effects are monitored by staff and reviewed by appropriate clinicians at appropriate levels (VI. F.5). The Remedial Plan indicates that the County must develop policies and procedures "to ensure that medication efficacy and side effects are monitored by staff and reviewed at appropriate levels." The chronic disease policy assigns the responsibility to explain and monitor side effects to a RN. However, chronic disease policies and protocols need to clarify that medical providers must explain the purposes of medication and their side effects at initiation and must, at each chronic disease visit, review eMARs to assess the patient's medication adherence, drug efficacy, and side effects, and to provide handouts if available. Nurses also need to review medication adherence and reeducate the patient as needed. Record review shows that medical providers do not consistently assess medication adherence at each visit but do document side effects when present.

[26] Patient #19

Based on chronic care reviews, providers are not consistently and adequately educating patients about all their medications and side effects. One patient experienced a low potassium while receiving a diuretic (water pill) for the management of his high blood pressure.[27] Another diabetic patient was prescribed a mental health medication that can cause or exacerbate diabetes, and no documentation was found that indicated the patient was made aware of this.[28] This same patient presented to the jail with uncontrolled diabetes, and the medical staff did a great job of bringing it under control. A third patient with multiple medical conditions did not have all chronic illnesses or active medications addressed during their chronic care encounter. This case is especially concerning because there is a high probability of drug-drug and or drug disease interactions when you have complex medical conditions that require multiple medications. [29]

Documentation issues related to the lack of a bi-directional software interface.
A concerning issue that was previously reported is the lack of a bi-directional interface between the Fusion eMar and the pharmacy software (CIPS). ACH has been collaborating with Fusion and CIPS to develop a bi-directional interface; however, it has not yet been completed. When providers order medications, the order is electronically entered on the medication administration record (MAR). The order is then reviewed and approved by the pharmacist, and the medication is packaged for administration. The monitors' review of patient records found that duplicate orders are documented on the MAR, creating opportunities for medication errors. An example is Doxycycline, which was ordered for five days on December 30, 2024.[30] The first dose was given at the time the provider gave the order. Then three separate orders were recorded on the MAR. One order is for Doxycycline twice daily for four days, with a start date of December 31 and an end date of January 3, 2025. The second documented order is for doxycycline, administered twice daily for five days, with a start date of December 30, 2024, and an end date of January 3, 2025. The third order is a duplicate of the second order, Doxycycline twice daily for five days with a start date of December 30, 2024, and an end date of January 3, 2025. This outcome is confusing and dangerous. Fortunately, the nurses carefully navigated the MAR, and the patient was not administered duplicate doses. ACH reports that the EHR vendor is scheduled to provide a new version of the eMAR in the first quarter of 2025, which includes a barcode scanning feature, theoretically correcting the pharmacy errors.

The County continues to utilize a Keep-On-Person (KOP) program for patients prescribed medications for chronic disease and other potentially emergent conditions such as asthma and angina. Pharmacy staff prepare and administer the medication to the patients. The medication name, dose, and administration date are documented on the eMAR; however, the amount of medication administered is not. The pharmacy staff can view the amount of medication administered in the pharmacy software program; however, health staff, including providers, cannot. Because there is no bi-directional interface between the eMAR and CIPS, the administration documentation remains incomplete. The date, time, and quantity of medication

[27] Patient #1
[28] Patient #6
[29] Patient # 7
[30] Patient #19

must be documented on the eMAR. When healthcare staff assess patient compliance with self-administration, it is essential that they can determine the number of doses the patient should have in their possession at any given time (VI. F.6).

Compliance Assessment:

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

Recommendations:

1. The County needs to establish an interface between the pharmacy software (CIPS) and the Fusion EHR eMAR to eliminate the ongoing risk of medication error and potential harm to patients.
2. Specific insulin sliding scale orders must be visible in both the eMAR and the electronic medical record.
3. All administered insulin must be documented on the eMAR.
4. Keep-on-person medication administration documentation on the eMAR must include the quantity of medicine provided to the patient.
5. The County needs to ensure adequate custody staffing to ensure the timely delivery of all medications at all scheduled times, seven days a week.
6. The County needs to implement a process that ensures ordered medications are administered before departure when patients attend off-site specialty appointments and are on work details.
7. The County needs to implement a process for the timely transfer of patient-specific medications for all intra-system transfers, ensuring no disruption in patients' ordered medication regimen.
8. The County should monitor and reinforce proper medication administration practices with both custody and nursing staff at the Main jail.

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.
4. The County shall ensure that patients in medical placements are not forced to sleep on the floor, including by providing beds with rails or other features appropriate for patient's clinical needs and risk of falling.
5. 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.

Findings: ACH reports securing additional exam room stations on each floor, in each wing, with confidential space to complete services, including nursing sick call. All exam rooms at Main Jail are visually and auditorily confidential, and there are now "confidential booths" or "privacy pods" installed on each wing. However, the monitors noted that these booths and pods are not equipped with exam tables and hand-washing stations. Nurses make use of these pods and booths when other rooms are not available and transport equipment that's needed on carts. The intake area was modified to have four confidential rooms that allow for privacy for all arrestees. At RCCC, all medical and psychiatric offices are confidential and free of recording; there are no cameras in medical offices; MHU Cells are recorded, but there is no audio (VI. G. 1).[31]

ACH plans for long-term privacy improvements through additional construction of an annex that includes a new booking loop with enhanced privacy space adjacent and connected to the current Main Jail. The County reported that the Board of Supervisors adopted the completed peer review, including the recommendation to revisit all potential solutions. A formal County group has been identified to draft a scope of work in preparation to release a request for proposal for a comprehensive assessment.

At the Main Jail, the negative pressure isolation room located on 2 Medical is functional per ACH, but is still without an attached anteroom, which is required for infection control purposes. Construction is still needed to achieve compliance with this provision of the Consent Decree (VI. G.2).[32]

[31] 10th Sacramento County Remedial Plan Status Report. January 7, 2025. Page 129.
[32] 10th Sacramento County Remedial Plan Status Report. January 7, 2025. Page 130

Enhanced medical equipment and inventory in stock to support medical stations on each floor (exam carts with computers, privacy screens) have been implemented, along with a daily healthcare service schedule that assigns exam rooms and times for RNs to provide nursing sick call, as well as other service functions.[33]

During the last site visit, the monitors noted an improvement in the cabinetry on 2-Medical. The area appeared more organized, and surfaces more amenable to disinfecting. The monitors did not notice supplies being stored on the floor like before.

Patients housed in the medical housing units do not sleep on the floor, and bedding was adequate to meet clinical needs. However, new arrestees who are assessed as "under the influence" are forced to sleep on the floor in the Intake area.

Recreation time is not meeting the intended outcome. Patients are offered outside time but frequently decline because they are forced to stay too long in inclement weather. This is recorded as a refusal, but the monitors feel it is unreasonable to force patients to stay out in the cold (VI.G.3).

There are still no infirmary beds for females at RCCC and therefore the monitors remain concerned about timey transportation to higher level of care, delays in clinical interventions and needless suffering of female patients. The County is responsible for providing equal access to a higher level of care for both genders. This can be accomplished by constructing an infirmary at RCCC. The lack of efficient and effective acute care housing for female inmates renders provision VI.G.3 partially compliant. This provision requires, "providing beds with rails or other features appropriate for patients' clinical needs and any risk of falling."

Patients with battery powered CPAP machines are still allowed to reside in general population and therefore, VI.G.4 remains in substantial compliance.

The monitors review of medical placement in the M2 medical unit, or infirmary finds concerns. These concerns include but are not limited to:

- Clinical encounters are not sufficient for acuity presentations.
- No response to patient's complaints via intercom.
- Abnormal vital signs are not addressed.
- Medication administration at inappropriate intervals and not associated with an order.
- Insulin and meal dissociations.

The below patient illustrates the need to improve the infirmary care program:

Patient #28 is a 34-year-old female with an established history of Type 1 diabetes, housed in 2M, who submitted a complaint regarding her insulin regimen and concern that ACH was not

[33] 10th Sacramento County Remedial Plan Status Report. January 7, 2025. Page 129.

equipped to manage her condition. As a result of her concern, she threatened to harm herself by refusing to eat or take insulin. She was appropriately referred to mental health, and during the mental health assessment, the patient denounced the desire to kill herself and endorsed the wish to live and become a lawyer. Her false claim to self-harm appeared to be related to her frustration with her diabetic care and distrust for ACH.

The review of the medical record indicates the diabetic care was erratic throughout the entire incarceration. The doses of insulin administered were inconsistent with orders and the patient's glucose levels widely varied day after day. The patient was instrumental in the amount of pre-meal coverage for anticipated carbohydrate ingestion, but it was clear that the patient was not capable of determining this and there was no documented correlation of meals received. The record indicates that Lantus was not given on each day, and when it was given, the dose did not always match the order. There were several discrepancies between the glucose values attained by staff (manual) and those attained by the keep-on-person monitor (CGM). The staff appropriately offered to replace the self-monitor, but the patient declined. The patient reported a very high glucose level (371), via the intercom, and the nurse did not assess the patient.

Summary: The evidence of care documented in the medical record supports the concerns expressed by the patient. The patient was correctly housed in the infirmary, but did not receive the appropriate frequency of clinical encounters required for her instability. The medical staff appeared to be task-focused and not care-focused. This was a complex patient with Type 1 diabetes that required supervision of a physician to ensure the development of an appropriate treatment plan.

There were several critical vital signs unaddressed by the nursing staff, primary care provider and Gastroenterologist. The patient exhibited several episodes of high blood pressure that may have been an indication of new onset hypertension or a cardiac event. The episodic fast heart rates could have been a sign of dehydration, silent ischemia which is a well-known phenomenon in diabetics, or metabolic derangement resulting from the wide swings of glucose values or electrolyte imbalance. An EKG should have been obtained during the elevated heart rate episodes to determine the rhythm.

The ACH provider and the Gastroenterologist erroneously recorded "RRR" (regular rate and rhythm) for their cardiac exam. Diabetic ketoacidosis is a common occurrence in patients with Type 1 diabetes, and this can occur when the sugars are normal or high. None of these possible clinical entities was considered in this case. IV hydration is a staple in the management of uncontrolled diabetes, and this patient should have been offered intravenous fluids and assessment for urine ketone. There was a drastic drop in the systolic blood pressure, without a compensatory increase in the heart rate on 4/1/25, at 09:19, and this was not recognized. Patients with Type 1 diabetes can be a challenge to manage, and sometimes meticulous care is required to maintain steady glucose readings before meals and at bedtime. As mentioned by the patient, unpredictable mealtimes made it impossible to effectively care for her illness. Around-the-clock consistency in meals and medication is imperative to establish and maintain control. Many medications were administered too soon, and this may have been the cause of her

frequent complaints of nausea which were never adequately assessed. Nausea can also be a symptom of unstable angina and especially in diabetics. The overall management of this patient's clinical presentation grossly fell below the standard of care.

Compliance Assessment:

- G.1=Partial Compliance
- G.2=Noncompliance
- G.3=Partial compliance
- G.4=Noncompliance↓
- G.5=Substantial Compliance

Recommendations:

1. All patient complaints, via the call system, must be entered into the health record and appropriately addressed.
2. Utilize multi-disciplinary team plans of care for complex patients.
3. Flexibility with medication administration times, including insulin, is paramount in the infirmary setting.
4. Establish a formal Infirmary Policy that clearly delineates required encounter intervals based on acuity.
5. Revise the electronic health record format such that the infirmary documentation/forms are in a unique, and separate tab/location from the general out-patient documentation.
6. Prioritize staffing of one full-time provider for the infirmary to improve continuity of care and supervision of Nurse Practitioners.
7. Cease utilizing HSRs and nursing protocols for infirmary patients.
8. Custody staff should implement flexibility in the duration of time required to stay outside when the weather is not favorable.
9. Add thick mattresses or boats to the sobering cell in Intake.
10. Establish a fully functional negative pressure room that includes an attached anteroom and quality assurance monitoring schedule. This should take priority.
11. Establish an Infirmary setting to accommodate the female population with acute/subacute medical illness and pregnant patients in the 3rd trimester.
12. The Director of Nursing should work with the CQI Director and develop an auditing tool to monitor the appropriate escalation of abnormal vital signs.
13. The Director of Nursing should work with the CQI Director and develop an auditing tool to monitor the appropriate administration of medications.

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.

Findings: The County has developed policies and procedures that guide insurance of appropriate confidentiality during patient care encounters. The monitors acknowledge that the County is no longer allowing custody or other inmates to intercept health care requests. However, after reviewing multiple medical records, it is evident that the consistent implementation of policy is grossly lacking. Implementation is the most important part of the policy. Encounters are frequently conducted at cell side and without auditory privacy. Due to the prevalence of non-confidential encounters documented in the medical records, the monitors maintain the Consent Decree component VI.H.1 is still in partial compliance and respectfully disagree with the County's self-assessment of substantial compliance. [34]

[34] 10th Sacramento County Remedial Plan Status Report. January 7, 2025, page 131.

The installation of the standalone pods on a few units was a significant step toward providing additional space to improve access to patients; however, there is no exam table for proper physical examinations, and no hand-washing stations are available. These pods are perfect for encounters that require conversation only. If an examination is warranted, the County would have to orchestrate the movement of the patient to another location to complete an appropriate evaluation. This would require escorting the patient and the availability of a vacant examination room. During the site visit, the monitors learned that when an exam room lacks the required equipment for a complete exam, the patient and the accompanying staff member must wait for the availability of a custody escort. This scenario creates the risk that the full examination may not take place or that the patient may refuse to stay.

The monitors acknowledge the improvements made within the Intake suite regarding patient privacy. The County needs to continue focusing on correcting the elements and practices interfering with private clinical encounters. The monitors will give credit for the progress made and agree with the County's self-assessment that the Consent Decree component VI.H.2 is moved from non-compliance to partial compliance.

The monitors agree with the County that the medical record now captures whether a clinical visit is confidential or not and that "maintaining auditory privacy is difficult due to space configuration."[35] This is what was consistently found during patient record reviews. The monitors are in complete agreement with the County that, when warranted, custody should be present to maintain safety. The County's policy adequately addresses this. As clearly stated above, private encounters do not consistently occur, and for this reason, the monitors disagree with the County's assessment of substantial compliance for the Consent Decree component VI.H.3.[36] The monitors' findings support partial compliance for this reporting period, representing an improvement from the previous assessment. The monitors encourage the County to ensure detailed documentation is included in the record whenever a patient presents a security concern that interferes with their confidential evaluation.

The monitors maintain that the Consent Decree component VI.H.4 remains substantially compliant.

Compliance Assessment:

- H.1=Partial Compliance
- H.2=Partial Compliance↑
- H.3=Partial Compliance↑
- H.4=Substantial Compliance

Recommendations:

1. Continue to modify the physical plant to increase the number of available exam rooms for private encounters.

[35] 10th Sacramento County Remedial Plan Status Report. January 7, 2025, page 133.
[36]10th Sacramento County Remedial Plan Status Report. January 7, 2025, page 133.

2. Explore “staging” of patients in all examination room areas to ensure a constant flow of patient availability in a confidential setting.
3. Add exam tables and portable handwashing stations to the standalone pods to effectively maximize their use.

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 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.

Findings: ACH continues to utilize Centricity Fusion, now called AthenaPractice™ , an electronic health record (EHR) software, which provides healthcare staff with access to comprehensive medical, behavioral health, and dental records. However, the software does not bi-directionally interface with the Correctional Inpatient Pharmacy Software (CIPS). The lack of bi-directional interface presents several challenges, including the ability to generate sufficient administrative reports required for effective data analytics and population health management. Other challenges are described below.

Lack of Fusion eMAR and CIPS interface results in medication errors.
As previously reported, there is no bidirectional interface between the Fusion eMAR and the Correctional Inpatient Pharmacy Software (CIPS). Provider medication orders are input into the eMAR in real-time, but not concurrently into CIPS for pharmacy review, which would ensure accurate dosing, identification of allergies, and detection of drug-to-drug or drug-to-disease interactions, among other purposes. The absence of an interface leads to medication errors, including duplicate orders, potential for duplicate dosing, and a risk of serious patient harm.

Another previously identified software issue is that when providers order a course of treatment (e.g., Amoxicillin 500 mg twice daily for 14 days, or 28 doses), the number of scheduled doses on the eMAR is for the number of days (14), rather than the number of doses (28). If the pharmacy processes the medication order after the morning medication administration, only 27 doses are scheduled to be given to the patient, causing predictable errors of omission. The record review showed that this error occurs repeatedly. The County has attempted to mitigate the number of errors by advising providers to order non-urgent medications to start the next day, or by ordering a STAT dose today, followed by the course of treatment beginning the following day. However, this is provider-dependent and not consistently done. Moreover, a stat order should be reserved for emergent clinical need and not as a workaround for a broken system. This could cause

confusion in the interpretation of care. Another issue is that if a provider writes an incomplete order, it is not forwarded to CIPS, and pharmacists are unaware of the order. As a result, they may contact the provider to correct or complete the order. A review of patient records reveals that this issue persists. This practice has to be corrected quickly because neither the ordering provider nor the pharmacist will be aware of the deficiency until the patient complains of not receiving an expected medication or an untoward outcome occurs as a result of missing a prescribed medication.

On 1/4/25, at 23:50, a provider ordered Augmentin twice daily for 7 days.[37] The nurse administered the first dose at the time the order was received. The eMAR shows the stat dose administered on 1/4/25 at 23:50 and an additional order for Augmentin with a start date of 1/4/25 and end date of 1/11/25, for a total of 14 doses. The nurses administered the second dose on 1/5/25, at 09:16, and continued to administer the medication twice daily through 1/11/25. The patient received a total of 15 doses, rather than the 14 doses ordered.

On 12/30/24, at 13:27, the provider prescribed doxycycline twice daily for 5 days, for a total of ten doses.[38] He also ordered the first dose given stat. The nurse gave the first dose at 20:57, over seven hours later. The eMAR has two medication order entries: one for the stat dose and a second order for doxycycline BID, with a start date of 12/31/24 and an end date of 1/3/25, for a total of eight doses. The patient received only nine of the ordered ten doses.

As previously reported, the insulin sliding scale orders are not documented in the patient's record or on the eMAR. The insulin is ordered to be administered on a sliding scale; however, the specific order, e.g., two units, three units, etc., is not documented in the health record or on the eMAR. Nursing staff document the patient's blood glucose on the flowsheet in the health record. Nursing documentation of the amount of insulin administered is inconsistent. Some nurses document the number of units administered, e.g., "two units," in the comment section on the eMAR, while others simply mark that the insulin was administered. The specific insulin orders must be documented in the health record and on the eMAR. Nursing standards of care require nurses to document the exact dose of insulin administered to a patient.

The monitors previously recommended correcting the lack of a bidirectional interface, and mitigation is pending. These software issues result in the electronic health record not being fully integrated. These ongoing medication errors are potentially dangerous for patients and are not compliant with provider medication orders (VI.I.1, 2).

Untimely review of lab reports.
Providers did not consistently review lab reports in a timely manner. In one case, an abnormal Pap smear report was not reviewed for three weeks. All lab reports need to be reviewed within three business days of being reported.[39]

[37] Patient #18
[38] Patient #19
[39] Patient #4.

Lack of timely retrieval of emergency department and hospital records.
Patient #1: This 39-year-old female was admitted to SCJ on October 19, 2024, and was released on October 29, 2024. Her medical history includes opioid and methamphetamine use disorders, uncontrolled hypertension, concussion status post bicycle accident, urinary tract infection, and depression. Her medications were lisinopril, hydrochlorothiazide and suboxone. On 10/21/24, the patient was sent to Mercy General Hospital ED for a hypertensive emergency. She was then directly transferred to UC Davis for concern for a dissecting celiac artery aneurysm. UC Davis ruled out a celiac and aortic aneurysm, but the patient was given discharge papers for a dissecting aortic aneurysm. The UC Davis medical records were faxed to the jail on 10/22/24 at 08:36 however they were not timely scanned into the jail health record until 10/28/24 at 08:25. This resulted in medical providers being unaware that UCD had ruled out a dissecting aortic aneurysm (AA). Based upon the belief that the patient had a dissecting aortic aneurysm, when the patient continued to complain of nausea and abdominal pain, providers twice sent the patient within 24 hours to two different emergency departments. At the last visit, the ED physician was upset that the jail providers were unaware that AA had been ruled out and that the patient had been sent to three different hospital systems to evaluate the patient (in an approximately 72-hour period). The lack of timely retrieval of ED records and immediate scanning into the EHR likely contributed to two preventable ED visits.

Patient #3: This 52-year-old female was admitted to SCJ on September 25, 2024, and was discharged on November 1, 2024. Her medical history includes methamphetamine use disorder, hypertension, chronic hepatitis C infection without treatment, and poor oral hygiene. Medications were amlodipine-valsartan. On 10/30/24, the patient was sent to Kaiser ED with chest pain and elevated blood pressure. The patient was discharged from Kaiser South with patient instructions for chest pain. Emergency Department Medical Records were not obtained and scanned into the EHR, until 12/2/24, over one month later.

The monitors were provided with the request of information (ROI) logs for review. The logs list the date the ROI was received, the patient's name and number, and the person from whom the information was requested. The logs do not indicate when the information was received or if and when additional requests were made. Timely receipt of important outside medical records requires an active process with routine and frequent follow-up. Simply keeping a log of requests does not accomplish the goal of ensuring a complete health record for the patient.

Custody Medical Transport continues to have access to protected health information.
This issue was previously reported and remains unchanged. ACH case management staff do not schedule outside health appointments, but they provide information, including Protected Health Information (PHI), to Custody Medical Transport to facilitate the scheduling of the appointment. This violates patient confidentiality. HIPAA regulations permit the sharing of protected health information with custody if such information is necessary for the provision of health care to inmates. However, using custody staff to schedule medical appointments is not necessary to provide the services to the patient, as this is a health care responsibility. Alternatively,

transporting patients to healthcare appointments is a necessary custody function for which staff need to be provided with sufficient information to complete the appointment.[40] This is further discussed in Utilization Management. The County agreed to assume the responsibility for scheduling and to provide Custody Medical Transport staff of the date of the appointment with any special instructions, such as the need for the patient to be fasting, etc., which preserves confidentiality. However, the County later reported that for several reasons, including medical and possibly custody resources, they were unable to assume responsibility for scheduling appointments. The addition of case management staff can facilitate the resolution of this issue.

The County Information Technology department maintains and supports the electronic health record system. The County IT staff collaborate with ACH EHR Support team and the software vendor to generate data reports necessary for monitoring compliance with clinical services. The ACH EHR Support team assists the end users as needed and refers complex EHR software issues to the athenaPractice™ Fusion help desk (VI. I.3.).

Compliance Assessment:

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

Recommendations:

1. Implement a bidirectional interface between the Fusion electronic health record, eMAR, and CIPS.
2. Modify the software such that the total doses of ordered medications align with the providers' medication orders.
3. Modify the log of requests for information (ROIs) to include tracking and documenting the date the information was received, as well as the date follow-up requests were sent.
4. Place document scanners in the booking suite, M2, and other strategic clinical areas so that HSRs and outside records accompanying patients to the jail are immediately scanned into the health record, and if necessary, staff HIMS personnel at the jail to timely upload documentation.
5. Implement a system for timely notification of labs and outside health records to providers.
6. Consider having providers endorse the outside medical records before scanning into the EHR. This will ensure a provider is aware of the information received and can determine if it is sufficient for continuity of care.
7. Modify the eMAR to enable nurses and clinicians to see the dates that medications are discontinued or extended.
8. Modify the EHR to ensure that sliding scale orders are complete in medical orders and display the amount of insulin to be administered based on blood sugar results. Modify the eMAR to show complete sliding scale orders.

[40] See 45CFR 164.512(k)(5).

9. Train nursing staff to document the blood glucose and the specific amount of insulin administered each time the sliding scale is used.
10. Reengineer the system for timely retrieval, scanning, tracking, and reporting that includes aging for:
    a. Release of Information (ROI) requests.
    b. Health services requests (HSR).
    c. Department and hospital reports.
    d. Laboratory, radiology, and imaging reports.
    e. Specialty services reports.
11. If not already in place, establish a protocol and formal collaboration with the laboratory service/vendor to have all abnormal pathology reports directly communicated with an ACH staff. This should already exist for critical labs and x-ray reports.

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.
4. The UM system shall include an appeal process to enable patients and providers to appeal a decision denying a referral request.

Findings: ACH has implemented policies regarding the utilization management (UM) system. An established Utilization Management (UM) subcommittee includes service line directors, CQI, Mental Health (MH), and Case Management (CM). ACH reports 400-500 referrals per month. Case Management, nursing and providers are now working together to more efficiently prepare the required clinical justification and supporting documents. Some specialty care guidelines have been developed. These are in use along with access to Rubicon and order sets to help facilitate appropriate offsite referrals. Training is continually provided to assist providers in submitting sufficient documentation.

As noted in the Specialty Services section of this report, both Utilization Management and Specialty Services processes are convoluted. This continues to create delays in care and potential for harm (VI.J.1). The UM physician reports that preparation for offsite consults varies based on the clinical scenario. Once all data is collected, the provider submits the order for an appointment. The monitors are pleased to learn that ACH management meets regularly to discuss changes and progress.

Case Management is coordinating both on-site and off-site specialty services. On-site specialty clinics are still held approximately one to two times monthly and this, along with competition for specialty appointments from community patients, creates a challenge to get inmates timely care based on the Consent Decree timeframes.

Case Management still does not use an evidence-based algorithm to make decisions regarding the medical necessity of each referral. ACH has assigned a dedicated physician to the authorization process of specialty requests. Along with the use of Rubicon, this physician utilizes their independent knowledge and medical reference of choice to determine medical necessity. An additional physician has been hired to support the review of specialty referrals, and ACH has entered into renegotiations with InterQual. This is a step in the right direction, but enhanced oversight is still required to prevent interruptions in continuity of care, as demonstrated in Patient #30 shared in Section E., Specialty Services section of this report.

Patient #30

Summary: This is a 49-year-old male who was presented in Section E, Specialty Services. As mentioned before, Sections J, Utilization Management, and Specialty Services overlap in their general precepts. ACH failed to ensure the patient received post-surgery physical therapy, which led to diminished recovery and the need for another referral for physical therapy. The second referral was honored, but the patient received an insufficient number of visits due to the limited on-site availability of a physical therapist. When a required service is not available on-site, the County must make provisions to transport the patient off-site to meet the clinical need.

The County has increased the number of vehicles to meet the demand for off-site transportation, and this reportedly has resulted in improved off-site care access. Per interview with the dedicated physician, the new review process has improved the rendering of alternative treatment for non-essential care and reduced the unnecessary transportation needs. The extent to which this new practice has impacted the process will require the establishment of benchmarks and contemporary tracking. This information is required to assess substantial compliance of (J.2).

Case Management is now notifying providers when they are unable to secure appointments as requested. A written message is sent to the ordering provider. However, it is not clear how or if this notification is acknowledged or if the provider orders follow-up visits to ensure stability between the time of the original request and the date of the scheduled appointment. The monitors did not have the opportunity to review documentation to confirm monitoring of the patients whose urgent and routine appointments were beyond 14 and 90 days, respectively (J.3). We will conduct chart reviews in the next monitoring cycle.

As mentioned in the 6th Report, the monitors expressed concern about ACH capturing all referrals and tracking their status throughout the entire process. The monitors could not definitively determine compliance with patients being seen according to expected timeframes and or if a patient was never seen.

The County ran a Fusion Order Manager list and pulled for specialty services from 1/1/2021-1/31/2024. Data showed that 15,320 CM Specialty Care Referrals were ordered. 7,494 were completed, 7,821 were cancelled, five were in process, and zero were in Administrative Hold. This information is encouraging; however, the monitors found orders for patients with specialty referrals that were not on the tracking log, and other patients that were lost to follow-up, so it is not known whether the data captured all patients.

The UM physician reports variation in the notification of providers by CM when ordered appointments are delayed. ACH has a plan in place now to standardize communication. The monitors will review the content of the Fusion Order Manager's List and communication follow-through to validate the data and practice with a chart review during the next site visit. This review will allow for proper assessment of compliance.

Compliance Assessments:

- J.1=Partial Compliance↓
- J.2=Partial Compliance↑
- J.3=Partial compliance↑
- J.4=Not Evaluated

Recommendations:

1. Consider placing case management staff with Custody Medical Transport whose responsibility would be to communicate with off-site medical provider's offices and work with the case management team to schedule the appointment within acceptable time frames. The County needs to comprehensively re-evaluate utilization management specialty services processes to provide timely and appropriate care to patients with serious medical needs.
2. Develop and implement a standard specialty consultation template for providers to complete that will ensure all clinical information that justifies the clinical necessity is provided. This will improve the efficiency and quality of the requests and help mitigate unnecessary delays in the review process.
3. Reestablish the use of InterQual or another reputable source to assist with specialty referrals.
4. The case management template and log need to accurately reflect the date a provider ordered the referral. Consider auto-populating as much information as feasible.
5. The UM physician needs to review all referrals daily for authorization or render an alternative treatment plan (ATP).
6. Revise the case management template in the EHR to include all required elements that need to be captured for the tracking log. Specifically, the template needs to include:
    a. The dates that case managers received the referral
    b. The date case management processed the referral.
    c. Whether the referral was authorized or an ATP was rendered.
    d. Whether the referral was approved via InterQual or other criteria, and the name of the physician making the UM decision.
    e. Notification of the ordering provider when CM is unable to get an appointment based on the provider's request.
    f. Date that the appointment was made, as well as date of the appointment.
    g. Include multiple entries in the event the appointment was canceled and/or rescheduled and the reason why, including lack of custody resources.
    h. Date the specialist or imaging report was received.
    i. Whether the specialist requested follow-up (e.g., labs, scans, or an appointment)
    j. Date of scheduled follow-up appointment with a medical provider
    k. Date of completed medical provider appointment.
7. Establish productivity expectations for on-site consultants (e.g., to see x number of patients within four or eight hours. Case managers should schedule appointments based upon priority of need.
8. Conduct a UM and specialty services audit at least every three months to assess the functionality and effectiveness of the UM and specialty services process.

K. Sanitation

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.

Findings: In 2022, the County consulted an expert in environmental care. Diane Skipworth published her findings on June 21, 2022 (VI. K.1). ACH maintains a contract for environmental cleaning services, as recommended by the expert.

The County provided Environmental Inspection reports for both facilities from April 2024. Also provided were Title 15 reports for both facilities, completed on April 11, 2024. The reports identified several findings requiring repair or replacement. Also identified were areas within the housing units that required cleaning. Findings in the reports included:

- Lack of hot or cold water in showers/sinks
- Inoperable showers/sinks/toilets
- Unclean toilets/sinks/drinking fountains
- Mold, mildew, algae, and scum buildup in showers

The monitors did not inspect the housing unit bathrooms and showers during the tour, but they did tour the kitchen areas at both facilities. Although inmate workers were observed mopping floors, monitors noted that shelving units had dirt and debris on them, as well as leaking faucets. Patients complained about the cleanliness of the food trays and the temperature of the food. A patient presented a live worm, reportedly found in the food served, to the Prison Law Office attorney. The cleanliness of the living and food preparation areas in the facilities is crucial in preventing the risk of infection and the spread of disease to the jail population.

The monitors also observed torn mattresses piled outside housing units during the tour. These openings present a portal of entry and medium for the growth of bacteria. These should be immediately taken out of service and replaced.

ACH recently hired a registered nurse who serves as the Infection Control Coordinator for both facilities. The monitors' interview with the nurse found that he has been tasked with reading most of the TB skin tests. He also coordinates the reporting of communicable diseases to the health department. He does not participate in the environmental rounds.

Surveillance, prevention, and control of communicable diseases are essential in the carceral setting. The Infection Control Coordinator is responsible for ensuring the effectiveness of the infection control program at both facilities. Tasking him with reading most of the TB skin tests is not an effective use of his skills, knowledge, and time. The reading of the TB skin tests should be delegated to the medical assistants who are initiating them. With proper training, they can assume responsibility, freeing the Infection Control Nurse to focus on more critical tasks. One such task is completing environmental rounds. The Infection Control nurse should coordinate

with custody staff and participate in rounds. The experienced Infection Control nurse's educated and skilled lens will strengthen the team, enabling them to complete inspections more effectively and identify critical issues, such as a lack of soap and hot water for handwashing, mold in showers, and ripped and torn mattresses.

By delegating the reading of TB skin tests, the Infection Control nurse has time to ensure that necessary sanitation tasks are completed when instances of conditions such as lice, foodborne illness, athlete's foot, skin infections, and Methicillin-Resistant Staphylococcus Aureus (MRSA) are identified. The Infection Control nurse can also provide ongoing training, education, and surveillance of health staff to ensure disinfection of exam tables, equipment, and rooms is accomplished between patients.

Although this provision has been addressed and must be found to be in substantial compliance, adequate sanitation must be maintained to ensure a safe and healthy environment and prevent preventable illnesses, infections, and diseases.

Compliance Assessment:

- K.1=Substantial Compliance

Recommendations:

1. Provide the monitors and the ACH Infection Control Nurse with the most recent Title 15 Environmental Inspection Reports.
2. Include the Infection Control Nurse on the SSO environment rounds and inspections.
3. Reassign tasks to other healthcare staff, freeing the Infection Control Nurse to conduct enhanced surveillance, including reviewing prescribed antibiotics, reports of wounds, infections, and vermin, and ensuring that adequate mitigation of identified infection control concerns is completed.
4. The Infection Control nurse should intermittently observe health staff during patient encounters to ensure appropriate infection control practices are being adhered to.
5. Develop an infection control checklist and CQI Tool for the IC Nurse.

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.

Findings: The previous monitoring report found the county to be in partial compliance with VI.L.1. The monitors will maintain the same status for this report, given the case reviews that reflect evidence of inconsistent timeliness and appropriate care rendered to the obstetric patient. The patient summaries below demonstrate ongoing concerns with detox management of the pregnant patient, acknowledgment of abnormal vital signs, accuracy of point-of-care pregnancy test in Intake, appropriate dosing intervals of medications, nurses' compliance with doctor's orders, and confidential assessments. Post-partum care and mental health services were not applicable to the random cases selected for review during this reporting period.

Chart reviews demonstrated consistent inquiries of patients' desires regarding their pregnancy (VI.L.2). The monitors reviewed five medical records to specifically assess the county's birth control practice. ACH has added two questions to their Phase 2 assessment that specifically inquire about the patient's birth control use and desire. One hundred percent of the records reflected partial compliance with the consent decree requirement. The portion that is missing is the "non-directive counseling about contraception" (VI.L.3). Educating the patient about birth control is essential to accomplish the goal and spirit of the consent decree. For this reason, the monitors will maintain this provision in partial compliance.

Patient #4
This 30-year-old female arrived at SCJ on 11/21/24 and was released on 1/21/25. Her medical history includes polysubstance use disorder, including Fentanyl, pregnancy, abnormal Pap smear, bipolar disorder, and poor dental health. Her medications were Methadone, prenatal vitamins, and ondansetron.

Summary: This 30-year-old female had three admissions during this review period. The first admission was from 9/22/24 to 9/23/24. During this brief admission, the patient was noted to have opioid use disorder with Fentanyl, was 19 weeks pregnant, and reported suicidal thoughts. She had no prenatal care. She was declared unfit for confinement and taken to a hospital. She did not return to jail.

The second admission was from 10/12/24 to 10/14/24. During this brief admission, the patient was declared unfit for confinement due to pregnancy and opioid use disorder. She still had no

prenatal care. The patient was sent to Sutter Medical Center and treated for a urinary tract infection. She was not sent to UCD Maternal Fetal Medicine for admission, prenatal care, and induction on medication-assisted treatment. On 10/12/24, when she returned from Sutter to jail, a nurse did not notify the OB/GYN provider regarding the patient's arrival and whether to immediately send the patient to UCD. Although the patient was having withdrawal symptoms, the patient was not provided medication-assisted treatment prior to her release on 10/14/24, resulting in preventable suffering for the patient and the fetus.

During the third admission, from 11/19/24 to 1/25/25, the patient was evaluated after arrest at Mercy Hospital in Folsom, where she was confirmed at 27 weeks gestation and treated for a urinary tract infection, but not for her opioid use disorder. She was released from the ED and brought to jail. Although she was pregnant and in active withdrawal, she was declared fit for confinement. The provider was contacted for the urinary tract infection, but OB-GYN or the addiction treatment provider was never contacted. A pregnant patient must receive orders for withdrawal medication right away. This requires providers to be notified directly and not depend on a referral process to accomplish this. On 11/22/4 at 09:00, the OB/GYN provider was notified, and the patient was immediately sent to UCD, where she was admitted for five days for prenatal care and methadone induction. This is a significant delay in referral to obstetrics and Methadone induction. Once the patient returned to the jail, she received Methadone treatment, but it was at inconsistent intervals. This allowed for breakthrough withdrawal symptoms that went untreated for over 12 hours on some days. The documented COWS scores were incongruent with the clinical presentation.

The patient received timely and appropriate obstetrical care. OB/GYN providers ordered labs that were performed timely, as well as anatomy and growth ultrasounds that were also performed timely. Case management documented the status of the review and scheduling of the ultrasounds. This is a significant improvement from the last review period. The patient was timely referred to the CORE outpatient drug treatment program, and the patient was enrolled in the program prior to discharge. Although the patient was initially not provided with timely access to opioid use disorder treatment, once enrolled, the medical providers closely monitored the patient and adjusted treatment.

However, a concern is that the patient was scheduled for an anatomy ultrasound that was to be completed before 12/20/24 per OB orders. The day the appointment was scheduled, a medical assistant (MA) documented that the patient refused the appointment through the intercom and signed a refusal form, and the patient had been counseled regarding the risks of an unspecified appointment/procedure. An MA is not trained and qualified to counsel the patient regarding the risks of refusing an anatomy ultrasound. The patient should have been escorted to 2M, where a medical provider could explain the risks of refusing the ultrasound. This was not an informed refusal. Fortunately, case management immediately rescheduled the appointment, which took place timely.

At the time of release, the patient was seven months pregnant, but there was no documentation of birth control counseling following the pregnancy. Overall, the patient received timely and appropriate prenatal care once housed in the jail.

Findings:

- Lack of appropriate orders for obstetrics and addiction medicine referral.
- Significant delay in Referral to OB and Methadone treatment.
- Inconsistent and extended methadone dosing Intervals.
- Improper refusal of education by a medical assistant.
- Lack of documented birth control counseling.

Patient #31

Summary: This is a 35-year-old female who was booked into jail on 2/15/25 with a history of amphetamine and cannabis use, adjustment disorder, and latent syphilis for which she was actively receiving antibiotic treatment (penicillin). Her Phase 1 assessment was completed at 11:17, and she was without complaints. Her vital signs were normal; her weight was 147 lbs.

The Phase 2 assessment occurred at 11:46 am. A pregnancy test was completed and was positive. Her fetal heart tones were 140. The patient reported 35 weeks gestation, and this was her seventh pregnancy. She reported compliance with prenatal care and OB appointments prior to arrest. Her last OB visit was 2/11/25. In addition to Penicillin, she admitted to being prescribed prenatal vitamins (PNV) and Iron supplements but had not started those yet. She denied active use of drugs or alcohol.

Documentation reflected the answer “no” to the question, “did provider give order.” However, right below are documented “verbal orders.” This reflects inconsistent documentation.

The patient received appropriate lab orders, diet, and referrals. The initial OB visit occurred on 2/28/25; no vitals were included, and her weight was 151 lbs; treated for Bacterial Vaginosis without supporting documented history or examination. The notes reflected that the patient was in the cell, and the diagnosis of bacterial vaginosis was determined by Sure swab, which suggests that an examination was conducted. A one-hour glucose tolerance test was ordered to evaluate for diabetes. Overall, the patient received timely obstetric care during her short incarceration. The patient was released from custody on 2/28/25.

Findings:

- Incongruent nursing documentation during the Phase 2 assessment.
- No documentation of history or physical to support the diagnosis of bacterial vaginosis.

Patient #32

Summary: This is a 27-year-old female who booked into jail on 1/28/25 with a history of opioid use disorder (heroin) and hepatitis C virus (HCV). She was transferred from the Salano County Jail after a three-day stay, and per the transfer summary, she was on opioid detox protocol. Her

active medications were daily Suboxone (16mg) and as needed loperamide, Tylenol, and meclizine. The patient reported her last dose of Suboxone was on 1/26/25. The Phase 1 assessment occurred at 10:56, and the patient was without complaints. Her vitals were normal, and her weight was 150 lbs. The Phase 2 assessment occurred at 11:04, and the assessment was confidential. The patient was clinically stable. Her pregnancy test was positive times two, and the patient was unaware. She reported her last menstrual period was 12/25/24. The initial COWS score was one, and a stat dose of Suboxone of 16 mg and expedited admission to 2M was ordered. Withdrawal assessments were ordered for every six hours, along with all pertinent labs, medications, diet, and referrals. At 22:17, a non-confidential cell-side assessment occurred, and the patient had no complaints and no signs or symptoms of withdrawal. Her vitals were normal, and the COWS score was one. The patient was instructed to comply with all medical recommendations and meals and to notify medical staff of any complaints. The withdrawal monitoring was changed to twice a day, but it is not clear which provider gave this order.

Note: The 22:17 COWS assessment exceeded the six hours as ordered. On 1/29/25, an OB ultrasound showed "no intrauterine gestational sac", and a follow-up exam was recommended in one to two weeks. At 08:37, a withdrawal assessment occurred, and the COWS score was zero. No contemporary vitals were recorded. On 1/30/25, at 22:10, the patient refused to come out of her cell for evaluation. She was educated and signed the refusal.

Note: This attempt was over 36 hours since the last assessment, and the order was for twice a day. On 1/31/25, the patient declined to be seen by the OB physician and signed a refusal. At 15:06, a non-confidential encounter (no auditory privacy) occurred, and the patient had no complaints and no withdrawal symptoms. She stated the medications were working and her vitals were normal.

The initial OB visit occurred on 2/7/25. The patient had no complaints, and contemporary vitals were not recorded. The provider entered "the last blood pressure was 104/68 mm Hg, on 1/31/25." The provider noted the last menstrual period of 12/15/24 and estimated date of delivery of 9/20/25; last drug use five years prior and on Suboxone for 1.5 years; an OB ultrasound was ordered, and the patient did not require aspirin (ASA).

On 2/9/25, at 12:26, the patient had a nursing sick call encounter after complaining or "seeing small amount blood [sic] earlier on bathroom tissue, after wiping." The patient denied cramps, pain, and the presence of blood in undergarments. She was given a sanitary pad and advised to return to the clinic if she sees blood. Her vitals were normal, and her weight was 148 lbs. At 13:51, another non-confidential encounter occurred (no auditory privacy) at 2M. The patient returned to be evaluated for "bleeding on her sanitary pad; the blood was dark brown, but now is red." She denied cramps, nausea, or pain. Her vitals were normal. She was calm and in no acute distress. The nurse examined the pad and noted "light amount of dark brown blood." The physician was informed, and the patient was instructed to let medical staff know if the blood gets worse or changes to bright red. The patient was sent back to her unit, but no information was documented regarding whether directives were given by the physician.

On 2/17/25, at 16:12, the patient had a nurse sick call follow-up for vaginal bleeding. The patient had no complaints of bleeding, but did request stool softeners due to no bowel movement in the past three days. Her vitals were normal, and she weighed 147 lbs. No abdominal exam was documented by the nurse. The patient was given a stool softener. On 2/21/25, at 10:29, the physician informed the patient that her pregnancy test done on 2/18/25 was negative and therefore, no further follow-up was required. The patient declined birth control medication because she was planning for a pregnancy. The provider removed pregnancy from the problem list, but did not stop the prenatal vitamins. The patient received all ordered doses. The positive point of care pregnancy test obtained at Intake, followed by the negative OB ultrasound on the same day, and the repeated negative pregnancy test call into question the accuracy of the original testing in booking. It took 21 days to confirm that this patient was not pregnant.

The patient received all Suboxone doses per order. The monitors' concern is the short interval between each dose. The patient received two doses per day, approximately six hours apart, except on 2/4/24, when there were four hours between administration. Fortunately, the patient did not experience withdrawal symptoms, but the monitors have expressed concern about the inappropriate administration of medications that need to be corrected. The patient was released from custody on 2/27/25.

Findings:

- Discrepancy in point-of-care pregnancy testing in Intake and OB Ultrasound.
- The nurse did not follow the provider's orders for COWS assessments.
- Contemporary vital signs are not consistently included in withdrawal assessments.
- The OB physician did not include contemporary vitals in the initial OB evaluation.
- The administration of medication ordered twice a day occurred too soon.
- Private encounters are inconsistent.
- The nurse treated the patient without examination.

Patient #33

Summary: This is a 32-year-old female who booked into jail on 2/7/25 with a history of opioid and stimulant use disorders, latent syphilis, and treated MRSA (methicillin-resistant Staphylococcus aureus). She was homeless and not on active medications. The Phase 1 assessment occurred at 13:41. The vital signs were normal, and she weighed 125.4 lbs. The patient admitted to active drug use (methamphetamines and Fentanyl), but not alcohol. She did not exhibit active signs of withdrawal. The patient was accepted. Phase 2 assessment occurred at 14:13. The patient was stable and without complaints; initial COWS score of one; pregnancy test positive; urine drug screen positive for methamphetamines, Fentanyl, and stimulants. All appropriate labs, medications, referrals, and diet were ordered. Withdrawal assessments were ordered for every six hours, along with MAT Detox, but no notification was made to the provider for initiation of Suboxone. In this case, the provider needs to be notified directly because the risk of withdrawal is high and waiting for a referred visit may put the mother and fetus at risk.

On 2/7/25, at 14:42, a non-confidential encounter occurred. The COWS score was zero and the nurse noted "patient was receiving 16mg of Suboxone." At 20:48 another non-confidential encounter occurred in the booking area; her vitals were normal, and the COWS score was two. On 2/8/25, at 22:18 (over 12 hours later), the patient was assessed on 2M by a physician. She denied withdrawal symptoms. Her vitals were normal, and the COWS score was two. The patient requested a repeat of the pregnancy test which was granted and affirmed as positive. The physician modified the COWS assessment order to twice a day. On this same day, the patient had an OB ultrasound that showed "no yolk sac or visible embryo." On 2/9/25, at 19:55, the patient was without complaint and the COWS score was one. On 2/10/25, at 22:18, (26 hours later), the patient was assessed at the cell-side while lying on her bunk. She refused vitals. She complained of nausea, body aches, and restlessness. The refusal form was signed by the nurse and the officer. The patient was not treated, and she should have at least been offered the as-needed medication that was ordered. The patient was instructed to hydrate and report worsening of symptoms. The COWS documentation reflected "1" for restlessness; "1" for joint, bone, or joint ache; and "2" for gastric upset. The remainder of the COWS assessment was recorded as "0" for pupil size; "0" for runny nose or tearing; "0" for observation of tremors, yawning, anxiety, and irritability. The monitors' concern is that the documented assessment of pupils, runny nose, tearing, and tremors cannot be accurate because the patient did not allow examination. The total score was recorded as four.

On 2/11/25, at 20:52 (approximately 23 hours later), another non-confidential assessment occurred in the day room of the pod. The patient complained of nausea and body pain. The nurse noted yawning and that the patient was in no acute distress. Her vitals were normal, and COWS score was four. On 2/12/25, at 9:09, another non-confidential assessment occurred in the day room of the pod. The patient complained of nausea, back pain, restlessness, and anxiety. Her vitals were normal, and the COWS score was six. Suboxone was increased to 24 mg per day by a physician, and the patient was cleared from detox monitoring. The monitors' concern is that the patient's COWS score was increasing and required an increase in the dose of Suboxone. It would have been more appropriate to keep the patient under watch and continue monitoring to evaluate her response to the change in treatment.

On 2/14/25, at 10:44, the initial OB visit occurred. The vitals were normal, and she weighed 129 lbs. This was an unplanned pregnancy, and the termination option was discussed, and the patient elected to move forward. The estimated date of delivery is 10/8/25. The provider ordered a repeat OB ultrasound to confirm fetal viability. On 2/21/25, at 10:50, a follow-up OB visit occurred. The patient complained of mild nausea, but no vomiting, bleeding, or pelvic pain. She was already prescribed medication for nausea. The ultrasound was pending, and the physician ordered a follow-up after it was completed. On 2/28/25, at 07:50, the provider documented results of the ultrasound: fetal heart rate of 147 and 7 weeks, 3 days viable intra-uterine gestation. On 3/7/25, the provider documented the patient's blood type and antibody screen.

On 3/21/25, at 08:19, the OB provider assessed the patient. Her vitals were normal, and she weighed 137 lbs. The patient had no complaints. All lab results were normal, and the syphilis titer reflected successful treatment. The patient missed only four doses of prenatal vitamins from

2/8/25 and 2/11/25. She received all doses from 2/12/25 through 4/15/25. The patient received all her Suboxone doses except for the dose on 2/20/25. The monitors could not find documentation of the reason for the missed dose. The patient is still in custody, and the records indicate she is receiving appropriate prenatal care. The approach to withdrawal management is a concern.

Findings:

- The patient's withdrawal symptoms were increasing when the provider released her from monitoring.
- There were several non-confidential encounters.
- COWS assessments were not completed as ordered.

Patient # 34

Summary: This is a 28-year-old female who booked into jail on 2/8/25 with a history of asthma, chest pain, stroke, pulmonary embolism (clot in the lung) and Factor V Leiden mutation (blood clotting disorder). The Phase 1 assessment occurred at 17:22 pm, and her vitals were: blood pressure 169/110 mm Hg; heart rate 106 per minute; respiratory rate 20 per minute; temperature 98.5 F; SpO2 98%, and weight of 154 lbs. The patient admitted to drug (stimulants) use, but not alcohol use. She had no evidence of active withdrawal and had no complaints associated with her abnormal vitals. She was declared fit for confinement. The Phase 2 assessment occurred at 17:33. The patient refused HCV, HIV, and other screening labs. She accepted the point-of-care pregnancy test, which was positive. The patient declined the offer of birth control or emergency contraception. She reported no prenatal care prior to arrest. She appeared under the influence and was shouting obscenities. Her urine drug screen was positive for three formulations of methamphetamines. She denied active MAT medications. The patient declined the referral to a SUD counselor. The nurse documented that the provider was notified due to medical history, pregnancy, and use of stimulants. There is no documentation that the nurse informed the provider about the abnormal vitals, and no orders were given by the provider. The nurse ordered an urgent provider (24 hours) and mental health (36 hours) referral. The patient refused to give consent for care. An OB sick call, follow-up for consent for care, prenatal vitamins, and pregnancy diet were ordered.

On 2/14/25, at 09:27, the patient had her initial OB visit. Her vitals were blood pressure 132/83 mm Hg; heart rate 71 per minute; temperature 98.0 F; respiratory rate 16 per minute; and weight 192.4 lbs. The documented weight was listed as being obtained on 2/8/25 , but review of the encounter found the weight documented as 154 lbs., and not 192.4 lbs. Although the patient's UCD's medical record indicated a history of five pregnancies and three deliveries, the patient stated to the physician, "She did not recall ever having been pregnant before, and her memory is not good, after a bite from a reptile." She did not know the date of her last menstrual period and denied vaginal discharge or bleeding. The patient reported not taking any medications. The patient expressed the desire to keep the pregnancy. The OB physician recognized the need for lifetime anticoagulation and history of "severe Asthma" and referred the patient to a physical health provider for management. A fetus viability ultrasound and OB follow-up were ordered.

On 2/15/25, at 10:15, a Nurse Practitioner (NP) met with the patient to address her refusal to consent to treatment at Intake. The NP captured the patient's past medical history and completed a physical exam that was unremarkable. The patient consented for care and the NP ordered all appropriate lab work and a chronic care visit in one week. On 2/18/25, the INR (0.9) was normal, the Factor V Leiden mutation was negative, and the variant was not detected. These lab values were not consistent with this blood clotting disorder and the provider appropriately removed this diagnosis from the problem list**.** On 2/19/25, an OB ultrasound confirmed intrauterine pregnancy. On 2/21/25, the physician noted the ultrasound results confirmed nine weeks of gestation and an estimated delivery date of 9/19/25. Gonorrhea and Chlamydia labs were negative, and Aspirin was appropriately started. On 2/26/25, the provider ordered a high-risk maternal fetal referral.

On 3/7/25, the next OB visit was unremarkable. The patient had no complaints. Her vitals were normal, and the OB physician noted she had begun Lovenox (blood thinner), but "missed two doses due to being asleep." Lovenox was appropriate due to the patient's history of blood clots in her lungs, which requires a lifetime of blood thinners. Her remaining pregnancy-related lab results were all normal. On 3/11/25, the first order for an Albuterol inhaler and nebulizer treatment by a physician was entered in the medical record. The monitors could not find a chronic care assessment in the EHR, after reviewing the MD sick call, MD chronic care, and provider chronic care sections. The monitors reviewed the nursing sick call section of the EHR to determine if a sick call encounter had led to the physician's order; however, there was no corresponding sick call documentation for this date.

On 3/21/25, the patient declined to see the OB physician. On 3/26/25, the physical health provider documented receiving notification from the OB physician regarding the patient's "med refusals". The record read, "patient had been refusing almost all doses of Aspirin (ASA) which is scheduled in the am; taking almost all prenatal vitamins which is ordered at night; refusing majority of morning doses of Lovenox, but accepting most pm doses; suspect patient has difficulty/unwilling to wake up for medications; per notes, patient says won't remember to take KOP secondary to memory issues." This physician changed the ASA from am to pm and contacted the provider who was scheduled to see the patient this same day for sick call to address adherence to the blood thinner and establish a treatment plan. The monitors' review of the medication administration record confirmed the physician's account of the patient's inconsistent medication adherence. At 15:13, a Nurse Practitioner interviewed the patient about her nonadherence and conducted an examination. The patient had no complaints and reported to be a deep sleeper as her reason for missing meds. Her exam was unremarkable, and the fetal heart tone was 141 per minute. The provider ordered "Chart pop-up alert to wake patient up for meds." The patient verbalized understanding of the importance of medication adherence.

On 4/3/25, at 13:51, a physician met with the patient again to review medication adherence. The patient was without complaints, and the vitals were normal. The patient had been compliant with all her medications, except for a single dose of prenatal vitamins and ASA, following the orders to change her medication to daily and at night. The provider documented that the patient said she "uses her KOP inhaler less than once a week." This was an acknowledgment of the

patient's asthma diagnosis, but no evidence of a chronic care assessment was noted. On 4/4/25, at 12:29, the patient had an OB visit. Her vitals were normal, and she weighed 186.6 lbs. She had no complaints, but the provider noted she is not consistently adhering to her blood thinner because she sleeps until noon. The OB physician documented that the patient had received all her aspirin doses, except for one dose since 3/26/25, and all doses of her blood thinner after it was changed from twice a day to once a day**.** On 4/9/25, at 08:53, a Nurse Practitioner documented, "chart reviewed; she is coherent with meds including Lovenox injection.

Except for the nurse not informing the provider of the abnormal intake vitals sign and no documented chronic care visit, the patient received appropriate prenatal care. The medical staff is to be commended for their collective efforts to improve the patient's medication adherence. This was an extremely important component of her care, given her medical history.

Findings:

- The intake nurse did not inform the provider of abnormal vitals obtained during Phase 1. (See recommendations in the Intake section.)
- No chronic care visit was documented. (See recommendation in the Chronic Care section.)

Compliance Assessment:

- L.1=Partial Compliance
- L.2=Substantial Compliance
- L.3=Partial Compliance

Recommendations:

1. Ensure Methadone administration intervals are appropriate for the clinical scenario and avoid breakthrough symptoms.
2. The DON must ensure that there is adequate supervision of the Intake suite and performance of the Nurse Manager.
3. Retrain Intake staff on the criteria for confinement.
4. Conduct daily review of newly arriving pregnant patients to ensure all appropriate escalations, orders, and referrals are completed and timely.
5. The DON must ensure refusals are conducted by qualified staff
6. ACH needs to add discrete documentation of birth control counseling to the EHR for ease of consent decree compliance confirmation.
7. ACH needs to create a "NA" option in their EHR for appropriate questions to avoid ambiguity in interpretation and incongruent documentation.
8. Providers need to complete adequate and pertinent history and physical exams before treating patients, and when it is not possible, they should document why.
9. ACH needs to conduct regular quality assurance on the point-of-care pregnancy test in Intake to ensure the accuracy of results.
10. Nurses need to follow providers' COWS assessment orders as submitted.

11. Nurses need to conduct a private exam before offering treatment to patients, according to the nursing protocol.
12. ACH needs to review the OB physician's documentation to ensure contemporary vitals are always included in evaluations.

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.

Findings: The county was found in substantial compliance with V1.M.1 in the previous report. ACH's policy 05-12, *Transgender and Gender Diverse Health Care* governs the practice, and its contents meet the Consent Decree's requirement. The monitors recommended that the County improve their tracking log to include the patients' labs and pending appointments. Per communication with the Health Administrator, the County has not adopted this recommendation as of this reporting period. The County reports that patients presenting to the jail on prescribed hormone therapy are maintained on their treatment. The patients are routinely referred to physical and mental health providers, and those who qualify are referred to the gender-affirming clinic. The county recognizes that not all qualified patients have been seen timely in the Transgender clinic[41] (VI.M.1). The expected initial appointment is to occur within fourteen days of admission or sooner, if clinically indicated.[42] The monitors reviewed eleven medical records of transgender patients. The following table represents the monitors' findings:

Clinical Item	Present	Absent	Not Applicable	Comments
Hormone Medication	8/11 (73%)	3/11 (27%)		Not all patients desired hormone treatment.
Mental Health Evaluation	11/11 (100%)			
Pertinent Labs	5/8 (63%)	3/8 (37%)	3/11 (27%)	All three patients without labs were incarcerated long enough to have labs completed.

[41] 10th Sacramento County Remedial Plan Status Report. January 7, 2025, page 141.
[42] ACH policy 05-12, *Transgender and Gender Diverse Health Care*

				The three non-applicable apply to those patients not on hormonal therapy.
Transgender Clinic Visit	11/11 (100%)			
Diagnosis on Problem List	11/11 (100%)			

The County assessed provision VI.M.1 as Substantial Compliance, and the monitors agree.

"The Mental Health staff worked with a consultant to develop training on the WPATH Standards of Care, LGBTQIA, and Health Equity." ACH reports the enhancement of the previously approved training by incorporating the medical experts' recommendation to correlate WPATH standards with the ACH policy. Newly hired staff are trained on the policy within three months of the hire date, and training courses occur approximately every four to six months. The County reports that ninety-five percent of the mental health staff, sixty-nine percent of permanent ACH, and three percent of registry staff were trained by December 2024 on WPATH and LGBTQ. An established Nurse Educator is charged with training and tracking compliance going forward[43] (VI.M.2). ACH has made great strides in their training of Mental Health staff, and the monitors are looking forward to documented improvement in the training of the permanent and registry staff by the next report.

Compliance Assessment:

- M.1=Substantial Compliance
- M.2=Partial Compliance↓

Recommendations: (no change from previous report)

1. Develop a tracking system that includes lab results and future appointments.
2. Continuing to train staff in WPATH Standards.

[43] 10th Sacramento County Remedial Plan Status Report. January 7, 2025, page 141.

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.
   - (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.

Findings: The County continues to provide assessment, treatment, and Medication Assisted Treatment (MAT) for patients at risk for withdrawal from alcohol, opiate, and Benzodiazepines. Addiction medicine providers initiate medication-assisted treatment (MAT) and adjust therapy as needed. The County recently revised its policies for the medically supervised withdrawal and treatment of alcohol, opiates, and benzodiazepines. The monitors provided comments, and the finalized policies are pending (IV. N.1). A review of the records reveals several ongoing areas of concern.

Nurses do not consistently complete withdrawal monitoring in a timely manner, as ordered and required by ACH policy, (IV. N.2.i), and do not monitor patients placed in the sobering cell as required by ACH policy.

Patient 20: A 33-year-old patient[44] arrived on 1/11/25 at 00:40 with a history of daily use of one pint of alcohol and experiencing withdrawal when he quit drinking. His PAWS score was three, and his CIWA-Ar score was three. The nurse ordered withdrawal assessments every six hours; however, they were not done. The initial CIWA-Ar assessment was done at midnight by the intake nurse. The next assessment was not completed until 15:40, more than fifteen hours later. On 1/11/25, the patient's assessment was reduced to twice daily per policy. On January 12, 2025, the initial assessment was completed at 11:37, and the second assessment was completed at 20:53, only nine hours later. The next assessment was completed on 1/13/25 at 10:30, fourteen hours later.

[44] Patient #20

Patient 21: Another 49-year-old patient[45] arrived on 1/2/25 at 10:11 with a history of polysubstance abuse, including daily drinking a pint of alcohol, cannabis, and buprenorphine. His urine drug screen was positive for amphetamine, buprenorphine, cannabis, methamphetamines, morphine, and methylenedioxymethamphetamines. His PAWS score was four, his COWS score was two, and his CIWA-Ar score was one. The nurse ordered withdrawal monitoring every six hours per policy. His COWS assessment was repeated six hours later; however, his CIWA-Ar was never repeated.

Patient 27: A 34-year-old homeless female[46] had multiple incarcerations, four of them in 2025. Most recently, she arrived on 4/21/25 at 18:47 and reported a known SUD history using Fentanyl and alcohol. Significant history included that on 4/13/25, during her last jail admission, she was sent to the ED in alcohol withdrawal, and she had demonstrated a pattern of refusing withdrawal monitoring. There is no documentation that demonstrates that the nursing staff reviewed and appreciated this previous history. After completion of the Phase 1 and Phase 2 screenings, she was placed in a sobering cell, and then the nurse ordered withdrawal monitoring (CIWA/COWS) every six hours. The nursing documentation does not indicate the exact time she was placed in the sobering cell; however, the Phase 2 documentation was completed at 17:04, and her booking location was changed to the sobering cell at 18:48. She remained in the sobering cell until 4/22/25 at 13:49, nineteen hours after her arrival. There are zero entries in the health record demonstrating RN monitoring every two hours as required by policy.

In addition to not monitoring her while she was in the sobering cell, the withdrawal monitoring was not accomplished every six hours as ordered. She was documented as refusing withdrawal monitoring; however, there are several encounters where the nurse documented that "she refused to come out". It's not clear if the documented refusals were informed refusals since the patient did not come out of her cell, nor did the nurse enter the cell and attempt a bedside assessment. On 4/23/25 at 10:17, a provider completed a CIWA assessment, documenting a score of 12, but she was not sent to the emergency department. At 21:00, nursing documented she refused her withdrawal assessment and was observed lying in her cell on her left side, with emesis on the cell floor. The nurse returned to her cell at 22:08 with medication to treat her vomiting, and she was found unresponsive. EMS was called, and the patient was pronounced deceased. Preliminary autopsy findings are pending.

During the monitoring site visit, the monitors observed patients being placed and monitored in the sobering cell. Nursing staff were asked how they monitor and ensure that the required assessments of the patients are completed as ordered. They reported that they must look at the patient's medical record to determine when upcoming assessments are due. There was no tool utilized that facilitated communication between nursing staff or supervision of whether the assessments were timely completed.

Withdrawal assessments and resulting scores are often incorrect and vary between nursing staff.

[45] Patient #21
[46] Patient #27

Patient 19: A 37-year-old patient[47] arrived at the jail on 12/30/25 at 13:09 with a history of polysubstance abuse, including alcohol and opiates. He was placed on COWS and CIWA-Ar monitoring. On 1/1/25, the nurse completed a CIWA-Ar assessment for the patient. The narrative documentation reported that the patient was unable to eat breakfast due to vomiting. When the patient is vomiting, the CIWA-Ar scale requires a score of three; however, the nurse assigned the patient a score of one, resulting in an erroneously lower score.

On 1/3/25, he was transferred to the hospital for management of his withdrawal symptoms. He returned on 1/3/25 at 17:24 and was housed on 6 East. At 20:55, the nurse completing the COWS assessment documented that he refused to get up for vital signs, but later ambulated to his cell door, asking for water. The nurse assigned a COWS score of four. However, documentation shows that he refused to have his vital signs taken. The COWS assessment requires documentation of the patient's pulse. Assigning an assessment score without completing all assessment criteria results in an erroneous score. Additionally, when patients are unable or unwilling to ambulate, it is critical that the nurse enters the cell and completes the assessment at the bedside (IV. N.2.ii).

In February, nursing staff assigned to withdrawal monitoring received training from the nurse educator to enhance accuracy in completing the assessments. The monitors observed the withdrawal assessments conducted by a newly hired nurse and found her assessments to be well done. The County is commended on providing additional education, and we expect to see improvement in the review of records in the next monitoring cycle.

Nurses, however, are duplicating their documentation of the assessment. They complete the withdrawal monitoring tool and then complete a narrative document, repeating the assessments recorded on the tool. The withdrawal tools are nationally recognized, validated scoring instruments that provide a comprehensive assessment. The only narrative documentation required is by exception, when signs or symptoms are present that are not captured by the assessment tool. Duplication of documentation increases the risk of error and is a waste of productive time.

Patients with substance use disorders were not timely referred to an addiction specialist following arrival.

Patient 5: A 23-year-old male[48] arrived on 8/19/24 and is still at the jail. His medical history includes alcohol, benzodiazepine, and opioid use disorders, sexually transmitted infections, priapism, and erectile dysfunction following priapism, adjustment disorder with mixed anxiety and depressed mood. Medications are Suboxone and mirtazapine. This case was referred to the monitors by class counsel.

The patient's blood pressure was elevated. The intake RN did not refer the patient to a medical provider for a history and physical, MAT RN, SUD counselor, or MAT housing. The patient is

[47] Patient #19
[48] Patient #5

currently not under the care of an addiction medicine specialist, but his prescriptions for Suboxone are automatically renewed without a clinical visit. The patient is not being provided timely and appropriate care for his opioid use disorder, including discharge planning.

Patient 4: A 30-year-old female[49] arrived at SCJ on 11/21/24 and was released on 1/21/25. Her medical history included polysubstance use disorder, including Fentanyl, pregnancy, abnormal Pap smear, poor dental health, and bipolar disorder. Her medications were Methadone, prenatal vitamins, and ondansetron. The patient had two prior admissions to the jail during the review period that are summarized below.

The first admission was from 9/22/24 to 9/23/24. During this brief admission, the patient was noted to have opioid use disorder with Fentanyl, was 19 weeks pregnant, and reported suicidal thoughts. She had no prenatal care. She was appropriately declared unfit for confinement and was taken to the hospital. She did not return to the jail.

The second admission was from 10/12/24 to 10/14/24. During this brief admission, the patient was declared unfit for confinement due to pregnancy and opioid use disorder. She still had no prenatal care. The patient was sent to Sutter Medical Center and treated for a urinary tract infection. On 10/12/24, when she returned from Sutter to the jail, a nurse did not notify an OB/GYN provider regarding the patient's arrival and whether to immediately send the patient to UCD. Although the patient was having withdrawal symptoms, she was not provided medication-assisted treatment prior to her release on 10/14/24, resulting in preventable suffering for the patient and the fetus. The patient was not provided with an appropriate referral to UC Davis Maternal Fetal Medicine for initial prenatal care, opioid use disorder, and induction of Methadone or Subutex.

The third admission was from 11/19/24 to 1/25/25. On 11/21/24, the patient was arrested and taken to Mercy Hospital in Folsom, where she was noted to be 27 weeks pregnant and had opioid use disorder. The ED provider treated her for a urinary tract infection but did not address her opioid use disorder. The arresting officer brought the patient to the jail.

Lack of appropriate intake orders for Obstetrics and Addiction Medicine Referrals.
On 11/19/24 at 18:00, a nurse conducted Phase 1 screening. Although the patient was pregnant and in active withdrawal, the patient was declared fit for confinement. This was not appropriate. The intake nurse contacted a provider about the patient's urinary tract infection. It does not appear that the nurse or provider considered sending the patient to UC Davis. The nurse also did not notify an OB/GYN provider regarding the patient's pregnancy and withdrawal symptoms. The nurse also did not order a referral to an addiction medicine provider, MAT Induction Housing, a MAT RN referral, low-tier and low-bunk , prenatal vitamins or health snack.

Delayed referral to obstetrics and methadone induction.

[49] Patient #4

On 11/22/4 at 09:00, the OB/GYN provider was notified and immediately sent the patient to UC Davis, where she was admitted for five days for prenatal care and Methadone induction.

Inconsistent and extended methadone dosing Intervals result in predictable withdrawal symptoms and inaccurate COWS assessment scores. (IV. N.2.iii, and IV. N.2.iv)
Upon her return to the jail, the patient was under the care of both obstetrics and an addiction medicine specialist who, in coordination with the CORE program, adjusted the patient's Methadone dose over the next two months. A concern is that addiction medicine and other providers documented that the patient was having significant withdrawal symptoms requiring frequent Methadone dosing adjustments. Nurse COWS assessment scores were low, and they discontinued COWS monitoring until the providers reordered the withdrawal assessments along with increases in Methadone dosing.

Nurses administered morning doses of Methadone between 08:30 and 09:00 and the afternoon at 15:00 to 16:00. This is a scheduled dosing interval of 6 to 8 hours, which results in the patient not being dosed for another 16 to 18 hours. This prolonged dosing interval resulted in the patient having recurrent withdrawal symptoms in the late evening or early morning, subjecting the patient and her fetus to withdrawal symptoms. Moreover, sometimes morning doses can be given later than 09:00, and afternoon doses by 16:00, which can further compress the time between the first two doses. Daily dosing for Methadone and Suboxone needs to be closer to ten to twelve hours to provide continuous coverage, prevent withdrawal symptoms, and decrease the need for increasing medication doses.

The patient was referred to the CORE outpatient drug treatment program in a timely manner and enrolled in the program prior to discharge. Although the patient was not initially provided with timely access to opioid use disorder treatment, once enrolled, medical providers closely monitored the patient and adjusted treatment.

This pregnant patient was not provided timely access to care for her opioid use disorder. Once treated, the patient did not receive Methadone dosing at consistent and proper intervals, resulting in both the patient and fetus experiencing withdrawal symptoms. Provider notes indicate that the patient was having significant withdrawal assessments when nursing withdrawal assessment scores were low, reflecting inadequate and inaccurate withdrawal assessments.

Patient 1: A 39-year-old female[50] was admitted to SCJ on 10/19/24 and released on 10/29/24. Her medical history includes opioid and methamphetamine use disorders, uncontrolled hypertension, concussion status-post bicycle accident, urinary tract infection, and depression. Her medications were Lisinopril, Hydrochlorothiazide and Suboxone.

[50] Patient #1

This patient had four admissions and releases from SCJ in 2024.[51] The second and third admissions were notable for intake nurses not reviewing the patient's previous medical records, which showed the patient had opioid and Methamphetamine use disorder, in order to initiate opioid withdrawal monitoring timely. At each admission, the patient had hypertensive emergencies that were treated; however, nurses did not timely monitor the patient's blood pressure following stat doses of antihypertensive medication

The patient's first admission arrival date at the jail was 4/30/24.[52] The patient was homeless. At intake, she reported having hypertension but taking no medication. She reported opioid and methamphetamine use, ingesting ten Percocet per day, and smoking methamphetamine daily for two years. Her blood pressure was 200/114 mm Hg, and her pulse was 66 beats per minute. Her pregnancy test was negative. The documented plan was to recheck her blood pressure in three hours. The nurse notified the medical provider who ordered Clonidine 0.1 mg, stat. She was released the same day. The nurse needed to monitor the patient and recheck her blood pressure within 30 minutes of receiving Clonidine. Twice weekly blood pressure checks are not sufficient for a patient with severe uncontrolled hypertension. This patient would have benefited from monitoring in the 2 Medical Infirmary.

Her second admission occurred on 7/11/24 at 21:37. A RN conducted a confidential medical screening. The patient reported a history of hypertension and depression, but did not know the medication names or the pharmacy. The patient reported taking substances, but then denied use of opioids, alcohol, benzodiazepines, and methamphetamines. The patient was homeless. Her weight was 220 pounds; her temperature was 97.5°F; her blood pressure was 185/94 mm Hg; her pulse was 82 beats per minute and irregular; her respirations were 18 per minute, and her oxygen saturation was 100%. The RN ordered a COVID-19 vaccination vaccine check, tuberculosis skin test, intake dental assessment, blood pressure checks twice weekly, an urgent provider H&P, mental health referral, discharge planning, and a lower bunk. The nurse contacted a medical provider, who ordered a stat dose of lisinopril 20 mg; however, the patient refused. The provider also ordered Lisinopril 20 mg and Hydrochlorothiazide 25 mg daily. The RN did not review the previous admission in April 2024, when the patient reported daily opioid and methamphetamine use. The patient's Avatar showed no mental health history. On 7/14/24 at 13:51, the patient was released.

During the patient's admission to the jail in April 2024, she gave a history of hypertension and opioid and Amphetamine use; however, at the July 2024 admission, the RN did not review the patient's previous medical records and note this information. The patient had poorly controlled hypertension and an irregular pulse at intake. The intake nurse ordered an urgent history and physical examination (H&P), but this did not occur. Her third admission occurred on 8/28/24 at 02:31. The patient reported hypertension and not taking medication. She said she used substances but then denied specific substance use. Her weight was 190 pounds, temperature 97.9°F, blood pressure 170/90 mm Hg, pulse 80 beats per minute and regular, respirations 18 per

[51] The first admission in April 2024 is outside the current review period.
[52] This admission was prior to the current review period.

minute, and oxygen saturation was 100%. A pregnancy test was not completed. The RN ordered a COVID-19 vaccination check, tuberculosis skin test, intake dental assessment, CNA/MA follow-up, blood pressure checks twice weekly, an urgent medical provider H&P, and discharge Planning. The nurse contacted a medical provider, who ordered Lisinopril 20 mg and Hydrochlorothiazide 25 mg to be taken daily. The RN did not review the patient's previous April (and July) admission information that showed the patient had opioid and Methamphetamine use disorders. The RN did not order a referral to an addiction medicine provider, COWS monitoring, detox housing, or a lower bunk.

The patient received the first dose of antihypertensive medications (<24 hours) on 8/28/24, at 08:49. Her blood pressure on 8/29/24, at 09:38, was 154/89 mm Hg.

On 8/29/24, at 14:46, a social worker saw the patient following a medical referral, noting the patient had opioid use disorder and hypertension. She became homeless after her husband was murdered two years prior. The social worker scheduled an appointment for bereavement counseling. The social worker noted the patient's history of opioid use disorder (OUD), which was not addressed by the intake nurse. It is unclear how this was communicated to a nurse.

On 8/29/24, at 22:12, an RN conducted a non-confidential COWS assessment outside the control area. The nurse did not take an opioid use history. The nurse noted that the patient had no tremors or tongue fasciculations. Her blood pressure was 150/95 mmHg, and pulse 95 beats per minute. Her COWS score was two. Orders included a provider sick call referral, COWS monitoring twice daily x five days, MAT induction, and a mental health assessment.

On 8/30/24, at 11:02, an RN saw the patient outside the control area. The patient reported using 1.5 grams of Fentanyl daily for one year. She denied alcohol and benzodiazepine use. She reported a history of one overdose. She was previously on Suboxone, but was unable to recall the dose. She reported having nausea, a runny nose, cold sweats, and body pain. The nurse observed gooseflesh skin. Her blood pressure was 154/89 mm Hg, pulse 68 per minute, and the urine drug screen was positive for Fentanyl, amphetamines, and methamphetamines. Her pregnancy test was negative. Her COWS score was eight, and the nurse contacted a medical provider who ordered a stat dose of Suboxone 8 mg and 8 mg ongoing, to begin tomorrow. The nurse administered Suboxone and monitored the patient, who reported feeling better. Current orders include detox monitoring, MAT induction housing, referrals to a MAT nurse, and an addiction treatment provider. A medical provider signed the note the same day. On August 30, 2024, at 16:51, the patient was released from jail.

The patient was in jail for less than 72 hours. The intake nurse did not review previous medical records that showed the patient had opioid and methamphetamine use disorder. It was the social worker who noted the patient's history of opioid use disorder, and then opioid withdrawal monitoring was initiated. A MAT nurse saw the patient approximately 36 hours after she was admitted to the jail. The patient reported symptoms of withdrawal, and her COWS score had increased to eight. The nurse appropriately contacted a medical provider who initiated Suboxone. The nurse monitored the patient, whose symptoms then decreased.

Her fourth admission to the jail was on October 19, 2024, and she remained in the jail for ten days. During this admission, several system issues were identified with the patient's care. During medical screening, a nurse noted that the patient placed a small amount of Fentanyl to mouth [sic] and complained of chest pain. The nurse performed an EKG.

Note: The nurse's documentation that the patient placed Fentanyl on her lips required the nurse to stop medical screening so the patient could be searched for Fentanyl on her person for her safety and that of other patients. There is no documentation that the nurses' observations were reported to a nursing supervisor, medical provider, or custody.[53]

After screening, a medical provider saw the patient, noting that she complained of headache, neck, and chest pain following being struck by a car. The provider concluded there was no evidence of an intracranial bleed, neck, or chest fracture. The provider noted the patient's hypertension; however, the provider did not order the patient's antihypertensive medications. The provider did not order cervical or chest x-rays to support the clinical conclusion of no fractures.

A social worker saw the patient and noted that she appeared to be under the influence of Fentanyl, and due to suicidal ideation, placed the patient on suicide precautions. An LCSW checked on the patient later and noted that the patient was unresponsive, both verbally and nonverbally, to her repeated attempts to engage. The patient was fully covered with a blanket. Despite multiple attempts to engage the patient, she was unresponsive. At this point, it is unclear whether the patient was alive or not; however, the LSCW and custody personnel did not enter the cell or pull back the blanket, to determine whether the patient was alive or not.

The LCSW notified a nurse who observed that the patient was lying on the floor covered by a blanket and refused to come out of the cell for a withdrawal assessment. The nurse then documented an assessment from outside the cell while the patient was covered by the blanket.

The nurse did not enter the cell, uncover the patient, assess her level of consciousness, or attempt to take her vital signs. This was particularly important given the patient's recent head injury, uncontrolled hypertension, and Fentanyl use the same day. This assessment was completely inadequate, and the failure to take further action was dangerous to the patient. For the next approximately eight hours, the patient remained completely unresponsive to staff, but no action was taken to assess the patient's medical condition.

Over the next two days, the patient complained of a headache that was ten out of ten in severity, and she had a hypertensive emergency (blood pressure of 200/114 mm Hg). A nurse notified a provider who ordered stat medication. The nurse did not recheck the patient's blood pressure,

[53] ACH reports that this documentation was a miscommunication, and that the patient did not put fentanyl to her lips. It should be noted that the patient was subsequently unresponsive during monitoring.

which should have been done 15-30 minutes after the medication was administered. Elevated blood pressure of this magnitude, associated with severe headaches, requires a neurologic exam.

Staff do not recognize patients experiencing severe and potentially life-threatening intoxication and immediately transfer them to a facility for care. (IV. N.2.v)

Patient 22: A 31-year-old male arrived at the jail on 3/18/25, at 10:30.[54] The monitors observed him during the phase 1 intake screening and noted him to be sleeping during the assessment. His blood pressure was 159/78 mm Hg, pulse 92 beats per minute, respirations 16 per minute, and oxygen saturation 96%. The nurse noted his sleepy presentation and endorsement of using Fentanyl that morning. He also endorsed using methamphetamines and cannabis. He was given a yellow wristband and expedited to the Phase 2 screening.

His Phase 2 screening was initiated and was directly observed by the monitor and the Director of Nursing. He endorsed using alcohol, Fentanyl, methamphetamines, and cannabis within the last 30 days, and all three within the past 24 hours. His urine drug screen was positive for amphetamines, Fentanyl, methamphetamines, and methylenedioxymethamphetamines. He had a prior overdose of Fentanyl. The nurse documented that he had mild drowsiness or lethargy, which was inaccurate. The patient was difficult to arouse, requiring repeated verbal stimuli and touching of his arm for him to awaken. He was drooling from his mouth and experiencing periodic episodes of slumping forward in his chair. The nurse's documentation of his neuro evaluation included "hard to stay awake," which is incongruent with the documentation of "mild" drowsiness. His initial COWS score was three, CIWA-Ar was zero, and his PAWS score was one. The nurse attempted to remove the patient's jacket to examine his arms but was unable to do so. When the Director of Nursing asked the nurse if he wanted the officer to uncuff the patient, the nurse responded, "They don't usually do that". The DON facilitated the patient's uncuffing. The nurse ordered a tuberculin skin test, COWS monitoring every six hours, MAT induction housing, lower bunk, every two-hour observation in the observation cell, 30-minute welfare checks, and referral to a provider for a history and physical.

The patient was placed on the bench in the booking suite and was observed by the monitors. He continued to drool and slump over while sitting on the bench. Approximately ten minutes later, the supervising RN conducted a welfare check, asking the patient how much Fentanyl he had used and the time of the last use. This assessment breached patient confidentiality, as it was conducted in front of at least four other arrestees waiting on the benches.

The patient was unable to provide answers to the questions. The nurse practitioner was called and asked to see the patient. He arrived in the booking suite and requested that vital signs be taken, and he then completed a thorough examination. The patient was unable to remember how much Fentanyl he used or when he used it. The nurse practitioner compassionately discussed the treatment plan with the patient, who begged him not to administer Narcan. At 11:41, he was given diphenhydramine 50 mg IM and ordered transported to the hospital. It is

[54] Patient #22

noted that the medication was not recorded on the medication administration record, as required by nursing standards of care.

The nursing supervisor documented that the patient continued to experience sleepiness, and that officers assured him they would be leaving within minutes. The Nurse Practitioner ordered Narcan to be administered if he became unresponsive. The transporting officer reported he had Narcan available in the vehicle. The patient was taken to the hospital and did not return to the jail.

The supervising nurse was interviewed and asked what prompted him to call the nurse practitioner and request that he assess the patient. He stated that he saw that the monitor and the Director of Nursing were concerned, so he opted to call the nurse practitioner.

Direct observation of the assessment and treatment of this patient is deeply concerning. The patient should have been deemed unfit during the Phase 1 screening. The nurse completing the Phase 2 screening also did not determine him unfit and ordered him placed in the medical observation cell in the booking suite. The documentation in the health record does not accurately depict the patient's presentation and the seriousness of his intoxication and condition.

The RN supervisor also failed to appreciate the seriousness of the patient's condition and summoned the nurse practitioner only because the monitors and the DON were observing and appeared concerned. The supervisor also attempted to complete an assessment of the patient while he was on the bench in the booking suite, sitting with other arrestees, breaching confidentiality. Even if he had not had an altered level of consciousness, it's unlikely that he would have provided accurate answers when multiple people were observing the interaction.

When patients have overdosed and use of Narcan may be indicated, that patient should be transported via ambulance because other medical emergencies may arise for which administration of Narcan may not reverse, and custody personnel are not equipped or trained to intervene. A single officer, in a squad car, is unable to drive and monitor the patient's level of consciousness, breathing, and other vital signs.

In addition, and most disturbing in this scenario, was the administration of 50 mg of Benadryl. This is not indicated in a presumed drug overdose and undoubtedly would have exacerbated the clinical picture of a "sedated" patient. Narcan use is the standard of care to reverse an opioid overdose.

Direct observation of the nursing care and treatment in the booking suite will be required to monitor compliance with intake screening, intoxication treatment, and withdrawal monitoring policies and procedures. This case illustrates that a record review, without direct observation, can provide false assurance of operational compliance.

Compliance Assessment:

- N.1=Partial Compliance↑

- N.2=Noncompliance↓

Recommendations:

1. Develop a comprehensive nursing training curriculum that includes proper use, assessment, and scoring of withdrawal from alcohol, opiates, and benzodiazepines. Document individual staff training and demonstration of competency.
2. Develop a comprehensive nursing training curriculum that addresses proper monitoring of patients placed in the sobering cell.
3. Develop a nursing management tool that documents and tracks the ongoing monitoring of patients in the sobering cell to ensure they are closely monitored per ACH policy.
4. Develop a comprehensive nursing training curriculum that addresses accurate assessment of patients' level of consciousness, potential drug overdose, and fitness for confinement.
5. Ensure that RN supervisors actively manage the booking process and provide adequate oversight to ensure the proper assessment and disposition of arriving arrestees.
6. The County needs to conduct daily record reviews of all newly arrived patients with substance use disorders to ensure that appropriate referrals have been made to the addiction medicine specialists, medical providers, detox housing, and lower bunks.
7. Conduct comprehensive qualitative and quantitative CQI studies to assess compliance with substance abuse screening, withdrawal monitoring, intoxication monitoring, and administration of prescribed treatment.
8. Conduct comprehensive qualitative and quantitative CQI studies to assess compliance with substance abuse screening, withdrawal monitoring, intoxication monitoring, and administration of prescribed treatment.
9. Reeducate nursing staff on documenting all ordered and administered medication on the medication administration record (MAR).
10. Consider developing written guidance for nursing staff that addresses conditions that can be safely transported by car versus those that require transport by trained medical staff.
11. The Nurse Practitioner needed to explain the clinical rationale for administering Diphenhydramine.

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.

Findings: There has been no significant change since the last monitoring report was issued. The ACH protocols establish low, medium, and high-risk categories, which include the administration of approved over-the-counter medications. They also include directives on when to notify a provider when a medium-risk condition is identified and directives to transfer the patient to a higher level of care when the clinical presentation requires emergency stabilization.

Issues persist at RCCC regarding the conduct of nursing sick call in non-clinical settings. The nurse had completed morning sick call in an office adjacent to the examination room, because the provider occupied the clinical examination room. The office lacked an exam table and handwashing facilities. The nurse used a portable cart to store a small number of bandages and other supplies. The only sanitation between patients was the use of hand sanitizer. Sick call services are also conducted in the main clinic area, located just inside the door, utilizing privacy screens adjacent to a desk. Again, no exam table, medical supplies, or handwashing facilities are available in this area. Nursing administration reports that if an examination is required, the patient is taken to the clinic space where an exam table is available. Requiring the nurse and patient to wait until a clinical examination room is available slows the flow of patients in the queue for nursing sick call. It inherently discourages the completion of physical examinations required by all nursing standardized protocols.

Observation of nursing sick call also revealed that patient staging is still not occurring. Custody staff bring patients one at a time, resulting in significant downtime for the nurse. Coordination of the patient appointment list is required to ensure an adequate flow of patients is available to all health staff who are simultaneously seeing patients.

In prior reports, the monitors discussed the need for revision of the standardized nursing protocols as they remain poorly designed. In their current state, nurses are required to make a medical diagnosis before selecting a protocol. Additionally, the protocols lack clinical assessment pathways that sufficiently guide nurses in decision-making and the establishment of nursing diagnoses (VI. O.1). Because the nurse must select a procedure, based on a presumed diagnosis,

before assessing the patient, errors in the assessment, development of a nursing diagnosis, and non-compliance with procedure occur.

Effective nursing procedures are systems-based, requiring nurses to obtain both subjective and objective data from patients. The data methodically guides the nurse through a clinical pathway, ultimately arriving at a nursing diagnosis and an associated plan of care. The Medical Director authorizes the plans of care and includes thresholds for referrals to a provider, orders for over-the-counter medications, and appropriate patient education. Without effective, standardized nursing protocols, the quality of the patient assessment is dependent upon the individual nurse's training, experience, and expertise. The standardized protocols should be designed such that templates are programmed into the electronic health record. The monitors previously provided feedback and protocol samples to assist ACH in the revision process.

A review of records and direct observation of the nursing sick call process found that nursing staff were not adhering to the protocols (IV. O.2). They do not methodically collect related subjective and objective data; they fail to complete a thorough physical examination, and often order over-the-counter medications not authorized by the specific protocol they have chosen to use. Direct observation of nursing staff completing nursing sick call assessments revealed that they wrote notes on the patient schedule to be used later for documentation purposes. Effective nursing protocol templates serve as a guide and tool to document the data being gathered and the physical assessment, contemporaneously.

On 3/13/25, a 61-year-old male patient with a history of serious mental illness, seizure disorder, chronic back pain, and a history of methamphetamine use submitted a health service request complaining "very dizzy at time constant migrane [sic] headaches had two anxiety attacks since 3-6-25 need to speak with doctor ASAP".[55] The patient was seen in nursing sick call on 3/14/25. His blood pressure was 99/61 mm Hg, pulse 78 per minute, respirations 16 per minute, and temperature 97.7°F. His weight and oxygen saturation were not measured. A nursing protocol was not used, and in the comment sections of the document, the nurse wrote: "Pt c/o feeling dizzy. Pt. may be consuming an excessive amount of water. Pt. states 10 cups tid. Encouraged short term Tylenol." The nurse ordered acetaminophen 500 mg, two tablets twice daily for five days.

The standardized nursing protocol for Headaches requires the nurse to document the onset, nature, and duration of symptoms, the location of pain, precipitating factors, associated nausea and vomiting, vertigo, visual disturbances, and previous episodes. It also requires assessment of the patient's level of consciousness and recording of vital signs. Additionally, an evaluation of the patient's eyes, assessment of the temporomandibular joint, observation of gait and stance, and completion of a neurological assessment are also required. None of these assessment criteria were addressed. The authorized plan for a mild headache is Tylenol 650 mg twice daily for three days. If the headache is believed to be a migraine headache, Tylenol 1000 mg is authorized twice daily for three days.

[55] Patient #23

The nurse did not complete an adequate assessment, nor was the type of headache described. If the headache was believed to be a migraine headache, the Tylenol authorized by the protocol was for three days, not five as ordered. Also, if the nurse's assessment raised the question of polydipsia, this required an immediate referral to a provider for further evaluation and development of a treatment plan. Not only did the nurse fail to refer the patient with a potentially fatal condition, but no education about restricting fluid intake was given to the patient.

On 3/17/25, the same patient submitted four health service requests.[56] He complained of arthritis in his right hand with pain and stiffness, body and feet that were very ashy, only having one bowel movement a week and being constipated, and having extreme, serious back pain. The nurse saw the patient on 3/18/25 during nursing sick call, and the encounter was observed by the monitors and the Director of Nursing.

The nurse wrote notes on the schedule, rather than directly entering the assessment data into the electronic health record. Nursing protocols were not used. The nurse documented, "Pt states had BM yesterday. Want to resume Colace. Fluids encouraged. c/o dry skin, will provide moisture. c/o chronic arthritis. Currently on Tylenol, has a pending MDSC appt- chronic pain. Declined MRI today." The MRI had been ordered for urological issues, unrelated to the complaints addressed in nursing sick call.

There are standardized nursing protocols for Emergent and Non-emergent abdominal conditions, skin, non-traumatic musculoskeletal, and chronic back pain. The abdominal complaint protocol requires observation, auscultation, and palpation of the abdomen. The nurse did not obtain a complete history of the constipation complaint, as outlined in the protocol, and did not assess the patient's abdomen.

For constipation, the protocol authorizes Colace 250 mg twice daily. The Colace was ordered once daily in the evening, rather than twice daily per the standardized protocol. This patient had complained of constipation and had been ordered Colace by nursing staff four times in two months. He was seen by a provider on 3/26/25; however, the ongoing constipation was not addressed. Constipation on the surface is generally considered not acute; however, ongoing, continued constipation can be indicative of a more serious medical condition that should be evaluated.

The nurse did not complete the non-traumatic musculoskeletal-chronic back pain protocol or the skin irritation-dry skin protocol, including obtaining the required subjective data and examining the affected areas. Aquaphor ointment was ordered twice daily for one month; however, it is not authorized by the skin protocol. The patient's back pain was not addressed, nor was he examined and provided treatment for relief of his pain.

[56] Patient #23

Generally, nursing staff do not consistently follow nursing protocols, collect the required subjective data, complete adequate physical examinations, or adhere to authorized treatment plans. The lack of completed assessments and non-compliance with following the approved protocols is dangerous and does not meet the nursing standard of care.

Nursing protocols should be revised to be symptom-based, guiding nurses through a clinical pathway that leads to the development of a nursing diagnosis. When effectively written, the protocol guides the nurse through a thorough patient interview that includes inquiring about important symptoms and leads to an adequate physical examination, resulting in a nursing diagnosis supported by a physician-ordered, approved plan of care. Additionally, safeguards should be included in the protocols to ensure that appropriate referrals to providers occur when a patient continues to experience and complain about the same, unresolved symptoms multiple times.

Until the revision of the nursing protocols is complete, nurses should follow the protocols as written, conduct a comprehensive physical examination in a clinical setting, and order medications only as authorized by the protocol. Direct supervision and related qualitative QI studies are necessary to ensure compliance with nursing practice.

Compliance Assessment:

- O.1=Partial Compliance
- O.2=Partial Compliance

Recommendations:

1. Conduct nursing sick call in a clinical setting with access to necessary equipment, supplies, and handwashing facilities.
2. Revise the standardized nursing protocols in a body systems format that guides the nurse down a clinical pathway, requiring a complete and thorough assessment.
3. Revision of nursing protocols should include nursing diagnoses, rather than medical diagnoses, which are outside the scope of practice for registered nurses.
4. Revised nursing protocols should be incorporated into the electronic health record to facilitate guided, contemporaneous documentation of findings and avoid incomplete narrative documentation in a comment box.
5. Revise the nursing protocols to include referral to a provider when complaints of an unresolved problem occur twice within a month and a provider has not yet evaluated the patient.
6. Require nurses to follow the current nursing standardized procedures as written and document complete objective data, findings of a complete physical examination, and order only authorized over-the-counter medications.
7. Require nurses to document contemporaneously, directly in the health record.
8. Coordinate patient schedules with security escorts to ensure the efficient staging of patients and maintain an adequate flow of patients to all health staff simultaneously conducting clinical encounters.

9. Conduct qualitative QI studies to measure compliance with nursing protocols, with a particular focus on the quality of the medical history, review of symptoms, physical assessment, and whether patients were appropriately referred to a higher-level provider. The QI studies should sample a wide range of staff utilizing the protocols and include a range of times over several weeks to ensure the sample is adequate.
10. Consider randomly interviewing patients about the physical examination that was completed to ensure the documentation accurately reflects the examination that was performed.

P. Reviews of 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.

Findings: There were two in-custody mortalities for this reporting period. The monitors conducted an independent review of each as well as of those completed by the County. In general, both the County and the monitors identified many of the same findings. This is a positive step in the right direction. Introspection and transparency are paramount to an effective mortality review. Preliminary reviews of deaths occur within thirty days following the event; however, the County's reviews do not adequately correlate the clinical practice, deficient processes, systems, and professional performances that directly contribute to the clinical outcomes (VI.P.1).

The monitors understand that deaths will occur from time to time. The goals for the County should be to quickly identify those that are expected and adjust the care accordingly, and prevent those that are avoidable. The challenges that the County continues to struggle with and that will hinder substantial compliance with this provision are multifactorial and interdependent. Systems, processes, procedures, policies, clinical guidelines, quality assurance and improvement audits, and clinical competencies must all align to mitigate patients' harm, maintain their health, and improve clinical outcomes. ACH is still evolving to accomplish these alignments.

A mortality review requires a structured Root Cause Analysis to help the organization uncover critical and pertinent components associated with a death. These components are divided into three main categories: People, Process, and Technology. From these three broad categories, the County may devise subcategories in need of attention. The monitors' observation of the County's approach to findings and corrective action plans (CAPS) is that neither is well defined. The CAPS are voluminous and would be too burdensome to meet, track, monitor, and assess for effectiveness, and they do not reflect progressive disciplinary actions for repeat offenders. The County must ensure the right skill set is in the right position, in the right location, and never practicing beyond the scope of their licensure.

Unfortunately, the chronic care management of one death (patient #51) was conducted primarily by a pharmacist. This is unacceptable practice, and it placed this patient in harm's way. The County omitted to ensure treatment plans were first established by a responsible physician, followed by established collaboration with a clinical pharmacist for monitoring and continuity of care. In this case, the pharmacist appeared to manage the patient independently and failed to consider the complete complexity of the patient's medical conditions. The pharmacist managed

the numbers, not the patient, because they are not trained or qualified to assume the responsibility for the comprehensive care of patients.

Patient # 50

Summary: This is a 72-year-old male who presented to ACH on 6/5/23 with multiple medical conditions. His medical screening was non-confidential and showed normal vital signs, a weight of 180 lbs., and a glucose reading of 122. He could not recall all his medications and was referred for an urgent provider history and physical. Glucose and blood pressure checks were ordered, along with a lower bunk and a general population residence.

The patient's medical history included, hypertension, diabetes, hyperlipidemia, gastric reflux (heart burn), Degenerative joint disorder of his spine that required two surgeries, traumatic vision loss of right eye, peripheral neuropathy (nerve damage to extremities), atherosclerotic disease that manifested in a heart attack and stroke, coronary artery bypass, aortic valve replacement (major heart valve), inguinal hernia, enlarged prostate, aortic aneurysm (ballooning of the artery) and peripheral artery disease (cholesterol buildup in the arteries of the extremities). The patient was receiving all the appropriate medications for his chronic illnesses.

From June 2023 through November 17, 2024, the patient had all appropriate laboratory tests ordered, except for a lipid level. His diabetes was overall well controlled (HbA1c 6-7.3), although the approach to management was not always appropriate. His kidney function remained fairly normal throughout his care. The patient showed an iron-deficient anemia that was not adequately addressed. In males, Iron deficiency anemia must be worked up to rule out an occult intestinal cancer. The medical record did not reflect that this was ever pursued. The patient was prescribed Iron replacement without determining the cause.

The patient had regular visits with the providers. They included chronic care visits, sick call visits for complaints related to his hernia and diarrhea. The providers generally included all his medical conditions in their assessments, but did not consistently include the control status of each in their documentation. No provider included the lipid level in their evaluation. This was critical, given this patient's heart and stroke history. When the provider indicated the control status was poor, they did not increase the frequency of the patient's chronic care encounters per policy. On July 24, 2024, and September 26, 2024, the physician's physical documentation showed a normal heart exam. These were not accurate. This patient has a heart valve replacement and is expected to have a murmur (blowing sound) on auscultation. Some providers captured this in their exam. The findings of a normal heart exam beg the question of whether an exam was performed and whether the physician can recognize a heart murmur. The patient refused his medications multiple times, and the refusals were inconsistently documented by staff. Providers attempted to meet with the patient to address his non-adherence, but this effort was insufficient compared to the frequency of non-adherence to critical medications.

From June 2023 through October 2024, the patient had seven Electrocardiograms (EKGs) performed that were related to chest pain complaints. All but one was abnormal. Of note is the change in the EKG readings on 7/20/23 that showed a first-degree heart block for the first time.

The monitors were unable to determine who signed the report. This finding alone is not a concern; however, in the context of this patient, it should have been noted, but it was not. On 7/23/23, another EKG was performed, and the computer read "Sinus Arrhythmia and consider premature supraventricular complexes." The person (unable to be identified) who signed the EKG documented, "No change from 6/6/23 EKG." This was not accurate. On 8/22/23, the EKG showed new changes. The heart rate was forty-seven (low heart rate), and there was a prolonged conduction delay. The combination of these findings and the fact that there were new changes for this patient was significant and should have been recognized. Once again, the person who signed the report was not identifiable, and the interpretation was "no ischemia." The monitors agree that this EKG did not show the common objective signs of ischemia, but this finding is not the only thing to be assessed when reading an EKG. Moreover, the changes in the EKG could have been an indication of previous ischemic (loss of oxygen) events that caused damage to the structure of the electrical system of the heart. These findings were not recognized. When this patient complained of chest pain, he also complained of associated shortness of breath. A low heart rate, in his case, could have been the etiology of his symptoms, or his underlying heart condition could have been causing the symptoms. This patient was on a medication that causes a lowering of the heart rate, and the medical record did not show that a provider considered this as a cause or the need for possible medication adjustment.

The patient was at the Napa State Hospital from December 20, 2023, through July 24, 2024. Upon return to the jail, the patient was evaluated by the medical provider, and all appropriate medications were maintained. From July 2024 through November 17, 2024 (date of death), he had a few evaluations for Clostridium Difficile-related diarrhea that resulted from an antibiotic prescribed by the dentist, a chronic care visit, and a transport to the emergency room for chest pain that was diagnosed as Gastric Reflux.

The patient was treated appropriately for his diarrhea and underwent successful surgery for his right inguinal hernia. When the patient presented with acute clinical symptoms and the provider was notified, he was properly managed and transferred to a higher level of care. Except on one occasion, the provider administered Nitroglycerin for chest pain, not Aspirin. Aspirin must be administered when chest pain is believed to be related to the heart, unless there is a contraindication. His cardiac workups were negative, and he was seen within a reasonable time by a provider upon return from his hospital visits.

The patient was doing well until the date of his death. The medical record shows that around 20:00, he walked out into the area where the nurses were conducting sick-call and was directed to return to his pod by custody because he was not on the list. "The video of the patient heading to sick call demonstrated that he had a steady gait while using a walker to assist him. While walking back, he paused halfway to the cart, becoming noticeably slower, then sitting [sic] down on the cart. The patient then fell onto his left side."[57] The Deputy rushed to the patient and found him unresponsive to his name being called and incontinent of urine and stool. The Deputy called for backup, cleared the bench of the patients waiting, and alerted the nurses in the medical office

[57] ACH's Mortality Review

that there was a man down. The nurses arrived at the side of the patient around 20:02, and upon arrival, he was unresponsive to calling his name, breathing spontaneously, but snoring, and with a weak pulse. The nurse documents the inability to obtain a blood pressure reading. The pulse rate, respiratory rate, temperature, or oxygen saturation level were not recorded, and the finger glucose value was 135. The nurse started the patient on six liters of oxygen. At 20:09, the patient lost his pulse, and cardio-pulmonary-resuscitation (CPR) commenced. The automated external defibrillator (AED) arrived at the location at 20:15 and was placed on the patient. "The AED showed the patient presenting with a brady (slow) systolic rhythm, with a wide complex QRS consistent with pulseless electrical activity, with a rate in the 40s. Throughout the resuscitation, during the rhythm checks, the AED up until 20:22 showed the same wide complex rhythm at a similar rate. At 20:22, the AED shows asystole."[58] No shocks were advised throughout the resuscitation. Emergency Medical Services (EMS) arrived on the scene at 20:25 and assumed control of CPR efforts. The record does not indicate the time EMS was notified. This documentation is necessary to assess the proper triaging and response time of emergency services. The record shows EMS worked to revive the patient for approximately thirty minutes, but to no avail. The patient was pronounced on site at 20:47.

Findings:

1. Documentation with illegible signatures.
2. The provider failed to address EKG changes.
3. There was inadequate assessment of control status for all chronic care conditions and failure to include lipid values.
4. Providers documented normal cardiac exams when the patient had aortic valve replacement that created a murmur.
5. Providers failed to evaluate Iron deficiency anemia.
6. Provider failed to administer Aspirin during a chest pain assessment that was believed to be related to the heart.
7. Staff did not recognize agonal breathing as a medical emergency.
8. The AED arrived at the emergency scene late.
9. Documentation does not include a thorough timeline of the resuscitation activity.

Patient # 51

Summary: The patient was a 54-year-old white female who presented to ACH on 8/28/24 as a repeat arrestee and with the history of Type 2 diabetes, peripheral neuropathy, osteomyelitis of several toes that required amputation, congestive heart failure (CHF), hypertension (HTN), diabetic retinopathy, poor dentition, hepatitis, post-traumatic stress disorder (PTSD), schizoaffective disorder and anxiety.

During previous incarcerations, the patient was receiving Amlodipine and Lisinopril for her blood pressure management. Her blood pressure was 149/100 mm Hg during her intake assessment,

[58] ACH's Mortality Review

which was not addressed. She was referred to the pharmacist-led chronic care clinic for hypertension and diabetes medication management.

On 8/29/24, at 8:13, a Nurse Practitioner (NP) assessed the patient for complaint of being "tackled the night before arrest." Vital signs were normal, except for elevated blood pressure (162/93 mm Hg). The pain in her left shoulder was "greater than 10." The exam was significant for swelling over the front of the collarbone joint. There were no neurologic deficits, and the patient was treated with an analgesic and a sling. The NP also ordered an X-ray of the shoulder. Although pain can cause an elevation in blood pressure, the NP never addressed the differential diagnosis during this presentation, and this should have been done because this was a new arrest, the patient has CHF, and high blood pressure poses a risk of cardiac decompensation. The blood pressure should have been repeated after she received pain medication to see if the elevation was related to pain or her chronic Hypertension that would need additional management. The shoulder x-ray was completed on the same day, and it showed a "mild separation of the AC joint (located between the collar and shoulder bones)." This finding did not require a change to the treatment already ordered for her shoulder pain.

On 8/30/24, A NP assessed the patient and captured the patient's history of CHF, HTN, and diabetes. Records from Sutter Medical Center from 07/04/2024 were reviewed, and the patient demonstrated significantly elevated B-type natriuretic peptide (BNP). This lab assay is used to evaluate the status of heart failure, and the elevated value indicated the patient was in heart failure in July. The vital signs during the visit with ACH's NP were normal, except for the patient's blood pressure (144/94 mm Hg) and oxygen saturation (93%). The NP did not address the patient's comprehensive and complex medical conditions. There was no acknowledgement of the low oxygenation. The NP indicated that the patient's CHF was in poor control and the blood pressure was in fair control. This is the second day that the blood pressure has been elevated and not adequately addressed by a provider. The NP ordered a jail panel, BNP, hepatitis, HIV, and urine pregnancy tests, and wound care for the left great toe. The NP did not include an extremity exam in her assessment, and given the patient's history and active wound, this was a major oversight. Patients with diabetes and wounds require meticulous care and antibiotics that combat a broad range of bacteria. The NP did not order an antibiotic. No retinopathy (eye exam) screening order was placed. The NP did not initiate blood pressure medications.

On 9/2/24, the lab results showed the BNP was normal; lipid level (103); creatinine (1.09); GFR (60); Thyroid-Stimulating Hormone (0.08); HbA1c (9.8); and Hematocrit (30.4). All these labs were abnormal and never addressed. Collectively, they represent that the patient's kidneys were failing; she was anemic; her thyroid gland was hyperactive, and she required treatment with a statin drug to lower her lipid level to 70 or lower. All Hepatitis values were normal, but this diagnosis was not removed from the problem list. Failure to promptly address the abnormalities puts this patient at high risk for a poor clinical outcome, given her co-morbidities.

On 9/22/24, at 12:18, the nurse assessed the patient for vomiting of bile color fluid, headache, and elevated blood pressure (199/113 mm Hg). The patient was in a wheelchair and appeared ill. There was no physical examination recorded. The nurse notified the NP and received orders to

transport to the emergency department (ED). Acute Coronary Syndrome was mentioned in the record as the justification for the ED transfer, but the NP did not manage the patient accordingly. The patient did not receive any medication for her blood pressure. There is no documentation that intravenous (IV) access was attempted. The patient was transported via EMS. The monitors consulted with a provider to determine what happened with the patient after her ED assessment. We learned that the patient returned the same day from Sutter ED. The only document scanned into the ACH health record listed a diagnosis of Hyperglycemia, but not Acute Cystitis (bladder infection). No ED labs were available for review. The scanned document included a paper prescription for Keflex. ACH's NP co-signed the order, and the medication was started. The patient was never seen by a provider after her return from the ED. The medical record does not include information on urine cultures that should have been obtained to determine the bacteria type and the most appropriate antibiotic treatment. Empiric treatment for a urinary tract infection is Bactrim or Nitrofurantoin. Empiric treatment is implemented based on evidence-based studies, while awaiting definitive results. Keflex was not the appropriate treatment, and the NP should have recognized this and made a change in the treatment, and requested the records with the urine test results and a follow-up appointment.

On 9/30/24, at 4:01, the nurse did a non-confidential follow-up visit with the patient to check on her response to a urinary tract infection. The patient stated she felt better, and her vital signs were normal. On 10/22/24, the patient requested a "mood stabilizing medication that does not cause weight gain." She was referred to mental health. Psychiatry attempted to see the patient on 11/10/24, but she was hospitalized.

On 9/11/24, 10/2/24, and 10/15/24, the pharmacist encountered the patient to address her uncontrolled diabetes and hypertension. The pharmacist adjusted her medications based on numbers alone. The records do not show that a provider ever established a treatment plan for the patient's chronic illnesses, and the monitors did find documentation that the pharmacist consulted with a provider.

On 11/7/24, at 7:07, the nurse conducted a non-confidential assessment for the patient's complaint of "moderate to severe left side chest pain with deep breaths." Her blood pressure was 102/66 mm Hg; heart rate 86 per minute; temperature of 98 F.; respiratory rate of 16 per minute, and oxygenation level of 93%. The patient had diminished breath sounds in the left upper lobe of her lungs on examination. The nurse notified the physician, who initially ordered the patient to be transported to the ED via the custody van. This was not appropriate. This patient was critical and required immediate 911 notification and establishment of an intravenous line for fluids while waiting for EMS. The record showed the physician stated, "if oxygen requires [sic], send out via code 2 instead of van." This order indicates the physician did not recognize the seriousness of the clinical presentation.

Between 7:07 and the arrival time of EMS on the scene, at 7:37, the patient's oxygen level dropped critically low to 82%. It is not clear when 911 was called. Various oxygen concentrations were administered to elevate the oxygen level, and different media were used to deliver the oxygen, which were not always appropriate. The patient's blood pressure dropped as low as

83/59 mm Hg, and her heart rate never got above 83. Her vital signs reflected an inappropriate physiological response. Whenever the blood pressure drops, the heart rate is expected to increase. When this does not happen, the first diagnosis to consider is sepsis. This patient was at high risk for infection because she had uncontrolled diabetes; she had a foot wound, a previous urinary infection, poor dentition, and anemia.

EMS departed with the patient at 7:46. She was admitted to the hospital and treated for pneumonia and sepsis caused by Klebsiella bacteria. The monitors suspect this was the bacteria in her urine that seeded her blood. Klebsiella should be treated with a third-generation cephalosporin antibiotic. The patient was receiving a first-generation cephalosporin. The inappropriate treatment of the patient's urinary tract infection, coupled with her co-morbidities, contributed to her deterioration into multi-organ failure and death on 11/12/24.

It is the monitors' opinion that this patient's care significantly fell below the standard of care on a multitude of fronts. Had her complex chronic illnesses been managed by a qualified physician, her untoward fate may have been avoided. This case highlights the urgency of the County's need to secure a Medical Director and establish oversight of the entire clinical program. As mentioned in the Chronic Care section of this report, nurse practitioners must be supervised; high acuity and complex patients must be identified early; their treatment plans established by a physician, and the effectiveness of the treatment plan monitored by a physician.

Findings:

1. Providers failed to manage all chronic care conditions based on evidence-based medicine.
2. The pharmacist was allowed to independently manage a complex patient without the guidance and supervision of a physician.
3. The NP failed to recognize the wrong treatment for urinary tract infection.
4. The provider failed to recognize signs of sepsis as a medical emergency, which caused a delay in activating emergency medical services and emergent treatment with antibiotics and fluids.
5. The County failed to synthesize and analyze all clinical information and contributing factors that may have led to the death of this patient.

Compliance Assessment:

- P.1=Non-Compliance↓
- P.2=Non-Compliance↓

Recommendations:

1. Stop the Clinical Pharmacist collaboration practice until the Medical Director is on board and can design a program that ensures clinical practice is safe, congruent with the scope of practice, and has proper oversight.
2. The County should include a structured root cause analysis component in its Mortality reviews.
3. As previously recommended, obtain name stamps for all clinical staff or require them to print their name and credentials after each signature.

4. Train providers on EKG interpretation and application of findings on a case-by-case basis.
5. Train staff on the clinical presentation of agonal breathing and the importance of activating 911 immediately.
6. Conduct peer reviews on the providers involved in the care of both patients and take the necessary actions, based on findings.
7. Train all nursing staff upon hire on effective emergency response in various clinical presentations. Require a written examination, return demonstration, and a declaration of competency prior to assigning them to a working post.
8. Retrain all nursing staff on emergency response and the use of emergency equipment and assess competency through return demonstration.
9. ACH should establish code teams for each shift and delineate who is accountable for each role.
10. Conduct frequent emergency response drills that include video review, critique, and staff feedback until consistent, effective emergency response skills are demonstrated.
11. Train providers on the management of acute coronary syndrome.
12. Establish a high acuity criterion and assign physicians as primary care providers to ensure appropriate treatment plans are implemented and followed.
13. Train providers on the empiric treatment of infections in patients with diabetes, and genital-urinary infections in females.

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.

Findings: There has been no significant change in reentry services since the last monitoring report was issued. Challenges persist in providing a 30-day supply of medications to patients upon their release from jail. A primary cause is that the Sacramento County Sheriff's Office cannot provide an actual release date to the pharmacy for sentenced inmates. The only date provided is a projected date, which is subject to various variables, including additional charges, court orders, and the court calendar. Because of these variables, the actual release dates are subject to change (VI. Q.1).

The County provided a list of sentenced patients who had been supplied medication at discharge. The report provided no data analysis that showed measurements such as the percentage of sentenced patients who received their medication, the rate of released sentenced patients who did not receive medication, or the number of sentenced patients released without notification to the pharmacy. Raw data without analysis fails to accurately measure compliance. No data were provided to measure compliance with providing presentenced inmates with a prescription for a 30-day supply of their current medication (IV. Q.2).

The County also provided a list of patients who had a completed discharge planning encounter. However, this raw data did not include an analysis, demonstrating the total number of patients who received reentry services in comparison to the total number that were released who qualified for services. Also missing is the provision of specific assistance required, which includes assistance to patients with chronic diseases, such as referrals and appointments, public benefits, inpatient treatment, and other reentry services.

The County reports that planning is in place to provide 24-hour pharmacy services to facilitate the administration of medications to patients upon discharge. ACH reported that their practice of calling in prescriptions for a 30-day supply of medication to a community pharmacy was discontinued, secondary to a low rate of patient compliance with picking up ordered medication. Pre-sentenced patients are now required to visit the County's Primary Care Pharmacy and request a supply of their medication. The community pharmacy then calls the ACH pharmacy or the 2M office to obtain the prescription for filling and administration to the patient. This requires the patient to get transportation to the community pharmacy and wait, which could potentially

be a significant amount of time to obtain their discharge medications. This arrangement presents a potential barrier to access to care. There are successful processes used in other jurisdictions that utilize community pharmacies; however, these processes typically begin at the jail during discharge. The nurse communicates directly with the patient and then ensures the medication order is called to a community pharmacy near the location where the patient is being discharged.

The County is jointly working with the Sacramento Sheriff's Office to implement CalAIM 90-day pre-release benefits for patients, which include the filing of prescriptions upon release. Establishing this process, however, is not anticipated until June 2025, secondary to staffing and other operational issues.

The monitors' review of records found several instances where reentry services and discharge planning had not been provided as indicated. Examples include a 39-year-old female[59] who was admitted to the jail on 10/19/24 and was released on 10/29/24. Her medical history includes opioid and methamphetamine use disorders, uncontrolled hypertension, concussion status-post bicycle accident, urinary tract infection, and depression. Her medications were Lisinopril, Hydrochlorothiazide, and Suboxone. The patient was not given discharge medications for antihypertensive medications, suboxone, or Levofloxacin for a urinary tract infection.

Another 58-year-old male[60] arrived at the jail on 10/28/24 and was released on 10/30/24. His medical history includes hypertension. Medications were amlodipine and Lisinopril. This patient had uncontrolled hypertension and was having a hypertensive emergency upon arrival. On 10/29/24, at 10:22, the patient was sent to the ED for uncontrolled hypertension and abnormal EKGs and returned the same day at 16:58. On 10/30/24, at 10:33, the patient was given the first dose of antihypertensive medications (<24 hours). On 10/30/24 at 14:07, the patient was released. There is no documentation that the patient was provided with discharge medications. This case was challenging due to the short interval between the time the patient was released from the ED and the time they were released from jail.

A 52-year-old female[61] arrived at the jail on 9/25/24 and was released on 11/1/24. Her medical history includes methamphetamine use disorder, hypertension, chronic hepatitis C infection without treatment, and poor oral health. Medications were amlodipine-valsartan. This patient was in jail for five weeks. The patient was hypertensive upon arrival and was timely treated at intake. Her history and physical took place 19 days after arrival. The provider addressed the patient's hypertension and hepatitis C infection and ordered appropriate labs, but did not order a chronic disease follow-up visit. There is no documentation that the patient received discharge medications.

Compliance Assessment:

[59] Patient #1
[60] Patient #2
[61] Patient #3

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

Recommendations:

1. The County needs to establish a mechanism for reporting reliable release dates to ACH, such that adequate discharge planning and a supply of discharge medications are provided to patients being released.
2. Establish reports that provide data analytics and proof of practice for each component of this Consent Decree requirement.
3. Evaluate and hire the necessary staff to provide discharge planning, manage the required data to demonstrate proof of practice, and comply with the Consent Decree and CalAIM.
4. The County should evaluate the release process for non-sentenced patients and implement steps necessary to ensure they receive a supply of their ordered medications upon release without posing barriers to patient access.

R. Training

1. The County shall develop and implement, in collaboration with Plaintiffs' 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.

Findings: The County has made progress in developing its required training program since the last report. Per documents provided to the monitors, the following topics have been established: Medical Issues and Universal Precautions; Medical Legal Issues; Behavioral Health interventions that include interview and de-escalation techniques, triggers of violence, interpersonal and tactical communication, rights of the mental health offender, recognition of behavioral and verbal cues that require intervention and suicide precautions; CPR and Automatic External Defibrillator.

Documentation of training on recognizing medical emergencies and acute medical needs for custody was not provided to the monitors. ACH clinical leadership may be instrumental in assisting with this. Training on relevant bias, cultural competency, and confidentiality standards was also not provided for this reporting period.

Compliance Assessment:

- R.1=Partial Compliance↑

Recommendations:

1. Develop all remaining curricula required by the Consent Decree.
2. Ensure that training is performed and documented every two years.
3. Maintain a centralized records and tracking system of staff training.

IX. Quality Assurance Systems for Health Care Treatment

C. Quality Assurance Medical Care

1. The County shall establish a Quality Assurance/Quality Improvement Unit to develop accurate tracking mechanisms and monitor the timeliness and effectiveness of the following processes of health care, ensuring that all are reviewed at least annually, and shall recommend corrective action for all deficiencies;
   a. Intake screenings;
   b. Emergent, urgent, and routine requests from patients and staff referrals for health care, including Health Service Request availability;
   c. Clinical monitoring of patients, including delivery of chronic care services to those patients who qualify as chronic care patients;
   d. Prescriptive practices by the prescribing staff;
   e. Medication verification, including the initiation of verified medications, the first doses of medications, medication errors; patient refusals, and patterns of medication administration;
   f. Grievances regarding healthcare;
   g. Specialty care (including outside diagnostic tests and procedures;
   h. Clinical caseloads:
   i. Coordination between custody staff and medical staff, including escorts to medical appointments and delivery of care.
2. The studies shall be done with sufficient sample numbers to arrive at statistically valid conclusions. The studies shall include:
   a. Clearly articulated goals, objective, and methodology to determine if standards have been met, including sample strategy;
   b. Data collection;
   c. Analysis of data to identify trends and patterns;
   d. Analysis to identify the underlying causes of problems;
   e. Development of strategies to solve problems;
   f. A written plan that identifies responsible staff and establishes a specific timeline for implementing remedies;
   g. Follow-up data collection; and
   h. Analysis to determine if remedies are effective.
3. The QA/QI Unit study recommendations shall be published to all staff.
4. The County will conduct peer review and supervisory reviews of all medical staff and professionals at least annually to assess compliance with policies and procedures and professional standards of care.

Findings: The County has established a Quality Assurance/Quality Improvement Unit and has implemented several tracking systems to facilitate monitoring the timeliness and effectiveness of some key healthcare delivery components. ACH appointed a new CQI Director and hired a Nurse Educator during this monitoring cycle. The addition of the Nurse Educator position is a step in the right direction toward building an effective CQI program.

There remain, however, several service delivery areas that require study development and implementation, e.g., chronic diseases, prescriptive practices, coordination between custody and medical staff, including escort to medical appointments.

Quality improvement (QI) studies that were accomplished during FY 2023/2024 include:

- Intake Receiving Screening-Intake Referrals(IX.C.1.a.)
- Intake Receiving Screening-Suicide Risk Assessment (IX. C. 1.a.)
- Intake Receiving Screening-ADA (IX. C.1.a)
- Health Services Requests/Access to Care (IX. C.1.b.)
- Diabetes Chronic Care (IX. C.1.c.)
- Nursing Sick Call (IX. C.1.b.)
- Medication Orders (IX. C.1.e.)
- MAT Administration (IX.C.1.e.)
- Healthcare Grievances (IX. C.1.f.)
- Specialty Services (IX. C.1.g.)

Quality improvement (QI) studies that were accomplished during FY 2024/2025 and thatwere provided to the monitors during this monitoring cycle include:

- Waste Management
- Specialty Care Referrals Nurse Intake Referrals
- Nurse Intake Suicide Risk
- Nurse Intake ADA Documentation
- Health Service Requests
- Chronic Care Diabetes Management
- Healthcare Grievances
- Incident Reports
- Medication Administration (Pill Call)
- Medication Orders

Studies that were not completed required for compliance with the Consent Decree include:

- Chronic Care Diseases-Hypertension, Asthma, HIV, Seizure Disorder, and other Chronic Diseases (IX. C.1.c.)
- Prescriptive Practices (IX.C.1.d.)
- Medication Verification, Patient Refusals, and Patterns of Administration (IX. C. 1.e.)
- Clinical Caseloads (IX. C.1.h.)
- Coordination Between Custody and Medical Staff (IX. C.1.i.)

The monitors previously recommended redesigning the QI sampling process to collect data over different days and times, rather than the “point in time” sampling methodology. ACH has changed its methodology, as demonstrated by the studies completed during this monitoring cycle (IX. C.2.b.). The studies summarized the data analysis, trends, and patterns (IX. C.2.c.).

A review of the completed studies reveals that the goals, objectives, methodology, and sample strategies are not always clearly identified (VIX. C.2.a). The sampling size is not always sufficient to arrive at statistically sound conclusions (IX. C.2). Associated corrective action plans lack specificity and often repeat previous mitigation strategies that were ineffective, e.g., education. They also lack timely follow-up and remeasure of the effectiveness of mitigation actions.

The Waste Management study sufficiently analyzed the underlying causes of noncompliance. The Specialty Care Referral study did not sufficiently identify the root causes of the identified problems. However, it did recommend the need for additional studies (IX. C.2.d.) Both studies made recommendations but did not include strategies to solve problems, identify the specific staff responsible, or establish a specific timeline for implementing remedies. Additionally, a timeframe for re-study to determine the effectiveness of planned remedies was not included (IX. C.2.e.f. and g.). The Medication Orders study, completed on 7/25/25, which studied medication orders from 1/1/24-6/30/24, used a sampling size of only 3%, which is not sufficient for statistically valid conclusions (IX. C.2).

The Grievance QI study appropriately categorizes the complaints relative to specific patient concerns but does not indicate the number of grievances that were founded in comparison to those that were unsubstantiated. The intake screening study was limited to referrals, suicide risk, and documentation of ADA needs. The requirement to study intake screening is broad and will require a comprehensive approach that considers both qualitative and quantitative measures. It will require observation of nursing staff practice to ensure that documentation aligns with the patient's presentation and subsequent nursing assessments, documentation, and actions.

ACH reports the CQI Director shares recommendations in Executive team meetings, QI Improvement committee meetings and subcommittee meetings, as appropriate. These forums are held quarterly, with QI Committee Chairs responsible for ensuring study indicators are reviewed and tracked, discussing recommendations and corrective action plans, and conducting follow-up as necessary. Audits and recommendations are published on the ACH intranet for all staff access; however, there is currently no report and analysis done for staff compliance in reviewing the information.[62](IX.C.3).

The prior Medical Director developed a peer review program, utilizing a standardized form created by an ACH provider consultant. A policy was drafted and is under review. The process includes the 0.5 Assistant Medical Director providing feedback to providers when issues are identified, including disciplinary action when indicated. The process does not provide an adequate methodology for assessing medical provider quality (e.g., too few records, annual review rather and quarterly, and sufficient record sampling strategies)(IX.C.4.).

The Consent Decree requires peer review and supervisory reviews of all medical staff and professionals to be conducted annually. ACH reports that performance evaluations are required annually for permanent County staff and more frequently for probationary staff. No data was

[62] 10th Sacramento County Remedial Plan Status Report, page 209

provided to the monitoring team demonstrating proof of practice. ACH also reported that a Utilization Nurse review tool was developed for use during chart review. It is unclear how this contributes to the peer review process of providers. Provider-specific peer review documents were not provided to the monitoring team.[63] In addition to provider peer review, a process for nursing and dental staff peer review is required for compliance with this Consent Decree component.

An effective QI program provides a solid foundation for measuring critical service delivery components of the healthcare delivery system. To adequately measure the overall effectiveness of the delivery system and compliance with the Consent Decree, each program component must be assessed at least annually, with critical components assessed more frequently (e.g., sentinel events, emergency transfers). When QI studies identify program components that are insufficient, a corrective action plan must be developed that includes mitigation steps that address root causes of problems, assigned to specific staff, with specific deadlines for completion, and a planned follow-up study to measure the success of the corrective actions. Given the challenges that remain in the ACH health services program, much work is required. When successfully executed, a comprehensive QI program provides effective tools and critical data to program leadership, serving as a guide in prioritizing program redesign and allocating resources.

Compliance Assessment:

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

Recommendations:

1. The County needs to assess the process of QI program design, study design and development, and staff involvement from study initiation to the communication of findings and required corrective action steps to all staff, regardless of their full-time equivalent (FTE) status. Establish a process that documents the receipt and review of the studies by staff. Generate a report that demonstrates proof of practice.
2. The County needs to integrate studies that have a medical and mental health overlap (e.g., medication adherence for patients with serious mental illness).
3. Develop a QI study calendar that measures compliance of each clinical and administrative component of the Health Services Program, and each component of the Consent Decree, resulting in all studies being completed in a calendar year.
4. Design QI studies required by the Consent Decree, that are outstanding, e.g., Hypertension, Asthma, HIV, Seizure Disorder, and other Chronic Diseases; Prescriptive Practices; Medication Verification, Errors, Patient Refusals, and Pattern of Administration; Clinical Caseloads; and Coordination Between Custody and Medical Staff.

[63] 10th Sacramento County Remedial Plan Status Report, page 209

5. Implement a CQI monthly audit of a random selection (30 charts) of chronic care encounters to collect, analyze and trend data.
6. For each QI study, clearly define and label the study goals, objectives, methodology, and sampling strategy to ensure sufficient analysis and statistical significance.
7. Include clinical line staff when analyzing root cause and mitigation strategies.
8. Corrective action plans must be developed for each study component that fails to meet a pre-determined threshold.
9. Corrective action plans must include the projected date of a follow-up study to determine the effectiveness of the completed mitigation and corrective action steps. Follow-up studies should be scheduled no later than 90-120 days after completion of the corrective action plan.
10. In addition to posting QI studies on the ACH intranet, proof of relevant training and documentation of each staff member's review and understanding of the corrective action plan is required.
11. Develop a peer review and supervisory review process for all medical and professional staff at least annually and provide proof of practice.
12. Create and implement a comprehensive QI Log that tracks all QI studies, corrective action plans, and QI follow-up studies.
13. Create and implement a log that tracks Supervisory Reviews and Peer Reviews for all medical and professional staff.
14. Consider sourcing technical assistance with experience in managing a carceral administrative and clinical quality improvement program.

Medical Remedial Plan Compliance Summary

	Provision	Substantial Compliance	Partial Compliance	Noncompliance	Not Evaluated
1.	A.1.		3/2025		
2.	A.2.		3/2025		
3.	B.1.	3/2025			
4.	B.2.	3/2025			
5.	B.3.		3/2025		
6.	B.4.		3/2025		
7.	B.5.		3/2025		
8.	B.6.		3/2025		
9.	B.7.		3/2025		
10.	C.1.	3/2025			
11.	C.2.		3/2025		
12.	C.3.a			3/2025	
13.	C.3.b			3/2025	
14.	C.3.c		3/2025		
15.	C.3.d		3/2025		
16.	C.4.		3/2025		
17.	C.5			3/2025	
18.	C.6.	3/2025			
19.	C.7.a			3/2025	
20.	C.7.b			3/2025	
21.	D.1.			3/2025	
22.	D.1.a		3/2025		
23.	D.1.b		3/2025		
24.	D.1.c			3/2025	
25.	D.1.d		3/2025		
26.	D.2.			3/2025	
27.	D.3	3/2025			
28.	E.1.		3/2025		
29.	E.2.		3/2025		
30.	E.3.			3/2025	
31.	E.4.		3/2025		
32.	E.5		3/2025		
33.	E.6.		3/2025		
34.	E.7.			3/2025	
35.	E.8.	3/2025			
36.	E.9			3/2025	
37.	E.10.		3/2025		
38.	F.1.a	3/2025			

	Provision	Substantial Compliance	Partial Compliance	Noncompliance	Not Evaluated
39.	F.1.b		3/2025		
40.	F.2.		3/2025		
41.	F.3.		3/2025		
42.	F.4.		3/2025		
43.	F.5.		3/2025		
44.	F.6.	3/2025			
45.	G.1.		3/2025		
46.	G.2.			3/2025	
47.	G.3.		3/2025		
48.	G.4			3/2025	
49.	G.5	3/2025			
50.	H.1.		3/2025		
51.	H.2.		3/2025		
52.	H.3.		3/2025		
53.	H.4.	3/2025			
54.	I.1.		3/2025		
55.	I.2.		3/2025		
56.	I.3	3/2025			
57.	J.1.		3/2025		
58.	J.2.		3/2025		
59.	J.3.		3/2025		
60.	J.4				3/2025
61.	K.1	3/2025			
62.	L.1.		3/2025		
63.	L.2.	3/2025			
64.	L.3.		3/2025		
65.	M.1.	3/2025			
66.	M.2.		3/2025		
67.	N.1.		3/2025		
68.	N.2.			3/2025	
69.	O.1.		3/2025		
70.	O.2.		3/2025		
71.	P.1.			3/2025	
72.	P.2.			3/2025	
73.	Q.1.		3/2025		
74.	Q.2.			3/2025	
75.	Q.3.		3/2025		
76.	R.1.		3/2025		
77.	IX C.1		3/2025		
78.	IX C.2		3/2025		

	Provision	Substantial Compliance	Partial Compliance	Noncompliance	Not Evaluated
79.	IX. C.3		3/2025		
80.	IX. C.4			3/2025	
	Total	**14 (18%)**	**46 (57%)**	**19 (24%)**	**1 (1%)**