Fourth Monitoring Report of the Medical Consent Decree

Mays et al. v. County of Sacramento

Case No. 2:18-cv--02081

Submitted
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FINAL

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Contents

Introduction

On July 31, 2018, Plaintiffs Lorenzo Mays, Ricky Richardson, Jennifer Bothun, Leertese Beirge, and Cody Garland filed a federal class action complaint[1] alleging that Defendants failed to provide minimally adequate medical and mental health care to incarcerated persons in its jail, 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 a Consent Decree and Defendants agreed to implement measures set forth in a Remedial Plan to be monitored by court-appointed Court Experts.[2] On January 13, 2020, the Consent Decree was approved by the federal court. 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, Defendants' 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 Defendants.

We thank Noel Vargas, Deputy Director of the Department of Health Services, Primary Health Division, Stephanie Kelly, Health Services Administrator, and Deputy Chief Dan Donelli, Sacramento Sheriff's Office, 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] Madeleine LaMarre MN, FNP -BC and Angela Goehring are the Medical Experts. Mary Perrien is the Mental Health Expert. Lindsay Hayes is the Suicide Prevention Expert.

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 measure compliance more accurately 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 have utilized such a system in prior federal court monitoring assignments. As such, the court-appointed experts agreed to the following definitions for compliance measurement for each of the provisions in this Remedial Plan:

Substantial Compliance: Defendants have achieved compliance with most or all components of the relevant provision of the Consent Decree for both the quantitative (e.g., 90% performance measure) and qualitative 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 will have 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 for each provision is that relevant policies and procedures must be compliant with Remedial Plan requirements; they 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 that 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 double cells with solid doors, and some single cells. As of 6/27/23, Main Jail population was 1,798, 75% of the official 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 6/27/23 RCCC population was 1,484, or 91% of rated capacity.

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

Due to the age of the jails, they were not designed for health care and are not compliant with the American with Disabilities Act (ADA) or Health Insurance Portability and Accountability Act (HIPAA), which were enacted at later dates. The County is planning to renovate Main Jail to provide a new acute psychiatric unit, and construct an Intake and Health Services Facility (IHSF) medical building to become compliant with the Consent Decree.

Executive Summary

The Monitors conducted an on-site tour at Sacramento County Jail from March 20 to March 23, 2023. We express our appreciation to the County for the level of cooperation, transparency, and engagement during, and following the site visit.

We particularly thank Noel Vargas Deputy Director, Primary Health Services, Stephanie Kelly, Health Service Administrator, Nicole Harper, Quality Improvement Director, Tianna Hammock, Quality Improvement and Compliance Coordinator, Scarlett Ong, Interim Chief of Nursing, Mike Wanless, Pharmacist in Charge, Veer Babu, Medical Director, and Lieutenant Branden Culp, Jail Division Compliance Commander.

The timeframe for completion of this report was extended to permit the County to submit documentation of progress following the March 2023 site visit. This review showed meaningful progress on Consent Decree requirements. Twenty-five (25) provisions were found to be in substantial compliance, an increase of 12 provisions since the Third Mays Report; and 25 provisions were in partial compliance, an increase of 3 provisions. Twenty-five (25) provisions remain in noncompliance. Although COVID-19 is no longer a major impediment to access to care, the County has made this progress under extremely challenging conditions and is to be commended for significantly improving compliance.

Substantive Area	Total Provisions	Substantial Compliance	Partial Compliance	Non-Compliance	Not Evaluated
Medical	**75**	**25 (33%)**	**25 (33%)**	**25 (33%)**	**0 (0%)**

However, as noted in previous monitoring reports, this review showed persistence of *critical* issues that impact access to- and quality of care that resulted in serious harm to patients, and places the inmate population at risk of harm if not immediately addressed. These include:

- Insufficient health care staffing;
- Insufficient custody staff dedicated to health care delivery;
- Lack of patient access to care, including custody barriers to care;
- Lack of evaluation of medical care quality, including mortality reviews;
- Lack of timely access to specialty services and implementation of recommendations;
- Failure to deliver ordered care (e.g., cancellation of medication administration);
- Inadequate evaluation, treatment, and monitoring of patients with substance use disorders;
- Lack of a Medication Assisted Treatment (MAT) program to induct patients on suboxone or other treatment;
- Inadequate treatment space and environment of care.

These issues are described below.

There are insufficient health care staff to meet Consent Decree requirements.

The County continues to implement a multi-year staffing plan and has had success at hiring medical providers either full- or part time, as well as registered nurses. However, there continues to be insufficient nursing and ancillary staff to meet Remedial Plan requirements. The lack of staffing has resulted in serious consequences, including lack of patient access to nurse sick call, cancellation of medication administration, failure to conduct substance use withdrawal monitoring, delays in laboratory draws, and delays in scanning documents into the electronic health record (EHR). Lack of staffing in health information has also resulted in providers and nurses not having timely access to emergency department (ED), hospitalization, and specialty services reports so that recommended diagnostic testing and treatment could be implemented.[3] The County needs to take immediate action to provide adequate staff to carry out critical health care functions.

There are insufficient custody staff to provide timely access to care.

Since the Second Mays Report, the monitors recommended that the County perform an analysis of essential health care functions requiring custody escorts to identify the numbers of deputies needed to provide timely access to care, 24 hours, 7 days per week. Custody positions for health care delivery need to be established as posts that cannot be diverted to other, non-medical operations.

A staffing analysis has not been performed, and although custody has submitted growth requests for other needs, it has not included staff to be dedicated to health care operations, including medical transport staff. This has been a major factor contributing to lack of patient access to care. Record review shows multiple instances in which deputies were not available to escort patients to medical and mental health appointments. Nurses are unable to perform ordered medical care, such as withdrawal monitoring and medication administration, because routine, daily operations such as chow, laundry, and commissary are prioritized above medical and mental health care.

In addition, we found that custody obstructs access to care by denying patients access to medical appointments. There were many instances in which custody informed providers and nurses that they were not permitted to see patients due to lack of escorts, "behavioral issues," or because unspecified activities were taking place in the housing unit. In one case, custody refused to allow a pregnant woman to attend her obstetrical appointment because the patient "had a fight last week and could not come out of her cell." [4] This is obstructing access to medical care and should never occur. *This has been pointed out in previous reports but continues to occur.*

[3] The Adult Correctional Healthcare (ACH) responded that nursing leadership has established a contingency plan to administer medications in the event of a staffing shortage. Nursing leadership has also created a new team of medical assistants (MAs) and licensed vocational nurses (LVNs) to perform blood draws under the direction of the Infection Control and Prevention Coordinator. In addition, the County has established a committee focused on lab processes, reports, and productivity.

[4] Patient #13 and #9.

While it is understood that custody is responsible for safety and security of the institution, it is the role of custody to *facilitate* appointments taking place, not prevent them. When behavioral issues are a factor, medical and mental health staff need to be consulted. These occurrences need to be escalated up the health care and custody chains of command in real time to resolve the situation and provide patient access to care.

Daily medical operations include transports to the emergency department, hospital, and specialty services. Custody shift reports show that as many as 10 patients are transported daily for medical reasons. Each transport requires two deputies who may not be available for the remainder of the shift. Deputies are reassigned from the floors to transport patients, and are *not available for escorting patients to health care appointments and other medical operations.* Custody shift reports also show that the jail is operating below minimum staffing.

Sometimes custody does not transport a patient to the hospital when ordered by a medical provider. In one case, a physician ordered that the patient be transported to the emergency department for a brain CT. Custody advised that there was no van to transport the patient.[5] Fortunately, the patient was sent the next day and suffered no harm, however the situation could have resulted in an adverse outcome.

Custody unilaterally reschedules specialty services appointments due to staffing issues, but does not consult Case Management to determine if the appointment can be safely delayed. This has resulted in delayed diagnosis and treatment which has harmed patients.[6]

Since the March 2023 site visit, Sacramento County Sheriff's Office (SSO) has been working with Adult Correctional Healthcare (ACH) to provide deputies that are dedicated to health care operations, ranging from 2 to 5 deputies. Although this deputy allocation is a modest step in the right direction, this allocation of deputies is clearly insufficient to provide access to care for all health care operations.

In summary, the County Sheriff's Department needs to *immediately* provide sufficient custody staffing to provide timely access to care for both daily health care operations and medical transports to the emergency department, hospital, and specialty services. ACH needs to ensure that all transports are medically necessary.

The County has not conducted timely medical screening for newly arriving inmates.

In late July 2023, the monitors became aware that the County was not conducting timely medical screening for newly arriving inmates. Upon arrival, nurses conducted pre-booking (Tier 1)

[5] Patient #5.
[6] Patient #1.

screening to determine fitness for confinement (FIT), and if the patient was found to be fit, the arresting officer was released. Tier 2 medical screening (Tier 2) was to be conducted "as soon as possible" and "without delay" to ensure that emergent and urgent needs are met.[7] The County proposed a pilot program to delay Tier 2 screening until custody determined whether the arrestee would be released. However, this was predicated upon all new arrivals remaining in the booking loop and rapid determination by custody of whether inmates would be released, so that Tier 2 medical screening could take place.

However, review of two recent deaths showed that inmates were being taken out of the booking loop and processed by custody before medical screening took place.[8] Data was provided to the monitors that showed that during the weeks of June 25 and July 2, 2023 the average time to complete medical screening was 10 and 13 hours, respectively. Data also showed that no Tier 2 screening was performed for 17% to 41% of new intakes, presumably due to being released however it is unknown how long inmates patients were at the jail before they were released without medical screening. *There are 7 inmates still at the jail who had not yet had an intake screening at the time of this report, some who have been at the jail for more than a month. That this was occurring is alarming.*

Upon learning of the delays in medical screening, the Monitors contacted the parties, and following joint discussion, the County agreed to medically screen all newly arriving inmates upon arrival, without delay, and prior to the start of the booking process.[9] We request that the County continue to monitor the timeliness of medical intake screening and report to the monitors and the parties on a monthly basis. This provision of the Consent Decree was downgraded from substantial compliance to noncompliance due to extended delays, and in some cases, no medical screening being conducted for newly arriving inmates.

The County does not provide patients timely access to care for their serious medical needs.

Inadequate health care and custody staffing, and lack of clinical examination space has resulted in lack of access to care, resulting in provider and nursing appointment backlogs. At the time of the March site visit there were 391 pending nurse sick call and 244 pending medical provider appointments at Main Jail.

Currently, Health Services Requests (HSRs) are date and time-stamped upon receipt and provided to a Supervising Registered Nurse (SRN). The SRN triages all health services requests (HSR) for emergencies. The SRN then triages medical HSRs for urgent or routine disposition, but does not

[7] Standards for Health Care in Jails. 2018. J-E-02. National Commission on Correctional Health Care (NCCHC).
[8] Patients #38 and #39. The length of time to conduct Tier 2 medical screening was 5.5 hours for each of the patients. The cause of death for these two patients is unknown, and it is not possible to determine whether delays in Tier 2 medical screening contributed to their deaths.
[9] On 8/11/2023, the County committed to reestablishing the previous practice to conduct Tier 1 screening, followed by Tier 2 screening without delay.

triage mental health and dental HSRs.[10] The HSRs are forwarded to dental and mental health staff to triage. However, mental health and dental staff do not date, time and sign the HSRs, nor document the urgency of HSR. As a result, Adult Correctional Healthcare (ACH) Continuous Quality Improvement (CQI) studies were unable to determine the timeliness of mental health or dental HSRs. In the short term, this can be remedied by having the SRN conduct the initial triage for *all* HSRS, and forward them to mental health and dental staff to conduct secondary triage.[11] This step would not delay dental or mental health triage and access to care.

ACH has revised the Health Services Request policy and plans to fully implement it soon. It involves the SRN triaging all HSRs for emergencies, and then staff are to scan the HSRs into an electronic folder for each discipline to triage and schedule the patient in accordance with their acuity. ACH reports that this will allow monitoring timelines for each step of the process and to measure compliance with ACH policy and the Consent Decree. Until the new policy is implemented, dental and mental health staff need to timely review and document the date and time of triage, triage disposition, along with a legible signature and credentials. This is not currently happening.

Currently, nurses are not provided all-day access to examination rooms to perform nursing assessments. At the time of the site visit, nurses conducted cell-side assessments to identify patients with urgent conditions or address patient's minor complaints. However, cell-front screening risks missing patients with serious medical conditions because the nurse cannot perform a confidential interview, properly examine the patient, and does not have access to the electronic health record (EHR). Cell-front screening does not meet the requirements of the Consent Decree and demonstrates lack of adequate clinical space at the jail. Because nurse sick call is the *primary point of patients access to care*, it must be prioritized along with provider sick call. ACH reports that nurses now conduct sick call-in examination rooms at 4 pm when not occupied by a physician, however delaying sick call until 4 pm means that there is no provider on-site to see the patient if needed. This may result in preventable emergency department send-outs using scarce custody resources. *Nursing sick call needs to be integrated into the daily clinic schedule to ensure timely access to care.*

The County proposes a short-term plan to increase clinic space for nurse sick call and mental health interviews, which is to construct examination and interview rooms in the housing units. These examination rooms need to be properly equipped and supplied and provide privacy in order to meet the Consent Decree.[12]

The County has not consistently provided patients medically ordered treatment. In the two weeks prior to the site visit, medication administration was cancelled twice at Main Jail, resulting in *all* patients not receiving their medications, including critical medications such as insulin,

[10] Except for dental HSRs on weekends and holidays.

[11] ACH needs to ensure that SRNs triage dental requests and see patients with complaints of infection or pain on weekends and holidays.

[12] The County reports it has purchased "pop-up" interview rooms and has determined their locations, and reports that it has purchased iPads to be placed in clinics for virtual visits with providers.

antibiotics, HIV, and mental health medications. Record review also showed previous blank spaces on the medication administration record indicating that nurses did not administer medication for those doses. A patient with right thumb and arm cellulitis missed more that 50% of the two antibiotics prescribed for him, which went unnoticed by nurses and medical providers.[13] Patients not receiving ordered medications is unacceptable, severely impacts the effectiveness of the prescribed treatment plan, and should never occur.

Following the site visit, ACH and SSO collaborated to conduct additional nurse and provider clinics including on weekends. This reduced the backlogs, but unless other strategies are implemented, they are likely to recur. We recommend increasing provider productivity to prevent future backlogs as well as providing nurses access to exam rooms *during daytime hours*. *In addition, the County needs to monitor to the contingency plan to ensure delivery of services when there are critical staff shortages.*[14]

The County is not providing timely patient access to specialty services, resulting in delayed diagnosis and treatment.

Review of medical records and the specialty services tracking log show systemic issues with respect to timeliness of specialty services appointments. Review of the tracking log also showed that 99% of all consults were designated as routine priority, when some patients clearly required urgent priority. This included patients with complex fractures, chest pain, hypertensive emergencies, and imaging for cancer.[15]

During the site visit, the Monitors learned that Custody Transport at Main Jail and RCCC schedules all outside medical appointments, which has resulted in significant delays in access to care, and serious harm to patients. This arrangement, not described in policy, is a legacy practice in place since before ACH provided medical care at the jail. *Case Management, who understands the medical needs of the patient and urgency of the referral, needs to schedule all specialty services.*

Custody Transport schedules and *unilaterally* reschedules appointments based upon the availability of deputies and transport vans. *Under this arrangement, the County cannot ensure that patients are scheduled in accordance with their serious medical needs.* For example, a patient suffered a complex fracture in November 2022, and in December an orthopedist recommended surgical repair as soon as possible. Subsequently, a surgeon did not see the patient until March 2023. At that time the patient was informed that his bones had healed incorrectly, requiring more complicated surgery to correctly align the bones, and restore function.[16]

[13] Patient #5.

[14] ACH reports that a contingency coverage plan has been developed for staffing shortages.

[15] The designation of routine versus urgent appeared to be based on how soon the appointment could be scheduled and not the clinical needs of the patient.

[16] Patient #1. The monitors contacted ACH in December regarding this case and urged close follow-up to ensure timely care.

When Custody Transport schedules appointments, deputies have daily access to Protected Health Information (PHI), in violation of HIPPA[17] and the Consent Decree. The monitors toured the Custody Transport office and found specialty services requests needing to be scheduled lying on the desk, visible to staff coming in and out of the office. This is further addressed in the Utilization Management section of this report.

Following the monitors site visit, the County agreed that Adult Correctional Healthcare (ACH) would assume responsibility for scheduling all specialty services appointments and has completed this for RCCC. However, Case Management is currently not resourced to meet the demand for scheduling Main Jail appointments, which involves coordination with hospitals, specialists, and custody transportation, as well as scheduling on-site specialty appointments, tracking receipt of hospital, emergency department and specialty reports, and monitoring the specialty services tracking log. The need to meet specialty services time frames required by the Consent Decree requires additional Case Management and custody transport resources including ADA compliant vans[18]. Case Management has received an additional Case Management nurse; however, this allocation is insufficient to meet the demand to provide timely specialty services. Lack of timely access to specialty services is a critical issue. *The County to needs to immediately conduct an analysis of resource needs and expedite requests for Case Management and custody resources so that ACH can assume responsibility for all scheduling by October 1, 2023.*

As noted in previous reports, record review showed that in many cases medical providers did not timely review consultant recommendations and develop a treatment plan, which delayed diagnosis and treatment.[19] This has been noted in previous reports, but the County has not provided sufficient medical oversight of specialty services to ensure that patient appointments are consistent with the patient's medical needs, assess whether providers timely see patients and address consultant recommendations, and timely monitor the patient until the desired clinical outcome is achieved.

The County is challenged by the limited availability of some specialty services, and some hospitals and specialists will not see prisoners. This will require the County to pursue contracts with other specialists, and allocate additional funding for specialty services contracts if necessary. As some specialists will more readily treat patients via telemedicine, consider implementing telemedicine soon. As the County makes plans to construct the new Intake and Health Services Facility (IHSF), allocate dedicated space for telemedicine expansion, which can help to reduce transports to outside specialists.[20]

[17] Health Insurance Portability and Accountability Act (HIPPA).
[18] Americans with Disability Act (ADA).
[19] Patient #3.
[20] CDCR has an extensive telemedicine program. ACH may wish to consult CDCR regarding their program.

The County has not conducted evaluation of medical care quality, including mortality reviews.

The Consent Decree provision A.2. requires that: "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."

In the over 3 years since the Consent Decree has been in effect, the County has not developed and implemented any system for evaluation of medical care quality to ensure that it meets contemporary standards of medical care. In the third monitoring report, Dr. Karen Saylor noted lapses of medical care, which are persistently found during this review.

Medical record review shows that many providers conscientiously address patient's serious medical needs. However, there are other providers who appear to be responsible for multiple lapses in care, and preventable emergency department visits. These are noted in case reviews attached to this report. [21]

The chronic disease program has been implemented, but some medical providers do not evaluate chronic diseases at each visit. In some cases, providers do not conduct any evaluation of a chronic disease. They assess the condition (e.g., asthma) as being in good control without any supporting clinical information. A systems issue is that no provider seems to "own" the patient, to provide continuity of care. For example, one medical provider may order a consultation (e.g., cardiology), but the providers who see the patient thereafter do not consistently monitor timeliness of scheduled consultations and intervene if delays will cause harm to the patient. Providers also do not consistently monitor whether consultant recommendations timely reviewed and implemented. [22]

The mortality review process has improved with respect to identification of system or nursing issues. *However, identification and evaluation of medical care quality is virtually absent, even in mortality records that show multiple lapses in care (See Mortality Review Section).* Corrective action plans are exclusively devoted to system and nursing issues, not medical care quality issues.

Without regular and meaningful evaluation of medical care quality, lapses in medical care quality will not be timely identified, addressed, and corrected. Patients will continue to suffer preventable harm.[23] This has been a persistent issue throughout monitoring resulting in adverse

[21] The Medical Director believes that only 2 of 37 records showed lapses of medical quality. This report, as well as the appendix with detailed case reviews shows multiple lapses in care in many records.
[22] ACH Providers may not agree with some consultant recommendations. In these cases, providers need to address each recommendation and document the rationale for not implementing consultant recommendations and develop an alternate treatment plan for the patient's condition.
[23] The County responded that our review showed medical quality issues in only 2 of 37 records, however this review showed multiple medical care quality issues that are described in the body of this report and in Patient Case Reviews, submitted as an attachment.

patient outcomes. *The County needs to immediately develop a plan to address the lack of medical quality monitoring.*

The County has not provided patients at risk of, or experiencing substance use withdrawal timely treatment and monitoring.

At intake, nurses did not consistently take complete alcohol and drug use histories, this resulted in failure to recognize patients that were at increased risk for severe withdrawal, and who required treatment to be initiated at intake.[24]

Nurses referred patients with substance use disorders to a medical provider, but providers did not consistently evaluate and treat the patient. In one case, a patient was actively withdrawing but the provider did not address the patient's substance use history and evaluate the patient. An hour later, a RN ordered treatment according to a Standardized Nurse Procedure (SNP) due to high alcohol and opioid withdrawal scores. [25]

Nurses did not conduct withdrawal assessments[26] in accordance with patients clinical needs and Consent Decree requirements, even on the newly established detox unit. Withdrawal monitoring is a medical order that needs to be carried out, and like any medical order, if nurses are unable to complete the order, they need to document in the electronic health record (EHR) that it was not done, and the reason why.[27, 28]

Contributing factors for lack of timely monitoring include insufficient nurse staffing and custody escorts, and lack of nurses access to patients. At times, nurses go to units to conduct withdrawal assessments, and are prevented from doing so because custody staff prioritizes daily operations (e.g., chow, laundry) above providing nurses access to patients. This is dangerous, as patients may develop worsening withdrawal symptoms, which can result in severe dehydration, seizures, and death. Record review showed that multiple patients were sent to the emergency department to receive Intravenous (IV) fluids for withdrawal-related dehydration.

Because the County has been unable to reliably conduct withdrawal monitoring, the monitors recommend that fixed dose treatment be initiated at intake for all patients with a history of severe

[24] If the patient is unable to provide the information due to being intoxicated or mentally ill, nurses need to reattempt to get the information within 2 hours of arrival.
[25] Patient #21.
[26] CIWA for alcohol and benzodiazepines and COWS for opioid withdrawal.
[27] If nurses are unable to conduct withdrawal monitoring, the nurse needs to escalate the matter up the chain of command.
[28] ACH reports that they have dedicated one RN to oversee the MAT program, and who will provide oversight on all nurses assigned to the floor and clinical areas. The detox and MAT program will require increased staffing due to the volume of patients and requirements of an adequate program.

alcohol, benzodiazepine, and opioid use disorders to prevent worsening withdrawal.[29, 30] *This is a critical patient safety issue.*

A significant improvement is that the County has established a substance use detoxification (detox) unit at Main Jail for patients needing withdrawal treatment and monitoring. The County is to be commended for establishing this unit. However, the County needs to develop and implement the full spectrum of a detox program that include nursing, medicine, mental health, substance use counseling, enrollment into medication assisted treatment (MAT), and discharge planning to link the patient with community resources. The Monitors have provided contact information to jails that have developed successful detox units. In the interim, the County needs to ensure that providers timely evaluate patients following admission, and nurses conduct withdrawal rounds and implement treatment in accordance with standardized procedures.[31]

In early July, two patients died on the detox unit. Although the causes of death are unknown, record review showed that for one patient housed on the detox unit, nurses did not conduct any withdrawal monitoring during the six days prior to his death. Health care leadership must provide adequate supervision to be aware in real time that monitoring is not taking place and to intervene to ensure that withdrawal monitoring is conducted. To that end, the County submitted an updated flow chart for substance use withdrawal monitoring that the Monitors are currently reviewing and will provide feedback to the parties.[32]

The County has not provided access to Medication Assisted Treatment (MAT).

Medical record review and patient interviews show that inmates have free access to opioids and other drugs, including fentanyl.

During our March site visit, three inmates overdosed on 7 West, with one experiencing cardiac arrest.[33] In April 2023, an inmate died while in a holding cell after ingesting a substance, and as noted above, in July 2023, two patients died in the detox unit. Although the cause of the deaths is unknown, fentanyl overdose is suspected. [34]

[29] The Medical and Nursing Directors need to establish criteria of when not to initiate fixed dose treatment at intake, including contraindications.
[30] The monitors recognize this will increase the volume of medication administration.
[31] On 7/2/2023, a patient was admitted to the detox unit with alcohol and opioid substance use disorder but nurses did not monitor the patient for the six days the patient was in the unit. The patient died on the morning of 7/8/2023. The cause of death is not yet known.
[32] For two detox flow sheets, the County indicates that nurses conduct twice daily monitoring for patients at risk of withdrawal but noting also noting that for patients at risk of alcohol withdrawal monitoring will be conducted twice daily x 48 hours, then once daily for 5 days. The Consent Decree requires twice daily monitoring a minimum f 5 days (and more frequently as clinically indicated).
[33] Thanks to rapid response by custody and health care staff, the patient was resuscitated.
[34] Patients #22, #38, and #39. The cause of death for these patients is unknown, however patient #39 was taken to the ED for reportedly swallowing fentanyl, just prior to being booked into the jail.

Record review showed that one patient at RCCC was detoxing from drugs for almost 5 months with persistent nausea and vomiting and 50- pound weight loss. There is no detox unit at RCCC, although the need for one is clear, given the availability of opioids. The patient was sent to the Emergency Department (ED) for Intravenous (IV) fluids. The patient expressed an interest in medication assisted treatment but it was not available at the jail at that time.[35]

The County has recognized the need to implement a MAT program, and following the site visit, made plans to implement the program in phases beginning in July 2023. The County is fortunate to have Dr. Jacqueline Abdalla, a MAT experienced physician who can provide expertise and guidance regarding implementation of the program, including prioritization of patients for treatment. In addition to a detox unit, the County is establishing a (MAT) housing unit for patients prescribed suboxone. These new units should promote monitoring, medication adherence, and reduce hoarding and bartering of suboxone.[36]

The County also plans to place Narcan in housing units and strategic locations around the jail for ready access in the event of patient overdose, but the plan has not yet been implemented, and needs to be prioritized.[37]

The environment of care at the jail is inadequate to enable the jail to provide constitutional health care and meet Consent Decree Requirements.

There have been physical plant improvements in the booking area and 2 Medical, however the facility still lacks adequate clinic space for health care staff to evaluate patients. There is no functional respiratory isolation room, which will not be remedied until construction of the Intake and Medical Services Facility (IMSF).

Following publication of the *Main Jail Capacity to Meet the Consent Decree Report*[38] and *Sacramento County Jail Study Report*[39], the County developed plans to implement recommendations to reduce the inmate population and remedy physical plant deficiencies. On 12/8/22 the Sacramento Board of Supervisors approved a two-tiered approach that included steps to achieve population reduction and remedy space issues consistent with consultant recommendations. This includes construction to create an acute psychiatric unit (APU) and to build a new Intake and Health Services Facility (IHSF). This plan is anticipated to take years to implement and will require interim measures to meet Consent Decree requirements.

[35] Except for pregnant patients and those already on treatment.
[36] Patient #10 reported that he was taking suboxone, he was not prescribed the medication.
[37] Some correctional systems provide correctional staff Narcan as part of their equipment, that they wear on their belt (e.g., Cumberland County Jail in Portland Maine).
[38] Main Jail Capacity to Meet the Consent Decree Report Nacht&Lewis. March 31, 2022
[39] Sacramento County Jail Study. Kevin O'Connell. May 2022.

Conclusion

During this monitoring period, the County has made meaningful progress toward Consent Decree compliance. However, critical issues remain that place patients at continuous risk of harm. The County needs to immediately provide additional health care and custody resources at the jail. We also believe that health care leadership needs to provide increased and real time supervision of critical processes, to achieve progress toward providing patients timely and appropriate health care, and to meet Consent Decree requirements. The monitors are available to work with the County towards the goal of improved health care and full Consent Decree Compliance.

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: The County has not yet provided and maintained sufficient medical, mental health and custody staffing to meet professional standards of care, and 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 (A.1.).

The County has made progress to establish new positions, and conduct staff recruitment and hiring. The County has increased positions for medical staff from 118.5 FTE's Pre-Consent Decree in FY 2107/18, to 217.5 FTEs in FY 2022/23. County ACH medical and administrative staff has increased to 239.5 permanent allocated FTEs.

With respect to health care staffing, the January 2023 vacancy report showed an overall vacancy rate of 29%[40] that by May 2023 has been reduced to 24%.[41]

The vacancy rate for registered and licensed vocational nurses is 31% (41 of 134 FTEs vacant). Nursing vacancies (and call-ins) have resulted in inability to carry out basic health care operations such as medication administration, substance use withdrawal monitoring, and nursing sick call. Due to lack of staffing, space, and custody escorts, RNs cannot meet the demand for nurse sick call, a critical point of access to care. At the March site visit, there were 391 pending nurse sick call appointments at Main Jail. ACH conducted weekend "blitzes" to bring down the backlog, and on 6/24/23, there were 217 pending appointments at Main Jail and 215 at RCCC. While improved from March, it is still an unacceptably high backlog.

The medical provider (physician and nurse practitioner) vacancy rate is 54% (7 of 13 FTEs vacant). The County has filled 8 physician FTE's this fiscal year. The Medical Director has recruited

[40] 68 of 233.5 FTEs vacant.
[41] ACH Remedial Plan Medical Provision Status Update, 5/18/23

physicians to work part time and provide on-call services. An Assistant Medical Director position's salary was recently updated by the Department of Personnel Services (DPS) to include a differential, and the position will be available for recruitment by the end of the fiscal year.

Provider productivity sheets for April to May 2023, show that between 16 to 21 providers worked at the jail.[42] Providers work from 7 am to 3:30 pm, with some providers working limited hours on weekends.

Providers are scheduled to see 12 patients per clinic day, or 1.5 patients per hour.[43] ACH data from March 2023 through May 2023 shows the number of patients seen each month, and average number of patients seen daily. These are noted below.

- In March 2023, provider productivity ranged from 0.7 to 1.8 patients per hour. Nine of 21 providers saw 1.2 or less patients per hour. Average provider productivity per hour was 1.35.
- In April 2023, provider productivity ranged from 1.0 to 2.0 per hour. Average provider productivity was 1.4 per hour.
- In May 2023, provider productivity ranged from 1.2 to 1.9 patients per hour. Average productivity per hour was 1.57 patients per hour.

This level of productivity has not enabled the County to meet the health needs of the population. At the monitors site visit in March 2022, there were 244 pending medical provider appointments. Following the site visit, ACH and SSO staff worked on weekends to bring down the backlog, and as of 6/23/23, there were 72 pending appointments at Main Jail, and 67 pending provider appointments at RCCC. The County is to be commended for reducing the provider back logs, but to prevent recurring backlogs, custody escorts and provider productivity needs to increase.

We recommend that scheduled provider appointments be increased to 3.0 patients per hour, and then revaluate productivity after 3 months, relative to provider backlogs.

All medical providers are assigned to work from 7 am 3:30 pm, which leaves the jail without on-site medical provider coverage for 16 hours. We understand that the Medical Director is exploring expanding provider coverage by assigning shifts that cover evenings. We strongly support this strategy, as there would be providers on-site to evaluate patients with urgent conditions, and possibly reduce send outs to the ED.

Consider hiring nurse practitioners or physician assistants (preferably with suturing skills) to work 4 ten-hour shifts, or 3 twelve-hour shifts to provide evening and weekend coverage.

[42] ACH Provider Productivity Reports for March, April, and May 2023.

[43] For comparison, at another county jail in California of comparable size and population, medical providers are scheduled 10 patients per 4-hour morning clinic or 4-hour afternoon clinics.

Health care staff productivity is negatively impacted by lack of custody staffing. We spoke to a medical provider who had been waiting 2 hours to see a patient, and another who reported in midafternoon that she had seen only 5 patients up to that time. A nurse was delayed conducting alcohol and drug withdrawal monitoring, due to lack of a custody escort to see patients.

With respect to custody staffing, the County provided a sample of duty rosters for 11 days in October and November 2022, and March 2023, that included emergency department/hospital transports. The intent of the monitors' review was not to analyze the adequacy of custody staffing, which is beyond our expertise, but to understand Sacramento Sherriff's Office (SSO) determinations of the *minimum* custody staffing needed each shift, the *authorized* staffing for the shift, and the *actual* numbers of deputies working each shift. These rosters show that the *actual* number of custody staff was consistently less than *minimum* staffing SSO determined was needed to operate the jail. SSO utilizes overtime and a pool of retired annuitants to fill vacancies below established minimum post numbers, however there remain shifts in which the number of available deputies still falls beneath the minimum requirement. This significantly contributes to the lack of custody escorts for health care operations.

The duty rosters included the number of patients sent to the emergency department and patients admitted to the hospital. On some days, there were as many as 10 medical transports to the hospital. Each transport or admission requires two transport deputies per patient that are sometimes pulled from other jail posts, which also negatively impacts access to care. The County needs to provide adequate staffing for jail operations and emergency transports. ACH needs to ensure that all emergency department send outs are medically necessary.

As noted earlier in this report, access to health care is also negatively impacted by custody prioritizing other routine activities (e.g., chow, laundry), above medical activities (e.g., transporting patients to appointments, conducting substance use withdrawal monitoring etc.). Custody needs to adopt in policy and practice that health care services are an *essential component of daily operations that must continue throughout the day.*

On 3/30/23, following our site visit, the monitors sent a letter to the County outlining the critical issues that either have caused harm, or place patients at risk of harm, with recommendations for immediate remedial actions. Included in the list of critical issues was lack of patient access to care due to inadequate number of deputies dedicated to health care operations. *As in previous monitoring reports, we recommend the County perform an analysis of all health care functions requiring custody escorts, including transports for specialty services and emergency department run, to determine the total number of custody FTEs needed in each 24-hour period. Subsequently, the County needs to submit growth requests specifically for deputies dedicated to health care operations.*

In response to our 3/30/23 letter, ACH and SSO at Main Jail collaborated to reassign on-call deputies to the compliance unit during the week to provide escorts, and additional on-call

deputies are being reassigned to provide medical escorts.[44] Daily staff huddles include the number of deputies assigned to health care operations and range from 2-5 deputies.[45] While this is a positive step forward, this allocation of deputies is insufficient to meet the current demand for health care services. *SSO needs to provide sufficient custody escorts needed for health care operations can be completed.*

In summary, the County has insufficient nurse and custody staffing. While medical provider staffing appears to be adequate, provider coverage and productivity needs to increase to meet the demand for services. These factors create barriers to patients access to care which results in delay in access and treatment for patients with serious medical needs. (A.1).

The Consent Decree provision A.2 requires that: 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.

During this monitoring period the County did not conduct regular evaluation of provider quality as required by the Consent Decree (A.2). This review showed the following types of issues related to medical quality:

Providers did not:

- Review the patient's medication regimens at intake nor document the rationale for not continuing the patient's medications.[46] This resulted in undertreatment of a patient's condition (e.g., diabetes).[47]
- Conduct evaluations of patients with substance use disorders referred from intake.[48]
- Timely review and address emergency department and hospital recommendations, even though the information was available in the electronic health record (EHR). This caused delays in diagnosis and treatment. [49]
- Evaluate patients with chronic diseases in accordance with published standards of care.[50]

In addition, to these findings the monitors found that:

[44] ACH Remedial Plan Medical Provision Status
[45] See Huddle reports from 4/6/23 to 5/23/23.
[46] The monitor recognizes that there are legitimate reasons for providers to not continue a patient's medication regimen at intake, however, providers need to address the patient's prescribed medications and document the reason for not continuing certain medications and/or dosages.
[47] Patient #8
[48] Patient #21.
[49] Patient #5
[50] Patient #11

- As noted in prior reports, providers copy and paste *previous* examinations into the progress note, *without amending the note to reflect the actual condition of the patient*.[51]
- Providers conducted inadequate medical evaluations and treatment leading to deterioration of the patient.[52]

These cases are described in the body of this report and in patient case reviews attached in the appendix to this report.

A serious concern is discrepancies between provider documentation and the actual condition of the patient. As noted above, it is the practice of some providers to copy previous notes with prior symptoms and physical examinations, and paste them into the new note, but without amending the note to reflect the actual condition of the patient.[53]

One provider documents the same physical examination in every note as follows:

Physical Exam: awake, alert, in no distress. Can ambulate, no obvious tachypnea, no visible neck pulsations, no asymmetry of the mouth or face.

While these findings may be accurate, they are typically unrelated to the patient's presenting illness. This provider may add a word or sentence or two, but the fact that this examination is documented for virtually all medical conditions raises the question as to whether this evaluation was performed.

In the Mays Third Monitoring report, Dr. Karen Saylor addressed the practice of cutting and pasting notes by noting the following:

> *The practice of providers cutting and pasting notes risks documenting history and physical examinations and education that have not been conducted and, in some cases, simply amounts to falsification of medical records. The Medical Director needs to address this with providers as it is a patient safety issue.*

We found two cases with possible falsification of actions and documentation. They are briefly described below.

- (1) The patient developed an abscess on her back, and the provider (AM) documented performing incision and drainage (I&D) of the abscess, under aseptic technique. However, the abscess progressively worsened and 5 days later the patient was sent to the ED for incision and drainage. The emergency department physician documented that the patient

[51] Patient #21 and #24
[52] Patient #21 and #24
[53] Patient 21, 2/1/23 encounter.

…. States that she did not have intervention by way of a scalpel, that the initial provider used their hands to try and pop the pimple." [54]

In this case, the emergency department physician documented that the physician did not use a scalpel to conduct incision and drainage of the abscess. This is consistent with what the provider reported to the monitor, that he does not perform surgical procedures, as he is an internist.

- (2) In February 2023, another patient had a motor vehicle collision that contused to his right hip. Over the next month, the patient submitted health requests complaining of right hip pain. On 3/9/23 the same provider documented that the patient that mild left hip pain and swelling, and diagnosed him with right hip joint pain. [55]

  Five hours later, an RN documented that the patient had a large area of redness and swelling of his right hip that the patient said he had for a month. Fever=101.6°F. The patient was sent to the ED where he was found to have a *deep abscess measuring 10.1 cm x 10.9 cm x 21.9 cm, and sepsis.* The patient was taken to the operating room for incision and drainage and a drain was placed in the wound. Discharge instructions were to remove the drain in two weeks by cutting the suture and pulling the drain, *which could be done by a nurse.* On 3/27/23 the provider noted that the patient refused removal of the drain and requested to be sent to the hospital *to which the provider agreed and submitted a surgical consult* [56] Later that day, an infirmary nurse noted that the patient complained of pain because the doctor "tried to pull the Penrose drainage tube today." Weeks later, the patient sterilized clippers and removed it himself. A provider (RK) then sent the patient to the ED, where the patient told the physician that "*I was supposed to have it removed 2 weeks ago, but they would not bring me to the hospital. The doctor tried to pull it out but he could not. I sterilized some nail clippers and removed it."*

In this case, the provider failed to conduct an adequate examination of the patient, and that was more accurately described by a nurse. The provider also documented that the patient refused a procedure that involved clipping one stitch and pulling out the drain. The provider then submitted a surgical consult for removal of the drain that could have been done by a nurse. However, documentation by a nurse and the ED physician supports that the provider tried to remove the drain by pulling it out, hurting the patient, who then refused to let the provider treat him. It is unclear why the on-call physician sent the patient to the ED since the drain should have been removed weeks earlier.

Given that these types of medical quality issues were outlined in previous reports, it is deeply concerning that the Medical Director has taken no meaningful action to address these types of medical quality issues.

[54] This provider called the Monitor to discuss another case with similar concerns (Patient #24). During the conversation the provider stated that he "does not do procedures, I am an internist."
[55] Patient #24.
[56] We did not find a surgical consult request for this patient.

The County reports that in response to the report findings, the Medical Director is currently working on the process of creating criteria for monitoring the quality of care for chronic diseases (e.g., diabetes, hypertension, HIV, asthma, and pre-hospitalization care). Once criteria in those areas have been established, the Medical Director plans to expand monitoring to include congestive heart failure, transgender treatment and services, obstetrics, and sexually transmitted infection treatment.

Until these QI indicators are developed, we recommend that Medical Director review certain emergency department and hospital sends using the Agency for Healthcare Quality and Research (AHQR) Prevention Quality Indicators (QI's).

"These are a set of measures that can be used with hospital inpatient discharge data to identify "ambulatory care-sensitive conditions." These are conditions for which good outpatient care can potentially prevent the need for hospitalization or for which early intervention can prevent complications or more severe disease.

Even though these indicators are based on hospital inpatient data, they provide insight into the quality of the health care system outside the hospital setting. Patients with diabetes may be hospitalized for diabetic complications if their conditions are not adequately monitored or if they do not receive the patient education needed for appropriate self-management. Patients may be hospitalized for asthma if primary care providers fail to adhere to practice guidelines or to prescribe appropriate treatments. Patients with appendicitis who do not have ready access to surgical evaluation may experience delays in receiving needed care, which can result in a life-threatening condition—perforated appendicitis.

The Prevention QIs consist of the following 16 ambulatory care sensitive conditions which are measured as rates of admission to the hospital:

- *Bacterial pneumonia.*
- *Dehydration.*
- *Urinary tract infection.*
- *Perforated appendix.*
- *Angina without procedure.*
- *Congestive heart failure.*
- *Hypertension.*
- *Adult asthma.*
- *Chronic obstructive pulmonary disease.*
- *Diabetes short-term complication.*
- *Diabetes long-term complication.*
- *Uncontrolled diabetes.*
- *Lower-extremity amputation among patients with diabetes.*
- *Seizure*
- *Sepsis or any diagnosis of significant infection (e.g., endocarditis, fasciitis, etc.)*
- *Delirium tremens or drug withdrawal symptoms*

- *Altered mental status*
- *Soft tissue infection*
- *Uncommon illnesses requiring specialized care (e.g., ulcerative colitis, sickle cell disease, myasthenia gravis, etc.)*

Although other factors outside the direct control of the health care system, such as poor environmental conditions or lack of patient adherence to treatment recommendations, can result in hospitalization, the Prevention QIs provide a good starting point for assessing quality of health services in the community. Because the Prevention QIs are calculated using readily available hospital administrative data, they are an easy-to-use and inexpensive screening tool. They can be used to provide a window into the community—to identify unmet community health care needs, to monitor how well complications from several common conditions are being avoided in the outpatient setting, and to compare performance of local health care systems across communities." [57]

Among the preventable indicators is dehydration, which is common among patient's experiencing alcohol and drug withdrawal, and for which ACH patients are being sent to the Emergency Department for intravenous fluids (IV). The County reported that it can administer IV's on site. We suggest the County focus on these patients to determine if their alcohol and drug withdrawal is being adequately treated, and whether IV fluids are or could have been administered on-site to prevent an emergency department send out.[58]

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

Recommendations: The County needs to:

1. Conduct an analysis of health care operations and custody positions that are needed to provide timely access to care. (A.1)
2. Conduct a staffing analysis to determine whether there is sufficient health care staffing (e.g., nurses, ancillary personnel) to meet demands for health care services. (A.1)
3. Analyze root causes of vacancies, roadblocks in recruiting, and determination of the current market rate for nursing positions. (A.1)
4. Increase the number of scheduled patients that providers are expected to see per day to keep pace with the demand for medical appointments. (A.1)
5. Expand medical provider coverage at the jail, including some weekend hours. (A.1)
6. Conduct more robust and real time oversight of medical care and address lapses of medical care. (A.2)

[57] The Prevention Quality Indicators. Edited for Corrections by Mike Puisis DO.
[58] And minor suturing.

7. Consider using AHRQ Quality Prevention Indicators when selecting records to review pre-hospital and post-hospital care. (A.2)
8. Reeducate and reinforce that providers are expected to perform procedures that can be safely performed such as suturing, drain removal, IV fluids and other minor procedures to reduce emergency department send outs. Consider implementing the use of i-STAT machines to rapidly evaluate blood samples for abnormalities.[59]
9. Assess the frequency of patients detoxing at RCCC. Establish a detox unit for both men and women to treat and monitor patients, and reduce emergency department send-outs.

[59] The County advised that providers are expected to perform minor procedures such as suturing, and IV fluids and antibiotics can be given on site. Email 6/27/23.

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: Review of medical records and documentation provided by the County show that:

- Registered nurses **did not** perform intake screening upon arrival for all newly arriving inmates, due to custody removing inmates from the booking loop to conduct custody processing (B.1.).
- Medical confidentiality is not yet provided despite physical plant improvements (B.2.).

- The County collaborated with Class Counsel to make changes to the intake screening form, and the County continues to make changes as medical intake processes are amended. (B.3.).
- Intake nurses do not consistently review medical records from prior admissions (B.4).
- Intake nurses attempt to verify medications. However, when medications are verified, medical and mental health providers sometimes do not acknowledge the patient's prescribed medications, and if not continued, do not document the clinical rationale for changing the patient's medication regimen.
- Nurses do not conduct COWS and CIWA screening in compliance with policy and the Consent Decree.
- In some cases, Release of Information (ROI) forms related to medication are not followed up upon, resulting in delays of treatment for serious medical conditions (B.5.).[60]
- Intake nurses enter orders for medical provider follow-up, but not consistently in accordance with the patient's medical acuity (B.6).
- The County trains nurses performing intake screening annually (B.7.).
- Medical providers do not consistently review hospital records and pertinent labs to guide their treatment plan.
- There are issues related to provider quality with respect to performing pertinent review of systems and physical examinations; timely addressing of abnormal lab findings and monitoring patients in accordance with their disease control.

Since the last site visit, the County has made physical plant and process changes to the medical intake area in the booking loop that include:

- Improved sanitation
- Renovation to create larger intake screening cubicles
- Installation of solid plexiglass between the nurse and patient
- Renovation of the examination room with new cabinets and removal of clutter
- Changes to Tier 1 and Tier 2 medical screening

While physical plant changes have been made in the booking area, concerns about privacy remain.[61] Record review shows the most nurses check that the encounter is non-confidential. The installation of plexiglass serves to provide safety for the nurse, but it is difficult for nurse and patient to hear one another, requiring them to speak louder, rendering confidentiality moot. We tested this by sitting in the patient's chair and speaking to the nurse, and although the booking area was not busy nor loud, we had to raise our voices to be heard. The nurse suggested that a

[60] Patient #8, Patient #5

[61] ACH reports that inmates often deny substance use disorders or suicide issues because arresting or custody officers are nearby.

small, narrow window be created in the lower part of the plexiglass to allow for communication at a lower volume.[62]

As noted in the executive summary, in late July 2023, the monitors became aware that the County was not conducting timely medical screening for newly arriving inmates.

Upon arrival, nurses conducted pre-booking (Tier 1) screening to determine fitness for confinement (FIT), and if the patient is found to be fit, the arresting officer is released. Tier 2 medical intake screening (Tier 2) is to be conducted as soon as possible and without delay to ensure that emergent and urgent needs are met.[63]

Early in 2023, the County proposed a pilot program to delay Tier 2 screening until custody determined whether the arrestee would stay or be released. This was predicated upon all new arrivals remaining in the booking loop, rapid determination by custody of whether inmates would be released, so that Tier 2 medical screening could take place, and that patients with serious medical needs identified at Tier 1 screening would proceed to Tier 2 screening without delay. [64] *However, review of two recent deaths showed that inmates were not brought to Medical for Tier 2 screening until the booking, dressing in, and housing determination had been completed by custody.*[65] Without timely completion of Tier 2 medical screening, health care staff is unaware of patient's serious medical or mental health needs that require immediate evaluation and treatment. In addition, there is no tracking system for health care staff to know where the patients needing Tier 2 screening are and how long they have been waiting.

Data was provided to the monitors that showed that during the weeks of June 25th and July 2nd, the average time to complete medical screening was 10 and 13 hours, respectively. *Data also showed that Tier 2 screening was not performed for 17% to 41% of new intakes. These inmates have been released, but it is unknown how long they were at the jail before they were released. Data also showed there were 7 inmates still at the jail who had not yet had a medical intake screening.*

Upon learning of the delays in medical screening, the monitors were alarmed at the extent of the delays and risk of harm to patients. We contacted the parties, and following joint discussion, the County agreed to medically screen all newly arriving inmates upon arrival, without delay, and prior to the start of the booking process. We request that the timeliness of medical intake screening is monitored and reported to the monitors and the parties on a monthly basis.

Review of the intake screening process showed that staff also did not:

[62] Nursing leadership has requested that a transaction window be installed on the plexiglass.
[63] Standards for Health Care in Jails. 2018. J-E-02. National Commission on Correctional Health Care (NCCHC).
[64] Conversation with Rick Heyer, Esq.
[65] The length of time to conduct Tier 2 medical screening for these patients was approximately 5.5 hours. The cause of death for these two patients is unknown and it is not possible to determine whether delays in Tier 2 medical screening contributed to their deaths.

- Document a completed drug and alcohol history including the type, frequency, amount, and the last use of drugs or alcohol.[66]
- Consistently order COWS and CIWA screening.
- Order alcohol withdrawal regimens at intake, even for patients with a history of drinking a fifth of alcohol daily, and a history of alcohol withdrawal seizures.
- Conduct withdrawal monitoring as ordered.
- Notify providers of abnormal vital signs and elevated blood sugars (>350).[67]
- Continue previous medication regimens known at the time of intake, or document the clinical rationale for not continuing the medication. [68]

With respect to sexually transmitted infection (STI) testing, patients are offered opt-out screening for HIV, syphilis, and hepatitis C, however the EHR has been programmed to order testing when the patient has refused opt-out testing, and to not order testing when patients do not opt-out. We discussed this at the site visit, and ACH is addressing this programming error.

The following cases illustrate the concerns noted above.

Patient #8

This 35-year-old man was booked into SCJ on 9/25/22 and released on 10/1/22. His medical history includes polysubstance use disorder, including opioids, Type 1 diabetes mellitus, diabetic neuropathy, history of deep vein thrombosis, and chronic back pain with sciatica. His medications include Lantus and Humalog insulin, empagliflozin, furosemide, aspirin, gabapentin, mirtazapine, and duloxetine. On 10/31/222, the patient was readmitted and is still at the jail.

On 9/25/22, the patient was arrested and taken to Methodist Hospital for high blood sugar (575) with trace ketones. A urine drug screen was positive for opioids and amphetamines. Methodist Hospital record show the patient was prescribed: *Lantus Insulin 32 units twice daily, Lispro insulin 24 units three times daily before meals, empagliflozin 10 mg daily, furosemide 20 mg daily, and gabapentin 100 mg three times daily.*

Note: The hospital records were received on 9/26/22 and reviewed by the nurse, but not scanned into the EHR until 1/19/23.

On 9/26/22 at 00:16 a RN conducted intake screening. The patient was uncooperative, drowsy, and appeared to be under the influence of substances. The patient reported a 2 to3-year history of heroin, cocaine, and marijuana use. The patient was a type 1 diabetic and takes Lantus insulin

[66] Patient #6
[67] Patient #5, Patient #8
[68] Patient #8

and Lispro short acting three times a day. *The RN documented all medications noted on the Methodist Hospital discharge paperwork.* Weight=203 lbs. VS=WNL. COWS=1. The RN noted an infected ulcer on the patient's left ankle 1.25 x 1.5 cm with erythema (redness) extending another 4.5 cm x 4.5 cm. FSBS=143. A1C=Error message. The RN called the on-call provider at 00:55, 02:55 and 03:40 but did not document whether she was able to reach the physician, and if so, what orders were given with each call. *The RN later reached a provider and received medication orders for Lantus 20 units every evening and Lispro (Humalog) insulin 10 units three times daily before meals.* The RN ordered a Covid test, quarantine and health checks, COWS assessments, Essential Medication Check, Urgent Provider Sick Call, finger stick blood sugars three times daily, Nurse MAT/SUD referral, 2 East Placement, and discharge planning. The RN completed a ROI.

Note: The intake nurse did not conduct a COWS assessment and although COWS assessments were ordered, they were not performed for 18 hours. The nurse ordered urgent provider sick call but not an H&P or chronic disease visit.

On 9/26/22 at 03:02 a RN documented that the patient was somnolent and kept falling asleep during questions. FSBS=143. A1C=Error message. At 04:26, a RN administered Humalog Insulin 10 units.

On 9/26/22 at 11:20, a physician (GN) documented an essential medication review, noting that the patient had polysubstance abuse and poorly controlled DM-1. "Despite an apparent diagnosis of DM-1, intake screen lists Jardiance which is not indicated for DM-1." All medication orders have been entered. MDSC Ordered. Add Diabetic diet.

Note: Although the RN documented the patient's medications in the intake note, the medical provider did not address each of the currently prescribed medications in the Methodist Hospital Discharge Summary. There was no documentation for the clinical rationale for not continuing the patient's current medications.

On 9/27/22 the patient twice did not get out of bed for insulin administration, and twice for an urgent provider appointment. The nurse did not go to the patient to determine if he was ill and needed urgent medical attention.

On 10/1/22, the patient was released from the jail.

Summary: Issues with this admission include the following:

- At intake, the nurse documented calling a medical provider three times, but did not document whether she was able to reach the provider and what orders were given with each call.

- At the 9/26/22 admission, a medical provider did not address the patient's current medication regimen contained in the Methodist Hospital discharge summary, and that was documented in the nurses intake note. Providers use discretion when deciding whether to continue, discontinue or modify medication dosages. However, when patients arrive with a current medication prescription, the provider needs to document the rationale for making changes to the patient's medication regimen.[69] By not addressing the patient's current prescriptions, there is no documentation that the provider is even aware of the patients medications.
- At the 11/1/22 admission, the provider significantly reduced the patient's diabetes regimen without documenting a clinical rationale, and the patient's blood sugar remained in poor control with blood sugars in the 300-400 range. Two weeks later the patient's hemoglobin A1C was extremely high (HbA1c=14.5%). [70]
- Nurses did not contact a provider for high blood sugars (>350), so that adjustments in the patients baseline regimen could be made. Nurses did not perform a urine for ketones or notify a medical provider.
- The intake nurse did not conduct an initial COWS assessment.
- A RN did not perform a COWS assessment for almost 18 hours after the patient arrived, and although he scored 8 on the COWS assessment, medications were not given for another 6 hours. COWS monitoring was not performed thereafter according to policy/Consent Decree.
- On 9/27/22, the patient did not come out of his cell twice for insulin and twice for an urgent provider appointment, but nurses did not speak directly to the patient to assess whether the patient was too ill to get up and needed medical attention, or if it was a true refusal in which case the nurse would obtain an informed refusal of care.

Readmission to the Jail

On 10/31/22 at 10:30 the same patient returned to the jail on a court remand.[71] Upon arrival, the patent complained of blurred vision, sweating, drowsy, and dry mouth, and believed his blood sugar was high. FSBS=575. He was unable to urinate for a ketone test. He had a history of poor type 1 diabetes control, and recent treatment at Mercy General for hyperglycemia. The nurse documented that he took Lantus 20 units and Humalog 10 units three times daily, last dose

[69] ACH disputes that the patients medications regimen from Methodist Hospital were known at intake. However, on 9/26/2022, a nurse documented the patient's medications from the hospital in the intake screening note, and the provider noted that the patient was prescribed Jardiance indicating that he reviewed the list.

[70] While this largely reflected the patient's poor blood sugar control prior to admission to the jail, medical providers did not note this very abnormal test result and adjust the patient's insulin in response. On 11/24/22 a LVN referred the patient to an RN for hyperglycemia (FSBS=412). The RN called a medical provider (RK) who increased the patient's insulin and ordered sick call in the morning. However, when the provider saw the patient the next day, he did not evaluate his diabetes, and the patient was not seen again for his first chronic disease appointment in 6 weeks, two months after arrival. This is not timely management of poorly controlled diabetes.

[71] Patient #8

this morning. His last meal was at approximately 05:00. The nurse declared the patient unfit. IV started. Code 3 transport to Sutter ER. EMS given verbal report.

Note: The RN appropriately declared the patient unfit for admission to the jail.

At Sutter Hospital the patient was treated for hyperglycemia. Current medications=Lantus 42 units twice daily, Lispro 24 units three times daily before meals, empagliflozin 10 mg every morning, furosemide 20 mg day, gabapentin 100 mg three times daily, and released back to the jail. Needs insulin sliding scale and monitoring of blood sugar. Weight=205 lbs. Elevated glucose (448). Trace ketones. Medically fit for incarceration. Follow-up with PCP in 2-4 days. The patient was discharged and booked into the jail.

On 10/31/22 at 18:12 a RN conducted intake screening. The patient reported being at the hospital and having a leg wound. He was using his mother's walker. *Hospital discharge papers reviewed.* BP=146/97 mm Hg. The nurse noted the patient's medications as reported by the patient as: Lantus 10 units every morning, short acting insulin (Lispro), three times a day, Jardiance 5 mg twice daily, Lasix dose unknown, daily, Baclofen 10 mg every pm, gabapentin dose unknown, twice daily. Medications picked up at CVS Laguna and Franklin. The patient reported taking heroin, methadone, and methamphetamines daily. He was somnolent when the nurse did not actively engage him. A urine drug test was positive for heroin, amphetamine, and methamphetamines. COWS=1. The nurse noted the patient needed detox monitoring and to be placed on 2 East.

Note: Although the hospital discharge instructions included the patient's medication regimen, the RN documented a different regimen which significantly decreased the patient's treatment for diabetes. We interviewed the patient who reported that he told the nurse that he should be on a higher dose of diabetes medication, but the RN disregarded what he told her.

The RN ordered SARS CoV-2 and tuberculin skin tests, COVID intake quarantine, COVID Health Checks, Referral to Dental, 2 East placement, Assistive device (Walker) Essential Medication Check, Provider Sick Call, Provider H&P. Referral to SUD counselor, discharge planning. The RN completed a ROI. The RN notified a provider (JFG) who ordered 2 East placement.

On 11/1/22 at 09:08 a physician (GN) conducted essential medication review. However, the physician did not note or address the patient's medication regimen at the time of discharge from the hospital.

Note: Hospital discharge information contained the patient's current medications. On the left below shows what the patient was prescribed upon discharge and on the right, medications ordered by the ACH physician.

Lantus insulin 42 units twice daily	*Lantus insulin 10 units every morning*
Lispro Insulin 24 units before meals	*Lispro insulin 10 units before meals*
Jardiance 10 mg daily	*Jardiance 5 mg daily*
Lasix 20 mg daily	*Lasix 40 mg daily*
Gabapentin 100 mg three times daily	*Gabapentin 300 mg twice daily (defer)*

The physician orders significantly reduced the patient's treatment for type 1 diabetes, immediately following an emergency department visit for hyperglycemia without diabetic ketoacidosis (DKA). It is the prerogative of providers to continue, discontinue, or modify medication doses. However, when patients arrive at the jail with verified medications, providers need to document the rationale for discontinuing or modifying medications.

Although the physician ordered Lantus, for reasons that are unclear, it does not appear in the list of administered medications until 11/4/22.

On 11/2/22 at 04:40 an SRN documented a refusal of treatment for fingerstick blood sugar and insulin because the patient "refused to come out". The SRN did not check on the patient.

On 11/2/22 at 09:20 COWS=11. The RN initiated an opioid withdrawal SNP and ordered COWS monitoring and provider sick call (no urgency specified).

Note: Despite COWS score of 11, no further COWS assessments were conducted until 11/8/2022.

On 11/2/22 at 14:31 a physician (SP) saw the patient. Weight=195 lbs. (Weight=205 lbs. on 10/31/22). The physician addressed a chief complaint of a draining, left lower extremity wound, and his walker being removed. The patient reported difficulty with walking since having a DVT. "He reports he is unknown (sic) which medication he was taking."

Note: The provider did not address the patient's diabetes and recent hospitalizations for hyperglycemia, conduct a diabetes ROS, or take a history of the patient's DVT. The physician did not describe the patient's draining wound. The provider did not examine the patient for DVT, order a Doppler ultrasound, but ordered rivaroxaban (a blood thinner) without evidence that the patient had current DVT.

On 11/3/22 medical records from the 10/31/22 Mercy Hospital Emergency Department visit were scanned into the EHR, including the patient's current medications as noted above. On 12/13/22 a NP signed the entry of the medical records.

Note: Medical records from Mercy Hospital were scanned into the EHR on 11/3/22, but there is no documentation that a provider reviewed these records and the patient's current medication

list for almost 6 weeks. Even then, the medical provider did not note the discrepancy of medications that were ordered prior to admission versus the patients current regimen.

This case is included in the Chronic Disease section of this report.

Summary: This review includes the patient's first 30 days following his second admission. His record is also included in the chronic care section of this report. Concerns for this admission include the following.

- Providers did not address the patients prescribed medication regimen at intake, although the hospital discharge summary containing the patient's medications was available, and documented in the nurse intake screening. Medication information was also available from the patient's previous admission.
- It is the medical providers discretion to continue, discontinue, or amend medications dosages. However, when patients arrive at the jail with verified medications, providers need to address and document the clinical rationale for changes in each of the patient's medications.
- Nurses did not conduct COWS screening in accordance with standardized procedures and the Consent Decree.
- When the patient did not come out of his cell for insulin and an urgent provider appointment, nurses did not check on the patient to determine if was too ill to get out of bed and needed medical treatment.
- With exceptions, nurses did not contact medical providers for blood sugars >350 or test the patient's urine for ketones.
- A medical provider did timely see the patient following his emergency department visit just prior to admission and did not conduct a 14-day initial history and physical.
- A provider did not conduct an initial chronic disease visit for 2 months after the patient's admission to the jail.

Compliance Assessment:

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

Recommendations: The County needs to:

1. Conduct complete alcohol and drug assessments for every patient.

2. Order alcohol treatment regimens for patients at risk of severe alcohol as indicated by a history of drinking large amounts of alcohol daily (e.g., a fifth of alcohol) and withdrawal related seizures, in accordance with standardized nurse procedures (SNPs).
3. Order COWS and CIWA assessments, and conduct the assessments in accordance with the patient's clinical needs, policy, and the Consent Decree
4. Address patient's verified medications and document the clinical rationale for changing or discontinuing the medication, including mental health patients.
5. Ensure that medical providers conduct assessments of patients with alcohol and drug use disorders referred urgently from intake, and at the 14-day history and physical examinations.
6. Ensure that nurses timely contact providers for patients with elevated blood sugars and abnormal vital signs.
7. Conduct medical quality reviews of intake screening records.

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: During this review period, the County did not provide patients timely access to care via the Health Services Request (HSR) policy. The reasons are multifactorial and include:

- Nurses are not provided daily access to a medical examination room where they can provide adequate examinations that affords privacy and confidentiality.
- Insufficient deputies assigned to escort patients for access to care.
- Insufficient number of nurses that enable all patients to be seen within policy and Consent Decree timeframes.
- Custody obstructed access to medical appointments (e.g., obstetrical visits, nursing, and medical provider appointments).
- Staff not elevating access to care issues up the health care and custody chains of command when there are obstacles to nursing and medical evaluation of patients.

On 11/2/22, ACH CQI conducted a small, point in time study (N=18) for Main Jail and RCCC that showed:

- Eleven of 11 (100%) of medical HSR's were triaged within 24 hours of receipt.

- ACH was not able to determine the timeliness of triage for non-emergent mental health and dental HSRs (N=7). This is because the SRN does not triage these requests. They are referred to the respective disciplines who do not document when the HSRs are received, and the date and time of triage.
- A nurse timely saw the patient in 3 of 4 (75%) urgent requests, and in 2 of 9 (29%) of routine requests. [72]

ACH CQI analysis determined that it was not possible to:

- Determine if HSRs are collected twice daily;
- Verify the date the patient submitted the HSR and the date and time it was received, as the HSR's had not been scanned into the electronic medical record.

This can be remedied by utilization of an electronic HSR tracking log that includes the following information (C.5):

- Patient Name and X-ref number;
- Date the patient wrote the HSR;
- Date and time the HSR were collected;
- Date and time the SRN triaged each HSR, including dental and mental health;
- Triage disposition (Emergent, Urgent and Routine);
- Date the RN saw the patient;
- Location of the encounter (examination room, cell-side, other);
- Provider referral (Yes/No);
- Date *scheduled* to see provider (dental and mental health staff would enter this information onto the electronic tracking log);
- Date of reschedule or cancellation;
- Reason for reschedule or cancellation (e.g., patient released, lack of escorts, provider not available, etc.);
- Date that a medical, dental, or mental health provider *saw* the patient.

A tracking log is a management tool that quickly allows nurses and other stakeholders real time information that assists in determining root causes of obstacles to patient access and that can be reported at morning huddles so that appropriate action can be taken. A certified nurse assistant (CNA) can be assigned to enter HSR data on the log, and track missing information. SRN's need to review the tracking log each shift to determine the status of each patient that was to be seen that day.

[72] We believe the design of the study was limited in that it examined access to care on a single day, instead of over time (e.g., 30–60-day time frame,) and excluded records that should have been included in study. We have discussed this with the CQI team.

ACH revised the Health Services Requests policy (05-09, revised 2/6/23) including changing the Health Services Request (HSR) form to incorporate the date and time that the HSR was initially received.

Patients reported having ready access to the HSR forms, either from deputies or nursing staff (C1.) Patients complete the HSR form and either hand it to the nurse during medication administration, or place it in locked boxes located in each housing unit (C.2). We randomly checked HSR boxes and found that HSRs had been collected. Patients are permitted to submit more than one complaint on the HSR (C.6.), however, if an HSR has a dental and mental health complaint, it appears that the form is forwarded to one discipline or the other, resulting in only one of the patient's complaints being addressed. *This is highly problematic. It can be corrected by having a RN initially see all patients to address both complaints, and make referrals to dental or mental health, who can see the patient in accordance with their dental or mental health acuity, the other option is for the SRN to make a copy of the HSR and forward it to the respective disciplines.*

The nurse/CNA retrieving the HSRs takes them to the medical units where staff are to date and time stamp them and give them to a Supervising Registered Nurse (SRN) to triage. Review of HSRs scanned into the EHR show that many are not date-stamped, and when they are, often the date is faded and illegible (C.3). *This can be remedied by purchase of new date stamp machines in each area they are used and clear guidance to date stamp all HSRs upon receipt.*

Nurses do not consistently document the date and time of triage, nor document a complete, legible signature with credentials. *This can be remedied by use of a name stamp with credentials, that is then initialed by the nurse.*

The SRN triages the HSRs for emergencies, then sorts them into their respective discipline (e.g., medical, dental, and mental health). The SRN then triages medical HSRs and dates and signs them. The SRN does not triage, date and time, or sign non-medical HSRs, rather forwards them to the respective discipline. This does not provide accountability for when the HSR was first reviewed by health care staff. Review of dental and mental health (and some medical) HSRs show that staff does not date and time the HSRs and does not document triage dispositions on the form. Therefore, it is not possible to determine the disposition and timeliness of dental and mental health HSRs and some medical HSRs.

This system does not include entering each HSR on a tracking log, which needs to be done when the HSRs are received (C.5.). SRNs need to triage, date, time, and sign each HSR, and forward non-medial HSR's to dental and mental health staff, to conduct a secondary triage and schedule the patient to be seen. If clinically indicated, dental and mental health professionals can change the priority of the HSR). This would immediately improve compliance with the policy and Consent Decree.

According to ACH policy nurses are to see patients with urgent medical complaints within 24 hours (sooner if clinically indicated), and patients with routine health needs within 48 hours.

However, record review showed that many patients were not seen timely, if at all. On 3/1/23, during the site visit, there were 391 pending nurse sick call appointments at Main Jail, 46 of which were urgent.

Although "blitzes" were conducted in late March and April, ACH has not been able to keep up with the volume of HSRs. As of 6/23/23, there were 217 pending HSRs at Main Jail and 215 pending HSRs at RCCC. This number likely includes many duplicate HSRs that patients submit when they do not receive a response to a previous HSR. The inability to keep up with HSRs not only delays access to care, but also creates more workload for nurses.

Primary reasons for backlogs of HSRs are lack of nursing staff, lack of access to clinic exam rooms and lack of custody escorts. During our site visit, one RN was assigned to sick call, however she had no access to an examination room and no custody escort to see patients.

With exceptions, medical provides are assigned to examination rooms from 7 am to 3:30 pm. On some days, a provider is not at the jail and a clinic room is assigned to the nurse. However, if an on-site consultant is at the jail (e.g., orthopedics, etc.) the nurse is displaced.

Note: ACH leadership needs to ensure that om a daily basis, nurses have access to a clinical exam room to see patients, and at reasonable hours, i.e., nursing sick call should not be delegated to the evening shift when medical providers are not available for consultation and referral.

ACH provider productivity data for March, April, and May 2023, showed that medical providers saw 1.2, 1.4, and 1.5 patients per hour, respectively. This is in part because providers are scheduled to see 12 patients per 8 hours (1.5 patients per hour), and completed appointments can be lower due to lack of custody escorts. As a result, there is considerable down time during which the examination room is not accessible to the nurse to conduct sick call.

Not having dependable access to clinic space, nurses see patients cell side to determine if any patient needs urgent medical attention. We understand this is being done to mitigate harm, but nurses are not able to conduct adequate assessments cell-side, and it provides no privacy for the patient. Moreover, nurses may miss critical information resulting in delay in diagnosis and treatment of serious medical conditions. In one case, a nurse was unable to assess a patient in an examination room because it was occupied by a medical provider, and the nurse closed the appointment because the patient's heart rate had decreased. This patient later died of complications of GI hemorrhage. [73] *Conducting cell-site assessments is not clinically appropriate and does not comply with Consent Decree requirements.*

The following cases are examples of these problems, with other examples contained in Patient Case Reviews:

[73] Patient #34. This case was complex, involving patient refusals of care, nevertheless, he was known to be a high-risk patient.

- **Patient #8:** On 11/19/22, a patient submitted an HSR stating that he needed "my medication and the right insulin." It was received on 11/19/22. The RN assigned it as routine sick call. A RN did not see the patient.[74]

- **Patient #7:** This 47-year-old man arrived at SCJ on 3/16/2021 and is still at the jail.[75] His medical history includes hypertension, history of heart murmur, subcutaneous neck mass/abscess, disseminated cocci, increased liver enzymes, low back pain, neuropathic pain, hematuria, and vesicular rash.

  On 5/31/23 the patient submitted an HSR stating that he was having lots of pain and swelling to left and right leg, also illegible with chest pains at illegible & breathing." The date stamp is illegible. On 6/2/23 at an undocumented time, a RN (*illegible name and credentials) made an urgent referral to medical.*

  On 5/31/23 at 22:39, a RN documented contacting K Barracks x 2, but was *unable to accommodate for nursing sick call d/t (due to) undisclosed custody concerns unrelated to the patient.* The nurse noted that: Nurse Sick Call (NSC) appointment pending, medical provider sick call (MDSC) x 2 also pending.

  Note: the EHR showed that a RN received the HSR on 5/31/22 about 22:39 but was unable to see the patient. However, a nurse did not document triage of the HSR form until 6/2/23.

  On 6/2/23 at 07:24, a RN documented: "Face to Face completed. Patient denies chest pain at his time. *Unable to see patient due to custody issues*. Patient informed that NSC appointment will be scheduled. Patient verbalized understanding.

  Note: This appears to be a cell-side encounter in which a patient whose complaint of chest pain was not assessed. Although the nurse refers to the encounter as a Face-to Face encounter, it is a cell side encounter, and no assessment was conducted.

  On 6/2/23 at 10:05, a RN noted "*Try to see patient for urgent NSC, no space available. Ortho doctor in nursing office."*

  On 6/2/23 at 14:16, a RN noted that "Patient seen during Urgent NSC related to complaints of chest pain and BLE (Bilateral lower extremity edema). "I do not have chest pain right now, but I have ongoing issues with muscular discomfort in the chest and swollen feet. No new onset of any discomfort. The RN performed a cardiovascular (CV) review of systems (ROS). VS=Normal. BLE some swelling noted. The RN contacted an NP, "no need for patient to be seen now, no new issues reported. Patient will be seen during pending provider appointment on 6/6/23."

[74] Patient #8
[75] Patient #7.

Note: The sole physical examination conducted by the RN was to examine the patient's feet for swelling. The RN did not auscultate the patient's heart or lungs. The RN appropriately notified a nurse practitioner.

The RN attempted to see the patient once on 5/31/23, but was unable to for unspecified custody reasons, and twice on 6/2/23, was initially not able to see the patient because orthopedics was in the room designated for nurse sick call.

- **Patient #6:** On 7/16/22, a patient submitted an HSR complaining that two teeth fillings fell out, and needing pain medication. [76]
    - On 7/19/22, a dental assistant did not document a triage decision, but placed the patient on the dental sick call list.
    - On 7/19/22, the dentist saw him in the day room, and noted a large hole in #18 and distal decay on #19. He prescribed Tylenol and placed him on the dental sick call list.
    - On 8/28/22 the patient submitted a HSR complaining again two fillings that fell out and reporting it was impossible to eat. He also wrote that he transferred from the Main Jail where appointments were scheduled.
    - On 8/31/22 the patient again wrote an HSR complaining of having two fillings that fell and the inability to eat. *The RN noted that he was already on the dental sick call list and did not see the patient.*
    - On 9/12/22, the RN noted the HSR was received, and that the patient had put in multiple kites. *The RN did not see the patient.*
    - On 10/1/22 the patient submitted a third HSR complaining of two broken teeth causing pain and that he was having difficulty eating food.
    - On 10/4/22, the RN referred him to dental clinic, but did not document a triage disposition.
    - On 10/11/22, the dentist saw the patient who offered extraction of tooth #19, but did not document a plan for #18.

Summary: Several of these HSRs were submitted during the prior review period, but the patient's condition extended into this review period. In late August, the patient submitted two HSRs complaining of inability to eat, but was not seen by anyone, including a RN, until the dentist saw him on 10/11/22, almost 6 weeks later. *Unless dental staff can see patients timely, a RN must see the patient to assess the urgency of the patient's condition and implement a dental SNP and provider over the counter medications.*

[76] Patient #6.

- **Patient #8:**
  - On 11/11/2022 a patient submitted a HSR form stating he needed his pain and diabetic medications.[77] The HSR is not date stamped, but unknown staff wrote 11/13/22 at the top of the HSR. The RN assigned a routine disposition. *A RN did not see the patient.*
  - On 11/19/22, the patient wrote a second HSR stating he needed his medication for his neuropathy. *The RN assigned a routine disposition. A nurse did not see the patient.*
  - On 11/23/22, the patient submitted another HSR, asking for his neuropathy medication, stating his feet were hurting and burning all day long. On 11/25/22, it was triaged by the RN as routine.
  - Two days later, on 11/25/2022, a medical provider saw the patient and addressed his neuropathy, but did not address his diabetes at all.

Summary: There appears to be a two-day delay from when the patient wrote HSRs from when the form was collected and/or triaged. A RN did not timely see the patient following submission of HSRs. Medical providers did not timely address the patient's poorly controlled diabetes and peripheral neuropathy.

- **Patient #4.** On 9/8/22 the patient submitted an HSR complaining of having a dental emergency. His face was swollen and "tooth is swelling up my gum. Need pain pills and antibiotics. A RN documented that the form was received on 9/10/22 and assigned a *routine* dental referral. On Sunday, 9/11/22 a RN saw the patient as a referral from the nurse administering medications. The patient complained of severe pain, 10 of 10 in severity. His left face was mildly swollen. The nurse implemented the dental abscess protocol. P: Augmentin 875 twice daily. Acetaminophen. Ice Pack. On 9/12/22 the dentist removed a maxillary arch bar and ordered clindamycin. Several teeth were decayed and required extraction. [78]

  Note: It appears that there is a two-day delay in collection and/or triage of this HSR. The RN did not make and appropriate triage decision, and did not see the patient. However, the nurse administering medications appropriately made an urgent referral to the nurse, and the dentist saw the patient the following day. Nurses need to see all patients with dental complaints unless the dentist can timely see the patient.

Obstacles to Access to Care

During the site visit, the monitors observed an alarming situation that obstructed access to care at Main Jail. We attempted to observe a RN conducting withdrawal assessments and medication administration on the detox unit (6E). The Director of Nursing (DON) attempted to contact the deputies in the control room by knocking on the door, and then approaching a separate side window, but no one responded to the Director of Nursing. She needed them to locate the RN

[77] Patient #8.
[78] Patient #4.

assigned to do the withdrawal assessments and to communicate that the nurse needed to see patients and the monitors were there to observe the process. After being unsuccessful in gaining the assistance of custody staff in the control room, she attempted to reach the nurse supervisor via her cell phone, however the reception was extremely poor, and she was unsuccessful. She sent a message with a staff member to deliver a verbal message to the nurse. It took more than 20 minutes for the elevator to arrive for the staff member to leave and find the RN to deliver the message to come to the detox unit.

Simultaneously, while standing in the detox unit and observing the vestibule just outside the unit, a provider was sitting waiting on patients to be escorted for their appointments. After approximately 30 minutes, the RN arrived to 6E and alerted deputies that she was there to access 5 of the 11 patients due for their withdrawal assessment. Six of the patients had been assessed by a provider seeing the patients for other reasons. The nurse waited approximately 15 minutes, and when the elevator opened and an inmate with chow trays appeared. The slider to the unit the nurse was waiting to access opened for the inmate worker and the nurse was required to either wait until chow was completed or leave and to return later. The total time spent on 6E observing this lack of access to the patients in need of care was approximately 50 minutes. *During this 50-minute window of time, the provider had not had a patient escorted to the exam room nor had the RN accomplished any of the withdrawal monitoring assessments and medication administration that were pending. This is a patient safety issue as patients that are withdrawing from alcohol or opioids may rapidly deteriorate and require a hospitalization, that with timely treatment can be prevented.*

Health care staff do not confirm patient refusals

In the last report, concern was expressed about health care staff not independently determining if patients refused appointments, failure to counsel the patient, and to obtain a signed refusal of care as required by consent decree (C. 7.a, 7.b). This continues to be a concern. Medical record review showed that health staff continue to not independently determine if patients refused health care appointments. This is a systemic issue that is occurring for patients withdrawing from alcohol and opioids, mental health patients, as well as patients prescribed essential medications. It also applies to patients that are scheduled for specialty services.

- On 9/26/22 a patient with Type 1 diabetes mellitus, history of deep vein thrombosis, polysubstance and opioid substance use disorder, and an infected ulcer on his left ankle, arrived at the jail. On 9/26/2022 at 17:31 the patient scored an 8 on the COWS assessment but was not provided his first dose of medication for withdrawal symptoms until 23:00. On 9/27/2022 at 04:00 the nurse noted the patient refused to get out of bed to receive his insulin. The RN failed to check on the patient to assess his level of withdrawal and whether he was too ill to get out of bed. Counseling of the patient was also not completed. On the same day at 10:53, a LVN noted the patient refused his insulin by refusing to come out of his cell. At 13:21, a medical assistant documented that a second attempt to see the patient for an urgent physician sick call was done however the refusal of treatment form was completed

without the patient's signing the form. Again, the nurse failed to check on the patient to assess his level of withdrawal, whether he was too ill to come out of his cell, and whether he understood the risks of refusing treatment. On 9/28/22 at 00:00, a LVN documented the patient refused his insulin because he refused to come out of his cell. Again, the nurse did not assess whether the patient was too ill to ambulate out of his cell to receive his insulin.[79]

- On 9/15/22, a patient with a history of opioid substance abuse disorder, fentanyl use, and pregnancy was admitted to the jail. On 9/30/2022 it was reported that she was refusing her OB appointment. A refusal of treatment form was completed however the form stated that "custody reported the patient had a fight last week and could not come out of her cell for her appointment." In this case, deputies obstructed access to obstetrical care, and the nurse needed to escalate it up the chain of command, which did not occur.

- On 12/4/22, a 40-year-old patient experiencing dental pain was documented by the dentist and deputy as refusing his examination because he was sleeping. The patient did not sign the refusal and there was no documentation that efforts were made to waken him.[80] During daytime hours, when the dentist is holding dental clinic, patients should be wakened and provided the opportunity to attend their scheduled appointments. Simply documenting the patient is sleeping is not an informed refusal.

On 3/16/23, ACH modified an Access to Care form that staff are required to complete when they are unable to access a patient due to custody barriers. This form will provide data with improved detail to assist in identifying specific root causes of lack of access. An example of the reasons often experienced include short staffing, chow time, laundry, unsafe environment (fights), etc.

Another issue that negatively impacts access to care is the time the service is offered.

- **Patient #17**: On 1/14/2023 a patient with insulin-dependent diabetes was admitted to the jail. On 1/23/2023, he refused fingerstick blood sugars to monitor blood glucose 3 times in 3 days. The time the testing was offered ranged from 03:00 to 03:49, interrupting the patients' natural sleep cycle (and any other patient with diabetes for whom FSBS is ordered.). This is an unreasonable barrier to care and refusals that occur as a result does not enable providers to fully evaluate the patient's diabetes.[81]

- **Patient #21**: At RCCC, we observed a female patient during a nursing sick call encounter.[82] She requested that her Zoloft be discontinued. The nurse did not explore with the patient the reason she wanted it discontinued. We interviewed the patient who reported that

[79] Patient #8
[80] Patient #28
[81] Patient #17
[82] Patient #21.

> deputies awaken her housing unit every day at 03:30 to conduct count. All inmates are required to sit upright in their beds with all lights on, for security to complete count, which takes approximately 15 minutes to complete. At 04:30, one hour later, lights are turned back on for breakfast. At 06:30, again she is required to sit upright with all lights on for count. Between 06:30 and 08:30, she is again awakened 2 more times for medication administration and distribution of inmate tablets. At 08:30 she attends class. She described her need for sleep as outweighing her perceived benefit of the prescribed medication. We discussed this with a Lieutenant who was unaware of the practice of waking inmates up at 03:30 to conduct count. He indicated that he would investigate.[83]

On 3/30/23 the medical monitors sent a letter to ACH outlining critical issues that have caused harm to patient and place the inmate population at risk of harm if not immediately addressed. In response to the letter, ACH developed a remedial action plan that included executing a "nursing sick call blitz" at both the Main jail and RCCC, to catch up on the backlog. This activity required freeing up clinical space, allocating additional RNs and dedicated security escorts to ensure patient movement. The blitz at the Main jail occurred on 4/22/2023 with 156 pending sick call encounters and an additional 99 outstanding follow-up treatments such as weight checks and labs. All the 156 pending sick call encounters were accomplished or refused by the patient and all 99 outstanding follow-up treatments were accomplished or refused by the patient. Another nursing sick call blitz is scheduled at RCCC for 5/6/2022.

Although completing a blitz to reduce patient backlogs is laudable, further remediation will be required to address root causes of the backlogs. In response to the 3/30/23 letter from the monitors outlining critical issues, ACH included in their remedial action plan the development of an analysis of all health care functions requiring escorts to determine the number of custody FTEs needed in a 24-hour period and the following measures:

Short-Term Plan:

1. ACH will coordinate with SSO to identify additional exam room stations to provide additional, confidential space to complete services on each floor in each wing – including NSC.
2. Inventory medical equipment currently in stock as well as additional needed to support additional fully functioning stations on each floor in each wing, including, but not limited to:
    a. Exam carts with computers;
    b. Exam equipment and materials;
    c. Privacy screens;
    d. Lab chairs;
3. Submit purchase orders for all equipment identified to establish additional exam stationing areas as soon as possible.

4. ACH will implement a Daily Healthcare Service Schedule that will assign exam rooms and times for RNs to provide NSC, as well as all service functions.

Also included in the remedial action plan is the addition of on-call deputy resources to the Compliance Unit at the Main jail to use as medical escorts to address immediate needs. RCCC will gain 14 positions using on-call and RO1 positions beginning 7/1/23. These new positions will be used to assist with providing escorts for health care operations.

The County's long-term plan includes:

1. Potential use of transparent interviewing cubicles to be constructed on each floor in each wing.
2. Completion of Intake and Medical Services Facility (IMSF) building.

How the short-term and long-term plans are executed determines whether these proposed solutions will be adequate. We encourage the County to keep the Monitors fully informed as the plans are implemented to determine whether they are appropriate and meet Consent Decree requirements.

Compliance Assessment:

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

Recommendations: The County needs to:

1. Provide adequate nurse staffing to conduct HSR clinic.
2. *Provide nurses access to a clinical examination room daily (7 days a week) at a time that does not constitute a barrier to access (e.g., only in the afternoons and up to 11:30 pm).*
3. Provide sufficient custody escorts to meet the demand for health service requests and other medical operations.
4. Establish an electronic Health Services Request tracking system that includes:
    a. Patient Name and X-ref number;
    b. Date the patient wrote the HSR;
    c. Date and time the HSR was collected;

d. Date and time the SRN triaged each HSR, including dental and mental health;[84]
e. Triage disposition (Emergent, Urgent and Routine);
f. Date the RN saw the patient;
g. Location of the Encounter (examination room, cell-side, other);
h. Provider referral (Yes/No);
i. Date scheduled to see provider (dental and mental health staff would enter this information onto the electronic tracking log);
j. Date of reschedule or cancellation;
k. Reason for reschedule or cancellation (e.g., patient released, lack of escorts, provider not available, etc.);
l. Date that a medical, dental, or mental health provider saw the patient.

5. Review the nurse sick call tracking log daily to ensure that it is complete and that patients are timely seen.
6. Conduct a daily huddle with ACH and SSO representatives at the beginning of the day shift to review sentinel events (e.g., emergency department transfers and hospitalizations) that happened since the last huddle, as well as other metrics (e.g., nursing and provider backlogs, specialty services, appointments, etc.).
7. Monitor and resource additional staff in real time, to avoid nursing and provider sick call backlogs.
8. Timely see all patients following submission of HSRs and then refer to medical, dental, and mental health staff in accordance with patient acuity and Consent Decree referral time frames.
9. Prioritize and schedule nurse sick call to be conducted in an adequately equipped examination room at a designated time, 7 days a week. Nurse sick call should not be scheduled and conducted at times that present a barrier to care (e.g., up to 11:30 pm).
10. Perform CQI studies regarding access to care, to include all Consent Decree and policy requirements. CQI studies need to be expanded beyond a specific point in time to measure performance over time (e.g., 30–60-day period that includes records selected from all 7 days of the week. Sample sizes need to be expanded to 30 per facility for high volume activities (e.g., intake, nurse and provider sick call, medication administration, etc.) in order to have sufficient data to demonstrate compliance.
11. Regarding CQI study methodology, HSR's that are not found to have dates and times should be counted as non-compliant and/or unable to determine, rather than reducing the sample size and artificially elevating the scoring. ACH policy requires HSRs and all patient encounters to be date and time stamped.
12. Provide a means of communication for nurses (e.g., radios, cell phones) to permit nursing supervisors to locate their staff and communicate with them, and for nurses to timely contact supervisors when the need arises.
13. Escalate information regarding obstacles to care up the chain of command.

[84] This includes verbal requests that have been documented onto an HSR.

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 Chronic Disease Management policy was published on 8/18/2021 and revised on 11/14/2022. The written policy is compliant with Consent Decree requirements. The 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 [85]

To date, the Medical Director has developed Provider Treatment Guidelines for Asthma, Hypertension and HIV infection. There is a policy for hepatitis C infection, but not a clinical guideline. (D.1.) The monitors have reviewed and commented on the Asthma, Diabetes, Hypertension, and HIV guidelines:

- The Asthma Guideline was developed 11/19/2021 and is consistent with UpToDate, an evidenced-based clinical decision support resource. Current national asthma guidelines were updated in 2023. The ACH asthma guideline has not yet been updated.[86]

- The Hypertension Protocol was revised in February 2023 following comments from Dr. Karen Saylor. It is consistent with the 2017 Guidelines for Prevention, Detection, Evaluation, and Management of High Blood Pressure in Adults.[87] The monitors have provided comments regarding identification of patients with hypertension at intake and the process for enrollment into the chronic disease program. The Monitors await feedback on the recommendations.

- The HIV treatment guideline is not consistent with national HIV treatment guidelines.[88] The guideline is a policy focused on process for new arrivals, frequency of clinics, etc. We have previously recommended the County adopt the Department of Health and Human

[85] Patients are provided care management and monitoring by mental health psychiatric providers and/or social workers depending on the level of service needed.
[86] The Global Strategy for Asthma Management and Prevention was updated in 2023.
[87] Whelton PK, Carey RM, Aronow WS, et al. 2017 ACC/AHA/AAPA/ABC/ACPM/AGS/APhA/ASH/ASPC/NMA/PCNA Guideline for the Prevention, Detection, Evaluation, and Management of High Blood Pressure in Adults: A Report of the American College of Cardiology/American Heart Association Task Force on Clinical Practice Guidelines. Hypertension 2018; 71:e13.
[88] DHHS Guidelines for the Use of Antiretroviral Agents in HIV-1 infected Adults.

Services (DHHS) Guidelines for the use of Antiretroviral Agents in Adolescents and Adults with HIV, however this has not taken place. [89]

- The Hepatitis C Infection policy includes criteria for treatment, but is not a hepatitis C treatment guideline. The American Association for the Study of Liver Diseases (AASLD) and Infectious Disease Society (ISDA) have developed guidelines for the treatment of hepatitis C. The County needs to adopt these guidelines

Currently, there is no functional chronic disease tracking system. The current electronic health record does not have the capacity to produce reports with an associated tracking system. This is a major impediment to ensuring that all patients are enrolled in the program and timely seen. The tracking system would facilitate scheduling of appointments and labs to be drawn in advance of clinic visits, so providers have current information upon which to base treatment decisions. An electronic tracking log would include the following information.

- Name and X-ref
- Date of arrival
- Diagnosis (es)
- Date of history and physical
- Date of initial chronic disease appointment
- Date that initial labs are scheduled
- Date that labs are completed
- Date of follow-up appointments
- Date that follow-up labs are scheduled.
- Date that labs are completed.

The tracking log could also include required testing such as annual diabetic eye and foot examinations, and immunizations, etc.

The County has hired physicians since the last monitoring period, and staffing should no longer be an impediment to timely seeing chronic disease patients. The County has designated certain providers to see chronic disease patients, but some patients are also managed by other providers. In some cases, patients can be seen by 5 or more physicians which contributes to fragmentation of care.

[89] The County responded that an infectious disease specialist manages HIV patients, however the County needs to develop guidelines that are consistent with national guidelines, and monitor compliance with current guidelines. https://clinicalinfo.hiv.gov/sites/default/files/guidelines/documents/adult-adolescent-arv/guidelines-adult-adolescent-arv.pdf

Medical Record review shows that not all chronic disease patients are timely enrolled into the program.[90] At intake, nurses refer patients with chronic diseases for a history and physical or provider sick call appointment. However, the history and physical visit does not always occur, and when it does, some medical providers address acute care problems but not chronic diseases (1.a.) One patient with poorly controlled diabetes was not seen for over two months after his arrival at the jail.[91]

There are some chronic disease templates (e.g., asthma) in the EHR to prompt the provider to address all disease components, such as conducting a review of systems, physical examination, labs, and medication adherence. However, providers do not consistently use the template(s) and do not address key information needed to assess disease control.

For example, evaluating asthma or COPD control includes performance of peak expiratory flow using a peak flow meter.[92] However, neither nurses nor providers use peak flow meters for chronic disease or urgent encounters.[93] This has been noted in previous reports but there has been no change in practice.[94] Peak expiratory flow (PEF) monitoring provides objective data to assess asthma control, particularly in the evaluation of the effectiveness of treatment for acute asthma exacerbations.

The Medical Director has responded that use of peak expiratory flow monitoring is only recommended for patients with severe asthma. However, according to the Global Strategy for Asthma Management and Prevention (2023 Update), peak expiratory flow monitoring has the following short and long-term benefits:

Short term monitoring:

- Patients should be trained to keep track of their symptoms and take to action if symptoms start to worsen;
- Peak Expiratory Flow (PEF) monitoring may be useful following an exacerbation, to monitor recovery following a change in treatment, and to help in assessing whether the patient has responded;
- If symptoms appear excessive (for objective evidence of degree of lung function and impairment); and
- To assist in the identification of occupational or domestic triggers.

For long-term monitoring:

[90] ACH has not provided CQI studies to demonstrate that patients with chronic diseases are timely enrolled in the chronic disease program, that patients are timely monitored, and that medical care meets the standard of care.
[91] Patient #8.
[92] Peak Expiratory Flow (PEF) provides objective information about airway restriction in asthmatics. Spirometry is used to evaluate patients with COPD. However, some patients have components of asthma and COPD, and PEF use for exacerbations and monitoring, can contribute objective data to assess disease control.
[93] Patient #24.
[94] The Medical Director dispute the need for use of Peak Flow Meters to assess airway restriction or obstruction in patients with asthma, expect for severe asthmatics, citing current GINA guidelines.

- Earlier detection of exacerbations, mainly in patients with poor perception of airflow limitation;
- For patients with a history of sudden severe exacerbations; and
- For patients who have difficult-to-control or severe asthma.

Some providers document assessments of chronic disease control (e.g., asthma), without performing any assessment of the disease.[95] *This is highly problematic.* For the reasons cited above, we believe the County needs to use peak expiratory flow measurements in the assessment of asthma control. For chronic disease clinics, nurses can perform these measurements prior to the medical provider's visit.

The County has modified the intake screening form to conduct opt-out testing for HIV, syphilis, and hepatitis C (1.b.). Record review showed that patients were not tested for hepatitis C infection when they *did not opt-out*. The reason appears to be confusion about the wording of the question. In addition, the EHR was programmed to generate an order for testing when the patient *refused* testing and did not generate an order when patients desired testing. his was discussed and demonstrated during the site visit. We suggest that the wording of the sentence be amended as follows:

> *"You will receive a blood draw for the following communicable diseases unless you refuse testing. Do you wish to refuse testing?*

A "No" means the person wants to be tested and a "Yes" means the person does not want to be tested. The EHR needs to reprogrammed accordingly. Another challenge to performing hepatitis C testing when it is ordered is backlogs in laboratory draws. During the site visit, ACH reported there were 610 pending lab draws. After the site visit, ACH implemented a "blitz" to reduce the backlog.

The Consent Decree requires the County to develop a comprehensive diabetic management program consistent with the American Diabetes Association. The program is to be developed in coordination with custody administration to address normal circadian rhythms, food consumption times, and insulin dosing time. The County has not yet developed and implemented a comprehensive program. Nurses perform fingerstick blood sugars at 3 am, resulting in many refusals. Providers order diabetic and other medical diets (e.g., minced moist) [96], but the County has not employed a dietician to develop and supervise medical diets. Nursing leadership reported that the County has contracted with a dietician, who does not come on site. (1c.). A comprehensive diabetic program would include patient education and counseling regarding the cause and effects of diabetes, complications, glycemic goals, nutrition, exercise, and self-management of diabetes.

[95] Patient #24, #3.
[96] Patient #40.

The Consent Decree requires that chronic disease patients prescriptions are automatically renewed unless the provider determines that it is necessary to see the patient before renewing the medication. Currently medications are prescribed for one year. Prior to expiration, pharmacy sends an EHR alert for the providers to renew. The County cal Director will work with the Pharmacy Director to make renewals automatic when the clinical pharmacists are implemented into the chronic care program (1.d.).

Records that exemplify issues discussed above are below:

- **Patient #10:** This 27-year-old man was admitted to SCJ on 7/18/22 and is still at the jail. His medical history includes HIV infection, syphilis, chlamydia, asthma, pneumonia, elevated liver function tests, chronic urticaria, adjustment disorder with mixed anxiety and depressed mood. His medications are Genvoya, levalbuterol, aripiprazole, MVI and Lubriderm.

  Upon admission, the patient did not initially report having HIV infection, but reported it to a nurse 2 months after admission. Not disclosing his HIV infection delayed his medical evaluation. There was an opportunity to diagnose the patient sooner as he did not opt out of HIV and STD testing, but the tests were not performed. Once evaluated for HIV, the patient was timely treated and monitored. The patient was intermittently nonadherent to HIV medications, and on two occasions in the 2 weeks prior to our site visit, nurses did not administer medications to all patients in Main Jail, due to inadequate staffing. The patient still has a detectable HIV viral load.

  Medical providers did not obtain an asthma interval history at each visit, perform peak expiratory flow rates (PEFR), or assess inhaler use, or perform PEFRs, but assessed the patient's asthma as being in good control without subjective and objective measures supporting the assessment.

  When the patient complained of shortness of breath, LVN's did not conduct an adequate assessment of the patient and refused to administer his rescue inhaler. Refusing to administer a patient's recue inhaler is not following a medical order. There were delays in performing labs, provider review of laboratory reports, and scanning documents into the EHR (e.g., HSRs). Nurses, mental health, and dental staff do not consistently date stamp Health Services requests and legibly sign their full name and credentials, or document triage dispositions. On 10/12/22, a provider reviewed a lab report showing the patient had chlamydia and ordered doxycycline twice daily for 7 days. She did not meet with the patient to inform him of the test result. We interviewed this patient who reported that he was not informed that he had chlamydia, and when a nurse administered doxycycline to the patient, he asked what it was for, and she did not know the reason. The patient was not informed he had chlamydia.

- **Patient #8:** This 35-year-old man was booked into SCJ on 10/31/22 and is still at the jail. His medical history includes polysubstance and opioid substance use disorder, Type 1 diabetes mellitus, diabetic neuropathy, history of deep vein thrombosis, and chronic back pain with

sciatica. His medications include Lantus and Humalog insulin, empagliflozin, furosemide, aspirin, gabapentin, mirtazapine, and duloxetine. The patient had two admissions to the jail.

First Admission 9/25/22 to 10/1/22

Upon arrival, the medical provider did not address the patient's current medication regimen, although the intake nurse documented the information in the nurse intake note.

The patient had repeated blood sugars >350 but nurses did not perform a urine for ketones or notify a medical provider, even though it was clinically indicated.

Second Admission 10/31/22 to the present

On 10/31/22, the patient was readmitted to the jail. During this admission, the following individual performance and systems issues were noted: The physician did not address the current medication regimen of the patient and document a clinical rationale for changing the patient's medication regimen. The patient's medications were known from a previous admission one month prior. Hospital records show the patient was prescribed medications listed on the left and the ACH provider ordered medications on the right.

Lantus insulin 42 units twice daily	Lantus insulin 10 units every morning
Lispro Insulin 24 units before meals	Lispro insulin 10 units before meals
Jardiance 10 mg daily	Jardiance 5 mg daily
Lasix 20 mg daily	Lasix 40 mg daily
Gabapentin 100 mg three times daily	Gabapentin 300 mg twice daily (defer)

As noted earlier in the report, medical providers have discretion to continue, discontinue, or modify medication dosages. However, when the patient arrives at the jail with a current prescription, the medical provider needs to document the clinical rationale for changing the patient's medication regimen. In this case, the physician significantly reduced the dosage for all the patient's medications, including Lantus insulin, immediately following an emergency department visit, without documenting the rationale for doing so. Other issues include:

- A medical provider did not conduct a 14-day initial history and physical.
- A medical provider saw the patient for sick call, but did not review the patient's hospital medical records, fingerstick blood sugars, and did not note the patient's hemoglobin A1C of 14.5%, which warranted immediate adjustment of therapy and close monitoring.
- The patient's diabetes was poorly controlled, but he was not seen in the chronic care program for two months after admission.
- Nurses did not contact medical providers for blood sugars >350 or test the patient's urine for ketones.
- There are delays in scanning in hospital records and lack of a provider notification system. Medical records from Mercy Hospital were scanned into the EHR on 11/3/22,

but no provider reviewed these records and the patient's current medication list for almost 6 weeks. Even then, the medical provider did not note the discrepancy in what medications were ordered for the patient.

- **Patient #11:** This 44-year-old man was admitted to SCJ on 11/11/22 and is still at the jail. His medical history includes opioid substance use disorder, cirrhosis, GERD, rectal bleeding, COPD, seizure disorder, hyperlipidemia, adjustment disorder with mixed anxiety and depressed mood and PTSD. His medications are tamsulosin, pantoprazole, levalbuterol, levetiracetam, mirtazapine and naproxen. At a prior incarceration at SCJ in April 2020, the patient reported a history of alcohol and opioid substance use disorder. He had a history of seizures but only took Dilantin while incarcerated. [97]

  On 12/6/2022 a provider saw the patient for an initial history and physical, however the provider did not address each chronic disease and develop an initial plan, or enroll the patient in the chronic disease program. The provider did not order labs for hepatitis C infection, including HCV antibody test with reflex HCV viral load, liver function tests, and evaluation for GI bleeding (CBC, fecal occult blood test) given the patient's complaint of epigastric pain and history of hematemesis (vomiting blood), concerning for esophageal varices in the setting of cirrhosis. Medical providers need to order necessary medications, tests and follow-up and not rely on patient report of impending release or transfer. The provider did not order the tests because he thought the patient was leaving the following day. The patient did not leave the following day.

  On 1/14/23 a provider did not evaluate and treat all the patient's chronic diseases. For the patient's history of cirrhosis and hepatitis C, the provider did not conduct a GI review of systems (e.g., nausea, vomiting blood, rectal bleeding, ascites), elicit or address the history of hematemesis or liver transplant (documented by the MH NP), inquire about treatment for hepatitis C infection or review recent liver function tests. He did not refer the patient for a GI consult or order an abdominal ultrasound. The provider did not examine the patient's abdomen or note the patient's 10 lbs. weight gain since intake which is pertinent given the patient's history of ascites. The provider also did not conduct a meaningful evaluation of the patient's COPD, including pulmonary ROS, and exercise tolerance. The provider did not order spirometry to assess the severity of COPD. The provider did not document a treatment plan for the patient's hyperlipidemia, other than obtaining previous medical records. The provider did not evaluate the patient's seizure history noted in a previous admission.

  A total of 5 different providers saw the patient for chronic disease management resulting in fragmentation of care. A medical and mental health provider documented that the patient had stage 4 cirrhosis, but a different physician he had a low probability of cirrhosis.

[97] This patient was described in the

- **Patient #3:** This is a 50-year-old woman admitted to SCJ on 7/18/22 and is still at the jail. Her medical history includes systemic lupus erythematosus (SLE), obesity, type 2 diabetes, hypertension, bradycardia, seizure s/p TBI, urinary tract infection, and schizoaffective disorder.

- **Summary:** This patient has multiple serious medical and mental health comorbidities resulting in four emergency department visits and requiring multiple specialty services, including rheumatology, cardiology, optometry, and imaging studies. The issues related to specialty services are discussed under the Specialty Services section of this report. However, because delays in specialty services negatively impacted chronic disease management, this case is included in chronic disease as well.

    - Upon booking the patient reported that custody confiscated her continuous glucose monitoring (CGM) device and insulin pump. This is not documented in the EHR, but if true, custody confiscated a needed medical device that maintained the patient's blood sugar control.

    - At intake on 7/22/22, the patient gave a history of Systemic Lupus Erythematosus (SLE) and was not provided timely medical evaluation during such time she suffered from SLE symptoms.[98] It does not appear that the requested records from Parkland Medical Clinic in Texas were received.

    - On 8/5/22, labs showed that the patient had a positive ANA and high ANA titer suggesting autoimmune disease, the report was not generated until 11/25/22 and a provider did not review them until 12/6/22. [99]

    - Delays in a cardiology workup delayed treatment for SLE until 4/19/23, 9 months after her arrival at the jail. During this time, she experienced SLE symptoms.[100]

    - On 8/4/22. a physician ordered an optometry consult for a retinal examination, but the appointment did not place until 2/2/23, approximately 6 months.

[98] The Medical Director disputes that the patient has systemic lupus erythematosus, however Dr. VTN is treating the patient for SLE with methotrexate, which she receives at the time of this report. The diagnosis of SLE is not documented on the Problem List.

[99] The Medical Director states that the delay in obtaining labs was due to the outside reference laboratory and outside the providers control. However, the provider ordered the labs in August 2022 and never noticed that the labs had not been reported. *It is the provider's responsibility to monitor whether ordered tests have been completed and reported.*

[100] The Medical Director states that the delay in completion of the cardiology consultation was due to "unintended and uncontrollable delays, and that it should not be attributed to the providers. However, providers are responsible to monitor the patient to determine if ordered laboratory and diagnostic studies are timely scheduled and performed. If the specialty services are scheduled outside an acceptable time frame with respect to timely diagnosis and treatment, providers need to act on behalf of the patient, and reach out to Case Management or the Medical Director, if needed, to seek other sources of care.

- On 9/27/22, a physician ordered a cardiology consult for chest pain and bradycardia following an emergency department (ED) visit. On 11/10/22, Case Management submitted the request for an appointment to Custody Transport, but the appointment was not completed until 12/16/22. While this routine consult was completed in 90 days, given the patient's chest pain, palpitations, shortness of breath, and hypertensive emergencies, the consult needed to be performed urgently.
- On 12/20/22, a provider reviewed the recommendations but did not order a nuclear stress test.
- On 3/3/23, the patient had recommended cardiology studies, including Holter Monitor (HM), but the patient informed us she took the pads off because she was allergic. Neither the cardiologist nor ACH providers noted that the Holter Monitoring was not completed. This is concerning because the patient complained of palpitations, had severe bradycardia (pulse-38-43/minute) and an EKG at the hospital showed the patient had a prolonged QT interval.
- On 3/23/23 cardiology saw the patient and reviewed the results of studies but did not address the lack of Holter Monitoring report. Cardiology did not address clearance for starting hydroxychloroquine which was the initial reason for the consult.
- On 2/8/23 a physician saw the patient for follow-up of poorly controlled hypertension and other chronic diseases. The physician ordered a Rubicon consult for secondary hypertension. On 2/9/23 a renal artery doppler was ordered. On 2/25/23, Case Management submitted the request for an appointment that was scheduled for 4/7/23, but the appointment was canceled because the patient was not kept NPO (nothing by mouth) after midnight. It does not appear there was any coordination between custody and medical regarding the need to keep the patient NPO. The delay is a concern because as recently as 1/12/23 the patient had blood pressures as high as 255/116 mm Hg, 230/122 mm Hg, and 234/188 mm Hg.

Compliance Assessment:

- D.1=Partial Compliance
- 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: The County needs to ensure that:

1. Intake nurses refer chronic disease patients to a medical provider to be seen based upon their medical acuity.

2. An electronic tracking system for chronic disease patients is developed and implemented to include:
    a. Date of arrival
    b. Date of initial history and physical examination
    c. Date of initial labs
    d. Date of initial chronic disease visit
    e. Dates that lab tests are to be performed prior to the next chronic disease visit
    f. Dates of follow-up visits
3. A nurse is assigned to monitor the tracking log to ensure that appointments are timely kept.
4. Medical providers address all chronic diseases at each visit by performing a review of systems, pertinent physical examination, review of labs, and treatment plan
5. Medical providers timely review and address chronic disease findings and recommendations when patients return from specialty services appointments, emergency departments and hospitalizations.
6. Medical providers monitor whether medical orders are timely implemented and reviewed, such as lab tests, x-rays, and imaging.
7. Medical providers and nurses use peak flow meters to assess airflow restriction for patients with asthma and COPD, and not rely on oxygen saturation.[101]
8. Nurses contact providers for elevated blood sugars (>350) and abnormal vital signs, and that providers timely see patients following significantly abnormal findings to adjust the treatment plan.
9. Medical reviews related to provider quality are timely performed and documented with a corrective action plan and timely reevaluation of performance that falls below the standard of care.
10. CQI studies related to clinical quality measures are also performed. These clinical quality measures need to be based upon national guidelines, and not be limited to timeliness of appointments and labs.
11. The EHR is reprogrammed so that patients that chose not to opt-out of STI testing are automatically scheduled for a test, ideally within 21 days.

[101] This recommendation has been made in previous reports.

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.
    d. The County shall consider creating a physical therapy clinic at the jail to more efficiently meet the demand for service at the jail.
10. The County shall consider creating a physical therapy clinic at the jail to more efficiently meet the demand for this service.

Findings: During this review period, patients were not provided timely specialty services in accordance with the acuity of their condition, particularly for patents with urgent medical conditions. As a result, patients suffered preventable harm.

The status of Consent Decree provision compliance is as follows:

- ACH revised the Specialty Referrals policy and procedure (revised 9/7/2022). ACH utilizes InterQual criteria to make decisions about the appropriateness of medical referrals (E.1).[102]
- The policy referral time frames meet Consent Decree Requirements; however, ACH has not consistently met these time frames, particularly with respect to urgent referrals (E.2).[103]
- Providers do not consistently monitor or keep patients informed whose specialty services have not been timely completed in 90 days (E.3).
- Providers do not timely review emergency department and hospitalization reports and recommendations. For some patients, providers do not address the recommendations at all (E.4).
- ACH maintains a tracking log that contains all required elements (E.5).
- ACH tracks the length of time it takes to grant or deny specialty services requests, and the reason for denials (E.6).
- ACH twice a year conducts audits examining the timeliness of the Specialty service Referral Log described in subsections (5) and (6), and completes a report as to whether each category is completed in a reasonable time frame. (E.7).
- The County has implemented Rubicon, an e-referral system (E.8)
- Case Management does not notify providers whether the referral appointment is scheduled to occur within the time frame pursuant to the referral, and/or clinical information (E.9).
- The County has considered creating a physical therapy clinic but in the past review period, no physical therapy referrals are included on the tracking log (E.10).

ACH conducted a Specialty Services audit from July 2022 to December 2022 (reported in June 2023) (E.7). During this time, 337 (99%) consults were classified as routine, and 5 (1%) were classified as urgent. The study found that 72% of routine consults were timely performed with 28% past the time 90-day time frame, pending an appointment, or the patient was released after the 90-day compliance date.

[102] The County's self-assessment matched the monitors assessment of substantial compliance for provisions E.1, E.5, E.6, E.7, E.8, and E.10. The County's assessments do not match the monitors for E.2 due to the untimely provision of urgent consult.

[103] ACH's self-assessment is substantial compliance, which is not supported by record reviews.

During the same time frame, there were 5 urgent consults, 2 in July, 2 in August, and 1 in November. One patient was excluded from the study because he was at a state hospital. Of the remaining 4 urgent consults, 3 (75%) were timely performed and 1 (25%) was not.

Based upon review of the Specialty Service Tracking Log, the number of urgent consults during the review period is artificially low. There were many consultations and procedures that were classified as routine, but were clearly urgent. This included fractures, imaging for cancer, and cardiac consults for high-risk patients with chest pain, etc.

Examples are described below:

- On 11/1/22, a 33-year-old man who suffered a distal fracture of his right arm, was seen by the onsite orthopedist on 11/11/22. The arm was initially splinted to reduce the fracture, but it became displaced, and on 12/22/22 the on-site orthopedist recommended surgery as soon as possible. On the tracking log, the consult was designated as routine. The appointment with the outside surgeon did not take place until 3/7/23, four months after the fracture. By that time, the patient's fracture had healed incorrectly and would require a more complicated surgery to repair his arm. After the surgeon explained that the repair would involve rebreaking his arm with risks of nerve damage and infection, the patient declined surgery.[104]

- A 46-year-old man with a history of cancer of the eye (ocular melanoma) arrived at the jail in 2021 and is being treated with Avastin injections in his right eye at UC Davis. Since February 2022, ophthalmology recommended that the patient return every 4 weeks for treatment, falling into an urgent/expedited consult status. Since March 2022, many of his appointments have not been timely with intervals as long as 9 weeks. After delays, ophthalmologists noted that the patient's vision has worsened and emphasized the importance of returning every 4 weeks. The patient was treated on 10/21/22 and was not treated again until 12/20/22, an 8-week interval. There were external issues affecting timeliness, including UCD rescheduling, custody cancelling transports, and when the patient got COVID-19. Since January 2023, treatments have been timelier.

  Since the patient's treatment plan was to return every 4 weeks, it was important to immediately schedule future appointments, or have UCD ophthalmology schedule the appointments and notify Case Management, as the treatment did not require new CM approval.

  Other records show that, independent of consult urgency, patients were not provided with timely access to specialty services. The following are examples:

[104] Patient #1.

- A 50-year-old woman with a history of systemic lupus erythematosus (SLE), diabetes, heart surgery, hypertensive emergencies, chest pain, shortness of breath, palpitations, and severe bradycardia (pulse=38-43/minute) was admitted on 7/22/22. This patient has multiple medical and mental health comorbidities requiring multiple specialty services and imaging; however, the patient was not provided timely access to consultants, ordered studies, and treatment for SLE.
    - At intake on 7/18/22, the patient gave a history of Systemic Lupus Erythematosus[105] (SLE). Past medical records were requested, but it does not appear that the requested records from Parkland Medical Clinic were received or that staff were tracking the status of the records.
    - The patient reported to the monitors that she had a continuous glucose monitor (CGM) and insulin pump, but custody took it away from her. Her diabetes is not well controlled.
    - On 7/22/22 the patient presented with chest pain and blood pressure of 185/111 mm Hg. The patient was sent to the ED. The patient would have multiple hypertensive emergencies and hypertensive urgencies[106] This includes blood pressures of 203/97 mm Hg, with chest pain and an abnormal EKG suggestive of ischemia, and blood pressures of 255/116 mm Hg and 230/112 mm Hg in January 2023.
    - On 8/4/22 a physician ordered an optometry consult for a retinal examination, but the appointment did not take place until 2/2/23, approximately 6 months.
    - On 8/5/22, labs show the patient has a positive ANA and high ANA titer suggesting autoimmune disease, the report was not generated until 11/25/22, and a provider did not review the report until 12/6/22. It does not appear that providers tracked the missing lab report during the interval to find out the status of the labs.
    - On 9/27/22 a physician ordered a cardiology consult for chest pain and bradycardia following a second emergency department (ED) visit. Case management did not submit the request to Custody Transport to schedule an appointment until 11/10/22, and the appointment was completed 5 week later, on 12/16/22. While this routine consult was completed in 90 days, given the patient's chest pain, palpitations, shortness of breath, and hypertensive emergencies warranting ED visits, the consult needed to be performed urgently. The cardiologist ordered several cardiac tests, *including nuclear stress test as soon as possible*, echocardiography, and a Holter Monitor.

[105] SLE is a chronic, occasionally life=threatening, multisystem immune-mediated disorder. Patients may present with a wide array of symptoms, signs and laboratory findings and have variable prognosis that depends on disease severity and type of organ involvement. UpToDate. June 2023.

[106] A hypertensive emergency is defined as a significantly elevated blood pressure (Systolic BP=>180 and diastolic BP>120 mm Hg with signs of end-organ damage such as headache, shortness of breath, chest pain, blurry vision, heart palpitations, anxiety, dizziness, etc.

- On 12/6/22, a provider ordered a rheumatology consult via Rubicon, four and a half months after arrival. This delay was likely due to the delay in receiving lab reports confirming the patient had autoimmune disease.
- On 12/20/22 the ACH physician reviewed cardiology recommendations, and ordered an echocardiogram and Holter Monitor, but did not order a nuclear stress test to be completed 'as soon as possible'.
- On 1/4/23 Case Management forwarded the request for an appointment for cardiac studies to RCCC Custody Transport, two weeks after they were ordered.
- On 3/3/23 the patient had the recommended cardiology studies, including Holter Monitoring (HM), but the patient informed the monitors that she took the pads off because she was allergic and the test was not completed. Neither the cardiologist nor ACH providers noted that the Holter Monitoring was not completed. This is concerning because the patient complained of palpitations and had severe bradycardia (pulse-38-43/minute), and the patient was referred to cardiology specifically for clearance to take hydroxychloroquine to treat her SLE.
- On 3/23/23 cardiology saw the patient and reviewed the results of studies but did not address the lack of Holter Monitoring report. Cardiology did not address the question of clearance for starting hydroxychloroquine, which was the reason for the consult. [107]
- The cardiologist also recommended evaluation for sleep apnea and to address the patient's weight. These recommendations were not addressed.
- On 2/8/23 a physician saw the patient for follow-up of poorly controlled hypertension and other chronic diseases. The physician ordered a Rubicon consult for secondary hypertension. On 2/9/23 a renal artery doppler was ordered, an appointment requested on 2/25/23 and scheduled for 4/7/23, but the appointment was canceled because the patient was not kept NPO (nothing by mouth) after midnight. It does not appear there was any coordination between custody and medical regarding the need to keep the patient NPO. The delay is a concern because as recently as 1/12/23 the patient had blood pressures as high as 255/116 mm Hg, 230/122 mm Hg, and 234/188 mm Hg, and is at high risk for stroke, heart attack and kidney disease.
- On 4/8/23 a provider started the patient on hydroxychloroquine for treatment of SLE, 9 months after she arrived at the jail.

[107] The County notes that the monitor is not a cardiologist and does not have the qualifications needed to review the quality of care by the specialist. However, the cardiologist ordered tests he believed were needed to determine whether it was safe to give the patient hydroxychloroquine which is used to treat SLE. The patient had a significantly slow heart rate (pulse=38 to 43 beats per minute} and the Holter Monitor was to provide further information about the patient's heart rhythm. If the cardiologist believed the test was medically necessary and ordered the test, it needed to be completed. Moreover, the primary reason for the referral to the cardiologist was for an opinion as to whether it was safe for ACH providers to prescribe hydroxychloroquine for the patient's SLE, but the cardiologist did not document an opinion regarding this question. An ACH provider started the patient on the medication anyway.

- This was a medically complex patient who needed close monitoring and coordination of care, but her care was fragmented and delayed.

- This 47-year-old man arrived at SCJ on 3/16/2021 and is still at the jail. His medical history includes hypertension, history of heart murmur, subcutaneous neck mass/abscess, disseminated cocci, low back pain and neuropathic pain. In April 2022, the patient was diagnosed with disseminated coccidioidomycosis (cocci) after a year of symptoms (since May 2021), and was started on treatment. The delayed diagnosis was due to a low index of suspicion for cocci and *outside medical facilities failure to send culture reports that were positive for cocci to the County in July 2021 and February 2022.* Following diagnosis, there were delays in requesting initial and follow-up specialty services, and delays in receiving diagnostic reports. As of June 2023, he has not had timely follow-up by infectious disease. Specific Issues in this case during this monitoring period include the following:

  - On 4/26/22, at a follow-up visit more than 2 months after excision of a neck mass, ENT noted that the patient's cultures showed coccidioidomycosis. ENT informed the patient of the diagnosis and consulted Infectious Disease (who did not see the patient) who recommended fluconazole and ID follow-up. The patient's fluconazole order expired in August 2022, and was subsequently reordered.
  - The patient was not referred and seen by Infectious disease (ID) until 9/15/22, almost 5 months after his diagnosis. ID noted the patient's cultures were positive for cocci in July 2021 and February 2022. [108]
  - Infectious disease saw the patient for follow-up 11/17/22 and requested labs (cocci titers) and follow-up in 4-6 weeks.
  - As of 6/5/23 cocci titers have not been drawn and ID has not seen the patient for follow-up.

- This 59-year-old man had two admissions to the jail. He was admitted to SCJ on 10/22/22 and released 11/8/22. He was readmitted on 1/14/2023 and released on 5/31/23.[109] His medical history includes diabetes mellitus, gastroparesis secondary to diabetes, methamphetamine use disorder, hepatitis C infection, poor dentition, myopia, and unspecified schizophrenia. He has intractable nausea, vomiting, and abdominal pain due to diabetic gastroparesis. In the past, he had a Peg[110] tube (feeding tube) placed in his stomach, presumably due to inability to retain food. He does not currently have a Peg

[108] This raises the question of why the facilities that performed the cultures (including SJGH) did not notify ACH when the reports were available. There was no documentation in the record that the cultures were performed by the outside facility, so case management did not know to ask for a report.
[109] Patient #20.
[110] Percutaneous Endoscopic Gastrostomy (PEG) tube. He has intractable nausea, vomiting, and abdominal pain due to gastroparesis secondary to diabetes.

tube, but in the community he had almost monthly outside emergency department visits. In March 2022, he weighed 170 lbs.

- During his first admission, he was sent to the emergency department 4 times in 5 days for abdominal pain, nausea, and vomiting.[111]
- On 10/22/22 at booking he was declared unfit and sent to the ED. His weight=147 lbs. [112]
- On Monday, 10/24/22 at 4:20 pm, the patient was sent to the ED for severe abdominal pain, nausea, and vomiting. He was not evaluated by a physician prior to the send-out. An abdominal x-ray was normal. He was treated for nausea and vomiting. He was also diagnosed with fracture of his left ring finger.
- On 10/27/22, about 4 am, the patient was sent to the UC Davis ED for persistent abdominal pain, nausea, and vomiting and returned at noon. Thirty minutes later, at 12:30 a physician (RK) saw the patient and sent him out again for nausea, vomiting and abdominal pain. At the ED the patient had a right upper quadrant ultrasound that showed no acute findings. The provider did not address the patient's fractured finger. At UC Davis, the ED provider recommended follow-up with GI if symptoms persist.
- The provider (RK) documented a plan for a GI consult, but the consult was not found on the consult tracking log. The patient was released on 11/8/22.[113]
- During the patient's first admission the patient lost 13 lbs. (134.5 lbs.) and when he was readmitted his weight reached a low of 121.5 lbs. [114] Given this, he needed urgent referral to endocrinology or GI to evaluate his diabetic gastroparesis, gastritis, and other causes of weight loss (e.g., malignancy). This did not take place.
- An incidental finding is that on 2/16/23, an on-site test for hemoglobin A1C was 5.3% (normal). *The same day, labs were drawn and sent to the lab and showed the patient's hemoglobin A1C was 8.1%.* This shows the onsite machine did not provide an accurate test result and if so, patients are likely undertreated or overtreated base upon inaccurate test results. This can be dangerous if over treatment results in severe hypo or hyperglycemia. We suggest further CQI study, in which both an onsite test and outside labs results are compared for accuracy.
- Also, fingerstick blood sugars are being conducted at 3 am. This is an unreasonable barrier to care, and likely to result in many refusals.

During this site visit, the Monitors learned that Custody Transport at Main Jail and RCCC, made all outside medical appointments. This arrangement has apparently has been a

[111] One 10/22/22 the patient was declared unfit and sent to the ED. He was also sent to the ED on 10/24/22 and twice on 10/27/23 by the same physician.
[112] In March 2022 prior to admission, the patient's weight=170 lbs. In March 2023 it reached a nadir of 121.5 lbs.
[113] The County states that the provider did order a GI consult but states that it was cancelled.
[114] On 3/16/23, the most recent weight=125 lbs.

legacy practice since before ACH provided medical care at the jail, but is not described in policy.

Custody Transport schedules and *unilaterally* reschedules appointments based upon the availability of deputies and transport vans. Under this arrangement, The County cannot ensure that patients are scheduled in accordance with their medical needs. This is compounded by the fact that 99% all consults were designated as routine priority, when some patients clearly required urgent priority. It is the responsibility of the Medical Director to ensure that patients needing specialty services are assigned the appropriate priority commensurate with their medical needs.

When Custody Transport schedules appointments, deputies have daily access to Protected Health Information (PHI) and confidentiality is not provided. In addition. when monitors toured Custody Transport, we found specialty services requests to be scheduled laying on the desk, visible to staff coming in and out of the office. This is further addressed in the Utilization Management section of this report.

In summary, the practice of custody staff scheduling appointments based upon existing resources has resulted in systemic harm, particularly to patients with urgent medical needs.

Following the site visit, the Monitors sent a letter of critical items that needed to be addressed immediately, including custody scheduling medical appointments. In response, ACH developed an action plan to transition scheduling to Case Management as soon as possible. ACH reports that, as of the publication of this report, CM is scheduling all specialty appointments. *The County is to be commended for rapid implementation of this action plan.*

The corrective action plan includes:

- Case Management sending the Medical Director a weekly list of specialty services requests;
- Medical Director reviews the list of 'Routine" specialty referrals for appropriateness;
- Medical Director meets weekly with CM to review the referral list and discuss updates or resource options;
- Medical Director will continue to train providers on the need to designate referrals Urgent when appropriate;
- Medical Director will monitor inappropriate priority referral trends and meet with providers 1:1.
- The Medical Director reviewed referrals in April 2023 and changed the designation of several referrals from routine consults to urgent.

As Case Management assumes control of scheduling pending appointments, this will result in increased demand for custody staff and ADA compliant transportation vans. We recommend that

The County conduct an analysis of the need for additional vans and transport officers at RCCC. ACH is proceeding with this analysis examining the length of time RCCC that appointments are currently scheduled out in time, and appointment availability, factoring in unexpected barriers. It is likely that the demand for services will require a significant increase in resources.

Another obstacle is that on-site consultants frequently cancel their clinics, including ENT and orthopedics, sometimes for weeks or longer, delaying access to care.

Record review showed that Spectrum, the hemodialysis vendor did not reliably provide staff, resulting in cancellation of dialysis clinics, and requiring the County to send dialysis patients to an outside hospital or vendor 3 times weekly, putting a strain on custody resources. Consequently, ACH developed a contract with Satellite, an offsite vendor. But due to transportation demands and Spectrum's desire to continue services, in June 2022, Spectrum agreed to train and provide staff to continue services, with Satellite as the off-site back up.

Dialysis chairs and equipment are currently at Main Jail, but will be moved to RCCC. The plan is to create a 2-chair dialysis unit at RCCC MHU, with a requisition form (330) submitted and waiting on approval. If approved, a design consideration is that there must be sufficient space so the dialysis area is not cramped or cluttered in any way, to maintain sanitation and disinfection. If a fixed space has been designated that would not accommodate this requirement, we recommend working with architects to ensure that the area is of sufficient size.

Case examples illustrating these issues are described below.

- **Patient #1:** This 33-year-old man arrived at SCJ on 2/3/22. His medical history includes a right arm fracture on 11/1/22, ulnar neuritis, and elevated blood pressure. His medication is Trazodone.

  On Monday, 11/1/22 at 23:05, a RN saw the patient for right elbow pain due to playing basketball and hitting his right arm against the wall. The RN noted that his right elbow was swollen and that he could not move his arm. He denied right arm and hand numbness. The RN consulted a provider (RK) who ordered a right elbow x-ray in the morning and Naproxen 500 mg twice daily.

  On Tuesday, 11/2/22 at 07:45, the physician saw the patient who was unable to move his right arm secondary to pain. His right arm was in a sling. The patient had significant edema extending from his upper to mid lower arm. He was unable to extend or flex at the elbow due to pain. She ordered an urgent x-ray, ice, and follow-up in 2 days.

  On Wednesday, 11/3/22 at 11:05, the physician (ST) saw the patient who had not had the x-ray. He was unable to move right forearm down and starting to feel numb in right hand. He had a very swollen right upper arm that was tense, but not hot or warm. A/P: Concern for compartment syndrome. Send to ED today.

On 11/3/22 at 14:00, a medical assistant documented a note implying a delay in care. I forgot to put the X-Ref number of patient on ITI…it was a very busy day…everything happening at the same time…multiple phone calls…..but all is well and taken care of.."

On 11/3/22 at 15:55, a RN documented that the patient returned from the ED with a diagnosis of distal humerus fracture. Splint in place. No complaints of discomfort. Urgent physician sick call was scheduled.

On Thursday, 11/4/22 at 08:45, a physician (SN) documented that the patient had a distal humerus fracture and the ED advised ortho follow-up in 3-5 days. The ortho clinic was cancelled that day, and the patient would be seen the next week per case management.

On 11/4/22 at 16:57, a right arm x-ray showed "a comminuted spiral type fracture of the distal humerus diaphysis is demonstrated with slight displacement and angulation. It was reported on 11/4/22. On 11/7/22, A provider (RK) signed the report.

On 11/10/22 a provider (SN) signed the report.

On 11/11/22 at 08:11, the orthopedist, Dr Ho saw the patient and reviewed the x-ray. No signs of ulnar nerve damage. He discussed options including: 1) No treatment; 2) continued splint immobilization; and 3) surgical ORIF (open reduction and internal fixation). He documented that that the patient chose continued immobilization. A coaptation splint from the neck to the axilla was applied. The patient was instructed to let his arm hang to maintain fracture reduction. Dr. Ho counseled the patient about risks of loss of reduction during treatment and that he may need surgery in the future. Dr. Ho ordered follow-up x-ray and an appointment in 2 weeks.

On 11/11/22 at 21:36, a RN saw the patient who reported increased pain and tingling in his right fingertips, which was new onset. The nurse contacted Dr. Ho and the patient was to be scheduled for follow-up with ortho tech the next day to assist with re-wrapping. There is no documentation this took place.

On 11/15/22, the physician saw the patient. Plan: Send message to ortho to clarify splint recommendations. Follow-up in 2 weeks.

On 11/16/22, a RN saw the patient for right arm swelling.

On 11/18/22, Dr. Ho saw the patient. If patient does not tolerate splint, he may require surgical ORIF. He documented that the patient does not want surgery. Follow up next week.

On 12/1/22, a physician (SN), noted he was due for a right elbow x-ray and follow-up with Dr. Ho.

On 12/2/22, Dr. Ho noted that the patient had a right distal humerus diaphyseal fracture 4 weeks ago. Since he was last seen 2 weeks ago, the patient said his pain and swelling

had improved. There is interval loss of fracture reduction with coaptation splint immobilization. He discussed x-rays and treatment plan with the patient. Plan: Prompt surgical ORIF. A case management consult is placed. Remain in splint. The urgency of specialty services request was noted to be *routine* on the specialty services tracking log.

On 12/5/22, Case Management submitted an expedited ortho surgical clinic to RCCC Custody Medical Transport.

Note: The expedited appointment was not scheduled until 2/7/2023, 3 months after his fracture. Then the appointment was cancelled because the patient was out to court. The appointment was rescheduled for 3/7/23. During this time, Dr. Ho did not monitor the patient's condition and was unaware that the patient's surgery consult had not taken place, in order to intervene on behalf of the patient.

On 12/15/22, a RN saw the patient who told him he was in constant pain and requested stronger pain medication and wanted to know when his surgery would take place.

On 12/20/22, a physician (CE) saw the patient for ongoing pain related to his fractures and that he requesting pain medication. He was pending surgical ORIF. Plan: Naproxen and follow-up one month.

On 1/18/23, a RN saw the patient for chronic pain related to his fractured arm. The patients primary concern was about getting the surgery done which was pending, now as an urgent referral.

On 1/20/23 a physician (SN) saw the patient, noting that the patient's splint was loose and has not been rewrapped in a while. The physician rewrapped the splint and planned to check weekly until surgery.

On 2/7/23 the patient was not taken to the orthopedist appointment at SJGH because the patient was at court.

On 2/23/23, a RN rewrapped the patient's splint because it was dirty.

On 2/24/23 an ortho tech replaced the patient's splint.

On 3/7/23, an outside orthopedic surgeon saw the patient and noted that the patient sustained a distal third humerus fracture 4 months ago. It was noted one month later that he had lost reduction in his splint and was recommended for orthopedic evaluation. This is his first visit. He is still having pain as well as deformity of the arm. He denies neurological issues. He is unable to do his normal activities. The surgeon advised the patient about treatment options, including risks and benefits, and he agreed to have surgery.

On 3/17/23, Dr. Ho saw the patient who had agreed to surgery, noting that it was pending.

Note: On 3/20/23 we interviewed the patient who indicated that because he was not timely seen by a surgical orthopedist following the fracture, the surgeon advised the patient that surgery would be much more complicated, and that he would have to rebreak the bones, and the procedure came with risk of infection and nerve damage. The patient believed that the surgeon did not want to perform the surgery, and informed us that he decided not to proceed with surgery. On 3/17/23, Dr. Ho saw the patient, who was pending surgery at that time, but since that appointment, had changed his mind.

After interviewing the patient on 3/20/23, we recommended that the patient be referred to Dr. Ho to counsel the patient, document the patient's decision, and to determine if any non-surgical treatment would benefit the patient, and to cancel the order for surgery. He declined our request to see the patient.

On 3/23/23, a provider saw the patient who advised he "was not feeling like he wants to proceed with surgery especially after seeing his x-ray last week. Also felt like the surgeon may not have been confident in his plan for surgery, and the risks outweighed the benefits.

On 3/24/23, a RN completed a refusal of treatment form.

Note: An RN should not complete a refusal of treatment form for a patient who needed surgery but was refusing it. A RN is not qualified to explain the risks and benefits of surgery, and this case carries increased liability due to significant failures in access to an orthopedic surgeon.

On 3/24/23, a provider noted an email from Dr. Ho: "I saw the patient last week. His humerus fracture is 5 months old and healed already, but in malunion. If he wants to defer reconstructive surgery now, that is his choice. He does not need more splinting as his fracture is healed. He can follow-up with Ortho PRN. Please let me know if there is any other reason for me to see him today." There is no indication that Dr. Ho notified Case Management (CM) that the patient no longer desired surgery.

On 4/7/23, Case Management forwarded documentation for expedited ortho surgery to SJGH. Request for Services forwarded to Med Transport to schedule the appointment. Med Transport scheduled the surgery for 5/31/23, 6 weeks later.

Note: No provider including Dr. Ho, had notified Case Management that the patient had changed his mind about surgery, and proceeded to schedule it.

On 5/24/23, Case Management forwarded pre-op labs to the physician.

On 5/24/23, an RN noted that the patient was scheduled on 5/31/23 for surgery and needed to be NPO on 5/30/23.

On 5/25/23, a physician (SN) met with the patient for follow-up and confirmed he did not want surgery, and sent a notice to Case Management.

Summary: This patient did not receive timely care for his fractured arm, and he now has malunion of his fractured humerus and limited range of motion. On 12/2/22, Dr. Ho noted he experienced interval loss of reduction of his humerus and ordered an orthopedic surgery consult as soon as possible, but on the tracking log, it was listed as Routine. On 12/5/22, Case Management submitted the request to schedule the surgery to RCCC custody medical transport. On 12/22/22, Dr. Ho recommended surgery as soon as possible. It appears that the initial date for the appointment at SJGH was 2/7/23, but rescheduled because the patient was out to court, and rescheduled to 3/7/23, which was over 120 days since the fracture, and 90 days after Dr. Ho recommended surgery as soon as possible.

We reached out to ACH in December 2022, to inquire about the status of the patient with respect to scheduling the expedited surgery so that additional oversight would be provided for the patient. It is unclear whether ACH notified Custody Medical Transport of the urgency of the surgery. This patient has suffered an adverse outcome as a result of the delay in evaluation and treatment of his right fractured humerus.

- **Patient #2:** The patient is a 33-year-old woman admitted to SCJ on 6/21/22 and released on 3/27/23. Her medical history includes morbid obesity, sleep apnea, asthma, seizures, palpable breast lump and serious mental illness. Her medications are levalbuterol, Dulera, Keppra, prazosin and aripiprazole.

  On 8/24/22 a physician (AM) saw the patient who requested a gynecological examination and breast examination by a female provider. The patient reported a family history of breast cancer (aunt and grandmother) and her father had lymphoma. The physician planned to order an OB/GYN visit and breast ultrasound, and radiology (mammogram).

  On 9/6/22 a bilateral breast ultrasound showed no evidence of right breast sonographic abnormality either cystic, solid, or mixed. *The left breast in the 9 o'clock position 8 cm from the areolar demonstrates a hypoechoic area measuring 0.7 x 0.4 cm x 0.5 cm and in the 10 o'clock position 9 cm from the areolar demonstrates a moderately hypoechoic area measuring 0.9 x 0.7 x 0.8 cm which is not a cyst. Correlation with mammography is recommended.*

  On 9/9/22 a physician saw the patient noting that she had a strong history of breast cancer affecting two maternal aunts and maternal and paternal grandmothers. Breast exam was normal. Breast ultrasound was inconclusive and to correlate with mammogram. The provider ordered a mammogram.

  On 9/9/22, another physician noted that a mammogram was "ordered as per radiology".

  On 9/24/22 Case Management forwarded a request for mammogram with ultrasound if indicated to RCCC Custody Medical Transport. The mammogram with ultrasound was scheduled for an appointment 3 months later, on 12/28/22.

On 12/28/22 the patient had a mammogram that showed intramammary lymph nodes in the upper outer quadrant of the left breast. No masses or suspicious microcalcifications were identified. Impression: No mammographic evidence of malignancy.

On 1/6/23 a medical provider met with the patient and advised that no further follow-up was needed.

Note: Although the mammogram did not show suspicious masses, the 9/6/22 left breast ultrasound showed two hypoechoic areas, one determined not to be a cyst. According to current guidance (UpToDate), given these findings and the patient's strong family history of breast cancer, the patient needed to be referred for breast biopsy and genetic counseling. We forwarded our concerns to ACH, who indicated the breast biopsy was not indicated. After further discussion, ACH agreed to refer the patient to a breast surgeon and genetic counseling.

On 2/2/23, Case Management referred the paperwork and request for an appointment at UCD Genetics.

On 2/3/23, the Medical Director met with the patient, who agreed to an appointment with a breast surgeon.

On 2/9/23, Case Management noted that UCD Genetics denied the referral due to lack of capacity. On 3/3/23 a physician signed the note.

Note: There is no documentation that any further action was taken to secure a genetic counseling for the patient.

On 2/4/23 Case Management referred the request for an expedited breast surgeon appointment to RCCC Custody Medical Transport. The appointment was scheduled for 2/23/23.

On 2/23/23 the patient refused the appointment because she thought she was getting out in 3 days, and would address it on the outside.

On 2/24/23 a NP counseled the patient about the risks of refusal of the consult, including cancer, metastasis, and death. The patient wished to address it when she was released.

On 3/25/23, a pharmacist noted discharge medical and mental health medications to be prepared for release.

On 3/27/23 the patient was released.

Summary: The patient did not receive timely evaluation for a palpable breast mass and strong family history of breast cancer. On 9/24/22, two weeks after mammogram it was ordered, Case Management submitted the request to RCCC Custody Transport to schedule an appointment. *The mammogram appointment was scheduled over 3.5 months*

from the time it was determined to be medically necessary. The medical record does not reflect that medical providers and case management monitored the timeliness of the mammogram-ultrasound appointment. Based upon the patient's strong family history of breast cancer, and guidelines for evaluation of a breast mass, the monitors recommended that the patient be offered a consult with a breast surgeon and genetic counseling. The patient accepted but was released prior to the appointment with the breast surgeon. An appointment for genetic counseling was not followed up after UCD Genetics declined to see the patient. This is another case in which RCCC Custody Medical Transport did not schedule a timely medical appointment, and Case Management/ Medical Director did not monitor the timeliness of the appointment.

- **Patient #7:** This 47-year-old man arrived at SCJ on 3/16/2021 and is still at the jail. His medical history includes hypertension, history of heart murmur, subcutaneous neck mass/abscess, disseminated cocci, increased liver enzymes, low back pain, neuropathic pain, hematuria, and vesicular rash. His medications are amlodipine, metoprolol, posaconazole, duloxetine, cetirizine, and acetaminophen.

  This patient arrived at Sacramento County Jail in March 2021. In May 2021 he presented with a large neck mass and draining wounds on his left hip and rib.

  On 8/31/21, an ear, nose, and throat (ENT) physician noted the patient had a neck mass and recommended removal of the mass. On 2/16/2022, the ENT excised the patient's neck mass and sent it for biopsy and cultures.

  In April 2022, ENT saw the patient for follow-up excision of a neck mass in February 2022. The ENT noted that cultures showed the patient had disseminated coccidioidomycosis (cocci). This was approximately one year after the patient showed symptoms of cocci and 8 months after excision of the neck mass was recommended. The ENT consulted Treatment with fluconazole was begun, with recommendations for Infectious disease follow-up. The patient's prescription for fluconazole expired in August and was restarted.

  On 9/15/2022, five months after the patient was diagnosed with cocci, Infectious Disease (ID) saw the patient for an initial consult and ordered an antifungal medication. On 11/17/22 Infectious disease saw the patient for follow-up and ordered labs and follow-up in 4-6 weeks.

  As of 6/5/23 cocci titers have not been drawn and Infectious Disease still has not seen the patient for follow-up.

  Summary: This patient had symptoms of coccidioidomycosis in May 2021 but was not diagnosed until April of 2022. Delayed diagnosis was due in part to delayed specialty services but also two outside hospitals failure to forward lab reports in July 2021 and February 2022 that were positive for cocci. Therefore, the County is not solely responsible

for the delayed diagnosis. However, once diagnosed, the County has not provided the patient timely access to Infectious Disease follow-up and treatment.

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

Recommendations: The County needs to:

1. Continue the transition for specialty services appointment scheduling from Custody Transport to Case Management.
2. Timely approve/deny specialty services referrals. The approval should not be delayed pending lab work or imaging.
3. Routinely inform providers of the dates of appointments (not sharing the information with the patient) and rescheduled dates.
4. Regularly monitor high-risk patients to ensure their condition is not deteriorating and needing intervention.
5. Bring all patients returning from appointments to 2 Medical or the Medical Housing Unit (MHU) so that a nurse can review findings and recommendations and notify a provider of urgent recommendations requiring immediate orders.
6. Consider having the clinic RN seeing the patient at return visits order provider follow up appointments and notify Case Management, so that it can be tracked on the log.
7. Review all consultant recommendations, develop a treatment plan, and educate the patient about the diagnosis and treatment recommendations. Schedule follow-up as clinically indicated or requested by the specialist.
8. Assess the demand for specialty services and custody staff needed to transport patients to specialty services appointments, and submit growth requests. Health Protected Information (HPI) needs to kept confidential.
9. Exploring contracts with other on-site consultants, if on-site providers do not provide reliable services, which delays diagnosis and treatment for the patient.
10. Conduct CQI studies on the timeliness of labs and radiology reports.

F. Medication Administration and Monitoring

3. 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.
4. The County shall provide sufficient nursing and custody staffing to ensure timely delivery and administration of medication.
5. 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.
6. 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.

1. 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.
2. 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 revised pharmacy and medication policies and procedures, including for patients that are sent out to court (F.1.a, F.1.b, and F.4).

ACH Policy 04-20 allows Keep-On-Person (KOP) medications that include nitroglycerin, medications for chronic diseases, inhalers, and over-the-counter medications (F.6). ACH is currently working to fully implement the Keep on Person program.

ACH CQI conducted a point in time audit on August 17, 2022, to determine if new medications were timely administered and whether medications were renewed without interruption. The study showed the 100% (N=35) of new medication orders were timely, and 86% (N=6) of patients with medication renewals were timely renewed. This represents an improvement from the ACH CQI study conducted on February 2, 2022, that reflected 100% (N=65) of new medication orders were administered timely and 64% (N=7) of patients with medication renewals were continued without delay. However, we note that the sample of records selected for medication order renewals was small (N=7) and does not provide sufficient data to demonstrate that medications are timely renewed.

At the time of our last report, medications were scheduled to be given twice daily, at 7 am and 7 pm (F.3.). Standards of nursing practice permit medications to be given one hour before and one hour after a designated medication time. Nursing staff schedules began at 7 am and does not allow nurses to take full advantage of the window of time permitted to administer the 7 am dose (6 am to 8 am). The medication administration times, and the nursing schedule remain unchanged, resulting in medications being administered beyond the permitted two-hour window and sometimes as late as 3 or 4 hours later.

For example, a patient complained of not timely receiving his medications, and review of the medication administration records from March 22, 2023, through May 4, 2023 supported his claim. During this timeframe, the patient timely received medication doses only 2% of the time; 11% of medication doses were administered 1-2 hours later; and 74% of medication doses were administered 2-4 hours later; and 11% of medication doses were given greater than 2 hours late, and sometimes as late as 9 hours after the scheduled dose.[115] Untimely medication administration, particularly for drugs like insulin, presents a patient safety risk (e.g., hypoglycemia or hyperglycemia), and may impact the efficacy of the medicine.

In two independent interviews, patients reported not receiving their 7 pm medications on 3/12 and 3/16/23, and review of medication administration records support their claim.[116] The medication administration records are blank on these days for the 7 pm scheduled doses. Critical medications such as insulin and HIV medicines were not provided as ordered, falling below the nursing standard of care, and creating both a clinical and safety issue for many patients. Nursing leadership confirmed that medications were not administered secondary to a shortage of nursing staff. Cancellation of medication administration is a *"never event"* and cannot be allowed to happen.

[115] Patient #26
[116] Patients #8 and #10.

Observation of the practice of medication administration showed non-compliance with nursing standards of care, and ACH medication policies and procedures. ACH policy 04-17 requires nursing staff to positively identify the patient using their armband, and if the patient does not have an armband, the nurse is to verify identification using the patient's name, date of birth, jail number (X-ref), and the booking photo in the electronic health record. Nurses observed conducting medication administration had unit-dose packages labeled with the patient's cell number and were observed most identifying patients without an armband by asking their cell number, rather than relying on name, date of birth, X-Ref number, and the booking photo as required by policy. Even when a patient presented the nurse with his armband for identification, the nurse did not use the armband to identify the patient, and instead asked the patient for his cell number.

The Sheriff's Department Operations Order, Medication Distribution "Pill Call," requires custody staff to visually inspect the mouth of each patient after they take a dose of medication, to confirm the medication is fully consumed. Observation of medication administration found that neither the custody officer nor the nurse conducted an inspection of the patients' oral cavities to ensure that patients did not "cheek" or "palm" of medications, even when administering psychotropic medicines. Failure to inspect oral cavities to ensure ingestion can result in hoarding, bartering, trading, and utilizing medications for purposes other than disease management.

When patients failed to report to the medication administration line, the nurse and officer went cell to cell to administer medications. The nurse failed to take the computer and the medication cart inside the housing unit reporting "it's not a good idea." The nurse carried the packages of medications in a small hand-held basket. Conducting medication administration without the benefit of the patient's health record and medication administration record is a patient safety issue. This also results in delay of contemporaneous documentation, a nursing standard of care.

The accompanying officer failed to ensure the light was on in the patients' cells making it difficult to identify and observe the patients while they still in their bunks. Also, patients were allowed to approach the cell door to interact with the nurse without being required to be dressed. Rather than the nurse leading the medication administration process by engaging each patient, the officer approached each cell and asked the patient if they wanted their medication. If they declined, the nurse accepted the report as a refusal by the patient. The nurse did not engage the patient, provide patient education, or attempt to identify the reason the patient was refusing their ordered medicines.

Additionally, while the nurse was going cell to cell, she used the cell number as the identification of the patient, rather than the armband as required by policy. At one point, the officer asked the nurse who the patient was, and she referred to the packaged medication, again marked with a cell number, to provide the inmate's name to the officer. The cells were double bunked so the risk of administering medications to the wrong inmate is high, without proper patient identification. Again, there was no inspection of the patients' oral cavities to ensure the medication was swallowed, and the officer closed the door prior to the patient obtaining water from their sink for ingestion of the medication.

Nursing standards of care requires nurses conducting medication administration to comply with standard infection control practices. One nurse was observed dropping a pill on the housing unit floor, retrieving it from between her feet, and asking the patient if he wanted it, which he accepted and ingested. This action by the nurse as quite concerning, as administering anything to a patient that has dropped on the floor is unacceptable practice in any healthcare setting, and more disturbing given the nurse was aware she was being observed for compliance with policy and procedure.

Nurses were observed tearing the tops of all medications due for the patient at one time and dumping the pills into a cup. This practice does not allow for positive identification of single medications that the patient may choose to decline, leaving the nurse to guess which pill to remove from the cup. We recommend that the nurse review medications with the patient to determine whether the patient will accept or refuse medications.

During medication administration in the female unit, a patient was noted to have a string, which appeared to be a shoelace, tied around her neck. The nurse asked her to remove it and the patient argued that it was not tight, and removal was not necessary. The officer failed to intervene, leaving the nurse to tell the patient she would secure scissors and return to remove the string. At that point, the patient became angry and broke the string from her neck after several hard tugs. At no time did the officer take command of the situation to ensure the patient's safety.

Observation of several medication administration rounds revealed an unusually high number of patients receiving nutritional supplements such as Ensure and Carnation instant breakfast. On multiple occasions, patients used the receipt of these supplements as a bargaining chip with the nurse. They would ask for their Ensure and if the nurse did not have it available or responded that it was not ordered, the patient would refuse their medication. Nursing staff reported that nutritional supplements are used as a reward system for medication compliance. *Nutritional supplements such as Ensure have a very high calorie content, and its regular use without medical indications contributes to weight gain and obesity. This is a particular concern for mental health patients who may be prescribed medications that also result in undesired weight gain and obesity.*

Record review showed that patients prescribed albuterol rescue inhalers on an as needed basis (PRN), were escorted to 2M for evaluation by a registered nurse. We found that nurses denied patients use of their prescribed inhaler, based on their assessment of the patient. It is concerning that nurses would deny a patient a rescue inhaler prescribed on a PRN basis. This is underscored by the fact that nurse assessments were typically inadequate as nurses did not use peak flow meters to measure airflow restriction, an objective measure of asthma severity. Rescue inhalers should be prescribed as keep on person (KOP), particularly if the patient has a history of moderate or severe asthma or is on a steroid inhaler. Ready access to an inhaler reduces the risk of rapid deterioration of the patient's condition. If a nurse finds a patient is in respiratory distress, the patient should be given an immediate dose of rescue inhaler and escorted to the clinic for further assessment.

Medical record review shows that medical providers routinely assess patients for efficacy of medications and side effects, and make modifications to therapy as clinically indicated (F.5).

During our site visit, we interviewed a patient who reported experiencing two severe allergic reaction followed by an anaphylactic reaction to a medication (Naproxen). [117] On the afternoon of 3/6/2023, the patient reported that he had developed hives after taking new medications (Naproxen and imodium). The RN notified the physician (AM) who did not evaluate the patient, and did not review the patient's medication list to determine which medication was likely to cause hives. *The patient received another dose of Naproxen the same evening.*

On 3/7/2023 at about 04:00, the patient developed hives and swelling of his right eye. At 05:10, the on-call physician ordered the patient sent back to the hospital via van. However, 1 hour 40 minutes elapsed before custody transported the patient to the hospital via van. This was dangerous to the patient, who received epinephrine and IV solumedrol at the hospital. Upon his return, the physician (AM) discontinued his Naproxen, but did not order the recommended dose of prednisone (20 mg instead of recommended 30 mg) and document the clinical rationale for departure from hospital recommendations.

On 3/8/2023 at 08:39, a RN documented that the patient's hives appeared to be worse than yesterday. At 11:55 the patient was having difficulty breathing with abnormal lungs sounds. Two hours later, the physician (AM) examined the patient who was now in respiratory distress, using accessory muscles, and ordered the patient sent to the hospital code 3.

Note: We interviewed the patient during the site visit. He reported that the day after he returned from the ED following a severe allergic reaction (3/7/23), a nurse administered another dose of Naproxen to him. This Naproxen dose may have been for 3/7/23, but not given because the patient was at the hospital with a severe allergic reaction. If the information from the patient is accurate, it was a serious medication error. This error would have been prevented if ACH had a system in which the nurse had the computer immediately available and scanned the patient's wristband to identify the patient, which would bring up the MAR and show that the medication had been discontinued the day before. This is a patient safety issue.

For this patient, both ED visits were sentinel events, one that was not preventable, and one that was likely preventable. In discussions with health care leadership, these ED visits were not recognized and treated as sentinel events, nor were they investigated to determine the cause and what could be done to prevent future events.

Regarding providing medications to patients going out to court, traveling off-site to specialty appointments, or transferring to other institutions receive their medications, this requires coordination with security and the pharmacy. ACH provided policy 04-17, Medication Administration, that requires the night shift nurse to deliver the medication to the patient prior to departing the jail however, the policy does not provide specific operational guidance to direct

[117] Patient #24

staff on the required steps to ensure the patient receives the medication, along with instructions on when to take the medicine, information on how the medicine is packaged, and a tracking process to measure compliance. The policy needs to address the role of patients and/or deputies transporting medications to be taken at court and outside appointments, access to water to take medications, and confirming the medication was taken, if not done at the time of delivery.

Compliance Assessment:

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

Recommendations: The County needs to:

1. Assess the adequacy of nurse staffing and the staffing schedule to perform medication administration within a two-hour time window.
2. Retrain all nursing staff on medication administration including positive identification of patients and standard infection control practices.
3. Train nurse nursing staff to take the computer into the housing unit and administer medications with the medication administration record available to them.
4. Train security staff on managing the patients during medication administration including ensuring they are appropriately clothed with their cell lights on.
5. Train security staff on the requirement of conducting oral cavity checks.
6. Establish a contingency plan for medication administration when there are insufficient nurses.
7. Without delay, provide adequate security staff to escort health staff during medication administration.
8. Escalate issues related to lack of custody escorts for nurses to conduct timely medication administration up the medical and custody chains of command.
9. Conduct CQI studies regarding timely medication renewals to ensure continuity of medications,, using a larger sample size over a designated period (30 days).
10. Implement the EHR technology to scan the patient and medication to ensure that that the nurse is giving the right medication to the right patient at the right time.
11. Fully implement the Keep on Person program and include a process for monitoring compliance of patients self-administering medications.
12. Discontinue the practice of nurses independently deciding whether to administer as needed medications, including rescue inhalers, and perform adequate asthma assessments (i.e., symptom review and measuring peak expiratory flow (PEF)
13. Allow patients to keep lifesaving medications as KOP, including rescue inhalers.
14. Revise the Medication Administration policy with specific operational guidance that addresses how patient medications being provided for off-site transport or transfer are

packaged, communication to the patient on when to take the medication, access to water for consumption, security of the medication during transport, and tracking and documentation of the compliance with the administration of the medicine. ‘

G. Clinic Space and Medical Placements

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

Findings: The County acknowledges that space limitations continue to negatively impact service delivery and patient confidentiality.[118] For example,

- The County has not provided sufficient clinical space for health care staff to conduct examinations and interviews with privacy (G.1);
- The negative pressure room on 2 Medical is not functional (G.2).
- A patient living on 2M as a medical placement is not permitted to come out of his infirmary room to recreate. He is confined to his room 24 hours a day (G.3). [119]
- Patients with C-Pap machines living on 2 East at Main Jail can access programs and recreation (G.4.).

[118] Fifth Mays Status Report. Page 4.

[119] The monitors confirmed this with a Sargent who stated that if she “made an exception for him, she would have to make an exception for everyone on the unit. This does not acknowledge that unlike other infirmary patients, this is his permanent assigned living space.

Since the last report, the County has made some improvements that include:

- Improved sanitation in the booking area and 2 Medical;
- Terminal cleaning and painting in the intake screening area;
- Renovated to enlarge nurse screening stations, and installation of plexiglass between the nurse and patient for nurse safety;
- Replaced of broken equipment and examination room cabinetry.
- Established a detoxification unit and another unit to house patients on the Medication Assisted Treatment program.

The County is to be commended for these improvements.

There are structural issues and operational practices that do not support compliance with Consent Decree requirements. These include:

- Modifications to the screening stations are insufficient to provide auditory privacy for detainees as they go through the medical screening process.
- Detainees requiring monitoring for alcohol and drug withdrawal are placed in a "Sobering Cell," a large room that is used to monitor a person for withdrawal symptoms. It is dehumanizing and no place for any type of therapeutic monitoring.
- There are insufficient clinical examination rooms for nurses to perform adequate nurse assessments with privacy, and nurses continue to perform cell-front assessments.
- The negative pressure room used to house tuberculosis suspects on 2M does not have an anteroom and the room lacks negative pressure needed to provide respiratory isolation. It cannot be used to house tuberculosis and other patients requiring respiratory isolation.
- East 100 is designated for disabled inmates in wheelchairs. It has five cells and, according to staff is always full.

Following publication of the Nacht&Lewis and Kevin O'Connell reports, the County has moved forward with plans to both reduce the population and remedy physical plant deficiencies to meet Consent Decree requirements. On 12/8/22, the Board of Supervisors approved a two-tiered approach that included steps to achieve population reduction consistent with Kevin O'Connell's report and new construction to create an acute psychiatric unit and an intake and health services building. This in anticipated to take years to implement this plan.

Finally, the monitors note that the MHU at RCCC serves male patients only. *As a result, females housed at RCCC are unable to access the same care and treatments that are available to the male population. This is unacceptable, especially because RCCC has a sizable female population. This situation also leads to unnecessary hospital send-outs because females are transported offsite for basic procedures like the provision of IV fluids.*[120] *The County needs to renovate the MHU to designate space where females can be treated, or devise an alternative plan to ensure that female*

[120] Patient #21.

patients at RCCC have access to the same options for treatment as male patients. We suggest this be done when the MHU is renovated for a new dialysis unit.

Compliance Assessment:

- G.1=Noncompliance
- G.2=Noncompliance
- G.3=Noncompliance
- G.4=Substantial Compliance

Recommendations: The County needs to:

1. Develop an interim plan to meet Consent Decree requirements to provide patient privacy.
2. Reassess privacy measures for intake screening.
3. Create additional exam rooms on each floor for nursing sick call (and mental health encounters). For nurses to conduct adequate examinations, the room needs to be large enough to contain:
    a. Desk and 2 chairs
    b. A computer with access to the electronic medical record
    c. An examination table and exam paper[121]
    d. A medical supply cart containing equipment and supplies
    e. Electronic weight scale
    f. Hand held visual acuity chart
    g. Adequate lighting
    h. Privacy screens
    i. Handwashing capability (e.g., portable sink)
4. For the new intake and health services building, include a respiratory isolation room with an anteroom.
5. Consider including the following space in the plans to facilitate Consent Decree compliance.
    a. Examination rooms in booking for medical providers to see urgent referrals
    b. Specialty services
    c. Telemedicine
    d. Discharge Planning
    e. Dialysis
    f. Medical Infirmary for males and females
    g. Other space as identified in this report.
6. Modify the MHU to ensure that females can be treated in that space. We suggest this is done at the same time the MHU is renovated for a dialysis unit.

[121] The County asked if a lab chair could be used instead of an examination table, however this is unlikely to permit adequate abdominal examinations.

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: At this time, the County ACH and SSO does not provide confidentiality and privacy to patients for clinical and other health related encounters (H.1).

ACH has revised policies involving patient privacy, but has been unable to fully implement these policies in a manner that provides privacy and confidentiality of medical information. Both Main Jail and Elmwood have insufficient clinical space to provide confidential clinical encounters (H.2).

This is supported by medical record documentation in which health care staff note that intake screening and other encounters are non-confidential. When there is no available space to see the patient, or when there is no deputy to escort the patient to an examination room, nurses and providers conduct cell side interviews/assessments which are not confidential (H.3).

ACH and SSO are also exploring construction of a clinical examination room on each floor for nurses and/or mental health to see patients, but this has not yet been implemented.

ACH and SSO have made some process improvements to provide privacy and confidentiality. ACH separated clinical information from the Intent to Incarcerate (ITI) forms used by custody to transport patients to the hospital, thus maintaining confidentiality of medical information (H.1). However, at the same time, we learned during this site visit that custody staff schedules all specialty services appointments, and have access to Protected Health Information (PHI), violating patient confidentiality daily (see Utilization Management section).

ACH and SSO have made physical plant improvements in booking, however they are insufficient to ensure privacy. The medical intake area was renovated to increase the size of each cubicle and install plexiglass at each nurses' station. We interviewed intake nurses in the booking loop when there happened to be no patients and it was not noisy. Sitting at one of the nurses' stations with plexiglass separating us, and speaking at normal volumes, we had difficulty hearing one another, requiring each of us to repeat our questions at a higher volume. The nurse acknowledged that when intake screening is being conducted, it is typically noisier and she and the patient must speak loudly to hear one another. She reported that under these circumstances, confidentiality cannot be maintained. The RN indicated that if a small section at the bottom of the plexiglass were cut out, she believed that it would not be necessary to speak as loudly in order to be understood. This would be a temporary remedy until a permanent solution is found.

ACH and SSO plan to construct rooms on each floor for nurses and mental health to examine and interview patients (See Clinic Space). The examination rooms need to be of sufficient size to include necessary furniture and equipment. designed to enable privacy such as opaque half walls, of sufficient size to equip the room to perform adequate assessments. This includes:

- Desk and 2 chairs
- Computer desk with access to the EHR
- Examination table to perform heart and abdominal assessments
- Electronic scale
- Supply cart containing blood pressure cuff, stethoscope, pulse oximeter, otoscope, hand sanitizer alcohol wipes, gauze, small visual acuity chart, and other supplies
- Privacy Screen
- Handwashing capability (e.g., portables sink)
- Patient Education Materials

If these examination rooms are not properly equipped and supplied, *this will predictably result in inadequate nursing assessments.*[122]

[122] Proposals to escort the patient to another examination room that is adequately equipped (e.g., exam table) is not feasible due to providers occupying the room, and will result in the examination not being performed.

As noted in our last report, patient privacy is a cornerstone of the patient-provider relationship. Lack of privacy deters patients from sharing clinically relevant information needed for providers to timely diagnose and treat patients. Patients unable to freely communicate with providers results in delayed or missed diagnoses, and preventable harm. Lack of privacy also limits what providers share with patients, inhibiting provider-patient communication.

Compliance Assessment:

- H.1=Noncompliance
- H.2=Noncompliance
- H.3=Noncompliance
- H.4=Substantial Compliance

Recommendations: The County needs to:

1. Continue to make modifications to the physical plant, to provide patient privacy and confidentiality.
2. Provide adequate numbers of deputies to escort patients to an examination room that provides privacy and confidentiality.

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 uses the Centricity electronic health record and health staff have access to medical, behavioral health, and dental records for each patient (I.1.). As mentioned in previous reports, the software does not meet administrative needs specific to data analytics and population health management. There is a long-term plan to procure a new electronic health record, however a specific project timeline has not been established.

The County made modifications to several health record forms including the receiving screening forms, and separated clinical information from the Intent to Incarcerate (ITI forms used by custody when transporting patients to the hospital or off-site medical appointments.

Medical staff do not have access to health information needed to provide timely medical care (I.2). Record review shows that some outside records are not timely received and scanned into the electronic health record. In some cases, request for Release of Information (ROI) are not received.

In some cases, consultants order MRIs and CT scans. When the patient returns for follow-up, only the report is provided to the consultant, and not the disk containing images that the consultant needs to review in order to develop a treatment plan. This has resulted in delays of care and repeat scans, using scarce custody resources. This requires coordination between Health Information Management (HIM) and Case Management.

During the March site visit, we learned that Custody Health Transport schedules all medical appointments for Main Jail and RCCC. In doing so, custody staff have access to Protected Health Information (PHI) on an ongoing basis, violating patient confidentiality. This is addressed in the Utilization Management section of this report.

The system for notifying medical providers of received specialty services reports is not reliable at this time, resulting in further delays of care. When reports are available, some medical providers sign the report, but do not document a progress note indicating that they have reviewed it, or developed a treatment plan for each recommendation. This raises the question of whether the provider read the signed report.[123]

Examples of delayed scanning and/or delayed provider review of reports are noted below:

- On 8/18/22, a patient was sent to the emergency department (ED). On 11/9/22 the records were scanned into the EHR.[124]
- On 9/17/22, a patient was sent to the ED. On 1/19/23 the report was scanned into the record.[125]
- On 10/13/22, a patient underwent a procedure at UCD. On 1/20/23 the report was scanned into record.[126]
- On 9/25/22, a patient was sent to the hospital for hyperglycemia. On 1/19/22, the records were scanned into the EHR.[127]
- On 11/15/22, a medical assistant performed a point of care (POC) A1C test that was critically high (A1C=14.5%). The MA documented the result in a general note, but did not

[123] Patient #5.
[124] Patient #4.
[125] Patient #4.
[126] Patient #5.
[127] Patient #8

notify a provider. Providers did not become aware of the patient's A1C for 6 weeks in late December 2022.[128]

Providers generally do not select the templates available to them in the EHR. For example, providers often do not select the chronic care template and instead document on a sick call template. This may result in providers not knowing what took place at the last chronic disease visit. Similarly, the obstetric providers did not select the OB template or OB flowsheet enabling tracking of trends.

The County Information Technology (IT) department supports ACH staff and the electronic health record with a help desk. Help desk calls are assigned, tracked, and reports generated that analyze volume, type, frequency, etc. ACH staff have access to the Fusion software help desk for more complicated troubleshooting and development of reports specific to healthcare data tracking and population health management. Healthcare data reports, currently available to ACH staff, are not sufficient to support data analysis needs. For example, the ability to track and analyze ordered labs, radiology, and off-site specialty appointments are not currently available inside the Centricity application (I.3).

Compliance Assessment:

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

Recommendations: The County needs to:

1. Reevaluate systems for timely retrieval and scanning of health documents including:
    a. Release of Information (ROI) requests;
    b. Emergency Department and Hospitalization reports;
    c. Specialty Services reports;
    d. Laboratory, radiology, and imaging;
    e. Ensure that all health documents (e.g., lab, ED and hospital records, and specialty services reports) are timely scanned and providers notified of need for chart review when indicated.
2. Create a robust system for notifying health care providers of received reports.
3. Timely review reports and document treatment plans in response to the reports.
4. Establish a definitive project timeline for procurement of a new electronic health record system that is customized to align with ACH workflows, and provide sufficient data

[128] Patient #8

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 developed Specialty Services and Utilization Management policies that were revised following feedback from Plaintiffs and medical monitors (J.1). The policies include an appeals process (J.4). However, as noted in the Specialty Services section of this report, with respect to scheduling appointments, each policy states the following:

> *If an offsite specialty clinic is appropriate, the Case Management nursing staff shall coordinate the appointment for the patient within the required timeframe. (Specialty Services)*
>
> *Once approved, urgent referrals will be scheduled to occur in 14 days or sooner as clinically indicated by the medical provider. Diagnostic imaging will be scheduled to occur in 30 days or sooner if clinically indicated. Routine referrals will be scheduled to occur in 90 days or sooner if clinically indicated. (Utilization Management).*

The policies imply that Case Management schedules the appointments, however, during this site visit, we learned that at both Main Jail and RCCC, Custody Medical Transport makes specialty services appointments based upon custody schedule and transport resources. This has resulted in systemic delays in specialty services and preventable harm, or increased risk of harm to patients, described in the Specialty Services section of this report (J.2).

For example, during our March 2023 site visit, at the RCCC Custody Medical Transport office, we found the following specialty services requests sitting on the desk that had not yet been scheduled:

- An 8/23/22 request for a CT scan with contrast for a patient with a pulmonary nodule. On 3/1/23 Case Management sent an email to reschedule the appointment.

- An 11/19/22 request for an ENT consult for a patient with nasal bone fractures seen in the emergency department, that was initially scheduled for 3/14/23, but a case management note indicated that it had to be rescheduled.
- A 2/11/23 request for an esophagogastroduodenoscopy (EGD)[129] for a patient whose blood count had dropped from 12.3 to 10.7 grams, a concern for GI bleeding.
- A 3/4/23 request for a CT scan with contrast as soon as possible for a patient with a history of rectal cancer and chronic gastroesophageal reflux disease (GERD).

These are significant delays in scheduling appointments for procedures to rule out cancer, GI bleeding and treatment of fractures. When custody schedules medical appointments, Case Management/Medical Director does not have control over the ability to provide timely care for patients with serious medical needs. Upon further inquiry, ACH advised us that this is a legacy practice in effect since ACH became the health care provider.

Since the March 2023 site visit, ACH advised the Monitors that as of mid-June, Case Management assumed responsibility for scheduling RCCC specialty services appointments, that has resulted in other positive changes related to coordination of appointments, including being able to fill an appointment from a waiting list if the scheduled patient has been released, is out to court, or refuses their appointment.

Case Management will assume responsibility for scheduling specialty services at Main Jail as well as RCCC. However, Case Management is currently not resourced to meet the demand for scheduling Main Jail appointments, which involves coordination with hospitals, specialists, and custody transportation. In addition, Case Management schedules on-site specialty appointments, and tracks receipt of hospital, emergency department and specialty reports. The need to meet specialty services time frames required by the Consent Decree will require additional Case Management and custody transport deputies and ADA vans. Case Management has received an additional registered nurse; however, this allocation is insufficient to meet the demand to provide timely specialty services. We encourage the County to prioritize and expedite adequate Case Management and custody transport resources.

Review of the Specialty Services Tracking Log shows that it contains required elements of the Consent Decree. The Tracking Log shows improvement in the timeliness of review and approval/denial by Case Management, however there are some requests that were not approved within policy time frames (e.g., urgent=24 hours, routine=3 business days).

For this monitoring period, *virtually all specialty services were assigned as a routine request, including for fractures requiring surgical intervention and cancer evaluation and treatment.* This appeared to be related to when the service was available, and not the clinical urgency of the patient's condition. *The Medical Director is ultimately responsible for ensuring that patient's*

[129] An EGD is a procedure to place an endoscope into the esophagus and stomach to examine for abnormalities such as bleeding or tumor.

receive timely access to specialty services, and it is deeply concerning that this did not occur for many patients. The monitors discussed this with ACH and for specialty services requests submitted in May 2023, the Medical Director amended the urgency of the request for several patients.

A concern is that Case Management/Medical Director denies specialty services requests if labs or diagnostic tests needed by the consultant have not been performed prior to the specialty services request. This is different from a denial due to a provider not performing an adequate work-up to justify the consult. When medical providers have determined that a consult is medically necessary, and there is no disagreement about the need, Case Management should approve the request, and coordinate labs and/or diagnostic tests required by the consultant to be performed as soon as possible, which facilitates appointment timeliness. If the consult is not medically justified, then it is appropriate for Case Management/Medical Director to deny the consult.

Medical record review shows that Case Management did not consistently inform medical providers of appointment time frames. Providers do not adequately monitor the patient and address appointment time frames that are beyond what is medically acceptable for the patient. (J.3). [130]

Record review also showed that medical providers did not timely inform patients of the status of their specialty services request.[131] We note that in the weeks prior to an appointment, ACH does not meet with the patient to determine if the patient still wants to have the specialty service appointment. Because of sometimes extensive delays, some patients may have changed their minds or are unprepared on the day of the appointment. This likely contributes to patient refusals for specialty services, which is a waste of resources that could be utilized by another patient, as well as harm working relationships with specialists.

The UM policy includes an appeal process. According to the County no appeals were submitted during this monitoring period (J.4)

In summary, during this review period, many patients did not receive timely access to medical care in accordance with the urgency of their medical needs and which caused preventable harm. Contributing factors were:

- Inappropriate assigning of clinical urgency;
- Custody Medical Transport not timely scheduling appointments;
- Lack of contracts with specialists;
- Case Management/Medical Director not monitoring and intervening when appointments were not timely: and;

[130] Patient #1, Patient #7, and Patient #25.
[131] Not to include information about appointments dates)

- Failure of some providers to monitor and effectively advocate for the patient when specialty services were not timely.[132]

ACH has developed a plan to address these concerns including the following measures:

1. ACH Case Management (CM) sends the Medical Director weekly the list of patients who have been assigned "Routine" Specialty Referrals for review.
2. Medical Director reviews the list of "Routine" Specialty referrals to monitor to the appropriateness of the priority and updates to "Urgent" or "Expedite" – to be completed within 30 days of review when indicated.
3. Medical Director meets weekly with CM to review the referral list and discuss any updates or other resource options.
4. Medical Director will provide ongoing training in Provider meetings on the need to indicate a priority of "Urgent" (outside of ER Send-Outs) when appropriate – reviewing common referral types and examples – sharing that if attaining an appointment in 14 days is not possible, CM will alert Provider to reevaluate.
5. Medical Director will train Providers to indicate "Routine – expedite" in the note for CM when "Urgent" priority is not needed, yet recommending appointments within 45 days.
6. CM will review and attempt to schedule accordingly. Medical Director will monitor and address inappropriate priority referral trends or challenges and follow up accordingly during Provider 1:1 or with ACH leadership to problem-solve.

The County informed the monitors that as of mid-June, Case Management is scheduling all specialty appointments at RCCC. This has increased Case Management's flexibility to add another patient to an appointment if the scheduled patient refuses or is otherwise not available. This is a positive change and hopefully will result in more timely access to care. However, the County will need to increase Case Management resources in order to assume responsibility for scheduling appointments at Main Jail, and which needs to be expedited to permit timely scheduling and monitoring of appointments.

Compliance Assessments:

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

Recommendations: The County needs to:

1. Amend the Utilization Management and Specialty Services policies to reflect the current appointment scheduling process.

[132] Patient #3.

2. Render approval/denial decisions in accordance with policy timeframes.
3. Reeducate providers regarding the need to:
    a. Properly assign dispositions related to urgency of the specialty service;
    b. Communicate with the patient regarding the status of the consult (excluding appointment dates);
    c. Monitor the patient in accordance with their medical needs while the appointment is pending;
    d. Intervene if the time fame of the appointment is not medically appropriate or the patient's condition is deteriorating;
4. Assess custody and transportation resources, including ADA compliant vans, needed to meet the demand for specialty services appointments.
5. To reduce refusals, Medical Providers or nurses need to meet with the patient in the weeks prior to the specialty appointment to ensure that the patient understands and agrees to the appointment and any prep required (e.g., colonoscopy prep, NPO status, etc.).

K. Sanitation

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

Findings: The monitors observed improvement in sanitation and cleanliness of the medical areas of the jail, including medical intake in the booking area and medical clinics.

In 2022, the County contracted with Diane Skipworth, MCJ, RDN, LD, RS, CCHP, an Environment of Care expert, to conduct and evaluation of facilities where patients are housed and/or receive clinical treatment. On March 7-9, 2022 Ms. Skipworth conducted a tour of the facilities and on 6/21/2022 published her report with recommendations. Her findings were that sanitation, including in health care units was poor. Refer to the specific findings and recommendations in Ms. Skipworth's report (K.1).

The County contracted with DGS for professional cleaning services and a custodial schedule was provided to the monitors. However, DGS staff does not clean medical exam surfaces, equipment, and other specific medical areas, requiring medical staff to clean these areas and there are no reports of periodic environmental inspections. ACH is collaborating with the County and DGS to contract for professional hospital grade cleaning at both facilities. Until a contract is secured for professional medical cleaning services, the SSO is using Federal inmates to clean medical units and patient medical cells. The projected time frame for completion of the contact is in the next fiscal year (FY 23-24).

We requested environmental inspection reports and were provided a 9/22/22 Environmental of Care action report, and an 10/13/22 Safety Committee Meeting minutes. We were not provided documentation of sanitation inspections in medical and mental health areas of the jail.

On 2/14/23, the California Department of Public Health (CDPH) conducted an Infection Prevention Facility Assessment and published a summary and recommendations. The facility assessment was in response to a patient who tested positive for Carbapenem Resistant Enterobacteriaceae (CRE) upon admission to the acute care hospital from the Main Jail medical unit. The focus of the CDPH inspection was the medical areas of the facility including intake, 2M medical unit, pharmacy, and exam rooms in the medical unit.

Recommendations of the assessment included:

- Installing additional alcohol-based hand sanitizer dispensers at strategic locations throughout the second-floor medical unit;
- Providing hand hygiene education for all staff;
- Establishing a policy for when and where PPE should be used and educate both custody and medical staff:
- Establish a routine cleaning/disinfection policy for all areas of the medical unit; and
- Educate all staff responsible for cleaning and disinfection on daily room cleaning including product contact/dwell time, high touch areas, and hand hygiene between dirty and clean tasks.

Compliance Assessment:

- K.1=Substantial Compliance

Recommendations: The County needs to:

1. Contract for professional medical cleaning services as soon as possible.
2. Establish a schedule of monthly sanitation/infection control inspections in all medical and mental health areas of the jail.
3. Implement all recommendations made by the California Department of Public Health Infection Prevention consultant.
4. After implementing the above measures, consider engaging Diane Skipworth, the Environment of Care expert, to conduct a site visit and consultation.

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 County has an active contract with UCD to provide obstetrical and gynecological services. Overall, pregnant patients receive timely and appropriate care.

We reviewed 4 medical records of pregnant women involving 35 obstetrical (OB) and Medication Assisted Treatment (MAT) provider encounters from August 2022 to April 2023. Overall, we found that patients received timely and appropriate care, including close monitoring of patients with potential pregnancy complications. When sent out to the emergency department, medical providers timely saw patients upon their return and implemented recommendations. (L1.). With respect to documentation, physicians do not utilize Centricity Flowsheets to document the progression of the pregnancy.

With one exception, nurses immediately referred pregnant women with opioid use disorder to the MAT physician, Dr. Jacqueline Abdalla, who either continued patients on methadone or inducted patients on suboxone. However, nurses did not conduct COWS assessments according to the Consent Decree and ACH policy, and as clinically indicated. This is a significant concern because the MAT physician documented that some patients were experiencing ongoing withdrawal symptoms, but nurses were not conducting COWS assessments during this time. It is important for nurses to notify the MAT physician immediately if pregnant patients are experiencing withdrawal symptoms so that alcohol or opioid withdrawal treatment can be adjusted.

Patients were provided prenatal vitamins, a pregnancy diet, and assigned a low bunk for safety. Certified Nursing Assistants (CNAs) or Medical Assistants (MAs) documented delivering snack directly to the patient instead of custody.

OB ultrasounds were performed with timely physician review of these reports. Genetic counseling was provided as needed. Prenatal labs were usually, but not always performed as ordered, likely due to a backlog of lab draws during this period.

The Consent Decree requires that the County provide comprehensive counseling to pregnant patients regarding their options. Obstetricians document whether the patient's pregnancy was planned and desired, however documentation of counseling is limited. (L.2) Patients who

requested pregnancy termination were provided access to therapeutic abortions, and were monitored following the procedure. Two patients were provided birth control upon request, but it is unclear whether contraception is part of the routine patient obstetrical evaluation (L.3). This is consistent with ACH CQI findings that found no mention of contraception in their sample of records.[133]

We found instances in which OB appointments were not kept due to custody reports of patient refusal. *However, in one reported refusal, it was custody who refused to allow the patient out of her cell, because she was being disciplined for having a fight the week before. This was not a refusal, it obstruction of health care. Nurses should not document it as a refusal and escalate these situations up the medical and custody chains of command.*

A summary of each case is described below, noting opportunities for improvement, as applicable.

- This patient received timely prenatal care. The patient had opioid use disorder and was taking methadone prior to admission; however, the intake RN did not immediately notify a medical provider and 12 hours later the MAT physician, conducting essential medication review, ordered the patient brought to 2M for evaluation of withdrawal and possible admission to UCD. Nurses did not conduct COWS assessments in compliance with the Consent Decree. Some, but not all prenatal labs (HIV and RPR) were completed. Custody obstructed an obstetrical medical appointment. *As noted above, on 9/30/2022 at 09:30 a refusal of treatment form for an OB appointment was completed, however it was not a true refusal. Custody reported that the patient had a fight last week and could not come out of her cell for her appointment, thus she was not permitted to attend her appointment due to discipline imposed by custody. This is a never event.* [134]

- This high-risk pregnant woman was provided timely and appropriate prenatal care. OB timely saw the patient following ED visits. The medical record contained documentation that the pregnancy was desired, and the patient was offered and accepted birth control following delivery of her child. The patient was provided genetic counseling for a cystic fibrosis gene. A concern is that the patient was noted to refuse an OB appointment based upon deputy report, and a refusal of medical care form was completed without the patient's signature. [135]

- This patient was provided timely and appropriate prenatal care. The obstetrician documented that the pregnancy was unplanned but desired. Previous medical records were requested and timely received. [136]

[133] Reproductive Services Audit Report. October 6, 2022.
[134] Patient #13.
[135] Patient #14.
[136] Patient #15.

- This patient was provided timely prenatal care.[137] She had opioid use disorder and was referred to the MAT physician who inducted the patient on suboxone and closely monitored the patient. Medication Administration Records show the patient received ordered MAT medications. A concern is that nurses did not conduct any COWS assessments, although the MAT physician documented that the patient experienced withdrawal symptoms for weeks after admission. Obstetricians documented that the patient initially desired the pregnancy, but later changed her mind, and she was timely referred for therapeutic abortion. The patient requested and was provided long-acting birth control. Kaiser medical records showed the patient had thalassemia resulting in blood transfusions, and major depression with treatment with venlafaxine, however it does not appear that medical and mental health providers reviewed the record. Prior to release, a SUD counselor and discharge planner met with the patient. An opportunity for improvement is that the intake RN did not document the patient's last menstrual period (LMP) or conduct a pregnancy test. A week elapsed before she had a urine test that confirmed the pregnancy.

Compliance Assessment:

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

Recommendations: The County needs to:

1. Ensure that intake nurses ask pregnancy related (LMP) and birth control questions. If a urine pregnancy test is not conducted at intake, document the reason and order follow-up testing within 24 hours.
2. Order COWS assessments and conduct monitoring in accordance with the Consent Decree and as clinically indicated, even for patients already on MAT, until withdrawal symptoms are controlled.
3. Document obstetrical care on the Centricity flowsheet, including whether all pregnancy related labs have been ordered and performed.
4. Conduct CQI studies to assess whether labs, tests, and nutritional supplements ordered by the obstetrician, consistent with ACOG standards of care, were timely completed including:
    a. Prenatal vitamins and nutritional supplements
    b. RhD type and red blood cell antibody screen
    c. Hematocrit/Hemoglobin and MCV
    d. Documentation of immunity to rubella and varicella
    e. Qualitative assessment of urine protein
    f. Assessment for asymptomatic bacteriuria (i.e., urine culture)
    g. Cervical cancer screening guidelines
    h. Testing for syphilis, hepatitis B antigen, hepatitis C antibody, and chlamydia

[137] Patient #16

   i. OB ultrasounds[138]
5. In order to provide documentation of comprehensive counseling, obstetricians need to document topics discussed during the visit. (e.g., Effect of alcohol and other drugs on the fetus, tobacco cessation, proper nutrition, or other relevant topics)
6. Consider group education for pregnant women led by a registered nurse and document in each medical record what topics are covered.
7. Ensure that contraceptive counseling is routinely included in prenatal care.
8. Consider incorporating contraceptive counseling for non-pregnant women at 14-day physical exams, or by registered nurses working with the provider.
9. Not accept refusals of medical appointments based upon deputy report, but speak with the patient and conduct an informed refusal of care.
10. Ensure that deputies do not obstruct medical appointments. ACH staff need to escalate situations up the chain of command when custody does not permit patient access to medical appointments.

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: We find that patients who identify as transgendered receive timely and appropriate care.

ACH policy 05-12, Transgender and Gender Diverse Health Care, revised 1/18/2023 is compliant with the Consent Decree. ACH is in process of training staff regarding the revised policy. Staff have not yet been trained on WPATH Standards of Care.

Currently there are 9 transgender patients at the jail. We reviewed 2 records with 13 provider encounters specifically related to transgender care during this review period (October 2022-present).

[138] UpToDate. June 2023

We found that transgendered patients are timely enrolled and monitored in the Transgender clinic, consistent with the patient's medical needs. Patients are treated by a single provider, Dr. Janet Abshire, who provides continuity of care for patients. Dr. Abshire is also the HIV provider at the jail, and treats patients with both conditions.

Our review of two cases is described below.

- **Patient #17:** This 33-year-old transgender woman was admitted to SCJ on 4/14/22 and is still at the jail. Her medical history includes heroin and methamphetamine use disorder, intravenous drug use, HIV infection, transgender male to female hormone therapy since 2016, anal condyloma s/p cryosurgery, schizoaffective disorder, bipolar type. Her medications are Triumeq, estradiol, spironolactone, Latuda and buspirone.

  Prior to this monitoring period, beginning in May 2022, the HIV/MAT provider (JA) began evaluating and monitoring the patient. HIV: No history of AIDS. The patient reported nonadherence (50%) to HIV medications and off medications for one month.. HIV viral load=1,000 copies/mL. CD4 count normal. The patient was interested in methamphetamine rehab including Wellbutrin and Naltrexone. The physician addressed HIV, opioid SUD, and transgender status. The patient did not desire transgender medications at that time. P: Triumeq and Naltrexone.

  On 5/30/22, the physician saw the patient who requested injectable hormones. The physician reviewed side effect (SE) for injectable hormones. Patient is aware of estrogen SE. The provider conducted an HIV pertinent review of systems (ROS). Weight=161 lbs. VS normal except pulse=106/minute. The physical exam was pertinent to HIV infection. No rectal exam was performed at that time, but the provider made a notation about anal warts after the patient left. Assessment/Plan: HIV in fair control, adherent to Triumeq in jail. Anal Warts: Poor control, possible referral for biopsy. Transgender: Fair control. Restart hormones. Restarting lower dose Aldactone, serial potassium, baseline levels. The physician ordered HIV clinic follow-up, ROI from San Francisco General Hospital, vital signs, and labs.

  On 6/1/22, the physician noted the patient had an ASCUS anal pap smear at SF General. BP and pulse normal. HIV ROS. In 2021 viral load=35 copies, and CD4=881 cells/mm3. Labs pending on Triumeq. A:P: HIV infection and Transgender in good control. Anal warts in poor control due to poor follow-up. Referral. Patient counseled about medical conditions and management. Patient verbalized understanding.

  On 6/22/22, the physician performed an anal Pap smear. HIV well controlled, viral load in 4 months. Transgender: increasing Aldactone to 100 mg bid, no potassium issues. JPL in 2 weeks. The anal pap sample was insufficient. The physician signed the report on 6/29/22.

On 6/29/22, Case management submitted a request for heme/oncology to SJGH. On 7/11/22 heme/oncology saw the patient for leukocytosis. Following evaluation, the hematologist recommended no further follow-up.

On 7/18/22, the patient reportedly refused an appointment with the HIV physician because he refused to come out of his cell.

Note: There is no documentation the nurse spoke to the patient and no patient signature on the form.

On 7/19/22, the physician saw the patient for HIV follow-up…..HIV viral load=Undetectable CD4=824 cells/mm3. History of ASCUS per OCH, recent consult pending. All chronic disease were assessed to be in good control, except anal warts and acne. P: Await report (? Pap), and refill benzoyl peroxide. Plan: Labs, HIV clinic, and on-site referral to dental.

Care provided during this monitoring period is noted below.

On 10/6/22 HIV viral load=nondetectable.[139]

On 10/17/22, the HIV/TG physician noted the patient's HIV viral load=undetectable. Estrogen levels were high: 1,114 versus 738 on 6/7/22 at same dose. P: Will lower estrogen dose.

On 12/7/22, the HIV/TG physician saw the patient for follow-up of HIV, transgender and anal warts. HIV infection: good control, Transgender: fair control due to high estrogen, Anal warts: fair control. Plan reduce estrogen and order kit for anal pap smear.

On 12/14/22, serum estrogen sample not measured due to insufficient sample.

On 1/10/22, a MA noted that an anal pap smear was not in stock.

On 1/10/23, the physician saw the patient who stated he had an anal mass. Checking with radiology if ultrasound (US) is possible. Needs anal pap smear, later this week. Refer to surgery clinic.

On 1/12/23, the physician saw the patient to perform an anal pap smear, but a kit was not available.

On 1/13/23, Case Management submitted a request for surgery to SJGH.

On 1/30/23, an anal pap smear was performed but was of insufficient cellularity.

On 2/1/23, the physician noted the Pap smear findings.

[139] This begins the period of review for this monitoring report.

On 2/6/23, SJGH surgery saw the patient for a history of anal warts/rectal mass. Unable to see any on anoscopy. Recommend high resolution anoscopy. A RN saw the patient upon return from the appointment and scheduled a physician follow-up. These records were requested on 3/9/23 and scanned into the EHR on 3/13/23.

Note: Medical records were not timely requested from SJGH.

On 2/7/23, a physician saw the patient for report of intra anal mass about 3 weeks ago. He had a swab cellular biopsy that was inadequate. He was evaluated yesterday in general surgery clinic and had limited anoscopy which was reported to be normal. It was recommended to have further evaluation under general anesthesia for special staining and possible biopsy. Denies anal sex or trauma, denies blood, mucus, or discharge. He is on transgender medications with good tolerance and no report of SE. He declined an anal exam as it was done the day prior. Anal mass suspicious.

On 2/8/23, the physician (JA) noted the consult recommendations and made a referral for biopsy.

On 2/15/23, the physician saw the patient for follow-up. The patient was scheduled for anoscopy with biopsy excision.

On 3/3/23, the patient underwent surgery for anoscopy and biopsy. Five suspicious lesions were sent to pathology.

On 3/8/23, a physician (NF) saw the patient for rectal bleeding since Friday (3/3/23) after he had an anal procedure. Frequent defecation with feeling constant flow and urgency…. blood on tissue and blood in toilet (sic). No fever, chills, abdominal pain, eating and drinking well. The physician did not examine the patient. Weight=168.5 lbs., Temp=97.9, BP=91/64 mm Hg, pulse=89/minute. A/P: Proctitis, Metronidazole. Hydrocortisone. Obtain records, follow-up in one week. On 3/9/23 a ROI was sent.

On 3/14/23, labs showed the patient's HIV infection was well controlled. (HIV viral load=undetectable and CD4=1,148 cells.

On 3/15/23, a physician (NF) reviewed the pathology report noting the patient had condyloma acuminata. *Treatment options were noted.* Need to see surgery OP (operative) report to see if ablation of the lesions is done or the patient would need additional follow-up procedures P: Anucort HC suppository 25 mg bid KOP.

On 3/20/23, the patient refused a follow-up surgery appointment. The patient was counseled regarding the refusal.

On 3/20/23, the HIV physician saw the patient noting that the anal biopsy found condyloma acuminata, no malignancy. HIV viral load=undetectable, CD4=1,114. On hormones, no side effects. Plan: HIV=good control, labs in July; anal warts, biopsy report in record; Transgender: good control, labs in 4 months.

On 4/9/23, GI saw the patient who reported some rectal bleeding at times. Reviewed pathology report. A:P: s/p treatment in the past, Fibercon, refer to surgery, continue HIV meds, RTC in 4 months.

The patient's MAR's show that he received HIV and transgender medication. However, there was a duplicate order for the patient's HIV medication. Triumeq was ordered on 3/28/22 to 3/27/23. On 4/12/23 Triumeq was renewed for a year. The patient missed no doses because there was a duplicate order for Triumeq that began on 5/2/22 to 5/4/23.

Summary: This patient received timely care for transgender status and HIV infection. There was a delay in treatment of anal condyloma in part because of insufficient Pap smear samples in beginning in June 2022. This delay is concerning because of the risk of malignancy. Fortunately, in March 2023 the lesions were biopsied and showed no evidence of malignancy. The patient refused a follow-up visit with the surgeon post biopsy. On 3/15/23, a different physician not primarily responsible for managing the patient, documented that the patient may further treatment for anal condyloma. However, the physician managing the patient did not indicate that further treatment was necessary. There were two simultaneous and overlapping order for Triumeq which should not occur. We referred this case to ACH for follow-up to address the discrepant plans by the primary provider and other provider and duplicate order for Triumeq.

- **Patient #18:** This 39-year-old transgender (male to female) patient was admitted to SCJ on 7/13/22, and is still at the jail. Her medical history includes methamphetamine use disorder, transgender male to female, HIV infection, resolved hepatitis C infection, syphilis, major depression, schizoaffective disorder, bipolar type, osteomyelitis, and dental caries. Her medications are Biktarvy, estradiol, spironolactone, Bupropion, Buspirone, Mirtazapine, Docusate Sodium, and Vitamin D3.

  On 7/3/22 at 10:32, the HIV provider reviewed the patient's record, noting the patient was nonadherent to HIV medications, and takes them only when incarcerated.

  The patient was released on 7/6/22 and readmitted on 7/12/22.

  On 7/12/22 at 21:26, a RN conducted intake screening. The patient reported being male and bisexual (not transgender). The patient reported amphetamine use, but no other substances. She reported having HIV and hepatitis C infection. She was taking no medications for HIV infection. BP=156/98 mm Hg. The nurse ordered labs and referred the patient for an essential medication review, HIV clinic and MH referral.

  On 7/17/22 at 21:49, the patient presented to 2M with a discolored, swollen and severely painful left 5th finger x 2-3 days. Afebrile. The RN contacted the on-call physician who ordered doxycycline. No follow-up referral to a MD. The patient received the first dose the same day.

On 7/18/22 at 07:27, the HIV physician conducted a history and physical examination, noting the patient transferred from Yolo County Jail on Biktarvy, but HIV diagnosis was questionable. The patient denied seizure history, indicating that he reported it because he wanted a low bunk. HIV test pending. The provider ordered a left finger x-ray, Naproxen and Tylenol. An ROI was sent to Yolo County Jail.

Note: The patient's Transgender status was entered on the Problem list on 6/29/2021, but was not addressed by the physician at this initial visit.

On 7/18/22 at 10:57, a physician (RK) reviewed a wet reading of the patient's x-ray noting a left 5th finger fracture and made a referral to orthopedics. The MA called the orthopedic tech for a splint and left a voicemail.

On 7/18/22 at 19:10, the radiologist raised a concern for osteomyelitis. Radiographic and clinical follow-up is recommended. The same day, the orthopedic tech placed a splint on the patients' left finger. On 7/19/22 the HIV physician reviewed the x-ray.

On 7/22/22, the onsite orthopedist saw the patient and noted no fracture, and diagnosed the patient with osteomyelitis, recommending 6 weeks of IV antibiotics. Referral back to the HIV physician to coordinate care.

Note: There was no immediate follow-up appointment with the HIV physician, and the recommendation for the HIV provider to coordinate care for 6 weeks of antibiotics did not take place.

On 7/23/22, the orthopedist ordered wound care.

On 7/25/22, case management submitted paperwork for an expedited outside orthopedic surgery consult.

On 8/11/22, the onsite orthopedist reviewed a left finger x-ray and noted further cortical loss and lucency about the distal phalanx and osteomyelitis is to be considered. The orthopedist did not document a plan.

On 8/12/22, the patient was not transported to the orthopedic clinic for follow-up of osteomyelitis.

Note: There is no documentation as to why the patient was not transported.

On 8/14/22, a RN noted that per Marcia SRN, (the patient) needs to be seen regarding 5th digit per Ortho Dr. Ho. Should have started protocol for IV antibiotics & PICC line for osteomyelitis. Chart review. Did not get IV antibiotics. Took Doxycycline bid x 10 days on 7/17/22 to 7/26/22.

On 8/15/22, at 07:59 a physician (RK) saw the patient and ordered amoxicillin for the patient's osteomyelitis.

Note: The physician (RK) did not address the orthopedist's recommendations for IV antibiotic and instead ordered an oral antibiotic for osteomyelitis.

On 8/15/22, the patient was sent to UCD for PICC line insertion. Medical history included that the patient was transgender, and syphilis, HIV and HCV infection, s/p treatment. Medication history included Biktarvy, estradiol and spironolactone. She stopped Biktarvy after 1-2 months. Plan: ED ID and ortho referral. *IV antibiotics were started and PICC line initially ordered. IV Dalbavancin 1500 mg x 2 (every 12 hours) and to be given again in 7 days, levofloxacin 750 mg daily for 6 weeks,* CD4 and viral load, will start Biktarvy today, history of late, latent syphilis, patient will need repeat RPR, done as outpatient, Gender dysphoria, health maintenance, rectal GC/CL and Covid vaccine #1. Ortho consulted and no need for amputation. ID determined that a PICC line was not necessary at this time. Patient to return on 8/24/22 for second dose of Dalbavancin.

On 8/16/22, at 16:46 a RN noted the patient was discharged from UCD where he had received IV Rocephin and Vancomycin (?). Reports has not taken HIV medications for 3 months. Referral to MD.

On 8/17/22, the patient refused an expedited orthopedic surgery clinic because he "had already been seen."

On 8/17/22 the UCD medical records were scanned into the EHR.

On 8/17/22, the HIV provider saw the patient for follow-up and addressed the patient's HIV, transgender status, and osteomyelitis. She noted the patient tested positive at UCD. Ordered labs and started Biktarvy, estradiol, spironolactone, and Levaquin 750 mg daily. Infusion is planned.

Note: On 8/19/2022, a physician (RK) signed the UCD report but did not address the recommendations for Dalbavancin in one week and levofloxacin 750 mg daily for 6 weeks.

On 8/21/22, Dr. Ho saw the patient for follow-up, noting that UCD was managing the patient's osteomyelitis.

On 8/22/22, previous medical records show the patient was diagnosed with HIV infection in 2021 and started on Biktarvy. The records were scanned into the EHR on 11/15/22.

Note: The records have not been signed as having been reviewed by a medical provider.

On 8/24/22, the patient was sent to UCD for insertion of a PICC line. Medical records only included lab results. HIV antibody test was reactive. Blood cultures were drawn. Sed rate and CRP were normal (5, normal=5-15, and 0.2, normal=<0.5), CBC and CMP were normal. The patient received the second dose of *Dalbavancin.*

On 8/25/22, the patient submitted an HSR stating that he *illegible* bone infection and supposed to receive antibiotics for 6 weeks, but only got it for one week. There is no date of receipt and the form was not triaged and signed by a RN.

Note: There is not documentation that this HSR was addressed by a RN.

On 8/26/22 a fax to UCD ID that included 8/15/22 medical records, noted that the patient was treated for osteomyelitis on 8/15/22 and needed to f/u with ID clinic in 4 to 6 weeks.

Note: This document was scanned into the EHR on 1/20/23.

On 8/30/22, HIV labs were performed. HIV viral load=134 copies. This report was signed on 9/7/22. CD4=742 cells. This report was signed by the HIV physician on 12/7/22.

On 8/31/22, the HIV provider reviewed UCD medical records. ID f/u planned per CM. The provider addressed all medical conditions but did not note the patient had not been prescribed recommended Levaquin for a total of 6 weeks.

On 10/2/22, the patient submitted an HSR requesting suboxone for heroin addiction. It was received the same day and noted to be a duplicate request. Referral to MAT made.

On 10/19/22, outside ID services saw the patient for follow-up. ID did not note the discrepancy between what was recommended (Levaquin x 6 weeks) and what was received (Levaquin x 1 week). Labs were ordered. Left fifth finger x-ray showed persistent erosive changes of the fifth distal phalanx compatible with known infection.

On 10/28/22, a physician (SS) saw the patient and reviewed the ID consult notes. Refer to orthopedics and to MAT physician.

On 11/25/22, a mental health provider attempted to see the patient, first the floor was busy and there was a take down by custody. On the second attempt, there was no custody to escort the provider to the patient.

Note: The patient did not receive access to care due to lack of custody escorts.

On 12/27/22, the HIV/TG provider reviewed labs. On 12/28/22 the HIV/TG provider adjusted the patient's estradiol medication, based upon current labs.

On 1/17/23, the HIV/TG provider saw the patient for follow-up.

On 2/1/23, ID saw the patient. On 2/8/23 the HIV provider wrote a note reviewing ID consult. Removed osteomyelitis as a problem.

On 2/15/23, the ID clinic faxed a request for labs to be done and forward to the ID clinic. A RN reviewed the request and contacted a physician.

On 2/17/23, HIV viral load=31 copies. Estradiol level was high.

On 2/22/23 the HIV provider reviewed labs.

On 3/9/23 the HIV provider saw the patient to discuss labs and the treatment plan.

On 3/28/23 a SW saw the patient for discharge planning.

On 4/19/23 the HIV provider saw the patient for follow-up.

On 4/24/23 a SUD counselor saw the patient who reported taking non-prescribed suboxone in the jail. The SUD counselor planned to refer the patient to a MAT program in the community.

Summary: This patient was closely monitored for HIV infection and transgender status. However, there were coordination of care issues regarding treatment of the patient's left 5th finger osteomyelitis, in which emergency department recommendations for antibiotics were not implemented.

On 7/22/22, Dr. Ho diagnosed the patient with osteomyelitis and ordered IV antibiotics to be coordinated by the HIV provider, however there is no documentation that Dr. Ho notified the HIV provider of his request for coordination of care, and no documentation that she was aware of Dr. Ho's request. this recommendation by Dr. Ho, and the patient did not receive IV antibiotics at that time. Three weeks later, on 8/14/22 a RN noted that the patient did not receive IV antibiotics, and on 8/15/22, the patient was sent to the ED at UCD for evaluation and treatment of osteomyelitis. Amputation was considered, but a decision was made to start antibiotics. Discharge orders included IV antibiotics and to return in 7 days for another dose of Dalbavancin, and Levaquin daily for 6 weeks, however the patient received only 1 week of Levaquin. This went unnoticed by medical providers. In October 2022, a physician referred the patient back to Dr. Ho, however we do not find that this occurred. The patient's condition appears to be improved; however, we suggest that the patient be referred to Dr. Ho to determine if any further treatment is needed.

The patient also reports taking non-prescribed suboxone at the jail. This raises questions about the source of suboxone and whether it is a result of bartering with another inmate or received from an external source. At minimum, ACH needs to ensure that medication nurses observe patients taking suboxone, and have them wait in the immediate area for 15 minutes to ensure that the suboxone is ingested and absorbed by the patient. See Section F. Medication Administration.

Staff have not yet been fully trained on WPATH standards of care.

Compliance Assessment:

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

Recommendations:

1. Complete training on the ACH policy and procedure.
2. Complete training on WPATH Standards of Care.
3. Providers need to discontinue existing prescriptions, when reordering the medication.
4. Pharmacists need to note duplicate orders and contact the provider to discontinue the older prescription.

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 has developed policies and protocols for assessment, treatment and monitoring of patients with alcohol, benzodiazepine, and opioid use disorders that are consistent with the Consent Decree. (N.1). However, observation and record review by the monitors showed systemic failures to adequately assess, monitor, and treat patients for substance use withdrawal, resulting in daily harm and increased risk of hospitalization or death. Review of medical records and observation of substance use withdrawal assessments shows that:

Nurses did not:

- Take complete alcohol and drug use histories;
- Order alcohol and/or opioid withdrawal treatment regimens consistent with their histories of alcohol/opioid use and withdrawal severity;
- Consistently order COWS and CIWA assessments;
- Conduct withdrawal assessments twice daily for 5 days, or longer, if clinically indicated; and in some cases, were not conducted at all;[140]

[140] Patient #8

- Follow all the steps of withdrawal assessments;
- Consistently order urgent medical provider appointment;
- Ordered SUD counselling and MAT referrals, but these appointments often did not take place.

Medical providers did not:

- See patients within 24 hours;
- Address patients substance use histories, evaluate the patient, or conduct CIWA and COWS assessments, or order treatment, even when patients were actively withdrawing.

Major contributing factors include:

- Delays in medical screening due to custody removing patients from the booking loop before medical screening was completed (See Section B. Intake);
- Insufficient nursing resources assigned to conduct withdrawal monitoring;
- Insufficient custody resources assigned to escort nurses during withdrawal monitoring rounds;
- Custody prioritizing other activities (e.g., chow, laundry, commissary) above medical monitoring, preventing, or delaying treatment of patients actively withdrawing.

The County established a detox unit at Main Jail on 6 East, which houses some, but not all patients with substance use disorders at the jail. However, review of record of a patient who died on the detox unit in July 2023, showed that his intake screening was delayed for more than 5 hours, and nurses conducted no withdrawal rounds for this patient during the 6 days he was on the detox unit.[141] A day prior to his death, a medical provider saw the patient who was experiencing withdrawal symptoms. The provider did not conduct a CIWA or COWS assessment. The cause of the patient's death is unknown, however, independent of the cause of death, this patient did not receive adequate treatment and monitoring for his substance use disorder. Other record reviews show the same pattern of insufficient withdrawal monitoring following medical screening. These findings are confirmed by ACH CQI studies.

ACH CQI conducted a small point in time study (N=9) in February 2023, to assess compliance with substance use withdrawal protocols. The study found that:

- 0% of patients were monitored per policy
- Only 56% were monitored for greater than 3 days;
- For 2 of 4 (50%) patients with alcohol use disorder, a detox regimen was timely ordered. 2 of 4 were untimely or not ordered.
- For 3 of 8 patients, withdrawal medications were administered within 2 hours of being ordered.
- Provider referrals were ordered in 8 of 9 (89%) of cases, and;
- Providers timely saw patients with alcohol use disorder 60% of cases and patients with opioid withdrawal in 75% of cases.

[141] Patient #38.

CQI conducted an analysis of the results, noting that the biggest roadblock to completing COWS and CIWA monitoring was lack of nurse staffing. The list of patients to be monitored each day is longer than one nurse can complete, and when the jail is short staffed, intake and 2 Medical are prioritized. ACH developed a corrective action plan to address findings, however the CAP did not address the lack of timely physician appointments.

At the time of the March site visit, the County had just established a detox unit at Main Jail. The County is to be commended for establishing the unit which will hopefully result in more timely monitoring and treatment, and increase patient safety. There is no similar detox unit at RCCC.

It has become apparent that drugs, including fentanyl are readily available at Main Jail, and at RCCC. Record review also shows that patients were detoxing from fentanyl for the duration of their incarceration (five months) and were sent out to the emergency department for intravenous fluids due to persistent vomiting.[142]

Currently, the County provides Medication Assisted Treatment (MAT) with suboxone only for patients with a current prescription entering the jail, and pregnant patients addicted to opiates. The need for an expanded MAT program was illustrated by an incident during our site visit, in which three women overdosed at Main Jail, including one woman who had a cardiac arrest. Fortunately, custody and medical staff quickly responded and resuscitated the patient after the administration of 7 Narcan and CPR.

The need for an expanded MAT program to prevent suffering and save lives is clear. The County avoided a death through the rapid response, but given the apparent wide availably of drugs at the jail, it is only a matter of time before future deaths occur. Two deaths on the detox unit occurred in early July 2023, however the cause of death for these patients is not yet known.

The County agrees with the need for the program and is in process of securing funding and submitting growth requests for increased staff. The County plans to implement the program in 3 phases, beginning in July 2023, for patients sent to the hospital with fentanyl overdose. The next phases will be implemented on September 1 and October 1, 2023.

With respect to programmatic and clinical decisions, the County is consulting CDCR and other facilities who have implemented MAT programs. The County needs to involve a MAT experienced physician at every stage of planning, and is fortunate to have Dr. Jacqueline Abdalla, who treats patients with substance use disorders (SUD) at the jail.

The issues described above are exemplified by the following three cases:

- **Patient #21:** This 33-year-old woman was admitted to SCJ on 12/27/22 and was released on 5/31/23. Her medical history includes alcohol, methamphetamine, and

[142] Patient #21.

opioid/fentanyl use disorder, cervical lymphadenopathy, migraines, open wound at back, s/p abscess and I&D. Her medication history included suboxone.

Summary: This patient had a long history of substance use disorder and reported previous treatment with suboxone, for which induction is not currently available at the jail. The patient was withdrawing from alcohol and opioids upon arrival at the jail, but neither the intake nurse nor the provider performing the history and physical (H&P) evaluated her substance use disorders. Within an hour of the H&P, a RN started an alcohol withdrawal regimen for both alcohol and opiate withdrawal symptoms due to her increased CIWA and COWS scores. Thereafter, no CIWA assessments were performed.

The patient reported to us that drugs were freely available at Main Jail, but less so at RCCC. She continued to use opioids/fentanyl throughout her incarceration. From December 2022 to March 2023, she was in active withdrawal with nausea and vomiting, and 50-pound weight loss. However, her weight loss went unnoticed by medical providers.[143] While in withdrawal, she was not admitted to a medical bed for closer monitoring and treatment of dehydration (the MHU only houses men). Providers twice sent her to the emergency department (ED) for IV fluids due to nausea and vomiting. In one case, a provider was onsite but did not personally evaluate the patient. It does not appear that any consideration was given to administering IV fluids at the jail, which might have prevented an ED send out.

A detailed review of the case is found below.

On 12/27/22 at 20:54 an RN conducted medical screening. The patient gave a history of alcohol, opioid and methamphetamine SUD. The nurse did not take a history for each substance, including quantity, frequency, and last use. The patient did not decline to be tested for HIV, HCV, and STI's. O: Weight=154 lbs. VS normal. Pregnancy test=negative. UDS=+ for methamphetamines and opioids. Breathalyzer=0. COWs=11, CIWA=not done, urine dipstick=+ leukocytes add ketones, and negative for glucose. Left voicemail for a provider (RK). Detox risk. The RN ordered SARS CoV-2 and tuberculin skin tests, COVID intake quarantine, COVID Health Checks, Provider Sick Call, Nurse MAT/SUD referral and COWS assessments. The RN also started an opioid withdrawal detox regimen.

Note: The nurse did not take a history for each substance use, including quantity, frequency, and last use. There was insufficient information to assess the patient's risk of alcohol withdrawal. The RN did not order CIWA assessments.

On 12/28/22 at 10:11, a provider saw the patient for an H&P. The patient reported large lymph nodes on the back of her neck.

[143] From 154 to 105 lbs.

The provider did not take a history of the patient's alcohol and opioid substance use disorder including whether the patient injected drugs intravenously and at risk for HIV and hepatitis C infection. The provider did not conduct a CIWA and COWS assessment. Within the hour, a RN saw the patient who was experiencing both alcohol and opioid withdrawal and started the patient on an alcohol withdrawal regimen.

On 12/28/22 at 11:00, a RN performed an assessment. S: I am not feeling good. Claims drinking vodka or whiskey daily for a "long time," last drink the day of arrest, with history of alcohol detox protocol. Complains of hot and cold sweats, body shakes, dry heaving, loose stool. O: No signs of intoxication, pulse=112/minute, BP=108/85 mm Hg, SpO2=98%. COWS=11, CIWA=8. UPT=negative. P: alcohol detox regimen. CIWA twice daily. Provider sick call (urgency not specified). Discontinue clonidine per SNP.

Note: Although the patient had a CIWA score of 8, and a COWS score of 11, no further assessments were performed on 12/28, 12/29, 12/30, 12/31/22, or 1/1/2023 in violation of the patient's needs, policy, and Consent Decree.

On 1/03/23 at 00:23, a RN performed a COWS assessment. Weight=149.5 lbs. The patient's pulse=120/minute. COWS=9. The RN reordered an opiate withdrawal regimen.

Note: Another COWS assessment did not take place for approximately 18 hours.

On 1/11/23, a provider (VTN) saw the patient for a chronic disease visit and follow-up of UTI. Her medical history included headaches, and possible malignancy (e.g., lymphoma/leukemia) 10 years prior. Lost to follow-up. PE: Neck: posterior cervical lymphadenopathy, multiple nodes. The provider did not address SUD, including withdrawal symptoms. Plan: Ultrasound and Migraine Relief. RTC=2 weeks.

On 1/12/23 at 13:47, a different provider (ET) saw the patient for follow-up of the problems addressed by the provider on 1/11/23. Weight=143 lbs. Plan: Will message oncology. ROI's were faxed to South Sacramento Treatment Center, VA hospital.

On 1/12/23, HIV=NR[144], HCV=NR and RPR=NR. CBC and CMP were normal. WBC=7.0.

On 1/21/23, a LCSW saw the patient and took a detailed substance use history, including that the patient drank 1/5 to 1-2 pints of unspecified alcohol daily x 17 years. Receives psych meds for anxiety and PTSD. Plan: Refer to MH provider, gave patient # for hotline if she needed to talk to someone about sexual assault.

Note: This history needed to be elicited by the intake nurse and medical provider. Nurses and providers need to review intake mental health screening to determine if there is relevant medical information in the note.

[144] NR=nonreactive.

On 2/1/23 at 09:30 a provider (AM) saw the patient for feeling feverish and sick. Follow up on ultrasound. HPI: Patient gives a history of lymphoma, treated 11 years ago and medical records are still being (sic). Today she c/o sore throat, feeling feverish with body aches, runny nose, and fatigue.

Note: The provider had elicited symptoms of fever, runny nose, sore throat, body aches and fatigue. The patient also has decreased hearing. The provider then copied and pasted the following review of systems. Conflicting information is in bold.[145]

Constitutional: ***No fever or chills, my myalgias or arthralgias,*** no weight loss, or anorexia.
Neuro: No headache, no weakness, No tremors, no numbness or tingling, No dizziness, or seizures.
HEENT: ***No sore throat,*** *no pain or difficulty swallowing****, no nasal congestion***, No earache, No ear discharge, ***No loss of hearing.***
Eyes: No blurred vision, no photophobia, no pain, no watering.
CVS: No chest pain, no SOB, No swollen feet, No palpitations, no syncope
Lungs: No cough, No sputum, No wheezing, No Sob

The provider's examination was as follows:

O: Temp: 98 F°. BP=109/78 mm Hg, pulse=116/minute.
PE: *awake, alert, in no distress. Can ambulate, no obvious tachypnea, no visible neck pulsations, no asymmetry of the mouth or face.* Throat is inflamed ther (sic) are shotty, very small palpable lymph nodes in ant(erior) and posterior neck triangle. Rapid strep, Covid and flu are all negative. A/P: Coryza, fluids and Tylenol, cervical lymphadenopathy, awaiting ultrasound. Follow-up one week.

Note: The provider documented that the patient had upper respiratory symptoms, but populated the note with a review of systems and did not modify the note to reflect the patient's actual symptoms. Many of the review of system questions are unrelated to the patient' presenting complaint. This raises questions about whether the provider asked any of the questions in the ROS or simply copied and pasted it.

The following day, on Thursday, 2/2/23 at 12:05, a RN saw the patient in the medical unit. The patient reported that she was having nausea and vomiting for 2-3 days and said she could not keep anything down today. Reported yellow color emesis, denies any bloody vomiting, no abdominal pain or acid reflect at this time, but per record ...patient had a history of acid reflux, keep (sic) saying I don't feel good, everything hurts, my chest hurts, pointing at middle of chest, non-radiating. States "chest hurts to breath (sic)." Denies

[145] Bolding is by the Monitor to show how the prepopulated note, differs from what the patient told the provider.

history of heart problems. Has an IUD. Temp=98.47 °F. (sic) BP=127/87 mm Hg, pulse=75, resp=16/minute. Oxygen saturation=100%. Urinalysis= +Ketones, +protein, trace blood, +urobilinogen, and negative for leukocytes and nitrites. Urine pregnancy=negative. EKG=normal sinus rhythm. Covid=negative. Mucus membranes dry, Abdomen: soft, non-tender, with +BS all 4 quadrants. *Plan: RN contacted a medical provider (SN) who did not see the patient but ordered the patient sent to the ED.*

Note: The RN saw the patient approximately 27 hours after the provider encounter and gave a history of having nausea, vomiting, and could not keep anything down for 2 to 3 days. This history was not elicited by the provider (AM). On Thursday 2/2/23 at 12:05 a physician sent the patient to the ED without medically evaluating the patient who was dehydrated from withdrawing from fentanyl. The patient's vital signs were normal and it does not appear that any consideration was given to giving the patient IV fluids in 2M. This was possible was a preventable hospitalization.

On 2/2/23 at 18:41 the patient returned from the ED. At 19:38 a RN evaluated the patient who noted the patient was sent out for nausea and vomiting and *mild* dehydration. She told the ED staff that she was in withdrawal. History of taking fentanyl x 1.5 years, smoked it, was also getting it at Main Jail, LD (? last dose) two weeks ago. On 1/19/23 she was still getting it in powder form from other inmates. Still feels nauseated, difficulty keeping fluids down. CBC and chemistry normal. COWS=10, n/v/d, vomited x 4 today, diarrhea yesterday 2-3 times, this am x 1 +gooseflesh, body aches, HCG=negative. O: Temp=99.5 BP=125/80/minute, pulse=63/minute, Plan: Ordering opiate detox with Zofran IM. NSC check in 4-6 hours after patient takes meds, LB (sic) x 7 days. NSC BP check prior to taking clonidine, hold if BP=<100; Low bunk, provider sick call, SUD counselor.

On 2/2/23 at 22:49, a RN administered Zofran 4 mg IM. UDS=negative. Patient reported taking fentanyl.

On 2/3/23 at 14:26, COWS=5.

On 2/3/23 at 14:45, a provider (SN) saw the patient for opiate withdrawal, noting the patient was taking 2g/day on the outside for 1.5 years, continued daily use while in MJ. States when transferred to RCCC had to stop and bad withdrawal symptoms started 2 weeks ago. Not eating, just lying in bed. No vomiting. In ER last night, labs were done and normal, and IV fluids given per patient. Dx: Opiate withdrawal. The provider advised the patient to focus on fluids. Continue detox protocols.

Note: The provider did not order COWS assessments and none were performed after this encounter.

On 2/3/2023 at 20:12, the patient reported vomiting and requesting another injection of Zofran. The nurse advised that "we need to witness or verify she has been vomiting. Advised to keep emesis in cup…& notify officers.

Note: This patient was actively withdrawing from fentanyl with nausea and vomiting that required an ED visit. Zofran is used to treat nausea and vomiting. The patient had an active order for oral Zofran. The nurse should not have withheld the medication. The nurse should have given the medication, and if it was not effective, notify a provider.

On 2/8/23, at 13:49, a provider (AM) saw the patient for follow-up of coryza. HPI: the patient gives a history of lymphoma treated 11 years ago, and medical records are still being (sic) today she comes in for f/u (follow-up) since she recently had a sore throat of being feverish and body aches, runny nose, and fatigue. All her symptoms have resolved, but she has chronic backache due to prior accidents and reports same however (sic) she reports severe pain behind her left shoulder with a tender spot for 4 days. ROS negative. *PE: awake, alert, in no distress. Can ambulate, no obvious tachypnea, no visible neck pulsations, no asymmetry of the mouth or face.* Small shotty palpable lymph nodes in neck and a tender abscess over her back that has come to a head with surrounding erythema. A:P: abscess with cellulitis back. *Plan: I&D of abscess under aseptic condition.* Bactrim DS 1 tablet bid x 10 days, Naproxen 500 mg 1 bid, Follow-up one week.

Note: The provider did not acknowledge that the patient was recently in withdrawal and sent to the ED for dehydration.

On 2/9/23, a RN saw the patient for a welfare check s/p opiate withdrawal. Weight=133.2 lbs. No complaints.[146]

On Friday, 2/10/23, the patient submitted an HSR stating that she was having a lot of back pain and needed ice packs STAT. The HSR was date stamped 2/10/23 at 14:34. A RN triaged the HSR on 2/10/23 at 15:33. The RN assigned that HSR for NSC, but did not assign an urgency to the disposition.

On Saturday, 2/11/23 at 14:40, A RN saw the patient for sick call. The patient reported constant, severe left scapular back pain that was not helped by Bactrim. She was seen by provider (AM) and is on an antibiotic and Naproxen. Patient is still complaining of pain and requesting an ice pack. RN conducted a ROS. O: Patient calm and cooperative. Temp=98°F, BP=100/70 mm Hg, pulse=105/minute. Patient's abscess looks open and purulent with yellow drainage, no foul odor. Erythema and tenderness around the wound. A:P Cleaned wound with NS, applied bacitracin and covered with a dressing, secured w/tape. Will send an alert to the physician to notify about the patient's condition. Added Tylenol for pain.

On 2/12/23, at 16:07, a RN provided wound care. Wound 1 cm x 1 cm x 0.2 cm. Wound bed color yellow with serous drainage. Pain 2 of 10. Scheduled urgent MDSC to evaluate patient's wound.

[146] A complete signature was documented but no legible credentials.

On 2/13/23, a provider (CE) saw the patient for severely worsening abscess on her left upper back. Pain=10 of 10, unable to sleep or eat or drink due to pain. Peeing very little…dehydrated. She has been taking Bactrim since 2/8/23, tolerating. Afebrile, pulse=131/minute, Skin: Orange sized, 6 cm abscess on left upper back with surrounding erythema and mild drainage of purulent material. Very tender to palpation. A:P: Large and likely deep complex abscess, >6 cm, *Patient also with tachycardia, likely dehydrated, not tolerating oral fluids due to pain. Due to female inmate and unable to give IV fluids, pain control and management in MHU (male inmates only, will send to ED for IV fluids & evaluation of this large abscess. Follow-up after 2 days.*

On 2/13/23 at 12:18, the patient was sent to SJGH for a large abscess on her upper back and tachycardia. The patient was unable to tolerate I&D at that clinic. On Bactrim since 2/8/23. *At the ED, the patient reported it had been there for a week and that a provider "popped the pimple" …. States that she did not have intervention by way of a scalpel, that the initial provider "used their hands to try and pop the pimple."* Medications included Suboxone, (however she was not receiving this at the jail), lithium and prazosin. She says her pain is 8 of 10 and she has a hard time, laying (sic) flat on her back to sleep or rest. The ED provider noted the patient had a large abscess and incision and drainage was performed with 10 cc's of purulent drainage. WBC=18.6, with 84% neutrophils. The wound was packed with AMD antimicrobial, Keflex 500 4 x day for 14 days and Bactrim 1 tab 2 times a day for 14 days, Continue Suboxone 2 mg-05 mg SL three times daily. Return to ED if symptoms worsen, return to ED for wound check in 3 days, Tylenol or Motrin for pain or fever. This report was scanned into the EHR on 3/10/23.

Note: There is a significant discrepancy in what the provider (AM) documented on 2/8/23, that he performed incision and drainage under aseptic conditions, and what the patient told the ED physician, the initial provider "used their hands to try and pop the pimple." In a span of 5 days, the patient developed a deep complex abscess that required ED send out. This raises serious questions about the accuracy of the provider's documentation.[147] *A question is that given the patient's elevated white blood cell count indicating systemic infection, did the ED physician consider IV antibiotics?*

On 2/14/23 at 08:38, a RN saw the patient and noted that she continued to have pain after the I&D and that the wound started to drain more. She was prescribed two antibiotics from SJGH but only received one.

On 2/14/23, a provider saw the patient for follow-up, noting that the patient had right upper back cellulitis, 2 small areas of I&D …and moderate serosanguinous drainage…area

[147] This provider called the monitor in reference to Patient #24. At that time, the provider stated that he does not do surgical procedures, that he was an internist. This information was shared with the Medical Director.

of erythema surrounding both I&D sites measures 9 cm in diameter. Entire area is tender to palpation. Continue Keflex for 10 days, and continue remaining Bactrim.

Note: On 2/14/23, The ACH provider did not reference the ED discharge orders and did not order medications consistent with the discharge orders. The ACH provider ordered Keflex 500 mg 1 capsule twice daily for 10 days, which was not consistent with discharge orders for Keflex 500 mg 1 capsule four times daily for 14 days. On 2/16/23, the Keflex order was corrected. The original Bactrim order written on 2/8/23 for 10 days, was maintained in effect after the patient returned from the hospital, although a new order had been written on 2/13/23. Given the severity of the patient's infection, the original order needed to be discontinued, and the new order implemented which would have extended the duration of the antibiotic.

On 2/16/23 at 11:07, a provider (SN) saw the patient for follow-up, noting the patient was detoxing, vomiting for the past month, and had lost weight from 150→133.2 lbs. The provider's documentation questioned what was the course of treatment for the patient's back abscess and whether blood cultures were performed (to detect systemic rather than localized infection).[148] Pulse=137/minute. Dressing change with open wound 1.5 x 3 cm, surrounded by dark erythema. (Gauze) packing with purulence and large serosanguinous drainage on bandage. No induration or warmth. Packing placed. The provider changed the antibiotic orders to be consistent with hospital recommendations.

Note: Given that the patient still had purulence and a large amount of serosanguinous drainage, consider sending the patient back to the ED for IV antibiotics.

On 2/16/23 at 14:12, a RN changed the patient's dressing noting the wound bed color was read with bloody drainage. The RN packed the wound.

On 2/17/23, a provider (RN) saw the patient. BP=92/61 mm Hg, pulse=107/minute. The NP prescribed metoprolol.[149]

On 3/11/23, Weight=105 lbs.

On 3/31/23 at 14:51, a provider saw the patient who reported not vomiting because she had stopped taking anything by mouth. The provider documented the patient was argumentative and seemed to exaggerate her symptoms, pulse=148 earlier. The provider ordered the patient to the ED for vomiting and hydration. A: Possible malingering, but refusing fluids and heart rate elevated earlier today. Plan: ER by van for IV hydration. At the ED the patient was given IV fluids and antinausea medication.

[148] This suggests that the Emergency Department documentation of treatment (not discharge summary) was un available to the provider.

[149] The clinical rationale for prescribing metoprolol, a medication prescribed for hypertension, chest pain and heart failure is unclear. The patient had a mildly rapid pulse and was hypotensive, likely due to dehydration.

Note: The patient reported not vomiting because she was not taking anything by mouth, which appeared to be a conscious decision. The provider did not note that patient had lost 50 lbs. in 3 months. It does not appear that consideration was given to providing IV fluids on site.

- **Patient #19:** This 34-year-old woman transferred from Yolo County to SCJ on 3/16/2023 and is still at the jail. Her medical history includes alcohol and opioid substance use disorder, withdrawal seizures, hypertriglyceridemia, *H pylori* infection, and schizoaffective disorder. Her medications are Mirtazapine and Naproxen. Yolo County Jail sent a medical transfer sheet that indicated she was being treated for opioid withdrawal.

  Summary: This patient has a history of drinking a gallon of unspecified alcohol daily, but was not placed on alcohol withdrawal regimens at intake. Nurses did not perform COWS and CIWAs in accordance to the patient's clinical needs, ACH policy and Consent Decree. When COWS and CIWAs were not performed, nurses did not document the reason it was not done as scheduled (e.g., staffing, custody, etc.). This needs to be done, just as with any order.

  On 3/21/23, a provider saw the patient for a burned hand but did not review the patient's history of alcohol and fentanyl use disorder. The provider attributed the patient's symptoms of nausea, vomiting and diarrhea to a history of *h. pylori* infection, rather than consider alcohol or opiate withdrawal.

  On 3/23, 3/24, and 5/7/23 the patient obtained and used Fentanyl. On 5/7/23, Narcan was used to treat the patient.

  The patient gave a history of alcohol withdrawal seizures, and seizures independent of alcohol use, and she was placed on Keppra. Staff witnessed the patient having a seizure on more than one occasion. The patient was found to be hoarding Keppra and other pills. As a result, a provider labeled the patient a malingerer due to pseudoseizures and hoarding medication, and discontinued her seizure medication. Since the patient was observed to have seizures, the basis for labeling the patient a malinger is unclear. If the medication is clinically indicated, it should be continued with nurses performing thorough oral cavity checks. While patients are not always truthful, labelling a patient as a malingerer and documenting it on the Problem List is prejudicial for future medical encounters, and risks health care staff not believing the patient, even when the patient's symptoms are real.

  The case is described in detail below:

  On 3/16/23 at 09:26, a RN conducted medical screening in a non-confidential encounter. The nurse noted the patient appeared to be under the influence of substances and had one or more of the following symptoms: sweating, tremors, anxiety, self-neglect, and/or disheveled. The nurse observed that the patient also had signs of skin infection. The

patient reported heroin use via intravenous injection in the 20 or more out of the 30 days as well as Fentanyl, and oxycodone. She also reported drinking a fifth of unspecified alcohol daily. Last use on 3/14/23. She had a history of alcohol withdrawal seizures. VS WNL. Weight=105 lbs. Urine Drug Screen was positive for opioids. The patients' pregnancy test was negative. COWS=8. CIWA=1, PAWSS=3, previous PAWSS score=7. The patient had a history of self-harm. The patient had a burn on her left hand which the nurse cleaned and placed a band-aid. The nurse declared the patient FIT for incarceration.

The RN ordered RPR, HIV, HCV antibody and tuberculin skin tests, continue opioid withdrawal treatment, COWS and CIWA monitoring every 12 hours, low bunk, wound care, routine provider H&P, MH referral and discharge planning. She noted the patient was a detox risk and the reason for provider H&P referral was withdrawal seizures. On 3/20/23 the Medical Director signed the form.

Note: The nurse did not order the schedule II alcohol withdrawal regimen or an urgent medical referral. Although the patient's CIWA score was low, based upon her history of drinking a fifth of alcohol daily and last use two days prior to admission, the patient needed to be treated with an alcohol withdrawal regiment and placed in 2M for frequent monitoring. The nurse did not order an urgent MD and MAT/SUD referral.

On 3/16/23 at 21:35, COWS=3, no CIWA performed. Opioid withdrawal medications were ordered from 3/16/23 to 3/20/23.

On 3/17/23 at 10:53, COWS=6, CIWA=3.

Note: Despite the patient's history of alcohol withdrawal seizures, nurses did not perform any other CIWA assessments for 10 days, until 3/26/23 at 08:09.

On 3/18/23, COWS=Not performed.

On 3/19/23, at 12:13 COWS=1.

On 3/20/23, COWS=Not performed.

On 3/21/23 at 10:53, COWS=8, no CIWA. The patient was nauseated and the RN ordered ondansetron 4 mg IM. This was signed by physician the following day.

On 3/21/23 an NP saw the patient for her burned hand, but did not address her alcohol, opioid, and fentanyl use disorder.

On 3/21/23, a RN ordered opioid detox medications according to a standardized procedure, until 3/24/23.

Note: On 3/21/23, we interviewed the patient at Main Jail who was assigned to the top tier, and interviewed the patient. She advised us that she was in alcohol withdrawal, with nausea and vomiting. The RN was conducting this assessment because the patient refused

earlier. The RN did not have a computer with EHR access to document assessment findings. The RN had the patient step out of her cell, took vital signs, but then did not perform a complete COWS assessment. The RN documented a COWS score of 8 in the EHR. The RN had no Gatorade to give the patient, and no medications with her to treat the patients' nausea.

On 3/22/23, COWS=Not performed. CIWA=Not performed

On 3/22/23, at 15:11 a provider (LB) saw the patient for an H&P and addressed her burned hand and history of seizure disorder, noting that she has had seizures for at least 20 years…and reports seizures not associated with drug withdrawal. The patient reported nausea, vomiting and diarrhea, the provider noted that the patient had a history of *H. pylori and diabetes*. O: Weight=125 lbs. BP=92/60 mm Hg, Pulse=88/minute A/P: The provider ordered Keppra, ondansetron, Pedialyte and diphenhydramine.

Note: The NP did not evaluate the patient's history of drinking a fifth of alcohol daily or alcohol withdrawal seizures. The provider did not evaluate the patient's alcohol and opioid withdrawal, but treated the patient for nausea, vomiting and nausea related to a history of H. pylori. The provider did not order tests to determine whether the patient had active Pylori infection. The provider did not obtain a ROI regarding the patient's history of seizures.

On 3/23/23 at 12:55, a MAT RN saw the patient for follow-up, and conducted an adequate assessment. COWS=3, no CIWA.

On 3/23/23 at 16:45, custody asked a RN to assess the patient because her roommate overdosed today…. Patient vacillates if she does drugs, states she took something from her roommate, but did not state what, or if she had ingested it. Custody had the patient body scanned in booking prior to the nurses assessment. Patient given urine cup for drug screen. Patient states she just urinated but will give sample later. Custody is interviewing her now in private 2M holding. Later a UDS was negative, but she was not tested for Fentanyl. She denied using drugs but custody found pills on her they believe are Fentanyl. The nurse consulted a provider (RK) who ordered patient to be housed in 2M overnight and provider sick call in the morning.

On Friday, 3/24/23 at 16:02, a RN responded to a Man Down from custody for possible seizure. The Patient stated that she did not think she had a seizure. "I think I am detoxing and need to go to medical." COWS=8. Opioid detox restarted, *as patient has been using Fentanyl in jail and never really detoxed.* The patient was transported to 2M. An RN initiated the opioid withdrawal detox regimen. Low bunk. MD sick call in am.

Note: The patient is being treated for opioid withdrawal but not alcohol withdrawal. The patient has a history of alcohol withdrawal seizures, and was observed to have a possible

seizure. The RN should have immediately notified or referred the patient to a medical provider, however there are no physicians onsite after 15:30.

On 3/24/23 at 08:30 a provider (LB) saw the patient and noted that she snorted fentanyl yesterday and was detoxing. Denies seizures since last visit.

Note: The provider did not evaluate the for alcohol and opioid withdrawal symptoms.

On 3/25/23 at 09:38 COWS=6

On 3/25/23 at 20:32 COWS=3

On 3/26/23 at 07:50 COWS=5

On 3/26/23 at 08:09 a physician saw the patient who reported taking Fentanyl on 3/24/23. The provider performed a CIWA=3 and COWS=3. A RN observed the patient fall and have a seizure. The patient denied this to the physician.

Note: The patient has a history of drinking a fifth of alcohol daily and had a history of alcohol withdrawal seizures. The patient was still having alcohol withdrawal symptoms and had a witnessed seizure. The provider did not consider treating the patient for alcohol withdrawal. The physician also noted the patient was pre-diabetic, but did not take a history of the patient's diabetes.

On 3/26/23 at 20:13 COWS=5.

Note: Although the patient's COWS scores were still positive, no further COWS assessments were performed.

On 3/27/23 at provider saw the patient for chronic disease follow-up. Denies seizures, no withdrawal symptoms, wishes to go back to her floor.

On 3/30/23 at 10:56 a provider saw the patient for reported seizure. Pills were found in her room (Keppra and Tylenol) from the evening before. O: HbA1C=5.3%. A: Malingering and hoarding medication. The provider discontinued Keppra.

On 5/7/23 at 15:04 a RN responded to a Man Down, where the patient was pale, clammy. Wheeled to 2M and nodded yes when asked if she took drugs on the pod. BP=122/86 mm Hg, pulse=142/minute. FSBS=98.

On 5/7/23 at 15:24 a physician saw the patient who was pale, clammy, and non-responsive. She was given Narcan x 1 and regained consciousness. Will observe on the floor. Noted the patient had withdrawal seizures.

- **Patient #11:** This 44-year-old man was admitted to SCJ on 11/11/22 and is still at the jail. His medical history includes opioid substance use disorder, cirrhosis, GERD, rectal bleeding, COPD, seizure disorder, hyperlipidemia, adjustment disorder with mixed

anxiety and depressed mood and PTSD. His medications are tamsulosin, pantoprazole, levalbuterol, levetiracetam, mirtazapine and naproxen. At a prior incarceration at SCJ in April 2020, the patient reported a history of alcohol and opioid substance use disorder. He had a history of seizures but only took Dilantin while incarcerated.

Summary: This patient has a history of alcohol and opioid substance use disorder, hepatitis C infection and cirrhosis. At intake, the patient reported a history of alcohol withdrawal seizures and had a CIWA score of 5 and PAWSS score of 6, but the nurse did not initiate an alcohol withdrawal regimen and nurses did not conduct COWS/CIWA monitoring in accordance with the SNP, clinical needs of the patient and the Consent Decree.

A physician saw the patient for an initial history and physical over 3 weeks after arrival but did not perform a meaningful evaluation of the patient's chronic diseases, order labs tests, or enroll the patient in the chronic disease program because he believed the patient was going to be released the following day. This did not occur.

On 1/13/23, the patient complained of severe right upper quadrant (RUQ) abdominal pain.

On 1/14/23, a different provider saw the patient and did not perform a meaningful evaluation and treat the patient's chronic diseases. For the patient's history of cirrhosis and hepatitis C, the provider did not conduct a GI review of systems (e.g., nausea, vomiting blood, rectal bleeding, ascites), elicit or address the history of hematemesis or liver transplant documented by the MH NP, inquire about treatment for hepatitis C infection or review recent liver function tests. He did not refer the patient to GI or order an abdominal ultrasound. The provider did not examine the patient's abdomen or note the patient's 10 lbs. weight gain since intake which is pertinent given the patient's history of ascites. The provider also did not conduct a meaningful evaluation of the patient's COPD, including pulmonary ROS, exercise tolerance and peak flow expiratory rate (PEFR), objective measures of airflow obstruction to assess the severity of COPD. The provider did not document a treatment plan for the patient's hyperlipidemia, other than obtaining previous medical records. The provider did not evaluate the patient's seizure history noted in a previous admission.

On 2/14/23 a different physician saw the patient and performed a more thorough evaluation of the patient, including reviewing medical records that the patient had in his possession showing he had cirrhosis and evidence of COPD, acute pulmonary edema, and pulmonary effusion. These records were not scanned into the EHR. The physician developed a comprehensive plan for each condition, including referral to hepatology and imaging.

The patient believes that he has liver pain, however a KUB ultrasound showed a possible kidney stone, which is consistent with his severe but intermittent RUQ/flank pain. The

patient is pending an abdominal ultrasound, that given his severe pain, should be urgently performed to establish a diagnosis.

The record shows the patient submitted multiple health request forms; however, these are not scanned into the EHR, and nursing documentation does not include when the patient wrote the HSR, and the date and time it was received, or the nursing triage disposition.

Details of the case are described below.

On 11/11/22 at 19:18 a RN conducted medical screening. The patient reported COPD, liver cirrhosis, PTSD, anxiety, depression, and bipolar disorder. He reported polysubstance use with alcohol, heroin, fentanyl, and methamphetamines. The patient reported drinking 2 pints of an unspecified alcohol for 10 years. Last use the same day. UDS=positive for amphetamines and methamphetamines, Goes to VA hospital in Mather for prescriptions. *ROI signed.* Did not decline HCV and STI testing. Weight=180 lbs. BP=138/89 mm Hg, pulse=110/minute. COWS=10. CIWA=5, PAWSS=6. *The patient reported a history of alcohol withdrawal seizures.* The RN ordered SARS CoV-2 and tuberculin skin tests, COVID intake quarantine, COVID Health Checks, COWS and CIWA assessments, Nurse MAT/SUD referral, Opioid withdrawal SNP, Essential Medication Check, MH Referral, Provider H&P, low bunk, and discharge planning. The RN completed a ROI.

Note: Although the patient had a PAWSS score of 6, with a history of alcohol withdrawal seizures, the nurse did not order with alcohol withdrawal SNP or make an urgent referral to a medical provider. Although the RN noted that a ROI for the VA in Mather was signed, there is no scanned copy in the EHR. It appears that these records were not obtained. This raises a question of how ROIs are tracked at the jail.

On 11/11/22 at 20:40, the patient's location was NMH BKG M.

On 11/11/22 at 21:09 the patient received the first dose of the opioid withdrawal protocol.

On 11/12/22 at 04:42, CIWA=10. The patient had nausea and vomiting and severe tremors. COWS=11. Daily drinker since the age of 10. The nurse ordered the Schedule I alcohol withdrawal regimen.

On 11/12/22 at 05:40 the patient received diazepam 10 mg and opioid detox medications.

On 11/12/22 at 09:33 a RN conducted booking rounds. The patient ambulated to the sobering cell door without difficulty and stated: "Its freezing in there." Patient shaking, states it is from the cold. Complained of nausea but no other symptoms. CIWA=1, COWS=1. Given detox medications. Patient to be moved to holding cell.

Note: The RN needed to document an objective assessment for tremors by taking the patient out of the cold environment having the patient hold his arms out to assess the severity of his tremors.

On 11/12/22 at 13:07 a physician (SN) conducted an essential medication review, noting the patient's history of cirrhosis and COPD. Ordered levalbuterol. Follow-up H&P.

Note: CIWA and COWS monitoring was performed once 11/11/22, twice on 11/12/22, refused once on 11/13/22, and once on 11/17/22, which is not in compliance with the Consent Decree.

On 12/6/22 a physician (GV) saw the patient, noting a history of mild, transient, epigastric pain a week ago that has resolved, history of hepatitis C and alcoholic cirrhosis. Has had hematemesis and ascites as complications. The provider did not ask about rectal bleeding. Treated at Mather VA in April 23 (sic). *He noted the patient had COPD but did not perform a ROS, assess exercise tolerance, perform peak expiratory flow rate (PEFR), or medication history. The provider assessed the patient's cirrhosis, HCV, and COPD as being in fair control. The provider did not order labs because the patient was to be released the following day. The provider did not evaluate the patient's COPD or enroll the patient in the chronic disease program. The patient was not released the following day.*

Note: At the initial history and physical, the provided needed to perform an initial evaluation of each of the patient's chronic diseases, develop an initial plan, and enroll the patient in the chronic disease program. In this case, the provider did not order labs for hepatitis C infection, including HCV antibody test with reflex HCV viral load, liver function tests, and evaluation for GI bleeding (CBC, fecal occult blood test) which was indicated given the patient's complaint of epigastric pain and history of hematemesis (vomiting blood. Vomiting blood is concerning for esophageal varices[150] in the setting of cirrhosis. Medical providers need to order necessary medications, tests and follow-up and not rely on patient report of impending release or transfer.

On 12/18/22 a MH NP performed an initial psychiatric assessment in a nonconfidential encounter, noting the patient was diagnosed with stage 4 liver cirrhosis and COPD and was denied a liver transplant due to his substance use and high-risk behaviors. He was denied an early release. He had increased anxiety due to finishing his detox medications. He reports a poor appetite. He was sexually abused as a child. History of multiple suicide attempts. The NP started the patient on Latuda for mood stabilization and reported history of bipolar disorder. Start Benadryl, RTC 4 weeks and PRN while in custody.

[150] Esophageal varices are enlarged veins in the esophagus, usually related to cirrhosis. Varices can leak or burst, causing life-threatening hemorrhage. Patients with cirrhosis need to be screened for varices with endoscopy.

On 12/28/22 labs showed that serum chemistry, LFTs and CBC were normal. LDL=96. Triglycerides=309.

On 1/1/23 an MH NP signed the lab report noting the patient's elevated triglycerides. She ordered a referral to medical.

On 1/13/23 at 18:05 the patient presented to a 2M RN with complaints of severe right upper quadrant abdominal pain. The patient reported that it is due to cirrhosis of the liver and had been present for approximately 2 years. He was holding his abdomen. The RN asked deputies to escort him to a holding cell but patient decided to go back to his cell. The RN notified Dr. Nageswaran and ordered urgent provider sick call.

On 1/14/23 at 11:52 a physician (JB) saw the patient for a chronic disease visit. The physician noted the patient reported RUQ abdominal pain and stage 4 liver (cirrhosis) diagnosed in April 2022. VA records not in our system yet. Patient reported he has started a lawsuit against one of the providers and refused to sign another ROI, reportedly on attorney advice……. Reports diagnosis with hepatitis C with sonogram showing some liver damage. Last alcohol around 11/10/22, drank about 3-4 bottles of whiskey…..reports drinking variably since the age of 10. Weight=190 lbs. The provider did not examine the patient's abdomen. The provider did not meaningfully address the patient's other chronic diseases, COPD, and hypertriglyceridemia. A/P:

HLD: Will hold off on medications until after getting prior records.

COPD, Asthma: Suspected, advised patient to use rescue inhaler, though "seems to have much improved control without smoking/vaping."

Abdominal Pain: Awaiting prior records from the VA. Reports he will have attorney send prior records. RTC one month.

Note: The provider did not perform a meaningful evaluation and treat the patient's chronic diseases. For the patient's history of cirrhosis and hepatitis C, the provider did not conduct a GI review of systems (e.g., nausea, vomiting blood, rectal bleeding, ascites), elicit or address the history of hematemesis or liver transplant documented by the MH NP, inquire about treatment for hepatitis C infection or review recent liver function tests. He did not refer the patient to GI or order an abdominal ultrasound. The provider did not examine the patient's abdomen or note the patient's 10 lbs. weight gain since intake which is pertinent given the patient's history of ascites. The provider also did not conduct a meaningful evaluation of the patient's COPD, including pulmonary ROS, exercise tolerance and peak flow expiratory rate (PEFR), objective measures of airflow obstruction to assess the severity of COPD. The provider did not document a treatment plan for the patient's hyperlipidemia, other than obtaining previous medical records. The provider did not evaluate the patient's seizure history noted in a previous admission.

On 1/15/23 a RN documented that an HSR was received from the patient, stating that "my liver is hurting a lot. Saw doctor on 1/14. The nurse did not document a disposition or plan, including nurse sick call. The HSR was not scanned into the EHR. The patient was not seen by anyone.

On 1/27/23 a MH NP saw the patient for follow-up, noting that the patient reported seeing the VA doctor for liver cirrhosis and that he has hepatitis C as well……His appetite is not good, he is feeling sick. Patient declined to sign a ROI for his VA records…..Continue current medication regimen.

On 2/3/23 a RN saw the patient for wheezing earlier in the day and he requested his metered dose inhaler. PEFRs=300, 450, and 500. No wheezing. The RN advised the patient if he had wheezing he could request to return to 2M.

Note: This was prior to the policy for permitting patients to have inhalers KOP.

On 2/3/23 the patient was transferred to RCCC.

On 2/13/23 at 21:51 a RCCC RN saw the patient in a nonconfidential encounter at the request of custody. The patient stated: I have pain in my liver and it feels like someone is stabbing me over and over because of liver cirrhosis. The pain was 10 of 10 in severity. The patient was anxious and restless. BP=121/68 mm Hg, pulse=102/minute. The patient had abdominal tenderness and was guarding is abdomen. The RN called a provider who ordered Tylenol 1000 mg and an urgent provider sick call. The patient was released back to the housing unit.

Note: The RN did not conduct a GI ROS. Vital signs were not repeated. The patient still had moderate pain when released back to the housing unit.

On 2/14/23 a physician (CE) saw the patient for RUQ abdominal pain. *The patient showed the provider a 4/16/22 US report that showed stage 4 cirrhosis of the liver from the VA hospital and a chest x-ray report that showed COPD changes and acute pulmonary edema and a pleural effusion. No outside records are scanned into the EHR although a ROI was signed at intake.* History of hepatitis C, treated in 2019. He takes albuterol for COPD. He denies symptoms of wheezing, SOB today. He has an extensive smoking history. He was diagnosed with seizure disorder in 2008 from a head injury and swelling of the brain. Was given phenytoin and gabapentin for his seizures in the past. He has not been given any seizure medication since his incarceration. He also reports 2-3 weeks of rectal bleeding. Lots of blood, also reports black and tarry stool 2-3 week. +heartburn symptoms. ROS: The patient complains of dysphagia (difficulty swallowing), melena, hematochezia, and heartburn. Patient denied seizures. O: VS stable. Tenderness to light palpation in the RUQ. No rebound. No guarding. Right CVA tenderness A:P GERD, rectal bleeding, cirrhosis of the liver, seizure disorder. Refer to hepatology, ultrasound right upper quadrant, labs including fibro test. Reduce Tylenol to <2 grams per day. Avoid NSAIDS. Seizure disorder:

Start Keppra. Bloody stool: Refer for endoscopy, concern for esophageal varices given cirrhosis of the liver. FIT test. KUB for gallstones. Urine chem panel. ROI faxed to Mather hospital. Follow-up one month.

On 2/18/23, labs showed liver function tests were elevated: AST=65, ALT=103. Hgb/Hct=14.3/Hct=40.6%, Platelets=165,000, Cr=1.06 Triglycerides=313. Fibrosis score=0.04 or F0, showing no fibrosis. On 2/22/23 and 2/24/23 providers signed the reports. Urine drug screen was negative for opiates, benzodiazepine, and m methamphetamine.

On 2/18/23 at 15:44 a RN saw the patient for RUQ abdominal pain that lasts for 30 minutes and then goes away on its own. BP=139/85 mm Hg, pulse=93. Alert, shaky, diaphoretic, shaky voice, guarding RUQ. Attempted to palpate but the patient pulled away. The nurse telephoned the on-call provider who ordered Toradol IM once daily x 2 days, add jail panel to pending labs, MDSC follow-up.

On 2/20/23 a RN saw the patient for abdominal pain similar to 2/18/23. The patient reported having liver cancer and needed a transplant. Toradol administered.

On 2/20/23 a KUB showed a radiodensity at right ischial spine level in pelvis that may represent a distal ureteral calculus (kidney stone). Consider sonography for further evaluation.

On 2/21/23 a physician (CE) saw the patient for follow-up of acute RUQ pain. He received Toradol and feels somewhat better, but still complains of right flank pain. The provider reviewed the results of the KUB and liver function tests and performed a pertinent examination. A/P: RUQ Pain: Elevated liver function tests, viral hepatitis labs pending, RUQ US pending, Flank Pain: possible ureteral calculus on KUB, Flomax and US of kidneys, Hyperlipidemia: Diet and exercise, repeat in 6 months. Acid Reflux: GI bleeding, FIT test given to patient today, Hgb normal, Start PPI, GI referral pending. Follow-up one month.

On 2/21/2021 FIT test was negative.

On 2/22/23 a RN documented that an email referenced a court order for a medical appointment.

On 2/22/23 a different physician (SP) noted the elevated cholesterol and liver enzymes and ordered chronic care to assess for medication. It does not appear that the physician reviewed the 2/21/23 note by another physician.

On 2/22/23 a RN saw the patient as an urgent walk in for pain. She notified the provider (CE) who ordered Toradol. The provider wrote a note documenting his clinical opinion and rationale for the current treatment plan.

On 2/24/23 labs showed: Hepatitis C antibody=positive, HCV RNA viral load=Undetectable. HBsAg=negative, HIV=negative.

On 3/4/23 at 19:23 a RN saw the patient for acute RUQ pain and administered Toradol.

On 3/6/23 another physician (ST) saw the patient for follow-up of RUQ pain. He documented the encounter was non-confidential for unspecified custody reasons. He assessed the patient's chronic RUQ and possible liver cirrhosis, noted fibro test indicated low probability of cirrhosis.? ureteral stone: check urinalysis to see if any evidence of calculus. Plan: Abdominal US pending. ROI completed. He discontinued tramadol due to patient's lack of cooperation with oral cavity checks.

Compliance Assessment:

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

Recommendations: The County needs to:

1. Provide adequate nursing and custody staffing to permit timely monitoring and treatment of patients in withdrawal.
2. Retrain intake nurses regarding taking adequate alcohol and drug histories, performing CIWA and COWS assessments, and ordering urgent provider referrals.
3. Implement fixed dose treatment regimens (as opposed to symptom triggered treatment) to prevent escalation of withdrawal syndromes, until the County demonstrates it can provide timely monitoring.
4. Medically evaluate patients with substance abuse withdrawal in 24 hours to evaluate the patient for complications of substance use disorder (i.e., skin infections, evidence of sepsis, etc.).
5. Develop the substance use disorder withdrawal program, that includes criteria for admission to and discharge from the unit, daily physician rounds, mental health provider involvement, and transition to the MAT program.
6. Increase medical supervision of patients undergoing substance use disorder monitoring and treatment housed both in and outside the detox unit.
7. Create a detox unit for men and women at RCCC due to the wide availability of fentanyl at the jail.
8. Provide Narcan in housing units and other strategic locations around the jail.
9. Continue to expand the Medication Assisted Treatment (MAT) program.
10. Conduct CQI studies to include metrics of performance for all health care disciplines involved in the substance use disorder withdrawal monitoring and treatment (e.g., nurses, providers, and mental health professionals).

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: The implementation of nursing protocols is based on the timely collection, triage, and scheduling of patient complaints and requests. As referenced in section C., Access to Care, there is a profound lack of patient access to health care that includes access to nursing sick call. ACH's CQI study reported on 1/27/23 found that only 29% of patients with routine health requests were timely seen. The multi-factorial reasons are discussed in that section.

Standardized nursing protocols, developed and approved by the sponsoring physician, facilitate, and guide the nurse in obtaining a comprehensive history, conducting a thorough physical assessment, and executing a standardized treatment plan for common patient complaints. Standardized nursing protocols must also contain sufficient clinical guidance and include red flag symptoms, that guide the nurse in determining the urgency of the condition, and appropriate treatment plan, including the urgency of referral to a provider.

ACH has revised standardized nursing protocols. The medical monitors have not completed review of all standardized nursing protocols (SNPs); but will do so following this report. However, we have given feedback on some protocols that have not been revised. For example, the SNP-Adult -Cardio and Lung-Asthma protocol does not include the use of peak flow meters to measure peak expiratory flow (PEF), which is an objective measure of airway restriction. Oxygen saturation does not measure airway restriction, and a low oxygen saturation rate (<93%) is a *late* sign of severe asthma.

Medical records show that neither nurses nor medical providers use peak flow meters to measure airway obstruction, however measurement of PEF before and after treatment with inhalers or nebulizers provided objective data to determine whether the patient's condition is improving or worsening, requiring further treatment.[151]

[151] The Medical Director states that use of peak flow meters to measure peak expiratory flow (PEF) is only indicated in patients with severe asthma. The chronic disease section of this report references national asthma guidelines that outline the benefits of PER, regardless of disease severity.

The dental nursing protocol primarily utilizes the subjective degree of pain to indicate the urgency of the condition and referral, which is not the only criteria that must be considered to arrive at the disposition. Criteria such as swelling, presence of signs of infection, and the impact on the patient's ability to masticate, sleep, and tolerate hold and cold liquids are important in triaging the dental condition.

As discussed in the last report, nurses continue to not adhere to the current SNPs. The monitors find that nurses often do not see the patient at all, or if seen, complete only portions of the patient history interview and examination, and execute selective parts of the SNP treatment plan. This can be remedied by incorporating SNP's into the electronic medical record.

Some examples are noted below:

- On 1/13/23, a RN saw the patient who complained of abdominal pain. The nurse failed to ask the patient if there were recent injuries or past surgeries. There was no assessment of the quality or severity of the patient's pain, or presence of nausea, vomiting, or anorexia. The nurse did not perform auscultation of bowel sounds, palpation of the abdomen to assess for guarding or tenderness, and other assessments required by the nursing protocol. The protocol requires the nurse to obtain urine for dipstick testing and that was not done. The provider was called and gave the nurse an order to schedule the patient for an urgent provider sick call the following day. The appointment did not occur.[152]

- On 2/14/23 at 15:21, a patient with a history of diabetes and diabetic gastroparesis, reported to a deputy of having abdominal pain, and the deputy called the medical unit. The nurse documented the patient had recently come back from the emergency department for the same complaint and had been seen by the provider 3 days prior. The nurse documented the patient was scheduled for follow-up with the provider in 2 weeks, and the appointment with the physician would be moved up. The nurse did not assess the patient. At 21:46, the patient walked to the 2M medical unit complaining of chest pain that had started one hour prior. The nurse failed to assess the patient's severity of pain, auscultate the lungs and heart, palpate the chest wall for tenderness, and or obtain a set of orthostatic vital signs, all required by the nursing protocol. *An EKG was obtained, and showed minor high-lateral repolarization disturbance, consider ischemia, LV overload, or a specific change. The nurse documented the EKG was without significant abnormalities and noted the patient had an appointment pending for MD sick call.* The nurse did not notify a provider as required by the nursing protocol.[153] A registered nurse cannot interpret an EKG and make a clinical decision on the disposition of the patient. A medical provider needs to review the EKG, make a diagnosis, and develop a plan of care. The nurse's action was outside her scope of practice.

[152] Patient #11
[153] Patient #20

- On 1/1/23, another patient submitted a health services request writing that she needed to see an OB/GYN doctor as soon as possible because she wished to terminate her pregnancy. She indicated she had seen the doctor but had not heard anything and was worried that she was getting further along in her pregnancy. On 1/1/23, a RN triaged the request as routine with "case management" circled. The nurse did not see the patient nor did the nurse communicate with the patient, to address her concerns, and reassure her that that a plan was in place to provide the desired abortion. The patient went off-site for a therapeutic abortion on 1/12/23.[154]

Compliance Assessment:

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

Recommendations: The County needs to:

1. Continue to revise the Standardized Nursing Protocols (SNPs) in conjunction with the Medical Director.
2. Provide clear nurse to provider referral criteria including the urgency of referral in each SNP, to minimize the risk that nurses will exceed their scope of practice.
3. Perform CQI studies to assess nursing compliance with the SNPs, with particular attention to the quality of the history and physical assessment. CQI studies need to include timeliness of nurse to provider referrals.
4. Revise CQI study methodology to expand the sample (e.g., 30 records) and measure performance over time (30-60) days instead of a single point in time). For example, designating the study time frame as a 1–2-month study, with a sample of records selected each week representing different days (weekdays, weekends) and different shifts in each jail.

P. Review in Custody Deaths

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

Findings: The Medical Director conducts preliminary mortality reviews within 30 days of the patient's death. These preliminary reviews are more substantive and contain more analysis than previous reviews (P.1). This is a significant improvement.

[154] Patient #16

For the period of review, only one final mortality report was provided. ACH indicated that they have not received autopsy reports for the other deaths, and therefore have not finalized other mortality reviews. ACH does not consistently receive death certificates, and when they do, sometimes the cause of death is "pending."

While current mortality reviews address nursing and systems issues, the reviews do not meaningly address *lapses in medical care*. This includes providers failure to:

- Send a recently arrived patient who had serious medical illness and *alarm symptoms* to the hospital for diagnosis and treatment;[155]
- Address all chronic diseases;[156]
- Address ED physician recommendations, timely if at all;[157]
- Perform and document physical examinations that accurately reflect the patient's clinical condition, and that markedly depart from ED physician's findings performed within hours of the ACH provider examination;[158]
- Follow-up on recommended specialty services for the patient from emergency department or specialty service providers;
- Assess medication adherence.[159]

Two of the deaths reviewed involved patients that were intellectually/seriously mentally ill, and gravely disabled. In one of the cases, the patient refused multiple treatments, including laboratory monitoring and treatment for lice/scabies (a public health concern), but there was no substantive collaboration with mental health to address the patients refusals of treatment.[160]

When patients who are gravely disabled refuse all medical and mental health treatment, medical and mental health providers, through case management need to determine whether the patient has mental capacity for decision making, and whether refusal of care is life-threatening, will result in deterioration, or is a public health risk, requiring further measures.[161]

The following cases illustrate these opinions.

- **Patient #5:** This 52-year-old man was intellectually disabled, and severely mentally ill. He was often gravely disabled and unable to communicate his needs. Upon arrival he gave a

[155] Patient #35.
[156] Patient #5
[157] Patient #5
[158] Patient #5
[159] Patient #5
[160] Patient #5 and #36.
[161] Patient #5 and #36

history of hypertension and seizures. He also had a history of schizophrenia and bipolar disorder with inpatient care.

On 9/28/22, ACH received a list of psychotropic medications prescribed for the patient at North Valley which included Haldol, Chlorpromazine, Seroquel, Klonopin, gabapentin, Depakote, and propranolol. On 9/30/22 a MH provider reviewed this list but did not continue the medication and on 10/4/22 a psychiatrist reviewed the medication list, but the medications were not continued. Neither MH provider documented the clinical rationale for not continuing the medications.

After intake, a medical provider (RK) addressed the patient's history of hypertension but not seizures. Outside medical records showed that the patient was prescribed Keppra 500 mg twice daily, but this was never considered or ordered while the patient was at the jail.

On 10/6/22, a medical provider noted the patient had a large right inguinal hernia that was *not reducible increasing risk of incarceration of the hernia and strangulation of bowel tissue. It can be life-threatening and requires immediate surgery*. The provider ordered a scrotal ultrasound and to consider a surgical consult, instead of urgent referral for surgical repair.[162]

On 10/10/22, at an unknown time, the patient's right thumb was injured when it was *caught in a door.* At 01:45 a RN noted the patient was crying hysterically and calling for an ambulance. He was presumed to be agitated and treated with Ativan.

On 10/11/22, a provider (JA) sent the patient to the emergency department for right thumb trauma and cellulitis, and large inguinal hernia. The ED physician recommended antibiotics and follow-up by plastic surgery in two days, and referral to a surgeon for hernia repair in two days. *Upon return from the ED, a provider did not acknowledge or address these recommendations, and the patient was not referred to a surgeon for hernia repair. The patient continued to complain of groin pain and incontinence throughout his incarceration, but providers did not follow-up on the 10/11/23 ED physician recommendation for surgical repair of his hernia*.[163]

On 10/13/22, the patient presented for worsening infection of his thumb. The physician (RK) diagnosed him with osteomyelitis and sent the patient to the ED.[164] *The admitting*

[162] UpToDate. Overview and treatment of inguinal and femoral hernias.

[163] The Medical Director responded that ACH physicians independently assessed the patient and found there was no immediate urgency for surgical repair at the time of the ED physicians recommendation. This response fails to recognize that ACH physicians did not even address the ED physicians recommended for urgent referral to a surgeon for hernia repair. In one case, the ED physicians were unable to reduce the patient's hernia due to pain and the patient was taken to the operating room where the hernia was reduced under sedation.

[164] Osteomyelitis is a bone infection that occurs over time with an inadequately treated infection. Given that the trauma event occurred 3 days prior, it was unlikely to be osteomyelitis. The provider did not note the patient's right hand and arm cellulitis extending to the patient's elbow.

hospital physician diagnosed the patient with right hand and arm cellulitis and lymphedema extending to the patient's elbow. The physician's (RK) description of the patient did not accurately reflect the patient's clinical condition.

On 10/19/22 a physician (JA) reduced the patients right inguinal hernia and submitted a request for a surgical consult, *but we find no entry on the Specialty Services Tracking log and the patient did not receive a surgical consult for his large hernia.*

The patient's October 2022 MAR shows the patients antibiotics were ordered on 10/12/22, however Keflex was ordered three times daily and not 4 times daily as ordered by the ED physician. Ten doses on the MAR were completely blank, indicating that medications were not administered by nurses. Another six doses were No Shows. The patient received only 17 of 33 doses of Keflex. The patient received only 11 of 16 doses of Bactrim. No Shows should not be permitted, but particularly for a severely intellectually and mentally ill patients. Medical providers did not review the patient's medication adherence and address that nurses were not administering antibiotics and other medications to the patient.

On 11/3/22 a physician ordered the patient sent to the ED for a brain MRI and possible worsening thumb infection. *Custody informed a RN that they could not send the patient because there was no van. The patient was sent the following day.*

There were repeated issues with custody not escorting the patient for medical evaluation and nurses not evaluating the patient due to his behavior of smearing feces in his cell. This delayed diagnosis of complications of his inguinal hernia. On 1/4/23, a social worker noted the patient's penis was swollen and reported it to the 2M nurse who asked custody to bring the patient when available. Custody did not bring the patient. On 1/5/23, custody did not escort the patient because he was urinating on the door. On 1/6/23 custody did not escort the patient because there was "lots of movement and chow time at this time." On 1/9/23 a RN did not see the patient because his room was smeared with feces, and on 1/10/23 a RN observed through the cell window that the patient's penis was swollen, did not examine the patient, instead referring the patient to a provider. This is deeply concerning because the patient was at risk for an incarcerated hernia, which can be life-threating.

Note: Some of these custody issues were addressed in the mortality review, as well as the need to address access to care barriers due to hazardous cell conditions.

On 1/12/23, eight days after a RN referred the patient to a provider, a physician saw the patient and noting his hernia was the size of a grapefruit. He was sent to the ED where the patent's hernia was reduced under sedation. The discharge notes stated: right groin mass for multiple months: Right inguinal hernia. The physician recommended surgical referral. On 1/18/22 a physician *did not see* the patient but noted the recommendation for surgical referral and that the patient had a future physician appointment, but did not

order the surgical referral. *A provider did not see the patient before he died on 1/24/23 and he did not receive recommended surgical treatment for his large inguinal hernia that was recommended by both emergency department and ACH providers, and caused him pain throughout his incarceration.*

Note: The mortality review noted the lapse that a medical provider did not see the patient following return from the ED.[165]

On 1/24/23, the patient was found unresponsive in his cell and initiated CPR. There is no death certificate or autopsy report.

Summary: This mortality review identified issues with lack of access to care due to custody; lack of continuity of care after ED visits; lack of referral to mental health to address behaviors impacting access to care; and failure of health care staff to report hazardous cell conditions. The corrective action plan noted that "personnel issues" were a root cause contributing to the patient's death, but did not identify the issues and did not develop a corrective action plan. The CAP focused exclusively on actions to be taken by nursing, mental health, and CQI. The review and corrective plan did not identify lapses in medical care that include:

- Following intake, a provider addressed the patient's hypertension but not his seizure disorder, including not ordering Keppra, which he took prior to admission.[166]
- On 10/13/22, the provider did not review or address recommendations for referral to a surgeon in two days, following his 10/11/23 ED visit. This constituted an urgent referral to the surgeon.
- On 10/13/22, the provider's clinical description of the patient did not match findings of right thumb and arm cellulitis and lymphedema documented by the physician at the ED.
- Providers did not review the MAR to that showed the patient was receiving only half of his prescribed antibiotics for his right thumb and arm cellulitis.
- The provider who saw the patient following his 1/18/23 ED visit, did not order surgical referral, but deferred it because the patient had a future provider appointment.

A separate issue is why the hospital did not admit the patient for urgent surgical care of his hernia. We recommend that County explore this further to determine whether this is based on a medical decision or lack of custody officers to be assigned for a hospital stay.

Because the patient was gravely disabled that may have impacted his medical treatment, the Monitors requested that Mary Perrien, Mental Health Expert, review mental health care provided to this patient. Her questions and opinions are as follows:

[165] UpToDate. Overview and treatment of inguinal and femoral hernias.

1. Why was the patient repeatedly referred to acute MH treatment but not admitted despite documentation not supporting actual symptom alleviation? He was repeatedly referred and therefore identified as requiring the highest level of care, but did not receive it.
2. MH providers did not have adequate clinical justification to remove patient from acute psychiatric unit (APU) wait list but did so repeatedly.
3. The patient did not receive required level of care given functional impairment. He was simply on and off the APU list with only one brief admission.
4. His legal determination of "non restorable" should have automatically resulted in inpatient admission. He should have been closely monitored by MH, especially when it was determined that his MH status interfered with his ability to access healthcare.
5. Outside providers should have been contacted and ROI submitted to access those records. He should have received daily clinical treatment. There were repeated referrals to MH due to his MSE (mental status examination) interfering with his ability to access medical care. His treatment team should have focused on that as part of his treatment plan.
6. There were multiple points of possible intervention that were ignored and contributed to this preventable death (by mental health). Mental health did not document adequate assessments or treatment planning.
7. Consultation on this case did not occur as would have been expected and supervisory oversight appeared deficient based on documentation.
8. It is severely troubling that mental health did not adequately treat and monitor the patient knowing his acuity level and failed to see the urgency of providing inpatient treatment to this patient.

The patient below was reviewed by Dr. Karen Saylor and was included in the Third Mays Report. It is included here because the mortality review was revised and provided to the Medical Experts.

- **Patient #35:** This 67-year-old man arrived at SCJ on 7/12/2022 and died of sepsis on 7/24/2022. His medical history included opioid substance use disorder, untreated intestinal cancer diagnosed 4 months previously, 60 lbs. weight loss, and back surgery. He was taking methadone. The day following his arrival the patient submitted a health request that he had sepsis and a heart infection. Nurses did not timely address this urgent health request.

  On 7/15/2022 a medical provider saw the patient who reported profound weight loss, intestinal cancer, inability to tolerate solid foods without vomiting, and rectal bleeding. The patient was 6' 2' and weighed 106 lbs. In our opinion, these alarm symptoms warranted immediate admission to the hospital for medical evaluation of his intractable

nausea and vomiting, rectal bleeding, and history of cancer. The medical provider ordered labs and follow-up in one month, treating his condition as routine.

On 8/22/2022, the Medical Director completed a preliminary mortality review. The review did not identify lapses in care and identified the only issue as "No care was provided for a Health Services Request submitted on 7/21/2022".

On 9/22/22, the Medical Director revised the mortality review that addressed lapses in nursing and systems issues identified by the Medical Experts. With respect to medical care, the mortality report states the following:

> *On 7/15/22, the patient saw a provider. There was no evidence of active infection/sepsis during this initial MD appointment. Also, Patient had been non-compliant with treatment for approximately a year. Given the patient's documented clinical stability, there was no reason for provider to refer for inpatient services at this time. However, the provider ordered a 1-month follow-up, which was markedly too long for a patient with alarm symptoms. Close MD follow-up appointments (anywhere from daily to at least once per week) should have been ordered and performed. The provider also did not order labs with urgent priority. These errors may have contributed to a lack of appropriate monitoring for the patient's condition.*

Summary: Given that the patient elicited a history of untreated intestinal cancer, cachexia with 60-pound weight loss, vomiting, inability to retain solid foods, and bright red blood in his stool, the patient needed medical evaluation and treatment. The revised mortality review correctly identifies that the patient was having *alarm symptoms,* which warranted immediate referral to the hospital for an inpatient evaluation. We do not understand the basis for determining that *the patient was clinically stable*. An autopsy revealed that the patient had a lung mass that may have been a tumor or pneumonia.

In this case, Dr. Saylor is deeply concerned that the Medical Director finds the physician's care to be medically appropriate *except* for the timeliness of follow-up. The Medical Director's failure to recognize, acknowledge and address serious lapses in medical care quality is likely not to result in improvement in medical care quality for patient's in custody.

- **Patient #4:** This was a 44-year man who arrived at SCJ on 8/2/22 and died on 12/30/22 following his release from jail on 11/29/22. His medical history included hypertension, stage 4 testicular cancer, oliguria due to urinary obstruction and methamphetamine substance use disorder. This is an unfortunate case of a patient who was diagnosed and treated for testicular cancer in 2009, but was lost to follow-up until October of 2021 when he presented with metastatic disease that obstructed his urinary tract and included a lung

lesion. His course of treatment was complicated by the patient's difficulty in tolerating chemotherapy and non-adherence to medical appointments.

At the time of his arrest on 8/2/22, the patient's disease was advanced. ACH staff referred him to Stanford oncology who saw him on 9/1/22 and recommended salvage chemotherapy. It is unclear from the notes whether he was administered chemotherapy the same day.

On 10/4/22, oncology saw the patient for follow-up and Dr. Khaki's notes indicate that, despite the patient's poor prognosis, the patient agreed to salvage chemotherapy. The ACH physician documented that the patient did not want chemotherapy but did not document an informed refusal of chemotherapy. Within days of this encounter, the patient said that he did not decline chemotherapy.

Based on the ACH physician 's progress note that the patient did not want chemotherapy, Case Management notified Stanford oncology to cancel chemotherapy treatment at Stanford. This was done without an informed and signed refusal of treatment. Later the patient would say that he did not refuse chemotherapy. With the oncologist indicating that the patient agreed to treatment, the patient indicating that he did not refuse treatment, and no informed and signed refusal of treatment, there is no clear evidence that the patient refused chemotherapy. This is a provider and systems issue that ACH needs to address.

As the patient's disease progressed, he was housed in the RCCC Medical Housing Unit (MHU). Nurses' infirmary notes document assessments and the patient's increasing pain levels, however nurses did not document pain assessments nor the patient's response to pain medication. On 11/14/22, the patient was transferred back to 2M at Main Jail and then to 2 East. *Although this patient was terminally ill and needing frequent narcotics to manage his pain, there are virtually no nursing notes once he was transferred to Main Jail, until his release on 11/29/22.* Per class counsel, on 12/20/22 the patient died. Whether housed in the infirmary or 2 East, nurses should have monitored the patient's condition each shift with particular attention to his level of pain, and document the response to pain medications.

Opinion: While this patient's prognosis was dire, there were documentation discrepancies regarding the patient's desire to continue chemotherapy, and concerns with pain management. This patient died after release and there is no mortality review for the patient.

- **Patient #22:** This 35-year-old man was admitted to SCJ on 4/5/23, and died on 4/6/23. He had no significant medical history. He was taking no medications.

  On 4/5/23 at 04:3, a RN conducted medical screening. She noted that the interview was nonconfidential. The patient reported no substance use in the past 30 days. The

patient refused COVID-19 vaccine. The RN ordered a tuberculin skin test TST) and COVID-19 vaccination checks.

On 4/5/23 at about 15:49, the patient was found unresponsive, laying down on a wooden bench in booking holding cell 1 unresponsive in a booking holding cell. His pupils were fixed and dilated. The patient was removed from the cell and placed on supine on the floor in the hallway. The patient was still unresponsive and pulseless. CPR initiated. Narcan was given x 4 at 1551, 15:54, 15:56 and 15:58. AED pads placed at 15:58, and advised no shock as the patient was in asystole. Fire EMS arrived at 16:01 and continued CPR until 16:15 when the patient was pronounced dead. A RN documented that the patient was noted to have taken an unknown substance given to him in holding, suggesting possible overdose.

Summary: This death may not have been preventable. At the time of the response, the patients' pupils were fixed and dilated suggesting that the patient had been without a pulse for several minutes before the patient was responded to. Nurses appropriately administered Narcan to the patient. However, there was a 9-minute delay in applying AED pads and use of the AED. Video later showed the patient ingested a substance before arresting.

- **Patient #38** On 7/2/23 at 05:31 this patient arrived at the jail. His medical history included of diabetes and alcohol, benzodiazepine, and heroin use disorder. The patient drank a pint of hard liquor daily. The RN conducted what appears to be a full medical screening. The RN ordered medical expedite to 2E, detox housing, and low bunk, but not COWS or CIWA assessments, an alcohol or opioid withdrawal, regimen, or referral to a medical provider. The nurse also ordered a second (Tier 2) intake assessment. Custody removed the patient from the booking loop for processing, and Tier 2 medical screening took place about 5.5 hours later. The patient appeared to be under the influence. CIWA-Ar=2, CIWA-B=3, and COWS=6. [167] The nurse ordered CIWA and COWS screening twice daily and an opioid and benzo/alcohol detox regimen, Detox housing, H&P, and mental health, etc. The patient was housed at Main Jail 6 East detox unit for six days. During this time, nurses did not conduct any alcohol, benzodiazepine, and opioid withdrawal monitoring. [168]

  On 7/7/23 a provider saw the patient for withdrawal symptoms and documented that the patient reported no symptoms. On 7/8/23, the patient went into cardiac arrest. The cause of death is unknown.

  Summary: This death occurred about 30 days prior to the draft of this report, and the County has not yet conducted a mortality review for this patient. The issues noted in

[167] CIWA-Ar is for alcohol withdrawal, CIWA-B is for benzodiazepine withdrawal.
[168] Nursing leadership reported that no withdrawal monitoring was conducted due to staffing issues.

review of this case, are that custody removed the patient from the booking loop prior to completion of Tier 2 medical screening, which took place 5.5 hours later, delaying initiation of SUD withdrawal treatment and monitoring. The second, and urgent concern is that nurses did not conduct withdrawal monitoring while the patient was in the detox unit. Nursing leadership cited staffing issues as the reason. *However, for withdrawal monitoring to not have taken place for six days in the detox unit is completely unacceptable, and is an ACH leadership issue as well as a staffing issue. Any reasons that prevented withdrawal monitoring needed to be brought to the attention of ACH health care leadership to determine what could be done to bring on additional staffing to conduct monitoring rounds and address any other obstacles to the timely performance of rounds.* Rounds conducted once a day, although not adequate would have been better than no rounds in the unit.

- **Patient #39** This patient arrived on 7/20/23 at 14:46, from the ED after he reported ingesting fentanyl and was medically screened by a nurse. He had a history of fentanyl use and continuous alcohol consumption. The nurse saw the patient for a return from the ED and completed what appeared to be the full medical screening. The patient's COWS score was 1. The nurse ordered detox housing, but not other routine orders such as COWS and CIWA assessments, alcohol/opioid detox regimens, or an urgent referral to a provider. The RN then ordered a second nurse intake assessment.

  The inmate was in male classification and dressed out at 9 pm and was to be housed in 8 East. At 22:00, a LCSW saw the patient in the 2E Indoor recreation. At 22:23, a RN conducted a second full assessment in booking, about 5.5 hours after the first screening. The patient's COWS score had risen to 9. The RN ordered an opioid detox regimen and gave a first dose, ordered detox housing, COWS monitoring twice daily, a lower bunk, and a medical provider referral. He went into cardiac arrest 12 hours later with suspected drug overdose.

  Summary: A mortality review has not yet been completed. However, concerns are that after Tier 1 screening, the patient was taken out of the booking loop for processing by custody before Tier 2 medical screening was conducted. In the 5.5 hours before a nurse saw the patient, his COWS score increased from 1 to 9. Given his history of fentanyl and alcohol substance use disorder, starting the patient on opioid and alcohol detox regimens needed to be considered, however because Tier 2 screening was delayed, it was not.

- **Arrestee/Patient #37:** We reviewed an *incident report* of an arrestee who died waiting to be booked into the jail and that indicated that "medical staff was not involved."[169] On Monday, 8/2/2022 at 15:35, a RN contacted an SRN to request more assistance in booking due to being busy. He also reported that an arrestee died approximately one hour before and was currently in the garage, but "nursing was not involved in the case." A CNA

[169] Patient #37. He did not have an X-ref number.

reported that the arrestee walked in and out of (COVID) Arrestee Station # 3 with some assistance from the officer. He was diaphoretic, and did not request help from the CNA. The arresting officer used a pulse oximeter from the nurses' cart to take the arrestees pulse, then requested the CNA to take the arrestee's pulse, which was in the 150s/minute. As soon as the arrestee's heart rate was taken, the arresting officer said that they would not wait for nurse intake but would take the arrestee to the hospital. Per the incident report, the SRN was then informed that paramedics had responded, performed CPR, and the arrestee was pronounced dead in the garage.

At approximately 16:20, the SRN received a call from the RN who reported that a CSI agent, via custody, was asking the nurse to take the deceased person's temperature while CSI took a picture. (The) reason (was) unknown, but suspected for investigation purposes. The SRN contacted Dr. Babu, who advised not to get involved. The SRN went down to booking and the RN advised her that an intake officer took a thermometer and measured the patient's temperature which was 91°F. The Senior Nurse Manager reviewed the incident report and clarified that *no ACH nurses/staff were involved during the emergency response that took place in the garage.*

Opinion: This incident report, if accurate, is extremely disturbing. First, when the CNA noted the patient was diaphoretic with a pulse in the 150 range, the CNA needed to have the patient sit or lay down and take a full set of vital signs, including oxygen saturation, to determine whether the patient's vital signs were unstable, warranting that the patient should not be moved, and ACH needed to call 911. An arresting officer taking an arrestee with unstable vital signs to the hospital in a police car risks a cardiac arrest in the vehicle with no emergency equipment and ability to implement Advance Cardiac Life Support (ACLS). The CNA also needed to notify a RN of her findings.

The timing of when the arrestee went into cardiac arrest and when paramedics were called is unknown is at this time. However independent of whether arresting officers notified emergency medical services (EMS) before or after the patient went into cardiac arrest, ACH nurses should have also been notified to respond to the arrestee.

In addition, the fact that a CSI agent would request that a nurse take the temperature of a deceased person for an investigation is inexplicable, and raises serious questions about the integrity of the investigation.

It is also concerning that had nursing staff been timely notified of the arrestee's condition, there was no physician available to respond to the scene.

Recommendations: Although it has been 10 months since this occurred, it is a sentinel event, and warranting a critical incident debriefing, if it has not already been done.

Summary: The quality of the mortality reviews and corrective action plans have improved with respect to identifying nursing and system issues. The mortality review process does not address medical quality issues.

When patients have serious mental illness but are gravely disabled and lacking in decision making capacity, there needs to be coordination of care between medical and mental health to determine what the patient needs so that further treatment measures can be taken, including involuntary medication. Mental health and medical mortality reviews are conducted independently, and when the preliminary and final mortality review are conducted, medical and mental health staff do not meet to discuss findings and whether there were opportunities for improvement.

Compliance Assessment:

- P.1=Substantial Compliance
- P.2=Noncompliance

Recommendations:

1. The County needs to conduct more robust analysis of the timeliness and appropriateness of medical care provided to deceased patients.
2. Consider establishing a mortality review process in which other ACH physicians participate in the review process.
3. We recommend a Corrections Expert review all custody incident reports and videotapes related to the arrestee's death, as well as the CSI investigation report.

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: The ACH Reentry Services program is in development. ACH revised its Discharge Medication policy (04-10) on 10/29/2021 and its Discharge Planning for Reentry policy (05-10) on 5/18/2022. Both policies are compliant with Consent Decree requirements (A.3).

ACH tracks referrals to community resources for different types of services including finding a medical and or mental health provider, transportation, and food/nutrition assistance. From January through April 2023, ACH made 71, 68, 67, and 58 referrals respectively. This included referrals for Medication Assisted Treatment (MAT), although the numbers are currently low. In April 2023, ACH made 8 referrals for Buprenorphine and 2 referrals for methadone treatment (A.3.).[170]

During this review period, ACH did not provide documentation showing that a 30-day supply of current medications were provided to all patients who have been sentenced and have a scheduled release date (Q.1). ACH reports that pharmacy improved its process of pulling Sentenced Discharge data, no longer relying on weekly release lists from SSO that is produced weekly, and patients were released in-between the weekly lists. The table below reflects January 2023 Sentenced Discharge data from the EHR, and shows that 86 (97%) of 89 sentenced inmates were released with medications. [171]

Sentenced Discharge Data January 1 – 31, 2023	
Release Status	**Patients**
Projected to be released	98
Released	89
Released with Medications	86/89 (97%)

Due to a software problem with ATIMS and Centricity, there is no data from December 2022 to April 2023 to show that sentenced patients received a 30-day supply of medications at release.

ACH provided court-ordered medications for some patients from February to April as noted below.

2023 Sentenced Release Medications		
Month	**# Patient Received Meds**	**# of Court Ordered Medications filled**
February	111	46
March	115	38
April	87	36
May	134	28

For Presentenced Discharge medications, ACH provided data From September through November 2022, that showed that the number of prescriptions called into the pharmacy declined each month and is very low. ACH determined that the extremely low number of patients picking up their prescriptions did not justify the amount of provider time to call in the prescriptions. A

[170] These numbers reflect patients who are already prescribed buprenorphine and methadone, and would be expected to increase as the County expands its MAT program.
[171]ACH R.3 Sentenced Discharge Medications. January 2023.

decision was made to call in the prescription when patients arrived at the pharmacy. Since that decision, ACH reports that this is being revisited, as CalAIM requires that patients receive a prescription discharge if they meet eligibility for these services. ACH will be updating its policy based on these requirements in preparation for go-live in Jan 2024.

Currently, ACH has the following positions allocated to Discharge Planning: 1 SRN, 1 RN, 1 LVN and 4 medical assistants. ACH's long-term plan is to submit a growth request for Discharge Planning/Reentry based upon CalAIM requirements and move Discharge Planning/Reentry under Case Management to support resources where needed for linkage to needed services during incarceration and in preparation for reentry to ongoing care.

Compliance Assessment:

- Q.1=Partial Compliance
- Q.2=Noncompliance ↓
- Q.3=Substantial Compliance ↑

Recommendations:

1. Continue to collect discharge medications data for sentenced and presentenced inmates and analyze results to identify root causes and targeted solutions.
2. Expand the program as resources are obtained through growth requests.
3. As planning takes place for the new Annex, consider a discharge planning office that all inmates must pass through to pick up medications and/or prescriptions, as well as community referrals at the time of release.

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 provided training rosters for custody staff that are trained in cardiopulmonary resuscitation (CPR). However, the County did not provide documentation of jail custody staff being trained in the topics required by the Consent Decree.

Compliance Assessment:

- R.1=Noncompliance

Recommendations: The County needs to:

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

Medical Remedial Plan Compliance Summary

	Paragraph	Substantial Compliance	Partial Compliance	Noncompliance	Not Evaluated
1.	A.1.		01/21/2021 8/27/2021 9/1/2022 **7/1/2023**		
2.	A.2.			01/20/2021 8/27/2021 9/1/2022 **7/1/2023**	
3.	B.1.	1/20/2021 8/27/2021	9/1/2022	**7/1/2023**	
4.	B.2.			8/27/2021 9/1/2022 **7/1/2023**	01/20/2021
5.	B.3.	9/1/2022 **7/1/2023**	01/20/2021 8/27/2021		
6.	B.4.		8/27/2021 9/1/2022 **7/1/2023**	01/21/2021	
7.	B.5.	**7/1/2023**	01/20/2021 8/27/2021 9/1/2022		
8.	B.6.		01/20/2021 8/27/2021 9/1/2022 **7/1/2023**		
9.	B.7.	9/1/2022 **7/1/2023**			01/20/2021 8/27/2021
10.	C.1.	8/27/2021 **7/1/2023**		01/20/2021	9/1/2022
11.	C.2.		01/20/2021 8/27/2021 **7/1/2023**		9/1/2022
12.	C.3.a			01/20/2021 8/27/2021 9/1/2022 **7/1/2023**	
13.	C.3.b			01/20/2021	

	Paragraph	Substantial Compliance	Partial Compliance	Noncompliance	Not Evaluated
				8/27/2021 9/1/2022 **7/1/2023**	
14.	C.3.c			01/20/2021 8/27/2021 9/1/2022 **7/1/2023**	
15.	C.3.d		**7/1/2023**	01/20/2021 8/27/2021	9/1/2022
16.	C.4.			01/20/2021 8/27/2021 9/1/2022 **7/1/2023**	
17.	C.5			01/20/2021 8/27/2021 9/1/2022 **7/1/2023**	
18.	C.6.	8/27/2021 9/1/2022 **7/1/2023**		01/20/2021	
19.	C.7.a		8/27/2021 9/1/2022	01/20/2021 **7/1/2023**	
20.	C.7.b		8/27/2021 9/1/2022	01/20/2021 **7/1/2023**	
21.	D.1.		**7/1/2023**	01/20/2021 8/27/2021 9/1/2022	
22.	D.1.a		**7/1/2023**	01/20/2021 8/27/2021 9/1/2022	
23.	D.1.b		**7/1/2023**	01/20/2021 8/27/2021 9/1/2022	
24.	D.1.c		9/1/2022 **7/1/2023**	01/20/2021 8/27/2021	
25.	D.1.d		9/1/2022 **7/1/2023**	01/20/2021 8/27/2021	
26.	D.2.			01/20/2021 8/27/2021	

	Paragraph	Substantial Compliance	Partial Compliance	Noncompliance	Not Evaluated
				9/1/2022 **7/1/2023**	
27.	D.3	**7/1/2023**		01/20/2021 8/27/2021 9/1/2022	
28.	E.1.	8/27/2021 9/1/2022 **7/1/2023**			01/20/2021
29.	E.2.	8/27/2021	**7/1/2023**	9/1/2022	01/20/2021
30.	E.3.			9/1/2022 **7/1/2023**	01/20/2021 8/27/2021
31.	E.4.		8/27/2021 **7/1/2023**	9/1/2022	01/20/2021
32.	E.5	**7/1/2023**		8/27/2021 9/1/2022	01/20/2021
33.	E.6.	9/1/2022 **7/1/2023**		8/27/2021	01/20/2021
34.	E.7.		**7/1/2023**	8/27/2021 9/1/2022	01/20/2021
35.	E.8.	8/27/2021 9/1/2022 **7/1/2023**			01/20/2021
36.	E.9			9/1/2022 **7/1/2023**	01/20/2021 8/27/2021
37.	E.10.	8/27/2021 9/1/2022 **7/1/2023**			01/20/2021
38.	F.1.a	01/20/2021 8/27/2021 9/1/2022 **7/1/2023**			
39.	F.1.b	01/20/2021 8/27/2021 9/1/2022 **7/1/2023**			
40.	F.2.			01/20/2021 8/27/2021 9/1/2022 **7/1/2023**	
41.	F.3.		8/27/2021	01/20/2021	

	Paragraph	Substantial Compliance	Partial Compliance	Noncompliance	Not Evaluated
			9/1/2022	**7/1/2023**	
42.	F.4.		**7/1/2023**	01/20/2021 8/27/2021	9/1/2022
43.	F.5.	**7/1/2023**		01/20/2021 8/27/2021 9/1/2022	
44.	F.6.		01/20/2021 8/27/2021 9/1/2022 **7/1/2023**		
45.	G.1.		01/20/2021	8/27/2021 9/1/2022 **7/1/2023**	
46.	G.2.			8/27/2021 9/1/2022 **7/1/2023**	01/20/2021
47.	G.3.			**7/1/2023**	01/20/2021 8/27/2021 9/1/2022
48.	G.4	**7/1/2023**			01/20/2021 8/27/2021 9/1/2022
49.	H.1.			01/20/2021 8/27/2021 9/1/2022 **7/1/2023**	
50.	H.2.		01/20/2021	**7/1/2023**	
51.	H.3.			**7/1/2023**	01/20/2021
52.	H.4.	**7/1/2023**		01/20/2021	
53.	I.1.	01/20/2021 8/27/2021 9/1/2022 **7/1/2023**			
54.	I.2.		01/20/2021 8/27/2021 9/1/2022 **7/1/2023**		
55.	I.3	**7/1/2023**		01/20/2021 08/27/2021	

	Paragraph	Substantial Compliance	Partial Compliance	Noncompliance	Not Evaluated
				9/1/2022	
56.	J.1.	8/27/2021 9/1/2022 **7/1/2023**	01/20/2021		
57.	J.2.		01/20/2021 9/1/2022 **7/1/2023**		8/27/2021
58.	J.3.		**7/1/2023**	01/20/2021 9/1/2022	8/27/2021
59.	J.4	**7/1/2023**	8/27/2021	01/20/2021	9/1/2022
60.	K.1	9/1/2022 **7/1/2023**		01/20/2021 8/27/2021	
61.	L.1.	**7/1/2023**	01/20/2021 8/27/2021 9/1/2022		
62.	L.2.		01/20/2021 8/27/2021 **7/1/2023**	9/1/2022	
63.	L.3.		**7/1/2023**	9/1/2022	
64.	M.1.	**7/1/2023**	9/1/2022	01/20/2021 8/27/2021	
65.	M.2.		**7/1/2023**	01/20/2021 8/27/2021 9/1/2022	
66.	N.1.		9/1/2022 **7/1/2023**	01/20/2021 08/27/2021	
67.	N.2.		9/1/2022	01/20/2021 08/27/2021 **7/1/2023**	
68.	O.1.		9/1/2022 **7/1/2023**	01/20/2021	
69.	O.2.		**7/1/2023**	01/20/2021 8/27/2021 9/1/2022	
70.	P.1.	**7/1/2023**	9/1/2022	01/20/2021 8/27/2021	
71.	P.2.			01/20/2021 8/27/2021 9/1/2022 **7/1/2023**	

	Paragraph	Substantial Compliance	Partial Compliance	Noncompliance	Not Evaluated
72.	Q.1.		01/20/2021 8/27/2021 9/1/2022 **7/1/2023**		
73.	Q.2.		9/1/2022	01/20/2021 8/27/2021 **7/1/2023**	
74.	Q.3.	**7/1/2023**	9/1/2022	01/20/2021 8/27/2021	
75.	R.1.			8/27/2021 9/1/2022 **7/1/2023**	01/20/2021
	Total	**25 (33%)**	**25 (33%)**	**25 (33%)**	**0 (0%)**