OFFICE OF THE INSPECTOR GENERAL

• PROMOTING INTEGRITY •

STEVE WHITE, INSPECTOR GENERAL

MANAGEMENT REVIEW AUDIT

WARDEN DERRAL G. ADAMS

CALIFORNIA SUBSTANCE ABUSE TREATMENT FACILITY AND STATE PRISON CORCORAN, CALIFORNIA

SUPPLEMENT TO
JANUARY 2003 REPORT

GRAY DAVIS, GOVERNOR

STATE OF CALIFORNIA

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Memorandum

Date: March 4, 2003

To: EDWARD S. ALAMEIDA, JR.
Director, Department of Corrections

From: STEVE WHITE
Inspector General

Subject: **COMMENTS ON THE DEPARTMENT OF CORRECTIONS RESPONSE TO THE MANAGEMENT REVIEW AUDIT OF CALIFORNIA SUBSTANCE ABUSE TREATMENT FACILITY AND STATE PRISON AT CORCORAN**

This is to acknowledge receipt of your memorandum dated January 30, 2003, along with the department's written response to the Office of the Inspector General's management review audit of the California Substance Abuse Treatment Facility and State Prison at Corcoran. Unfortunately, the response did not arrive until Monday, February 3, 2003. As you know, the report of the management review audit was issued without a written response on January 30, 2003, the day after the department's second deadline extension for providing a response had expired.

Although the department missed the deadline, we will include the response with every copy of the report we provide to any party with the legal authority to review it. Because the attachments that were included with the response are so voluminous, we will make them available for review at the Office of the Inspector General. At the department's request, and to ensure confidentiality, we have eliminated from the response the names of staff and inmates, as well as inmate identification numbers.

We note from the response that the Department of Corrections for the most part concurs with the findings and recommendations presented in the report. We will use the corrective actions cited in the response and the medical corrective action plan described in the attachments as the basis of our follow-up review, to be conducted one year from now.

The attached document presents the comments of the Office of the Inspector General concerning some of the issues raised in the department's response. The comments are cross-referenced by number to the department's response.

Please contact me if you have questions regarding this matter.

JC/dj

Attachment

cc: Robert Presley, Secretary, Youth and Adult Correctional Agency

COMMENTS OF THE OFFICE OF THE INSPECTOR GENERAL

Following are the comments of the Office of the Inspector General on the response of the Department of Corrections to the California Substance Abuse Treatment Facility and State Prison at Corcoran management review audit. The numbered items correspond to circled numbers in the department's response.

1. In Finding 1, page 17 of the management review audit report, the Office of the Inspector General cited the large number of sex offenders and mentally ill inmates in the substance abuse program as a factor in the program's failure to reduce recidivism. In response, the Department of Corrections noted that the UCLA evaluators had reported that mental health status was not a "significant predictor" of recidivism and that recidivism rates for these offenders were similar to those of other inmates in the program.

   The substance of the Office of the Inspector General's finding is that in large numbers sex offenders and mentally ill inmates can disrupt the programming of other inmates and inhibit the success of the therapeutic community model. The Office of the Inspector General also pointed out, and the department acknowledged in its response, that sex offenders and mentally ill inmates also are difficult to place in aftercare — the community treatment deemed critical to substance abuse program success.

2. In Finding 1, page 18 of the report, the Office of the Inspector General said that contract providers of substance abuse treatment services are obliged to accept large numbers of sex offenders and mentally ill inmates because the department, operating under a financial incentive, supplies the program with as many participants as possible. In its response, the department contends that it is in the state's best interest to maintain capacities in the programs in order to serve the maximum number of inmates. The department also noted that the Level II population available for participation in the substance abuse treatment program, after many Level II inmates have been assigned to other minimum custody facilities, includes a high percentage of sex offenders and mentally ill inmates. The department also again cited the lack of correlation found by UCLA researchers between recidivism and inmates with those characteristics.

   Although the UCLA data identified no statistically significant difference between the recidivism rates of the mentally ill and sex offender subgroups and those of the other inmates under study, the parolees from the substance abuse program as a whole nonetheless failed to demonstrate a recidivism rate lower than the control group at another prison that had received no substance abuse treatment. The UCLA study did cite concerns by provider counselors that substance abuse treatment at the prison was inadvisable for mentally ill inmates "because of their limited comprehension skills and tendency to be either disruptive or disengaged from the therapeutic process." Despite its response to the finding, the department has advised the Office of the Inspector General that in the future the percentage of mentally ill inmates in the substance abuse program would not exceed their percentage in the Department of Corrections inmate population as a whole. According to the department, that policy will reduce the percentage of mentally ill inmates in the program from 33 percent to 12 percent.

3. In Finding 1, page 18 of the report, the Office of the Inspector General noted that the large number of beds in the substance abuse treatment program deviates from the therapeutic community treatment model and that, according to the director of the UCLA study, may work to the detriment of the program's success. In its response, the department contends there is no data to support that conclusion.

   The substance abuse treatment program at the California Substance Abuse Treatment Facility and State Prison at Corcoran has not demonstrated success, while other treatment programs designed on the same therapeutic community treatment model but with fewer beds have been successful. The other programs have 200 beds compared to the 739 beds per provider in this program. The substance abuse treatment program at this institution is an experiment to determine whether large-scale therapeutic community treatment works in an in-prison setting. So far, the program has not demonstrated that the large-scale version can be successful.

4. In Finding 1, pages 21 and 22 of the report, the Office of the Inspector General recommended that the department and the institution cease the policy of forcing inmates to participate in the substance abuse treatment program, but consider mandating aftercare treatment as a condition of parole. In its response, the department said it found the second recommendation "somewhat contrary" to the first. The department acknowledged that participation in both in-prison and aftercare treatment is critical to success, but argued that it would be more desirable to use incentives to encourage participation in aftercare.

   The Office of the Inspector General's specific recommendation was that the department and the institution "evaluate all means of increasing aftercare participation, including possible legislation to mandate aftercare as a condition of parole for substance abuse treatment program inmates." The incentives cited by the department might be one such means, as would mandating aftercare as a condition of early release. Clearly, referrals to aftercare must increase dramatically if the program is to demonstrate effectiveness.

5. In Finding 2, on page 23, the Office of the Inspector General summarized generally the regulatory requirements governing inmate medical care and reported that the institution has been deficient in meeting the requirements. In its response, the department said that specific examples of the deficiencies were not included in the report. On the contrary, following the general summary on page 23, the report goes on to include more than ten pages of examples of deficiencies in the medical care provided to inmates at the institution. The names of particular inmates involved were not included in the report, but were provided to the medical staff during the audit field work.

6. In Finding 2, pages 23 and 24, the Office of the Inspector General described three cases in which inmates died as the possible result of deficient medical care. In one of the cases, an inmate who had been diagnosed with the blood disorder *polycythemia rubra vera* died in a local community hospital three days after he was examined by a doctor at the correctional treatment center emergency room. The report said that the inmate was supposed to have had regular monitoring of his hemoglobin levels and had developed complications because the medical staff failed to perform the monitoring. When he was taken to the correctional treatment center emergency room, the emergency room doctor did not fully evaluate his vital signs or request laboratory tests and instead sent him back to his housing unit. After his condition worsened he was taken to the community hospital where he died.

In its response, the department said that the overall care of the inmate was adequate, that his blood condition had been regularly monitored, and that his death had been caused mainly by bleeding *esophagel variaces* associated with cirrhoses of the liver, rather than by the blood disorder *polycythemia rubra vera.*

Yet, the inmate's medical records raise serious questions about his diagnosis and treatment. The records show that he was diagnosed with *polycythemia rubra vera* in January 1997. The disorder is characterized by a chronic increase in blood volume and an abnormal increase in the number of red blood cells. The treatment recommended at diagnosis was withdrawal of one unit of blood, to be repeated at intervals of two or three weeks until the hemoglobin level decreased to between 13 and 14. That treatment was to be followed by periodic blood tests and future blood draws (phlebotomies) to maintain the appropriate hemoglobin level. Although the initial diagnosis of *polycythemia* indicated the source of the problem to be in the kidneys, the liver, the cerebella, or circulatory system, and even though concurrent monitoring of the kidneys was recommended, there is no evidence that medical treatment other than the period blood testing and phlebotomies was conducted. And despite the possibility of liver or kidney disease indicated by his condition, his medical file indicates that he was never tested for cirrhosis and was not diagnosed with that disease until after his death.

According to the records, between January 2000 and February 28, 2001, the inmate underwent blood tests pursuant to the *polycythemia* diagnosis on an average of every three to five weeks. With few exceptions, the blood tests showed hemoglobin levels outside the 13-14 range. Yet, according to the records, the last phlebotomy was performed on September 21, 2000 and no blood tests were conducted during the eleven weeks between February 28, 2001 and the inmate's death on May 17, 2001. The inmate was also supposed to have three-month follow-up appointments with an oncologist because of the *polycythemia*, and the records show that he had been scheduled for a three-month follow-up appointment with an oncologist on December 8, 2000, but that appointment was cancelled by the doctor. The appointment was to have been rescheduled, but there is no documentation that it ever took place.

According to the records, the inmate had reported that whenever the blood volume became too high, he became weak and had difficulty breathing. On Friday, May 11, 2001, he was seen in the clinic with a complaint of high hemoglobin levels, saying that he needed to have blood drawn. He was sent to the correctional treatment center emergency room for evaluation. According to the emergency room documentation, the inmate reported that he had muscle cramps in both legs, felt weak and dizzy, and could not walk. There is no documentation that laboratory tests were ordered, and the inmate was simply released with instructions to go to doctor's lines on Monday, May 14, 2001. On May 14, 2001 he was seen by a doctor who noted that the inmate had experienced an episode of the flu but now "felt fine." On the evening of May 16, 2001, the inmate was found prone on the floor of his cell. According to notes made in his medical record by a nurse, the inmate said that "the doctors say he's fine, but he says he has no energy and can't go on." Again, the inmate was simply instructed to report to the clinic in the morning for evaluation by a doctor. At 9 a.m. May 17, 2001, the inmate was found in his cell with severe *hematemesis* (vomiting of blood) and leg pain. He was taken to the emergency room with CPR in progress and was pronounced dead shortly before 10 a.m.

7. In Finding 2, page 24 the Office of the Inspector General described a second case in which an inmate died as a possible result of inadequate medical care. In that case, an inmate who had been

undergoing treatment for kidney disease died at the local community hospital the day after he had been seen twice at the correctional treatment center emergency room with a complaint of abdominal pain. The inmate had been scheduled for dialysis treatment on March 1, 2002 and died on the morning of March 3, 2002. The report said that the medical staff did not adequately monitor the inmate after he returned from the dialysis appointment.

In its response, the department said it found no evidence of neglect in the inmate's treatment. The department reported that the dialysis treatment that had been scheduled for March 1, 2002 had been postponed until March 3, 2002. The department said that although the inmate's creatinine, blood urea nitrogen, and potassium levels were found to be high when he was taken to the emergency room on March 2, 2002 complaining of abdominal pain, that those levels "would be normal for a person due to have dialysis the following day."

But the Office of the Inspector General found that the information that the dialysis treatment had not been performed on March 1, 2002 was not in the inmate's medical file at the time he appeared in the emergency room and had still not been added to the file almost three months later when the Office of the Inspector General reviewed the records on May 23, 2002. Therefore, the medical staff could not have known that he did not undergo dialysis on March 1, 2002 or that the dialysis had been rescheduled for March 3, 2002. And although the department's response appears to imply that the inmate underwent laboratory tests when he was brought to the emergency room and that the test results were found to be normal under the circumstances, in fact the medical records contain no evidence that any laboratory tests were performed at that time. The test results cited by the department in its response came from the records of the community hospital reported after the inmate's death. The institution medical staff, therefore, had no basis for knowing that the inmate's creatinine, blood urea nitrogen, and potassium levels were "normal for someone due to have dialysis the following day."

The records show that the inmate had been taken to the dialysis appointment on March 1, 2002 and was returned that evening to his housing facility. When he was brought to the emergency room early in the morning of March 2, 2002 complaining of abdominal pain, he received no tests or treatment. The nurse, purportedly acting on orders conveyed by the doctor over the telephone, simply sent him back to his housing unit with instructions to return later that morning. He was brought back to the emergency room after he was found down in his cell eleven hours later, and he died at the local community hospital about five hours after that.

In reviewing this case, the Office of the Inspector General also found that information from the dialysis vendor reporting results of dialysis treatment routinely do not arrive at the institution to be added to the inmate's medical file for several days or even weeks after the treatment has been administered. As a result, the medical staff lacks vital information when treating inmates for complications related to the dialysis treatment or for other problems.

8. In Finding 2, page 24, the Office of the Inspector General described a case in which an inmate suffered a heart attack and died shortly after the only member of the nursing staff assigned to the facility left before the end of the scheduled shift. Because the nurse left early, the facility had no medical staff on duty at the time of the attack, and, as a result more than eight minutes passed before medical help from another facility arrived and began emergency treatment. In the interim, no one began CPR or rescue breathing. Yet, in its response, the department claimed that there was no evidence of a delay in responding to the inmate's collapse. At the same time, the department

raised other questions about the medical care provided to the inmate, noting that during the nine days between his intake interview and his death, he had not received hypertensive medications ordered by the intake physician. Both of these circumstances clearly demonstrate that the medical care provided to this inmate was not adequate.

9. In Finding 2, page 24, the Office of the Inspector General described a case in which inmates and members of the custody staff were exposed to tuberculosis over a period of several months because a staff physician failed to notify the custody staff that an inmate had tested positive for the disease and should be isolated. Two correctional officers and an inmate who had come in contact with the inmate later tested positive for tuberculosis. Although the department confirmed numerous errors in the handling of the case and cited the need for corrective action, it also said that the documentation was not sufficient to determine whether exposure to the inmate in question caused the positive tests in the two correctional officers. The department claimed there had been a two-year time span between skin tests in the case of one officer and that no previous testing had been performed on the other officer. In fact, however, the Office of the Inspector General found documentation that both officers tested negative for tuberculosis in January 2001 and that both tested positive for the disease about a year later after they had been exposed to the inmate. One tested positive in January 2002 and the other tested positive in February 2002.

10. In Finding 2, pages 25 and 26, the Office of the Inspector General reported that specialty clinics are backlogged, with inmates waiting several weeks to as long as six months for treatment. As one reason for the backlogs, the report noted that clinics are often cancelled for various reasons, and that for example, between January and June 2002, 29 (25 percent) of the 114 specialty clinics scheduled were cancelled. The report also said that as of April 3, 2002, the radiology department had a backlog of 60 orders for medical resonance images dating back to November 2001. The report noted in addition that during the audit fieldwork, a scheduled visit from a portable medical resonance imaging unit was cancelled because of delinquent payments.

    In its response, the department said that the visit of the magnetic resonance imaging unit scheduled during the audit was cancelled because of "contract renewal/bidding process errors," not because of delinquent payments. The department also said that even though 25 percent of the specialty clinics were cancelled in the period from January to June 2002, the institution nonetheless provided about three specialty clinics a week. It also said that waits of three to six months for specialty treatment may be consistent with community care standards.

    The Office of the Inspector General was able to document that the visit by the magnetic resonance imaging unit scheduled for March 25, 2002 was cancelled by the vendor because of lack of payment. The rest of the department's response does not address the issue that the institution is months behind in processing magnetic resonance imaging orders, some of which are for suspected neck and brain tumors, or that clinic cancellations contribute to the backlogs for all of the specialty clinics.

11. In Finding 2, page 26, the Office of the Inspector General described the case of an inmate who reported in an interview that a delay in seeing a specialist had caused damage to his spine to become permanent and that according to the surgeon, his condition will continue to deteriorate. The department commented in response that the Office of the Inspector General should have verified the inmate's claim through his medical records. In fact, the Office of the Inspector General did review the inmate's medical records, including the results of examinations, and

recommendations of consulting specialists. As noted in the report, the documents were consistent with the inmate's statements.

12. In Finding 2, page 27 the Office of the Inspector General reported that there were 91 errors identified in prescriptions written at the institution in January and February 2002 in medications that included *Prozac, nitroglycerin,* and *Baclofan.* The report noted that the most common error was the omission of vital information such as the patient's identification, the medication dosage or frequency, or the doctor's signature and that in many cases the dosage ordered by the physician exceeded the manufacturer's recommended daily maximum. In its response, the department said that the significance of the 91 errors cannot be determined without knowing the sample size and the distribution of errors among the physicians. The department did describe a corrective action plan to address the problem, however.

    It is not possible to determine an error rate represented by the 91 errors because they were not part of a statistical random sample. It nonetheless is significant that such a high number of errors occurred in such a short period of time and that many of the errors were made in prescriptions for medications having the potential to have a deleterious effect if prescribed incorrectly.

13. In Finding 2, page 29, the Office of the Inspector General said that medical technical assistants at the institution perform triage assessments and make other medical judgments they are not trained or licensed to make. This occurs when medical technical assistants are the only members of the nursing staff present during sick call and when they are the only members of the nursing staff assigned to a housing facility. In response, the department commented that physicians and registered nurses are available for consultation with medical technical assistants at all times. The response does not address the point that medical technical assistants are not licensed or trained to fulfill these functions and should not be performing medical assessments at all. The Office of the Inspector General found that they are not only performing the assessments, but are doing so without consulting the physicians and nurses.

14. In Finding 4, page 40, the Office of the Inspector General reported that dentists at the institution regularly work less than the 40 hours a week for which they are paid and that they typically put in a total work week of about 22 hours. The report also noted that one or two of the full-time dentists and both of the part-time dentists also maintain private practices on the side. In response, the department said that maintaining a private practice is allowed provided there is no conflict of interest and the dentist "maintains a priority of service to the institutional needs." But whether or not they maintain private practices, if the dentists are not working the hours they are paid to work, they cannot be meeting institutional needs. Maintaining a private practice in addition to holding a 40-hour-a-week position is an obvious indication that the 40-hour commitment is not being met. The larger point of the finding is that inmates have limited access to dental services, partly because the dentists are available only a few hours a week, and that, as a result, inmates typically wait months for a dental appointment. The limited availability of the dentists contributes to the institution's failure to meet regulatory requirements that inmates receive regular dental examinations.

15. Response page 25: In an earlier draft, the Office of the Inspector General noted that 1,635 inmate dental patients were seen at the institution in the period January through March 2002. Although that language did not appear in the final report, the department contends in its response that the 1,635 figure, amounting to about one-quarter of the inmate population, would equate to the entire

inmate population of 6,200 receiving dental services every year. That assumption is invalid, however, in that the 1,635 figure includes large numbers of patients who were seen multiple times during the quarter. Far from the entire inmate population receiving dental services every year, the report noted that 67 percent of a random sample of inmates under the age of 50 had not seen a dentist within the previous two years, even though *California Code of Regulations* Title 15 requires that inmates in that age range have a dental examination at least every two years. Similarly, a random sample of inmates over the age of 50 found that none had received the annual dental examination required for that age group by Title 15.

State of California

Department of Corrections

Memorandum

Date : January 30, 2003

To : John Chen
Chief Deputy Inspector General
Office of the Inspector General
801 K Street, Suite #1900
Sacramento, CA 95814

Subject: **MANAGEMENT REVIEW AUDIT–CALIFORNIA SUBSTANCE ABUSE TREATMENT FACILITY AND STATE PRISON, CORCORAN**

Attached is the response concerning the Management Review Audit of the California Substance Abuse Treatment Facility and State Prison at Corcoran (SATF) conducted by the Office of the Inspector General (OIG).

The response addresses issues raised by the OIG in the December 2002 report sent to Derral Adams, Warden, SATF.

If there are any questions or concerns regarding this matter, please contact Judy Buckman, Special Assistant to the Director, at 445-7688.

E. V. Alameida

EDWARD S. ALAMEIDA, JR.
Director
Department of Corrections

Attachments

cc: Judy Buckman

* CDC 1617 (3/89)

RESPONSE TO THE OFFICE OF THE INSPECTOR GENERAL'S AUDIT OF THE SUBSTANCE ABUSE TREATMENT PROGRAM AT THE SUBSTANCE ABUSE TREATMENT FACILITY AND STATE PRISON AT CORCORAN

FINDING 1

The Office of the Inspector General (OIG) found that deficiencies in the substance abuse treatment program are preventing the program from achieving its purpose of reducing recidivism by helping inmates overcome drug dependency.

➢ ***High number of sex offenders and mentally ill inmates in the program.***

The OIG reports that the success of the program is hindered by a high percentage of inmates who are either sex offenders or require Correctional Clinical Case Management Systems (CCCMS) level of care within the mental health delivery system. Inmates who require CCCMS level of care are deemed to be stable general population inmates who may require periodic mental health evaluation or medication. The OIG audit expressed concern over including these inmates within the Therapeutic Community (TC) treatment model. However, the data received at the University of California, Los Angeles (UCLA), evaluators reported that, "In terms of recidivism, mental health status was not a significant predictor." In fact, UCLA did not find that CCCMS or sex offenders returned to custody at any greater frequency than the remainder of the treatment population. In addition, the UCLA report found that only 1.6 percent of the inmates removed from the substance abuse treatment program were removed for CCCMS related factors. Contract staff report that these populations pose more difficult treatment problems. Placement in community treatment after completion of the in-prison phase is problematic due to the limited number of facilities able to meet this level of care. (1)

➢ ***Poor recruitment of inmates who might benefit from the program.***

The OIG reports that despite the prevalence of drug abuse among inmates, reception center processing has emphasized placing Level I and II inmates in fire camps and other assignments over placement in substance abuse treatment programs. The Department has increased the priority for substance abuse program placement and directed reception centers to identify a specific number of substance abuse program eligible inmates for transfer to the Substance Abuse Treatment Facility and State Prison at Corcoran (SATF) program. Additionally, the Department is attempting to limit the number of Level II inmates with immigration holds transferred to the general population facilities at SATF. The Level II facilities at SATF should serve as a primary source of eligible program inmates.

➢ ***Contractual arrangements lead to high numbers of participants unsuited to the program.***

Current contract structure reimburses each contractor for actual costs of program operation. It is in the State's best interest to maintain the capacities in each of the programs so that the maximum

number of inmates may be served with the available contract resources. The OIG believed that the pressure to fill program vacancies contributed to higher numbers of inmates with either sex offense histories or CCCMS mental health needs being included in the program. The competition for all eligible inmates to serve in minimum custody assignments such as fire camp, minimum support facility, and Community Correctional Reentry Centers (CCRC), results in the remainder of the Level II population having higher proportions of sex offenders and inmates who require any sort of medical or mental health treatment. However, as pointed out previously, the UCLA data failed to show any correlation between recidivism and these population characteristics. (2)

➢ ***Large number of beds.***

The OIG audit includes an opinion from a UCLA staff person that the large number of beds at SATF may work to the detriment of the program's success. However, there is no data to support this conclusion. The UCLA's report states, "We are not aware of any controlled studies of the effects of a substance abuse program's size on post-released outcomes." The design of the treatment facilities within SATF were based upon the expertise of community treatment providers and consultants with extensive histories of providing in-prison treatment services. The isolated nature of the facilities makes it an ideal environment for the therapeutic community treatment model. (3)

➢ ***Forced participation by inmates.***

The OIG audit cites the UCLA evaluation finding which reported that inmates who were placed in the program on an involuntary basis were more likely to return to custody than those who did not. The UCLA report identified that the involuntary population tended to be younger and have more extensive criminal justice histories than inmates who volunteered for treatment. The UCLA report supports the Department's efforts to target volunteers for treatment in reception centers, enhance motivation for treatment to improve client retention and consider other incentives for program participation.

➢ ***Counselors frequently absent from counseling groups.***

The OIG audit reported that 8 of 18 group sessions had no contract counselor present. Contract staff reported that selected peer mentor inmates were allowed to facilitate groups while the staff were catching up on clinic notes. The Department informed contractors that this was clearly inappropriate and that the practice must cease.

➢ ***Inadequate number of counselors.***

The OIG reported that there was a shortage of contract counselors within the program. The shortage was attributed in part to the institution's rural location, which makes it difficult to retain qualified staff. The treatment providers have been working closely with local junior colleges and other substance abuse treatment providers to recruit counselors for the in-prison component of the program. Experience has shown that many individuals accept an assignment at the prison only to realize that working in a restricted, custody driven environment is very challenging.

➢ *Counseling groups too large.*

The contract with the providers require that group sessions be limited to no more than 18 participants per staff member. The OIG audit reported that 2 of 18 sessions exceeded this level of participants. The providers have been reminded of the contractual requirement to maintain staffing ratios in group sessions; however, it is noted that it is acceptable for groups of more than 18 inmates to participate in seminars and classroom activities as opposed to small group counseling sessions.

➢ *Treatment plans deficient.*

The OIG audit reported that 47 percent of the cases reviewed needed either a revision to the treatment plan or an inmate's signature on the document. A recent review of clinical files by staff of the Office of Substance Abuse Programs (OSAP) confirmed that treatment plans are insufficient. Contractors have been directed to develop a corrective action plan to address this deficiency.

➢ *Participants may not leave the program.*

The OIG report expresses that inmates who are involuntarily assigned to the program may resort to disruptive behavior to force their removal from the treatment program. Very little in the prison experience is voluntary. Offenders do not usually choose to come to prison and their ability to make appropriate decisions for self-improvement are questionable. However, if an inmate is found to be disruptive or not amenable to treatment, the contractors do have the ability to request that the inmate be reassigned.

➢ *Deficiencies in aftercare services.*

Although the OIG audit did not include a review of aftercare services and outcome, the audit expressed concern over the small percentage of inmates who accepted an aftercare placement and completed at least three months aftercare. The UCLA report indicates that 24.9 percent of inmates who accepted an aftercare referral entered an aftercare facility upon release. Of these, approximately 50 percent remained in treatment for 3 months or more. UCLA goes on to state that "Overall, SATF SAP participants who received at least 3 months of any form of aftercare were significantly less likely to have been returned to custody than those who did not; 31.7 percent versus 54.6 percent respectively."

➢ *Inadequate monitoring of providers by the Department.*

The OIG audit notes that detailed monitoring of the program was discontinued in May of 2000 when the institution lost the funding for the position used to perform that function. Presently, substance abuse treatment services at SATF are monitored via a three-dimensional team effort between OSAP Correctional Counselor IIIs, Parole Agent IIs, and the assigned OSAP headquarters' program manager. This involves more than an on-site visit and includes telephonic communication, and program committee meetings to address program deficiencies. Contract requirements have been for the program manager to make site visits once per month and OSAP has been compliant with that requirement.

➢ *Lack of recourse against providers for noncompliance with contract requirements.*

The OIG recommends the Department include liquidated damages provisions to allow the Department to withhold payments if contractors fail to meet specific contract requirements. While it is true that the current contracts provide very little flexibility short of termination, the present contractors are extremely cooperative and make every effort to correct deficiencies in the program.

The following recommendations were provided to improve the substance abuse treatment program at SATF:

➢ ***Develop a process for recruiting eligible inmates from other institutions into the program, including those who may be receiving fire camp, facilities maintenance, and similar assignments in lieu of substance abuse treatment program assignments.***

The Department will increase the priority of assignment to substance abuse programs while recognizing that competing manpower needs for critical assignments such as fire camp must be maintained. Additional attention to reception center processing to identify all eligible program inmates will be required.

➢ ***Cease the policy of forcing inmates to participate in the substance abuse treatment program.***

The Department will explore methods to identify and target volunteer participation in the in-prison substance abuse treatment programs. The Department will explore incentives and other positive re-enforcement mechanisms to encourage participation in treatment programs.

➢ ***Develop alternative methods of providing substance abuse treatment to sex offenders, perhaps by grouping them into specially designated clusters.***

The Department is reviewing alternative methods to provide substance abuse treatment to inmates with sex offense histories. Public safety demands that this high-risk population receive the treatment services necessary to reduce the triggering behaviors, which may contribute to re-offending.

➢ ***Limit the percentage of CCCMS inmates and sex offenders that contractors must accept into the substance abuse treatment program.***

Although the UCLA data fails to show any significant difference in return to custody rates, effective aftercare placement for these populations is difficult. Limits should be placed on the program to ensure that the facilities do not become a "dumping ground" of nonprogramming inmates. Contract staff have expressed concern over the unique needs of this population and excessive numbers of sex offenders, and inmates with a CCCMS level of care tend to draw attention of the contract staff from the remainder of the treatment population.

➢ *Conduct systematic, in-depth monitoring of providers for contract compliance. Deficiencies noted should require corrective action plans with deadlines, as well as follow-up monitoring to verify that satisfactory corrective action has taken place.*

The Department agrees with this recommendation and is evaluating several monitoring tools to assist in this program quality control and contract compliance process.

➢ *Investigate methods of helping providers retain counselors and other staff members.*

The Department currently funds and administers a workforce development program for community contractors. The expansion of in-prison programs has lead to an increase demand for competent counseling staff. In coordination with the University of California, San Diego (UCSD), a comprehensive curriculum has been developed to instruct and train newly hired contract staff.

➢ *Propose legislation to mandate aftercare as a condition of parole for substance abuse treatment program inmates.*

Although somewhat contrary to the early recommendation of ceasing the policy of forcing inmates to participate in treatment, it is recognized that participation in both in-prison and community aftercare treatment is critical to success. However, it would be more prudent to explore incentives to encourage increased participation in substance abuse treatment services in the community. (4)

➢ *In future contracts with providers, include withholding of payments or other fiscal sanctions as alternatives to contract termination in the event of non-compliance.*

The Department is evaluating the inclusion of performance measures in future substance abuse contracts.

➢ *Review, evaluate, and act upon the recommendations of the UCLA evaluation for the substance abuse treatment program.*

The Department continues to review and evaluate all recommendations submitted by the project evaluators. Meaningful process evaluation and outcome results guide the Department in achieving the most efficient programs for our inmate and parolee populations.

FINDING 2

The OIG found serious deficiencies in the medical care provided to inmates at SATF, placing the health of the inmates and staff at risk and exposing the State to possible legal actions.

➢ *Regulatory requirements for inmate medical care.*

• Title 22, Division 5, Chapter 12, Article 3, Section 79601(a)(1) states, "Inmate Patient evaluation, including an admission history and physical within 24 hours for immediate care planning."

"A complete written history and physical examination shall be in the record within 72 hours unless done within 5 days prior to admission." The issue is presented for the documentation required for admission to the Correctional Treatment Center (CTC). The general comment does not clarify the incidents/occurrences upon which the admission history and physical examination were not done. Specific examples of the incidents/occurrences found to be deficient were not presented in the report.

The Medical Department at SATF will ensure that all inmate-patients admitted to CTC will have an admission history and physical examination in the medical record of the inmate-patient. Please provide specific examples from your review with the names and CDC numbers of the inmate-patients that do not have an inmate-patient evaluation, including an admission history and physical within 24 hours for immediate care planning, in order for the medical staff to complete these deficient items.

- Title 22, Division 5, Chapter 12, Article 3, Section 79601(a)(1) states, "...A complete written history and physical examination shall be in the record within 72 hours unless done within 5 days prior to admission."

The issue is presented for the documentation required for admission to CTC. The general comment does not clarify the incidents upon which the admission history and physical examination were not done. Specific examples of the incidents/occurrences found to be deficient were not presented in the report.

The medical department at SATF will ensure that a complete written history and physical examination shall be in the record within 72 hours, unless done within 5 days prior to admission to CTC.

- Title 22, Division 5, Chapter 12, Article 3, Section 79601(a)(6) states, " Health record progress notes at least every three days or more often as the inmate-patient's condition requires. A progress note will be documented on each visit by the attending physician."

This issue presented is in regards to the inmate-patients present in CTC. Specific examples of the incidents/occurrences found to be deficient were not presented in the report. (5)

The medical staff at SATF will ensure a written progress note shall be present in the health records for all inmate-patients at least every three days or as required by the inmate-patient's condition until discharge from CTC. The Chief Physician and Surgeon and the Health Care Manager shall ensure that each attending physician completes health record progress notes at least every three days or more often as the inmate-patient's condition requires. The attending physician will document a progress note on each visit. The Chief Physician and Surgeon and Peer Review Committee will audit this practice in the chart review for presentation to the Medical Executive Committee when physicians demonstrate recurring trend of this deficiency. The chart review will be a random sampling of each physicians charts done on a periodic basis.

• Title 22, Division 5, Chapter 12, Article 3, Section 79601(a)(2) states, "Re-evaluation of the inmate-patient's condition, including review and updating of orders for care, at least every 30 days, upon change of attending physician and upon transfer."

This issue is in regards to the inmate-patients present in CTC. Specific examples of the incidents/occurrences found to be deficient were not presented in the report.

A reevaluation of the inmate-patient's condition shall be done at least every 30 days, including the review and updating of orders for care upon change of the attending physician and upon transfer. The Chief Physician and Surgeon and the Health Care Manager shall ensure that each attending physician completes health record progress notes at least every three days or more often as the inmate-patient's condition requires. The attending physician will document a progress note on each visit. The Chief Physician and Surgeon and Peer Review Committee will audit this practice in the chart review for presentation to the Medical Executive Committee when physicians demonstrate a recurring trend of this deficiency. The chart review will be of a random sampling of each physician's charts done on a periodic basis.

• In May 2001 an inmate with a blood disorder who was supposed to have regular monitoring of his hemoglobin levels developed complications because the medical staff failed to perform the monitoring. He was taken to the Correctional Treatment Center emergency room, but the emergency room doctor did not fully evaluate his vital signs or request laboratory tests, and sent him back to his housing unit. When his condition worsened, he was taken to the community hospital, where he died.

[redacted] This inmate was known to have polycythemia rubra vera for years. His blood count had been followed regularly for an extended period of time and units of blood were regularly taken. Reviews of his CVC's, which were accounted for on a monthly basis, revealed the last CVC to have a hemoglobin of 13.8 and a hematocrit of 40. The previous showed a hemoglobin of 15 and a hematocrit of 43. He was seen in the emergency room on May 12, with cramping abdominal pain. He had an evaluation; had a normal pulse, and blood pressure. He was seen in the clinic on May 14, and stated to the physician that he was feeling better. On May 17, he was taken to the Medical Clinic and subsequently to the Emergency Room with a complaint of hematemesis. At that time, his blood pressure was low and while in the emergency room he sustained cardiac arrest and ACLS protocol was begun. This was not successful and the inmate was subsequently pronounced dead. An autopsy was obtained and this showed cirrhosis of the liver with esophageal varices. The main cause of death in this inmate was not his polycythemia rubra vera, the "blood disorder," mentioned by the Office of the Inspector General, but rather the bleeding esophagel varices. In my view the overall care of this inmate was adequate. *January 9, 2003;* [redacted] *MD, Health Care Manager (A), SATF.* (6)

The review of the inmate-patient's chart by the Health Care manager indicates that the direct correlation to the chronic condition and the lack of monitoring of that condition is not the direct cause of the death of the inmate-patient in this case. The main cause of death in this inmate was not his polycythemia rubra vera, the "blood disorder," mentioned by the OIG, but rather the bleeding esophageal varices. In the opinion rendered by the Health Care Manager, the overall care of this inmate was adequate.

The corrective action required, in this and similar cases, is the completion of the grand rounds including a peer review process. This process will indicate deficiencies in the treatment planning for each patient with the consultative efforts of the organized medical staff. Therefore, the effect of this consultative peer review and education of the attending physician will provide a greater resource for the effective treatment and prevention, where possible, of complications related to complicated chronic disease states.

- In March 2002 the medical staff did not adequately monitor an inmate with kidney disease after the returned from a dialysis treatment. He developed complications and was taken to the CTC emergency room, where he did not receive appropriate treatment. He was returned to the housing unit, became worse, was taken to the community hospital, and died.

[redacted]: This inmate was known to have renal insufficiency and was receiving dialysis. He was scheduled for dialysis on March 1, 2002, but this was canceled for unknown reasons and was rescheduled for March 3, 2002. On March 2, 2002, the inmate was seen at 0300 with a complaint of leg cramps and abdominal pain. He was reported by the nurse to have normal rounded stool. He came back to the emergency room later that day with a continued complaint of abdominal pain and one place in the chart mentions chest pain, although this is not further mentioned and was not mentioned by the physician in his history and physical. He was admitted to the CTC at 1600 hours for observation and was found nonresponsive at 1915 hours. He was transferred to Corcoran District Hospital at approximately 2000 hours and subsequently transferred to Hanford Community Hospital where he was pronounced dead the following morning at 0815 hours. Records from Corcoran district hospital show a hemoglobin hematocrit slightly below the normal range but consistent with previous studies, and also show the glucose level of apparently 88, although it is difficult to tell from the poor copy. His potassium was 7.8. The EKG supplied demonstrated a junctional rhythm at a rather lower rate of 35-40. No autopsy was ordered for this inmate that can be detected from the records and no Hanford Community Hospital records are present. The statement that the OIG makes as to not adequately monitoring the inmate after returning from dialysis treatment is false as is evidenced by the fact that this inmate was scheduled for dialysis on March 1, but this was canceled and moved to March 3, therefore, on the date of this episode he was not immediately post-dialysis and studies do not show any significant deviation from normal except for increased creatinine and Blood Urea Nitrogen, and increased potassium, which would be normal for a person due to have dialysis the following day. In reviewing the record quite thoroughly, I can uncover no evidence of neglect. There was some deviation from the standard; however, in that the inmate's vital signs were taken on admission but not again until he was found in respiratory arrest. Found the cause of death in this inmate is obviously related to his renal insufficiency and the final event may be an acute Myocardial infarction or sudden arrhythmia. *January 9, 2003;* [redacted], *MD, Health Care Manager (A), SATF.* (7)

The Health Care Manager, Chief Physician, and Surgeon will ensure that policies and procedures are developed and adopted for the scheduling, receipt of discharge orders, and appropriate management and follow-up of all End Stage Renal Disease patients receiving dialysis.

- On April 13, 2002, an inmate suffered a heart attack and died soon after the only member of the nursing staff assigned to one of the housing units left before the end of the scheduled shift. Eight minutes had elapsed before the nursing staff summoned from another housing facility arrived.

The nursing staff responding to the incident administered cardiopulmonary resuscitation and rescue breathing without success.

Inmate [redacted] This is a morbidly obese male who was transferred to SATF on April 4, 2002. He was noted to be morbidly obese, hypertensive, and on hypertensive medications. His intake interview on April 4, 2002, reflects that orders were written for his medications but this order sheet is not found in the chart. There is an order sheet dated April 9, 2002, which does renew this inmate's medications. There is also a short physician's note on April 9, 2002. On checking the Medication Administration Record (MAR), no evidence is present that the inmate was given this medication from the time of his arrival at SATF. As mentioned before, the orders written on reception April 4 are not found in the chart. There is no evidence that there was a delay in responding to this inmate's collapse. If the OIG has documentation to suggest this, it should be forthcoming. The cardiac resuscitation and the procedure subsequent to this inmate going down in the yard were appropriate. The deviation from the standard of care I see here is that the inmate did not receive any of his ordered medications from his day of arrival until the day of his death (nine days). The probable cause of death, pernicious anemia in this patient, was sudden fatal arrhythmia as would be common. His autopsy showed cardiac dilatation and left ventricular hypertrophy suggestive of hypertensive cardiovascular disease. *January 9, 2003; J[redacted]n, MD, Health Care Manager (A), SATF.* (8)

The corrective action in this case as noted in the report is the lack of the receipt of the medications by the patient as ordered by the attending physician. The medical staff at SATF will implement measures required to ensure that medications are dispensed and administered in a timely manner as ordered by the attending physician. This will include timely reviews of MAR within each housing unit, necessary follow-up by the treating physician, and ducating of the inmate for follow-up with the yard clinic medical staff and treating physician, if necessary, within the guidelines of appropriate medical care and the Inmate Medical Services plan.

- An inmate tested positive for tuberculosis (TB) in August 2000 and began receiving medication, but stopped taking medication prematurely without the awareness of key medical staff. A chest X-ray confirming the diagnosis was not performed until April 2001, and although medical documents indicate that a staff physician was notified at the time, another seven months passed before the inmate was isolated from other inmates and custody staff alerted. As a consequence, numerous inmates and employees were exposed to tuberculosis. Two correctional officers and an inmate, who had contact with the inmate subsequently tested positive for the disease.

Inmate [redacted] The retrospective review of the inmate-patient chart is identified in the following bullets:

- There is no documentation that the prophylactic medications were given as ordered, nor that laboratory tests to monitor their effect were done.
- There is no routine physician signature or indication that any chest X-rays or laboratory test results have been seen or reviewed.
- The patient presented to a registered nurse with signs of acute illness on 10/16/01, yet was referred back to the general population without a physician exam, tests, medications, or notification.

- Although the patient was advised to follow up with a physician the next day (10/17/01), no follow up by a physician was done until the patient again presented as ill on 10/29/01.
- At the time of the visit of 10/29/01, the physician gives no indication of having been aware or reviewing the previous signs of illness dating back to 10/16/01.
- Laboratory tests collected were not sent to the standardized County Health Department as per protocol, but to the contracted laboratory that does not have public health experience and did not provide prompt nor complete results.
- Memos notifying staff and inmates of an active case should not reveal the individual's name due to confidentiality issues, instead using the cell and housing number.
- Documentation of staff or inmates who received initial contact screening and what guidelines, recommendations, or treatment were presented to them is unclear.
- Documentation of which staff or inmate contacts who did not get screened is not provided. For employees, a list of those failing to comply should be provided to the warden and to the local County Health Officer. For inmates, refusal to take recommended medications should be documented for contact tracing, as well as their individual charts.
- Follow up contact tracing is not clearly documented.
- In the reviewing officer's documentation, it is not sufficient to enable determination if exposure to this inmate's active TB was the cause for the skin test conversions from nonsignificant to significant. In one case, there is a two-year span between skin tests; in the other, there is no indication for previous testing, which is needed to determine significance of current results. (9)
- The memo of 12/20/2002 from [redacted] to [redacted] states that an analysis of the TB alert code 33 on 8/27/02, showed many variations from its intended purpose. Thus, the TB Alert System is rendered unreliable for monitoring for prevention and control of TB disease.
- Chest X-ray dated September 13, 2000 and February 8, 2001, ordered by Dr.'s [redacted] and [redacted], respectively, report impression "negative chest" as by [redacted], MD, APC.
- Chest X-ray requested by Dr. [redacted] on April 30, 2001, indicate, "Large right sided pleural reaction which is felt to represent a pleural effusion," also reported [redacted] MD, APC.
- Upon review of Dr. [redacted], Health Care Manager (A), SATF, the pleural effusion appears not related to the later diagnosis of TB.
- Chest X-rays requested by Dr. [redacted] of November 19, 2001, report that both TB and Valley Fever should be considered.
- There is confusion regarding inmate-patient's admission to CTC was on 11/19/2001 or 11/29/2001, as indicated previously.
- The first sputum results done on 12/17/01 are negative for TB.
- The report on January 30, 2002, of specimens collected December 17, 2001, indicate the culture was negative for acid-fast bacilli (Mycobacterium tuberculosis) after six weeks culture although showing heavy growth of Enterobacter aerogenes.
- Dr. [redacted] requested follow up chest X-ray on January 17, 2002, reporting an impression, "Bilateral pulmonary infiltrates with cavitations seen on the left, active

pulmonary tuberculosis should be considered." Laboratory cultures of January 16, 17, and 24, 2002, that were reported on March 20, 2002 (2 reports) and March 1, 2002, reveal culture of Mycobacterium TB confirmed.

The gaps and errors in this instance indicate the necessity for the following corrective measures:

- Specific detailed review of the importance of health record notes and follow up.
- A comprehensive review of TB and overall case contact management will be provided by Health Care Services Division (HCSD). The Public Health and Medical Policy Sections will do this in on-site direction/training at SATF, in conjunction with the County Health Department's support. Such policies are a portion of the comprehensive inmate Medical Services Plan per the Plata agreement.
- Improve the coordination, knowledge, and accountability within the institutional health care system related to control of infectious disease processes for all staff through training.
- Provide ongoing quality assessment and assistance with monitoring for improvement within the infection control committee planning of policies and procedure implementation.

➢ ***Inmates do not have reliable access to doctors.***

- Doctor lines average three hours per day, four days per week.
- Doctor lines end early.
- Inmates do not have reliable access to doctors, in that the doctor lines end at lunch hour, with several scheduled inmates still left to be seen.
- Inmates require rescheduling causing delays in treatment and diagnosis.
- Increased trips to CTC emergency room.
- More expensive treatment was needed later by contract facilities.
- Insufficient number of patients seen during doctor lines and sick call.

All professional staff will be changed to a schedule of eight hours per day, five days per week. The inmate-patients will be ducated at a rate of 20-25 patients per clinic, not including walk up-patients and increase the number to keep the clinic open until 1:00 p.m. All scheduled ducats will be seen the day of their appointment. A report will be produced by each yard clinic to indicate the number of patients seen each day and compiled into weekly and monthly reports. Increase of level and efficiency of supervision through the continual assessment and audit of weekly and monthly reports of ducated inmates to the clinics.

(Please see Corrective Action Plan 1-6-03, attachment #C, items number 6, 36, 39, 42, 43, 44, 45, 63, and 67)

➢ ***Doctors routinely leave the institution early and do not work the required hours.***

- Lack of local management monitoring of the arrival and departure of the doctors.

- Lack of local management monitoring of the normal working hours of doctors under alternate work schedules.
- Lack of local management having a sufficient number of doctors to cover all clinics during normal doctor line hours and sick call availability.
- Lack of on-call coverage from 4:00 p.m. to 7:00 a.m. (This is the normal protocol for the coverage of weekends, holidays, and evening hours.)

All professional staff will be changed to a schedule of eight hours per day, five days per week. The inmate-patients will be ducated at a rate of 20-25 patients per clinic, not including walk up patients and increase the number to keep the clinic open until 1:00 p.m. All scheduled ducats will be seen the day of their appointment. A report will be produced by each yard clinic to indicate the number of patients seen each day and compiled into weekly and monthly reports. Increase of level and efficiency of supervision through the continual assessment and audit of weekly and monthly reports of ducated inmates to the clinics.

(Please see Corrective Action Plan 1-6-03, attachment #C, items number 6, 11, 36, 37, 39, 42, 43, 44, 45, and 63)

➢ ***Some doctors see only a few patients and engage in personal activities during work hours.***

All professional staff will be changed to a schedule of 8 hours per day, 5 days per week. The inmate-patients will be ducated at a rate of 20-25 patients per clinic, not including walk up patients and increase the number to keep the clinic open until 1:00 p.m. All scheduled ducats will be seen the day of their appointment. A report will be produced by each yard clinic to indicate the number of patients seen each day and compiled into weekly and monthly reports. Increase of level and efficiency of supervision through the continual assessment and audit of weekly and monthly reports of ducated inmates to the clinics.

(Please see Corrective Action Plan 1-6-03, attachment #C, items number 5, 6, 11, 36, 39, 41, 42, 43, 44, 45, 47, and 63)

➢ ***Doctors refer most patients to specialists rather than performing even most routine procedures.***

(Please see Corrective Action Plan 1-6-03, attachment #C, items number 6, 10, 11, 36, 37, 39, 41, 42, 43, 44, 45, 55, 56, 57, 63, 65, 66, and 67)

➢ ***Specialist clinics are backlogged resulting in long wait times to see specialists.***

- Backlogs of up to several weeks to see urologists, audiologists, and podiatrists.
- Backlogs of up to six months to be seen in orthotics, by orthopedists, and in surgical specialty clinics.
- Specialty clinics are canceled due to lack of notification by specialists
- Lockdowns, weather conditions, and security issues.
- Lack of payment of contractors resulting in delayed access of inmates to care.

- The institution does not have an adequate policy to triage the scheduling of specialty services due to urgency or chronology.
- Inmates often end up in the emergency room.

The OIG is incorrect in that the scheduled visit from the portable magnetic resonance imaging unit was canceled because of contract renewal/bidding process errors, not delinquent payment for billing. The period of review of January to June 2002 has 28 weeks during which 114 specialty clinics were scheduled. Dividing the number of weeks by the number of clinics results in approximately 4 clinics per week. Even if the 29 specialty clinics were canceled, resulting in 85 specialty clinics, that would leave the institution providing approximately three specialty clinics per week. One would have to examine the number of patient referrals to these clinics and the appropriateness of the referrals to make any statement regarding significant wait times to see specialists. This statement should also have a comparative analysis with the community. Wait times of three to six months for specialty referrals made in the community after completing the referral process may not be out of the normal limits for the standard of care, provided regular follow up of the inmate-patient condition is completed. This report fails to indicate the diagnoses of the patients that ended up in the emergency room and whether the diagnosis was directly related to the specialty clinic referral. (10)

(Please see Corrective Action Plan 1-6-03, attachment #C, items number 55, 56, 57, 63, 64, 65, and 67)

➢ ***Delays in specialist care may result in permanent damage.***

An inmate who was injured in a December 2001 fall was delayed in receiving X-rays and the services of an orthopedic specialist, with the result that on March 18, 2002, a doctor noted that the inmate now has a deformed finger on the left hand and restricted motion in the right knee. Another inmate, who waited more than three months for an appointment with the contract neurosurgeon, told OIG that according to the surgeon, the delay caused damage to his spine to become permanent and that his condition will continue to deteriorate.

This information is the impression of an inmate-patient and should be verified by chart notes and not the interpretation of the inmate-patient. (11)

(Please see Corrective Action Plan 1-6-03, attachment #C, items number 55, 56, 57, 63, 64, 65, and 66)

Please see Corrective Action Plan 1-6-03, attachment #C, items number 17, 18, 28, 47, 51, 55, 56, 57, 42, 43, 45, 63, 64, 65, 66, and 67 for the last three bulleted items.

➢ ***Because of delays in seeing a doctor, inmates often end up in the emergency room.***

➢ ***Doctors sometimes write prescriptions without seeing the patient.***

- 7 of 13 inmates on seizure medication had their medications renewed without a follow up visit to review their condition.
- An asthma patient's prescription for theophylline was renewed on five separate occasions even though no progress notes or other examinations were noted in the medical record.

Specific examples of the incidents/occurrences found to be deficient were not presented in the report. Please provide the specific examples for peer review and educational purposes in preventing recurrence of this practice.

All automatic renewals will be canceled. All automatic refill orders will be continued as medically necessary for the treatment and stabilization of the inmate-patient disease state. The medical, dental, and mental health units will be notified two weeks in advance of a pending discontinuation of a prescription by written list from the pharmacy. Any inmates pending renewal of his prescribed medication shall be ducated for reevaluation by the yard clinic physician, dentist, or case manager to determine the medical appropriateness of continuation of their prescription. This practice shall be reevaluated as to its effectiveness every six months in the Pharmacy Services Committee meeting.

(Please see Corrective Action Plan 1-6-03, attachment #C, items number 17, 18, 28, 47, 48, and 49)

➢ ***Institution doctors write an unnecessarily large number of prescriptions.***

- o Eight physicians were writing an average of 110 prescriptions per day for 6,200 inmates, many for over-the-counter medications.
- o Increased from 800 to 1,000 during the course of the audit.
- o Doctors write prescriptions to placate inmates.
- o Prescriptions written without seeing inmates.
- o Overburdens the pharmacy.
- o Contributes to cost overruns for drugs and pharmaceutical supplies.

Over-the-counter medications are commonly included in the formulary and must be prescribed by a physician. The sample size/number of prescriptions should be presented/reviewed to indicate whether the prescriptions were inappropriate medically. The percentage to which this unusually large number of prescriptions contributes to the cost overruns is of importance due to the fact that the increasing costs to obtain pharmaceuticals in the community, approximately 17 percent during the previous year, without necessary budgetary adjustment must be determined. The level of acuity of the inmate-patient population is also a contributing factor in the prescribing practices of the physicians resulting in increased costs and budgetary deficiencies.

(Please see attachment #C, items 18, 19, 20, 21, 22, 23, 27 of the corrective action plan (1/6/03).

➢ ***Doctors' prescriptions contain a high number of errors.***

There were 91 errors found in a review of a random sample from January to February 2002. These include missing patient identification, medication dosage and frequency, doctor's signature, and inappropriate dosages. (12)

The OIG did not provide specific examples of the incidents/occurrences found to be deficient and were not presented in the report.

The number of errors cannot be determined to be significant without the size of the random sample and the distribution of the errors among the physicians. Based on the information provided earlier in this report, a sample size based on one day's prescriptions would indicate a 9.1 percent error rate. If the sample size were of half the period designated for review, about 22,000 for the average number of workdays in a month, the error rate would approximate .46 percent. Therefore, one may assume that this rate is statistically insignificant. Additionally, in order to determine whether these errors were of a systemic nature or individual deficiencies further analysis is required. The report fails to state the number of these errors caught by the pharmacy and corrected. Without a comparison to the community, this may or may not be of statistical significance. As a result, one may not be able to determine whether the error rate is outside of the normal limits for the community practice in general.

The Chief Physician and Surgeon, Health Care Manager, Pharmacy Manager, and the Pharmacy Services Committee shall prepare a CME regarding submission of prescriptions orders and stress the importance of ensuring medication dose and frequency is correct. The pharmacy shall review all orders are written correctly and appropriately and are consistent with the medication profiles of the inmate-patients in order to prevent medication errors of this nature. All prescribing personnel shall be issued pagers in order to respond to questions regarding their prescriptions. A monthly report shall be developed based on a medication error log maintained in the pharmacy to trend and appropriately manage medication errors to prevent recurrence of errors.

(Please see Corrective Action Plan 1-6-03, attachment #C, items number 18, 24, 27, and 50)

- ***Nurses do not routinely take necessary vital signs, compromising patient diagnoses.***
  - Usually only weight and blood pressure.
  - No needed specimens.
  - No heart rate/temperature.
  - No blood sugar in diabetics.
  - In one instance, the medical file of a patient with a seizure condition indicated that the laboratory tests had to be done at an outside hospital because no vital sign measurements and laboratory work had been done at the institution.

The Director of Nursing shall prepare a training and audit tool for all nursing staff that shall include all required aspects of taking and noting vital signs for patients. This training shall stress the importance and necessity of vital signs. The Director of Nursing shall also present the manner of the audits to be performed and the frequency with which the audits will be conducted. The results of the audit shall be shared during weekly meetings of the nursing staff in a fashion that promotes education and compliance.

(Please see Corrective Action Plan 1-6-03, attachment #C, items number 44, 45)

- ***Nurses do not keep inmate medication records up to date.***
  - Health care notes are not dated and signed.

- MAR's not dated signed by nursing staff to indicate the type, dosage, time, route and site of administration, if other than orally.
- Nurses do not complete MAR's in a timely fashion.
- The delay in filing documents for a long period of time.
- MAR's were found in a separate box from the medial records
- MAR is questionable due to redundant entries, duplicative doses and entries long after medications administered.

Title 22, Division 5, Chapter 12, Article 3, Section 79635(a)(3) states, "Tests and measurement of vital signs, upon which administration of medications or treatments are conditioned, shall be performed as required and the results recorded."

Title 22, Division 5, Chapter 12, Article 5, Section 79805(a)(9)(I) states, "Dated and signed health care notes including...medication records including the name, dosage, and time of administration of medications and treatments given. The route of administration and site of injection shall be recorded if other than by oral administration."

The Director of Nursing shall prepare a training and audit tool for all nursing staff that shall include all required aspects of the Title sections above. This training shall stress the importance and necessity of medication records. The Director of Nursing shall also present the manner of the audits to be performed and the frequency with which the audits will be conducted. The results of the audit shall be shared during monthly meetings of the nursing staff in a fashion that promotes education and compliance.

(Please see Corrective Action Plan 1-6-03, attachment #C, items number 50, 40, 38, 48, 41, 47, 16, 24, and 49)

➢ ***Nursing staff does not check medication deliveries.***

- No check for the accuracy of medication dosage, complete medications, mistakes, delivery, missing medications.
- Nurses do not inventory medications that are delivered to the housing units in multigallon bags.
- Nurses do not independently verify the type and quantity of medications delivered including matching the label with the medication.

Title 22, CCR section 79627(b)(2) states, "Notifying the attending physician or the attending clinician promptly of the facility's inability to obtain or administer, on a prompt and timely basis, drugs, equipment, supplies, or services as prescribed when this presents a risk to the health, safety, or security of the inmate-patient."

Title 22 CCR section 79627(e)(2) states. "...a record of all medications and treatments administered."

Title 22 CCR section 79649(a)(3) states, "Monitoring of the drug distribution system, which includes ordering, dispensing, and disposal of medications."

The regulatory citations noted are applicable to the management and licensure of Correctional Treatment Centers and revolve around inmate-patient management within that setting. The notations are consistent with the inpatient management of medication delivery. This is a prudent and appropriate practice for outpatients.

The Director of Nursing shall prepare a training and audit tool for all nursing staff that shall include all required aspects of the Title sections above. This training shall stress the importance and necessity of medication delivery. The Director of Nursing shall also present the manner of the audits to be performed and the frequency with which the audits will be conducted. The results of the audit shall be shared during monthly meetings of the nursing staff in a fashion that promotes education and compliance.

(Please see Corrective Action Plan 1-6-03, attachment #C, items number 16, 23, 24, 25, 27, 28, 47, 49, and 50)

➢ ***Nurses are not adequately supervised.***

- o Managers do not address staff shortages.
- o Provide direct supervision.
- o Have sign in and sign out sheets.
- o Monitor the performance of basic evaluative nursing functions.
- o Have regular meetings with nursing staff.

(Please see Corrective Action Plan 1-6-03, attachment #C, items number 10, 11, 13, 31, 36, 38, 39, 41, 42, 44, 45, 49, and 50)

➢ ***Nursing staff shortages.***

- o The institution has been unable to fill 13 of 38.6 RN positions and there are too few nurses to adequately cover all nursing functions and staff of each clinic.

There will be an increase in recruitment efforts and participation in all recruiting events.

(Please see Corrective Action Plan 1-6-03, attachment #C, items number 44 and 45)

➢ ***Registry Nurses lack sufficient training in correctional institution nursing care.***

- o Registry nurses do not receive adequate training in preparation for interacting with inmates, responding to inmate fights, safeguarding supplies and instruments, and understanding/applying departmental policies and procedures. The registry nurses are basically trained through on the job processes.

The training provided is in the form of a two-day orientation followed by on the job training. The registry staff training will be reviewed and updated as necessary.

(Please see Corrective Action Plan 1-6-03, attachment #C, items number 38, 39, 44, 45, and 62)

➢ ***Required audits and reviews of nursing services are not performed.***

- o Selection and audit of patient charts and care plans is not done on a quarterly basis.
- o Nursing management does not audit direct-observed therapy of medication administration.

(Please see Corrective Action Plan 1-6-03, attachment #C, items number 6, 11, 16, 24, 25, 27, 31, 38, 39, 40, 41, 44, 45, 49, and 50)

➢ ***Medical Technical Assistants may work beyond licensing limits.***

- o They perform triage assessments and make medical judgments not within the scope of their license.

Physician's and Registered Nurses are available at all times for consultation if coverage has not been provided. (13)

(Please see Corrective Action Plan 1-6-03, attachment #C, items number 10, 38, 44, and 45)

➢ ***Shortage of Medical Technical Assistants.***

- o 11 of the 31 positions are vacant
- o 5 actual vacancies
- o 3 long-term sick (stress related)
- o 3 out for illegal or inappropriate activities related to pharmacy operations

There are only 28.6 positions allocated. There are two positions in the 902 blanket due to IDL and NDI. This is a statewide issue and is being dealt with through assigned recruitment liaisons at each institution.

There will be an increase in recruitment efforts and participation in all recruiting events

➢ ***Poor coordination of medical services.***

- o Communication is lacking.
- o X-ray services are requested without response even in high priority cases, possible exposure to tuberculosis.

- Lack of notification of scheduled or canceled specialty clinics.

(Please see Corrective Action Plan 1-6-03, attachment #C, items number 1, 2, 4, 7, 9, 10, 12, 13, 16, 18, 24, 25, 26, 35, 41, 45, 52, 53, 54, 64, 66, and 68)

➢ ***Radiology services are backlogged more than four months.***

- 60 MRI's back to November 2001.
- 200 X-rays back to October 2001.
- Radiology Department does not have a means of tracking and scheduling based on urgency of the case.
- Radiology Department does not have an adequate tracking system to monitor productivity.
- Radiology Department does not report on completion of scheduled x-rays.
- Radiologist reports are not tracked for impressions.
- Radiology reports are not tracked for communication to inmate-patients.
- Senior Radiologic Technician is absent without explanation, leaves without completing the daily schedule, and without authorization to leave.

(Please see Corrective Action Plan 1-6-03, attachment #C, items number 6, 11, 51-54, and 64)

➢ ***Radiology services are out of compliance with regulations.***

- There is no eligible or certified physician oversight of radiological services. California Code of Regulations (CCR) Title 22, section 70715 requires that a physician have overall responsibility for radiological services.

The correct citation is:
Title 22, division 5, chapter 12, Article 4, Section 79715(a-), which states, "(a) A physician shall have overall responsibility for the radiological service. This physician shall be certified or eligible for certification by the American Board of Radiology or the Osteopathic Board of Radiology. If such a radiologist is not available on a full time or regular part time basis, a physician, with training and experience in radiology, may administer the service. In this circumstance, a radiologist, qualified as above, shall provide consultative services.
(b) Sufficient certified radiologic technologists shall be employed to meet the needs of the service being offered.
(c) Radiologic services shall be available to the correctional treatment center at all times for the provision of services on all shifts and for emergencies. Such services may be provided on the correctional treatment center or through a contractual arrangement."

The institution will maintain such services may be provided on the Correctional Treatment Center or through a contractual arrangement until such time as an on staff physician and surgeon is hired with the appropriate eligibility or certification.

(Please see Corrective Action Plan 1-6-03, attachment #C, items number 44 and 45)

➢ *Inmate medical records are months out of date.*

- o A filing backlog back to October 2001.
- o Medical records are out of date to the extent that the decisions made regarding treatment and diagnoses are not made with all the possible pertinent information.
- o There is a delay in the reporting of laboratory results.
- o Lapses and duplication of medication administration.
- o There is missing information, including, but not limited to referral documentation, medical chronologies, medication records, laboratory results, and disability verification forms.

(Please see Corrective Action Plan 1-6-03, attachment #C, items number 16, 17, 27, 28, 36, 44, 45, 47, 48, 49, 50, and 68)

➢ *Inmate medical records are not readily accessible to medical staff.*

- o There is no automated or effective and adequate manual system to manage inmate information in a manner to ensure appropriate follow up. Requests and orders made are in fact completed and reported to the requesting physician.
- o No adequate review before the MD lines, sick call, or in the CTC Emergency Room.
- o Nurses do not have sufficient opportunity to note orders and ensure requests for medications and medication profiles are available for follow up appointments, and tracking of specialist referrals, including the reports and impressions from specialists.
- o Doctor's order for phenobarbitol in a patient who has a seizure condition without the medical record is noted.

(Please see Corrective Action Plan 1-6-03, attachment #C, items number 47, 48, 49, and 50)

➢ *Medical care for chronically ill inmates is inadequate.*

- o Chronically ill inmates are not adequately monitored,
- o Laboratory testing is inadequate.
- o Lapses in medication.
- o No chronic care for diabetics.

All chronically ill inmate-patients will be ducated for regular monthly visits, or more frequently as medically necessary, until the physician gathers data that the disease process has been controlled on two consecutive visits. The patient will then be seen every six months, or as needed to renew any medications. The institution is scheduled to begin compliance with the Inmate Medical Services Program, which contains guidelines and monitoring for chronic disease processes.

(Please see Corrective Action Plan 1-6-03, attachment #C, items number 16, 49, and 68)

➢ *Inmate appeals system inundated with appeals relating to problems with medical care.*

(Please see Corrective Action Plan 1-6-03, attachment #C, items number 31-35)

➢ *Americans with Disabilities Act requests are backlogged.*

(Please see Corrective Action Plan 1-6-03, attachment #C, items number 58-61)

➢ *Medical committees are not operating as required by licensing regulations.*

- Governing Body Title 22, Division 5, Chapter 12, Article 5, Sections 79773
- Medical Director Title 22, Division 5, Chapter 12, Article 5, Section 79773(b) and 79775
- Administrator Title 22, Division 5, Chapter 12, Article 5, Section 79773(c) and 79777
- Patient Care Policy 79781(d)(1) meeting annually
- Infection Control 79781(d)(2) meeting quarterly
- Pharmaceutical Service 79781(d)(3) meeting quarterly

(Please see Corrective Action Plan 1-6-03, attachment #C, items number 1, 2, 3, 4, 5, 6, 7, 19, 26, 55, 57, and 65)

FINDING 3

The OIG found that pharmacy operations at SATF are seriously deficient.

➢ *Pharmacy's tracking system is inadequate to handle the large number of prescriptions.*

(Please see Corrective Action Plan 1-6-03, attachment #C, items number 14 and 15)

➢ *Prescription records not matched to doctor's orders.*

(Please see Corrective Action Plan 1-6-03, attachment #C, items number 16, 17, and 18)

➢ *Pharmacy sometimes fills prescriptions incorrectly.*

(Please see Corrective Action Plan 1-6-03, attachment #C, items number 14, 15, 16, 17, 22, 24, and 26)

➢ *When inmates transfer to other housing units within the institution, medication cannot be forwarded and instead is discarded.*

Title 22 CCR, section 79789: Patient Transfer
(a) The licensee shall maintain written transfer agreements with one or more general acute care hospitals to make the services of those facilities accessible and to facilitate the transfer of patients.

(b) Complete and accurate patient information, in sufficient detail to provide for continuity of care, shall be transferred with the patient at the time of transfer. The Department shall make a copy of the current agreement available for review.
(c) No patient shall be transferred or discharged for purposes of effecting a transfer from a facility to another facility, unless arrangements have been made in advance for admission to such a health facility.
(d) When a patient is transferred to another facility, the following shall be entered in the patient health record:

(1) The date, time, condition of the patient and a written statement of the reason for the transfer.
(2) Documentation that the receiving facility has been informed of the patient's transfer.

- Title 22 CCR, section 79809: Transfer Summary

A transfer summary shall accompany or precede the inmate-patient upon transfer to another facility where continuing care will be provided. The transfer summary shall include essential information relative to the inmate-patient's diagnosis, treatment course, medications, dietary requirements, known allergies and treatment plan.

The attending physician shall provide a transfer summary to include essential information relative to the inmate-patient's diagnosis, treatment course, medications, dietary requirements, known allergies and treatment plan. The nursing staff shall ensure that all medications are transferred with the inmate-patient per the operating procedure.

(Please see Corrective Action Plan 1-6-03, attachment #C, items number 25, 28)

- Title 22 CCR, section 79665: Pharmaceutical Service- Disposition of Drugs

All returned medications within intact containers shall be disposed by the pharmacy in a manner consistent to ensure safety and security of the institution including all possible methods to avoid drug diversion.

(Please see Corrective Action Plan 1-6-03, attachment #C, items number 27, 28, and 67)

➢ ***Pharmacy door unlocked.***

Title 22 CCR, section 79661(i) states, "Drugs shall be accessible only to licensed health professionals designated in writing by the license."

Title 22 CCR, section 79663(a) states, "Drugs listed in schedule II of the Federal Comprehensive Drug Abuse Prevention and Control Act of 1970, Title 21, United States Code, section 801et seq, shall be stored in a locked cabinet or a locked drawer, separate from non-controlled drugs unless they are supplied on a scheduled basis as part of a unit dose medication system."

The pharmacy shall ensure compliance with the above sections in order to prevent unauthorized access to the medications.

(Please see Corrective Action Plan 1-6-03, attachment #C, items number 16, 18, 19, and 20)

FINDING 4

The OIG found that the dental care program at SATF is seriously deficient and that inmates are not receiving dental services required under State regulations.

➢ ***Management deficiencies.***

- Organization of the dental department.
  (Please see Corrective Action Plan 1-6-03, attachment #C, items number 1 and 4)
- Operate in a crisis mode.
  (Please see Corrective Action Plan 1-6-03, attachment #C, items number 2 and 3)
- Poor continuity of care.
  (Please see Corrective Action Plan 1-6-03, attachment #C, items number 5 and 6)
- Little preventive dentistry.
  (Please see Corrective Action Plan 1-6-03, attachment #C, items number 36)
- Low productivity.
  (Please see Corrective Action Plan 1-6-03, attachment #C, items number 10, 11, 12, 13, and 36)
- No computerized tracking system.
- Dentists do not work 40 hours.
  (Please see Corrective Action Plan 1-6-03, attachment #C, items number 42, 43, 44, and 45)
- Inmates wait months for an appointment.
  (Please see Corrective Action Plan 1-6-03, attachment #C, items number 66)
- Inmates are transferred or paroled before their appointment.
  (Please see Corrective Action Plan 1-6-03, attachment #C, items number 66)
- Dental clinics are held three to four mornings a week.
  (Please see Corrective Action Plan 1-6-03, attachment #C, items number 42, 43, 44, and 45)
- Inmates are being seen without the dental record.
  (Please see Corrective Action Plan 1-6-03, attachment #C, items number 47)
- Lack of timely follow up makes tooth repair inappropriate causing a greater number of extractions.
  (Please see Corrective Action Plan 1-6-03, attachment #C, items number 39, 47, and 49)
- The Chief Dental Officer has not been held accountable for the establishment of appropriate policies and procedures, standards for treatment, and the revision of those policies and procedures on an annual basis.

California Code of Regulations (CCR) Title 22, Section 79675

(a) Written policies and procedures for the scope of services to be provided shall be developed and maintained by the person responsible for the service. Procedures shall be approved by the administration.
(b) The responsibility and the accountability of the dental service to the administration shall be defined.
(c) There shall be a well-defined treatment plan for oral health care, based on patient need, the size of the treatment center and the type of service provided.
(d) There shall be a well-organized plan for emergency dental care.
(e) There shall be a record of all dental services provided to the inmate-patient and this shall be made a part of the inmate-patient medical record.
(f) Periodically, an appropriate committee of staff members shall evaluate the services provided and make appropriate recommendations to the treatment center administration.

Management deficiencies are present in that there is a lack of supervision of the dental staff with respect to the following:

- Hours of work.
  (Please see Corrective Action Plan 1-6-03, attachment #C, items number 42, 43, 44, and 45)
- Productivity levels.
  (Please see Corrective Action Plan 1-6-03, attachment #C, items number 6, 10, 11, 12, 13, and 36)
- Timely scheduling and completion of routine dental examinations.
  (Please see Corrective Action Plan 1-6-03, attachment #C, items number 39, 47, and 49)
- Individual dental treatment plans for each inmate-patient shall be reviewed by the Chief Dental Officer on a periodic basis.
  (Please see Corrective Action Plan 1-6-03, attachment #C, items number 39, 40, and 41)

➢ ***Regulatory requirements governing dental services delivery to inmates not met.***

- There is no adequate tracking program to ensure that inmates are seen for routine regular dental examinations.

The facility will implement a new ducating system for the examination and follow up of all inmate-patients within the facility. This ducating system will assist the institution in complying with their annual regulatory requirements per Title 15 CCR, section 3355.1, which mandates the following:

- Complete dental examination within 14 days of arrival.
- All inmate-patients under age 50 receive a dental examination once every two years.
- All inmate-patients over age 50 receive a complete dental examination once every year.
- Individual treatment plans for dental care, preventive dental care, and continuity of dental care.

A tracking program for dental services will be implemented.

➢ ***Dentists work short hours and maintain private practices on the side.***

Maintaining a private practice is allowed, provided there is no conflict of interest and the dentist maintains a priority of service to the institutional needs. (14)

The institution will require all medical staff to file conflict of interest statements and have on file agreements to approve the maintenance of a private practice.

(Please see Corrective Action Plan 1-6-03, attachment #C, items number 6, 36, 39, 42, 43, and 63)

➢ ***Clinics are open only a few hours per week regardless of how many inmates need to be seen.***

(Please see Corrective Action Plan 1-6-03, attachment #C, items number 6, 36, 39, 42, 43, and 63)

➢ ***Dentists see only a small number of patients at each scheduled clinic.***

(Please see Corrective Action Plan 1-6-03, attachment #C, items number 6, 36, 39, 42, 43, and 63)

The OIG indicates in this draft report that during the period of January to March 2002, approximately 1635 inmate-patients were seen. Taking into account the great turnover in the population, lack of follow up, along with the previous statements in items # 5, 6, and 7, the report seems to make contradictory statements. The stated population at the time of the report is 6200 inmates. The percentage of inmates seen during that period of time indicates that approximately 25 percent of the population was seen during the first quarter of the year. This would seem to indicate that the whole population is seen every year. This is more frequent than the required once every one to two years depending on age. This however does not resolve the 14-day requirement. (15)

➢ ***Inmates wait months for a dental appointment and may never see a dentist.***

(Please see Corrective Action Plan 1-6-03, attachment #C, items number 64 and 66)

➢ ***A large proportion of the dental care consists of tooth extractions and denture work.***

(Please see Corrective Action Plan 1-6-03, attachment #3, items number 64, 65)

➢ ***Dentists sometimes lack access to medical records when they provide treatment.***

(Please see Corrective Action Plan 1-6-03, attachment #C, items number 47, 48, and 49)

➢ ***Dentists prescribe medication even when they cannot consult patient medical records.***

(Please see Corrective Action Plan 1-6-03, attachment #C, items number 16, 18, 40, 45, and 47)

➢ ***Dentists do not provide follow-up care after prescribing medication.***

(Please see Corrective Action Plan 1-6-03, attachment #C, items number 19, 20, 27, 28, and 49)

➢ ***Dentists and dental assistants do not document medications provided to inmates.***

(Please see Corrective Action Plan 1-6-03, attachment #C, items number 18, 24, 49, and 50)

Title 22, Division 5, Chapter 12, Article 1, Section 79627 states, "Drug administration means the act in which a single dose of a prescribed drug or biological is given to a patient. The complete act of administration entails removing an individual dose from a container (including a unit dose container), verifying the dose with the prescribes orders, identifying the patient, giving the individual dose to the patient, and promptly recording the time, method of administration, and dose given."

The dental department staff will implement a tracking log to indicate, "the complete act of administration" which details who removes an individual dose from a container (including a unit dose container), verifying the dose with the prescribed orders, identifying the patient, who administers the individual dose to the patient, recording the time, method of administration, and the dose administered.

FINDING 5

The OIG found that a projected deficit of $8.4 million in the 2002-03 budget for SATF could significantly affect institution operations.

➢ ***Continue to request resources to address the issues driving deficits in the institutions.***

The California Department of Corrections (CDC) has recognized several structural funding deficiencies that contribute to the ongoing departmental deficit. The Department continues to evaluate the impact of these issues, and requests funding via both Budget Change Proposal (BCP) and the Spring Finance Process to secure adequate funding for the following:

- Under-budgeted sick leave for posted positions.
- Workers compensation shortfall.
- Medical guarding and transportation.
- Overtime for posted positions.
- Administrative Segregation Overflow.
- Utilities costs.
- Mission changes.
- Population increases.

If current CDC efforts to secure adequate funding for the above are successful, institutional deficits will be reduced. The CDC will continue to pursue funding for unresolved fiscal issues.

➢ ***Prepare cost estimates of all changes to employee bargaining unit contracts before committing to changes in the contracts. Request additional funding to mitigate the effect of increased sick leave usage in future fiscal years.***

The Department of Personnel Management (DPA) negotiates with the exclusive representatives of CDC bargaining units regarding the wages, hours, and terms and conditions of employment for represented employees.

The CDC prepares cost estimates related to the fiscal impact of negotiated issues prior to the finalization of contract negotiations. The Financial Services Division (FSD) to the extent possible captures any additional costs associated with the implementation of contract provisions. Commensurate funding is then pursued in compliance with the strictures of the budget process. Any changes at the local level that rise to the meet and confer obligations outlined in the memoranda of understanding require delegation from the DPA to meet and confer, notification to headquarters' Labor Relations Branch, and an institutional fiscal impact assessment that is submitted to FSD for review prior to entering into a new labor agreement.

The impact of increased sick leave upon the CDC deficit has long been recognized, and every effort to pursue additional funding is pursued.

To comply with the requirements of Article XVI, Section 16.06 of the new Bargaining Unit 6 Memorandum of Understanding, the additional funding previously received for sick leave relief as part of the approved 2001/2002 Under Budgeted Leave BCP has been redirected by the administration to fund Institutional Vacancy Plan Vacation and Holiday position activations at the institutions as also required by the recent bargaining unit agreement. The administration has also approved additional sick leave funding for 2002/2003 and 2003/2004 fiscal years. The CDC still projects a deficit due to current usage patterns, and will continue to pursue additional sick leave funding in the next budgetary process.

- ***Provide institutions with adequate resources before initiating policy changes, such as designating an institution for dialysis treatment.***

Departmental policy contained in Department Operations Manual, Chapter 2, Article 1, Budget Planning, requires that the FSD be notified of any new policy, procedures or changes in policy and procedures that may have a fiscal impact. CDC administrators must notify the appropriate chain of command and the FSD of an emergency that may require expenditures to be incurred prior to securing the Directorate's approval and the appropriate funding. The FSD works with the Department of Finance on the best approach to acquire additional resources within the budget cycle. Funding necessary to implement nonurgent requests must be approved through the normal budgetary process prior to implementation of the policy change.

In the case of dialysis treatment, CDC was ordered by the Department of Health Services to terminate inmate dialysis treatment at several institutions. Due to CDC's mandate to continue the provision of adequate health care to the inmate population, this order resulted in an emergency situation, which necessitated the consolidation of the dialysis population. The cost of this alternative was weighed against the monetary damages, which would have inevitably resulted from a failure to act. Funding associated with this issue is being pursued in the current budgetary process.

➢ *Assist the institutions in improving the control and monitoring of pharmaceuticals.*

The Health Care Services Division (HCSD) is currently in the process of formalizing a Central Office Pharmacy Services Management Unit, which will provide numerous functions including, but not limited to the following:

Pharmacy Services Administration

- Development and implementation of standardized statewide pharmacy policies and procedures.
- Development and implementation of a plan to improve the pharmacy delivery system, cut costs, and improve health care.
- Evaluation of methods to improve quality health care and pharmacy delivery.
- Standardization of pharmacy services operations to address key aspects of procurement, contract monitoring, inventory control, and reporting of medication errors.

Pharmacy Clinical Services Management

- Development of treatment guidelines and drug protocols for physicians and pharmacists.
- Standardization of physician's prescribing practices.
- Development of utilization criteria for the most costly medications.

Formulary Management

- Monitor Use of the closed Formulary.
- Update of the Formulary has recently been completed.
- Monitor non-formulary requests.
- Track patient use of drugs.
- Track individual physician's prescribing practices.

Expand the Membership and Functions of HCSD Pharmacy & Therapeutics Committee

- Monitor drug utilization.
- Monitor use of formulary and update formulary periodically.
- Perform analysis of drug costs.
- Develop restrictions and guidelines for certain drugs on the formulary.

Development of a Pharmacy Education and Training Program

- Provide educational information for physicians, pharmacist, and patients to include therapeutic guidelines, formulary information, cost information, and patient information materials.

- Provide training to health care staff to reduce waste, reduce medication errors, and improve quality of care to the patients.

Management of Drug Contracts

- Maximize CDC volume buying power in negotiating discounts with pharmaceutical companies.
- Negotiate rebates from manufacturers on the most highly utilized drugs.
- Identify more cost-effective methods to purchase drugs.
- Consolidate purchasing power for drugs.

Improve Communication Between Entities

- Establish e-mail capability at all institutional pharmacies.

HCSD has taken the following steps to date toward implementation of cost containing measures:

- The recently updated Formulary is in the process of being printed and distributed to all institutions with orientation to the Formulary planned for March 2003.
- The Pharmacy & Therapeutics Committee meets on a regular basis and is currently expanding its membership and functions to better monitor drug utilization, control costs, and update the Formulary periodically.
- HCSD has procured and is in the process of installing modems to allow for e-mail and internet capability in all the pharmacies statewide. This will provide a means of communication between the pharmacies to share "best practices" and to keep current on changes occurring in the pharmacy industry.
- HCSD attends the Department of General Services meetings on a regular basis to have a greater impact on contracting and procurement options.
- HCSD is a member of the Common Drug Formulary Committee, which is responsible for developing, implementing, and administering a Common Drug Formulary System and for participating in a statewide pharmaceutical procurement program.
- HCSD is a member of the Pharmacy Advisory Board that works toward coordinating the efforts of various State of California agencies to implement and administer a statewide pharmaceutical program and medical supply program.

However, even with all of the above activities concerning the control of pharmaceuticals, CDC will require an integrated information technology (IT) system to achieve maximum cost containment and prescription monitoring. To date, CDC has been unsuccessful in obtaining the necessary funding for an adequate IT system.

FINDING 6

The OIG found that a significant percentage of employees and managers of SATF are not fulfilling annual training requirements.

- ***Twenty-seven (22.3 percent) of a sample of 121 employees did not meet the minimum requirement of 40 hours of annual training. The employees failed to fulfill the 40-hour requirement by an average of 16 hours.***

The In-Service Training (IST) office is now generating training deficiency (out-of-compliance) lists, which are sent to the Warden for review, then distributed to the area managers/supervisors for follow-up and corrective action. Training classes are continuously scheduled to accommodate staff schedules. Additionally, through the use of a new monthly training system and a field-training sergeant, effective January 2003, training is also provided at the immediate worksites, as appropriate. A memorandum has been disseminated to department heads advising them of the expectations. Appropriate progressive disciplinary action will follow for noncompliance with training requirements.

- ***Twenty-five (28.9 percent) of the sample of 121 employees did not attend mandatory training classes required for specific classifications, with the number of training classes not attended ranging from 1 to 8. For example, five custody employees, including the custody captain and the Investigative Services Unit Lieutenant, did not attend annual firearms range training. Three facility captains did not complete baton and chemical agent training.***

The IST has established a tracking system that generates training deficiency lists on a regular basis and progressive disciplinary action is being taken when warranted. Pursuant to Administrative Bulletin 02-05 and effective 9/12/02, annual side-handle baton certification for correctional and facility captains is only required if their assignment requires the use of a side-handle baton. The institution has no captain positions with this requirement.

- ***Sixteen (38.1 percent) of 42 managers and supervisors in the sample had not completed Supervisor Orientation, and 7 (16.7 percent) had not completed Basic Supervision. Ten (40percent) of 25 managers had not completed Advanced Supervision and the Management Training Program.***

The IST has established a tracking system to capture training deficiencies and will schedule Supervisors Orientation no later than March 2003 for all staff members who are out-of-compliance. The IST will continuously monitor and schedule new supervisors for the required basic and Advanced Supervision training and all peace officer supervisors within the six-month requirement, via the Advanced Training Unit in Galt, California. The IST records show four new managers that require Management Training, which will be scheduled as training slots become available via the Advanced Training Unit in Galt, California (IST notes that prior training files have not been transferred for some employees, thereby not having a certificate as proof of training. In some instances, the files go back several years before certificates were issued or before the computerized tracking of training). The office assistants in IST have been tracking current transfer files. The problem has been with older files or with several transfers throughout the years for some employees. Staff will continue with its efforts to obtain these files.

- *From January 2001 through February 2002, 211 custody employees failed to attend the required number of "7K" training hours. Eight employees missed between 20 and 24 hours of training.*

The 7K Sergeant has developed a system to monitor and track employees who fail to attend required 7K training. The appropriate disciplinary action and pay-docks have been taken. Progressive disciplinary action will follow for those whom without authorization fail to meet their 7K training requirements. It should be noted that due to authorized reasons such as medical leave, military leave, Family Medical Leave Act, etc., this number of missed training hours is quite possibly far less.

FINDING 7

The OIG found that the Investigative Services Unit is not following proper procedures for the temporary storage of evidence.

- *The subevidence room has only one drying locker (for drying clothing and similar articles that may contain forensic evidence such as blood), creating an environment for cross contamination of evidence should articles from different subjects be placed together in the same locker. Further, the subevidence room consists of a small entryway leading to the Central Control office.*

A memorandum has been issued to move the sub-evidence rooms from the complex controls to the Central Services building, which will gain more room and allow for an additional seven drying lockers to be installed. This is a restricted area and will require the Evidence Officer or the Watch Sergeant for access.

- *The refrigerator used to store urine samples awaiting laboratory analysis is not equipped with a lock.*

The moving of the evidence rooms will also allow for additional refrigerators to be installed and locking devices added.

- *A loose-leaf binder serves as an evidence log for recording details of initial evidence acquisition, and of subsequent movement and disposition of evidence.*

Hardbound logbooks with numbered pages and a separate urinalysis logbook are now being utilized.

FINDING 8

The OIG found that the institution is not properly documenting inmate activity in the administrative segregation units.

- *Inmate movements and other activities are not being recorded on CDC Form 114, Isolation Log Book, immediately as they occur.*

On-the-job-training has been provided to staff and expectation on proper documentation reaffirmed. This will be monitored by the supervisors.

FINDING 9

The OIG found that the institution has not consistently followed required state hiring practices.

- ***There were three positions that were not advertised.***

During the year 2000/01, the institution experienced recruitment and retention difficulties for correctional lieutenants. To compound matters, there was no certification list and inadequate applicable candidate pools causing the number of vacancies to exceed the candidate pool, making it necessary to advertise for a continuous filing. Although the positions in question for correctional lieutenants were advertised for continuous filing, due to the archiving of records for the year 2000, the flyer could not be located. The institution has established a Recruitment and Hiring Process that will ensure all applicable vacancies are advertised.

There were three appointments made with no interviews conducted [Administrative Assistant/Public Information Officer (AA/PIO), 2 Correctional Lieutenants]. One of the lieutenant positions in question was a mutual agreement between hiring authorities (Salinas Valley State Prison and SATF) as a swap of employees, which predated the current warden. The other lieutenant position appointment was made when the number of vacancies exceeded the number of candidates. The issues related to the AA/PIO position have been addressed with the warden by CDC headquarters. The institution will adhere to the established Recruitment and Hiring Process.

- ***Interview panel members did not consistently keep thorough notes of the interviews and hiring process.***

All panels will adhere to the institution's established Recruitment and Hiring Process. Additionally, all panels are now provided with an orientation to outline their roles and responsibilities.

- ***One appointment (AA/PIO) was made after interviews in which the interview panel consisted only of the Warden.***

Adhere to the institutions established Recruitment and Hiring Process. This issue has been addressed with the warden by CDC headquarters.

- ***In six instances, the institution did not appoint the candidate with the highest interview scores and instead appointed candidates with lower scores.***

It should be noted, while the interview is an eminent component in the hiring process, other factors must also be taken into consideration when evaluating the best candidate for a position such as, reference checks, overall education and experience, work history and experience relevant to the position. Hiring panels will adhere to the established Recruitment and Hiring Process for assurance that the appropriate standardized ranking is utilized. If deviating from the ranking when selecting candidate, panels will have to provide in detail an explanation to accompany the hire package.

➢ *The warden consistently neglected to date the hiring documents, raising questions about when in the process the documents were completed.*

Adhere to the Institution's Recruitment and Hiring Process for assurance that all hiring documents are dated. The warden is now consistently dating documents.

FINDING 10

The OIG found while institution employees generally regard the warden's communication and management skills to be satisfactory, some described his management style as "reactive," said that he does not communicate adequately with managers and line staff.

➢ *The warden does not adequately communicate with line staff.*

Open forums are scheduled for staff attendance. Information affecting the operation of the institution is disseminated via memorandums addressed to all staff, through the institutional IST Bulletin, and posted throughout the institution on staff bulletin boards, in addition to the warden having an "open door" policy to all staff.

➢ *The warden has a reactive management style.*

The nature of the business and issues that are dealt with in this line of work, unfortunately do not always allow for a systematic approach. However, it is general practice to be proactive instead of reactive when situations and time permit.

➢ *The warden does not ensure that managers implement his commitments.*

A system is in place to track and monitor all directives/assignments and ensure completion. Additionally, these issues are regularly addressed during management meetings, to ensure progress and effectiveness.

➢ *The warden does not visit secured areas.*

Weekly tours are regularly conducted as time and schedule permits. However, due to the size of the institution and its complex and diverse missions, there is still minimal exposure provided to individual staff and inmates for all watches.

➢ *The warden does not meet regularly with the inmate advisory councils.*

Due to the size and missions of the institution, and the fact that SATF has seven inmate advisory committees, the warden has designated and directed the associate wardens to meet with the committees on a monthly basis. The inmate advisory committees will personally meet with the warden/chief deputy wardens on a quarterly basis.

➢ *The warden does not respond to inmate advisory council proposals.*

All proposals are reviewed and evaluated. It has always been SATF's intention to resolve issues at the lowest level possible, unless the issues warrant the warden's intervention.

➢ *The warden has not provided inmate advisory councils with needed office space.*

Although not dedicated, available office space is provided for the inmate advisory council to perform their functions.

➢ *The institution does not have an inmate advisory council coordinator.*

The respective associate wardens have been designated as coordinators for their areas.