indicating the inmate was not seen, no other record is kept which would indicate whether the inmate is a carryover from the previous list. Such inmates are not given priority at the next nurse sick call. This fact, combined with the fact that sick call is not always held Monday through Friday, means there is potential for an inmate to not be seen for up to four days, or even longer in rare instances.

c. An inmate can press the call button in the cell and ask a guard to take him to a doctor or nurse. Whether this happens is dependent totally on the custody staff.

d. An inmate can sign up for doctor sick call.

4) There is no formal process for maintaining data regarding the operation of the jail health care system. Thus, while various procedures such as the two hour expedite process are in place, there are no data as to whether and to what degree the system is successful. There are no data to show how many inmates are not seen once they sign up for nurse sick call. There are no data available regarding the number of times that inmates who have signed up for nurse sick call are seen on the day they submitted their request, or on a subsequent day.

The one area where data are informally maintained is in regard to inmate complaints. One of the supervising nurses diligently reviews inmate complaints regarding health care and makes a determination whether the complaint has merit. This information is maintained on hand written spread sheets, and the summary numbers are reported to the Director of Nursing and the Medical Director. However, no standards have been developed as to whether the number of overall complaints, or the number of complaints that have been determined to have merit, are significant, i.e., have reached a threshold that should cause the supervisors to take some action.

For example, a review of the spread sheets indicates a range of complaints over the period from May 2004 to October 2005, from a high of 189 in one month to a low of 70 in another. These same records indicate that approximately 5 to 10% of these complaints have merit, ranging from items such as incorrect medications being given inmates, to being denied access to medications. No one to whom the Grand Jury spoke could state whether these numbers exceeded rates of acceptability established by the jail medical staff.

5) The lack of quantified standards and measured results is exacerbated because the jail health care system is not accredited. In 2003, the Institute for Medical Quality conducted a preliminary review to determine whether the jail could meet its standards. The Institute found several problems. Among them, the jail lacks a pharmacy dispensing system meeting the minimum Institute standards. In addition, jail nurses are required to collect forensic evidence, which is in opposition to accreditation standards. Sacramento County Jail nurses are the only nurses in the state of whom this is required. These factors have prevented accreditation.

However, the Grand Jury believes accreditation would provide the types of documents and concrete standards that allow the public to better judge the operations of the jail health care system. Accreditation would also allow the public to compare the Sacramento County Jail with other jails that are accredited throughout the state. This type of accountability is vital to maintain public confidence in an area that will always be contentious. For reasons stated below, the

Grand Jury takes the position that the county should halt the process of nurses collecting forensic evidence. This would allow the jail to seek accreditation, since the pharmacy issue is being addressed.

6) The Grand Jury learned of several incidents involving attempted assaults on nurses during the past year. These incidents occurred when nurses were alone with the inmate in the examination room during nurse sick call. No custody staff was immediately outside of the examination room. As a result of these incidents, the nurse conducting sick call is now accompanied by a nurse's assistant during the examination. However, the option of having custody staff outside the examination room has not been implemented.

A second potential risk to nurses is posed by the practice of having nurses collect forensic evidence. This practice conflicts with the nurse's role of providing care to the inmates, in that the nurse takes on an investigatory role. This means when the nurse encounters the inmate again, after taking the evidence, the inmate may act out against the nurse. Thus, the practice not only creates a potential conflict of interest for the nurse, but also creates the possibility of harm. This practice was cited by the Board of Corrections in its biennial inspection report as a violation of California Code of Regulations, Title 15, which establishes minimum standards for local adult detention facilities.

7) While the Grand Jury received complaints in regard to specific cases of inmate care, it was not able to evaluate those complaints for several reasons. First, the only medical review the Grand Jury was able to determine exists is conducted by the Sacramento-Sierra County Medical Society. The Grand Jury sought copies of those reviews, but was told by jail staff the reviews were confidential and would have to be obtained from the Medical Society. However, when the Grand Jury contacted the Medical Society, they adamantly refused to provide any specific information about the reviews, citing legal provisions making such medical reviews confidential. The Medical Society indicated it would not provide the information, and any effort to obtain it by the Grand Jury would be met with legal action.

Thus, while the Grand Jury was able to determine that such reviews do occur and are reviewed by the Medical Director, there was no practical way for the Grand Jury to determine the nature of the problems found by the reviews and what, if any, actions have been taken by the medical staff to address those problems. In addition, the Grand Jury does not have access to health care specialists who could review medical records and provide an independent medical evaluation.

In closing, the Grand Jury would like to emphasize that, throughout interviews with medical staff, there was no indication of any indifference to care being provided to the inmates or any lack of professionalism. In fact, the contrary certainly appeared to be the case. A commitment to providing the best possible care was expressed by all the staff.

Findings and Recommendations

Finding 1. Chronic understaffing of nurses has lead to an inability to consistently conduct nurse sick call Monday through Friday. This raises the likelihood that inmates who sign up for nurse sick call may not be seen for up to four days from the date of request to see a nurse. Since nurse sick call is the primary way for an inmate to be seen by a jail physician, this means that inmates who need to be seen by a physician have their care delayed, possibly leading to serious harm to the inmate.

Recommendation 1. The 30% vacancy rate for nurses needs to be significantly lowered and the reliance on the Nurse Registry should be reduced.

Finding 2. Quality assurance and the overall collection of data about healthcare in the jail are conducted on an informal basis. This means there is an inability to measure success or failure and an inability to quantify the goals of the health care system. It also means that there can be limited oversight of the system, since it is difficult to determine exactly what is occurring.

Recommendation 2. The jail should seek accreditation by the Institute for Medical Quality through their Corrections and Detentions Survey Program. This would provide measurable performance standards that permit the jail officials and the public to better assess the quality of health care delivery.

Finding 3. Several incidents in the past year highlight the risks to nurses during nurse sick call when they are alone while examining an inmate.

Recommendation 3. A custody officer needs to be stationed outside the examination room during nurse sick call to ensure that, if an incident occurs, a response can occur within seconds.

Finding 4. The current system of dispensing medication is a manual system that increases the risk of incorrect medications being given, does not allow for the avoidance of medications being given that might dangerously interact, and does not allow for inventory control. While the jail staff has indicated for several years that the system is going to be replaced, there have been difficulties with the process, and delays have occurred. However, the latest schedule indicates a new system will be in place, at least in the jail, by the middle of 2006.

Recommendation 4. Jail officials need to regularly keep this and successor Grand Juries updated on the progress of replacing the old manual system, including progress reports on the implementation and its utilization of the system. These updates should be provided on a quarterly basis.

Response Requirements

Penal Code sections 933 and 933.05 require that specific responses to both the finding and recommendations contained in this report be submitted to the Presiding Judge of the Sacramento Superior Court by October 1, 2006 from:

- **Sheriff, County of Sacramento**