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OFFICE OF THE INSPECTOR GENERAL

Medical Inspection Program

Policy Compliance
Medical Inspection Tool (MIT)

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FOREWORD

The Office of the Inspector General's (OIG) medical inspection program consists of two main components: a comprehensive compliance review component and a qualitative clinical case review component. The compliance component measures specific health care services provided to patients and administrative processes that are in place against established policies and procedures applicable to the delivery of health care. The case review component evaluates the overall quality of health care provided to patients, based on assessments conducted by OIG's independent physicians and nurses. This inspection tool focuses on describing the methodologies the OIG uses to conduct the compliance review component, while the case review component is described in detail in a separate document.

In total, the compliance and case review components assess 15 different quality indicators of health care, which include 14 primary (clinical) indicators and one secondary (administrative) indicators. The primary quality indicators cover clinical categories that directly relate to the health care provided to patients. The secondary quality indicator addresses the administrative functions that support a health care delivery system. Although all 15 of the quality indicators are identified in the Table of Contents, only those indicators applicable to the compliance review component are further detailed in the body of this document.

The compliance review component of OIG's medical inspection evaluates 11 of the 14 primary (clinical) indicators and the secondary (administrative) indicator. The compliance component does not review the following clinical indicators: Emergency Services, Nursing Performance, and Provider Performance. While the case review component of the inspection may evaluate any of the 14 primary (clinical) indicators, it does not evaluate the secondary indicator, Administrative Operations.

The OIG's medical inspection evaluates only those quality indicators that are applicable to the institution under inspection. For example, quality indicator Prenatal and Postpartum Care would not pertain to an institution housing only male patients. Similarly, indicators Reception Center and Specialized Medical Housing only pertain to certain institutions.

PRIMARY INDICATORS

Access to Care

The Office of the Inspector General (OIG) will determine if the institution is scheduling medical appointments and specialty appointments in compliance with California Correctional Health Care Services (CCHCS) policies and procedures. We will review the institution's compliance with scheduling chronic care appointments, referral appointments for new patient arrivals, nurse appointments when patient requests to be seen for medical services, and scheduling follow-up appointments for patients returning from an outside hospital. Finally, inspectors will perform on-site inspections at housing units to determine if patients have a means to request medical services.

Sample Methodology

Test 1.001

Sample selection also used for tests 7.001 and 9.008.

Note 1: For compliance testing, the OIG attempts to select patient samples that are different than the clinician case review samples.

Sample selection steps to be completed prior to inspection:

1. Using the master patient registry provided by CCHCS for the institution under review on the same day the job start documents are due, the analyst imports the (raw) data into an excel worksheet and sorts by patient's chronic condition.

2. From the universe of names obtained in step 1, generate a random list of 50 patients with one or more chronic medical conditions. The OIG will test a sample of 25 patients.

   The MIU analyst will ensure that at least one of each relevant chronic conditions (see test question 1.001 step 2) is included in the selected sample. The remaining patients contained on the list will be held as backup (replacements), as needed.

   Note 2: The samples selected for this test are also used to test medication management (MIT 7); therefore, the OIG will not test patients who only have: Hepatitis C condition not being treated with medications. This condition will be tested in conjunction when other chronic conditions are identified.

3. Review the Electronic Health Records System (EHRS) for each of the patients in the OIG's sample. Determine whether the sample patients have the chronic care condition(s) noted in the Master Registry, or have any of the listed conditions but was not identified in the Master Registry.

4. Verify the sample patient had a chronic care visit between the first day of the OIG inspection week and nine months prior to the OIG's inspection and had at least one other chronic care visit before their most recent visit (as defined under test 1.001 *Note #2*). Replace those patients who do not meet this requirement (i.e. both chronic care appointments occurred at the institution under inspection) with the next available name from the sample generated in step 2 until all 25 patients with the specified chronic care conditions have been chosen.

<u>Test 1.002</u>

Sample selection also used for tests 6.001 – 6.003. See MIT 6 for sample methodology.

<u>Tests 1.003 – 1.006</u>

Sample selection steps to be completed by the OIG analyst prior to inspection:

1. From the Clinic appointment list provided by CCHCS, identify the institution's universe of patients from all housing types who requested a face-to-face encounter with a registered nurse between the past two months and nine months. Clinic appointment data is sorted as "RN appointment date" and does not specifically identify that an appointment was the direct result of a face-to-face encounter generated from Form 7362 (Health Care Services Request Form); therefore, additional filters are applied.

2. To arrive at the sample, randomly select five patients from each of the institution's facility clinics and any other stand-alone clinics such as: ASU, SHU, psychiatric services unit, etc.

   Note 1: For institutions with less than six clinics, the OIG will increase the sample size per clinic in order to test a minimum of 30 patients per institution.

   Note 2: If the patient submits the Form 7362, but then refuses the FTF encounter, the sample will be used; however, the answer to questions 1.005 & 1.006 will be "NA."

3. Review the EHRS and select a Form 7362 that is closest to the date of the random RN appointment date identified by the Clinic appointment list, and that indicates the patient requests an RN face-to-face encounter based on medical symptoms described on the request. If the Form 7362 is not requesting an RN face-to-face encounter (examples: medication refill only, dental or mental health request), the OIG will review the EHRS for the entire two to nine month time frame to identify a useable Form 7362 that results in an RN face-to-face encounter in the clinic being tested. If there is no such request during the

designated time frame the document will be replaced with an alternate and the OIG will select another Form 7362 from the next listed patient.

Test 1.007

Sample selection also used for tests 4.003, 4.005 and 7.003.

1. Using the 'CADDIS Off-Site Hospital Admissions' information obtained from the CCHCS, import the data into an excel worksheet and import the 'Rx Count' data from the Master Registry and match with the remaining patient names; filter out patients not prescribed medication.

2. Randomly select a total of 25 patients over the six month period. Patients who are sent to an emergency room, admitted less than 48 hours, and who are not admitted to the hospital for in-patient care will be removed from the sample, and should not be tested.

3. Patients who were transferred from a community hospital and directly admitted to an OHU, CTC, SNF, or MHCB; or admitted directly to the PIP, will not be sampled (replace with alternate sample.)

4. When medications are selected in test 7.003, the following medications will be reviewed:

   All newly ordered medications except PRN (unless they are rescue inhaler or nitroglycerin); all medications that were previously prescribed (prior to the hospitalization); discontinued and restarted by the provider upon the patient's return from the hospital; all medications ordered to be given as intravenous (IV) solutions.

5. Patients who are sent to the hospital for a series of treatments, such as chemotherapy, and return to the institution should be removed from the sample and not tested.

Test 1.008

Sample selection also used for tests 14.001 – 14.009. See MIT 14 for sample methodology.

Inspection Procedures

Ref # 1.001

HQ INSPECTOR (Rev. 12/16/2021)

Chronic care follow-up appointments: Was the patient's most recent chronic care visit within the health care guideline's maximum allowable interval or within the ordered time frame, whichever is shorter?

Testing Methodology (Sample 25):

This test shares the same sample as tests 7.001 and 9.008.

Determine if the patient's most recent chronic care visit (as defined in *Note 2* below) was within the time frame required by policy or as ordered by the primary care provider (PCP), by performing the following steps:

1. Review Chronic Care Follow-up Visit Progress Notes, Physician's Orders, or Intake History and Physical to identify the patient's two most recent chronic care visits.

Note 1: For anticoagulation therapy (i.e. warfarin), we will accept a pharmacist's progress note if a complete face-to-face encounter occurs. A pharmacist's note that only includes an analysis of INR lab results will not be sufficient for this testing.

Note 2: The most recent chronic care visit is usually defined as the last provider visit which occurred prior to the start of the medical inspection's first day of OIG inspection week. However, if the patient's chronic care visit is currently overdue (i.e. not within the maximum guidelines defined below or beyond the provider's ordered follow-up visit date), then the OIG defines the most recent visit as the one that is currently overdue.

Note 3: OIG inspectors will test episodic care visits if the provider discusses the status of the chronic care condition and discusses an appropriate intervention. For example: If PCP documents HTN status using keywords like stable, at goal, or controlled, this is acceptable and the answer to this question is "Yes." No additional intervention is needed for a stable chronic condition. If the PCP documents HTN using keywords like high, unstable, not at goal, uncontrolled, or poorly controlled, the OIG inspector will look for a corresponding intervention. If the PCP documents a corresponding intervention, such as medication changes or lifestyle changes, the answer to this question is "Yes." If the PCP failed to document an intervention for the uncontrolled condition, the answer to this question is "No."

Note 4: In the absence of face-to-face encounter due to CCHCS Covid-19 health care operation guidelines, review any phone visits occurring within the testing period.

Evaluate if the patient's chronic care conditions were discussed and addressed by the provider.

2. Review the documentation for the second most recent chronic care visit and identify the interval for the next visit specified by the provider. Intervals specified by the provider cannot exceed the following time frames:

- Anticoagulation –
  - **Revision 9/2019:** as clinically indicated (as specified by the ordering provider).
  - **Revision 3/2021:** First year: 3 months, 6 months, and 12 months or more often as clinically indicated. Follow-up **at least every 6 months thereafter**
  - **Effective 9/2021:** same guidelines from 3/2021 revision date
- Asthma –
  - **Revision 6/2019:** as clinically indicated, or as specified by the ordering provider but at least every 365 days.
  - **Effective 11/2021:** same guidelines from 6/2019 revision date
- Diabetes (Do not include pre-diabetes) –
  - **Prior to 8/2018**: 180 days.
  - **Revision 3/2020**: if A1C is at goal: 180 days; If A1C is **NOT** at goal, at least every 90 days.
  - **Effective 8/2021**: same guidelines from 3/2020 revision date
- Hepatitis C (chronic, not receiving antiviral treatment) – 12 months
- Hepatitis C (receiving antiviral treatment) –
  - **Revision 3/2021:** as clinically indicated, or as specified by the ordering provider.
- HIV infection –
  - **Revision 5/2019-8/2019:** as clinically indicated or as specified by the ordering provider.
  - **Revision 9/2020:**
    - On HIV Treatment: 2-8 weeks after start of treatment, every 4-8 weeks until HIV VL is undetectable, then every 3-4 months if HIV VL is undetectable for 2 years, then may increase interval every 6 months.
    - Post Treatment: Clinically indicated
  - **Effective 9/2021:** same guidelines from 9/2020 revision date
- Hyperlipidemia (Dyslipidemia)
  - **Prior to 9/2021:** 12 months
  - **Effective 9/2021:** same guidelines from prior to revision date 9/2021
- Hypertension –
  - **Revision 6/2019-6/2020:** If HTN **not at goal**: every 1 month until controlled: If HTN **at goal**: PCP re-assess every 3-6 months.

- **Effective 8/2021:** same guidelines from 6/2020 revision date
- Seizure Disorders – 180 days

Once the appropriate time frame is identified on the second most recent visit, compare the date on that second most recent visit with the date on the patient's most recent chronic care visit to determine whether the most recent visit occurred within the appropriate time frame. If the visit did not occur within the appropriate time frame, the answer to this question is "No."

If the provider did not document the time interval for the next visit (on the progress note or the corresponding provider's order), then determine if the second most recent visit and the most recent visit took place within the above-noted default time frames for each applicable chronic condition. If the two visits did not occur within the earlier of the provider's written order or the maximum allowable interval (identified above), the answer to this question is "No."

References: April 2019 CCHCS HC DOM Ch.3 Article 1 3.1.5.C.3.G.2; Current CCHCS Care Guides (for associated chronic condition); OIG Medical Inspection Unit

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Ref # 1.002

HQ INSPECTOR (Rev. 08/10/2021)

For endorsed patients received from another CDCR institution: Based on the patient's clinical risk level during the initial health screening, was the patient seen by the clinician within the required time frame?

Testing Methodology (Sample 25):

For patients transferring from institution to institution, review the Initial Health Screening form for male or female patients for evidence of a medical clinician referral. Referral time frames are dependent on a patient's clinical risk level (high, medium, or low) and/or the complexity of care management needed.

Identify the medical referral as indicated by the RN; review the electronic health record for a corresponding Interdisciplinary Progress Notes (Nursing), or for MD Progress Notes and determine if the clinician visit occurred within the nurse's referred time frame. CCHCS procedures outline the following referral timelines:

Revision 4/2019 **HC DOM:** referral time frame of patient's clinical risk level may range as follows:

- High Risk Patients: PCP encounter within 7 calendar days.
- Medium/Low risk patients with one or more *chronic conditions with prescribed medications: PCP or PCRN encounter within 30 calendar days or as ordered by the provider (appointment may be scheduled on a later date).

- Medium/Low risk patients without known *chronic conditions with prescribed medications shall be seen by a care team member (PCP, RN, or LVN Care Coordinator) as needed, or based on applicable care guides.

**Note 1: According to CCHCS Quality Management patient registries, the following medical problem list are considered chronic conditions: Asthma, Diabetes, Cardiovascular Disease (i.e. Arrhythmia, Cerebrovascular, Hypertension, Peripheral Vascular Disease, Thromboembolic, and Valvular Heart Disease), Hepatitis C, End Stage Liver Disease, HIV, Anticoagulation, Chronic Pain, and Seizures.*

Note 2: If a patient's clinical risk level is either medium or low, determine if patient has one or more chronic conditions, or no known chronic condition using EHRS, or Patient Summary (Master Registry). Then test the appropriate referral time frame according to the patient's clinical risk level.

Note 3: If the nurse does not make a medical referral or makes a referral but does not specify a time frame, refer to the flagging sheet (the analyst will identify the patient's clinical risk level through SOMS at the time of transfer) to identify the patients risk level at the time of transfer. Based on the patient's clinical risk level, the inspector should review the EHRS to determine if the patient received an appropriate clinician appointment based on the patient's clinical risk level.

Note 4: The inspector also should ensure the RN made the proper referral according to the patient's clinical risk level. For example, if patient is high risk, but the RN made a referral for a medium risk, the inspector should ensure the patient received an appointment based on their actual risk level at the time of transfer, which would be for a high-risk patient in this case. However, if the RN makes a referral for a shorter time frame than is required, the inspector will test to ensure the patient was seen within the shorter time frame.

Note 5: For this test, do not test or consider the appropriateness of mental health referrals.

Note 6: If initial LVN encounter with a low-risk patient warranted further evaluation, the LVN shall document the referral to the PCP or RN.

Note 7: In the absence of face-to-face encounter due to CCHCS Covid-19 health care operation guidelines, review any phone visits occurring within the testing period. Evaluate if the patient was seen based on their clinical risk level.

References: April 2019 CCHCS HC DOM Ch.3 Article 1 3.1.9.C.3.B.4.a-d

Ref # 1.003

HQ INSPECTOR (Rev. 08/10/2021)

Clinical appointments: Did a registered nurse review the patient's request for service the same day it was received?

Testing Methodology (Minimum 30 samples):

Review Part II of Form 7362 (Health Care Services Request Form) and verify that the form was received and reviewed on the same day as indicated by the reviewer's signature (or initials) and date(s).

Note: The OIG will document the date that the patient signed the Form 7362 for information purposes only.

References: April 2019 CCHCS HC DOM Ch. 3 Article 1 3.1.5.C.2.B.3.a.1-2

Ref # 1.004

HQ INSPECTOR (Rev. 08/10/2021)

Clinical appointments: Did the registered nurse complete a face-to-face visit within one business day after the CDCR Form 7362 was reviewed?

Testing Methodology (Minimum 30 samples):

Compare the date the RN reviewed the request for health care services on Part II of Form 7362 (Health Care Services Request) with the completion date of the face-to-face. The nurse shall document the face-to-face triage on a 7362 Nursing Face-to-Face, and it shall include Subjective, Objective, Assessment, and Plan.

Note 1: If Form 7362 does not document a face-to-face triage, nor does an accompanying nursing encounter form or nursing progress note, the question will be answered "No."

Note 2: If the patient submits the Form 7362, but then refuses the FTF encounter, the sample will be used for this test (i.e. was the refusal timely completed); however, the answer to questions 1.005 & 1.006 will be "NA."

References: April 2019 CCHCS HC DOM Ch. 3 Article 1 3.1.5.C.2.B.3.a.3 & B.3.b.1.2

Ref # 1.005

HQ INSPECTOR (Rev. 08/10/2021)

Clinical appointments: If the registered nurse determined a referral to a primary care provider was necessary, was the patient seen within the maximum allowable time or the ordered time frame, whichever is shorter?

Testing Methodology (Minimum 30 samples):

Generally, the maximum allowable time frame for a routine (non-emergent) referral to occur is 14 calendar days.

Compare the date the RN referred the patient to a PCP on Part II of Form 7362 (Health Care Services Request) with the date the PCP saw the patient as recorded on Interdisciplinary Progress Notes.

Test Example – If the RN makes a provider referral such as "Routine 3-4 weeks" the inspector will ensure that the patient was seen within 14 days as required by policy. Conversely, if the RN makes a referral such as "Routine-10 days," the inspector will use the shorter time period of 10 days.

Note 1: If the visit did not occur timely or the patient did not refuse timely, the answer to this question is "No."

Note 2: Both the electronic Form 7362 and the paper Form 7362 have the following disposition referral time frames: emergency -immediately; urgent – within 24 hours; or routine -within 14 days. (If the nurse makes a medical referral but does not specify a time frame, determine whether the provider visit occurred within 14 days of the referral).

Note 3: If the RN does not make a new referral but indicates the patient is to be seen during a previously scheduled future appointment and verify that the appointment is within 14 calendar days, then the answer to Tests 1.005 & 1.006 is "NA," unless the RN documents (on the Form 7362) the date or time period (i.e. 11/7 or "next week") in which the future appointment is to occur. If the date or time period is documented, the inspector will conduct tests 1.005 & 1.006 (as applicable).

Note 4: In the absence of face-to-face encounter due to CCHCS Covid-19 health care operation guidelines, review any phone visits occurring within the testing period. Evaluate if the patient's sick call complaint was discussed and addressed by the provider.

References: April 2019 CCHCS HC DOM Ch. 3 Article 1 3.1.5.C.2.B.3.a.4; Current CCHCS Care Guides (for associated chronic condition)

Ref # 1.006

HQ INSPECTOR (Rev. 08/10/2021)

Sick call follow-up appointments: If the primary care provider ordered a follow-up sick call appointment, did it take place within the time frame specified?

Testing Methodology (Minimum 30 samples):

Review the initial provider encounter (identified and tested in 1.005). If the provider requested an additional follow-up visit, identify the follow-up request date documented on the initial Interdisciplinary Progress Notes and/or Physician's Order, and confirm that either the follow-up visit occurred timely, or that the patient refused the visit timely. If the time frame identified in the progress notes differs from that identified in the physician's order, use the physician's order.

Note 1: If the visit did not occur timely or the patient did not refuse timely, the answer to this question is "No."

Note 2: If no follow-up was required, a follow-up was ordered but no time frame was specified, or the patient was moved to a higher level of care, the answer to this question is "NA."

Note 3: If the follow-up visit was ordered to be seen by the RN, the answer to this question is "NA."

References: April 2019 CCHCS HC DOM Ch. 3 Article 1 3.1.5.C.3.H

Ref # 1.007

HQ INSPECTOR (Rev 08/24/2021)

Upon the patient's discharge from the community hospital: Did the patient receive a follow-up appointment with a primary care provider within the required time frame?

Sampling Note - This test shares the same sample as tests 4.003, 4.005 and 7.003.

Testing Methodology (Sample 25):

A. First, determine the date of the patient's hospital discharge.

B. Next, determine if the patient had a post-hospitalization return health care evaluation. (Usually this occurs in the TTA on the day of return, and the evaluation is often performed by an RN). If an evaluation was performed, review the 1) corresponding progress notes, and 2) corresponding follow-up orders; and, determine if the evaluating clinician made an expedited referral or disposition that intended for the patient to be seen by the regular (non-TTA)

provider in a period of less than 5 calendar days of the hospital return. If no such expedited referral request is found, then the default time period (per CCHCS policy) for the patient to be seen by their regular provider is 5 calendar days.

C. Finally, determine the date of the patient's primary care follow-up appointment and verify that it (or a refusal) occurred within the time frame determined in Step B above.

Note 1: CCHCS HCDOM requires patients to be seen for a follow-up appointment within five calendar days of discharge from a community hospital; however, if a TTA hospital return provider (or other CDCR provider) orders the appointment to occur sooner, the shorter time frame applies. However, a TTA doctor visit upon return from the community hospital does not suffice as a PCP visit (unless that provider just happens to be the patient's regular PCP and a thorough follow-up evaluation was performed).

Note 2: If a RN / Provider clearly indicates (in the Disposition & Referral section of the hospital return progress note) that a PCP follow-up visit (shorter than 5 calendar days) is needed, but the RN/provider fails to actually create the corresponding order; then, for the purposes of this test, the time frame identified in the progress notes will be the operative time frame for the provider follow-up appointment and the inspector will test for compliance with the shorter time frame.

Note 3: If the patient was discharged from a community hospital directly or within 48 hours to an OHU, CTC, SNF, or MHCB; or admitted directly to the DSH, then do not test. Replace with an alternate sample.

Note 4: This test is deemed N/A (with an appropriate comment) if at the time of the first provider visit, following hospital discharge, a final or preliminary hospital discharge report was not available.

Note 5: In the absence of face-to-face encounter due to CCHCS Covid-19 health care operation guidelines, review any phone visits occurring within the testing period. Evaluate if the patient had a timely follow-up appointment with the provider after discharge from hospitalization.

References: April 2019 CCHCS HC DOM Ch. 3 Article 1 3.1.9.C.3.F.6; April 2019 CCHCS HC DOM Ch.3 Article 1 3.1.5.C.3.G.4

Ref # 1.008

HQ INSPECTOR (Rev. 08/24/2021)

Specialty service follow-up appointments: Did the clinician follow-up visits occur within required time frames?

Testing Methodology (Sample 45):

Sampling Note - This test shares the same sample with the following tests: High priority (14.001 – 14.003) 15 samples, Medium priority (14.004 – 14.006) 15 samples, and Routine priority (14.007 – 14.009) 15 samples.

Identify the date the specialty service was provided by reviewing the EHRS to identify the corresponding consultant's report related to the provided service. The report may be documented on the bottom half of the Form 7243 (Physician Request for Services), electronic version of RFS, or it may be a separately scanned document.

1. Verify that a PCP follow-up visit occurred within the following required time frames:

   a. For high-priority specialty services: The patient must be seen by PCP within five (5) calendar days after a high priority specialty services appointment.

   b. For medium priority or routine specialty services: The Primary Care Team (PCT) shall review the clinical documentation and schedule the patient for a follow-up appointment with the PCP or RN, as clinically indicated. If the PCT decides to conduct a follow-up appointment, the OIG inspector will verify the order of the follow-up appointment, and determine if the patient received the appointment as scheduled. If patient did not receive follow-up appointment as scheduled, the answer is "No".

Note 1: For this test, a TTA physician's encounter with a patient does not qualify as a follow-up visit.

Note 2: In the absence of face-to-face encounter due to CCHCS Covid-19 health care operation guidelines, review any phone visits occurring within the testing period. Evaluate if the patient had a timely follow-up appointment with the provider after returning from specialty service appointment.

References: July 2020 CCHCS HC DOM Ch. 3 Article 1 3.1.11.C.5.B & C

Ref # 1.101

REGIONAL INSPECTOR (Rev. 08/24/2021)

Clinical appointments: Do patients have a standardized process to obtain and submit health care services request forms?

Testing Methodology:

Visit the institution's housing facilities and determine if patients have adequate access to health care by performing the following steps:

1. Visit the institution's Administrative Segregation Unit (and overflow if applicable) and Security Housing Unit to ensure that inmates in those units have access to copies of the Form 7362 (Health Care Services Request Forms). Verify that patients have access to an operational lockbox or to a nurse who collects the forms daily.

2. For all other housing locations, select one housing unit on each yard and verify that a supply of the Form 7362 (Health Care Services Request Forms) is available to patients. Verify that at least one accessible and operational lockbox is available on the yard or in the clinic area for inmates to submit their forms.

   Note 1: Test six total locations with no more than five housing units from Step 2 above.

   Note 2: If the sampled location has: 1) the Form 7362 immediately available; and, 2) a locked box or daily nursing access to submit the forms, the answer to this question is "Yes".

   Note 3: Interview custody staff assigned in the housing unit regarding the correct process for ordering and ensuring inmates have access to the Form 7362, if the custody staff cannot describe a custody process to reorder form, the answer to this question is "No".

References: April 2019 CCHCS HC DOM Ch. 3 Article 1 3.1.5.C.2.B.2.d

Diagnostic Services

The Office of the Inspector General will determine whether radiology, laboratory, and pathology services were timely provided to the patient; whether the primary care provider timely reviewed the results; and, whether the results were communicated to the patient within the required time frames. In addition, for pathology services, the OIG will determine whether the primary care provider timely reviewed and communicated the results.

Sample Methodology

Sample Methodology for each of the four diagnostic service areas—select 10 samples, resulting in a total of 40 samples.

Radiology Sample

Tests 2.001 – 2.003

For institutions using a radiology services tracking log: go back 90 days before the date of the OIG's visit and select and list 10 radiology services performed more than 90 days but less than 9 months before the first day of the EHRS inspection week. Select 10 patients with abnormal radiology results and list their names, CDCR numbers, and the dates that the radiology services were completed.

Laboratory Sample

Tests 2.004 – 2.006 & Tests 2.007 – 2.009

1. From CCHCS headquarters, obtain electronic data of Quest laboratory hematology and chemistry services performed more than 90 days but less than 9 months before the first day of the EHRS inspection week. Randomize the data and create a list of 10 patients with abnormal results.

2. If the institution performs its own laboratory diagnostic testing on-site, obtain their data electronically and verify that it has the needed information for sampling purposes. Randomize the data and create a list of 10 patients with abnormal hematology and chemistry test results.

   Note 1: If the lab service is ordered by a pharmacist, psychiatrist, or dentist, the sample will be replaced for all tests 2.004 – 2.006, and 2.007-2.009.

Pathology Sample

Tests 2.010 – 2.012

From CCHCS headquarters, obtain electronic Interqual data for pathology services performed more than 90 days but less than 9 months before the first day of the EHRS inspection week. Randomize the data and create a list of 10 patients, including their name, CDCR number, and the date the pathology service was completed. This document selection should be for specialty services requests and not routine gynecological examinations such as Pap Smear.

Inspection Procedures

Ref # 2.001

HQ INSPECTOR (Rev. 08/24/2021)

Radiology: Was the radiology service provided within the time frame specified in the health care provider's order?

Testing Methodology (Sample 10):

Compare the date the radiology service was performed (from the diagnostic report) with the date of the request for service on Physician's Orders or Form 7243 (Request for Service), and determine whether the service was performed as specified by the provider, or consistent with the following timelines:

- STAT: Performed within one (1) hour of the order
- High Priority: provided as ordered or within 14 calendar days from the date of the order if a timeframe is not specified
- Medium Priority: as ordered or within 15-45 calendar days from the date of the order if a timeframe is not specified
- Routine Priority: as ordered or within 46-90 calendar days from the date of the order if a timeframe is not specified

Note 1: The OIG will test "plain film" radiology services; scans, contrast studies, etc., will be evaluated in the Specialty Services MIT.

References: December 2018 CCHCS HC DOM Ch. 3 Article 1 3.1.13.C.1.A.1-4

Ref # 2.002

HQ INSPECTOR (Rev. 08/24/2021)

Radiology: Did the ordering health care provider review and endorse the radiology report within specified time frames?

Testing Methodology (Sample 10):

Compare the date the radiology test was electronically reported (i.e. electronically signed by the radiologist) to the institution, with the date the ordering health care provider reviewed the diagnostic report (as indicated by endorsement date), and determine whether it was reviewed within the applicable time frame:

Three calendar days of when the diagnostic report was first made available to the institution for their review.

Note 1: For this test, the ordering health care provider must actually review and endorse results. The EHRS properties scan date or supplemental progress notes cannot be used to establish that the ordering health care provider reviewed the report within the required time frame.

Note 2: For this test, the date the radiology report is electronically signed by the radiologist is deemed to also be the same date that the report was received by the institution because once the report is electronically signed; it is technically available for the institution's review on the same day.

References: December 2018 CCHCS HC DOM Ch. 3 Article 1 3.1.13.C.3.F

Ref # 2.003

HQ INSPECTOR (Rev. 08/24/2021)

Radiology: Did the ordering health care provider communicate the results of the radiology study to the patient within specified time frames?

Testing Methodology (Sample 10):

Compare the date the institution received (i.e. the date the report was electronically signed by the radiologist) the final radiology diagnostic report to the date the health care provider prepared the patient letter and determine whether the results were communicated to the patient within the applicable requirements:

Radiology results communicated within three calendar days. The health care provider shall include the following key elements in the patient letter:

- Date of the examination results
- Reviewing health care provider's name
- Whether the results are within normal limits
- Whether a follow-up appointment with the provider is required and will be scheduled

For this test, the ordering health care provider shall inform the patient of the results based on the official radiology test results report and not based on a TTA provider's preliminary or initial "wet" read results of the x-ray.

Note 1: For this test, the date the radiology report is electronically signed by the radiologist is deemed to also be the same date that the report was received by the institution

because once the report is electronically signed; it is technically available for the institution's review on the same day.

References: December 2018 CCHCS HC DOM Ch. 3 Article 1 3.1.13.C.3.G

Ref # 2.004

HQ INSPECTOR (Rev. 12/27/2021)

Laboratory: Was the laboratory service provided within the time frame specified in the health care provider's order?

Testing Methodology (Sample 10):

Compare the date the laboratory service was performed (from the diagnostic report) with the date of the request for service on Physician's Orders, and determine whether the service was performed (specimen collected) as specified by the health care provider, or consistent with the following timelines:

- ASAP: Collected within the next day (Saturday and Sunday are included)
- Routine:
  - Prior to 4/2021: within the timeframe ordered or collected within 14 calendar days of the date of the order
  - Revision 4/2021: The laboratory specimen shall be obtained from the patient on the requested collection date
  - Effective 12/2021: The laboratory specimen shall be obtained from the patient on the requested collection date. The specimen may be collected prior to the requested collection date unless prohibited by policy or the ordering provider or as follows:
    - Laboratory staff may collect a routine lab test the next business days should the requested collection date fall on a weekend or holiday.
- Timed Study: Orders with a provider specified due date must be collected by the specific date.

Note 1: If the lab service is ordered by a pharmacist, psychiatrist, or dentist, the sample will be replaced for all three tests 2.004 – 2.006. An alternate patient will be selected for testing.

Note 2: Applicable to samples prior to 4/2021 – If the routine laboratory service was performed earlier than the compliance date (stop date and time), the inspector will verify if the service was completed within 14 days from the compliance date. If the routine laboratory service was performed earlier than the required aforementioned timeframe, the answer to this question is "No".

References: December 2021 CCHCS HC DOM Ch. 3 Article 1 3.1.14.C.1.A-D.1-4

Ref # 2.005

HQ INSPECTOR (Rev. 12/27/2021)

Laboratory: Did the health care provider review and endorse the laboratory report within specified time frames?

Testing Methodology (Sample 10):

Compare the date the laboratory test result was received at the institution (or otherwise communicated to the health care provider), with the date the health care provider reviewed the diagnostic report (as indicated by endorsement date), and determine whether it was reviewed within three calendar days (prior to 12/2021) or five calendar days (effective 12/2021) of when the diagnostic report was received.

Note 1: For EHRS, the health care provider must take action by endorsing the results to qualify that the laboratory results was verified and reviewed. The supplemental progress notes cannot be used to establish that the health care provider reviewed the report within the required time frame.

References: December 2021 CCHCS HC DOM Ch. 3 Article 1 3.1.14.C.4.D

Ref # 2.006

HQ INSPECTOR (Rev. 12/27/2021)

Laboratory: Did the health care provider communicate the results of the laboratory test to the patient within specified time frames?

Testing Methodology (Sample 10):

Compare the date the institution received the laboratory diagnostic report to the date the health care provider prepared the patient letter and determine whether the results were communicated within three calendar days (prior to 12/2021) or five calendar days (effective 12/2021). The health care provider shall create a patient notification letter in the health record at the time of review and endorsement of each laboratory result. The patient letter shall include the following key elements:

- Date of the test/screening to identify the laboratory test/diagnostic screening
- Reviewing health care provider's name
- Whether the results are within normal limits
- Whether a follow-up appointment with the provider is required and will be scheduled

References: December 2021 CCHCS HC DOM Ch. 3 Article 1 3.1.14.C.4.E

Ref # 2.007

HQ INSPECTOR (Rev. 12/27/2021)

Laboratory: Did the institution collect the STAT laboratory test and receive the results within the required time frames?

Testing Methodology (Sample 10):

Compare the date and time the laboratory service was performed (from the diagnostic report) with the date and time of the health care provider's order, and determine whether the service was performed (specimen collected- Refer to NOTE 4) **as specified by the health care provider**, or consistent with the following timelines:

- STAT order for Non-Rural Institutions: Collected and resulted in four (4) hours from the time of specimen collection
- STAT order for Rural Institutions*: Collected and resulted in five (5) hours from the time of specimen collection

**Note 1: Rural Institutions are as follows: CVSP, CAC, ISP, PBSP, HDSP, and CCC.*

Note 2: If the lab service is ordered by a pharmacist, psychiatrist, or dentist, the sample will be replaced for all three tests 2.007 – 2.009. An alternate patient will be selected for testing.

Note 3: If the institution did not receive the STAT laboratory results timely, review other documentations such as progress notes or TTA notes and determine whether the notes included specific documentation that nursing staff attempted to contact the laboratory. If the documented attempt was timely, the answer should be "Yes."

Note 4: STAT Laboratory orders shall be retrieved by a designated health care team member for collection and processing immediately; which the OIG interpreted to be completed within one (1) hour from the time health care provider placed the order.

References: December 2021 CCHCS HC DOM Ch. 3 Article 1 3.1.14.C.2.E-H; OIG Medical Inspection Unit

Ref # 2.008

HQ INSPECTOR (Rev. 12/27/2021)

Laboratory: Did the provider acknowledge the STAT test results, OR did nursing staff notify the provider within the required time frames?

Testing Methodology (Sample 10):

Compare the date and time the laboratory test result was received and when the provider acknowledge the STAT test results, OR nursing staff notify the ordering health care provider of STAT test results.

For STAT test results received during business hours (08:00-17:00), determine whether provider acknowledge, OR nursing staff notify the ordering HCP within one (1) hour. For STAT test results received after hours or the ordering HCP is unavailable, determine whether TTA staff notify the on-call provider within 30 minutes.

> *Note 1: If the notification was not timely, review other documentations such as progress notes or TTA notes and determine whether the notes included specific documentation that nursing staff attempted to contact the ordering or on-call provider (after hours). If the documented attempt was timely, the answer should be "Yes."*

References: December 2021 CCHCS HC DOM Ch. 3 Article 1 3.1.14.C.2.I; OIG Medical Inspection Unit

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Ref # 2.009

HQ INSPECTOR (Rev. 12/27/2021)

Laboratory: Did the health care provider endorse the STAT laboratory results within the required time frames?

Testing Methodology (Sample 10):

Compare the date the STAT laboratory test result was received at the institution (or otherwise communicated to the health care provider), with the date the health care provider reviewed the laboratory result (as indicated by endorsement date), and determine whether it was reviewed within three calendar days (prior to 12/2021) or five calendar days (effective 12/2021) of when the diagnostic report was received.

> *Note 1: For EHRS, the health care provider must take action by endorsing the results to qualify that the laboratory results was verified and reviewed. The supplemental*

progress notes cannot be used to establish that the health care provider reviewed the report within the required time frame.

References: December 2021 CCHCS HC DOM Ch. 3 Article 1 3.1.14.C.4.D

Ref # 2.010

HQ INSPECTOR (Rev. 08/31/2021)

Pathology: Did the institution receive the final pathology report within the required time frames?

Testing Methodology (Sample 10):

This test measures the institution's ability to regularly obtain a final pathology report within a reasonable time of when it becomes available. In addition, this test measures the institution's practices of following-up to request and receive a final report, when one is not provided.

1. Determine if the institution received (as evidenced by a date stamped, fax date, or EHRS scan date) a "Final" pathology report within 5 business days of the pathologist's report date (for emergent/ urgent requests) and 14 calendar days (for routine/medium priority requests). If the report was received timely, the final answer is "Yes" and **STOP HERE**.

   If a Final report was not received timely, continue to Step 2. (If no "Final" report was ever received, go to Step 4.)

2. If a "Final" report was received, but late, determine if a preliminary report was received within 5 business days (for emergent/ urgent requests) or 14 calendar days (for routine/medium priority requests) of the patient encounter date*. (Note: If the preliminary report is late, but the institution made a good-faith effort to obtain the report, then extra time will be allowed to receive the preliminary report.) Next, determine whether a Final report was received. Use the earliest date as evidenced on the report (date stamped, print date, fax date, or EHRS scan date) within 30 calendar days of the preliminary report date.

   If the Final report was received within 30 days of the preliminary report, the answer is "Yes" and **STOP HERE**.

   If a Final report was not received timely, continue to Step 3.

   ** For the patient encounter date, use the date that the specimen (used for the biopsy) would have most likely been first made available to the pathologist (such as the date a kidney is removed).*

3. If a "Final" report is not received within 30 calendar days of the preliminary report date, the answer is "No," unless the institution documented reasonable efforts to request and obtain the Final report within 5 business days after the 30-day period ended, in which case the answer is "Yes. **STOP HERE**.

   If a Final report was not received timely and no documented evidence was found that the institution requested the report timely, continue to Step 4.

4. If a "Final" report was never received and the institution's staff did not timely document their efforts to request and obtain the final report (as discussed in Step 3), the final answer is "No."

   Note 1: If an outpatient location (such as a hospital) performs a procedure that results in a pathology test being performed, a final stand-alone pathology report must be issued by the hospital/ pathology entity within timelines discussed above. Further, if an outside hospital (or other entity) sends a pathology specimen to another entity to perform a primary or secondary analysis, the institution must receive a copy of that entity's report findings.

   Note 2: For this test, pathology reports labeled as "Preliminary" will not be considered a "Final" report. If the hospital's discharge report or a doctor's progress notes simply detail a second-hand narrative discussion of what the pathologist found, this will be considered a "Preliminary."

   Note 3: For this test, the urgency level (Emergent, Urgent, Medium Priority or Routine) for the pathologic report to be received by the institution is the same urgency as the corresponding Form 7243. For example: if a provider orders an urgent colonoscopy service to be performed, the pathology report must be received within the urgent time frame (as determined by the testing methodology described above).

References: OIG Medical Inspection Unit

Ref # 2.011

HQ INSPECTOR (Rev. 12/27/2021)

Pathology: Did the health care provider review and endorse the pathology report within specified time frames?

Testing Methodology (Sample 10):

Compare the date the "Final" pathology report was received at the institution (or otherwise communicated to the health care provider), with the date the health care provider reviewed the diagnostic report (as indicated by initials and date, endorsement date), and determine whether it

was reviewed within three calendar days (prior to 12/2021) or five calendar days (effective 12/2021) of when the diagnostic report was received.

Note 1: Pathology reports labeled as "Preliminary" will not be used for purposes of this test.

Note 2: If the received date is not clearly indicated on the report, use the ***earliest date evidence*** *on the report (fax date, print date, date stamp, or EHRS scan date).*

Note 3: If no final Pathology report is found in the EHRS, this test is not applicable.

Note 4: For this test, the health care provider must actually endorse the report. The EHRS scan date or supplemental progress notes cannot be used to establish that the health care provider reviewed the report within the required time frame.

References: December 2021 CCHCS HC DOM Ch. 3 Article 1 3.1.14.C.4.D; OIG Medical Inspection Unit

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Ref # 2.012

HQ INSPECTOR (Rev. 12/27/2021)

Pathology: Did the health care provider communicate the results of the pathology study to the patient within specified time frames?

Testing Methodology (Sample 10):

Compare the date the institution received the "final" pathology diagnostic report to the date the HCP prepared the patient letter and determine whether the results were communicated to the patient within three calendar days. The health care provider shall include the following key elements in the patient letter:

- Date of the test to identify the pathology service
- Reviewing health care provider's name
- Whether the results are within normal limits
- Whether a follow-up appointment with the provider is required and will be scheduled

Note 1: If the received date is not clearly indicated on the report, use the print or fax sent date indicated at the top or bottom margins of the report. If there is no indication on the report as to when it was sent or received, use the EHRS scan date.

Note 2: If no final Pathology report is found in the EHRS, this test is not applicable.

References: December 2021 CCHCS HC DOM Ch. 3 Article 1 3.1.14.C.4.E; OIG Medical Inspection Unit

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Emergency Services

The Emergency Services quality indicator will be assessed during case reviews conducted by OIG's clinicians and is not applicable for the compliance portion of the medical inspection. The methodologies that the clinicians use to evaluate emergency services are presented in a separate inspection document entitled, OIG MIU Retrospective Case Review Methodology.

Inspection Procedures

Ref# 3.999 - Non Scoring

REGIONAL INSPECTOR (Rev. 08/31/2020)

Emergency Services Data Collection

In the week prior to the inspection the MIU Analyst will provide a list of unscheduled emergency medical send out incidents. When possible, incidents involving CPR emergency medical response incidents on site will be provided to OIG RNs for inclusion into this program. The documents to be collected shall consist of the following:

- Complete version (summary & staff) of the sampled incident report (Form 837),
- Documents maintained by the EMRRC coordinator related to the sampled incident,
- Vehicle Sally Port Logs that identified the ambulance's (or other code 3 transport vehicle's) specific arrival and departure times related to the incident, and
- Evidence as to when the transport custody arrived to escort the patient.

Note: The REGIONAL INSPECTOR assigned this task is responsible for providing the institution the list of selected incidents for case review testing. The institution will collect the supporting documentation, and will electronically scan the documents to CCHCS Headquarters. CCHCS Headquarters will then send the documents to the OIG via the SSH File Transfer Protocol (SFTP). The MIU analyst for the inspection will notify the SRN for availability of documents. The EMRRC data collected for this test may go back as far as 13 months.

Health Care Environment

The Office of the Inspector General will conduct interviews, observe practices, and perform testing within all clinical care areas to assess the clinical environment and related services. Inspectors will determine whether health care management implements and maintains practices that promote infection control through general cleanliness, adequate hand hygiene protocols, and control of blood-borne pathogens and contaminated waste. In addition, OIG Inspectors will review the adequacy of clinical areas and services, including: medical supplies and equipment; emergency response bags, and the facility infrastructure.

The OIG will make a reasonable effort to inspect each of the institution's clinical exam areas, including but not limited to mainline, reception center, R&R, TTA, MSF, ASU, SHU, OHU, CTC, & PIP locations. However, our testing of some clinics may be limited by such factors as clinic operational hours.

MIT Introductory Note: If the inspector desires to sit in on a clinical assessment, then the inspector should request that the clinician ask the patient for his or her approval. For patient observations, the inspector will select two different exam rooms (preferably one nurse and one provider) and observe 2-3 patient encounters for each. The observations may be during outpatient clinic hours to assess the adequacy of hand hygiene practices.

In addition, some clinics may use clinic hallways to conduct triage stations (i.e., for blood pressure checks) or injection lines. The inspector should try to observe two or three of these types of encounters to review nurses compliance with hand hygiene practices and patients' audio privacy.

Specialty Service Clinics – For those institutional areas deemed to be specialty service clinics or exam rooms, the inspector ***will still perform the same MIT 5 tests*** *required of any other clinic/ exam room area. (i.e. test 2 exam rooms for compliance). However, if the area fails a test because it does not have the minimally required core equipment or supplies, the regional RN will confirm the actual services provided both to the specialty clinic exam room in question or the clinic as a whole (for questions applicable missing items). The inspector will then notify the Supervising Regional Nurse (SRN) of the deficiencies. The SRN will then consult with the OIG's Chief Physician and Surgeon (CP&S) on whether the deficiency is acceptable based on the specialty services provided. Special note – "telemed only" exam rooms are not included or tested unless the room is also used to perform non telemed specialty services.*

For those tests in which the OIG CP&S allows an exception, the following example comment will be placed in the worksheet's applicable comment area. "Based on OIG Medical Inspection Unit`, the specialty service clinic / exam area's core

medical equipment and supplies were deemed appropriate for the type of specialty service(s) provided."

To assist inspectors in initially determining the number of specialty clinics and services offered, refer to the OIG's pre-inspection questionnaire. However, final determination of actual clinical areas and services offered should be concluded based on observations and interviews with specialty service clinic staff.

Inspection Procedures

Ref # 5.101

REGIONAL INSPECTOR (Rev. 08/31/2021)

Infection control: Are clinical health care areas appropriately disinfected, cleaned, and sanitary?

Testing Methodology:

Visit all mainline/specialized housing clinics and inpatient clinical areas and determine whether the institution's healthcare management maintains a program that promotes infection control through general cleanliness. If available, request the institution's infection control monitoring plan for review. Questions identified below as *for information only* are not scored; the inspector should gather background information and utilize the input to confirm/ observe staff concerns when conducting the inspection.

1. *For information only*—randomly interview health care staff at each medical location and determine if they have any "significant" concerns in their work areas regarding adequate sanitation, or infection control and prevention. Additionally, ask staff if they could identify areas in which adequate sanitation or infection control and prevention may not always exist. If applicable, take photos during the inspection and obtain management's comments related to the concern.

2. Perform an inspection of common areas, exam rooms, patient waiting areas, laboratory/draw station areas, storage areas and restrooms, and determine if areas are adequately clean and well maintained based on the following:

    a. Verify that the cleaning process for each area includes chemicals intended for disinfection in a hospital environment.

    b. Verify that the cleaning process results in environmental surfaces such as floors, sinks, cabinet shelves/ drawers, counter and refrigerator tops being adequately clean and free of dust build-up. Ensure that floor-corners are free of debris and accumulated grime.

Note 1: To assess cleanliness, you should be able to wipe a lightly dampened paper towel on a surface and not have any noticeable dirt residue transferred to the towel. (It is also a problem if the substance remains adhered to the surface even after wiping). When warranted, take a deviation photo.

Note 2: Damaged or worn furniture including taped-over surfaces that a clinician might have an occasional need to touch during an encounter (such as an exam room desk drawer-front or cabinet door where supplies are stored) are not appropriate in a

clinical setting. These types of surfaces could harbor infection because they cannot be properly cleaned or sanitized. If this condition is observed, the answer is "No."

Note 3: Waiting areas for R&R's are not reviewed for cleanliness.

c. Verify that an empty red biohazard bag is used for each clinic day in which patient care is provided.

Note 4: Biohazard receptacles/bags containing waste shall be removed from the clinic at the end of each clinic day.

3. Verify that an adequate cleaning program exists for each clinic by performing the following:

   a. For the most recent 30-day period, identify where the cleaning logs for each clinic's common areas, exam rooms, waiting areas and bathroom are located and the days per week the clinic's cleaning logs are required to be completed. Verify that cleaning logs exist for each applicable day. If the inspector finds that logs are unaccounted for or incomplete, the answer is "No."

Note 5: Although the current weekly cleaning logs are kept in the clinic, the institution usually stores their historical cleaning logs in one central location. For efficiency, one inspector should be assigned to review all centralized historical cleaning logs on behalf of the whole inspection team.

   b. For the most recent 30-day period, verify that cleaning logs for all clinical common areas, exam rooms, waiting areas and bathrooms identify the work completed, who performed the work, and when the work was completed. Completion of logs shall serve as evidence the staff person or porter who performed the cleaning certified the work was complete. If the inspector finds significant omissions to the log, the answer is "No."

Note 6: Every clinic should be cleaned daily and ready to accept patients in an emergency, even if appointments are not scheduled. Unless specific documentation can be provided that demonstrates a clinic was not operational since it was last cleaned, evidence of daily cleaning is required. If clinics (such as a TTA) have exam rooms that are used infrequently, the rooms at a minimum should be cleaned once per week. Review clinician work schedules or other evidence of clinic operation for verification.

Note 7: The inspector shall be aware that particular tasks may be completed on an "as needed" only basis. Also, for R&R waiting areas, no cleaning logs are required for this test.

c. If a porter performed the cleaning and completed log entries, ensure that a staff person also confirms the work was complete and signs the logs. If the clinical area does not use inmate porters, the answer to this sub-question is "NA."

d. Interview clinic staff and determine if the institution's cleaning protocols are significantly impacted during modified programming. If the inspector finds that regularly required cleaning is not achieved, the answer is "No."

e. Interview cleaning staff and determine if those persons who perform normal after hours clinical cleaning are ever prevented from performing their normal daily cleaning duties due to locked doors or unavailable staff.

References: May 2019 CCHCS HC DOM Ch. 1 Article 2 1.2.12.c.2.B-D, & d.2-3; CCR Title 22, Division 5, Chapter 12, Article 6, Section 79843; CDC Guidelines for Environmental Infection Control in Health-Care Facilities, 2003; CDC Guide to Infection Prevention for Outpatient Settings, September 2016; OIG Medical Inspection Unit

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Ref # 5.102

REGIONAL INSPECTOR (Rev. 08/31/2021)

Infection control: Do clinical health care areas ensure that reusable invasive and non-invasive medical equipment is properly sterilized or disinfected as warranted?

Testing Methodology:

There are distinct requirements for cleaning reusable invasive medical equipment and reusable non-invasive equipment. To test step one below, interview knowledgeable staff to verify the process to sterilize reusable invasive medical equipment. For test step two below, inspect 2 exam rooms per clinic (preferably 1 RN and 1 PCP) and observe 2-3 encounters (per exam room), and interview knowledgeable staff to verify the following protocols listed below are in place (when applicable):

1. Invasive Medical Equipment: Interview knowledgeable staff to determine the following:

   a. Verify that the clinic has procedures to ensure reusable invasive medical equipment (e.g. reusable needles, clamps, or other surgical equipment) that comes in contact with a patient is sterilized. The sterilization process may be completed on- or off-site. The process may also use either a manual soak chemical solution or a more automated autoclave sterilization unit. *Note - The OIG's pre-inspection questionnaire may provide insight to which process(es) the institution utilizes.*

      1. If the institution uses a chemical sterilization process, the inspector will interview knowledgeable health care staff and assesses whether their knowledge and actual cleaning process substantially agrees with the institution's LOP regarding the process. If the institution does not have a current LOP, the test answer is "No."

b. If the institution uses an autoclave - Verify that if medical equipment sterilizations are completed on-site, determine how often spore testing is required for the on-site sterilizer and confirm that the last two (2) tests were performed timely by reviewing test result information.

c. As a matter of regular routine practice, verify that (autoclave) medical equipment sterilizations are logged.

d. Inspect the current inventory of previously (autoclave) sterilized equipment and verify that invasive equipment was successfully sterilized by confirming that the equipment's packaging label correctly changed colors as a result of a successful sterilization outcome. As a general rule, sterilization packaging should change colors from one initial (pre-sterilization) color to another (post-sterilization) color—check with knowledgeable staff to confirm the correct pre- and post-sterilization colors.

e. Verify that (autoclave) sterilized equipment packaging allows penetration of the sterilant, provides protection against contact contamination during handling, provides an effective barrier to microbial penetration, and maintains the sterility of the processed item after sterilization. Ensure that each package is date stamped permitting identification if the autoclave is subsequently found to be out of calibration (i.e. the spore test fails) or if the facility uses an "Event-Related Practice", ensure that the facility recognizes that the product should remain sterile until some event causes the item to become contaminated (i.e. tear in the packaging, packaging becomes wet, seal is broken, etc.).

2. Non-Invasive Medical Equipment: Determine the following:

a. Interview knowledgeable staff and determine if examination tables are disinfected prior to the start of each shift (interview staff regarding the daily start-up protocols).

b. Verify (through observation) that exam table paper is removed after each patient encounter (if the patient used the table).

c. Verify (through observation) that reusable non-invasive medical equipment items are cleaned and disinfected, if needed, after each patient encounter. Items that do not ordinarily touch the patient or that touch only "intact skin" are not involved in disease transmission, and generally do not necessitate disinfection between uses on different patients. For example, items such as blood pressure cuffs, stethoscopes, and chairs that the patient uses do not necessarily need to be cleaned between uses, unless the inspector observes a need to do so. Specifically, if equipment touches the patient's mucous membranes or an open wound, or the chair has bodily fluids on it after the patient leaves, the equipment should then be cleaned.

References: CCR Title 22, Div. 5, Chapter 12, Article 6, Section 79837; OIG Medical Inspection Unit

Ref # 5.103

REGIONAL INSPECTOR (Rev. 09/29/2021)

Infection control: Do clinical health care areas contain operable sinks and sufficient quantities of hygiene supplies?

Testing Methodology:

Perform the following steps to conclude if clinical health care areas contain sufficient quantities of hygiene supplies:

1. Randomly interview two (2) health care nurses or providers and determine if, in the last six (6) months, health care staff were unable to maintain good hand hygiene due to a lack of adequate supplies (i.e. antiseptic soap or alcohol-based hand rub/ sanitizer) or facilities (i.e. operational sinks) with disposable towels (or air dryer). If an inability to maintain good hygiene has been a problem, the answer is "No," and the inspector should follow-up/ validate staff's responses when conducting the inspection.

2. Verify that clinical exam areas have operable sinks and/or adequate hand-hygiene supplies:

   a. *Exam areas where medical procedures are performed*—determine if clinical staff have access to an operational sink, antiseptic soap, and disposable towels (or air dryer) in exam rooms or within reasonable exam room proximity, such as the clinic hallway. Examples of medical procedures include wound care, sutures, or other invasive procedures with the potential for exposure to blood or other bodily fluids—vaccinations are not considered a procedure.

   b. *Exam areas where medical procedures are not performed*—determine if clinical staff have access to **one of the following**:

      - Operational sink, antiseptic soap and disposable towels (or air dryer) or
      - Alcohol-based hand rub/ sanitizer

   c. Some clinics perform blood-draw stations in clinic hallways—regardless of the location, verify that staff who work in the clinic's blood-draw station has access to a working sink and antiseptic soap with disposable towels (or air dryer) available. *(Note: Normally the phlebotomist only has to use hand sanitizer and gloves between patient encounters; however, in those instances where his/her hands are exposed to bodily fluid, such as excessive bleeding, the hands must be washed).*

3. Verify that inmate and staff restrooms, located within the clinic, have a functioning sink and adequate hand-hygiene supplies, such as antiseptic soap and disposable towels (or air dryer). If there are no restrooms within the clinic, but staff use restrooms located within the

immediate vicinity outside the clinic, verify the adequacy of the sinks and supplies in those restrooms. If there are no restrooms within the clinic or its immediate vicinity, the answer is N/A for this step.

Note: The availability of gloves is tested under step 5.108.3

References: CDC Guidelines for Environmental Infection Control in Health-Care Facilities, 2003; September 2016 CDC Guide to Infection Prevention for Outpatient Settings; CDC Guideline for Hand Hygiene in Health-Care Settings, MMWR, 2002; OIG Medical Inspection Unit

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Ref # 5.104

REGIONAL INSPECTOR (Rev. 08/31/2021)

Infection control: Does clinical health care staff adhere to universal hand hygiene precautions?

Testing Methodology:

Perform the following steps to conclude if clinics adhere to universal and/or standard precautions by use of hand hygiene indications, techniques, and antiseptic products. Questions identified below as for information only are not scored; the inspector should gather background information and utilize the input to confirm/ observe staff concerns when conducting the inspection.

1. *For information only*—randomly interview at least two (2) health care nurses or providers and determine if they have any concerns regarding health care workers' ability to adhere to proper hand hygiene practices.

2. For this test, select two different exam rooms (preferably one nurse and one provider) and observe 2-3 patient encounters for each (see MIT 5 Introductory Note) during outpatient clinic hours to assess the adequacy of hand hygiene practices.

   Note 1: Inpatient units are not applicable under this testing.

   In addition to observing exam room encounters, the inspector should observe 2-3 blood-draw station encounters to ensure that the phlebotomist follows proper hand hygiene.

   In each clinical area, verify that staff performs **adequate hand hygiene*** for any of the interventions identified below:

   a. Clinical services where staff **must** wash hands with antiseptic soap:

      - Immediately before and after an invasive procedure such as wound care, sutures, or other procedures with the potential for exposure to blood or other bodily

fluids—injections, such as vaccinations or insulin are not considered a procedure.

- Immediately before and after contact with blood, bodily fluids, excretions, mucous membranes, non-intact skin, and wound dressings.

- After any blood-draw—if bleeding/blood is visibly present.

Note 2: Immediately following any of the above, clinicians must remove their gloves (if worn) and wash hands.

b. Non-invasive procedures: Clinical services where staff must **either** wash hands with antiseptic soap or use alcohol-based hand sanitizer rub/wipes:

- Immediately before performing a service that requires intentional physical contact with the patient (i.e., blood- draws, injections, blood pressure checks, or other instances when clinicians physically touch patients).

- Immediately following any physical contact (with or without wearing gloves), clinicians must wash or re-sanitize their hands.

Note 3: Ensure the correct hand washing or hand sanitation procedures are employed (as dictated by the situations outlined above) prior to and after any use of gloves by the clinician.

** **Adequate hand hygiene** means that, depending on the situation, staff must adhere to the following techniques:*

- *Antiseptic soap and water—Wet hands, apply product per manufacturer's guidelines, rub hands and fingers vigorously for at least 15 seconds, rinse with water, and dry with disposable towel (or air dryer). An antiseptic soap is a detergent containing an antimicrobial agent (e.g., alcohols, chlorhexidine, chlorine, hexachlorophene, iodine, chloroxylenol, quaternary ammonium compounds, and triclosan).*

- *Alcohol-based hand rub—The product is an alcohol-containing preparation designed for application to hands without using water. Apply product to one hand, rub hands together to cover all hand and finger surfaces until hands are dry, or per product manufacturer's guidelines.*

- *Gloves—If the medical staff utilizes protective gloves to provide routine services, they must also follow one of the two hand sanitation practices above. Wearing protective gloves is an addition to, not a substitute for, sanitizing hands. If wearing*

gloves when attending to multiple patients, the medical staff member must remove gloves between patient encounters and sanitize hands.

References: January 2002 CCHCS HC DOM Ch. 3 Article 8 3.8.3.d.3 & d.4.D; CCR Title 8, Section 5193(I); CDC Guideline for Hand Hygiene in Health-Care Settings, MMWR, 2002; OIG Medical Inspection Unit

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Ref # 5.105

REGIONAL INSPECTOR (Rev. 08/31/2021)

Infection control: Do clinical health care areas control exposure to blood-borne pathogens and contaminated waste?

Testing Methodology:

Perform the following steps to conclude if the institution's health care management maintains a clinical environment that promotes infection control through management of blood-borne pathogens and contaminated waste:

1. Based on inspector observations, determine if objects that come in contact with biohazard waste (i.e. blood, secretions, excretion, exudate, tissue, cultures, or other potentially infectious bodily fluids) are disinfected after each patient encounter.

   Note 1: This test is best performed by observing an actual encounter that involves biohazard waste; however, such an event may not occur during the inspection. If the inspector is unable to observe an encounter involving biohazard waste ask two (2) nursing staff to "describe the timing of disinfection after spills or contamination of blood-borne pathogens." If staff does not demonstrate an understanding of when disinfection is necessary, the answer is "No."

2. Determine if personal protective equipment (PPE) is readily accessible (See Note 2) to clinical staff. Randomly pick two (2) RNs or providers and determine if the clinic maintains a supply of all the PPE that staff needs to perform their clinical job duties. Needed personal protective equipment supplies may include latex or synthetic disposable gloves, disposable gowns, face shields, and eye protection devices (goggles or glasses).

   Note 2: With the exception of disposable gloves, PPE does not need to be in the exam room, but must be stored in the clinic and accessible to staff. While a supply of non-latex (or synthetic) gloves must be present somewhere in the clinic, other PPE only needs to be present if staff have a need for a particular type of equipment. The presence of gloves in exam rooms is tested under Step 5.108.3.

3. Verify that needles/ sharps are deposited in puncture resistant (i.e. rigid red) containers readily accessible to staff. The containers should be secured to a fixed object and not filled past the container's safety line. Identify 2-3 containers and make appropriate observations.

   Note 3: With the exception of specialty clinics (see special note below), OIG clinicians have determined that all exam rooms must have a sharps container even if staff indicates that they do not normally use injection needles. Also, if the sharps container is not affixed to a permanent object, then it should be a large enough container that a patient cannot easily conceal under a loose jacket.

   (Rule Exception: some clinics may utilize a small portable sharps container for patients to directly deposit used needles—this type of container must remain under staff's observation and control).

   For specialty clinics, the regional nurse will consult with the OIG's CP&S via the Supervising Regional Nurse to determine if sharps containers are applicable for the exam room (based on the services provided).

4. Verify that generated biohazard waste (i.e. blood, secretions, excretion, exudate, tissue, cultures that are flaking, saturated, or dripping or other infectious bodily fluids) has not been deposited in the regular trash.

   Waste suitable for the regular trash typically includes:

   - Cotton balls or gauze that contains some blood but which is not flaking, saturated or dripping.

   Biohazard waste not suitable for the regular trash includes:

   - Items that are freely dripping liquid or potentially infectious materials that could release infectious materials if compressed.
   - Items containing dried blood that could release flakes if compressed or otherwise handled.

   Note 4: If possible, take photos that show any inappropriate disposal of biohazard waste.

5. Determine if the clinic's generated biohazard waste is properly secured in a storage location that is labeled as a "biohazard" area.

   Note 5: If exam room generated waste is never temporarily stored in the clinic, the answer is "NA." If the clinic is simply not using biohazard containers in each of its exam rooms, the answer here is "NA (with an appropriate comment), and the answer to test 5.108.3 is "No."

References: January 2002 CCHCS HC DOM Ch. 3 Article 8 3.8.3.d; May 2019 Ch. 1 Article 2 1.2.12.d.3.A.1, 3, 5 & 8, d.3.B.1-2, 4, d.3.D-F, & d.5.B; CDC Guidelines for Environmental Infection Control in Health-Care Facilities, 2003; September 2016 CDC Guide to Infection Prevention for Outpatient Settings; California Health and Safety Code, Sections 117600-118360; OIG Medical inspection Unit

Ref # 5.106

REGIONAL INSPECTOR (Rev. 09/29/2021)

Warehouse, conex, and other non-clinic storage areas: Does the medical supply management process adequately support the needs of the medical health care program?

Testing Methodology:

Visit the institution's main warehouse and all conex and other non-clinic bulk storage areas and determine whether the institution adequately manages (non-medication) medical supplies. The inspector should gather background information and utilize the input to confirm/observe staff concerns when conducting the inspection.

1. **For Information Only**: Interview the CEO to discuss the institution's medical supply management process intended to ensure clinical areas are properly supported. Determine from the interview whether the institution's health care management has significant concerns with the medical supply chain or its communication relationships with the main supply warehouse.

2. **For Information Only**: Interview the institution's warehouse manager to determine if there are significant concerns related to the following:

    a. The process for ordering supplies and maintaining needed "medical" supply levels,

    b. Challenges in issuing or distributing supplies to the institution's medical clinics,

    c. Clinical health care staff's ability to follow approved supply management protocols,

    d. The institution's ability to maintain an effective supply re-ordering system that functions as intended, and

    e. If the warehouse manager has an open line of communication with health care management.

3. Tour the main warehouse and other equivalent (bulk) storage locations (e.g. Conex boxes, etc.) and determine whether the warehouse adequately stores and provides medical supplies to the clinical units by observing the following:

    a. Medical supply storage location(s) do not have expired items.

Note: If excess bulk medical supplies resulting from over-ordering, non-use, or obsolescence are identified, the OIG will not take exception to the issue on the testing worksheet or in the medical inspection report because this concern is related to efficient use of state resources and not directly related to the quality of provided health care. Should the regional inspector identify an over ordering concern, he/she will provide detailed information to the Supervising Regional Nurse who will then draft a formal notification memorandum to the Chief Assistant Inspector General release to CCHCS and the applicable institution.

b. Medical supplies are stored in packaging situated off the floor and in a clean and dry location that is not subject to excessive heat or moisture.

References: OIG Medical Inspection Unit

Ref # 5.107

REGIONAL INSPECTOR (Rev. 08/31/2021)

Clinical areas: Does each clinic follow adequate protocols for managing and storing bulk medical supplies?

Testing Methodology:

1. Identify and tour all common clinical areas (and two exam room areas) where storage exists for bulk (non-medication) medical supplies. Determine whether each clinic exercises good supply protocols by observing the following:

Note 1: During the inspection of each clinical area, talk to nursing staff and ask what the process is to ensure the clinic area has ample supply of necessary medical items. Determine if there are any problems with supply management.

a. Determine from knowledgeable clinical staff if they have all of the medical supplies they need to perform their job and if they have ever had a problem getting needed supplies.

b. Verify that an inventory replenishment supply system is in place to ensure that clinic exam rooms are stocked or restocked on a regular basis and that bulk supplies are not in excess of established inventory quantities. The inspectors will use their professional judgment to determine if stored supplies are excessive.

c. Verify that the storage room for bulk supplies is orderly and supplies are stored on shelves (i.e. off floors) are clearly identifiable / properly labeled for easy identification.

d. Verify that bulk medical supply storage rooms/locations that are also used to store staff's personal belongings have a designated and distinct space for those items that is separate from the stored medical supplies. The inspectors will use their professional judgment to determine if the storage locations are distinctly different. For example, if staff members use a shelf cubby-hole to temporarily store personal belongings, the inspector should not find medical supplies in the same cubby hole. If this situation is found, the answer is "No."

e. Verify that bulk medical supplies are stored separately from the employee's personal food items, medications, test agents, germicides, disinfectants, and other household substances.

f. Verify that food (such as coffee, sugar, or cream) is not stored long-term in the bulk medical supply storage room/location.

Note 2: The storage and labeling of supplies in individual exam rooms is tested in MIT 5.110, step 4.

Note 3: This test relates only to the storage of medical supplies and not medication supplies.

References: OIG Medical Inspection Unit

Ref # 5.108

REGIONAL INSPECTOR (Rev. 12/28/2021)

Clinical areas: Do clinic common areas and exam rooms have essential core medical equipment and supplies?

Testing Methodology:

Visit all clinical areas (yard clinics, Ad-Seg, PSU, SHU, R&R, TTA, CTC, PIP, and OHU) and determine the following:

1. Determine if there are any barriers that adversely affect the clinic's ability to obtain or maintain essential medical equipment or supplies. If a problem is identified, determine its potential impact on meeting the equipment requirements identified in steps 2. and 3. below.

   a. Non-operational essential equipment - Interview knowledgeable clinical staff to determine if the clinic has any non-operational essential medical equipment or "overdue" work orders related to the equipment and whether the equipment's inoperability adversely affects the clinic's ability to provide adequate medical services. For purposes of this test, do not consider "infrastructure" items, include them under step

5.999 below. For any essential equipment that is non-operational, identify the equipment item, nature of the issue, repair request date, estimated corrective action date, and barrier(s) to fixing the item. Forward the issue(s) to OIG headquarters so the OIG clinical team can assess whether it impacts the delivery of quality and timely health care to patients.

b. Equipment Calibration protocols - The inspector should review the pre-inspection questionnaire documentation to determine the institution's equipment calibration protocols, including the date of the last calibration certification and identification of any normally calibrated equipment that the institution considers exempt from calibration requirements.

c. Medical supply chain - Interview knowledgeable clinical staff and determine if the clinic has had problems maintaining or keeping sufficient quantities of needed medical supplies.

2. Required minimum equipment and supplies for **each applicable clinic**:

Unless a noted exception applies, verify through observation that at least one of each of the following equipment items listed below are present (somewhere) in each clinic and that the equipment is in working order. Also, verify that the items, including but not limited to the list in step 2.a. below, have a calibration sticker that demonstrates the equipment was calibrated within the last 12 months. New equipment items may not need calibration if it can be demonstrated that the item was purchased since the date of the last annual calibration (See Note 1 below).

a. Required Equipment – (Subject to calibration)

- AED equipment (only 1 required per yard, but if present must be calibrated) – Verify for the last 30 days that an AED or a defibrillator performance check has been completed according to the manufacturer's guidelines and recorded.

Note 1: Defibrillator performance check should be recorded on the Defibrillator Performance Test form (CDCR 7548).

Note 2: If the yard has a licensed facility or TTA, the AED must be present in that location.

Note 3: For CTF, DVI, and CMF, each inner "facility" or yard must have an AED.

- Automated vital sign equipment
- Blood pressure equipment (calibration required only if automated)
- EKG (**TTA Only**, but if found elsewhere it must be calibrated)
- Nebulization unit for asthmatics & persons with COPD
- Pulse Oximeter

- Weight scales

Note 4: Essential equipment serviced by the institution's calibration vendor will typically have a sticker decal to identify when the equipment was serviced, or is due for service. If equipment does not have a sticker, inspectors should ask the nurse if the clinic maintains a log of equipment serviced, and verify proper maintenance of equipment from the log. For equipment issues that cannot be resolved by talking to clinical staff during observations, request the chief support executive or designee to research why the equipment was not calibrated. If the institution can provide documented evidence that the equipment was acquired or calibrated within the 12 month period from the last annual inspection date, the institution will receive a "Yes" for the test. If there is no supporting documentation or if documentation does not explain why the equipment was not calibrated, the answer is "No."

b. Other Required Equipment (Not subject to calibration)

- Emergency Response Bag [1]
- Glucometer (and strips)
- Medication refrigerator
- Overhead light or portable light source (applicable to a TTA or other treatment rooms where procedures are performed)
- Peak flow meter and disposable tips (the tips should be available near the flow meter)
- Thermometer Vital sign equipment
- Snellen chart for eye examinations, including evidence of a clearly marked line on the floor (or wall) at 10 or 20 feet (may be tape or painted). The line on the floor must be consistent with the type of eye chart, which indicates on the chart if the line needs to be 10 or 20 feet away.
- Stretcher (**TTA Only**)

c. Female Institutions Only: Additional Equipment Required

The following item is required at all female institutions:

- Exam table with stirrups

The following items are required at all female institutions except the Folsom Women's Facility at FSP:

- Diapers and baby blankets

[1] The contents of the emergency response bag are tested under step 5.111.

- Emergency delivery kit
- Fetal Doppler (must be calibrated)
- Incubator (baby warmer)

3. Verify that **each clinic exam room**, except highly specialized diagnostic or treatment rooms (i.e. X-ray, fetal heart monitor, etc.), have the following equipment items (except where noted):

    - Bio-Hazard waste durable receptacle (or in lieu of a durable receptacle, Bio-Hazard labeled plastic bags are acceptable if the clinic's immediate vicinity has a clearly designated durable container storage area where used Bio-Hazard bags can be temporarily stored.)
    - Exam table with disposable paper
    - Hemoccult cards (Only applicable in rooms where providers might work)

    Note 5: Due to the CCHCS memorandum, establishing the transition of Fecal Occult Blood Test (FOBT) to Fecal Immunochemical Test (FIT), beginning October 2021, the OIG will no longer test for the availability of hemoccult cards in the examination rooms.

    - Lubricating jelly (Only applicable in rooms where providers might work)
    - Oto-ophthalmoscope (must be calibrated) (If applicable, batteries must be charged)
    - Tips for otoscope device
    - Tongue depressors (must be in a sanitary container)
    - Non-Latex Gloves (any exam type) (Note: The general availability of PPE is covered under step 5.105.2)

4. R&R clinics must include the following equipment and if required, it must be calibrated:
    a. Exam Table with disposable paper (only needs to be in the immediate area)
    b. Vital Sign Equipment
    c. Pulse Oximeter
    d. Thermometer
    e. Glucometer
    f. AED
    g. Otoscope and ophthalmoscope
    h. Tips for otoscope device
    i. Weight Scale
    j. Non-Latex Gloves (any exam type) (Note: The general availability of PPE is covered under step 5.105.2)

    Note 6: See MIT 5 preamble regarding required equipment for specialty service clinics.

References: OIG Medical Inspection Unit

Ref # 5.109

REGIONAL INSPECTOR (Rev. 08/31/2021)

Clinical areas: Are the environments in the common clinic areas conducive to providing medical services?

Testing Methodology:

Visit all clinical areas (yard clinics, Ad-Seg, PSU, SHU, R&R, TTA, CTC, OHU) and tour the common areas and determine the following:

1. Privacy in common area triage stations (i.e. triage stations, vital sign check stations, blood-draw stations):

   Determine if clinical triage areas that are set-up in clinical hall-ways or common areas (i.e. not in an exam room) provide reasonable auditory privacy. Verify that the location is a sufficient distance from areas where other inmates cannot over-hear the triage nurse's communications with the patient being assessed. If possible, observe 2-3 triage encounters to ascertain whether audio privacy reasonably exists.

   Note 1: This test will require the inspectors to use their professional judgment. The judgment will be based on the patient's physical distance from other inmates and the area's normal ambient noise level. If the physical distance between the patient being assessed and the location where other patients are waiting or loitering is less than 5 feet, there is a strong possibility that auditory privacy is not assured.

2. Wheel chair accessibility:

   Determine whether each clinic (regardless of its ADA/ yard mobility status) has at least one examination room that can accommodate a wheelchair and no impediment to examination is present in the room. In addition, verify that there are no narrow door entry-ways or stairs limiting access to the room.

3. LVN /medication nurse common area workspace:

   Verify that nursing station LVNs who perform medication functions have sufficient EHRS access and space to perform their preparation and administration duties. For this test, nurses do not necessarily need their own individual computer terminals. Rather, they need readily available access to a shared terminal. For example, in a medication preparation room used simultaneously by four LVNs, two or three terminals would be sufficient. In addition, verify that each person has adequate space to perform their preparation and medication administration duties. This answer will be determined based on the inspector's interviews with knowledgeable staff and the inspector's professional judgment.

4. Other common area workspace:

   Determine whether clinical staff who work in the clinic's common areas (non-exam rooms) have sufficient space to work. If two or more nurses are assigned to an inpatient location (i.e. a CTC, OHU, etc.) and their duties are to monitor patients, they do not each need their own designated exam room. Also, in CTCs, OHUs, and yard clinics the nursing station and physician areas must have sufficient computers or terminals, chairs, and sufficient counter space for the number of simultaneously assigned nurses and providers on the unit. In general, each clinician (except LVN/LPT medication nurses) should have access to their own EHRS terminal. Note that medication nurse common area work space is addressed in step 3. above. Also, clinic exam room work space is tested in MIT 5.110, step 7.

   Note 2: Some institutions provide clinicians with portable wireless laptops to access the EHRS instead of having a computer terminal in the clinic work area. This practice is acceptable given that the clinician has the laptop in their possession during the inspection. If the clinician states they access the EHRS with a laptop, but it is not available, the answer to this question is "No."

5. ***For Information Only*** – Inspect indoor and outdoor waiting areas. Determine if there is any overhang or shade protection. Take photos of indoor and outdoor waiting areas. Take photos of outdoor overhang or shade protection, in broad daylight if possible. Interview knowledgeable health care and custody staff at each medical location. Ask the staff if they believe the waiting areas had sufficient seating space and what additional steps they take, if any, to prevent overcrowding for patients waiting indoors for their clinical appointments. For outdoor waiting areas, ask the staff if they believe existing overhang or shade provide sufficient protection and what additional steps they take, if any, to protect patients from extreme heat or inclement weather.

References: September 2015 CCHCS HC DOM Ch. 2 Article 2 2.2.5.d.2; CCR Title 22, Division 5, Ch.12, Article 3, Section 79643(b), (c); The CA Confidentiality of Medical Information Act, CA Civil Code, Sections 56-56.16; OIG Medical Inspection Unit

Ref # 5.110

REGIONAL INSPECTOR (Rev. 09/08/2021)

Clinical areas: Are the environments in the clinic exam rooms conducive to providing medical services?

In each clinic, take an initial tour of the facility and then select (at least 2) exam rooms and verify compliance with the following:

1. Adequacy of exam room open space:

   Make observations and interview clinicians to determine whether clinical staff have adequate space in exam rooms to perform patient examinations. Sufficient space should be present for a patient to standup, twist and turn (with arms out-reached), bend-over, and walk two steps without being hindered by an object.

   Note 1: Typically, exam rooms should be at least 100 square feet in size to have sufficient space. However, the inspector will have to use his/her judgment and other considerations (such as the furniture configuration) to determine if the clinical space is sufficient. If the space is deemed too small, measure the dimensions of the room, take a photograph, and answer the question "No."

2. Clutter:

   Determine whether exam rooms contain unnecessary clutter (i.e. an accumulation of equipment items that are not needed, overstocked supplies, boxes with loose documents, or other unnecessary items). The inspector will use their judgment to determine if clutter is present in the exam room.

3. Furniture in disrepair:

   Verify that exam room furniture, such as exam tables or other furniture that clinicians use frequently, are not in disrepair. For example, exam tables should not have cracks or worn spots (in the vinyl cover) that could harbor infection and be hard to clean. Similarly, frequently used desk drawers should not have make-shift modifications, such as duct-tape repairs, that would make the surface hard to adequately clean.

4. Organization of exam room supplies:

   Determine whether exam room cabinets and drawers used to store supplies are well organized. Ensure that labels are affixed to cabinet shelves or drawers to identify certain items in a manner that would allow any new or temporarily assigned clinician to easily find needed items. Labeling may not be needed for all items. For example, larger items do not need labeling if it is obvious what the item is. Also, ensure that employees are not storing

food items and personal belongings in cupboards or drawers that are designated for the storage of supplies, unless the area is clearly designated for that purpose. Also ensure that food items used on a long-term basis are not stored close to supplies. The inspector will use their judgment to determine if the exam room supplies are organized and labeled.

5. Exam table suitability:

   Determine whether the clinician has unimpeded access to the examination table and the patient is able to lie fully extended (i.e. supine) on the examination table without obstructions to the patient's head or feet. Only one side of the table needs to be accessible to the clinician with the following exception: For female facilities, the examination table should have sufficient space on the sides and foot of the table so that a gynecological examination can be conducted.

6. Oto-ophthalmoscopes adequacy:

   Determine whether oto-ophthalmoscopes are easily accessible to the clinician while examining the patient on the examination table. For example, if the scope happens to be wall mounted, its cord should be long enough so that the patient may be examined while lying on the exam table.

7. Clinic exam room assignments and computer access:

   Determine whether each clinic has one examination room for each clinician on shift and that each room has a computer terminal so the clinician can access the EHRS. For example, if a nurse and a doctor work simultaneously in the same clinic, there should be two examination rooms and two computer terminals (except as noted below).

Exceptions to the rule:

1) If there is an exam location (such as an ASU) where the RN triages an individual patient and then a PCP immediately visits with the patient, the RN and PCP may share a room.

2) If multiple RN's are assigned to an inpatient location (i.e. a CTC, OHU, etc.) and their duties are to monitor patients, they do not each need their own designated exam room.

Note 2: Some institutions provide clinicians with portable wireless laptops to access the EHRS instead of having a computer terminal in the clinic work area. This practice is acceptable given that the clinician has the laptop in their possession during the inspection. If the clinician states they access the EHRS with a laptop, but it is not available, the answer to this question is "No."

8. Audio and visual privacy in exam rooms:

a. Determine whether the clinic exam rooms are set up in a manner that provides reasonable assurance (see *Notes 3 to 5*) of auditory and visual privacy for patients during provider examinations and nurses' face-to-face assessments. For the R&R clinic, ASU and SHU the inspector shall ask medical staff how they ensure privacy for patients.

Note 3: For this test, reasonable assurance of visual privacy is established if a provider or nurse conducting an exam has the "capability" during an exam to easily close-off or screen-out all windows and doors to outside viewers. For auditory privacy to be established, patients in one exam room/area should not be able to hear the conversations in the next exam room/area. For TTA's (i.e. emergency exam areas), the clinicians only need a means to provide visual privacy and do not need to ensure auditory privacy. In addition, medical staff should not obtain or discuss patient medical information in waiting areas when there are other patients present.

Note 4: CCHCS policy requires that primary care encounters be conducted in a room that affords privacy, conducted in a confidential manner, and that nursing staff conduct patient interviews in a manner that ensures the privacy of their health information subject to the safety and security concerns of the institution. The California Patient Bill of Right requires that patients receive privacy in treatment. The California Confidentiality of Medical Information Act and the National Corrections Accreditation Agency also addresses patient confidentiality during a patient's treatment.

Note 5: If patients are required to sit in clinical exam room door-ways (for security purposes), ensure that the clinical area provides for a reasonable level of auditory privacy (i.e. is there a sufficient off-setting ambient noise level & lack of other patient traffic in the area.) The presence of custody and medical staff is not considered a privacy violation.

b. Verify that confidential medical records (including those designated for shredding) are not visible or easily accessible to patients or inmate-porters.

Note 6: Rather than shredding records immediately following each encounter, clinicians may temporarily store the records face-down in a box on the floor through-out the day, but those records should all be shredded at the end of their shift. In addition, medical records that are not designated for shredding should also not be left out overnight in unsecured clinical areas.

Note 7: For specialized housing units (i.e. CTC / OHU) that perform encounters in a patient's cell instead of an exam room, the clinical must have all of the normally required exam room items (i.e. sharps container, bio-hazardous bags, lubricating jelly, etc.) located in the immediate area of the clinic.

References: September 2015 CCHCS Ch. 2 Article 2 2.2.5.d.1-3; CCR Title 22, Division 5, Ch.12, Article 3, Section 79643(b), (c); The CA Confidentiality of Medical Information Act, CA Civil Code, Sections 56-56.16; OIG Medical Inspection Unit

Ref # 5.111

REGIONAL INSPECTOR (Rev. 09/08/2021)

Clinical areas: Are emergency medical response bags and emergency crash carts inspected and inventoried within required timeframes, and do they contain essential items?

Testing and Methodology:

Prior to testing, the OIG inspector will first determine if the institution tested has completed the Emergency Medical Response Program (EMRP) (See list of institutions below for roll-out and completion dates). Then, test the institution according to its current EMRP process.

Initial Roll-out date	Completion Date	Institution
March 4-22, 2019	September 22, 2019	California State Prison, Solano
April 8-26, 2019	October 26, 2019	Pleasant Valley State Prison
April 8-26, 2019	October 26, 2019	California State Prison, Sacramento
April 29-May 17, 2019	November 17, 2019	Mule Creek State Prison
April 29-May 17, 2019	November 17, 2019	Folsom State Prison
June 3-21, 2019	December 21, 2019	California Medical Facility
July 8-26, 2019	January 26, 2020	San Quentin State Prison
July 8-26, 2019	January 26, 2020	California Correctional Center
September 9-27, 2019	March 27, 2020	Pelican Bay State Prison

September 9-27, 2019	March 27, 2020	High Desert State Prison
October 7-25, 2019	April 25, 2020	Sierra Conservation Center
October 7-25, 2019	April 25, 2020	Deuel Vocational Institution
November 4-22, 2019	May 22, 2020	Substance Abuse Treatment Facility
November 4-22, 2019	May 22, 2020	California State Prison, Corcoran
January 6-24, 2020	July 24, 2020	California State Prison, Calipatria
January 6-24, 2020	July 24, 2020	California State Prison, Centinela
January 27-February 14, 2020	August 14, 2020	California Men's Colony
January 27-February 14, 2020	August 14, 2020	Avenal State Prison
February 24-March 13, 2020	September 13, 2020	California State Prison, Los Angeles County
May 17-21, 2021	November 21, 2021	California Correctional Institution
June 7-11, 2021	December 11, 2021	Chuckawalla Valley State Prison
July 12-16, 2021	January 16, 2022	California Institution for Men
September 13-17, 2021	March 17, 2022	California Rehabilitation Center
October 25-29, 2021	April 29, 2022	Salinas Valley State Prison

December 13-17, 2021	June 17, 2022	Valley State Prison
January 31-February 4, 2022	August 4, 2022	California Institution for Women
March 7-11, 2022	September 11, 2022	Central California Women's Facility
April 11-15, 2022	October 15, 2022	Ironwood State Prison
May 16-20, 2022	November 20, 2022	Correctional Training Facility
To Be Determined	To Be Determined	Richard J. Donovan Correctional Facility
To Be Determined	To Be Determined	Wasco State Prison
To Be Determined	To Be Determined	California City Correctional Facility
To Be Determined	To Be Determined	North Kern State Prison
To Be Determined	To Be Determined	Kern Valley State Prison
To Be Determined	To Be Determined	California Health Care Facility

Visit the treatment and triage area (TTA) and each clinic or associated housing unit where the emergency medical response (EMR) bags and crash carts are kept, and select one bag, and crash cart from each location.

Note 1: Most clinics will maintain an EMR bag either in their clinic or in a nearby housing unit to which it provides services (or both). While the OIG does not require each clinic to have an EMR bag, one bag must be present on each" yard" (and further, two yards cannot share a bag). For sampling purposes, inspectors will select one EMR bag from only one area/location serviced by each clinic (with the exception of

a CTC & R&R which will not be tested). R&R clinic locations typically do not conduct History and Physical (H&P) examinations (usually found at a non-reception center institutions).

Verify that the bag and crash cart are inspected daily, inventoried monthly, and that it contains essential items by completing the following steps:

1. Verify that for each of the thirty most recent days in which clinical staff were posted to an EMRB location, there was log entry evidence that staff verified the bag's compartments were sealed and intact.

   Note 2: If the institution has not implemented the Headquarters newly revised Emergency Medical Response Bag Checklist (CDCR 7188-1) rev. 07/2019, the inspector will review the institution's generated EMRB checklist.

   Note 3: Policy states, in part, that bags are to be inspected each watch (in which staff are posted) to ensure seals are intact. Further, an inventory of the sealed compartments is required monthly or whenever the seal is broken.

   Note 4: Since clinics are generally closed on weekends, emergency medical response bag inspections (stored in these areas) do not have to occur for those days unless the clinic was open. Further, on 1st watch, 3rd watch and weekends, medical responses are usually made by the TTA staff using their program's emergency response bags, not the clinic's response bags.

2. Verify that a log evidences that the EMRB was inventoried within the last 30 days. If prior month's log is immediately available, quickly scan that information to ensure that the most recent 6 months were also completed timely.

3. For each sampled EMR Bag, break the seal and verify that the following essential items are present and unexpired (when applicable):

   - <u>CPR-related pieces of equipment</u>:
     - Disposable ambu-bag
     - Oral airways (large, medium, and small)
     - Two CPR micro-masks (only applicable if using EMRB checklist prior to revision date 07/2019- see Note 2).
     - Properly pressurized oxygen tank and mask (must be in area, if too large to fit in bag).

     Note 5: The portable oxygen must have the valve attached (pressure gauge must be above 1000 psi) and availability of oxygen wrench if applicable for immediate access.

- NPA Airways- sizes 28, 32, 36 Fr (only applicable in EMRB checklist revision date 07/2019- *see Note 2*).
- (2) NRB Mask, Adult and (2) Nasal Cannula (Inspectors will only test one (1) of each item if the institution is utilizing an EMRB checklist prior to revision date 07/2019-*see Note 2*).

- Non-CPR-related pieces of equipment:
  - Blood pressure cuffs (adult and thigh or extra-large)
  - Stethoscope
  - Rigid cervical collar(s)
  - Instant glucose (2 unexpired tubes)
  - Glucometer (requires daily QC, review last 30 days of the log for EMRB checklist revision date 07/2019)
  - Glucometer QC control box (unexpired) (only applicable for EMRB checklist revision date 07/2019)
  - Medium/large sizes of non-latex (e.g. synthetic, nitrile) gloves.
  - Naloxone, 4 mg intranasal (6 unexpired medications) (only applicable for EMRB checklist revision date 07/2019).

Note 6: Only those items listed on the checklist shall be kept in the bag. If extra items are deemed needed, they can be kept in a separate bag that can be attached to the EMRB.

Note 7: If the TTA or clinic has more than one response bag, the OIG inspector will only test one bag. If essential items are missing or expired, the overall answer will be "No."

4. Visit the TTA, CTC, and each clinic or associated housing unit where crash carts are kept. Randomly select 10 items from the Crash Cart Inventory Report (CDCR 7547) (for institutions that **have not completed** the EMRP) or Treatment Cart Inventory Report (CDCR 7547-1) (for institutions **that completed** the EMRP) and verify minimum par levels are present and unexpired (if applicable). If inventory levels are not matching with the par levels, review the Crash Cart Daily Check Sheet (CDCR 7544) (for institutions that **have not completed** the EMRP) or Treatment Cart Daily Check Sheet (CDCR 7544-1) (for institutions **that completed** the EMRP) to ensure it has not been greater than 3 business days since the yellow tag was placed on the cart indicating it was tagged as missing an item. In addition, review the CDCR 7544 or CDCR 7544-1 and determine if ***reasonable inventory substitutions*** were noted on the CDCR 7544 or CDCR 7544-1 and the substitutions were present in the crash cart to maintain minimum par levels.

References: July 2019 CCHCS HC DOM Ch. 3 Article 7 3.7.1-1.i.1-2; July 2012 Ch. 3 Article 7 3.7.3.d.1-3; November 2016 Ch. 3 Article 7 3.7.5.d & e; OIG Medical Inspection unit

Ref # 5.999

For Information Purposes Only (Not Scored)

REGIONAL INSPECTOR (Rev. 09/08/2021)

For Information Purposes Only: Does the institution's health care management believe that all clinical areas have physical plant infrastructures that are sufficient to provide adequate health care services?

1. Interview the CEO/CME/CNE and Plant Operations Manager (or designee) to identify any clinical areas with physical plant infrastructure problems that negatively impact (limit) the institution's ability to provide adequate health care services. Compare OIG observation results (from test 5.108 and 5.109) and discuss any noted deficiencies. Then identify whether:

    a. The institution has a system to report facility infrastructure problems.

    b. Based on interviews with management, are all of the institution's clinical areas deemed to have a good infrastructure environment? (i.e. One that does not prevent or preclude adequate health care from being delivered.)

    c. Determine if the institution currently has any significant projects planned or underway to improve infrastructure deficiencies? If so, (if not previously obtained as part of the OIG's CEO questionnaire) obtain detailed information regarding the improvement project such as: infrastructure project improvement name, description of project, goal of project improvement, project start date and project completion date. (Also, if not previously received as part of the CEO questionnaire), obtain the Health Care Facility Improvement Plan.

    d. For incomplete corrective actions, determine the primary reason(s) for the delays (i.e., determine whether the institution has control over correcting the deficiency and not yet corrected it or if the institution is waiting for headquarters to fund or otherwise approve the project).

    e. If infrastructure concerns (that affect the institution's ability to provide adequate health care) are identified, do the institution's CEO, CNE, and CME each believe that the concerns do not ultimately prevent the institution from currently providing adequate health care?

References: (**For Information Only and Not Scored**); OIG Medical Inspection Unit

Health Information Management (Medical Records)

The OIG will evaluate whether: 1) various medical documents are timely scanned into the patient's EHRS; 2) health care information is correctly labeled, organized and available in the EHRS; and 3) hospital discharge summaries include key elements and are timely reviewed by a PCP.

Sample Methodology

Test 4.001 (Health Care Services Request Forms)

This test consists of using sampled patients evaluated in questions 1.004 for a total sample size of 20.

Test 4.002 (Specialty documents)

This test consists of using ten high-priority sampled patients evaluated in question 14.002, ten medium-priority sampled patients evaluated in question 14.005, and ten routine-priority sampled patients evaluated in question 14.008 for a total sample size of 20.

Test 4.003 (Community hospital discharge documents)

This test consists of using 20 sampled patients evaluated in question 4.005.

Test 4.004 (EHRS scanning accuracy)

The sample universe for this test will be any incorrectly scanned EHRS document identified as a result of reviewing EHRS files during the OIG's testing period, the related sample selection period, or the last 12 months.

Test 4.005 (Community hospital discharge documents)

This test consists of using 25 patients evaluated in question 1.007 and 7.003, which use the same sample. See MIT 1 for sample methodology.

Inspection Procedures

Ref # 4.001

HQ INSPECTOR (Rev. 12/16/2021)

Are health care service request forms scanned into the patient's electronic health record within three calendar days of the encounter date?

Testing Methodology (Sample 20):

Select 20 patients evaluated in question 1.004. For each patient, use the focus document (CDCR 7362 Health Care Service Request form) applicable to each test question and determine whether the document was scanned within three calendar days from the patient encounter date.

Reference: CCHCS Dashboard; OIG Medical Inspection Unit

Ref # 4.002

HQ INSPECTOR (Rev. 09/08/2021)

Are specialty documents scanned into the patient's electronic health record within five calendar days of the encounter date?

Testing Methodology (Sample 30):

For patients tested in MIT 14.002, 14.005, and 14.008 (ten each in high-priority, medium-priority, and routine-priority), determine whether the specialty notes document reviewed was scanned within five calendar days from the date of the patient's encounter. Specialty documents include: Specialty Consult Progress Notes or external/outside provider specialty report results (electronic equivalent). (See Note 1 below). If no specialty notes are found for the patient, select the next patient for a total sample size of 30.

> *Note 1: The specialty services consulting report may be documented on the bottom half of the Form 7243 Physician's Request for Services and/or on the consultant's custom letter-head format report. If both versions are found, the OIG will test to ensure that at least one of them was scanned within 5 calendar days from the date of the patient's encounter.*

Reference: August 2016 CCHCS HC DOM Ch. 2 Article 1 2.3.7.F.3

Ref # 4.003

HQ INSPECTOR (Rev. 09/08/2021)

Are community hospital discharge documents scanned into the patient's electronic health record within three calendar days of hospital discharge?

Testing Methodology (Sample 20):

For patients tested in MIT 4.005, determine whether the community hospital discharge document reviewed was scanned within three calendar days from the community hospital discharge date. If no community hospital discharge documents are found for the patient, select the next patient for a total sample size of 20.

Reference: August 2016 CCHCS HC DOM Ch. 2 Article 1 2.3.7.F.4

Ref # 4.004

HQ INSPECTOR (Rev. 09/08/2021)

During the inspection, were medical records properly scanned, labeled, and included in the correct patients' files?

Testing Methodology (Sample size 24):

1. Throughout the inspection process, identify instances where documents in a patient's EHRS were mislabeled, located in the incorrect tab, scanned illegibly (backwards or folded-over), included documents for a different patient, or were missing from the patient's file. Do not take exception to missing documents if the fact that they were missing directly caused a "No" answer to another specific question elsewhere in this inspection program (i.e. do not double count a single exception in two different areas of the program).

2. Document each occurrence articulating the type of discrepancy and describe the corrective factor (e.g. if the document was incorrectly filed, identify the incorrect location of the EHRS document as well as the proper or remedial scan location).

3. Throughout the inspection, the OIG will allow the institution under inspection no more than 24 possible EHRS scanning errors. If 24 errors are found, the question will be answered "No," and the institution will receive a score of 0%. Conversely, if the OIG does not identify a single error, the institution will receive a score of 100% for this question. If the OIG identifies at least one but less than 12 errors, the score will be prorated accordingly (e.g. 1 error out of 24 possible = 95.8% success…23 errors out of 24 = 4.3% success).

References: August 2016 CCHCS HC DOM Ch. 2 Article 1 2.3.8.F; OIG Medical Inspection Unit

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For patients discharged from a community hospital: Did the preliminary or final hospital discharge report include key elements and did a provider review the report within five calendar days of discharge?

Testing Methodology (sample 25):

This test shares the same sample as tests 1.007 and 7.003.

Review the hospital's discharge report and verify that either the PCP or a TTA provider reviewed the preliminary or final discharge report within five calendar days following the patient's discharge. The PCP or TTA provider must review the discharge report as evidence by electronic signature, or provide evidence in the face-to-face progress note that the report was reviewed for the answer to be "Yes."

Note 1: To be considered an acceptable discharge report, the OIG has determined that the report must include, at a minimum, the following key elements:

- *Admission date,*
- *Discharge date,*
- *Nature of events/diagnosis, and*
- *Discharge medications (if applicable).*

Note 2: We can accept a Provider Telephone/Consultation Note (TTA MD Progress Note) in place of a hospital discharge summary if the note includes the above four elements and that the discussion was with another provider at the hospital.

Note 3: TTA RN's phone call and corresponding TTA progress notes to an on-call TTA provider (to discuss the discharge report) does not qualify as a provider's review of the hospital discharge report. If this occurs, the TTA provider must clearly articulate in the progress notes, that (upon return to the institution) the actual report was reviewed (as opposed to having just been told about the discharge summary information over the phone by the TTA nurse).

Note 4: If the patient's hospital service was a result of a series of treatments, such as chemotherapy, they should be removed from this sample. Per the OIG Medical Inspection Unit, the institution's providers do not need to follow-up with the patient until the end of treatment. In addition, any patient who was sent to an emergency room and/or admitted under observation status, or admitted less than 48 hours will be excluded from the sample.

References: April 2019 CCHCS HC DOM Ch. 3 Article 1 3.1.9.C.3.F.6

Medication Management

The Office of the Inspector General (OIG) will confirm that staff adhere to policies and procedures and standards of nursing practice for medication security and medication administration protocols. The OIG will determine if patients receive their newly ordered and long-term medications in a timely manner, and will observe (at medication administration lines) that nursing staff follow hand hygiene and contamination, and medication administration protocols. The OIG will also confirm medication controls in the main and remote pharmacy areas, including medication error reporting.

Sample Methodology

Test 7.001
(Sample 25)

Sample selection also used for tests 1.001 and 9.008. See MIT 1 for sample methodology.

Test 7.002
(Sample 25)

From the master registry, the MIU analyst will filter and import data to generate a list of all patients who are identified as taking at least one medication during the last nine months, and will then randomize the list. The OIG will select the first 50 patients for testing; however, if the patient has been tested in # 7.001 and 7.003 we will replace the sample (to avoid duplication in testing). Further, the analyst will identify the most recently ordered new medication, but if the patient did not have any new orders during the 9-month period, or the only new orders were Pro Re Nata (PRN) or vaccination only, the sample will be replaced. The OIG will only test essential PRN medications such as rescue inhalers or Nitroglycerin for timely issuance.

Test 7.003
(Sample 25)

Sample selection of 25 also used for tests 1.007, 4.003 and 4.005. See MIT 1 for sample methodology.

Note: If the patient was not on any medications during the hospital stay or the only medications ordered upon the patient's return were PRN medications such as rescue inhaler (for asthma) or Nitroglycerin (for heart condition). The OIG will test these types of essential PRN medications for timely issuance.

Test 7.004
(Sample 20)

Sample 20 items, selection also used for tests 12.001 – 12.008. See MIT 12 for sample methodology.

Test 7.005
(Sample 25)

The MIU analyst will query the MAPIP Transfers Registry database to identify 25 patients who, during the last 2 months to 8 months, had one of the following intra-facility movements:

- Moved from an ASU/SHU/GP/EOP/PSU or SNY housing area to another non-medical housing area/ yard,
- Any movement into a SHU/ASU (except those from OHU, SNF, CTC or mental health crisis bed),
- Filter to select patients who are taking NA/DOT medications only.

Note: When possible, the analyst will select a sample from an array of different housing unit movements. Bed moves that occur from one housing unit to another similar type of housing unit on the same yard will not be sampled. Do not sample any movements to or from a CTC, SNF, OHU, or mental health crisis bed.

The analyst will document the date that a patient transferred to a new housing unit, and the nature of the transfer (where the patient transferred from and to).

Test 7.006
(Sample 10)

The MIU analyst will query the SOMS database to identify and randomly select 30 patients who, during the last 2 months to 8 months, were temporarily housed at the facility (aka unendorsed en routers). If a sample of 10 cannot be reached from the original sample of 30, no further samples will be tested and the sample size will be the applicable patients from the original sample. The analyst will document transfer dates identified in SOMS.

Tests 7.101 – 7.104

OIG field inspectors will conduct interviews, observe practices, and perform testing within all clinical care areas (including medication line areas) to assess each area's medication storage practices.

Tests 7.105 – 7.107

OIG field inspectors will select six to eight medication (pill-pass or insulin) lines to test from various clinical areas. Do not test pill-pass lines at inpatient settings such as an OHU, CTC, PIP, SNF, Hospice, etc. Housing areas typically have two different types of pill-pass lines that can be held simultaneously or at different times/locations. One line type is for nurse administered (NA) and direct observation therapy (DOT) medications and the other is for keep-on-person (KOP) medications. Select only NA/DOT pill-pass and or insulin lines. Also, some yards, clinics, and housing units have multiple NA/DOT lines ─ the main line and an additional cell-door delivery service for restricted units such as the ASU, SHU, and PSU. When selecting the six to eight medication lines to test, select a variety of different yards/clinics, AM/PM shifts, and cell-door service and walk-up service processes. Try to include at least one restricted unit and one insulin line (if applicable).

Tests 7.108 – 7.112

OIG field inspectors will conduct testing at the main and remote pharmacies and the office of the Pharmacist-in-Charge (PIC).

Note 1: Some institutions have multiple pharmacy locations and some of these multi-pharmacy institutions have more than one PIC. For tests 7.108 – 7.112, if the institution has multiple pharmacy locations, but only 1 PIC, all of the pharmacies will be treated as one area/ entry on the testing worksheet. However, if the institution has more than 1 PIC, the area/pharmacy that each PIC oversees, will be treated as separate areas/entries on the testing worksheet.

Test 7.998

For Information Only

The sample universe for this test will be any medication error identified by OIG inspectors as a result of reviewing EHRS files during the OIG's compliance and case review testing period.

Test 7.999

For Information Only

Obtain from the PIC the "Active Medication Listing" of all patients who are currently prescribed a KOP rescue (asthma) inhaler or a KOP nitroglycerin medication. OIG HQ requested that this list be ready for the field inspectors upon arrival. The listing should include: the last name, CDC #, medication name, and unit-housing. From the list, identify all patients who are currently housed in restricted housing units, such as an ASU, SHU, or PSU. For each unique restricted housing unit location/building (i.e. main ASU, stand-alone ASU, PSU, etc.), select a sample of 10 patients to test. For SHU institutions with large housing areas, select a sample of 20 patients to test.

Note 2: In accordance with December 2021 CCHCS HC DOM Ch. 3 Article 5 3.5.31.b & May 2019 CCHCS HC DOM Ch. 3 Article 5 3.5.5.C.17., the OIG will apply the following as applicable in the tests below: For medications deemed to be clinically equivalent (by the system-wide pharmacy & therapeutics—P&T—committee), the pharmacist may write an order for a therapeutic substitution. The substituted order does not have to be co-signed by the provider. If the OIG is unable to find documentation supporting that the patient received a new medication order as written by the PCP, we will look for, and accept, a pharmacist order. The pharmacist order must be documented on a EHRS Medication Order , and include: the phrase, "automatic substitution per policy"; the name, dose, route, and duration of the original medication; automatic substitution medication with dose, route, and duration; and signature of the pharmacist. The OIG will not confirm whether or not the substituted medication has been approved by the P&T Committee.

Note 3: The OIG will also apply the following as applicable in the tests below: For "nonformulary" drug requests, the OIG will review CDCR Form 7374, Nonformulary Drug Request (NFDR) to determine whether the form is signed and dated by the institution's Facility Medical Authority (FMA), who is the Chief Medical Executive or designee, for approval or denial. If approved, the approval date will be used to determine when the medication was ordered. Unless otherwise specified on the NFDR, nonformulary drugs shall be approved for 12 months. For patients transferring between CDCR institutions, an approved NFDR remains valid at the receiving institution. Reception Centers may continue nonformulary medications for patients arriving from non-CDCR facilities for up to 30 days, after which a NFDR form must be approved by the FMA to continue the non-formulary medication. (Ref. November 2021 CCHCS HC DOM Ch. 3 Article 5 3.5.4.C.2.A&B)

Note 4: Throughout the inspection process, the inspector will document medication errors identified during testing and confirm that the error(s) has been properly identified and reported by the institution (in accordance with December 2021 CCHCS HC DOM Ch. 3 Article 5 3.5.27). Errors identified in MIT 7 (7.001 – 7.006), will be carried forward to MIT 7.998 for further evaluation. Tests 7.001 – 7.006 and 7.998 will be evaluated separately. For example, if a patient's chart indicates that a medication was not received as required this results in a "No" answer to 7.001 – 7.006 questions. If this "No" response indicates a medication error may have occurred, the information will be carried forward to 7.998 to evaluate whether the medication error was properly managed. The OIG identified the types of medication errors to test at 7.998 (listed as i. – vi.).

Inspection Procedures

Ref # 7.001

HQ INSPECTOR (Rev. 09/15/2021)

Did the patient receive all chronic care medications within the required time frames or did the institution follow departmental policy for refusals or no-shows?

Testing Methodology (Sample 25):

This test shares the same sample as tests 1.001 and 9.008.

1. **Scope of medication testing**: This test will focus on the continuity of medications during an extended period of time. Specifically, receipt of patients' Keep on Person (KOP) medications will be reviewed for the three most recent calendar months while Nurse Administered (NA) and Direct Observation Therapy (DOT) medications will be reviewed for the most recent two-month period of time.

Note 1: The testing time period will exclude the most recent full month prior to the OIG's EHRS file review week. For example, if the OIG's inspection occurs in June, the three-month testing period for KOP medications would be February, March, and April (May would be excluded). The two-month testing time period for NA/ DOT medications would be March and April (May would be excluded).

Note 2: Only medications taken for the following chronic care conditions will be tested: Anticoagulation, Asthma, Diabetes, Dyslipidemia / Hyperlipidemia, Hepatitis C, HIV, HTN, Seizure Disorders. However, if the patient was not on any medication or was only on Pro Re Nata (PRN or "As Needed") medications, the answer to this question is "N/A." In addition, for this test, the OIG analysts initially identify each patient's chronic care conditions based on the CCHCS's Master Registry; however, this source is not always all inclusive or accurate. As a result, the OIG analyst and testing inspector, will also review other chronic care conditions (and their corresponding medications) if they are subsequently identified during the sampling and chart review portion of the test.

Note 3: For this test, 81 mg Aspirin is treated as a chronic care medication when prescribed long-term.

Note 4: If a (non-PRN) chronic care medication dosage changes (i.e. new order) occurred during the tested time period, the inspector will verify that old dosage medication was discontinued timely and the new dosage medication was received timely. Also, if a (non-PRN) chronic care medication is discontinued altogether, confirm that the discontinuation was timely (i.e., that the patient did not receive excess medication).

Note 5: For this test, do not consider mental health as a chronic condition or test its associated medications.

Note 6: If the patient received all of the chronic care medications and/or required counseling encounters, the answer to this question is "Yes." If there are deviations noted, the answer is "No." Once the OIG identifies three "No" events/deviations (e.g., unexplained missed doses or missed counseling encounters as described above), the answer to this question is "No" and discontinue testing for that patient.

Note 7: During this test, if the MAR indicates that a missed dose resulted in a medication error report being generated, then the missed dose will not be counted as a deviation as long as the deviation does not occur more than once per month.

For all routine medications (KOP or NA/DOT):

Non-urgent new medication orders received by pharmacy on any business day shall be made available to the patient no later than three business days later, unless otherwise ordered (e.g., order specifies medication is to start today). *Note: CCHCS defines non-urgent medications as medications needed no later than three business days based on provider's judgment*.

Replenishments of non-urgent renewed "**Request refill**" medications - For this test, do not test for timely re-issuance of a request refill medication, unless a provider issued a new order. If a new order is issued, follow the non-urgent new medication orders testing rule discussed above.

Replenishments of non-urgent renewed "**auto-fill**" medications shall be made available to the patient no less than one business day prior to exhaustion. When health care staff become aware that a patient with a valid routine med order has run out of his/her medication supply, staff shall request the refill and the pharmacy shall dispense & deliver the medication supply (during business hours) or staff shall administer dose-by-dose medication from the after-hours medication supply.

Urgent medication orders and renewals: Providers may order medications as "start today" or at a specified future date, as appropriate. Pharmacy shall provide the ordered medications during working hours; nursing staff shall obtain the ordered medication from the after-hours medication supply after hours; similarly, providers may order medications as "STAT" in the TTA, urgent/emergent treatments areas, or licensed inpatient areas. If any such medications are unavailable, the prescribing or on-call provider shall immediately be notified for treatment recommendations.

KOP medication pick up:

Patients will be notified that their KOP medications are available for pick up at the pill window. In the event a patient does not pick up a KOP medication within four business days of the medication becoming available, health care staff should follow the institution's LOP to ensure the patient reports to the medication line. These processes may include ducating the patient or notifying custody to have the patient escorted to the medication line.

NA/DOT No-Shows:

If the patient is no-show for an NA or DOT medication, licensed nursing staff shall coordinate with nursing supervisor, Facility Captain, Lieutenant, Sergeant, or Associate Warden for Health Care Services to locate the patient and to assist with resolving any identified barriers to medication administration as appropriate, and make every effort to bring the patient to the medication for:

a. Medication administration; and

b. Documentation of barriers that prevented the patient from presenting to the medication line (e.g., lockdowns or transfers to another area or institution); or

c. Documentation of their refusal and reason for refusal of the medication.

Medication Refusals

Licensed nursing staff shall document each refusal of an NA or DOT medication in the EHRS Medication Administration Wizard or electronic Medication Administration Record and document the reason for each medication refused, as stated by the patient.

a. If a patient refuses methadone administration by the Narcotic Treatment Program, licensed nursing staff shall have the patient sign a CDCR 7225 Refusal of Examination and/or Treatment. The Addiction Medicine Central Team and the patient's PCT shall be notified via the EHRS Message Pool.

Licensed nursing staff shall notify the prescriber when the patient refuses to pick up KOP medication, provide medication adherence counseling as determined by the prescriber, and document in the health record.

Prescribers shall consider changing prescriptions, discontinuing medications, or discontinuing auto-refill for medication refusals and document the rationale for the action in the health record.

Medication Non-Adherence Counseling for Critical and Non-critical medications:

Clinical health care staff shall review medication adherence by way of the Automated Huddle Report or EHRS Message Pool for licensed health care staff to perform medication counseling.

- For critical medications on the Critical Adherence Medications List, the PCT shall be notified verbally and in writing when a patient misses a critical medication by the end of medication pass. Patients shall be seen by licensed health care staff within 24 hours when referred for missing or refusing a dose of a critical medication.

Critical Adherence Medication List		
Missed a dose of:	Refer: verbally and in writing immediately per institution policy	Response
Active tuberculosis (TB) disease medications (not prophylaxis)	Primary Care Team	Patients shall be seen by licensed health care staff from the Primary Care Team or a mental health prescriber from the Mental Health Team within 24 hours from receipt of the notification of medication non-adherence
Anti-rejection medication post-transplant (see Note 1)	Primary Care Team	
Hepatitis C antiretrovirals (or did not pick up a KOP dispense)	Primary Care Team	
Clozapine	Mental Health Team	
Long-acting injectable anti-psychotics (see Note 2)	Mental Health Team	
PC 2602 medications	Mental Health Team	
PC 2604 medications (see Note 3)	Primary Care Team	

Note 1: Refer to CCHCS Care Guide: Post Renal Transplant Revision 4/2020 page 32 for complete list of anti-rejection post-transplant medication.

Note 2: Per CCHCS, the following drugs are commonly prescribed long acting injectable formulations: Paliperidone palmitate, Fluphenazine decanoate, Risperidone, Haloperidol decanoate, Aripiprazole, and Aripiprazole lauroxil.

Note 3: Refer to CCHCS Care Guide: Palliative Care Revision 5/2021 page 13 for complete list of common medicines for Palliative Care on CCHCS Formulary.

- For non-critical medications, licensed health care staff shall provide medication adherence counseling as determined by the PCT and document in the health record. When indicated, licensed health care staff shall contact the prescriber for guidance.

Patients prescribed psychiatric medications by a mental health prescriber:

1. For medications on the Critical Adherence Medication List, the patient shall be seen by a mental health prescriber for an urgent mental health referral within 24 hours from receipt of the notification of medication non-adherence.
2. For non-critical medications, a mental health prescriber shall review the health record and document in the health record the plan of action within seven calendar days from receipt of the notification of medication non-adherence.
    a. The documented plan of action should take into account anticipated future medication non-adherence.
    b. A mental health prescriber shall follow up with a face-to-face session addressing the medication non-adherence as soon as clinically indicated, but no longer than 30 calendar days from the first day the mental health prescriber is notified of non-adherence.
3. Any medication adherence counseling session with a mental health prescriber shall be documented in a detailed note, and shall take place in a confidential setting, unless the patient refuses to attend.

All refusals shall be signed by the patient and co-signed by licensed health care staff. If the patient refuses to sign the CDCR 7225, two licensed health care staff shall sign. In unusual circumstances (e.g., Administrative Segregation Unit, Mental Health Crisis Bed), the CDCR 7225 may be signed by two staff members, one of whom shall be a licensed health care staff.

When refusal is signed, the original refusal form shall be forwarded to Health Information Management to be scanned to the health record.

Ref # 7.002

HQ INSPECTOR (Rev. 09/14/2021)

Did health care staff administer, make available, or deliver new order prescription medications to the patient within the required time frames?

Testing Methodology (Sample 25):

Verify that the new medication was administered or delivered timely to the patient.

1. **Medications to select for testing**: If a physician or dentist's new order includes multiple medications, the inspector will test all the medications. The newest medication can be a NA, DOT, or KOP type of medication. The inspector shall utilize the new order identified by the analyst (who follows the Sample Methodology above). Both the inspector and the analyst will ensure that the sample item meets the criteria discussed below:

   Note 1: The OIG will test the most recent new medication order that is not a renewal (i.e., if the patient currently has an existing (unexpired) prescription order for the exact same medication including identical dosage amount and administration time(s)). Any medication order that changes any of these prescription parameters, results in the order being deemed a "new" order for the OIG's testing purposes. However, a brand name for generic name substitution does not, by itself, make it a new prescription if all the other prescription instructions remain unchanged.

   Medication testing Rules: (Do not test PRN medications, except rescue medication for chronic care, i.e. asthma inhalers and nitroglycerin. If a PRN medication is tested, only test to ensure that it is timely made available, do not test for timely administration.)

2. All routine medications (KOP or NA/DOT):

   Non-urgent medication time frames: Non-urgent new medication orders received by pharmacy on any business day shall be available to the patient no later than three business days later, unless otherwise ordered (e.g., order specifies medication is to start today). Note: CCHCS defines non-urgent medications as medications needed no later than three business days based on provider's judgment.

   Urgent medication time frames: Providers may order medications as "start today" or at a specified future date, as appropriate. Pharmacy shall provide the ordered medications during working hours; nursing staff shall obtain the ordered medication from the after-hours medication supply after hours; similarly, providers may order medications as "STAT" in the

TTA, urgent/emergent treatments areas, or licensed inpatient areas. If any such medications are unavailable, the prescribing or on-call provider shall immediately be notified for treatment recommendations.

NA/DOT No-Shows: If the patient is no-show for an NA or DOT medication, licensed nursing staff shall coordinate with nursing supervisor, Facility Captain, Lieutenant, Sergeant, or Associate Warden for Health Care Services to locate the patient and to assist with resolving any identified barriers to medication administration as appropriate, and make every effort to bring the patient to the medication for:

a. Medication administration; and

b. Documentation of barriers that prevented the patient from presenting to the medication line (e.g., lockdowns or transfers to another area or institution); or

c. Documentation of their refusal and reason for refusal of the medication.

No-show KOP: Patients will be notified that their KOP medications are available for pick up at the pill window. If a patient fails to pick up KOP medication within four business days of the medication becoming available, health care staff should follow the institution's LOP to ensure the patient reports to the medication line to accept or refuse the medication. These processes may include ducating the patient or notifying custody to have the patient escorted to the medication line.

Medication Refusals

Licensed nursing staff shall document each refusal of an NA or DOT medication in the EHRS Medication Administration Wizard or electronic Medication Administration Record and document the reason for each medication refused, as stated by the patient.

a. If a patient refuses methadone administration by the Narcotic Treatment Program, licensed nursing staff shall have the patient sign a CDCR 7225 Refusal of Examination and/or Treatment. The Addiction Medicine Central Team and the patient's PCT shall be notified via the EHRS Message Pool.

Licensed nursing staff shall notify the prescriber when the patient refuses to pick up KOP medication, provide medication adherence counseling as determined by the prescriber, and document in the health record.

Prescribers shall consider changing prescriptions, discontinuing medications, or discontinuing auto-refill for medication refusals and document the rationale for the action in the health record.

Medication Non-Adherence Counseling for Critical and Non-critical medications:

Clinical health care staff shall review medication adherence by way of the Automated Huddle Report or EHRS Message Pool for licensed health care staff to perform medication counseling.

- For critical medications on the Critical Adherence Medications List, the PCT shall be notified verbally and in writing when a patient misses a critical medication by the end of medication pass. Patients shall be seen by licensed health care staff within 24 hours when referred for missing or refusing a dose of a critical medication.

Critical Adherence Medication List		
Missed a dose of:	Refer: verbally and in writing immediately per institution policy	Response
Active tuberculosis (TB) disease medications (not prophylaxis)	Primary Care Team	Patients shall be seen by licensed health care staff from the Primary Care Team or a mental health prescriber from the Mental Health Team within 24 hours from receipt of the notification of medication non-adherence
Anti-rejection medication post-transplant (see Note 1)	Primary Care Team	
Hepatitis C antiretrovirals (or did not pick up a KOP dispense)	Primary Care Team	
Clozapine	Mental Health Team	
Long-acting injectable anti-psychotics (see Note 2)	Mental Health Team	
PC 2602 medications	Mental Health Team	
PC 2604 medications (see Note 3)	Primary Care Team	

Note 1: Refer to CCHCS Care Guide: Post Renal Transplant Revision 4/2020 page 32 for complete list of anti-rejection post-transplant medication.

Note 2: Per CCHCS, the following drugs are commonly prescribed long acting injectable formulations: Paliperidone palmitate, Fluphenazine decanoate, Risperidone, Haloperidol decanoate, Aripiprazole, and Aripiprazole lauroxil.

Note 3: Refer to CCHCS Care Guide: Palliative Care Revision 5/2021 page 13 for complete list of common medicines for Palliative Care on CCHCS Formulary.

- For non-critical medications, licensed health care staff shall provide medication adherence counseling as determined by the PCT and document in the health record. When indicated, licensed health care staff shall contact the prescriber for guidance.

Patients prescribed psychiatric medications by a mental health prescriber:

1. For medications on the Critical Adherence Medication List, the patient shall be seen by a mental health prescriber for an urgent mental health referral within 24 hours from receipt of the notification of medication non-adherence.
2. For non-critical medications, a mental health prescriber shall review the health record and document in the health record the plan of action within seven calendar days from receipt of the notification of medication non-adherence.
    a. The documented plan of action should take into account anticipated future medication non-adherence.
    b. A mental health prescriber shall follow up with a face-to-face session addressing the medication non-adherence as soon as clinically indicated, but no longer than 30 calendar days from the first day the mental health prescriber is notified of non-adherence.
3. Any medication adherence counseling session with a mental health prescriber shall be documented in a detailed note, and shall take place in a confidential setting, unless the patient refuses to attend.

All refusals shall be signed by the patient and co-signed by licensed health care staff. If the patient refuses to sign the CDCR 7225, two licensed health care staff shall sign. In unusual circumstances (e.g., Administrative Segregation Unit, Mental Health Crisis Bed), the CDCR 7225 may be signed by two staff members, one of whom shall be a licensed health care staff.

When refusal is signed, the original refusal form shall be forwarded to Health Information Management to be scanned to the health record.

Ref # 7.003

HQ INSPECTOR (Rev. 09/14/2021)

Upon the patient's discharge from a community hospital: Were all ordered medications administered, made available, or delivered to the patient within required time frames?

Testing Methodology (Sample 25):

Sampling Note: This test shares the same sample as tests 1.007, 4.003 and 4.005.

Pre-amble: CCHCS policy specifically states that *"Patients arriving in the institution from a site other than a CDCR institution who are on prescription medications shall be seen by a health care provider or have their prescription medications ordered within eight hours of arrival to prevent any interruption in medication delivery. New medication orders shall be filled by pharmacy staff during working hours. After-hours ordered medications shall be obtained by health care staff from the designated after-hours medication supply. The medication shall be administered at the next dosing time and no later than the next calendar day."* The OIG has further interpreted the policy to mean that the medications must be administered by the next calendar day *from the date of hospital return, or as specified by the provider's start date of the medication order.*

The OIG will determine whether patients who return from a hospital and who have prescription medication orders written receive their medication(s) without interruption by doing the following:

a. Verify that the hospital return medications were timely ordered with 8 hours of return:

1. Determine that the provider ordered hospital return medications within 8 hours of the patient returning from the hospital (the time is usually found on the TTA nursing notes or SOMS). If the provider did not order "new" medications within 8 hours of the hospital return, then a justification that no medications are needed must be documented within 8 hours of return, or the overall answer to this test is "No."

   The hospital return medications may be identified in EHRS under the Medication Order tab. Compare the order date/time on the provider's order to the TTA nurse's hospital return progress notes or SOMS. For this test, to timely comply with the 8 hour ordering requirement, the provider may either order medication(s), or document a proper justification. The inspector will only test the timeliness of the first set of post hospital return provider orders that include medication orders. Only the initial set of hospital return medication orders will be tested.

Note 1: This test only applies to the first post-hospital return provider related encounter or physician order that results in a medication order. In most cases, a patient will typically be immediately seen in the TTA where the hospital return medications will be ordered. In addition, a primary care provider will typically see the patient 3-5 days after hospital discharge and order additional medications, these additional medications will not be tested if other medications had been previously ordered by the TTA. If the primary care provider's medication order is the only order found, then the sample will most likely fail this test because the medications were probably not ordered within 8 hours of the hospital return. (Unless the TTA provider clearly justified that the patient did not require any medications.)

Note 2: For TTA provider phone orders, the date the TTA nurse took the phone order is deemed to be the order time, not the time the doctor subsequently approved the order.

b. Next, verify that the post arrival medications were timely made available and administered/ issued using the following criteria:

Medication testing Rules: Do not test PRN medications, except rescue medication for chronic care, i.e. asthma inhalers and nitroglycerin. If a PRN medication is tested, only test to ensure that it is timely made available, do not test for timely administration. Do not test MH medication prescribed by a psychiatrist and dental medication prescribed by a dentist**,** unless medication was ordered for medical use and ordered by a medical provider.

- **NA/DOT:** Were the medications made available & administered <u>at the next dosing interval</u> (from order time). In addition, were the medications made available no later than one calendar day (after arrival).

- **KOP:** Were the meds made available at the <u>next dosing interval</u> (from order time) or unless otherwise ordered (e.g., order specifies medication is to start today) and issued within 4 business days of being made available. In addition, the medications must be made available no later than one calendar day after arrival. <u>For PRN medications</u>, only test to ensure the meds are timely made available, do <u>not</u> test for timely administration.

Note 3: If there are deviations noted, the answer is "No." Once the OIG identifies three "No events/deviations, the answer to this question is "no" and discontinue testing for that patient.

- **NA/DOT No-Shows:** If the patient is no-show for an NA or DOT medication, licensed nursing staff shall coordinate with nursing supervisor, Facility Captain, Lieutenant, Sergeant, or Associate Warden for Health Care Services to locate the

patient and to assist with resolving any identified barriers to medication administration as appropriate, and make every effort to bring the patient to the medication for:

a. Medication administration; and

b. Documentation of barriers that prevented the patient from presenting to the medication line (e.g., lockdowns or transfers to another area or institution); or

c. Documentation of their refusal and reason for refusal of the medication.

- **No-show KOP**: Patients will be notified that their KOP medications are available for pick up at the pill window. If a patient fails to pick up KOP medication within four business days of the medication becoming available, health care staff should follow the institution's LOP to ensure the patient reports to the medication line to accept or refuse the medication. These processes may include ducating the patient or notifying custody to have the patient escorted to the medication line.

- **Medication Refusals**

  Licensed nursing staff shall document each refusal of an NA or DOT medication in the EHRS Medication Administration Wizard or electronic Medication Administration Record and document the reason for each medication refused, as stated by the patient.

  a. If a patient refuses methadone administration by the Narcotic Treatment Program, licensed nursing staff shall have the patient sign a CDCR 7225 Refusal of Examination and/or Treatment. The Addiction Medicine Central Team and the patient's PCT shall be notified via the EHRS Message Pool.

  Licensed nursing staff shall notify the prescriber when the patient refuses to pick up KOP medication, provide medication adherence counseling as determined by the prescriber, and document in the health record.

  Prescribers shall consider changing prescriptions, discontinuing medications, or discontinuing auto-refill for medication refusals and document the rationale for the action in the health record.

- **Medication Non-Adherence Counseling for Critical and Non-critical medications:**

  Clinical health care staff shall review medication adherence by way of the Automated Huddle Report or EHRS Message Pool for licensed health care staff to perform medication counseling.

- For critical medications on the Critical Adherence Medications List, the PCT shall be notified verbally and in writing when a patient misses a critical medication by the end of medication pass. Patients shall be seen by licensed health care staff within 24 hours when referred for missing or refusing a dose of a critical medication.

Critical Adherence Medication List		
Missed a dose of:	Refer: verbally and in writing immediately per institution policy	Response
Active tuberculosis (TB) disease medications (not prophylaxis)	Primary Care Team	Patients shall be seen by licensed health care staff from the Primary Care Team or a mental health prescriber from the Mental Health Team within 24 hours from receipt of the notification of medication non-adherence
Anti-rejection medication post-transplant (see Note 1)	Primary Care Team	
Hepatitis C antiretrovirals (or did not pick up a KOP dispense)	Primary Care Team	
Clozapine	Mental Health Team	
Long-acting injectable anti-psychotics (see Note 2)	Mental Health Team	
PC 2602 medications	Mental Health Team	
PC 2604 medications (see Note 3)	Primary Care Team	

Note 1: Refer to CCHCS Care Guide: Post Renal Transplant Revision 4/2020 page 32 for complete list of anti-rejection post-transplant medication.

Note 2: Per CCHCS, the following drugs are commonly prescribed long acting injectable formulations: Paliperidone palmitate, Fluphenazine decanoate, Risperidone, Haloperidol decanoate, Aripiprazole, and Aripiprazole lauroxil.

Note 3: Refer to CCHCS Care Guide: Palliative Care Revision 5/2021 page 13 for complete list of common medicines for Palliative Care on CCHCS Formulary.

- For non-critical medications, licensed health care staff shall provide medication adherence counseling as determined by the PCT and document in the health record. When indicated, licensed health care staff shall contact the prescriber for guidance.

Patients prescribed psychiatric medications by a mental health prescriber:

1. For medications on the Critical Adherence Medication List, the patient shall be seen by a mental health prescriber for an urgent mental health referral within 24 hours from receipt of the notification of medication non-adherence.
2. For non-critical medications, a mental health prescriber shall review the health record and document in the health record the plan of action within seven calendar days from receipt of the notification of medication non-adherence.
    a. The documented plan of action should take into account anticipated future medication non-adherence.
    b. A mental health prescriber shall follow up with a face-to-face session addressing the medication non-adherence as soon as clinically indicated, but no longer than 30 calendar days from the first day the mental health prescriber is notified of non-adherence.
3. Any medication adherence counseling session with a mental health prescriber shall be documented in a detailed note, and shall take place in a confidential setting, unless the patient refuses to attend.

All refusals shall be signed by the patient and co-signed by licensed health care staff. If the patient refuses to sign the CDCR 7225, two licensed health care staff shall sign. In unusual circumstances (e.g., Administrative Segregation Unit, Mental Health Crisis Bed), the CDCR 7225 may be signed by two staff members, one of whom shall be a licensed health care staff.

When refusal is signed, the original refusal form shall be forwarded to Health Information Management to be scanned to the health record.

References: April 2019 CCHCS HC DOM Ch. 3 Article 1 3.1.9.C.3.F.4-5; January 2016 Ch. 3 Article 2 3.2.2.C.2.F.1.; January 2016 Ch. 3 Article 2 3.2.4.C.5.C.4; August 2021 CCHCS HC DOM Ch. 3 Article 5 3.5.41.c.2-6; OIG Medical Inspection Unit

Ref # 7.004

HQ INSPECTOR (Rev. 09/14/2021)

For patients received from a county jail: Were all medications ordered by the institution's reception center provider administered, made available, or delivered to the patient within the required time frames?

Testing Methodology (Sample 20) (for all applicable NA/DOT & KOP medications ordered):

Sampling Note: This test shares the same sample as tests 12.001 – 12.008.

Pre-amble: CCHCS policy specifically states that *"Patients arriving in the institution from a site other than a CDCR institution who are on prescription medications shall be seen by a health care provider or have their prescription medications ordered within eight hours of arrival to prevent any interruption in medication delivery. New medication orders shall be filled by pharmacy staff during working hours. After-hours ordered medications shall be obtained by health care staff from the designated after-hours medication supply. The medication shall be administered at the next dosing time and no later than the next calendar day."* The OIG has further interpreted the policy to mean that the medications must be administered by the next calendar day *from the date of arrival, or as specified by the provider's start date of the medication order.*

The OIG will determine whether patients who arrived at the institution from a county jail and who are on prescription medications receive their medication(s) without interruption by doing the following:

a. Verify that the new arrival medications were timely ordered within 8 hours of arrival:

1. Determine that the provider ordered the medications within 8 hours of the patient arriving at the institution. If the patient was on medications at the county jail, and the provider did not order any "new" medications within 8 hours of the arrival, then a justification that no medications are needed must be documented within 8 hours of return, or the overall answer to this test (7.004) is "No."

   Note 1: If the patient was not on medications prior to arrival (i.e. at the county jail), and a provider does not order any new medications upon arrival, this test 7.004 answer is "N/A." Do not use sample replacement for this test.

   The new arrival medications will be identified in EHRS under the Medication Order tab. Compare the order date/time on the provider's order to the TTA nurse's hospital return progress notes or SOMS. For this test, to timely comply with the 8 hour ordering requirement, the provider may either order new, or document a proper justification (when applicable). For this test, only the first set of post arrival medication orders will be tested.

b. Next, verify that the post arrival medications were timely made available and administered/ issued using the following criteria:

Medication testing Rules: Do not test PRN medications, except rescue medication for chronic care, i.e. asthma inhalers and nitroglycerin. If a PRN medication is tested, only test to ensure that it is timely made available, do not test for timely administration. Do not test **MH medication prescribed by a psychiatrist and dental medication prescribed by a dentist,** unless medication was ordered for medical use and ordered by a medical provider.

- **NA/DOT:** Were the medications made available & administered at the next dosing interval (from order time). In addition, were the medications made available no later than one calendar day (after arrival).

- **KOP:** Were the meds made available at the next dosing interval (from order time) or unless otherwise ordered (e.g., order specifies medication is to start today) and issued within 4 business days of being made available. In addition, the medications must be made available no later than one calendar day after arrival. For PRN medications, only test to ensure the meds are timely made available, do not test for timely administration.

Note 2: The medication must be both made available and timely administered/issued (except PRN) or else the final answer is "No."

Note 3: If the patient was not on meds prior to the arrival and a provider does not order any medications upon the patient's arrival, the test is N/A. Sample is not subject to replacement for this reason.

Note 4: If no medication order was found, review the EHRS and determine if the patient was on any medication (just prior to transfer) at the non-CDCR sending facility. This can be determined by reviewing the patient's medical file from the sending location which is typically filed in the EHRS under an encounter date that is on or near the date of arrival. If the patient was not on any medications at the sending location, the answer to the question is "N/A." If the patient was on medications at the sending location but the medications were not continued at the receiving institution, then a PCP should have written a progress note indicating why the medications were not continued.

- **NA/DOT No-Shows:** If the patient is no-show for an NA or DOT medication, licensed nursing staff shall coordinate with nursing supervisor, Facility Captain, Lieutenant, Sergeant, or Associate Warden for Health Care Services to locate the patient and to assist with resolving any identified barriers to medication administration as appropriate, and make every effort to bring the patient to the medication for:

a. Medication administration; and

b. Documentation of barriers that prevented the patient from presenting to the medication line (e.g., lockdowns or transfers to another area or institution); or

c. Documentation of their refusal and reason for refusal of the medication.

- **No-show KOP**: Patients will be notified that their KOP medications are available for pick up at the pill window. If a patient fails to pick up KOP medication within four business days of the medication becoming available, health care staff should follow the institution's LOP to ensure the patient reports to the medication line to accept or refuse the medication. These processes may include ducating the patient or notifying custody to have the patient escorted to the medication line.

- **Medication Refusals**

  Licensed nursing staff shall document each refusal of an NA or DOT medication in the EHRS Medication Administration Wizard or electronic Medication Administration Record and document the reason for each medication refused, as stated by the patient.

  a. If a patient refuses methadone administration by the Narcotic Treatment Program, licensed nursing staff shall have the patient sign a CDCR 7225 Refusal of Examination and/or Treatment. The Addiction Medicine Central Team and the patient's PCT shall be notified via the EHRS Message Pool.

  Licensed nursing staff shall notify the prescriber when the patient refuses to pick up KOP medication, provide medication adherence counseling as determined by the prescriber, and document in the health record.

  Prescribers shall consider changing prescriptions, discontinuing medications, or discontinuing auto-refill for medication refusals and document the rationale for the action in the health record.

- **Medication Non-Adherence Counseling for Critical and Non-critical medications:**

  Clinical health care staff shall review medication adherence by way of the Automated Huddle Report or EHRS Message Pool for licensed health care staff to perform medication counseling.

  - For critical medications on the Critical Adherence Medications List, the PCT shall be notified verbally and in writing when a patient misses a critical

medication by the end of medication pass. Patients shall be seen by licensed health care staff within 24 hours when referred for missing or refusing a dose of a critical medication.

Critical Adherence Medication List		
Missed a dose of:	Refer: verbally and in writing immediately per institution policy	Response
Active tuberculosis (TB) disease medications (not prophylaxis)	Primary Care Team	Patients shall be seen by licensed health care staff from the Primary Care Team or a mental health prescriber from the Mental Health Team within 24 hours from receipt of the notification of medication non-adherence
Anti-rejection medication post-transplant (see Note 1)	Primary Care Team	
Hepatitis C antiretrovirals (or did not pick up a KOP dispense)	Primary Care Team	
Clozapine	Mental Health Team	
Long-acting injectable anti-psychotics (see Note 2)	Mental Health Team	
PC 2602 medications	Mental Health Team	
PC 2604 medications (see Note 3)	Primary Care Team	

Note 1: Refer to CCHCS Care Guide: Post Renal Transplant Revision 4/2020 page 32 for complete list of anti-rejection post-transplant medication.

Note 2: Per CCHCS, the following drugs are commonly prescribed long acting injectable formulations: Paliperidone palmitate, Fluphenazine decanoate, Risperidone, Haloperidol decanoate, Aripiprazole, and Aripiprazole lauroxil.

Note 3: Refer to CCHCS Care Guide: Palliative Care Revision 5/2021 page 13 for complete list of common medicines for Palliative Care on CCHCS Formulary.

- For non-critical medications, licensed health care staff shall provide medication adherence counseling as determined by the PCT and document in the health record. When indicated, licensed health care staff shall contact the prescriber for guidance.

Patients prescribed psychiatric medications by a mental health prescriber:

1. For medications on the Critical Adherence Medication List, the patient shall be seen by a mental health prescriber for an urgent mental health referral within 24 hours from receipt of the notification of medication non-adherence.

2. For non-critical medications, a mental health prescriber shall review the health record and document in the health record the plan of action within seven calendar days from receipt of the notification of medication non-adherence.

    a. The documented plan of action should take into account anticipated future medication non-adherence.

    b. A mental health prescriber shall follow up with a face-to-face session addressing the medication non-adherence as soon as clinically indicated, but no longer than 30 calendar days from the first day the mental health prescriber is notified of non-adherence.

3. Any medication adherence counseling session with a mental health prescriber shall be documented in a detailed note, and shall take place in a confidential setting, unless the patient refuses to attend.

All refusals shall be signed by the patient and co-signed by licensed health care staff. If the patient refuses to sign the CDCR 7225, two licensed health care staff shall sign. In unusual circumstances (e.g., Administrative Segregation Unit, Mental Health Crisis Bed), the CDCR 7225 may be signed by two staff members, one of whom shall be a licensed health care staff.

When refusal is signed, the original refusal form shall be forwarded to Health Information Management to be scanned to the health record.

References: April 2019 CCHCS HC DOM Ch. 3 Article 1 3.1.8.C.1.D.3.e; January 2016 Ch. 3 Article 2 3.2.2.C.2.F.1; January 2016 Ch. 3 Article 2 3.2.4.C.5.C.4; August 2021 CCHCS HC DOM Ch. 3 Article 5 3.5.41.c.2-6; OIG Medical Inspection Unit

Ref # 7.005

HQ INSPECTOR (Rev. 09/14/2021)

Upon the patient's transfer from one housing unit to another: Were medications continued without interruption?

Medications to select for testing: Review only medications that are ordered as NA/ DOT to ensure that when a patient transfers between housing unit locations his or her medications are continued without interruption. Only select patients who have at least one NA/DOT medication that was not issued as PRN (as needed). Do not test the patient's KOP medications. For all patients who do not have at least one testable medication, replace the sample with an alternate-patient. A total of 25 samples will be tested.

Testing Methodology (Sample 25):

To ensure intra-facility transfer patients continue to receive their NA/DOT (Non-PRN) medications without interruption just before, during, and just after relocating to a new housing unit, the inspector will review the MAR for the dosing period that occurred just before, during, and just after the housing relocation. The inspector should verify that the MAR(s) includes proper documentation showing that the patient either received their required NA/DOT (non-PRN) medication dose for each applicable administration. In lieu of receiving the required medications, the institution must comply with the "no-show" or refusal requirements detailed below in order to receive a "Yes" for this test.

- **NA/DOT No-Shows:** If the patient is no-show for an NA or DOT medication, licensed nursing staff shall coordinate with nursing supervisor, Facility Captain, Lieutenant, Sergeant, or Associate Warden for Health Care Services to locate the patient and to assist with resolving any identified barriers to medication administration as appropriate, and make every effort to bring the patient to the medication for:

    a. Medication administration; and

    b. Documentation of barriers that prevented the patient from presenting to the medication line (e.g., lockdowns or transfers to another area or institution); or

    c. Documentation of their refusal and reason for refusal of the medication.

- **No-show KOP**: Patients will be notified that their KOP medications are available for pick up at the pill window. If a patient fails to pick up KOP medication within four business days of the medication becoming available, health care staff should follow the institution's LOP to ensure the patient reports to the medication line to accept or refuse the medication. These processes may include ducating the patient or notifying custody to have the patient escorted to the medication line.

- **Medication Refusals**

  Licensed nursing staff shall document each refusal of an NA or DOT medication in the EHRS Medication Administration Wizard or electronic Medication Administration Record and document the reason for each medication refused, as stated by the patient.

  a. If a patient refuses methadone administration by the Narcotic Treatment Program, licensed nursing staff shall have the patient sign a CDCR 7225 Refusal of Examination and/or Treatment. The Addiction Medicine Central Team and the patient's PCT shall be notified via the EHRS Message Pool.

  Licensed nursing staff shall notify the prescriber when the patient refuses to pick up KOP medication, provide medication adherence counseling as determined by the prescriber, and document in the health record.

  Prescribers shall consider changing prescriptions, discontinuing medications, or discontinuing auto-refill for medication refusals and document the rationale for the action in the health record.

- **Medication Non-Adherence Counseling for Critical and Non-critical medications:**

  Clinical health care staff shall review medication adherence by way of the Automated Huddle Report or EHRS Message Pool for licensed health care staff to perform medication counseling.

  - For critical medications on the Critical Adherence Medications List, the PCT shall be notified verbally and in writing when a patient misses a critical medication by the end of medication pass. Patients shall be seen by licensed health care staff within 24 hours when referred for missing or refusing a dose of a critical medication.

Critical Adherence Medication List		
Missed a dose of:	Refer: verbally and in writing immediately per institution policy	Response
Active tuberculosis (TB) disease	Primary Care Team	

medications (not prophylaxis)		Patients shall be seen by licensed health care staff from the Primary Care Team or a mental health prescriber from the Mental Health Team within 24 hours from receipt of the notification of medication non-adherence
Anti-rejection medication post-transplant (see Note 1)	Primary Care Team	
Hepatitis C antiretrovirals (or did not pick up a KOP dispense)	Primary Care Team	
Clozapine	Mental Health Team	
Long-acting injectable anti-psychotics (see Note 2)	Mental Health Team	
PC 2602 medications	Mental Health Team	
PC 2604 medications (see Note 3)	Primary Care Team	

Note 1: Refer to CCHCS Care Guide: Post Renal Transplant Revision 4/2020 page 32 for complete list of anti-rejection post-transplant medication.

Note 2: Per CCHCS, the following drugs are commonly prescribed long acting injectable formulations: Paliperidone palmitate, Fluphenazine decanoate, Risperidone, Haloperidol decanoate, Aripiprazole, and Aripiprazole lauroxil.

Note 3: Refer to CCHCS Care Guide: Palliative Care Revision 5/2021 page 13 for complete list of common medicines for Palliative Care on CCHCS Formulary.

- For non-critical medications, licensed health care staff shall provide medication adherence counseling as determined by the PCT and document in the health record. When indicated, licensed health care staff shall contact the prescriber for guidance.

Patients prescribed psychiatric medications by a mental health prescriber:

1. For medications on the Critical Adherence Medication List, the patient shall be seen by a mental health prescriber for an urgent mental health referral

within 24 hours from receipt of the notification of medication non-adherence.

2. For non-critical medications, a mental health prescriber shall review the health record and document in the health record the plan of action within seven calendar days from receipt of the notification of medication non-adherence.

    a. The documented plan of action should take into account anticipated future medication non-adherence.

    b. A mental health prescriber shall follow up with a face-to-face session addressing the medication non-adherence as soon as clinically indicated, but no longer than 30 calendar days from the first day the mental health prescriber is notified of non-adherence.

3. Any medication adherence counseling session with a mental health prescriber shall be documented in a detailed note, and shall take place in a confidential setting, unless the patient refuses to attend.

All refusals shall be signed by the patient and co-signed by licensed health care staff. If the patient refuses to sign the CDCR 7225, two licensed health care staff shall sign. In unusual circumstances (e.g., Administrative Segregation Unit, Mental Health Crisis Bed), the CDCR 7225 may be signed by two staff members, one of whom shall be a licensed health care staff.

When refusal is signed, the original refusal form shall be forwarded to Health Information Management to be scanned to the health record.

References: August 2021 CCHCS HC DOM Ch. 3 Article 5 3.5.41.c.2-6; January 2016 Ch. 3 Article 2 3.2.6.C.2.A-B; April 2019 Ch. 3 Article 1 3.1.9.C.3.E.3-4, & 7.a-c; OIG Medical Inspection Unit

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Ref # 7.006

HQ INSPECTOR (Rev. 09/14/2021)

For patients en route who lay over at the institution: If the temporarily housed patient had an existing medication order, were medications administered or delivered without interruption?

Testing Methodology (Sample 10):

This test will focus on the continuity of medications received during a temporary layover period not to exceed the first 5 days of the layover (i.e., the OIG will test the shorter of the first five days after arrival or the entire length of the temporary stay).

Note 1: Sampling exclusion: If the patient was not on any medication or the medication(s) was ordered PRN (as needed) or "Request-Refill," the sample will be replaced with an alternate.

Note 2: If a sample of 10 cannot be reached from the original sample of 30, no further samples will be tested and the sample size will be the applicable number of patients from the original sample. If no samples are found, the test will not be applicable to that institution.

Note 3: Temporarily housed patients endorsed to another prison are often referred to as 'en-routers' or 'layovers' while they are in transit to their ultimate location. The CCHCS HC DOM does not specifically address what intake or interim procedures the lay-over institution should follow for these temporary situations. However, a transfer envelope shall accompany all patients transferring from one CDCR institution to another CDCR institution. The transfer envelopes should contain (at least): Interfacility Transfer Form.

Note 4: At least a three day supply of all current KOPs and NA/DOTs (excluding narcotics) shall be placed in the patient's transfer envelope, with the exception of Clozapine which requires a seven day supply. Medications are packed and transported with the patient, and shall be made immediately available to the receiving institution upon the patient's arrival. Patients missing medications shall be provided with their medications under their current prescription orders. If the medication is unavailable, an equivalent substitute order shall be obtained to ensure medication continuity.

Note 5: The RN assigned to the R&R shall obtain medication from the transfer envelope, the onsite medication supply, or the pharmacy for each patient; administer the medication; document on the MAR or on a temporary MAR.

Note 6: The OIG will not test rescue inhalers (for asthma) or Nitroglycerin (for heart condition), as they should be kept on the patient's person throughout the transfer process. When in doubt, the inspector will consult with an OIG clinician to determine whether these essential medications were appropriately made available to the inmate.

Testing Methodology (for all medications):

1. Identify all medications prescribed to the patient as of his or her transfer date by reviewing the Interfacility Transfer Form completed at the sending institution.

2. Review the patient's EHRS MAR Summary at the time of the inmate's arrival (and during the layover period) and based on each medication's written instructions, verify that the

patient received all medications without interruption (i.e. at the next dosing interval) or that a refusal or no-show was documented.

a. If a MAR for a Nurse Administered (NA) or Direct Observation Therapy (DOT) indicates an unexplained missed dose, or the R&R Nurse failed to document on the KOP MAR or Progress Note the administration of KOP medications, consider the patient's departure and arrival date and time (per SOMS) and determine whether the missed dose occurred during travel time—in these cases the OIG will not take exception to the missed dose.

b. If the medication was made available to the patient at the next dosing interval, but the patient was either a "no-show" or "refused" the medication, the answer is "Yes" if the clinical staff made every attempt to ensure medication administration and appropriately documented the MAR as follows:

- **NA/DOT No-Shows:** If the patient is no-show for an NA or DOT medication, licensed nursing staff shall coordinate with nursing supervisor, Facility Captain, Lieutenant, Sergeant, or Associate Warden for Health Care Services to locate the patient and to assist with resolving any identified barriers to medication administration as appropriate, and make every effort to bring the patient to the medication for:

    a. Medication administration; and

    b. Documentation of barriers that prevented the patient from presenting to the medication line (e.g., lockdowns or transfers to another area or institution); or

    c. Documentation of their refusal and reason for refusal of the medication.

- **No-show KOP**: Patients will be notified that their KOP medications are available for pick up at the pill window. If a patient fails to pick up KOP medication within four business days of the medication becoming available, health care staff should follow the institution's LOP to ensure the patient reports to the medication line to accept or refuse the medication. These processes may include ducating the patient or notifying custody to have the patient escorted to the medication line.

- **Medication Refusals**

  Licensed nursing staff shall document each refusal of an NA or DOT medication in the EHRS Medication Administration Wizard or electronic Medication Administration Record and document the reason for each medication refused, as stated by the patient.

a. If a patient refuses methadone administration by the Narcotic Treatment Program, licensed nursing staff shall have the patient sign a CDCR 7225 Refusal of Examination and/or Treatment. The Addiction Medicine Central Team and the patient's PCT shall be notified via the EHRS Message Pool.

Licensed nursing staff shall notify the prescriber when the patient refuses to pick up KOP medication, provide medication adherence counseling as determined by the prescriber, and document in the health record.

Prescribers shall consider changing prescriptions, discontinuing medications, or discontinuing auto-refill for medication refusals and document the rationale for the action in the health record.

- **Medication Non-Adherence Counseling for Critical and Non-critical medications:**

  Clinical health care staff shall review medication adherence by way of the Automated Huddle Report or EHRS Message Pool for licensed health care staff to perform medication counseling.

  - For critical medications on the Critical Adherence Medications List, the PCT shall be notified verbally and in writing when a patient misses a critical medication by the end of medication pass. Patients shall be seen by licensed health care staff within 24 hours when referred for missing or refusing a dose of a critical medication.

Critical Adherence Medication List		
Missed a dose of:	Refer: verbally and in writing immediately per institution policy	Response
Active tuberculosis (TB) disease medications (not prophylaxis)	Primary Care Team	Patients shall be seen by licensed health care staff from the Primary
Anti-rejection medication post-transplant (see Note 1)	Primary Care Team	
Hepatitis C antiretrovirals (or did	Primary Care Team	

not pick up a KOP dispense)		Care Team or a mental health prescriber from the Mental Health Team within 24 hours from receipt of the notification of medication non-adherence
Clozapine	Mental Health Team	
Long-acting injectable anti-psychotics (see Note 2)	Mental Health Team	
PC 2602 medications	Mental Health Team	
PC 2604 medications (see Note 3)	Primary Care Team	

Note 1: Refer to CCHCS Care Guide: Post Renal Transplant Revision 4/2020 page 32 for complete list of anti-rejection post-transplant medication.

Note 2: Per CCHCS, the following drugs are commonly prescribed long acting injectable formulations: Paliperidone palmitate, Fluphenazine decanoate, Risperidone, Haloperidol decanoate, Aripiprazole, and Aripiprazole lauroxil.

Note 3: Refer to CCHCS Care Guide: Palliative Care Revision 5/2021 page 13 for complete list of common medicines for Palliative Care on CCHCS Formulary.

- For non-critical medications, licensed health care staff shall provide medication adherence counseling as determined by the PCT and document in the health record. When indicated, licensed health care staff shall contact the prescriber for guidance.

Patients prescribed psychiatric medications by a mental health prescriber:

1. For medications on the Critical Adherence Medication List, the patient shall be seen by a mental health prescriber for an urgent mental health referral within 24 hours from receipt of the notification of medication non-adherence.

2. For non-critical medications, a mental health prescriber shall review the health record and document in the health record the plan of action within seven calendar days from receipt of the notification of medication non-adherence.

a. The documented plan of action should take into account anticipated future medication non-adherence.

b. A mental health prescriber shall follow up with a face-to-face session addressing the medication non-adherence as soon as clinically indicated, but no longer than 30 calendar days from the first day the mental health prescriber is notified of non-adherence.

3. Any medication adherence counseling session with a mental health prescriber shall be documented in a detailed note, and shall take place in a confidential setting, unless the patient refuses to attend.

All refusals shall be signed by the patient and co-signed by licensed health care staff. If the patient refuses to sign the CDCR 7225, two licensed health care staff shall sign. In unusual circumstances (e.g., Administrative Segregation Unit, Mental Health Crisis Bed), the CDCR 7225 may be signed by two staff members, one of whom shall be a licensed health care staff.

When refusal is signed, the original refusal form shall be forwarded to Health Information Management to be scanned to the health record.

References: April 2019 CCHCS HC DOM Ch. 3 Article 1 3.1.9.C.3.A.6., & D.4; January 2016 Ch. 3 Article 2 3.2.2.C.2.F.2; January 2016 Ch. 3 Article 2 3.2.4.C.5.C.3-6; August 2021 CCHCS HC DOM Ch. 3 Article 5 3.5.41.c.2-6; January 2016 Ch. 3 Article 2 3.2.6.C.4.G & P; OIG Medical Inspection Unit

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Ref # 7.101

REGIONAL INSPECTOR (Rev. 09/14/2021)

All clinical and medication line storage areas for narcotic medications: Does the institution employ strong medication security controls over narcotic medications assigned to its storage areas?

Testing Methodology:

In each clinical area, interview knowledgeable staff to identify all areas where controlled substances (narcotics) are stored for both the clinic's general use, as well as, each of the clinic's associated medication line use. Perform the following steps to conclude whether the institution follows policies, procedures, and standards of nursing practice for narcotic medication security.

1. Verify that narcotics cabinets or lockers are securely maintained in the medication area at all times and remain locked when not in active use. Narcotics must be securely stored under double lock in the medication area at all times. For stationary storage areas within a clinic, the locked door to the clinic counts as one lock and the locked cabinet or locker as the

second lock. However, if a medication cart is used to store narcotics, the narcotics must be locked up in a lockbox within the medication cart to meet the double-lock (at all times) requirement. This includes narcotics and other controlled substances that are designated for disposal but are temporarily stored in the medication cart pending deposit into a pharmaceutical waste container.

2. Ensure that only designated staff have keys to the clinic narcotics cabinets or lockers, and that keys are not left hanging on the wall available to anyone. The institution's CNE is responsible for key control to controlled substances stored in medication administration areas and designating the staff who should have key access to narcotics cabinets and lockers in clinical areas. In addition, on a sample basis, survey staff to determine if medication carts have different key controls (i.e. the carts are keyed differently.)

3. During Automated Dispensing Cabinet (ADC) downtimes or in medication areas where an Automated Drug Delivery System (ADDS) is not installed, review the Narcotics Log Book for the past 30 days (if applicable) and verify that a documented controlled substance (narcotic) physical inventory is performed at every shift change between two licensed nursing staff. For each narcotics locker, a Narcotics Log Book should be found near the medication area that evidences a physical count took place and, if applicable, the following:

    a. For the destruction/disposal of controlled substances the nursing staff will complete the following information in a new row in the log: the date, time, patient name, CDCR number, dose to be administered, quantity removed from stock, quantity remaining in stock (running total), amount of waste, reason for waste, and confirm the entry is counter-signed by two licensing nursing staff.

    b. When all balances of medications are recorded, each time a nurse obtains a controlled medication from the designated locked area, licensed nursing staff will complete the following information in a new row in the log: the date, time, patient name, CDCR number, dose to be administered, quantity removed from stock, quantity remaining in stock (running total), signature of the administering licensed nursing staff, and names and strengths of controlled substances.

4. Interview clinic and medication-line nursing staff to ensure that they are aware of the required medication error reporting process.

    a. Interview at least one line staff nurse and ask that they describe the actions that would be taken if a controlled substance discrepancy was identified. If the nurse's response includes issuing "a report" to the CNE and PIC, the answer is "Yes." However, if the line nurse's response is incomplete but he/she indicates they would notify their supervisor, the OIG inspector must also interview the individual's SRN. If the SRN indicates that a report would be sent to the CNE and PIC, the answer is "Yes."

5. Narcotic Reconciliations

   a. Verify that nurses remove stock from the narcotic locker in a manner that always allows a spontaneous count of the narcotics log to be performed. In other words, verify that nurses do not wait until the end of the administration process to update the narcotics log.

   b. With a licensed nurse, perform a spontaneous physical count of three narcotic drug types chosen by the OIG inspector (preferably those that have been the subject of discrepancies in the past) and compare it to the unit's most recent shift count balance at the time of inspection. If the count is not accurate or the inspector cannot reconcile the narcotic physical inventory, the discrepancy will be noted as a deficiency.

References: April 2020 CCHCS HC DOM Ch. 3 Article 5 3.5.11.D.4; December 2021 Ch. 3 Article 5 3.5.16.d.7.B.6 & C, 8.A-B, 9.E.1-3 & F; January 2016 Ch. 3 Article 2 3.2.3.C.2.A-E; May 2019 Ch. 3 Article 5 3.5.7.C.8.A-D; OIG Medical Inspection Unit

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Ref # 7.102

REGIONAL INSPECTOR (Rev. 09/14/2021)

All clinical and medication line storage areas for non-narcotic medications: Does the institution properly secure and store non-narcotic medications in the assigned storage areas?

Testing Methodology:

In each clinical area (Clinic/Pill-Line), interview knowledgeable staff to identify where non-narcotic medications are stored. This could include: clinic floor stock locations; carts used for medication pill-pass lines; refrigerator/freezer; docu-med wall units (if applicable), and Automated Dispensing Cabinet (ADC) or also known as Omnicell used for after-hour supplies; or crash carts.

Note 1: For this test, storage controls and practices related to medication lines may only be tested for those medication lines selected for observation testing.

Once a storage location is found, the inspector will identify who primarily uses the medications—either the general clinic staff, for unissued or floor stock medications, or the pill-line staff for medications already designated for inmate/patients.

Visit each location and complete the steps below to conclude whether the area employs adequate storage protocols.

1. Non-refrigerated and Refrigerated/Frozen Medications

   a. Verify that all clinical and medication preparation/ administration areas including any rooms, cabinets, drawers, refrigerators, freezers, or other areas where non-narcotic medications are stored, remain locked when not in active use. Also verify that

medication (pill-pass) carts are locked when not in active use—however, medication carts and refrigerators may remain unlocked if they are stored in a locked room.

b. Verify that the medications are stored in a clean and orderly manner in cabinets/drawers, refrigerators, freezers, or carts of sufficient size to prevent crowding/clutter.

c. Interview clinical staff and determine if the medication storage location utilized by staff have a system in place to temporarily store non-refrigerated and refrigerated/frozen medications pending return to pharmacy. Returned medication must be clearly identified and stored separately from other medications.

Note 2: In addition, verify the process of separating returned KOP medications previously in possession by a patient from DOT medications that can be potentially restocked and reissued by pharmacy. Inspector needs to use clinical judgment to determine if the process prevented contamination of KOP and DOT medications.

2. <u>After-Hours Medication Storage</u>

For clinics and medication line staff that use Docu-med wall units or ADC to store medications for use during hours when the pharmacy is closed, perform the following verification:

- Verify that access to the storage units is controlled and access is limited to designated staff only. For example, the medication supply should be secured and locked. In addition, if the medication storage location has a seal issued by the pharmacy and maintains a log. If Docu-med units are present, verify that the log book shows that a nurse is checking the security lock daily and inventoried monthly.

- Verify that a pharmacist and nurse are inventorying the ADC ***monthly*** for DEA-controlled substances and ***quarterly*** for non-DEA-controlled medications.

3. <u>Crash Carts</u>

For clinics that have a crash cart, perform the following verification:

- Verify that the emergency medication supply (crash) cart is secured and sealed with a red tamper-resistant, number seal, which must be broken to gain access to the medications. Also, verify that the crash cart log book shows that a nurse is checking the security lock each shift and that a pharmacist and nurse are inventorying it monthly.

References: April 2017 CCHCS HC DOM Ch. 3 Article 5 3.5.6.C.1.A.C-E, 3.A-B, D, & F, & 4.A; May 2019 Ch. 3 Article 5 3.5.7.C.4.D.8.E.2.C., & E.6.B-C; November 2016 Ch. 3 Article 3.7.5.E.1; OIG Medical Inspection Unit

Ref # 7.103

REGIONAL INSPECTOR (Rev. 09/14/2021)

All clinical and medication line storage areas for non-narcotic medications: Does the institution keep non-narcotic medication storage locations free of contamination in the assigned storage areas?

Testing Methodology:

In each clinical area (Clinic/Pill-Line), interview knowledgeable staff to identify where non-narcotics medications are stored. This could include: clinic floor stock locations; carts used for medication pill-pass lines; refrigerator/freezer; docu-med wall units and ADC used for after-hour supplies; or crash carts.

Note: For this test, storage controls and practices related to medication lines may only be tested for those medication lines selected for observation testing.

Once a storage location is found, the inspector will identify who primarily uses the medications—either the general clinic staff, for unissued or floor stock medications, or the pill-line staff for medications already designated for inmate/patients.

Visit each location and complete the steps below to conclude whether the area employs adequate storage protocols.

1. Non-refrigerated, Refrigerated or Frozen Medications

    a. Verify that bulk non-refrigerated medications are not stored on the floor or subject to moisture.

    b. Verify that the storage of non-refrigerated medications for internal (oral) use, such as medications in liquid, tablet, capsule, or powder form; are separated from medications for external (topical) use, such as creams and ointments. Oral and topical medications may be separated in different drawers or separated within one drawer by a divider or other means.

        Note 1: Non-stock oral and topical medications that have already been designated for a specific patient do not have to be separated. However, pre-designated medications must still be in blister-packs or enclosed in an envelope (and not loose).

    c. Verify that non-refrigerated medications are stored separately from the employee's personal food items, germicides, disinfectants, and other household substances.

d. Verify that all medication refrigerators and frozen medication storage areas do not contain employee's personal food, drink items or laboratory specimens. If the storage location has a refrigerator or freezer designated for staff use, verify that it does not contain medications or supplies for medical use. If any such items are found, the answer to the question is "No."

e. Use a thermometer to measure the room temperature where medications are stored and determine if it is in the required range for medication storage. The appropriate temperature range for a room storing medication is between 15ºC (59ºF) and 30ºC (86ºF).

Note 2: The room temperature shall be recorded at the beginning of the shift. For medication storage areas closed on third watch, the room temperature shall be recorded at the end of second watch shift. For medication areas not staffed for either shift, the log shall indicate area as being "closed."

f. Verify that staff maintains temperature logs in compliance with policy. Policy requires that institutions maintain their medication storage locations at the temperatures listed below.

<u>Required Temperature Ranges:</u>

- Refrigerator: between 2ºC (36º F) and 8ºC (46ºF)
- Freezer: between -50ºC (-58º F) and -15ºC (5ºF)
- The manufacturer recommendation for storage temperature shall be adhered to when different from above.

i. Check the refrigerator or freezer's thermometer(s) for compliance with the temperature ranges above. If the temperature appears off, it may be because the thermometer was too close to the unit's door or cooling element. If this is the case, re-locate the thermometer to the middle of the unit and re-check it in 30 minutes. If the unit is still out of the required temperature range, the answer is "No."

ii. Verify that twice daily during hours of operation, temperature logs are kept for the refrigerator and freezer. Scan the log for the last 60 days and look for signs of incompleteness on days the location would have been operating. If three or more entries are missing during any 30 day period, the answer is "No."

Note 3: Because clinics are required to have a refrigerator as a core piece of equipment (See MIT 5.108), OIG Medical Inspection Unit have concluded that the equipment must be maintained in working order. Further, a temperature log is evidence as to whether the equipment is properly functioning. As a result, temperature logs are required to be maintained even during periods when no medication is currently being stored.

iii. Verify for the last 60 days that recorded refrigerator and freezer temperatures were within the ranges listed above. If three or more entries are outside the required ranges during any 30 day period, the answer is "No."

References: April 2020 CCHCS HC DOM Ch. 3 Article 5 3.5.11.d.2.A.1-4, & 9-10, B.2.d, C.1-3., & D.1.a-d, 2.a-b; January 2016 Ch. 3 Article 2 3.2.3.c.1.F; OIG Medical Inspection Unit

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Ref # 7.104

REGIONAL INSPECTOR (Rev. 09/14/2021)

All clinical and medication line storage areas for non-narcotic medications: Does the institution safely store non-narcotic medications that have yet to expire in the assigned storage areas?

Testing Methodology:

In each clinical area (Clinic/Pill-Line), interview knowledgeable staff to identify where non-narcotic medications are stored. This could include: clinic floor stock locations; carts used for medication pill-pass lines; refrigerator/freezer; docu-med wall units and ADC used for after-hour supplies; or crash carts.

Note: For this test, storage controls and practices related to medication lines may only be tested for those medication lines selected for observation testing.

Once a storage location is found, the inspector will identify who primarily uses the medications—either the general clinic staff, for unissued or floor stock medications, or the pill-line staff for medications already designated for inmate/patients.

Visit each location and complete the steps below to conclude whether the area employs adequate storage protocols.

1. Non-refrigerated and Refrigerated/Frozen Medications

    a. Select three (3) unopened medications from each storage area (i.e., all areas where non-narcotic refrigerated and non-refrigerated medications are stored within the clinic; and one selected cart per pill-line location) and verify that the items are not expired. If any one item is expired, the answer is "No."

    b. In addition, select up to ten (10) previously opened multi-dose non- refrigerated and refrigerated/frozen medications (including vials & over-the-counter stocks) and verify if the medications are labeled with the beyond-use date (the calculation of when it was first opened and the manufacturer's guidelines for continued use). Verify that solutions such as lactate ringers are not removed from their original

sterilization packaging longer than the time period recommended by the manufacturer. In addition, verify that refrigerated/ frozen solutions or other special medications are not removed from their original sterilization packaging longer than the time period recommended by the manufacturer.

Note 1: For multi-dose vial medications, verify if the medications are labeled 28 days from the medications were first opened (unless the manufacturer specifies differently) and has the nurse's initials on the label or vial.

Note 2: The Regional RN will review the manufacturer's guidelines for reusability information. If the manufacturer guidelines are not available onsite or online, the RN will consult with the OIG's Supervising Regional Nurse to determine specific strategies for making determinations regarding the medication.

Note 3: Medications supplied in the manufacturer's original packaging and stored appropriately shall be usable until the expiration date (considered to be midnight of the last day of the month indicated, unless otherwise stated on the package).

References: April 2020 CCHCS HC DOM Ch. 3 Article 5 3.5.11.d.5.A-C; OIG Medical Inspection Unit

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Ref # 7.105

REGIONAL INSPECTOR (Rev. 09/14/2021)

Medication preparation and administration areas: Do nursing staff employ and follow hand hygiene contamination control protocols during medication preparation and medication administration processes?

Testing Methodology:

Preparation and administering: Select six to eight medication (pill-pass or insulin) lines for testing. Identify where and when the nursing staff conduct their preparation and administration processes for each pill line selected for sampling. The preparation and administration processes can take place at two different times and locations, or they can take place simultaneously. For example, if a nurse runs a pill-line on a yard, the nurse will prepare the medications ahead of time at a clinic location and deliver them in a cart out to the yard. Alternatively, if a nurse runs a pill-line at a clinic window, they prepare the medications immediately before they administer them.

For each pill-pass or insulin line selected for sampling, observe nursing staff's hand hygiene practices during their preparation and administration of medications and conduct the following tests:

1. Determine if the medication nurses have readily accessible access either to running water and antimicrobial soap, or alcohol based hand rub sanitizer/wipes.

2. Determine if the medication nurses have access to a supply of non-latex gloves.

3. Determine through observation or interview, whether medication nurses sanitize their hands during the preparation and administering of medications (and wear gloves when required) under the required conditions listed below:

   a. Prior to preparing medications and administering medications, nurses must sanitize their hands using antiseptic soap and water, or alcohol-based hand rub.

   b. If nurses elect wear gloves, they must sanitize their hands prior to putting on clean gloves, as well as, each time there after that gloves are re-applied.

   c. Medication Administration:

      i. Verify that nursing staff re-sanitize their hands and change gloves (if applicable) before the intentional touching of a patient's skin, such as when performing an injection.

      ii. Verify that nursing staff re-sanitize their hands and change gloves (if applicable) after touching an inmate's skin when administering medications.

      iii. Verify that nursing staff re-sanitize their hands and change gloves (if applicable) when visibly soiled or if the integrity of the glove is compromised.

   d. Medication Preparation: Also, verify that nursing staff use gloves during the medication preparation process if they come into direct contact with medications that are intended for subsequent ingesting.

Note: To avoid direct contact with medications, the nurse may pour medications directly from a manufacturer sealed blister package or bulk medication baggie directly into the patient's medication cup and place the cup on the countertop (or food port ledge) for the patient to pick up.

References: CDC Guideline for Hand Hygiene in Health-Care Settings, MMWR, 2002; OIG Medical Inspection Unit

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Ref # 7.106

REGIONAL INSPECTOR (Rev. 06/30/2020)

Medication preparation and administration areas: Does the institution employ appropriate administrative controls and protocols when preparing medications for patients?

Testing Methodology:

Preparing and administering medications: For each of the six to eight medication/ insulin lines selected for sampling in MIT 7.105 above, observe and interview nursing staff while they prepare

medications for patients. Verify that they ensure the right patient receives the right medication and right dose, by the right route, at the right time, and that each patient's Medication Administration Record (MAR) includes the right documentation.

1. Perform observations or interviews to determine whether nurses who receive bulk supplies of new order medications diligently compare and reconcile the medication's identity/dosage and the related MAR information to the corresponding physician's order (or equivalent electronic medication reconciliation process). The nurses must ensure that the medication received and the administration instructions found on the MAR agree exactly with the physician's order. If not, the reason for the discrepancy must be determined.

   Note 1: Periodically, pill-line nurses receive bags filled with new medications. Each medication will have a corresponding MAR. By law, prior to distributing medications to the patient, the administering nurse is required to reconcile the patient's newly received medication and MAR against the nurse's file copy of the provider's medication order. If they do not match, the medication cannot be dispensed until the discrepancy is resolved. However, there are two exceptions to this reconciliation process: 1) If the medication received is simply a replenishment for an existing order and not a newly prescribed or modified prescription order, then the nurse does not need to compare the medication to the provider's order; and 2) The pharmacy can substitute generic drugs for the same dosage of a brand name medication and vice versa.

2. Verify that medication nurses maintain unissued medications in their original labeled packaging.

   Note 2: It is acceptable for a nurse to remove a medication from the original packaging and place it in a pill cup or coin envelope if the same nurse is going to personally dispense the medication during same shift in which the medication was initially removed from the original packaging.

3. For nursing staff who prepare medications in advance, ensure that the same nurse who prepared the medications is the nurse who distributes NA/DOT medications to inmate/patients.

References: January 2016 CCHCS HC DOM Ch. 3 Article 2 3.2.4.c.1.C-F April 2020 Ch. 3 Article 5 3.5.11.d.2.A.4; OIG Medical Inspection Unit

Medication preparation and administration areas: Does the institution employ appropriate administrative controls and protocols when administering medications to patients?

Testing Methodology:

Preparing and administering medications: For each of the six to eight medication/ insulin lines selected for sampling in MIT 7.105 above, observe and interview nursing staff while they administer (distribute) medication to patients. Verify that they ensure the right patient receives the right medication and right dose, by the right route, at the right time, and that each patient's Medication Administration Record (MAR) includes the right documentation. Inspectors should observe 10-15 medication-pass encounters at each of the six to eight pill lines tested.

1. Interview at least two pill-line nurses and determine if they are fully aware of, and follow, standard practices related to reconciling medications and reporting medications errors to management by submitting a Health Care Incident Report.

2. Verify that nursing staff compares the medication's unit dose to the inmate's corresponding MAR prior to when the medications are administered.

   Note: The nurse may perform this verification during the preparation process.

3. Verify that nursing staff distribute medications to patients within the time period one hour prior to or one hour after the normal daily distribution time frame. The Morning or "a.m." distribution time frame is 7:00 a.m., noon is 12:00 p.m., and Dinner or "p.m." is 6:00 p.m. Therefore, an "a.m." medication should be distributed between 6:00 a.m. and 8:00 a.m. In addition, some medications are distributed at "Bedtime," which is typically 8:00 p.m. and 10:00 p.m.

4. Verify the nurse identified the patient using a picture ID with name and/or CDCR number prior to administering medication.

5. For at least two patients, confirm that the medications distributed agree with the MAR.

6. Identify and observe the distribution of direct observation therapy (DOT) medications for at least two patients.

   Licensed health care staff shall observe the patient take the oral medications into his/her mouth and swallow all pills followed by an adequate amount of water. The patient shall remain clearly visible to health care staff. Licensed health care staff, with assistance from custody as needed, shall verify that the patient swallowed the medications by completing a visual mouth check, viewing the empty cup, and other checks as indicated. If staff cannot verify the patient swallowed the medication, upon the health care staff

person's request, custody shall escort the patient to an area with clear visibility where medication administration can be verified.

- For self-injected medication, the patient must inject themselves with a syringe within visible sight of the administering nurse. For all other nurse administered (NA) medications (i.e., non-DOT), the nurse is not required to make a visual confirmation of consumption.

7. Verify that the nurse provided medication education/instruction to patients, when requested or needed.

8. Verify that the nurse documents by scanning each medication pill-pass on the MAR (via initials and date) at the time of medication administration.

9. Based on observations, verify that nurses administer medications in accordance with departmental policies and procedures, or otherwise follow industry standards, and best practice protocols. (For example, verify that medication injections were appropriate and did not involve inappropriately mixing contraindicated insulin medications into the same syringe)

References: November 2018 CCHCS HC DOM Ch. 1 Article 2 1.2.7.a.2.A; December 2021 Ch. 3 Article 5 3.5.27.d.1.B; January 2016 Ch. 3 Article 2 3.2.4.c.1-5; OIG Medical Inspection Unit

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Ref # 7.108

REGIONAL INSPECTOR (Rev.09/27/2021)

Pharmacy: Does the institution employ and follow general security, organization, and cleanliness management protocols in its main and remote pharmacies?

Testing Methodology:

At the main pharmacy and each remote pharmacy, interview key staff and conduct tests to determine if controls are maintained related to general security, organization and cleanliness. Complete the following steps:

1. Verify that all pharmacy doors are kept locked to prevent unauthorized entry.

2. Verify that the narcotics locker is locked when not in active use.

3. Through observation, verify that pharmacy staff has access to operational hand hygiene facilities.

4. Briefly tour and determine if the medication preparation area is clean and uncluttered.

Note: See the Sampling Methodology's Note 1 above for important information on how to treat institutions with multiple PICs or pharmacy locations.

References: April 2020 CCHCS HC DOM Ch. 3 Article 5 3.5.11.d.3; CCR Title 16 Division 17 Article 2 Section 1714; OIG Medical Inspection Unit

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Ref # 7.109

REGIONAL INSPECTOR (Rev. 09/27/2021)

Pharmacy: Does the institution's pharmacy properly store non-refrigerated medications?

Testing Methodology:

Interview the pharmacist-in-charge (PIC) or other knowledgeable person and identify all the remote pharmacy locations areas where non-refrigerated medications are stored. Perform the tests below at each location. In addition, ask the PIC if the pharmacy has any known medications that are unlabeled or not being stored in their original containers—if "yes," test under step 1.b below, as appropriate. Next, visit the location(s) and complete the steps below to conclude whether the pharmacy employs adequate storage protocols.

Non-refrigerated Medications:

1. Visit the main, remote and bulk storage pharmacy locations for non-refrigerated medications (not-supplies) and complete the following steps:

    a. Verify that the pharmacy stores medications in a clean and organized manner. Medication is not to be stored on the floor or subject to moisture.

    b. Judgmentally select three (3) medications and verify the items are stored in their original containers, are properly labeled (drug name, dosage amount and expiration date), and are not expired. If any one item does not meet each criterion, the answer is "No."

    c. Verify that employees store personal food items separately from stored medications.

    d. Use a thermometer to measure the room temperature and determine if it is in the required range for medication storage. The appropriate temperature range for a room storing medication is between 15ºC (59º F) and 30ºC (86ºF).

    Note 1: When logging procedures are required, for each pharmacy the room temperature shall be recorded at the time of the pharmacy closing (or in the early evening). If closed for the day, the log shall indicate the area as being "closed."

    Note 2: See the Sampling Methodology's Note 1 above for important information on how to treat institutions with multiple PICs or pharmacy locations.

Ref # 7.110

REGIONAL INSPECTOR (Rev. 09/27/2021)

Pharmacy: Does the institution's pharmacy properly store refrigerated or frozen medications?

Testing Methodology:

Interview the pharmacist-in-charge (PIC) or other knowledgeable person and identify all the remote pharmacy locations areas where refrigerated and frozen medication storage exists. Perform the tests below at each location. In addition, ask the PIC if the pharmacy has any known medications that are unlabeled or not being stored in their original containers—if "yes," test under step 1.b. below, as appropriate. Next, visit the location(s) and complete the steps below to conclude whether the pharmacy employs adequate storage protocols.

Refrigerated or Frozen Medications:

1. Visit the main, remote and bulk storage pharmacy locations for refrigerated medications and complete the following steps:

    a. Verify that all refrigeration and frozen medication storage areas are clean and organized.

    b. Judgmentally select three (3) medications and verify the items are stored in their original containers, are properly labeled (drug name, dosage amount and expiration date), and are not expired. If any one item does not meet each criterion, the answer is "No."

    c. Verify that employees store personal food items separately from stored medications.

    d. Policy requires that institutions maintain their medication storage locations at the temperatures listed below, unless a particular medication requires other special temperature ranges. Verify pharmacy staff maintains temperature logs in compliance with policy.

    Required Temperature Ranges:

    - Refrigerator: between 2ºC (36º F) and 8ºC (46ºF)
    - Freezer: between -50ºC (-58º F) and -15ºC (5ºF)
    - The manufacturer recommendation for storage temperature shall be adhered to when different from above.

Upon arrival to the pharmacy refrigerator or freezer medication storage location(s) do the following:

i. Check the refrigerator or freezer's thermometer(s) for compliance with the temperature ranges above. If the temperature appears off, it may be because the thermometer was too close to the unit's door or cooling element. If this is the case, re-locate the thermometer to the middle of the unit and re-check it in 30 minutes. If the unit is still out of the required temperature range, the answer is "No."

ii. Verify that twice daily during hours of operation, temperature logs are kept for the refrigerator and freezer. Scan the log for the last 60 days and look for signs of incompleteness on days the location would have been operating. If three or more entries are missing during any 30 day period, the answer is "No."

iii. Verify for the last 60 days that recorded refrigerator and freezer temperatures were within the ranges listed above. If three or more entries are outside the required ranges during any 30 day period, the answer is "No."

iv. Verify that the pharmacy has a system in place that requires its staff to properly segregate medications returned from clinical units or medication areas until such time that the medications can be screened for re-stocking and re-use suitability.

e. If the pharmacy has a refrigerator or freezer designated for staff use, quickly scan it for medication inventory items that are not for staff consumption. If any such items are found, the answer to the question is "No."

f. **For Information Only** - Verify that the pharmacy requires clinics and medication administration areas to store all medications identified as "return to pharmacy" in a specifically designated/ segregated area (pending a physical return to the pharmacy). Exception will be taken under test 7.102 if clinics are found to not be properly segregating medications earmarked for return to pharmacy.

Note 1: Some institutions have multiple pharmacy locations and some of these multi-pharmacy institutions have more than one PIC. For tests 7.108 – 7.112, if the institution has multiple pharmacy locations, but only 1 PIC, all of the pharmacies will be treated as one area/ entry on the testing worksheet. However, if the institution has more than 1 PIC, the area/pharmacy that each PIC oversees, will be treated as separate areas/entries on the testing worksheet.

References: April 2020 CCHCS HC DOM Ch. 3 Article 5 3.5.11.d.2; May 2019 Ch. 3 Article 5 3.5.25.c.2.D-E; OIG Medical Inspection Unit

Ref # 7.111

REGIONAL INSPECTOR (Rev. 12/13/2021)

Pharmacy: Does the institution's pharmacy properly account for narcotic medications?

Testing Methodology:

1. Obtain from the PIC the records of controlled medication inspection results for all medication storage areas inside and outside of the pharmacy for the last 6 months and perform the following:

   Note 1: For this test, the inspector does not need to visit each medication area storage location. The pharmacy maintains all completed controlled substances inventory records for each of the last 6 months under review.

   a. Verify that a pharmacist conducted a monthly physical inventory of all controlled substances in the pharmacy.

   b. Verify that a pharmacist conducted a monthly physical inventory of controlled substances in all medication administration areas of the institution (non-pharmacy areas except Omnicell) and documented the results on the form CDCR 7477, Medication Area Inspection Checklist (subpart "Controlled Medications").

   c. If permission is granted by the Statewide Chief of Pharmacy Services for an Automated Dispensing Cabinet (ADC, also known as Omnicell) to contain controlled substances, verify that pharmacy staff conducted a physical inventory of all controlled substances in each ADC monthly.

   d. Verify the pharmacist responsible for completing each inventory record and the RN, LVN, or LPT present at the completion of the medication area inspection printed his/her name, and signed and dated the form.

      Note 2: The RN, LVN, or LPT present at the completion of the medication area inspection shall acknowledge receipt of the CDCR 7477 by printing his/her name, and signing and dating the form.

   e. Verify the PIC responsible for the inspected medication area reviewed the completed CDCR 7477, printed his/her name, and signed and dated the form.

   f. Identify any discrepancies discovered during the physical inventory of controlled substances. If discrepancies were unresolved, determine if the controlled substances inventory record or other evidence demonstrates the PIC investigated and reported the error(s).

2. From the Pharmacy's supply of medications - Perform a physical count of 3 narcotic drug types (preferably those that have been the subject of discrepancies in the past) and compare it to the Pharmacy's perpetual inventory record (PIR) for accuracy.

3. While reviewing the 3 narcotic medications (from step 2 above), ensure they are not expired. All pharmacy stock should have current dates, and the institution should have a process in place to remove medications prior to the time they become expired. If any item is expired, the answer is "No."

Note 3: Some institutions have multiple pharmacy locations and some of these multi-pharmacy institutions have more than one PIC. For tests 7.107 – 7.111, if the institution has multiple pharmacy locations, but only 1 PIC, all of the pharmacies will be treated as one area/ entry on the testing worksheet. However, if the institution has more than 1 PIC, the area/pharmacy that each PIC oversees, will be treated as separate areas/entries on the testing worksheet.

References: December 2021 CCHCS HC DOM Ch. 3 Article 5 3.5.16.d.7.B.3-4, & 9.F; May 2019 Ch. 3 Article 5 3.5.25.c.1 & 2.H; May 2019 Ch. 3 Article 5 3.5.7.e.6.B.2-3; April 2020 Ch. 3 Article 5 3.5.11.d.4.I; OIG Medical Inspection Unit

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Ref # 7.112

REGIONAL INSPECTOR (Rev. 12/13/2021)

Pharmacy: Does the institution follow key medication error reporting protocols?

Background: A health care worker who causes or discovers a medication error, must complete the centralized electronic Health Care Incident Reporting (eHCIR) system within 24 hours of occurrence or discovery. Per California Code of Regulations Title 16 Div. 17, Article 2, Section 1711, "medication error" means any variation from a prescription or drug order not authorized by the prescriber. When a pharmacist or designee determines that a medication error has occurred, they shall as soon as possible communicate to the patient and prescriber that a medication error has occurred and take the steps required to avoid injury or mitigate the error. A record of the quality assurance review shall be immediately retrievable in the pharmacy and shall contain at least the following:

- The date, location, and participants in the quality assurance review
- The pertinent data and other information relating to the medication error(s) reviewed and documentation of any patient contact
- The findings and determinations generated by the quality assurance review; and,

- The recommended changes to pharmacy policy, procedure, systems or processes, if any.

The institution's PIC or designee shall complete the "**CDCR Pharmacy Error Follow-up Form**" within 2 business days of pharmacy staff becoming aware of the medication error based on CCHCS policy and procedure. For this testing, the OIG will give 3 business days to complete the CDCR Pharmacy Error Follow-up Form.

Testing and Sampling Methodology:

I. For pharmacy related medication errors:

1. From the pre-inspection documents submitted by CCHCS for the most recent 12 months, sample 25 Medication Error Reports. Use the following selection criteria to select the samples:

   a. First, select all severity level 4, 5, or 6 medication error reports. If there are more than 25 of these medication error reports, then randomly select the sample of 25 from these error reports.

   Note 1: For Folsom State Prison, first select five medication errors reported from medication administration areas that service female patients before selecting the remaining 20 medication errors.

   b. Second, randomly select the remaining severity level 1, 2 or 3 medication error reports in order to complete the sample size of 25.

   c. Third, if there are still insufficient error reports to reach 25 samples, the SRN shall examine any remaining medication error reports that have no severity level assigned. If the SRN determines that any of those medication errors "reached the patient," then those medication error reports shall be added to the sample until the sample size reaches 25.

2. Test the 25 sampled Medication Error Reports for the following conditions:

   a. Ensure that the PIC or pharmacist designee completed the CDCR Pharmacy Error Follow-up form within 3 business days from the error's reported date.

Note 2: Using the Health Care Incident Reporting list, use the reported date to determine if the PIC or pharmacist designee completed the CDCR Pharmacy Error Follow-up form within 3 business days (For this testing, the OIG will give 1 additional business day grace period to complete the pharmacy error follow-up form).

Note 3: Some institutions have multiple pharmacy locations and some of these multi-pharmacy institutions have more than one PIC. For tests 7.108 – 7.112, if the

institution has multiple pharmacy locations, but only 1 PIC, all of the pharmacies will be treated as one area/ entry on the testing worksheet. However, if the institution has more than 1 PIC, the area/pharmacy that each PIC oversees, will be treated as separate areas/entries on the testing worksheet.

b. Ensure that the PIC or pharmacist designee notified the patient and the prescriber of the medication error.

Note 4: Medication error with severity levels 1-6 "that reached the patient" requires notification to the patient and prescriber as required by the CCR, Title 16, Sec. 1711. Using the CDCR Pharmacy Error Follow-up form, verify if the PIC or pharmacist designee provided a notification date for both the patient and the prescriber. If the notification date for either the patient or prescriber is missing, the answer to this question is "No."

c. Ensure that the PIC or pharmacist designee conducted an investigation of each medication error to assess the cause and any contributing factors such as systems or process failures. The CDCR Pharmacy Follow-up Form shall contain at least the following information:

- The date, location (institution name), and the PIC or pharmacist designee name.
- The pertinent data and other information relating to the medication error(s) reviewed and documentation of any patient notification (CDCR Pharmacy Follow-up form section 2).
- The findings and determinations generated by the PIC or pharmacist designee (CDCR Pharmacy Follow-up form section 3).
- The recommended changes to pharmacy policy, procedure, systems, or processes, if any (CDCR Pharmacy Follow-up form section 4).

Note 5: If the PIC or pharmacist designee failed to document any of the required information listed under (c), the answer to this question is "No."

d. Verify if the PIC or pharmacist designee discussed all sampled medication error reports with the appropriate local quality committee (i.e. Quality Management Committee, Patient Safety Committee).

Note 6: If the PIC or pharmacist designed failed to provide evidence that all 25 sampled medication error reports were shared to the local appropriate committee, the answer to this question is "No."

II. For non-pharmacy health care incident reports:

1. ***For Information only:*** Discuss the medication error process with the CME, CNE, and PIC at the institution to determine the institution's system in place to monitor, investigate, and warrant a corrective action for all non-pharmacy health care incident reports.

References: November 2018 CCHCS HC DOM Ch. 1 Article 2 1.2.7.a.2.A; December 2021 Ch. 3 Article 5 3.5.27.d.2.A & D; CCR Title 17, Div. 17, Article 2, Section 1711; OIG Medical Inspection Unit

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Ref # 7.998

For Information Purposes Only (Not Scored)

HQ INSPECTOR (Rev. 12/13/2021)

During compliance testing, did the OIG find that medication errors were properly identified and reported by the institution?

Testing Methodology:

Step 1

1. a. Non-clinical inspectors - Throughout the inspection process (primarily tests 6.003, 7.001-7.006, 9.001 & 13.004), inspectors will identify instances where medication errors have been noted to occur. At the conclusion of the EHRS file review, identify all medication errors from the testing worksheets that meet the criteria below (or any other noteworthy instance related to medication management), and report them to OIG's Chief Physician and Surgeon (CP&S) to determine if any errors fall into the severity range of 4-6 and warrant further review, under Step 2 below.

Common types of medication errors

- Medication is started late, or not at all (in accordance with provider order),
- Wrong drug is prescribed, prepared or administered,
- Medication is given to the wrong patient,
- Medication is given at the wrong time/frequency,
- Medication is given by way of the wrong route (e.g. oral, I/M versus Subcutaneous, IV),
- or by way of the wrong method (i.e. as a KOP instead of a DOT)
- Medication is given in the wrong dose,
- Medication is incorrectly documented.

Note 1: CCHCS defines medication error severity levels as:

0 = did not reach the patient, 1 = reached the patient but did not result in harm, 2 = resulted in increased monitoring but no change in vital signs and no harm, 3 = required increased monitoring and change in vital signs but no ultimate harm, 4 = resulted in need for additional treatment with another drug or hospitalization, 5 = resulted in permanent harm, 6 = may have contributed or resulted in death.

Step 2

2. a. The HQ RN inspector will review all reported medication errors identified in Step 1 above and identify those errors that, based on the inspector's comments provided, appear to fall within the severity level range of 4-6. For the identified errors, the HQ RN inspector will list out the key elements of the medication error in the "Preliminary" columns of the 7.998 testing worksheet.

   Note 2: If the medication error for the patient has already been identified and tested in the OIG's regional test/question 7.112 Pharmacy-Medication Errors, then note those results on the testing worksheet and determine if the sample should be excluded from this test. For example, do not test the same medication error if the error was appropriately rated at a severity level of 4 – 6.

2. b. Using the worksheet created in 2a above, contact the PIC and obtain the following documents for each medication error identified:

   - electronic Health Care Incident Reporting (eHCIR) (completed by the person that committed or discovered the error),
   - CDCR Medication Error Follow-Up Report (completed by the PIC for all reported errors),

   For those errors that the PIC rated at a severity level of 4 – 6, obtain the following documents:

   - Incident Summary report
   - Documentation to provide evidence that the PIC submitted the Incident Summary Report to both the local committee (e.g. e-mailing members of the local Pharmacy & Therapeutics / Patient Safety / Quality Control Committee(s), as applicable)

   Note 3: For the PIC to efficiently identify the corresponding medication error reports, the worksheet's "Preliminary" column information may have to be provided to the institution via hand-delivery, phone call, or the secure File Depot account. Do not e-mail the medical information to the PIC.

2. c. Review the reports for all medication errors and determine the following:

   - Ensure that all required documents were completed.

- Determine if the PIC completed the Medication Error Follow-up Report within 2 business days of the error being received. To determine when the PIC was notified of the error, review the "Medication Error Report" date stamp or the notification date indicated on the lower left section of that report. Do not use the date on the top of the PIC's "Medication Error Follow-up Report."

- Verify that the Medication Error Follow-up Report (or other documentation) indicates that the report was shared with the local committee(s) identified in 2b. above.

2. d. For errors that the PIC assigned a severity level of less than 4, review the original error report and discuss it with the CP&S. If the CP&S still believes the incident warranted a level 4 – 6 rating, ask the PIC to substantiate why it was rated at a lower level.

Step 3

Summarize the results of this information-only test for inclusion in the draft report.

References: December 2021 CCHCS HC DOM Ch. 3 Article 5 3.5.27.d.1-3; CCR Title 17, Div. 17, Article 2, Section 1711; OIG Medical Inspection Unit

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Ref # 7.999

For Information Purposes Only (Not Scored)

REGIONAL INSPECTOR (Rev. 12/13/2021)

Pharmacy: For Information Purposes Only: Do patients in restricted housing units have immediate access to their KOP prescribed rescue inhalers and nitroglycerin medications?

Note 1: This test should not be done during medication pill-pass because officers will not be available to assist with the test.

Testing Methodology:

1. On the day of the site visit, obtain from the Pharmacist-in-Charge (PIC) an "Active Medication Listing" of all patients who are currently prescribed a KOP rescue (asthma) inhaler or a KOP nitroglycerin medication. The listing should include: the last name, CDCR number, medication name, and unit-housing. If the institution being inspected houses administratively restricted inmates who are endorsed at another institution (e.g. CRC houses its Ad Seg inmates at CIM), ask the PIC for a similar list of those patients who are prescribed KOP inhalers or Nitroglycerin.

2. From the Active Medication Listing, identify all patients who are currently housed in restricted units such as ASU, SHU, and PSU. For this test, do not include inmates housed in an OHU, CTC, SNF, or Mental Health Crisis Bed.

a. Test a maximum of 10 patients for each unique restricted housing unit location/building inspected (i.e. main ASU, stand-alone ASU, PSU, etc.) For SHU institutions with large housing areas, test no more than 20 patients per location.

3. For those patients prescribed KOP medications that consist of either "rescue" inhalers or nitroglycerin and housed in restricted units, determine if the patient currently has possession of their required KOP medication by doing the following:

A. Visit each restricted housing unit location and have custody staff help you interview the applicable patients who are physically available at the time of the inspection. Ask the patient if they currently have possession of their "rescue inhaler" or Nitroglycerin medication.

1. If the patient confirms they have the medication, then the institution is compliant with this test: otherwise got to #2 below.

2. If the patient indicates they do not have their medication(s) then, ask the inmate:

a. How long they have not had the medication,

b. The reason they do not have the medication, and

c. If, when, and who, they told someone about the need for the medication.

4. For those patients who are identified as needing (***i.e. they do not physically have an inhaler at the time of the inspector's inquiry, regardless if they actually want it***) but not having their KOP rescues medications, the OIG inspector will immediately provide a draft copy of the testing worksheet (i.e. listing of names) to the prison's CEO. The inspector should request that the CEO perform due diligence in confirming whether the identified inmate(s) actually need(s) an inhaler (or nitroglycerin) and re-issue the medication to the patient within one business day, if needed.

5. The inspector should obtain a follow-up written confirmation from the CEO on whether the patient was ultimately provided with a replacement inhaler or nitroglycerin along with the date the replace occurred (if applicable). Further, the inspector will inform the CEO that the OIG will review each patient's medical record (a few days after the inspection) to confirm that the patient was timely provided with the needed medication. If the inspector's verification process does not support the CEO's assertions or timely actions, the test answer will be "No."

Note 2: While the CEO and institutional health care program should diligently determine if the identified inmate(s) actually need a medication re-issued, the CEO will be allowed a few days to inform the OIG of the actual action(s) taken. Typically, an institution has three choices: ***a)*** *the patient must be issued a replacement inhaler*

within 1day (or evidence found that the patient actually has the inhaler), ***or b)*** *a patient refusal to accept a replacement inhaler must be documented* ***and/or*** *a PCP must stop the medication or convert it to a DOT medication.*

Note 3: If the CEO indicates that the patient was to be issued a replacement rescue medication (as opposed to having a previously issued medication found and returned), the regional OIG inspector shall review the patient's electronic medical record to confirm the timely reissuance.

Note 4: If the regional inspector concludes that the CEO did not take timely and appropriate action, the inspector should contact their supervisor and the HQ inspection coordinator to determine if a written letter of concern should be issued to CCHCS and the institution.

6. **Scoring the testing worksheet**: Based on each patient's interview responses and the actions the CEO ultimately took in re-issuing rescue medications (upon the OIG's notification), determine whether each patient in isolation housing units have immediate access to their KOP prescribed rescue inhalers and nitroglycerin medications by employing the following guidelines:

Answer: "NA" if . . .

- The CEO reports that the patient's medication was actually previously stopped or the patient is on a Keyhea treatment.

Answer: "Y" if . . .

- The OIG inspector found that the patient had their medication,
- The CEO concludes the patient actually had their medication, or

- The CEO took appropriate action (within one business day of the OIG's notification) to either have the medication timely issued to the patient, document a current refusal (in the EHRS), or stop /change the medication order.

Answer: "N" if …

The CEO does not provide adequate information that supports why the patient does not need to have replacement medication issued (For example; the patient was not re-issued the medication within one business day of the OIG's notification), a current refusal is not documented in the EHRS, or a provider did not stop /change the medication order.)

Or answer “N”, if the CEO indicates that the patient received a replacement medication from the institution’s pharmacy supply and it is not supported by the information found in the MAR Summary.

References: October 2021 CCHCS HC DOM Ch. 3 Article 5 3.5.13.a.1 & 3.A-D

Special Note - N/A – This test is for informational only. Due to the fact that it is not practical for the OIG to have inmate housing units searched to confirm an inmate’s assertions regarding possession of their KOP medications, the OIG does not score this test.

Prenatal and Postpartum Care

The Office of the Inspector General (OIG) will determine whether the institution provided required prenatal and postpartum care to a sample of pregnant patients.

Sample Methodology

Tests 8.001 – 8.007

1. Obtain the institution's tracking list for pregnant patients for the most recent 12 month period and sort it in descending order by delivery date.

2. Select a total of ten patients to include:

   - Five patients who recently gave birth at the institution between 2 and 6 months prior to the OIG's EHRS test week. Select the most recent births first and work backwards in time. (If an insufficient sample size is found, expand the sampled time period to include 7-12 months from the EHRS test week).

   - Five pregnant patients who arrived at the institution between 10 to 12 months prior to the OIG's EHRS test week. (If an insufficient sample size is found, expand the sampled time period to include all of the last 12 months. Choose the oldest sample first).

   Note 1: For this MIT, if the patient both initially arrived at the institution and also gave birth at the institution include them in the first bullet sample selection above until 5 samples are obtained. If more than 5 patients are sampled that met this condition, then include them in the 2nd bullet selection criteria until 5 more samples are identified.

3. Test all prenatal and postpartum care attributes that are applicable while the patient was housed at the institution.

   Note 2: For compliance testing by the inspector, the OIG will select a separate patient sample than the clinician case review sample (as time permits).

   Note 3: For this MIT, we will not test patients that are tested in MIT 12, reception center arrivals.

Inspection Procedures

Ref # 8.001

HQ INSPECTOR (Rev. 09/15/2021)

For patients identified as pregnant, did the institution timely offer initial provider visits?

Testing Methodology (10 samples):

For this test verify that the provider visit occurred within the testing time frames described below.

For institutions where pregnancy was initially confirmed at the current institution (usually a reception center/ i.e. CCWF): CCHCS policy requires that the Primary Care Provider evaluate patients within 7 calendar days of self-reporting a suspected pregnancy or when pregnancy is suggested by the patient's physical appearance, and/or signs and symptoms of pregnancy are present." Further, once pregnancy is confirmed (usually via a urine test or blood test), policy requires that an initial Obstetrician (OB) provider or OB nurse practitioner must also take place within 7 calendar days of the pregnancy diagnosis.

For institutions where the patient transferred in from another state prison with a previously confirmed pregnancy (usually a non-reception center/ i.e. CIW, FWF): CCHCS policy does not specifically require that a previously confirmed pregnant patient have an immediate provider visit upon arrival at another State run institution; however, the first OB provider (following arrival) visit must still be in accordance within the standard scheduled time frames outline below that are required of all pregnant patients:

Unless otherwise indicated by the obstetrician, pregnant patients shall be scheduled for their OB visits.

Prior to Revision 9/2021:

- Every four weeks in the first trimester and up to 24-26 weeks gestation.
- Every three weeks up to 30 weeks gestation.
- Every two weeks up to 36 weeks gestation.
- Weekly after 36 weeks gestation up to delivery

Effective 9/2021:

- Every four weeks in the first trimester and up to 24-28 weeks gestation.
- Every two weeks thereafter up to 36 weeks gestation.
- Weekly after 36 weeks gestation up to delivery.

Note 1: Pregnancy diagnosis – Pregnancy may initially be confirmed using a "urine" test, but then it will most likely be re-confirmed with a pregnancy panel lab test which will include an HCG test (Human chorionic gonadotropin) along with several other tests (as detailed in step 8.005 below). If the HCG level is greater than 5, the patient is generally deemed pregnant.

Note 2: For new reception center arrivals, policy requires women to be offered a pregnancy test and for a PCP to follow-up to ensure that one was offered within 7 days of arrival.

References: September 2021 CCHCS HC DOM Ch. 3 Article 1 3.1.16.e.1.B, 2.A.1 & 2.D.1-3; CCR Title 15, Division 3, Chapter 1, Subchapter 4, Article 8, Section 3355.2, Treatment for Pregnant Inmates; October 2020 Assembly Bill No. 732 Chapter 321; OIG Medical Inspection Unit

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Ref # 8.002

HQ INSPECTOR (Rev. 09/15/2021)

Was the pregnant patient timely issued a comprehensive accommodation chrono for a lower bunk and lower-tier housing and did the patient receive the correct housing placement?

Testing Methodology (10 samples):

1. Review the patient's health record to ensure that a lower bunker housing accommodation was issued at the "approximate" time of the first OB provider visit following pregnancy confirmation. (If the accommodation is not issued timely because the first OB visit was not held timely, exception would be taken under 8.001, not under this test.)

   Note 1: As long as the chrono (see Note 3) is not expired or cancelled, issued chrono's are valid at all state prisons. As a result, transferred patients with a pre-existing chrono do not need a new chrono re-issued upon arrival from another state prison. Also, CIW and CCWF only have lower tier general population housing units (so, lower housing tier chrono's are not normally applicable at these institutions).

   Note 2: If the pregnant patient came from another state institution and a lower bunk chrono was not issued, then the current institution's OB provider should issue a chrono at the time of the first provider visit.

2. Verify that the patient actually received a lower bunk assignment during her entire pregnancy stay at the institution. For this test, review SOMS' – "Population Tracking (Internal) – Bed Assignments – Bed #" and ensure that all of the bed assignments end in the letter "L" (which represents a lower bunk assignment). Test the applicable time period from when the OB provider initially saw the patient through to the date of delivery. Disregard time spent at another institution.

Note 3: Current CCHCS policy requires that pregnant patients be prescribed a low bunk/low tier housing accommodation. As a result, the OIG has concluded that at the first OB visit following pregnancy confirmation, the OB provider should issue the accommodation chrono for a lower bunk (and lower tier accommodation, if housed in a multi-tier housing unit). However, since CCWF and CIW only have single tier housing units in their GP living areas, the OIG has concluded that providers do not need to issue a lower tier chrono for these living areas.

Note 4: Prior to Revision 9/2021: Per CCHCS policy: pregnant patients shall be prescribed or issued: a CDCR Form 1845 (Disability Placement Program Verification chrono) for lower bunk (and lower tier housing, if housed in a multi-tier housing unit). Further, while the current policy is silent, the OIG has concluded that the Form 7410 (Comprehensive Accommodation Chrono) is also a currently acceptable form in which to order a housing accommodation. Effective 9/2021: A CDCR 7410, Comprehensive Accommodation Chrono, for lower bunk and lower tier if housed in a multi-tier housing unit and any other necessary medical clearances or restrictions in their third trimester or earlier, if medically indicated.

Note 5: Pregnancy diagnosis – Pregnancy may initially be confirmed using a "urine" test, but then it will most likely be re-confirmed with a pregnancy panel lab test which will include an HCG test (Human chorionic gonadotropin) along with several other tests (as detailed in step 8.005 below). If the HCG level is greater than 5, the patient is generally deemed pregnant.

References: September 2021 CCHCS HC DOM Ch. 3 Article 1 3.1.16.e.2.B.3; October 2020 Assembly Bill No. 732 Chapter 321

Ref # 8.003

HQ INSPECTOR (Rev. 09/15/2021)

Did medical staff promptly order recommended vitamins, extra daily nutritional supplements and food for the patient?

Testing Methodology (10 samples):

For institutions where pregnancy was initially confirmed at the current institution (usually a reception center/ i.e. CCWF): Review the health care record and verify that the patient was timely prescribed the required prenatal items (listed below) following pregnancy confirmation (See note 2 below).

Required order date for prenatal vitamins, extra daily nutritional supplements and food:

- Within 7 calendar days of pregnancy confirmation

- Prenatal vitamins (including iron & folic acid)
- Dietary supplementation to include:
  - Two (2) additional cartons of milk;
  - Two (2) additional servings of fresh fruit; and
  - Two (2) additional servings of fresh vegetables daily

For institutions where the patient transferred in from another state prison with a previously confirmed pregnancy (usually a non-reception center/ i.e. CIW, FWF): If the patient had a pre-existing order for vitamin supplements, extra milk, and extra food order at the sending institution, the receiving institution should perform what's known as an "order reconciliation" within approximately 24 hours of the patient's arrival. This process will basically re-establish the previously existing orders at the current institution.

However, if the sending institution did not previously issue orders for vitamin supplements (plus iron & folic acid), extra milk, and extra food order, and the OB provider/ nurse practitioner did not perform this task at the first patient encounter (following arrival), the answer is "No."

Note 1: In the EHRS, look for the Physician's Order to verify that the PCP ordered extra supplements (vitamins, iron, and folic acid) and food. The information may be found under the "orders" screen.

Note 2: Pregnancy diagnosis – Pregnancy may initially be confirmed using a "urine" test, but then it will most likely be re-confirmed with a pregnancy panel lab test which will include an HCG test (Human chorionic gonadotropin) along with several other tests (as detailed in step 8.005 below). If the HCG level is greater than 5, the patient is generally deemed pregnant.

References: September 2021 CCHCS HC DOM Ch. 3 Article 1 3.1.16.e.2.B.1-2; OIG Medical Inspection Unit

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Ref # 8.004

HQ INSPECTOR (Rev. 09/15/2021)

Did timely patient encounters occur with an OB physician or OB nurse practitioner in accordance with the pregnancy encounter guidelines?

Testing Methodology (10 samples):

Review OB progress notes or other patient records such as Prenatal Flow Records (i.e. POPRAS OB records) to determine whether the patient received care according to the following guidelines (unless otherwise indicated by the Obstetrician):

Prior to Revision 9/2021:

- every four weeks during the first trimester and up to 24-26 weeks gestation; then
- every three weeks up to 30 weeks gestation; then
- every two weeks up to 36 weeks gestation; then
- weekly after 36 weeks gestation up to delivery.

Effective 9/2021:

- every four weeks in the first trimester and up to 24-28 weeks gestation.
- every two weeks thereafter up to 36 weeks gestation.
- weekly after 36 weeks gestation up to delivery.

References: September 2021 CCHCS HC DOM Ch. 3 Article 1 3.1.16.e.2.D.1-3; CCR Title 15, Division 3, Chapter 1, Subchapter 4, Article 8, Section 3355.2, Treatment for Pregnant Inmates; October 2020 Assembly Bill No. 732 Chapter 321; OIG Medical Inspection Unit

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Ref # 8.005

HQ INSPECTOR (Rev. 12/27/2021)

Were the results of the patient's initial prenatal screening tests timely completed and reviewed?

Note 1: This test is normally only applicable to institutions where patients arrived pregnant and then had their pregnancy initially confirmed while at the institution (usually reception centers, i.e. CCWF). In most cases, this test will not be applicable to CIW or FWF (unless the patient got pregnant while incarcerated or the patient was not otherwise properly tested at the sending institution).

Testing Methodology (10 samples):

1. Verify that the diagnostic study results used to initially confirm patient pregnancy were both ordered within 7 calendar days of suspecting pregnancy and then the results were received by the institution within 3 business days of the provider order. (Often times this will be confirmed via an on-site urine test, but it can also be done via Quest blood test where the HCG level is greater than 5.)

2. Verify that (unless otherwise ordered) all of the other standard (Routine) prenatal lab tests (listed below) were ordered within 7 calendar days of pregnancy confirmation, reviewed, and endorsed each laboratory result by a health care provider within 3 calendar days (prior to 12/2021) or five calendar days (effective 12/2021) of the date receipt. (For this test, any evidence of provider review is acceptable.)

Note 2: Per policy, pregnant patients shall be provided an initial OB visit scheduled to occur within seven days of pregnancy diagnosis (see test 8.001, Note 3); as well as, diagnostic studies; ordered as medically necessary.

Standard/ Routine pregnancy confirmation lab tests:

- Hematocrit (Hct)
- Hemoglobin (Hbg)
- Platelets
- Urinalysis for protein and glucose
- VDRL/RPR (for syphilis)
- Rubella titers
- Antibody (Rh) Screen
- HIV antibody (patient option)
- Gonorrhea- < or equal to 35 y.o.
- Chlamydia- < or equal to 35 y.o.

Note 3: For Quest Diagnostic lab reports, the date the institution "received" the report is considered to be the "Printed by" date located in the bottom-center of the document. If that date is not present or illegible, use the "Reported" date located at the top-center of the document. Do not use the institution's "Received" date stamp date.

References: September 2021 CCHCS HC DOM Ch. 3 Article 1 3.1.16.e.1.C, & 2.A.2; April 2019 Ch. 3 Article 1 3.1.8.c.2.a.1&3; December 2021 Ch. 3 Article 1 3.1.14.c.4.D; OIG Medical Inspection Unit

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Ref # 8.006

HQ INSPECTOR (Rev. 09/15/2021)

Was the patient's weight, fundal height, and blood pressure documented at each clinic OB visit?

Testing Methodology (10 samples):

Review all OB encounters that occurred between the period following pregnancy confirmation thru child birth and verify that the patient's weight, fundal height, and blood pressure were recorded at each visit (which included an OB provider, OB nurse practitioner, or other obstetric related issue).

Note: Do not test visits that occurred at another institution.

References: OIG Medical Inspection Unit

Ref # 8.007

HQ INSPECTOR (Rev. 09/15/2021)

Did the patient receive her six-week post-partum obstetric visit?

Testing Methodology (10 samples):

Review Provider Progress Notes for documentation to confirm that the six week check-up occurred timely.

The 6 week post-partum obstetric follow-up visit must be within 5 business days of the 42nd calendar day (i.e. 6th week) following child birth.

References: January 2021 CDCR Operations Manual Ch. 5 Article 45 Section 54045.7; CCR Title 15, Division 3, Chapter 1, Subchapter 4, Article 8, Section 3355.2, Treatment for Pregnant Inmates; OIG Medical Inspection Unit

Preventive Services

The Office of the Inspector General will assess whether required preventive medical services are offered or provided to patients meeting certain age and gender requirements, including cancer screening, tuberculosis evaluation, and where applicable, influenza immunizations. In addition, the OIG will assess whether certain institutions take preventive actions to relocate patients identified as being at higher risk for coccidioidomycosis (i.e. "valley fever").

Sample Methodology

Sample selection steps to be completed prior to the inspection:

STEP 1—All Institutions (Male and Female):

Tests 9.001 – 9.002

From the institution's TB patient list data, create a random list of as many patients as possible (to a maximum of 30 patients) that are still at the institution (when sample sizes permit) who, over the previous nine months (from just prior to day one of inspection), were either on Isoniazid (INH), Rifapentine (Priftin), or other TB medications as discussed below for at least three months. Select all applicable (up to 25) from that list to test whether institutions appropriately managed latent TB infection.

Special Note - Although the test questions 9.001 & 9.002 reference "INH" medication, these tests are also applicable to patients who are on other alternate TB medications such as: Rifapentine (Priftin), Ethambutol (Myambutol), Rifampin, Pyrazinamide, Ethionamide (Trecator), and Rifabutin.

For the Rifapentine (Priftin) medications, these are usually a 12 week regimen that require weekly monitoring. For other alternate medications, the inspector/analyst will consult with the OIG Chief Physician and Surgeon for the medications' required weekly/monthly monitoring period and applicability to tests 9.001 & 9.002.

STEP 2—All Institutions (Male and Female):

From the institution roster provided by CCHCS, generate the following lists (all lists below must contain only inmates endorsed at the institution):

Test 9.003

1. Create a random list of 30 patients who have been at the institution at least 12 months. Select the first 25 from that list to test whether institutions completed annual TB screening during their birth month.

Test 9.004

Create a random list of 30 patients who have been at the institution since before the most recently completed influenza season (September 1st through February 28th). Select the first 25 inmates from that list to test whether institutions offered an influenza vaccination.

Test 9.005

Create a random list of 30 patients prior to 8/2021: age of 50 through the age of 75, and effective 8/2021: age of 45 through the age of 75 who have been at the institution for at least 24 months. Select the first 25 inmates from that list to test whether institutions appropriately screened patients for colorectal cancer.

Female Institutions only:

Test 9.006

Create a random list of 30 patients from the age of 51 through the age of 74 who have been at the institution for at least 36 months. Select the first 25 inmates from that list to test whether institutions properly screened inmates for breast cancer. If the patient has undergone a double mastectomy, replace with an alternate.

Test 9.007

Create a random list of 30 inmates from the age of 22 through the age of 65 who have been at the institution for at least 12 months. Select the first 25 inmates from that list to test whether institutions appropriately screened inmates for cervical cancer. Identify the percent of patients who were offered a pap smear. If the patient no longer has an intact uterus, replace with an alternate.

STEP 3—All Institutions (Male and Female):

Test 9.008

Sample selection also used for tests 1.001 and 7.001. See MIT 1 for sample methodology. Sample 25. See testing instructions below for additional comments.

STEP 4—All Cocci (Valley Fever) restricted institutions:

- Area 1—CAC, CCI, CMC, COR, KVSP, NKSP, SATF, WSP
- Area 2—ASP, PVSP

Special Note – Per CCHCS P&P Vol. 4. Ch.29.2 - Attachment A #E: CCF's & MCCF's have the same Cocci designation as their parent hub facility.

Test 9.009

Create a list of all patients identified as “Ineligible” (Cocci Area 1 and/or 2) at the institution within the past two – eight months. Verify that each patient was identified as “Ineligible” at least 60 business days prior to the start of the inspection. All patients, but no more than 25, identified as “Ineligible” for 60 business days or more prior to the inspection will be tested to determine whether the institution transferred them within the appropriate time frame. If more than 25 patients are identified as ineligible, the analyst will randomize the sample to select applicable patients for testing.

Note – This test is only applicable for the following institutions:

- Area 1—CAC, CCI, CMC, COR, KVSP, NKSP, SATF, WSP
- Area 2—ASP, PVSP

Inspection Procedures

Ref # 9.001

HQ INSPECTOR (Rev. 09/22/2021)

Patients prescribed TB medication: Did the institution administer the medication to the patient as prescribed?

Special Note - This test question previously referenced "INH" medication. However, this test is also applicable to patients who are on other TB medications including Rifapentine (Priftin). Typically, Rifapentine is prescribed as a 12-week regimen.

Other medications that may qualify for this test include: Ethambutol (Myambutol), Rifampin, Pyrazinamide, Ethionamide (Trecator), Rifabutin. For these other medications, the inspector/analyst will consult with the OIG Chief Physician and Surgeon for the applicability to this test.

Sampling Methodology (Sample 25):

This test samples the most recent 9 month period of time to determine if health care staff are ensuring that TB patients receive their TB medications timely. The 9 month sample test period is defined as the time period that immediately preceded the first day of the inspection week (per the OIG's master inspection calendar). No TB doses received outside of the 9 month sample time period will be considered. Each patient's sampled TB medication records are reviewed to ensure that they received the most recent 3 months' worth of TB medications timely (which occurred during the 9 month sample test window).

Note 1: If the tested time period in which the patient actually received the medication was less than 3 months, the inspector must verify that the patient timely received all of their required doses, including their first and last dose. In particular for this test, the inspector must be alert to the fact that there may be missed TB doses that should have occurred before the patient received their first medication dose (as documented on the MAR) or after their last medication dose (as documented on the MAR).

Example #1, unless approved by a provider, a patient cannot miss a required TB dosing period just because the patient recently transferred into the institution and the health care staff did not enroll the patient in to the local TB program timely.
Example #2, if the patient paroles, the inspector must ensure the patient received all of their TB medications up to the date of parole, unless a provider stopped the order, or other acceptable justification exists.

In those situations where a patient's institution location is unclear, the inspector should research SOMS to verify that the patient was actually housed at the institution during the applicable portion of the test.

Note 1a: The OIG analyst will provide the inspector with a flagging sheet that will identify when the medications were started and stopped, however, this is only preliminary information that may not include additional dosing periods ordered by the provider, or pre-mature stoppage of the medication. The inspector must review the physician's orders and the MAR summary information to identified the most recent 90 day period of TB medication administration that should be used for this test.

Testing Methodology (Sample 25):

Review MAR Summary to determine whether the patient received two doses of medication each week (*or as otherwise ordered*) for the most recent three months. If the patient received, or was offered TB medications timely all doses for the three month period, the answer to this question is "Yes." If the patient missed any doses over the three months, determine whether medical staff documented the refusal and the reason for refusal, or no-show and any barriers that prevented the patient from presenting to the medication line (see Note 6).

Note 2: Verify if sampled patients taking TB medications (see Special Note for list of TB medications) is treated for TB disease or latent TB infection. For example, a patient may be taking Ethambutol or Rifabutin for Mycobacterium Avium Complex and not for TB disease or latent TB infection. If so, the inspector needs to select another sample to be tested.

Note 3: The most recent three months is defined as the most recent 90 day period in which the patient was on the TB medication. On occasion, the inspector may have to test less than a three-month time period such as when the patient had not yet been on the medication for a full three months, or the patient transferred in/out of the institution during the testing time period.

Note 4: Further, for this test, only determine whether the medication was delivered timely based on the MAR instructions (i.e. twice weekly on Tuesday and Thursdays) beginning with the first medication administration that fell within the sample time period. Do not test the pre-administration interval from when the provider ordered the TB medication to when the medication was actually first administered to the patient. *This procedural practice is tested under MIT 7.002 – New order medications.*

Note 5: The answer to this question is "No" if the required documentation on MAR does not exist or if either the required visit or the required counseling was not documented.

Note 6: Medication Refusals and Non-Adherence Counseling: If a patient misses three consecutive days or at least 50 percent of scheduled doses of NA/DOT TB medication in a week,

determine if licensed health care staff shall provide medication adherence counseling as determined by PCT and document in health record. When indicated, licensed health care staff shall contact the prescriber for guidance. All refusals shall be signed by the patient and co-signed by licensed health care staff. If the patient refuses to sign the CDCR 7225, two licensed health care staff shall sign. In unusual circumstances (e.g., Administrative Segregation Unit, Mental Health Crisis Bed), the CDCR 7225 may be signed by two staff members, one of whom shall be a licensed health care staff. When a refusal is signed, the original refusal form shall be forwarded to the Health Information Management to be scanned to the health record.

Note 7: Throughout the inspection process, the inspector will document medication errors identified during testing and confirm that the error(s) has been properly identified and reported by the institution. Errors identified in this question (MIT 9.001), will be carried forward to MIT 7.998 for further testing. Tests 9.001 and 7.998 will be evaluated and scored separately. For example, if a patient chart indicates that a medication was not received as required this results in a "No" answer to 9.001. If this "No" response indicates a medication error may have occurred, the information will be carried forward to 7.998 to evaluate whether the medication error was properly managed. The OIG will identify the following types of medication errors:

i. Medication is started late or not at all (in accordance with provider order),
ii. Wrong drug is prescribed, prepared or administered,
iii. Medication is given to the wrong patient,
iv. Medication is given at the wrong time/frequency,
v. Medication is given by way of the wrong route (e.g. oral, I/M versus Subcutaneous, IV)
vi. or by way of the wrong method (e.g. KOP instead of DOT)
vii. Medication is given in the wrong dose,
viii. Medication is incorrectly documented.

References: January 2016 CCHCS HC DOM Ch. 3 Article 2 3.2.4.c; August 2021 CCHCS HC DOM Ch. 3 Article 5 3.5.41.c.3.A & 6.D.2 & 6.H-I; April 2017 CCHCS Care Guide: Tuberculosis Disease; February 2018 CCHCS Care Guide TB Infection Management

Ref # 9.002

HQ INSPECTOR (Rev. 09/25/2019)

Patients prescribed TB medication: Did the institution monitor the patient per policy for the most recent three months he or she was on the medication?

Special Note - This test question previously referenced "INH" medication. However, this test is also applicable to patients who are on other TB medications including Rifapentine (Priftin). For these particular medications, the inspector must ensure that all "weekly" required monitoring occurred during each sampled month. Typically, Rifapentine is prescribed as a 12-week regimen and it typically requires once weekly monitoring for 12 weeks. When weekly monitoring is required, the monitoring may be completed within the calendar week. Once the patient receives his last dose of weekly TB medication(s), monitoring is no longer required. For other TB medications, the inspector/analyst will consult with the OIG Chief Physician and Surgeon for the applicability to this test.

Testing Methodology (Sample 25):

Review the Tuberculosis (TB) Monthly Monitoring form in EHRS to determine if medical staff clinically monitored the patient for each month of the three-month period. For each month's monitoring, the clinician must document the patient's weight and a response for every symptom line within the 'Symptoms' section on the form.

Note 1: In the EHRS scanned documents, the form may be labeled as TB Monthly Monitoring.

Note 2: A PCP provider note may substitute for an RN's TB monitoring form, as long as all relevant monitoring information is included in the progress notes, similar to the TB Monthly Monitoring form (i.e. information regarding: weight, weight change, appetite, nausea/vomiting, fatigue, fever/chills/night sweats, cough, jaundice/icterus, unspecified rash, ABD pain, joint pain.)

Note 3: Because the term "monthly monitoring" is loosely described in current policy, OIG clinical experts have further clarified that a patient's INH monitoring should occur within 5 calendar days of the date that the monitoring occurred in the prior month. The OIG's CPS has determined that for "weekly monitoring" it can be monitored at any time within a calendar week.

Note 4: The following LTBI treatment regimens are monitored as follows: 3HP (Isoniazid and Rifapentine) monitored weekly, 4R (Rifampin) monitored weekly, and 9H (Isoniazid) monitored monthly.

References: February 2018 CCHCS Care Guide TB Infection Management; March 2016: Centers for Disease Control and Prevention: Tuberculosis- Signs & Symptoms; OIG Medical Inspection Unit

Ref # 9.003

HQ INSPECTOR (Rev. 12/13/2021)

Annual TB screening: Was the patient screened for TB within the last year?

Testing Methodology (Sample 25):

1. Verify that the patient had a properly documented TB signs and symptoms evaluation in his/her most recent birth month (in accordance with *Note 2*).

Note 1: A valid TB signs and symptoms evaluation includes a review for fever/chills/night sweats, loss of appetite, weight loss, fatigue, prolonged cough, and productive cough. Per the CCHCS care guides, this evaluation will be completed on the Tuberculin Testing/ Evaluation Report. In addition, the form's" history section" does not need to be completed for this type of evaluation; however, if clinician concludes that the patient has any of the above signs or symptoms, the inspector will verify that the patient was expeditiously referred to and seen by a provider.

Note 2: Do not sample any inmate whose entire birth month has not fully surpassed as of the inspection's EHRS testing start date (i.e. day one of inspection week). For example, if day 1 of inspection week is May 3, only sample and test inmates with birth months that occurred in February, March, and April.

Note 3: There is no exemption for inmates who recently arrived at the institution and received a signs and symptoms evaluation or skin test as part of the intake process. As a result, inmates who in a recent month received the test as part of the intake process must still be re-evaluated during their birth month (even if that birth month immediately follows the arrival month), unless Note 4 or 5 applies.

Note 4: Do not sample or test patients who are already on active TB medications during their birth month. Throw the sample out and re-sample. Also, do not sample or test inmates who transferred out of the institution during their birth month.

Note 5: Patients who refuse the screening must be referred to a provider for counseling.

References: November 2021 CCHCS HC DOM Ch. 3 Article 8 3.8.7.c; September 2018 CCHCS Care Guide: Tuberculosis Surveillance; Centers for Disease Control and Prevention: Tuberculosis, Tuberculin Skin Test; July 2006 CDC: Prevention and Control of Tuberculosis in Correctional and Detention Facilities; OIG Medical Inspection Unit

Ref # 9.004

HQ INSPECTOR (Rev. 09/22/2021)

Were all patients offered an influenza vaccination for the most recent influenza season?

Testing Methodology (Sample 25):

Using both the patient's EHRS and Master Registry, review the Immunization Vaccine section or the Inmate Influenza Vaccine Documentation form and determine whether the form reflects that the patient received (or refused) an influenza vaccine for the most recently completed influenza season. For purposes of this test, we are defining the influenza season as September 1st through February 28th. If the results do not indicate that the patient received the vaccine for the most recently completed influenza season, the inmate's refusal must be documented.

Note 1: The inspector will determine whether patients received their influenza vaccine for the most recently completed influenza season. However, if OIG's EHRS review occurs anytime during the period of September 1st and February 28th, the HQ RN inspector will determine when the institution will complete all influenza offerings for the current season. When feasible, the OIG will delay testing so that the current influenza season's vaccine offering is tested. For this test, the OIG will only test one season's influenza offerings.

Note 2: Vaccines timely refused by patients are scored as a "Yes" for compliance testing. However, for the HEDIS "information data collection only" column that indicates whether the patient (actually) physically received the vaccination, the answer is "No" when a refusal occurs. In addition, if no evidence is found in the EHRS that the patient received or refused the vaccine (during the most recent flu season), both the compliance test and the HEDIS information data collection column are answered "No."

Note 3: For this test, Master Registry may be utilized as a reference point only. If the patient refuses the flu vaccination, a timely signed refusal on a CDCR Form 7466 Patient Influenza Vaccine Documentation or CDCR Form 7225 Refusal of Examination and/or Treatment must be found in EHRS for a "Yes" answer.

References: June 2016 CCHCS HC DOM Ch. 3 Article 1 3.1.6.c.3; Centers for Disease Control, Prevention and Control of Seasonal Influenza with Vaccines: Recommendations of the Advisory Committee on Immunization Practices (ACIP)—United States, 2021-22; OIG Medical Inspection Unit

Ref # 9.005

HQ INSPECTOR (Rev. 09/22/2021)

Prior to 8/2021: All patients from the age of 50 through the age of 75: Was the patient offered colorectal cancer screening?

Effective 8/2021: All patients from the age of 45 through the age of 75: Was the patient offered colorectal cancer screening?

Testing methodology (Sample 25):

1. Using the patient's EHRS and Master Registry, review the patient's laboratory results, Health Maintenance in EHRS, and Progress Notes to determine whether the patient received a fecal occult blood test (FOBT) or a fecal immunochemical test (FIT) within the previous 12 months. If a completed (or refused) FOBT or FIT screening is not documented, review the health maintenance, diagnostic results in EHRS, and/or progress notes to determine whether there is documentation of the patient receiving a normal colonoscopy within the last 10 years. A colonoscopy is considered normal when there is no indication that an expedited (i.e. less than ten years) follow-up colonoscopy is needed. For example, even though the colonoscopy indicates there were polyps, the physician may consider those results normal and not require a follow-up colonoscopy.

2. Document the FOBT or FIT refusal or received date. If the patient did not receive or refuse any of these tests within specified timelines, the answer to this question is "No." Answer this question "Yes" if the following is documented in the patient's record:

   - Completed FOBT or FIT screening within the previous 12 months,
   - Refused FOBT or FIT screening within the previous 12 months,
   - Completed normal colonoscopy within the last 10 years.

   Note 1: Colorectal screenings that are timely refused by patients are scored as a "Yes" for compliance testing. However, for the HEDIS "information data collection only" column that indicates whether the patient (actually) physically received the screening procedure, the answer is "No" when a refusal occurs (unless the inmate has had a normal colonoscopy within the last 10 years, in which case the answer to both columns is "Yes"). Master Registry may be utilized as a reference point only. If no evidence is found in the EHRS that the patient either received or refused the screening procedure (or had a normal colonoscopy within the last 10 year), both the compliance test and the HEDIS information data collection column are answered "No."

Note 2: For this test, the OIG analyst or inspector should research the CCHCS's Colon Cancer Screening Registry as a "starting point" to determine the dates of when the patient's most recent colon cancer screening tests may have occurred. However, the OIG's CP&S has determined that the proof or confirmation of the screening tests must be found in the patient's actual electronic medical record (i.e. the EHRS) in order for the final answer to be "Yes."

Note 3: For this test, the 12 month period is calculated as the 12 month period ending on Day 1 of the OIG's EHRS chart review test period.

Note 4: The OIG CP&S has concluded that evidence of patient refusal must be documented on a 7225 Refusal of Treatment/Examination.

Note 5: For determination on whether a colonoscopy result is deemed normal or abnormal, the OIG CP&S (or designee) should be consulted.

References: June 2016 CCHCS HC DOM Ch. 3 Article 1 3.1.6.c.3; February 2021 Centers for Disease Control and Prevention: Colorectal Cancer Screening Tests; May 2021 US Preventive Services Task Force: Colorectal Cancer Screening; OIG Medical Inspection Unit

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Ref # 9.006

HQ INSPECTOR (Rev. 09/22/2021)

Female patients from the age of 50 through the age of 74: Was the patient offered a mammogram in compliance with policy?

Testing Methodology (Sample 25):

1. Using both the patient's EHRS and Master Registry, review the patient's radiology results, and determine whether the results reflect that the patient received a baseline mammogram screening at age 50, then every 24 months thereafter unless otherwise recommended (see Note 5). If the results do not indicate that the patient received a mammogram as specified, the inmate's refusal must be documented.

2. Document the mammogram refusal or received date. If the patient did not receive or refuse her mammogram within specified timelines, the answer to this question is "No."

3. The testing time period for a mammogram to be timely received or refused is the 24 month period immediately preceding the start of the official health record chart review (i.e. day 1 of inspection week, according to the master scheduling calendar).

Note 1: For this test, the MIU analyst or RN inspector should research the CCHCS's Breast Cancer Screening Registry as a "starting point" to determine the dates of when the

patient's most recent breast cancer screening tests may have occurred. However, the OIG's CP&S has determined that the proof or confirmation of the screening tests must be found in the patient's actual electronic medical record (i.e. the EHRS) in order for the final answer to be "Yes."

Note 2: Mammogram screenings that are timely refused by patients are scored as a "Yes" for compliance testing. However, for the HEDIS "information data collection only" column that indicates whether the patient (actually) physically received the service, the answer is "No." Also, if no evidence is found in the EHRS, or Master Registry that the patient either received or refused the mammogram (within the last 24 months), both the compliance test and the HEDIS information data collection column are answered "No."

Note 3: The OIG CP&S has concluded that evidence of patient refusal must be documented on a 7225 Refusal of Treatment/Examination.

Note 4: If documentation indicates that the patient has undergone a double mastectomy, then replace with an alternate. Examples of documentation may include Forms: Interdisciplinary Progress Notes, History and Physical, Reception Center History & Physical, Initial Health Screening-Female Inmates.

Note 5: Even though a mammogram specialty service consult may result in a recommendation for a 1 year follow-up, based on CDCR policy, the OIG will only require a 24 month follow-up (unless the test is abnormal in which case the OIG's CPS will determine the appropriate time for a follow-up to occur).

References: June 2016 CCHCS HC DOM Ch. 3 Article 1 3.1.6.c.3; Agency for Healthcare Research and Quality, Guide to Clinical Preventive Services, 2014 Section 2; January 2016 U.S. Preventive Services Task Force: Breast Cancer: Screening; OIG Medical Inspection Unit

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Ref # 9.007

HQ INSPECTOR (Rev. 09/22/2021)

Female patients from the age of 21 through the age of 65: Was patient offered a pap smear in compliance with policy?

Testing Methodology (Sample 25):

1. Using both the patient's EHRS and Master Registry, review the inmate's laboratory results and determine whether the results reflect that the patient received a Pap smear screening within the most recent 36 months (unless otherwise recommended) for all female patients except those that are less than 21 and those who do not have an intact uterus (see Note 2). For those patients that recently turned 21, a base-line Pap smear should have occurred

within 12 months of turning 21. If the results do not indicate that the patient received a Pap smear as specified above, the inmate's timely refusal must be documented.

Note 1: The inspector should review the patient's most recent Pap smear encounter/ test result to determine if the PCP ordered a follow-up of less than 36 months.

2. Document the Pap smear screening refusal or received (i.e. sample collection date) date. If the patient did not receive or refuse her Pap smear within specified timelines, the answer to this question is "No."

Note 2: If documentation indicates that the patient does not have an intact uterus then replace with an alternate. Examples of documentation may include Forms: Interdisciplinary Progress Notes, History and Physical, Reception Center History & Physical, Initial Health Screening- Female Inmates.

Note 3: Screenings timely refused by patients are scored as a "Yes" for compliance testing. However, for the HEDIS "information data collection only" column that indicates whether the patient (actually) physically received the service, the answer is "No. Also, if no evidence is found in the EHRS that the patient either received or refused the Pap Smear (within the required time frame), both the compliance test and the HEDIS information data collection column are answered "No."

Note 4: If the patient refused PAP smear, the PCP should offer it yearly to receive credit for timeliness of offering PAP smear screening.

Note 5: For this test, the MIU analyst or RN inspector should research the CCHCS's Cervical Cancer Screening Registry as a "starting point" to determine the dates of when the patient's most recent cervical cancer screening tests may have occurred. However, the OIG's CP&S has determined that the proof or confirmation of the screening tests must be found in the patient's actual electronic medical record (i.e. the EHRS) in order for the final answer to be "Yes."

Note 6: The OIG CP&S has concluded that evidence of patient refusal must be documented on a 7225 Refusal of Treatment/Examination.

References: June 2016 CCHCS HC DOM Ch. 3 Article 1 3.1.6.c.3; Agency for Healthcare Research and Quality, Guide to Clinical Preventive Services, 2014 Section 2; August 2018 U.S. Preventive Services Task Force: Cervical Cancer: Screening; OIG Medical Inspection Unit

Ref # 9.008

HQ INSPECTOR (Rev. 09/29/2021)

Are required immunizations being offered for chronic care patients?

Sampling Methodology:

This test shares the same sample as tests 1.001 and 7.001 with the exception that this test further excludes those patients who do not have at least one of the chronic care conditions which has an associated immunization (i.e. Asthma, Diabetes, Hep C, HIV). For this test, if the patient does not have one of these chronic conditions, they are excluded from the test without replacement. (Sample 25).

Testing Methodology (Sample 25):

1. For those chronic conditions requiring vaccinations, review the following documents to determine if the patient is current: Immunization and Health Maintenance in EHRS, Master Registry, Flow Sheet(s), Chronic Care Progress Notes, Physician's Orders, or Intake History and Physical.

2. Confirm that the inmate was offered/received the following vaccinations for these specified chronic conditions:

   - Asthma, Diabetes and Hepatitis C:
     - Annual Influenza
     - Pneumovax
       - For patients 19-64 y.o: 1 dose PPSV23
       - For patients 65 years or older: if PPSV23 was administered prior to age 65 years, administer 1 dose PPSV23 at least 5 years after previous dose (note: only 1 dose PPSV23 recommended at age 65 years or older)

     Note 1: If both PCV13 and PPSV23 were administered, verify if PCV13 was administered first. PCV13 and PPSV23 should not be administered during the same visit.

     Note 2: PCV13 and PPSV23 should be administered at least 1 year apart.

   - Hepatitis C: in addition to Annual Influenza and Pneumovax- Hepatitis A & B
   - HIV infection:
     - Annual Influenza
     - Hepatitis A & B

- Pneumovax:
  - For patients 19 y.o or older:

Source material: https://eziz.org/assets/docs/IMM-1152.pdf

  - For patients 65 y.o or older: 1 dose PPSV23 at least 5 years after most recent PPSV23 (note: only 1 dose PPSV23 recommended at age 65 years or older)

Note 3: Patients may refuse vaccinations, but the declination statement must be documented in the EHRS.

Note 4: Vaccines timely refused by patients are scored as a "Yes" for compliance testing. However, for the HEDIS "information data collection only" column that indicates whether the patient (actually) physically received the vaccination(s), the answer is "No" when a refusal occurs. In addition, if no evidence is found in the EHRS that the patient received or refused the vaccine(s) (during the required time period), both the compliance test and the HEDIS information data collection column are answered "No." The OIG's CP&S has determined that other sources such as the DASHBOARD Master Registry or other sub-registries cannot be used to support a "Yes" answer for this test.

Note 5: The annual flu (influenza) season generally occurs from September through February.

Note 6: If a Hepatitis C patient is already immune to Hepatitis A or B (aka: "reactive," these two vaccinations are not needed.

Note 7: If an HIV patient has chronic Hepatitis A&B or is already immune, then no Hepatitis A&B vaccine is needed.

Note 8: The OIG will update the criteria annually based on CDC standards.

Note 9: For this test, do not include inmates who only have "pre-diabetes."

Note 10: The inspector will determine whether patients received their influenza vaccine for the most recently completed influenza season. However, if OIG's EHRS review occurs anytime during the period of September 1st and February 28th, the HQ RN inspector will determine when the institution will complete all influenza offerings for the current season. When feasible, the OIG will delay testing so that the current influenza season's vaccine offering is tested. For this test, the OIG will only test one season's influenza offerings.

Note 11: Based on OIG medical inspection unit, if the patient's CDCR Form 7420-A Problem list (may be found under Archive Section in EHRS) identifies that a patient has had certain immunizations, but no actual immunization document is found in the EHRS the OIG will accept the problem list as evidence the patient received the immunization (as long as the immunization falls within the appropriate time frame).

Note 12: If the patient does not have one of the 4 primary chronic care conditions subject to this test (i.e. asthma, diabetes, HEP C, HIV), the answer is "NA."

Note 13: The OIG CP&S has concluded that evidence of patient refusal must be documented on a 7225 Refusal of Treatment/Examination.

References: June 2016 CCHCS HC DOM Ch. 3 Article 1 3.1.6.c.3; Current CCHCS Care Guides and corresponding 'Quality of Care' Review Questionnaire {for associated chronic condition}: February 2021 Centers for Disease Control and Prevention: Immunization Schedules

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Ref # 9.009

HQ INSPECTOR (Rev. 09/27/2020)

Are patients at the highest risk of coccidioidomycosis (valley fever) infection transferred out of the facility in a timely manner?

Testing Methodology (Sample 25):

The OIG performs tests for Coccidioidomycosis, also known as Valley Fever or Cocci, at ten CDCR adult institutions contained within the Cocci endemic area—Restricted Cocci Area 1 comprises eight prisons (CAC, CCI, CMC, COR, KVSP, NKSP, SATF, & WSP), and Restricted Cocci Area 2 comprises two prisons (ASP, PVSP). Patients considered to have a high risk for Cocci disease are restricted and thus ineligible to reside in the Cocci endemic area. To obtain the most current information on transfer dates, inspectors should either conduct this test at the end of the inspection testing process, or follow-up (at the end of the inspection) on those patients who had not been timely transferred (at the time of the testing) to identify when the patient was eventually transferred.

Note 1: Per CCHCS HC DOM Ch. 1 Article 2 Appendix 1 1.2.14: CCF's & MCCF's have the same Cocci designation as their parent hub facility.

The inspector will determine whether patients who were medically restricted from the Cocci endemic area, because of a change in their medical condition, were timely transferred. Samples include those patients who were identified as ineligible 60 business days or more prior to the inspection start date; therefore, if patients were not transferred within 60 business days from the

time they were determined ineligible, the answer will be "No", unless the inspector determines that the patient currently has or previously had Valley Fever (see step 5. below)

1. Using the analyst's sampling flagging sheet, select a maximum of 25 patients who were classified as (Cocci Area 1 and/or 2) ineligible at the institution within the past two – eight months prior to the start of the inspection's EHRS week. (Only patients identified as ineligible for 60 business days or more prior to the inspection will be tested to determine whether the institution transferred them within the appropriate time frame.)

2. Using SOMS data, identify the patient's transfer date. If the patient has not been transferred as of the end of the inspection testing period, enter: "N/A" in the testing worksheet's column D, "SOMS Transfer Column."

3. For all transfers that occurred prior to the end of the inspection testing period, the testing worksheet column B & D will calculate the total days to transfer, from the point at which the patient was determined ineligible for placement at the institution. For patients who had not transferred from the institution by the end of the inspection, the worksheet column E will be zero. Column F will calculate the total days ineligible from the date the patient was determined ineligible to the inspection start date (identified in column A). In the Comments column for these patients, enter the "*as of*" date for the end of the inspection testing and indicate that *the patient had not yet transferred*.

4. For those patients who were transferred out of the institution within 60 business days from the date they were ineligible, the answer is "Yes." For those patients who were transferred out of the institution beyond 60 business days from the date they were ineligible, the answer is "No."

5. For those patients who were deemed ineligible more than 60 business days prior to the inspection start date and who were not transferred as of the end of the inspection testing, review the EHRS to determine if there is any indication that the patient currently has or previously had the Valley Fever infection. If the patient has or had Valley Fever, the answer is "Yes" since the patient was actually eligible to remain at the institution. For all other patients, the answer is "No."

References: May 2019 CCHCS HC DOM Ch. 3 Article 8 3.8.5.e.1-2; September 2017 Ch. 1 Article 2 1.2.14 Appendix 1 f.1-2; August 2013 Coccidioidomycosis Care Guide.

Reception Center

The Office of the Inspector General will determine whether the institution follows required health screening procedures for those inmates newly received from non-CDCR facilities by reviewing the institution's ability to timely: perform initial health screenings, complete required health screening assessment documentation, conduct PCP referral visits (including a History and Physical exam), complete diagnostic lab testing and communicate results to the patient timely, and conduct required tuberculin testing.

Sample Methodology

Tests 12.001 – 12.008

Sample selection also used for test 7.004.

Use the same 20 samples for all tests. The MIU analyst will obtain the institution's most recent download of the Strategic Offender Management System (SOMS) and will import and filter the data using the following parameters:

- Patients who are currently at the institution and have been there between 2 months to 8 months.
- Patients who transferred in from a non-CDCR institution.
- The SOMS data that is needed to complete this sample includes: patient name, CDCR #, arrival date, and where the patient arrived from.

The analyst will generate a random list of all patients meeting the criteria described above and select the first 20 patients from that list. The remaining patients will be held as backup in case any of the first 20 cannot be tested.

Note: Reception centers include: CCWF (women), CIM, NKSP, SQ, WSP

Inspection Procedures

Ref # 12.001

HQ INSPECTOR (Rev. 09/22/2021)

For patients received from a county jail: Prior to 04/2019: Did nursing staff complete the initial health screening and answer all screening questions on the same day the patient arrived at the institution? Effective 04/2019: Did nursing staff complete the initial health screening and answer all screening questions upon arrival of the patient at the reception center?

Testing Methodology (Sample 20):

Review the Initial Health Screening form, and when applicable for female institutions, review the Initial Health Screening – Female form.

Do the following:

1) Determine whether the nursing staff completed the form(s) on the same day the patient arrived at the institution. In addition, finger stick blood glucose must be obtained for patients with a history of diabetes.

2) Verify that nursing staff [i.e., Licensed Psych Tech (LPT)/Licensed Vocational Nurse (LVN)/Registered Nurse (RN)] who complete the screening form circle each "Yes" or "No" box, provide details (as applicable) for each "Yes" answer, and sign and date the form(s).

3) Verify that the nurse documented a complete set of vital signs including pain assessment, height, and weight.

Note 1: The RC initial health screening and triage shall be accomplished prior to the patient being placed in housing.

Note 2: For purposes of this test, the OIG requires nursing staff (i.e., LPT/LVN/RN) to answer Yes/No for each question on the Initial Health Screening form. In addition, the OIG requires nursing staff to provide an explanation for "Yes" responses, excluding those questions related to language, health care appliances, and allergies.

Note 3: The focus of this test is on nursing staff's (i.e., LPT/LVN/RN) initial screening and not the subsequent assessment/disposition only to be completed by a RN. In many cases, a RN completes both functions. If the same RN performed both the initial screening and the assessment/disposition, the RN may not document a completion date for the initial screening. As a result, defer to the date the RN signed and dated

the Assessment/Disposition section of the form to determine the date the initial screening occurred.

References: April 2019 CCHCS HC DOM Ch. 3 Article 1 3.1.8.c.1.A-D; OIG Medical Inspection Unit

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Ref # 12.002

HQ INSPECTOR (Rev. 09/25/2019)

For patients received from a county jail: Prior to 04/2019: When required, did the RN complete the assessment and disposition section of the health screening form, and sign and date the form on the same day staff completed the health screening? Effective 04/2019: Did the RN complete the assessment and disposition section, and sign and date the completed health screening form upon patient's arrival at the reception center?

Testing Methodology (Sample 20):

If any questions on the Initial Health Screening and Initial Health Screening (Supplemental)—Female Inmates (if applicable) are answered "Yes," determine whether a RN completes an assessment/disposition (i.e. referral) and signs and dates the initial health screening form(s) on the same day staff completed the health screening.

Note 1: This test focuses solely on the RN's completion of an assessment/disposition, when required. If, after nursing staff (i.e., LPT/LVN/RN) completes the initial health screening, any of the responses are answered "Yes," a RN shall be notified for an assessment and disposition; however, the OIG will not require an assessment/disposition for "Yes" answers related to language, health care appliances, and allergies. If a RN does not complete the assessment/disposition, sign, and date the Initial Health Screening form on the same day staff completed the health screening, the answer to this test will be "No."

Note 2: The same RN may complete both the initial screening and the assessment/disposition.

Note 3: If the assessment and disposition section is not required because there were no "Yes" responses on the screening questions, the test answer is N/A, even if the RN completes and signs the disposition section.

References: April 2019 CCHCS HC DOM Ch. 3 Article 1 3.1.8.c.1.D.h

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Ref # 12.003

HQ INSPECTOR (Rev. 09/25/2019)

For patients received from a county jail: If, during the assessment, the nurse referred the patient to a provider, was the patient seen within the required time frame?

Testing Methodology (Sample 20):

Review the bottom portion of the Initial Health Screening or Initial Health Screening (Supplemental) -Female Inmates, and determine if a nurse made a referral to see a provider for the newly arrived patient. If a referral was made, determine whether the provider visit occurred within the required time frame by reviewing the EHRS for a corresponding Interdisciplinary Progress Notes. Compare the date of the provider visit to the date required by the nurse's referral. The provider visit must occur within 7 calendar days of arrival unless a shorter time frame is indicated on the Initial Health Screening referral.

Note: CCHCS policy requires a provider complete the required history and physical (H&P) examination within 7 days of the RC inmate's arrival. If the nurse's referral appears to only be for the need to have a history and physical completed (i.e. H&P) then the answer to this question is "N/A." The testing for timely completion of an H&P referral will be tested below under step 12.004.

References: April 2019 CCHCS HC DOM Ch. 3 Article 1 3.1.8.c.1.D.1.a-h

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Ref # 12.004

HQ INSPECTOR (Rev. 09/25/2019)

For patients received from a county jail: Did the patient receive a history and physical by a primary care provider within seven calendar days?

Testing Methodology (Sample 20):

Review Intake History and Physical Form or Progress Notes and compare the date on the form with the patient's arrival date from SOMS (or other documentation) to determine whether the history and physical exam was completed within 7 calendar days.

Note 2: For testing purposes, if a History and Physical Form or Progress Note (when applicable) is not available in the EHRS, the answer will be "No."

References: April 2019 CCHCS HC DOM Ch. 3 Article 1 3.1.8.c.2.A

Ref # 12.005

HQ INSPECTOR (Rev. 12/27/2021)

For patients received from a county jail: Were all required intake tests completed within specified timelines?

Testing Methodology (Sample 20):

1. Review Intake History and Physical Form and the laboratory section of the EHRS verify that:

    a. All patients shall be offered the following screening tests based on the Opt-Out screening method.
        - HIV antibody screening
        - Varicella Immunoglobulin G (IgG)
        - Rapid Plasma Reagin (RPR)
        - Hepatitis C Virus (HCV) antibody with reflex to HCV viral load
        - IGRA Blood Test
            - If the patient declines an IGRA test, a TST can be offered or performed. This will be tested under 12.007.

    b. All patients **if less than or equal to 35 years old** received or offered: Gonorrhea/Chlamydia Urine

    c. All female patients shall be offered the following screening tests based on the Opt-Out screening method:
        - Pap smear (all females as clinically appropriate [i.e., cervix intact]

    d. All female patients under age 60 received or offered the following intake test:
        - Serum Pregnancy Test - (unless they had documentation of a hysterectomy).

2. Verify that the labs tests were offered within 7 calendar days of arrival (as documented on Initial Health Screening, or in SOMS).

3. Compare the date the laboratory service was performed (from the diagnostic report) with the date of the request for service on Physician's Orders, and verify that the lab tests were completed (specimens collected timely) as specified by the provider, or consistent with the following timelines:

    - STAT order for Non-Rural Institutions: Collected and resulted in four (4) hours from the time of specimen collection

- STAT order for Rural Institutions: Collected and resulted in five (5) hours from the time of specimen collection

  Note 2: The following Rural Institutions are as follows: CVSP, CAC, ISP, PBSP, HDSP, and CCC.

- ASAP: Collected within the next day (Saturday and Sunday are included)
- Routine:
  - Prior to 4/2021: within the timeframe ordered or collected within 14 calendar days of the date of the order
  - Revision 4/2021: the laboratory specimen shall be obtained from the patient on the requested collection date
  - Effective 12/2021: the laboratory specimen shall be obtained from the patient on the requested collection date. The specimen may be collected prior to the requested collection date unless prohibited by policy or the ordering provider or as follows:
    - Laboratory staff may collect a routine lab test the next business day should the requested collection date fall on a weekend or holiday.

  Note 3: If the provider does not specify a time frame, the order will be treated as "Routine."

4. For new reception center arrivals, policy requires women to be offered a pregnancy exam or test and for a PCP to follow-up to ensure that one was offered within 7 days of arrival. Ensure that a provider visit occurred within seven calendar days of arrival and that a physical exam or lab test was ordered to confirm the pregnancy.

   Note 4: If the patient declines a routine Opt-Out tests, review patient's health record and determine if the refusal was documented and signed by the patient.

   Note 5: If the answer to any of steps above is "No," the final answer is "No."

References: April 2019 CCHCS HC DOM Ch. 3 Article 1 3.1.8.c.1.D.2.a-g & 2.C.6; July 2017 Ch. 3 Article 1 3.1.16.e.2.A.1-2; December 2021 Ch. 3 Article 1 3.1.14.c.1.A-J

Ref # 12.006

HQ INSPECTOR (Rev. 12/27/2021)

For patients received from a county jail: Did the health care provider review and communicate the intake test results to the patient within specified timelines?

Testing Methodology (Sample 20):

1. Compare the date the laboratory test was received at the institution (or otherwise communicated to the health care provider), with the date the health care provider reviewed the diagnostic report (as indicated by endorsement date), and verify that it was reviewed within three calendar days (prior to 12/2021) or five calendar das (effective 12/2021) of the date received.

2. Compare the date the health care provider reviewed each laboratory diagnostic report (as indicated by endorsement date) to the date the health care provider prepared the patient letter and verify that the labs were communicated to the patient within three calendar days (prior to 12/2021) or five calendar days (effective 12/2021) from when the results were received.

3. Health care provider must review results and create a patient notification letter in the health record at the time of review and endorsement of each laboratory result. The patient letter shall include the following key elements:

- Date of the test/screening to identify the laboratory test/diagnostic screening
- Reviewing health care provider's name
- Whether the results are within normal limits
- Whether a follow-up appointment with the provider is required and will be scheduled

References: December 2021 CCHCS HC DOM Ch. 3 Article 1 3.1.14.c.4.D-E

Ref # 12.007

HQ INSPECTOR (Rev. 07/25/2019)

For patients received from a county jail: Was a Tuberculin Testing and Evaluation completed and if applicable, was a tuberculin test both administered and read timely?

Testing Methodology (Sample 20):

For reception center arrivals, verify that new arrivals received an adequate TB screening by doing the following:

1) Verify that the Tuberculin Testing Evaluation/Report signs and symptoms and history section was properly completed including all nine boxes of the "TST Administration" history portion of the form. The signs and symptoms, and history section can be completed by a registered nurse (RN), licensed vocational nurse (LVN), or a licensed psychiatric technician (LPT).

2) Verify that the TB test was initially administered within 72 hours of placement into a reception center. **Only applies if patient declined IGRA blood test.**

   Verify that the skin test was read by an RN, LVN or LPT between 48 and 72 hours after administration. Patients who do not return within 72 hours need to be retested, and the OIG Inspector should determine whether a second test was then expeditiously and timely administered and read. Review Tuberculosis Skin Test (TST) Reading Form and compare the date TST administered in the MAR Summary. Review to ensure that either an RN, LVN, or LPT documented that they read the TB test results on the Tuberculin Skin Test (TST) Reading Form.

   A properly documented TB test includes information regarding the TB serum manufacturer name, lot number, and expiration date which should be included in the patient's health record.

   Note 1: Per Penal Code, patients cannot refuse TB testing. However, if there is documentation of a TB test completed within the previous 30 days of arrival, the test is not required and the answer is "N/A."

   Note 2: If county jail records indicate the patient had a prior positive TB test, the patient only needs to be screened for signs and symptoms and have a chest x-ray; a TB test is not required.

References: April 2019 CCHCS HC DOM Ch. 3 Article 1 3.1.8.c.1.D.1.e; September 2018 CCHCS HC DOM Ch. 3 Article 8 3.8.7.c.1.A-E; September 2018 CCHCS Care Guide: Tuberculosis Surveillance

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Ref # 12.008

HQ INSPECTOR (Rev. 06/29/2020)

For patients received from a county jail: Was a Coccidioidomycosis (Valley Fever) skin test offered, administered, read, or refused timely?

Testing Methodology (Sample 20):

1. For reception center arrivals, determine whether a Coccidioidomycosis (Valley Fever) skin test (CST) was ordered and offered timely / administered timely, and read / documented in a timely manner by licensed health care staff. Verify the following:

(Male only RC prisons)

CCHCS policy April 2019 CCHCS HC DOM Ch. 3 Article 1 3.1.8.c.1.D.2.a.5 incorporated CST testing with other diagnostic tests. Based on this change, Inspectors will test patients that arrive at the institution as follows:

a. The CST must be offered within seven calendar days of arrival.

b. The CST must be read by a licensed health care worker between 48 to 52 hours after administration (see note 4).

Note 1: CCHCS policy states the reading of the CST shall be performed by licensed nursing staff trained in reading CSTs. The OIG clinicians have concluded that an LVN, LPT, or RN may read the CST based on current community standard practices.

Note 2: Per CCHCS policy, patients can refuse CST testing. The OIG CP&S has concluded that evidence of patient refusal must be documented on a 7225 Refusal of Treatment/Examination. If the patient refuses to sign the refusal form, two staff members shall sign as witnesses.

Note 3: This test does not apply to female reception centers such as CCWF.

Note 4: Per electronic form Cocci Skin Testing: The injection site should be assessed for induration at 48 hours (+4 hours) following administration.

References: April 2019 CCHCS HC DOM Ch. 3 Article 1 3.1.8.c.1.D.2.d.1; May 2019 Ch. 3 Article 8 3.8.5.e.1-2; OIG Medical Inspection Unit

Specialized Medical Housing (OHU, CTC, SNF, Hospice)

The Office of the Inspector General (OIG) will determine whether medical staff have reasonably unimpeded access to patient cells.

Sample Methodology

Tests 13.001 – 13.003 (effective 04/2019 samples selected, 13.003 will no longer be tested)

For these tests, identify patients who were recently admitted to the institution's higher level of care facilities. Obtain the admission/discharge report for the most recent 2 – 8 months month period of time for each of the institutions applicable: OHU, CTC, SNF and Hospice facilities. Identify patients whose placement lasted at least five calendar days (ten calendar days for the California Medical Facility's CTC due to its "program flex").

Generate a random list of 20 patients (from each applicable admission/ discharge report) meeting the criteria and select the first 10 patients from that list. The remaining 10 patients will be held as alternates in case any of the first 10 do not comply with required criteria or were not placed in the OHU/CTC/SNF/Hospice for a medical reason.

For all tests covered by this indicator, do not include psychiatric inpatient locations (i.e. PIP).

Test 13.004

Sample selection (10) also used for tests 13.001-13.003.

For the ordered medication test:

1. When medications are selected in test 13.004, the following medications will be reviewed:

   All newly ordered medications (NA, DOT, KOP) except PRN (unless they are rescue inhaler or nitroglycerin) upon admission to a specialized medical housing; all medications that were previously prescribed (prior to the hospitalization) upon returning from the hospital and admitted directly to a specialized medical housing.

Test 13.101 – 13.102

These are regional tests and sample selection and testing is described within each question.

Inspection Procedures

Ref # 13.001

HQ INSPECTOR (Rev. 09/27/2021)

For OHU, CTC, and SNF: Prior to 04/2019: Did the registered nurse complete an initial assessment of the patient on the day of admission, or within eight hours of admission to CMF's Hospice? Effective 04/2019: Did the registered nurse complete an initial assessment of the patient at the time of admission?

Effective 04/2019 revised policy and procedure: Definition: Specialized Health Care Housing: include the following levels of care: Outpatient Housing Unit (OHU), Correctional Treatment Center (CTC), Mental Health Crisis Bed (MHCB), Psychiatric Inpatient Program (PIP), Skilled Nursing Facility (SNF), Hospice, Acute Care Facility (Mental Health), and Intermediate Care Facility (Mental Health).

Testing Methodology (Sample 10):

Compare the date of RN assessment on the Admission Assessment and History or other applicable forms with the date of admission order on Physician's Orders.

Note 1: Other forms the RN may use to conduct the assessment include Interdisciplinary Progress Notes, Emergency Care Flow Sheet, and Nursing Care Observation Record. This test is applicable to all higher level care facilities including OHU, CTC, SNF, & Hospice.

Note 2: The PCP's admission order is usually the same date as the actual admission time and date in SOMS. If there's a discrepancy with admission time and date, refer to SOMS.

Note 3: The initial assessment form must be completed at the time of patient's admission, which the OIG has interpreted to be completed within two (2) hours from the time of admission.

References: April 2019 CCHCS HC DOM Ch. 3 Article 1 3.1.10.d.1.C; OIG Medical Inspection Unit

Ref # 13.002

HQ INSPECTOR (Rev. 09/27/2021)

For CTC and SNF only (effective 04/2019, include OHU): Was a written history and physical examination completed within the required time frame?

Testing Methodology (Sample 10):

Compare the date of SOMS admission or PCP's admission order to the date the primary care provider or attending physician conducted an admission history and physical examination*, and determine if the encounter occurred within 24 hours of admission.* The documented H&P should be complete, thorough and documented timely otherwise the answer is "No." If you are unsure on the completeness of the history and physical, consult with a nurse or physician inspector.

Note 1: ***Prior to 04/2019 policy and procedure only****: OIG clinicians have determined that if the patient had an H&P within five days of being admitted to the CTC, the prior H&P can be used by the institution as long as the patient receives a provider encounter within the first 24 hours, and the providers progress note clearly indicates the H&P was reviewed, and made changes to the patient's history as necessary.*

Note 2: ***Effective 04/2019, note 1 is no longer applicable.***

Note 3: The PCP's admission order is usually the same date as the actual admission time and date in SOMS. If there's a discrepancy with admission time and date, refer to SOMS.

References: April 2019 CCHCS HC DOM Ch. 3 Article 1 3.1.10.d.1.B; CCR Title 22, Division 5, Article 3, Section 72303(b)(1); OIG Medical Inspection Unit

Ref # 13.003

HQ INSPECTOR (Rev. 04/16/2019)

For OHU, CTC, SNF, and Hospice (applicable only for samples prior to 04/2019): Did the primary care provider complete the Subjective, Objective, Assessment, and Plan notes on the patient at the minimum intervals required for the type of facility where the patient was treated?

Testing Methodology (Sample 10):

Review Progress notes and determine whether the PCP completed SOAP notes at the intervals required for the type of facility where the patient was treated.

- Hospice: minimum of every 14 days
- SNF: minimum of every 30 days
- CTC: minimum of every 3 days (except CMF, SQ, and CHCF whose CTC has a program flex waiver: PCP SOAP note every 7 days)
- OHU: minimum of every 14 days for the first month, and then no less than every 30 calendar days thereafter. Note 2 below applies for OHU testing.

Note 1: This test's starting point will be the date of admission unless, the H&P was conducted 72 hours prior to arrival, in which case, the test starting point will be the date of the H&P. For OHU, SNF, and Hospice only test the first six-month period after placement. For CTC only test the first one- month period after placement.

Note 2: If the OIG identifies one missed note, the answer to this question is "No." Once two or more exceptions (missed notes) are identified, stop testing. If the patient is in the facility less than the minimum period of time requiring a SOAP note and the PCP completes SOAP notes, answer this question "Yes." If the patient is in the facility less than the minimum period of time requiring a SOAP note and the PCP did not complete SOAP notes, answer this question "NA."

Note 3: Per OIG clinicians, for patients admitted to a Mental Health Crisis Bed in the CTC, this test does not apply. Therefore, answer the question "NA."

Note 4: This testing will no longer apply for samples selected effective 04/2019.

References: June 2016 CCHCS P&P Vol.4 Ch.14.2. IV.B.1.c; April 2016 Vol.4 Ch.15.2. IV.C.3; CMF—Hospice P&P 2/13/2013 Vol.17. Pg.7-1-3.2. b; Title 22, Division 5, Section 72451(b)

Ref # 13.004

HQ INSPECTOR (Rev. 09/22/2021)

Upon the patient's admission to specialized medical housing: Were all medications ordered, made available, and administered to the patient within required time frames?

Testing Methodology (Sample 10):

The OIG will determine whether patients who were admitted to a specialized medical housing and have medication orders written receive their medication(s) without interruption by doing the following:

a. Verify that all medications were timely ordered within the following parameters:

1. Determine that the provider ordered medications within 8 hours of the patient returning from the hospital and admitted directly to a specialized medical housing (verify admission time using SOMS). If the provider did not order medications within 8 hours of the

admission, then a justification that no medications are needed must be documented within 8 hours of return, or the overall answer to this test is "No."

2. Determine that the provider ordered medications within 24 hours of admission to Outpatient Housing Unit (OHU), Skilled Nursing Facility (SNF), and Correctional Treatment Center (CTC) (verify admission time using SOMS). If the provider did not order medications within 24 hours of admission, then a justification that no medications are needed must be documented within 24 hours of admission, or the overall answer to this test is "No."

   The admission medications may be identified in EHRS under the Medication Order tab. Compare the order date/time on the provider's order to patient's admission time using SOMS. For this test, to timely comply with the parameters, the provider may either order medication(s), or document a proper justification. The inspector will only test the timeliness of the **first set of admission provider orders that include medication orders**. Only the initial set of admission medication orders will be tested.

   Note 1: This test only applies to the first admission provider related encounter or physician order that results in a medication order. In addition, a provider may order additional medications, these will not be tested if other medications had been previously ordered by the initial admission.

   Note 2: For TTA provider phone orders, the date the TTA nurse took the phone order is deemed to be the order time, not the time the doctor subsequently approved the order.

b. Next, verify that the admission medication orders were timely made available and administered/ issued using the following criteria:

Medication testing Rules: Do not test PRN medications, except rescue medication for chronic care, i.e. asthma inhalers and nitroglycerin. If a PRN medication is tested, only test to ensure that it is timely made available, do not test for timely administration. Do not test **MH medication prescribed by a psychiatrist and dental medication prescribed by a dentist,** unless medication was ordered for medical use and ordered by a medical provider.

- **NA/DOT No-Shows:** If the patient is no-show for an NA or DOT medication, licensed nursing staff shall coordinate with nursing supervisor, Facility Captain, Lieutenant, Sergeant, or Associate Warden for Health Care Services to locate the patient and to assist with resolving any identified barriers to medication administration as appropriate, and make every effort to bring the patient to the medication for:

  a. Medication administration; and

b. Documentation of barriers that prevented the patient from presenting to the medication line (e.g., lockdowns or transfers to another area or institution); or

c. Documentation of their refusal and reason for refusal of the medication.

- **No-show KOP**: Patients will be notified that their KOP medications are available for pick up at the pill window. If a patient fails to pick up KOP medication within four business days of the medication becoming available, health care staff should follow the institution's LOP to ensure the patient reports to the medication line to accept or refuse the medication. These processes may include ducating the patient or notifying custody to have the patient escorted to the medication line.

- **Medication Refusals**

  Licensed nursing staff shall document each refusal of an NA or DOT medication in the EHRS Medication Administration Wizard or electronic Medication Administration Record and document the reason for each medication refused, as stated by the patient.

  a. If a patient refuses methadone administration by the Narcotic Treatment Program, licensed nursing staff shall have the patient sign a CDCR 7225 Refusal of Examination and/or Treatment. The Addiction Medicine Central Team and the patient's PCT shall be notified via the EHRS Message Pool.

  Licensed nursing staff shall notify the prescriber when the patient refuses to pick up KOP medication, provide medication adherence counseling as determined by the prescriber, and document in the health record.

  Prescribers shall consider changing prescriptions, discontinuing medications, or discontinuing auto-refill for medication refusals and document the rationale for the action in the health record.

- **Medication Non-Adherence Counseling for Critical and Non-critical medications:**

  Clinical health care staff shall review medication adherence by way of the Automated Huddle Report or EHRS Message Pool for licensed health care staff to perform medication counseling.

  - For critical medications on the Critical Adherence Medications List, the PCT shall be notified verbally and in writing when a patient misses a critical medication by the end of medication pass. Patients shall be seen by licensed

health care staff within 24 hours when referred for missing or refusing a dose of a critical medication.

Critical Adherence Medication List		
Missed a dose of:	Refer: verbally and in writing immediately per institution policy	Response
Active tuberculosis (TB) disease medications (not prophylaxis)	Primary Care Team	Patients shall be seen by licensed health care staff from the Primary Care Team or a mental health prescriber from the Mental Health Team within 24 hours from receipt of the notification of medication non-adherence
Anti-rejection medication post-transplant (see Note 1)	Primary Care Team	
Hepatitis C antiretrovirals (or did not pick up a KOP dispense)	Primary Care Team	
Clozapine	Mental Health Team	
Long-acting injectable anti-psychotics (see Note 2)	Mental Health Team	
PC 2602 medications	Mental Health Team	
PC 2604 medications (see Note 3)	Primary Care Team	

Note 1: Refer to CCHCS Care Guide: Post Renal Transplant Revision 4/2020 page 32 for complete list of anti-rejection post-transplant medication.

Note 2: Per CCHCS, the following drugs are commonly prescribed long acting injectable formulations: Paliperidone palmitate, Fluphenazine decanoate, Risperidone, Haloperidol decanoate, Aripiprazole, and Aripiprazole lauroxil.

Note 3: Refer to CCHCS Care Guide: Palliative Care Revision 5/2021 page 13 for complete list of common medicines for Palliative Care on CCHCS Formulary.

- For non-critical medications, licensed health care staff shall provide medication adherence counseling as determined by the PCT and document in the health record. When indicated, licensed health care staff shall contact the prescriber for guidance.

Patients prescribed psychiatric medications by a mental health prescriber:

1. For medications on the Critical Adherence Medication List, the patient shall be seen by a mental health prescriber for an urgent mental health referral within 24 hours from receipt of the notification of medication non-adherence.

2. For non-critical medications, a mental health prescriber shall review the health record and document in the health record the plan of action within seven calendar days from receipt of the notification of medication non-adherence.

    a. The documented plan of action should take into account anticipated future medication non-adherence.

    b. A mental health prescriber shall follow up with a face-to-face session addressing the medication non-adherence as soon as clinically indicated, but no longer than 30 calendar days from the first day the mental health prescriber is notified of non-adherence.

3. Any medication adherence counseling session with a mental health prescriber shall be documented in a detailed note, and shall take place in a confidential setting, unless the patient refuses to attend.

All refusals shall be signed by the patient and co-signed by licensed health care staff. If the patient refuses to sign the CDCR 7225, two licensed health care staff shall sign. In unusual circumstances (e.g., Administrative Segregation Unit, Mental Health Crisis Bed), the CDCR 7225 may be signed by two staff members, one of whom shall be a licensed health care staff.

When refusal is signed, the original refusal form shall be forwarded to Health Information Management to be scanned to the health record.

References: April 2019 CCHCS HC DOM Ch. 3 Article 1 3.1.9.c.3.F.4-5; January 2016 Ch. 3 Article 2 3.2.2.C.2.F.1.; January 2016 Ch. 3 Article 2 3.2.4.C.5.C.4; ; August 2021 CCHCS HC DOM Ch. 3 Article 5 3.5.41.c.2-6; OIG Medical Inspection Unit

Ref # 13.101

REGIONAL INSPECTOR (Rev. 09/22/2021)

For specialized health care housing (CTC, SNF, Hospice, OHU): Do specialized health care housing maintain an operational call system?

Testing Methodology:

1. Working call system utilization determination

   For each specialized health care housing location (CTC, SNF, Hospice, OHU) the inspector should conduct interviews and determine if the unit area utilizes a call system. If the unit does not have call system capabilities, continue to test 13.102.

   Note 1: Per Title 22 Section 79839 (a), A call system shall be maintained in operating order in all nursing units. Call systems shall be maintained to provide visible and audible signal communication between nursing personnel and patients.

   a. Interview nursing staff, custody staff, and patients about their understanding for the use and expectations regarding the call system. Unclear use or expectations for the call system may cause delays or impact access to patients.

   b. If the specialized health care housing utilizes a call system, judgmentally test and verify that at least two call buttons are in proper working order (See Note 2 and 3 for testing rules).

   c. If the specialized health care housing utilizes a call system and some of the call buttons are in disrepair (not operational), determine the number and location of those buttons and confirm the call buttons are clearly labeled or identified.

   Note 2: For inpatient housing units (CTC, SNF, Hospice): If the call system and/or some buttons are not operational, the answer to this question is "No" and continue to test 13.102.

   Note 3: For outpatient housing unit (OHU): If the call system and/or some buttons are not operational, the answer to this question is "N/A" and continue to test 13.102.

References: CCR Title 22, Division 5, Sections 79839(a) & 72631; OIG Medical Inspection Unit

Ref # 13.102

REGIONAL INSPECTOR (Rev. 09/22/2021)

For specialized health care housing (CTC, SNF, OHU, Hospice): Do health care staff perform patient safety checks according to institution's local operating procedure or within the required time frames?

Testing Methodology:

1. Specialized health care housing locations without working call buttons

   For those in/out-patient areas that either do not have a call system or have buttons in disrepair, determine if a local operating procedure is in place at the time the call system is found in disrepair and verify if health care staff perform patient safety checks according to the institution's local operating procedure (LOP):

   a. ***For information only (non-scored):*** Interview nursing staff about their understanding of the institution's local operating procedure in performing safety check/rounds if the call system is found in disrepair or not available.

   b. **For specialized health care housing with local operating procedure**: Review a sampling of patient logs to verify that staff made their most recent round timely (at the time of fieldwork). If staff's most recent log update(s) was not timely, the test answer is "No."

   Note 1: While some in/out-patient units may use a single log to track all patients' safety checks; other units may use a separate log for each patient. Institution may document patient safety checks in patient's medical record. Inspectors will need to verify documentation of patient safety checks with nursing staff at the time of fieldwork.

      i. **Based on the institution's LOP for patient safety check/rounds**: If the unit uses a different log for each patient, then judgmentally select up to 3 patients and verify that all safety check/rounds entries were made timely during the most recent 24 hour time period. When applicable, record the date, bed location and any deviations noted. For deviations only, copy or take a photo of the applicable log documentation, if possible.

      ii. **Based on the institution's LOP for patient safety check/rounds**: If the unit uses a single log for all patients, then review the most recent 72 hour period for timely entries. Record the dates of review and any noted deviations. When applicable, record the date, bed location and any deviations noted. For deviations only, copy or take a photo of the applicable log documentation, if possible.

   c. **For specialized health care housing with no local operating procedure**:

i. For inpatient areas (CTC, SNF, Hospice): Determine if health care staff perform patient safety checks/rounds once every shift. Judgmentally select up to 3 patients, and verify that all patient safety checks/rounds were made timely during the most recent 24 hour time period. When applicable, record the date, bed location and any deviations noted. For deviations only, copy or take a photo of the applicable log documentation, if possible.

ii. For outpatient area (OHU): Determine if health care staff perform patient safety checks/rounds at least daily. Judgmentally select up to 3 patients for the most recent 72 hour period. When applicable, record the date, bed location and any deviations noted. For deviations only, copy or take a photo of the applicable log documentation, if possible.

2. Clinician Unimpeded Access to specialized health care housing

Determine whether health care staff who must enter patient cells have prompt access without delay from custody officers to unlock cell doors for routine, urgent or emergent situations by following the steps below:

a. ***For information only (non-scored):*** Interview the nursing staff and ask them the following: During the last 6 months, did any situations occur in which staff experienced unacceptable delays in gaining access to a patient's cell during an urgent or emergent situation. If any situations did occur, ask them if the delay in getting access to the patients' cell caused any harm to the patient, or could have caused harm to the patient.

HQ Notification *-As a result of this test, if the REGIONAL INSPECTOR concludes that clinical staff were unable to gain access to patient cells timely then, the applicable regional inspector must notify the OIG's Supervising Registered Nurse II of this finding, immediately upon conclusion of the site-visit.*

References: April 2019 CCHCS HC DOM Ch. 3 Article 1.10, (d)2.B&C, (e)1&2; OIG Medical Inspection Unit

Specialty Services

The Office of the Inspector General (OIG) will determine whether patients are receiving approved specialty services timely, whether the PCP reviewed related specialty service reports timely and documented their follow-up action plan for the patient, and whether patients who transferred from another institution received their previously approved or scheduled specialty service appointment. For specialty services the institution denied, the OIG will determine whether the denials were within policy, and if the patient was timely notified of the denial.

Sample Methodology

Tests 14.001 – 14.009

Sample selection also used for test 1.008.

Using CDCR's Clinic Appointment list data base for specialty services requests, the MIU analyst will sort the data by the requesters "order" date and then identify the universe of those patients who had their outpatient specialty services "approved" during the past three to nine months from the start of the inspections EHRS start date (i.e. day one of inspection week). From the universe list:

1. Randomly select 25 high-priority approved primary care provider specialty service requests, and select 15. The MIU analyst will then select 15 initial RFS for testing.

2. Effective 04/2019 sample selected: Randomly select 25 medium priority approved primary care provider specialty service requests, and select 15. The MIU analyst will then select 15 initial RFS for testing.

3. Randomly select 25 routine approved primary care provider specialty service requests, and select 15. The MIU analyst will then select 15 initial RFS for testing.

Note 1: ***Updated as of 9/28/2020:*** *When selecting the samples for tests 14.001, 14.004 and 14.007 (effective 04/2019), the OIG will exclude Audiology Consult to Gynecology, Consult to Public Health/Specialty RN, Chemo, Dialysis, Dietary, ECG 12-Lead (EKG), Hep C, HIV (clinic), Mammogram, Occupational Therapy, Ophthalmology, Optometry, Oral Surgery, Orthotics, Physical Therapy, Physiatry, Podiatry, and Radiology services from its sample. The specialty service is generally initiated via a Form 7243 (or Cerner system equivalent). However, a Physician's Order can be used in lieu of the Form 7243. Unless otherwise stated, the specialty service ordered on a Physician's order is considered a routine service that should be provided within 90 days.*

Note 2: A Form 7243 (RFS) is valid for six months. Specialty follow-up services occurring six months or later from the date of the original service require a new RFS order. As discussed in Note 1 above, generally OIG testing will be limited to initial service

requests where a Form 7243 was used. (If the analyst/ inspector believes a Form 7243 or EHRS equivalent form was or should have been used but was not properly documented in the health record, the sample may still be used with an appropriate deviation cited.

Note 3: ***Updated as of 12/2019:*** *When selecting samples prior to 12/2019, the OIG will treat urgent RFS as high priority.*

Test 14.010

Based on a data request received from the CCHCS, the MIU analyst will produce a list of 20 non-reception center patients (plus 5 alternates) who during the last 3 to 9 months transferred into the institution with a scheduled or pending specialty appointment. Note: If the inspected prison is a reception center, only transfers who came from other CDCR institutions will be included in this test sample.

Note 1: The OIG will exclude any specialty service appointments that do not have a clinician order on a Form 7243 (or EHRS equivalent) or Physician's Order. Generally, a specialty service is initiated via a Form 7243 (or EHRS equivalent). However, a Physician's Order can be used in lieu of the Form 7243. Unless otherwise stated, the specialty service ordered on a Physician's Order is considered a routine service that should be provided within 90 days.

Note 2: ***Updated as of 09/28/2020:*** *Excluding specialty services such as Audiology, Chemo, Consult to Gynecology, Dialysis, Dietary, Mammogram, Occupational Therapy, Ophthalmology, Oral Surgery, Orthotics, Physiatry, Physical Therapy, Podiatry, Radiology Services, Optometry, EKG, specialty RN/consult to Public Health, Hep C, and HIV (clinic).*

Tests 14.011 and 14.012

1. Obtain and review the Institutional Utilization Management Committee (IUMC) meeting minutes for the last three to nine months. Next, list all IUMC denials, and randomize all denials on the list.

2. Obtain the institution's Interqual denial database from CDCR headquarters for the period of the last three to nine months. Next, list all denials, and randomize all denials on the list.

Note 1: For samples selected using the Interqual database, the IUMC meeting minutes must also be reviewed for at least three months beyond the Interqual date to ensure that the denial was: 1) not appealed to a third level SMART; and, 2) not ultimately approved by a SMART. If the sample is reviewed by a SMART and denied, then the required time frame for a timely denial changes for our testing purposes. If a

SMART approves the sampled specialty service, then the sample is replaced and an alternate for that month will be used.

Note 2: In some instances, it may be necessary to contact the UM nurse during the EHRS week to obtain the most recent IUMC meeting minutes (for some recent service requests) or otherwise verify that a sample is applicable.

Inspection Procedures

Ref # 14.001

HQ INSPECTOR (Rev. 07/19/2020)

Did the patient receive the high-priority specialty service within 14 calendar days of the primary care provider order or the Physician Request for Service?

Testing Methodology (Sample 15):

This test shares the same sample as test 1.008, 4.002, 14.002 – 14.003.

Using Form 7243 (Physician Request for Services) or electronic RFS, compare the date the high priority service was ordered with the date the service was provided to determine whether the service was provided (received by the patient) within 14 calendar days.

References: July 2020 CCHCS HC DOM Ch. 3 Article 1 3.1.11.Definition of High Priority Health Care Request

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Ref # 14.002

HQ INSPECTOR (Rev. 09/22/2021)

Did the institution receive and did the primary care provider review the high priority specialty service consultant report within the required time frame?

Testing Methodology (Sample 15):

This test shares the same sample as test 1.008, 4.002, 14.001, 14.003.

1. Identify the date the high priority specialty service was provided by reviewing the EHRS to find the corresponding consultant's report related to the service provided. The report may be documented on the bottom half of the Form 7243 (Physician Request for Services) or it may be a separate scanned document.

2. Determine the date the institution received the specialty report and the date the PCP reviewed the report. The PCP must review the consultant's report within 3 calendar days of the date the report was received (prior to 07/2020), and within 3 business days of the date the report was received (effective 07/2020). However, for this test, the maximum allowable time for a report to be received is 3 calendar days from the service date. If a report (either initial or final) is not received within 3 calendar days, and then also reviewed within 3

calendar days of receipt (prior to 07/2020), and within 3 business days of receipt (effective 07/2020), the answer is "No."

Note 1: The above criteria are based on CCHCS policy for telemed specialty services and (based on OIG clinical expert guidance) is being applied to all specialty services.

Note 2: If the received date is not clearly indicated on the report, use the ***earliest date evidence*** *on the report (fax date, print date, date stamp, or EHRS scan date).*

3. If the PCP or proxy did not sign or initial and date the consultant's report, review the first face-to-face Provider Progress Notes following the receipt of the consultant's report. If there is specific evidence in the provider notes regarding the PCP's review of the specialty service results, the answer is "Yes."

   Note 3: For this test, the PCP only needs to perform an initial review of the consultant's findings within 3 calendar days (prior to 07/2020), and within 3 business days (effective 07/2020). As a result, the PCP may review either a preliminary or final Form 7243 or review a separately issued consultant's report within the required time frame. To evidence the review, the PCP may initial or sign the document, or discuss in a progress note that the report was reviewed. For this test, the inspector should not rely on indirect evidence (such as a provider order or issuances of another Form 7243) as evidence that the consultant's report was reviewed.

4. Determine the number of "days late" starting with the first attribute that was deemed non-compliant (i.e. report not received timely, or report received timely but not reviewed timely).

References: July 2020 CCHCS HC DOM Ch. 3. Article 1 3.1.11.c.3.I.1-3 and c.5.A; May 2015 Ch. 3 Article 4 3.4.2.b.3.D; OIG Medical Inspection Unit

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Ref # 14.003

HQ INSPECTOR (Rev. 07/19/2020)

Did the patient receive the subsequent follow-up to the high-priority specialty service appointment as ordered by the primary care provider?

Testing Methodology (Sample 15):

This test shares the same sample as test 14.001 – 14.003, 4.002, 1.008.

Using Form 7243 (Physician Request for Services) or electronic RFS, compare the date the follow-up specialty service was ordered with the date the service was provided, and determine whether the service was provided (received by the patient) as specified by the primary care provider.

References: July 2020 CCHCS HC DOM Ch. 3 Article 1 3.1.11.c.5.D-E

Ref # 14.004

HQ INSPECTOR (Rev. 07/19/2020)

Did the patient receive the medium-priority specialty service within 15-45 calendar days of the primary care provider order or the Physician Request for Service?

Testing Methodology (Sample 15):

This test shares the same sample as test 1.008, 4.002, 14.005 – 14.006.

Using Form 7243 (Physician Request for Services) or electronic RFS, compare the date the medium priority service was ordered with the date the service was provided to determine whether the service was provided (received by the patient) within 15-45 calendar days.

References: July 2020 CCHCS HC DOM Ch. 3 Article 1 3.1.11.Definition of Medium Priority Health Care Request

Ref # 14.005

HQ INSPECTOR (Rev. 09/22/2021)

Did the institution receive and did the primary care provider review the medium priority specialty service consultant report within the required time frame?

Testing Methodology (Sample 15):

This test shares the same sample as test 1.008, 4.002, 14.004, 14.006.

1. Identify the date the medium priority specialty service was provided by reviewing the EHRS to find the corresponding consultant's report related to the service provided. The report may be documented on the bottom half of the Form 7243 (Physician Request for Services) or it may be a separate scanned document.

2. Determine the date the institution received the specialty report and the date the PCP reviewed the report. The PCP must review the consultant's report within 3 calendar days of the date the report was received (prior to 07/2020), and within 3 business days of the date the report was received (effective 07/2020). However, for this test, the maximum allowable time for a report to be received is 3 calendar days from the service date. If a report (either initial or final) is not received within 3 calendar days, and then also reviewed within 3

calendar days of receipt (prior to 07/2020), and within 3 business days of receipt (effective 07/2020), the answer is "No."

Note 1: The above criteria are based on CCHCS policy for telemed specialty services and (based on OIG clinical expert guidance) is being applied to all specialty services.

Note 2: If the received date is not clearly indicated on the report, use the ***earliest date evidence*** *on the report (fax date, print date, date stamp, or EHRS scan date).*

3. If the PCP or proxy did not sign or initial and date the consultant's report, review the first face-to-face Provider Progress Notes following the receipt of the consultant's report. If there is specific evidence in the provider notes regarding the PCP's review of the specialty service results, the answer is "Yes."

   Note 3: For this test, the PCP only needs to perform an initial review of the consultant's findings within 3 calendar days (prior to 07/2020), and within 3 business days (effective 07/2020). As a result, the PCP may review either a preliminary or final Form 7243 or review a separately issued consultant's report within the required time frame. To evidence the review, the PCP may initial or sign the document, or discuss in a progress note that the report was reviewed. For this test, the inspector should not rely on indirect evidence (such as a provider order or issuances of another Form 7243) as evidence that the consultant's report was reviewed.

4. Determine the number of "days late" starting with the first attribute that was deemed non-compliant (i.e. report not received timely, or report received timely but not reviewed timely).

References: July 2020 CCHCS HC DOM Ch. 3. Article 1 3.1.11.c.3.I.1-3 and c.5.A; March 2015 Ch. 3 Article 4 3.4.2.b.3.D; OIG Medical Inspection Unit

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Ref # 14.006

HQ INSPECTOR (Rev. 09/22/2021)

Did the patient receive the subsequent follow up to the medium-priority specialty service appointment as ordered by the primary care provider?

Testing Methodology (Sample 15):

This test shares the same sample as test 14.004 – 14.005, 1.008, 4.002.

Using Form 7243 (Physician Request for Services) or electronic RFS, compare the date the follow-up specialty service was ordered with the date the service was provided, and determine whether the service was provided (received by the patient) as specified by the primary care provider.

References: July 2020 CCHCS HC DOM Ch. 3 Article 1 3.1.11.c.5.D-E

Ref # 14.007

HQ INSPECTOR (Rev. 09/22/2021)

Did the patient receive the routine-priority specialty service within 90 calendar days of the primary care provider order or Physician Request for Service?

Testing Methodology (Sample 15):

This test shares the same sample as test 1.008, 4.002, 14.008 – 14.009.

Using Form 7243 (Physician Request for Services) or PCP order, compare the date the routine priority service was ordered with the date the service was provided to determine whether the service was provided (received by the patient) within 46-90 calendar days (effective 04/2019).

Note 1: Absent a Form 7243, a Physician's Order (Procedures/Approved Referrals in EHRS) can be used. Unless otherwise stated, a specialty service ordered on a physician's order is considered to be a routine request in which the services generally must be provided within 46-90 calendar days (effective 04/2019).

References: July 2020 CCHCS HC DOM Ch. 3 Article 1 3.1.11.Definition of Routine Priority Health Care Request

Ref # 14.008

HQ INSPECTOR (Rev. 09/22/2021)

Did the institution receive and did the primary care provider review the routine specialty service consultant report within the required time frame?

Testing Methodology (Sample 15):

This test shares the same sample as test 1.008, 4.002, 14.007, 14.009.

1. Identify the date the routine specialty service was provided by reviewing the EHRS to find the corresponding consultant's report related to the service provided. The report may be documented on the bottom half of the Form 7243 (Physician Request for Services) or it may be a separate scanned document.

2. Determine the date the institution received the specialty report and the date the PCP reviewed the report. The PCP must review the consultant's report within 3 calendar days of the date the report was received (prior to 07/2020), and within 3 business days of the date

the report was received (effective 07/2020). The maximum allowable time for a report to be received is within 3 calendar days from the service date. If a report (either initial or final) is not received within 3 calendar days but reviewed within 3 calendar days of receipt (prior to 07/2020), and within 3 business days of receipt (effective 07/2020), the final answer is "No."

Note 1: The above criteria are based on CCHCS policy for telemed specialty services and (based on OIG clinical expert guidance) is being applied to all specialty services.

Note 2: If the received date is not clearly indicated on the report, use the ***earliest date evidence*** *on the report (fax date, print date, date stamp, or EHRS scan date).*

1. If the PCP did not sign or initial and date the consultant's report, review the first face-to-face provider Progress Notes following the receipt of the consultant's report. If there is specific evidence in the provider notes regarding the PCP's review of the specialty service results, the answer is "Yes."

   Note 3: For this test, the PCP only needs to perform an initial review of the consultant's findings within 3 calendar days (prior to 07/2020), and within 3 business days (effective 07/2020). As a result, the PCP may review either a preliminary or final Form 7243 or review a separately issued consultant's report within the required time frame. To evidence the review, the PCP may initial or sign the document, or discuss in a progress note that the report was reviewed. For this test, the inspector should not rely on indirect evidence (such as a provider order or issuances of another Form 7243) as evidence that the consultant's report was reviewed.

2. Determine the number of "days late" starting with the first attribute that was deemed non-compliant (i.e. report not received timely, or report received timely but not reviewed timely).

References: July 2020 CCHCS HC DOM Ch. 3. Article 1 3.1.11.c.3.I.1-3 and c.5.A; May 2015 Ch. 3 Article 4 3.4.2.b.3.D; OIG Medical Inspection Unit

Ref # 14.009

HQ INSPECTOR (Rev. 07/19/2020)

Did the patient receive the subsequent follow-up to the routine-priority specialty service appointment as ordered by the primary care provider?

Testing Methodology (Sample 15):

This test shares the same sample as test 14.007 – 14.008, 1.008, 4.002.

Using Form 7243 (Physician Request for Services) or electronic RFS, compare the date the follow-up specialty service was ordered with the date the service was provided, and determine whether the service was provided (received by the patient) as specified by the primary care provider.

References: July 2020 CCHCS HC DOM Ch. 3 Article 1 3.1.11.c.5.D-E

Ref # 14.010

HQ INSPECTOR (Rev. 09/22/2021)

For endorsed patients received from another CDCR institution: If the patient was approved for a specialty services appointment at the sending institution, was the appointment scheduled at the receiving institution within the required time frames?

Testing Methodology (Sample 20):

Using Form 7243 (Physician Request for Services), Interfacility Transfer Text, *Specialty Consult Progress Notes, *Physicians Orders, or *Progress Note, the inspector will determine the receiving institution's compliance date for providing specialty provider appointments by completing the steps below:

*The EHRS system has electronic version of these documents which are found under the Documentation tab or the Order tab.

1. Determine whether the sampled specialty appointment (approved at the sending institution) is for an initial/follow-up service or for an on-going service:

If the appointment is for an initial/follow-up service:

a. Determine date the PCP ordered initial/follow-up specialty service appointment,

b. Identify whether the initial/follow-up requested specialty service was High Priority, Medium Priority or Routine (effective 04/2019).

c. Date specialty service was scheduled per Interfacility Transfer Text or other available information in EHRS.

d. If the appointment is part of a series of approved specialty visits (i.e., the appointment being tested was driven by the last specialty appointment and not a new Form 7243 request):

e. Determine the date of last specialty service appointment, and

f. Date of next scheduled specialty service appointment; or, if not scheduled, date PCP at sending institution approved next appointment to occur by.

2. Determine the compliance date for the specialty service appointment to occur by (at the receiving institution)

a. **Unscheduled** - For each previously approved but not yet scheduled initial or follow-up specialty consult or procedure generated using Form 7243 (including those appointments that are the first in a series of approved visits), determine whether the receiving institution ensured the consultation or procedure was provided within the time frames below. For an appointment that is part of a series of approved ongoing visits but that is not the first in the series, see *Note 1* below under "Scheduled."

b. Effective 04/2019 revised policy and procedure:

- *Routine: 46-90 calendar days of the PCP order.
- *Medium priority: 15-45 calendar days of the PCP order
- *High priority: 14 calendar days of the PCP order.

***The above due dates for unscheduled appointments are firm, even if the date occurs less than 14 days after arrival.**

c. **Scheduled –Effective 04/2019 revised policy and procedure:** If a patient is approved for a medium priority or routine specialty service and is subsequently transferred to another institution before the service occurs, the receiving institution shall not cancel or void the specialty service unless the PCP at the receiving institution examines the patient and determines that it is no longer medically necessary or can be rescheduled to a later date. The PCP shall document his/her findings in the health record at the time the specialty service is cancelled or rescheduled. The OIG will no longer apply 30 days grace period from the scheduled date of specialty service.

*Note 1: **Effective 04/2019 revised policy and procedure:** Patients with pending high priority specialty services shall be placed on a medical hold to prevent transfer and discontinuity of care pursuant to IMSP&P, Vol. 4, Ch. 29.2 Medical Classification System Procedure.*

Note 2: If a patient arrives at the institution with a previously scheduled specialty service, and a provider at the receiving institution documents in an order that the specialty service should occur sooner than the time frame than policy would require, then the patient should be seen within the time frame ordered by the provider at the receiving institution.

Note 3: For pregnant patients arriving at CIW and CCWF, the first OB provider visit must be in accordance within the standard scheduled time frames outlined below that are required of all pregnant patients - Unless otherwise indicated by the obstetrician, pregnant patients shall be scheduled for their OB visits as follows:

Prior to Revision 9/2021:

- *Every four weeks in the first trimester and up to 24-26 weeks gestation.*
- *Every three weeks up to 30 weeks gestation.*
- *Every two weeks up to 36 weeks gestation.*
- *Weekly after 36 weeks gestation up to delivery.*

Effective 9/2021:

- *Every four weeks in the first trimester and up to 24-28 weeks gestation.*
- *Every two weeks thereafter up to 36 weeks gestation.*
- *Weekly after 36 weeks gestation up to delivery.*

3. Determine the date of the specialty service appointment actually occurred. If the appointment occurred timely, the final answer is "Yes." If the appointment did not occur timely, the final answer is "No"

4. If the specialty service appointment did not actually occur at the receiving institution, determine whether a treating physician examined the patient within specialty service time frames and provided support for why the specialty consult/procedure was no longer necessary. If this evidence is found in the EHRS, the answer is "Yes."

References: July 2020 CCHCS HC DOM Ch. 3 Article 1 3.1.11.c.1.C-D; September 2021 CCHCS HC DOM Ch. 3 Article 1 3.1.16.e.2.B.3; October 2020 Assembly Bill No. 732 Chapter 321; OIG Medical Inspection Unit

Ref # 14.011

HQ INSPECTOR (Rev. 09/22/2021)

Did the institution deny the primary care provider request for specialty services within required time frames?

Background Information / Level of Authorization & Review:

1st Level Review = Utilization Management (UM) Nurse
2nd Level Review = CME or CP&S
3rd Level Review = 3rd level review will be completed by the Statewide Medical Authorization Review Team (SMART)

Note 1: If the denial occurred at the 3rd level SMART, skip Step 1 below and go to Step 2.

Note 2: For those samples chosen using Interqual data, see the Sampling Methodology section's Note 2 above.

Note 3: Exclude testing RFS that was denied due to lack of clinical information only.

Testing Methodology (Sample 20):

Note 3: For tests 14.011 and 14.012, 20 samples in total. Ten samples that originated from the SMART data set and 10 that originated for the Interqual data set. If 10 samples are not available from one of the data sets, additional samples will be selected from the other data set (until 20 useable samples are selected).

1. If the denial date occurs at the first or second level only (i.e. does not get appealed to the SMART), identify the denial date on the Form 7243 (Physician Request for Services) and verify the denial occurred within the required time frames below:

   Effective 04/2019 revised policy and procedure:

   a. High or medium priority specialty services—Compare the denial date to the receipt date of the completed Form 7243 and ensure the denial occurred within five calendar days from the date of the RFS order.

   Routine Requests— Compare the denial date to the completion date (i.e. PCP request date) of the Form 7243 and ensure the denial occurred within 7 calendar days from the date of the RFS order.

2. Effective 04/2019: **FOR INFORMATION PURPOSES ONLY:** Third Level appeals- If the denial occurs at the 2nd level: The PCP has the option of appealing the denial to a third level. When an appeal occurs, the Form 7243 is submitted to the SMART whose review

shall occur within sufficient time to allow for the specialty service to occur within 14 calendar days of the Form 7243 request date for a high or medium priority, and within 60 calendar days for a routine service.

References: July 2020 CCHCS HC DOM Ch. 3 Article 1 3.1.11.c.2.A-E; December 2018 Ch. 3 Article 1 3.1.13.c.2.D; OIG Medical Inspection Unit

Ref # 14.012

HQ INSPECTOR (Rev. 09/22/2021)

Following the denial of a request for specialty services, was the patient informed of the denial within the required time frame?

Testing Methodology (Sample 20): (*See Note 3 for the test above.)*

Identify the denial date on the Form 7243 and compare it to the date of the first PCP visit following the highest level of denial (the denial may occur at the 1st and 2nd level or at the 3rd SMART meeting level). Verify that the PCP encounter occurred (as documented on Interdisciplinary Progress Notes) within 30 calendar days from the date of denial.

Note 1: Policy requires that when a specialty service is denied, the PCP shall document the decision and provide the patient with alternate treatment strategies during the next visit, which is to be within 30 days.

Note 2: The inspector must determine the highest level at which the Form 7243 was denied and then determine the date at which that denial took place. The denial may be identified directly on Form 7243, but SMART denial dates are not always identified on the form. If the final denial date is not clear or omitted from the Form 7243, the inspector may have to research the SMART minutes to determine the date.

Note 3: There may be more than one PCP visit that occurs subsequent to the denial date. At the first PCP visit following the denial, the provider may not be aware of the denial because she/he: 1) is seeing the patient for another condition, 2) is not the physician who ordered the request for specialty services, or 3) the denial has not yet been communicated. Therefore, evaluate any subsequent PCP appointment that occurred within 30 calendar days after the denial for compliance with this requirement.

Note 4: In the absence of face-to-face encounter due to CCHCS Covid-19 health care operation guidelines, review any phone visits occurring within the testing period. Evaluate if the provider discussed the denied specialty service request and provided alternate treatment strategies with the patient.

References: July 2020 CCHCS HC DOM Ch. 3 Article 1 3.1.11.c.2.F; OIG Medical Inspection Unit

Transfers

The Office of the Inspector General (OIG) will determine whether the institution adequately manages patients' medical needs during Inter- and Intra-facility transfers by reviewing the institution's ability to timely: perform initial health screenings, complete required health screening assessment documentation (including tuberculin screening tests), and deliver medications to patients received from another institution. This section also reviews the institution's ability to ensure that patients involved in various types of transfers are identified when scheduled for specialty service appointments and receive all medications timely including medication transfer packages. The types of patients reviewed in this section include endorsed inmates received from another CDCR facility and inmates transferring out of the facility.

Sample Methodology

Tests 6.001 – 6.003

Sample selection also used for test 1.002.

The MIU analyst will obtain the institution's most recent download of the Strategic Offender Management System (SOMS); the analyst will import and filter the data using the following parameters:

- Patients who transferred into the institution between 3 months to 9 months.
- Patients who transferred directly from another institution.

From the SOMS data, identify each patient name, CDCR #, arrival date, and the institution the patient transferred from. Filter the data to select patients who are taking Rx medications.

Generate a random list of all patients meeting the criteria described above and select the first 25 patients from that list for testing. The remaining patients will be held as alternates.

Test 6.101

The OIG will test 10 patient transfers-out of the institution. The regional inspector will contact the institution's classification services representative (CSR) (or PIO) to determine the dates, approximate times, and approximate number of patient transfers-out that will occur during the course of the OIG's on-site inspection. When feasible, the inspector will sample/test a single transfer that includes 10 or more patients. On the morning of the sampled R&R transfer, OIG regional inspector will judgmentally sample 10 patients who are 1) being transferred to another CDCR facility, and 2) that are currently prescribed medications (when possible).

Inspection Procedures

Ref # 6.001

HQ INSPECTOR (Rev. 09/22/2021)

For endorsed patients received from another CDCR institution or COCF: Did nursing staff complete the initial health screening and answer all screening questions within the required time frame?

Testing Methodology (sample 25):

This test shares the same sample as tests 6.002, 6.003, & 1.002.

1). Review Initial Health Screening and Initial Health Screening (Supplemental)—Male/Female Inmates and determine whether the nursing staff completed the form(s) on the same day the patient arrived at the institution. Nursing staff [i.e., Licensed Psych Tech (LPT)/Licensed Vocational Nurse (LVN)/Registered Nurse (RN)] that completes the screening shall answer each "Yes" or "No" box, provide details supporting a "Yes" answer (see Note 2 - Rule Exception), if additional information is required, and sign and date the form(s).

2). Verify that the nurse documented a complete set of vital signs and weight. In addition, finger stick blood glucose must be obtained for patients with a history of diabetes.

*Note 1: **Effective 04/2019**: Per OIG Medical Inspection Unit, the Initial Health Screening form must be completed prior to patient being placed in housing. However, in those cases when the patient arrives late in the evening (i.e., after normal business hours) and the forms are completed the following calendar day, the answer is "Yes."*

Note 2: For purposes of this test, the OIG requires nursing staff (i.e., LPT/LVN/RN) to answer Yes/No for each question on the Initial Health Screening form. In addition, the OIG requires nursing staff to provide supporting details for "Yes" responses when additional information is required to be provided for a specific question (e.g. listing the medications that the patient is currently taking) For this test, while all questions must be answered "Yes" or "No", the inspector will exclude the 'additional information documentation requirement' from testing for those questions related to language, health care appliances, and allergies.

Note 3: The focus of this test is on nursing staff's (i.e., LPT/LVN/RN) initial screening and not the subsequent assessment/disposition only to be completed by a RN. In many cases, a RN completes both functions. If the same RN performed both the initial screening and the assessment/disposition, the RN may not document a completion date for the initial screening. As a result, defer to the date the RN signed and dated the

Assessment/Disposition section of the form to determine the date the initial screening occurred.

Note 4: If no Initial Health screening form is found, the answer is "No", unless the patient is returning from another prison where he/she was temporarily housed in a mental health crisis bed, in which case the sample item should be thrown-out and replaced.

References: April 2019 CCHCS HC DOM Ch. 3 Article 1 3.1.9.c.3.B.1.a; March 2016: Centers for Disease Control and Prevention: Tuberculosis- Signs & Symptoms; OIG Medical Inspection Unit

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Ref # 6.002

HQ INSPECTOR (Rev. 09/22/2021)

For endorsed patients received from another CDCR institution or COCF: When required, did the RN complete the assessment and disposition section of the initial health screening form; refer the patient to the TTA if TB signs and symptoms were present; and sign and date the form on the same day staff completed the health screening?

Testing Methodology (Sample 25):

This test shares the same sample as tests 6.001, 6.003, & 1.002.

3. If any questions on the Initial Health Screening and Initial Health Screening (Supplemental)—Male/Female Inmates are answered "Yes," determine whether a RN completes an assessment/disposition (i.e. referral) and signs and dates the initial health screening form(s) on the same day staff completed the health screening. If a RN does not complete the assessment/disposition, signs and dates the initial health screening form on the same day staff completed the health screening, the answer to this test will be "No."

   Note 1: The same RN may complete both the initial screening and the assessment/disposition. Further, if the assessment and disposition section is not required because there were no "Yes" responses on the screening questions, the test answer is N/A, even if the RN completes and signs the disposition section.

4. TB screening—if the answer is "Yes" to any TB signs or symptoms are documented, determine whether the RN promptly referred the patient to the TTA for a clinical evaluation.

   Note 2: For patients coming from another CDCR facility, health care staff will screen (rather than conduct a skin reaction test) patients for possible signs and symptoms associated with TB and record interview results on initial health screening form. While there are many symptoms that could be associated with TB, leading

indicators are prolonged and productive cough (for more than 3 weeks), fever, chills, loss of appetite, fatigue, weight loss, and night sweats.

References: April 2019 CCHCS HC DOM Ch. 3 Article 1 3.1.9.c.3.B.1.b & 2; September 2018 Ch. 3 Article 8 3.8.7.c.2.A; September 2018 Care Guide: Tuberculosis Surveillance; March 2016: Centers for Disease Control and Prevention: Tuberculosis- Signs & Symptoms; OIG Medical Inspection Unit

Ref # 6.003

HQ INSPECTOR (Rev. 12/13/2021)

For endorsed patients received from another CDCR institution or COCF: If the patient had an existing medication order upon arrival, were medications administered or delivered without interruption?

Testing Methodology (Sample 25):

Special Note - This test shares the same sample as tests 6.001, 6.002, & 1.002.

Refer to Initial Health Screening form, Interfacility Transfer form, and MAR Summary to determine whether the patient was on any medications upon arrival at the institution. If the patient was found to be on medications, verify whether the medications were administered within required time frames.

Note 1: If a provider at the receiving institution documented why all medications were not to be administered or re-issued upon arrival, the answer will be "N/A."

Note 2: If the patient was not on any medications or was not on any medications subject to this test, the final answer is "N/A."

Note 3: For this test, do not test or include medications ordered as:
1) PRN (unless chronic care medications),
2) "Request Refill" (unless chronic care medications)
3) KOPs that arrived with the patient (except as noted above), or
4) Vaccines, allergy medications.

For all other medications:

For all NA, DOT, and KOP medications that did not arrive with the patient, consider each medication's written instructions and determine whether the patient received continuation of the medication(s) without interruption, i.e. the patient received the medication at the next dosing interval or the nurse documented that the patient was a no-show or refused it. The nursing staff must properly complete and sign the MAR or other documentation to receive a "Yes" answer.

Discontinued medications: If the patient did not timely receive a medication, review Interdisciplinary Progress Note to determine whether the physician documented why the patient's

medications were not continued. If there is no discontinuation order found, the answer to this question is "No."

For patients who arrive without a sufficient supply of medications: For active orders, the pharmacy provides the meds during working hours or nurses obtain meds from after-hours medications supplies. The medication shall be administered NA or DOT and documented on the patient's MAR. Patients who arrive with an insufficient supply of routine (KOP or NA/DOT) medications and whose orders are at or near expiration should have their medications renewed by a provider within eight hours of arrival, as indicated.

Note 4: For inmates transferring between CDCR institutions, an approved Nonformulary Drug Request remains valid at the receiving institution. If patients arrive with an order for a nonformulary medication, and the sending institution does not send the nonformulary medication with the inmate, then the receiving institution has one business day to fill an order for the medication. If the order is after 3:00 PM on the day of arrival, the sending institution has two business days to fill the order.

Note 5: If the patient did not receive every applicable dose of NA, DOT, or KOP medication without interruption, the answer to this question is "No."

- **NA/DOT No-Shows:** If the patient is no-show for an NA or DOT medication, licensed nursing staff shall coordinate with nursing supervisor, Facility Captain, Lieutenant, Sergeant, or Associate Warden for Health Care Services to locate the patient and to assist with resolving any identified barriers to medication administration as appropriate, and make every effort to bring the patient to the medication for:

  a. Medication administration; and

  b. Documentation of barriers that prevented the patient from presenting to the medication line (e.g., lockdowns or transfers to another area or institution); or

  c. Documentation of their refusal and reason for refusal of the medication.

- **No-show KOP**: Patients will be notified that their KOP medications are available for pick up at the pill window. If a patient fails to pick up KOP medication within four business days of the medication becoming available, health care staff should follow the institution's LOP to ensure the patient reports to the medication line to accept or refuse the medication. These processes may include ducating the patient or notifying custody to have the patient escorted to the medication line.

- **Medication Refusals**

  Licensed nursing staff shall document each refusal of an NA or DOT medication in the EHRS Medication Administration Wizard or electronic Medication

Administration Record and document the reason for each medication refused, as stated by the patient.

a. If a patient refuses methadone administration by the Narcotic Treatment Program, licensed nursing staff shall have the patient sign a CDCR 7225 Refusal of Examination and/or Treatment. The Addiction Medicine Central Team and the patient's PCT shall be notified via the EHRS Message Pool.

Licensed nursing staff shall notify the prescriber when the patient refuses to pick up KOP medication, provide medication adherence counseling as determined by the prescriber, and document in the health record.

Prescribers shall consider changing prescriptions, discontinuing medications, or discontinuing auto-refill for medication refusals and document the rationale for the action in the health record.

- **Medication Non-Adherence Counseling for Critical and Non-critical medications:**

  Clinical health care staff shall review medication adherence by way of the Automated Huddle Report or EHRS Message Pool for licensed health care staff to perform medication counseling.

  - For critical medications on the Critical Adherence Medications List, the PCT shall be notified verbally and in writing when a patient misses a critical medication by the end of medication pass. Patients shall be seen by licensed health care staff within 24 hours when referred for missing or refusing a dose of a critical medication.

Critical Adherence Medication List		
Missed a dose of:	Refer: verbally and in writing immediately per institution policy	Response
Active tuberculosis (TB) disease medications (not prophylaxis)	Primary Care Team	

Anti-rejection medication post-transplant (see Note 1)	Primary Care Team	Patients shall be seen by licensed health care staff from the Primary Care Team or a mental health prescriber from the Mental Health Team within 24 hours from receipt of the notification of medication non-adherence
Hepatitis C antiretrovirals (or did not pick up a KOP dispense)	Primary Care Team	
Clozapine	Mental Health Team	
Long-acting injectable anti-psychotics (see Note 2)	Mental Health Team	
PC 2602 medications	Mental Health Team	
PC 2604 medications (see Note 3)	Primary Care Team	

Note 1: Refer to CCHCS Care Guide: Post Renal Transplant Revision 4/2020 page 32 for complete list of anti-rejection post-transplant medication.

Note 2: Per CCHCS, the following drugs are commonly prescribed long acting injectable formulations: Paliperidone palmitate, Fluphenazine decanoate, Risperidone, Haloperidol decanoate, Aripiprazole, and Aripiprazole lauroxil.

Note 3: Refer to CCHCS Care Guide: Palliative Care Revision 5/2021 page 13 for complete list of common medicines for Palliative Care on CCHCS Formulary.

- For non-critical medications, licensed health care staff shall provide medication adherence counseling as determined by the PCT and document in the health record. When indicated, licensed health care staff shall contact the prescriber for guidance.

Patients prescribed psychiatric medications by a mental health prescriber:

1. For medications on the Critical Adherence Medication List, the patient shall be seen by a mental health prescriber for an urgent mental health referral within 24 hours from receipt of the notification of medication non-adherence.

2. For non-critical medications, a mental health prescriber shall review the health record and document in the health record the plan of action within seven calendar days from receipt of the notification of medication non-adherence.

    a. The documented plan of action should take into account anticipated future medication non-adherence.

    b. A mental health prescriber shall follow up with a face-to-face session addressing the medication non-adherence as soon as clinically indicated, but no longer than 30 calendar days from the first day the mental health prescriber is notified of non-adherence.

3. Any medication adherence counseling session with a mental health prescriber shall be documented in a detailed note, and shall take place in a confidential setting, unless the patient refuses to attend.

All refusals shall be signed by the patient and co-signed by licensed health care staff. If the patient refuses to sign the CDCR 7225, two licensed health care staff shall sign. In unusual circumstances (e.g., Administrative Segregation Unit, Mental Health Crisis Bed), the CDCR 7225 may be signed by two staff members, one of whom shall be a licensed health care staff.

When refusal is signed, the original refusal form shall be forwarded to Health Information Management to be scanned to the health record.

References: April 2019 CCHCS HC DOM Ch. 3 Article 1 3.1.9.c.3.B.5; December 2021 Ch. 3 Article 5 3.5.27.d.1-2; January 2016 Ch. 3 Article 2 3.2.2.c.1.E.4, F.1-2 & 2.F.2.; January 2016 Ch. 3. Article 2 3.2.6.c.4; August 2021 CCHCS HC DOM Ch. 3 Article 5 3.5.41.c.2-6; OIG Medical Inspection Unit

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Ref # 6.101

REGIONAL INSPECTOR (Rev. 09/27/2021)

For patients transferred out of the facility: Do medication transfer packages include required medications along with the corresponding transfer packet required documents?

Testing Methodology (Sample 10):

1. In the days prior to the site visit, contact the institution's classification and parole representative (C&PR) (or PIO) to determine the dates, approximate times, and approximate number of patient transfers-out that will occur during the course of the OIG's on-site inspection. When feasible, the inspector will sample/test a single transfer that includes 10 or more inmates.

2. Visit the R&R just prior to the inmates' departure and obtain a list of patients transferring out of the institution. The inspector will judgmentally select 10 patients who have at least one medication tested under #3 below (if possible).

3. In the presence of the R&R nurse, first confirm that the transfer packages are deemed complete and ready for the inspector's official review. Then, open each sampled transfer packet envelope contained in the packet. The transfer envelope shall include information necessary to ensure continuity of care which may include, but is not limited to, the following, **as applicable*:**

   - Transfer-Bus Content
   - Patient Summary Sheet
   - CDCR 7465, Physician Orders for Life-Sustaining Treatment (POLST)/ CDCR 7421, Advance Directive for Health Care
   - First Responder Data Collection Tool
   - Emergency Care Flow Sheet
   - Emergent Transfer Report
   - Inpatient Discharge Summary
   - Medications (e.g. Nurse Administered (NA)/ Direct Observation Therapy (DOT)/ Keep-On-Person (KOP))
   - DME and Medical Supplies (*Note: Visually confirm availability of DME and medical supplies. If not found, determine if sufficient documentation was included if DME and medical supplies are missing or not available).*

   *Contents may vary based on the patient's condition, the urgency of the transfer, and the method of transportation.

   The transfer envelope must **not** include:

   - Narcotics (prohibited by law to be transported)
   - Rescue medications: Albuterol (Xopenex/ Levalbuterol), Nitroglycerin, and
   - Glucose tabs or gel

   If all KOP medications are not accounted for on the day of transfer (i.e. the KOP meds are not in the envelope and the patient did not bring their KOP meds), the R&R/Transfer RN must notate in the transfer packet regarding missing medications. The receiving institution will ensure that the prescribed medications are continued following the usual medication ordering processes.

   Note 1: CCHCS policy requires that the R&R and transportation staff shall allow patients to keep their nitroglycerin tablets (for heart condition) and/or "inhalers" (for asthma) on their person during transfer.

Note 2: For patients who pose a security risk if allowed to carry medications during transportation, alternate methods, as determined by health care staff, may be used to transport the medication while allowing the patient access to the medication.

4. Record the results of the visual inspection on the patient's copied medication reconciliation form including information on how patient's Flovent/ Albuterol/ Xopenex/ Levalbuterol Nitroglycerin, or Glucose tabs/gel medications will be transported (i.e. whether the patient will carry the medications or health care staff has approved an alternate transport method).

Note 3: When possible the inspector will attempt to confirm the health care staff's assertions about the patient carrying their rescue inhaler, Nitroglycerin, or Glucose tabs/gel on their person with the transport custody officer. This is to ensure that custody is not acting outside medical staff's authority.

Note 4: If the required medication was not located in the transfer package or other special (i.e. refrigeration) storage location on the bus, then the answer is "No." When possible, the inspector will notify Receiving and Release staff of the discrepancy(ies), so that corrections can be made.

Note 5: For this test, the OIG will not test any KOP medication that was ordered as "PRN" (i.e. "As Needed") or as "Request Refill," unless the medication is deemed to be a chronic care or other essential medication such as Flovent/ Albuterol/ Xopenex/ Levalbuterol rescue inhaler, Nitroglycerin, or Glucose tabs/gel. These types of essential medications will be tested for the presence during transfers (but only the mentioned medications must be on the inmate's person during transport).

Note 6: Transfers include patients transferring to another CDCR institution or Law Enforcement Entity, which includes the Department of State Hospitals.

Note 7: If after reviewing the transfer packages, the OIG inspector is not required to remain at the R&R location to ensure that the required but missing mediations are retrieved (via the pharmacy, omni-cell, etc.) prior to the transfer bus leaving the institution, unless the patient is on a rescue mediation such as asthma inhaler, nitroglycerin, or Glucose tabs/gel. For these types of missing medications, the inspector should obtain confirmation that the meds are sent with the patient prior to the bus leaving the institution.

Note 8: If the patient is on PC 2602 medications, contact the OIG's supervising regional nurse on whether the specific medications should be included in the transfer package.

Note 9: For this test, the inspector must scan the copied medication reconciliations from the sampled patients' transfer packages and electronically store the documents in the applicable OIG medical inspection folder.

References: April 2019 CCHCS HC DOM Ch. 3 Article 1 3.1.9.c.2.B.1-9; January 2016 Ch. 3 Article 2 3.2.6.c.4; September 2013 Ch. 3 Article 5 3.5.28.c.3.A-B; OIG Medical Inspection Unit

SECONDARY INDICATOR:

Administrative Operations

The Office of the Inspector General will assess whether the institution completes internal reviews, processes medical appeals, and holds committee meetings in compliance with policy. The Office of the Inspector General will also determine whether the institution adequately manages its health care staffing resources by evaluating whether: job performance reviews are completed as required; professional licenses and/or certifications are current; and, training requirements are met. The OIG will also determine whether clinical and custody staff members are current with emergency response certifications.

Sample Methodology

For the tests below, all documents are initially requested from CCHCS:

Test 15.001

Obtain the institution report of sentinel events that resulted in RCA provided by CCHCS and judgmentally select five events that required the submission of a Root Cause Analysis. The CCHCS HQ Health Care Incident Review Committee (HCIRC) is required to maintain information about sentinel events resulted in RCA in a tracking system. The OIG receives a report generated from the tracking system for sentinel events with RCA that occurred during the most recent 12 months (from the date of the job start letter) and is submitted to the OIG with the pre-inspection document request packet. The OIG will use the information contained in this report to select the sample.

Test 15.002

Obtain the QMC meeting minutes for the last six months.

Test 15.003

Obtain the EMRRC (or its institutional equivalent) meeting minutes for the last six months. Select the first two incidents reviewed by the committee for a total of 12 samples. If less than 2 incidents are reviewed for the month then, judgmentally select an alternate sample(s) from either the prior or a subsequent month.

Note: In support of clinical case reviews that may require more than 6 months of data, the OIG requests 12 months' worth of data.

Test 15.004

For each institution with a licensed care facility (i.e. CTC, SNF), obtain and review the meeting minutes of Local Governing Body, or its equivalent, for the previous 12 months.

Test 15.101

Obtain the Medical emergency response drill summary reports and supporting documentation for each watch for the most recent full quarter.

Test 15.102

See test 15.102 for the sampling methodology.

Test 15.103

Obtain the list of deaths from the most recent 12 months, the corresponding signed/final copies of Initial Inmate Death Report, and the proof of notifications indicating submission time and date for the corresponding Initial Inmate Death Report reported to CCHCS' Death Review Unit.

Tests 15.104-15.110 (except 15.106)

The OIG will interview staff and review various files, reports, and documents as specifically outlined in the testing methodologies. The OIG will obtain a copy of the institution's listing of licensed health care staff, including employee name, position, date of employment, and medical licenses and certifications held.

Test 15.106

The OIG will use the provider listing sent by the institution. The provider list should include all MD, DO, NP and PA staff at the institution.

Test 15.998

See inspection procedures for test 15.998 for the sampling methodology. The data collected is provided as information only.

Inspection Procedures

Ref # 15.001

HQ INSPECTOR (Rev. 09/27/2021)

FOR INFORMATIONAL PURPOSES ONLY: For health care incidents requiring root cause analysis (RCA): Did the institution meet RCA reporting requirements?

Definitions:

Health Care Incident: *"An unusual or unexpected occurrence in the clinical management of a patient or patients such as an error, sentinel event, near miss, accident, or medication event that has or may have adverse health consequences for patients and/or staff, and requires submission of a written description of the event to the Statewide Health Care Incident Review Committee."*

Root Cause Analysis: *"A structured and standardized process by which a multidisciplinary team analyzes a health care incident, near miss, or sentinel event; determines the fundamental reasons why the event occurred; and designs and implement a Plan of Action to prevent similar events from occurring in the future.*

Sentinel Event: "*A patient safety event, including adverse events as defined in the California Health and Safety Code, not primarily related to the natural course of the patient's illness or underlying condition that results in death, permanent harm, or a temporary impairment that affects the patient and limits their ability to function normally for a significant amount of time."*

Testing Methodology:

For selected sentinel events that resulted in root cause analysis (RCA) , determine whether the institution: timely reported the RCA to Health Care Incident Review Committee (HCIRC), submitted a final report that the HCIRC approved, and submitted a monthly Plan of Action update for a minimum of four consecutive months following submission of RCA report or until the HCIRC closes the case.

1. Determine whether the institution reported the sentinel event to the electronic Health Care Incident within 24 hours of occurrence (or its discovery):

    a. Record the date and time the sentinel event occurred or discovered and the date and time institution health care staff reported the sentinel event to the eHCIR.

    b. Compare the information obtained and verify whether the event was reported timely; if not timely, calculate the number of days it was late.

Note 1: Most events will be discovered at the point of care by institution staff, but some events may be identified and reported by a person or entity not employed at the institution. Regardless of the source, the HCIRC should log information into their tracking database, communicate it to the institution, and notify the institution if an RCA (with action plan) is required. If the sentinel event occurred at the institution but was reported by someone outside the institution (or anonymously), then this question is answered "N/A."

2. If the sentinel event required RCA report completion, determine whether the institution submitted an RCA report to the HCIRC and if the HCIRC approved the report packet by completing step a. or b., below. For this step, the OIG will confirm that the HCIRC approved the report, which indicates the HCIRC has deemed the report packet to be thorough and credible.

Note 2: The institution should conduct an (internal) root cause analysis process and submit an RCA Report to the HCIRC. The final report packet should include (among other things) whether there were root causes that contributed to the Sentinel event, any applicable root cause findings, and an action plan that will include corrective actions. As the HCIRC evaluates the initial notification (and works with the institution), it will notify the institution whether or not an RCA is required. When notified, the institution should submit an RCA Report to the HCIRC (the institution will receive up to 45 business days to submit the RCA report from the date that the RCA was assigned.

Note 3: If upon review of the RCA Report, the HCIRC requests clarification or revision of the report, the institution shall make necessary clarifications or revisions and submit the revised RCA Report to the HCIRC within 15 business days of the request.

a. <u>For an institution that submitted an RCA report</u>, determine if the HCIRC approved the report:

   i. If the report is approved, the response to this step is "Yes."

   ii. If the report is not approved (as of the date the source document was submitted in the pre-inspection packet), the response to this step is "N/A."

b. <u>For an institution that did not submit a report</u>, record the date the HCIRC notified the institution that an RCA was required, and perform the following:

   i. Calculate the due date within 45 business days of the notification.

      - If the due date hasn't arrived yet, then the response to this step is "N/A."

ii. Calculate the number of days late if the date has arrived and it is greater than 45 business days.

- If the report is late, then the response to this step will be "No."

3. Determine whether the institution submitted a monthly Plan of Action status update by the last day of the reporting month for a minimum of four consecutive months following submission of the RCA report, or until the HCIRC closes the case.

   a. Record the date of each of the first four monthly status reports submitted, as applicable.

Note 4: The institution must receive a "Yes" response for each of the three indicators noted above, as applicable (sentinel event reported within 24 hours of occurrence or its discovery) an RCA Report was approved, and four monthly status reports were submitted) for the adverse/sentinel event tested to receive an overall "Yes" response.

Note 4: For this test, the OIG will not employ the sample-of-one testing methodology. In other words, if the institution only has one sentinel event during the sampled test period, it will still be sampled and scored.

References: November 2018 CCHCS HC DOM Ch. 1 Article 2 1.2.6.d; November 2018 Ch. 1 Article 2 1.2.7.1-2, 5.D-F

Ref # 15.002

HQ INSPECTOR (Rev. 09/27/2021)

Did the institution's Quality Management Committee (QMC) meet monthly?

Testing Methodology:

To determine if the institution Quality Management Committee (QMC) met at least monthly:

Note 1: It is recommended that the institution QMC meet weekly. However, at a minimum, the committee will meet no less than monthly. If the institution meets more often than monthly, sample all committee meetings that occurred during the six-month period.

1. Identify the most recent 6-month review period.

2. Document the QMC meeting dates that occurred during the six-month review period.

3. Conclude whether the meetings occurred at least monthly.

References: December 2012 CCHCS HC DOM Ch. 1 Article 2 1.2.5.d.2.C.3

For Emergency Medical Response Review Committee (EMRRC) reviewed cases: Did the EMRRC review the case timely, and did the incident packages reviewed include the required documents?

Sampling Methodology:

Review the Emergency Medical Response Review Committee's (EMRRC) meeting minutes from the most recent 6 month period of time and select the first two incidents reviewed by the committee each month for a total of 12 samples. If the committee reviews less than 2 incidents for a particular month, then select replacement samples from months 7 through 12 until the sample size of 12 is reach. For any one month, do not select more than 2 samples. If the EMRRC held no meeting during the month, skip the month and select a viable sample from the following month.

Testing Methodology:

1. For Institutions that **have not completed** training for the NEW Emergency Medical Response Program (see list of institutions below for roll-out and completion date)**:** Compare the incident date with the date of the initial EMRRC meeting where the sampled incident was first discussed. The initial review needs to have taken place at the regular monthly meeting following the date of the incident. In addition, the meeting minutes must be signed by the CEO and Warden; otherwise, the answer to the question is "No."

   Note 1: The EMRRC meetings no longer have to be within 30 day intervals; rather, the EMRRC meetings have to occur sometime during the month, each month).

   Note 2: Applicable to Step 1 and Step 2: The warden may send a designee (either the AW for Health Care or the CDW) to attend the EMRRC meetings; however, the warden must be the person who signs the meeting minutes along with the CEO.

   Note 3: CCHCS July 2012 P&P requires the CME and CNE/DON (or their designees) to "review the clinical care delivered during each emergency medical response incident for suicide attempts, deaths, and all unscheduled transfers out of the institution which have occurred since the prior review."

2. For Institutions that **completed training** for the NEW Emergency Medical Response Program (see list of institutions below for roll-out and completion date): Compare the incident date with the date of the process review (EMRRC QA Review) meeting where the sampled incident was reviewed. Events shall be reviewed within 30 calendar days of their occurrence. In addition, the meeting minutes must be signed by the CEO and Warden; otherwise, the answer to the question is "No."

Note 4: CCHCS HC DOM July 2019 requires CME or designee, and the CNE or designee to "review the documentation and the clinical care delivered during each EMRS incident for suicide attempts, deaths, and all unscheduled transfers out of the institution which have occurred since the prior review."

3. The incident package must also include the following required documents to be a complete package; otherwise, the answer to the question is "No":

   a. Emergency Medical Response Review form—referred to as the Emergency Medical Response Review Event Checklist form or CDCR 7186-1 Emergency Medical Response and Unscheduled Transport Event Checklist. ***Special Note - All key checklist questions on the form must be answered for the form to be deemed complete.***

   b. EMRRC Meeting Minutes Case Review template—referred to as the Emergency Medical Response Case Review Minutes Template or CDCR 7189-1 Emergency Medical Response Review Committee Agenda Template and Minutes

Note 4: The institution is not required to call its committee the "Emergency Medical Response Review Committee," however it must have an established committee for this purpose.

Note 5: Per policy, the institution's EMRRC should include a clinical review of all emergency medical response incidents for suicide attempts, deaths, and all unscheduled transfers out of the institution which have occurred since the prior review. Only those clinical reviews actually performed by the committee will be sampled. If it is discovered that the institution had transfers out that were not reported on the minutes, i.e. code 2s, standard language will be added to the report to address the issue as well as a recommendation made. It is encouraged that compliance speak with case review i.e. NCPRs regarding their findings for code 2 send outs.

Note 6: If no EMRRC meeting was held for a particular month, the OIG will not take exception but rather select a sample from a subsequent month.

Initial Roll-out date	Completion Date	Institution
March 4-22, 2019	September 22, 2019	California State Prison, Solano
April 8-26, 2019	October 26, 2019	Pleasant Valley State Prison
April 8-26, 2019	October 26, 2019	California State Prison, Sacramento

April 29-May 17, 2019	November 17, 2019	Mule Creek State Prison
April 29-May 17, 2019	November 17, 2019	Folsom State Prison
June 3-21, 2019	December 21, 2019	California Medical Facility
July 8-26, 2019	January 26, 2020	San Quentin State Prison
July 8-26, 2019	January 26, 2020	California Correctional Center
September 9-27, 2019	March 27, 2020	Pelican Bay State Prison
September 9-27, 2019	March 27, 2020	High Desert State Prison
October 7-25, 2019	April 25, 2020	Sierra Conservation Center
October 7-25, 2019	April 25, 2020	Deuel Vocational Institution
November 4-22, 2019	May 22, 2020	Substance Abuse Treatment Facility
November 4-22, 2019	May 22, 2020	California State Prison, Corcoran
January 6-24, 2020	July 24, 2020	California State Prison, Calipatria
January 6-24, 2020	July 24, 2020	California State Prison, Centinela
January 27-February 14, 2020	August 14, 2020	California Men's Colony
January 27-February 14, 2020	August 14, 2020	Avenal State Prison

February 24-March 13, 2020	September 13, 2020	California State Prison, Los Angeles County
May 17-21, 2021	November 21, 2021	California Correctional Institution
June 7-11, 2021	December 11, 2021	Chuckawalla Valley State Prison
July 12-16, 2021	January 16, 2022	California Institution for Men
September 13-17, 2021	March 17, 2022	California Rehabilitation Center
October 25-29, 2021	April 29, 2022	Salinas Valley State Prison
December 13-17, 2021	June 17, 2022	Valley State Prison
January 31-February 4, 2022	August 4, 2022	California Institution for Women
March 7-11, 2022	September 11, 2022	Central California Women's Facility
April 11-15, 2022	October 15, 2022	Ironwood State Prison
May 16-20, 2022	November 20, 2022	Correctional Training Facility
To Be Determined	To Be Determined	Richard J. Donovan Correctional Facility
To Be Determined	To Be Determined	Wasco State Prison
To Be Determined	To Be Determined	California City Correctional Facility

To Be Determined	To Be Determined	North Kern State Prison
To Be Determined	To Be Determined	Kern Valley State Prison
To Be Determined	To Be Determined	California Health Care Facility

References: July 2012 CCHCS HC DOM Ch. 3 Article 7 3.7.4.f.1.B.1.a-e; July 2019 Ch. 3 Article 7 3.7.1-1.j.1-6; OIG Medical Inspection Unit

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Ref # 15.004

HQ INSPECTOR (Rev. 09/27/2021)

For institutions with licensed care facilities: Did the Local Governing Body (LGB) or its equivalent, meet quarterly and discuss local operation procedures and any applicable policies?

Testing Methodology:

1. For each institution with a licensed care facility (i.e. CTC, SNF), obtain and review the meeting minutes of the Local Governing Body, or its equivalent, for the previous 12 months.

2. For the 4 most recent quarters, verify that the LGB met at least one time during each quarter.

3. Determine if meeting minutes provide evidence that the following items were discussed (see Note below):

    a. The adoption of Local Operating Procedures (LOPs) and

    b. General management and planning consistent with CCHCS policies and applicable federal, state, and local regulations and directives. (This objective will be met if the LGB discusses topics that are generally covered in CCHCS policy).

    Note: For this test, if multiple meetings occurred during the same quarter, only one of the quarter's meeting minutes must include evidence that the items identified above were discussed.

4. Verify that the LGB meeting minutes were timely approved at the next regularly scheduled meeting (even if held on a weekly or monthly basis). For this test, the OIG allows 5

business days after the next meeting date, for the committee chair (i.e. usually the Warden and the CEO) to sign and approve the minutes.

References: January 2002 CCHCS HC DOM Ch. 1 Article 1 1.1.2.b

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Ref # 15.101

REGIONAL INSPECTOR (Rev. 09/08/2021)

Did the institution conduct medical emergency response drills during each watch of the most recent quarter, and did the health care and custody staff participate in those drills?

Testing Methodology:

Obtain the summary reports and related documentation for the emergency response drills for each watch for the most recent full quarter (for a total of three reports).

For this test, the most recent full quarter is determined as follows: The OIG allows 30 calendar days after the end of the prior quarter for the institution's management to complete and approve the required emergency drill documentation. As a result, if the OIG's medical inspection document submittal due date falls wills within 30 days of the end of the quarter, the OIG will accept either the most recent quarter or the prior quarter (which ever documentation the institution provides).

For example, if the document due date for the medical inspection is January 20, the regional inspector may accept either the July 1 – Sept. 30th quarter or the Oct. 1 – Dec. 31 quarter as the official quarter to test.

1. **For Institutions that have not completed training for the NEW Emergency Medical Response Program (see list of institutions below for roll-out and completion date):** Determine whether the reports contained the following required elements:

   - A synopsis of the event
   - Date and time of the drill
   - Drill location and participants involved
   - Time frame of all elements
   - Recommendations on areas needing improvement or additional training

2. **For Institutions that completed training for the NEW Emergency Medical Response Program (see list of institutions below for roll-out and completion date):** Determine whether the **Emergency Medical Response System Mock Code Template** contained the following required elements:

   - A synopsis of the event
   - Date and time of the drill

- Drill location and participants involved
- Time frame of all elements
- Recommendations on areas needing improvement or additional training

Initial Roll-out date	Completion Date	Institution
March 4-22, 2019	September 22, 2019	California State Prison, Solano
April 8-26, 2019	October 26, 2019	Pleasant Valley State Prison
April 8-26, 2019	October 26, 2019	California State Prison, Sacramento
April 29-May 17, 2019	November 17, 2019	Mule Creek State Prison
April 29-May 17, 2019	November 17, 2019	Folsom State Prison
June 3-21, 2019	December 21, 2019	California Medical Facility
July 8-26, 2019	January 26, 2020	San Quentin State Prison
July 8-26, 2019	January 26, 2020	California Correctional Center
September 9-27, 2019	March 27, 2020	Pelican Bay State Prison
September 9-27, 2019	March 27, 2020	High Desert State Prison
October 7-25, 2019	April 25, 2020	Sierra Conservation Center
October 7-25, 2019	April 25, 2020	Deuel Vocational Institution
November 4-22, 2019	May 22, 2020	Substance Abuse Treatment Facility
November 4-22, 2019	May 22, 2020	California State Prison, Corcoran

January 6-24, 2020	July 24, 2020	California State Prison, Calipatria
January 6-24, 2020	July 24, 2020	California State Prison, Centinela
January 27-February 14, 2020	August 14, 2020	California Men's Colony
January 27-February 14, 2020	August 14, 2020	Avenal State Prison
February 24-March 13, 2020	September 13, 2020	California State Prison, Los Angeles County
May 17-21, 2021	November 21, 2021	California Correctional Institution
June 7-11, 2021	December 11, 2021	Chuckawalla Valley State Prison
July 12-16, 2021	January 16, 2022	California Institution for Men
September 13-17, 2021	March 17, 2022	California Rehabilitation Center
October 25-29, 2021	April 29, 2022	Salinas Valley State Prison
December 13-17, 2021	June 17, 2022	Valley State Prison
January 31-February 4, 2022	August 4, 2022	California Institution for Women
March 7-11, 2022	September 11, 2022	Central California Women's Facility
April 11-15, 2022	October 15, 2022	Ironwood State Prison

May 16-20, 2022	November 20, 2022	Correctional Training Facility
To Be Determined	To Be Determined	Richard J. Donovan Correctional Facility
To Be Determined	To Be Determined	Wasco State Prison
To Be Determined	To Be Determined	California City Correctional Facility
To Be Determined	To Be Determined	North Kern State Prison
To Be Determined	To Be Determined	Kern Valley State Prison
To Be Determined	To Be Determined	California Health Care Facility

3. Determine whether staff completed any or all of the following relevant forms:

- Form 837 (Crime/Incident Report) – NOT ALWAYS APPLICABLE
- First Medical Responder - Data Collection Tool
- Triage and Treatment Services Flow sheet – NOT ALWAYS APPLICABLE
- Progress Notes – NOT ALWAYS APPLICABLE
- Form 7219 (Medical Report of Injury or Unusual Occurrence) – NOT ALWAYS APPLICABLE
- Cardiopulmonary Resuscitation Record – NOT ALWAYS APPLICABLE

Note 1: Form 837(Crime/Incident Report) - If the emergency medical incident results in the death of the inmate, custody staff will complete a Form 837, regardless of whether or not they were the first on the scene. Also, if the incident requires immediate life support measures, then custody staff will complete a Form 837. If custody staff are not first on the scene of a medical emergency (and the incident does not result in a death or require immediate life support measures), then they do not have to complete a Form 837. If the Health Care First Responder (HCFR) determines that the incident is an "urgent response, treatment, and transportation" incident, rather than an "emergency medical response" incident, then custody staff do not have to complete a Form 837.

Note 2: Progress Notes-If care and treatment are provided by other clinical responders at the scene (i.e. besides the HCFR), there should be corresponding interdisciplinary progress notes completed. In lieu of the Progress Notes, OIG clinicians have concluded that the "Notes" section of the Cardiopulmonary Resuscitation Record may be used to document clinical responder's participation.

Note 3: Cardiopulmonary Resuscitation Record-If CPR is not performed, this form is not needed.

4. Determine whether the summary reports (or related drill documentation such as the Emergency Medical Response Drill Checklist) indicate participation of health care and custody staff within the institution.

Note 4: All peace officers who respond to a medical emergency are required to provide immediate life support until medical staff arrives to continue life support measures. Form 837 is completed by the responding peace officer to document the decisions made regarding life support and actions taken or not taken. Also, in the event of a patient death, if CPR was not initiated by non-health care staff, that staff needs to document the reason(s) on Form 837.

Note 5: IST Form 844- verify all listed participant staff on the emergency drill is accounted in Form 844.

References: July 2012 CCHCS HC DOM Ch. 3 Article 7 3.7.1.g.2.B.3, & g.4; July 2012 Ch. 3 Article 7 3.7.2.d & f.1; CDCR DOM Section 51020.17.6; July 2019 Ch. 3 Article 7 3.7.1-1.e.1.h, & h.3.I; OIG Medical Inspection Unit

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Ref # 15.102

REGIONAL INSPECTOR (Rev. 05/14/2019)

Did the responses to medical grievances address all of the inmates' appealed issues?

Testing Methodology:

Visit the institution's health care (HC) grievance office and obtain either 1) a list of grievances closed in the last six months, or 2) access the health care grievances file. Next, judgmentally select a sample of ten CDCR 602 HC grievance that were closed within the last 6 months and that had an institutional level response issued to the patient. Review the patient's original 602 HC grievance issue(s) and the corresponding institutional level response. Ascertain whether the response addressed each of the patient's issues.

Note 1: Per policy, inmates must submit separate 602 HC grievances if they are appealing multiple issues. However, if the issues are related, multiple issues may be combined on a single 602 HC form.

Note 2: For the institution to receive a "Yes" on this test, the respondent must have specifically responded to the patient's issue(s).

Note 3: For this test, the OIG is not testing the health care grievance to assess whether the determination of "Intervention or No Intervention" was appropriate, but whether the institutional respondent staff addressed each of the patient's issues when making their response.

Note 4: A complete list of recently completed institutional level health care grievance responses may be obtained from CCHCS and should be requested by the HQ Inspection Coordinator prior to the site visit.

The REGIONAL INSPECTOR will capture the patient names and dates of all sampled health care grievances. Obtain a copy of any health care grievances that resulted in a "No" answer.

References: California Code of Regulations, Title 15, Division 3, Chapter 2, Subchapter 2, Article 5, Section 3.999.227 (e).

Ref # 15.103

REGIONAL INSPECTOR (Rev. 09/19/2019)

Did the medical staff review and submit initial inmate death reports to the CCHCS Death Review Unit on time?

Testing Methodology:

Using the inmate deaths data in the sample methodology above, select the ten most recent inmate deaths and perform the following steps. If there are less than ten deaths select all deaths during the time period.

1. Review Initial Inmate Death Report to determine whether the death was reported to the CCHCS Death Review Unit via email or fax no later than noon the next business day following the date of death.

   Note 1: As part of the OIG's pre-inspection data request, the OIG requests e-mail or fax confirmation of death report notifications to CCHCS.

   Note 2: If, in the inspector's judgment, the institution's death report notification was expeditious but ultimately deemed untimely due to the actions or protocols of an outside hospital, the OIG will not take exception to reasonable notification delays.

   Note 3: For the Initial Inmate Death Report, if a physician other than the CME completes and signs the form, the OIG will give the institution credit, as long as the provider signing the form is a physician or mid-level provider. If the document is signed by

an RN or LVN, then the institution would receive a "No" answer for this test. For the Initial Inmate Death Report determined as a Suicide death, the form designee must be a mental health practitioner, being a psychiatrist or licensed psychologist.

References: October 2015 CCHCS HC DOM Ch. 1 Article 2 1.2.10.d.1.A, C-D

Ref # 15.104

REGIONAL INSPECTOR (Rev. 09/27/2021)

Did nurse managers ensure the clinical competency of nurses who administer medications?

Testing Methodology:

Complete the following steps to determine if nursing staff that have been at the institution for more than a year and administer medication are current on their annual competency validation, or received orientation training, if re-assigned to an outpatient medication administration location during the year.

Note 1: If an employee has been with the institution less than one year, they will be tested in 15.110 below for clinical competency during new employee orientation. Therefore, do not test any employee with less than one year of service under this test. Nurses could include LVN, RN or Licensed Psych Techs (LPT) as long as they regularly administer medications (see Note 4 below).

Note 2: For this test, do not include registry staff.

1. Discuss the nursing competency validation process with the CNE/DON at the institution to determine how the institution incorporates competency validations for nurses administering medications.

    a. Ask the CNE/DON how the institution assesses and documents clinical competency validations for nursing staff. Policy states the institution can assess competency from observation of staff's performance, verbal demonstration of knowledge, or written test.

    b. Request the CNE/DON to provide a list of all nursing staff who are currently in positions that require the administration of medications to patients (e.g., Monthly Nursing Schedules, Daily Schedule Sheets).

2. Using the list, select a random sample of 10 staff that are in various nursing positions that require medication administration and request to review their Nursing Education File. If possible, attempt to sample employees at various clinics throughout the institution.

a. The nursing supervisor must ensure that their subordinate nurses have a competency validation completed annually. Review the employee's file to determine if a current competency validation is in the file. The employee must have a current competency validation as of the date of the inspection. If a current competency validation is in the employee's file, the institution will receive a "Yes"

Note 3: For this test only, the OIG will allow a 30 day grace period for the employee to receive their annual competency testing. As a result, each sampled employee will receive a "Yes" answer only if they have received their training within the last 395 days (365+30) from the OIG's test date.

Note 4: CCHCS P&P states that "RN" nurse competency testing is required for all nurses. Further, while most medication nurses are classified as "LVNs," the OIG has interpreted the P&P to apply to RNs, LPTs and LVNs (since all of these separate classifications did not exist in 2002 when the P& P was originally issued.) In addition, the competency test may cover a broad range of topics and does not need to be directly related to medication administration.

References: December 2017 CCHCS HC DOM Ch. 1 Article 4 1.4.1.e & f.2; OIG Medical Inspection Unit

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Ref # 15.105

REGIONAL INSPECTOR (Rev. 09/27/2021)

Did physician managers complete provider clinical performance appraisals timely?

Testing Methodology:

1. Identify all institutional providers including mid-level providers and those currently on probation. Providers are identified in the CEO pre-inspection questionnaire and there should also be an additional employee roster available for review as well. The regional inspector will reconcile the two provider listing documents to ensure that all providers are identified for this test. Enter all provider names on the testing worksheet; however, for those providers that are not subject to this test (such as "Registry Providers" or recently separated providers) enter "*NA*" as the final answer with an appropriate justification in the comments column.

2. Interview the CME (and/or CP&S) and perform the following:

   a. Obtain a general understanding of the process the institution uses to ensure that reviews are completed and retained,

   b. Identify which providers are recent hires or new appointments in the last 12 months and thus subject to probationary reviews,

c. Identify who is responsible for completing provider performance reviews.

Note 1: The institution may employ various types of providers. The reference to "provider" is the term used for: ***medical doctor—MD, doctor of osteopathy—DO, physician assistant—PA, nurse practitioner—NP****. Registered nurses—RN, Licensed Vocational Nurses—LVN, and Licensed Psych Techs—LPT* *are not considered providers. For this test, do not review other types of disciplines such as dentist, psychiatrists, etc.*

3. Verify that evaluation include the required documentation - Locate and review each provider's recent performance evaluation packet and confirm they are completed and that each packet includes all of the following required document:

a. Performance Appraisal requirements for Licensed Medical Provider:

1. **Probationary Reviews providers –** All probationary providers shall receive a probationary report for each 2 month period of the first six months of employment. The following are required for each probe:

First (2-month) probe (*see Note 2)*:

Report of Performance for Probationary Employee (Std. Form 636), plus:
- Initial Focused Professional Practice Evaluation (IFPPE) (*see Note 5)*

Note 2: First (2 month Probe) shall be completed no more than 60 calendar days after appointment.

Second (4-month) probe (*see Note 3)*:

Report of Performance for Probationary Employee (Std. Form 636), plus
- Initial Focused Professional Practice Evaluation (IFPPE) *(see Note 5)*

Note 3: Second (4-month probe) shall be completed no more than 120 calendar days after appointment.

Third (6-month) probe (*see Note 4)*:

Report of Performance for Probationary Employee (Std. Form 636)

Note 4: Third (6-month probe) shall be completed no more than 180 calendar days after appointment.

2. **Annual Reviews** – Licensed Medical Provider (i.e. Non- Probationary) **–**
All non-probationary providers – must have the following completed on providers birth month:

- Individual Improvement Plan (IIP)
- Ongoing Professional Practice Evaluation (OPPE)

Note 5: IFPPE are required of at least ten clinical encounters managed by the provider, involving ten separate patients. The IFPPE should include: the review of records completed and by whom, documentation that the reviewer discussed the reviews with the provider and any corrective actions if problems have been identified.

Note 6: Per policy, the CME and/or CP&S must also complete the Form 636 or IIP.

Note 7: Established providers (permanent hires) are required to have annual (12 month) evaluations (IIP) during their birth month.

Note 8: New providers (on probation) are typically required to have three evaluations during the probationary period (Std. Form 636) (usually a six-month period from hire).

Note 9: For each sample employee's final answer to be "Yes," the most recently completed review must have included all of the required documents and it must have been completed within the required time frame.

Note 10: The CME is not subject to this test.

References: April 2021 CCHCS HC DOM Ch. 1 Article 4 1.4.4.e.2, & e.8.A & C; December 2017 Ch. 1 Article 4 1.4.1.e.1 &3, f.1.B.5, & f.2.A-C; November 2019 Ch. 1 Article 4 1.4.7.f.1.A & D, & f.2.B; February 2021 Ch. 1 Article 4 1.4.6.f.E.1.b, f.2.A.2 & C, & f.9.B.

Ref # 15.106

REGIONAL INSPECTOR (Rev. 09/27/2021)

Did the providers maintain valid state medical licenses?

Testing Methodology:

1. Using the provider list sent by the institution, the inspector will test 100 percent of MD, DO, NP and PA providers to verify their license status is current.

    a. Verify the status of each provider's medical license using the Department of Consumer Affairs license check website at site https://www.breeze.ca.gov/datamart/mainMenu.do then, navigate to the verification page:

        i. Go to the DCA website, and click on the "Breeze" link
        ii. Click the link to access Breeze online services
        iii. Click on "verify a license" (you do not need to create a user ID)
        iv. Click "Search by Personal or Business Name"

v. Click the "Search by Individual" radio button and enter the providers name

b. Following the steps above, the inspector will verify that each provider has a current license. If the provider's license has expired, the answer to this question is "No." In addition, the inspector should determine.

c. In those instances where a provider is found to have a currently expired license, the inspector will contact the institution to determine whether the employee has been working in a non-medical capacity since the expiration date.

Note: In those instances, were providers have been found to be working in a medical capacity without a current license, the OIG chief physician and surgeon will be immediately notified so that the case review portion of the inspection may be modified if deemed appropriate.

Reference: December 2017 CCHCS HC DOM Ch. 1 Article 4 1.4.5; February 2021 Ch. 1 Article 4 1.4.6

Ref # 15.107

REGIONAL INSPECTOR (Rev. 09/27/2021)

Did the staff maintain valid Cardiopulmonary Resus citation (CPR), Basic Life Support (BLS), and Advance Cardiac Life Support (ACLS) certifications?

Testing Methodology:

1. Interview the CME (Providers), CNE/DON, Nurse Educator (Nursing staff) and the In-Service Training Manager (Custody staff) to determine how the institution ensures staff receives the required Advanced Cardiac Life Support (ACLS) certifications, Cardiopulmonary Resuscitation (CPR), and Basic Life Support (BLS). Determine who maintains tracking logs and/or documentation to verify staff have current certifications.

   Note 1: BLS and CPR are interchangeable (the certification card/documentation may indicate one or the other designation). Either/both are acceptable for this testing for nursing and custody staff.

   Note 2: Policy requires that the CEO and custody staff have a system in place to manage and track ACLS, CPR and BLS requirements. The tracking system may include a log or file system (for example, an electronic database, manual log, or other means to monitor staff who need current certifications). If no system is in place to determine staff members' certification expiration dates, the answer is "No" (for that applicable classification of staff) and no further testing is needed).

2. If no tracking system exists (see *Note 2* above). If the institution maintains a tracking system that allows the inspector to easily test 100 percent of the population, complete steps

2.a through 2.d below. If the tracking system does exist, but would be too cumbersome to include 100 percent of the population, then judgmentally select 10 total employees from the three affected groups of staff [providers, nursing staff, and custody staff (…including a few custody managers)] and verify that their certifications are current, in accordance with the testing requirements below:

a. Based on the interview with the CME, review the tracking log (if available) and supporting documentation to determine if providers are current with ACLS certification. Document all providers with expired certifications.

b. Based on the interview with the CNE/DON and the Nurse Educator, review the tracking log (if available) and supporting documentation to determine if nursing staff are current with BLS or CPR certification. Document all nursing staff with expired certifications.

c. Based on the interview with the IST Manager, review the IST training record to verify all custody staff are current with BLS or CPR certifications, and document custody staff with expired certifications.

d. If non-compliant staff are identified, determine the reason(s) why they have not been re-certified, and what action management has taken to correct the non-compliance. If the lack of re-certification is because the employee is not actively working (e.g., out on continuous long-term leave or otherwise absent), the OIG will not take exception. However, for those staff who are actively working at the institution (in any position, even if the employee has been taken "off the line" but still on active duty—such as the mailroom) and identified as noncompliant with current re-certification requirements (even if currently signed up for the next available class), the final answer is "No."

Note 3: Policy requires staff to be current in emergency medical response measures consistent with the American Heart Association (AHA) guidelines as follows:

- *Provider Staff, within the previous two years, must successfully complete a certification course in ACLS.*
- *Nursing staff, within the previous two years, must successfully complete a certification course in CPR or BLS.*
- *Correctional peace officers (custody), within the previous two years, must successfully complete a certification course in CPR or BLS. CCHCS policy requires that all peace officers be currently certified, which includes those in managerial classifications such as Captains, AW's and Warden.*

Note 4: For this test, do not include registry provider and nursing staff. The registry agency is responsible for ensuring that they are currently licensed and trained adequately.

3. Upon return from the onsite visit, the regional inspector will immediately notify the OIG Supervising Regional Nurse assigned to the inspection if there are health care staff that have expired certifications. The OIG Clinical Inspectors will then be notified by the OIG Supervising Regional Nurse to determine if individual provider-patient encounters need to be reviewed during the case review process.

References: July 2012 CCHCS HC DOM Ch. 3 Article 7 3.7.1.d.3.A-E; OIG Medical Inspection Unit

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Ref # 15.108

REGIONAL INSPECTOR (Rev. 12/13/2021)

Did the nurses and pharmacist-in-charge (PIC) maintain valid professional licenses and certifications, and did the pharmacy maintain a valid correctional pharmacy license?

Note: Prior to completing this test, the inspector should review the pre-inspection questionnaire for preliminary information previously received regarding professional licenses and certifications.

Testing Methodology:

1. Interview the CNE and/or CEO and determine how the institution ensures that nursing staff and the PIC possess current professional licenses and certifications, as required by their respective Department of Consumer Affairs licensing boards. Also ensure that the pharmacy is licensed as a correctional pharmacy by the California State Board of Pharmacy. Determine who maintains or can produce tracking logs or other supporting documentation. The appropriate responsible party for tracking may include: the CNE, DON, Nurse Educator, Pharmacist-in-Charge, and/or the CEO.

   Note 1: In addition to licensing requirements (e.g. RN/LVN/LPT), some nursing licensees are also required to have certifications for: nurse practitioner, furnishing nurse practitioner (to prescribe medications), public health nurse, and nurse midwife. (The certifications referred to are other than BLS/CPR which are covered under test 15.106)

2. Review the tracking logs or other supporting documentation that is available, and verify that staff have current, valid licenses and certifications in good standing for Registered Nurses (RN), Licensed Vocational Nurses (LVN), Licensed Psych Tech (LPT) and the Pharmacist-in-Charge.

   a. If tracking information is available, identify and document delinquent staff, OR

   b. If there is no tracking system in place, review 10 RN, 8 LVN, 2 LPT and the PIC file(s), and identify and document delinquent staff. (If the institution has no LPTs then, select 10 LVNs)

*Note 2: The OIG will rely on the institution's tracking system if it appears adequate and complete. If there is no tracking system, the institution will **not** automatically receive a "No" response to this question, but the results may be discussed in the narrative portion of our report. If there is no tracking system, the OIG will conduct additional testing, as outlined in 2.b., above.*

Note 3: For this test, do not include registry staff. The registry agency is responsible for ensuring that they are currently licensed and trained adequately.

3. In those instances where expired licenses or certifications are identified, the inspector will notify the CEO and confirm these staff are not currently assigned to any patient related duties or responsibilities.

   Note 4: If a license expired while staff was out on long-term-leave, and the staff is still out at the time of the inspection, the response is "NA" for that staff (e.g., the institution will not receive a "No" response).

4. Notify the OIG Supervising Regional Nurse assigned to the inspection if there are staff that are working with an expired or restricted license or certification (or otherwise are not in good standing with their licensing board), or that have been removed from patient-care duties. The OIG Clinical Inspectors will then be notified by the OIG Supervising Regional Nurse to determine if individual provider-patient encounters need to be reviewed during the case review process.

References: December 2021 CCHCS HC DOM Ch.1 Article 4 1.4.21.c.3.A.1 & 2; December 2017 Ch. 1 Article 4 1.4.5; July 2016 Ch. 3 Article 5 3.5.1; September 2021 Ch. 3 Article 5 3.5.3.b.1.D, E, G, & H

Ref # 15.109

REGIONAL INSPECTOR (Rev. 12/13/2021)

Did the pharmacy and the providers maintain valid Drug Enforcement Agency (DEA) registration certificates?

Testing Methodology:

1. Obtain the list of the institution's current providers, and their DEA registration numbers and expiration dates (that was provided via the pre-inspection questionnaire).

2. Pharmacy Registration - Determine if the pharmacy is currently registered with the DEA and that no recent lapse in status occurred by completing the following steps:

   a. Interview the Pharmacist-in-Charge (PIC) and ask where the pharmacy DEA registration is located. Review the document's expiration date to determine whether it is valid as of the date of the inspection.

b. If the registration expired (or was renewed) in the last 12 months, ask to review the prior registration to ensure that there was no break between registration periods. If there was a break, identify the period.

Note 1: Every pharmacy engaged in the distribution or dispensing of controlled substances must register with the DEA and renew the registration every three years. The registration must be maintained at the registered location. The CEO or designee is the certifying official and the registration is typically listed under the pharmacist-in-charge's name.

Note 2: A second registration number is required if the institution has a methadone treatment/detoxification program.

3. Medication Prescriber Registration – Interview the PIC and conduct testing to verify that controlled substances are only prescribed by the institution's providers who have a current DEA registration status and are authorized to do so.

   a. Ask the PIC to describe the control system/process he or she uses to ensure that providers who prescribe controlled substances maintain current DEA registrations and to ensure that providers with expiring registrations are identified timely and prevented from prescribing controlled substances.

   b. Verify that each provider listed as a DEA registrant is also listed as a provider on the institution's listing of licensed health care staff. Ask the PIC about any discrepancies.

   c. Using the DEA registrant list, identify any providers with an expired registration status. Ask the PIC if there are any other providers who are suspended from prescribing controlled substances due to newly expired DEA registrations or for other reasons. If applicable, identify those providers' names and the time period of any lapse in registration or suspension.

   d. Ask the PIC if they have had any instances in the last 12 months of providers with expired DEA licenses or suspended privileges that succeeded in prescribing controlled substance medications.

      i. For any providers identified with expired DEA licenses, or who are otherwise suspended from ordering controlled substances, if possible and practical, request the pharmacy staff to query the pharmacy database to identify and print a list of controlled substances ordered by the provider during the expiration or suspension period.

      ii. If the PIC does not have a database (or is otherwise unable to provide information requested in 1), above), determine where/how the PIC maintains provider prescription orders, and visually scan the (binder of) prescription orders for

controlled substances and verify that each ordering provider: i) had a current DEA registration status; ii) was on the institution's provider roster; and, iii) was not otherwise suspended from ordering medications at the time of the order.

Note 3: The OIG will confirm the following providers: MD—medical doctor, DO—doctor of osteopathy, PA—physician assistant, and NP—nurse practitioner. We will not evaluate other providers, such as a psychiatrists or dentists.

Note 4: Providers who prescribe controlled substances either to patients within the institution or who are transferred, paroled, or discharged, are required to maintain an individual DEA registration number.

4. Report the names of any providers with (currently) expired DEA registrations or suspended privileges to the OIG's Supervising NCPR and the institution's CEO.

References: December 2021 CCHCS HC DOM Ch. 3 Article 5 3.5.16.a.1, d.1.A, & d.2

Ref # 15.110

REGIONAL INSPECTOR (Rev. 09/27/2021)

Did nurse managers ensure their newly hired nurses received the required onboarding and clinical competency training?

Testing Methodology:

A standardized onboarding program must be provided to each new CDCR nursing staff (i.e., Licensed Psych Tech (LPT)/Licensed Vocational Nurse (LVN)/Registered Nurse (RN)). To ensure each institution is effective in providing newly hired nursing staff formal orientation and training, do the following:

1. Interview the CNE/DON and the Nurse Educator: 1) to determine how the institution ensures that nursing staff complete the required civil service staff onboarding program and 2) obtain a complete copy of the Nursing Civil Service Staff Onboarding and Competency Checklists. This checklists should identify the institution's required curriculum for CDCR nursing staff.

   Note 1: RNs, LVNs, and LPTs shall receive the same training as indicated on the Nursing Civil Staff Onboarding and Competency Checklist – Nursing Services Topics. Registry/Contracted Nursing Personnel is excluded from this test.

2. Review tracking logs or other supporting documentation to verify that nursing staff who have worked at the institution for less than one year completed all topics identified on the institution's Nursing Civil Service Staff Onboarding and Competency Checklists.

a. If tracking information is available, identify all nursing staff hired within the last 12 months who did not complete the onboarding program, or

b. If there is no tracking system in place, review the files of a sample of the following staff who were hired in the last 12 months: 10 RNs, 8 LVNs and 2 LPT (for a total of 20) and identify noncompliant staff. If the institution has no LPTs, then test 10 LVNs instead.

Note 2: Policy requires that an onboarding program for all newly hired nursing staff include orientation to all applicable institutional policies and procedures, to the medical services areas, and to the specific job assignment. The inspector will confirm that nursing staff completed medical services related orientation classes by comparing staff training records with the list of the institution's required Nursing Civil Service Staff Onboarding and Competency Checklists, which is maintained by the Nurse Educator. If any nursing staff did not attend required training, the answer to this question is "No." We will not verify staff attendance at any Onboarding training for general institutional policies and procedures.

Note 3: Due to the importance and safety factor related to new nursing staff onboarding, if any single deviation is found, the overall final answer is "No."

Note 4: Policy requires that staff onboarding and checklists shall be completed within twelve (12) weeks of staff hire date.

Note 5: If unforeseen circumstances arise that delay the onboarding process, additional time may be provided on a case-by-case basis to complete the onboarding process and checklists as soon as possible after the 12th week. Regional RNs shall obtain supporting documentation that justifies the delay.

Note 6: Registry/Contracted nursing personnel who convert to permanent civil service status shall complete the new civil service staff onboarding process. Topics on the Nursing Staff Onboarding and Competency Checklists, which must be tracked via Business Event Type code and for which the registry/contracted nursing personnel did not have a Personnel Number for tracking purposes will need to be repeated.

Note 7: If an employee received the new nursing civil service staff onboarding process as a registry nurse, and then accepts permanent state employment at that same institution, the OIG will give the employee credit for timely attending the onboarding process as long as the employee received a permanent state service appointment within one year of attending the new nursing civil service staff onboarding process. If the employee's permanent state service appointment was over one year from the time that the employee attended the new nursing civil service staff onboarding process as a registry nurse, and does not receive the onboarding process within 12 weeks of appointment, the overall answer will be "No". However, the SRN II or III with the coordination with the institution's CNE may adjust the

length of the onboarding plan on an individual basis to take into account the experience and competencies already achieved and demonstrated prior to converting to permanent civil service status.

References: February 2019 CCHCS HC DOM Ch. 1 Article 4 1.4.1.2.e.1.A, E, & e.5; February 2019 Ch. 1 Article 4 1.4.1.3.e.5; OIG Medical Inspection Unit

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Ref # 15.998

For Information Purposes Only (Not Scored)

HQ INSPECTOR (Rev. 09/19/2019)

For Information Purposes Only: Did the CCHCS Death Review Committee process death review reports timely?

Sampling Methodology:

Review a summary log of the institution's inmate deaths and select the 10 most recent deaths that occurred between the time period of 30 calendar days and 12 months prior to the OIG test date.

Note 1: In October 2015, CCHCS revised the policy time frames for reporting inmate deaths.

Testing Methodology:

1. Using sampling criteria described above, the OIG will obtain the Death Review Summary log from the OIG's Discipline Monitoring Unit (DMU) and determine whether the CCHCS Death Review Committee (DRC) reviewed the death within the following time frames:

    a. Level 1 (unexpected death) – CCHCS must complete the review and the DRC must review the report within 60 calendar days from the date of the inmate death.

    b. Level 2 (expected death) – CCHCS must complete the review and the DRC must review the report within 30 calendar days from the date of the inmate death.

2. Determine whether the CCHCS DRC submitted its death review summary to the institution's CEO within 7 calendar days following the required due date *(i.e. 60 days level 1, 30 days level 2*) of the DRC's summary report.

Note 2: The list of deaths provided by the institution should cross reference to the internal DRC listing maintained by the OIG's DMU.
Hint: Go to Z:\DMU\SAIG_RESOURCES\Death Review\Death Review Committee… and click on the "Death Review Finder" excel spreadsheet and perform the following 2 tasks:

a) Use the CTL-F (find) function to identify all of the inmate deaths that occurred at the institution under inspection and verify that there were no additional inmates on the Death Review Finder listing that had a death during the sample test period (which were not previously reported to the OIG by the institution/CCHCS).

b) For all applicable inmates found, obtain their needed testing attribute information by reviewing the corresponding meeting minutes for the inmate death summary report (unless previously provided by the institution). Note: The institution may have to be contacted to establish when they were officially notified (by the DRC/CCHCS) of the death review summary results.

Note 3: Since the CCHCS policies and procedures are silent regarding the time frame for CCHCS's DRC to provide the Death Review Summary to the CEO; the OIG has arbitrarily established 7 calendar days as a reasonable time period for CCHCS to provide the final report to the institution's CEO.

Note 4: If the death occurred within the last 60 days, the inspector may have to contact the CCHCS to obtain a copy of the recently completed death report summary.

Note 5: Prior to finalizing a death review summary, the DRC may issue interim death review updates. For this test, the OIG verifies only that the final report was issued timely. Final reports can be identified because the DRC will complete the Preventability/ Improvement Matrix portion of the death summary in which they identify whether there were areas for improvement and whether the death was preventable (look for evidence that the matrix was completed at the end of the report).

References: (**For Information Only and Not Scored**); October 2015 CCHCS HC DOM Ch. 1 Article 2 1.2.10.d.5-6