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OIG | OFFICE *of the* INSPECTOR GENERAL

Independent Prison Oversight

October 2022

Cycle 6
Medical Inspection Report

California State Prison Sacramento

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Introduction

Pursuant to California Penal Code section 6126 et seq., the Office of the Inspector General (the OIG) is responsible for periodically reviewing and reporting on the delivery of the ongoing medical care provided to incarcerated persons[1] in the California Department of Corrections and Rehabilitation (the department).[2]

In Cycle 6, the OIG continues to apply the same assessment methodologies used in Cycle 5, including clinical case review and compliance testing. These methods provide an accurate assessment of how the institution's health care systems function regarding patients with the highest medical risk who tend to access services at the highest rate. This information helps to assess the performance of the institution in providing sustainable, adequate care.[3]

We continue to review institutional care using 15 indicators, as in prior cycles. Using each of these indicators, our compliance inspectors collect data in answer to compliance- and performance-related questions as established in the *medical inspection tool* (MIT) available on the OIG's website.[4] We determine a total compliance score for each applicable indicator and consider the MIT scores in the overall conclusion of the institution's performance. In addition, our clinicians complete document reviews of individual cases and also perform on-site inspections, which include interviews with staff.

In reviewing the cases, our clinicians examine whether providers used sound medical judgment in the course of caring for a patient. In the event we find errors, we determine whether such errors were clinically significant or led to a significantly increased risk of harm to the patient.[5] At the same time, our clinicians examine whether the institution's medical system mitigated the error. The OIG rates the indicators as ***proficient***, ***adequate***, or ***inadequate***.

The OIG has adjusted Cycle 6 reporting in two ways. First, commencing with this reporting period, we interpret compliance and case review results together, providing a more holistic assessment of the care; and second, we consider whether institutional medical processes lead to

[1] In this report, we use the terms *patient* and *patients* to refer to *incarcerated persons.*

[2] The OIG's medical inspections are not designed to resolve questions about the constitutionality of care, and the OIG explicitly makes no determination regarding the constitutionality of care the department provides to its population.

[3] In addition to our own compliance testing and case reviews, the OIG continues to offer selected Healthcare Effectiveness Data and Information Set (HEIDIS) measures for comparison purposes.

[4] The department regularly updates its policies. The OIG updates our policy-compliance testing to reflect the department's updates and changes.

[5] If we learn of a patient needing immediate care, we notify the institution's chief executive officer.

identifying and correcting provider or system errors. The review assesses the institution's medical care on both system and provider levels.

As we did during Cycle 6, our office is continuing to inspect both those institutions remaining under federal receivership and those delegated back to the department. There is no difference in the standards used for assessing a delegated institution versus an institution not yet delegated. At the time of the Cycle 6 inspection of California State Prison, Sacramento, the receiver had not delegated this institution back to the department.

We completed our sixth inspection of California State Prison Sacramento, and this report presents our assessment of the health care provided at that institution during the inspection period between May 2021 and October 2021.[6] The data we obtained for SAC and the on-site inspections occurred during the COVID-19 pandemic.[7]

California State Prison, Sacramento (SAC), is located in the city of Folsom, in Sacramento County. SAC houses maximum and high-security incarcerated residents. SAC also houses patients requiring specialized mental health programming and patients with high-risk medical concerns.

SAC has three separate, self-contained facilities, each composed of eight housing blocks and a recreational yard. The institution operates multiple clinics where health care staff handle nonurgent requests for medical services. Patients requiring urgent or emergent care are treated in the triage and treatment area (TTA). Screenings for patients upon their arrival are conducted in the receiving and release (R&R) clinic. There is also a clinic for on-site and telemedicine specialty services. SAC has a correctional treatment center (CTC) for inpatient services.

CCHCS has designated SAC an "intermediate" health care institution for medical purposes; these institutions are predominantly located in urban areas, close to care centers and specialty care providers likely to be used by a patient population with higher medical needs, for the most cost-effective care.

[6] Samples are obtained per case review methodology shared with stakeholders in prior cycles. The case reviews include emergency noncardiopulmonary resuscitation (non-CPR) reviews between March 2021 and September 2021, emergency CPR reviews between December 2020 and January 2021, death reviews between May 2020 and January 2021, high-risk reviews between May 2021 and November 2021, hospitalization reviews between April 2021 and October 2021, transfer reviews between March 2021 and August 2021, and RN sick call reviews between March 2021 and October 2021.

[7] As of June 16, 2022, the department reports on its public tracker that 76% of its incarcerated population at SAC is fully vaccinated while 73% of SAC staff are fully vaccinated: www.cdcr.ca.gov/covid19/population-status-tracking.

Summary

We completed the Cycle 6 inspection of California State Prison, Sacramento (SAC) in March 2022. OIG inspectors monitored the institution's delivery of medical care that occurred between May 2021 and October 2021.

The OIG rated the overall quality of health care at SAC as ***inadequate.*** We list the individual indicators and ratings applicable for this institution in Table 1 below.

Table 1. SAC Summary Table

Health Care Indicators	Cycle 6 Case Review Rating	Cycle 6 Compliance Rating	Cycle 6 Overall Rating	Change Since Cycle 5
Access to Care	*Inadequate*	*Adequate*	*Inadequate*	↓
Diagnostic Services	*Adequate*	*Inadequate*	*Inadequate*	↓
Emergency Services	*Inadequate*	*N/A*	*Inadequate*	=
Health Information Management	*Adequate*	*Inadequate*	*Adequate*	↑
Health Care Environment	*N/A*	*Inadequate*	*Inadequate*	↓
Transfers	*Inadequate*	*Inadequate*	*Inadequate*	=
Medication Management	*Inadequate*	*Inadequate*	*Inadequate*	=
Prenatal and Postpartum Care	*N/A*	*N/A*	*N/A*	*N/A*
Preventive Services	*N/A*	*Adequate*	*Adequate*	↑
Nursing Performance	*Inadequate*	*N/A*	*Inadequate*	=
Provider Performance	*Inadequate*	*N/A*	*Inadequate*	=
Reception Center	*N/A*	*N/A*	*N/A*	*N/A*
Specialized Medical Housing	*Adequate*	*Adequate*	*Adequate*	↑
Specialty Services	*Adequate*	*Inadequate*	*Inadequate*	=
Administrative Operations†	*N/A*	*Inadequate*	*Inadequate*	⇊

* The symbols in this column correspond to changes that occurred in indicator ratings between the medical inspections conducted during Cycle 5 and Cycle 6. The equals sign means there was no change in the rating. The single arrow means the rating rose or fell one level, and the double arrow means the rating rose or fell two levels (green, from *inadequate* to *proficient*; pink, from *proficient* to *inadequate*).

† Administrative Operations is a secondary indicator and is not considered when rating the institution's overall medical quality.

Source: The Office of the Inspector General medical inspection results.

To test the institution's policy compliance, our compliance inspectors (a team of registered nurses) monitored the institution's compliance with its medical policies by answering a standardized set of questions that measure specific elements of health care delivery. Our compliance inspectors examined 375 patient records and 1,149 data points and used the data to answer 94 policy questions. In addition, we observed SAC processes during an on-site inspection in December 2021. Table 2 below lists SAC's average scores from Cycles 4, 5, and 6.

Table 2. SAC Policy Compliance Scores

100%–85.0% 84.9%–75.0% 74.9%–0

Medical Inspection Tool (MIT)	Policy Compliance Category	Cycle 4 Average Score	Cycle 5 Average Score	Cycle 6 Average Score
1	Access to Care	82.4%	87.0%	79.9%
2	Diagnostic Services	73.2%	81.1%	57.7%
4	Health Information Management	55.5%	64.1%	74.3%
5	Health Care Environment	65.5%	80.1%	49.3%
6	Transfers	84.7%	59.9%	64.4%
7	Medication Management	63.0%	66.2%	63.1%
8	Prenatal and Postpartum Care	N/A	N/A	N/A
9	Preventive Services	62.2%	65.5%	75.7%
13	Specialized Medical Housing	100%	100%	80.0%
14	Specialty Services	58.6%	72.8%	61.7%
15	Administrative Operations*	71.8%	91.6%	72.8%

* In Cycle 4, there were two secondary (administrative) indicators, and this score reflects the average of those two scores. In Cycle 5 and moving forward, the two indicators were merged into one, with only one score as the result.

Source: The Office of the Inspector General medical inspection results.

The OIG clinicians (a team of physicians and nurse consultants) reviewed 67 cases, which contained 1,224 patient-related events. After examining the medical records, our clinicians conducted a follow-up on-site inspection in March 2022 to verify their initial findings. The OIG physicians rated the quality of care for 25 comprehensive case reviews. Of these 25 cases, our physicians rated 19 ***adequate*** and six ***inadequate***. Our physicians found no adverse deficiencies during this inspection.

The OIG then considered the results from both case review and compliance testing, and drew overall conclusions, which we report in the 13 health care indicators.[8] Multiple OIG physicians and nurses performed quality control reviews; their subsequent collective deliberations ensured consistency, accuracy, and thoroughness. Our clinicians acknowledged institutional structures that catch and resolve mistakes that may occur throughout the delivery of care. As noted above, we listed the individual indicators and ratings applicable for this institution in Table 1, SAC Summary Table.

In November 2021, the Health Care Services Master Registry showed that SAC had a total population of 2,034. A breakdown of the medical risk level of the SAC population as determined by the department is set forth in Table 3 below.[9]

Table 3.SAC Master Registry Data as of November 2021

Medical Risk Level	Number of Patients	Percentage*
High 1	128	6.3%
High 2	315	15.5%
Medium	1,016	50.0%
Low	575	28.3%
Total	**2,034**	100.0%

* Percentages may not total 100 percent due to rounding.

Source: Data for the population medical risk level were obtained from the CCHCS Master Registry dated 11/19/21.

[8] The indicators for **Reception Center** and **Prenatal Care** do not apply to SAC.

[9] For a definition of *medical risk*, see CCHCS HCDOM 1.2.14, Appendix 1.9.

Based on staffing data the OIG obtained from California Correctional Health Care Services (CCHCS), as identified in Table 4 below, SAC had one vacant executive leadership position, no vacancies among primary care providers, vacancies of 4.2 positions among nursing supervisors, and 44 vacant nursing staff positions.

Table 4. SAC Health Care Staffing Resources as of November 2021

Positions	Executive Leadership*	Primary Care Providers	Nursing Supervisors	Nursing Staff†	Total
Authorized Positions	5.0	7.0	20.2	216.6	248.8
Filled by Civil Service	4.0	7.0	16.0	172.6	199.6
Vacant	1.0	0.0	4.2	44.0	49.2
Percentage Filled by Civil Service	80.0%	100.0%	79.2%	79.7%	80.2%
Filled by Telemedicine	0.0	3.0	0.0	0.0	3.0
Percentage Filled by Telemedicine	0.0%	42.9%	0.0%	0.0%	1.2%
Filled by Registry	0.0	1.0	0.0	11.0	12.0
Percentage Filled by Registry	0.0%	14.3%	0.0%	5.1%	4.8%
Total Filled Positions	4.0	11.0	16.0	183.6	214.6
Total Percentage Filled	80.0%	157.1%	79.2%	84.8%	86.3%
Appointments in Last 12 Months	2.0	6.0	5.0	26.0	39.0
Redirected Staff	2.0	0.0	0.0	0.0	2.0
Staff on Extended Leave‡	0.0	0.0	0.0	0.0	0.0
Adjusted Total: Filled Positions	2.0	11.0	16.0	183.6	212.6
Adjusted Total: Percentage Filled §	40.0%	157.1%	79.2%	84.8%	85.5%

* Executive Leadership includes the Chief Physician and Surgeon.

† Nursing Staff includes Senior Psychiatric Technician and Psychiatric Technician.

‡ In Authorized Positions.

§ Percentages may not total 100 percent due to rounding.

Notes: The OIG does not independently validate staffing data received from the department. Positions are based on fractional time base equivalents.

Source: Cycle 6 medical inspection preinspection questionnaire staffing matrix received November 4, 2021, from California Correctional Health Care Services.

Medical Inspection Results

Deficiencies Identified During Case Review

Deficiencies are medical errors that increase the risk of patient harm. Deficiencies can be minor or significant, depending on the severity of the deficiency. An *adverse event* occurs when the deficiency caused harm to the patient. All major health care organizations identify and track adverse events. We identify deficiencies and adverse events to highlight concerns regarding the provision of care and for the benefit of the institution's quality improvement program to provide an impetus for improvement.[10]

The OIG did not find any adverse deficiencies at SAC during the Cycle 6 inspection.

Case Review Results

OIG case reviewers (a team of physicians and nurse consultants) assessed ten of the thirteen indicators applicable to SAC. Of these ten indicators, OIG clinicians rated four ***adequate*** and six ***inadequate***. The OIG physicians also rated the overall adequacy of care for each of the 25 detailed case reviews they conducted. Of these 25 cases, 19 were ***adequate***, and six were ***inadequate***. In the 1,224 events reviewed, there were 399 deficiencies, 99 of which the OIG clinicians considered to be of such magnitude that, if left unaddressed, would likely contribute to patient harm.

Our clinicians found the following strengths at SAC:

- Diagnostic services staff completed radiology tests timely.
- Providers and nurses delivered appropriate and timely care in the correctional treatment center (CTC).

Our clinicians found the following weaknesses at SAC:

- SAC offered poor provider and specialty care access.
- Some providers showed poor assessment and decision-making skills.
- The providers and nurses struggled with addressing hospital recommendations for patients returning from hospitalizations. In addition, not all of these patients were followed up timely by the providers.

[10] For a definition of an event, see Table A-1.

- Nurses poorly managed abnormal blood sugar readings and insulin administration.

Compliance Testing Results

Our compliance inspectors assessed 10 of the 13 indicators applicable to SAC. Of these 10 indicators, our compliance inspectors rated three ***adequate*** and seven ***inadequate.*** We tested policy compliance in the **Health Care Environment**, **Preventive Services**, and **Administrative Operations** indicators, as these do not have a case review component.

SAC demonstrated a high rate of policy compliance in the following areas:

- Nursing staff reviewed health care services request forms, and providers completed nurse-to-provider referrals within the required time frames. In addition, SAC housing units maintained adequate supplies of health care request forms.

- SAC scheduled timely provider follow-up appointments for patients returning from hospital admission or specialty services.

- SAC nursing staff and providers completed assessments within the required time frame for patients admitted to the specialized medical housing unit.

SAC demonstrated a low rate of policy compliance in the following areas:

- Health care staff did not follow proper hand hygiene practices before or after patient encounters.

- SAC medical warehouse and clinics contained multiple medical supplies that were expired.

- Medical clinics tested were missing properly calibrated medical equipment required to provide standard medical care.

- Nursing staff did not regularly inspect emergency response bags and treatment carts.

- SAC staff frequently failed to maintain medication continuity for chronic care patients, patients discharged from the hospital, and patients admitted to the specialized medical housing unit. Also, there was poor medication continuity for patients who transferred into the institution, for patients transferring within the institution, and for patients who had a temporary layover at SAC.

- SAC often did not ensure that approved specialty services were provided within specified time frames. Furthermore, SAC did not retrieve these reports timely.

Population-Based Metrics

In addition to our own compliance testing and case reviews, as noted above, the OIG presents selected measures from the Healthcare Effectiveness Data and Information Set (HEDIS) for comparison purposes. The HEDIS is a set of standardized quantitative performance measures designed by the National Committee for Quality Assurance to ensure that the public has the data it needs to compare the performance of health care plans. Because the Veterans Administration no longer publishes its individual HEDIS scores, we removed them from our comparison for Cycle 6. Likewise, Kaiser (commercial plan) no longer publishes HEDIS scores. However, through the California Department of Health Care Services' *Medi-Cal Managed Care Technical Report,* the OIG obtained Kaiser Medi-Cal HEDIS scores to use in conducting our analysis, and we present them here for comparison.

HEDIS Results

We considered SAC's performance with population-based metrics to assess the macroscopic view of the institution's health care delivery. We list the nine HEDIS measures in Table 5.

Comprehensive Diabetes Care

Statewide comparison data is only available for one of the five diabetic measures. When compared with statewide Medi-Cal programs—California Medi-Cal, Kaiser Northern California (Medi-Cal), and Kaiser Southern California (Medi-Cal)—SAC performed better in poor HbA1c control than all managed care plans. We include HbA1c screening, HbA1c control, blood pressure control, and eye examination data for informational purposes.

Immunizations

Statewide comparative data were not available for immunization measures; however, we include this data for informational purposes. SAC had a 52 percent influenza immunization rate for adults 18 to 64 years old, and a 28 percent immunization rate for adults 65 years and older.[11] The pneumococcal vaccine rate was 68 percent.[12]

Colorectal Cancer Screening

Statewide comparative data were not available for colorectal cancer screening; however, we include these data for informational purposes. SAC had a 65 percent colorectal cancer screening rate.

[11] The HEDIS sampling methodology requires a minimum sample of 10 patients to have a reportable result. The sample for older adults did not include a full sample.

[12] The pneumococcal vaccines administered are the 13, 15, and 20 valent pneumococcal vaccines (PCV13, PCV 15, and PCV 20), or the 23 valent pneumococcal vaccine (PPSV23), depending on the patient's medical conditions. For the adult population, the influenza or pneumococcal vaccine may have been administered at a different institution other than the one in which the patient was currently housed during the inspection period.

Table 5. SAC Results Compared With State HEDIS Scores

HEDIS Measure	SAC Cycle 6 Results*	California Medi-Cal 2018†	California Kaiser NorCal Medi-Cal 2018 †	California Kaiser SoCal Medi-Cal 2018 †
HbA1c Screening	**100%**	–	–	–
Poor HbA1c Control (> 9.0%) ‡, §	**12%**	42%	34%	23%
HbA1c Control (< 8.0%) ‡	78%	–	–	–
Blood Pressure Control (< 140/90) ‡	88%	–	–	–
Eye Examinations	69%	–	–	–
Influenza – Adults (18–64)	52%	–	–	–
Influenza – Adults (65+) ‖	28%	–	–	–
Pneumococcal – Adults (65+) ‖	68%	–	–	–
Colorectal Cancer Screening	65%	–	–	–

Notes and Sources

* Unless otherwise stated, data were collected in November 2021 by reviewing medical records from a sample of SAC's population of applicable patients. These random statistical sample sizes were based on a 95 percent confidence level with a 15 percent maximum margin of error.

† HEDIS Medi-Cal data were obtained from the California Department of Health Care Services publication titled, Medi-Cal Managed Care External Quality Review Technical Report, (published April 2022).

‡ For this indicator, the entire applicable SAC population was tested.

§ For this measure only, a lower score is better.

Source: Institution information provided by the California Department of Corrections and Rehabilitation. Health Care plan data were obtained from the CCHCS Master Registry.

Recommendations

As a result of our assessment of SAC's performance, we offer the following recommendations to the department:

Access to Care

- The department and the institution's medical leadership should consider changing the practice of cancelling outstanding appointments and reordering them as new appointments with new compliance dates, rather than rescheduling.
- Medical leadership should consider, when the institution is in Open Phase (New Normal), discontinuing the practice of performing chart reviews in lieu of face-to-face appointments. In addition, appointments in which patients are not seen should not be marked as completed.
- Medical leadership should ensure that patients with chronic care conditions and patients transferring from another department institution are timely seen by the provider.

Diagnostic Services

- Medical leadership should ensure that pathology reports are retrieved timely and that providers communicate those results to patients timely.
- Medical leadership should ensure that providers send patient notification letters with appropriate key elements, as required by CCHCS policy, for diagnostic test results.
- Medical leadership should evaluate laboratory processes to ensure that laboratory orders are completed within the specified time frame, including STAT laboratory specimen collection, results receipt, and provider notification.

Emergency Services

- Nursing leadership should ensure that triage and treatment area (TTA) nurses follow urgent and emergent nursing protocols and properly initiate calls to emergency medical services (EMS) for emergent and urgent transport when the provider is not on-site.
- Medical leadership should consider including a provider position in the TTA to handle emergent and urgent patients.

Health Information Management

- The department should consider adjusting the default drop-down menu on the results letter in the electronic health record

system so that the menu defaults to *patient letter* instead of *DDP-Scan*; the department should train providers to generate the results letters appropriately.[13]

- The department should consider developing and implementing a patient results letter template that autopopulates with all elements required by CCHCS policy.

Health Care Environment

- Medical leadership should remind staff to follow universal hand hygiene precautions. Implementing random spot checks could improve compliance.

- Nursing leadership should consider performing random spot checks to ensure that staff follow equipment and medical supply management protocols.

- Nursing leadership should direct each clinic nursing supervisor to review the monthly emergency medical response bag (EMRB) logs to ensure that the EMRBs are regularly inventoried and sealed.

Transfers

- The department should consider developing and implementing measures to ensure that receiving and release (R&R) nursing staff properly complete the initial health screening questions and that providers see patients face-to-face in the required time frames.

- Nursing leadership should consider developing and implementing measures to ensure that discharge summary recommendations are reviewed and addressed by nurses and providers.

- Nursing leadership should remind nursing staff to document complete vital signs as part of the patient's initial health screening assessment.

Medication Management

- The institution should consider developing and implementing measures to ensure that staff timely make medication available to the patients and that staff administer medications within the specified time frames.

- Nursing leadership should educate nursing staff on the proper documentation of medication refusal in the patient's medication administration record, as described in CCHCS policy.

[13] DDP is the abbreviation for the Developmental Disability Program.

Preventive Services

- Nursing leadership and the public health nurse should educate nursing staff on properly documenting the tuberculosis (TB) signs and symptoms when monitoring patients taking TB medications.

Nursing Performance

- Nursing leadership should ensure that nurses perform more detailed assessments and interventions during patient appointments, and leadership should consider implementing corrective action plans.

- Nursing leadership should review the nursing intervention process for diabetic patients with abnormal blood sugar readings and should implement a process to ensure that patients receive appropriate assessments and interventions.

Provider Performance

- Medical leadership should consider, in Phase 3 operations, discontinuing the practice of routinely deferring scheduled nonemergent and nonurgent patient appointments.[14]

- Medical leadership should consider ways of improving provider continuity of care.

- Medical leadership should consider offering specific provider training on improved documentation and should consider monitoring medical decision making.

Specialized Medical Housing

- Nursing leadership should consider developing and implementing an audit tool to ensure that nursing assessments, including vital signs, are complete and related to the patient's complaint and presentation.

Specialty Services

- Medical leadership should ensure that patients receive their approved specialty service appointment and subsequent follow-up specialty service appointments within the specified time frame.

- Medical leadership should ascertain the challenges in retrieving specialty reports to ensure that reports are received, scanned,

[14] Phase 3 is the Open Phase (New Normal) https://www.cdcr.ca.gov/covid19/reopening/.

and endorsed in a timely manner. Medical leadership should ensure that eye specialist reports are endorsed by providers.

- Medical leadership should determine the root cause of challenges to timely notifying patients of denied specialty services, as required by CCHCS policy.

Access to Care

In this indicator, OIG inspectors evaluated the institution's performance in providing patients with timely clinical appointments. Our inspectors reviewed the scheduling and appointment timeliness for newly arrived patients, sick call, and nurse follow-up appointments. We examined referrals to primary care providers, provider follow-ups, and specialists. Furthermore, we evaluated the follow-up appointments for patients who received specialty care or returned from an off-site hospitalization.

Overall Rating
Inadequate

Case Review Rating
Inadequate

Compliance Score
***Adequate* (79.9%)**

Results Overview

SAC's performance was variable in this indicator. As in Cycle 5, SAC delivered poor access to care, primarily due to poor provider access for clinic, transfer, and hospital patients, as well as poor specialty access. Nurses performed well in reviewing medical requests for services; however, patients were not always seen timely. SAC had good access for specialized medical housing with providers and for TTA follow-up with providers. After considering all factors, we rated this indicator as ***inadequate***.

Case Review and Compliance Testing Results

We reviewed 180 provider, nursing, specialty, and hospital events that required the institution to generate appointments. We identified 21 deficiencies relating to **Access to Care**, of which 16 were significant.[15]

Access to Clinic Providers

SAC performed poorly in referrals to providers and requests for provider follow-up. Failure to ensure provider appointment availability can cause lapses in care.

Compliance testing showed that chronic care appointments occurred within the maximum allowable time or the ordered time frame only 64.0 percent of the time (MIT 1.001). On the other hand, RN-to-provider sick calls and provider-ordered follow-up appointments always occurred as ordered (MIT 1.005, 100% and MIT 1.006, 100%); however, only a few of the applicable samples were testable.

Our case review clinicians reviewed 97 outpatient provider encounters. Case reviewers found that provider appointments were often delayed due to scheduling issues, as well as providers' frequently cancelling and reordering the appointments. Of the 27 access-to-care deficiencies,

[15] Significant deficiencies occurred in cases 11, 12, 17, 18, 22, 24, and 27–29.

eleven deficiencies were related to provider access, and nine were significant.[16] Examples include the following:

- In case 11, the provider ordered the patient to be evaluated for complaints of orthopnea within 14 days.[17] The appointment was repeatedly cancelled and rescheduled, and the patient was not seen for orthopnea until 78 days later.

- In case 22, the CCHCS headquarters medication-assisted treatment (MAT) provider transferred active MAT care to the institution's on-site provider and ordered an appointment within 14 days.[18] Due to multiple scheduling delays and the reordering of the chronic care MAT appointments, the appointment occurred 99 days late.

We identified a practice of providers cancelling and rescheduling appointments. Also, we identified a practice of documenting appointments as completed, even though patients were, in fact, not seen. This is further discussed in the **Provider Performance** indicator.

Access to Specialized Medical Housing Providers

Compliance testing showed that CTC (correctional treatment center) history and physical exams were completed within the required time frames 100 percent of the time (MIT 13.002); however, only a few of the applicable samples were testable. Most of the CTC admissions were for mental health crises and were primarily managed by mental health staff.

Case review found no deficiencies in access to specialized medical housing providers. We reviewed four admissions for three cases: cases 1, 66, and 67. There were eight provider events, and we found no access deficiencies.

Access to Clinic Nurses

SAC provided good access to clinic nurses. Compliance testing showed that RNs reviewed patient requests for medical services the same day the requests were received 100 percent of the time (MIT 1.003) and saw the patient in a face-to-face appointment within one business day, as required by policy, 76.7 percent of the time (MIT 1.004). Case reviewers found that the nurses performed well in access to care, with one significant deficiency:

- In case 20, the RN follow-up appointment was ordered every other day for wound care to both arms. The patient was not scheduled for two days.

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[16] Deficiencies occurred in cases 10–12, 17, 22, 24, and 27–28. Significant deficiencies occurred in cases 10-11, 20, 22, 24, and 27-28.

[17] Orthopnea means shortness of breath while lying flat.

[18] MAT is the Medication Assisted Treatment program for substance use disorder.

Access to Specialty Services

SAC performed poorly in access to specialty services. Compliance testing found that patients usually did not receive initial routine, medium-priority, or high-priority specialty appointments by the compliance date (MIT 14.007, 60.0%; MIT 14.004, 60.0%; and MIT 14.001, 53.3%). Patients who transferred from another institution with an approved specialty referral had the appointment scheduled within the required time frame only 35.0 percent of the time (MIT 14.010). Case reviewers also identified poor performance in specialty access.[19] These cases are discussed further in the **Specialty Services** indicator.

Compliance testing showed that SAC also performed poorly regarding receipt of specialty follow-up appointments. Patients did not receive high-priority, medium-priority, and routine specialty service follow-up appointments timely (MIT 14.003, 61.5%; MIT 14.006, 66.7%; and MIT 14.009, 57.1%). Case review did not find any significant deficiencies in follow-up referrals.

Follow-Up After Specialty Service

Compliance testing showed that providers saw patients for specialty services follow-up appointments 81.6 percent of the time (MIT 1.008). Case reviewers found that when provider follow-up appointments for specialty visits were scheduled, they were usually done. We reviewed 38 total specialty consultations that could require provider follow-up appointments; of those 38 consultations, 29 appointments were ordered, and 21 appointments were completed. Most of the appointments that were not completed were patient refusals. Providers did not see patients after specialty appointments three times.[20] One deficiency was significant:

- In case 24, a 14-day PCP appointment was ordered for a urology specialty follow-up after surgical procedure. The follow-up appointment did not occur until the patient placed a health care services request stating that he was in severe pain and that he was having difficulty walking and performing ADLs.[21] The provider specialty follow-up occurred over two months late, delaying care to the patient.

Follow-Up After Hospitalization

SAC had mixed results for hospital follow-up. Compliance testing showed that patients were seen for hospital follow-up appointments within the required time frame 81.8 percent of the time (MIT 1.007). Case review clinicians, however, found that fewer hospital follow-up appointments occurred as ordered. The delays were often very extended

[19] Deficiencies occurred in cases 8, 12, 17, 18, and 29. Significant deficiencies occurred in cases 12, 17, 18, and 29.

[20] Deficiencies occurred in cases 10, 12, and 24.

[21] ADL means activity of daily living.

and placed the patients at potential health risks. We reviewed 16 hospital events, involving ten patients.[22] After hospitalization, three of those patients did not see a provider at all or did not see a provider for extended durations:

- In case 10, a five-day follow-up appointment was scheduled for a diabetic patient who was hospitalized from a life-threatening blood sugar elevation and kidney injury. The provider planned to reschedule this appointment either the next day or after a 14-day quarantine. However, twelve days later, the same provider then cancelled the follow-up appointment, stating that it was a duplicate appointment. No provider had reassessed the patient's kidney function nor had a provider assessed the patient since hospitalization to ensure that life-threatening problems were not recurring. Two weeks after that cancellation, the provider again deferred the appointment and documented that a chart review was done for the same hospital follow-up appointment. The patient was eventually seen by a provider for the hospital return 40 days late.

- In case 11, the patient was scheduled for a return-from-hospital follow-up appointment for weakness, dizziness, and leg pain. Eleven days after this appointment was due, the provider documented the reason for the appointment as leg pain and refusing a heart study, rather than as a hospital follow-up appointment, as it was originally scheduled. Instead of seeing the patient, the provider performed a chart review, cancelled the appointment, and reordered it for eight days later. Several more appointment reschedulings and cancellations occurred. The patient was eventually seen for this hospital follow-up 85 days late.

- In case 23, the provider documented an outpatient note that a posthospital follow-up appointment occurred for the patient with right arm cellulitis. However, the provider did not see the patient, obtain a current history, or perform a hospital follow-up examination. As a result, the patient was not seen by a provider for hospital follow-up at all during the review period.

Follow-Up After Urgent or Emergent Care (TTA)

Case reviewers examined 30 TTA events. Sixteen of those urgent or emergent events led to patient hospitalizations, and in nine of the events, the patient was returned to housing. In three of those events, PCP follow-up appointments were ordered, and those appointments occurred in a timely manner. In case 11, the provider did not order the medically necessary follow-up appointment; this is discussed further in the **Provider Performance** indicator.

[22] Events occurred in cases 1, 10, 11, 12, 21-24, and 66.

Follow-Up After Transferring Into the Institution

Compliance testing showed that patients arriving from other institutions received an initial health screening based upon their clinical risk level only 32.0 percent of the time (MIT 1.002). Case review also found that patients were not seen for their initial intake evaluations in the three following cases:

- In case 6, a provider documented an initial intake assessment on the high-risk patient as completed but did not see the patient. The patient was not seen for an initial intake assessment for nearly one month.

- In case 17, the high-risk transfer patient did not receive an initial new arrival assessment or see a provider for his diabetes for over six months after his arrival.

- In case 28, the patient on high-risk medication and with several chronic medical problems was not seen by a medical provider for over four months after arriving at the facility.

These delays placed the patients at risk of potential harm.

Clinician On-Site Inspection

Our clinicians met with medical and custody leadership, scheduling management, and staff. There were no scheduling staffing shortages during our review period.

Nursing was adequately staffed during the review period and reported no staffing challenges related to COVID-19. During the on-site visit, nursing reported little to no appointment backlog.

Leadership reported that there were no COVID-19 outbreaks at the institution during our review period. All providers were scheduled full-time, delivering on-site care. Custody stated that SAC was in CCHCS Institutional Roadmap to Reopening Phase 3 – New Normal Programming throughout the review period, with intermittent quarantines based on incarcerated persons who tested positive for COVID-19.[23] Even though SAC was operating under Phase 3, normal operations, providers reported that since the preceding year, they had been instructed by medical leadership to see only urgent and emergent appointments. The chief medical executive (CME) and the chief physician and surgeon (CP&S) confirmed this instruction, which also included the direction that providers were to review the chart if the patient were not seen for a scheduled appointment, and, if the patient would not be seen, to communicate the plan to the patient in a letter. One provider stated that he was instructed to defer the chronic care appointments under his care.

[23] Phase 3 is the Open Phase (New Normal) https://www.cdcr.ca.gov/covid19/reopening/.

Medical leadership and staff reported that one of the clinics had a chronic intermittent staffing shortage and that supervising nurses (SRNs) or providers reviewed the outstanding appointments and rescheduled them to meet compliance dates. This same yard staff stated that there was no backlog for chronic care appointments despite the yard's provider's frequently being absent. During case review, there were frequent appointment cancelations and reorders of canceled appointments with new compliance dates. Medical leadership confirmed that they instructed a telemedicine provider to review the backlog appointments for at least two clinics, triage the appointments for chart review or rescheduling, and reschedule "at the provider's discretion." One provider mentioned that this practice caused delays in specifically ordered care that he had intended for his patients. Providers confirmed that even though they were more familiar with the patients, they were not consulted when these cancelations and reschedulings occurred.

In all cases that required transfer or hospital follow-up, the patients were placed in quarantine, and in almost all instances, the providers would either not see the patients until quarantine was over or would perform chart review. When this was discussed with the providers, they mentioned that they were instructed to see only urgent or emergent patients in quarantine; however, the definition of "urgent or emergent" was not clear. The provider progress notes frequently stated that the patient was in quarantine and could not be brought to the clinic. Medical leadership reported there was no personal protective equipment (PPE) shortage, and staff confirmed that PPE was always available. Custody and medical leadership also confirmed that there were no health care custody staff shortages. Nursing was required to go to the quarantine units.

Compliance Testing Results

Table 6. Access to Care

Compliance Questions	Scored Answer			
	Yes	No	N/A	Yes %
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? (1.001) *	16	9	0	64.0%
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? (1.002) *	8	17	0	32.0%
Clinical appointments: Did a registered nurse review the patient's request for service the same day it was received? (1.003) *	30	0	0	100%
Clinical appointments: Did the registered nurse complete a face-to-face visit within one business day after the CDCR Form 7362 was reviewed? (1.004) *	23	7	0	76.7%
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 the shorter? (1.005) *	8	0	22	100%
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? (1.006) *	3	0	27	100%
Upon the patient's discharge from the community hospital: Did the patient receive a follow-up appointment within the required time frame? (1.007) *	9	2	0	81.8%
Specialty service follow-up appointments: Did the clinician follow-up visits occur within required time frames? (1.008) *,†	31	7	7	81.6%
Clinical appointments: Do patients have a standardized process to obtain and submit health care services request forms? (1.101)	5	1	0	83.3%
				Overall percentage (MIT 1): 79.9%

* The OIG clinicians considered these compliance tests along with their case review findings when determining the quality rating for this indicator.

† CCHCS changed its specialty policies in April 2019, removing the requirement for primary care physician follow-up visits following specialty services. As a result, we tested MIT 1.008 only for high-priority specialty services or when staff ordered follow-ups. The OIG continued to test the clinical appropriateness of specialty follow-ups through its case review testing.

Source: The Office of the Inspector General medical inspection results.

Table 7. Other Tests Related to Access to Care

	Scored Answer			
Compliance Questions	**Yes**	**No**	**N/A**	**Yes %**
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? (12.003) *	N/A	N/A	N/A	N/A
For patients received from a county jail: Did the patient receive a history and physical by a primary care provider within seven calendar days? (12.004) *	N/A	N/A	N/A	N/A
For CTC and SNF only (effective 4/2019, include OHU): Was a written history and physical examination completed within the required time frame? (13.002) *	2	0	0	100%
For OHU, CTC, SNF, and Hospice (applicable only for samples prior to 4/2019): 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? (13.003) *,†	0	0	2	N/A
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? (14.001) *	8	7	0	53.3%
Did the patient receive the subsequent follow-up to the high-priority specialty service appointment as ordered by the primary care provider? (14.003) *	8	5	2	61.5%
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? (14.004) *	9	6	0	60.0%
Did the patient receive the subsequent follow-up to the medium-priority specialty service appointment as ordered by the primary care provider? (14.006) *	6	3	6	66.7%
Did the patient receive the routine-priority specialty service within 90 calendar days of the primary care provider order or Physician Request for Service? (14.007) *	9	6	0	60.0%
Did the patient receive the subsequent follow-up to the routine-priority specialty service appointment as ordered by the primary care provider? (14.009) *	4	3	8	57.1%

* The OIG clinicians considered these compliance tests along with their case review findings when determining the quality rating for this indicator.

† CCHCS changed its policies and removed mandatory minimum rounding intervals for patients located in specialized medical housing. After April 2, 2019, MIT 13.003 only applied to CTCs that still had state-mandated rounding intervals. OIG case reviewers continued to test the clinical appropriateness of provider follow-ups within specialized medical housing units through case reviews.

Source: The Office of the Inspector General medical inspection results.

Recommendations

- The department and the institution's medical leadership should consider changing the practice of cancelling outstanding appointments and reordering them as new appointments with new compliance dates, rather than rescheduling.

- Medical leadership should consider, when the institution is in Open Phase (New Normal), discontinuing the practice of performing chart reviews in lieu of face-to-face appointments. In addition, appointments in which patients are not seen should not be marked as completed.

- Medical leadership should ensure that patients with chronic care conditions and patients transferring from another department institution are timely seen by the provider.

Diagnostic Services

In this indicator, OIG inspectors evaluated the institution's performance in timely complete radiology, laboratory, and pathology tests. Our inspectors determined whether the institution properly retrieved the resultant reports and whether providers reviewed the results correctly. In addition, in Cycle 6, we examined the institution's performance in timely completing and reviewing immediate (STAT) laboratory tests.

Overall Rating ***Inadequate***

Case Review Rating ***Adequate***

Compliance Score ***Inadequate*** **(57.7%)**

Results Overview

SAC had a mixed performance in this indicator. Overall, SAC performed poorly in completing and retrieving diagnostic tests: this performance has worsened since Cycle 5. Staff performed well with timely completion of radiology studies, radiology report receipt, and provider endorsement of radiology results. Laboratory test completion, however, was usually delayed. STAT laboratory specimens were often not collected immediately, or test results not received timely, and providers were not notified of the results within required time frames. Staff did not always timely retrieve and relay pathology results. Providers usually sent patient results letters without complete information. Considering all factors, including the clinical importance of STAT laboratories and pathology report management, we rated this indicator ***inadequate***.

Case Review and Compliance Testing Results

Our clinicians reviewed 287 diagnostic events and found 84 deficiencies, of which six were significant. Of those 84 deficiencies, we found 71 related to health information management and 13 pertaining to the completion of diagnostic tests.[24]

In health information management, we considered test reports that were never retrieved or reviewed to be problem as severe as tests that were not performed.

Test Completion

SAC radiology performed well in completion of X-rays (MIT 2.001, 100%). The laboratory, however, performed poorly, completing routine laboratory tests as ordered only 30.0 percent of the time (MIT 2.004), and completing STAT laboratory tests as ordered only 50.0 percent of the time (MIT 2.007).

[24] Deficiencies occurred in cases 1, 2, 4, 7–12, 15–27, 38, and 66. Significant deficiencies occurred in cases 1, 2, 11, 17, and 27.

In contrast, case reviewers found that most diagnostic tests were performed when ordered. Only three minor deficiencies were identified.[25]

Health Information Management

SAC providers timely reviewed X-rays (MIT 2.002, 90.0%) and laboratory results (MIT 2.005, 90.0%). Nursing, however, only notified providers of STAT laboratory results 40.0 percent of the time (MIT 2.008). Pathology results were retrieved timely 70.0 percent of the time (MIT 2.010), and providers reviewed the reports within required time frames 87.5 percent of the time (MIT 2.011); however, providers performed poorly in notifying the patient of the pathology test results (MIT 2.012, 25.0%). Case review found that radiology and laboratory results were usually endorsed by providers timely. Consistent with compliance testing results, our clinicians found one case in which the pathology report was not communicated with the patient timely. Our clinicians reviewed four STAT laboratory events but did not identify any deficiencies in the providers' review of STAT laboratory results.

Compliance and case review both identified a pattern of providers' sending patient results letters that did not contain all four required components specified in CCHCS policy. 67 case review deficiencies were identified; all were considered minor. These are discussed further in the **Health Information Management** indicator.

Clinician On-Site Inspection

Case review clinicians interviewed medical leadership, diagnostic supervisors, and providers about diagnostic workflows and deficiencies. Laboratory supervisors reported that they have had difficulty filling a clinical laboratory specialist position since September 2020 and have operated with staffing shortages at times since February 2021 due to the COVID-19 pandemic. Radiology had one vacancy since September 2021. Laboratory supervisors stated that the laboratory results deficiencies that case review identified were often related to staffing or ordering issues.

[25] Deficiencies occurred in cases 2, 4, and 7.

Compliance Testing Results

Table 8. Diagnostic Services

Compliance Questions	Scored Answer			
	Yes	No	N/A	Yes %
Radiology: Was the radiology service provided within the time frame specified in the health care provider's order? (2.001) *	10	0	0	100%
Radiology: Did the ordering health care provider review and endorse the radiology report within specified time frames? (2.002) *	9	1	0	90.0%
Radiology: Did the ordering health care provider communicate the results of the radiology study to the patient within specified time frames? (2.003)	2	8	0	20.0%
Laboratory: Was the laboratory service provided within the time frame specified in the health care provider's order? (2.004) *	3	7	0	30.0%
Laboratory: Did the health care provider review and endorse the laboratory report within specified time frames? (2.005) *	9	1	0	90.0%
Laboratory: Did the health care provider communicate the results of the laboratory test to the patient within specified time frames? (2.006)	1	9	0	10.0%
Laboratory: Did the institution collect the STAT laboratory test and receive the results within the required time frames? (2.007) *	5	5	0	50.0%
Laboratory: Did the provider acknowledge the STAT results, OR did nursing staff notify the provider within the required time frames? (2.008) *	4	6	0	40.0%
Laboratory: Did the health care provider endorse the STAT laboratory results within the required time frames? (2.009)	8	2	0	80.0%
Pathology: Did the institution receive the final pathology report within the required time frames? (2.010) *	7	3	0	70.0%
Pathology: Did the health care provider review and endorse the pathology report within specified time frames? (2.011) *	7	1	2	87.5%
Pathology: Did the health care provider communicate the results of the pathology study to the patient within specified time frames? (2.012)	2	6	2	25.0%
				Overall percentage (MIT 2): **57.7%**

* The OIG clinicians considered these compliance tests along with their case review findings when determining the quality rating for this indicator.

Source: The Office of the Inspector General medical inspection results.

Recommendations

- Medical leadership should ensure that pathology reports are retrieved timely and that providers communicate those results to patients timely.

- Medical leadership should ensure that providers send patient notification letters with appropriate key elements, as required by CCHCS policy, for diagnostic test results.

- Medical leadership should evaluate laboratory processes to ensure that laboratory orders are completed within the specified time frame, including STAT laboratory specimen collection, results receipt, and provider notification.

Emergency Services

In this indicator, OIG clinicians evaluated the quality of emergency medical care. Our clinicians reviewed emergency medical services by examining the timeliness and appropriateness of clinical decisions made during medical emergencies. Our evaluation included examining the emergency medical response, cardiopulmonary resuscitation (CPR) quality, triage and treatment area (TTA) care, provider performance, and nursing performance. Our clinicians also evaluated the Emergency Medical Response Review Committee's (EMRRC) performance in identifying problems with its emergency services. The OIG assessed the institution's emergency services mainly through case review.

Overall Rating
Inadequate

Case Review Rating
Inadequate

Compliance Score
(N/A)

Results Overview

SAC's performance was unsatisfactory in emergency services. Compared with its performance in Cycle 5, the institution significantly improved on responding to medical emergencies. However, the institution continued to struggle with complete nurse assessments, appropriate patient transport to the TTA, and timely initiation of nursing protocols. In addition, the EMRRC and nursing supervisors did not always cite the deficiencies that our clinicians had identified. The OIG rated this indicator ***inadequate.***

Case Review Results

We reviewed 28 urgent or emergent events and identified 29 emergency care deficiencies, 10 of which were significant.

Emergency Medical Response

SAC staff responded promptly to emergencies throughout the institution. Medical and custody staff worked well together to initiate CPR when appropriate. In non-CPR cases, however, our clinicians identified a trend in which staff delayed consultation with providers and notification of 9-1-1 for patients with emergent symptoms requiring a higher level of medical care. In addition, staff sometimes did not identify the proper mode of patient transportation to the emergency room when EMS transportation services are delayed. Below are two examples:

- In case 11, the patient who had complaints of severe shortness of breath and a cough was transported to the TTA via wheelchair with custody staff. Because of the shortness of breath, nurses should have accompanied the custody staff and patient.

- In case 12, the TTA nurse assessed the patient for chest pain. The nurse completed the EKG, which revealed that the patient had an abnormally elevated heart rate due to an acute, irregular heart rhythm. However, the TTA nurse delayed activating 9-1-1

or calling the provider for 30 minutes after the EKG was performed.

Cardiopulmonary Resuscitation Quality

During the review period, we reviewed five cases that required cardiopulmonary resuscitation (CPR). Our clinicians found that staff initiated CPR, activated emergency medical services, provided appropriate interventions, and transported the patients to TTA for further medical treatment timely.

Provider Performance

The primary care physicians were available for consultation with TTA nursing staff during business hours, and on-call providers consulted with TTA nurses after hours. However, our clinicians identified three opportunities for improvement related to provider documentation and two opportunities for improvement related to poor clinical decision-making. We discuss this in further detail in the **Provider Performance** indicator.

Nursing Performance

Nurses responded promptly to emergency events. However, our clinicians identified that nurses did not always perform complete assessments, demonstrate appropriate clinical decision-making in initiating nursing protocols, and contact 9-1-1 when appropriate. Below are examples of opportunities for improvement:

- In case 11, the patient with COPD was seen in the TTA on two occasions.[26] On the first occasion, the patient had shortness of breath, an abnormally elevated heart rate, and an increased respiratory rate; however, the patient was transported to the TTA via wheelchair instead of by gurney. Approximately two months later, the patient was seen in the TTA for chest pain. The TTA RN delayed calling the provider when the nurse assessed the patient with low blood pressure and low oxygenation. The TTA nurse also delayed obtaining an EKG for this patient with chest pain. The nurse completed the EKG 30 minutes after the patient arrived to the TTA.

- In case 12, the patient was seen in the TTA for chest pain and an abnormally elevated heart rate. The nurse delayed calling the provider or initiating emergency medical services after obtaining an EKG that showed abnormal findings. In addition, by delaying oxygen administration, the nurse did not follow CCHCS chest pain protocol.

[26] COPD is chronic obstructive lung disease.

- In case 20, the patient was seen by the provider for headache and symptoms of dehydration. The provider referred the patient to the TTA. Upon the patient's arrival at the TTA, the nurse did not perform a focused assessment, which would include a skin assessment, that can show objective signs of dehydration.

- In case 23, the PT (psychiatric technician) informed the TTA nurse of the patient's complaint of increasing pain after the patient was prescribed antibiotics for a skin infection on the arm. The TTA nurse did not assess the patient for the symptom.

Nursing Documentation

Nurses in the TTA usually documented care provided for emergency events. We identified minor documentation deficiencies.

Emergency Medical Response Review Committee

The Emergency Medical Response Review Committee's (EMRRC) responsibility is to review all unscheduled medical transports to the community emergency room or hospital as well as all deaths and suicide attempts. The EMRRC helps to identify opportunities for improvement made apparent by any lapses in patient care from the time of the medical emergency until the patient is transferred to the community hospital emergency room. The committee helps improve patient care outcomes by provided training to staff and implementing corrective actions plans to prevent the reoccurrence of identified deficiencies.

Compliance testing showed that the EMRRC did not perform initial reviews within required time frames (MIT 15.003, 8.3%). Our case review clinicians reviewed 15 EMRRC events in nine cases and identified five deficiencies, including one significant deficiency.[27] Like the findings from compliance testing, our clinicians' findings showed opportunities for improvement. In five cases, the committee either did not identify deficiencies or did not document that training was provided to staff for deficiencies identified. An example follows:

- In case 2, staff evaluated the patient in the TTA for a gunshot wound to the back. The medical leadership did not perform a clinical review for this medical emergency.

Clinician On-Site Inspection

We interviewed TTA nurses, supervisors, and nursing leadership. Nursing staffs the TTA 24 hours a day. However, the TTA does not have a designated provider: similar to the process we found in Cycle 5, the nursing staff and nursing supervisor reported that the TTA nurse contacts the patient's primary care provider (PCP) during business hours and contacts the on-call provider after hours. At the time of our

[27] The nine cases were cases 1, 2, 3, 10, 11, 12, 13, 14, and 66. Deficiencies occurred in cases 2, 3, 10, 12, and 14. Significant deficiencies occurred in case 12.

inspection, the institution also did not maintain a log of all EMMRC events. Instead, a nurse checks a box on the emergency medical review checklist if the event required review in EMRRC.

Recommendations

- Nursing leadership should ensure that triage and treatment area (TTA) nurses follow urgent and emergent nursing protocols and properly initiate calls to emergency medical services (EMS) for emergent and urgent transport when the provider is not on-site.

- Medical leadership should consider including a provider position in the TTA to handle emergent and urgent patients.

Health Information Management

Overall Rating
Adequate

Case Review Rating
Adequate

Compliance Score
Inadequate
(74.3%)

In this indicator, OIG inspectors evaluated the flow of health information, a crucial link in high-quality medical care delivery. Our inspectors examined whether the institution retrieved and scanned critical health information (progress notes, diagnostic reports, specialist reports, and hospital-discharge reports) into the medical record in a timely manner. Our inspectors also tested whether clinicians adequately reviewed and endorsed those reports. In addition, our inspectors checked whether staff labeled and organized documents in the medical record correctly.

Results Overview

Overall, SAC performed adequately with health information management. Staff retrieved and scanned hospital reports timely and that providers reviewed them properly. During urgent and emergent medical care, documentation was usually completed well and timely. Specialty report receipt was often delayed; however, once the reports were received, they were scanned timely. Eye specialist reports were often not endorsed by providers. Staff frequently mislabeled documents in the electronic health record system (EHRS). Taking both case review and compliance testing results into account, we rated this indicator ***adequate***.

Case Review and Compliance Testing Results

Our clinicians reviewed 1,224 events and found 89 deficiencies related to health information management, three of which were significant.[28]

Hospital Discharge Reports

Compliance testing showed that staff performed very well in timely receiving, promptly scanning, and properly reviewing hospital records (MIT 4.003, 100% and MIT 4.005, 100%). This was consistent with case review findings.

Specialty Reports

SAC managed specialist's reports with varied performance. Specialty reports were scanned timely 76.7 percent of the time (MIT 4.002). However, routine specialty reports were usually not received within the required time frames (MIT 14.008, 46.7%). Performance was poor in the receipt and endorsement of medium- and high-priority specialty reports (MIT 14.005, 71.4% and MIT 14.002, 73.3%).

[28] Deficiencies occurred in cases 2, 4, 7–13, 15–27, and 66–67. Significant deficiencies occurred in cases 8, 15, and 27.

Our case review clinicians found a pattern of providers' not endorsing optometry reports: three optometry reports were not endorsed.[29] Two of the three deficiencies were considered severe because the reports were never endorsed by a provider and important recommendations were at risk of being missed.

Diagnostic Reports

SAC also had mixed performance in diagnostic reports. Our clinicians reviewed 287 diagnostic events and found that providers usually endorsed routine test results timely and that most sent patient results letters within required time frames, but nearly all of the letters omitted at least one required component. Most of these deficiencies were not significant.

Compliance testing showed that nursing did not notify the providers of STAT laboratory test results within required time frames either during or after business hours. There was also evidence that providers did not acknowledge STAT laboratory test results timely (MIT 2.008, 40.0%). Final pathology reports were reviewed by a provider 87.5 percent of the time (MIT 2.011); however, the providers did not communicate the results to the patients (MIT 2.012, 25.0%). Our clinicians reviewed only one pathology report—in case 2—and found it consistent with compliance testing's findings: the report was reviewed timely but a patient results letter was not sent nor the results discussed with the patient within the required time frames. This was considered a significant deficiency.

Diagnostic health information management performance is discussed further in the **Diagnostic Indicator**.

Urgent and Emergent Records

Our clinicians reviewed 28 emergency care events and found that SAC nurses performed well and usually recorded these events sufficiently. Providers often documented sufficiently; however, there were three significant deficiencies due to missing provider progress notes.[30] These are discussed further in the **Provider Performance** indicator.

Scanning Performance

As in Cycle 5, SAC's scanning performance was variable. Compliance testing showed that medical records were mislabeled or misfiled in the medical record (MIT 4.004, zero). Nearly all of the patient results letters reviewed were created in the medical record as a "DDP-Scan," which is not the correct document type, thereby causing the documents to be misfiled in the medical record.[31] Case review identified similar findings;

[29] Deficiencies occurred in case 2. Two significant deficiencies occurred in case 4.

[30] Significant deficiencies occurred in cases 11, 22, and 27.

[31] DDP is the Developmental Disability Program.

however, patient results letters were filed under the correct date and were accessible to medical staff for review.[32]

Clinician On-Site Inspection

We discussed health information management processes with SAC office technicians, health information management supervisors, ancillary staff, diagnostic staff, nurses, and providers. Medical records leadership reported that due to a 33 percent staff vacancy rate, they experienced some staff shortages during the review period that affected their service. They also reported that although the medical record is mostly automated, they receive a high volume of requests to review medical files. They process approximately sixty thousand pages of medical records per month in response to legal requests.

HIM leadership and staff reported that there was an oversight in training that left some optometry reports scanned but not forwarded to a provider for endorsement. They stated that this oversight has been corrected with staff training. They also reported that it is not the responsibility of HIM leadership to train providers in how to write patient results letters.

Nursing reported that the institution will not accept a patient returned from a hospitalization without at least the discharge report and recommendations in hand. This helps ensure continuity of care. Medical records staff stated that they have electronic access to one of the local hospital's medical records, which expedites obtaining records from that facility.

[32] DDP misfile deficiencies occurred in cases 7, 8, 10, 18, and 25.

Compliance Testing Results

Table 9. Health Information Management

Compliance Questions	Scored Answer			
	Yes	No	N/A	Yes %
Are health care service request forms scanned into the patient's electronic health record within three calendar days of the encounter date? (4.001)	19	1	10	95.0%
Are specialty documents scanned into the patient's electronic health record within five calendar days of the encounter date? (4.002) *	23	7	15	76.7%
Are community hospital discharge documents scanned into the patient's electronic health record within three calendar days of hospital discharge? (4.003) *	11	0	0	100%
During the inspection, were medical records properly scanned, labeled, and included in the correct patients' files? (4.004) *	0	24	0	0
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? (4.005) *	11	0	0	100%
Overall percentage (MIT 4): **74.3%**				

* The OIG clinicians considered these compliance tests along with their case review findings when determining the quality rating for this indicator.

Source: The Office of the Inspector General medical inspection results.

Table 10. Other Tests Related to Health Information Management

	Scored Answer			
Compliance Questions	**Yes**	**No**	**N/A**	**Yes %**
Radiology: Did the ordering health care provider review and endorse the radiology report within specified time frames? (2.002) *	9	1	0	90.0%
Laboratory: Did the health care provider review and endorse the laboratory report within specified time frames? (2.005) *	9	1	0	90.0%
Laboratory: Did the provider acknowledge the STAT results, OR did nursing staff notify the provider within the required time frame? (2.008) *	4	6	0	40.0%
Pathology: Did the institution receive the final pathology report within the required time frames? (2.010) *	7	3	0	70.0%
Pathology: Did the health care provider review and endorse the pathology report within specified time frames? (2.011) *	7	1	2	87.5%
Pathology: Did the health care provider communicate the results of the pathology study to the patient within specified time frames? (2.012)	2	6	2	25.0%
Did the institution receive and did the primary care provider review the high-priority specialty service consultant report within the required time frame? (14.002) *	11	4	0	73.3%
Did the institution receive and did the primary care provider review the medium-priority specialty service consultant report within the required time frame? (14.005) *	10	4	1	71.4%
Did the institution receive and did the primary care provider review the routine-priority specialty service consultant report within the required time frame? (14.008) *	7	8	0	46.7%

* The OIG clinicians considered these compliance tests along with their case review findings when determining the quality rating for this indicator.

Source: The Office of the Inspector General medical inspection results.

Recommendations

- The department should consider adjusting the default drop-down menu on the results letter in the electronic health record system so that the menu defaults to patient letter instead of DDP-Scan; the department should train providers to generate the results letters appropriately.

- The department should consider developing and implementing a patient results letter template that autopopulates with all elements required by CCHCS policy.

Health Care Environment

In this indicator, OIG compliance inspectors tested clinics' waiting areas, infection control, sanitation procedures, medical supplies, equipment management, and examination rooms. Inspectors also tested clinics' performance in maintaining auditory and visual privacy for clinical encounters. Compliance inspectors asked the institution's health care administrators to comment on their facility's infrastructure and its ability to support health care operations. The OIG rated this indicator solely on the compliance score, using the same scoring thresholds as in the Cycle 4 and Cycle 5 medical inspections. Our case review clinicians do not rate this indicator.

Overall Rating
Inadequate

Case Review Rating
(N/A)

Compliance Score
Inadequate
(49.3%)

Results Overview

SAC's performance declined in this indicator, compared with its performance in Cycle 5. In the present cycle, multiple aspects of SAC's health care environment needed improvement: multiple clinics contained expired medical supplies; multiple clinics lacked medical supplies or contained improperly calibrated medical equipment; emergency medical response bag (EMRB) logs were missing staff verification or inventory was not performed; and staff did not regularly sanitize their hands before or after examining patients. These factors resulted in an ***inadequate*** rating for this indicator.

Compliance Testing Results

Outdoor Waiting Areas

The institution had no waiting areas that required patients to be outdoors.

Indoor Waiting Areas

We inspected indoor waiting areas. Patients had enough seating capacity while waiting for their appointments. Depending on the population, patients were either placed in a holding area or held in individual modules to await their medical appointments (see Photos 1 and 2, next page). During our inspection, we observed compliance with social distancing requirements in the clinics' indoor waiting areas.

Photo 1. Indoor patient waiting area (photographed on 12-15-21).

Photo 2. Individual waiting modules for patients (photographed on 12-16-21).

Clinic Environment

All clinic environments were sufficiently conducive to medical care: they provided reasonable auditory privacy, appropriate waiting areas, wheelchair accessibility, and nonexamination room work space (MIT 5.109, 100%).

Of the 13 clinics we observed, eleven contained appropriate space, configuration, supplies, and equipment to allow their clinicians to perform proper clinical examinations (MIT 5.110, 84.6%). The remaining two clinics had one or both of the following deficiencies: there was a torn examination table vinyl cover, or the examination room had unsecured confidential medical records that were not shredded on a daily basis.

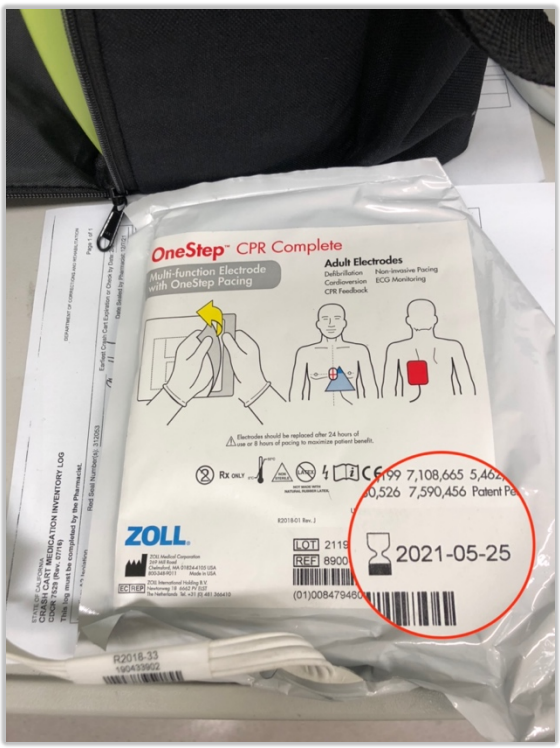


Photo 3. Expired medical supply dated 5-25-21 (photographed on 12-16-21).

Clinic Supplies

Only four of the 13 clinics followed adequate medical supply storage and management protocols (MIT 5.107, 30.8%). We found one or more of the following deficiencies in nine clinics: expired medical supplies (see Photos 3, left, and 4, below), unidentified medical supplies, disorganized medical supply cabinets or drawers, cleaning materials stored with medical supplies, staff members' personal items and food stored in the supply storage cabinet location, medical supplies stored directly on the floor, and compromised sterile medical supply packaging (see Photo 5, next page).

Photo 4. Expired medical supplies dated Aug. 2020 (photographed on 12-14-21).

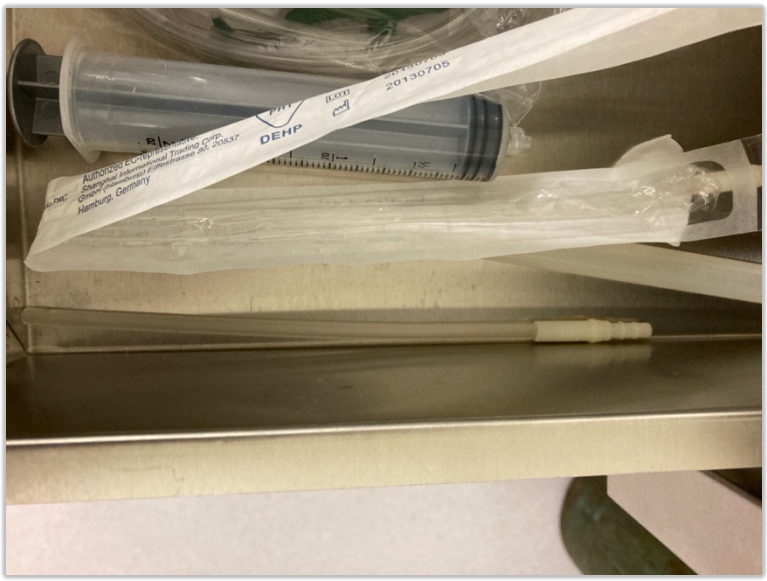


Photo 5. Compromised medical supplies; sterile packaging (photographed on 12-16-21).

Photo 6. Examination table missing disposable paper (photographed on 12-15-21).

Only three of the 13 clinics met requirements for essential core medical equipment and supplies (MIT 5.108, 23.1%). The remaining 10 clinics lacked medical supplies or contained improperly calibrated or nonfunctional equipment. The missing items included an automated external defibrillator (AED), nebulization unit, examination table, and examination table disposable paper (see Photo 6, left). Several clinics had improperly calibrated nebulization units.

We found the Snellen eye chart placed at an improper distance (see Photo 7, right). SAC's staff either did not log or did not properly log the results of the AED and defibrillator performance test within the last 30 days.

Photo 7. Snellen eye chart had an inaccurately established and misidentified the distance line on the floor label (photographed on 12-16-21).

Photo 8. EMRB end pocket not sealed when not in use (photographed on 12-16-21).

We examined emergency medical response bags (EMRBs) to determine whether they contained all essential items. We checked whether staff inspected the bags daily and inventoried them monthly. Only one of the 11 EMRBs passed our test (MIT 5.111, 9.1%). We found one or more of the following deficiencies with ten EMRBs: staff failed to ensure that the EMRB's compartments were sealed and intact; staff failed to seal compartments when not in active use (see Photo 8, left); staff had not inventoried the EMRBs when the seal tags were replaced or had not inventoried the EMRBs in the previous 30 days; an EMRB did not satisfy the minimum medical supply level when compared with the EMRB checklist at the time of inspection; and staff inaccurately logged or failed to log EMRB daily glucometer quality control results. Staff in the CTC-2 failed to complete the Treatment Cart Daily Check Sheet (CDCR Form 7544-1) to ensure that the treatment cart was sealed and intact when not in active use.

Medical Supply Management

None of the medical supply storage areas located outside the medical clinics contained medical supplies stored adequately (MIT 5.106, zero). We found expired medical supplies (see Photo 9, right).

According to the chief executive officer (CEO), SAC did not have any concerns about the medical supplies process. Health care managers and medical warehouse managers expressed a positive response to the new Kanban system that the institution uses.[33] They also had no concerns about the medical supply chain or about their communication process in using the new system.

Photo 9. Expired medical supplies dated July 2019 (photographed on 12-14-21).

[33] The Kanban system is an inventory control system.

Photo 10. Dead cockroach found in medication room at the time of inspection (photographed on 12-15-21).

Infection Control and Sanitation

Staff appropriately disinfected, cleaned, and sanitized only two of 11 clinics (MIT 5.101, 18.2%). In nine clinics, we found one or more of the following deficiencies: cleaning logs were not maintained; a medication room had dead a cockroach (see Photo 10, left); an examination table or an examination room cabinet was unsanitary (see Photo 11, below).

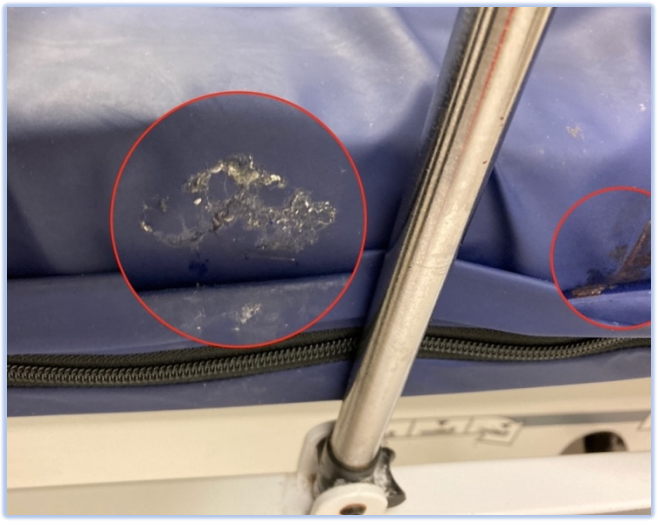
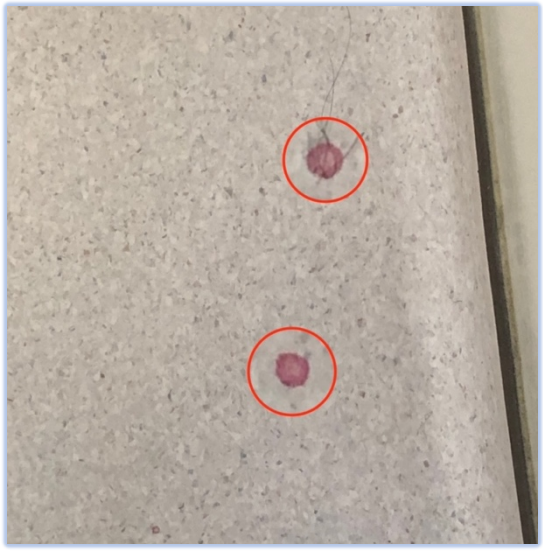


Photo 11. Unsanitary examination table (photographed on 12-16-21).



A clinic floor had a blood-like stain (see Photo 12, left); biohazardous waste was not emptied after each clinic day; and inmate-porters reported that newly mixed chemicals intended for cleaning were not tested for the desired sanitizing solution concentration by using the PIA-provided test strips.

Photo 12. Blood-like substance on the clinic floor (photographed on 12-15-21).

Staff in all clinics properly sterilized or disinfected medical equipment (MIT 5.102, 100%).

We found operating sinks and hand hygiene supplies in the examination rooms in seven of 13 clinics (MIT 5.103, 53.9%). The patient restrooms in five clinics lacked either antiseptic soap or disposable hand towels. The remaining clinic's patient restroom had a nonfunctional sink (see Photo 13, right).

Photo 13. Nonfunctioning sink in patient restroom (photographed on 12-16-21).

We observed patient encounters in nine clinics. In seven clinics, clinicians did not wash their hands before or after examining their patients, before applying gloves, or after performing blood draws (MIT 5.104, 22.2%).

Health care staff in all clinics followed proper protocols to mitigate exposure to bloodborne pathogens and contaminated waste (MIT 5.105, 100%).

Physical Infrastructure

SAC's health care management and plant operations manager reported that all clinical areas' infrastructures were in good working order and did not hinder health care services.

At the time of our medical inspection, the institution reported that the health care facility improvement program (HCFIP) project had plans to renovate Medical Building A and build new medication distribution rooms for all yards; these construction projects were anticipated to start between the third and fourth quarters of 2022. The institution estimated that the projects would be completed between the first and fourth quarter of 2024. In addition, the new pharmacy building was still in the designing phase (MIT 5.999).

Compliance Testing Results

Table 11. Health Care Environment

Compliance Questions	Scored Answer			
	Yes	No	N/A	Yes %
Infection control: Are clinical health care areas appropriately disinfected, cleaned, and sanitary? (5.101)	2	9	2	18.2%
Infection control: Do clinical health care areas ensure that reusable invasive and noninvasive medical equipment is properly sterilized or disinfected as warranted? (5.102)	13	0	0	100%
Infection control: Do clinical health care areas contain operable sinks and sufficient quantities of hygiene supplies? (5.103)	7	6	0	53.9%
Infection control: Does clinical health care staff adhere to universal hand hygiene precautions? (5.104)	2	7	4	22.2%
Infection control: Do clinical health care areas control exposure to blood-borne pathogens and contaminated waste? (5.105)	13	0	0	100%
Warehouse, conex, and other nonclinic storage areas: Does the medical supply management process adequately support the needs of the medical health care program? (5.106)	0	1	0	0
Clinical areas: Does each clinic follow adequate protocols for managing and storing bulk medical supplies? (5.107)	4	9	0	30.8%
Clinical areas: Do clinic common areas and exam rooms have essential core medical equipment and supplies? (5.108)	3	10	0	23.1%
Clinical areas: Are the environments in the common clinic areas conducive to providing medical services? (5.109)	11	0	2	100%
Clinical areas: Are the environments in the clinic exam rooms conducive to providing medical services? (5.110)	11	2	0	84.6%
Clinical areas: Are emergency medical response bags and emergency crash carts inspected and inventoried within required time frames, and do they contain essential items? (5.111)	1	10	2	9.1%
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? (5.999)	This is a nonscored test. Please see the indicator for discussion of this test.			
	Overall percentage (MIT 5): **49.3%**			

* The OIG clinicians considered these compliance tests along with their case review findings when determining the quality rating for this indicator.

Source: The Office of the Inspector General medical inspection results.

Recommendations

- Medical leadership should remind staff to follow universal hand hygiene precautions. Implementing random spot checks could improve compliance.

- Nursing leadership should consider performing random spot checks to ensure that staff follow equipment and medical supply management protocols.

- Nursing leadership should direct each clinic nursing supervisor to review the monthly emergency medical response bag (EMRB) logs to ensure that the EMRBs are regularly inventoried and sealed.

Transfers

Overall Rating
Inadequate

Case Review Rating
Inadequate

Compliance Score
Inadequate
(64.4%)

In this indicator, OIG inspectors examined the transfer process for those patients who transferred into the institution as well as for those who transferred to other institutions. For newly arrived patients, our inspectors assessed the quality of health screenings and the continuity of provider appointments, specialist referrals, diagnostic tests, and medications. For patients who transferred out of the institution, inspectors checked whether staff reviewed patient medical records and determined the patient's need for medical holds. They also assessed whether staff transferred patients with their medical equipment and gave correct medications before patients left. In addition, our inspectors evaluated the performance of staff in communicating vital health transfer information, such as preexisting health conditions, pending appointments, tests, and specialty referrals; inspectors confirmed whether staff sent complete medication transfer packages to the receiving institution. For patients who returned from off-site hospitals or emergency rooms, inspectors reviewed whether staff appropriately implemented the recommended treatment plans, administered necessary medications, and scheduled appropriate follow-up appointments.

Results Overview

SAC performed poorly in this indicator. The institution's processes for transfer-ins, the transfer-outs, and hospital returns showed opportunities for improvement. Nurses did not always ensure that patients receive their medications prior to transferring out of the institution, and nurses did not inform the receiving facility of pending specialty appointments. The institution struggled with reconciling hospital discharge recommendations, which led to lapses in medication continuity. Considering all aspects of case review and compliance testing, we rated this indicator ***inadequate.***

Case Review and Compliance Testing Results

In case review, our clinicians reviewed 19 cases in which patients transferred into or out of the institution or returned from an off-site hospital or emergency room. We identified 19 deficiencies, 13 of which were significant.[34]

Transfers In

SAC's transfer-in process had variable results in case review and compliance testing. Our clinicians reviewed five transfer-in cases and found SAC's transfer-in process satisfactory. The receiving nurses evaluated the patients appropriately and requested provider and nursing follow-up appointments within appropriate time frames in the cases we

[34] Deficiencies occurred in cases 10, 11, 22, 23, 24, 28, 29, 30, 31, 32, 33, and 67. Significant deficiencies occurred in cases 10, 11, 22, 28, 29, and 67.

reviewed. However, compliance testing found nurses frequently did not complete the initial health screening form thoroughly (MIT 6.001, 16.0%). Analysis of the compliance data revealed that nurses frequently did not document vital signs, including weight, on the intake screening form and frequently did not provide a comment for questions that required a further explanation. However, the nurses performed well in completing the assessment and disposition section of the health screening form (MIT 6.002, 100%).

SAC did not perform well in timely access to primary care providers. Compliance testing showed that provider appointments for new arrivals did not occur timely (MIT 1.002, 32.0%). In case review, we found similar results, including the following examples:

- In case 17, the newly arrived patient did not see a provider for an initial transfer chronic care appointment. The patient was not seen until six months later.

- In case 28, the patient with multiple chronic care conditions transferred from another institution. Initially, the provider performed a chart review, with a plan to see the patient in one month. However, the patient was not seen, and another chart review was performed. The patient was seen approximately four months after arriving to the institution.

Compliance testing showed that transfer-in patients frequently did not receive their medication timely (MIT 6.003, 58.3%) and that patients who arrived on layovers did not receive their medication timely (MIT 7.006, 50.0%). In contrast, our clinicians found good medication continuity for newly arrived patients.

Both compliance and case review testing showed that appointments did not always occur within the required time frames for patients who transferred into the institution with preapproved specialty appointments (MIT 14.001, 53. 3%). Our clinicians identified two deficiencies; they were significant deficiencies in a single case. [35]

- In case 29, the newly transferred patient arrived with medium-priority appointments for neurosurgery and infectious disease consultations. The neurosurgery consult occurred 12 days late and the infectious disease consult occurred over six weeks late.

Transfers Out

The SAC transfer-out process was satisfactory, but had opportunities for improvement. Compliance testing showed that the transfer packets included required medication (MIT 6.101, 83.3%). Our clinicians reviewed four transfer-out cases and found that nurses completed face-to-face evaluations on the day of transfer. Our clinicians identified deficiencies in the lack of notification to the receiving facility of pending specialty

[35] Deficiencies occurred in case 29. Significant deficiencies occurred in case 29.

appointments, the lapse in medication continuity on the day of transfer, and in the incomplete vital signs prior to transfer.

- In case 32, the transfer nurse did not take the patient's blood pressure, oxygen saturation, or pulse prior to the patient's transfer. Also, the nurse did not notify the receiving facility of the pending Hepatitis C specialty follow-up appointment.

- In case 67, the transfer nurse did not ensure that the patient received the evening chronic care medications prior to transfer and did not document whether the patient transferred with a five-day supply of medications.[36] The nurse also did not notify the receiving facility of the pending neurology and physical therapy appointments and did not document that the patient transferred with the prescribed durable medical equipment (DME).

Hospitalizations

Patients returning from an off-site hospitalization or emergency room are at high risk for lapses in care quality. These patients have typically experienced severe illness or injury. They require more care and place strain on the institution's resources. Also, because the patients have complex medical issues, successful health information transfer is necessary for good quality care. Any transfer lapse can result in serious consequences for these patients.

Compliance testing revealed that patient discharge documents were always scanned within the required time frame (MIT 4.003, 100%) and providers reviewed the discharge documents timely (MIT 4.005, 100%). Our clinicians found that all documents were scanned and retrieved timely.

Our clinicians reviewed 16 events in 10 cases in which the patient returned from an off-site hospitalization or emergency room. We identified seven deficiencies, two of which were significant.[37] We found that nurses assessed patients appropriately but showed a trend of not informing the provider of new recommended discharge medications. As a result, there were lapses in medication continuity. Examples follow:

- In case 10, the diabetic patient was hospitalized for a wound debridement. The discharge summary recommended that the patient's long-acting insulin dosage be changed from a bedtime administration to a twice-a-day administration. The insulin order was not changed. Also, the hospitalist recommended that the patient's antifungal medication continue for three additional days. Instead, the antifungal medication was ordered and administered for a total of seven days.

[36] The provider ordered transfer medications for the patient.

[37] Deficiencies occurred in cases 10, 23, and 24. Significant deficiencies occurred in cases 10 and 23.

- In case 24, the patient returned from a hospital admission with a recommendation to start a new nerve medication, gabapentin. The nurse did not notify the on-call provider of the recommended medication; consequently, the patient never received the medication.

Compliance testing showed that provider follow-up appointments occurred within the required time frames (MIT 1.007, 81.8%). Case review clinicians did not identify any deficiencies.

Clinician On-Site Inspection

Our clinicians found the transfer nurse knowledgeable about the transfer process. Receiving and release (R&R) nurses reported that the R&R did not stock medications. Instead, when patients required medication for transfers, medications were obtained from the Omnicell[38] in the CTC unit to provide nurse-administered medications to patients upon arrival. The transfer nurses also reported that the time frame to obtain medications and return to the R&R clinic is approximately 10 minutes.

The transfer nurses reported that low, medium, and high medical risk patients are ordered a 30-day follow-up appointment with the primary care registered nurse (RN) as part of the *Whole Person Care* program.[39] When the patient arrives at SAC, the transfer nurse notifies the specialty nurses of pending specialty appointments. The transfer nurse also notifies the public health nurse (PHN) regarding new arrivals on Hepatitis C treatment.

[38] An Omnicell is an automated medication dispensing machine.

[39] CCHCS's Whole Person Care program "recognizes that the best way to improve health outcomes is to consider the full spectrum of a patient's needs—including medical, behavioral, socioeconomic, and beyond." CCHCS HC DOM 3.1.1.

Compliance Testing Results

Table 12. Transfers

Compliance Questions	Scored Answer			
	Yes	No	N/A	Yes %
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? (6.001) *	4	21	0	16.0%
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? (6.002)	25	0	0	100%
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? (6.003) *	14	10	1	58.3%
For patients transferred out of the facility: Do medication transfer packages include required medications along with the corresponding transfer packet required documents? (6.101) *	5	1	0	83.3%
				Overall percentage (MIT 6): **64.4%**

* The OIG clinicians considered these compliance tests along with their case review findings when determining the quality rating for this indicator.

Source: The Office of the Inspector General medical inspection results.

Table 13. Other Tests Related to Transfers

	Scored Answer			
Compliance Questions	**Yes**	**No**	**N/A**	**Yes %**
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? (1.002) *	8	17	0	32.0%
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? (1.007) *	9	2	0	81.8%
Are community hospital discharge documents scanned into the patient's electronic health record within three calendar days of hospital discharge? (4.003) *	11	0	0	100%
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? (4.005) *	11	0	0	100%
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? (7.003) *	6	5	0	54.6%
Upon the patient's transfer from one housing unit to another: Were medications continued without interruption? (7.005) *	17	8	0	68.0%
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? (7.006) *	5	5	0	50.0%
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? (14.010) *	7	13	0	35.0%

* The OIG clinicians considered these compliance tests along with their case review findings when determining the quality rating for this indicator.

Source: The Office of the Inspector General medical inspection results.

Recommendations

- The department should consider developing and implementing measures to ensure that receiving and release (R&R) nursing staff properly complete the initial health screening questions and that providers see patients face-to-face in the required time frames.

- Nursing leadership should consider developing and implementing measures to ensure that discharge summary recommendations are reviewed and addressed by nurses and providers.

- Nursing leadership should remind nursing staff to document complete vital signs as part of the patient's initial health screening assessment.

Medication Management

Overall Rating
Inadequate

Case Review Rating
Inadequate

Compliance Score
Inadequate
(63.1%)

In this indicator, OIG inspectors evaluated the institution's performance in administering prescription medications on time and without interruption. The inspectors examined this process from the time a provider prescribed medication until the nurse administered the medication to the patient. When rating this indicator, the OIG strongly considered the compliance test results, which tested medication processes to a much greater degree than case review testing. In addition to examining medication administration, our compliance inspectors also tested many other processes, including medication handling, storage, error reporting, and other pharmacy processes.

Results Overview

SAC performed poorly in this indicator. Compared with Cycle 5, the institution's performance in medication administration and continuity had declined even though there were fewer deficiencies in case review. In this Cycle, compliance testing showed that SAC had room for improvement in the following medications processes: new medication prescriptions, chronic medication continuity, hospital discharge medication, specialized medical housing medication, and transfer medication. We rated this indicator ***inadequate.***

Case Review and Compliance Testing Results

We reviewed 169 medication events in 39 cases related to medications and found 22 medication deficiencies, three of which were significant.[40]

New Medication Prescriptions

Compliance testing showed that new medications were available and administered at a rate of 68.0 percent (MIT 7.002). In contrast, our clinicians found that patients received newly prescribed medication timely. We reviewed 134 new medication orders and found three deficiencies in three cases.[41]

Chronic Medication Continuity

Compliance testing produced low scores for chronic care medication continuity (MIT 7.001, 15.8%). In contrast, our clinicians found that most chronic care medications were administered timely.

[40] Deficiencies occurred in cases 1, 4, 8, 10, 12, 15, 16, 17, 18, 21, 26, 29, and 66. Significant deficiencies occurred in cases 10 and 16.

[41] Deficiencies occurred in cases 4, 8, and 10.

Hospital Discharge Medications

Compliance testing showed that when patients returned from a hospital admission or emergency room visit, the patients did not receive their medications within the required time frame (MIT 7.003, 54.6%). Our clinicians reviewed 16 hospital returns and found three deficiencies related to medication management, two of which were significant.[42] The following is an example:

- In case 10, the diabetic patient returned from a hospitalization after receiving extensive wound care. The hospitalist recommended that the patient's long-acting insulin dose be increased from once a day to twice a day. However, the recommended insulin dosage was not ordered.

Specialized Medical Housing Medications

Compliance testing revealed that when patients were admitted to the correctional treatment center (CTC), they did not receive their medications within the required time frame (MIT 13.004, 50.0%). Our clinicians found that patients mostly received their medications in the CTC without interruption. We found two deficiencies in two cases.[43] An example follows:

- In case 1, the patient did not receive the cholesterol, blood pressure, and diabetes medications on multiple occasions during the month.

Transfer Medications

Compliance testing showed that SAC did not perform well for patients transferring into the institution (MIT 6.003, 58.3%). In contrast, our clinicians found that there were no lapses in medication continuity for patients who transferred into the institution.

For transfer-out patients, compliance testing showed that the institution performed well in ensuring that transfer packets included transfer medication (MIT 6.101, 83.3%). However, our clinicians identified a pattern of poor documentation and of chronic medication's not transferring with the patient.[44] Examples are listed below:

- In case 31, the patient did not transfer with KOP medication.
- In cases 33, the transfer nurse did not document whether the patient transferred with medication.

[42] Deficiencies occurred in case 10.

[43] Deficiencies occurred in cases 1 and 10.

[44] Deficiencies occurred in cases 31, 33, and 67. A significant deficiency occurred in case 67.

- In case 67, prior to transfer, the patient did not receive essential evening medications for hypertension, cholesterol, and gastrointestinal reflux disease.

Compliance testing also showed that the institution did not perform well in medication continuity when patients transferred between housing units (MIT 7.005, 68.0%).

Medication Administration

Compliance testing showed that nurses were sufficient in administering prescribed tuberculosis (TB) medications at a rate of 80.0 percent (MIT 9.001). Also, our clinicians found that most nurses administered medication properly, except insulin. The medication nurses struggled with administering insulin timely, inquiring about signs and symptoms when the patient's blood sugar was abnormally low or elevated, and notifying the provider of abnormal findings. See **Nursing Performance** indicator for detailed information.

Clinician On-Site Inspection

Our clinicians interviewed medication nurses and found them to be knowledgeable about the medication process. The medication nurses reported that the clinic provider was called during business hours for blood sugars greater than 400 mg/dl, and the on-call provider was called after hours. They also reported that patients with abnormally elevated blood sugars are transported to the TTA and that at times, custody staff preferred the person to walk.

Compliance Testing Results

Medication Practices and Storage Controls

The institution adequately stored and secured narcotic medications in all applicable clinic and medication line locations (MIT 7.101, 100%).

SAC appropriately stored and secured nonnarcotic medications in five of 13 clinic and medication line locations (MIT 7.102, 38.5%). In eight locations, we observed one or more of the following deficiencies: medications with expired pharmacy labels were stored in the clinic and were not placed in the designated return-to-pharmacy bin; the crash cart log had incomplete staff security check entries; open over-the-counter (OTC) medications were stored in the staff's drawer; the medication storage cabinet was disorganized; and the medication area lacked a clearly labeled designated area for nonrefrigerated and refrigerated medications that were to be returned to the pharmacy.

Staff kept medications protected from physical, chemical, and temperature contamination in six of the 13 clinic and medication line locations (MIT 7.103, 46.2%). In seven locations, we observed one or more of the following deficiencies: staff did not record or did not consistently

record the room or refrigerator temperatures; the medication refrigerator was unsanitary; staff's personal food items were stored in the medication room cabinet area; medication was not stored within the correct temperature range; medications were stored with household items and disinfectant; and staff did not separate the storage of oral and topical medications.

Staff successfully stored valid, unexpired medications in five of the 13 applicable medication line locations (MIT 7.104, 38.5%). In eight locations, medication nurses failed to label the multiuse medication as required by CCHCS policy. In one of the eight locations, medication was stored past the staff-labeled beyond-use date.

Nurses exercised proper hand hygiene and contamination control protocols in six of eight locations (MIT 7.105, 75.0%). In two locations, we observed one or both of the following deficiencies: nurses neglected to wash or sanitize their hands before initially putting on gloves and before each subsequent regloving.

Staff in seven of eight medication preparation and administration areas demonstrated appropriate administrative controls and protocols (MIT 7.106, 87.5%). In one location, medication nurses did not maintain nonissued medication in its original labeled packaging.

Staff in five of eight medication areas used appropriate administrative controls and protocols when distributing medications to their patients (MIT 7.107, 62.5%). In three locations, we observed one or more of the following deficiencies: medication nurses did not reliably observe patients while they swallowed direct observation therapy medications; medication nurses did not appropriately administer medication as ordered by the provider; medication nurses did not consistently verify patient identification by using a picture form of identification; and nurses did not follow insulin protocols properly. While observing insulin administration, we noted that some medication nurses did not properly disinfect the vial's port prior to withdrawing medication.

Pharmacy Protocols

SAC followed general security, organization, and cleanliness management protocols for nonrefrigerated and refrigerated medications stored in its pharmacy (MITs 7.108, 7.109, and 7.110, 100%).

The pharmacist-in-charge (PIC) did not correctly account for narcotic medications stored in SAC's pharmacy. The PIC did not perform monthly inventories of controlled substances in the institution's clinic and medication storage locations from June 2021 to December 2021. In addition, the PIC did not correctly complete several medication area inspection checklists (CDCR Form 7477) and neglected to sign, date, and print his name on several inventory records. These errors resulted in a score of zero in this test (MIT 7.111).

We examined 25 medication error reports. For eight reports, the PIC was not able to provide evidence that a pharmacy error follow-up review was

performed. As a result, SAC received a score of 68.0 percent in this test (MIT 7.112).

Nonscored Tests

In addition to testing the institution's self-reported medication errors, our inspectors also followed up on any significant medication errors found during compliance testing. We did not score this test; we provide these results for informational purposes only. At SAC, we did not find any applicable medication errors (MIT 7.998).

We interviewed patients in isolation units to determine whether they had immediate access to their prescribed asthma rescue inhalers or nitroglycerin medications. Of 40 applicable patients, 38 interviewed indicated they had access to their rescue medications (MIT 7.999). The remaining two patients verbalized that the medications was taken away and placed in their property when they transferred to the restrictive housing unit. We promptly notified the CEO of this concern, and health care management immediately issued a replacement rescue medication to the patients.

Compliance Testing Results

Table 14. Medication Management

Compliance Questions	Scored Answer Yes	No	N/A	Yes %
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? (7.001) *	3	16	6	15.8%
Did health care staff administer, make available, or deliver new order prescription medications to the patient within the required time frames? (7.002)	17	8	0	68.0%
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? (7.003) *	6	5	0	54.6%
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? (7.004) *	N/A	N/A	N/A	N/A
Upon the patient's transfer from one housing unit to another: Were medications continued without interruption? (7.005) *	17	8	0	68.0%
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? (7.006) *	5	5	0	50.0%
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? (7.101)	12	0	2	100%
All clinical and medication line storage areas for nonnarcotic medications: Does the institution properly secure and store nonnarcotic medications in the assigned storage areas? (7.102)	5	8	1	38.5%
All clinical and medication line storage areas for nonnarcotic medications: Does the institution keep nonnarcotic medication storage locations free of contamination in the assigned storage areas? (7.103)	6	7	1	46.2%
All clinical and medication line storage areas for nonnarcotic medications: Does the institution safely store nonnarcotic medications that have yet to expire in the assigned storage areas? (7.104)	5	8	1	38.5%
Medication preparation and administration areas: Do nursing staff employ and follow hand hygiene contamination control protocols during medication preparation and medication administration processes? (7.105)	6	2	6	75.0%
Medication preparation and administration areas: Does the institution employ appropriate administrative controls and protocols when *preparing* medications for patients? (7.106)	7	1	6	87.5%
Medication preparation and administration areas: Does the institution employ appropriate administrative controls and protocols when *administering* medications to patients? (7.107)	5	3	6	62.5%
Pharmacy: Does the institution employ and follow general security, organization, and cleanliness management protocols in its main and remote pharmacies? (7.108)	1	0	0	100%
Pharmacy: Does the institution's pharmacy properly store nonrefrigerated medications? (7.109)	1	0	0	100%
Pharmacy: Does the institution's pharmacy properly store refrigerated or frozen medications? (7.110)	1	0	0	100%
Pharmacy: Does the institution's pharmacy properly account for narcotic medications? (7.111)	0	1	0	0
Pharmacy: Does the institution follow key medication error reporting protocols? (7.112)	17	8	0	68.0%
Pharmacy: For Information Purposes Only: During compliance testing, did the OIG find that medication errors were properly identified and reported by the institution? (7.998)	This is a nonscored test. Please see the indicator for discussion of this test.			
Pharmacy: For Information Purposes Only: Do patients in restricted housing units have immediate access to their KOP prescribed rescue inhalers and nitroglycerin medications? (7.999)	This is a nonscored test. Please see the indicator for discussion of this test.			
				Overall percentage (MIT 7): **63.1%**

* The OIG clinicians considered these compliance tests along with their case review findings when determining the quality rating for this indicator.

Source: The Office of the Inspector General medical inspection results.

Table 15. Other Tests Related to Medication Management

	Scored Answer			
Compliance Questions	**Yes**	**No**	**N/A**	**Yes %**
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? (6.003) *	14	10	1	58.3%
For patients transferred out of the facility: Do medication transfer packages include required medications along with the corresponding transfer-packet required documents? (6.101) *	5	1	0	83.3%
Patients prescribed TB medication: Did the institution administer the medication to the patient as prescribed? (9.001) *	4	1	0	80.0%
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? (9.002) *	0	5	0	0
Upon the patient's admission to specialized medical housing: Were all medications ordered, made available, and administered to the patient within required time frames? (13.004) *	1	1	0	50.0%

* The OIG clinicians considered these compliance tests along with their case review findings when determining the quality rating for this indicator.

Source: The Office of the Inspector General medical inspection results.

Recommendations

- The institution should consider developing and implementing measures to ensure that staff timely make medication available to the patients and that staff administer medications within the specified time frames.

- Nursing leadership should educate nursing staff on the proper documentation of medication refusal in the patient's medication administration record, as described in CCHCS policy.

Preventive Services

In this indicator, OIG compliance inspectors tested whether the institution offered or provided cancer screenings, tuberculosis (TB) screenings, influenza vaccines, and other immunizations. If the department designated the institution as at high risk for coccidioidomycosis (valley fever), we tested the institution's performance in transferring out patients quickly. The OIG rated this indicator solely according to the compliance score, using the same scoring thresholds used in the Cycle 4 and Cycle 5 medical inspections. Our case review clinicians do not rate this indicator.

Overall Rating
Adequate

Case Review Rating
(N/A)

Compliance Score
Adequate
(75.7%)

Results Overview

SAC performed adequately in administering TB medications to patients, screening patients annually for TB, offering patients an influenza vaccine for the most recent influenza season, offering colorectal cancer screening for patients from ages 45 through 75, and offering required immunizations to chronic care patients. However, SAC did not monitor patients taking prescribed TB medications, which is not in accordance with CCHCS policy. We rated this indicator ***adequate***.

Compliance Testing Results

Table 16. Preventive Services

Compliance Questions	Scored Answer			
	Yes	No	N/A	Yes %
Patients prescribed TB medication: Did the institution administer the medication to the patient as prescribed? (9.001)	4	1	0	80.0%
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? (9.002) †	0	5	0	0
Annual TB screening: Was the patient screened for TB within the last year? (9.003)	23	2	0	92.0%
Were all patients offered an influenza vaccination for the most recent influenza season? (9.004)	25	0	0	100%
All patients from the age of 45 through the age of 75: Was the patient offered colorectal cancer screening? (9.005)	23	2	0	92.0%
Female patients from the age of 50 through the age of 74: Was the patient offered a mammogram in compliance with policy? (9.006)	N/A	N/A	N/A	N/A
Female patients from the age of 21 through the age of 65: Was patient offered a pap smear in compliance with policy? (9.007)	N/A	N/A	N/A	N/A
Are required immunizations being offered for chronic care patients? (9.008)	18	2	5	90.0%
Are patients at the highest risk of coccidioidomycosis (valley fever) infection transferred out of the facility in a timely manner? (9.009)	N/A	N/A	N/A	N/A
Overall percentage (MIT 9): **75.7%**				

* The OIG clinicians considered these compliance tests along with their case review findings when determining the quality rating for this indicator.

† In April 2020, after our review but before this report was published, CCHCS reported adding the symptom of *fatigue* into the electronic health record system (EHRS) PowerForm for tuberculosis (TB)-symptom monitoring.

Source: The Office of the Inspector General medical inspection results.

Recommendations

- Nursing leadership and the public health nurse should educate nursing staff on properly documenting the tuberculosis (TB) signs and symptoms when monitoring patients taking TB medications.

Nursing Performance

Overall Rating
Inadequate

Case Review Rating
Inadequate

Compliance Score
(N/A)

In this indicator, the OIG clinicians evaluated the quality of care delivered by the institution's nurses, including registered nurses (RNs), licensed vocational nurses (LVNs), psychiatric technicians (PTs), and certified nursing assistants (CNAs). Our clinicians evaluated nurses' performance in making timely and appropriate assessments and interventions We also evaluated the institution's nurses' performance in many clinical settings and processes, including sick call, outpatient care, care coordinating and management, emergency services, specialized medical housing, hospitalizations, transfers, specialty services, and medication management. The OIG assessed nursing care through case review only and performed no compliance testing for this indicator.

When summarizing overall nursing performance, our clinicians understand that nurses perform numerous aspects of medical care. As such, specific nursing quality issues are discussed in other indicators, such as **Emergency Services**, **Specialty Services**, and **Specialized Medical Housing**.

Results Overview

Nursing care was poor overall. Compared with their performance in Cycle 5, SAC nurses improved in timely assessing patients with urgent symptoms in most cases and in documenting patient care. However, nurses continued to struggle in some areas such as not performing complete assessments, not timely notifying providers of patients with urgent symptoms, and not intervening appropriately. Also, the nurses did not always make good clinical judgements regarding the management of diabetic patients with abnormal blood sugars. After careful consideration, we rated this indicator ***inadequate***.

Case Review Results

We reviewed 278 nursing encounters in 65 cases. Of the nursing encounters we reviewed, 209 were in the outpatient setting. We identified 161 nursing performance deficiencies, 35 of which were significant.[45]

Nursing Assessment and Interventions

A critical component of nursing care is the quality of nursing assessment, which includes elements that are subjective (patient interview) and those that are objective (observation and examination). SAC nurses generally provided poor nursing assessments and interventions. Our clinicians identified trends in incomplete nursing

[45] Deficiencies occurred in cases 1–3, 7, 8, 10–12, 14, 17–24, 27, 29-30, 32, 33, 34, 36, 37–46, 48, 49, 51–54, 57–62, and 65–67. Significant deficiencies occurred in cases 1, 10–12, 21, 23, 24, 43, 54, 59, 61, and 66.

assessments and in urgent symptomatic sick call requests that were not triaged for same-day evaluations. The following are examples:

- In case 1, the clinic nurse saw a diabetic patient for a toenail that fell off. The nurse did not perform a complete assessment on the affected toe and did not notify the provider.

- In case 11, the nurse administered nitroglycerin for chest pain. However, the nurse did not reassess the patient's symptoms within five minutes, did not perform the EKG, and did not directly contact the provider.

- In case 21, on multiple occasions, the nurses saw the diabetic patient with hypertension. The patient's blood pressure was frequently elevated, but the nurses did not perform an objective cardiac assessment. Also, the patient was seen for medication noncompliance for multiple chronic conditions; however, the nurse did not take vital signs at the appointment.

- In case 54, the patient complained of a rash in the buttock area. The nurse instructed the patient to notify nursing if the rash became worse. However, the nurse did not examine the patient for the presence of a rash.

Nursing Documentation

Complete and accurate nursing documentation is an essential component of patient care. SAC nurses generally documented their care appropriately.

Nursing Sick Call

Our clinicians reviewed 54 sick call requests. The nurses reported that an average of 10 patients were seen a day, and clinic staff did not report any nursing backlog. Our clinicians identified 23 deficiencies, three of which were significant.[46] Most nurses performed appropriate assessments and interventions; however, case review clinicians identified opportunities for improvement in the following examples:

- In case 7, the sick call nurse did not schedule a same day appointment for urgent symptoms for the diabetic patient complaining of a urinary tract infection.

- In case 11, the patient submitted a sick call request for complaints of nasal discharge with loss of smell and taste. The sick call nurse did not evaluate the patient the same day to rule out COVID-19. Instead, the nurse evaluated the patient the following business day. The patient did not receive a COVID-19 test until 10 hours later. In addition, the nurse did not place the

[46] Deficiencies occurred in cases 11, 21, 23, 24, 43, 54, 59, and 61. Significant deficiencies occurred in cases 11, 23, 24, and 61.

patient in isolation, despite his having multiple COVID-19 symptoms.

- In case 24, the patient had difficulty walking and had increased pain due to excess fluid in the scrotum. The sick call nurse reviewed this symptomatic sick call request but did not place an order for the patient to be seen within one business day. The patient was seen 14 days later.

- In case 61, the sick call nurse reviewed a sick call request for the patient complaining of blackouts and a major headache. The nurse called the patient in to provide an excused absence from required duties but did not perform an assessment until the following day.

Chronic Care

We reviewed 14 cases in which nurses saw the patients for chronic care appointments. SAC nurses were proactive in offering preventive health screenings, reoffering vaccines and preventative screening tests that patients initially refused, providing patient education for medication noncompliance and laboratory test refusals, and offering chronic care appointments for conditions such as diabetes and Hepatitis C. However, we found that nurses often performed incomplete nursing assessments:

- In cases 2 and 20, the patients were seen multiple times for medication noncompliance education. However, the chronic care nurses did not review the patients' medication compliance.

- In case 21, the patient was noncompliant with blood pressure medication. The patient was scheduled often for follow-up appointments to discuss medication noncompliance. On multiple occasions, the chronic care nurse did not take the patient's vital signs, including blood pressure. Also, on multiple appointments for blood pressure checks, the chronic care nurse did not perform thorough cardiovascular assessments when the patient's blood pressure was elevated.

Wound Care

We reviewed seven cases in which wound care was provided to patients. Our clinicians identified seven deficiencies, including one significant deficiency.[47] The nurses frequently provided satisfactory wound care. However, opportunities for improvement were identified in the lack of education provided to the patient on wound care ordered and, in two cases, wound care that was not completed as ordered.

[47] Nurses provided wound care in cases 10, 18, 20, 23, 24, 26, and 27. Deficiencies occurred in cases 10, 23, and 24. A significant deficiency occurred in case 24.

Emergency Services

Our clinicians reviewed 28 urgent or emergent events and identified 21 nursing deficiencies, eight of which were significant. Assessments and interventions showed room for improvement, which we detail further in the **Emergency Services** indicator.

Hospital Returns

Our clinicians reviewed 16 cases in which patients returned from hospitalizations or emergency room visits. We identified four nursing deficiencies, including one significant deficiency.[48] Nurses provided appropriate assessments and interventions in most cases. We identified opportunities for improvement in nurses' not providing necessary information to the on-call provider regarding hospital recommendations. This is detailed further in the **Transfers** indicator.

Transfers

Our clinicians reviewed nine cases that involved the transfer-in and transfer-out processes. We identified assessment and intervention deficiencies in five cases; none of the deficiencies were significant. However, we also identified incomplete vital signs when patients are transferring into and out of the institution and a lack of notification to the receiving facility regarding pending specialty appointments. This is detailed further in the **Transfers** indicator.

Specialized Medical Housing

We reviewed four cases with a total of 29 nursing events We identified 17 nursing deficiencies, four of which were significant.[49] CTC nurses performed satisfactory assessments. However, we identified opportunities for improvement in assessment of and intervention for wound care. This is detailed further in the **Specialized Medical Housing** indicator.

Specialty Services

We reviewed five cases in which patients returned from off-site specialty appointments. The patients frequently refused assessments, and we identified only one deficiency, when the nurse did not perform a COVID-19 screening after the patient returned from an off-site specialty appointment.

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[48] Deficiencies occurred in cases 10, 23, and 24. A significant deficiency occurred in case 23.

[49] Deficiencies occurred in cases 1, 10, 66, and 67. Significant deficiencies occurred in cases 1, 10, and 66.

Medication Management

We reviewed 39 cases. Five cases involved the medication administration of insulin. In the five cases, we found eleven deficiencies, including four significant deficiencies.[50] The nurses often did not ensure that patients were assessed for symptoms of hyperglycemia or hypoglycemia and often did not timely notify providers of abnormal blood sugar readings.

- In case 8, the medication nurse obtained an abnormally elevated blood sugar reading. In two instances, the nurses did not ask whether the patient was experiencing symptoms of an abnormally elevated blood sugar and did not notify the provider of the abnormal finding.

- In case 10, the medication nurse obtained an abnormally elevated blood sugar reading on an asymptomatic patient. The nurse messaged the provider of the abnormal finding instead of calling the provider to obtain orders for a plan of care. The nurse also did not recheck the patient's blood sugar. On a later date, a nurse obtained an abnormally elevated blood sugar reading when the patient reported to the medication line for blood sugar check and medication administration. The nurse did not recognize that the patient was exhibiting signs and symptoms of an elevated blood sugar and delayed calling the provider for 50 minutes.

- In case 17, the patient refused insulin on multiple occasions over a two-month period and asserted that custody staff was intimidating him. The clinic nurses did not elevate the patient's concern to nursing supervisors. Instead, the nurses continued to document that the custody issue had been addressed.

Clinician On-Site Inspection

Our clinicians spoke with nurses and nurse managers in the TTA, CTC, R&R, specialty clinics, outpatient clinics, and medication areas. Nursing staff reported that morale was mixed.

We discussed with nursing leadership the deficiencies our case review had revealed. We mentioned health care staff review specialty and hospitalization reports before they are scanned into the electronic health record system. Our clinicians discussed medication cases with the chief nursing executive (CNE). The CNE reported that when nurses manually enter a medication into the medication administration record instead of scanning the medication administered, the process bypasses any patient safety alert prompts. The consequences of not scanning the medications include the possibility that the patients may receive incorrect doses or incorrect times. In addition, when medications are manually entered, the system does not generate a medication error report for nursing leadership, resulting in a lack of awareness of potential patient safety issues. Also, the TTA nursing supervisor reported that when medication

[50] Deficiencies occurred in cases 8, 10, and 17. Significant deficiencies occurred in case 10.

nurses obtain abnormal values, the expectation is that the LVN or PT will call the provider. If the patient requires further evaluation, the medication nurse arranges to have the patient escorted to TTA. Nursing leadership addressed our findings and acknowledged several opportunities for improvement. Nursing leaders reported they will implement work groups to correct these gaps in patient care.

Recommendations

- Nursing leadership should ensure that nurses perform more detailed assessments and interventions during patient appointments, and leadership should consider implementing corrective action plans.

- Nursing leadership should review the nursing intervention process for diabetic patients with abnormal blood sugar readings and should implement a process to ensure that patients receive appropriate assessments and interventions.

Provider Performance

Overall Rating
Inadequate

Case Review Rating
Inadequate

Compliance Score
(N/A)

In this indicator, OIG case review clinicians evaluated the quality of care delivered by the institution's providers: physicians, physician assistants, and nurse practitioners. Our clinicians assessed the providers' performance in evaluating, diagnosing, and managing their patients properly. We examined provider performance across several clinical settings and programs, including sick call, emergency services, outpatient care, chronic care, specialty services, intake, transfers, hospitalizations, and specialized medical housing. We assessed provider care through case review only and performed no compliance testing for this indicator.

Results Overview

As they did in Cycle 5, SAC providers performed poorly. In this Cycle, their poor performance was primarily due to poor assessment and poor decision-making regarding patients' medical issues as well as inappropriate deferrals of patient appointments. Providers did not always timely see hospital, transfer, and clinic patients. Providers sometimes did not address abnormal vital signs; provider continuity was poor; and documentation was frequently missing in on-call and co-consult provider progress notes. On the positive side, providers referred patients to the appropriate specialists within appropriate time frames and reviewed diagnostic studies timely. Overall, we rated the **Provider Performance** indicator as ***inadequate.***

Case Review Results

In our inspection, we reviewed a total of 132 provider encounters, including outpatient care, specialty care, and emergency care, and we found a total of 84 deficiencies. Of these, 35 were significant. In addition, our clinicians examined the care quality in 25 comprehensive case reviews. Of these 25 cases, none were proficient, 19 were adequate, and six were inadequate.[51]

Assessment and Decision-Making

Some providers made good assessments and sound decisions; however, others did not. Examples include the following:

- In case 19, the patient had deep venous thrombosis (DVT), for which the hematologist did not recommend any further prophylactic treatment. The provider saw the patient to discuss the hematology eConsult and started the patient on aspirin.[52]

[51] Deficiencies occurred in cases 1, 2, 4, 6–12, 16–19, 21–27, 38, 53, and 66. Significant deficiencies occurred in cases 1, 2, 4, 6, 10, 11, 17, 18, 19, 21, 23, 24, and 66.

[52] eConsult is an electronic specialty consulting service whereby providers can inquire of specialists about medical questions and receive advice and recommendations for patient care.

Aspirin is not a prophylactic for DVT. The provider did not document the medical reasoning for prescribing aspirin. Also, the patient had a slow pulse, which the provider did not address.

- In case 24, the patient underwent a hydrocelectomy with placement of a postsurgical drain in the left scrotal hydrocele.[53] The night of the surgery, the drain fell out. The next day, the RN saw the patient and contacted the provider, who ordered a catheter as a replacement for the postsurgical drain; however, the provider did not document this replacement in a progress note. The next day, the nurse again saw the patient and reported that the drain, due to be removed that day, had fallen out on its own. The provider saw the patient and, even though the surgeon recommended drain removal that day, recommended that the patient continue with catheter replacement at least every other day and that provider be notified of any new or worsening symptoms. The provider instructed the patient to reinsert the catheter himself, and for a much longer duration than the surgeon had recommended. Postsurgical drain replacement should be performed by trained medical staff in a clean environment and the drain should not be retained in the body any longer than necessary to avoid infection or injury.

- In case 66, the patient was hospitalized for an acute, severe allergic reaction. The hospitalist recommended a specific prednisone taper dose; however, the provider placed the patient on a much lower dose.[54] The lower dose increased the risk of allergic reaction recurrence, respiratory failure, and repeat hospitalization. Three days later, the patient was hospitalized with acute respiratory failure and remained hospitalized for seven days.

Our clinicians identified a pattern of providers' making poor decisions about deferring medically necessary provider appointments, including intrafacility transfers, hospital returns, and quarantine patients. Examples of significant deficiencies include the following:

- In case 6, the provider documented an interfacility transfer medical appointment on a new medical high-risk patient as having been completed, even though the patient was not seen. The patient was not seen by a provider for nearly one month after transferring to the institution.

- In case 11, when a patient with COPD who complained of orthopnea[55] was due for his provider appointment, the provider chose to not see the patient because the patient was in quarantine. Fifty days after that appointment was due, the

[53] A hydrocelectomy is a surgical procedure to repair fluid buildup around a testicle.

[54] Prednisone is a steroid medication used to reduce swelling and inflammation in allergic reactions.

[55] COPD is chronic obstructive lung disease. Orthopnea is shortness of breath that occurs while lying down. This can be a symptom of heart failure.

provider documented the appointment as completed. In addition, the provider noted that the patient had a chronic care appointment scheduled for 28 days later, and that the complaint could be addressed at that time. The provider should have seen the patient initially when the patient had orthopnea.

- In case 24, the patient complained of severe scrotal pain and swelling 12 days postoperatively. The nurse contacted the on-call provider for treatment. The provider ordered pain medication for the patient's symptoms but did not order any provider evaluation of the patient's symptoms.

We also identified a pattern of providers not addressing abnormal vital signs. Examples include the following:

- In case 2, on three separate occasions during a three-week period, the provider did not address the patient's abnormally elevated heart rate.

- In case 19, the provider performed a chart review in lieu of a scheduled telemedicine patient appointment because the appointment ended early. The patient's heart rate was abnormally slow; the provider documented this abnormality but did not address it. Furthermore, the provider closed the appointment as "completed" even though the patient was not seen by the provider. The provider reordered this appointment to occur two weeks later, which was a delay in care.

- In case 21, the nurse saw the patient for a blood pressure check and called the provider for critically elevated blood pressures. In this patient with a known history of cardiac risk factors, the provider should have delivered timely treatment, evaluated the patient the same day, or sent the patient to TTA.

Review of Records

Most providers often reviewed medical records carefully; however, a few opportunities for improvement were identified.[56] Case reviewers did not identify any significant deficiencies.

Emergency Care

SAC providers usually managed patients in the TTA with urgent or emergent conditions appropriately. Of 31 TTA/emergent events, eight provider performance deficiencies were identified, with three considered significant:[57]

[56] Deficiencies occurred in cases 4, 7, 10, and 21.

[57] Deficiencies occurred in cases 3, 10-12, and 21–23. Significant deficiencies occurred in cases 10, 11, and 23.

- In case 10, the provider was notified that ambulance transport for the patient suspected of diabetic ketoacidosis (DKA) would be delayed 90 minutes.[58] The EKG was abnormal, showing life-threatening signs from the effects of the DKA. The provider did not order a higher-level code transport, thereby placing the patient's health at further risk.

- In case 11, the patient with history of severe COPD presented in the TTA with respiratory distress and hypotension, but the TTA on-call provider did not consider short-acting bronchodilator treatment, nor did he provide intravenous fluids for the hypotensive patient. Both are standard of care and could have improved the patient's condition.

- In case 23, the provider saw a patient with a right arm infection and documented a concern for necrotizing fasciitis or compartment syndrome, both of which are medical emergencies.[59] The provider sent the patient to the hospital via state car rather than the more expedited transport with medical support available. The provider did not take a thorough medical history or perform a complete physical exam.

Chronic Care

Some providers managed their patient's chronic medical conditions well, while others did not. Examples of deficiencies related to chronic care include the following:

- In case 4, the provider cancelled an order for a chronic care appointment on a high-risk medical patient, whose last chronic care face-to-face provider appointment had occurred over 16 months earlier. During this 16-month period, the patient's chronic care appointment was deferred several times and was documented as completed, even though the patient was not seen. The patient should have been seen by his provider.

- In case 10, the nurse messaged the provider that the patient had many critically high blood sugar readings and that the patient stated he has diabetic ketoacidosis (DKA). The provider did not see the patient but rather made a minor adjustment to the patient's insulin. The provider should have seen and evaluated the patient and initiated an appropriate treatment plan. A few days later, the patient was sent to the hospital for DKA. The hospitalization could have been avoidable.

- In case 11, the provider documented that a patient had coarse breath sounds on examination and complained of shortness of

[58] Diabetic ketoacidosis is a life-threatening medical condition that requires emergent medical treatment in a closely monitored hospital setting.

[59] Necrotizing fasciitis is bacterial infection of the soft tissue that can spread rapidly, leading to a potentially fatal infection. Compartment syndrome is a medical condition in which increased pressure in muscles cause pain and damage to the tissues and nerves.

breath at night. The patient had COPD, but did not have a short-acting bronchodilator (SABA) to use in the event of an emergency. The provider did not order the SABA, which is standard of care. Twenty-six days later, the patient was sent to the hospital for an acute COPD exacerbation. Three days after hospitalization, the provider again saw the patient, but again, the provider did not order the short-acting bronchodilator. A SABA could have been lifesaving.

Specialty Services

SAC providers appropriately referred patients for specialty consultation when needed and reviewed the specialist recommendations thoroughly to implement specialty recommendations. Eye specialist appointments were not endorsed by the providers. We discuss providers' specialty performance further in the **Specialty Services** indicator.

Documentation Quality

Our clinicians noted a pattern of providers' not documenting on-call progress notes or providers' writing clinic progress notes without documenting the medical reasoning for their decision-making. [60] Examples include the following:

- In case 19, the provider started the patient on a treatment for history of deep venous thrombosis (DVT) that is not community standard, and the provider did not document the reason this treatment path was selected.

- In case 24, the nurse contacted the on-call provider for the patient's severe scrotal pain and swelling 12 days postoperatively. The provider only ordered pain medication without provider evaluation or sending the patient to a higher level of care, and the provider did not write an on-call progress note documenting the medical decision-making.

- In case 66, when the patient returned from the hospital for a severe allergic reaction, the provider placed the patient on a steroid dosage less than recommended by the hospital and did not write an on-call progress note documenting the medical decision-making. The patient's symptoms worsened, and he was hospitalized again three days later.

Provider Continuity

Generally, the institution offered poor provider continuity. Of 25 detailed cases our clinicians reviewed, seven cases had provider continuity deficiencies and two deficiencies were considered significant.[61] One

[60] Deficiencies occurred in cases 1, 4, 11, 17–19, 22, 23, 24, 26, 27, and 66.

[61] Provider continuity deficiencies occurred in cases 4, 9, 17, 18, 24, 25, and 27. Significant deficiencies occurred in cases 4 and 17.

provider frequently placed orders or cancelled or rescheduled patient appointments for patients that the provider had never seen.

Clinician On-Site Inspection

Our clinicians met with SAC medical leadership, with providers, and with nursing, scheduling, and custody staff. Executive leadership reported that SAC was fully staffed during the review period, but that one provider frequently called in sick. Medical leadership and providers stated there was difficulty retaining staff, noting they had lost three providers.

The providers reported that physician morale was low due to a high rate of physician turnover, difficult call shifts, coverage of other providers' clinics, and a population with a high rate of litigation. Several providers also complained that specialty referrals were difficult to obtain after the approval process was moved to headquarters. The leadership added that SAC has one of the most difficult patient populations, with a high rate of significantly mentally ill patients and a high rate of inmate attacks on staff.

Several of the providers reported that on-call duty is unusually rigorous, not only because of the difficult population at SAC but also because nursing runs primary care RN clinics on the weekends and evenings when the on-site providers are not available, requiring nursing to contact the on-call physicians for orders. Providers stated that at times documentation was poor because they received so many calls that it was not possible to document them all in the electronic health record system when returning to work the next day or after a weekend. Leadership reported that they expected providers to write progress notes on all significant patient medical encounters and to at least review and cosign TTA progress notes. There was no clear definition of what was considered significant. We identified on case review that there were several missing provider on-call progress notes without TTA RN progress notes cosigned by a provider.

Custody reported that SAC was in Phase 3 throughout the case review period, which extended from May 1 to October 31, 2021. [62]

SAC providers were not restricted by policy to urgent or emergent appointments, yet patient provider appointments were frequently cancelled or rescheduled and often not by a provider familiar with the patient. It is standard medical practice that providers see patients for their scheduled appointments, face-to-face. We searched for extenuating circumstances that might make it appropriate for providers to cancel scheduled appointments and perform chart reviews in lieu of face-to-face appointments, but we did not find any. There were no COVID-19 outbreaks during the review period, no shortage of PPE, and medical and custody staff both confirmed there was never a shortage of health care

[62] Phase 3 is the Open Phase (New Normal). https://www.cdcr.ca.gov/covid19/reopening/.

custody staff to transport patients to the clinic or supervise patients while in the clinic.

Prior to receiving the Phase information from custody, the chief medical executive (CME) and the chief physician and surgeon (CP&S) stated that due to the pandemic, they instructed providers to see only urgent or emergent appointments. If an appointment was not urgent or emergent, the providers could use their own discretion to see the patient at the appointment or complete the appointment by chart review without seeing the patient. If a provider decided to perform a chart review instead of seeing the patient, the provider was instructed to generate a patient letter, close the existing appointment, and order a follow-up appointment, if needed. Our clinicians saw many chart reviews, but only rarely saw associated letters to patients discussing the care determined by chart review.

The CME and CP&S stated they also requested a telemedicine provider to review the provider appointment backlog, review the patients' charts, and cancel or reschedule patient appointments. Providers stated that this telemedicine provider frequently just "kicked the can down the road," did not provide meaningful care during chart reviews, and/or rescheduled patient appointments that the on-site providers stated they felt must be seen as ordered. This provider also cancelled hospital follow-up appointments that were required by CCHCS policy to occur within five days. During the on-site inspection, our clinicians requested several times to interview this telemedicine provider but were never given access, even though the telemedicine provider continued to work for CCHCS and had an assigned telephone number. In light of this, we were unable to verify the exact instructions or reasoning behind this provider's actions.

Recommendations

- Medical leadership should consider, in Phase 3 operations, discontinuing the practice of routinely deferring scheduled nonemergent and nonurgent patient appointments.[63]
- Medical leadership should consider ways of improving provider continuity of care.
- Medical leadership should consider offering specific provider training on improved documentation and should consider monitoring medical decision making.

[63] Phase 3 is the Open Phase (New Normal) https://www.cdcr.ca.gov/covid19/reopening/.

Specialized Medical Housing

Overall Rating ***Adequate***

Case Review Rating ***Adequate***

Compliance Score ***Adequate*** **(80.0%)**

In this indicator, OIG inspectors evaluated the quality of care in the specialized medical housing units. We evaluated the performance of the medical staff in assessing, monitoring, and intervening for medically complex patients requiring close medical supervision. Our inspectors also evaluated the timeliness and quality of provider and nursing intake assessments and care plans. We assessed staff members' performance in responding promptly when patients' conditions deteriorated and looked for good communication when staff consulted with one another while providing continuity of care. Our clinicians also interpreted relevant compliance results and incorporated them into this indicator. At the time of our inspection, SAC's specialized medical housing consisted of a correctional treatment center (CTC).

Results Overview

SAC performed satisfactorily in this indicator. The institution performed very good in compliance testing, particularly in the timeliness of the initial nursing and provider assessments. Case review found that providers generally delivered good care. The nurses completed timely admission assessments. However, there were patterns of nursing deficiencies related to nurses' not notifying the provider of abnormal findings on assessments and nurses' not completing assessments. Overall, we rated this indicator ***adequate.***

Case Review and Compliance Testing Results

We reviewed four CTC cases that included eight provider events and 29 nursing events. Because of the care volume that occurs in specialized medical housing units, each nursing event represents up to two weeks of nursing care. We identified 26 deficiencies, six of which were significant.[64]

Provider Performance

Compliance testing showed that providers completed admission histories and physicals timely (MIT 13.002, 100%). Our clinicians found that providers generally delivered good patient care. Case review clinicians found five deficiencies in specialized medical housing; two were significant.[65] We describe the deficiencies as follows:

- In case 1, the provider reviewed abnormal laboratory tests and sent the patient a letter stating that a follow-up provider appointment would be scheduled. However, the provider did not see the patient nor order a follow-up appointment or follow-up

[64] Deficiencies occurred in cases 1, 10, 66, and 67. Significant deficiencies occurred in cases 1, 10, and 66.

[65] Deficiencies occurred in cases 1. Two significant deficiencies occurred in case 1.

laboratory tests. The provider did not document a progress note indicating his medical reasoning or treatment plan. Later in this case, a different provider evaluated the patient. The patient's vital signs were not obtained, and the provider did not order them, even though the patient had a recent significant infection. The provider reordered the antibiotics without an adequate examination.

Nursing Performance

SAC nurses performed well in completing the admission assessments timely (MIT 13.001, 100%). However, nurses did not always perform vital signs and complete assessments. Our clinicians found nursing assessment and intervention deficiencies in the following cases:

- In case 1, the patient was admitted to the CTC. The nurse did not perform a patient assessment and did not complete vital signs.

- In case 10, the diabetic patient was admitted to CTC after a hospitalization for wound debridement. Upon admission, the CTC nurse did not obtain an order and perform a dressing change, as per hospital recommendations. As the patient was being discharged from the CTC, the patient became symptomatic for low blood sugar. The nurse performed a blood sugar check, administered glucose gel, gave the patient a snack, and continued with discharge orders. However, the nurse did not notify the provider of the abnormal findings.

- In case 66, the patient was admitted to CTC for anaphylactic reactions. The provider ordered vital signs to be completed twice a day. However, vital signs were not done as ordered on two separate days. On a later date, the nurse performed vital signs and found an abnormally elevated pulse. The CTC nurse did not reassess the patient's pulse until the next day and did not notify the provider of this abnormal finding.

Medication Administration

SAC had a mixed performance in medication administration. Compliance testing showed that newly admitted patients did not always receive their medications within the required time frame (MIT 13.004, 50.0%). Analysis of the compliance data that showed compliance testing had two applicable samples. Our clinicians identified only two deficiencies in two cases related to medication management, which we discuss in the **Medication Management** indicator.[66]

[66] Deficiencies occurred in cases 1 and 10.

Clinician On-Site Inspection

The institution's CTC had two medical beds. Nursing staff was assigned one registered nurse to five patients. During our inspection, custody staff accompanied nurses during morning rounds, which included time for nurses to assess patients and administer medication. The CTC supervising nurse (SRN II) reported that the TTA nurse contacts the provider and obtains phone orders for medication reconciliation for patients newly admitted to the CTC. Nursing staff was available 24 hours per day. Compliance testing showed that the call light system was not always functional (MIT 13.101, 50.0%).

Our clinicians also attended a well-organized huddle and found the huddle collaborative, with multiple disciplines represented, including medical, custody, mental health, and nursing. During this huddle, a custody officer reported that the room temperature was cold and that the work order had been submitted more than a year ago.

Compliance Testing Results

Table 17. Specialized Medical Housing

Compliance Questions	Scored Answer			
	Yes	No	N/A	Yes %
For OHU, CTC, and SNF: Prior to 4/2019: 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 4/2019: Did the registered nurse complete an initial assessment of the patient at the time of admission? (13.001) *	2	0	0	100%
For CTC and SNF only (effective 4/2019, include OHU): Was a written history and physical examination completed within the required time frame? (13.002) *	2	0	0	100%
For OHU, CTC, SNF, and Hospice (applicable only for samples prior to 4/2019): 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? (13.003) *,†	0	0	2	N/A
Upon the patient's admission to specialized medical housing: Were all medications ordered, made available, and administered to the patient within required time frames? (13.004) *	1	1	0	50.0%
For OHU and CTC only: Do inpatient areas either have properly working call systems in its OHU & CTC or are 30-minute patient welfare checks performed; and do medical staff have reasonably unimpeded access to enter patient's cells? (13.101) *	1	1	0	50.0%
For specialized health care housing (CTC, SNF, Hospice, OHU): Do health care staff perform patient safety checks according to institution's local operating procedure or within the required time frames? (13.102) *	1	0	1	100%
				Overall percentage (MIT 13): **80.0%**

* The OIG clinicians considered these compliance tests along with their case review findings when determining the quality rating for this indicator.

† CCHCS changed its policies and removed mandatory minimum rounding intervals for patients located in specialized medical housing. After April 2, 2019, MIT 13.003 only applied to CTCs that still have state-mandated rounding intervals. OIG case reviewers continued to test the clinical appropriateness of provider follow-ups within specialized medical housing units through case reviews.

Source: The Office of the Inspector General medical inspection results.

Recommendation

- Nursing leadership should consider developing and implementing an audit tool to ensure that nursing assessments, including vital signs, are complete and related to the patient's complaint and presentation.

Specialty Services

Overall Rating
Inadequate

Case Review Rating
Adequate

Compliance Score
***Inadequate* (61.7%)**

In this indicator, OIG inspectors evaluated the quality of specialty services. The OIG clinicians focused on the institution's performance in providing needed specialty care. Our clinicians also examined specialty appointment scheduling, providers' specialty referrals, and medical staff's retrieval, review, and implementation of any specialty recommendations.

Results Overview

As in Cycle 5, SAC performed poorly in providing specialty services. The OIG found poor access to specialty services for both existing and transfer patients. Specialty report receipt and scanning were often delayed, thus resulting in delay of care. Providers ordered specialty services timely and appropriately; however, providers did not always endorse specialty eye reports. Nursing performed well on assessments for patients returning from off-site specialists. Overall, due to the significance of poor access, compounded with delays in report receipt, the OIG rated this ***inadequate***.

Case Review and Compliance Testing Results

We reviewed 73 **Specialty Services** events. Of these, 38 were specialty consultations and procedures, and 22 were CCHCS provider encounters whereby the providers were functioning as specialists (19 medication-assisted treatments and three HIV treatments). We found 14 deficiencies in this category, five of which were significant.[67]

Access to Specialty Services

SAC performed poorly in access to specialty services. Compliance testing showed that patients usually did not receive routine, medium-priority or high-priority specialty appointments by the compliance date (MIT 14.007, 60.0%; MIT 14.004, 60.0%; and MIT 14.001, 53.3%). Case reviewers also identified deficiencies in specialty access. Of 38 specialty referrals, case reviewers found five deficiencies, three of which were considered significant.[68] Examples of significant deficiencies follow:

- In case 12, the provider submitted a medium-priority referral for a cardiac ablation, a procedure to restore normal heart rhythm, to treat a potentially life-threatening abnormal heart rhythm. The referral was due within 45 days. Over 90 days later, the provider messaged the nurse asking for a status report. The nurse responded that the order did not "come to my queue" and

[67] Deficiencies occurred in cases 7, 8, 12, 15, 17, 18, 27 and 67. Cases 8, 12, 15, 17, and 18 had significant deficiencies.

[68] Deficiencies occurred in cases 8, 12, 17, and 18. Significant deficiencies occurred in cases 12, 17, and 18.

would be processed immediately. The appointment was scheduled 98 days late.

- In case 17, the provider ordered a colonoscopy for a new anemia diagnosis and a positive stool test for blood that could be caused by internal bleeding or cancer. The colonoscopy was ordered to be done as medium priority, within 45 days; however, it was completed 95 days late.

- In case 18, the provider ordered a medium-priority ophthalmology appointment for a patient taking a medication that is high risk to eyes and who required an annual ophthalmology evaluation. The referral was due within 45 days. Twenty days after the initial referral was due, the nurse noted that the appointment could not be completed within the requested time frame and initiated a new order. At the end of our case review period, the patient still had not seen the ophthalmologist.

When patients transferred from another institution with an approved specialty referral, an appointment was scheduled within the required time frame at SAC only 35.0 percent of the time (MIT 14.010). Of the three transfer-in cases reviewed by our clinicians, two cases transferred with pending, approved, medium-priority specialty referral orders. We identified two significant deficiencies, both in case 29:

- The patient was seen for a neurosurgery evaluation 12 days late.

- The patient was seen by the infectious disease specialist over six weeks late.

Case review findings are also discussed in the **Access to Care** indicator.

Provider Performance

Case reviewers found that providers referred patients appropriately to the correct specialist and usually reviewed and followed specialty recommendations.

Regarding provider follow-up after a specialty appointment, compliance testing showed that patients were seen by their providers as ordered 81.6 percent of the time (MIT 1.008). Of the 74 specialty events reviewed, case review found that 29 had provider follow-up appointments and that the appointments usually occurred within the ordered time frames. We found a few deficiencies in provider follow-up to specialty care, and only one was significant:

In case 24, the patient was seen by the provider for a postoperative urology appointment two months late.

Nursing Performance

Nurses performed well in specialty services. Nurses usually evaluated patients properly after returning from off-site specialty appointments. Case review clinicians identified only one minor deficiency.[69]

Health Information Management

Compliance testing showed that SAC performed poorly in retrieving routine specialty and high-priority specialty reports (MIT 14.008, 46.7%; MIT 14.002, 73.3%). Medium-priority reports were both received and endorsed by a provider within required time frames only 71.4 percent of the time (MIT 14.005). The institution had borderline performance in scanning records once received, with most of the deficiencies occurring in routine reports (MIT 4.002, 76.7%). Case reviewers also identified a pattern of optometry reports not being endorsed by a provider. These are discussed further in the **Health Information Management** indicator.

Clinician On-Site Inspection

We discussed specialty referral management with SAC managers, supervisors, providers, and specialty and utilization management nurses. **Specialty Services** leadership reported there were no specialty staffing shortages during our review period.

At the time of the inspection, the providers reported that all specialty requests were being reviewed and approved by a headquarters physician, not by local management.[70] Several providers complained that the new process made obtaining approvals difficult and that there were frequent denials and resubmissions. The chief medical executive and the chief physician and surgeon noted that they were happy with the headquarters approval service, as it took a large task from their responsibility.

Specialty nursing is responsible for collecting any on-site or telemedicine specialty reports and sending them to health information management for scanning and forwarding to the providers for review. Off-site reports are the responsibility of the health information management staff, who will contact the specialty facility directly to obtain missing reports and scan them into the electronic health record system. Off-site specialty reports were not reviewed for completeness or accuracy. The staff acknowledged that there is a gap in their system for collecting specialty reports, and they have established a work group, including nursing, to improve this process.

During the review period, specialty leadership reported that the areas with the most significant backlogs were with colonoscopy, esophagogastroduodenoscopy (EGD), ophthalmology, optometry, and cardiology. The GI provider for on-site EGD and colonoscopies would

[69] The deficiency occurred in case 67.

[70] CCHCS headquarters informed the OIG that this process will continue at least through April 15, 2022.

frequently cancel appointments without advance notice, so SAC staff could not reschedule with an off-site provider within compliance time frames. Specialty leadership stated that they have since cancelled the contract with that provider and implemented a contract with another off-site GI provider for these services.

Compliance Testing Results

Table 18. Specialty Services

Compliance Questions	Scored Answer			
	Yes	No	N/A	Yes %
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? (14.001) *	8	7	0	53.3%
Did the institution receive and did the primary care provider review the high-priority specialty service consultant report within the required time frame? (14.002) *	11	4	0	73.3%
Did the patient receive the subsequent follow-up to the high-priority specialty service appointment as ordered by the primary care provider? (14.003) *	8	5	2	61.5%
Did the patient receive the medium-priority specialty service within 15-45 calendar days of the primary care provider order or Physician Request for Service? (14.004) *	9	6	0	60.0%
Did the institution receive and did the primary care provider review the medium-priority specialty service consultant report within the required time frame? (14.005) *	10	4	1	71.4%
Did the patient receive the subsequent follow-up to the medium-priority specialty service appointment as ordered by the primary care provider? (14.006) *	6	3	6	66.7%
Did the patient receive the routine-priority specialty service within 90 calendar days of the primary care provider order or Physician Request for Service? (14.007) *	9	6	0	60.0%
Did the institution receive and did the primary care provider review the routine-priority specialty service consultant report within the required time frame? (14.008) *	7	8	0	46.7%
Did the patient receive the subsequent follow-up to the routine-priority specialty service appointment as ordered by the primary care provider? (14.009) *	4	3	8	57.1%
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? (14.010) *	7	13	0	35.0%
Did the institution deny the primary care provider's request for specialty services within required time frames? (14.011)	20	0	0	100%
Following the denial of a request for specialty services, was the patient informed of the denial within the required time frame? (14.012)	11	9	0	55.0%
Overall percentage (MIT 14): **61.7%**				

* The OIG clinicians considered these compliance tests along with their case review findings when determining the quality rating for this indicator.

Source: The Office of the Inspector General medical inspection results.

Table 19. Other Tests Related to Specialty Services

Compliance Questions	Scored Answer			
	Yes	No	N/A	Yes %
Specialty service follow-up appointments: Did the clinician follow-up visits occur within required time frames? (1.008) *, †	31	7	7	81.6%
Are specialty documents scanned into the patient's electronic health record within five calendar days of the encounter date? (4.002) *	23	7	15	76.7%

* The OIG clinicians considered these compliance tests along with their own case review findings when determining the quality rating for this indicator.

† CCHCS changed its specialty policies in April 2019, removing the requirement for primary care physician follow-up visits following most specialty services. As a result, we test 1.008 only for high-priority specialty services or when the staff orders PCP or PC RN follow-ups. The OIG continues to test the clinical appropriateness of specialty follow-ups through its case review testing.

Source: The Office of the Inspector General medical inspection results.

Recommendations

- Medical leadership should ensure that patients receive their approved specialty service appointments and subsequent follow-up specialty service appointments within the specified time frame.

- Medical leadership should ascertain the challenges in retrieving specialty reports to ensure that reports are received, scanned, and endorsed in a timely manner. Medical leadership should ensure that eye specialist reports are endorsed by providers.

- Medical leadership should determine the root cause of challenges to timely notifying patients of denied specialty services, as required by CCHCS policy.

Administrative Operations

Overall Rating
Inadequate

Case Review Rating
(N/A)

Compliance Score
Inadequate
(72.8%)

In this indicator, OIG compliance inspectors evaluated health care administrative processes. Our inspectors examined the timeliness of the medical grievance process and checked whether the institution followed reporting requirements for adverse or sentinel events and patient deaths. Inspectors checked whether the Emergency Medical Response Review Committee (EMRRC) met and reviewed incident packages. We investigated and determined whether the institution conducted the required emergency response drills. Inspectors also assessed whether the Quality Management Committee (QMC) met regularly and addressed program performance adequately. In addition, the inspectors determined whether the institution provided training and job performance reviews for its employees. We checked whether staff possessed current, valid professional licenses, certifications, and credentials. The OIG rated this indicator solely according to the compliance score, using the same scoring thresholds used in the Cycle 4 and Cycle 5 medical inspections. Our case review clinicians do not rate this indicator.

Because none of the tests in this indicator affected clinical patient care directly (it is a secondary indicator), the OIG did not consider this indicator's rating when determining the institution's overall quality rating.

Results Overview

SAC's performance was mixed in this indicator, as the institution scored well in some applicable tests, but faltered in others. The Emergency Medical Response Review Committee (EMRRC) did not always review cases within the required time frames or did not always complete the required checklists. The local governing body or its equivalent did not regularly meet quarterly and discuss local operating procedures and any applicable policies. In addition, the institution conducted medical emergency response drills with incomplete or inconsistent documentation. Physician managers did not always complete annual or probationary performance appraisals in a timely manner. These findings are set forth in the table on the next page. Overall, we rated this indicator ***inadequate***.

Nonscored Results

SAC did not have any applicable adverse sentinel events requiring root cause analysis during our inspection period (MIT 15.001).

We obtained CCHCS Death Review Committee (DRC) reporting data. Five unexpected (Level 1) deaths occurred during our review period. In our inspection, we found that the DRC did not complete any death review reports promptly. The DRC finished three reports 17 to 29 days late and submitted the reports to the institution's CEO 10 to 22 days after that (MIT 15.998).

Compliance Testing Results

Table 20. Administrative Operations

Compliance Questions	Scored Answer			
	Yes	No	N/A	Yes %
For health care incidents requiring root cause analysis (RCA): Did the institution meet RCA reporting requirements? (15.001) *	N/A	N/A	N/A	N/A
Did the institution's Quality Management Committee (QMC) meet monthly? (15.002)	6	0	0	100%
For Emergency Medical Response Review Committee (EMRRC) reviewed cases: Did the EMRRC review the cases timely, and did the incident packages the committee reviewed include the required documents? (15.003)	1	11	0	8.3%
For institutions with licensed care facilities: Did the Local Governing Body (LGB) or its equivalent meet quarterly and discuss local operating procedures and any applicable policies? (15.004)	0	4	0	0
Did the institution conduct medical emergency response drills during each watch of the most recent quarter, and did health care and custody staff participate in those drills? (15.101)	0	3	0	0
Did the responses to medical grievances address all of the inmates' appealed issues? (15.102)	10	0	0	100%
Did the medical staff review and submit initial inmate death reports to the CCHCS Death Review Unit on time? (15.103)	3	0	0	100%
Did nurse managers ensure the clinical competency of nurses who administer medications? (15.104)	10	0	0	100%
Did physician managers complete provider clinical performance appraisals timely? (15.105)	3	5	0	37.5%
Did the providers maintain valid state medical licenses? (15.106)	10	0	0	100%
Did the staff maintain valid Cardiopulmonary Resuscitation (CPR), Basic Life Support (BLS), and Advanced Cardiac Life Support (ACLS) certifications? (15.107)	2	0	1	100%
Did the nurses and the pharmacist-in-charge (PIC) maintain valid professional licenses and certifications, and did the pharmacy maintain a valid correctional pharmacy license? (15.108)	5	0	2	100%
Did the pharmacy and the providers maintain valid Drug Enforcement Agency (DEA) registration certificates? (15.109)	1	0	0	100%
Did nurse managers ensure their newly hired nurses received the required onboarding and clinical competency training? (15.110)	1	0	0	100%
Did the CCHCS Death Review Committee process death review reports timely? (15.998)	This is a nonscored test. Please refer to the discussion in this indicator.			
What was the institution's health care staffing at the time of the OIG medical inspection? (15.999)	This is a nonscored test. Please refer to Table 4 for CCHCS-provided staffing information.			
	Overall percentage (MIT 15): **72.8%**			

* Effective March 2021, this test was for informational purposes only.

Source: The Office of the Inspector General medical inspection results.

Recommendations

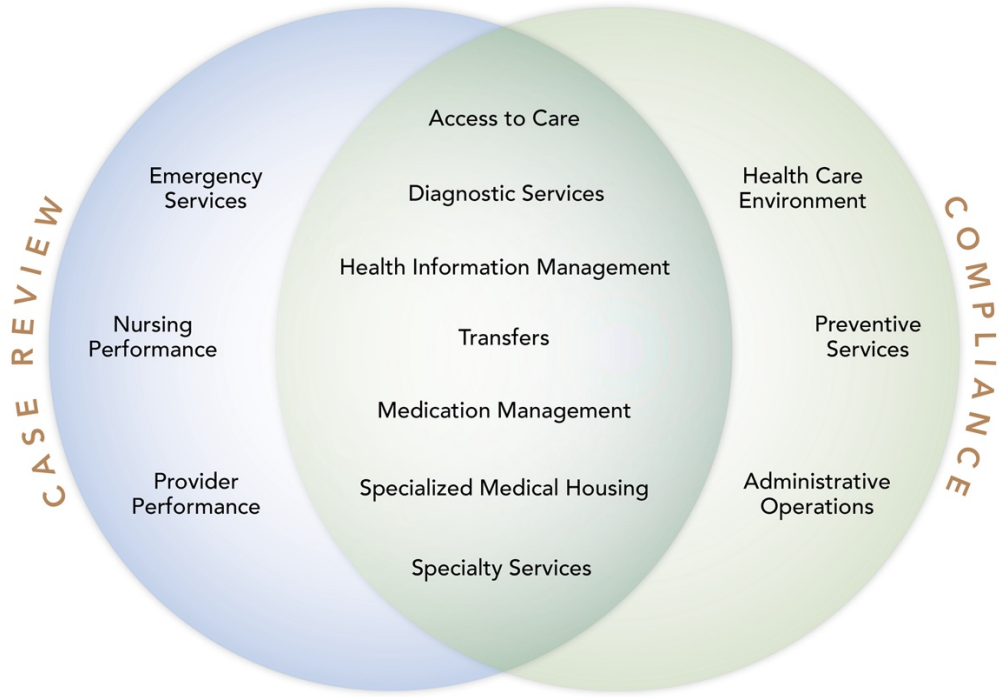
The OIG offers no recommendations for this indicator.

Appendix A. Methodology

In designing the medical inspection program, the OIG met with stakeholders to review CCHCS policies and procedures, relevant court orders, and guidance developed by the American Correctional Association. We also reviewed professional literature on correctional medical care; reviewed standardized performance measures used by the health care industry; consulted with clinical experts; and met with stakeholders from the court, the receiver's office, the department, the Office of the Attorney General, and the Prison Law Office to discuss the nature and scope of our inspection program. With input from these stakeholders, the OIG developed a medical inspection program that evaluates the delivery of medical care by combining clinical case reviews of patient files, objective tests of compliance with policies and procedures, and an analysis of outcomes for certain population-based metrics.

We rate each of the quality indicators applicable to the institution under inspection based on case reviews conducted by our clinicians or compliance tests conducted by our registered nurses. Figure A–1 below depicts the intersection of case review and compliance.

Figure A–1. Inspection Indicator Rating Distribution for SAC



Source: The Office of the Inspector General medical inspection results.

Case Reviews

The OIG added case reviews to the Cycle 4 medical inspections at the recommendation of its stakeholders, which continues in the Cycle 6 medical inspections. Below, Table A–1 provides important definitions that describe this process.

Table A–1. Case Review Definitions

Case, Sample, or Patient	The medical care provided to one patient over a specific period, which can comprise detailed or focused case reviews.
Comprehensive Case Review	A review that includes all aspects of one patient's medical care assessed over a six-month period. This review allows the OIG clinicians to examine many areas of health care delivery, such as access to care, diagnostic services, health information management, and specialty services.
Focused Case Review	A review that focuses on one specific aspect of medical care. This review tends to concentrate on a singular facet of patient care, such as the sick call process or the institution's emergency medical response.
Event	A direct or indirect interaction between the patient and the health care system. Examples of direct interactions include provider encounters and nurse encounters. An example of an indirect interaction includes a provider reviewing a diagnostic test and placing additional orders.
Case Review Deficiency	A medical error in procedure or in clinical judgment. Both procedural and clinical judgment errors can result in policy noncompliance, elevated risk of patient harm, or both.
Adverse Event	An event that caused harm to the patient.

The OIG eliminates case review selection bias by sampling using a rigid methodology. No case reviewer selects the samples he or she reviews. Because the case reviewers are excluded from sample selection, there is no possibility of selection bias. Instead, nonclinical analysts use a standardized sampling methodology to select most of the case review samples. A randomizer is used when applicable.

For most basic institutions, the OIG samples 20 comprehensive physician review cases. For institutions with larger high-risk populations, 25 cases are sampled. For the California Health Care Facility, 30 cases are sampled.

Case Review Sampling Methodology

We obtain a substantial amount of health care data from the inspected institution and from CCHCS. Our analysts then apply filters to identify clinically complex patients with the highest need for medical services. These filters include patients classified by CCHCS with high medical risk, patients requiring hospitalization or emergency medical services, patients arriving from a county jail, patients transferring to and from other departmental institutions, patients with uncontrolled diabetes or uncontrolled anticoagulation levels, patients requiring specialty services or who died or experienced a sentinel event (unexpected occurrences resulting in high risk of, or actual, death or serious injury), patients requiring specialized medical housing placement, patients requesting medical care through the sick call process, and patients requiring prenatal or postpartum care.

After applying filters, analysts follow a predetermined protocol and select samples for clinicians to review. Our physician and nurse reviewers test the samples by performing comprehensive or focused case reviews.

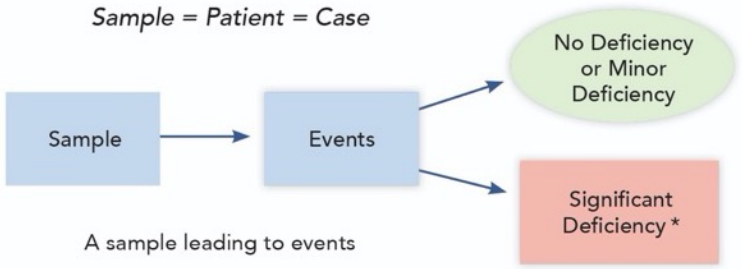
Case Review Testing Methodology

An OIG physician, a nurse consultant, or both review each case. As the clinicians review medical records, they record pertinent interactions between the patient and the health care system. We refer to these interactions as case review ***events***. Our clinicians also record medical errors, which we refer to as case review ***deficiencies***.

Deficiencies can be minor or significant, depending on the severity of the deficiency. If a deficiency caused serious patient harm, we classify the error as an ***adverse event***. On the next page, Figure A–2 depicts the possibilities that can lead to these different events. After the clinician inspectors review all the cases, they analyze the deficiencies, then summarize their findings in one or more of the health care indicators in this report.

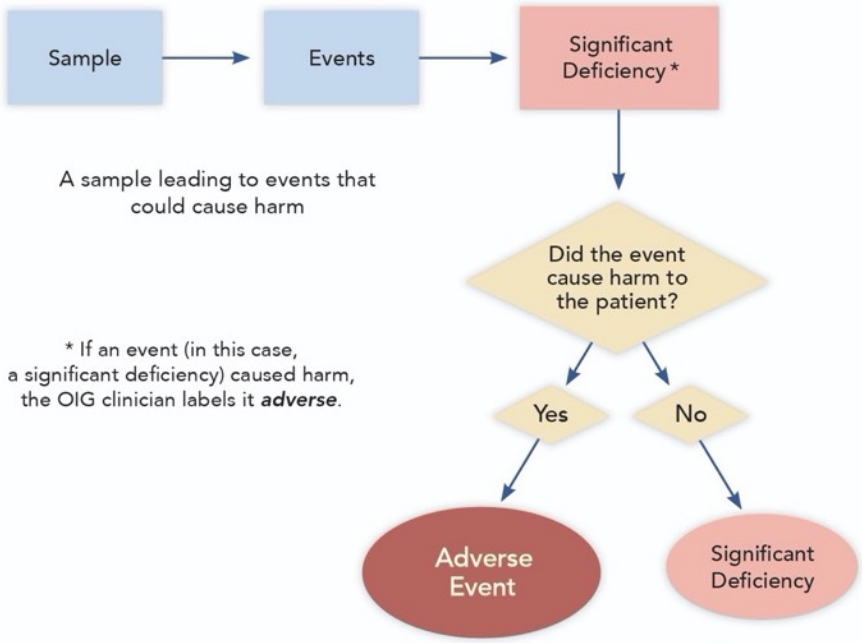
Figure A–2. Case Review Testing

The OIG clinicians examine the chosen samples, performing either a ***comprehensive case review*** or a ***focused case review***, to determine the events that occurred.



Deficiencies

Not all events lead to deficiencies (medical errors); however, if errors did occur, then the OIG clinicians determine whether any were ***adverse***.



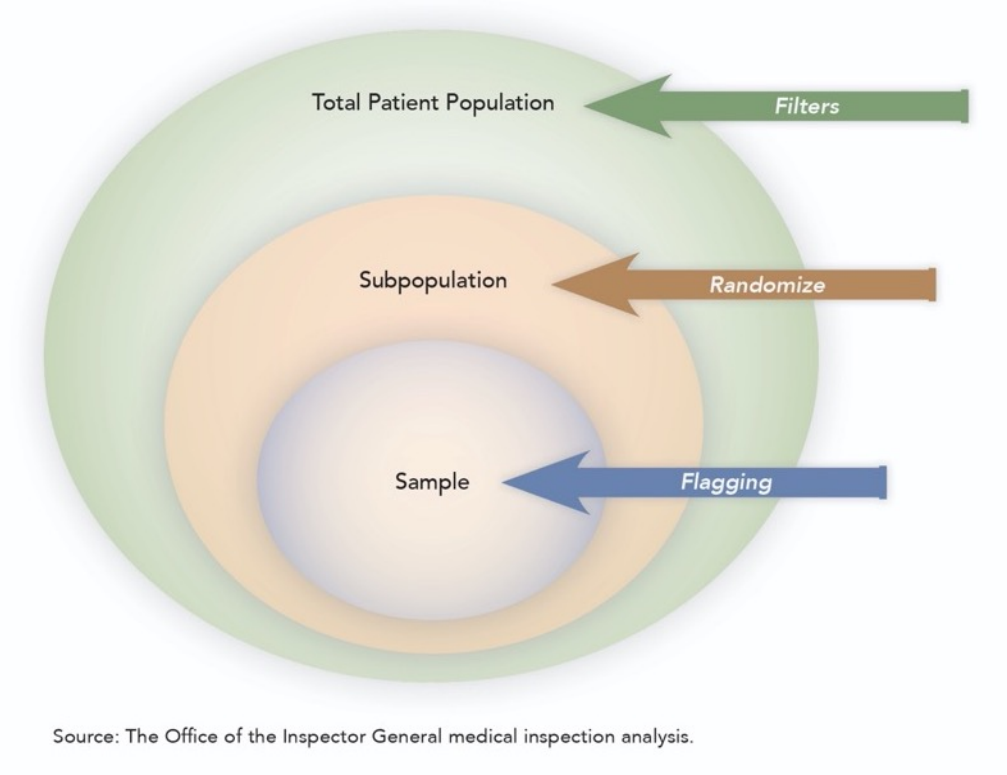
Source: The Office of the Inspector General medical inspection analysis.

Compliance Testing

Compliance Sampling Methodology

Our analysts identify samples for both our case review inspectors and compliance inspectors. Analysts follow a detailed selection methodology. For most compliance questions, we use sample sizes of approximately 25 to 30. Figure A–3 below depicts the relationships and activities of this process.

Figure A–3. Compliance Sampling Methodology



Source: The Office of the Inspector General medical inspection analysis.

Compliance Testing Methodology

Our inspectors answer a set of predefined medical inspection tool (MIT) questions to determine the institution's compliance with CCHCS policies and procedures. Our nurse inspectors assign a ***Yes*** or a ***No*** answer to each scored question.

OIG headquarters nurse inspectors review medical records to obtain information, allowing them to answer most of the MIT questions. Our regional nurses visit and inspect each institution. They interview health care staff, observe medical processes, test the facilities and clinics, review employee records, logs, medical grievances, death reports, and other documents, and obtain information regarding plant infrastructure and local operating procedures.

Scoring Methodology

Our compliance team calculates the percentage of all Yes answers for each of the questions applicable to a particular indicator, then averages the scores. The OIG continues to rate these indicators based on the average compliance score using the following descriptors: ***proficient*** (85.0 percent or greater), ***adequate*** (between 84.9 percent and 75.0 percent), or ***inadequate*** (less than 75.0 percent).

Indicator Ratings and the Overall Medical Quality Rating

To reach an overall quality rating, our inspectors collaborate and examine all the inspection findings. We consider the case review and the compliance testing results for each indicator. After considering all the findings, our inspectors reach consensus on an overall rating for the institution.

Appendix B. Case Review Data

Table B–1. SAC Case Review Sample Sets

Sample Set	Total
Anticoagulation	3
CTC	2
Death Review/Sentinel Events	3
Diabetes	3
Emergency Services – CPR	2
Emergency Services – Non-CPR	3
High Risk	5
Hospitalization	4
Intrasystem Transfers-In	3
Intrasystem Transfers-Out	3
RN Sick Call	32
Specialty Services	4
	67

Table B–2. SAC Case Review Chronic Care Diagnoses

Diagnosis	Total
Anemia	6
Anticoagulation	3
Arthritis/Degenerative Joint Disease	2
Asthma	13
COPD	1
COVID-19	3
Cancer	4
Cardiovascular Disease	3
Chronic Kidney Disease	4
Chronic Pain	16
Cirrhosis/End Stage Liver Disease	3
Coccidioidomycosis	2
Deep Venous Thrombosis/Pulmonary Embolism	4
Diabetes	8
Gastroesophageal Reflux Disease	6
Gastrointestinal Bleed	2
HIV	4
Hepatitis C	22
Hyperlipidemia	17
Hypertension	24
Mental Health	34
Migraine Headaches	3
Rheumatological Disease	1
Seizure Disorder	2
Sleep Apnea	1
Substance Abuse	30
Thyroid Disease	1
	219

Table B–3. SAC Case Review Events by Program

Program	Total
Diagnostic Services	300
Emergency Care	51
Hospitalization	32
Intrasystem Transfers-In	15
Intrasystem Transfers-Out	6
Outpatient Care	634
Specialized Medical Housing	68
Specialty Services	117
	1,224

Table B–4. SAC Case Review Sample Summary

	Total
MD Reviews Detailed	25
MD Reviews Focused	0
RN Reviews Detailed	17
RN Reviews Focused	38
Total Reviews	80
Total Unique Cases	67
Overlapping Reviews (MD & RN)	13

Appendix C. Compliance Sampling Methodology

California State Prison, Sacramento

Quality Indicator	Sample Category	No. of Samples	Data Source	Filters
Access to Care				
MIT 1.001	Chronic Care Patients	25	Master Registry	• Chronic care conditions (at least one condition per patient—any risk level) • Randomize
MIT 1.002	Nursing Referrals	25	OIG Q: 6.001	• See Transfers
MITs 1.003–006	Nursing Sick Call (6 per clinic)	30	Clinic Appointment List	• Clinic (each clinic tested) • Appointment date (2–9 months) • Randomize
MIT 1.007	Returns From Community Hospital	11	OIG Q: 4.005	• See Health Information Management (Medical Records) (returns from community hospital)
MIT 1.008	Specialty Services Follow-Up	45	OIG Q: 14.001, 14.004 & 14.007	• See Specialty Services
MIT 1.101	Availability of Health Care Services Request Forms	6	OIG on-site review	• Randomly select one housing unit from each yard
Diagnostic Services				
MITs 2.001–003	Radiology	10	Radiology Logs	• Appointment date (90 days–9 months) • Randomize • Abnormal
MITs 2.004–006	Laboratory	10	Quest	• Appt. date (90 days–9 months) • Order name (CBC or CMPs only) • Randomize • Abnormal
MITs 2.007–009	Laboratory STAT	10	Quest	• Appt. date (90 days–9 months) • Order name (CBC or CMPs only) • Randomize • Abnormal
MITs 2.010–012	Pathology	10	InterQual	• Appt. date (90 days–9 months) • Service (pathology related) • Randomize

Quality Indicator	Sample Category	No. of Samples	Data Source	Filters
Health Information Management (Medical Records)				
MIT 4.001	Health Care Services Request Forms	30	OIG Qs: 1.004	• Nondictated documents • First 20 IPs for MIT 1.004
MIT 4.002	Specialty Documents	45	OIG Qs: 14.002, 14.005 & 14.008	• Specialty documents • First 10 IPs for each question
MIT 4.003	Hospital Discharge Documents	11	OIG Q: 4.005	• Community hospital discharge documents • First 20 IPs selected
MIT 4.004	Scanning Accuracy	24	Documents for any tested inmate	• Any misfiled or mislabeled document identified during OIG compliance review (24 or more = No)
MIT 4.005	Returns From Community Hospital	11	CADDIS Off-site Admissions	• Date (2–8 months) • Most recent 6 months provided (within date range) • Rx count • Discharge date • Randomize
Health Care Environment				
MITs 5.101–105 MITs 5.107–111	Clinical Areas	13	OIG inspector on-site review	• Identify and inspect all on-site clinical areas.
Transfers				
MITs 6.001–003	Intra-system Transfers	25	SOMS	• Arrival date (3–9 months) • Arrived from (another departmental facility) • Rx count • Randomize
MIT 6.101	Transfers Out	6	OIG inspector on-site review	• R&R IP transfers with medication

Quality Indicator	Sample Category	No. of Samples	Data Source	Filters
Pharmacy and Medication Management				
MIT 7.001	Chronic Care Medication	25	OIG Q: 1.001	See Access to Care • At least one condition per patient—any risk level • Randomize
MIT 7.002	New Medication Orders	25	Master Registry	• Rx count • Randomize • Ensure no duplication of IPs tested in MIT 7.001
MIT 7.003	Returns From Community Hospital	11	OIG Q: 4.005	• See Health Information Management (Medical Records) (returns from community hospital)
MIT 7.004	RC Arrivals—Medication Orders	N/A at this institution	OIG Q: 12.001	• See Reception Center
MIT 7.005	Intra-facility Moves	25	MAPIP transfer data	• Date of transfer (2–8 months) • To location/from location (yard to yard and to/from ASU) • Remove any to/from MHCB • NA/DOT meds (and risk level) • Randomize
MIT 7.006	En Route	10	SOMS	• Date of transfer (2–8 months) • Sending institution (another departmental facility) • Randomize • NA/DOT meds
MITs 7.101–103	Medication Storage Areas	Varies by test	OIG inspector on-site review	• Identify and inspect clinical & med line areas that store medications
MITs 7.104–107	Medication Preparation and Administration Areas	Varies by test	OIG inspector on-site review	• Identify and inspect on-site clinical areas that prepare and administer medications
MITs 7.108–111	Pharmacy	1	OIG inspector on-site review	• Identify & inspect all on-site pharmacies
MIT 7.112	Medication Error Reporting	25	Medication error reports	• All medication error reports with Level 4 or higher • Select total of 25 medication error reports (recent 12 months)
MIT 7.999	Restricted Unit KOP Medications	40	On-site active medication listing	• KOP rescue inhalers & nitroglycerin medications for IPs housed in restricted units

Quality Indicator	Sample Category	No. of Samples	Data Source	Filters
Prenatal and Postpartum Care				
MITs 8.001–007	Recent Deliveries	N/A at this institution	OB Roster	• Delivery date (2–12 months) • Most recent deliveries (within date range)
	Pregnant Arrivals	N/A at this institution	OB Roster	• Arrival date (2–12 months) • Earliest arrivals (within date range)
Preventive Services				
MITs 9.001–002	TB Medications	5	Maxor	• Dispense date (past 9 months) • Time period on TB meds (3 months or 12 weeks) • Randomize
MIT 9.003	TB Evaluation, Annual Screening	25	SOMS	• Arrival date (at least 1 year prior to inspection) • Birth month • Randomize
MIT 9.004	Influenza Vaccinations	25	SOMS	• Arrival date (at least 1 year prior to inspection) • Randomize • Filter out IPs tested in MIT 9.008
MIT 9.005	Colorectal Cancer Screening	25	SOMS	• Arrival date (at least 1 year prior to inspection) • Date of birth (51 or older) • Randomize
MIT 9.006	Mammogram	N/A at this institution	SOMS	• Arrival date (at least 2 yrs. prior to inspection) • Date of birth (age 52–74) • Randomize
MIT 9.007	Pap Smear	N/A at this institution	SOMS	• Arrival date (at least three yrs. prior to inspection) • Date of birth (age 24–53) • Randomize
MIT 9.008	Chronic Care Vaccinations	25	OIG Q: 1.001	• Chronic care conditions (at least 1 condition per IP—any risk level) • Randomize • Condition must require vaccination(s)
MIT 9.009	Valley Fever	N/A at this institution	Cocci transfer status report	• Reports from past 2–8 months • Institution • Ineligibility date (60 days prior to inspection date) • All

Quality Indicator	Sample Category	No. of Samples	Data Source	Filters
Reception Center				
MITs 12.001–008	RC	N/A at this institution	SOMS	• Arrival date (2–8 months) • Arrived from (county jail, return from parole, etc.) • Randomize
Specialized Medical Housing				
MITs 13.001–004	Specialized Health Care Housing Unit	2	CADDIS	• Admit date (2–8 months) • Type of stay (no MH beds) • Length of stay (minimum of 5 days) • Rx count • Randomize
MITs 13.101–102	Call Buttons	All	OIG inspector on-site review	• Specialized Health Care Housing • Review by location
Specialty Services				
MITs 14.001–003	High-Priority Initial and Follow-Up RFS	15	Specialty Services Appointments	• Approval date (3–9 months) • Remove consult to audiology, chemotherapy, dietary, Hep C, HIV, orthotics, gynecology, consult to public health/Specialty RN, dialysis, ECG 12-Lead (EKG), mammogram, occupational therapy, ophthalmology, optometry, oral surgery, physical therapy, physiatry, podiatry, and radiology services • Randomize

MITs 14.004–006	Medium-Priority Initial and Follow-Up RFS	15	Specialty Services Appointments	• Approval date (3–9 months) • Remove consult to audiology, chemotherapy, dietary, Hep C, HIV, orthotics, gynecology, consult to public health/Specialty RN, dialysis, ECG 12-Lead (EKG), mammogram, occupational therapy, ophthalmology, optometry, oral surgery, physical therapy, physiatry, podiatry, and radiology services • Randomize
MITs 14.007–009	Routine-Priority Initial and Follow-Up RFS	15	Specialty Services Appointments	• Approval date (3–9 months) • Remove consult to audiology, chemotherapy, dietary, Hep C, HIV, orthotics, gynecology, consult to public health/Specialty RN, dialysis, ECG 12-Lead (EKG), mammogram, occupational therapy, ophthalmology, optometry, oral surgery, physical therapy, physiatry, podiatry, and radiology services • Randomize
MIT 14.010	Specialty Services Arrivals	20	Specialty Service Arrivals	• Arrived from (other departmental institution) • Date of transfer (3–9 months) • Randomize
MITs 14.011–012	Denials	20	InterQual	• Review date (3–9 months) • Randomize
		N/A	IUMC/MAR Meeting Minutes	• Meeting date (9 months) • Denial upheld • Randomize

Quality Indicator	Sample Category	No. of Samples	Data Source	Filters
Administrative Operations				
MIT 15.001	Adverse/sentinel events (ASE)	0	Adverse/sentinel events report	• Adverse/Sentinel events (2–8 months)
MIT 15.002	QMC Meetings	6	Quality Management Committee meeting minutes	• Meeting minutes (12 months)
MIT 15.003	EMRRC	12	EMRRC meeting minutes	• Monthly meeting minutes (6 months)
MIT 15.004	LGB	4	LGB meeting minutes	• Quarterly meeting minutes (12 months)
MIT 15.101	Medical Emergency Response Drills	3	On-site summary reports & documentation for ER drills	• Most recent full quarter • Each watch
MIT 15.102	Institutional Level Medical Grievances	10	On-site list of grievances/closed grievance files	• Medical grievances closed (6 months)
MIT 15.103	Death Reports	3	Institution-list of deaths in prior 12 months	• Most recent 10 deaths • Initial death reports
MIT 15.104	Nursing Staff Validations	10	On-site nursing education files	• On duty one or more years • Nurse administers medications • Randomize
MIT 15.105	Provider Annual Evaluation Packets	8	On-site provider evaluation files	• All required performance evaluation documents
MIT 15.106	Provider Licenses	10	Current provider listing (at start of inspection)	• Review all
MIT 15.107	Medical Emergency Response Certifications	All	On-site certification tracking logs	• All staff ◦ Providers (ACLS) ◦ Nursing (BLS/CPR) • Custody (CPR/BLS)
MIT 15.108	Nursing Staff and Pharmacist in Charge Professional Licenses and Certifications	All	On-site tracking system, logs, or employee files	• All required licenses and certifications

Quality Indicator	Sample Category	No. of Samples	Data Source	Filters
Administrative Operations				
MIT 15.109	Pharmacy and Providers' Drug Enforcement Agency (DEA) Registrations	All	On-site listing of provider DEA registration #s & pharmacy registration document	• All DEA registrations
MIT 15.110	Nursing Staff New Employee Orientations	All	Nursing staff training logs	• New employees (hired within last 12 months)
MIT 15.998	Death Review Committee	5	OIG summary log: deaths	• Between 35 business days & 12 months prior • California Correctional Health Care Services death reviews

California Correctional Health Care Services' Response

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October 4, 2022

Amarik Singh, Inspector General
Office of the Inspector General
10111 Old Placerville Road, Suite 110
Sacramento, CA 95827

Dear Ms. Singh:

The Office of the Receiver has reviewed the draft Medical Inspection Report for California State Prison, Sacramento (SAC) conducted by the Office of the Inspector General (OIG) from May to October 2021. California Correctional Health Care Services (CCHCS) acknowledges the OIG findings.

Thank you for preparing the report. Your efforts have advanced our mutual objective of ensuring transparency and accountability in CCHCS operations. If you have any questions or concerns, please contact me at (916) 896-6780.

Sincerely,

DocuSigned by:
Robin Hart
8052220F6D6A411...

Robin Hart
Associate Director
Risk Management Branch
California Correctional Health Care Services

cc: Clark Kelso, Receiver
Diana Toche, D.D.S., Undersecretary, Health Care Services, CDCR
Directors, CCHCS
Roscoe Barrow, Chief Counsel, CCHCS Office of Legal Affairs
Jackie Clark, Deputy Director, Institution Operations, CCHCS
DeAnna Gouldy, Deputy Director, Policy and Risk Management Services, CCHCS
Renee Kanan, M.D., Deputy Director, Medical Services, CCHCS
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Annette Lambert, Deputy Director, Quality Management, CCHCS
Regional Health Care Executive, Region I, CCHCS
Regional Deputy Medical Executive, Region I, CCHCS
Regional Nursing Executive, Region I, CCHCS
Chief Executive Officer, SAC
Katherine Tebrock, Chief Assistant Inspector General, OIG
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Misty Polasik, Staff Services Manager I, OIG

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HEALTH CARE SERVICES

P.O. Box 588500
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Cycle 6
Medical Inspection Report

for

California State Prison
Sacramento

OFFICE *of the*
INSPECTOR GENERAL

Amarik K. Singh
Inspector General

Neil Robertson
Chief Deputy Inspector General

STATE *of* CALIFORNIA
October 2022

OIG