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OIG | OFFICE *of the* INSPECTOR GENERAL

Independent Prison Oversight

March 2023

Cycle 6
Medical Inspection Report

Sierra Conservation Center

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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 people[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).[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***.

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

[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 (HEDIS) 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.

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 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 5, our office continues 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 Sierra Conservation Center (SCC), the institution had been delegated back to the department by the receiver.

We completed our sixth inspection of SCC, and this report presents our assessment of the health care provided at this institution during the inspection period from August 2021 to January 2022.[6] The data obtained for SCC and the on-site inspections occurred during the COVID-19 pandemic.[7]

Sierra Conservation Center (SCC), located near Jamestown in Tuolumne County, opened in 1965. SCC provides housing, programs, and services for minimum- and medium-custody inmates. It is one of the only two prisons in the state responsible for the training and placement of incarcerated men in the Conservation Camp Program. SCC administers 20 male camps located from Central California to the California–Mexico border. SCC houses incarcerated people who are designated low to medium medical risk, having infrequent care needs that are mostly managed at local community hospitals or with transfer from a camp back to the main SCC facility for a higher level of managed care. The institution runs five medical clinics where medical personnel handle nonurgent requests for medical services. SCC conducts screening in its receiving and release clinical area, treats patients who need urgent or emergent care in its triage and treatment area, and treats patients requiring outpatient health services and assistance with activities of daily living in the outpatient housing unit (OHU). SCC's OHU was closed and under renovation at the time of our review. California Correctional Health Care Services has designated SCC a *basic care institution*. Basic institutions are in rural areas, away from tertiary care centers and specialty care providers whose services would likely be used by higher-risk patients. Basic institutions can provide limited specialty medical services and consultation for a generally healthy patient population.

[6] Samples are obtained per case review methodology shared with stakeholders in prior cycles. The case reviews include death reviews between December 2020 and November 2021, transfer reviews between May 2021 and October 2021, and RN sick call reviews between July 2021 and February 2022.

[7] As of October 21, 2022, the department reports on its public tracker that 69% of its incarcerated population at SCC is fully vaccinated while 58% of SCC staff are fully vaccinated: http://www.cdcr.ca.gov/covid19/population-status-tracking/.

Summary

We completed the Cycle 6 inspection of SCC in June 2022. OIG inspectors monitored the institution's delivery of medical care that occurred between August 2021 to January 2022.

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

Table 1. SCC 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	*Adequate*	*Adequate*	*Adequate*	=
Diagnostic Services	*Adequate*	*Inadequate*	*Inadequate*	↓
Emergency Services	*Adequate*	*N/A*	*Adequate*	=
Health Information Management	*Adequate*	*Proficient*	*Adequate*	↓
Health Care Environment	*N/A*	*Inadequate*	*Inadequate*	=
Transfers	*Adequate*	*Adequate*	*Adequate*	↑
Medication Management	*Adequate*	*Inadequate*	*Inadequate*	=
Prenatal and Postpartum Care	*N/A*	*N/A*	*N/A*	*N/A*
Preventive Services	*N/A*	*Adequate*	*Adequate*	↓
Nursing Performance	*Adequate*	*N/A*	*Adequate*	=
Provider Performance	*Adequate*	*N/A*	*Adequate*	=
Reception Center	*N/A*	*N/A*	*N/A*	*N/A*
Specialized Medical Housing	*N/A*	*N/A*	*N/A*	*N/A*‡
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.

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

‡ Specialized medical housing was not tested in Cycle 6 because SCC's outpatient housing unit (OHU) was closed and under renovation at the time of our review.

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 335 patient records and 996 data points and used the data to answer 85 policy questions. In addition, we observed SCC processes during an on-site inspection in February 2022. Table 2 below lists SCC average scores from Cycles 4, 5, and 6.

Table 2. SCC Policy Compliance Scores

Scoring Ranges

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	82.1%	83.7%	83.3%
2	Diagnostic Services	90.8%	73.3%	67.7%
4	Health Information Management	57.1%	91.4%	90.2%
5	Health Care Environment	83.8%	53.0%	58.3%
6	Transfers	81.2%	66.7%	78.0%
7	Medication Management	91.4%	69.8%	59.8%
8	Prenatal and Postpartum Care	N/A	N/A	N/A
9	Preventive Services	82.1%	88.0%	79.8%
12	Reception Center	N/A	N/A	N/A
13	Specialized Medical Housing	98.0%	93.3%	N/A
14	Specialty Services	87.1%	81.9%	71.6%
15	Administrative Operations	75.9%*	74.4%	66.0%

* 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.

OIG clinicians (a team of physicians and nurse consultants) reviewed 45 cases, which contained 904 patient-related events. After examining the medical records, our clinicians conducted a follow-up on-site inspection in June 2022 to verify their initial findings. The OIG physicians rated the quality of care for 21 comprehensive case reviews. Of these 21 cases, our physicians rated 19 ***adequate*** and two ***inadequate***. Our physicians found no adverse events 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 12 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 which may occur throughout the delivery of care. As noted above, we listed the individual indicators and ratings applicable for this institution in Table 1, the SCC Summary Table.

In March 2022, the Health Care Services Master Registry showed that SCC had a total population of 2,952. A breakdown of the medical risk level of the SCC population as determined by the department is set forth in Table 3 below.[9]

Table 3. SCC Master Registry Data as of March 2022

Medical Risk Level	Number of Patients	Percentage*
High 1	13	.4%
High 2	47	1.6%
Medium	455	15.4%
Low	2,437	82.6%
Total	**2,952**	**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 3-18-22.

[8] The indicators for **Reception Center, Prenatal and Postpartum Care, and Specialized Medical Housing** did not apply to SCC.

[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, SCC had 1.0 vacant executive leadership positions, no primary care provider vacancies, 0.2 nursing supervisor vacancies, and 10.7 nursing staff vacancies.

Table 4. SCC Health Care Staffing Resources as of March 2022

Positions	Executive Leadership*	Primary Care Providers	Nursing Supervisors	Nursing Staff†	Total
Authorized Positions	5.0	5.5	11.7	55.7	77.9
Filled by Civil Service	4.0	6.0	11.5	45.0	66.5
Vacant	1.0	0.0	.2	10.7	11.9
Percentage Filled by Civil Service	80.0%	109.1%	98.3%	80.8%	85.4%
Filled by Telemedicine	0	0	0	0	0
Percentage Filled by Telemedicine	0%	0%	0%	0%	0%
Filled by Registry	0	0	0	8.0	8.0
Percentage Filled by Registry	0%	0%	0%	14.4%	10.3%
Total Filled Positions	4.0	6.0	11.5	53.0	74.5
Total Percentage Filled	**80.0%**	**109.1%**	**98.3%**	**95.2%**	**95.6%**
Appointments in Last 12 Months	1.0	0	6.0	19.0	26.0
Redirected Staff	0	0	0	0	0
Staff on Extended Leave‡	0	0	0	8.0	8.0
Adjusted Total: Filled Positions	**3.0**	**6.0**	**11.5**	**45.0**	**65.5**
Adjusted Total: Percentage Filled	**60.0%**	**109.1%**	**98.3%**	**80.8%**	**84.1%**

* Executive Leadership includes the Chief Physician and Surgeon.

† Nursing Staff includes Senior Psychiatric Technician and Psychiatric Technician.

‡ In Authorized Positions.

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 received March 2022, 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 events at SCC during the Cycle 6 inspection.

Case Review Results

OIG case reviewers (a team of physicians and nurse consultants) assessed 9 of the 12 indicators applicable to SCC. Of these 9 indicators, OIG clinicians rated all 9 ***adequate***. The OIG physicians also rated the overall adequacy of care for each of the 21 detailed case reviews they conducted. Of these 21 cases, none were proficient, 19 were ***adequate***, and two were ***inadequate***. In the 904 events reviewed, there were 226 deficiencies, 17 of which 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 SCC:

- Staff provided good access to providers and nurses for outpatient care and for follow-up after specialty services and hospitalizations.
- Providers generally managed chronic conditions well.
- Staff retrieved and reviewed hospital records timely.

Our clinicians found the following weaknesses at SCC:

- Providers did not always document a complete progress note in their provider–patient encounters.
- Providers did not always send complete patient results notification letters nor send timely patient results notification letters with all the elements required by policy.
- Nursing assessments, interventions, and documentations for emergency services were not always adequate.
- Staff did not always ensure that new medications were administered timely or that there was continuity of chronic medications without any delays.

[10] For a further discussion of an adverse event, see Table A–1.

Compliance Testing Results

Our compliance inspectors assessed nine of the 12 indicators applicable to SCC. Of these nine indicators, our compliance inspectors rated one ***proficient***, three ***adequate***, and five ***inadequate***. We tested policy compliance in the **Health Care Environment**, **Preventative Services**, and **Administrative Operations** as these indicators do not have a case review component.

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

- Staff performed well in scanning initial health care screening forms, community hospital discharge reports, and requests for health care services into patients' electronic medical records within required time frames.

- Nursing staff processed sick call request forms, performed face-to-face evaluations, and completed nurse-to-provider referrals within the required time frames.

- Staff performed well in administering prescribed tuberculosis (TB) medications, offering influenza vaccinations, and providing colorectal cancer screenings to all sampled patients timely.

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

- Patients often did not always receive their chronic care medications within the required time frames. There was poor medication continuity for patients returning from hospitalizations, for patients transferring into SCC, and for patients laying over at SCC.

- Health care staff did not consistently follow universal hand hygiene precautions during patient encounters.

- The institution did not consistently provide routine laboratory services within the specified time frames. In addition, the providers did not often communicate results of diagnostic services timely. Most patient letters communicating these results were missing of the date of the diagnostic service, the date of the results, and notification of whether the results were within normal limits.

- SCC did not perform well in ensuring that approved specialty services were provided within specified time frames. Furthermore, the institution did not receive specialty services reports within required time frames, and providers did not review these reports within required time frames.

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 California Medi-Cal and Kaiser Medi-Cal HEDIS scores for one diabetic measure to use in conducting our analysis, and we present that here for comparison.

HEDIS Results

We used population-based metrics in considering SCC's performance to assess the macroscopic view of the institution's health care delivery. SCC's results compared favorably with those found in State health plans for poor HbA1c control. We list the applicable HEDIS measures in Table 5.

Comprehensive Diabetes Care

When compared with statewide Medi-Cal programs—California Medi-Cal, Kaiser Northern California (Medi-Cal), and Kaiser Southern California (Medi-Cal)—SCC performed better in the one diabetic measure that has statewide comparative data: poor HbA1c control.

Immunizations

Statewide comparative data were also not available for immunization measures; however, we include this data for informational purposes. SCC had a 54 percent influenza immunization rate for adults 18 to 64 years old and a 79 percent influenza immunization rate for adults 65 years of age and older.[11] The pneumococcal vaccine rate was 90 percent.[12]

Cancer Screening

Statewide comparative data were not available for colorectal cancer screening; however, we include these data for informational purposes. SCC had a 90 percent colorectal cancer screening rate.

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11 The HEDIS sampling methodology requires a minimum sample of 10 patients to have a reportable result.

12 The pneumococcal vaccines administered are the 13-, 15-, and 20-valent pneumococcal vaccines (PCV13, PCV15, and PCV20), or 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. SCC Results Compared with State HEDIS Scores

HEDIS Measure	SCC Cycle 6 Results*	California Medi-Cal 2018†	Kaiser NorCal Medi-Cal 2018†	Kaiser SoCal Medi-Cal 2018†
HbA1c Screening	**100%**	–	–	–
Poor HbA1c Control (> 9.0%) ‡, §	**10%**	42%	34%	23%
HbA1c Control (< 8.0%) ‡	74%	–	–	–
Blood Pressure Control (< 140/90) ‡	88%	–	–	–
Eye Examinations	60%	–	–	–
Influenza – Adults (18–64)	54%	–	–	–
Influenza – Adults (65+)	79%	–	–	–
Pneumococcal – Adults (65+)	90%	–	–	–
Colorectal Cancer Screening	90%	–	–	–

Notes and Sources

* Unless otherwise stated, data were collected in April 2022 by reviewing medical records from a sample of SCC'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, dated July 1, 2020–June 30, 2021 (published April 2022). https://www.dhcs.ca.gov/dataandstats/reports/Documents/EQRTechRpt-Vol1.pdf

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

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

Source: Institutional 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 SCC's performance, we offer the following recommendations to the department:

Access to Care

- Medical leadership should determine the root cause(s) of challenges to the timely provision of chronic care follow-up appointments; the timely provision of medium-priority, routine, and follow-up specialty appointments; and the timely provision of transfer follow-up appointments. Leadership should implement remedial measures as appropriate.

Diagnostic Services

- Medical leadership should ensure that clinic providers create patient notification letters with all four elements required by CCHCS policy.

- Medical leadership should ascertain the causes of the untimely provision of laboratory services and should implement remedial measures as appropriate.

Health Care Environment

- Executive leadership should consider performing random spot checks to ensure that medical supplies are adequately stored in medical supply storage areas located outside the clinics.

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

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

Transfers

- Nursing leadership should develop and implement internal auditing of staff to ensure complete screenings of patients transferring to another institution, including documentation of pending specialty appointments.

- Nursing leadership should ensure that patients arriving to the institution from another departmental institution and patients returning from the hospital experience no delay in medication continuity.

- Nursing leadership should ensure that nursing staff administers medications without interruption for patients arriving from another departmental institution.

Medication Management

- Nursing leadership should ensure that documentation in the Medication Administration Record for nonautomatic refills reflect, when applicable, that the patient did not submit a refill request; the documentation in such circumstances should not read "Not Done: Task Duplication."

- The institution should reevaluate the medication process for fire camp patients to ensure that the fire camp patients receive all medications without delay.

- Medical and nursing leadership should ensure that chronic care, newly ordered, hospital discharge, and layover patients receive their medications timely, without interruption.

Preventive Services

- Nursing leadership should consider developing and implementing measures to ensure that the nursing staff monitor according to CCHCS policy those patients who are prescribed TB medications.

Provider Performance

- Medical leadership should ensure that providers timely complete appropriate progress notes for consultations provided to nursing staff.

- Medical leadership should ensure that providers include subjective and objective patient care data in all patient encounters, as required by policy.

Specialty Services

- Medical leadership should ascertain the challenges to receiving specialty reports within the required time frame as well as challenges to providers' timely review of those reports, and leadership should implement remedial measures as appropriate.

- Medical leadership should ensure that patients receive the ordered specialty services within the specified time frame.

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 calls, 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
Adequate

Case Review Rating
Adequate

Compliance Score
Adequate
(83.3%)

Results Overview

SCC provided good access to care in this cycle, as it did in Cycle 5. Compliance testing found that the staff performed satisfactorily in providing access for sick call and nurse follow-up visits. Patients generally had timely follow-up appointments with providers. After reviewing all aspects of access to care, the OIG rated this indicator ***adequate***.

Case Review and Compliance Testing Results

OIG clinicians reviewed 161 provider, nursing, specialty, emergency department, and hospitalization events that required a follow-up appointment. We identified nine deficiencies relating to **Access to Care**, two of which were significant.[13]

Access to Care Providers

SCC's performance was mixed in providing access to provider-ordered follow-up appointments. While compliance testing showed poor access to chronic care follow-up appointments (MIT 1.001, 48.0%), compliance testing showed excellent access to providers from nursing referrals (MIT 1.005, 100.0%). OIG clinicians reviewed 104 clinic provider encounters and identified three deficiencies, none of which was significant.[14]

Access to Specialized Medical Housing Providers

SCC's outpatient housing unit (OHU) was closed and under renovation at the time of our review.

Access to Clinic Nurses

SCC performed satisfactorily in access to nurse sick calls and provider-to-nurse referrals. Compliance testing found that nursing reviewed the patient's request for services on the same day (MIT 1.003, 100.0%), and completed face-to-face visits within one business day after a sick call request was placed (MIT 1.004, 100.0%). Our clinicians assessed 38 nursing sick call requests and identified three

[13] Deficiencies occurred twice in case 17 and in once each in cases 5, 9, 15, 22, 33, 36, and 38. Cases 15 and 36 had significant deficiencies.

[14] Deficiencies occurred in cases 17, 22, and 38.

deficiencies related to clinic nurse access, two of which were significant.[15] The significant deficiencies follow:

- In case 15, the patient was scheduled to be seen by the nurse for a symptomatic sick call request for trouble urinating. However, the patient was not evaluated by a sick call nurse until 19 days later.

- In case 36, a symptomatic sick call for heartburn was scanned into the electronic health record. However, no face-to-face nurse evaluation occurred for this sick call during this review period.

Access to Specialty Services

SCC had a mixed performance in specialty services. Compliance testing determined there was a good completion rate of high-priority appointments (MIT 14.001, 100.0%), but subpar completion of medium-priority (MIT 14.004, 73.3%) and routine-priority appointments (MIT 14.007, 73.3%). Case review clinicians found that most specialty appointments took place within requested time frames; we identified only one deficiency, which was not significant.[16]

Follow-Up After Specialty Services

SCC performed well in ensuring that patients saw their providers within the required time frames after specialty appointments. Compliance testing revealed that 78.6 percent of provider appointments after specialty services occurred timely (MIT 1.008). OIG clinicians reviewed 161 specialty service events, which had no deficiencies related to provider follow-up.

Follow-Up After Hospitalization

SCC generally ensured that providers evaluated patients after hospitalizations. Compliance testing showed that 100 percent of provider appointments after hospitalization occurred within the required time frame (MIT 1.007). OIG clinicians reviewed five hospitalization returns and did not identify any missed or delayed appointments.

Follow-Up After Urgent or Emergent Care (TTA)

Providers generally followed up with their patients as requested following a triage and treatment area (TTA) event. OIG clinicians reviewed seven TTA events and did not identify any delays in provider follow-up appointments.

Follow-Up After Transferring into the Institution

Access to care for patients who had recently transferred into the institution was mixed. Compliance testing showed poor access for intake appointments of newly

[15] Deficiencies occurred once in cases 15, 33, and 36. Significant deficiencies occurred in cases 15 and 36.

[16] A deficiency occurred in case 9.

arrived patients (MIT 1.002, 48.0%). Of eight cases in which patients transferred from another institution, case reviewers found only one deficiency in this area:

- In case 22, the nurse scheduled a newly arrived patient to be seen by the provider within seven days. However, the provider evaluated the patient twelve days later, five days after the required time frame.

Clinician On-Site Inspection

The OIG clinicians attended two separate morning huddles (A Yard and B Yard huddles were combined). The huddles were well attended by the care teams, who discussed relevant patient information.

SCC has three main outpatient clinics: Clinics A, B, and C. As part of ongoing HCFIP (Health Care Facility Improvement Program) projects, Clinics A and B are housed in the B Yard gym space. Clinics A and B had three providers; Clinic C had two providers. Clinics A and B housed most of the fire camp participants. Clinic C housed mostly chronic care and COVID-19 quarantine patients. The TTA was also located in the B Yard gym space.

At the time of the on-site visit, there were 94 patients in quarantine in C3 building and 24 patients were in COVID-19 isolation in the C Yard gym. A COVID-19 polymerase chain reaction (PCR) test would be completed on patients in quarantine who became symptomatic, and if the PCR test was positive, the patient would be transferred to the C Yard gym for isolation.

The clinic staff reported that sick calls submitted with possible COVID-19 symptoms were evaluated in the building day room after staff donned personal protective equipment (PPE). Vital signs would be completed at that time, and the patient would be escorted to the influenza-like illness (ILI) clinic if needed, or staff would hand off the patient to the SRN who coordinates patient movement to quarantine or isolation, if required. In the ILI clinic, located outside of AB swing space, patients with possible COVID-19 or influenza symptoms are evaluated by the clinic RN or TTA RN.[17] The ILI clinic has adequate space with vital signs equipment, exam table, computer, and a sink. However, the clinic did not have a weight scale.

SCC is responsible for the central and southern fire camps. At the time of our on-site inspection, there were 17 camps that are designated to SCC. The nearest fire camp was 25 minutes away in Angels Camp, and the fire camps were located as far away as San Diego. The fire camps can house up to 50 patients. Fire camp sick calls are completed by the TTA RN by phone triage. SCC also has a Medical Emergency Response Team that can be deployed as needed. This is more fully explained in the **Emergency Services** indicator. For urgent issues, SCC can request the nearest institution to evaluate the fire camp patients if needed.

Clinic staff reported backlog for the RN and PCP line in both A Yard and C Yard. The RN clinic line ranges from 15 to 20 per day. The A Clinic backlog involved the camp patients. The A Clinic staff reported the backlog was due to the COVID-19 outbreak

[17] A swing space is a temporary working area used while an existing workspace is renovated or constructed.

in February 2022 and March 2022. In addition, the A Yard normally had two providers, but at the time of the on-site visit, they had one provider covering the entire A Yard. All backlog is scheduled by the supervising registered nurse (SRN). To decrease the provider backlog for patients at the southern camps, SCC coordinates with CIM once a week for telemedicine clinic, which consists of the SCC provider and the CIM medical assistant. In addition, the SCC chief physician and surgeon and the chief medical executive assist with evaluating patients to decrease the backlog. The RN backlog consist mainly of the following appointments: the interfacility transfer, annual hepatitis C, and initial whole care appointments. Some of these appointments were more than six months overdue. To clear the LVN and RN camp backlog, the institution schedules the patients to be transported by the bus to the SCC camp office and has an RN or SRN II go to the designated camps to evaluate the patients.

C Yard had minimal backlog, which mainly included RN Hepatitis C follow-up and interfacility appointments. The clinic staff report they add backlog appointments to the RN or PCP lines as much as possible. C Yard clinics completed their renovation in 2019. C Yard is designated for low terrain, low bunk, and low tier patients. The administration segregation unit (ASU) is located in the C Yard and has its own designated clinic space. This clinic space is used interchangeably with the PCP, RN, and LVN lines.

OIG clinicians discussed their clinical findings with the scheduling staff. They reported that a few deficiencies were due to effects from the COVID-19 movement matrix and appointment scheduling for sick calls, and other appointments were based on a modified program or made according to an urgent or emergent need for medical care. The scheduling supervisors explained that their department handled appointment scheduling for SCC and all the fire camps. In addition, their department shared staff with specialty and the fire camps.

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) *	12	13	0	48.0%
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) *	12	13	0	48.0%
Clinical appointments: Did a registered nurse review the patient's request for service the same day it was received? (1.003) *	32	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) *	32	0	0	100%
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) *	14	0	18	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) *	1	0	31	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) *	7	0	0	100%
Specialty service follow-up appointments: Did the clinician follow-up visits occur within required time frames? (1.008) *,†	33	9	3	78.6%
Clinical appointments: Do patients have a standardized process to obtain and submit health care services request forms? (1.101)	3	1	2	75.0%
				Overall percentage (MIT 1): 83.3%

* 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

Compliance Questions	Scored Answer			
	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) *	N/A	N/A	N/A	N/A
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) *,†	N/A	N/A	N/A	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) *	15	0	0	100%
Did the patient receive the subsequent follow-up to the high-priority specialty service appointment as ordered by the primary care provider? (14.003) *	11	2	2	84.6%
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) *	11	4	0	73.3%
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) *	11	4	0	73.3%
Did the patient receive the subsequent follow-up to the routine-priority specialty service appointment as ordered by the primary care provider? (14.009) *	5	1	9	83.3%

* 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

- Medical leadership should determine the root cause(s) of challenges to the timely provision of chronic care follow-up appointments; the timely provision of medium-priority, routine, and follow-up specialty appointments; and the timely provision of transfer follow-up appointments. Leadership should implement remedial measures as appropriate.

Diagnostic Services

In this indicator, OIG inspectors evaluated the institution's performance in timely completing 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* (67.7%)**

Results Overview

SCC had mixed results for this indicator. Case reviewers identified satisfactory completion and retrieval of laboratory tests and radiology services. The case reviewers also found that providers performed satisfactorily in communicating results with patients, while compliance testing revealed low scores. The compliance team showed that while the providers reviewed and endorsed the pathology reports timely, the providers did not communicate timely, nor did the institution consistently retrieve pathology reports timely. Overall, in factoring both case review and compliance results, the OIG rated this indicator ***inadequate***.

Case Review and Compliance Testing Results

We reviewed 299 diagnostic events and found 58 deficiencies, one of which was significant. Of these 58 deficiencies, we found 53 related to health information management and five that pertained to the completion of diagnostic tests.[18]

For health information management, we consider test reports that were never retrieved or reviewed to be as severe a problem as tests that were never performed. This is discussed further in the **Health Information Management** indicator.

Test Completion

SCC performed well in completing radiology services (MIT 2.001, 90.0%), but poorly in completing laboratory tests (MIT 2.004, 30.0%). There were no compliance STAT laboratory samples during our testing period (MIT 2.007, N/A).

The OIG clinicians reviewed 288 laboratory tests and identified five deficiencies related to delayed laboratory test specimen collection. The following are two examples.

- In case 1, the laboratory test was not collected within the time frame specified by the provider.

[18] Deficiencies occurred 22 times in case 8, nine times in case 9, four times in cases 15 and 19, twice in cases 1, 11, 12, 13, 16, 18, 20, and 27, and once in cases 2, 14, and 17. Case 8 had one significant deficiency.

- In case 20, the provider ordered several blood tests; however, the blood test collection was performed 24 days late.

Health Information Management

Providers reviewed and endorsed the reports within specific time frames for radiology (MIT 2.002, 100%) and laboratory (MIT 2.005, 100%). Although staff did not always retrieve pathology reports within the required time frames (MIT 2.010, 60.0%), providers usually reviewed and endorsed the results in a timely manner (MIT 2.011, 88.9%). However, providers did not communicate the results of the pathology studies to the patients within specified time frames (MIT 2.012, zero).

OIG clinicians identified 53 deficiencies. We did not identify deficiencies involving delays in obtaining providers' endorsements of the results. Most deficiencies were related to health information management, involving incomplete and noncompletion in creating notification letters for patients (53 out of 58 deficiencies).[19] The following are examples:

- In case 2, the provider endorsed the results, but did not create a patient notification letter in the EHRS.

- In case 8, STAT labs were collected and processed but the results were not filed electronically into EHRS for 163 days.

- In case 9, the provider reviewed and endorsed laboratory test results, and created a patient notification laboratory test results letter; however, the letter did not indicate whether the laboratory test results were within normal limits.

- In case 15, the provider reviewed and endorsed laboratory test results and created a patient notification letter. However, the letter did not include the date and whether a follow-up appointment with the provider was required or would be scheduled.

Clinician On-Site Inspection

We discussed our findings with the chief support executive, the laboratory supervisor, and staff. They reported that SCC had limited staffing at the time due to FMLA (Family Medical Leave Act) and maternity leave and were unable to hire more staff through contracts and civil service. In addition, they informed us that the COVID-19 outbreaks placed the patients' yards on a modified movement program, affecting the phlebotomists' access to the patient. Finally, staff shared that patients who were stationed at a fire camp and needed laboratory tests were brought to a local laboratory. Because these laboratories did not always directly interface with EHRS, these laboratory specimen collections were tracked through a paper system and binder at the fire camp.

[19] Deficiencies occurred in cases 2, 8, 9, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, and 27.

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) *	9	1	0	90.0%
Radiology: Did the ordering health care provider review and endorse the radiology report within specified time frames? (2.002) *	10	0	0	100%
Radiology: Did the ordering health care provider communicate the results of the radiology study to the patient within specified time frames? (2.003)	7	3	0	70.0%
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) *	10	0	0	100%
Laboratory: Did the health care provider communicate the results of the laboratory test to the patient within specified time frames? (2.006)	7	3	0	70.0%
Laboratory: Did the institution collect the STAT laboratory test and receive the results within the required time frames? (2.007) *	N/A	N/A	N/A	N/A
Laboratory: Did the provider acknowledge the STAT results, OR did nursing staff notify the provider within the required time frames? (2.008) *	N/A	N/A	N/A	N/A
Laboratory: Did the health care provider endorse the STAT laboratory results within the required time frames? (2.009)	N/A	N/A	N/A	N/A
Pathology: Did the institution receive the final pathology report within the required time frames? (2.010) *	6	4	0	60.0%
Pathology: Did the health care provider review and endorse the pathology report within specified time frames? (2.011) *	8	1	1	88.9%
Pathology: Did the health care provider communicate the results of the pathology study to the patient within specified time frames? (2.012)	0	9	1	0
				Overall percentage (MIT 2): **67.7%**

* 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 clinic providers create patient notification letters with all four elements required by CCHCS policy.

- Medical leadership should ascertain the causes of the untimely provision of laboratory services and should implement remedial measures as appropriate.

Emergency Services

Overall Rating
Adequate

Case Review Rating
Adequate

Compliance Score
(N/A)

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.

Results Overview

SCC's performance was satisfactory for emergency services. In comparison to Cycle 5, we reviewed a similar number of cases and deficiencies. Providers performed well in delivering emergency care. Staff generally provided timely and appropriate care. However, there is room for improvement in the response time for the first responder as well as in the nursing assessments and interventions once the patient arrives in the TTA. The OIG rated this indicator ***adequate***.

Case Review Results

We reviewed 13 urgent or emergent events in 10 cases.[20] We identified 13 emergency care deficiencies, one of which was significant.[21]

Emergency Medical Response

SCC performed adequately in emergency medical response. Staff generally responded promptly to medical emergencies throughout the institution. Medical and custody staff worked cohesively to initiate care, activate emergency medical services (EMS), and transfer patients to a higher level of care when applicable. However, OIG clinicians identified deficiencies in SCC's emergency response, one of which was significant:

- In case 30, the clinic RN triaged the sick call request for a patient with complaints of difficulty breathing and extreme pain. The clinic RN should have activated a medical emergency for the urgent respiratory symptom or assessed the patient. However, the clinic RN referred the patient to the TTA over three hours after the triage of the sick call request.

[20] We reviewed urgent and emergent events in cases 1–5, 11, 17, 20, 30, and 38.

[21] Emergency care deficiencies occurred in cases 1, 2, 5, 11, 17, 20, 30, and 38. A significant deficiency occurred in case 30.

Cardiopulmonary Resuscitation Quality

During this period, we reviewed only one case in which cardiopulmonary resuscitation was initiated; the patient had a stab injury to the chest and became unconscious.[22] Custody and medical staff worked together to provide care, activated the 9-1-1 system from the scene, and transported the patient from Prison Industrial Authority (PIA) via the on-grounds ambulance to the helicopter pad for additional interventions.

Provider Performance

Providers performed well in urgent and emergent events and in after-hours care. The providers were available for consultation with the TTA staff. The providers generally made appropriate decisions, transferred patients to the community hospital when necessary, and documented these events thoroughly.

Nursing Performance

Nurses delivered good care during urgent and emergent events. TTA nurses frequently communicated with providers. However, OIG clinicians found that there is room for improvement in assessment and intervention, as described below:

- In case 2, nurses provided emergency care for the patient with an altered level of consciousness for possible opioid overdose. The nurse administered one dose of naloxone without any subsequent change in patient response.[23] However, the nurse did not repeat another dose of naloxone, assess the patient's neurological status every five minutes, and consult with the provider sooner than 38 minutes from the time the patient arrived in the TTA.

- In case 11, the TTA RN assessed the patient for bleeding in the mouth. The TTA RN did not complete a thorough exam to include assessing for pain and other signs of bleeding, did not review the patients' latest dental records, and did not check the vital signs.

- In case 20, the RN evaluated the patient for complaints of left wrist pain after falling while playing basketball. The nurse documented that the patient was able to move the affected wrist but did not thoroughly evaluate the patient for neurovascular compromise, such as swelling or numbness, and did not obtain vital signs. In addition, the nurse did not offer treatment such as ice or an ace bandage for the musculoskeletal injury.

- We found a pattern of incomplete or missing vital signs for patients who were evaluated in the TTA for cases 11, 17, and 20.

[22] CPR was initiated in case 4.

[23] Naloxone is a medication used for the emergency treatment of known or suspected opioid overdose.

Nursing Documentation

Nurses generally performed thorough documentation for urgent and emergent events.[24] Although we identified documentation deficiencies for these urgent and emergent events, these deficiencies are considered minor and did not significantly increase the risk of harm to patients. Examples follow:

- In case 1, the nurses provided emergency care to the patient for abdominal pain with nausea and vomiting. However, the TTA nurse documented that vital signs were performed after the patient had already departed to the community hospital.

- In case 17, the TTA nurse offered the patient TTA care for further evaluation for chest pain, and the patient refused. The nurse did not complete a refusal form or provide patient education for this nursing encounter. In addition, there was missing documentation of the timeline of events, such as the location of incident and when the TTA nurse departed the scene.

Emergency Medical Response Review Committee

EMRRC meetings are scheduled to occur monthly, as the committee discusses pertinent findings obtained from the EMR audits. Our compliance team found that the institution performed poorly in addressing EMRRC checklist concerns and completing the initial review timely; the institution also lacked incident packages and was missing EMRRC case review minutes (MIT 15.003, 25.0%). However, in case review we found that EMRRC meetings were generally conducted once a month and addressed EMRRC checklist concerns.[25]

Clinician On-Site Inspection

During our on-site visit, the Central Health building was under renovation. The renovation is scheduled to be completed in 2023. OIG clinicians toured the TTA, which was located in the gym swing space. The gym swing space also accommodated the A and B clinics and medication lines. The TTA had two gurneys, with sufficient space to provide emergency care.

Staffing for the TTA included two RNs for the morning and evening shifts. During the morning and evening shifts, one TTA RN remains in TTA and the other TTA RN is the first responder, who responds to all medical alarms on A Yard, B Yard, and C Yard. On the graveyard shift, the staffing includes one TTA RN, located in the TTA, who responds to medical emergencies in A Yard and B Yard, and a second TTA RN, located in the C Yard clinic, who responds to all C Yard medical emergencies. During normal business hours, SCC has a designated provider for the TTA; on weekends, holidays, and after-hours, SCC uses the on-call providers.

[24] Deficiencies in TTA nursing documentation occurred in cases 1, 2, and 17.

[25] Deficiencies in EMR audits occurred in cases 1, 2, and 5.

The TTA RN and the medication LVNs are the first responders for medical emergencies in A Yard and B Yard. They respond to the scene with the medical emergency response bag and a wheelchair. For a medical response in the C Yard, the TTA first responder has the emergency response bag and enters C Yard in a state vehicle, due to the distance. If the emergency requires additional transportation to the TTA, the on-grounds ambulance (OGA) team is notified. The OGA team includes the fire captain and the inmate fire crew. In addition, an RN will assist in the OGA team as needed to the TTA. The OGA team also responds to local emergencies within a 10-mile radius of the institution.

Medical emergencies involving patients with COVID-19 symptoms are evaluated by the TTA first responder, who dons personal protective equipment. At the time of our on-site inspection, COVID-19 isolation patients were housed in C Yard gym, and COVID-19 quarantine patients were housed in C Yard building 3.

The TTA nursing staff provide phone triage to the fire camp custody officer as needed for patients' medical concerns. Depending on the proximity of the fire camp, the patient can be evaluated at the nearest departmental institution or transferred to the community hospital. For camp patients who have a medical emergency, the fire camp officer activates 9-1-1 and contacts the SCC TTA.

SCC also has the Medical Emergency Response Team, which is activated by Cal Fire for fires outside of SCC. The team includes an SCC provider, a supervising RN (SRN), an RN or LVN, and a medical assistant (MA). When the Medical Emergency Response Team is activated, the team drives a mobile medical trailer to the site to provide treatment as needed to the incarcerated fire crew. The Medical Emergency Response Team uses a laptop to document in the electronic health record the treatment they provide to the incarcerated fire crew . The team rotates personnel every seven days and is available to provide medical care 24 hours a day. The SRNs reported that staffing in the clinics can be impacted due to the medical staff assigned to the Medical Emergency Response Team. The staff who are part of the team informed us that they enjoy being valuable members of the team.

Recommendations

The OIG offers no recommendations for this indicator.

Health Information Management

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 correctly labeled and organized documents in the medical record.

Overall Rating
Adequate

Case Review Rating
Adequate

Compliance Score
***Proficient* (90.2%)**

Results Overview

SCC had good health information management. In this indicator, the case reviewers and compliance team had different ratings. While case review rated SCC as *adequate*, compliance testing found that SCC performance was *proficient*. This was similar to Cycle 5. Taking all factors into account, the OIG rated this indicator ***adequate***.

Case Review and Compliance Results

OIG clinicians reviewed 904 events and found 58 deficiencies related to health information management, one of which was significant.[26] The majority of deficiencies (53 of 58) in health information management pertained to patient notification letters that were either not created or were incomplete.

Hospital Discharge Reports

The staff performed superbly in retrieving community hospital discharge documents and scanning them into the patients' EHRS within the required time frames (MIT 4.003, 100%). Our compliance team found that all the hospital discharge reports contained physician discharge summaries and that the providers reviewed the reports timely (MIT 4.005, 100%). Our case review team reviewed eight off-site emergency discharge department and hospital visits and did not identify any deficiencies.

Specialty Reports

SCC had differing levels of performance in managing specialty reports. Compliance testing showed satisfactory retrieval of specialty reports (MIT 4.002, 80.0%) and provider endorsement of high-priority specialty reports (MIT 14.002, 80.0%). In contrast, compliance testing also showed poor retrieval and provider review of medium-priority (MIT 14.005, 40.0%) and routine-priority specialty reports (MIT 14.008, 53.3%).

[26] Deficiencies occurred 22 times in case 8, nine times in case 9, four times in cases 15 and 27, thrice in case 19, twice in cases 11, 12, 13, 17, 18, and 20, and once in cases 2, 10, 14, and 16. A significant deficiency occurred in case 8.

Our clinicians reviewed 48 specialty reports and identified five deficiencies.[27] One deficiency was due to a specialty report's being scanned after the time frames required by policy. We also discuss these findings in the **Specialty Services** indicator.

Diagnostic Reports

The staff had a mixed performance in handling diagnostic reports. Compliance testing showed that providers endorsed radiology and laboratory reports within the required time frames (MIT 2.002, 100.0% and MIT 2.005, 100.0%). In contrast, staff generally did not receive the final pathology reports within the required time frames (MIT 2.010, 60.0%). While providers usually reviewed and endorsed the pathology reports in a timely manner (MIT 2.011, 88.9%), the providers performed poorly in communicating the results of the pathology studies to patients during the specified time period (MIT 2.012, zero). Our clinicians identified 53 deficiencies, one of which was significant.[28] The majority of deficiencies (52 of 53 deficiencies) pertained to patient notification letters. The following are examples:

- In case 11, the provider sent a patient notification laboratory test results letter that did not include whether the test results were within normal limits.
- In case 16, the provider endorsed a positive COVID-19 test and did not send a test results letter.

Please refer to the **Diagnostic Services** indicator for further detailed discussion about diagnostics.

Urgent and Emergent Records

OIG clinicians reviewed 13 emergency care events and found that nurses and providers documented these events adequately. Providers also recorded their emergency care sufficiently. However, our clinicians identified four nurse and provider documentation deficiencies.[29] The following is an example:

- In case 2, the nurse did not document that the ace wrap was provided to the patient.

The **Emergency Services** indicator provides additional details.

[27] Specialty health information management deficiencies occurred in cases 8, 10, 17, and 27. There were no significant deficiencies.

[28] Deficiencies occurred 22 times in case 8, nine times in case 9, four times in case 15, three times in case 19, twice in cases 11, 12, 13, 18, 20, and 27, and once in cases 2, 14, 16, 17, and 20. Case 8 had one significant deficiency.

[29] Deficiencies in TTA nursing documentation occurred in cases 1, 2, and 17.

Scanning Performance

Staff performed poorly in the scanning process. Compliance testing showed that staff did not always properly scanned and labeled medical files (MIT 4.004, 70.8%). Our clinicians did not find any deficiencies involving mislabeled documents.

Clinician On-Site Inspection

We discussed health information management processes with the health information management supervisor. The supervisor described the process of retrieving documents from on-site and off-site reports. Health information management (HIM) staff check the TTA log daily to track emergent patients requiring immediate medical attention who are sent out for a higher level of care. They also have access to a local hospital portal and print out records for these patients. The UM (utilization management) nurse sends HIM staff a daily email listing patients with off-site appointments for the day. The specialty nurse also sends an email to HIM staff with information on the day's on-site and telemedicine appointments. For these encounters, HIM staff maintain a spreadsheet that they use to track the reports. They contact each specialist to obtain the dictated report within three days. They scan the reports into EHRS and send the reports to the provider for review and signature. If there is no response from the provider, HIM staff will send a message to the chief physician and surgeon for further action.

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)	20	0	12	100%
Are specialty documents scanned into the patient's electronic health record within five calendar days of the encounter date? (4.002) *	24	6	15	80.0%
Are community hospital discharge documents scanned into the patient's electronic health record within three calendar days of hospital discharge? (4.003) *	7	0	0	100%
During the inspection, were medical records properly scanned, labeled, and included in the correct patients' files? (4.004) *	17	7	0	70.8%
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) *	7	0	0	100%
Overall percentage (MIT 4): **90.2%**				

* 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

Compliance Questions	Scored Answer			
	Yes	No	N/A	Yes %
Radiology: Did the ordering health care provider review and endorse the radiology report within specified time frames? (2.002) *	10	0	0	100%
Laboratory: Did the health care provider review and endorse the laboratory report within specified time frames? (2.005) *	10	0	0	100%
Laboratory: Did the provider acknowledge the STAT results, OR did nursing staff notify the provider within the required time frame? (2.008) *	N/A	N/A	N/A	N/A
Pathology: Did the institution receive the final pathology report within the required time frames? (2.010) *	6	4	0	60.0%
Pathology: Did the health care provider review and endorse the pathology report within specified time frames? (2.011) *	8	1	1	88.9%
Pathology: Did the health care provider communicate the results of the pathology study to the patient within specified time frames? (2.012)	0	9	1	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) *	12	3	0	80.0%
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) *	6	9	0	40.0%
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) *	8	7	0	53.3%

* 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

The OIG offers no recommendations for this indicator.

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
(58.3%)

Results Overview

In this cycle, multiple aspects of SCC's health care environment needed improvement: multiple clinics contained expired medical supplies; multiple clinics lacked medical supplies or contained improperly calibrated medical equipment; 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

We examined outdoor patient waiting areas (see Photo 1, right). Health care and custody staff reported existing waiting areas had sufficient seating capacity. The staff reported that the outdoor waiting area was only used when the indoor waiting area was at capacity. Also, staff reported that they only call patients close to their appointment time during inclement weather.

Photo 1. Outdoor waiting area (photographed on 4-13-22).

Indoor Waiting Areas

We inspected indoor waiting areas (see Photos 2 and 3, next page). Health care and custody staff reported that existing waiting areas contained sufficient seating capacity. During our inspection, we did not observe overcrowding or noncompliance with social distancing requirements in any of the clinics' indoor waiting areas.

Photo 2. Patient waiting area (photographed on 4-12-22).

Photo 3. Below, patient waiting area (photographed on 4-12-22).

Clinic Environment

Seven of eight clinic environments were sufficiently conducive to medical care. They provided reasonable auditory privacy, appropriate waiting areas, wheelchair accessibility, and nonexamination room workspace (MIT 5.109, 87.5%). In one clinic, the triage station did not have auditory privacy.

Of the eight clinics we observed, four contained appropriate space, configuration, supplies, and equipment to allow their clinicians to perform proper clinical examinations (MIT 5.110, 50.0%). In four clinics, we found one or more of the following deficiencies: the examination room had broken cabinets, staff reported that confidential medical records were not shredded at the end of their shift or on a daily basis, and examination room either did not have sufficient space for clinicians to conduct proper patient examination or allow patients to lie fully extended on the examination table without obstructions (see Photos 4 and 5, next page).

Photo 4. Patient was unable to lie fully extended on the examination table due to physical obstructions (photographed on 4-13-22).

Photo 5. Patient was unable to lie fully extended on the examination table due to physical obstructions (photographed on 4-12-22).

Clinic Supplies

Only one of the eight clinics followed adequate medical supply storage and management protocols (MIT 5.107, 12.5%). We found one or more of the following deficiencies in seven clinics: expired medical supplies (see Photo 6), unidentified medical supplies, disorganized medical supply cabinet or drawer (see Photo 7), staff members' personal items and food stored with medical supplies (see Photo 8), and medical supplies stored directly on the floor.

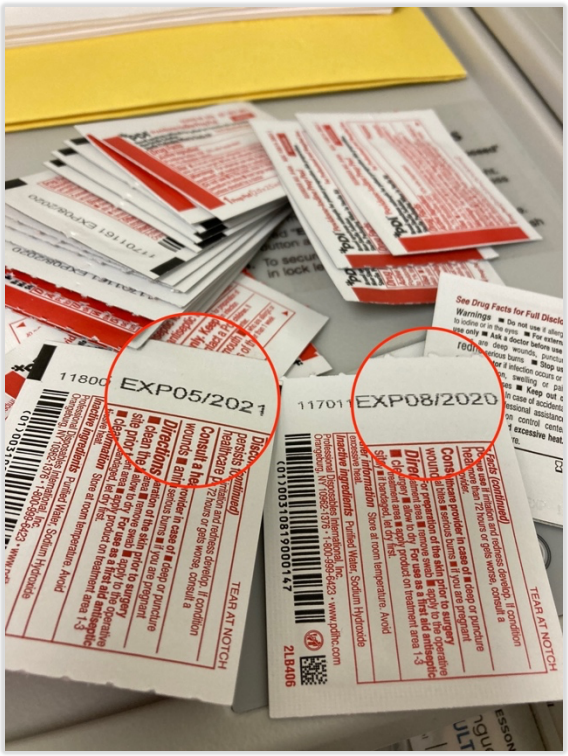

Photo 6. Expired medical supplies dated May 2021 and August 2020 (photographed on 4-13-22).

Photo 7. Disorganized medical supply storage (photographed on 4-13-22).

Photo 8. Medical supplies stored with employee's personal food item (photographed on 4-12-22).

Three of the eight clinics met the requirements for essential core medical equipment and supplies (MIT 5.108, 37.5%). The remaining five clinics lacked medical supplies or contained improperly calibrated or nonfunctional equipment. The missing medical supplies included an examination table, lubricating jelly, and examination table disposable paper. Staff had not properly calibrated the following medical equipment: automated external defibrillator (AED), nebulization unit, overhead light, and oto-ophthalmoscope. We also found that the Snellen reading chart did not have a corresponding distance line on the floor or wall. We found a nonfunctional oto-ophthalmoscope. In addition, staff did not consistently perform glucometer quality control.

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. Four of the five EMRBs passed our test (MIT 5.111, 80.0%). One EMRB did not contain an extra-large-sized blood pressure cuff.

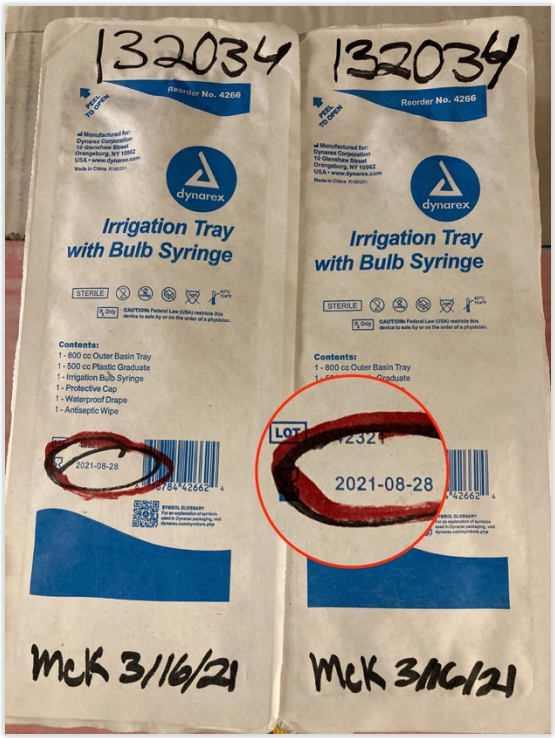

Photo 9. Expired medical supply dated August 28, 2021 (photographed on 4-13-22).

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, as well as medical supplies stored close to the ceiling, which subjected them to extreme heat (see Photos 9 and 10).

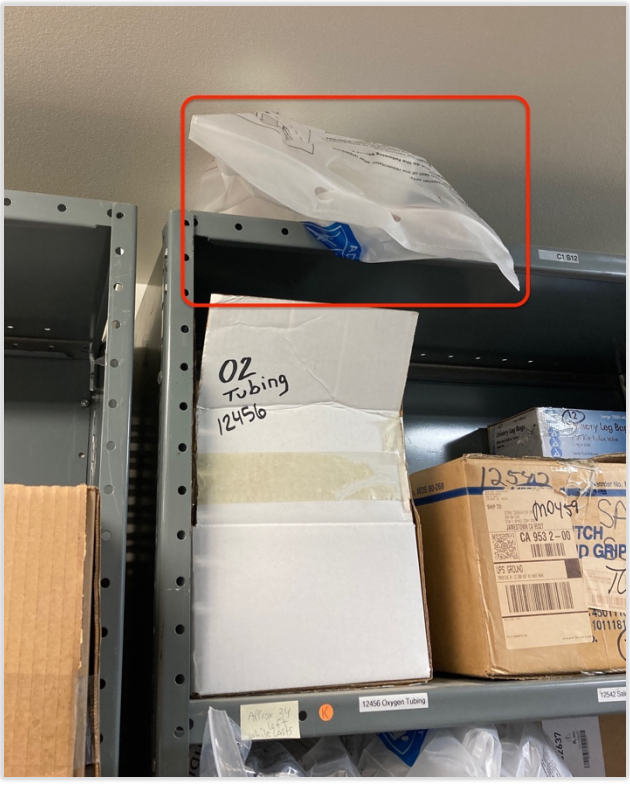

Photo 10. Medical supplies stored in the Conex trailer were placed close to the ceiling and subjected to inclement weather (photographed on 4-13-22).

According to the CEO, the institution did not have any concerns about the medical supplies process. Health care managers and medical warehouse managers expressed no concerns about the medical supply chain or their communication process.

Infection Control and Sanitation

Staff appropriately, cleaned, sanitized, and disinfected all clinics (MIT 5.101, 100%).

Staff in five of seven clinics (MIT 5.102, 71.4%) properly sterilized or disinfected medical equipment. In two clinics, staff did not mention disinfecting the exam table as part of their daily start-up protocol. In one of the two clinics, we observed the provider use the examination table without disposable table paper during patient encounter.

We found operating sinks and hand hygiene supplies in the examination rooms in six of eight clinics (MIT 5.103, 75.0%). The patient restrooms in one clinic lacked antiseptic soap and disposable hand towels. Although the examination room in another clinic had a portable sink with a motorized pump, we found the pump unplugged and nonoperational at the time of our inspection (Photo 11).

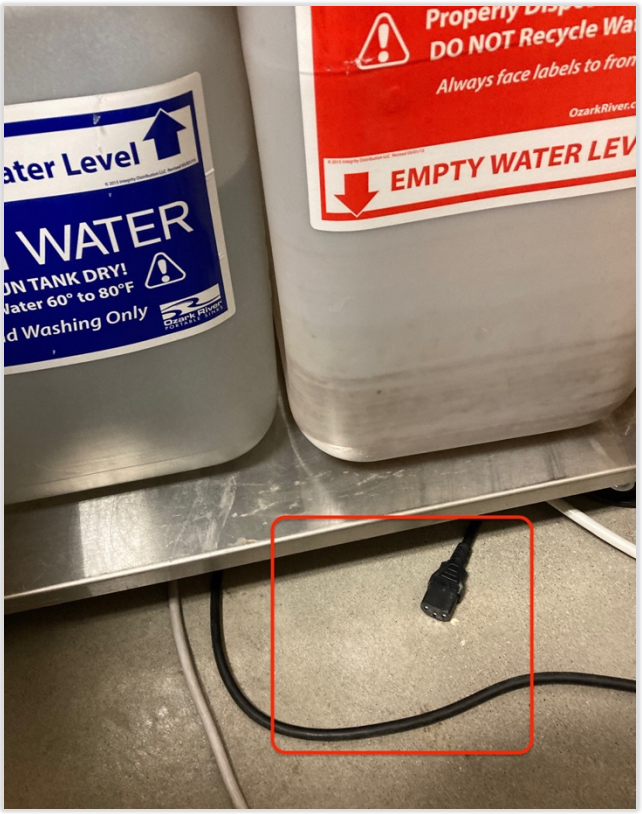

Photo 11. Unplugged portable sink observed at the time of inspection (photographed on 4-14-22).

We observed patient encounters in five clinics. In three clinics, clinicians did not wash their hands before or after examining their patient. We observed clinicians either not wearing gloves during patient examination or not washing or sanitizing hands in between patient encounters (MIT 5.104, 40.0%).

Health care staff in seven of eight clinics followed proper protocols to mitigate exposure to bloodborne pathogens and contaminated waste (MIT 5.105, 87.5%). In one clinic, we found the sharps container overfilled.

Physical Infrastructure

SCC'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 the Health Care Facility Improvement Program (HCFIP) project was renovating the Central Health Building. The project, which started November 2020, was scheduled to be completed

in December 2022. However, the project was delayed due to the COVID-19 pandemic and now has an estimated completion date of March 2023 (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)	8	0	0	100%
Infection control: Do clinical health care areas ensure that reusable invasive and noninvasive medical equipment is properly sterilized or disinfected as warranted? (5.102)	5	2	1	71.4%
Infection control: Do clinical health care areas contain operable sinks and sufficient quantities of hygiene supplies? (5.103)	6	2	0	75.0%
Infection control: Does clinical health care staff adhere to universal hand hygiene precautions? (5.104)	2	3	3	40.0%
Infection control: Do clinical health care areas control exposure to blood-borne pathogens and contaminated waste? (5.105)	7	1	0	87.5%
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)	1	7	0	12.5%
Clinical areas: Do clinic common areas and exam rooms have essential core medical equipment and supplies? (5.108)	3	5	0	37.5%
Clinical areas: Are the environments in the common clinic areas conducive to providing medical services? (5.109)	7	1	0	87.5%
Clinical areas: Are the environments in the clinic exam rooms conducive to providing medical services? (5.110)	4	4	0	50.0%
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)	4	1	3	80.0%
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): **58.3%**			

* 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

- Executive leadership should consider performing random spot checks to ensure that medical supplies are adequately stored in medical supply storage areas located outside the clinics.
- Nursing leadership should consider performing random spot checks to ensure that staff follow equipment and medical supply management protocols.
- Medical leadership should remind staff to follow universal hand hygiene precautions. Implementing random spot checks could improve compliance.

Transfers

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; and 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.

Overall Rating
Adequate

Case Review Rating
Adequate

Compliance Score
Adequate
(78.0%)

Results Overview

SCC performed adequately in this indicator. Staff generally ensured that patients who transferred to SCC from another institution receive sufficient and timely care; however, we found room for improvement in medication continuity for patients transferring into and out of the institution as well as for patients returning from a community hospital. Considering the results in both case review and compliance testing, the OIG rated this indicator ***adequate***.

Case Review and Compliance Testing Results

We reviewed 20 events in 14 cases in which patients transferred into or out of the institution or returned from an off-site hospital or emergency room. We identified 14 deficiencies, two of which were significant.[30]

Transfers In

SCC's performance for patients transferring into the institution was adequate. The compliance team found that the R&R nurses performed well in completing the initial health screening form (MIT 6.001, 92.0%), and the nurses were proficient in addressing signs and symptoms when screening for tuberculosis (MIT 6.002, 100%). OIG clinicians reviewed eight events in seven cases in which patients transferred into the facility from other institutions. We identified five deficiencies, one of which was significant.[31] Two of the five deficiencies were related to the patients being placed in COVID-19 quarantine upon arrival to SCC and the nurse not documenting

[30] Deficiencies occurred in cases 2, 5, 6, 8, and 21–26. Significant deficiencies occurred in cases 2 and 6.

[31] We reviewed transfer-in cases 3, 6, 7, 13, and 21–23. Deficiencies occurred in cases 6, 21, 22, and 23. A significant deficiency occurred in case 6.

the notifications to the supervising registered nurse, custody staff, and public health nurse.

The compliance team found that medication continuity for patients arriving at SCC from another institution was poor (MIT 6.003, 50.0%). The compliance team found that KOP topical creams were not provided timely in one out of two cases.[32] However, SCC ensured that medications were continued with minimal interruption upon the patient's transfer from one housing unit to another (MIT 7.005, 95.7%). Our case reviewers generally found that patients received medications without interruption when arriving at the institution, with no lapses in medication continuity except for one significant deficiency identified below:

- In case 6, the patient arrived at SCC from the fire camp and reported the KOP cholesterol medication and aspirin were left at the fire camp. The patient received the chronic care KOP medications five days after arriving at SCC.

The compliance team found that patients endorsed from another institution were not consistently seen by the clinician within the required time frame (MIT 1.002, 48.0%). Compliance testing showed that most of the appointments that did not occur within the required time frame were RN 30-day follow-up appointments for patients with no known chronic care conditions. OIG clinicians found one deficiency for a patient who was not evaluated timely by the provider:

- In case 22, the RN ordered an Interfacility Transfer Medical Evaluation to occur within seven days, as required by CCHCS policy for the patient with hepatitis C, hypertension, and a pacemaker. However, the provider cancelled this order and placed a new order for the appointment, which was to occur five days later than the required seven-day period. This increased the risk for a delay in care for the patient.

Transfers Out

SCC's transfer-out process was adequate. OIG clinicians reviewed four transfer-out cases and found four deficiencies, none of which was significant.[33] We identified documentation deficiencies of pending specialty appointments, as the examples below illustrate:

- In case 24, the RN documented on the interfacility transfer form that the patient had a pending telemedicine cardiology appointment. However, the RN did not document the pending appointments for optometry, imaging study of the heart, and ultrasound of the renal arteries.

- In case 25, the RN did not document the patient's pending routine specialty referral for an imaging study of the heart and the cardiology

[32] KOP means "keep on person" and refers to medications that a patient can keep and self-administer according to the directions provided.

[33] We reviewed transfer-out cases 1, 24, 25, and 26. Deficiencies occurred in cases 24, 25, and 26. No significant deficiencies were identified.

follow-up appointment to the receiving institution upon transfer. In addition, the nurse did not document whether the patient had any missing durable medical equipment.

Compliance testing found that patients who transferred out of the institution sometimes had their medications (MIT 6.101, 70.0%). The compliance team found that medications such as mental health and steroid anti-inflammatory medications were missing from the transfer envelope. Case reviewers found similar findings. We provide an example below:

- In case 24, the patient who transferred out of SCC did not receive his morning dose of the hypertension chronic care medication chlorthalidone.

Hospitalizations

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

SCC's hospitalization or emergency room return process was adequate. Our clinicians reviewed seven cases in which the patients returned from a hospitalization or the emergency room and found five deficiencies, one of which was significant:[34]

- In case 2, the RN evaluated the patient for right leg cellulitis after the patient returned from the hospital requiring wound care debridement. The nurse documented the right leg dressing change to be performed every other day. However, the nurse did not obtain an order to specify the instructions for the wound care required. The absence of specific wound care orders could have potentially caused a delay in healing.

Compliance testing showed that SCC performed poorly in medication continuity for patients who returned to the institution after discharging from the hospital (MIT 7.003, 50.0%). The compliance team found that medications for infection, gout, and blood pressure, as well as blood thinners and a bone marrow stimulant were not provided within the required time frames. OIG clinicians found three medication deficiencies, none of which was significant. Examples follow:

- In case 2, the patient returned from a hospital admission for right leg cellulitis. The patient was previously prescribed and taking Suboxone to treat narcotic dependence. However, after the patient returned to the institution, the Suboxone prescription was renewed two days later.

[34] The hospitalizations and outside emergency room events occurred in cases 1, 2, 3, and 5–8. Deficiencies occurred in cases 2, 5, and 8. A significant deficiency occurred in case 2.

- In case 5, the patient returned from the hospital after having surgery for acute appendicitis and was ordered to start new KOP prn pain medications (Tylenol and Naproxen).[35] However, the patient received the new KOP medications two days later. In addition, the patient was to start a new KOP medication for constipation after returning from the hospital and received it one day late.

SCC was proficient in providing follow-up appointments within the required time frame to patients returning from the hospital and from emergency room visits (MIT 1.007, 100%).

SCC was proficient in retrieving and scanning hospital records within three calendar days (MIT 4.003, 100%). Compliance testing found providers were proficient—at 100 percent—in reviewing and endorsing documents timely (MIT 4.005). Our case reviewers did not identify any deficiencies related to the timely review of scanned hospital records.

Clinician On-Site Inspection

Our clinicians interviewed the R&R nursing staff, who were knowledgeable about the transfer process and job duties. The R&R clinical area was staffed with an RN on the morning and evening shifts, excluding weekends and holidays.

We were informed that the R&R nurses obtain the patient's medical risk level from the medical risk classification and the patient health summary to help guide them in making appropriate transfers as well as in determining the appropriate provider follow-up appointments upon the patient's arrival at the institution.

Patients transferring out of SCC to another institution were sent with a five-day supply of medications. We were informed that the R&R clinical area did not have an Omnicell.[36] If medications were needed at the time of transfer or intake, nursing staff obtained the medications from the TTA Omnicell.

The R&R nursing staff informed us that they follow the COVID-19 matrix for patients transferring into or out of the institution. Transfer-out patients have a COVID-19 PCR test performed five days prior to transfer and a COVID-19 point-of-care (POC) test performed 24 hours before transfer.[37] Transfer-in patients have a COVID-19 PCR test on Day 5 and Day 10 after intake.

Patients returning from the fire camps to SCC were evaluated by the R&R RN and the intake process was followed. Patients transferring from SCC to the fire camps were not evaluated by the R&R RN. That process involved an SRN II notifying custody staff that the patient is cleared to transfer back to the fire camp after a COVID-19 POC test is completed and is negative.

[35] Prn means "as needed," and the patient can take a medication as needed according to the directions provided.

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

[37] PCR is Polymerase Chain Reaction.

We were informed by the office technician scheduler that the majority of the backlog for interfacility RN 30-day follow-up appointments were fire camp patients. The backlog at the camp was attributed to their previous COVID-19 outbreak. They reported that their solution to this backlog is to coordinate telemedicine RN appointments for the fire camp patients with California Institution for Men (CIM), transport patients to the SCC RN clinic, and or direct an RN or SRN II to travel to the fire camps to complete the RN evaluations.

Compliance On-Site Inspection

R&R nursing staff ensured that seven of 10 patients transferring out of the institution have the required medications, transfer documents, and assigned durable medical equipment (DME) (MIT 6.101, 70.0%). In three patients' transfer packets, we found one or more of the following deficiencies: the packet did not have the required medication; the packet included a licensed correctional clinic (LCC) medication supply; and the patient's DMEs were found either in the packet or in the patient's property container. We prompted the nurse to provide the DME to the patients prior to their transfer-out of the institution.

Compliance Testing Results

	Scored Answer			
Compliance Questions	**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) *	23	2	0	92.0%
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)	24	0	1	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) *	1	1	23	50.0%
For patients transferred out of the facility: Do medication transfer packages include required medications along with the corresponding transfer packet required documents? (6.101) *	7	3	0	70.0%
				Overall percentage (MIT 6): **78.0%**

* 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.

Table 12. Transfers

Table 13. Other Tests Related to Transfers

Compliance Questions	Scored Answer			
	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) *	12	13	0	48.0%
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) *	7	0	0	100%
Are community hospital discharge documents scanned into the patient's electronic health record within three calendar days of hospital discharge? (4.003) *	7	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) *	7	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) *	3	3	1	50.0%
Upon the patient's transfer from one housing unit to another: Were medications continued without interruption? (7.005) *	22	1	0	95.7%
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) *	1	3	0	25.0%
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) *	3	9	0	25.0%

* 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

- Nursing leadership should develop and implement internal auditing of staff to ensure complete screenings of patients transferring to another institution, including documentation of pending specialty appointments.

- Nursing leadership should ensure that patients arriving to the institution from another departmental institution and patients returning from the hospital experience no delay in medication continuity.

- Nursing leadership should ensure that nursing staff administers medications without interruption for patients arriving from another departmental institution.

Medication Management

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.

Overall Rating
Inadequate

Case Review Rating
Adequate

Compliance Score
Inadequate
(59.8%)

Results Overview

Overall, SCC performed poorly in medication management. As in Cycle 5, compliance scores remain low while case review show adequate performance. However, our clinicians reviewed more events and identified more significant deficiencies than in Cycle 5. Our compliance testing showed that SCC had interruptions in medication continuity in new prescription medications, chronic medications, hospital discharge medications, transfer-in and transfer-out medications, and in ensuring that patients temporarily housed at SCC receive medications timely. Compliance testing also revealed that the institution did not thoroughly monitor patients taking tuberculosis (TB) medications, as required by policy. In addition, case reviewers identified inaccurate documentation in the medication administration record for nonautomatic refill medications for patients who did not submit a refill request. Factoring both case review and compliance results, the OIG rated this indicator ***inadequate***.

Case Review and Compliance Testing Results

We reviewed 116 events in 29 cases related to medications and found 31 medication deficiencies, five of which were significant.[38]

New Medication Prescriptions

SCC performed poorly with new medication prescriptions. Compliance testing found that new medications were not available or were not administered timely (MIT 7.002, 56.0%). The medications not provided in the required time frames included antibiotics, heartburn medications, nonsteroidal anti-inflammatory medications, a steroid anti-inflammatory medication, medications to treat urinary retention and constipation, and nasal spray for seasonal allergy medications. OIG clinicians also found a pattern of delays in the administration of newly ordered medications. Case

[38] Medication deficiencies occurred in cases 2, 5–8, 10–13, 15–18, 24, 27, and 35. Significant deficiencies occurred in cases 6, 7, 12, and 13.

review identified six cases with delays in receiving newly prescribed medications, two of which were significant.[39] Examples are described below:

- In case 12, the patient did not receive his newly ordered keep-on-person (KOP) diabetic medication, Empagliflozin, until six days later. This increased the risk of worsening blood sugar levels in the interim.

- In case 13, the fire camp patient did not receive his newly prescribed KOP cholesterol (atorvastatin) and diabetes (metformin) medications timely. The patient received these new medications one week later. In addition, the patient had a new KOP diabetes medication (glipizide) dosage, to be increased to twice daily. However, the patient received the new medication dosage increase one day late.

- In case 16, the patient did not receive his newly prescribed dosage increase of the blood pressure medication lisinopril until one day later.

- In case 27, the patient did not receive his newly prescribed glaucoma eye drops, latanoprost. The nurse documented intermittently on the Medication Administration Record (MAR) "Not Done: Task Duplication." However, in the MAR, it was also documented that the patient received the new KOP eye drop medication seven days later.

Chronic Medication Continuity

During this review period, SCC performed poorly in chronic medication continuity. Compliance testing found that patients did not receive most of their chronic care medications within required time frames (MIT 7.001, 10.0%). Analysis of the compliance data showed that KOP medications to treat blood pressure, cholesterol, and diabetes were not made available within the required time frames. In contrast, our clinicians generally found that most of the patients received their chronic care medications timely; however, case review identified two significant deficiencies:[40]

- In case 6, the fire camp patient was scheduled to receive an automatic refill of KOP aspirin and cholesterol medications. However, the patient received the chronic care medications eight days late.

- In case 7, the camp patient was to receive the scheduled automatic refill of the KOP medication tamsulosin for his prostate condition. The patient received the chronic care medication 11 days later. In addition, the patient did not get the KOP tamsulosin timely in December 2021, even after submitting a refill request. The patient received the medication 25 days after the scheduled due date.

- In case 15, during the month of August 2021, the patient did not receive his KOP chronic care medication, Finasteride, to treat urinary retention.

[39] Newly prescribed medications were not received timely in cases 7, 8, 12, 13, 16–18, 27, and 35. Significant deficiencies occurred in cases 12 and 13.

[40] Chronic care medications were not received timely in cases 6, 7, 15, and 16. Significant deficiencies occurred in cases 6 and 7.

> The order expired; however, the provider did not renew the medication until eight days later. In addition, the patient did not receive his scheduled automatic refill KOP omeprazole for heartburn for the month of September 2021.

Case review also identified that out of the 31 medication deficiencies, nine deficiencies were related to documentation discrepancies in the MAR.[41] Patients are required to submit a refill request for nonautomatic refill medications. However, when patients did not submit a refill request, nursing staff were charting "Not Done: Task Duplication" for medications that have a nonautomatic refill instead of "Not Done: Refill Not Requested." As a consequence, the patient care team may not be aware that the patient did not request the refill and that the patient did not continue to receive the prescribed medications. Examples follow:

- In case 10, during the review period, the patient did not submit refill requests for glaucoma eye drops and acne rosacea cream. The nurse documented in the MAR "Not Done: Task Duplication." However, the nurse should have documented in the MAR "Not Done: Refill Not Requested."

- In case 16, during the review period, the patient was due to receive nonautomatic refills for seasonal allergy nasal spray and psoriasis cream but did not submit refill requests for these medications. The nurse documented in the MAR "Not Done: Task Duplication." However, the nurse should have documented in the MAR "Not Done: Refill Not Requested."

Hospital Discharge Medications

Compliance testing showed that SCC performed poorly in medication continuity for patients who returned to the institution after discharging from the hospital (MIT 7.003, 50.0%). Our clinicians reviewed seven cases in which patients returned from a hospitalization or the emergency room; we found five deficiencies, one of which was significant and not related to medication continuity.[42] These deficiencies are discussed further in the **Transfers** indicator.

Specialized Medical Housing Medications

SCC's OHU was closed for renovation during the review period.

Transfer Medications

SCC had a mixed performance in managing medications for patients who were temporarily housed at the facility and who had existing medications orders.

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[41] Medication deficiencies related to incorrect documentation in the MAR occurred in cases 10, 11, and 16.

[42] We reviewed the hospital or emergency room returns in cases 1, 2, 3, and 5–8. Deficiencies occurred in cases 2, 5, and 8. A significant deficiency occurred in case 2.

Compliance testing found that patients who transferred out of the institution only sometimes had their medications (MIT 6.101, 70.0%). Patients who were temporarily housed at the facility often did not receive their medications within the required time frames (MIT 7.006, 25.0%). Compliance testing also found that medication continuity for patients arriving to SCC from another institution was poor (MIT 6.003, 50.0%). However, SCC ensured that medications were continued with minimal interruption upon the patient's transfer from one housing unit to another (MIT 7.005, 95.7%).

Our case reviewers generally found that patients received medications without interruption when they transferred into the institution. Our clinicians identified minimal lapses in medication continuity, except for one significant deficiency. Please see the **Transfers** indicators for details.

Medication Administration

Compliance testing showed that nurses administered tuberculosis (TB) medications within the required time frames (MIT 9.001, 100%). However, the institution did not thoroughly monitor patients taking TB medications, as required by policy (MIT 9.002, 36.0%). Our clinicians did not identify any deficiencies related to TB medications.

Clinician On-Site Inspection

During the on-site inspection, our clinicians interviewed the pharmacist in charge (PIC) and the acting director of nursing (DON) to discuss specific medication-related deficiencies. We were informed that patients with nonautomatic medication refills are required to submit a refill request that the medication nurse will process with pharmacy. The PIC informed us that unit dose medications are ordered as nonautomatic refill medications to prevent waste such as creams, lotions, eye drops, and inhalers. The PIC and the acting DON informed us that medication nurses are instructed to choose the MAR options "Refill Not Requested" or "Task Duplication" when the patient does not request a refill. The pharmacist informed us that the option "Task duplication" recorded on the medication management dashboard does not reflect negatively on the patient compared to "Refill Not Requested." The acting DON acknowledged the need for accurate nursing documentation on the MAR.

We toured the medication administration areas and found that nurses were knowledgeable about the medication administration process. The A Yard, B Yard, and C Yard medication areas were clean, well-organized, and had no backlogs of KOP medications for delivery. Our clinicians attended huddles in A Clinic and C Clinic. During the huddles, the care teams discussed medication compliance, including medication nonadherence, as well as medication continuity for patients transferring into the institution, arriving from another yard, or returning from the hospital.

Medications for fire camp patients are managed by the A Yard medication nurses. The A Yard medication nurses scan the medications when received from pharmacy; then the pharmacy technician transports the medications and paper medication administration record (MAR) to the camp transportation office on SCC grounds.

Automatic refill medications are filled one week in advance of the dispense date to allow for adequate time for the camp patients to receive their medication with minimal delay in medication continuity. Medications can also be delivered overnight or called into a local community pharmacy to be picked up, depending on the urgency of medications.

The medications are transported by custody staff once a week via the regular scheduled bus and as needed to the fire camp sites. The northern custody officers pick up the medications at the fire camp office and transport the medications to each designated fire camp site. The medications designated for the southern fire camp sites are transported by custody staff to a central southern hub office, where they are picked up by custody staff and delivered to the southern fire camp sites.

Custody staff have the patients at the fire camp sign the paper MAR once they receive their medications; then custody staff transmits the signed MAR by fax to the SCC A Yard medication area. The A Yard medication nurse initials and dates the faxed MAR and documents in electronic health record system (EHRS) MAR the date the medication was received. Then the nurses provide the paper MAR to health information management to be scanned into the EHRS. The A Yard medication nurses have a tracking system in a fire camp binder to ensure that fire camp patients get their medications. In addition, the camps have over- the-counter (OTC) medications that custody staff distribute as needed.

Compliance Testing Results

Medication Practices and Storage Controls

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

SCC appropriately stored and secured nonnarcotic medications in all clinic and medication line locations (MIT 7.102, 100%).

Staff kept medications protected from physical, chemical, and temperature contamination in seven of the eight clinic and medication line locations (MIT 7.103, 87.5%). In one location, staff did not record the room temperature.

Staff successfully stored valid, unexpired medications in five of the eight applicable medication line locations (MIT 7.104, 62.5%). In three locations, nurses did not label the multiple-use medication, as required by CCHCS policy.

Nurses exercised proper hand hygiene and contamination control protocols in two of six locations (MIT 7.105, 33.3%). In four locations, we found one or more of the following deficiencies: some nurses neglected to wash or sanitize their hands before each subsequent regloving; nurses did not wash or resanitize their hands and change gloves when the gloves were compromised; and the medication nurse did not wear gloves prior to preparing and administering medication.

In three of six medication preparation and administration areas, staff demonstrated appropriate administrative controls and protocols (MIT 7.106, 50.0%). In three locations, nurses did not maintain unissued medication in its original labeled packaging.

Staff in four of six medication areas used appropriate administrative controls and protocols when distributing medications to their patients (MIT 7.107, 66.7%). In one location, nurses did not disinfect the insulin port before drawing medication for injection administration. In another location, nurses could not describe the medication error reporting process and did not consistently verify patients' secondary verification prior to administration of medications.

Pharmacy Protocols

Pharmacy staff followed general security, organization, and cleanliness management protocols in the main pharmacy (MIT 7.108, 100%). Staff properly stored nonrefrigerated medications (MIT 7.109, 100%).

The pharmacy did not have an identifiable designated area for nonrefrigerated and refrigerated medications returned to the pharmacy. As a result, SCC scored zero for this test (MIT 7.110).

The pharmacist-in-charge (PIC) did not correctly review monthly inventories of controlled substances in the institution's clinic and medication storage locations. Specifically, the PIC did not correctly complete the medication-area inspection

checklists (CDCR form 7477). In addition, the nurses present at the time of the medication-area inspection did not correctly complete several medication-area inspection checklists (CDCR Form 7477). These errors resulted in a score of zero in this test (MIT 7.111).

We examined 25 medication error reports. The PIC timely or correctly processed only 20 of these 25 reports (MIT 7.112, 80.0%). In five reports, the PIC did not complete a Medication Error Follow-up form at the time of our inspection.

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 SCC, OIG clinicians did not find any applicable medication errors (MIT 7.998).

OIG clinicians interviewed patients in restricted housing units to determine whether they had immediate access to their prescribed asthma rescue inhalers or nitroglycerin medications. Eight of nine applicable patients interviewed indicated they had access to their rescue medications. One patient stated that his rescue medication was taken away and placed in his property when he transferred to the restricted housing unit. We promptly notified the CEO of this concern, and health care management immediately issued a replacement rescue inhaler to the patient (MIT 7.999).

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) *	2	18	5	10.0%
Did health care staff administer, make available, or deliver new order prescription medications to the patient within the required time frames? (7.002)	14	11	0	56.0%
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) *	3	3	1	50.0%
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) *	22	1	0	95.7%
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) *	1	3	0	25.0%
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)	7	0	3	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)	8	0	2	100%
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)	7	1	2	87.5%
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	3	2	62.5%
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)	2	4	4	33.3%
Medication preparation and administration areas: Does the institution employ appropriate administrative controls and protocols when *preparing* medications for patients? (7.106)	3	3	4	50.0%
Medication preparation and administration areas: Does the institution employ appropriate administrative controls and protocols when *administering* medications to patients? (7.107)	4	2	4	66.7%
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)	0	1	0	0
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)	20	5	0	80.0%
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): **59.8%**

* 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) *	1	1	23	50.0%
For patients transferred out of the facility: Do medication transfer packages include required medications along with the corresponding transfer-packet required documents? (6.101) *	7	3	0	70.0%
Patients prescribed TB medication: Did the institution administer the medication to the patient as prescribed? (9.001) *	25	0	0	100%
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) *	9	16	0	36.0%
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) *	N/A	N/A	N/A	N/A

* 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

- Nursing leadership should ensure that documentation in the Medication Administration Record for nonautomatic refills reflect, when applicable, that the patient did not submit a refill request; the documentation in such circumstances should not read "Not Done: Task Duplication."

- The institution should reevaluate the medication process for fire camp patients to ensure that the fire camp patients receive all medications without delay.

- Medical and nursing leadership should ensure that chronic care, newly ordered, hospital discharge, and layover patients receive their medications timely, without interruption.

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 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 as 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
(79.8%)

Results Overview

SCC had a mixed performance in preventive services. Staff performed well in administering TB medications as prescribed, offering patients an influenza vaccine for the most recent influenza season, offering colorectal cancer screening for all patients ages 45 through 75, and offering required immunizations to chronic care patients. The institution faltered in monitoring patients who were taking prescribed TB medications and screening patients annually for TB. These findings are set forth in the table on the next page. Overall, the OIG 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)	25	0	0	100%
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) †	9	16	0	36.0%
Annual TB screening: Was the patient screened for TB within the last year? (9.003)	18	7	0	72.0%
Were all patients offered an influenza vaccination for the most recent influenza season? (9.004)	24	1	0	96.0%
All patients from the age of 45 through the age of 75: Was the patient offered colorectal cancer screening? (9.005)	25	0	0	100%
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)	9	3	13	75.0%
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): **79.8%**

* 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 should consider developing and implementing measures to ensure that the nursing staff monitor, according to CCHCS policy, those patients who are prescribed TB medications.

Nursing Performance

Overall Rating
Adequate

Case Review Rating
Adequate

Compliance Score
(N/A)

In this indicator, 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' documentation for accuracy and thoroughness. Clinicians reviewed nursing performance in many clinical settings and processes, including sick call, outpatient care, care coordination 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. Accordingly, specific nursing quality issues are discussed in other indicators, such as **Emergency Services**, **Specialty Services**, and **Specialized Medical Housing.**

Results Overview

In this Cycle, SCC delivered acceptable nursing care similar to Cycle 5. Nursing staff generally provided good assessments, interventions, and documentation. We had fewer nursing encounters but identified more nursing deficiencies. The significant deficiencies in Cycle 6 consist of an incomplete wound care order after the patient returned from the hospital, nurses not ordering the proper provider follow-up appointments after a high-priority specialty appointment, and COVID-19 isolation rounding not consistently being conducted twice a day as ordered. Nurses also had room for improvement in the sick call face-to-face assessments. Overall, the OIG rated this indicator ***adequate***.

Case Review Results

We reviewed 215 nursing encounters in 42 cases. Of the nursing encounters we reviewed, 143 occurred in the outpatient setting. We identified 62 nursing performance deficiencies, seven of which were significant.[43]

Nursing Assessment and Interventions

A critical component of nursing care is the quality of nursing assessment, which includes both subjective (patient interviews) and objective (observation and examination) elements. Nurses generally provided appropriate nursing assessments and interventions. Most of the deficiencies were related to incomplete nursing assessments. OIG clinicians identified a pattern of incomplete vital signs during sick

[43] Nursing performance deficiencies occurred in cases 1–3, 5–11, 13–31, 34, 38, 40, 42, 44, and 45. Significant deficiencies occurred in cases 2, 8, 16, 27, 30, and 44.

call evaluations. In addition, we identified a pattern of COVID-19 quarantine and isolation rounding not being completed consistently as ordered.

- In cases 2, 3, 5, 6, 7, 13, 14, 15, 17, 19, and 27, nurses did not perform COVID-19 quarantine rounds daily as ordered.
- In cases 10, 11, 13, 16, 20, and 27, nurses did not perform COVID-19 isolation rounds twice a day as ordered.
- In cases 17, 18, 28, and 34, nurses did not complete vital signs or obtain a full set of vital signs.

Nursing Documentation

Complete and accurate nursing documentation is an essential component of patient care. Without proper documentation, health care staff can overlook changes in patients' conditions. OIG clinicians found that nurses performed adequately in documentation for specialty and hospitalizations. However, the nurses had room for improvement in documentation for outpatient care, transfers, and emergencies. Examples of incomplete documentation include timeline discrepancies in emergency events, missing pertinent documentation for patient's transferring into or out of the institution, and missing documentation on the medication administration record.

Nursing Sick Call

The nursing sick call process involves reviewing each sick call request and triaging whether the patient's medical symptoms warrant an urgent or routine evaluation. OIG clinicians reviewed 38 nursing sick call requests and identified 15 deficiencies, one of which was significant.[44] Nurses often reviewed symptomatic sick call requests appropriately and saw patients timely. Most nurses performed appropriate assessments and interventions. However, the following are examples of deficiencies we identified:

- In case 17, the patient had a sick call evaluation for left ankle swelling. The nurse did not assess vital signs, pain level, pedal pulse, skin for bruising, or inquire about the injuries.
- In case 31, the nurse triaged a sick call request complaining of recurrent blood in the urine and scheduled the patient to be evaluated the next business day on the nurse's line. Considering the recurring blood in the urine, however, the nurse should have evaluated the patient the day of the sick call triage to ensure that the patient was clinically stable.
- In case 42, the sick call nurse evaluated the patient for symptoms of chronic severe lumbar spine pain, nausea, and loss of appetite from COVID-19 infection. The provider was consulted and medication orders

[44] Deficiencies in face-to-face assessments for sick call requests occurred in cases 9, 15, 17–19, 28, 29, 31, 34, 40, 42, 44, and 45. A significant deficiency occurred in case 44.

received. However, the nurse did not palpate the abdomen (to assess for masses, whether tender to the touch, and whether soft or rigid. In addition, the nurse did not provide COVID-19 infection and medication education.

- In case 44, the patient had a sick call evaluation for swelling to both feet and legs from chemotherapy and was in severe discomfort even when the patient stood to obtain a weight measurement. The nurse documented that the provider would be consulted in the morning. However, the nurse should have consulted the provider the same day for a further plan of care. In addition, the nurse did not document the consultation with the provider the next day.

- In case 45, the patient had a sick call evaluation for chronic constipation with intermittent blood in the stool for a year. The patient had a history of constipation and hemorrhoids. A routine stool test had been ordered the day prior. The nurse documented the stool as brown and ordered a laxative and suppositories, per the nursing protocol for constipation. However, the nurse did not ask when the last episode of bloody stools had occurred, nor the last bowel movement, and did not ask for a description of stool consistency. In addition, the nurse did not document on the medication administration record the administration of the laxative.

Care Management

OIG clinicians reviewed one case in which a patient was evaluated by a care manager.[45] Case reviewers did not identify any deficiencies in scheduling or evaluating patients for care management appointments.

Wound Care

We reviewed two cases in which outpatient wound care was provided.[46] During case review, OIG clinicians identified three wound care deficiencies, none of which was significant.

Emergency Services

SCC performed adequately when responding to patients with urgent or emergent needs. We reviewed 13 urgent or emergent events in 10 cases and found 13 deficiencies, one of which was significant.[47] Nurses generally responded promptly to emergent events. However, nursing assessments, interventions, and documentation

[45] Patients were evaluated by the care manager in case 13.

[46] Wound care was performed in cases 2 and 7. Deficiencies for wound care occurred in cases 2 and 7, none of which were significant.

[47] The urgent and emergent events occurred in cases 1–5, 11, 17, 20, 30, and 38. Deficiencies occurred in cases 1, 2, 5, 11, 17, 20, 30, and 38. A significant deficiency occurred in case 30.

showed room for improvement, which we detail further in the **Emergency Services** indicator.

Hospital Returns

We reviewed eight events in seven cases that involved returns from off-site hospitals or emergency rooms and found five deficiencies, one of which was significant.[48] The nurses performed well in nursing assessments and documentation, which we discuss further in the **Transfers** indicator.

Transfers

We reviewed 11 cases involving transfer-in and transfer-out processes.[49] Nurses generally evaluated patients appropriately and initiated provider appointments within appropriate time frames. However, the nurses showed room for improvement in medication continuity for patients transferring into the institution and for patients returning from the community hospital. In addition, case reviewers identified opportunities for nursing improvement in identifying and communicating pending specialty appointments upon patients' transferring to another institution. Please refer to the **Transfers** indicator for further details.

Specialized Medical Housing

We did not review any specialized medical housing cases during our review period because the OHU was closed for renovation.

Specialty Services

We reviewed 40 nursing events in 10 cases in which patients returned from specialty services, and found four deficiencies, three of which were significant.[50] Nurses generally evaluated patients appropriately, reviewed off-site documents for recommendations, and communicated information to the providers. We found room for improvement for nurses in ordering the appropriate provider follow-up appointments after a patient returns from a high-priority appointment. Please refer to the **Specialty Services** indicator for additional details.

- In case 8, the patient with a medical history of cancer returned to the institution after a high-priority referral for an ultrasound of the kidneys, and on a separate occasion, the patient returned from a high-priority referral for a PET scan.[51] For both referrals, the nurse initiated 14-day follow-up provider appointments. However, the nurse should

[48] The hospitalizations and outside emergency room events occurred in cases 1, 2, 3, and 5–8. Deficiencies occurred in cases 2, 5, and 8. A significant deficiency occurred in case 2.

[49] The transfer-in and transfer-out events occurred in cases 1, 3, 6, 7, 13, and 21–26.

[50] Nursing performance events in specialty services occurred in cases 1, 8–10, 15, 17–20, and 27. Deficiencies occurred in cases 8 and 27. Significant deficiencies occurred in both case 8 and case 27.

[51] A positron emission tomography (PET) scan is an imaging test of organs and soft tissues.

have initiated five-day follow-up provider appointments, as required by CCHCS policy for high-priority specialty referrals.

- On case 27, the patient returned from an ophthalmology appointment, where he had a glaucoma procedure to the right eye and the ophthalmologist recommended that the patient continue eye drops. The patient did not have a current order for eye drops, and the nurse did not contact the ophthalmologist or provider for clarification regarding the eye drops.

Medication Management

OIG clinicians examined 116 events in 29 cases involving medication management and found 31 medication deficiencies, five of which were significant.[52] Both compliance inspectors and case reviewers identified lapses in medication continuity. Please refer to the **Medication Management** indicator for additional details.

Clinician On-Site Inspection

At the time of our on-site inspection, the Central Health building was under renovation. Therefore, the A Clinic, B Clinic, and TTA were providing services from the AB gym as their designated swing space. The Central Health building is scheduled to be completed by May 2023. The dental and radiology services continue to operate out of the Central Health building. The OHU was closed for renovation.

The LVN staff reported serving as care coordinators, and their duties consist of performing vaccinations, COVID-19 testing, and wound care; reviewing asymptomatic sick calls; offering chronic care education; distributing durable medical equipment; and scheduling follow-up appointments with patients returning from off-site appointments and patients released from quarantine. In addition, the LVN care coordinator reported the duty of reviewing the quality management dashboard for screenings to be completed for TB, colon cancer, hepatitis C, advanced liver disease, and asthma.

Nurses reported feeling generally supported with the supervisory and executive team. The nurses reported challenges with insufficient levels of nursing staff, lack of orientation to different posts, changes in the management team, and the lack of communication when there are changes in processes.

The SRNs reported that morale was low due to SRN staff being assigned new positions that they have not been trained in. SRNs also reported the lack of having a seasoned nursing leadership present and an increase in staff turnover due to the institution's location.

We met with nursing leadership, who addressed our findings and acknowledged several opportunities for quality improvement. The DON is currently in an acting position. There was no designated CNE. The acting DON reported eleven vacant RN

[52] Medication deficiencies occurred in cases 2, 5–8, 10–13, 15–8, 24, 27, and 35. Significant deficiencies occurred in cases 6, 7, 12, and 13.

positions and that challenges for nursing include nurse vacancies and a lack of training for SRNs.

Recommendations

The OIG offers no recommendations for this indicator.

Provider Performance

Overall Rating ***Adequate***

Case Review Rating ***Adequate***

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 institution's 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, SCC providers continue to deliver good care. Providers generally made appropriate assessments or decisions and managed chronic medical conditions effectively. They referred patients appropriately to specialists or to a higher level of care when needed. There were some documentation deficiencies. Overall, the OIG rated this indicator ***adequate***.

Case Review Results

OIG clinicians reviewed 113 medical provider encounters and identified 58 deficiencies related to provider performance, two of which were significant.[53] In addition, our clinicians examined the quality of care in 21 comprehensive case reviews. Of these 21 cases, we found 19 ***adequate*** and two ***inadequate***.

Assessment and Decision-Making

Providers generally made appropriate assessments and sound decisions. Most of the time, providers diagnosed medical conditions correctly and ordered appropriate tests and specialty referrals. We found 20 deficiencies related to providers' decision-making, none of which was considered significant.[54] However, our clinicians identified 25 deficiencies related to incomplete assessments, two of which were considered significant:[55]

- In case 17, the provider assessed the patient at an appointment for chronic care and follow-up after a hematology specialty consultation. The patient complained of headache, and the provider placed an order

[53] Deficiencies occurred nine times in case 27, eight times in case 18, seven times in cases 8 and 9, four times in case 19, three times in cases 5, 15, and 20, twice in cases 7, 17, 31, and 38, and one time each in cases 1, 4, 13, 14, and 16. Cases 17 and 27 had significant deficiencies.

[54] Deficiencies occurred three times in cases 9 and 18, twice in cases 8, 20, 31, and 38, and one time each in cases 1, 5, 14, 15, 16 and 19.

[55] Deficiencies occurred seven times in case 27, four times in cases 8 and 18, three times in case 19, and one time each in cases 5, 7, 9, 13, 15, 17 and 20. Significant deficiencies occurred in cases 17 and 27.

for MRI of the brain. However, the provider did not obtain a detailed history and did not perform a physical examination during the visit.

- In case 27, the provider saw the patient for a pulmonology appointment follow-up and reviewed the pulmonology recommendations with the patient. The provider did not obtain any cardiovascular and pulmonary symptoms history or review of systems. In addition, the provider did not document vital signs or medications, and did not perform a physical exam.

Review of Records

Providers generally reviewed medical records carefully. OIG clinicians found one deficiency related to a provider not properly reviewing a specialty report, but the deficiency was not significant.

Emergency Care

Providers made appropriate triage decisions when patients arrived at the TTA for emergency treatment. Providers were mostly available for consultation with TTA nursing staff and usually documented progress notes. Our clinicians identified only one deficiency related to emergency care:

- In case 5, the TTA nurse consulted the provider before transferring the patient to a higher level of care at a community hospital emergency department. However, the provider did not document a consultation progress note in the health record.

Chronic Care

In most instances, providers appropriately managed the patient's chronic health conditions. Providers performed well in managing chronic medical conditions such as hypertension, diabetes, asthma, hepatitis C infection, and cardiovascular disease. We identified two deficiencies, neither of which were significant.[56]

Specialty Services

Providers appropriately referred patients for specialty consultations when needed. When specialists made recommendations, the providers generally reviewed special reports timely and followed the recommendations appropriately. We discuss providers' specialty performance further in the **Specialty Services** indicator.

Documentation Quality

Providers generally documented accurately. Documentation is important because it shows the provider's thought process during clinical decision-making. When contacted by nurses, the providers did not always document the interactions. Our

[56] Deficiencies occurred in cases 9 and 15.

clinicians found nine documentation deficiencies, none of which was rated as significant.[57] Five of these deficiencies were related to nurse co-consultations in which the nurse documented the encounter, but the provider did not.[58]

Provider Continuity

Provider continuity was generally good, with most providers attending to patients on one yard for long periods of time, and in some cases, for years. With the exception of the periods when patients were in COVID-19 isolation, patients were usually seen by their primary care provider. Clinic C providers generally provided care related to COVID-19 since that clinic was where quarantined patients were housed.

Clinician On-Site Inspection

Since Cycle 5, SCC has had a transition of leadership to a new chief medical executive (CME) and a new chief physician and surgeon. The providers with whom we spoke expressed concerns about their medical leadership and poor morale. Some providers felt that weekly provider meetings were unproductive and expressed frustration that these meetings centered on metrics as opposed to discussing challenging medical cases. Most providers felt the CME was fair, but they did not give supporting details.

The providers generally felt supported by the nurses, medical assistants, and office assistants, and they cited this support and good collaboration with other departments as sources of practice satisfaction. The providers reported averaging from one to 10 nurse co-consultations daily. One provider expressed concerned that their co-consultation work could only be "counted" towards their daily workload if they requested that the patient be booked an appointment on their patient line.

Providers reported taking rotations to staff the TTA. In addition, some provide care at the fire camp clinic, which can take a provider out of the institution for days at a time. Medical leadership reported that while SCC is allotted 5.5 full-time employees, leadership sees a need for increasing this number due to the workload of the on-site clinic and of off-site fire camp care. They cited the remote location of the institution and not having a pay differential as factors impeding recruitment efforts.

Recommendations

- Medical leadership should ensure that providers timely complete thorough progress notes for consultations provided to nursing staff.
- Medical leadership should ensure that providers include subjective and objective patient care data in all patient encounters, as required by policy.

[57] Deficiencies occurred in cases 5, 7, 8, 9, 17, 18, and 27.

[58] Deficiencies related to undocumented interactions occurred in cases 5, 8, 9, 17, and 18.

Specialty Services

In this indicator, OIG inspectors evaluated the quality of specialty services. 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.

Overall Rating
Inadequate

Case Review Rating
Adequate

Compliance Score
***Inadequate* (71.6%)**

Results Overview

SCC's performance was mixed for specialty services. High-priority specialty appointments and reports were appropriately addressed and completed within the required time frames. However, the institution had difficulties with medium and routine priority specialty appointments and reports. At the time of our inspection, SCC had backlogs for several specialties. Providers usually made appropriate referrals with timely follow-ups and nurses appropriately assessed patients upon off-site returns. Considering both case review findings and compliance scores, we rated this indicator ***inadequate***.

Case Review and Compliance Testing Results

OIG clinicians reviewed 120 events related to Specialty Services; these included 69 specialty consultations and procedures, and 39 nursing encounters. There were 10 deficiencies in this category, three of which were considered significant.[59]

Access to Specialty Services

SCC's performance in this area was mixed. Compliance testing showed that while patients received specialty services timely in high-priority referrals (MIT 14.001, 100%), patients did not always receive always medium-priority referrals (MIT 14.004, 73.3%) and routine-priority referrals (MIT 14.007, 73.3%) timely. Our clinicians identified one deficiency related to specialty appointments:[60]

- In case 9, the provider ordered the physiatry specialty referral. However, the referral was not completed until 22 days later, when a nurse contacted the provider to complete a request for service (RFS).[61] This caused a delay in care.

Provider Performance

Providers generally referred patients appropriately and followed the specialists' recommendations. Providers usually saw patients at follow-up appointments patients within required time frames after specialty service visits (MIT 1.008,

[59] Deficiencies occurred three times in cases 8 and 27, twice in case 17, and once in cases 9 and 10. Cases 8 and 27 had significant deficiencies.

[60] A deficiency occurred in case 9.

[61] The request for service (RFS) is a referral order for a specialty consultation.

78.6%). OIG clinicians identified one deficiency, in which the provider did not properly review a specialty report:

- In case 8, the provider endorsed a renal ultrasound report two days late.

Nursing Performance

Nursing performance in specialty services was satisfactory. Nurses generally evaluated patients returning from off-site appointments thoroughly and appropriately and communicated recommendations to the providers. Our clinicians reviewed 39 specialty nursing encounters and identified four deficiencies. This is discussed further in the **Nursing Performance** indicator.

Health Information Management

Providers reviewed high-priority specialty reports within the required time frame most of the time (MIT 14.002, 80.0%). However, providers did not always review routine-priority and medium-priority consultant reports within the required time frames (MIT 14.008, 53.3% and MIT 14.005, 40.0%). Staff generally scanned specialty reports into the EHRS timely (MIT 4.002, 80.0%). Our clinicians identified three deficiencies related to delay in retrieving and scanning specialist consultant reports within the required time frame:

- In case 10, the ophthalmologist assessed the patient. However, the ophthalmologist's consultation report was retrieved and scanned into EHRS two days late.

- In case 17, the ophthalmology specialist report was scanned into EHRS three days late. Also in case 17, the eye specialist assessed the patient, but the specialist's handwritten report is only partially legible. The staff should have contacted the specialist to clarify the report.

- In case 27, the cardiology consultation report was scanned into EHRS two days late.

Clinician On-Site Inspection

We discussed information processes with HIM staff, who reported that specialists sometimes provide handwritten recommendations on the RFS form that returns with the patient after an off-site specialty appointment. The HIM staff reported that they try to contact the specialists directly within three days of the appointment for dictated or typed consultation reports. Both HIM and specialty services staff track biopsy results, and specialty services staff stated that most results were obtained within one week. Utilization management (UM) staff reported that there were limited off-site specialists and cited this as a reason for noncompliance with appointment time frames. At the time of our inspection, staff reported that backlogs for appointments existed for cardiology, hematology, oncology, and urology specialties.

Compliance Testing Results

Table 17. 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) *	15	0	0	100%
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) *	12	3	0	80.0%
Did the patient receive the subsequent follow-up to the high-priority specialty service appointment as ordered by the primary care provider? (14.003) *	11	2	2	84.6%
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) *	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) *	6	9	0	40.0%
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) *	11	4	0	73.3%
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) *	8	7	0	53.3%
Did the patient receive the subsequent follow-up to the routine-priority specialty service appointment as ordered by the primary care provider? (14.009) *	5	1	9	83.3%
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) *	3	9	0	25.0%
Did the institution deny the primary care provider's request for specialty services within required time frames? (14.011)	7	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)	4	1	2	80.0%
				Overall percentage (MIT 14): **71.6%**

* 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 18. 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) *, †	33	9	3	78.6%
Are specialty documents scanned into the patient's electronic health record within five calendar days of the encounter date? (4.002) *	24	6	15	80.0%

* 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 ascertain the challenges to receiving specialty reports within the required time frame as well as challenges to providers' timely reviewing specialty reports, and leadership should implement remedial measures as appropriate.

- Medical leadership should ensure that patients receive ordered specialty services within the specified time frames.

Administrative Operations

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, our 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 based 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
(66.0%)

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

SCC's performance for this indicator worsened compared with that of Cycle 5. 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. In addition, the institution conducted medical emergency response drills with incomplete documentation and incomplete custody participation. Physician managers did not always complete annual appraisals in a timely manner. At the time of our inspection, the nurse educator was not able to provide sufficient documentation that newly hired staff received the civil service nursing staff onboarding and competency training within 12 weeks of the hire date. These findings are set forth in the table on the next page. Overall, we rated this indicator ***inadequate***.

Nonscored Results

SCC 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. One unexpected (Level 1) death occurred during our review period. In our inspection, we found that the DRC did not complete the death review report promptly. The DRC finished the report 51 days late and submitted it to the institution's CEO 46 days after the deadline for submitting the report (MIT 15.998).

Compliance Testing Results

Table 19. 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)	3	9	0	25.0%
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)	N/A	N/A	N/A	N/A
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)	1	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)	1	5	1	16.7%
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)	1	1	1	50.0%
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)	6	0	1	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)	0	1	0	0
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): **66.0%**			

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

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

Recommendations

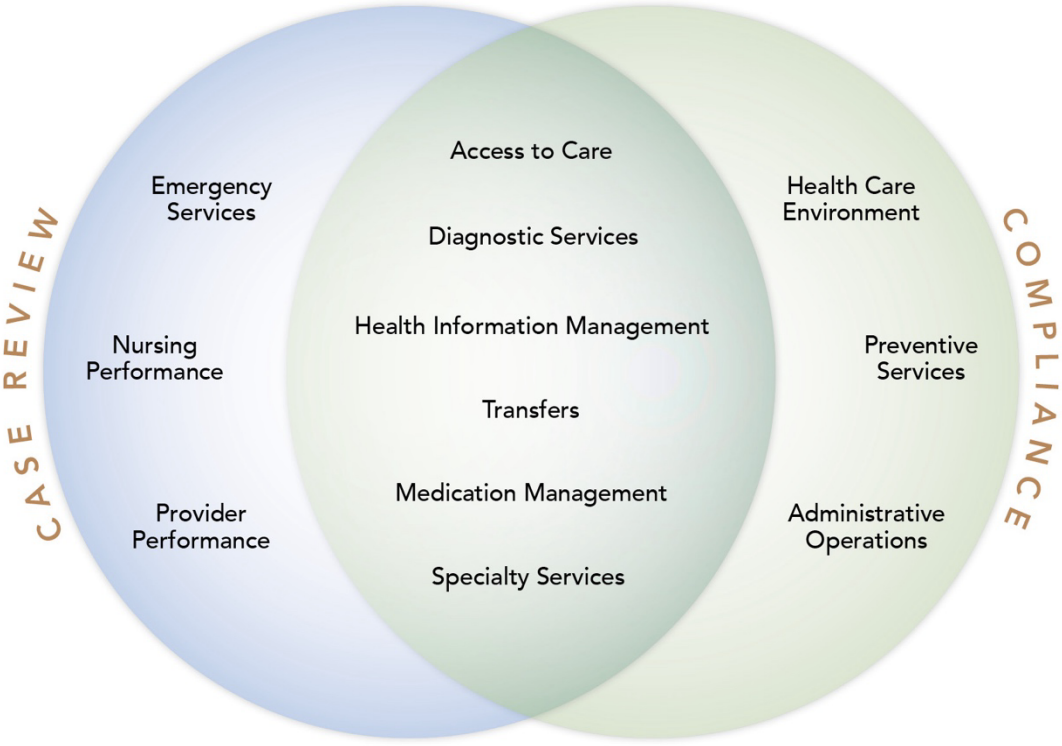
The OIG offers no recommendations for this indicator.

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 Review Distribution for SCC



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

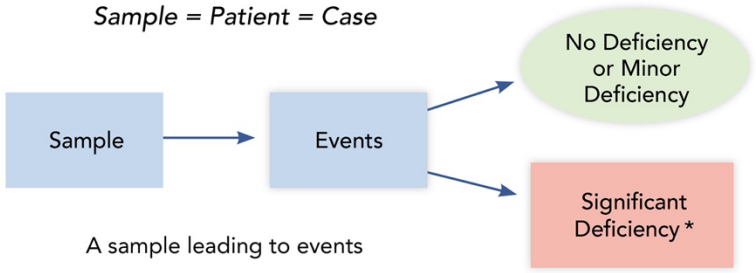
An OIG physician, a nurse consultant, or both review each case. As the clinicians review medical records, they record pertinent interactions between the patient and the health care system. We refer to these interactions as case review ***events***. Our clinicians also record medical errors, which we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

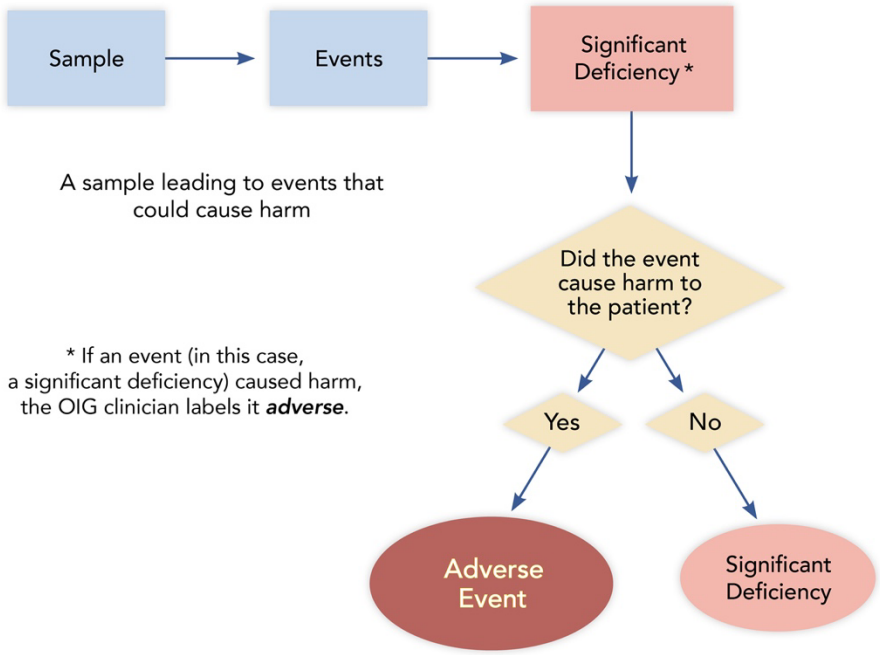
Figure A–2. Case Review Testing

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***.



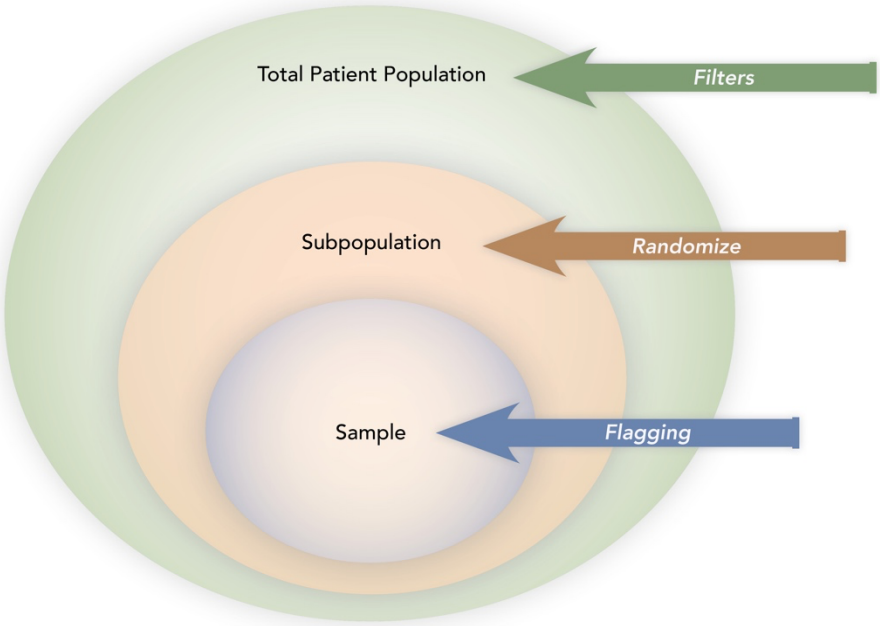
Source: The Office of the Inspector General medical inspection analysis.

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. SCC Case Review Sample Sets

Sample Set	Total
Anticoagulation	3
Death Review / Sentinel Events	2
Diabetes	3
Emergency Services – Non-CPR	2
High Risk	5
Hospitalization	4
Intra-system Transfers In	3
Intra-system Transfers Out	3
RN Sick Call	18
Specialty Services	2
	45

Table B–2. SCC Case Review Chronic Care Diagnoses

Diagnosis	Total
Anemia	1
Anticoagulation	3
Arthritis/Degenerative Joint Disease	9
Asthma	4
COPD	3
COVID-19	6
Cancer	3
Cardiovascular Disease	1
Chronic Pain	8
Cirrhosis/End-Stage Liver Disease	3
Diabetes	4
Gastroesophageal Reflux Disease	4
Hepatitis C	6
Hyperlipidemia	11
Hypertension	13
Mental Health	10
Migraine Headaches	1
Rheumatological Disease	1
Seizure Disorder	1
Sleep Apnea	1
Substance Abuse	8
Thyroid Disease	1
	102

Table B–3. SCC Case Review Events by Program

Diagnosis	Total
Diagnostic Services	229
Emergency Care	22
Hospitalization	12
Intra-system Transfers In	8
Intra-system Transfers Out	4
Outpatient Care	439
Specialty Services	120
	904

Table B–4. SCC Case Review Sample Summary

	Total
MD Reviews Detailed	21
MD Reviews Focused	3
RN Reviews Detailed	13
RN Reviews Focused	32
Total Reviews	69
Total Unique Cases	45
Overlapping Reviews (MD & RN)	24

Appendix C. Compliance Sampling Methodology

Sierra Conservation Center

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)	32	Clinic Appointment List	• Clinic (each clinic tested) • Appointment date (2–9 months) • Randomize
MIT 1.007	Returns From Community Hospital	7	OIG Q: 4.005	• See Health Information Management (Medical Records) (returns from community hospital)
MIT 1.008	Specialty Services Follow-Up	42	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	0	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	32	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	7	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	7	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	8	OIG inspector on-site review	• Identify and inspect all on-site clinical areas.
Transfers				
MITs 6.001–003	Intrasystem Transfers	25	SOMS	• Arrival date (3–9 months) • Arrived from (another departmental facility) • Rx count • Randomize
MIT 6.101	Transfers Out	10	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	7	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	Intrafacility Moves	23	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	4	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	9	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	25	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 (45 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	Reception Center	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	N/A at this institution	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	12	Specialty Services Arrivals	• Arrived from (other departmental institution) • Date of transfer (3–9 months) • Randomize
MITs 14.011–012	Denials	7	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	N/A at this institution	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	1	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	6	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	1	OIG summary log: deaths	• Between 35 business days & 12 months prior • California Correctional Health Care Services death reviews

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California Correctional Health Care Services' Response

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February 24, 2023

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 Sierra Conservation Center (SCC) conducted by the Office of the Inspector General (OIG) from August 2021 to January 2022. 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
Policy and Risk Management Services
California Correctional Health Care Services

cc: Diana Toche, D.D.S., Undersecretary, Health Care Services, CDCR
Clark Kelso, Receiver
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Cycle 6

Medical Inspection Report

for

Sierra Conservation Center

OFFICE *of the*
INSPECTOR GENERAL

Amarik K. Singh
Inspector General

Neil Robertson
Chief Deputy Inspector General

STATE *of* CALIFORNIA
March 2023

OIG