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OIG | OFFICE *of the* INSPECTOR GENERAL

Independent Prison Oversight

June 2023

Cycle 6
Medical Inspection Report

San Quentin State Prison

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Contents

Illustrations

Tables

Figures

Photographs

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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 is continuing to inspect both those institutions remaining under federal receivership and those delegated back to the department. There is no difference in the standards used for assessing a delegated institution versus an institution not yet delegated. At the time of the Cycle 6 inspection of the San Quentin State Prison (SQ), the receiver had delegated this institution back to the department.

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

San Quentin State Prison is California's oldest correctional institution, established on the site currently known as Point San Quentin in July 1852. The walled prison houses mostly medium-security (Level 2) inmates, and it has four large cell blocks (north, south, east, and west), one maximum-security cell block (the adjustment center), a central health care service building, a medium-security dormitory setting, and a minimum-security firehouse. The institution houses all of California's condemned male inmates who are on death row. The institution runs eight medical clinics where staff members handle nonurgent requests for medical services, and it treats patients needing urgent or emergent care in its triage and treatment area (TTA). SQ has a correctional treatment center (CTC) for inpatient services, which also includes a 40-bed psychiatric inpatient program. Patients are seen in the receiving and release (R&R) clinic on arrival at SQ, and there is one specialty services clinic. SQ has been designated an *intermediate care prison*; these institutions are predominately located in urban areas close to medical centers and specialty care providers who are likely to be used by a patient population with higher medical needs.

[6] Samples are obtained per case review methodology shared with stakeholders in prior cycles. The case reviews include emergency cardiopulmonary (CPR) reviews between July 2021 and March 2022, death reviews between July 2021 and March 2022, and specialty reviews between September 2021 and March 2022, and RN sick call reviews between October 2021 and April 2022.

[7] As of March 20, 2023, the department reports on its public tracker that 95% of its incarcerated population at SQ is fully vaccinated while 84% of SQ staff is fully vaccinated: http://www.cdcr.ca.gov/covid19/population-status-tracking/.

Summary

We completed the Cycle 6 inspection of SQ in September 2022. OIG inspectors monitored the institution's delivery of medical care that occurred between October 2021 to March 2022.

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

Table 1. SQ Summary Table

Ratings
Proficient *Adequate* *Inadequate*

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

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

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

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

To test the institution's policy compliance, our compliance inspectors (a team of registered nurses) monitored the institution's compliance with its medical policies by answering a standardized set of questions that measure specific elements of health care delivery. Our compliance inspectors examined 397 patient records and 1,208 data points and used the data to answer 92 policy questions. In addition, we observed SQ processes during an on-site inspection in June 2022. Table 2 below lists SQ's average scores from Cycles 4, 5, and 6.

Table 2. SQ Policy Compliance Scores

Scoring Ranges

100%–85.0%	84.9%–75.0%	74.9%–0

Medical Inspection Tool (MIT)	Policy Compliance Category	Average Score		
		Cycle 4	Cycle 5	Cycle 6
1	Access to Care	77.9%	67.6%	76.0%
2	Diagnostic Services	71.6%	75.9%	54.2%
4	Health Information Management	64.6%	83.3%	82.8%
5	Health Care Environment	75.4%	50.9%	43.2%
6	Transfers	87.0%	64.3%	63.0%
7	Medication Management	77.8%	35.0%	39.6%
8	Prenatal and Postpartum Care	N/A	N/A	N/A
9	Preventive Services	61.5%	66.6%	77.7%
12	Reception Center†	78.0%	77.0%	N/A
13	Specialized Medical Housing	71.4%	75.0%	82.5%
14	Specialty Services	77.5%	82.4%	60.1%
15	Administrative Operations	66.4%*	67.2%	69.0%

* 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.

† The reception center was deactivated at SQ prior to the Cycle 6 inspection review period.

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

The OIG clinicians (a team of physicians and nurse consultants) reviewed 63 cases, which contained 1,627 patient-related events. After examining the medical records, our clinicians conducted a follow-up on-site inspection in September 2022 to verify their initial findings. The OIG physicians rated the quality of care for 25 comprehensive case reviews. Of these 25 cases, our physicians rated none ***proficient***, 21 ***adequate,*** and four ***inadequate***. Our physicians found no adverse deficiencies during this inspection.

The OIG then considered the results from both case review and compliance testing, and drew overall conclusions, which we report in the 13 health care indicators.[8] Multiple OIG physicians and nurses performed quality control reviews; their subsequent collective deliberations ensured consistency, accuracy, and thoroughness. Our OIG 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 the SQ Summary Table.

In May 2022, the Health Care Services Master Registry showed that SQ had a total population of 3,193. A breakdown of the medical risk level of the SQ population as determined by the department is set forth in Table 3 below.[9]

Table 3. SQ Master Registry Data as of May 2022

Medical Risk Level	Number of Patients	Percentage*
High 1	460	14.4%
High 2	733	23.0%
Medium	1,144	35.8%
Low	856	26.8%
Total	**3,193**	**100.0%**

* Percentages may not total 100% due to rounding.

Source: Data for the population medical risk level were obtained from the CCHCS Master Registry dated 5-13-22.

[8] The indicators for **Reception Center** and **Prenatal and Postpartum Care** did not apply to SQ.

[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, SQ had one executive leadership position vacancy, two primary care provider vacancies, 4.7 nursing supervisor vacancies, and 26.6 nursing staff vacancies.

Table 4. SQ Health Care Staffing Resources as of May 2022

Positions	Executive Leadership*	Primary Care Providers	Nursing Supervisors	Nursing Staff †	Total
Authorized Positions	5.0	12.0	19.7	117.6	154.3
Filled by Civil Service	4.0	10.0	15.0	91.0	120.0
Vacant	1.0	2.0	4.7	26.6	34.3
Percentage Filled by Civil Service	80.0%	83.3%	76.1%	77.4%	77.8%
Filled by Telemedicine	0	0	0	0	0
Percentage Filled by Telemedicine	0	0	0	0	0
Filled by Registry	0	0	0	0	0
Percentage Filled by Registry	0	0	0	0	0
Total Filled Positions	4.0	10.0	15.0	91.0	120.0
Total Percentage Filled	**80.0%**	**83.3%**	**76.1%**	**77.4%**	**77.8%**
Appointments in Last 12 Months	2.0	0	2.0	18.0	22.0
Redirected Staff	0	0	0	0	0
Staff on Extended Leave‡	1.0	1.0	1.0	6.0	9.0
Adjusted Total: Filled Positions	3.0	9.0	14.0	85.0	111.0
Adjusted Total: Percentage Filled	**60.0%**	**75.0%**	**71.1%**	**72.3%**	**71.9%**

* Executive Leadership includes the Chief Physician and Surgeon.

† Nursing Staff includes the classifications of 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 on May 13, 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 SQ during the cycle 6 inspection.

Case Review Results

OIG case reviewers (a team of physicians and nurse consultants) assessed 10 of the 13 indicators applicable to SQ. Of these 10 indicators, OIG clinicians rated four ***adequate*** and six ***inadequate***. The OIG physicians also rated the overall adequacy of care for each of the 25 detailed case reviews they conducted. Of these 25 cases, none were ***proficient***, 21 were ***adequate***, and four were ***inadequate***. In the 1,627 events reviewed, there were 522 deficiencies, 99 of which the OIG clinicians considered to be of such magnitude that, if left unaddressed, would likely contribute to patient harm.

Our clinicians found the following strengths at SQ:

- Correctional treatment center (CTC) nurses performed timely admission assessments.
- Staff performed well in initiating cardiopulmonary resuscitation. Staff, including custody, initiated CPR immediately, activated EMS without delay, and notified the TTA in a timely manner.
- Patients arriving at SQ generally received medications without lapses in continuity.
- Staff performed well in the transfer-out process. Receiving and release (R&R) nurses ensured all transfer requirements were met.

Our clinicians found the following weaknesses at SQ:

- On-site specialty oversight was poor with lapses in test result endorsement, specialty report endorsement, and communication between on-site specialists and providers.

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

- Providers did not always address abnormal vital signs.
- Nursing assessments and interventions showed opportunities for improvement.
- Medication management was problematic for newly prescribed, chronic care, and hospital discharge medications.

Compliance Testing Results

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

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

- The institution's medical staff timely scanned requests for health care services into patients' electronic medical records and community hospital discharge reports. In addition, staff accurately scanned and labeled medical records in patient files.
- The institution's nursing staff and providers performed well in completing initial health assessments and evaluating patients admitted to specialized medical housing in a timely manner.
- Nursing staff reviewed health care services request forms and performed face-to-face encounters timely. In addition, SQ housing units contained adequate supplies of health care request forms.

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

- Patients did not always receive their chronic care medications within required time frames. There was poor medication continuity for both patients returning from hospitalizations and those admitted to specialized medical housing.
- Medication lines and the pharmacy at SQ did not properly store nonnarcotic refrigerated and nonrefrigerated medications.
- Health care staff did not follow proper hand hygiene practices before or after patient encounters.
- SQ's medical warehouse and clinics housed multiple medical supplies that had expired.
- Staff did not perform well in ensuring that approved specialty services were provided timely.

- The institution often did not ensure specialty service reports were received timely. Furthermore, providers often did not review specialty services reports within required time frames.

- The institution did not consistently provide routine and STAT laboratory services within the specified time frames.

- Providers often did not communicate results of diagnostic services timely. Most patient letters communicating these results were missing the date of the diagnostic service, the date of the results, and whether the results were within normal limits.

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 SQ's performance to assess the macroscopic view of the institution's health care delivery. 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)—SQ 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 these data for informational purposes. SQ had a 65 percent influenza immunization rate for adults 18 to 64 years old and an 80 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. SQ had a 76 percent colorectal cancer screening rate.

Table 5. SQ Results Compared With State HEDIS Scores

HEDIS Measure	SQ Cycle 6 Results*	California Medi-Cal 2018†	California Kaiser NorCal Medi-Cal 2018†	California Kaiser SoCal Medi-Cal 2018†
HbA1c Screening	98%	–	–	–
Poor HbA1c Control (>9.0%)‡,§	**12%**	42%	34%	23%
HbA1c Control (<8.0%)‡	76%	–	–	–
Blood Pressure Control (<140/90)‡	84%	–	–	–
Eye Examinations	43%	–	–	–
Influenza–Adults (18–64)	65%	–	–	–
Influenza–Adults (65+)	80%	–	–	–
Pneumococcal–Adults (65+)	90%	–	–	–
Colorectal Cancer Screening	76%	–	–	–

Notes and Sources

* Unless otherwise stated, data were collected in June 2022 by reviewing medical records from a sample of SQ'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 SQ population was tested.

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

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

[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, PCV 15, and PCV 20), 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.

Recommendations

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

Access to Care

- Medical leadership should determine the root causes(s) of challenges in the timely provision of chronic care follow-up appointments, routine specialty appointments and follow-up appointments, nurse-to-provider referrals, and provider-ordered follow-up appointments, and should implement remedial measures as appropriate.

Diagnostic Services

- Medical leadership should consider approaches to recruit and retain sufficient levels of laboratory and radiology staff.
- Medical leadership should ensure all medical record inboxes have appropriate coverage.
- Medical leadership should ascertain causative factors related to the untimely provision of routine and STAT laboratory services, and implement remedial measures as appropriate.
- Medical leadership should consider developing strategies to ensure STAT laboratory test results were acknowledged by providers or providers were notified within required time frames.
- The department should consider developing strategies to ensure that providers create patient letters at the time of review or endorsement and that patient letters contain all elements required per CCHCS policy.

Emergency Services

- Nursing leadership should consider performing TTA audits to ensure complete assessments, timely interventions, thorough documentation, and provide staff training as required.
- The Emergency Medical Response Review Committee (EMRRC) should thoroughly review emergency response events within the required time frame.
- Medical leadership should ensure providers order appropriate transportation for patients who need a higher level of care for emergent events.

Health Information Management

- Medical leadership should consider HIM access to the electronic medical record systems of off-site hospitals and specialty clinics to improve report retrievals.
- Medical leadership should consider reviewing the HIM workload to ensure adequate staffing and priorities are in place.
- Medical leadership should ascertain all key elements are included in the final hospital discharge report.

Health Care Environment

- Executive leadership should consider performing random spot checks to ensure medical supply storage areas, located inside and outside the clinics, store medical supplies adequately.
- Medical leadership should remind staff to follow universal hand hygiene precautions. Implementing random spot checks could improve compliance.
- Nursing leadership should direct each clinic nurse supervisor to review the monthly emergency medical response bag (EMRB) and treatment cart logs to ensure that the EMRBs and treatment carts are regularly inventoried and kept sealed.

Transfers

- Nursing leadership should develop and implement procedures for the internal auditing of staff to ensure thorough assessments are completed for patients returning from hospitalizations.
- Nursing leadership should educate nursing staff on how to thoroughly complete the initial health screening process including answering all questions and documenting an explanation for all "Yes" answers before the patient is transferred to the housing unit.

Medication Management

- Medical and nursing leadership should ensure that patients with newly prescribed medications, chronic care, and hospital discharge medications should receive their medications timely and without interruptions; leadership should implement remedial training as appropriate.

Preventive Services

- Nursing leadership and the public health nurse should educate nursing staff on completing weekly tuberculosis (TB) monitoring as

required per policy, and on properly documenting TB signs and symptoms when monitoring patients taking TB medications.

Nursing Performance

- Nursing leadership should ensure that nurses perform more detailed assessments and timely interventions.

Provider Performance

- Medical and nursing leadership should consider ensuring consistent, adequate nursing support is offered to medical providers.
- Medical leadership should ensure critical tools, such as wound culture kits, are readily available to providers in clinics.

Specialized Medical Housing

- Nursing leadership should ensure CTC nurses complete initial and daily patient assessments thoroughly.

Specialty Services

- The department should consider whether on-site specialists should be provisioned to enter progress notes and orders for patients in the electronic health records system (EHRS); and if that access should be provisioned, then the department should ensure appropriate EHRS training is offered before on-site specialists perform their duties; moreover, this training should include ongoing oversight, including timely endorsement of reports and test results, communication with on-site providers and nurses, and adequate support staffing.
- Medical leadership should ensure all specialty reports, including chemotherapy treatments, radiation visits, and specialty procedures, are scanned into EHRS timely.
- Medical leadership should ensure that patients receive their approved specialty service and subsequent follow-up specialty service appointments within specified time frames.
- Medical leadership should determine the root cause of challenges in notifying patients about specialty denials within the required time frame and implement remedial measures as appropriate.

Access to Care

Overall Rating
Adequate

Case Review Rating
Adequate

Compliance Score
***Adequate* (76.0%)**

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.

Results Overview

Compared with Cycle 5, SQ improved overall and provided sufficient access to care in most areas. Both case review and compliance testing found very good nursing access. Compliance testing found provider access was poor in several areas; however, case review did not find any significant deficiencies. Specialty services access for initial and follow-up routine priority appointments needed improvement. After reviewing all aspects of access to care, we rated this indicator ***adequate***.

Case Review and Compliance Testing Results

OIG clinicians reviewed 421 provider, nursing, urgent or emergent care (TTA), specialty, and hospital events that required staff to generate appointments. We identified 41 deficiencies relating to this indicator, 11 of which were significant.

Access to Care Providers

SQ's performance in provider access was mixed. Compliance testing showed poor access to chronic care follow-up appointments and for nurse-to-provider sick call referrals (MIT 1.001, 72.0% and MIT 1.005, 71.4%). Most significant was that provider-ordered follow-up appointments with providers occurred only 25.0 percent of the time (MIT 1.006). Case reviewers found no significant deficiencies in provider access.[13]

Access to Specialized Medical Housing Providers

SQ performed very well in access to specialized medical housing providers with only one deficiency in case 7.

Access to Clinic Nurses

SQ performed very well in access to nursing sick calls and provider-to-nurse referrals. Compliance testing found that nurses always reviewed patient requests for services and usually saw the patients within required time frames (MIT 1.003, 100% and MIT 1.004, 91.4%). Our clinicians assessed 61 nursing sick call requests,

[13] Deficiencies occurred in cases 6, 13, 17, 21, 22, 24, 28, and 49.

in which the health care services request form (CDCR 7362) was used. We identified five deficiencies related to clinic nurse access with only two being significant as discussed below:[14]

- In case 15, the patient submitted a sick call stating he could not get out of bed, had sweats, chills, vomiting, and "infection." The patient should have been evaluated on the same day for urgent symptoms; however, the patient was not seen for four days.

- In case 25, the provider ordered daily heart rate checks with the nursing staff to follow up with a patient who was recently started on amiodarone to treat a life-threatening heart arrythmia.[15] Seven of the 18 required heart-rate checks did not occur.

Access to Specialty Services

SQ performance was mixed. Compliance testing found that SQ performed well in completing high-priority initial and follow-up specialty appointments (MIT 14.001, 80.0% and MIT 14.003, 90.0%), fair for medium-priority initial and follow-up appointments (MIT 14.004, 80.0% and MIT 14.006, 75.0%), and poorly for routine-priority initial and follow-up specialty appointments (MIT 14.007, 26.7% and MIT 14.009, 50.0%).

SQ also only occasionally met compliance time frames for preexisting specialty appointments for departmental transfer-in patients (MIT 14.010, 30.0%). Case review also found deficiencies in specialty access.[16] This situation is discussed in more detail in the **Specialty Services** indicator.

Follow-Up After Specialty Services

Compliance testing revealed that 64.0 percent of post-specialty provider follow-up appointments occurred within the required time frame (MIT 1.008).

Follow-Up After Hospitalization

SQ's performance was fair in ensuring that providers saw patients after hospitalizations (MIT 1.007, 76.0%). Our clinicians identified two minor posthospitalization follow-up deficiencies in cases 20 and 22. The remaining hospitalization follow-ups occurred timely.

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[14] Deficiencies occurred in cases 15, 20, 25, 27, and 49. Significant deficiencies occurred in cases 15 and 25.

[15] Amiodarone is a medication used to treat and prevent serious abnormal heart rhythms. It is used to restore normal heart rhythm and to maintain a regular, steady heartbeat.

[16] Access to **Specialty Services** deficiencies occurred in cases 1, 3, 6–9, 12, 14, 16–17, 21, 23, and 25–27. Significant deficiencies occurred in cases 3, 6, 8–9, 12, 14, 17, 23, and 25.

Follow-Up After Urgent or Emergent Care (TTA)

Providers saw their patients following a triage and treatment area (TTA) event as requested. We reviewed 40 TTA events and did not identify any delays.

Follow-Up After Transferring Into the Institution

Primary care access to care for recent transfer-in patients was good. Compliance testing showed access to intake appointments for newly arrived patients occurred within specified timeframes (MIT 1.002, 84.0%). Case reviewers did not find any primary care access deficiencies in this area.

Clinician On-Site Inspection

SQ had eight main clinics, TTA, CTC, and a specialty clinic. The specialty clinic offered podiatry, nephrology, urology, ultrasound, physical therapy, optometry, dialysis, sleep study, and telemedicine.[17]

We spoke with SQ's medical and nursing leadership, scheduling managers, and staff regarding SQ's access to care. Scheduling managers reported that they had significant staffing shortages during the review period. They were allotted six office technicians (OT), however, there was only one on-site. Due to the inability to recruit new staff, SQ implemented a remote approach to scheduling and utilized departmental headquarters OTs to fill the institution's on-site positions. The scheduling managers reported that this is working well for them.

Scheduling staff stated that challenges to scheduling appointments timely included providers and nursing entering orders incorrectly and intrafacility transfer encounters not being closed correctly by the sending institution. They explained that if intrafacility transfers encounters are not closed correctly by the sending institution, then all health-care-related tasks (appointments, medications, etc.) continue to be sent to staff at that sending institution instead of to SQ staff, which means that SQ staff do not see the requested tasks. Furthermore, when the transfer encounter is eventually closed by the sending institution's staff, all the health-care-related task orders are closed. The transfer patients, therefore, would not be seen timely, and care could have been delayed. In addition, during the review period, scheduling staff stated that there was a significant primary care backlog due to provider absences and vacancies, but this situation improved recently due to an increase in providers.

[17] Nephrology is a specialty that focuses on kidney conditions and diseases.

Compliance Testing Results

All six housing units that were randomly tested at the time of our inspection had access to CDCR 7362 forms (MIT 1.101, 100%).[18] However, three of the six housing units did not have the original CDCR 7362 form. The institution reported that its staff provided a scanned version of the CDCR 7362 form saved on a staff member's desktop computer to use in making copies of the printed version. The staff provided this copied version of the form rather than procuring additional CDCR 7362 forms from the medical warehouse or custody program offices.

[18] A CDCR 7362 form is the Health Care Services Request Form. Patients can submit this form to request medical care.

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) *	18	7	0	72.0%
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) *	21	4	0	84.0%
Clinical appointments: Did a registered nurse review the patient's request for service the same day it was received? (1.003) *	35	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	3	0	91.4%
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) *	10	4	21	71.4%
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	3	31	25.0%
Upon the patient's discharge from the community hospital: Did the patient receive a follow-up appointment within the required time frame? (1.007) *	19	6	0	76.0%
Specialty service follow-up appointments: Did the clinician follow-up visits occur within required time frames? (1.008) *,†	16	9	20	64.0%
Clinical appointments: Do patients have a standardized process to obtain and submit health care services request forms? (1.101)	6	0	0	100%
				Overall percentage (MIT 1): **76.0%**

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

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

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

Table 7. Other Tests Related to Access to Care

	Scored Answer			
Compliance Questions	**Yes**	**No**	**N/A**	**Yes %**
For patients received from a county jail: If, during the assessment, the nurse referred the patient to a provider, was the patient seen within the required time frame? (12.003) *	N/A	N/A	N/A	N/A
For patients received from a county jail: Did the patient receive a history and physical by a primary care provider within seven calendar days? (12.004) *	N/A	N/A	N/A	N/A
For CTC and SNF only (effective 4/2019, include OHU): Was a written history and physical examination completed within the required time frame? (13.002) *	10	0	0	100%
For OHU, CTC, SNF, and Hospice (applicable only for samples prior to 4/2019): Did the primary care provider complete the Subjective, Objective, Assessment, and Plan notes on the patient at the minimum intervals required for the type of facility where the patient was treated? (13.003) *,†	0	0	10	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) *	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) *	9	1	5	90.0%
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) *	12	3	0	80.0%
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	2	7	75.0%
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) *	4	11	0	26.7%
Did the patient receive the subsequent follow-up to the routine-priority specialty service appointment as ordered by the primary care provider? (14.009) *	2	2	11	50.0%

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

† CCHCS changed its policies and removed mandatory minimum rounding intervals for patients located in specialized medical housing. After April 2, 2019, MIT 13.003 only applied to CTCs that still 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 causes(s) of challenges in the timely provision of chronic care follow-up appointments, routine specialty appointments and follow-up appointments, nurse-to-provider referrals, and provider-ordered follow-up appointments, and 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
Inadequate

Compliance Score
***Inadequate* (54.2%)**

Results Overview

SQ performed worse in this indicator than it did in Cycle 5 due to poor laboratory test completion rates, delayed provider test endorsements, a lack of monitoring on-site specialty-ordered test results, and poor communication of test results to the patients. We reviewed all aspects and rated this indicator ***inadequate***.

Case Review and Compliance Testing Results

We reviewed 327 diagnostic events and found 75 deficiencies, nine of which were significant.[19] Of these 75 deficiencies, we found 41 were related to missing patient results letters, 20 were related to provider laboratory result endorsements that were late, and eight were related to test-completion deficiencies.

Test Completion

SQ had a mixed performance. Staff performed excellent in radiology test completion in both case review and compliance testing (MIT 2.001, 100%). Compliance testing found that staff, however, performed poorly in completing both routine and STAT laboratory testing and in reporting STAT laboratory results to providers (MIT 2.004, 60.0%, MIT 2.007, 30.0%, and MIT 2.008, 30.0%). Case review found that, usually, diagnostic tests were done and results reported timely; however, several deficiencies were identified with two in the following being significant:[20]

- In case 9, a lab draw for an important blood clotting test (INR) was performed timely; however, the result was available 16 days after the collection.[21] The late result showed the patient had an elevated INR that required immediate medication adjustment to prevent bleeding.
- In case 14, the provider placed laboratory orders to follow up on an elevated potassium level, acidosis, and worsening renal function,

[19] Deficiencies occurred in cases 1, 3, 6–10, 13–15, 17–19, 22, 23–25, 27, and 62. Significant deficiencies occurred in cases 1, 7, 8, 9, 14, and 25.

[20] Deficiencies occurred in cases 7, 9, 13–15, 17, 19 and 25.

[21] The INR is a lab test to measure the body's blood clotting. This test is used to monitor the effectiveness of blood thinning medications such as warfarin.

which can all be life threatening. The orders were placed twice, but neither order was completed, placing the patient at medical risk.

Case reviewer did not have any sample cases with STAT laboratory orders.

Both case review and compliance testing found that SQ performed very well in obtaining pathology reports (MIT 2.010, 100%).

Health Information Management

SQ had a mixed performance in provider endorsement and communication of test results.

Compliance testing found that providers endorsed radiology studies within specified time frames only 50.0 percent of the time (MIT 2.002) and providers acknowledged or were notified of STAT lab results only 30.0 percent of the time (MIT 2.008). However, providers timely reviewed routine laboratory studies and pathology reports once they were received (MIT 2.005, 90.0% and MIT 2.011, 80.0%). Case reviewers also identified that providers endorsed the test results late. Case review clinicians found 29 diagnostics-related HIM deficiencies, 20 of which were late provider endorsements.[22] Three of the deficiencies were in case 25, which represented a pattern of tests not being endorsed timely by on-site specialists and that were considered significant. The following is an example:

- The on-site specialist ordered a chest X-ray that was abnormal; however, the chest X-ray result was endorsed by the on-site specialist 68 days late. The primary care team was not aware that the chest X-ray had been ordered or that the result was abnormal until approximately two weeks later when the patient's condition had worsened.

Availability and endorsement of studies ordered by on-site specialty is discussed further in the **Clinician On-Site Inspection** area below and the **Specialty Services** indicator.

Both compliance testing and case review found that providers performed poorly in communicating results to patients. Compliance testing found that laboratory, radiology, and pathology results were often not communicated to the patient (MIT 2.006, 10.0%, MIT 2.003, 20.0%, and MIT 2.012, zero). Case review found that of 327 diagnostic events, 41 deficiencies were cited for missing patient diagnostic results letters.[23]

Clinician On-Site Inspection

We met with diagnostic services management and staff, medical and nursing leadership, providers, and nurses. Diagnostic services includes administration of

[22] Deficiencies occurred in cases 1, 3, 6–7, 9-10, 13–14, 17, 23, 25, and 62.

[23] Deficiencies occurred in cases 1, 3, 6, 8, 10, 13, 14, 17–19, 22–24, 27.

on-site laboratory services, X-ray and scheduling of on-site CT, MRI and ultrasound services.[24]

Providers and nurses explained that laboratory tests were often delayed for extended periods. In December 2021, the laboratory had 593 overdue orders; by the time of our visit, that figure had increased to over 2,600. The additional COVID-19 laboratory testing further added to the high volume of tests. ISUDT was started near the pandemic, but due to the laboratory staffing shortage, the nursing department assumed urine toxicology collections required for that program.[25]

Diagnostic services management informed us that laboratory staffing has been a significant challenge since before the COVID-19 pandemic began. During the review period, the laboratory did not have a clinical laboratory supervisor, and only two of seven allotted laboratory assistants were employed. Leadership reported that recruitment and retention were difficult because of reported low CCHCS laboratory assistant pay when compared with CCHCS office technician salary and higher compensation rates offered by other employers in the surrounding area. Staff reported a contributing factor is the high cost of living in the San Francisco Bay area.

Staff reported that radiology services had no staff issues during the review period; however, during our on-site visit, they reported that their radiology technician had resigned, and the institution was without on-site X-ray services for two to three months. Staff stated that any urgent studies needed during that time had required the patient be sent to the local hospital. A temporary, part-time radiology technician recently was employed pending permanent staff hiring. The radiology technician confirmed that the off-site specialty RN had been doing the radiology scheduling during staff absences. The technician reported the radiology backlog was 300 studies at the time of the on-site visit. All on-site X-ray, MRI, ultrasound, and CT reports and available images are entered directly into the EHRS for provider endorsement.

In contrast to CCHCS policy, some on-site specialists entered laboratory testing orders directly into the patient's electronic health record.[26] When the test results were available, there was no assigned coverage for the specialist's inbox and no remote electronic health record access for specialists, leading to a delay in recognition of abnormal patient diagnostic results, which placed patients at significant medical risk.

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[24] A CT is a computerized tomography imaging scan. An MRI is a magnetic resonance imaging scan.

[25] ISUDT is the Integrated Substance Use Disorder Treatment program.

[26] HCDOM, Section 3.1.11 Outpatient Specialty Services, c.5.E. "Specialty providers may not directly order follow-up consultations, diagnostic studies or treatments. The specialty provider shall make recommendations and the PCP shall review these recommendations to determine the need based on clinical guidelines, if applicable, and medical necessity."

Compliance Testing Results

Table 8. Diagnostic Services

Compliance Questions	Scored Answer			
	Yes	No	N/A	Yes %
Radiology: Was the radiology service provided within the time frame specified in the health care provider's order? (2.001) *	10	0	0	100%
Radiology: Did the ordering health care provider review and endorse the radiology report within specified time frames? (2.002) *	5	5	0	50.0%
Radiology: Did the ordering health care provider communicate the results of the radiology study to the patient within specified time frames? (2.003)	2	8	0	20.0%
Laboratory: Was the laboratory service provided within the time frame specified in the health care provider's order? (2.004) *	6	4	0	60.0%
Laboratory: Did the health care provider review and endorse the laboratory report within specified time frames? (2.005) *	9	1	0	90.0%
Laboratory: Did the health care provider communicate the results of the laboratory test to the patient within specified time frames? (2.006)	1	9	0	10.0%
Laboratory: Did the institution collect the STAT laboratory test and receive the results within the required time frames? (2.007) *	3	7	0	30.0%
Laboratory: Did the provider acknowledge the STAT results, OR did nursing staff notify the provider within the required time frames? (2.008) *	3	7	0	30.0%
Laboratory: Did the health care provider endorse the STAT laboratory results within the required time frames? (2.009)	8	2	0	80.0%
Pathology: Did the institution receive the final pathology report within the required time frames? (2.010) *	10	0	0	100%
Pathology: Did the health care provider review and endorse the pathology report within specified time frames? (2.011) *	8	2	0	80.0%
Pathology: Did the health care provider communicate the results of the pathology study to the patient within specified time frames? (2.012)	0	10	0	0
				Overall percentage (MIT 2): **54.2%**

* 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.

Recommendations

- Medical leadership should consider approaches to recruit and retain sufficient levels of laboratory and radiology staff.
- Medical leadership should ensure all medical record inboxes have appropriate coverage.
- Medical leadership should ascertain causative factors related to the untimely provision of routine and STAT laboratory services, and implement remedial measures as appropriate.
- Medical leadership should consider developing strategies to ensure STAT laboratory test results were acknowledged by providers or providers were notified within required time frames.
- The department should consider developing strategies to ensure that providers create patient letters at the time of review or endorsement and that patient letters contain all elements required per CCHCS policy.

Emergency Services

Overall Rating ***Inadequate***

Case Review Rating ***Inadequate***

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

SQ provided poor emergency care in Cycle 6 compared with Cycle 5. This cycle had more overall deficiencies with an increase in significant deficiencies. Our case review found that nursing assessments, interventions, and documentation all offer opportunities for improvement. In addition, the EMRRC should perform more thorough reviews. On a positive note, during emergency medical response and CPR events, staff generally performed well. Taking all factors into consideration, we rated this indicator ***inadequate***.

Case Review Results

We reviewed 74 urgent and emergent events, and found 61 emergency care deficiencies.[27] Of these 61 deficiencies, 16 were significant.[28]

Emergency Medical Response

Staff responded promptly to emergencies throughout the institution. We reviewed 37 first medical responder events in 13 cases.[29] First medical responders mostly performed good assessments and documentation. However, there were delays in providing timely care as illustrated in the following cases:

- In case 3, a patient with a significant cardiac medical history complained of chest pain. There was a 39-minute delay in calling 9-1-1 for this patient.
- In case 14, the patient had a low blood-sugar level. The nurse did not administer glucose to the patient until 12 minutes later, which was a delay in care.

[27] We reviewed urgent and emergent events in cases 1–8, 10, 13–15, 17, 20–22, 25, 26, and 62. Deficiencies occurred in cases 1–3, 6–9, 14, 15, 17, 20, 22, 24, and 25.

[28] Significant deficiencies occurred in cases 3, 6, 8, 9, 14, 15, 17, and 25.

[29] We reviewed first medical responder events in cases 2–5, 7, 8, 14, 15, 17, 20–22, and 62. Multiple first medical responder events occurred in cases 2, 3, 8, 17, and 22.

Cardiopulmonary Resuscitation Quality

SQ performed well in this area. Our OIG clinicians reviewed three cases in which staff initiated cardiopulmonary resuscitation (CPR) and did not identify any deficiencies.[30] Staff, including custody, initiated CPR immediately, activated emergency medical services (EMS) without delay, and notified the TTA in a timely manner. Nurses responded to the scene and assessed the patient. They intervened by utilizing the automated external defibrillator (AED), providing oxygen, and performing thorough emergency time-line documentation.

Provider Performance

Providers' performance was sufficient in urgent, emergent situations, and after-hours care. Usually, provider assessment and medical decision making were appropriate. Nursing staff reported no difficulty in reaching providers for consultation. Provider progress notes were usually complete. Of the 74 TTA visits, we identified 10 provider deficiencies, six of which were considered significant. In three of the six significant deficiencies, mode of transport was a concern. Examples of significant deficiencies included the following:[31]

- In case 3, the patient with a significant cardiac history complained of chest pressure, nausea, lightheadedness, and fatigue. The provider documented that the symptoms could be cardiac in origin, but did not order an EKG or follow chest pain protocols. In addition, the provider sent the patient to the hospital by a State vehicle without medical assistance attending during the ride. The patient should have been transported emergently by advanced cardiac life-support ambulance.

- In case 6, the TTA nurse contacted the physician on call that a high-risk patient with liver and heart disease complained of having had an inability to urinate for one day and being constipated. The patient had very low blood pressure, and the results from an abdominal examination showed an abnormality that could have indicated a serious cause. The provider instructed the patient to drink more fluids, continue taking laxatives, and to follow up with a nurse on the next day. The patient was returned to his housing unit, but he should have been sent to a higher level of care immediately. The patient's condition worsened, and he was sent to the hospital the next day.

[30] Patients received cardiopulmonary resuscitation in cases 4, 5, and 8.

[31] Deficiencies occurred in cases 1–3, 6, 8–9, 17, and 25. Significant deficiencies occurred in cases 3, 6, 8, 9, 17 and 25. Cases 3, 8 and 9 had transport deficiencies.

Nursing Performance

Overall, nursing assessments and interventions had opportunities for improvement. Although first medical responders performed good assessments and documented well, we identified patterns of deficiencies for nursing assessments and interventions. We identified 40 nursing deficiencies, six of which were significant. The following are examples:

- In case 3, the patient was evaluated for chest pain in the TTA and transferred to a higher level of care. However, there was a delay of one hour and six minutes before staff notified emergency medical services personnel.

- In case 6, TTA nurses assessed the patient who reported constipation for seven days and an inability to void for one day. The patient's blood pressure was low, but nurses did not reassess the patient's blood pressure after the patient received intravenous fluids.

- In case 9, the provider ordered intravenous fluid for the patient, but the nurse did not administer the intravenous fluid as ordered.

- In case 15, the patient who had a urinary catheter complained of pain in the pubic area, urine leaking at the insertion site, and blood clots in the drainage bag. The nurse did not notify the on-call provider regarding these abnormal findings including the patient's pain level.

- In case 17, the patient complained to the medication nurse that he had experienced an episode of chest pain lasting two to three minutes. The patient was escorted to the TTA by a nonmedical person, an inmate worker. The medication nurse did not notify the TTA for a medical emergency or ensure that the patient was escorted to the TTA by medical staff. The medication nurse also did not document the patient assessment or interventions provided to this patient.

Nursing Documentation

TTA nursing documentation was fair. However, case reviewers identified a pattern of documentation deficiencies.[32] For example, nurses documented medication administration in the nurses' progress notes instead of doing so in the medication administration report (MAR).[33] The following three cases provide examples of other types of deficiencies:

- In cases 1 and 24, nurses assessed patients, but did not document which provider was notified.

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[32] TTA documentation deficiencies occurred cases 3, 6, 8, 17, 20, 22, and 24. Multiple deficiencies occurred in cases 3 and 17.

[33] Nurses did not document medication administration on the medication administration report (MAR) in cases 3, 8, and 17.

- In case 17, the nurse assessed the patient for gastroesophageal reflux problems, but did not document the assessment in EHRS.[34]

Emergency Medical Response Review Committee

Our case review reviewed 17 EMRRC events and identified six deficiencies.[35] EMRRC or supervising RN review had not always identified deficiencies that we identified. Examples include incomplete patient assessment and timeline documentation.[36] The following is an example:

- In case 8, we found no evidence that EMRRC reviewed or a supervising RN completed an event checklist for two different emergent events.

Our compliance findings showed poor results. EMRRC did not review cases timely, checklists were incomplete, and the chief medical executive (CME) and the chief nursing executive (CNE) did not answer required questions (MIT 15.003, zero).

Clinician On-Site Inspection

We interviewed TTA nursing and staff. They reported that the TTA has five beds and is staffed with two RNs on each shift. The nurses have two emergency vehicles that they use to respond to emergent situations. A provider is assigned to the TTA from 8:00 a.m. until 4:00 p.m. from Monday to Friday. They have a provider on call for after business hours. The TTA is used for diagnostic endoscopy procedures once a week. Patients who return from off-site medical appointments are processed in the TTA. TTA staff are familiar with the medical return process. The specialty nurse picks up off-site documents from the TTA daily and scans them into EHRS.

The TTA supervising RN stated that staff have received initial EMR (emergency response training). The EMR revision training was postponed due to the COVID-19 pandemic, but has been resumed.

We were informed that on second watch, emergent events are reviewed by the supervising RN of the location at which the event occurred. If not completed, the TTA supervising RN will complete the review. On third watch, the house nurse supervisor will review all unscheduled emergent events that require a higher level of care. There are three house supervisors on duty on third watch.

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[34] Gastroesophageal reflux disease (GERD) is a medical condition that occurs when stomach contents such as acid move back up into the tube (esophagus) connecting the mouth and the stomach. The acid can irritate the lining of the esophagus.

[35] We reviewed EMRRC events in cases 1–5, 7, 8, 21, and 22. Deficiencies occurred in cases 3, 7, 8, and 22.

[36] Deficiencies occurred in cases 3 and 22.

Supervisors and nursing staff reported issues with equipment, supplies, and work orders. Staff reported nursing morale had been affected by staffing shortages, frequently mandated overtime, and leadership changes. TTA nurses reported having a good rapport with custody.

Recommendations

- Nursing leadership should consider performing TTA audits to ensure complete assessments, timely interventions, thorough documentation, and provide staff training as required.
- The Emergency Medical Response Review Committee (EMRRC) should thoroughly review emergency response events within the required time frame.
- Medical leadership should ensure providers order appropriate transportation for patients who need a higher level of care for emergent events.

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 labeled and organized documents in the medical record correctly.

Overall Rating
Adequate

Case Review Rating
Adequate

Compliance Score
Adequate
(82.8%)

Results Overview

SQ performed satisfactorily in managing health information. The OIG found that, usually, hospital discharge records and diagnostic results were retrieved and scanned timely. Emergency documentation was usually complete. Off-site specialty reports were frequently obtained late, but once received, health information management (HIM) staff scanned them appropriately, and providers endorsed them timely. On-site specialty reports were often not endorsed, and there was frequently no evidence that on-site providers had reviewed these reports. Providers did not always endorse radiology within required time frames. After reviewing all aspects, we rated this indicator ***adequate.***

Case Review and Compliance Results

We reviewed 1,631 events and found 106 deficiencies related to health information management. Of these 106 deficiencies, 20 were significant.

Hospital Discharge Reports

We reviewed off-site emergency department and hospital visits. Compliance testing found that staff retrieved and scanned the discharge reports timely (MIT 4.003, 100%), and providers endorsed the reports timely once received, however, key elements of the scanned documents were missing (MIT 4.005, 48.0%).

Our case review clinicians reviewed 75 off-site emergency department and hospital visits and identified five HIM deficiencies.[37] None were considered significant. Usually, staff timely retrieved hospital discharge records, scanned them into EHRS, and reviewed them within required time frames.

Specialty Reports

SQ performed poorly regarding specialty reports. Compliance testing and case review found reports were often scanned late, endorsed late, and some not endorsed at all. Case review found that all but one of the unendorsed specialty

[37] Deficiencies occurred in cases 3, 7, 8 and 17.

reports were written by on-site specialists who entered their reports directly into EHRS. In contrast, all of the specialty reports that were scanned late were the off-site specialty reports.

These findings are discussed in more detail in the **Specialty Services** indicator.

Diagnostic Reports

SQ usually received diagnostic reports timely; however, it had poor rates of radiology report endorsement and poor communication of diagnostic test results provided to the patient.

Please refer to the **Diagnostic Services** and **Specialty Services** indicators for detailed discussion about diagnostics.

Urgent and Emergent Records

OIG clinicians reviewed 75 emergency care events and found that nurses and providers usually documented these events appropriately.[38] Providers also recorded their emergency care sufficiently, including off-site telephone encounters. Providers usually endorsed hospital records timely.

Please refer to the **Emergency Services** indicator for additional information regarding emergency care documentation.

Scanning Performance

Both case review and compliance testing found that SQ performed well with the scanning process. Compliance testing showed excellent scanning, labeling, and filing performance (MIT 4.004, 95.8%). Case review clinicians reviewed over 1,631 events and found that SQ usually scanned and labeled documents correctly. On occasion, documents were misfiled in the medical record; most of these were associated with specialty services. Specialty report scanning was frequently delayed. This is discussed further in the **Specialty Services** indicator.

Clinician On-Site Inspection

We discussed health information management processes with medical leadership, health information management supervisors, office technicians, ancillary staff, nurses, and providers.

HIM leadership reported that the institution was staffed with four health records technicians and one office technician during the review period; however, an additional four office assistant positions were vacant. In addition, HIM reported the area's workload increased significantly, creating difficulties in compliance. Reasons given for the workload increase were the following:

[38] Deficiencies occurred in cases 3, 7, and 17.

- HIM has been tasked to perform quality assurance on all nursing sick calls, in real time, to ensure they were assigned and processed timely.

- In addition, they stated there was a significant increase in COVID-19-related legal medical records requests.

HIM leadership reported other challenges that included the following:

- Death row inmate legal requests for documentation are significant, with one request requiring up to 15,000 pages of medical documentation.

- Some nursing staff incompletely or inaccurately filled clinic paperwork, including EKGs and refusals, which cannot be scanned until corrected. These documents then needed to be returned to nurses for correction and tracking. These documents may not have been returned corrected, timely, or at all.

HIM staff reported that they do not train providers in how to write correct patient results letters, but that they are assigned to track whether these types of letters have been completed. Due to inadequate staffing levels, HIM did not have the resources to complete this task.

Additional discussion regarding HIM and specialty consultation reports can be found in the **Specialty Services** indicator.

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	15	100%
Are specialty documents scanned into the patient's electronic health record within five calendar days of the encounter date? (4.002) *	21	9	15	70.0%
Are community hospital discharge documents scanned into the patient's electronic health record within three calendar days of hospital discharge? (4.003) *	20	0	5	100%
During the inspection, were medical records properly scanned, labeled, and included in the correct patients' files? (4.004) *	23	1	0	95.8%
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) *	12	13	0	48.0%
Overall percentage (MIT 4): **82.8%**				

* 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 10. Other Tests Related to Health Information Management

	Scored Answer			
Compliance Questions	**Yes**	**No**	**N/A**	**Yes %**
Radiology: Did the ordering health care provider review and endorse the radiology report within specified time frames? (2.002) *	5	5	0	50.0%
Laboratory: Did the health care provider review and endorse the laboratory report within specified time frames? (2.005) *	9	1	0	90.0%
Laboratory: Did the provider acknowledge the STAT results, OR did nursing staff notify the provider within the required time frame? (2.008) *	3	7	0	30.0%
Pathology: Did the institution receive the final pathology report within the required time frames? (2.010) *	10	0	0	100%
Pathology: Did the health care provider review and endorse the pathology report within specified time frames? (2.011) *	8	2	0	80.0%
Pathology: Did the health care provider communicate the results of the pathology study to the patient within specified time frames? (2.012)	0	10	0	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) *	6	8	1	42.9%
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) *	9	6	0	60.0%
Did the institution receive and did the primary care provider review the routine-priority specialty service consultant report within the required time frame? (14.008) *	4	8	3	33.3%

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

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

Recommendations

- Medical leadership should consider HIM access to the electronic medical record systems of off-site hospitals and specialty clinics to improve report retrievals.
- Medical leadership should consider reviewing the HIM workload to ensure adequate staffing.
- Medical leadership should ascertain all key elements are included in the final hospital discharge report.

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
(43.2%)

Results Overview

Compliance Testing Results

In this cycle, multiple aspects of SQ's health care environment needed improvement: medical supplies storage areas both in and outside the clinics contained expired medical supplies; emergency medical response bag (EMRB) logs were missing staff verification, inventory was not performed, or the bags were missing medical equipment; and staff did not regularly sanitize their hands before and after examining, or performing invasive procedures on, patients. These factors resulted in an ***inadequate*** rating for this indicator.

Outdoor Waiting Areas

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

Indoor Waiting Areas

We inspected indoor waiting areas. Patients had enough seating capacity while waiting for their appointments. Depending on the population, patients were either placed in a holding area (see Photo 1, right) or held in individual modules (see Photo 2, next page) to await their medical appointments.

Photo 1. Indoor waiting area (photographed on 6-8-22).

During our inspection, we did not observe overcrowding or noncompliance with social distancing requirements in any of the clinics' indoor waiting areas.

Clinic Environment

Of 11 clinic environments, 10 were sufficiently conducive for medical care. They provided reasonable auditory privacy, appropriate waiting areas, wheelchair accessibility, and nonexamination room workspace (MIT 5.109, 90.9%). In one clinic, we observed laboratory technicians provided services to two patients at the same time in the blood draw stations, which prohibited auditory privacy.

Photo 2. Individual patient waiting modules (photographed on 6-9-22).

Of the 11 clinics we observed, three contained appropriate space, configuration, supplies, and equipment to allow their clinicians to perform proper clinical examinations (MIT 5.110, 27.3%). The remaining eight clinics had one or more of the following deficiencies: the clinic's configuration did not allow patients to lie fully extended on the examination table without obstruction (see Photo 3, right); the examination room lacked visual and auditory privacy when conducting patient examination (see Photo 4, next page); the examination room chair had a torn vinyl cover (Photo 5, next page); and the examination room had unsecured confidential medical records.

Photo 3. Patient was unable to lie fully extended on the examination table due to physical obstructions (photographed on 6-8-22).

Photo 4. Examination room did not provide visual privacy during patient examinations (photographed on 6-7-22).

Photo 5. Examination table had torn vinyl cover (photographed on 6-7-22).

Clinic Supplies

Only one of the 11 clinics followed adequate medical supply storage and management protocols (MIT 5.107, 9.1%). We found one or more of the following deficiencies in 10 clinics: unidentified medical supplies, expired medical supplies (see Photo 6, below left), a disorganized medical supply cabinet or drawer, staff members' personal items and food stored with medical supplies (see Photo 7, below right), cleaning materials stored with medical supplies (see Photo 7), medical supplies stored directly on the floor, and compromised sterile medical supply packaging. In two of the 10 clinics, staff reported difficulty in receiving ordered medical supplies from the medical warehouse in a timely manner. Finally, a staff member in one of 10 clinics tested was uncooperative and refused to be observed by our team.

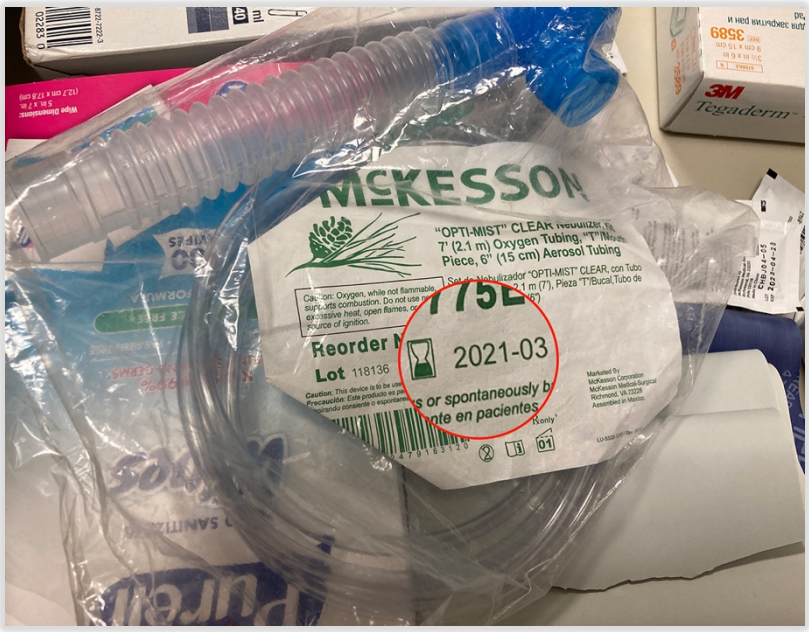

Photo 6. An expired medical supply dated March 2021 (photographed on 6-7-22).

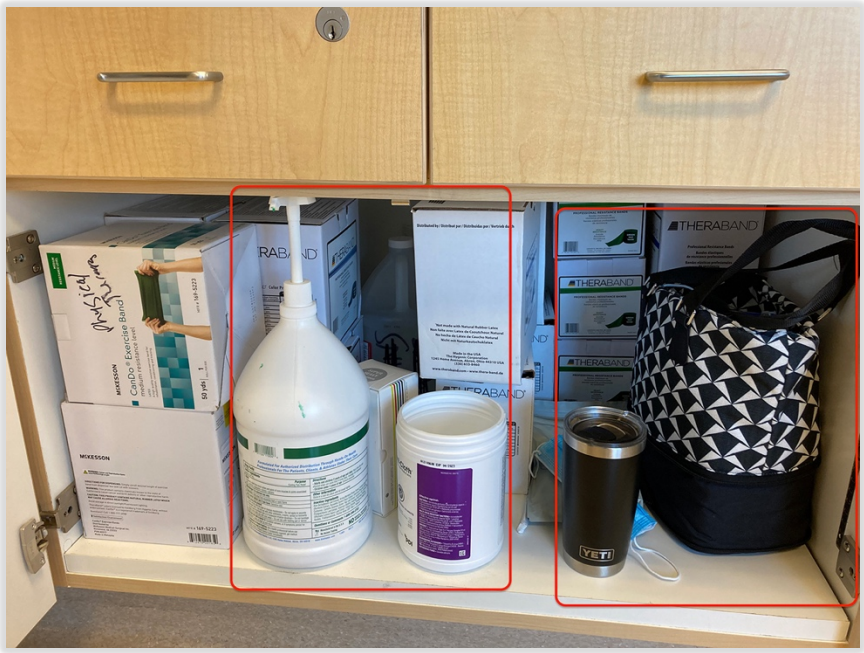

Photo 7. Staff stored their personal items and cleaning materials with medical supplies (photographed on 6-7-22).

Only two of the 11 clinics met the requirements for essential core medical equipment and supplies (MIT 5.108, 18.2%). The remaining nine clinics lacked medical supplies or contained improperly calibrated or nonfunctional equipment. Missing items included a nebulization unit, an examination table, examination table disposable paper, a glucometer, lubricating jelly, and an oto-ophthalmoscope. The staff had not properly calibrated a weight scale, a pulse oximeter, automated vital signs equipment, an electrocardiogram (EKG), a nebulization unit, and an automated external defibrillator (AED). We found several nonfunctional oto-ophthalmoscopes. At the time of our inspection, several SQ staff did not perform and log the results from having performed a glucometer quality-control test within the last 30 days.

We examined emergency medical response bags (EMRBs) to determine whether they contained all essential items. We checked whether staff inspected the bags daily and inventoried them monthly. Only one of the nine EMRBs passed our test (MIT 5.111, 11.1%). We found one or more of the following deficiencies with eight EMRBs: staff failed to ensure the EMRB's compartments were sealed and intact; staff had not inventoried the EMRBs when the seal tags were replaced; EMRBs lacked several pieces of medical equipment; EMRBs contained equipment with compromised packaging; staff failed to perform daily AED performance checks; staff failed to log EMRB daily glucometer quality control results; and staff inaccurately logged the EMRB glucometer control solution range when performing the daily glucometer quality control check. TTA staff failed to ensure Treatment Cart Daily Check Sheet (CDCR Form 7544) entries were complete. In addition, we found several expired medical supplies stored on the TTA treatment cart (see Photo 8).

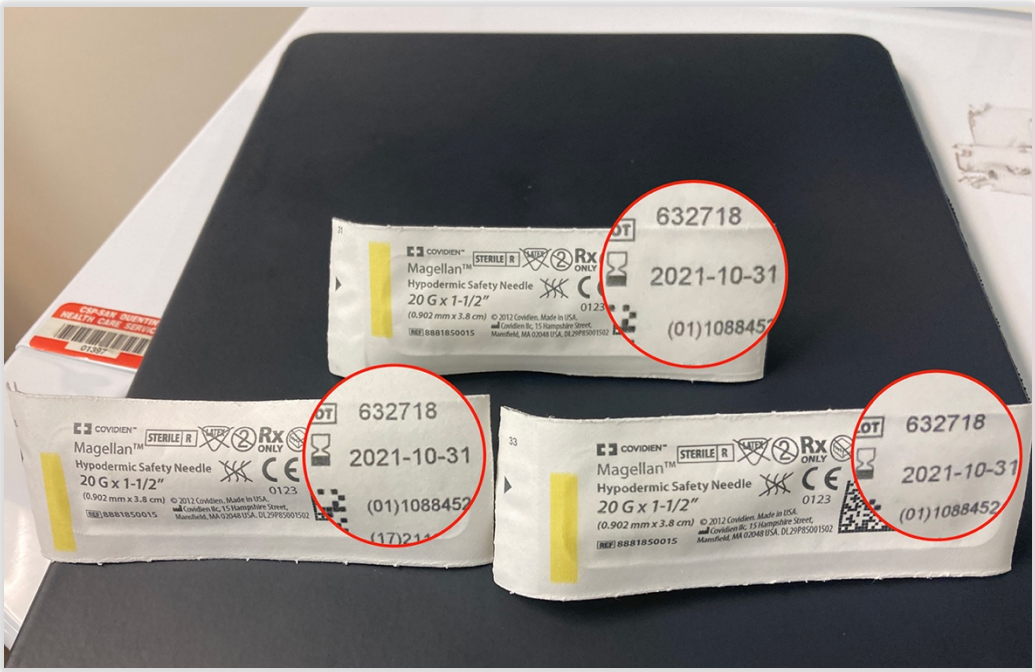

Photo 8. Expired medical supplies stored in the TTA treatment cart dated October 31, 2021 (photographed on 6-7-22).

Medical Supply Management

None of the medical supply storage areas located outside the medical clinics stored medical supplies adequately (MIT 5.106, zero). We found expired medical supplies (see Photo 9), medical supplies stored directly on the floor, and compromised sterile medical supply packaging.

According to the chief executive officer (CEO), the institution did not have any concerns about the medical supply process. Health care and warehouse managers expressed no concerns about the medical supply chain or their communication process with the existing system that was in place.

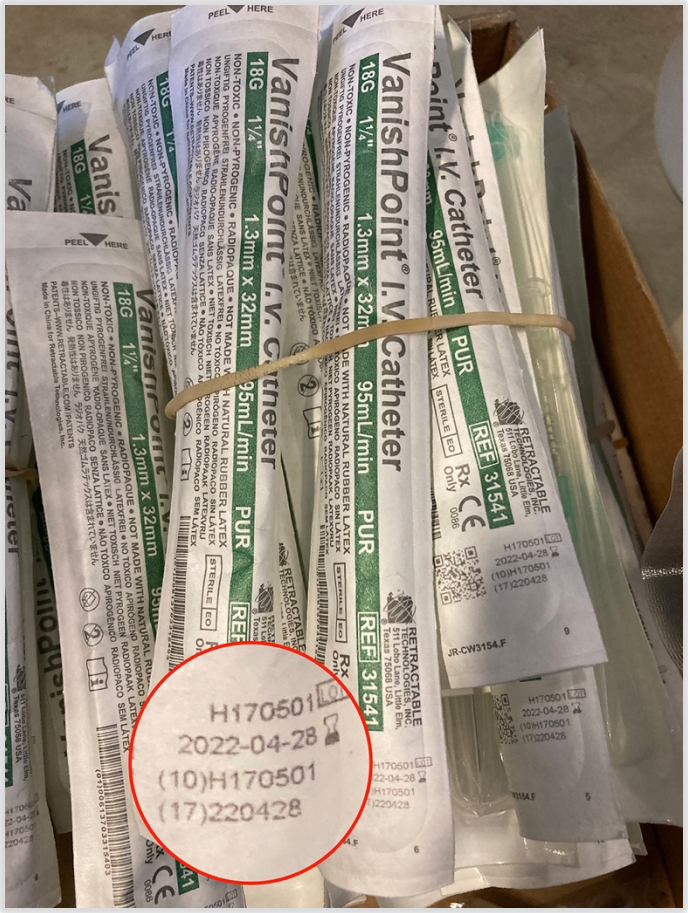

Photo 9. Expired medical supplies dated April 28, 2022 (photographed on 6-8-22).

Infection Control and Sanitation

Staff appropriately cleaned, sanitized, and disinfected 10 of 11 clinics (MIT 5.101, 90.9%). In one clinic, cleaning logs were not maintained, and biohazardous waste was not emptied after each clinic day.

Staff in seven of 11 clinics properly sterilized or disinfected medical equipment (MIT 5.102, 63.6%). In four clinics, staff did not mention disinfecting the examination table as part of their daily start-up protocol. In addition, in one of the four clinics, the staff did not remove and replace the examination table disposable paper in between patient encounters.

We found operating sinks and hand hygiene supplies in the examination rooms in eight of 11 clinics (MIT 5.103, 72.7%). In two clinics, patient restrooms lacked disposable hand towels. In one clinic, the examination room lacked disposable hand towels.

We observed patient encounters in 10 clinics. In nine clinics, clinicians did not wash their hands before or after examining their patients, before applying gloves, before subsequent regloving, before and after performing invasive procedures, or after contact with blood (MIT 5.104, 10.0%).

Health care staff in nine of 11 clinics followed proper protocols to mitigate exposure to blood-borne pathogens and contaminated waste (MIT 5.105, 81.8%). In one clinic, staff was not able to verbalize an adequate understanding of the disinfection process for equipment that came into contact with biohazardous waste. In another clinic, we found biohazardous waste not properly secured in the storage location.

Physical Infrastructure

At the time of our on-site inspection, the institution's administrative team reported no ongoing health care facility improvement program construction projects. The institution's health care management and plant operations manager reported that all clinical area infrastructures were in good working order (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)	10	1	1	90.9%
Infection control: Do clinical health care areas ensure that reusable invasive and noninvasive medical equipment is properly sterilized or disinfected as warranted? (5.102)	7	4	1	63.6%
Infection control: Do clinical health care areas contain operable sinks and sufficient quantities of hygiene supplies? (5.103)	8	3	1	72.7%
Infection control: Does clinical health care staff adhere to universal hand hygiene precautions? (5.104)	1	9	2	10.0%
Infection control: Do clinical health care areas control exposure to blood-borne pathogens and contaminated waste? (5.105)	9	2	1	81.8%
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	10	1	9.1%
Clinical areas: Do clinic common areas and exam rooms have essential core medical equipment and supplies? (5.108)	2	9	1	18.2%
Clinical areas: Are the environments in the common clinic areas conducive to providing medical services? (5.109)	10	1	1	90.9%
Clinical areas: Are the environments in the clinic exam rooms conducive to providing medical services? (5.110)	3	8	1	27.3%
Clinical areas: Are emergency medical response bags and emergency crash carts inspected and inventoried within required time frames, and do they contain essential items? (5.111)	1	8	3	11.1%
Does the institution's health care management believe that all clinical areas have physical plant infrastructures that are sufficient to provide adequate health care services? (5.999)	This is a nonscored test. Please see the indicator for discussion of this test.			
				Overall percentage (MIT 5): **43.2%**

* 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.

Recommendations

- Executive leadership should consider performing random spot checks to ensure medical supply storage areas, located inside and outside the clinics, store medical supplies adequately.

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

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

Transfers

Overall Rating
Inadequate

Case Review Rating
Inadequate

Compliance Score
Inadequate
(63.0%)

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.

Results Overview

SQ's performance for this indicator was unsatisfactory. Compared with Cycle 5, case review identified more deficiencies, which presented opportunities for improvement in nursing assessments. The overall low compliance scores were similar for both cycles. In Cycle 6, for patients arriving at SQ, preapproved specialty appointments were not always scheduled timely and initial health screenings were incomplete. While R&R nurses performed well for the transfer-out process, SQ did not always ensure medication continuity when patients returned from the hospital. Taking all factors into account, we rated this indicator ***inadequate.***

Case Review and Compliance Testing Results

We reviewed 46 events in 22 cases for which patients transferred into and out of the institution or returned from an off-site hospital or emergency room. We identified 30 deficiencies, five of which were significant.[39]

Transfers In

SQ's performance for the transfer-in process was variable. Our OIG clinicians reviewed four events in four cases for which patients transferred into the facility from other institutions. We identified four deficiencies, none of which were significant.[40]

[39] Deficiencies occurred in cases 2, 3, 7, 8, 14, 15, 20–23, 28–30, and 32. Significant deficiencies occurred in cases 3, 7, 8, and 21.

[40] Transfer-in events occurred in cases 10, and 28–30. Deficiencies occurred in cases 28–30.

Patients arriving at SQ received medications without a break in continuity. Both case review and compliance testing showed similar results (MIT 6.003, 81.8%). Medication continuity for patients transferring from yard to yard within the institution was very good (MIT 7.005, 88.0%). R&R nurses performed excellent in completing the assessment and disposition section of the initial health screening form (MIT 6.002, 100%).

Both case review and compliance testing found patients who arrived at SQ were frequently seen by the provider within the required time frame (MIT 1.002, 84.0%). Case review found only one deficiency in which provider follow-up appointment occurred nine days late.[41]

Case reviewers found that nurses frequently completed the initial health screening except for cases 28 and 29. The nurses did not accurately document the patient's valley fever risk factors. Compliance testing identified that the R&R nurses frequently did not complete an initial health screening and answer all screening questions (MIT 6.001, 20.0%). The low score mostly resulted from nurses completing the initial health screening after the patient was transferred to his housing unit. Nurses also did not document an explanation when patients answered "Yes" to the question regarding whether they were ever treated for mental illness.

Specialty services appointments for patients who arrived at SQ did not always occur within the required time frame (MIT 14.010, 30.0%). Only six of 20 sample patients tested received specialty appointments timely when they arrived at SQ. When late appointments occurred, they were three to 140 days late.

Transfers Out

SQ performed well for the transfer-out process. OIG clinicians reviewed three transfer-out cases and found one deficiency, which was not significant.[42] Overall, R&R nurses ensured all transfer requirements were met. Nurses communicated pending specialty appointments, ensured patients received ordered medications prior to transfer, performed required COVID-19 testing, and sent all durable medical equipment with the patient.

Compliance testing showed required medications and documents were sent with transfer packets only 50.0 percent of the time (MIT 6.101). This is discussed further in the **Medication Management** indicator.

Hospitalizations

Patients returning from an off-site hospitalization or emergency room are at high risk for lapses in care quality. These patients had 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,

[41] This deficiency occurred in case 28.

[42] Transfer-out events occurred in cases 31–33. A deficiency occurred in case 32.

successful health information transfer is necessary for good quality care. Any transfer lapse can result in serious consequences for these patients.

Our clinicians reviewed 37 events in 16 cases in which patients returned from an off-site hospitalization or emergency room visit. We identified 28 deficiencies, three of which were significant.[43]

Thorough patient assessments are necessary for patients returning from the hospital. Case reviewer identified a pattern of deficiencies for incomplete nursing assessments. Nurses did not always obtain the patient's weight, listen to lung and heart sounds, perform a skin assessment, or assess for level of pain.[44] Of the 28 deficiencies, 17 were related to nursing care. The following are examples of significant deficiencies:

- In case 3, the patient returned from an emergency room visit for neck and back pain, but was not assessed by a nurse on returning to the institution.

- In case 21, the patient returned from a hospitalization for multiple medical problems. On return, the nurse did not weigh the patient, assess the patient's pain level, or listen to the patient's heart and lung sounds. A thorough patient assessment is vital for patients returning from a hospitalization.

Compliance results showed poor continuity was provided for hospital-recommended medications (MIT 7.003, 24.0%). Case reviewers identified seven deficiencies, one of which was significant.[45] Please refer to the **Medication Management indicator** for further discussion.

Patients received provider follow-up appointments as required 76.0 percent of the time (MIT 1.007). Our clinicians identified two deficiencies in which provider follow-up occurred six days late.[46] Providers frequently reviewed hospital discharge documents within the required time frame; however, the discharge documents did not always include key elements such as the date of discharge (MIT 4.005, 48.0%). Hospital or emergency room summary reports were scanned into EHRS and made available timely (MIT 4.003, 100%).

Clinician On-Site Inspection

SQ's R&R staffing consists of an RN on each watch. Staff reported the R&R receives an email from custody staff at the end of each week with a projected list of patients arriving at, and transferring out of, the institution for the following week. Staff informed us that each day, they normally have four to six patients

[43] Patients returned from a hospitalization or emergency room visit in cases 1–3, 6–9, 14, 15, 17, 20–22, 26, 62, and 63. Deficiencies occurred in cases 2, 3 7, 8, 14, 15, and 20–23. Significant deficiencies occurred in cases 3, 7, and 21.

[44] A pattern of assessment deficiencies occurred in cases 2, 3, 8, 14, 20, 22, and 23.

[45] Deficiencies occurred in cases 3, 7, 8, and 20–22. Significant deficiencies occurred in cases 3 and 7.

[46] Deficiencies occurred in cases 20 and 22.

arriving and three to five patients transferring out. The nurse was very familiar with the transfer-in and the transfer-out processes. She stated that the process of specialty appointments for patients who arrive at SQ is to review EHRS for appointments from the sending institution. Once a pending appointment is identified, the R&R nurse communicates it to the provider and the specialty nurse via email. For those patients who have pending specialty appointments who transfer out of SQ, the R&R nurse reported their staff notifies the receiving institution via a phone call and documents the communication in EHRS.

The R&R staff reported having no supply issues. They reported their supervisor is supportive and maintains a good rapport with custody staff; however, staff stated that adequate staffing levels could improve nursing morale.

Compliance Testing Results

Table 12. Transfers

Compliance Questions	Scored Answer			
	Yes	No	N/A	Yes %
For endorsed patients received from another CDCR institution or COCF: Did nursing staff complete the initial health screening and answer all screening questions within the required time frame? (6.001) *	5	20	0	20.0%
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)	22	0	3	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) *	9	2	14	81.8%
For patients transferred out of the facility: Do medication transfer packages include required medications along with the corresponding transfer packet required documents? (6.101) *	1	1	0	50.0%
				Overall percentage (MIT 6): **63.0%**

* 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 13. Other Tests Related to Transfers

	Scored Answer			
Compliance Questions	**Yes**	**No**	**N/A**	**Yes %**
For endorsed patients received from another CDCR institution: Based on the patient's clinical risk level during the initial health screening, was the patient seen by the clinician within the required time frame? (1.002) *	21	4	0	84.0%
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) *	19	6	0	76.0%
Are community hospital discharge documents scanned into the patient's electronic health record within three calendar days of hospital discharge? (4.003) *	20	0	5	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) *	12	13	0	48.0%
Upon the patient's discharge from a community hospital: Were all ordered medications administered, made available, or delivered to the patient within required time frames? (7.003) *	6	19	0	24.0%
Upon the patient's transfer from one housing unit to another: Were medications continued without interruption? (7.005) *	22	3	0	88.0%
For patients en route who lay over at the institution: If the temporarily housed patient had an existing medication order, were medications administered or delivered without interruption? (7.006) *	N/A	N/A	N/A	N/A
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) *	6	14	0	30.0%

* 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 procedures for the internal auditing of staff to ensure thorough assessments are completed for patients returning from hospitalizations.

- Nursing leadership should educate nursing staff on how to thoroughly complete the initial health screening process including answering all questions and documenting an explanation for all "Yes" answers before the patient is transferred to the housing unit.

Medication Management

Overall Rating
Inadequate

Case Review Rating
Inadequate

Compliance Score
Inadequate **(39.6%)**

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

Results Overview

Overall, SQ performed poorly with medication management. Both case review and compliance scores showed poor performance in chronic medication continuity and hospital discharge medications. Specialized medical housing medications and new prescriptions had mixed results. Both compliance results and case review illustrated acceptable performance for transfer medications. Nurses generally administered medications as ordered. After considering all factors, we rated this indicator ***inadequate***.

Case Review and Compliance Testing Results

We reviewed 161 events in 27 cases related to medications and found 42 medication deficiencies, seven of which were significant.[47]

New Medication Prescriptions

SQ's performance showed mixed results for new medication availability. Our clinicians found a pattern of late administration for newly ordered medications.[48] Medications were mostly administered one day late. The following are examples:

- In case 14, during the month of November, the ordered medications were either late or the patient did not receive them.[49]
- In case 18, the patient was prescribed new medications, furosemide and potassium. The patient received these medications two days late.

Compliance testing found that new medications were administered timely (MIT 7.002, 80.0%).

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[47] Deficiencies occurred in cases 1–3, 6–9, 13, 14, 16, 18, 20–23, 26, 62, and 63. Significant deficiencies occurred in cases 3, 7, 9, 14, and 18.

[48] Newly prescribed medications were administered late in cases 6, 13, 14,18, 20, 22, 23, and 26.

[49] These medication included calcium, vitamin D, lidocaine film, and terazosin. The patient received the calcium and the vitamin D 31 days late.

Chronic Medication Continuity

During this review period, SQ performed poorly with chronic medication continuity. Patients did not always receive their chronic medications timely. Compliance testing showed low-scoring results (MIT 7.001, 9.1%). Chronic keep-on-person (KOP) medications were not made available at least one business day prior to exhaustion.[50] Case reviewers' findings were similar as we identified patterns of deficiencies where medications were not available, and patients did not receive their monthly KOP medications and nurse-administered medications as ordered.[51] The following are examples:

- In case 9, the patient did not receive his KOP medication, coumadin, during the month of December 2021.[52]
- In case 14, the patient received his KOP medications (atorvastatin, levetiracetam, metformin) from eight to 11 days late.[53]

Hospital Discharge Medications

SQ received a low score for patients receiving their discharge medications on return from an off-site hospitalization or emergency room visit. Compliance testing found that most patients did not receive their medications within required time frames (MIT 7.003, 24.0%). Medications were administered from one dose to three days late.

Our clinicians identified seven deficiencies related to hospital discharge medications.[54] The following is a significant deficiency:

- In case 7, the patient returned from the hospital. However, the patient did not receive his medications for two days after his return.

Specialized Medical Housing Medications

Medication continuity performance for patients admitted to the CTC was mixed. Compliance findings showed patients admitted to the CTC did not always receive their medications timely (MIT 13.004, 40.0%). Our OIG clinicians identified five deficiencies related to medication management, none of which were significant.[55] Examples include missed doses of medications and a

[50] KOP means keep-on-person and refers to medications in which a patient can keep and self-administer according to the directions provided.

[51] Patterns of chronic medication deficiencies occurred in cases 1–3, 6–9, 14, 16, 21, 26, and 63.

[52] Coumadin is a blood-thinning medication.

[53] Atorvastatin is a cholesterol medication. Levetiracetam is a seizure medication. Metformin is a diabetes medication.

[54] Deficiencies occurred in cases 3, 7, 8, and 20–22.

[55] Deficiencies occurred in cases 7, 8, 62, and 63.

documentation deficiency; however, these deficiencies did not affect the overall care of the patient.

Transfer Medications

Overall, SQ performed well for transfer medications. Our OIG clinicians did not identify any medication deficiencies for either patients who arrived at SQ or those who transferred out of the institution. Our compliance findings showed good results also. New arrivals at SQ frequently received their medications within required time frames (MIT 6.003, 81.8%). When patients transferred within the institution, compliance testing showed a very high rate of medication continuation of 88.0 percent (MIT 7.005). At the time of our inspection, there were no applicable patients to test for layover medications (MIT 7.006, N/A). Compliance testing showed a low score for patients transferring out of the institution (MIT 6.101, 50.0%). However, only two patients were tested for this sample. One of the two patients tested had a medication with an expired pharmacy label in his transfer packet. Our case review did not identify any deficiencies related to transfer-out medications. Patients received a five-day supply of medications when they transferred out of the institution.

Medication Administration

Our clinicians found that nurses generally administered medications as ordered. SQ performed well in administering TB medications (MIT 9.001, 92.0%). However, nurses did not always monitor patients who were on prescribed TB medications and did not always monitor all symptoms including weight changes and poor appetite (MIT 9.002, 16.0%).

Clinician On-Site Inspection

During the on-site visit, we interviewed the pharmacist who was well prepared for our questions. We also attended two clinic huddles. One was conducted via teleconference, which was already in progress when we joined; the other, we attended in person. The huddle we attended in person was well organized, thorough, and started on time. The medication LVN was present and showed good participation regarding patient medication concerns. We interviewed medication LVN staff in various areas throughout the facility. They reported that they attend daily huddles, Monday through Friday. One medication nurse stated that the huddles are helpful because clinical staff can discuss patient medication issues with all care team members at the same time. For example, a medication nurse observed that a particular patient would benefit from receiving his seizure medications as nurse administered rather than KOP. The provider was informed, and the patient was added to the nurse line on that same day to discuss the change in the method of medication administration.

The medication rooms have a radio available for communication, and the nurses respond to medical emergencies in their assigned areas. The LVN staff interviewed were familiar with KOP medications, patient no-shows, and the transfer processes. Staff reported challenges that included waiting for custody staff in the condemned units, short staffing, and a delay in receiving automatic

medication refills from the pharmacy. In addition, the medication LVNs reported medication pass had been challenging during the COVID-19 pandemic due to multiple units placed on quarantine, slow cell-side medication passes, and frequent emergency events.

Compliance Testing Results

Medication Practices and Storage Controls

The institution adequately stored and secured narcotic medications in all 10 clinic and medication line locations (MIT 7.101, 100%).

SQ appropriately stored and secured nonnarcotic medications in six of 11 clinic and medication line locations (MIT 7.102, 54.6%). In five locations, we observed one or more of the following deficiencies: the medication storage cabinet was disorganized; the medication area lacked a clearly labeled, designated area for refrigerated medications that were to be returned to the pharmacy; and medications were found stored beyond the prescription's expiration date rather than having them be returned to the pharmacy, where they can be, potentially, restocked, reissued, or relabeled by pharmacy staff.

Staff kept medications protected from physical, chemical, and temperature contamination in two of the 11 clinic and medication line locations (MIT 7.103, 18.2%). In nine locations, we found one or more of the following deficiencies: staff did not consistently record the room and refrigerator temperatures; staff did not store oral and topical medications separately; and staff did not separate medications from disinfectants.

Staff successfully stored valid, unexpired medications in three of the 11 applicable clinic and medication line locations (MIT 7.104, 27.3%). In eight locations, we found one or both of the following deficiencies: medication nurses did not label multiple-use medications as per CCHCS policy, or medications were stored beyond the expiration date.

Nurses exercised proper hand hygiene and contamination control protocols in two of seven locations (MIT 7.105, 28.6%). In five locations, some nurses neglected to wash or sanitize their hands before preparing and administering medications or before each subsequent regloving.

Staff in three of seven medication preparation and administration areas demonstrated appropriate administrative controls and protocols (MIT 7.106, 42.9%). In four locations, we observed one or both of the following deficiencies: medication nurses did not maintain unissued medication in its original labeled packaging or medication nurses did not describe the process they followed when reconciling newly received medications and the medication administration record (MAR) against the corresponding physician's order.

Staff in two of seven medication areas used appropriate administrative controls and protocols when distributing medications to their patients (MIT 7.107, 28.6%). In five locations, we observed one or more of the following deficiencies:

medication nurses did not reliably observe patients while they swallowed direct observation therapy medications, medication nurses did not consistently verify patient's identification prior to administering medication, and nurses did not follow insulin protocols properly. During insulin administration, we observed some medication nurses did not properly disinfect the vial's port prior to withdrawing medication.

Pharmacy Protocols

SQ followed general security, organization, and cleanliness management protocols in its pharmacy (MIT 7.108, 100%).

In its pharmacy, staff did not properly store nonrefrigerated medication. We found medications stored with expired pharmacy labels. As a result, SQ received a score of zero in this test (MIT 7.109).

The pharmacy did not have an identifiable designated area for nonrefrigerated and refrigerated medications returned to the pharmacy. In addition, the pharmacy did not utilize the Medication Storage Temperature Log (CDCR Form 7217) when recording room temperature for stored medications. As a result, SQ scored zero for this test (MIT 7.110).

The pharmacist-in-charge (PIC) did not adequately manage narcotic medications stored in SQ's pharmacy. The PIC did not correctly review monthly inventories of controlled substances in the institution's clinic and medication storage locations. Specifically, the PIC, pharmacy staff, and clinic staff did not correctly complete several medication area inspection checklists (CDCR form 7477). These errors resulted in a score of zero for this test (MIT 7.111).

We examined 25 medication error reports. The PIC timely or correctly processed only eight of these 25 reports (MIT 7.112, 32.0%). For one report, the PIC did not complete the pharmacy error follow-up review within the required time frame. For the remaining 16 reports, the PIC was not able to provide evidence that a pharmacy error follow-up review was performed.

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 SQ, the OIG did not find any applicable medication errors (MIT 7.998).

The OIG interviewed patients in restrictive housing units to determine whether they had immediate access to their prescribed asthma rescue inhalers or nitroglycerin medications. All 10 applicable patients interviewed indicated they had access to their rescue medications (MIT 7.999).

Compliance Testing Results

Table 14. Medication Management

Compliance Questions	Scored Answer			
	Yes	No	N/A	Yes %
Did the patient receive all chronic care medications within the required time frames or did the institution follow departmental policy for refusals or no-shows? (7.001) *	2	20	3	9.1%
Did health care staff administer, make available, or deliver new order prescription medications to the patient within the required time frames? (7.002)	20	5	0	80.0%
Upon the patient's discharge from a community hospital: Were all ordered medications administered, made available, or delivered to the patient within required time frames? (7.003) *	6	19	0	24.0%
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	3	0	88.0%
For patients en route who lay over at the institution: If the temporarily housed patient had an existing medication order, were medications administered or delivered without interruption? (7.006) *	N/A	N/A	N/A	N/A
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)	10	0	2	100%
All clinical and medication line storage areas for nonnarcotic medications: Does the institution properly secure and store nonnarcotic medications in the assigned storage areas? (7.102)	6	5	1	54.6%
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)	2	9	1	18.2%
All clinical and medication line storage areas for nonnarcotic medications: Does the institution safely store nonnarcotic medications that have yet to expire in the assigned storage areas? (7.104)	3	8	1	27.3%
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	5	5	28.6%
Medication preparation and administration areas: Does the institution employ appropriate administrative controls and protocols when *preparing* medications for patients? (7.106)	3	4	5	42.9%
Medication preparation and administration areas: Does the institution employ appropriate administrative controls and protocols when *administering* medications to patients? (7.107)	2	5	5	28.6%
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)	0	1	0	0
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)	8	17	0	32.0%
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): **39.6%**

* 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 15. Other Tests Related to Medication Management

Compliance Questions	Scored Answer			
	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) *	9	2	14	81.8%
For patients transferred out of the facility: Do medication transfer packages include required medications along with the corresponding transfer-packet required documents? (6.101) *	1	1	0	50.0%
Patients prescribed TB medication: Did the institution administer the medication to the patient as prescribed? (9.001) *	23	2	0	92.0%
Patients prescribed TB medication: Did the institution monitor the patient per policy for the most recent three months he or she was on the medication? (9.002) *	4	21	0	16.0%
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) *	4	6	0	40.0%

* 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

- Medical and nursing leadership should ensure that patients with newly prescribed medications, chronic care, and hospital discharge medications should receive their medications timely and without interruptions; leadership should implement remedial training as appropriate.

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
(77.7%)

Results Overview

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

Compliance Testing Results

Table 16. Preventive Services

Compliance Questions	Scored Answer			
	Yes	No	N/A	Yes %
Patients prescribed TB medication: Did the institution administer the medication to the patient as prescribed? (9.001)	23	2	0	92.0%
Patients prescribed TB medication: Did the institution monitor the patient per policy for the most recent three months he or she was on the medication? (9.002) †	4	21	0	16.0%
Annual TB screening: Was the patient screened for TB within the last year? (9.003)	21	4	0	84.0%
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)	22	3	0	88.0%
Female patients from the age of 50 through the age of 74: Was the patient offered a mammogram in compliance with policy? (9.006)	N/A	N/A	N/A	N/A
Female patients from the age of 21 through the age of 65: Was patient offered a pap smear in compliance with policy? (9.007)	N/A	N/A	N/A	N/A
Are required immunizations being offered for chronic care patients? (9.008)	9	1	15	90.0%
Are patients at the highest risk of coccidioidomycosis (valley fever) infection transferred out of the facility in a timely manner? (9.009)	N/A	N/A	N/A	N/A
Overall percentage (MIT 9): **77.7%**				

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

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

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

Recommendations

- Nursing leadership and the public health nurse should educate nursing staff on completing weekly TB monitoring as required per policy, and on properly documenting the TB signs and symptoms when monitoring patients taking TB medications.

Nursing Performance

Overall Rating ***Inadequate***

Case Review Rating ***Inadequate***

Compliance Score **(N/A)**

In this indicator, the OIG clinicians evaluated the quality of care delivered by the institution's nurses, including registered nurses (RNs), licensed vocational nurses (LVNs), psychiatric technicians (PTs), and certified nursing assistants (CNAs). Our clinicians evaluated nurses' performance in making timely and appropriate assessments and interventions. We also evaluated the institution's nurses' 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. As such, specific nursing quality issues are discussed in other indicators, such as **Emergency Services**, **Specialty Services**, and **Specialized Medical Housing**.

Results Overview

Overall, SQ provided poor nursing care. Nursing assessments and interventions show opportunities for improvement in several areas as discussed in this report. Our clinicians found that nurses often performed incomplete nursing assessments. In addition, we identified areas for improvement with timely and appropriate nursing interventions. Documentation in the TTA had some issues as discussed in the **Emergency Services** indicator. After considering all factors, we rated this indicator ***inadequate.***

Case Review Results

We reviewed 380 nursing encounters in 60 cases. Of the nursing encounters we reviewed, 232 were in the outpatient setting. We identified 84 outpatient nursing performance deficiencies, 17 of which were significant.[56]

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.

Overall, nurses did not always perform thorough patient assessments. Incomplete assessments can potentially lead to poor patient outcomes. **Emergency Services**, **Specialized Medical Housing**, and **Transfer** indicators showed patterns of deficiencies for patient assessments. Nurses also did not

[56] Deficiencies occurred in cases 1–3, 6, 8, 9, 14–23, 25, 35–37, 39–41, 43, 44, 46, 48, 50, 52, 54–56, and 61. Significant deficiencies occurred in cases 3, 9, 14, 19, 20, 23, 25, 35, 39, 55, and 61.

complete COVID-19 isolation and quarantine rounds as ordered in several cases.[57] Specialty nurses generally performed thorough assessments.

Nurses did not always intervene timely and appropriately in the TTA and outpatient settings. Please refer to the **Emergency Services** indicator for additional details. However, nurses in the areas of specialized medical housing, transfer, hospitalization, and specialty performed better. The following are examples of nursing deficiencies that occurred in the outpatient clinics:

- In case 25, the clinic nurse performed a follow-up with the patient who was evaluated by the provider for chest congestion and the inability to lie down completely due to cough and shortness of breath. The patient had elevated heart and respiratory rates, lower-leg edema, and labored breathing. The nurse inappropriately allowed the patient to ambulate back to his housing while experiencing labored breathing and did not notify the provider of the patient's assessment. The nurse also documented a provider follow-up appointment in 14 days. However, the nurse did not schedule the provider follow-up.

- Also in case 25, on another occasion, the clinic nurse performed a follow-up with the patient who reported an episode of stool incontinence and continued shortness of breath while lying down. His heart rhythm was irregular, he had a high respiratory rate, and his oxygenation level was low. The nurse did not notify the provider regarding the patient's abnormal assessment findings immediately via a phone call. Instead, the nurse sent an email to the provider and the psychiatrist requesting an adjustment of the patient's sleep medication. In the email, the nurse included the patient's low oxygenation level.

Nursing Documentation

Overall, nursing documentation was satisfactory. Complete and accurate nursing documentation is an essential component of patient care. Without proper documentation, health care staff can overlook changes in patients' conditions. Although nurses generally documented well, they did not always document TTA events thoroughly. We identified patterns of documentation deficiencies. For additional information, please refer to the **Emergency Services** indicator.

Nursing Sick Call

Our clinicians reviewed 61 sick call requests and identified 32 deficiencies, nine of which were significant.[58] There were patterns of deficiencies for incomplete

[57] Nurses did not perform COVID-19 isolation and quarantine rounds in cases 1–3, and 16–23.

[58] We reviewed sick call requests in cases 1, 2, 3, 8, 10, 14, 17, 21–23, 27, and 34–61. Deficiencies occurred in cases 1–3, 8, 9, 14, 15, 20–23, 25, 35–37, 39–41, 43, 44, 46, 48, 50, 52, 54–56, and 61, Significant deficiencies occurred in cases 14, 23, 25, 35, 39, 55, and 61.

patient assessments and a lack of timely interventions such as provider notification.[59] The following are examples of significant deficiencies in five cases:

- In case 25, the nurse reviewed a symptomatic sick call for a complaint of severe chest congestion and an inability to lie down completely without choking. The nurse ordered a follow-up in three days. The nurse should have assessed this patient the same day since his lying down affected his breathing.

- In case 35, the patient submitted a sick call request for heartburn, and rib and back pain. The nurse did not perform a thorough assessment related to the patient's complaints. The nurse did not assess for bowel and lung sounds, or inquire about recent injuries, or diet changes. The nurse also did not assess the patient's gait and his back.

- In case 39, the sick call nurse evaluated the patient for neck pain. The patient reported that he had experienced neck pain for three weeks that was not relieved with Tylenol, Motrin, capsaicin cream, or hot water bottle compresses. The nurse did not assess the patient for neurological signs or symptoms such as numbness or tingling to his upper extremities, range of motion to the neck, or inquire about any recent injuries. The nurse also did not notify the provider and scheduled the patient for a provider follow-up within 14 days. The nurse should have completed a more thorough assessment and notified the provider the same day.

- In case 55, the sick call nurse evaluated the patient with a history of bladder cancer and benign prostatic hypertrophy (BPH) for blood in his urine and painful urination. The nurse did not assess him for urinary symptoms such as urgency, frequency, or how long he had been experiencing painful urination. The nurse also did not notify the provider regarding the patient's complaints.

- In case 61, the patient submitted a sick call request for flu-like symptoms. The nurse evaluated the patient the following day. Instead, the nurse should have assessed the patient on the same day and placed the patient in quarantine to prevent the spread of a possible contagious illness.

Care Management

Care managers evaluate patients with chronic conditions such as diabetes and hypertension. Care manager duties include foot exams, monitoring of HgbA1c levels, blood pressure checks, and assessing patients for their knowledge about their conditions. Case review examined two cases in which patients were

[59] Sick call assessment deficiencies occurred in cases 2, 3, 8, 9, 14, 15, 21, 23, 35, 36, 39–41, 48, 50, 54–56, and 61. Deficiencies related to nursing interventions occurred in cases 9, 14, 23, 25, 35, 39, 55, and 61. Case 23 had multiple deficiencies.

evaluated by a care manager.[60] The only deficiency we identified was due to the following: The nurse did not provide patient education for the patient encounter.[61]

Wound Care

Nursing wound care performance was satisfactory. We reviewed seven cases in which wound care was provided by nurses.[62] During case review, we identified three deficiencies, one of which was significant, as discussed below:[63]

- In case 25, the nurse performed wound care on a diabetic patient with an abscess to the right upper leg. The nurse described the wound as painful and red, with purulent drainage that was not there the day before. The nurse did not notify the provider of the documented wound assessment that described signs of infection. The nurse also did not provide patient education about wound care.

Emergency Services

Emergency care performance was unsatisfactory. We reviewed 74 urgent and emergent events, and found 61 emergency care deficiencies, 16 of which were significant. Nursing assessments, interventions, and documentation show room for improvement. Please see the **Emergency Services** indicator for further details.

Hospital Returns

Nurses did not always perform complete assessments when patients returned from the hospital. We reviewed 37 events that involved returns from off-site hospitals or emergency rooms and identified 17 nursing deficiencies, two of which were significant. We provide additional details in the **Transfers** indicator.

Transfers

Nurses frequently evaluated patients appropriately and initiated provider appointments within required time frames. We reviewed seven cases that involved transfer-in and transfer-out processes. Please refer to the **Transfers** indicator for further details.

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[60] Patients were evaluated by the care manager in cases 3 and 23.

[61] The deficiency occurred in case 3.

[62] We reviewed wound care in cases 3, 8, 25–27, 62, and 63.

[63] All three deficiencies related to wound care occurred in case 25, including the significant deficiency.

Specialized Medical Housing

Overall, CTC nurses provided adequate patient care. We reviewed five cases with 59 nursing events. We identified 23 deficiencies, two of which were significant deficiencies. CTC nurses performed good documentation and timely notified the provider with changes in patient condition. However, patient assessments could have been more thorough. For additional discussion, please refer to the **Specialized Medical Housing** indicator.

Specialty Services

Specialty services nursing care was adequate. We reviewed 40 events in 17 cases and identified seven deficiencies. Case review did not identify any significant deficiencies. Please refer to the **Specialty Services** indicator for additional details.

Medication Management

SQ had lapses in medication continuity. We reviewed 161 events involving medication management and identified 42 deficiencies, seven of which were significant. For additional details, please refer to the **Medication Management** indicator.

Clinician On-Site Inspection

During our on-site visit, we interviewed nursing staff, including the supervising RNIII, the supervising RNII, RNs and LVNs. The chief nurse executive (CNE), who assumed the role in June 2022, was not on site during our visit. The supervising RNIII who had been in the role for six months reported some of the challenges were maintaining appropriate staffing levels and earning respect from staff. At the time of our on-site inspection, nursing leadership reported that they were assessing each clinic to identify issues and educating the staff on how to fix the issues. Evaluating nursing care will occur after these steps have been taken.

We interviewed several clinic nurses. One clinic nurse reported that nurse lines on average have 13 patients scheduled per nurse. The clinics encourage walk-ins, and patients are added to the nurse line based on patient need. Care-management patients are added to the daily nurse lines. This clinic did not report any supply issues. The medical assistant orders supplies weekly, and the supply closet is well stocked. The clinic nurses also assist with provider support at times.

In general, nurses reported nursing morale and administrative support were both fair, and the constant change in administrative leadership was challenging.

Recommendations

- Nursing leadership should ensure that nurses perform more detailed assessments and timely interventions.

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

SQ providers in general delivered acceptable care. Compared with Cycle 5, provider continuity was very good. Usually, assessment and decision making, emergency and chronic care, review of records, and referral for specialty services were acceptable. We identified late endorsements of diagnostic studies, missing patient results letters, and documentation deficiencies for this cycle. A large portion of the deficiencies were associated with only a few providers. Considering all factors, we rated this indicator ***adequate***.

Case Review Results

OIG clinicians reviewed 228 medical provider encounters and 75 emergency events and identified 138 deficiencies, 27 of which were significant.[64] Nearly one half of the significant deficiencies occurred in three cases. In addition, our clinicians examined the quality of care in 25 comprehensive case reviews. Of these 25 cases, we found 21 ***adequate*** and 4 ***inadequate***.

Assessment and Decision-Making

Case review found that providers usually made good assessments and sound decisions. Most of the time, when addressing acute conditions, providers took good patient medical histories, ordered appropriate tests, made the correct diagnosis, provided necessary care, and referred patients to proper specialists when needed. However, our clinicians identified 21 assessment and decision-making deficiencies, eight of which were considered significant.[65] Examples of significant deficiencies included the following:

- In case 8, the RN contacted the provider about a patient with end-stage liver disease who complained of arm and leg cramping, a rapid six-pound weight gain, and significantly worsening swelling of the

[64] Deficiencies occurred in cases 1–3, 6–15, 17–19, 21–25, and 27. Significant deficiencies occurred in cases 1, 3, 6, 8, 9, 14, 17, 21, 23, and 25.

[65] Deficiencies occurred in cases 6–8, 14, 17, and 21–25. Significant deficiencies occurred in cases 6, 8, 14, 21, 23 and 25.

abdomen, arms, and legs. The provider ordered Tylenol, but did not address these concerning signs of the patient's worsening medical condition, did not see the patient, or send him to a higher level of care for further evaluation. The provider should have assessed the patient urgently.

- In case 25, an immunocompromised, diabetic patient was not given timely antibiotic care for a skin infection. When additional lesions appeared, the patient was still not given antibiotics for an extended period, placing him at risk of worsening infection. Wound cultures were not obtained to ensure correct antibiotics were being prescribed.

Case review identified that, often, providers did not document medical decision making, or their documentation was incomplete. Twenty-four deficiencies were identified; however, none were significant.[66]

We also identified a pattern of not addressing missing or abnormal vital signs; however, most of the deficiencies were not considered severe.[67] This is discussed further in the **Clinician On-Site Inspection** area below.

Review of Records

Providers usually reviewed medical records carefully, with appropriate reviews of outside hospital records and specialty reports. However, oversight of two critical diagnoses in Case 6 accounted for several significant deficiencies:

- Throughout the review period, due to poor chart review, the provider did not address the patient's history of hepatitis C, cirrhosis, and esophageal varices that were found on at least two imaging studies since June 2019, but that had not been entered on the patient's medical problem list in EHRS.[68] These medical conditions had not been addressed, including screening ultrasounds for liver cancer since at least June 2019. During the review period, the patient was placed on dual anticoagulation therapy without adequate consideration of his high risk for bleeding. On his death, the patient was identified with cirrhosis with previously undiagnosed metastatic liver cancer and acute liver failure. Death may have been delayed had the conditions been recognized and treatment offered earlier.

Emergency Care

Providers usually appropriately managed patients in the TTA with urgent and emergent conditions. Providers were available to nursing for consultations; they made medically sound decisions and completed appropriate medical

[66] Deficiencies occurred in cases 1, 3, 6–9, 12, 14, 17, 22–23, and 25.

[67] Deficiencies occurred in cases 3, 6–8, 17, 23 and 25. Significant deficiencies occurred in cases 6 and 25.

[68] Esophageal varices are enlarged veins in the esophagus that occur from liver disease.

documentation. Of the 75 TTA emergency events, 10 deficiencies were cited, with six significant. Three of the significant deficiencies were primarily for improper mode of hospital transport. Up to the point of these poor transportation-related decisions, the medical care was usually considered appropriate. This is discussed further in the **Emergency Services** indicator.

Chronic Care

We reviewed 171 provider encounters in which patients had chronic conditions. Despite COVID-19 outbreaks, providers continued to see patients in person, performed pertinent exams, and rarely deferred visits. In most instances, they managed the patient's chronic health conditions and documented them appropriately; however, there were areas for improvement as follows:

- In case 6, nursing relayed to the provider that the patient on two blood thinners had complained of a nosebleed the day before that had lasted for hours. The provider did not see the patient nor request a nursing follow-up. The patient should have been seen immediately to ensure there were no additional warning signs and symptoms of abnormal bleeding.

- In case 25, the provider was advised that the patient's absolute neutrophil count (ANC) was critically low[69]; the provider requested an RN assessment, but did not order any follow-up laboratory testing, provider visits, RN follow-up visits, or take preventative actions to reduce the immunocompromised patient's risk of infection.

Providers and medical leadership performed very well in one particularly challenging case. In case 7, a relatively healthy patient went on repeated hunger strikes, which ultimately led to his death. During the hunger strikes, staff offered treatment, which he repeatedly refused. Despite the difficulties this patient presented, the patient care team and leadership provided the patient with good medical care.

Specialty Services

Providers performed well in specialty services. Providers usually referred patients appropriately for specialty care within required time frames, timely reviewed specialty documents once received, and usually followed specialty recommendations. Deficiencies in these areas were cited and discussed further in the **Specialty Services** indicator.[70]

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[69] A neutrophil is an important type of white blood cell needed for fighting infection. When the number of neutrophils (absolute neutrophil count) declines to a low level, the patient has an increased risk for infection because of the decreased ability to mount an appropriate immune response.

[70] Deficiencies occurred in case 6, 8–9, 17, 21–23 and 25. Significant deficiencies occurred in cases 17, 21, 23 and 25.

Patient Notification Letters

Providers did not always send patient notification letters to patients. We identified 33 missing patient results letters.[71] Compliance testing found that when letters were sent, they frequently were missing at least one of the required components. This is discussed further in the **Health Information Management** indicator.

Provider Continuity

Generally, SQ had very good provider continuity. Patients were usually seen by the same providers during the review period. This is also discussed in the **Clinician On-Site Inspection** area below.

Clinician On-Site Inspection

We met with the SQ medical leadership, providers, nursing, and scheduling staff. The chief executive officer (CEO) and one chief physician and surgeon (CP&S) were not available during our on-site visit. Since Cycle 5, the chief medical executive (CME) and CP&S are both new to their positions. There are two CP&Ss, and one arrived December 2021 from another CCHCS institution.

Executive leadership stated that there were two vacant provider positions, and there had been unplanned-for provider absences during the review period. On-site schedulers reported a backlog as high as 230 appointments, which had been reduced to 78 at the time of our on-site inspection. Providers have held additional weekend clinics to help with the appointment backlog. Executive leadership reported that two registry providers and 1.6 full-time civil service physicians were pending arrival.

Executive leadership stated that during the review period, despite COVID-19 outbreaks, providers were expected to see the patients assigned to their line. Rescheduling was discouraged.

Some providers felt supported by their management; however, morale was generally low. Providers discussed that leadership communicated primarily through email, with little face-to-face interaction. Most felt face-to-face interaction would be welcome and may be more effective. We were told that if there was a problem by one provider, an email would be sent out to all providers about needed improvements, which negatively affected morale. In addition, several providers expressed feeling overwhelmed by the volume of work, which was compounded by a lack of clinic nursing support.

We cited deficiencies when providers either did not address abnormal vital signs or did not note that vital signs checks were missing. When we asked providers why abnormal vital signs were not addressed, providers stated that, often, vital signs checks were not available or the patient appeared well, so providers did not

[71] Providers did not send letters in cases 3, 6, 8–10, 13–14, 17–19, 22–24, and 27. None of the deficiencies were considered significant.

address the abnormal vital signs. Several providers stated that they routinely are unable to get nursing assistance with obtaining patient vital signs and obtained vital signs themselves, which delays clinical care.

In at least two instances, deficiencies were cited because wound cultures were not obtained. Several providers reported that they could not perform wound cultures in the clinics because the culture kits are only available in the TTA. Obtaining them during a busy clinic period, especially without nursing support, is not possible without creating significant clinical delays among providers.

Recommendations

- Medical and nursing leadership should consider ensuring consistent, adequate nursing support is offered to medical providers.
- Medical leadership should ensure critical tools, such as wound culture kits, are readily available to providers in clinics.

Specialized Medical Housing

Overall Rating
Adequate

Case Review Rating
Adequate

Compliance Score
Adequate
(82.5%)

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

Results Overview

SQ performed sufficiently in this indicator. Nurses and providers timely completed admission assessments, medical histories, and physical examinations. Nurses monitored their patients as required, performed good documentation, and communicated with providers as needed. Nurses, however, could have performed more thorough assessments. Medication continuity had mixed results. Considering both case review and compliance testing, we rated this indicator ***adequate.***

Case Review and Compliance Testing Results

We reviewed five CTC cases that included 64 provider events and 59 nursing events. Due to the frequency of nursing and provider contacts in the specialized medical housing, we bundle up to two weeks of patient care into a single event. We identified 51 deficiencies, three of which were significant.[72]

Provider Performance

Providers performed well in caring for CTC patients. Compliance testing found that admission history and physical examinations were always done within required time frames (MIT 13.002, 100%). Case reviewers found that admission history and physicals examinations were done timely, and patients were seen at clinically appropriate intervals. When patients were seen, medical decisions were usually sound, care plans appropriate, and documentation complete. Twelve provider deficiencies were identified, with one significant:[73]

- In case 8, the provider endorsed abnormal kidney and liver test results, but did not address these abnormal results.

[72] We reviewed CTC care in cases 7, 8, 14, 62, and 63. Deficiencies occurred in cases 7, 8, 14, 62, and 63. Significant deficiencies occurred in cases 8 and 63.

[73] Deficiencies occurred in cases 7 and 8. One significant deficiency occurred in case 8.

Nursing Performance

SQ's CTC nurses conducted regular rounds and generally provided satisfactory care. Of the 50 CTC deficiencies, 23 were related to nursing. Both compliance results and case review found CTC nurses performed timely admission assessments (MIT 13.001, 90.0%). However, case review found CTC nurses did not always assess lung sounds, bowel sounds, or obtain the patient's weight on admission.[74] Daily nursing assessments revealed similar deficiencies.[75] CTC nurses frequently notified the provider of changes in patient condition and generally performed good documentation. Significant deficiencies occurred in the following cases:

- In case 8, the patient with a history of advanced liver disease was admitted to the CTC after a hospitalization. The nurse performed an incomplete admission assessment. The nurse did not assess the patient's heart, lung, and bowel sounds. In addition, the patient complained of lower abdominal pain, and the nurse did not assess the abdomen or the level of pain.

- In case 63, the patient with end-stage liver disease had very low blood pressure. The nurse did not reassess the patient's blood pressure, perform a patient assessment, or notify the provider.

Our compliance testing found that the CTC maintained an operational call system to ensure patients have access to care (MIT 13.101, 100%).

Medication Administration

Medication continuity performance for patients admitted to the CTC was mixed. Compliance testing showed that patients who were admitted to the CTC did not always receive their medications timely (MIT 13.004, 40.0%). Our OIG clinicians identified five deficiencies related to medication management, none of which were significant.[76] Please refer to the **Medication Management** indicator for further discussion.

Clinician On-Site Inspection

We interviewed CTC nursing staff. The CTC has 10 medical beds and four negative pressure rooms. Staffing consists of RNs, LVNs, and CNAs. Nurses reported having an average patient census of nine to 10 patients. During our visit, the CTC had nine patients. A dedicated provider was assigned to the CTC. Daily huddles occur in the morning, which RNs and the provider attend. The medication LVN attends the huddle if not performing a medication pass. The

[74] CTC nurses performed incomplete admission assessments in cases 7, 8, and 63.

[75] Incomplete daily assessments occurred in cases 7, 8, 62, and 63.

[76] Deficiencies occurred in cases 7, 8, 62, and 63.

LVN communicates medication concerns to the provider face to face or via email. Staff reported the pharmacy delivers medications at scheduled times.

CTC nurses reported issues with obtaining incontinence care supplies and concerns about staffing levels. In addition, nurses reported fair morale. Nurses also reported that custody staff was helpful.

Compliance Testing Results

Table 17. Specialized Medical Housing

	Scored Answer			
Compliance Questions	**Yes**	**No**	**N/A**	**Yes %**
For OHU, CTC, and SNF: Prior to 4/2019: Did the registered nurse complete an initial assessment of the patient on the day of admission, or within eight hours of admission to CMF's Hospice? Effective 4/2019: Did the registered nurse complete an initial assessment of the patient at the time of admission? (13.001) *	9	1	0	90.0%
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) *	10	0	0	100%
For OHU, CTC, SNF, and Hospice (applicable only for samples prior to 4/2019): Did the primary care provider complete the Subjective, Objective, Assessment, and Plan notes on the patient at the minimum intervals required for the type of facility where the patient was treated? (13.003) *,†	0	0	10	N/A
Upon the patient's admission to specialized medical housing: Were all medications ordered, made available, and administered to the patient within required time frames? (13.004) *	4	6	0	40.0%
For OHU and CTC only: Do inpatient areas either have properly working call systems in its OHU & CTC or are 30-minute patient welfare checks performed; and do medical staff have reasonably unimpeded access to enter patient's cells? (13.101) *	1	0	0	100%
For specialized health care housing (CTC, SNF, Hospice, OHU): Do health care staff perform patient safety checks according to institution's local operating procedure or within the required time frames? (13.102) *	0	0	1	N/A
				Overall percentage (MIT 13): **82.5%**

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

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

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

Recommendations

- Nursing leadership should ensure CTC nurses complete initial and daily patient assessments thoroughly.

Specialty Services

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

Overall Rating
Inadequate

Case Review Rating
Inadequate

Compliance Score
***Inadequate* (60.1%)**

Results Overview

SQ's performance in the indicator worsened since Cycle 5. The OIG found significant problems with routine specialty appointment access for both initial and follow-up specialty appointments as well as for transfer-in patients. Staff had difficulty obtaining specialty reports timely, and on-site specialists entered progress notes and orders without receiving either adequate oversight or appropriate training. On-site specialists performed well in most cases from a medical perspective; however, the oversight for these specialists was insufficient and placed the patients at increased medical risk. Primary care providers and nursing performed well. Considering compliance and case reviews, on balance, we rated this indicator ***inadequate***.

Case Review and Compliance Testing Results

The OIG clinicians reviewed 228 events related to specialty services: 174 were specialty consultations and procedures, 14 were SQ pharmacists and providers performing in specialty roles, and 40 were nurses completing off-site specialty return assessments and assisting with on-site telemedicine encounters. We found 104 deficiencies in this category, 30 of which were significant.[77]

Access to Specialty Services

SQ specialty services access performance was mixed. Compliance testing determined there was a good completion rate for initial high-priority and medium-priority appointments; however, the completion rate was poor for routine-priority appointments (MIT 14.001, 80.0%, MIT 14.004, 80.0%, and MIT 14.007, 26.7%). Similarly, access was very good for high-priority specialty follow-up appointments, fair for medium-priority follow-ups, and poor for routine-priority appointments (MIT 14.003, 90.0%, MIT 14.006, 75.0%, and MIT 14.009, 50.0%). Furthermore, SQ often did not provide timely specialty appointments for patients transferring in from another departmental institution with preexisting specialty appointments (MIT 14.010, 30.0%).

Case review clinicians also found that many specialty appointments did not occur within requested time frames. We identified 23 access to specialty care

[77] Deficiencies occurred in cases 1, 3, 6–9, 12, 14, 16–17, 21–27, 62, and 63. Significant deficiencies occurred in cases 1, 3, 6, 8–9, 12, 14, 17, 21, 23, and 25.

deficiencies with nine considered significant.[78] Examples of the significant deficiencies include the following:

- In case 3, the provider submitted a medium-priority referral for cardiothoracic surgery to implant a cardioverter-defibrillator (ICD).[79] The ICD was implanted 42 days late.
- In case 6, the provider ordered a chest CT to follow up on a previously abnormal chest CT; however, the follow-up CT scan was not performed.
- In case 9, a PET scan was performed to evaluate for possible metastatic cancer, but it occurred 70 days late, which placed the patient at significant medical risk.[80]

Provider Performance

Providers performed well in ordering appropriate specialty visits within medically appropriate time frames. Case review found that of the 174 specialty events reviewed, providers usually endorsed specialty reports and timely.[81] However, we identified deficiencies, with the following example:

- In case 17, the patient had an abnormal Zio Patch (heart rhythm monitor) report scanned into the EHRS. The provider endorsed the study five days late and did not address the abnormal report.

Providers usually followed specialists' recommendations; however, we identified six deficiencies, two of which were significant.[82] Providers usually ordered appropriate specialty appointments within medically appropriate time frames; however, we found four deficiencies with one significant as follows:[83]

- In case 23, the provider ordered an initial on-site oncology evaluation for a patient with Stage 2 colon cancer as a medium-priority appointment to be completed six weeks later. The patient should have been evaluated for the advanced cancer sooner.

On-Site Specialty Care

OIG clinicians found that some contracted specialists who came on-site were provisioned to enter orders and document specialty reports directly into EHRS,

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[78] Deficiencies occurred in cases 1, 3, 6–9, 12, 16–17, 21, 23, and 25–27. Significant deficiencies occurred in cases 3, 6, 8–9, 12, 17, 23, and 25.

[79] An implantable cardioverter-defibrillator (ICD) is a small electronic device that is placed in the chest to monitor, detect, and help regulate life-threatening abnormal heart rhythms. It can deliver electrical shocks to the heart to restore a regular heart rhythm.

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

[81] For specialty reports forwarded to providers, 10 deficiencies for delayed or missed specialty report endorsements occurred in cases 6, 8, 14, 17, 25, 62, and 63.

[82] Deficiencies occurred in cases 8, 21, 22, 23, 25. Significant deficiencies occurred in cases 21 and 25.

[83] Deficiencies occurred in cases 6, 8, 17, and 23.

as CCHCS providers and nurses do. These specialists entered follow-up appointment orders with themselves, provider and nursing follow-up appointments, medications, and diagnostic testing orders. At our onsite, we were told that they were not allowed to order new specialty referrals. Where applicable, the OIG assessed these specialists' actions based on existing patient care policies—less from a compliance perspective and more from one of patient safety. For those specialists given access, their workflow and patient care should interface seamlessly with the existing processes and policies in place to ensure safe patient care.

OIG clinicians identified 40 deficiencies related to on-site specialty care, five of which were considered severe.[84] Case review identified the following areas that on-site specialists or SQ staff did not perform well:

- They did not always forward the specialty reports to primary care providers for review and endorsement;
- They did not always communicate abnormal findings to primary care providers in the EHRS;
- They did not always place orders correctly; therefore, orders could not be completed;
- They did not always label their visit reports in EHRS correctly, thereby, causing misfiling of specialty reports;
- They did not always review and endorse specialty-ordered diagnostic tests within policy time frames; and
- They did not send patient results letters to notify patients of specialty-ordered diagnostic test results.

Examples of significant deficiencies were as follows:

- In case 1, the on-site specialist endorsed laboratory results indicating the patient had worsening renal function. The specialist did not perform the following actions:
    - respond to the worsening laboratory results or document a progress note with medical reasoning.
    - send the patient a results letter; therefore, the patient may not have been aware of his worsening condition.
- In case 23, the patient saw the nephrologist.[85] The patient reported bad diarrhea, nausea, and vomiting that were still occurring after chemotherapy was completed. The nephrologist suspected the

[84] Deficiencies related to on-site specialty care occurred in cases 1, 8, 14, 23, and 25. Significant deficiencies occurred in cases 23 and 25.

[85] A nephrologist is a physician who specializes in treating medical conditions related to the kidneys.

patient's worsening renal function was due to dehydration. The following lapses occurred:

  - The nephrologist did not advise the on-site primary care providers that the patient was symptomatic so that an evaluation and treatment would be provided.

  - The nephrologist's progress note was not forwarded to or endorsed by a primary care provider. The nephrologist incorrectly wrote the consultation as an outpatient visit note, which meant it could not be identified as a specialty visit.

  - The patient did not receive treatment for his symptoms until one week later, after he reported to nursing that he was very ill.

- In case 25, the patient complained of difficulty breathing and had an elevated heart rate. The on-site specialist evaluated the patient, and during a lung examination, noticed something abnormal; the specialist also found swelling in the patient's legs, signs of worsening condition, and ordered a chest X-ray. The chest X-ray result showed indications of worsening heart failure. The following occurred:

  - The specialist did not communicate the abnormal physical examination findings and vital signs to the on-site providers to advise them that a chest X-ray was ordered, and a primary care follow-up appointment was also not ordered.

  - The specialist incorrectly wrote the consultation as an outpatient visit note, which meant this appointment could not be identified as a specialty visit.

  - Furthermore, the specialist report was not forwarded to and endorsed by a provider; therefore, the primary care provider was not aware that the patient had worsening fluid retention and an abnormal lung examination until after the patient had become very ill, and hospitalization was needed.

We identified 11 diagnostic deficiencies related to on-site specialty, and three were considered severe.[86] In case 25, at different visits, we found the following deficiencies:

- The specialist ordered laboratory tests that showed the patient had a decreased sodium level and worsening kidney function. The laboratory tests were endorsed by the specialist 36 days late. The severity of this deficiency is mitigated by the fact that another

[86] Deficiencies occurred in cases 1, 23, and 25. Significant deficiencies occurred in case 25.

provider had ordered similar laboratory tests and did address them emergently.

- The specialist endorsed laboratory results seven days late showing the patient had an elevated white blood cell count. An elevated white blood cell count could be related to infection, but was not addressed timely.

- The specialist ordered a chest X-ray that was abnormal, but which was endorsed 68 days late. The primary care team was not aware that the chest X-ray had been ordered, and the report was not reviewed by the primary care team until the patient's condition had already worsened.

This case is also discussed in the **Clinician On-Site Inspection** area below.

Nursing Performance

Nursing performance with specialty services was acceptable. Nurses evaluated patients on their return from specialty appointments and generally performed complete assessments and interventions. Our clinicians reviewed 40 nursing events in 17 cases and identified seven deficiencies, none of which were significant.[87] Deficiency examples include incomplete assessments of the abdomen and not listening to lung and bowel sounds.

Health Information Management

SQ performed poorly regarding specialty reports. Compliance testing found specialty reports were scanned within policy time frames 70.0 percent of the time (MIT 4.002) and were usually not received or endorsed timely (high-priority MIT 14.002, 42.9%; medium-priority, MIT 14.005, 60.0%; and routine-priority MIT 14.008, 33.3%).

Case reviewers also found SQ managed specialty reports poorly. Of the 174 specialty visits reviewed and 57 specialty HIM deficiencies identified, 15 were significant.[88] Of the 18 unendorsed specialty reports, 17 were written by on-site specialists and were not forwarded to providers for endorsement. In addition, on-site specialists' consultation reports and notes were often misfiled as outpatient progress notes.

Case review also found that receipt and scanning of off-site specialty reports were often delayed or were missing; this occurred frequently in cardiology, and

[87] We reviewed specialty nursing events in cases 2, 3, 6–10, 14, 16, 17, 19, 22–25, 27, and 63. Deficiencies occurred in cases 8, 14, 16, 23, and 63.

[88] Deficiencies occurred in cases 1, 3, 6–9, 14, 17, 21–27, and 62–63. Significant deficiencies occurred in cases 1, 3, 6, 9, 17, 21, 23, and 25.

oncology assessments and treatments.[89] Examples of significant deficiencies include the following:

- In case 9, for a five-week period, the patient was seen frequently by the radiation oncologist for prostate cancer treatment. There are no radiation oncology treatment reports in EHRS for these dates.
- In case 23, the patient was provided outpatient chemotherapy treatment, but for two of these appointments, specialty reports were not scanned into EHRS.
- In case 25, the patient had a heart rhythm study completed. The report was scanned 28 days late. The result was significantly abnormal and should have been addressed quickly.

In addition, on-site specialists did not write patient results letters for tests that they ordered. This is also discussed in the **Diagnostic Services** and **Health Information Management indicators**, and the **Clinician On-Site Inspection** area below.

Clinician On-Site Inspection

We discussed specialty services processes with SQ medical leadership, nursing, office technicians, health information management supervisors, ancillary staff, providers and on-site specialists as available. SQ offers on-site specialists, off-site specialists, telemedicine specialists, and specialty procedures such as MRI scans, CT scans, and colonoscopies.

During the review period, SQ reported staffing shortages that had impacted scheduling. A retired annuitant had returned to assist part time in radiology until staff could be hired and trained.

We met with the off-site specialty nurse to discuss specialty services. The off-site specialty nurse reported knowledge of all specialty services processes and procedures, both on-site and off-site. This nurse discussed responsibilities for a large portion of the specialty scheduling, case management, and obtaining off-site reports during the review period. Many providers and nursing staff relied on this one nurse to answer questions, correct errors, and manage scheduling for many different types of specialty services. During staffing shortages, this RN mentioned about additional duties including scheduling radiology tests and procedures. New staff have been assigned to assist in specialty services and are currently in training.

The scheduling supervisor managed initial scheduling of the on-site specialty visits. On-site physical therapy (PT) and urology specialty were particularly impacted during the review period. Since our review period, the urology specialty has increased availability, which has reduced the backlog of appointments. The

[89] Deficiencies occurred in cases 1, 3, 6, 8, 9, 17, 21, 23, 24, 25, 26, and 27. Significant deficiencies occurred in cases 1, 3, 9, 17, 22, 23, and 25.

supervisor reported that PT appointments remain backlogged due to high utilization and few physical therapists.

Staff confirmed that on-site physical therapy, podiatry, nephrology including dialysis, and optometry had EHRS access, and providers for these areas could input their reports and orders directly into the system. Medical leadership stated that EHRS training had been completed by CCHCS headquarters. However, the on-site specialists stated that they had received minimal training on both how to use EHRS and EHRS policies. These specialists were unaware that their reports should be forwarded to the provider for endorsement or how that would be done. Two specialists stated they entered orders into the EHRS. One believed they were entering the orders correctly, but the other was not certain and did not know how to correctly enter follow-up orders or use the messaging system. One specialist did not label their report correctly, making the specialty report difficult to identify as a specialty report in the EHRS.

The on-site specialists were only intermittently on-site at SQ. They explained, and staff confirmed, there was no remote EHRS access for them to use for reviewing patient diagnostic studies or patient care messages while off-site. Specialists also confirmed that while they were away from the institution, there was no inbox coverage by CCHCS or SQ staff to ensure critical results and messages were reviewed timely, which placed the patients at risk.

On-site specialists stated that nursing support was only periodically available and then only to obtain patient vital signs; other support was rarely available. One specialist stated that they had trained an inmate patient to perform screenings because CCHCS staff had not been provided. Notably, telemedicine specialists have dedicated RN support to obtain vital signs and ensure communication of specialists' recommendations and abnormal findings to primary care providers.

The relatively new medical leadership team was not clear who was responsible for overseeing on-site specialists' work. The leadership team believed CCHCS headquarters did, but were not sure. HIM confirmed its staff do not follow up to ensure that on-site specialty reports are completed correctly or endorsed.

Several deficiencies were cited for late or missing specialty reports. While we were at our on-site visit, we learned that only one person, the off-site specialty RN, had direct electronic access to two local hospitals' medical records and the laboratory testing system. This fact might impact the institution's ability to obtain specialty reports in a timely manner. HIM leadership reported that one off-site cardiology procedure specialist, who had been consistently late in providing reports, had been replaced. We were told that the problems getting chemotherapy and radiation oncology visit reports consistently would be escalated to medical leadership.

Compliance Testing Results

Table 18. Specialty Services

Compliance Questions	Scored Answer			
	Yes	No	N/A	Yes %
Did the patient receive the high-priority specialty service within 14 calendar days of the primary care provider order or the Physician Request for Service? (14.001) *	12	3	0	80.0%
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) *	6	8	1	42.9%
Did the patient receive the subsequent follow-up to the high-priority specialty service appointment as ordered by the primary care provider? (14.003) *	9	1	5	90.0%
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) *	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) *	9	6	0	60.0%
Did the patient receive the subsequent follow-up to the medium-priority specialty service appointment as ordered by the primary care provider? (14.006) *	6	2	7	75.0%
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) *	4	11	0	26.7%
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) *	4	8	3	33.3%
Did the patient receive the subsequent follow-up to the routine-priority specialty service appointment as ordered by the primary care provider? (14.009) *	2	2	11	50.0%
For endorsed patients received from another CDCR institution: If the patient was approved for a specialty services appointment at the sending institution, was the appointment scheduled at the receiving institution within the required time frames? (14.010) *	6	14	0	30.0%
Did the institution deny the primary care provider's request for specialty services within required time frames? (14.011)	15	2	0	88.2%
Following the denial of a request for specialty services, was the patient informed of the denial within the required time frame? (14.012)	11	6	0	64.7%
				Overall percentage (MIT 14): **60.1%**

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

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

Table 19. Other Tests Related to Specialty Services

	Scored Answer			
Compliance Questions	**Yes**	**No**	**N/A**	**Yes %**
Specialty service follow-up appointments: Did the clinician follow-up visits occur within required time frames? (1.008) *,†	16	9	20	64.0%
Are specialty documents scanned into the patient's electronic health record within five calendar days of the encounter date? (4.002) *	21	9	15	70.0%

* 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

- The department should consider whether on-site specialists should be provisioned to enter progress notes and orders for patients in the electronic health records system (EHRS); and if that access should be provisioned, then the department should ensure appropriate EHRS training is offered before on-site specialists perform their duties; moreover, this training should include ongoing oversight, including timely endorsement of reports and test results, communication with on-site providers and nurses, and adequate support staffing.

- Medical leadership should ensure all specialty reports, including chemotherapy treatments, radiation visits, and specialty procedures, are scanned into EHRS timely.

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

- Medical leadership should determine the root cause of challenges in notifying patients about specialty denials within the required time frame and implement remedial measures as appropriate.

Administrative Operations

Overall Rating
Inadequate

Case Review Rating
N/A

Compliance Score
***Inadequate* (69.0%)**

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.

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

SQ's performance was similar with that of Cycle 5. The Emergency Medical Response Review Committee (EMRRC) did not always complete 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. SQ performed well in a few areas. The QMC met regularly. Also, nursing leadership ensured that nurses who administer medications had completed their clinical competency annually and newly hired nurses received the required onboarding and clinical competency training timely. These findings are set forth in the table on the next page. Overall, we rated this indicator ***inadequate***.

Nonscored Results

At SQ, the OIG 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. Three unexpected (Level 1) and four expected (Level 2) deaths occurred during our review period. In our inspection, we found the DRC did not complete any of its death review reports promptly. The DRC finished five reports 25 to 69 days late and submitted them to the institution's CEO 20 to 63 days after that. The remaining two reports were overdue at the time of OIG's inspection (MIT 15.998).

Compliance Testing Results

Table 20. Administrative Operations

Compliance Questions	Scored Answer			
	Yes	No	N/A	Yes %
For health care incidents requiring root cause analysis (RCA): Did the institution meet RCA reporting requirements? (15.001) *	N/A	N/A	N/A	N/A
Did the institution's Quality Management Committee (QMC) meet monthly? (15.002)	6	0	0	100%
For Emergency Medical Response Review Committee (EMRRC) reviewed cases: Did the EMRRC review the cases timely, and did the incident packages the committee reviewed include the required documents? (15.003)	0	12	0	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)	0	4	0	0
Did the institution conduct medical emergency response drills during each watch of the most recent quarter, and did health care and custody staff participate in those drills? (15.101)	0	3	0	0
Did the responses to medical grievances address all of the inmates' appealed issues? (15.102)	10	0	0	100%
Did the medical staff review and submit initial inmate death reports to the CCHCS Death Review Unit on time? (15.103)	6	3	1	66.7%
Did nurse managers ensure the clinical competency of nurses who administer medications? (15.104)	10	0	0	100%
Did physician managers complete provider clinical performance appraisals timely? (15.105)	3	7	0	30.0%
Did the providers maintain valid state medical licenses? (15.106)	15	0	0	100%
Did the staff maintain valid Cardiopulmonary Resuscitation (CPR), Basic Life Support (BLS), and Advanced Cardiac Life Support (ACLS) certifications? (15.107)	2	0	1	100%
Did the nurses and the pharmacist-in-charge (PIC) maintain valid professional licenses and certifications, and did the pharmacy maintain a valid correctional pharmacy license? (15.108)	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)	1	0	0	100%
Did the CCHCS Death Review Committee process death review reports timely? (15.998)	This is a nonscored test. Please refer to the discussion in this indicator.			
What was the institution's health care staffing at the time of the OIG medical inspection? (15.999)	This is a nonscored test. Please refer to Table 4 for CCHCS-provided staffing information.			
	Overall percentage (MIT 15): **69.0%**			

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

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

Recommendations

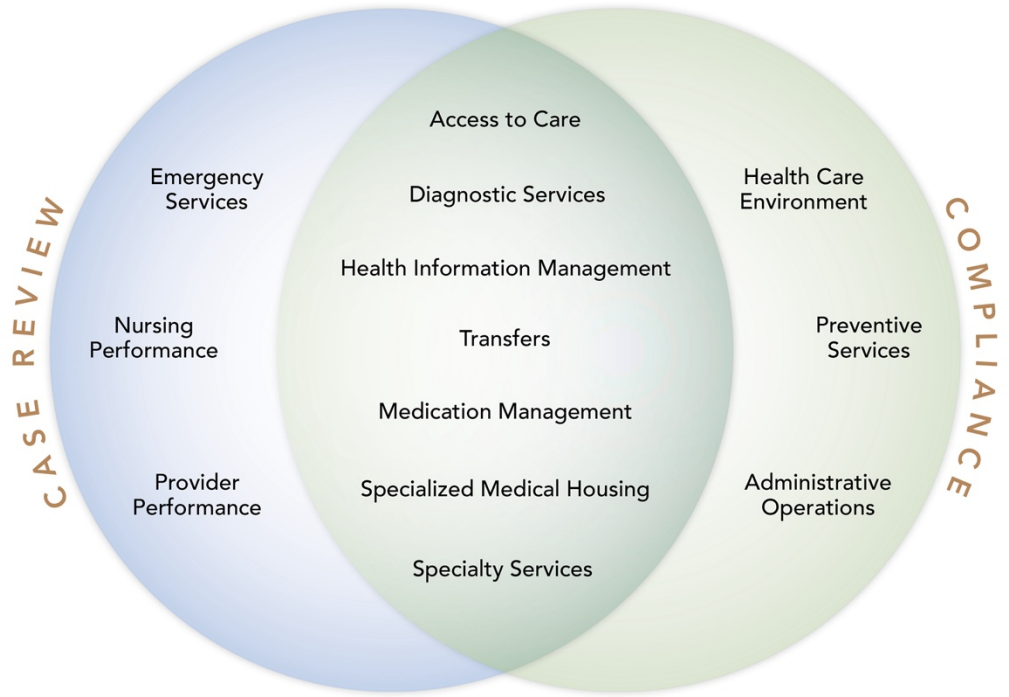
The OIG offers no recommendations for this indicator.

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 SQ



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

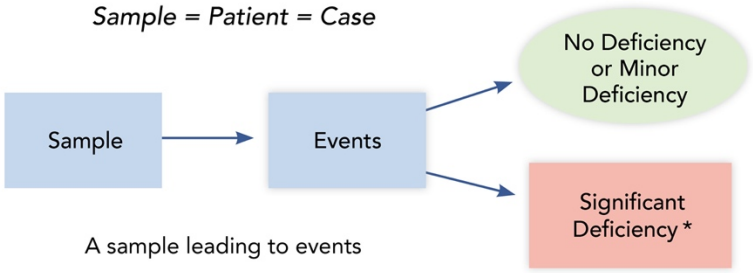
An OIG physician, a nurse consultant, or both review each case. As the clinicians review medical records, they record pertinent interactions between the patient and the health care system. We refer to these interactions as case review ***events***. Our clinicians also record medical errors, which we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

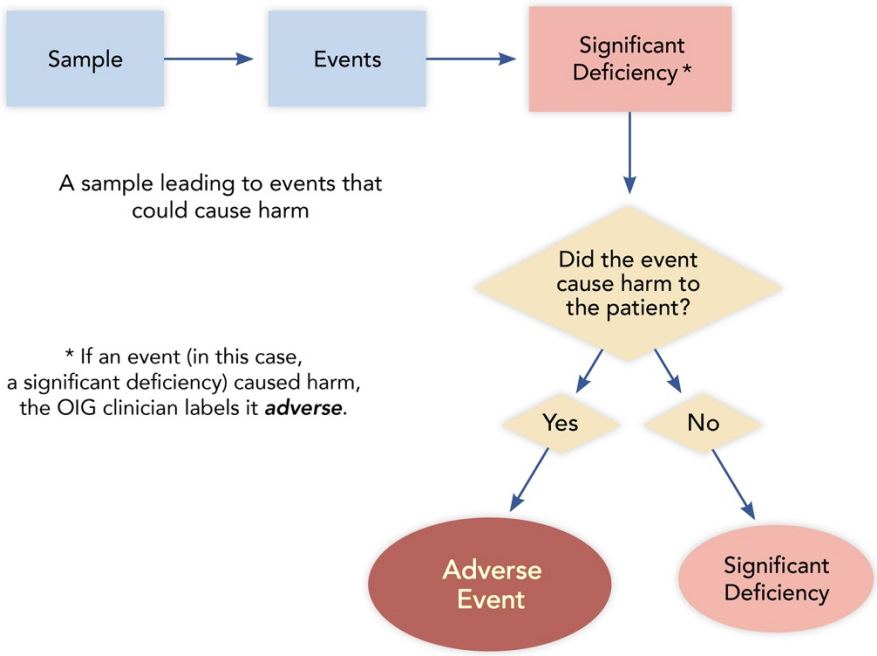
Figure A–2. Case Review Testing

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***.



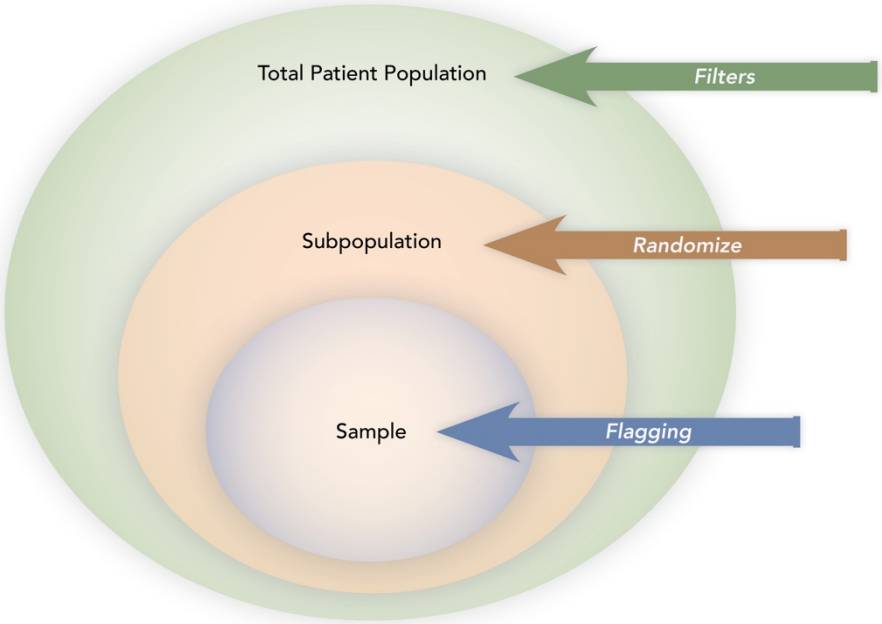
Source: The Office of the Inspector General medical inspection analysis.

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. SQ Case Review Sample Sets

Sample Set	Total
Anticoagulation	3
CTC/OHU	2
Death Review/Sentinel Events	3
Diabetes	3
Emergency Services – CPR	2
Emergency Services – Non-CPR	3
High Risk	5
Hospitalization	4
Intrasystem Transfers In	3
Intrasystem Transfers Out	3
RN Sick Call	28
Specialty Services	4
	63

Table B–2. SQ Case Review Chronic Care Diagnoses

Diagnosis	Total
Anemia	6
Anticoagulation	6
Arthritis/Degenerative Joint Disease	16
Asthma	10
COPD	8
COVID-19	7
Cancer	7
Cardiovascular Disease	13
Chronic Kidney Disease	9
Chronic Pain	15
Cirrhosis/End-Stage Liver Disease	8
Coccidioidomycosis	2
Diabetes	16
Gastroesophageal Reflux Disease	21
Gastrointestinal Bleed	1
HIV	3
Hepatitis C	13
Hyperlipidemia	32
Hypertension	42
Mental Health	19
Migraine Headaches	2
Seizure Disorder	1
Sleep Apnea	6
Substance Abuse	6
Thyroid Disease	5
	274

Table B–3. SQ Case Review Events by Program

Diagnosis	Total
Diagnostic Services	349
Emergency Care	102
Hospitalization	72
Intrasystem Transfers In	4
Intrasystem Transfers Out	5
Outpatient Care	670
Specialized Medical Housing	167
Specialty Services	258
	1,627

Table B–4. SQ Case Review Sample Summary

	Total
MD Reviews Detailed	25
MD Reviews Focused	0
RN Reviews Detailed	10
RN Reviews Focused	39
Total Reviews	74
Total Unique Cases	63
Overlapping Reviews (MD & RN)	11

Appendix C. Compliance Sampling Methodology

SAN QUENTIN STATE PRISON

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)	35	Clinic Appointment List	• Clinic (each clinic tested) • Appointment date (2–9 months) • Randomize
MIT 1.007	Returns From Community Hospital	25	OIG Q: 4.005	• See Health Information Management (Medical Records) (returns from community hospital)
MIT 1.008	Specialty Services Follow-Up	45	OIG Q: 14.001, 14.004 & 14.007	• See Specialty Services
MIT 1.101	Availability of Health Care Services Request Forms	6	OIG on-site review	• Randomly select one housing unit from each yard
Diagnostic Services				
MITs 2.001–003	Radiology	10	Radiology Logs	• Appointment date (90 days–9 months) • Randomize • Abnormal
MITs 2.004–006	Laboratory	10	Quest	• Appt. date (90 days–9 months) • Order name (CBC or CMPs only) • Randomize • Abnormal
MITs 2.007–009	Laboratory STAT	10	Quest	• Appt. date (90 days–9 months) • Order name (CBC or CMPs only) • Randomize • Abnormal
MITs 2.010–012	Pathology	10	InterQual	• Appt. date (90 days–9 months) • Service (pathology related) • Randomize

Quality Indicator	Sample Category	No. of Samples	Data Source	Filters
Health Information Management (Medical Records)				
MIT 4.001	Health Care Services Request Forms	35	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	25	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	25	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	12	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	2	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	25	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	25	MAPIP transfer data	• Date of transfer (2–8 months) • To location/from location (yard to yard and to/from ASU) • Remove any to/from MHCB • NA/DOT meds (and risk level) • Randomize
MIT 7.006	En Route	0	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	10	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	10	CADDIS	• Admit date (2–8 months) • Type of stay (no MH beds) • Length of stay (minimum of 5 days) • Rx count • Randomize
MITs 13.101–102	Call Buttons	All	OIG inspector on-site review	• Specialized Health Care Housing • Review by location
Specialty Services				
MITs 14.001–003	High-Priority Initial and Follow-Up RFS	15	Specialty Services Appointments	• Approval date (3–9 months) • Remove consult to audiology, chemotherapy, dietary, Hep C, HIV, orthotics, gynecology, consult to public health/Specialty RN, dialysis, ECG 12-Lead (EKG), mammogram, occupational therapy, ophthalmology, optometry, oral surgery, physical therapy, physiatry, podiatry, and radiology services • Randomize
MITs 14.004–006	Medium-Priority Initial and Follow-Up RFS	15	Specialty Services Appointments	• Approval date (3–9 months) • Remove consult to audiology, chemotherapy, dietary, Hep C, HIV, orthotics, gynecology, consult to public health/Specialty RN, dialysis, ECG 12-Lead (EKG), mammogram, occupational therapy, ophthalmology, optometry, oral surgery, physical therapy, physiatry, podiatry, and radiology services • Randomize
MITs 14.007–009	Routine-Priority Initial and Follow-Up RFS	15	Specialty Services Appointments	• Approval date (3–9 months) • Remove consult to audiology, chemotherapy, dietary, Hep C, HIV, orthotics, gynecology, consult to public health/Specialty RN, dialysis, ECG 12-Lead (EKG), mammogram, occupational therapy, ophthalmology, optometry, oral surgery, physical therapy, physiatry, podiatry, and radiology services • Randomize

MIT 14.010	Specialty Services Arrivals	20	Specialty Services Arrivals	• Arrived from (other departmental institution) • Date of transfer (3–9 months) • Randomize
MITs 14.011–012	Denials	17	InterQual	• Review date (3–9 months) • Randomize
		N/A	IUMC Meeting Minutes	• Meeting date (9 months) • Denial upheld • Randomize

Quality Indicator	Sample Category	No. of Samples	Data Source	Filters
Administrative Operations				
MIT 15.001	Adverse/sentinel events (ASE)	0	Adverse/sentinel events report	• Adverse/Sentinel events (2–8 months)
MIT 15.002	QMC Meetings	6	Quality Management Committee meeting minutes	• Meeting minutes (12 months)
MIT 15.003	EMRRC	12	EMRRC meeting minutes	• Monthly meeting minutes (6 months)
MIT 15.004	LGB	4	LGB meeting minutes	• Quarterly meeting minutes (12 months)
MIT 15.101	Medical Emergency Response Drills	3	On-site summary reports & documentation for ER drills	• Most recent full quarter • Each watch
MIT 15.102	Institutional Level Medical Grievances	10	On-site list of grievances/closed grievance files	• Medical grievances closed (6 months)
MIT 15.103	Death Reports	10	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	10	On-site provider evaluation files	• All required performance evaluation documents
MIT 15.106	Provider Licenses	15	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	7	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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June 9, 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 San Quentin State Prison (SQ) conducted by the Office of the Inspector General (OIG) from October 2021 to March 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:
DeAnna Gouldy
3B7F6B95AC0A4D1...

DeAnna Gouldy
Deputy 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
Directors, CCHCS
Roscoe Barrow, Chief Counsel, CCHCS Office of Legal Affairs
Renee Kanan, M.D., Deputy Director, Medical Services, CCHCS
Barbara Barney-Knox, R.N., Deputy Director, Nursing Services, CCHCS
Annette Lambert, Deputy Director, Quality Management, CCHCS
Robin Hart, Associate Director, Risk Management Branch, CCHCS
Regional Executives, Region I, CCHCS
Chief Executive Officer, SQ
Luu Nguyen, Chief Assistant Inspector General (A), OIG
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David Lavorico, Staff Services Manager I (A), OIG

CALIFORNIA CORRECTIONAL
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Cycle 6

Medical Inspection Report

for

San Quentin State Prison

OFFICE *of the*
INSPECTOR GENERAL

Amarik K. Singh
Inspector General

Neil Robertson
Chief Deputy Inspector General

STATE *of* CALIFORNIA
June 2023

OIG