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OIG | OFFICE *of the* INSPECTOR GENERAL

Independent Prison Oversight

December 2024

Cycle 7

Medical Inspection Report

Richard J. Donovan Correctional Facility

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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 7, the OIG continues to apply the same assessment methodologies used in Cycle 6, including clinical case review and compliance testing. Together, these methods assess the institution's medical care on both individual and system levels by providing 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. Through these methods, the OIG evaluates the performance of the institution in providing sustainable, adequate care. We continue to review institutional care using 15 indicators as in prior cycles.[3]

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). In addition, our clinicians complete document reviews of individual cases and also perform on-site inspections, which include interviews with staff. The OIG determines a total compliance score for each applicable indicator and considers the MIT scores in the overall conclusion of the institution's compliance performance.

In conducting in-depth quality-focused reviews of randomized cases, our case review clinicians examine whether health care staff 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. At the same time, our clinicians consider whether institutional medical processes led to identifying and correcting individual or system errors, and we examine whether the institution's medical system mitigated the error. The OIG rates each applicable indicator ***proficient***, ***adequate***, or ***inadequate,*** and considers each rating in the overall conclusion of the institution's health care performance.

In contrast to Cycle 6, the OIG will provide individual clinical case review ratings and compliance testing scores in Cycle 7, rather than aggregate all findings into a single overall institution rating. This change will clarify the distinctions between these differing quality measures and the results of each assessment.

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[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.

As we did during Cycle 6, our office continues to inspect both those institutions remaining under federal receivership and those delegated back to the department. There is no difference in the standards used for assessing a delegated institution versus an institution not yet delegated. At the time of the Cycle 7 inspection of Richard J. Donovan Correctional Facility, the institution had not been delegated back to the department by the receiver.

We completed our seventh inspection of the institution, and this report presents our assessment of the health care provided at this institution during the inspection period from December 2022 to May 2023.[4]

[4] Samples are obtained per case review methodology shared with stakeholders in prior cycles. The case reviews include death reviews between August 2022 and April 2023, anticoagulation reviews between December 2022 and May 2023, and transfer reviews between January 2023 and March 2023.

Summary: Ratings and Scores

We completed the Cycle 7 inspection of Richard J. Donovan Correctional Facility (RJD) in October 2023. OIG inspectors monitored the institution's delivery of medical care that occurred between December 2022 and May 2023.

The OIG rated the case review component of the overall health care quality at RJD ***adequate***.

The OIG rated the compliance component of the overall health care quality at RJD ***inadequate***.

OIG case review clinicians (a team of physicians and nurse consultants) reviewed 67 cases, which contained 1,286 patient-related events. They performed quality control reviews; their subsequent collective deliberations ensured consistency, accuracy, and thoroughness. Our OIG clinicians acknowledged institutional structures that catch and resolve mistakes that may occur throughout the delivery of care. After examining the medical records, our clinicians completed a follow-up on-site inspection in October 2023 to verify their initial findings. OIG physicians rated the quality of care for 25 comprehensive case reviews. Of these 25 cases, our physicians rated 21 ***adequate*** and four ***inadequate***.

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 398 patient records and 1,205 data points and used the data to answer 90 policy questions. In addition, we observed RJD's processes during an on-site inspection in July 2023.

The OIG then considered the results from both case review and compliance testing, and drew overall conclusions, which we report in 13 health care indicators.[5]

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

We list the individual indicators and ratings applicable for this institution in Table 1 below.

Table 1. RJD Summary Table: Case Review Ratings and Policy Compliance Scores

		Ratings		*Scoring Ranges*		
		Proficient / *Adequate* / *Inadequate*		100%–85.0% / 84.9%–75.0% / 74.9%–0		
		Case Review		**Compliance**		
MIT Number	**Health Care Indicators**	**Cycle 7**	**Change Since Cycle 6***	**Cycle 7**	**Cycle 6**	**Change Since Cycle 6***
1	Access to Care	Adequate	=	73.0%	84.3%	↓
2	Diagnostic Services	Adequate	=	57.7%	66.9%	=
3	Emergency Services	Inadequate	↓	N/A	N/A	N/A
4	Health Information Management	Adequate	↓	88.0%	91.8%	=
5	Health Care Environment†	N/A	N/A	41.7%	63.3%	=
6	Transfers	Adequate	=	72.1%	60.3%	=
7	Medication Management	Adequate	↑	51.9%	49.0%	=
8	Prenatal and Postpartum Care	N/A	N/A	N/A	N/A	N/A
9	Preventive Services	N/A	N/A	69.6%	59.3%	=
10	Nursing Performance	Inadequate	↓	N/A	N/A	N/A
11	Provider Performance	Adequate	=	N/A	N/A	N/A
12	Reception Center	N/A	N/A	N/A	N/A	N/A
13	Specialized Medical Housing	Adequate	=	70.0%	72.5%	=
14	Specialty Services	Adequate	↑	67.7%	67.5%	=
15	Administrative Operations†	N/A	N/A	61.2%	71.4%	=

* The symbols in this column correspond to changes that occurred in indicator ratings between the medical inspections conducted during Cycle 6 and Cycle 7. 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*).

† **Health Care Environment** and **Administrative Operations** are secondary indicators and are not considered when rating the institution's overall medical quality.

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

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.[6]

The OIG found no adverse events at RJD during the Cycle 7 inspection.

Case Review Results

OIG case reviewers (a team of physicians and nurse consultants) assessed 10 of the 13 indicators applicable to RJD. Of these 10 indicators, OIG clinicians rated none ***proficient***, eight ***adequate***, and two ***inadequate***. OIG physicians also rated the overall adequacy of care for each of the 25 detailed case reviews they conducted. Of these 25 cases, 21 were ***adequate***, and four were ***inadequate***. In the 1,286 events reviewed, we found 412 deficiencies, 66 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 RJD:

- RJD performed well in providing patient access to correctional treatment center (CTC) providers and clinic nurses as well as follow-up care after hospitalizations and triage and treatment area (TTA) events, as medically indicated.

Our clinicians found the following areas needing improvement at RJD:

- Nurses did not always document complete and relevant assessments of wound care and feeding tube interventions for patients in the specialized medical housing (SMH).
- Nurses performed poorly when responding to emergency medical alarms in their assessments, interventions, and plans of care.
- RJD nursing leadership often did not identify opportunities for improvement during Emergency Medical Response Review Committee (EMRRC) reviews.

Compliance Testing Results

Our compliance inspectors assessed 10 of the 13 indicators applicable to RJD. Of these 10 indicators, our compliance inspectors rated one ***proficient***, none ***adequate***, and nine ***inadequate***. We tested policy compliance in the **Health Care Environment**, **Preventative**

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

Services, and **Administrative Operations** as these indicators do not have a case review component.

RJD showed a high rate of policy compliance in the following areas:

- Staff performed excellently in scanning health care services request forms, specialty service reports, and community hospital discharge reports.
- Nurses at RJD reviewed health care services request forms and conducted face-to-face encounters within required time frames.
- Staff performed well in providing preventive services for patients, such as influenza vaccinations, annual testing for tuberculosis (TB), and colorectal cancer screenings.

RJD showed a low rate of policy compliance in the following areas:

- Medical warehouse and clinics had multiple expired medical supplies.
- Clinical staff did not consistently follow universal hand hygiene precautions before or after patient encounters.
- Nursing staff did not regularly inspect emergency response bags.
- Staff did not perform well in ensuring approved specialty services were provided within specified time frames.
- Patients did not always receive medications within the required time frames. These included newly ordered medications, chronic care medications, medications for patients returning from hospitalization, medications for patients admitted to specialized medical housing, medications for patients transferring within the facility, and medications for patients laying over at RJD.

Institution-Specific Metrics

Richard J. Donovan Correctional Facility (RJD) is in unincorporated San Diego County, near San Diego, and is approximately one and a half miles from the Mexico–United States border. The institution, which opened in July 1987, provides housing for general population and levels I, II, III, and IV incarcerated persons. The department designated RJD for incarcerated persons with severe mental illnesses as well as incarcerated persons with developmental disabilities. RJD has multiple clinics in which medical staff respond to nonurgent requests for medical services and a triage and treatment area (TTA) to provide urgent and emergent care. The facility has a licensed correctional treatment center (CTC) to provide health care to patients who need supervised health care beyond what is normally provided on an outpatient basis. The department has also designated RJD as an *intermediate care institution*. Intermediate institutions are located in predominantly urban areas, close to tertiary care centers and specialty care providers, for the most cost-effective care.

As of July 18, 2024, the department reported on its public tracker 85 percent of RJD's incarcerated population was fully vaccinated for COVID-19 while 64 percent of RJD's staff was fully vaccinated for COVID-19.[7]

In July 2023, the Health Care Services Master Registry showed RJD had a total population of 3,071. A breakdown of the medical risk level of the RJD population as determined by the department is set forth in Table 2 below.[8]

Table 2. RJD Master Registry Data as of July 2023

Medical Risk Level	Number of Patients	Percentage*
High 1	781	25.4%
High 2	691	22.5%
Medium	1,297	42.2%
Low	302	9.8%
Total	**3,071**	**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 07-17-23.

[7] For more information, see the department's statistics on its website page titled **Population COVID-19 Tracking.**

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

According to staffing data the OIG obtained from California Correctional Health Care Services (CCHCS), as identified in Table 3 below, RJD had no vacant executive leadership positions, no primary care provider vacancies, no nursing supervisor vacancies, and no nursing staff vacancies.

Table 3. RJD Health Care Staffing Resources as of July 2023

Positions	Executive Leadership*	Primary Care Providers	Nursing Supervisors	Nursing Staff †	Total
Authorized Positions	7.0	15.5	26.7	184.7	233.9
Filled by Civil Service	8.0	16.5	24.5	154.8	203.8
Vacant	0	0	2.2	29.9	32.1
Percentage Filled by Civil Service	114.3%	106.5%	91.8%	83.8%	87.1%
Filled by Telemedicine	0	0	0	2.0	2.0
Percentage Filled by Telemedicine	0	0	0	1.1%	0.9%
Filled by Registry	0	2.5	0	55.0	57.5
Percentage Filled by Registry	0	16.1%	0	29.8%	24.6%
Total Filled Positions	8.0	19.0	24.5	211.8	263.3
Total Percentage Filled	**114.3%**	**122.6%**	**91.8%**	**114.7%**	**112.6%**
Appointments in Last 12 Months	0	0	4.0	15.0	19.0
Redirected Staff	0	0	0	0	0
Staff on Extended Leave ‡	0	0	1.0	16.0	17.0
Adjusted Total: Filled Positions	**8.0**	**19.0**	**23.5**	**195.8**	**246.3**
Adjusted Total: Percentage Filled	**114.3%**	**122.6%**	**88.0%**	**106.0%**	**105.3%**

* 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 7 medical inspection preinspection questionnaire received on July 17, 2023, from California Correctional Health Care Services.

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 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 7. 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 to use in conducting our analysis, and we present them here for comparison.

HEDIS Results

We considered RJD's performance with population-based metrics to assess the macroscopic view of the institution's health care delivery. Currently, only two HEDIS measures are available for review: poor HbA1c control, which measures the percentage of diabetic patients who have poor blood sugar control, and colorectal cancer screening rates for patients ages 45 to 75. For poor HBA1c control, RJD's results compared favorably with those found in State health plans. We list the applicable HEDIS measures in Table 4.

Comprehensive Diabetes Care

When compared with statewide Medi-Cal programs—California Medi-Cal, Kaiser Northern California (Medi-Cal), and Kaiser Southern California (Medi-Cal)— RJD's percentage of patients with poor HbA1c control was significantly lower, indicating very good performance on this measure.

Immunizations

Statewide comparative data were not available for immunization measures; however, we include these data for informational purposes. RJD had a 54 percent influenza immunization rate for adults 18 to 64 years old and a 69 percent influenza immunization rate for adults 65 years of age and older.[9] The pneumococcal vaccination rate was 92 percent.[10]

Cancer Screening

When compared with statewide Medi-Cal programs—California Medi-Cal, Kaiser Northern California (Medi-Cal), and Kaiser Southern California (Medi-Cal)— RJD's

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

[10] The pneumococcal vaccines administered are the 13, 15, and 20 valent pneumococcal vaccines (PCV13, PCV15, and PCV20), or 23 valent pneumococcal vaccine (PPSV23), depending on the patient's medical conditions. For the adult population, the influenza or pneumococcal vaccine may have been administered at a different institution other than where the patient was currently housed during the inspection period.

colorectal cancer screening rate of 71 percent was higher, indicating very good performance on this measure.

Table 4. RJD Results Compared With State HEDIS Scores

HEDIS Measure	RJD Cycle 7 Results*	California Medi-Cal†	California Kaiser NorCal Medi-Cal†	California Kaiser SoCal Medi-Cal†
HbA1c Screening	100%	–	–	–
Poor HbA1c Control (> 9.0%) ‡,§	**6%**	36%	31%	22%
HbA1c Control (< 8.0%) ‡	86%	–	–	–
Blood Pressure Control (< 140/90) ‡	90%	–	–	–
Eye Examinations	58%	–	–	–
Influenza – Adults (18–64)	54%	–	–	–
Influenza – Adults (65+)	69%	–	–	–
Pneumococcal – Adults (65+)	92%	–	–	–
Colorectal Cancer Screening	71%	37%	68%	70%

Notes and Sources

* Unless otherwise stated, data were collected in July 2023 by reviewing medical records from a sample of RJD'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 Medi-Cal Managed Care External Quality Review Technical Report, dated July 1, 2022–June 30, 2023 (published March - April 2024); https://www.dhcs.ca.gov/dataandstats/reports/Documents/Medi-Cal-Managed-Care-Technical-Report-Volume-1.pdf

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

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

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

Recommendations

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

Access to Care

- Medical leadership should ensure patients with chronic care conditions and patients transferring from another state institution are timely seen by the provider and should implement remedial measures as appropriate.

- Medical leadership should determine the root cause of untimely sick call follow-up appointments with clinic providers and should implement remedial measures as appropriate.

Diagnostic Services

- Medical leadership should determine the root causes of challenges to the notification and the endorsement of anticoagulation laboratory results and should implement remedial measures as appropriate to ensure all laboratory tests are reviewed and signed by the providers who ordered the tests.

- The department should consider developing strategies to ensure providers create patient letters when they endorse test results and ensure patient letters contain all elements required by CCHCS policy.

- Medical leadership should ascertain causative factors related to the untimely collection of laboratory specimens and implement remedial measures as appropriate.

Emergency Services

- Nursing leadership should determine the challenges to ensuring nursing staff complete thorough assessments and provide appropriate interventions and documentation in emergent and urgent events. Leadership should implement remedial measures as appropriate.

- The chief nurse executive (CNE) and the chief medical executive (CME), or their designees, should identify and implement strategies to perform thorough clinical reviews of emergent events and identify opportunities for improvement or training issues as appropriate.

Health Care Environment

- Medical leadership should determine the root cause for staff not following all required universal hand hygiene precautions and take necessary remedial measures.

- Nursing leadership should determine the root cause for staff not ensuring clinic examination rooms contain essential core medical equipment. The

leadership should also verify staff follow equipment and medical supply management protocols and should take necessary remedial measures.

- Executive leadership should determine the root cause for staff not ensuring reusable noninvasive medical equipment is properly disinfected and take necessary remedial measures.

- Nursing leadership should determine the root causes for staff either not ensuring the EMRBs are regularly inventoried and sealed or not properly completing monthly logs and should implement all necessary remedial measures.

Transfers

- Nursing leadership should develop and implement internal auditing of staff to ensure complete and thorough assessments of patients returning from hospitalizations and should implement remedial measures as appropriate.

- Nursing leadership should identify the root causes for R&R nurses not completing the initial health care screening, including answering all questions and documenting an explanation for each "yes" answer; not documenting a complete set of vital signs as part of the patient's initial health care screening assessment; and not completing the initial health care screening form prior to the patient being placed in housing. Nursing leadership should implement remedial measures as appropriate.

Medication Management

- Medical and nursing leadership should ensure chronic care, hospital discharge, and en route patients receive their medications timely and without interruption; leadership should implement remedial measures as appropriate.

- The institution should consider developing and implementing measures to ensure staff timely make available and administer medications to patients as described in CCHCS policy and procedures.

- Nursing leadership should consider developing and implementing measures to ensure nursing staff document patients' refusal reasons and no-shows on MAR summaries, in accordance with CCHCS' policies and procedures.

Preventive Services

- Nursing leadership should consider developing and implementing measures to ensure nursing staff consistently perform patient monitoring, as described in CCHCS care guides, and nursing staff completely address TB signs and symptoms in their patient monitoring.

- Medical leadership should determine the root cause of challenges in the timely provisions of vaccinations to chronic care patients and implement remedial measures as appropriate.

Nursing Performance

- Nursing leadership should determine the challenges to ensuring nursing staff complete thorough assessments, provide appropriate interventions, and thoroughly document encounters. Leadership should implement remedial measures as appropriate.

- Nursing leadership should develop and implement measures to assess the clinical quality of nursing care, in addition to the current compliance audits, and should provide training and education as necessary.

Provider Performance

- Medical leadership should develop and implement monitoring strategies to ensure providers follow medical provider documentation expectations according to the department's HCDOM and RJD LOP.[11]

Specialized Medical Housing

- Nursing leadership should determine the challenges to ensuring nursing staff complete thorough documentation of wound care assessments, including clinical appearance of the wound, surrounding tissue, and measurements. Leadership should implement remedial measures as appropriate.

- Nursing leadership should ensure nursing staff completes initial assessments within the time frame required by CCHCS policy.

Specialty Services

- Medical leadership should determine the root causes of challenges to the timely provision of specialty services with high-priority referrals as well as their subsequent high-priority specialty follow-up appointments and should implement remedial measures as appropriate.

- The department should consider developing and implementing measures to ensure institutions timely receive the medium- and routine-priority specialty reports, and providers timely review these reports.

- Medical leadership should identify the root cause of challenges to the timely provision of preapproved specialty appointments for transfer-in patients and should implement remedial measures as appropriate.

[11] HCDOM is the Health Care Department Operations Manual. LOP is the local operating policy.

Access to Care

In this indicator, OIG inspectors evaluated the institution's performance in providing patients with timely clinical appointments. Our inspectors reviewed 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.

Ratings and Results Overview

Case Review Rating	Compliance Rating and Score
Adequate	***Inadequate* (73.0%)**

As in Cycle 6, case review found RJD provided sufficient access to care. Case reviewers found appointments with clinic providers and nurses were generally completed timely. Patients had good access to correctional treatment center (CTC) providers, sick call nurses, specialty services, and follow-up appointments with providers after specialty services. Factoring in all aspects of care, the OIG rated the case review component of this indicator ***adequate.***

Compliance testing showed RJD had mixed results in access to care. Staff performed excellently in reviewing patient sick call requests, completing face-to-face encounters, and ensuring provider follow-up appointments after returning from hospitalizations. However, compliance testing resulted in low scores for provider follow-up appointments for patients with chronic care conditions and for patients transferring into the institution. Based on the overall compliance score result, the OIG rated the compliance component of this indicator ***inadequate.***

Case Review and Compliance Testing Results

OIG clinicians reviewed 282 provider, nursing, urgent or emergent care (TTA), specialty, and hospital events that required the institution to generate appointments. We identified 20 deficiencies related to access to care, six of which were significant.[12]

Access to Care Providers

Access to clinic providers is an integral part of patient care in health care delivery. RJD had a mixed performance in providing chronic care follow-up appointments with clinic providers. Compliance testing showed chronic care face-to-face follow-up appointments and nurse-to-provider follow-up appointments occurred within required time frames less than half of the time (MIT 1.001, 44.0% and MIT 1.005, 46.7%). However, sick call follow-up appointments with nurses always occurred timely (MIT 1.006, 100%).

[12] Deficiencies occurred in cases 1, 11, 13, 21, 23, 26, 28, 29, 32, 46, 60, 66, and 67. Significant deficiencies occurred in cases 13, 21, 28, 29, and 32.

Due to movement restrictions related to the COVID-19 pandemic, we considered most cases of provider chart reviews to have been triage of nonurgent, low-, or medium-risk chronic care appointments and an acceptable alternative to face-to-face or telephonic encounters. OIG clinicians reviewed 127 clinic provider encounters and identified one deficiency:

- In case 13, the provider ordered an episodic medical follow-up appointment, which occurred five days late.

Access to Specialized Medical Housing Providers

RJD performed well in providing access to CTC providers. Compliance testing showed RJD almost always completed written history and physical examinations of patients admitted to the CTC within the required time frame (MIT 13.002, 90.0%). Our clinicians did not identify any deficiencies regarding patients' access to CTC providers.

Access to Clinic Nurses

RJD performed well in providing access to nursing sick calls and provider-to-nurse referrals. Compliance testing showed all nursing sick call requests were reviewed on the same day they were received (MIT 1.003, 100%), and nurses always completed face-to-face appointments within one day after triaging the sick call requests (MIT 1.004, 100%). Our clinicians reviewed 74 nursing sick call triage encounters and identified two deficiencies related to clinic nurse access:

- In case 21, a nurse reviewed a patient sick call submission and requested an appointment to occur the next day. However, the appointment was scheduled two days late.

- In case 46, a nurse performed sick call triage for two sick call requests from the patient. The nurse documented the patient as an "add on" to be seen on the same day, but the patient was not evaluated until the following day.

Access to Specialty Services

RJD had a mixed performance in access to specialty services. Compliance testing showed initial high-priority, medium-priority, routine-priority, and specialty appointments intermittently occurred within required time frames (MIT 14.001, 60.0%, MIT 14.004, 73.3%, and MIT 14.007, 73.3%). The institution also had variable results with follow-up specialty appointments. Compliance testing showed subsequent high-priority and medium-priority follow-up specialty appointments only sometimes occurred within required time frames (MIT 14.003, 57.1% and MIT 14.006, 61.5%); however, subsequent routine-priority specialty service appointments always occurred within the required time frame (MIT 14.009, 100%). Our clinicians reviewed 161 specialty service events and identified six deficiencies, two of which were significant.[13] The following are examples:

- In case 29, the neurosurgery specialist assessed the patient. The provider reviewed the specialist's report and requested a high-priority referral for an

[13] Deficiencies occurred in cases 23, 26, 29, and 67. Significant deficiencies occurred in case 29.

MRI of the lumbar spine. However, the MRI was completed over three months later.[14]

- In addition, in case 29, the provider assessed the patient following an initial consult with the neurosurgeon and ordered a referral for a follow-up with the neurosurgery specialist. However, the appointment with the specialist did not occur timely during the review period.

Follow-Up After Specialty Services

RJD's performance was only fair in ensuring providers evaluated their patients within the required time frame after specialty appointments. Compliance testing showed provider appointments after specialty services usually occurred within the required time frame (MIT 1.008, 78.1%). OIG clinicians identified one significant delayed provider appointment:

- In case 28, after the high-priority specialty services appointment, the nursing staff scheduled a provider follow-up appointment to occur within 14 days, instead of five calendar days.

Follow-Up After Hospitalization

RJD performed well in ensuring providers evaluated their patients within required time frames after hospitalizations. Compliance testing showed provider appointments after hospitalization generally occurred within required the time frame (MIT 1.007, 88.0%). OIG clinicians reviewed 30 hospital returns and did not identify any missed or delayed appointments.

Follow-Up After Urgent or Emergent Care (TTA)

Providers always evaluated their patients following triage and treatment area (TTA) events as medically indicated. OIG clinicians assessed 10 TTA events and did not identify any delayed or missed provider follow-up appointments.

Follow-Up After Transferring Into RJD

Access to care for patients who had recently transferred into the institution was mixed. Compliance testing showed poor access for intake appointments of newly arrived patients (MIT 1.002, 50.0%). OIG clinicians reviewed three transfer-in cases and found one significant deficiency:

- In case 32, when the patient transferred to RJD, the provider documented the patient was checked in for his scheduled interfacility transfer-in appointment, including MAT discussion; however, the patient left before the appointment occurred and was, thus, not seen.[15] The provider also

[14] An MRI is a magnetic resonance imaging scan.

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

documented the patient would be rescheduled. However, the patient was not seen until six weeks after the patient transferred into RJD.

Clinician On-Site Inspection

At the time of our inspection, RJD had the following clinics: A Clinic, B Clinic, C Clinic, D Clinic, E Clinic, ASU Clinic, EOP Clinic, the TTA, and the CTC. Each clinic was assigned one to three medical providers to care for patients. RJD also provided on-site specialty services for optometry, ophthalmology, audiology, physical therapy, podiatry, and a kidney dialysis unit. The nursing manager reported a nephrologist came on site weekly, and up to eight dialysis beds were operating, again at the time of our inspection.

OIG clinicians attended morning huddles and provider meetings, including medical subcommittee meetings, which were well attended. Medical leadership reported each clinic, in general, arranged 12 appointments per day for each provider: 10 scheduled and two left available for open access to accommodate same-day appointments. The office technician reported experiencing challenges in obtaining off-site specialty appointments. Medical leadership reported having vacancies for one provider and one registry provider.

Compliance On-Site Inspection

Three of six housing units randomly tested at the time of inspection had access to health care services request forms (CDCR form 7362) (MIT 1.101, 50.0%). In two housing units, custody officers did not have a system in place for restocking the forms. The custody officers reported relying on medical staff to replenish the forms in the housing units. We also found one housing unit that did not have a supply of CDCR form 7362 available.

Compliance Score Results

Table 5. 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)	11	14	0	44.0%
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)	11	11	3	50.0%
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)	35	0	0	100%
Clinical appointments: If the registered nurse determined a referral to a primary care provider was necessary, was the patient seen within the maximum allowable time or the ordered time frame, whichever is the shorter? (1.005)	7	8	20	46.7%
Sick call follow-up appointments: If the primary care provider ordered a follow-up sick call appointment, did it take place within the time frame specified? (1.006)	1	0	34	100%
Upon the patient's discharge from the community hospital: Did the patient receive a follow-up appointment within the required time frame? (1.007)	22	3	0	88.0%
Specialty service follow-up appointments: Did the clinician follow-up visits occur within required time frames? (1.008) *	32	9	4	78.1%
Clinical appointments: Do patients have a standardized process to obtain and submit health care services request forms? (1.101)	3	3	0	50.0%
				Overall percentage (MIT 1): **73.0%**

* 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 6. 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 (prior to 07/2022) or five working days (effective 07/2022)? (12.004)	N/A	N/A	N/A	N/A
Was a written history and physical examination completed within the required time frame? (13.002)	9	1	0	90.0%
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)	9	6	0	60.0%
Did the patient receive the subsequent follow-up to the high-priority specialty service appointment as ordered by the primary care provider? (14.003)	4	3	8	57.1%
Did the patient receive the medium-priority specialty service within 15-45 calendar days of the primary care provider order or the Physician Request for Service? (14.004)	11	4	0	73.3%
Did the patient receive the subsequent follow-up to the medium-priority specialty service appointment as ordered by the primary care provider? (14.006)	8	5	2	61.5%
Did the patient receive the routine-priority specialty service within 90 calendar days of the primary care provider order or Physician Request for Service? (14.007)	11	4	0	73.3%
Did the patient receive the subsequent follow-up to the routine-priority specialty service appointment as ordered by the primary care provider? (14.009)	9	0	6	100%

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

Recommendations

- Medical leadership should ensure patients with chronic care conditions and patients transferring from another state institution are timely seen by the provider and should implement remedial measures as appropriate.

- Medical leadership should determine the root cause of untimely sick call follow-up appointments with clinic providers 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 7, we examined the institution's performance in timely completing and reviewing immediate (STAT) laboratory tests.

Ratings and Results Overview

Case Review Rating	Compliance Rating and Score
Adequate	***Inadequate* (57.7%)**

As in Cycle 6, case review found RJD delivered a good performance in this indicator. Staff generally completed laboratory testing within required time frames. Staff also retrieved, and providers endorsed, these results timely. However, case review found opportunities for improvement in timely providing on-site special imaging services (ultrasound) appointments to patients. After reviewing all aspects, the OIG rated the case review component of this indicator ***adequate.***

Compliance testing was mixed in this indicator. RJD performed well in reviewing and endorsing diagnostic test results. However, staff performed poorly in providing and notifying patients of diagnostic test results and generating patient letters with all required key elements. Based on the overall compliance score result, the OIG rated the compliance component of this indicator ***inadequate***.

Case Review and Compliance Testing Results

We reviewed 219 diagnostic events and found 99 deficiencies, four of which were significant.[16] Of these 99 deficiencies, we found 91 related to health information management and six pertained to the delay in completing diagnostic tests.

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

Test Completion

RJD had variable performance in completing diagnostic tests. In compliance testing, staff performed very well in completing radiology services within required time frames (MIT 2.001, 90.0%), but needed to improve in completing laboratory tests (MIT 2.004, 50.0%).

[16] Deficiencies occurred in cases 2, 3, 9–18, 20–24, 26–30, 66, and 67. Significant deficiencies occurred in cases 12, 21, and 26.

OIG clinicians reviewed 26 radiology imaging studies and 188 laboratory tests and found seven deficiencies, one of which was significant.[17] The following are examples:

- In case 21, the provider ordered an abdominal ultrasound to be performed within 45 days for cancer surveillance. However, the ultrasound was not performed during the review period.

- In case 26, the provider ordered an urgent carotid ultrasound. However, the study was performed over two months later.

Neither case review nor compliance testing had any STAT laboratory tests in their samples (MIT 2.007, N/A).

Health Information Management

RJD staff often retrieved laboratory and diagnostic results promptly and sent them to providers for review. Compliance testing showed providers almost always endorsed radiology and always endorsed laboratory results timely (MIT 2.002, 90.0% and MIT 2.005, 100%).

RJD performed poorly in communicating test results with letters to patients. Compliance testing showed providers scored very low in communicating complete letters for radiology, laboratory, and pathology test results to the patients (MIT 2.003, 30.0%, MIT 2.006, 10.0%, and MIT 2.012, zero). Similarly, OIG clinicians identified 90 deficiencies; 81 related to patient test results notification letters, 60 of which were due to missing elements in the letters.[18] [19] Additionally, one deficiency related to a delay in scanning.[20] The following are examples:

- In case 21, the pathology results from an off-site esophago-gastroduodenoscopy (EGD) biopsy were scanned into the electronic health record system (EHRS) over two months late.[21]

- In case 24, the provider endorsed the laboratory test results and created a patient notification letter. However, the letter did not indicate whether the results were within normal limits.

We identified seven deficiencies in which staff did not forward test results to a provider for endorsement.[22] The following are examples:

- In case 12, the patient had anticoagulation tests, and the results became available the next day. However, no provider reviewed or signed the results for the patient.

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[17] Deficiencies occurred in cases 26, 66, and 67. A significant deficiency occurred in case 26.

[18] Deficiencies occurred in cases 2, 3, 9–18, 20–24, and 26–30.

[19] Deficiencies occurred in cases 2, 3, 9–14, 16–18, 20–24, and 26–30.

[20] This significant deficiency occurred in case 21

[21] In this procedure, the specialist uses a camera to examine the esophagus and the stomach.

[22] Deficiencies occurred in cases 12–14.

- In case 14, the patient had a laboratory anticoagulation test, and the result became available the next day. However, the results were not forwarded to a provider for endorsement.

Clinician On-Site Inspection

OIG clinicians met with laboratory and radiology staff. RJD provided on-site mobile CT, MRI, and ultrasound imaging services as well as on-site general x-ray services.[23] The senior radiologic technologist reported challenges in scheduling patients with an external mobile imaging vendor due to technician shortages, which resulted in frequent rescheduled appointments. At the time of our inspection, an external laboratory vendor was providing laboratory and pathology diagnostic services for the institution. After the vendor processed the laboratory and pathology specimens, the laboratory and pathology results interfaced directly into patients' electronic health records for the institution's health care teams to review. The laboratory technician reported any critical laboratory results were communicated through TTA staff directly by the vendor.

[23] A CT scan is a computed, or computerized, tomography imaging scan. CT, MRI, and ultrasound scans are types of advanced diagnostic tools that allow medical practitioners to visualize the internal structures of the body.

Compliance Score Results

Table 7. Diagnostic Services

Compliance Questions	Scored Answer			
	Yes	No	N/A	Yes %
Radiology: Was the radiology service provided within the time frame specified in the health care provider's order? (2.001)	9	1	0	90.0%
Radiology: Did the ordering health care provider review and endorse the radiology report within specified time frames? (2.002)	9	1	0	90.0%
Radiology: Did the ordering health care provider communicate the results of the radiology study to the patient within specified time frames? (2.003)	3	7	0	30.0%
Laboratory: Was the laboratory service provided within the time frame specified in the health care provider's order? (2.004)	5	5	0	50.0%
Laboratory: Did the health care provider review and endorse the laboratory report within specified time frames? (2.005)	10	0	0	100%
Laboratory: Did the health care provider communicate the results of the laboratory test to the patient within specified time frames? (2.006)	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)	N/A	N/A	N/A	N/A
Laboratory: Did the provider acknowledge the STAT results, OR did nursing staff notify the provider within the required time frames? (2.008)	N/A	N/A	N/A	N/A
Laboratory: Did the health care provider endorse the STAT laboratory results within the required time frames? (2.009)	N/A	N/A	N/A	N/A
Pathology: Did the institution receive the final pathology report within the required time frames? (2.010)	6	4	0	60.0%
Pathology: Did the health care provider review and endorse the pathology report within specified time frames? (2.011)	8	1	1	88.9%
Pathology: Did the health care provider communicate the results of the pathology study to the patient within specified time frames? (2.012)	0	9	1	0
			Overall percentage (MIT 2): **57.7%**	

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

Recommendations

- Medical leadership should determine the root causes of challenges to the notification and the endorsement of anticoagulation laboratory results and should implement remedial measures as appropriate to ensure all laboratory tests are reviewed and signed by the providers who ordered the tests.

- The department should consider developing strategies to ensure providers create patient letters when they endorse test results and patient letters contain all elements required by CCHCS policy.

- Medical leadership should ascertain causative factors related to the untimely collection of laboratory specimens and implement remedial measures as appropriate.

Emergency Services

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

Ratings and Results Overview

Case Review Rating	Compliance Rating and Score
Inadequate	***Not Applicable***

Case review found RJD needed improvement in this indicator. RJD nurses performed poorly in emergency services. We identified opportunities for improvement when nurses responded to medical alarms as well as for nursing assessments, interventions, and plans of care. In addition, when the institution's chief nurse executive (CNE) and chief medical executive (CME) or designees conducted clinical reviews, they frequently did not identify their staff's deficiencies. Furthermore, compared with Cycle 6, RJD had more overall and significant deficiencies. The OIG rated this indicator ***inadequate***.

Case Review Results

We reviewed 47 urgent and emergent events and found 65 emergency care deficiencies. Of these 65 deficiencies, 15 were significant.[24]

Emergency Medical Response

RJD staff usually responded promptly to emergencies throughout the institution. However, on one occasion, a custody officer did not have the correct keys to the emergency response vehicle, which led to a delay in the medical staff response.

Cardiopulmonary Resuscitation Quality

During this period, we reviewed seven cases in which CPR was initiated.[25] In each case, custody staff initiated CPR, and either custody or nursing staff administered naloxone. On three occasions, nurses responded to emergency medical alarms, and upon their arrival, they found custody staff performing CPR; however, nurses did not immediately attach an automated external defibrillator (AED) to patients who did not have a pulse or document reasons for why this did not occur. Moreover, nurses did not thoroughly

[24] Deficiencies occurred in cases 1–11, 23–26, 29, and 65. Significant deficiencies occurred in cases 2, 4, 6, 10, 11, and 23.

[25] Staff performed CPR in cases 4–10.

document the AED activity, and we found no AED printed activity scanned in the EHRS. An example of nurses' delayed AED application is given below:

- In case 4, two nurses responded to a medical alarm. On their arrival, they found custody staff performing CPR; however, staff did not attach an AED to the patient until six minutes after the nurses had arrived.

Provider Performance

Providers performed well in urgent and emergent situations as well as in after-hours care. However, at times, providers did not document communication and recommendations provided to nurses. Examples are detailed below:

- In case 11, a nurse documented consulting with a provider and receiving orders for a medication; however, the provider did not document having communicated with the nurse. We identified similar findings in cases 2, 23, and 28.

Nursing Performance

Although, RJD nurses timely evaluated their patients, we found opportunities for improvement in the areas of assessment, interventions, and documentation. We also identified a pattern of incomplete initial assessments prepared by responding licensed vocational nurses (LVNs). We identified 30 nursing deficiencies, eight of which were significant. Examples are detailed below:

- In case 2, the patient had chest pains. A provider ordered nitroglycerin and aspirin; the patient continued to complain of chest pains, but the nurse did not administer these prescribed medications.

- In case 10, the patient had an altered level of consciousness, an elevated pulse, and a decreased oxygen saturation. The registered nurse (RN) did not perform an independent assessment and did not recheck the vital signs before the patient was released to housing.

- In case 11, staff initiated a medical alarm. An LVN responded and documented the patient had slow, shallow breaths, but the LVN did not palpate the patient's carotid or femoral pulse. We identified similar deficiencies in cases 8 and 10.

- In case 25, the patient had shortness of breath and abnormal breath sounds. A nurse administered a breathing treatment but did not objectively or subjectively assess if the treatment was effective.

Nursing Documentation

Nurses in the TTA often provided thorough documentation for emergent events. However, at times, nurses' documentation was missing information or offered conflicting information.[26] Examples are listed below:

- In case 5, an RN documented the patient's vital signs were obtained after the patient had left the institution.
- In case 23, an RN documented the patient's oxygen saturation rate was obtained using a right finger but did not document the results.

Emergency Medical Response Review Committee

Our clinicians reviewed 30 events that warranted clinical reviews and found RJD's CNE and CME, or their designees, did not conduct clinical reviews of six events. In addition, in 14 events in which clinical reviews were completed, the CNE and the CME, or their designees, did not identify opportunities for improvement in nursing or provider performance the OIG clinicians identified.[27]

Compliance testing found a pervasive pattern of incomplete checklists, missing entries, and missing time documentation (MIT 15.003, zero).

Clinician On-Site Inspection

At RJD, the TTA had four bays, two of which were larger compared with the other two bays. The overnight shift was staffed with three RNs. The day shift was staffed with five RNs and one LVN. The TTA staff reported two RNs on the day shift were specifically assigned to respond to emergencies on E Yard. However, they were stationed in the main TTA, as the E Yard did not have a TTA. RJD staff also reported they had two emergency medical response vehicles (EMRV) to which one driver is always assigned to each vehicle; the officer assigned to the TTA desk served as a back-up driver.

During our on-site inspection, the TTA nurses indicated they had about 80 patient encounters a day. In addition, nursing leadership indicated having had an average of 1,481 medical emergency responses per month between January 2023 and September 2023.

OIG clinicians interviewed TTA nurses. These nurses were concerned with safety and indicated morale was poor. They also stated custody staff did not always search patients for weapons prior to the patients entering the TTA. In addition, nurses indicated patients were issued intranasal naloxone that contained a needle within the device, and they reported their concerns the needle could be accessed and altered by the patients for unintended, nonprescribed uses.

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[26] Documentation deficiencies occurred in cases 1, 2, 4, 5, 8, 10, 23, and 26.

[27] The CNE and the CME, or their designees, did not conduct clinical reviews in cases 2, 7, 10, 23, 26, and 65. RJD committee's clinical reviews did not identify opportunities for improvement in cases 1, 2, 4, 6, 8-11, 23, 24, and 26.

Recommendations

- Nursing leadership should determine the challenges to ensuring nursing staff complete thorough assessments and provide appropriate interventions and documentation in emergent and urgent events. Leadership should implement remedial measures as appropriate.

- The CNE and the CME, or their designees, should identify and implement strategies to perform thorough clinical reviews of the emergent events and identify opportunities for improvement or training issues as appropriate.

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.

Ratings and Results Overview

Case Review Rating	Compliance Rating and Score
Adequate	***Proficient*** **(88.0%)**

Case review found RJD performed well in health information management. RJD staff performed very well in retrieving and scanning hospital discharge reports as well as in documenting urgent and emergent events. However, case review found opportunities for improvement in providers communicating diagnostic test results to patients with notification letters containing complete information as well as in staff retrieving and scanning specialty reports timely. Factoring in all aspects, the OIG rated the case review component of this indicator ***adequate***.

Compliance testing showed RJD performed very well in this indicator. Staff's performed excellently in scanning patient health care services request forms and specialty documents. In addition, staff frequently retrieved, scanned, and endorsed hospital records and generally scanned medical records into the correct patient files. Based on the overall compliance score result, the OIG rated the compliance component of this indicator ***proficient***.

Case Review and Compliance Testing Results

We reviewed 1,288 events and found 126 deficiencies related to health information management, five of which were significant.[28]

Hospital Discharge Reports

RJD handled hospital discharge reports well. In compliance testing, RJD staff performed satisfactorily in timely retrieving and scanning hospital discharge documents into patients' electronic health records (MIT 4.003, 80.0%). Most hospital discharge reports contained physician discharge summaries, and providers reviewed these reports timely (MIT 4.005, 84.0%). OIG clinicians reviewed 30 off-site

[28] Deficiencies occurred in cases 2-6, 9-18, 20-24, 26-30, and 67. Significant deficiencies occurred in cases 21, 23, 26, and 29.

emergency department and hospital encounters and identified four deficiencies, none of which were significant.[29] An example is listed below:

- In case 9, the patient was seen at an emergency department for an evaluation. RJD staff scanned the emergency department report three days late.

Specialty Reports

For the most part, RJD staff performed well in retrieving and reviewing specialty reports. Compliance testing showed almost all specialty reports were scanned into the electronic health record within required time frames (MIT 4.002, 96.7%). Staff performed well in retrieving and reviewing high-priority specialty service consultant reports timely (MIT 14.002, 85.7%). However, RJD showed room for improvement in retrieving and reviewing medium-priority and routine-priority specialty-service consultant reports timely (MIT 14.005, 71.4% and MIT 14.008, 61.5%). Our clinicians reviewed 122 specialty reports and identified 22 deficiencies, four of which were significant.[30] The following is an example:

- In case 26, a 24-hour Holter monitor test was completed, but RJD staff did not scan the report into the electronic health record until over two months later.

We discuss specialty reports further in the **Specialty Services** Indicator.

Diagnostic Reports

RJD performed satisfactorily in retrieving and endorsing diagnostic reports timely. Compliance testing showed providers almost always endorsed radiology and always endorsed laboratory reports within required time frames (MIT 2.002, 90.0% and MIT 2.005, 100%). However, staff could improve in ensuring they receive final pathology study reports within the required time frame (MIT 2.010, 60.0%). Providers often reviewed and endorsed pathology reports within required time frames (MIT 2.011, 88.9%) but never sent complete pathology result letters to patients (MIT 2.012, zero). Our clinicians identified 91 deficiencies, none of which were significant.[31] Of those 91 deficiencies, 83 related to incomplete, or failures to create, patient test results notification letters.

Compliance testing and case review did not have any STAT laboratory tests in the testing or review samples.

The **Diagnostic Services** indicator provides more details on RJD's diagnostic services performance.

Urgent and Emergent Records

OIG clinicians reviewed 47 emergency care events. Providers recorded their emergency care sufficiently, including off-site telephone encounters. OIG clinicians found three

[29] Deficiencies occurred in cases 3, 9, and 11.

[30] Deficiencies occurred in cases 2, 14, 17, 20, 22–24, and 26–29. Significant deficiencies occurred in cases 23, 26, and 29.

[31] Deficiencies occurred in cases 2, 3, 9–18, 20–24, and 26–30. A significant deficiency occurred in case 21.

deficiencies in provider documentation.[32] The following is an example of a provider deficiency:

- In case 2, the patient with left-side chest pain at rest and with activity arrived at the TTA for further evaluation. The TTA RN performed an (electrocardiogram) EKG and consulted with the provider, who recommended the patient take acetaminophen. However, the provider did not document a progress note in the electronic health record.

Scanning Performance

RJD staff performed satisfactorily with the scanning process. Compliance testing showed staff often properly scanned and labeled medical files (MIT 4.004, 79.2%). OIG clinicians identified eight deficiencies related to delayed and missing medical documents.[33] The following is an example:

- In case 23, staff scanned the infectious disease report into the electronic health record 22 days late.

Clinician On-Site Inspection

Our clinicians discussed health information management processes with medical leadership, the medical records supervisor, office technicians, and providers. The supervisor reported implementing a tracking system on the spreadsheet for all off-site medical encounters by retrieving records and reconciling them using daily movement sheets. The technicians reported they collect documents three to four times daily from every yard clinic and the TTA to scan and upload them into the electronic health record.

[32] Deficiencies occurred in cases 2, 11, and 23.

[33] Deficiencies occurred in cases 4, 6, 10, 21, 23, 24, and 26. Significant deficiencies occurred in cases 21, 23, and 26.

Compliance Score Results

Table 8. 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)	29	1	15	96.7%
Are community hospital discharge documents scanned into the patient's electronic health record within three calendar days of hospital discharge? (4.003)	16	4	5	80.0%
During the inspection, were medical records properly scanned, labeled, and included in the correct patients' files? (4.004)	19	5	0	79.2%
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)	21	4	0	84.0%
			Overall percentage (MIT 4): **88.0%**	

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

Table 9. Other Tests Related to Health Information Management

	Scored Answer			
Compliance Questions	**Yes**	**No**	**N/A**	**Yes %**
Radiology: Did the ordering health care provider review and endorse the radiology report within specified time frames? (2.002)	9	1	0	90.0%
Laboratory: Did the health care provider review and endorse the laboratory report within specified time frames? (2.005)	10	0	0	100%
Laboratory: Did the provider acknowledge the STAT results, OR did nursing staff notify the provider within the required time frame? (2.008)	N/A	N/A	N/A	N/A
Pathology: Did the institution receive the final pathology report within the required time frames? (2.010)	6	4	0	60.0%
Pathology: Did the health care provider review and endorse the pathology report within specified time frames? (2.011)	8	1	1	88.9%
Pathology: Did the health care provider communicate the results of the pathology study to the patient within specified time frames? (2.012)	0	9	1	0
Did the institution receive and did the primary care provider review the high-priority specialty service consultant report within the required time frame? (14.002)	12	2	1	85.7%
Did the institution receive and did the primary care provider review the medium-priority specialty service consultant report within the required time frame? (14.005)	10	4	1	71.4%
Did the institution receive and did the primary care provider review the routine-priority specialty service consultant report within the required time frame? (14.008)	8	5	2	61.5%

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

Recommendations

The OIG offers no recommendations for this indicator.

Health Care Environment

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

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

Ratings and Results Overview

Case Review Rating	Compliance Rating and Score
Not Applicable	***Inadequate* (41.7%)**

Overall, RJD performed poorly with respect to its health care environment. Medical supply storage areas inside and outside the clinics contained expired medical supplies. Emergency medical response bag (EMRB) logs were missing staff verification, missing evidence of staff performing required inventories, or missing required medical equipment. Furthermore, staff did not regularly sanitize their hands before and after providing care to patients. Based on the overall compliance score result, the OIG rated this indicator ***inadequate***.

Compliance Testing Results

Patient Waiting Areas

We inspected only indoor waiting areas, as RJD had no outdoor waiting areas. Health care and custody staff reported the existing waiting areas contained sufficient seating capacity (see Photo 1). During our inspection, we did not observe overcrowding in any of the clinics' indoor waiting areas.

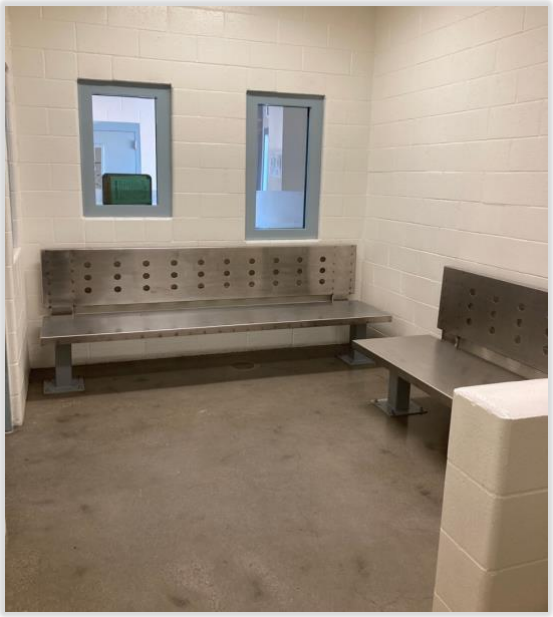

Photo 1. Indoor patient waiting area (photographed on 8-2-23).

Clinic Environment

Ten of 11 clinic environments were sufficiently conducive to providing medical care. They provided reasonable auditory privacy, appropriate waiting areas, wheelchair accessibility, and nonexamination room workspace (MIT 5.109, 90.9%). In one clinic, however, triage stations were within close proximity to each other, which hindered auditory privacy.

Of the 11 clinics we observed, six contained appropriate space, configuration, supplies, and equipment to allow their clinicians to perform proper clinical examinations (MIT 5.110, 54.6%).

The remaining five clinics had one or more of the following deficiencies: examination rooms lacked visual privacy; examination rooms were not set up in a manner that provided reasonable assurance of auditory privacy during patient encounters; and clinics had unsecured confidential medical records, or confidential medical records were not shredded daily. One of the five clinics had a chair with a worn cover and a torn mat (see Photo 2).

Photo 2. Torn mat (photographed on 8-2-23).

Clinic Supplies

Two of the 11 clinics followed adequate medical supply storage and management protocols (MIT 5.107, 18.2%). We found one or more of the following deficiencies in the remaining nine clinics: expired medical supplies (see Photo 3); compromised sterile medical supply packaging; unorganized, unidentified, or inaccurately labeled medical supplies; and cleaning materials stored with medical supplies (see Photo 4, next page)

Photo 3. Expired medical supplies (photographed on 8-23-23).

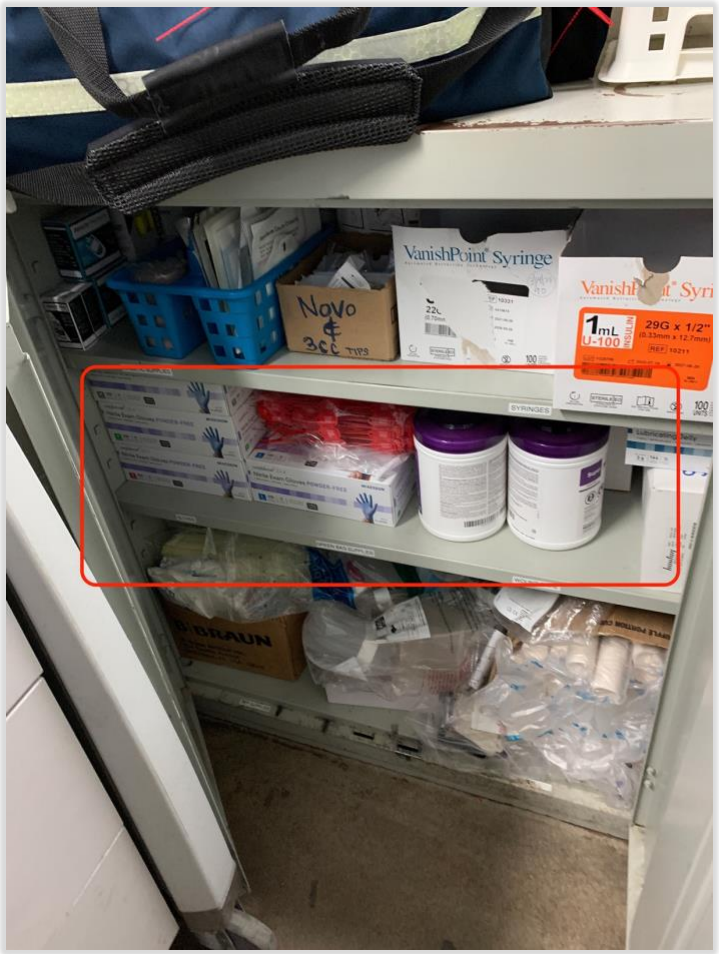

Photo 4. Cleaning materials stored with medical supplies (photographed on 8-17-23).

Six of the 11 clinics met requirements for essential core medical equipment and supplies (MIT 5.108, 54.6%). The remaining five clinics lacked medical supplies or contained improperly calibrated or nonfunctional equipment. The missing items included examination tables with disposable paper and tips for an otoscope device. We found nonfunctional oto-ophthalmoscopes and a weight scale that staff had not properly calibrated. In addition, we found Snellen reading charts placed at an improper distance or missing evidence of a clearly established distance line.

We examined 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 applicable 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; and EMRBs contained compromised supplies or missing items.

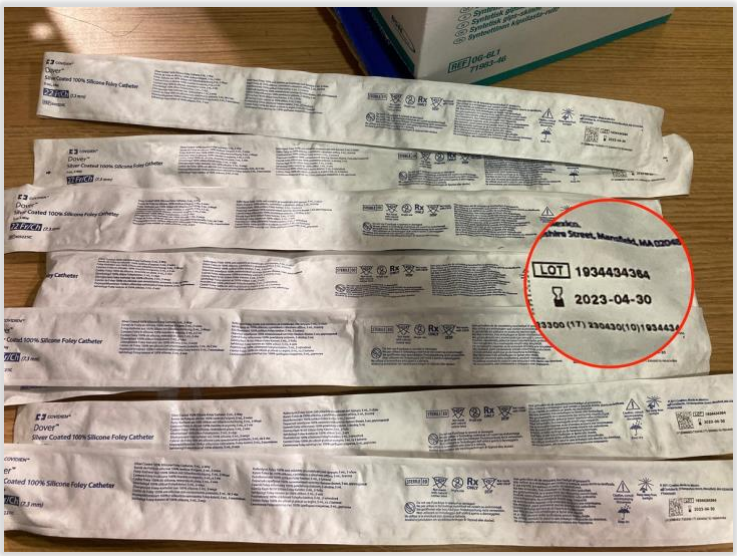

Photo 5. Expired medical supplies in medical warehouse (photographed 8-2-23).

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 in the warehouse (see Photo 5).

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

Infection Control and Sanitation

Staff appropriately disinfected, cleaned, and sanitized five of 11 clinics (MIT 5.101, 45.5%). In six clinics, we found one or more of the following deficiencies: staff did not maintain cleaning logs; and medical equipment, cabinets, clinic floors, or staff restrooms were unsanitary (see Photo 6).

Staff in four of 11 clinics properly sterilized or disinfected medical equipment (MIT 5.102, 36.4%). In seven clinics, we found one or more of the following deficiencies: staff did not mention disinfecting the examination table as part of their daily start-up protocol; staff did not use examination table paper during an examination; and staff did not change the examination table paper in between patient encounters. In one of the seven clinics, staff did not disinfect or properly store noninvasive medical equipment (see Photo 7, next page).

Photo 6. Staff restroom was unsanitary (photographed on 8-2-23).

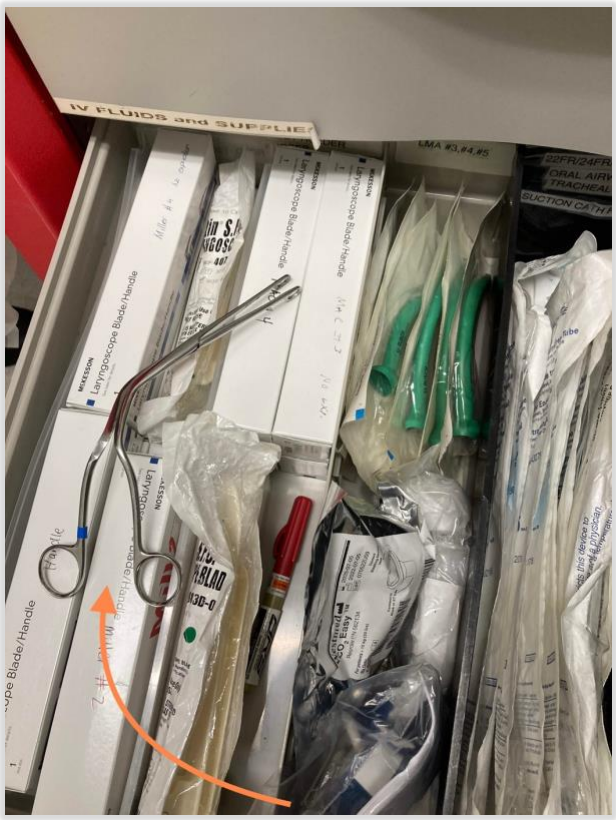

Photo 7. Forceps were not kept in sterilized packaging (photographed 8-1-23).

We found operating sinks and hand hygiene supplies in the examination rooms in four of 11 clinics (MIT 5.103, 36.4%). The patient restrooms in seven clinics lacked either antiseptic soap or disposable hand towels.

We observed patient encounters in nine applicable clinics. In eight clinics, clinicians did not wash their hands before or after physically touching their patients, before applying gloves, or after performing a blood draw (MIT 5.104, 11.1%).

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

Physical Infrastructure

We gathered information to determine whether the institution's physical infrastructure was maintained in a manner that supported health care management's ability to provide timely and adequate health care. When we interviewed health care managers, they did not have concerns about the facility's infrastructure or its effect on the staff's ability to provide adequate health care. At the time of our inspection, the institution had three infrastructure projects underway, which management staff thought would improve the delivery of care at RJD. These are described on the following page.

- Project A: A medication preparation room in Facility B, Housing Unit 6, which began in April 2023 and was expected to have been completed by August 2023.

- Project B: A medication preparation room in Facility B, Housing Unit 7, which began in June 2023 and was expected to have been completed by October 2023.

- Project C: A medication distribution room in Facility C, Housing Unit 7, which began in December 2022 and was expected to have been completed by February 2024.

Despite the projects described above, the CEO did not believe their lack of completion had negatively impacted the institution's current ability to provide good patient care (MIT 5.999).

Compliance Score Results

Table 10. 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)	5	6	0	45.5%
Infection control: Do clinical health care areas ensure that reusable invasive and noninvasive medical equipment is properly sterilized or disinfected as warranted? (5.102)	4	7	0	36.4%
Infection control: Do clinical health care areas contain operable sinks and sufficient quantities of hygiene supplies? (5.103)	4	7	0	36.4%
Infection control: Does clinical health care staff adhere to universal hand hygiene precautions? (5.104)	1	8	2	11.1%
Infection control: Do clinical health care areas control exposure to blood-borne pathogens and contaminated waste? (5.105)	11	0	0	100%
Warehouse, conex, and other nonclinic storage areas: Does the medical supply management process adequately support the needs of the medical health care program? (5.106)	0	1	0	0
Clinical areas: Does each clinic follow adequate protocols for managing and storing bulk medical supplies? (5.107)	2	9	0	18.2%
Clinical areas: Do clinic common areas and exam rooms have essential core medical equipment and supplies? (5.108)	6	5	0	54.6%
Clinical areas: Are the environments in the common clinic areas conducive to providing medical services? (5.109)	10	1	0	90.9%
Clinical areas: Are the environments in the clinic exam rooms conducive to providing medical services? (5.110)	6	5	0	54.6%
Clinical areas: Are emergency medical response bags and emergency crash carts inspected and inventoried within required time frames, and do they contain essential items? (5.111)	1	8	2	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): **41.7%**

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

Recommendations

- Medical leadership should determine the root cause for staff not following all required universal hand hygiene precautions and take necessary remedial measures.
- Nursing leadership should determine the root cause for staff not ensuring clinic examination rooms contain essential core medical equipment. The leadership should also verify staff follow equipment and medical supply management protocols and should take necessary remedial measures.
- Executive leadership should determine the root cause for staff not ensuring reusable noninvasive medical equipment is properly disinfected and take necessary remedial measures.
- Nursing leadership should determine the root causes for staff either not ensuring the EMRBs are regularly inventoried and sealed or not properly completing monthly logs and should implement all necessary remedial measures.

Transfers

In this indicator, OIG inspectors examined the transfer process for those patients who transferred into the institution as well as for those who transferred to other institutions. For newly arrived patients, our inspectors assessed the quality of health care 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 staff performance in communicating vital health transfer information, such as preexisting health conditions, pending appointments, tests, and specialty referrals. Inspectors further confirmed whether staff sent complete medication transfer packages to receiving institutions. For patients who returned from off-site hospitals or emergency rooms, inspectors reviewed whether staff appropriately implemented recommended treatment plans, administered necessary medications, and scheduled appropriate follow-up appointments.

Ratings and Results Overview

Case Review Rating	Compliance Rating and Score
Adequate	***Inadequate* (72.1%)**

Case review found RJD performed well with the transfer process. When patients transferred into and out of the institution, nurses usually performed sufficient assessments and ensured a safe transfer process. Nurses performed satisfactorily when patients returned from an emergency room or hospitalization; however, we found opportunities for improvement in medication continuity for patients returning to the institution. The OIG rated the case review component of this indicator ***adequate.***

Compliance testing showed RJD had a mixed performance in this indicator. The institution scored low in completing initial health screening forms. In contrast, the institution performed very well in completing the assessment and disposition sections of the screening process. Staff often ensured medication continuity for newly transferred patients and ensured transfer packets for departing patients included all required documents and medications. Based on the overall compliance score result, the OIG rated the compliance testing component of this indicator ***inadequate.***

Case Review and Compliance Testing Results

We reviewed 40 events in 25 cases in which patients transferred into or out of the institution or returned from an off-site hospital or emergency room. We identified 18 deficiencies, three of which were significant.[34]

[34]Deficiencies occurred in cases 1, 2, 3, 9–11, 26, 31, 32, 34–36, and 67. Significant deficiencies occurred in case 2 and 32.

Transfers In

RJD's transfer-in process reflected a mixed performance. The compliance testing showed problems in multiple areas of the transfer-in process. First, the timeliness of provider appointments was intermittent for newly arrived patients and poor for preapproved specialty consultations (MIT 1.002, 50.0% and MIT 14.010, 15.8%). Second, nurses only occasionally provided thorough initial screenings (MIT 6.001, 32.0%). However, compliance testing showed nurses performed excellently in completing their assessment and disposition sections of the initial health care screening form (MIT 6.002, 95.7%). In addition, compliance testing showed sufficient medication continuity (MIT 6.003, 77.3%).

OIG clinicians reviewed six events in four cases in which patients transferred into RJD from other institutions. We identified three deficiencies, one of which was significant.[35] Deficiencies occurred when a nurse did not consult with a provider when warranted and when medication continuity was interrupted. This significant deficiency is explained further in the **Access to Care** indicator.

Transfers Out

RJD's transfer-out process reflected satisfactory staff performance. OIG clinicians reviewed three transfer-out cases and found three documentation deficiencies.

Compliance testing showed patients who transferred out of the institution often transferred with their medications (MIT 6.101, 83.3%). Case reviewers observed similar findings.

Hospitalizations

Patients returning from an off-site hospitalization or emergency room are at high risk for lapses in care quality. These patients typically experienced severe illness or injury. They require more care and place a strain on the institution's resources. In addition, because these patients have complex medical issues, successful transfers of health information are necessary for good quality care to continue. Any lapses in the transfer process can result in serious consequences for these patients. Our clinicians found hospital emergency room returns in eight cases and identified 13 deficiencies, three of which were significant.[36]

RJD performed very well in providing follow-up appointments within required time frames to patients returning from hospitalizations and emergency room encounters (MIT 1.007, 88.0%). In addition, availability and review of the community hospital records was sufficient (MIT 4.004, 79.2% and MIT 4.005, 84.0%). However, both compliance and case review identified poor performance in ensuring medication continuity (MIT 7.003, 28.0%). The following is an example:

- In case 2, on two separate occasions, the patient with heart failure returned from a community hospital, and medication continuity was interrupted. On the first occasion, staff did not issue the newly prescribed cardiac medication. On the second occasion, staff

[35] Deficiencies occurred in case 31 and 32. A significant deficiency occurred in case 32.

[36] Deficiencies occurred in cases 1, 2, 3, 9–11, 23, 26, and 67. Significant deficiencies occurred in case 2 and 23.

did not issue a rescue inhaler and did not administer a dose of a chronic care cardiac medication.

Clinician On-Site Inspection

RJD's R&R department was staffed with an RN on each of the three shifts, excluding weekends and holidays. Our clinicians interviewed an R&R nurse, who indicated approximately 120 patients transferred into and out of RJD each week. We learned an LVN would occasionally assist with obtaining vital signs and administering medications. The R&R nurse described the process of receiving weekly notification of patients scheduled to transfer the following week along with daily updates. In addition, the R&R nurse indicated she often proactively reviewed the prescribed medications to anticipate any medication-related concerns. The nurse also shared she created a spreadsheet she used as a checklist to ensure each patient had their orders, patient education instructions, and other documentation required for transfer.

Compliance On-Site Inspection

R&R nursing staff ensured five of six patients transferring out of the institution had the required medications, transfer documents, and assigned durable medical equipment (MIT 6.101, 83.3%). For one patient, the transfer packet did not have the required medication.

Compliance Score Results

Table 11. Transfers

Compliance Questions	Scored Answer			
	Yes	No	N/A	Yes %
For endorsed patients received from another CDCR institution: Did nursing staff complete the initial health screening and answer all screening questions within the required time frame? (6.001)	8	17	0	32.0%
For endorsed patients received from another CDCR institution: 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	1	2	95.7%
For endorsed patients received from another CDCR institution: If the patient had an existing medication order upon arrival, were medications administered or delivered without interruption? (6.003)	17	5	3	77.3%
For patients transferred out of the facility: Do medication transfer packages include required medications along with the corresponding transfer packet required documents? (6.101)	5	1	0	83.3%
				Overall percentage (MIT 6): **72.1%**

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

Table 12. 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)	11	11	3	50.0%
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)	22	3	0	88.0%
Are community hospital discharge documents scanned into the patient's electronic health record within three calendar days of hospital discharge? (4.003)	16	4	5	80.0%
For patients discharged from a community hospital: Did the preliminary or final hospital discharge report include key elements and did a provider review the report within five calendar days of discharge? (4.005)	21	4	0	84.0%
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)	7	18	0	28.0%
Upon the patient's transfer from one housing unit to another: Were medications continued without interruption? (7.005)	18	7	0	72.0%
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)	2	8	0	20.0%
For endorsed patients received from another CDCR institution: If the patient was approved for a specialty services appointment at the sending institution, was the appointment scheduled at the receiving institution within the required time frames? (14.010)	3	16	1	15.8%

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

Recommendations

- Nursing leadership should develop and implement internal auditing of staff to ensure complete and thorough assessments of patients returning from hospitalizations and should implement remedial measures as appropriate.

- Nursing leadership should identify the root causes for R&R nurses not completing the initial health care screening, including answering all questions and documenting an explanation for each "yes" answer; not documenting a complete set of vital signs as part of the patient's initial health care screening assessment; and not completing the initial health care screening form prior to the patient being placed in housing. Nursing leadership should implement remedial measures as appropriate.

Medication Management

In this indicator, OIG inspectors evaluated the institution's performance in administering prescription medications on time and without interruption. The inspectors examined this process from the time a provider prescribed medication until the nurse administered the medication to the patient. In addition to examining medication administration, our compliance inspectors also tested many other processes, including medication handling, storage, error reporting, and other pharmacy processes.

Ratings and Results Overview

Case Review Rating	Compliance Rating and Score
Adequate	***Inadequate* (51.9%)**

Case review found RJD performed sufficiently in medication management. We found most patients received their prescribed medications within acceptable time frames. Although we identified opportunities for improvement, taking all aspects into consideration, the OIG rated the case review component of this indicator ***adequate***.

Compliance testing showed RJD needed to improve in this indicator. RJD had low scores in medication continuity for patients with chronic care medications, newly prescribed medications, and hospital discharge medications as well as patients transferring within or temporarily housed in RJD. Conversely, the institution showed good performance in employing general security for, and in storing medications in, its main pharmacy. Based on the overall compliance score result, the OIG rated the compliance component of this indicator ***inadequate.***

Case Review and Compliance Testing Results

We reviewed 31 cases related to medications and found 27 medication deficiencies in 12 cases, six of which were significant.[37]

New Medication Prescriptions

RJD needed to improve in ensuring administration and delivery of new medications within required time frames (MIT 7.002, 64.0%). Our clinicians also found a pattern of newly prescribed medications being administered late or not at all. The following are examples:

- In case 2, the patient received newly prescribed blood thinners one day late and did not receive a rescue inhaler.
- In case 21, the patient received a newly prescribed antibiotic two days late.

[37] Deficiencies occurred in cases 1, 2, 3, 6, 21–23, 25, 26, 28, 32, and 65. Significant deficiencies occurred in cases 2, 21, 23, 25 and 28.

- In case 22, the diabetic patient received a rescue medication (glucose) 10 days late.

Chronic Medication Continuity

Compliance testing revealed most patients did not receive their chronic care medications within required time frames (MIT 7.001, 9.5%). Analysis of compliance data showed patients frequently received their hypertension, diabetes, thyroid, and cholesterol medications late or not at all. In contrast, our clinicians found most patients received their chronic care medications within acceptable time frames.

Hospital Discharge Medications

We found mixed results in medication continuity when patients returned from a community hospital. Compliance testing showed, when patients missed medications, nurses frequently did not document the reason. In addition, the pharmacy did not always make medications available within required time frames. For the samples reviewed, when rescue medications were prescribed, patients generally did not receive them timely (MIT 7.003, 28.0%). Our clinicians identified four deficiencies, three of which were significant. One example follows:

- In case 23, when the patient returned after a hospitalization, the medication the patient was prescribed for congestive heart failure was not available.

Specialized Medical Housing Medications

Compliance tests showed RJD performed poorly in ensuring medications were made available and administered timely in the CTC (MIT 13.003, 20.0%). In half the deficiencies, the patients received their medications, but the pharmacy had not made the medication available within specified time frames. The other deficiencies occurred when the patients received their medication one day late or not at all. In contrast, our clinicians found only two minor deficiencies.[38]

Transfer Medications

RJD performed satisfactorily in ensuring patients who transferred into the institution received their medications (MIT 6.003, 77.3%). However, we identified a need for improvements when patients transferred from yard to yard or were temporarily housed at the institution (MIT 7.005, 72.0% and MIT 7.006, 20.0%).

Compliance testing showed RJD performed satisfactorily in ensuring all patients who transferred out of the institution had their needed medications (MIT 6.101, 83.3%). Our case reviewers did not identify any medication deficiencies for patients transferring from RJD. Additional information is discussed in the **Transfers** indicator.

[38] Two deficiencies occurred in case 65.

Medication Administration

RJD performed sufficiently in ensuring staff administered tuberculosis (TB) medications (MIT 9.001, 76.5%). However, nurses needed to improve when monitoring their patients who were prescribed TB medications (MIT 9.002, 53.3%).

OIG clinicians identified five cases in which pharmacy staff had delivered keep-on-person (KOP) medications[39] to the administration area, but nurses either did not issue the medication or issued it late.[40] We also identified two cases in which nurses documented the patient had not requested a refill; however, either the patient had requested the medication, or the patient was not required to request a refill because the medication was ordered to be automatically refilled each month. An example follows:

- In case 25, the patient requested an inhaler refill. Three days later, a nurse documented the patient was not provided with the inhaler because the patient had not requested it.

Clinician On-Site Inspection

During the on-site inspection, OIG clinicians met with the pharmacist in charge (PIC) and a nursing supervisor regarding specific questions identified during the clinical reviews. The PIC provided the OIG clinicians with detailed responses. In addition, our clinicians toured the medication administration areas and spoke with LVNs. We learned nursing staff provided custody staff with a list of patients who had KOP medications for pick up. Nurses also indicated pharmacy staff delivered medications to the administration areas several times per day.

Medication Practices and Storage Controls

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

RJD appropriately stored and secured nonnarcotic medications in seven of 11 clinic and medication line locations (MIT 7.102, 63.6%). In four of the clinic locations, we observed one or more of the following deficiencies: the medication storage location was disorganized or unsanitary; the medication area lacked a clearly labeled, designated area for medications to be returned to the pharmacy; nurses did not maintain unissued medication in its original labeled packaging; and medications were not properly secured as required by CCHCS policy.

Staff kept medications protected from physical, chemical, and temperature contamination in three of the 11 clinic and medication line locations (MIT 7.103, 27.3%). In seven locations, we observed one or both of the following deficiencies: staff did not store internal and external medications separately, and the medication refrigerator was unsanitary. In one location, staff did not maintain a temperature log for medications stored in the examination room.

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[39] *Keep on person* refers to medications a patient can keep and self-administer according to the directions provided.

[40] KOP medications not administered by nursing timely or not at all occurred in cases 1, 2, 21, 21, 26, and 28.

Staff successfully stored valid, unexpired medications in 10 of the 11 applicable medication line locations (MIT 7.104, 90.9%). In one location, nurses did not label the multiple-use medication as per CCHCS policy.

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

Staff in six of seven applicable medication preparation and administration areas showed appropriate administrative controls and protocols (MIT 7.106, 85.7%). In one location, medication nurses could not describe the process they followed when reconciling newly received medication and the medication administration record (MAR) against the corresponding physician's order.

Staff in three of seven applicable medication areas used appropriate administrative controls and protocols when distributing medications to their patients (MIT 7.107, 42.9%). In four clinics, we observed one or more of the following deficiencies: medication nurses did not distribute medications to patients within the required time frame; medication nurses did not reliably observe patients while they swallowed direct observation therapy medications; and nurses did not properly follow insulin protocols.

Pharmacy Protocols

RJD followed general security, organization, and cleanliness management protocols in its main and remote pharmacies (MIT 7.108, 100%). In its remote pharmacy, RJD properly stored nonrefrigerated medication. However, in its main pharmacy, we found compromised medication packaging (MIT 7.109, 50.0%). The institution did not properly store refrigerated or frozen medications in pharmacy locations. In both locations, we found unsanitary medication refrigerators (MIT 7.110, zero). The PIC correctly accounted for narcotic medications stored in RJD's pharmacies (MIT 7.111, 100%).

We examined 18 medication error reports. The PIC had no evidence a pharmacy error follow-up review was performed for any of the medication errors (MIT 7.112, zero).

Nonscored Tests

In addition to testing the institution's self-reported medication errors, our inspectors also follow 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 RJD, the OIG did not find any applicable medication errors (MIT 7.998).

The OIG interviewed patients in restricted housing units to determine whether they had immediate access to their prescribed asthma rescue inhalers or nitroglycerin medications. Fifteen of the 20 applicable patients we interviewed indicated they had access to their rescue medications. Five patients reported they did not have their prescribed rescue inhaler. One patient stated he did not possess his rescue inhaler during transfer to the restricted housing unit, while the remaining patients reported their medications were placed with their property when they were transferred to the restricted housing unit. We promptly notified the CEO of these concerns, and health care management immediately issued a replacement rescue inhaler to each applicable patient (MIT 7.999).

Compliance Score Results

Table 13. 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	19	4	9.5%
Did health care staff administer, make available, or deliver new order prescription medications to the patient within the required time frames? (7.002)	16	9	0	64.0%
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)	7	18	0	28.0%
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)	18	7	0	72.0%
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)	2	8	0	20.0%
All clinical and medication line storage areas for narcotic medications: Does the institution employ strong medication security controls over narcotic medications assigned to its storage areas? (7.101)	10	0	1	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)	7	4	0	63.6%
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)	3	8	0	27.3%
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)	10	1	0	90.9%
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	4	28.6%
Medication preparation and administration areas: Does the institution employ appropriate administrative controls and protocols when preparing medications for patients? (7.106)	6	1	4	85.7%
Medication preparation and administration areas: Does the institution employ appropriate administrative controls and protocols when administering medications to patients? (7.107)	3	4	4	42.9%
Pharmacy: Does the institution employ and follow general security, organization, and cleanliness management protocols in its main and remote pharmacies? (7.108)	2	0	0	100%
Pharmacy: Does the institution's pharmacy properly store nonrefrigerated medications? (7.109)	1	1	0	50.0%
Pharmacy: Does the institution's pharmacy properly store refrigerated or frozen medications? (7.110)	0	2	0	0
Pharmacy: Does the institution's pharmacy properly account for narcotic medications? (7.111)	2	0	0	100%
Pharmacy: Does the institution follow key medication error reporting protocols? (7.112)	0	18	0	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): **51.9%**

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

Table 14. Other Tests Related to Medication Management

	Scored Answer			
Compliance Questions	**Yes**	**No**	**N/A**	**Yes %**
For endorsed patients received from another CDCR institution: If the patient had an existing medication order upon arrival, were medications administered or delivered without interruption? (6.003)	17	5	3	77.3%
For patients transferred out of the facility: Do medication transfer packages include required medications along with the corresponding transfer-packet required documents? (6.101)	5	1	0	83.3%
Patients prescribed TB medication: Did the institution administer the medication to the patient as prescribed? (9.001)	13	4	0	76.5%
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)	8	7	2	53.3%
Upon the patient's admission to specialized medical housing: Were all medications ordered, made available, and administered to the patient within required time frames? (13.003)	2	8	0	20.0%

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

Recommendations

- Medical and nursing leadership should ensure chronic care, hospital discharge, and en route patients receive their medications timely and without interruption; leadership should implement remedial measures as appropriate.

- The institution should consider developing and implementing measures to ensure staff timely make available and administer medications to patients as described in CCHCS policy and procedures.

- Nursing leadership should consider developing and implementing measures to ensure nursing staff document patients' refusal reasons and no-shows on MAR summaries, in accordance with CCHCS' policies and procedures.

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 being at high risk for coccidioidomycosis (Valley Fever), we tested the institution's performance in transferring out patients quickly. The OIG rated this indicator solely according to the compliance score. Our case review clinicians do not rate this indicator.

Ratings and Results Overview

Case Review Rating	Compliance Rating and Score
Not Applicable	***Inadequate* (69.6%)**

RJD had a mixed performance in preventive services. Staff performed perfectly in offering influenza vaccines for the most recent influenza season and in screening patients annually for TB. The institution showed very good performance in screening patients from the ages of 45 through 75 for colorectal cancer and in administering TB medications. However, RJD performed poorly in monitoring patients taking prescribed TB medications or in offering required immunizations to chronic care patients. Based on the overall compliance score result, the OIG rated this indicator ***inadequate***.

Compliance Score Results

Table 15. 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)	13	4	0	76.5%
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)	8	7	2	53.3%
Annual TB screening: Was the patient screened for TB within the last year? (9.003)	25	0	0	100%
Were all patients offered an influenza vaccination for the most recent influenza season? (9.004)	25	0	0	100%
All patients from the age of 45 through the age of 75: Was the patient offered colorectal cancer screening? (9.005)	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)	0	12	13	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): **69.6%**

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

Recommendations

- Nursing leadership should consider developing and implementing measures to ensure nursing staff consistently perform patient monitoring as described in CCHCS care guides, and nursing staff completely address TB signs and symptoms in their patient monitoring.

- Medical leadership should determine the root cause of challenges in the timely provisions of vaccinations to chronic care patients and implement remedial measures as appropriate.

Nursing Performance

In this indicator, the OIG clinicians evaluated the quality of care delivered by the institution's nurses, including registered nurses (RN), licensed vocational nurses (LVN), psychiatric technicians (PT), certified nursing assistants (CNA), and medical assistants (MA). 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 across 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 nursing performance, our clinicians understand 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**.

Ratings and Results Overview

Case Review Rating	Compliance Rating and Score
Inadequate	***Not Applicable***

In Cycle 7, the RJD's nursing performance declined. Compared with Cycle 6, RJD nurses had more total deficiencies and more significant deficiencies. Our clinicians identified opportunities for improvement in several areas of the nursing process described in the areas below. The amount of significant assessment-related deficiencies could place patients at risk of harm. In addition, RJD's nursing leadership did not identify opportunities for improvement and did not have sufficient mechanisms in place to monitor the quality of nurses' clinical performance. The OIG rated this indicator ***inadequate***.

Case Review Results

We reviewed 279 nursing encounters in 66 cases. Of the nursing encounters we reviewed, 134 occurred in the outpatient setting, and 69 were sick call requests. We identified 147 nursing performance deficiencies, 26 of which were significant.[41]

Outpatient Nursing Assessment and Interventions

Our clinicians identified 82 outpatient nursing deficiencies, 13 of which were significant. Of the 82 deficiencies, 44 related to incomplete nursing assessments. These deficiencies occurred when nurses in the outpatient areas did not arrange a same-day nurse

[41] Deficiencies occurred in cases 1–8, 10, 11, 14, 16–18, 20, 21, 23–26, 29, 31, 34–36, 38–44, 46-50, 52–58, 61, 62, 64, 66, and 67. Significant deficiencies occurred in cases 2, 4, 6, 10, 11, 16, 21, 23, 24, 26, 29, 46, 48, 61, 65, and 66.

appointment and did not provide sufficient assessments or care plans. Examples are listed in the following cases:

- In case 16, an LVN documented the patient's finger-stick blood glucose result was critically low. However, the LVN did not inquire whether the patient had other signs or symptoms of hypoglycemia and did not consult with an RN or provider about the abnormal result.

- In case 21, the diabetic patient submitted a sick call request for a wheelchair cushion. During the sick call appointment, the patient complained of buttock and leg wounds; however, the nurse did not assess the wounds. In addition, in cases 1, 24, and 58, nurses did not thoroughly assess these diabetic patients' wounds.

- In case 24, the diabetic patient complained to an LVN about a new wound. Instead of arranging an RN or provider evaluation, the LVN advised the patient to submit a sick call request. The patient did submit a sick call request and also complained of calf swelling.[42] However, the RN conducting triage did not arrange for a same-day evaluation. When an RN evaluated this patient, the nurse did not perform a sufficient assessment, did not consult with a provider, and did not schedule a follow-up appointment. In addition, in cases 11, 26, and 48, nurses did not arrange same-day assessments of potentially urgent symptoms.

- In case 61, the patient complained of rectal bleeding and constipation. The nurse documented the patient's abdomen was asymmetric but did not consult with a provider regarding this abnormal finding. In addition, the nurse did not subjectively assess the onset, frequency, and characteristics of the patient's rectal bleeding.

Outpatient Nursing Documentation

Complete and accurate nursing documentation is an essential component of patient care. Without proper documentation, health care staff can overlook changes in patient conditions. On multiple occasions, nurses inconsistently documented or did not thoroughly document their assessment findings. The following are examples:

- In case 18, the patient had a rash; however, the nurse did not document the rash's appearance.

- In case 42, the patient experienced a hand injury. In the same assessment, the nurse documented the injured hand had both limited and full range of motion, which was contradictory.

Emergency Services

We reviewed 47 urgent or emergent events and identified 30 nursing deficiencies, eight of which were significant. Although nurses usually responded promptly to emergent events, we found a pattern of incomplete initial assessments. In addition, nursing assessments,

[42] Calf swelling is a symptom associated with a blood clot and warrants a same-day assessment.

interventions, and documentations showed room for improvement, which we detailed further in the **Emergency Services** indicator.

Hospital Returns

We reviewed 30 events that involved returns from off-site hospitals or emergency rooms. We identified four nursing deficiencies. Three related to incomplete assessment, intervention, and documentation. Otherwise, nurses performed good nursing assessments. Please refer to the **Transfers** indicator for additional details.

Transfers

Our clinicians reviewed seven cases involving transfer-in and transfer-out processes, and we identified four nursing deficiencies. Compliance testing showed nurses only occasionally provided timely initial screenings but performed well when completing the assessment and disposition portions of the initial health screening form. We found nurses did not always document pertinent information when patients transferred out of the institution. Please refer to the **Transfers** indicator for additional details.

Specialized Medical Housing

We reviewed four cases with a total of 41 nursing events and identified 28 nursing deficiencies, four of which were significant. These deficiencies related to both incomplete initial nursing assessments and nurses' failures to follow a provider's orders for activities of daily living and external feedings. An example is detailed below:

- In case 65, a provider ordered the patient to be placed in a wheelchair twice during the day and repositioned in bed every two hours, but nurses did not consistently follow these orders. In addition, nurses did not administer the tube feeding amounts as prescribed.

For more specific details, please refer to the **Specialized Medical Housing** indicator.

Specialty Services

We reviewed 27 events in which nurses evaluated patients after an off-site specialty procedure or consultation. We identified five nursing deficiencies related to specialty services, one of which was significant. Please refer to the **Specialty Services** indicator for additional details.

Medication Management

OIG clinicians examined 166 events involving medication management. Our clinicians found a pattern of nurses not issuing KOP medications within necessary time frames. An example is listed below:

- In case 1, pharmacy staff delivered the patient's KOP diabetes medication timely to the medication distribution area; however, nursing staff issued the medication 14 days later.

Please refer to the **Medication Management** indicator for additional details.

Clinician On-Site Inspection

Our clinicians spoke with nurses in the TTA, CTC, R&R, specialty services, outpatient clinics, and medication areas. We attended well-organized morning huddles and a medical subcommittee meeting. We found medical staff knowledgeable and familiar with their patient population. Our clinicians were impressed by the subcommittee meeting presentation and staff involvement; the subcommittee established deadlines, updates and discussions occurred, and subcommittee members reviewed tracking and trending of goals.

The CNE, who started her position with RJD in 2017, stated she had knowledgeable supervisors, and staff advocated for their patients. The CNE described challenges related to staffing allocation not correlating with the volume and complicated health conditions of RJD's patients. The CNE also disclosed psychiatric technician positions were difficult to fill, with the institution experiencing a 40 percent vacancy rate. In addition, in other areas with limited staff, nursing leadership reported using creative scheduling or overtime to meet staffing needs.

During our inspection, we spoke to nursing staff who informed us of their low morale. The CNE acknowledged this challenge and indicated the nurses had expressed their feelings of being overworked and of feeling "burnt out," both related to the high volume of patient encounters and low staffing ratios. However, the CNE indicated the leadership team was working on team building efforts and hoped morale would improve.

Our clinicians further inquired about how nursing leadership assessed the quality of care RJD's nursing staff provided. The CNE reported her nursing leadership conducted annual evaluations, performed audits, and monitored logs. This included auditing random sick calls, reviewing controlled medication mismatch reports, reviewing dashboards, participating in quality management meetings, reviewing health care incident reports, completing emergency clinical reviews, conducting R&R audits, and facilitating urgent and emergent care discussions. While these reviews and audits could be helpful in monitoring compliance with individual health care requirements, the OIG found many of the audits did not assess the quality of nurses' clinical performance.

Recommendations

- Nursing leadership should determine the challenges to ensuring nursing staff complete thorough assessments, provide appropriate interventions, and thoroughly document encounters. Leadership should implement remedial measures as appropriate.

- Nursing leadership should develop and implement measures to assess the clinical quality of nursing care, in addition to the current compliance audits, and should provide training and education as necessary.

Provider Performance

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.

Ratings and Results Overview

Case Review Rating	Compliance Rating and Score
Adequate	***Not Applicable***

RJD providers delivered acceptable medical care. Providers generally evaluated patients appropriately, diagnosed medical conditions correctly, and managed chronic conditions effectively. They appropriately referred patients to specialists and for a higher level of care when needed. However, we found opportunities for improvement for providers in performing pertinent physical examinations during evaluations and documenting progress notes when providing co-consultations with nursing staff. After careful consideration of all these factors, the OIG rated this indicator ***adequate***.

Case Review Results

OIG clinicians reviewed 175 medical provider encounters and identified 58 deficiencies, 13 of which were significant.[43] In addition, our clinicians examined the quality of care in 25 comprehensive case reviews. Of these 25 cases, we found 21 ***adequate*** and four ***inadequate***.

Outpatient Assessment and Decision-Making

Providers generally made appropriate assessments and sound medical decisions for their patients. Most of the time, providers diagnosed medical conditions correctly, ordered appropriate tests, and referred their patients to specialists when needed. However, our clinicians identified 39 deficiencies related to poor medical assessments and decision-making, nine of which were significant.[44] The following are examples:

- In case 3, the provider evaluated the patient for surgical clearance prior to undergoing total knee replacement. During the evaluation, the provider did not perform a comprehensive review of systems and symptoms, obtain vital signs, or perform a cardiopulmonary

[43] Deficiencies occurred in cases 2, 3, 10–14, 16, 17, 20–24, and 26–30. Significant deficiencies occurred in cases 3, 12, 16, 26, 28 and 29.

[44] Deficiencies occurred in cases 3, 10, 12-14, 17, 21, 24, and 26–30. Significant deficiencies occurred in cases 3, 12, 26, 28, and 29.

examination for this patient, who had cardiac and pulmonary disease. Furthermore, the provider did not review the MAR to either evaluate the current medication status or address the patient's frequent refusal of insulin.

- In case 26, the provider evaluated the patient for follow up after the CT scan of the brain showed evidence of ischemia.[45] The provider did not complete a full neurologic review of systems and did not perform a comprehensive neurologic examination during the encounter.

Review of Records

Providers generally performed well in reviewing medical records and addressing hospitalists' recommendations for patients returning from hospitalizations. However, we identified four deficiencies.[46] The following is an example:

- In case 26, at a follow-up appointment, the provider evaluated the patient with a history of stroke and speech difficulties. Although the patient had received a Holter monitor test two months prior to the appointment, the provider did not discuss the results of 24-hour Holter monitoring to assess for a possible embolic cause of the stroke as recommended by the neurologist.[47]

Emergency Care

Providers usually managed patients in the TTA with urgent or emergent conditions appropriately. In addition, providers were available for consultation with TTA staff. We identified three deficiencies related to emergency care, none of which were significant .[48] We also discuss these deficiencies in the **Emergency Services** indicator.

Chronic Care

In most instances, providers appropriately managed patients' chronic health conditions, such as hypertension, diabetes, asthma, hepatitis C infection, and cardiovascular disease. However, we identified one significant deficiency related to the management of diabetes as discussed in the following example:

- In case 16, the provider evaluated the patient at a follow-up appointment after an off-site return and for chronic care. However, the provider did not adequately assess the patient's diabetes in reviewing the fluctuating glucose finger-stick readings, which the provider should have done as the patient was receiving frequent steroids for cancer treatment. Furthermore, the provider did not address the patient's other chronic care conditions including

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[45] *Ischemia* means reduced blood flow to any tissue or organ of the body, resulting in insufficient blood supply.

[46] Deficiencies occurred in cases 3, 13, 20, and 26.

[47] An embolic cause of a stroke occurs when a blood clot from another part of the body travels through the bloodstream to the brain. The clot blocks the blood flow, resulting in a stroke.

[48] Deficiencies occurred in cases 1 and 15–17.

hypertension, hyperlipidemia, hepatitis C infection, and history of deep vein thrombosis during this encounter.

Specialty Services

Providers appropriately referred patients for specialty consultation when needed. When specialists made recommendations, providers usually followed the recommendations appropriately and reviewed specialty reports timely. We identified one deficiency for not thoroughly reviewing the specialty report, one for not timely referring the patient to the specialist, and two for not fully following specialists' recommendations. Only one was significant.[49] The following are examples:

- In case 16, the patient returned from an off-site chemotherapy appointment with instructions to return in one week. However, the provider did not thoroughly review the specialist's recommendations. Consequently, the chemotherapy appointment was delayed for the patient.

- In case 26, the provider evaluated the patient following a neurology consultation for stroke. The neurologist recommended the patient be referred to a cardiologist and receive an MRA as soon as possible.[50] However, the provider did not complete these referrals.

We discuss providers' specialty performance further in the **Specialty Services** indicator.

Documentation Quality

Providers generally documented outpatient encounters on the same day of the encounter. However, we identified one significant deficiency in not completing a progress note and five deficiencies with delays in completing progress notes.[51] The following are examples:

- In case 3, the provider evaluated the patient for a follow-up appointment after return from a higher level of care and abnormal laboratory results at a chronic care appointment. However, the provider did not document a progress note for the encounter including the rationale for medication changes and new laboratory orders.

- In case 16, the provider evaluated the patient in the clinic. However, the provider did not complete the progress note until six days later.

Documentation is important because it shows the provider's thought process during clinical decision-making. When contacted by nurses, providers did not always document those interactions. Our clinicians found five such undocumented interactions.[52] The following is an example:

- In case 26, a nursing staff co-consulted with the provider concerning this patient with an abscess and swelling of the left forearm. The provider

[49] Deficiencies occurred in case 16, 23, 16, and 27. A significant deficiency occurred in case 26.

[50] An MRA is a magnetic resonance angiography scan used to image the blood vessels in the body.

[51] Deficiencies occurred in case 16.

[52] Deficiencies occurred in cases 26, 27, and 28.

ordered antibiotics for the patient but did not document a progress note in the electronic health record.

Provider Continuity

RJD offered good provider continuity. Providers were assigned to specific clinics and took care of their assigned patients.

Clinician On-Site Inspection

OIG clinicians observed morning huddles and provider meetings, including the medical subcommittee meeting, which were well attended.

We discussed the expectations for medical provider documentation with medical leadership. The leadership reported, before the clinician on-site inspection, RJD provided updates on HCDOM 1.4.22, "Medical Provider Documentation Expectations," and a new RJD LOP, "RJD Medical Provider Documentation Expectations." Leadership reported the goals were to establish clear expectations for the staff to follow.

Medical leadership reported implementing a diabetes care manager (CM) program to improve in chronic care management. Under this program, designated nursing staff provided diabetes care by collaborating with clinic providers and patients to directly monitor glucose levels and medication compliance.

The OIG physician met with the CME, the chief physician and surgeon (CP&S), and individual clinic providers. Providers expressed medical leadership supported them well.

Recommendations

- Medical leadership should develop and implement monitoring strategies to ensure providers follow medical provider documentation expectations according to the department's HCDOM and RJD LOP.

Specialized Medical Housing

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. At the time of our inspection, RJD's specialized medical housing consisted of a correctional treatment center (CTC).

Ratings and Results Overview

Case Review Rating	Compliance Rating and Score
Adequate	***Inadequate* (70.0%)**

Case review found RJD performed satisfactorily in this indicator. We found providers evaluated their patients appropriately. Although nurses showed opportunities to improve their assessments, interventions, and documentation, the OIG rated the case review component of this indicator ***adequate***.

Compared with Cycle 6, compliance testing showed RJD needed to improve in this indicator. Providers performed well in completing history and physical examinations within required time frames. However, nursing staff needed to improve in timely completing initial assessments and in ensuring medication continuity for patients newly admitted to the specialized medical housing unit. Based on the overall compliance score result, the OIG rated the compliance component of this indicator ***inadequate.***

Case Review and Compliance Testing Results

We reviewed five CTC cases that included 32 provider events and 41 nursing events. Due to the frequency of nursing and provider contacts in the specialized medical housing, we may bundle up to two weeks of patient care into a single event. We identified 33 deficiencies, five of which were significant.[53]

Provider Performance

Case review clinicians evaluated five patients admitted to RJD's specialized medical housing unit and found no deficiencies. Compliance testing showed providers generally completed timely admission health and physical examinations (MIT 13.002, 90.0%). Providers completed their rounds at clinically appropriate intervals, developed good care plans, made sound medical decisions, and documented well.

[53] Deficiencies occurred in cases 1, 2, 23, and 65–67. Significant deficiencies occurred in cases 2, 65, and 66.

Nursing Performance

Compliance testing showed nurses needed to improve in completing timely admission assessments (MIT 13.001, 70.0%). In contrast, case review evaluated five nurse admissions and did not identify deficiencies in the timeliness of these admission assessments. However, in two cases, we found assessments were incomplete.[54] In addition, case review found opportunities for improvement in nurses' assessments, interventions, and documentation. The following are examples:

- In case 2, a CTC nurse performed an incomplete admission assessment. The nurse did not assess the patient's surgical site and did not perform a pain assessment despite the patient's complaint of pain.

- In case 65, the patient frequently complained of pain around the feeding tube site, but the nurses documented the patient did not have any pain. In addition, on a few occasions, nurses found a change in the patient's condition, but did not notify a provider.

- In case 66, this patient with esophageal cancer had multiple wounds; however, the labeling of the wound locations was inconsistent. In addition, nurses frequently documented administering enteral feeding amounts inconsistent with providers' orders.[55]

Medication Administration

Compliance testing revealed patients admitted to the CTC rarely received their medications timely (MIT 13.003, 20.0%). In contrast, our clinicians identified two deficiencies related to medication management.[56] We discuss these in the **Medication Management** indicator.

Clinician On-Site Inspection

The CTC had 14 medical beds, two of which were negative pressure rooms for respiratory isolation. At the time of our inspection, the CTC had two vacant rooms.

Nurses staffed the CTC 24 hours per day, and staffing included RNs, LVNs, and CNAs. In the CTC, staff completed grand rounds each week and conducted weekly meetings to review care plans for each patient.[57] The provider, the RN, the utilization management (UM) RN, and a mental health clinician attended these weekly meetings. Nursing staff reported they felt supported by nursing administration.

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[54] Incomplete nursing assessments occurred in case 2 and 66.

[55] Enteral feedings are used as a means to provide patient nutrient needs. Enteral feedings can include feeding tubes through the mouth, nose, or stomach.

[56] Deficiencies occurred in case 65.

[57] Grand rounds involve a multidisciplinary team approach that includes providers, nurses, and a care team, who gather to discuss the patient's plan of care.

During normal business hours, excluding weekends and holidays, providers were available on site. CTC nurses contacted the on-call provider, who generally had a laptop computer to access the patient's medical record.

At the time of our on-site inspection, the supervising registered nurse (SRN) had been acting in the position for two months. The SRN reported using compliance auditing tools to measure the quality of nursing performance in the CTC.

Compliance On-Site Inspection

At the time of the compliance on-site inspection, the CTC had a functional call light communication system (MIT 13.101, 100%).

Compliance Score Results

Table 16. Specialized Medical Housing

Compliance Questions	Scored Answer			
	Yes	No	N/A	Yes %
For OHU, CTC, and SNF: Did the registered nurse complete an initial assessment of the patient on the day of admission? (13.001)	7	3	0	70.0%
Was a written history and physical examination completed within the required time frame? (13.002)	9	1	0	90.0%
Upon the patient's admission to specialized medical housing: Were all medications ordered, made available, and administered to the patient within required time frames? (13.003)	2	8	0	20.0%
For specialized health care housing (CTC, SNF, hospice, OHU): Do specialized health care housing maintain an operational call system? (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): **70.0%**

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

Recommendations

- Nursing leadership should determine the challenges to ensuring nursing staff complete thorough documentation of wound care assessments, including clinical appearance of the wound, surrounding tissue, and measurements. Leadership should implement remedial measures as appropriate.

- Nursing leadership should ensure nursing staff completes initial assessments within the time frame required by CCHCS policy.

Specialty Services

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

Ratings and Results Overview

Case Review Rating	Compliance Rating and Score
Adequate	***Inadequate* (67.7%)**

Case review found RJD generally provided satisfactory specialty services for patients. Providers often appropriately referred to specialists and followed up after the specialty consultations. TTA nurses performed well in assessing patients after returning from specialty appointments. However, we found opportunities for improvement in providers reviewing and endorsing specialists' reports following specialist recommendations, and in staff retrieving and scanning the reports within required time frames. The OIG rated the case review component of this indicator ***adequate***.

Compliance testing showed RJD needs improvement in this indicator. RJD scored low in providing high-, medium-, and routine-priority specialty services. Staff needs improvement in providing preapproved specialty services for patients newly transferred into RJD as well as in endorsing and reviewing specialty reports. Based on the overall compliance score result, the OIG rated the compliance component of this indicator ***inadequate***.

Case Review and Compliance Testing Results

OIG clinicians reviewed 196 events related to specialty services, which included 154 specialty consultations and procedures, 15 on-site specialty services, and 27 nursing encounters. We identified 33 deficiencies in this category, eight of which were significant.[58]

Access to Specialty Services

Compliance testing showed patients sometimes received high-priority specialty referrals (MIT 14.001, 60.0%) and sporadically received continuity of specialty services upon transfer into the institution (MIT 14.010, 15.8%). In addition, patients intermittently received medium- and routine-priority specialty referrals within the required time frames (MIT 14.004, 73.3% and MIT 14.007, 73.3%). OIG clinicians identified six deficiencies

[58] Deficiencies occurred in cases 2, 12, 14, 17, 20, 22–24, 26, 27–29, and 67. Significant deficiencies occurred in cases 23, 26, 28, and 29.

related to specialty appointments, two of which were significant.[59] The following is an example:

- In case 26, the provider requested an urgent specialty referral for an MRI of the brain. The study was completed six days after the requested date.

Provider Performance

In general, providers appropriately referred patients and usually followed the specialists' recommendations. Compliance testing showed follow-up appointments with providers after specialty consultations often occurred within required time frames (MIT 1.008, 78.1%). OIG clinicians identified 13 deficiencies in which providers did not endorse specialists' reports timely, three of which were significant.[60] The following is an example:

- In case 26, staff scanned the patient's report for a 24-hour Holter monitor heart test into the electronic health record over two months after it was performed. Furthermore, the provider endorsed the report 19 calendar days after the report became available.

Nursing Performance

The specialty nurses reviewed specialty service requests and appropriately scheduled patients for specialty appointments. TTA nurses properly assessed patients after returning from off-site specialty appointments, reviewed specialists' recommendations, and communicated them to providers. OIG clinicians reviewed 27 nursing encounters related to specialty services and only identified one significant deficiency. The following is an example:

- In case 29, the neurosurgeon evaluated the patient with a high-priority referral. However, the specialty nurse did not provide the diagnostic MRI scan images to the specialist for evaluation. This delayed the neurosurgical interventional care for this patient, who had chronic cauda equina syndrome with severe spinal stenosis.[61]

This is discussed further in the **Nursing Performance** indicator.

Health Information Management

While providers mostly received and reviewed high-priority specialty reports within required time frames, they intermittently reviewed medium- and routine-priority specialty reports within required time frames (MIT 14.002, 85.7%, MIT 14.005, 71.4%, and MIT 14.008, 61.5%). Staff nearly always scanned specialty reports into the electronic health record within the required time frame (MIT 4.002, 96.7%). OIG clinicians identified one significant deficiency related to delays in retrieving and scanning the

[59] Deficiencies occurred in cases 23, 26, 28, and 29. A significant deficiency occurred in case 29.

[60] Delayed endorsement deficiencies occurred in cases 12, 20, 22, 24, and 26–29. Significant deficiencies occurred in cases 26 and 29.

[61] *Spinal stenosis* is a medical condition in which the spinal column narrows and compresses on the spinal cord. This may cause pain and disability. *Cauda equina* syndrome is a condition in which the nerves below the end of the spinal cord are damaged, resulting in effects on nerve function such as a loss of bladder and bowel control.

report, one deficiency related to not obtaining the report, and two deficiencies related to sending patient notification letters with results of specialty procedures.[62] The following are examples:

- In case 23, staff scanned the infectious disease specialist report 22 days late.
- In case 26, the nursing staff assessed the patient after an off-site speech therapy evaluation. The nurses documented the therapist's report was not available but did not attempt to obtain these records.

Clinician On-Site Inspection

We discussed specialty referral management with medical and nursing leadership, providers, specialty nurses, and the utilization management nurse. Nursing staff reported they review specialty requests, contact specialists for available appointments, and schedule the appointments. However, they reported challenges with staffing due to an increased number of off-site, on-site, and telemedicine referral requests. RJD offered on-site specialty services including audiology, ophthalmology, optometry, physical therapy, podiatry, and renal replacement therapy (hemodialysis services). Medical leadership reported obtaining space for an on-site coumadin clinic for anticoagulation therapy by a clinical pharmacist.

[62] Deficiencies occurred in cases 14, 23, and 26.

Compliance Score Results

Table 17. Specialized 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)	9	6	0	60.0%
Did the institution receive and did the primary care provider review the high-priority specialty service consultant report within the required time frame? (14.002)	12	2	1	85.7%
Did the patient receive the subsequent follow-up to the high-priority specialty service appointment as ordered by the primary care provider? (14.003)	4	3	8	57.1%
Did the patient receive the medium-priority specialty service within 15-45 calendar days of the primary care provider order or Physician Request for Service? (14.004)	11	4	0	73.3%
Did the institution receive and did the primary care provider review the medium-priority specialty service consultant report within the required time frame? (14.005)	10	4	1	71.4%
Did the patient receive the subsequent follow-up to the medium-priority specialty service appointment as ordered by the primary care provider? (14.006)	8	5	2	61.5%
Did the patient receive the routine-priority specialty service within 90 calendar days of the primary care provider order or Physician Request for Service? (14.007)	11	4	0	73.3%
Did the institution receive and did the primary care provider review the routine-priority specialty service consultant report within the required time frame? (14.008)	8	5	2	61.5%
Did the patient receive the subsequent follow-up to the routine-priority specialty service appointment as ordered by the primary care provider? (14.009)	9	0	6	100%
For endorsed patients received from another CDCR institution: If the patient was approved for a specialty services appointment at the sending institution, was the appointment scheduled at the receiving institution within the required time frames? (14.010)	3	16	1	15.8%
Did the institution deny the primary care provider's request for specialty services within required time frames? (14.011)	19	1	0	95.0%
Following the denial of a request for specialty services, was the patient informed of the denial within the required time frame? (14.012)	11	8	1	57.9%
				Overall percentage (MIT 14): **67.7%**

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

Table 18. Other Tests Related to Specialized 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) *	32	9	4	78.1%
Are specialty documents scanned into the patient's electronic health record within five calendar days of the encounter date? (4.002)	29	1	15	96.7%

* 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.

Recommendations

- Medical leadership should determine the root causes of challenges to the timely provision of specialty services with high-priority referrals as well as their subsequent high-priority specialty follow-up appointments and should implement remedial measures as appropriate.

- The department should consider developing and implementing measures to ensure institutions timely receive the medium- and routine-priority specialty reports, and providers timely review these reports.

- Medical leadership should identify the root cause of challenges to the timely provision of preapproved specialty appointments for transfer-in patients and should implement remedial measures as appropriate.

Administrative Operations

In this indicator, OIG compliance inspectors evaluated health care administrative processes. Our inspectors examined the timeliness of the medical grievance process and checked whether the institution followed reporting requirements for adverse or sentinel events and patient deaths. Inspectors checked whether the Emergency Medical Response Review Committee (EMRRC) met and reviewed incident packages. We investigated and determined whether the institution conducted 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. Our case review clinicians do not rate this indicator.

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

Ratings and Results Overview

Case Review Rating	Compliance Rating and Score
Not Applicable	***Inadequate* (61.2%)**

RJD's performance was mixed in this indicator. While RJD scored well in some applicable tests, it needed improvement in several areas. The Emergency Medical Response Review Committee (EMRRC) did not complete the required checklists and review the cases within required time frames. Meeting minutes from the local governing body were either missing the preinspection documents or missing approval documentation. In addition, the institution did not conduct live medical emergency response drills. Physician managers only occasionally completed annual performance appraisals in a timely manner. Lastly, the nurse educator did not ensure newly hired nurses received the required onboarding training timely. These findings are set forth in the table on the next page. Based on the overall compliance score result, the OIG rated this indicator ***inadequate***.

Compliance Testing Results

Nonscored Results

At RJD, the OIG did not have any applicable adverse sentinel events requiring root cause analysis during our inspection period (MIT 15.001).

We obtained CCHCS Mortality Case Review reporting data. In our inspection, for six patients, we found no evidence in the submitted documentation the preliminary mortality reports had been completed. These reports were overdue at the time of the OIG's inspection. The remaining four reports were beyond the inspection review period and were exempted (MIT 15.998).

Compliance Score Results

Table 19. Administrative Operations

Compliance Questions	Scored Answer			
	Yes	No	N/A	Yes %
For health care incidents requiring root cause analysis (RCA): Did the institution meet RCA reporting requirements? (15.001)	This is a nonscored test. Please refer to the discussion in this indicator.			
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	4	8	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 patients' appealed issues? (15.102)	10	0	0	100%
Did the medical staff review and submit initial patient death reports to the CCHCS Mortality Case Review Unit on time? (15.103)	8	2	0	80.0%
Did nurse managers ensure the clinical competency of nurses who administer medications? (15.104)	8	2	0	80.0%
Did physician managers complete provider clinical performance appraisals timely? (15.105)	5	9	0	35.7%
Did the providers maintain valid state medical licenses? (15.106)	19	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, and did the pharmacy maintain valid Automated Drug Delivery System (ADDS) licenses? (15.109)	2	0	0	100%
Did nurse managers ensure their newly hired nurses received the required onboarding and clinical competency training? (15.110)	0	1	0	0
Did the CCHCS Death Review Committee process death review reports timely? Effective 05/2022: Did the Headquarters Mortality Case Review process mortality 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 3 for CCHCS-provided staffing information.			
				Overall percentage (MIT 15): **61.2%**

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

Recommendations

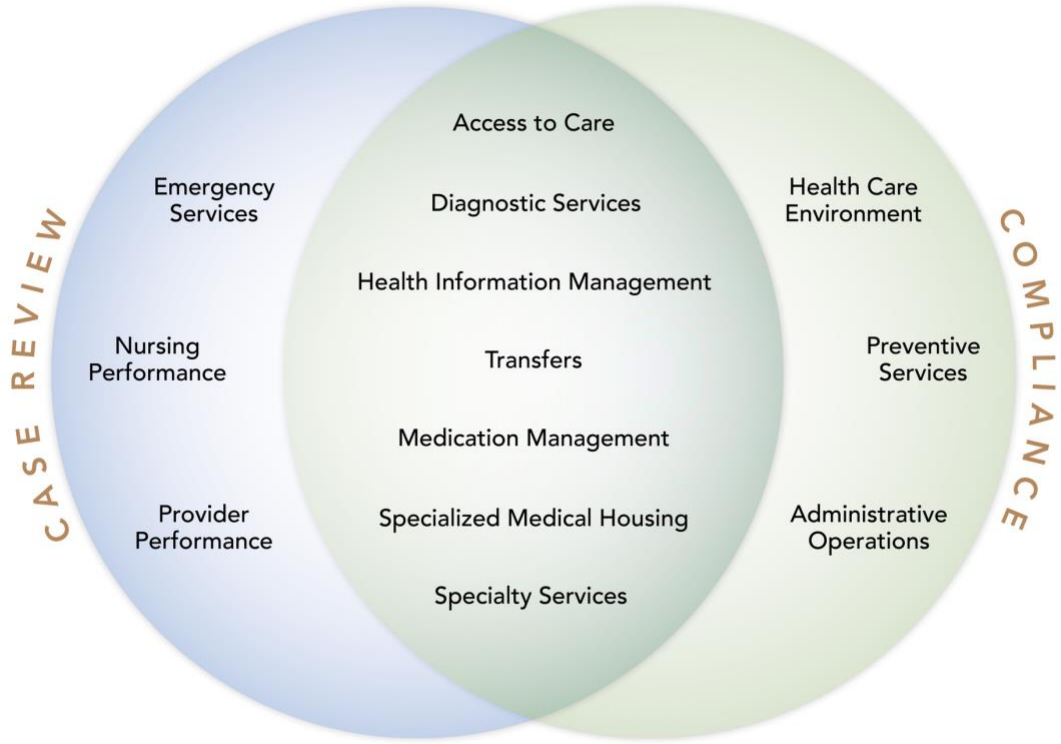
The OIG offers no recommendations for this indicator.

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 RJD



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 7 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

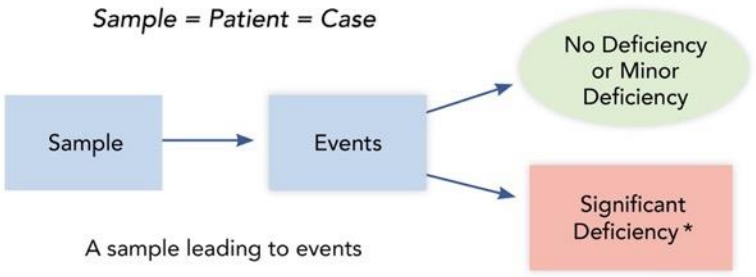
An OIG physician, a nurse consultant, or both review each case. As the clinicians review medical records, they record pertinent interactions between the patient and the health care system. We refer to these interactions as case review ***events***. Our clinicians also record medical errors, which we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

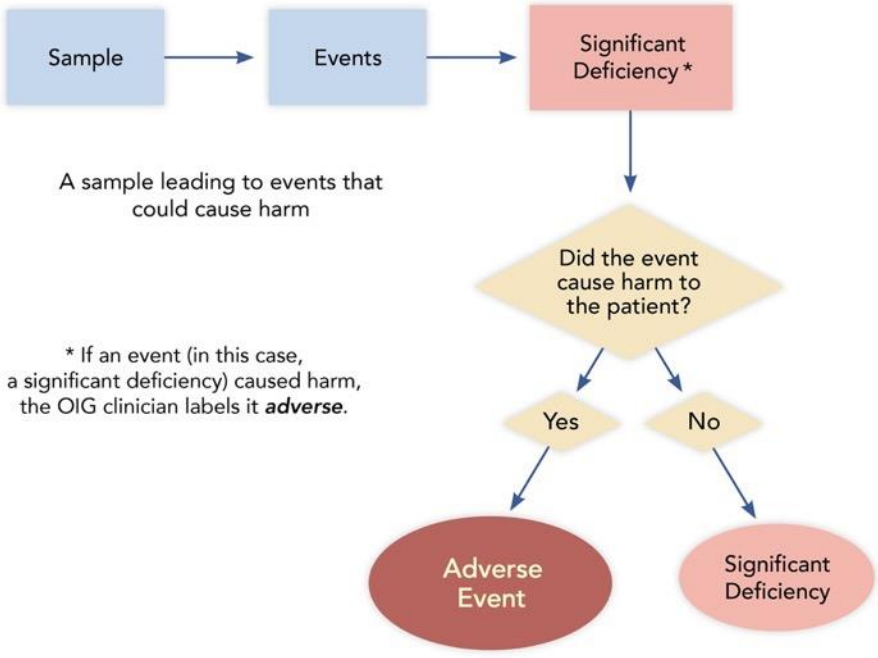
Figure A–2. Case Review Testing

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***.



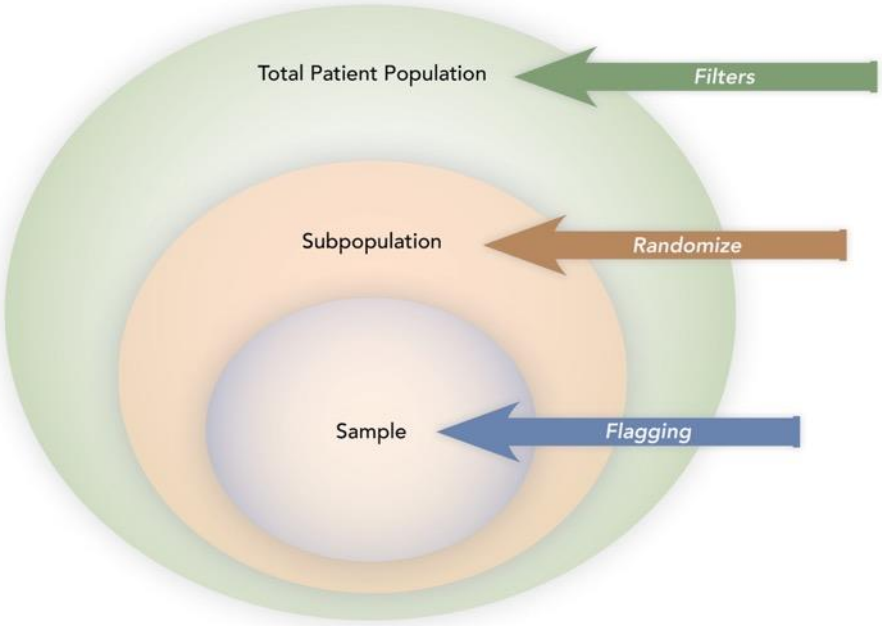
Source: The Office of the Inspector General medical inspection analysis.

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

The OIG medical inspection unit individually examines all the case review and compliance inspection findings under each specific methodology. We analyze the case review and compliance testing results for each indicator and determine separate overall indicator ratings. After considering all the findings of each of the relevant indicators, our medical inspectors individually determine the institution's overall case review and compliance ratings.

Appendix B: Case Review Data

Table B–1. RJD Case Review Sample Sets

Sample Set	Total
Anticoagulation	3
CTC/OHU	3
Death Review/Sentinel Events	3
Diabetes	3
Emergency Services – CPR	5
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
	67

Table B–2. RJD Case Review Chronic Care Diagnoses

Sample Set	Total
Anemia	8
Anticoagulation	5
Arthritis/Degenerative Joint Disease	16
Asthma	15
Cancer	5
Cardiovascular Disease	8
Chronic Kidney Disease	4
Chronic Pain	29
Cirrhosis/End Stage Liver Disease	10
Coccidioidomycosis	2
COPD	3
COVID-19	2
Deep Vein Thrombosis/Pulmonary Embolism	2
Diabetes	15
Gastroesophageal Reflux Disease	20
HIV	2
Hepatitis C	26
Hyperlipidemia	35
Hypertension	29
Mental Health	21
Seizure Disorder	3
Sleep Apnea	8
Substance Abuse	27
	295

Table B–3. RJD Case Review Events by Program

Diagnosis	Total
Diagnostic Services	273
Emergency Care	89
Hospitalization	55
Intrasystem Transfers In	6
Intrasystem Transfers Out	4
Outpatient Care	515
Specialized Medical Housing	98
Specialty Services	246
	1,286

Table B–4. RJD Case Review Sample Summary

Sample Set	Total
MD Reviews Detailed	25
MD Reviews Focused	3
RN Reviews Detailed	16
RN Reviews Focused	40
Total Reviews	84
Total Unique Cases	67
Overlapping Reviews (MD & RN)	17

Appendix C: Compliance Sampling Methodology

Richard J. Donovan Correctional Facility

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	0	Quest	• Appt. date (90 days–9 months) • Order name (CBC or CMPs only) • Randomize • Abnormal
MITs 2.010–012	Pathology	10	InterQual	• Appt. date (90 days–9 months) • Service (pathology related) • Randomize

Quality Indicator	Sample Category	No. of Samples	Data Source	Filters
Health Information Management (Medical Records)				
MIT 4.001	Health Care Services Request Forms	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 incarcerated person	• 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	11	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	6	OIG inspector on-site review	• R&R IP transfers with medication

Quality Indicator	Sample Category	No. of Samples	Data Source	Filters
Pharmacy and Medication Management				
MIT 7.001	Chronic Care Medication	25	OIG Q: 1.001	• See Access to Care • At least one condition per patient—any risk level • Randomize
MIT 7.002	New Medication Orders	25	Master Registry	• Rx count • Randomize • Ensure no duplication of IPs tested in MIT 7.001
MIT 7.003	Returns From Community Hospital	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	10	SOMS	• Date of transfer (2–8 months) • Sending institution (another departmental facility) • Randomize • NA/DOT meds
MITs 7.101–103	Medication Storage Areas	Varies by test	OIG inspector on-site review	• Identify and inspect clinical & med line areas that store medications
MITs 7.104–107	Medication Preparation and Administration Areas	Varies by test	OIG inspector on-site review	• Identify and inspect on-site clinical areas that prepare and administer medications
MITs 7.108–111	Pharmacy	2	OIG inspector on-site review	• Identify & inspect all on-site pharmacies
MIT 7.112	Medication Error Reporting	18	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	20	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	17	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 12.001–007	RC	N/A at this institution	SOMS	• Arrival date (2–8 months) • Arrived from (county jail, return from parole, etc.) • Randomize
Specialized Medical Housing				
MITs 13.001–003	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

Quality Indicator	Sample Category	No. of Samples	Data Source	Filters
Specialty Services (continued)				
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	20	InterQual	• Review date (3–9 months) • Randomize
		N/A	IUMC/MAR Meeting Minutes	• Meeting date (9 months) • Denial upheld • Randomize
Administrative Operations				
MIT 15.001	Adverse/sentinel events	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	4	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

Quality Indicator	Sample Category	No. of Samples	Data Source	Filters
Administrative Operations (continued)				
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	14	On-site provider evaluation files	• All required performance evaluation documents
MIT 15.106	Provider Licenses	19	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
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	CCHCS Mortality Case Review	10	OIG summary log: deaths	• Between 35 business days & 12 months prior • California Correctional Health Care Services mortality reviews

California Correctional Health Care Services' Response

Docusign Envelope ID: 963C9F9A-C939-4421-803B-688B991E0587

November 15, 2024

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

Dear Ms. Singh:

California Correctional Health Care Services (CCHCS) has reviewed the draft Medical Inspection Report for Richard J. Donovan Correctional Facility (RJD) conducted by the Office of the Inspector General (OIG) from December 2022 to May 2023. Thank you for preparing the report. While CCHCS disagrees with the findings for the compliance portion of the OIG Inspection for RJD, we understand that the OIG is forming a workgroup to revise the Medical Inspection Tool to reduce or eliminate subjectivity and complex, compound questions that make it difficult for CCHCS to determine areas of policy non-compliance. CCHCS looks forward to participating in such efforts and urges the OIG to begin the process as soon as possible.

If you have any questions or concerns, please contact me at (916) 691-3747.

Sincerely,

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
Jeff Macomber, Secretary, CDCR
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 IV, CCHCS
Chief Executive Officer, RJD
Heather Pool, Chief Assistant Inspector General, OIG
Doreen Pagaran, R.N., Nurse Consultant Program Review, OIG
Amanda Elhardt, Report Coordinator, OIG

CALIFORNIA CORRECTIONAL
HEALTH CARE SERVICES

P.O. Box 588500
Elk Grove, CA 95758

November 25, 2024, OIG Response to November 15, 2024, Letter Regarding RJD Report

STATE of CALIFORNIA
OIG | OFFICE of the INSPECTOR GENERAL
Independent Prison Oversight

Amarik K. Singh, Inspector General
Neil Robertson, Chief Deputy Inspector General

Regional Offices
Sacramento
Bakersfield
Rancho Cucamonga

November 25, 2024

DeAnna Gouldy
Deputy Director
Policy and Risk Management Services
California Correctional Health Care Services

Dear Ms. Gouldy:

OIG RESPONSE TO NOVEMBER 15, 2024, CCHCS LETTER REGARDING RJD REPORT

The OIG provided CCHCS the Cycle 7 draft report package for Richard J. Donovan Correctional Facility (RJD) on October 18, 2024 to review and provide feedback in accordance with our longstanding practice of resolving CCHCS's disputes with the OIG's medical inspection findings. Following the 30-day dispute period, CCHCS did not raise any concerns with any of the findings the OIG identified with respect to RJD's compliance testing. However, your formal November 15, 2024 Response Letter regarding the RJD medical inspection report states "CCHCS disagrees with the findings for the compliance portion of the OIG Inspection for RJD." Bypassing our long-standing dispute resolution process and simply asserting vague disagreement with our draft findings does not add value or transparency to the medical inspection process and does not permit the OIG an opportunity to reconsider the specific findings that CCHCS disagrees with.

Your formal response also claims the OIG's Medical Inspection Tool (MIT) contains subjective, complex, and compound questions that are difficult for CCHCS to understand. The MIT, which the OIG amends quarterly in collaboration with CCHCS and other stakeholders, is modeled after the policies CCHCS has formalized in its Health Care Department Operations Manual (HCDOM). The wording and the requirements of each MIT standard are taken directly from the different HCDOM rules and requirements that CCHCS has formulated with the expectation that its own staff can understand and implement. While the OIG's MIT critical review workgroup is in the process of considering whether to separate its compound testing questions, every compound question in the MIT was initially vetted for testing in that manner because the HCDOM itself requires each data point of these tests to be true to meet a singular HCDOM

Gavin Newsom, Governor

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requirement. If the testing measures are difficult for CCHCS to comprehend, CCHCS ought to consider HCDOM revisions to clarify the health care rules by which they intend to operate.

If CCHCS has specific concerns with any of our compliance testing findings, we encourage you to raise these issues via our longstanding dispute resolution process so we are able to consider any evidence or information we may have overlooked during the compliance testing process.

Sincerely,

Amarik Singh (Nov 25, 2024 09:47 PST)

Amarik K. Singh
Inspector General
Office of the Inspector General

cc: Diana Toche, D.D.S., Undersecretary, Health Care Services, CDCR
Clark Kelso, Federal Receiver
Directors, CCHCS
Roscoe Barrow, Chief Counsel, CCHCS Office of Legal Affairs
Renee Kanan, M.D., Deputy Director, Medical Services, CCHCS
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Robin Hart, Associate Director, Risk Management Branch, CCHCS
Regional Executives, Region III, CCHCS
George Perez, Chief Executive Officer, RJD
Heather Pool, Chief Assistant Inspector General, OIG
Medical Inspection Unit Management Team, OIG
Shaun Spillane, Chief Counsel, OIG

Cycle 7

Medical Inspection Report

for

Richard J. Donovan Correctional Facility

OFFICE *of the*
INSPECTOR GENERAL

Amarik K. Singh
Inspector General

Neil Robertson
Chief Deputy Inspector General

STATE *of* CALIFORNIA
December 2024

OIG