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OIG | OFFICE *of the* INSPECTOR GENERAL

Independent Prison Oversight

May 2025

Cycle 7

Medical Inspection Report

Folsom State Prison

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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.

[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 Folsom State Prison, the institution had 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 August 2023 to January 2024.[4]

[4] Samples are obtained per case review methodology shared with stakeholders in prior cycles. The case reviews include death reviews between January 2023 and October 2023.

Summary: Ratings and Scores

We completed the Cycle 7 inspection of Folsom State Prison (FSP) in July 2024. OIG inspectors monitored the institution's delivery of medical care that occurred between August 2023 and January 2024.

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

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

OIG case review clinicians (a team of physicians and nurse consultants) reviewed 63 cases, which contained 790 patient-related events. They performed quality control reviews; their subsequent collective deliberations ensured consistency, accuracy, and thoroughness. OIG clinicians acknowledged institutional structures that catch and resolve mistakes, which may occur throughout the delivery of care. After examining the medical records, our clinicians completed a follow-up on-site inspection in July 2024 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 350 patient records and 1,030 data points, and used the data to answer 88 policy questions. In addition, we observed FSP's processes during an on-site inspection in April 2024.

The OIG then considered the results from both case review and compliance testing, and drew overall conclusions, which we report in 12 health care indicators.[5]

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

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

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

MIT Number	Health Care Indicators	Case Review Ratings: Cycle 7	Case Review Ratings: Change Since Cycle 6*	Compliance Scores: Cycle 7	Compliance Scores: Cycle 6	Compliance Scores: Change Since Cycle 6*
		Ratings: Proficient, Adequate, Inadequate		*Scoring Ranges*: 100%–85.0%, 84.9%–75.0%, 74.9%–0		
		Case Review		Compliance		
1	Access to Care	Adequate	↑	82.2%	82.3%	=
2	Diagnostic Services	Adequate	=	53.6%	56.7%	=
3	Emergency Services	Inadequate	↓	N/A	N/A	N/A
4	Health Information Management	Inadequate	↓	89.7%	77.3%	↑
5	Health Care Environment†	N/A	N/A	52.7%	59.6%	=
6	Transfers	Adequate	=	70.7%	63.9%	=
7	Medication Management	Adequate	=	67.4%	69.6%	=
8	Prenatal and Postpartum Care	N/A	N/A	N/A	N/A	N/A
9	Preventive Services	N/A	N/A	89.0%	74.8%	↑↑
10	Nursing Performance	Adequate	=	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	N/A	N/A	N/A	N/A	N/A
14	Specialty Services	Adequate	=	69.8%	72.1%	=
15	Administrative Operations†	N/A	N/A	77.9%	67.8%	↑

* 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 did not find any adverse events at FSP during the Cycle 7 inspection.

Case Review Results

OIG case reviewers (a team of physicians and nurse consultants) assessed nine of the 12 indicators applicable to FSP. Of these nine indicators, OIG clinicians rated seven ***adequate*** and two ***inadequate***. The OIG physicians also rated the overall adequacy of care for each of the 25 detailed case reviews they conducted. Of these 25 cases, 21 were ***adequate***, and four were ***inadequate***. In the 790 events reviewed, we identified 228 deficiencies, 65 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 FSP:

- Staff offered excellent overall access to nurses and to providers for chronic care appointments as well as timely diagnostic tests.
- Providers documented their encounters appropriately and addressed most of their patients' chronic medical conditions.
- Nursing staff documented their clinical encounters well and sufficiently documented medication administration.
- Nursing staff appropriately screened patients who transferred into and out of the institution.

Our clinicians found the following weaknesses at FSP:

- Providers did not consistently include all required elements in patient notification letters.
- Providers needed improvement in managing their patients' diabetes.
- Nurses needed improvement in performing thorough assessments and in triaging same-day evaluations for urgent sick call requests.

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

- Nurses did not always apply appropriate supplemental oxygen during cases in which positive pressure was indicated during emergent events.

- Staff did not always timely obtain off-site specialty reports.

Compliance Testing Results

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

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

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

- Staff always offered influenza vaccinations and generally provided colorectal cancer screenings to all sampled patients.

- Staff performed very well administering tuberculosis (TB) medications and timely monitoring patients taking TB medications.

- Patients returning from outside community hospitals or specialty service appointments saw their primary care providers within specified time frames. Moreover, patients were referred to their providers upon arrival at the institution within required time frames.

- Nursing staff processed sick call request forms, performed face-to-face evaluations, and completed nurse-to-provider referrals within required time frames. In addition, FSP housing units contained adequate supplies of health care request forms

FSP revealed a low rate of policy compliance in the following areas:

- Providers needed improvement in timely reviewing radiology and laboratory results.

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

- Nurses did not regularly inspect emergency medical response bags.

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

- Staff frequently failed to maintain medication continuity for chronic care patients and patients discharged from the hospital. In addition, FSP maintained poor medication continuity for patients who transferred into the institution.

Institution-Specific Metrics

Located in the city of Folsom, in Sacramento County, FSP is California's second-oldest prison. The institution primarily houses medium-security general population Level II and Level III male patients. In addition, the institution houses minimum-security Level I male patients within a minimum-security facility located next to the main security perimeter. FSP offers rehabilitative programs, such as academic courses and career technical education, as well as volunteer-run rehabilitative programs. FSP operates medical clinics, where staff members handle nonurgent requests for medical services. FSP also treats patients requiring urgent or emergent care in its triage and treatment areas (TTAs). The institution has been designated by California Correctional Health Care Services (CCHCS) as an *intermediate care prison*; these institutions are predominantly located in urban areas close to tertiary care centers and specialty care providers likely to be necessary for a population with moderately high medical needs.

As of October 25, 2024, the department reported on its public tracker 67 percent of FSP's incarcerated population was fully vaccinated for COVID-19 while 63 percent of FSP's staff was fully vaccinated for COVID-19.[7]

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

On March 11, 2024, the Health Care Services Master Registry showed FSP had a total population of 2,744. A breakdown of the medical risk level of the FSP population as determined by the department is set forth in Table 2 below.[8]

Table 2. FSP Master Registry Data as of March 2024

Medical Risk Level	Number of Patients	Percentage*
High 1	99	3.6%
High 2	215	7.8%
Medium	685	25.0%
Low	1,745	63.6%
Total	**2,744**	**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 3-11-24.

[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, FSP had one vacant executive leadership position and zero vacant primary care provider, nursing supervisor, and nursing staff positions.

Table 3. FSP Health Care Staffing Resources as of March 2024

Positions	Executive Leadership*	Primary Care Providers	Nursing Supervisors	Nursing Staff †	Total
Authorized Positions	5.0	7.5	10.7	70.5	93.7
Filled by Civil Service	4.0	8.0	15.0	70.5	97.5
Vacant	1.0	0	0	0	1.0
Percentage Filled by Civil Service	80.0%	106.7%	140.2%	100.0%	104.1%
Filled by Telemedicine	0	0	0	0	0
Percentage Filled by Telemedicine	0	0	0	0	0
Filled by Registry	0	0	0	2.0	2.0
Percentage Filled by Registry	0	0	0	2.8%	2.1%
Total Filled Positions	4.0	8.0	15.0	72.5	99.5
Total Percentage Filled	**80.0%**	**106.7%**	**140.2%**	**102.8%**	**106.2**
Appointments in Last 12 Months	0	0	1.0	9.0	10.0
Redirected Staff	0	0	0	0	0
Staff on Extended Leave ‡	0	0	0	1.0	1.0
Adjusted Total: Filled Positions	**4.0**	8.0	15.0	71.5	98.5
Adjusted Total: Percentage Filled	**80.0%**	**106.7%**	**140.2%**	**101.4%**	**105.1%**

* 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 3-11-24, 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 that the public has the data it needs to compare the performance of health care plans. Because the Veterans Administration no longer publishes its individual HEDIS scores, we removed them from our comparison for Cycle 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 FSP'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. 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)—FSP'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. FSP had a 47 percent influenza immunization rate for adults 18 to 64 years old and a 56 percent influenza immunization rate for adults 65 years of age and older.[9] The pneumococcal vaccination rate was 94 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)—FSP's colorectal cancer screening was higher, indicating very good performance on this measure.

[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.

Table 4. FSP Results Compared With State HEDIS Scores

HEDIS Measure	FSP Cycle 7 Results*	California Medi-Cal†	California Kaiser NorCal Medi-Cal†	California Kaiser SoCal Medi-Cal†
HbA1c Screening	100%	–	–	–
Poor HbA1c Control (> 9.0%) ‡,§	**8%**	36%	31%	22%
HbA1c Control (< 8.0%) ‡	82%	–	–	–
Blood Pressure Control (< 140/90) ‡	92%	–	–	–
Eye Examinations	60%	–	–	–
Influenza – Adults (18–64)	47%	–	–	–
Influenza – Adults (65+)	56%	–	–	–
Pneumococcal – Adults (65+)	94%	–	–	–
Colorectal Cancer Screening	**83%**	37%	68%	70%

Notes and Sources

* Unless otherwise stated, data were collected in April 2024 by reviewing medical records from a sample of FSP'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 2024); **https://www.dhcs.ca.gov/dataandstats/reports/Documents/Medi-Cal-Managed-Care-Technical-Report-Volume-1.pdf**.

‡ For this indicator, the entire applicable FSP 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 FSP's performance, we offer the following recommendations to the department:

Diagnostic Services

- Medical leadership should determine the root cause(s) of challenges to timely collecting, receiving, and notifying providers of STAT laboratory results and should implement remedial measures as appropriate.

Emergency Services

- Nursing leadership should analyze the root cause(s) for nurses not completing thorough assessments, not appropriately providing positive pressure ventilation during CPR events, and not documenting accurate time lines. Leadership should implement remedial measures as needed.

- FSP medical and nursing leadership should develop and implement strategies to ensure the EMRRCs complete thorough clinical reviews for emergent events to properly identify care lapses and training needed.

Health Information Management

- The department should develop and implement strategies, such as potentially an electronic solution, to ensure providers create patient test result notification letters that contain all elements required by CCHCS policy when they endorse test results.

Health Care Environment

- Health care leadership should determine the root cause(s) for staff not following all required universal hand hygiene precautions and should implement necessary remedial measures.

- Health care leadership should determine the root cause(s) for staff not following equipment as well as medical supply management protocols and should implement necessary remedial measures.

- Nursing leadership should determine the root cause(s) for staff not ensuring EMRBs are regularly inventoried, stocked, or sealed appropriately and should implement necessary remedial measures.

Transfers

- Nursing leadership should identify the challenges to ensuring nurses review medical holds for patients prior to transfer to another institution and communicate pending specialty appointments for transferring patients to the receiving institutions. Nursing leadership should implement remedial measures as appropriate.

- Medical leadership should identify the challenges to ensuring previously approved specialty appointments are scheduled within required time frames and should implement remedial measures as appropriate.

- Nursing leadership should identify the root cause(s) for R&R nurses not completing the initial health screening, including answering all questions and documenting an explanation for each "yes" answer. Nursing leadership should implement remedial measures as appropriate.

Medication Management

- Medical and nursing leadership should determine the challenges to ensuring chronic care patients, hospital discharge patients, and patients newly arrived at FSP receive their medications timely and without interruption. Leadership should implement remedial measures as appropriate.

- Nursing leadership should determine the root cause(s) for nursing staff not documenting patient refusals and no-shows in the medication administration record (MAR), as described in CCHCS policy and procedures, and should implement remedial measures as appropriate.

Nursing Performance

- Nursing leadership should determine the challenges to nurses performing appropriate triage of sick calls, completing thorough face-to-face assessments, and co-consulting with providers when needed and should implement remedial measures as appropriate.

Provider Performance

- Medical leadership should identify the root cause(s) for providers' poor diabetes management and should implement remedial measures as appropriate.

Specialty Services

- Health care leadership should determine the root cause(s) of challenges to the timely provision of specialty appointments, including preapproved specialty appointments for transfer-in patients, and should implement remedial measures as appropriate.

- Health care leadership should determine the challenges to ensuring specialty reports are received, scanned, and endorsed in a timely manner and should implement remedial measures as appropriate.

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	***Adequate* (82.2%)**

Compared with Cycle 6, case review found FSP provided patients better access to care in Cycle 7. Nurses assessed patients timely for requested appointments. The institution offered good access for chronic care encounters. Providers generally evaluated patients timely after returns from hospitalizations and after emergent TTA encounters. While patients usually received initial specialty consultations timely, they did not always receive their follow-up specialty appointments timely. After reviewing all aspects of care access, the OIG rated the case review component of this indicator ***adequate***.

FSP's performance in compliance testing was mixed in this indicator. Compliance testing showed nurses performed very well in timely completing patient sick call requests as well as patient referrals to primary care providers, and excellently in completing face-to-face encounters. Staff frequently completed provider appointments for chronic care patients, newly transferred patients, patients returning after specialty service appointments, and patients returning after hospitalizations. Based on the overall compliance score result, the OIG rated the compliance component of this indicator ***adequate***.

Case Review and Compliance Testing Results

OIG clinicians reviewed 87 provider, nursing, urgent or emergent care (TTA), specialty, and hospital events that required the institution to generate appointments. We identified seven deficiencies relating to **Access to Care**, all of which were significant.[11]

Access to Care Providers

FSP performed well in access to provider appointments. Compliance testing showed satisfactory access to chronic care follow-up appointments (MIT 1.001, 84.0%) and nurse-to-provider referral appointments (MIT 1.005, 86.4%). OIG clinicians did not identify a significant pattern of deficiencies in the scheduling and completion of provider appointments.

[11] Deficiencies occurred in cases 1, 2, 14, and 23.

Access to Clinic Nurses

FSP performed well in access to nurse sick calls and provider-to-nurse referrals. Compliance testing showed nurses usually triaged sick call requests the same day they received them (MIT 1.003, 91.4%) and almost always performed face-to-face appointments timely (MIT 1.004, 94.3%). OIG clinicians reviewed 28 nursing sick call requests and identified two deficiencies related to clinic nurse access. The following is an example:

- In case 1, the patient submitted a sick call for vision loss, and the triage nurse ordered an appointment. When the patient transferred to the hospital for another medical condition, FSP staff did not reconcile the nurse appointment upon to the patient's return to FSP. Subsequently, the patient was not assessed by a nurse for his visual symptoms.

Access to Specialty Services

FSP performed variably with access to specialty services. Compliance testing showed good to very good timely completion of high-priority (MIT 14.001, 80.0%), medium-priority (MIT 14.004, 86.7%), and routine-priority (MIT 14.007, 86.7%) specialty appointments. In addition, staff performed satisfactorily with timely follow up to routine-priority specialty services (MIT 14.009, 83.3%) and fairly with timely follow up to medium-priority specialty services (MIT 14.006, 75.0%). However, performance was insufficient in timely follow-up appointments for high-priority specialty services(MIT 14.003, 57.1%). Case review found most specialty appointments occurred within requested time frames. However, we identified three deficiencies, all of which were significant.[12] The following is an example:

- In case 1, the provider requested an initial high priority appointment with a kidney specialist. This appointment occurred eight days late.

Follow Up After Specialty Services

Compliance testing revealed very good access to provider appointments after specialty services (MIT 1.008, 88.9%). Case review identified one deficiency related to provider follow-up after specialty services as follows:

- In case 14, the provider evaluated the patient for follow-up after an ophthalmologist consultation three days late.

Follow Up After Hospitalization

FSP offered excellent access to provider follow-up appointments for patients who were discharged from a community hospital (MIT 1.007, 90.9%). Case review did not identify any deficiencies in provider follow-up access after hospitalization.

[12] Deficiencies occurred in cases 1, 2, and 23.

Follow Up After Urgent or Emergent Care (TTA)

FSP providers almost always evaluated their patients following a triage and treatment area (TTA) event as medically indicated. OIG clinicians reviewed 26 TTA events and identified one deficiency in provider follow-up appointments:

- In case 11, the provider evaluated the patient at a follow-up appointment after a TTA encounter two days late.

Follow Up After Transferring Into FSP

Compliance testing showed very good access with intake appointments for newly arrived patients (MIT 1.002, 87.0%). Case review did not find any deficiencies in this category.

Clinician On-Site Inspection

FSP has six main clinics: buildings 1, 2, 3, 4, 5, and minimum. Each clinic had two on-site providers. All clinics were staffed with registered nurses (RNs), licensed vocational nurses (LVNs), and medical assistants (MAs). In addition to the providers having patient appointments, each non-provider staff member also conducted their own patient appointments. Office technicians reported the providers had no backlog during the period of review and no current backlog of appointments.

OIG clinicians attended morning huddles in the clinic, which were well attended by the patient care team and staff. The morning huddles lasted about 20 minutes and included pertinent patient information, including TTA encounters, return from off-site specialty services, patients with expiring medications, new patients to the care team, and discharges from the hospital. OIG clinicians met with the scheduling supervisor, who reported no staffing vacancies. The scheduling supervisor also reported appointments were infrequently rescheduled due to modifications in yard programs. Staff usually rescheduled these appointments within compliance dates.

Compliance On-Site Inspection

Only one 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, 16.7%). In five housing units, custody officers did not have a system in place for restocking the forms. The custody officers reported reliance on medical staff to replenish the forms in the housing units.

Compliance Score Results

Table 5. Access to Care

	Scored Answer			
Compliance Questions	**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)	21	4	0	84.0%
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)	20	3	2	87.0%
Clinical appointments: Did a registered nurse review the patient's request for service the same day it was received? (1.003)	32	3	0	91.4%
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)	33	2	0	94.3%
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)	19	3	13	86.4%
Sick call follow-up appointments: If the primary care provider ordered a follow-up sick call appointment, did it take place within the time frame specified? (1.006)	3	0	32	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)	10	1	0	90.9%
Specialty service follow-up appointments: Did the clinician follow-up visits occur within required time frames? (1.008) *	40	5	0	88.9%
Clinical appointments: Do patients have a standardized process to obtain and submit health care services request forms? (1.101)	1	5	0	16.7%
				Overall percentage (MIT 1): **82.2%**

* 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)	N/A	N/A	N/A	N/A
Did the patient receive the high-priority specialty service within 14 calendar days of the primary care provider order or the Physician Request for Service? (14.001)	12	3	0	80.0%
Did the patient receive the subsequent follow-up to the high-priority specialty service appointment as ordered by the primary care provider? (14.003)	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)	13	2	0	86.7%
Did the patient receive the subsequent follow-up to the medium-priority specialty service appointment as ordered by the primary care provider? (14.006)	3	1	11	75.0%
Did the patient receive the routine-priority specialty service within 90 calendar days of the primary care provider order or Physician Request for Service? (14.007)	13	2	0	86.7%
Did the patient receive the subsequent follow-up to the routine-priority specialty service appointment as ordered by the primary care provider? (14.009)	5	1	9	83.3%

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

Recommendations

The OIG offers no recommendations for this indicator.

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* (53.6%)**

Case review found FSP's performance was satisfactory in this indicator. Staff performed excellently in timely completing laboratory and radiology tests. However, providers sometimes did not endorse laboratory test results within required time frames and needed improvement in communicating with complete test results letters to patients. After reviewing all aspects, the OIG rated the case review component of this indicator ***adequate***.

In compliance testing, FSP scored low overall for this indicator. Staff performed excellently in completing radiology services and satisfactorily in completing routine laboratory services and retrieving pathology reports. However, staff only intermittently completed STAT laboratory tests within the required time frames, and providers struggled to endorse radiology and laboratory studies in a timely manner. In addition, providers rarely generated complete patient test results notification letters with all required elements. 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 149 diagnostic-related events and found 68 deficiencies, nine of which were significant.[13] Of the 68 deficiencies, all related to health information management, and none related to the noncompletion or delayed completion of ordered tests. We identified 59 deficiencies related to patient notification letters missing required elements or not being sent at all, and nine deficiencies related to delayed endorsement or lack of endorsement of laboratory test results. Although OIG clinicians identified a high number of deficiencies, those deficiencies did not significantly increase the risk of harm to patients.

Test Completion

FSP had a mixed performance in the timely completion of tests. Compliance testing showed perfect performance in completing radiology services (MIT 2.001, 100%) and satisfactory completion of laboratory tests (MIT 2.004, 80.0%) within required time frames. However, compliance testing revealed STAT laboratory service completion needed improvement (MIT 2.007, 50.0%). Case review did not find any deficiencies related to test completion.

[13] Deficiencies occurred in cases 1, 3, 9, 11–15, 17–19, 21–26, 28, and 29. A significant deficiency occurred in case 29.

Health Information Management

FSP performed variably in managing the results of diagnostic tests. Compliance testing showed providers sometimes endorsed laboratory results (MIT 2.005, 70.0%) and radiology results (MIT 2.002, 70.0%) timely. Case review identified nine significant deficiencies related to late endorsement of test results.[14] The following are examples:

- In case 18, the provider endorsed a blood chemistry panel 23 days late.
- In case 29, no providers endorsed the result of a urine microalbumin test.[15]

Staff performed satisfactorily in retrieving pathology reports (MIT 2.010, 80.0%), and providers performed very well in reviewing pathology reports (MIT 2.011, 90.0%). However, compliance testing revealed poor provider acknowledgement and nursing notification of STAT laboratory results (MIT 2.008, 33.3%) as well as intermittent provider communication of pathology results with complete patient notification letters (MIT 2.009, 50.0%). OIG clinicians did not identify any deficiencies related to STAT or pathology test results retrieval or provider review.

Compliance testing revealed FSP performed poorly with provider communication to patients with complete patient test results notification letters. Providers sporadically communicated results from radiology tests (MIT 2.003, 20.0%). In addition, providers never communicated results from laboratory studies (MIT 2.006, zero) or pathology (MIT 2.012, zero) within required time frames. Case review found 59 deficiencies related to incomplete notification letters or providers not sending letters to the patient.[16]

We discuss these further in the **Health Information Management** indicator.

Clinician On-Site Inspection

OIG clinicians interviewed the senior laboratory assistant and the correctional health services administrator (CHSA). They reported the institution had no staff shortages during the review period.

FSP offered routine x-rays, CT, MRI, and ultrasound on-site.[17] The CHSA stated FSP had no backlog of diagnostic studies. Providers did not report any problems with obtaining laboratory or imaging studies. They did not encounter any issues when ordering STAT laboratory tests or receiving results notifications.

[14] Significant deficiencies occurred in cases 3, 17, 18, 25, and 29.

[15] A urine microalbumin test measures the amount of microalbumin in the urine. Microalbumin is a protein and elevated levels of this protein in the urine indicates signs of kidney disease.

[16] Deficiencies in patient notification letters occurred in cases 1, 3, 9, 11–15, 17–19, 21–26, 28, and 29. None of these deficiencies were significant.

[17] A CT is a computed, or computerized, tomography scan while an MRI is a magnetic resonance imaging scan. Both create detailed images of the organs and tissues to detect diseases and abnormalities.

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)	10	0	0	100%
Radiology: Did the ordering health care provider review and endorse the radiology report within specified time frames? (2.002)	7	3	0	70.0%
Radiology: Did the ordering health care provider communicate the results of the radiology study to the patient within specified time frames? (2.003)	2	8	0	20.0%
Laboratory: Was the laboratory service provided within the time frame specified in the health care provider's order? (2.004)	8	2	0	80.0%
Laboratory: Did the health care provider review and endorse the laboratory report within specified time frames? (2.005)	7	3	0	70.0%
Laboratory: Did the health care provider communicate the results of the laboratory test to the patient within specified time frames? (2.006)	0	10	0	0
Laboratory: Did the institution collect the STAT laboratory test and receive the results within the required time frames? (2.007)	3	3	0	50.0%
Laboratory: Did the provider acknowledge the STAT results, OR did nursing staff notify the provider within the required time frames? (2.008)	2	4	0	33.3%
Laboratory: Did the health care provider endorse the STAT laboratory results within the required time frames? (2.009)	3	3	0	50.0%
Pathology: Did the institution receive the final pathology report within the required time frames? (2.010)	8	2	0	80.0%
Pathology: Did the health care provider review and endorse the pathology report within specified time frames? (2.011)	9	1	0	90.0%
Pathology: Did the health care provider communicate the results of the pathology study to the patient within specified time frames? (2.012)	0	10	0	0
				Overall percentage (MIT 2): **53.6%**

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

Recommendations

- Medical leadership should determine the root cause(s) of challenges to timely collecting, receiving, and notifying providers of STAT laboratory results and should 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 solely through case review.

Ratings and Results Overview

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

FSP's performance in emergency services worsened in this cycle compared with Cycle 6. Our clinicians reviewed a similar number of events in this cycle; however, we identified more deficiencies as compared with Cycle 6. Providers performed good assessments and delivered satisfactory emergency care. Nurses responded to medical emergencies promptly, initiated nursing protocols when appropriate, and timely notified providers. However, nurses performed incomplete assessments and did not always provide appropriate CPR interventions. Further, we found medical and nursing leadership clinical reviews of emergent events did not properly identify the care lapses we identified. Considering all factors, the OIG rated this indicator ***inadequate.***

Case Review Results

We reviewed 25 urgent or emergent events and identified 22 emergency care deficiencies, 10 of which were significant.[18]

Emergency Medical Response

Case review found FSP's medical response for urgent or emergent patients was poor. FSP custody and health care staff responded promptly to emergencies throughout the institution; however, we found areas needing improvement. Our clinicians identified delays in activating emergency medical services (EMS). The following are examples:

- In case 1, the provider evaluated the patient in the clinic for abnormal laboratory results. The provider then called the TTA and ordered the nursing staff to urgently transfer the patient to a higher level of care to rule out acute kidney failure. The patient arrived in the TTA, and nursing staff documented custody staff was aware of the requested medical transport. However, no staff requested EMS until over one hour later.

[18] Deficiencies occurred in cases 1–5, 7, 8, 10, 11, 16, 17, 23, and 24. Significant deficiencies occurred in cases 1, 3–5, 7, 10, 16, and 23.

- In case 3, staff found the patient with an altered level of consciousness and a critically low oxygen saturation rate. The nurse contacted the provider and received orders to transfer the patient to a higher level of care for further evaluation and treatment. However, staff did not notify EMS until nine minutes later.

Our clinicians reviewed six cases related to CPR events and identified a trend of improper nursing interventions. We identified four deficiencies, three of which were significant.[19] The following cases are examples:

- In case 4, nursing staff responded to a medical emergency for the unresponsive patient. The RN inappropriately administered oxygen via a nonrebreather mask instead of applying positive pressure ventilation to the patient with decreased respirations and an abnormally low oxygen saturation rate.[20]

- In case 5, staff found the unresponsive and nonbreathing patient with a suspected drug overdose. Upon arrival to the patient, nursing staff initiated CPR, applied the AED, and incorrectly administered oxygen via a nonrebreather mask instead of applying positive pressure ventilation to the patient with no spontaneous breathing and no pulse.[21]

- In case 10, nursing staff responded to the unresponsive and nonbreathing patient. Two licensed vocational nurses (LVNs) responded to the scene, and the TTA RN arrived shortly thereafter. Nursing staff did not document an assessment of the carotid pulse and delayed applying the AED. The nurses did not apply the AED until eight minutes later.

Provider Performance

Providers generally performed excellently in urgent and emergent situations, and in after-hours care. They made accurate diagnoses and documented thoroughly.

Nursing Performance

Overall, nurses generally provided good nursing assessments and interventions. However, our clinicians identified a trend in incomplete assessments and, at times, nurses did not intervene appropriately. The following are examples:

- In case 3, the TTA RN responded to the patient with an altered level of consciousness, a critically low oxygen saturation rate, and an irregular pulse. The nurse did not perform an initial neurological assessment or reassess the patient's neurological status while the patient was observed in the TTA. In addition, the nurse did not assess the patient's onset of symptoms and did not document the time oxygen was initiated.

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[19] CPR events occurred in cases 4–7, 9, and 10. Oxygen deficiencies occurred in cases 4, 5, and 7. Significant deficiencies occurred in cases 3, 4, 5, and 7.

[20] Positive pressure ventilation is the standard for nonbreathing patients because it provides greater benefit than simple oxygen.

[21] Automated External Defibrillator (AED) is a portable device that can help restore a normal heart rhythm in a patient with cardiac arrest.

- In case 4, the TTA RN responded to the patient, who was found unresponsive with a thready pulse, decreased respirations, and a low oxygen saturation rate. Nursing staff administered two doses of Narcan and initiated CPR. However, nursing staff did not reassess the patient's pulse rate or quality of the pulse until the patient arrived in the TTA four minutes later.

- In case 16, the TTA nurse assessed the patient for a foreign object in the right ear canal. The nurse removed the ear plug, performed an ear lavage, documented debris came from the right ear canal after lavage, and placed an order for follow-up with the provider. However, removing a foreign object from the ear warrants provider notification or evaluation. The nurse did not consult with the provider to discuss the treatment plan.

- In case 23, the TTA RN received a laboratory result showing the patient had a critically low blood count and electronically messaged the provider with the result. However, the TTA RN did not immediately locate or assess the patient. Nineteen minutes later, the patient walked into the clinic with symptoms of fatigue and dizziness.

Nursing Documentation

Nurses sufficiently documented care in urgent and emergent events. However, our clinicians identified patterns of timeline discrepancies and poor documentation of initial AED readings in CPR cases.

Emergency Medical Response Review Committee

Compliance testing found the EMRRC met monthly and reviewed emergency response care within required time frames; however, the EMRRC event checklists were sometimes incomplete (MIT 15.003, 57.1%). Case review also found FSP often performed clinical reviews timely; however, FSP frequently did not identify training issues with emergency medical responses during the clinical reviews or during the EMRRC meetings.[22]

Clinician On-Site Inspection

At the on-site inspection, OIG clinicians toured the TTA and spoke with staff and nursing leadership. The TTA contained four examination rooms. Staff consisted of two RNs on all shifts. The TTA had an assigned on-site provider during business hours four days a week, who was accessible via telemedicine one day a week. An on-call provider was available daily after-hours.

We discussed the case deficiencies related to the oxygen administration during emergency care. Our clinicians spoke with the nurse instructor and nursing leadership, who reported all nursing staff receive oxygen competency training every two years.

At the time of our inspection, FSP nursing leadership reported they had identified training issues with the timeliness of 9-1-1 activation and with AED placement on patients who had an internal pacemaker. Nurses opined the recent changes to the emergency medical response program had raised the level of nursing care they provided during emergency responses to a

[22] Nursing leadership and EMRRC did not identify the deficiencies OIG clinicians identified in cases 2–5, 7, 8, and 23.

community standard level. The FSP leadership reported an increase in the number of overdose patients. They discussed a day in which FSP had 14 overdoses in a 24-hour period and noted only one death occurred, meaning they had successfully revived and stabilized 13 patients. They attributed this success to their fast and professional response. Nurses reported nursing leadership was very supportive and that they worked well with custody.

Recommendations

- Nursing leadership should analyze the root cause(s) for nurses not completing thorough assessments, not appropriately providing positive pressure ventilation during CPR events, and not documenting accurate time lines. Leadership should implement remedial measures as needed.

- FSP medical and nursing leadership should develop and implement strategies to ensure the EMRRCs complete thorough clinical reviews for emergent events to properly identify care lapses and training needed.

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
Inadequate	***Proficient* (89.7%)**

Case review found FSP performed worse in Cycle 7 when compared with Cycle 6. Although FSP staff managed hospital discharge reports and scanned records well, we found providers did not consistently generate complete patient notification letters with all required components per CCHCS policy. In addition, OIG clinicians identified a minor pattern of providers not timely endorsing laboratory test results. Lastly, provider endorsement of specialty reports was problematic. After careful consideration, the OIG rated the case review component of this indicator ***inadequate***.

Compliance testing showed FSP performed very well in health information management. Staff excellently scanned patient sick call requests and reviewed hospitalization discharge reports within required time frames. Conversely, staff needed improvement in labeling and scanning 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 152 events and identified 97 deficiencies related to health information management, 13 of which were significant.[23]

Hospital Discharge Reports

FSP staff performed very well in retrieving hospital discharge records, scanning them into the electronic health records system (EHRS), and reviewing them within required time frames (MIT 4.003, 90.9%). OIG clinicians reviewed 11 off-site emergency department and hospital encounters and did not identify any deficiencies with retrieving and endorsing the reports related to these encounters.

[23] Deficiencies occurred in cases 1, 3, 9, 11–29, and 45. Significant deficiencies occurred in cases 3, 14, 17, 18, 22, 25, and 29.

Specialty Reports

FSP had mixed performance in managing specialty reports. Compliance testing showed very good timely retrieval of specialty reports (MIT 4.002, 86.7%). Providers also sufficiently endorsed high-priority specialty reports (MIT 14.002, 80.0%) within required time frames. However, they needed improvement in timely endorsing medium-priority (MIT 14.005, 66.7%) and routine-priority (MIT 14.008, 66.7%) specialty reports.

OIG clinicians reviewed 63 specialty reports and identified 24 deficiencies, four of which were significant.[24] The significant deficiencies included records that staff either did not send to the provider for endorsement or did not timely scan into the health record. The following are examples:

- In case 14, staff scanned an ophthalmology consultation report into the EHRS. However, they did not forward the report to the provider for endorsement.

We also discuss these findings in the **Specialty Services** indicator.

Diagnostic Reports

FSP also had mixed performance with diagnostic reports management. Providers usually reviewed pathology reports on time (MIT 2.011, 90.0%) but never communicated pathology results to patients with complete notification letters (MIT 2.012, zero). OIG clinicians identified 59 deficiencies related to incomplete or missing patient results notification letters, which accounted for most diagnostic health information management deficiencies.[25] OIG clinicians also identified a minor pattern of deficiencies related to late provider endorsement of diagnostic test results.[26] Please refer to the **Diagnostic Services** indicator for further detailed discussion about diagnostics.

Urgent and Emergent Records

OIG clinicians reviewed 22 emergency care events. FSP nurses and providers recorded these events well. Providers sufficiently documented their emergency care, including off-site telephone encounters. We did not identify any significant deficiencies or problematic patterns. The **Emergency Services** indicator provides additional details.

Scanning Performance

FSP performed variably with the scanning process. Compliance testing revealed staff only sometimes properly labeled, scanned, and filed documents (MIT 4.004, 70.8%). However, OIG clinicians did not identify any deficiencies.

Clinician On-Site Inspection

We discussed health information management with the health records technician (HRT) supervisor. The HRT supervisor reported having an internal tracking system to ensure staff

[24] Specialty health information management deficiencies occurred in cases 1, 11, 14, 15, 18, 20, 22, 27, and 29. Significant deficiencies occurred in cases 14, 18, 22, and 29.

[25] Deficiencies occurred in cases 1, 3, 9, 11–15, 17–19, 21–26, 28, and 29. No significant deficiencies occurred.

[26] Deficiencies occurred in cases 3, 17, 18, 25, and 29.

received and scanned reports. Staff tracked specialty reports through coordination with the utilization management (UM) nurse, who would promptly scan specialty documents upon receipt.

We discussed the tracking process for provider endorsement of reports. The HRT supervisor stated staff had completed an audit, similar to the one the OIG completes, to ensure providers review and endorse reports. The supervisor mentioned having no audit to assess whether providers completed patient notification letters to include all components as required by CCHCS policy.

The HRT supervisor reported adequate department staffing without any vacancies.

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)	26	4	15	86.7%
Are community hospital discharge documents scanned into the patient's electronic health record within three calendar days of hospital discharge? (4.003)	10	1	0	90.9%
During the inspection, were medical records properly scanned, labeled, and included in the correct patients' files? (4.004)	17	7	0	70.8%
For patients discharged from a community hospital: Did the preliminary or final hospital discharge report include key elements and did a provider review the report within five calendar days of discharge? (4.005)	11	0	0	100%
				Overall percentage (MIT 4): **89.7%**

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)	7	3	0	70.0%
Laboratory: Did the health care provider review and endorse the laboratory report within specified time frames? (2.005)	7	3	0	70.0%
Laboratory: Did the provider acknowledge the STAT results, OR did nursing staff notify the provider within the required time frame? (2.008)	2	4	0	33.3%
Pathology: Did the institution receive the final pathology report within the required time frames? (2.010)	8	2	0	80.0%
Pathology: Did the health care provider review and endorse the pathology report within specified time frames? (2.011)	9	1	0	90.0%
Pathology: Did the health care provider communicate the results of the pathology study to the patient within specified time frames? (2.012)	0	10	0	0
Did the institution receive and did the primary care provider review the high-priority specialty service consultant report within the required time frame? (14.002)	12	3	0	80.0%
Did the institution receive and did the primary care provider review the medium-priority specialty service consultant report within the required time frame? (14.005)	10	5	0	66.7%
Did the institution receive and did the primary care provider review the routine-priority specialty service consultant report within the required time frame? (14.008)	10	5	0	66.7%

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

Recommendations

- The department should develop and implement strategies, such as potentially an electronic solution, to ensure providers create patient test result notification letters that contain all elements required by CCHCS policy when they endorse test results.

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 quality rating.

Ratings and Results Overview

Case Review Rating	Compliance Rating and Score
Not Applicable	***Inadequate* (52.7%)**

Overall, FSP's performance in health care environment needed improvement. Medical supply storage areas contained unidentified or inaccurately labeled medical supplies. In addition, we found disorganized medical supplies. Several clinics did not meet the requirements for essential core medical equipment and supplies. Staff did not regularly sanitize or wash their hands during patient encounters. Emergency medical response bags (EMRBs) had not been properly inventoried, contained expired medical supplies and compromised medical supply packaging, or were missing required medical equipment. 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 FSP 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.

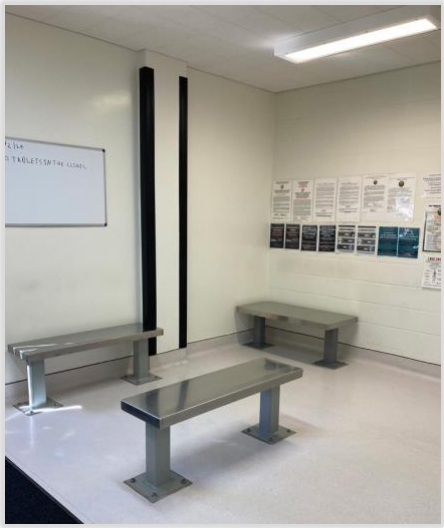


Photo 1. Indoor patient waiting area (photographed on 4-2-24).

Clinic Environment

Seven of nine clinic environments were sufficiently conducive for medical care. They provided reasonable auditory privacy, appropriate waiting areas, wheelchair accessibility, and nonexamination room workspace (MIT 5.109, 77.8%). In one clinic, the vital sign check station was within close proximity to the patient waiting area,

which hindered auditory privacy. The remaining clinic was not wheelchair accessible.

Of the nine clinics we observed, seven contained appropriate space, configuration, supplies, and equipment to allow their clinicians to perform proper clinical examinations (MIT 5.110, 77.8%). In one clinic, the gurney had a worn vinyl cover. The remaining clinic's examination room lacked visual privacy for conducting clinical examinations. We also observed clinical staff step out of the examination room while leaving the computer screen and the examination room door open, which left confidential medical records unsecured.

Clinic Supplies

Only one of the nine clinics followed adequate medical supply storage and management protocols (MIT 5.107, 11.1%). We found one or more of the following deficiencies in eight clinics: expired medical supplies (see Photo 2, below); unorganized, unidentified, or inaccurately labeled medical supplies; cleaning materials stored with medical supplies; long-term storage of staff members' food in the medical supply storage room (see Photo 3, below, and Photo 4, next page); and compromised sterile medical supply packaging.

Photo 3. Expired medical supply dated April 2022 (photographed on 4-4-24).

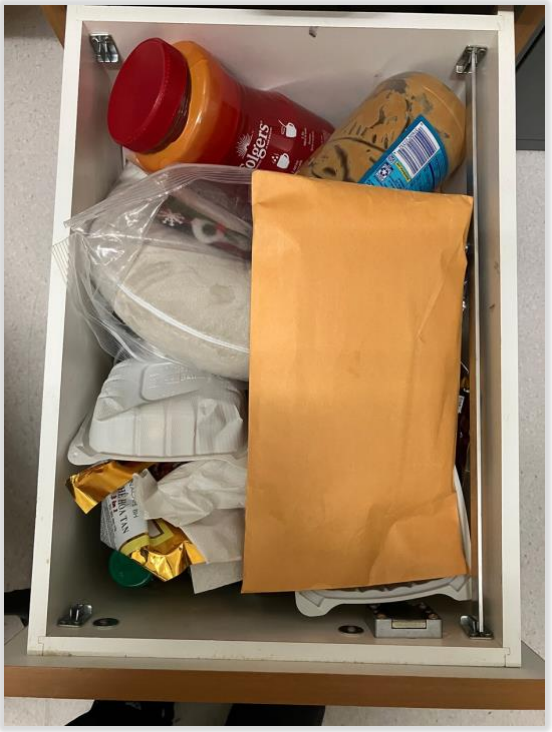


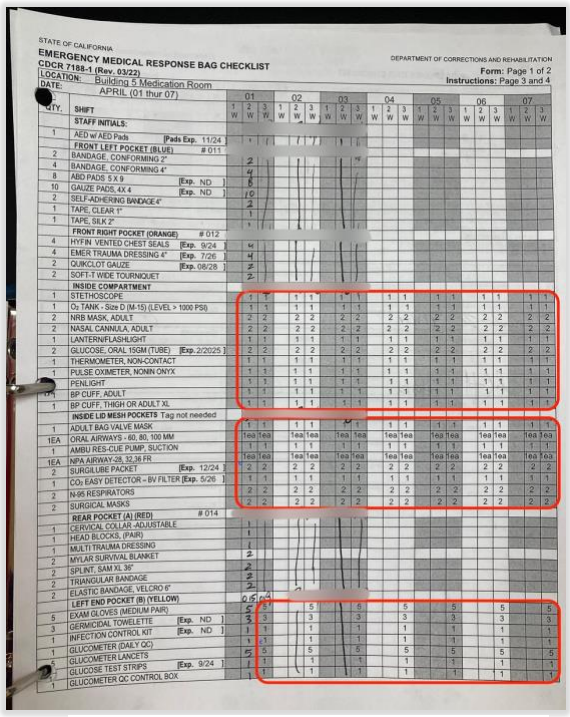
Photo 2. Long-term storage of staff members' food in the medical supply storage room (photographed on 4-4-24).

Photo 4. Long-term storage of staff members' food in the medical supply storage room (photographed on 4-4-24).

Four of the nine clinics met requirements for essential core medical equipment and supplies (MIT 5.108, 44.4%). The remaining five clinics lacked medical supplies or contained improperly calibrated equipment. The missing items included disposable paper on examination tables, an oto-ophthalmoscope, and an otoscope tip. The staff had not properly calibrated an oto-ophthalmoscope and weight scale. In addition, staff did not complete AED performance test log documentations within the last 30 days, and the clinic daily glucometer quality control logs were either inaccurate or incomplete.

We examined EMRBs to determine whether they contained all essential items. We checked whether staff inspected the bags daily and inventoried them monthly. None of the seven applicable EMRBs passed our test (MIT 5.111, zero). We found one or more of the following deficiencies with all seven EMRBs: staff failed to ensure the EMRB's compartments were sealed and intact; staff had not inventoried the EMRBs when the seal tags were replaced; EMRBs contained compromised or expired supplies; EMRBs were missing items; and several EMRB glucometer quality control logs were either inaccurate or incomplete.

In addition to the above findings, our compliance inspectors observed the nurses in the Building 5 medication distribution room used a prefilled EMRB log at the time of our inspection (see Photo 5).



STATE OF CALIFORNIA
EMERGENCY MEDICAL RESPONSE BAG CHECKLIST
CDCR 7188-1 (Rev. 03/22)
DEPARTMENT OF CORRECTIONS AND REHABILITATION
Form: Page 1 of 2
Instructions: Page 3 and 4
LOCATION: Building 5 Medication Room
DATE: APRIL (01 thur 07)

Photo 5. Staff prefilled the EMRB log (photographed on 4-4-24).

Medical Supply Management

None of the medical supply storage areas located outside the medical clinics stored medical supplies adequately (MIT 5.106, zero). The medical warehouse manager did not maintain a temperature log for medical supplies with manufacturer temperature guidelines stored in the warehouse. We found several bottles of liquid solutions had accumulated condensation (see Photo 6).

Photo 6. Condensation accumulated in several bottles of liquid solutions (photographed on 4-3-24).

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

Infection Control and Sanitation

Staff appropriately cleaned, sterilized, and disinfected six of nine clinics (MIT 5.101, 66.7%). In two clinics, staff did not maintain cleaning logs. In the remaining clinic, staff did not empty the biohazard waste after each clinic day.

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

We found operational sinks and hand hygiene supplies in the examination rooms in eight of nine clinics (MIT 5.103, 88.9%). The patient restroom in one clinic lacked antiseptic soap and disposable hand towels.

We observed patient encounters in seven clinics. In six clinics, clinicians rarely washed their hands before or after examining their patients, during each subsequent regloving, or before performing blood draws (MIT 5.104, 12.5%).

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

Physical Infrastructure

At the time of our medical inspection, the institution's administrative team reported no ongoing health care facility improvement program construction projects. The institution's health care management and the plant operations manager reported all clinical area infrastructures were in good working order (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)	6	3	0	66.7%
Infection control: Do clinical health care areas ensure that reusable invasive and noninvasive medical equipment is properly sterilized or disinfected as warranted? (5.102)	8	0	1	100%
Infection control: Do clinical health care areas contain operable sinks and sufficient quantities of hygiene supplies? (5.103)	8	1	0	88.9%
Infection control: Does clinical health care staff adhere to universal hand hygiene precautions? (5.104)	1	7	1	12.5%
Infection control: Do clinical health care areas control exposure to blood-borne pathogens and contaminated waste? (5.105)	9	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)	1	8	0	11.1%
Clinical areas: Do clinic common areas and exam rooms have essential core medical equipment and supplies? (5.108)	4	5	0	44.4%
Clinical areas: Are the environments in the common clinic areas conducive to providing medical services? (5.109)	7	2	0	77.8%
Clinical areas: Are the environments in the clinic exam rooms conducive to providing medical services? (5.110)	7	2	0	77.8%
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)	0	7	2	0
Does the institution's health care management believe that all clinical areas have physical plant infrastructures that are sufficient to provide adequate health care services? (5.999)	This is a nonscored test. Please see the indicator for discussion of this test.			
				Overall percentage (MIT 5): **52.7%**

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

Recommendations

- Health care leadership should determine the root cause(s) for staff not following all required universal hand hygiene precautions and should implement necessary remedial measures.
- Health care leadership should determine the root cause(s) for staff not following equipment as well as medical supply management protocols and should implement necessary remedial measures.
- Nursing leadership should determine the root cause(s) for staff not ensuring EMRBs are regularly inventoried, stocked, or sealed appropriately and should implement 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* (70.7%)**

Case review found FSP performed sufficiently in the transfer process. Compared with Cycle 6, providers improved in completing timely follow-up appointments after hospitalizations or emergency room encounters. FSP nurses improved in hospital return assessments. However, nurses continued to struggle with thoroughly documenting pertinent health information on the initial health screening forms for newly arrived patients. In addition, for patients who transferred out of the institution, nurses did not always document or communicate pending specialty appointments or referrals to the receiving institution. After reviewing all aspects, the OIG rated the case review component of this indicator ***adequate***.

Compliance testing showed mixed results with the transfer process. The institution showed excellent performance in ensuring transfer packets for departing patients included required documents and medications. However, FSP performed poorly in completing initial health screening forms and in ensuring medication continuity for newly transferred patients. 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 23 events in 15 cases in which patients transferred into or out of the institution or returned from an off-site hospital or emergency room. We identified 13 deficiencies, two of which were significant.[27]

[27] Deficiencies occurred in cases 1, 3, 21, 22, and 30–35. Significant deficiencies occurred in cases 22 and 31.

Transfers In

FSP's performance in the transfer-in process varied. Compliance testing showed nurses always completed the assessment and disposition section on the initial health screening form (MIT 6.002, 100%). However, nurses did not thoroughly complete screenings (MIT 6.001, 16.0%). The reasons for the low score included instances of nursing staff: completing the initial health screening after the patient moved to the housing unit; failing to document the patient's weight; and not documenting an explanation for "yes" answers on the initial health screening form. Case review identified three deficiencies, one of which was significant.[28] Our clinicians reviewed three transfer-in cases and found nurses performed satisfactorily in completing assessments and ordering provider appointments within required time frames.

Both case review and compliance testing showed FSP performed well with ensuring providers evaluated newly arrived patients within required time frames (MIT 1.002, 87.0%). Our clinicians did not identify any deficiencies with the timeliness of provider appointments for newly arrived patients.

Case review and compliance testing produced mixed results in medication continuity for transfer-in patients. Compliance data showed staff often did not deliver prescribed medications by the administration date and time ordered by providers (MIT 6.003, 66.7%). In contrast, our clinicians did not identify any concerns with medication continuity.

Case review and compliance testing also produced mixed results in timely scheduling specialty appointments. Compliance testing revealed FSP needed improvement in scheduling pre-approved specialty appointments for patients who transferred into the institution (MIT 14.010, 55.6%), as appointments occurred from 10 to 107 days late. In contrast, our clinicians did not identify any concerns with specialty appointments.

Transfers Out

FSP's performance for the transfer-out process was satisfactory. Compliance testing showed FSP performed well with ensuring patients transferred out with their medications and required documents (MIT 6.101, 100%). Our case review clinicians reviewed six events in three cases and identified four deficiencies, none of which was significant. However, nurses did not always document or communicate pending specialty referrals or appointments to the receiving facility and did not ensure patients had no medical holds in place prior to transfer:

- In cases 33, 34, and 35, nurses did not review the patients' medical records to determine whether a medical hold was necessary.
- In cases 33, 34, and 35, nurses did not notify the receiving institution of pending specialty services appointments, which included pending addiction medicine and hepatitis C appointments.

Hospitalizations

Patients returning from an off-site hospitalization or emergency room are at high risk for lapses in care quality. These patients typically have experienced severe illness or injury. They require more care and place a strain on the institution's resources. In addition, because these

[28] Transfer-in deficiencies occurred in cases 30–32. A significant deficiency occurred in case 31.

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

For hospital returns, FSP's performance resulted in different findings from case review and compliance testing. Compliance testing showed FSP performed poorly in maintaining continuity of hospital recommended medications (MIT 7.003, zero). The testing showed FSP did not dispense medications timely, and staff did not deliver prescribed medications by the administration date and time providers ordered.

In contrast, case review did not identify any concerns with medication continuity when patients returned from hospitalizations or emergency room encounters. However, OIG clinicians reviewed 11 events in four cases in which patients returned from a hospitalization or emergency room evaluation. We identified six deficiencies, one of which was significant.[29] OIG clinicians found nurses performed satisfactory assessments, but we identified a trend of incomplete assessments and delayed interventions. The following are examples.

- In cases 3 and 22, patients with medical histories of respiratory problems returned from hospitalization. These patients had orders for respiratory inhalers, but nursing staff did not inquire about patient use and did not ensure patients had rescue inhalers in their possession.

- In case 22, the patient with multiple medical conditions, including chronic cough and COPD, returned from the emergency room with a discharge diagnosis of aspiration pneumonia and abnormal imaging suggestive of liver cancer.[30] Nursing staff did not recognize the need for supplemental oxygen when the patient's oxygen saturation rate continued to drop and delayed administering oxygen to the patient.

Case review and compliance testing showed FSP performed very well in providing follow-up appointments after discharge from a community hospital (MIT 1.007, 90.9%). Staff almost always scanned hospital discharge documents into patients' electronic records (MIT 4.003, 90.9%), and providers always reviewed hospital discharge reports timely (MIT 4.005, 100%). Our clinicians similarly found most documents were scanned timely.

Clinician On-Site Inspection

At the on-site inspection, our clinicians interviewed nursing leadership, receiving and release (R&R) nurses, and pharmacy staff regarding transfer-in and transfer-out processes, including medication availability. Nursing staff and leadership reported custody staff escorted patients to the medication administration areas in their units prior to escorting them to R&R for transfer-out. Nursing staff discussed FSP's transfer-in and transfer-out processes, but the nurse was not clear on the medication reconciliation process for patients who transferred into FSP.

Nursing staff reported R&R nurses processed patients returning from medical returns in the R&R. The TTA RNs assessed patients returning from the hospital and emergency rooms.

[29] Deficiencies occurred in cases 1, 3, 21, and 22. Significant deficiencies occurred in case 22.

[30] Chronic obstructive lung disease (COPD) is a chronic and progressive lung disease with damage to the lung and restrictive airflow.

Compliance On-Site Inspection and Discussion

R&R nursing staff ensured all three applicable patients transferring out of the institution had the required medications, transfer documents, and assigned durable medical equipment (MIT 6.101, 100%).

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)	4	21	0	16.0%
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)	25	0	0	100%
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)	6	3	16	66.7%
For patients transferred out of the facility: Do medication transfer packages include required medications along with the corresponding transfer packet required documents? (6.101)	2	0	3	100%
				Overall percentage (MIT 6): **70.7%**

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)	20	3	2	87.0%
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)	10	1	0	90.9%
Are community hospital discharge documents scanned into the patient's electronic health record within three calendar days of hospital discharge? (4.003)	10	1	0	90.9%
For patients discharged from a community hospital: Did the preliminary or final hospital discharge report include key elements and did a provider review the report within five calendar days of discharge? (4.005)	11	0	0	100%
Upon the patient's discharge from a community hospital: Were all ordered medications administered, made available, or delivered to the patient within required time frames? (7.003)	0	9	2	0
Upon the patient's transfer from one housing unit to another: Were medications continued without interruption? (7.005)	20	5	0	80.0%
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)	4	0	0	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)	10	8	0	55.6 %

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

Recommendations

- Nursing leadership should identify the challenges to ensuring nurses review medical holds for patients prior to transfer to another institution and communicating pending specialty appointments for transferring patients to the receiving institutions. Nursing leadership should implement remedial measures as appropriate.

- Medical leadership should identify the challenges to ensuring previously approved specialty appointments are scheduled within the required time frame and should implement remedial measures as appropriate.

- Nursing leadership should identify the root cause(s) for R&R nurses not completing the initial health screening, including answering all questions and documenting an explanation for each "yes" answer. 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* (67.4%)**

Case review found FSP staff adequately ensured patients received their medications timely for patients transferring into and out of the facility. Staff further performed adequately with new medication prescriptions and hospital discharge medications. However, we identified opportunities for improvement with chronic medication continuity. The OIG rated the case review component of this indicator ***adequate***.

Compliance testing showed FSP performed poorly overall in medication management in Cycle 7, similar to Cycle 6. FSP scored low in providing patients with chronic care medications, newly prescribed medications as ordered, and community hospital discharge medications. 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 160 events in 31 cases related to medications and found nine medication deficiencies, three of which were significant.[31] Compared with Cycle 6, FSP showed improvement but continued to struggle with chronic care medication continuity.

New Medication Prescriptions

FSP's performance with new medication prescriptions varied. Compliance findings showed FSP performed poorly in administering new prescriptions timely (MIT 7.002, 48.0%). Staff did not deliver KOP medications by the ordered administration date and time providers prescribed.[32] In contrast, case review found most patients received their new prescription medications timely.

[31] Deficiencies occurred in cases 1, 3, 10, 14, 17, 22, 23, 26, and 35. Significant deficiencies occurred in cases 10, 22 and 23.

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

Chronic Medication Continuity

FSP also had mixed results for chronic medication continuity. Compliance testing showed a low score for chronic medication continuity (MIT 7.001, 47.1%), mostly due to the pharmacy not timely filling and dispensing medications. Our clinicians similarly found patients did not receive their chronic care medications in five cases, three of which contained significant deficiencies.[33] These cases are described below:

- In case 10, during January, March, and April 2023, the patient with a history of hypertension did not receive his monthly Lisinopril KOP medication. During our on-site inspection, our clinicians verified the pharmacy delivered the medication, but nursing staff did not administer the medication to the patient.

- In case 22, during August 2023, the patient submitted two medication refill requests for his steroid inhaler. The patient received his Atrovent inhaler eight days late. The medication was essential for the patient; he had been recently discharged from the hospital for acute respiratory failure with decreased oxygen levels and pneumonia.

- In cases 1 and 23, during the six-month review period, both patients received only one refill of their prescribed daily KOP steroid inhaler. Both medications required the patient to request refills, but the records contained no documentation indicating the patient care team (PCT) reviewed either case to assess noncompliance and determine whether the medications should have been switched to automatic refill medications.[34] As discussed in more detail in the **Clinician On-Site Inspection** section, this raises concerns because FSP appeared to have no mechanism in place to monitor whether medications should be automatically refilled.

Hospital Discharge Medications

Compliance testing showed FSP performed very poorly for patients receiving their discharge medications upon return from off-site hospitalizations (MIT 7.003, zero). Compliance testing showed, in every sample, either the pharmacy did not timely fill and dispense medications, or nursing staff did not timely administer medications to patients by providers' ordering dates. Our clinicians found one medication deficiency in which the nurse did not inquire whether the patient had his rescue inhaler in his possession.

Transfer Medications

Compliance testing showed FSP sporadically ensured continuity of medications for patients who transferred into the institution (MIT 6.003, 66.7%). However, when patients transferred from yard to yard, they often received their medications without interruption (MIT 7.005, 80.0%). In addition, FSP always ensured patients en route to another institution received their medications without interruption (MIT 7.006, 100%).

[33] Instances of patients not receiving chronic care medications timely occurred in cases 1, 10, 22, and 23. Significant deficiencies occurred in cases 10, 22, and 23.

[34] The patient care team (PCT) includes providers, nurses, and support staff.

Medication Administration

Compliance testing showed FSP performed very well in administering tuberculosis (TB) medications (MIT 9.001, 86.4%) and in monitoring patients' prescribed TB medications (MIT 9.002, 90.5%). Our clinicians similarly did not identify any deficiencies related to TB medications.

Clinician On-Site Inspection

During the on-site inspection, our clinicians toured various outpatient medication clinics and huddles. The medication nurses were very knowledgeable about medication administration times and the KOP pick-up process. They explained their task-list process to identify patients who had not picked up their medications. The medication nurses reported refill request medication orders did not populate on their medication task list; therefore, patients were required to submit a refill request for the medication. When we inquired how the patient care teams (PCTs) monitored these medications, FSP responded, because the refill request medication orders did not populate on the task list or huddle reports, they expected any PCT member who conducted a chronic care appointment to evaluate medication compliance and address continuity issues.[35] However, as discussed above, under the ***Chronic Medication Continuity*** sub-heading, this did not always occur, as evidenced in cases 1 and 23, in which both patients only requested one monthly refill each for their steroid inhaler over a six-month period. The medication nurses also reported KOP medications do not appear on the task list until 10:00 a.m., so they are unable to administer KOP medications when patients arrive for the morning medication pass at 5:30 a.m.

The medication nurses indicated they attended huddles daily. Nurses were expected to address any medication concerns with the provider during the huddle, or through the message pool. Nurses also shared they provided custody staff a list of patients who had medications to pick up. In addition, nurses would initiate one last call to the buildings if patients still had not picked up medications on the fourth day before they returned the medication to the pharmacy. Nurses stated they often kept medications in the clinic for longer than four days to give the patients more time to pick up medications.

The medication nurses were knowledgeable about the first medical response process. They reported they would respond to medical emergencies that were within proximity to their designated medication pass areas.

Compliance Testing Results

Medication Practices and Storage Controls

The institution adequately stored and secured narcotic medications in six of eight applicable clinic and medication line locations (MIT 7.101, 75.0%). In two locations, staff did not properly or securely store narcotic medications, as required by CCHCS policy.

FSP appropriately stored and secured nonnarcotic medications in four of eight applicable clinic and medication line locations (MIT 7.102, 50.0%). In three locations, nurses did not

[35] The patient care team (PCT) includes providers, nurses, and support staff.

maintain unissued medications in original labeled packaging. In the remaining location, the medication storage area was unsanitary.

Staff kept medications protected from physical, chemical, and temperature contamination in five of eight applicable clinic and medication line locations (MIT 7.103, 62.5%). In three locations, we found one or both of the following deficiencies: staff did not consistently record the room and refrigerator temperatures, and medication refrigerators were unsanitary.

Staff successfully stored valid and unexpired medications in all medication line locations (MIT 7.104, 100%).

Nurses exercised proper hand hygiene and contamination control protocols in three of six applicable locations (MIT 7.105, 50.0%). Some nurses neglected to wash or sanitize their hands when required. These occurrences included before preparing and administering medications, and before each subsequent regloving.

Staff in all medication preparation and administration areas demonstrated appropriate administrative controls and protocols when preparing medications for patients (MIT 7.106, 100%).

Staff in only two of six applicable medication areas used appropriate administrative controls and protocols when distributing medications to patients (MIT 7.107, 33.3%). In four locations, we observed one or more of the following deficiencies: medication nurses did not distribute medications to patients within required time frames; a medication nurse electronically signed the medication administration record (MAR) prior to preparing and administering the medication; medication nurses did not administer medication as the provider ordered; and some medication nurses did not properly disinfect the vial's port prior to withdrawing medication when administering insulin .

Pharmacy Protocols

FSP did not follow general security, organization, and cleanliness management protocols in its pharmacy (MIT 7.108, zero). We found the medication storage area to be unsanitary.

FSP properly stored nonrefrigerated medications (MIT 7.109, 100%) and refrigerated or frozen medications (MIT 7.110, 100%) in the pharmacy.

The PIC correctly accounted for narcotic medications stored in FSP's pharmacy (MIT 7.111, 100%).

We examined nine pharmacy related medication error reports. The PIC timely and correctly processed all reports (MIT 7.112, 100%).

Nonscored Tests

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

The OIG usually interviews patients in restricted housing units to determine whether they have immediate access to prescribed asthma rescue inhalers or nitroglycerin medications. At

the time of our inspection, the restricted housing unit did not house patients with prescribed asthma rescue inhalers or nitroglycerin medications. Therefore, we had no samples for this test (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)	8	9	8	47.1%
Did health care staff administer, make available, or deliver new order prescription medications to the patient within the required time frames? (7.002)	12	13	0	48.0%
Upon the patient's discharge from a community hospital: Were all ordered medications administered, made available, or delivered to the patient within required time frames? (7.003)	0	9	2	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)	20	5	0	80.0%
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)	4	0	0	100%
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)	6	2	2	75.0%
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)	4	4	2	50.0%
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)	5	3	2	62.5%
All clinical and medication line storage areas for nonnarcotic medications: Does the institution safely store nonnarcotic medications that have yet to expire in the assigned storage areas? (7.104)	8	0	2	100%
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)	3	3	4	50.0%
Medication preparation and administration areas: Does the institution employ appropriate administrative controls and protocols when preparing medications for patients? (7.106)	6	0	4	100%
Medication preparation and administration areas: Does the institution employ appropriate administrative controls and protocols when administering medications to patients? (7.107)	2	4	4	33.3%
Pharmacy: Does the institution employ and follow general security, organization, and cleanliness management protocols in its main and remote pharmacies? (7.108)	0	1	0	0
Pharmacy: Does the institution's pharmacy properly store nonrefrigerated medications? (7.109)	1	0	0	100%
Pharmacy: Does the institution's pharmacy properly store refrigerated or frozen medications? (7.110)	1	0	0	100%
Pharmacy: Does the institution's pharmacy properly account for narcotic medications? (7.111)	1	0	0	100%
Pharmacy: Does the institution follow key medication error reporting protocols? (7.112)	9	0	0	100%
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): **67.4%**

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)	6	3	16	66.7%
For patients transferred out of the facility: Do medication transfer packages include required medications along with the corresponding transfer-packet required documents? (6.101)	2	0	3	100%
Patients prescribed TB medication: Did the institution administer the medication to the patient as prescribed? (9.001)	19	3	0	86.4%
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)	19	2	1	90.5%
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)	N/A	N/A	N/A	N/A

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

Recommendations

- Medical and nursing leadership should determine the challenges to ensuring chronic care patients, hospital discharge patients, and patients newly arrived at FSP receive their medications timely and without interruption. Leadership should implement remedial measures as appropriate.

- Nursing leadership should determine the root cause(s) for nursing staff not documenting patient refusals and no-shows in the MAR, as described in CCHCS policy and procedures, and should implement remedial measures as appropriate.

Preventive Services

In this indicator, OIG compliance inspectors tested whether the institution offered or provided cancer screenings, tuberculosis (TB) screenings, influenza vaccines, and other immunizations. If the department designated the institution as 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	***Proficient*** **(89.0%)**

FSP performed very well in this indicator. Staff showed excellent performance in offering patients an influenza vaccine for the most recent influenza season. They also performed very well in administering TB medications, monitoring patients on TB medications, screening patients annually for TB, and offering colorectal cancer screening for patients ages 45 through 75. Lastly, the institution performed satisfactorily in offering required immunizations to chronic care patients. These findings are set forth in the table on the next page. Based on the overall compliance score result, the OIG rated this indicator ***proficient***.

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)	19	3	0	86.4%
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)	19	2	1	90.5%
Annual TB screening: Was the patient screened for TB within the last year? (9.003)	23	2	0	92.0%
Were all patients offered an influenza vaccination for the most recent influenza season? (9.004)	25	0	0	100%
All patients from the age of 45 through the age of 75: Was the patient offered colorectal cancer screening? (9.005)	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)	10	3	12	76.9%
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): **89.0%**

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

Recommendations

The OIG offers no recommendations for this indicator.

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

Ratings and Results Overview

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

FSP's overall nursing care was sufficient. Nurses delivered appropriate and timely care, showing improvements in nursing documentation compared with their performance in Cycle 6. Nurses performed satisfactory assessments and interventions for patients in the outpatient clinics, for patients transferring into or out of the institution, and for patients returning from medical appointments and hospitalizations. Our clinicians identified opportunities for improvement in several areas, such as appropriate triage of symptomatic patients with sick call requests as well as emergency care for patients during CPR events. Factoring all aspects of nursing performance, the OIG rated this indicator ***adequate***.

Case Review Results

We reviewed 153 nursing encounters in 58 cases. Of the nursing encounters we reviewed, 110 occurred in the outpatient setting and 64 were nursing sick call requests. We identified 73 overall nursing performance deficiencies, 20 of which were significant.[36]

Outpatient Nursing Assessment and Interventions

A critical component of nursing care is the quality of nursing assessment, which includes both subjective (patient interviews) and objective (observation and examination) elements.

[36] Deficiencies occurred in cases 1–5, 7–10, 12, 14,16–18, 21–24, 30–37, 39, 44, 46, 51, 54, 55, 58, and 60–63. Significant deficiencies occurred in cases 1, 2, 4, 5, 9, 12, 16, 17, 21, 22, 23, 31, 36, 39, and 63.

Our clinicians identified 50 outpatient nursing deficiencies, 11 of which were significant.[37] We evaluated nursing assessments and interventions in 39 symptomatic sick call requests. Nurses performed adequate assessments and interventions most of the time. However, we identified a trend of not scheduling patients with urgent symptoms with appointments on the same day and not performing complete assessments. The following are examples:

- In case 9, the nurse assessed the patient for irritated and itchy eyes. The nurse documented using nursing protocol but did not administer the eye drop medication to the patient per protocol. The patient continued to have symptoms and did not receive any eye drops for more than a month.

- In case 23, the nurse evaluated the patient for a sick call complaint of headaches. During the face-to-face appointment, the patient also reported intermittent rectal bleeding and possible hemorrhoid. The nurse did not check vital signs or perform a subjective or an objective abdominal assessment to include appetite, bowel habits, and past abdominal history. Five days later, the patient was transferred to the hospital due to a low blood count and subsequently hospitalized for a severe low blood count.

- In case 36, the nurse reviewed a symptomatic request for a patient's complaint of body chills, fever, headache, and muscle aches. The nurse did not arrange for the patient to be seen the same day for these urgent symptoms. Four days later, when the nurse evaluated the patient, he reported having low back pain. The nurse did not assess the patient's gait, extremity strength, sensation, or range of motion and did not educate the patient.

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 patients' conditions. Nursing staff generally documented care appropriately.

Case Management

Our clinicians reviewed 34 events in 12 cases in which a nursing care manager or care coordinator evaluated patients. In three cases, our clinicians identified 14 deficiencies, four of which were significant. Overall, care managers performed appropriate assessments and interventions.

Emergency Services

We reviewed 25 urgent or emergent events and found 22 emergency care deficiencies. Of these 22 deficiencies, 10 were significant. Nurses responded promptly to emergency events. However, their assessments, interventions, and documentation needed improvement, which we detail further in the **Emergency Services** indicator.

[37] Outpatient nursing deficiencies occurred in cases 1, 2, 3, 9, 12, 14, 17, 21–24, 36, 37, 39, 44, 46, 51, 54, 55, 58, and 60–63. Significant deficiencies occurred in cases 1, 2, 9, 17, 21, 22, 36, 39, and 63.

Hospital Returns

We reviewed 11 events involving returns from off-site hospitals or emergency rooms. Nurses performed satisfactory assessments, which we discuss further in the **Transfers** indicator.

Transfers

We reviewed six cases that involved transfer-in and transfer-out processes. Nurses evaluated patients appropriately and initiated provider appointments within required time frames. However, nurses did not always document pertinent information when patients transferred out of the institution. Please refer to the **Transfers** indicator for further details.

Specialty Services

We reviewed 24 events in eight cases in which patients returned from off-site specialty appointments and procedures. Overall, nurses performed good assessments when patients returned from off-site specialty appointments. Our clinicians identified four deficiencies, one of which was significant and is discussed below:

- In case 1, an FSP nurse assessed the patient, who returned from a specialty appointment with significantly elevated blood pressure. The nurse escorted the patient to the TTA for further evaluation. The TTA nurse assessed the patient and obtained a one-time order to administer a blood pressure medication. The TTA nurse did not enter the verbal order in the EHRS to administer the medication and did not monitor the patient in the TTA. Instead, the nurse discharged the patient and instructed the patient to take the medication in their housing unit. The nurse subsequently reassessed the patient in the housing unit.

Medication Management

We reviewed 160 events in 31 cases related to medication management and found nine medication deficiencies, three of which were significant.[38] Compared with Cycle 6, FSP showed improvement, but they continued to struggle with chronic care medication continuity. Please refer to the **Medication Management** indicator for further details.

Clinician On-Site Inspection

Our clinicians spoke with nurse instructors and nurses in the TTA, R&R, specialty, outpatient clinics, and medication areas. We attended organized huddles and population-management meetings. Staff were knowledgeable about their patients and coordinated patient management.

FSP had dedicated nursing care managers, who reviewed the various quality management chronic care reports and performed chronic care nursing assessments of their assigned patient panels. Nursing leadership reported whether patients were noncompliant with treatment or had abnormal laboratory results as the care manager more frequently saw those patients.

[38] Medication deficiencies occurred in cases 1, 3, 10, 14, 17, 22, 23, 26, and 35. Significant deficiencies occurred in cases 10, 22, and 23.

FSP supervising registered nurses audited 10 charts for outpatient nursing assessment each month. They randomly selected charts from the list of symptomatic sick call patient requests. The nursing supervisors completed the audit and reviewed the findings with the nurses. Nursing leadership reported most staff were doing well, and they discussed audit findings with nursing staff during their monthly meetings.

We met with nursing leadership, who addressed our findings and acknowledged opportunities for improvement in outpatient clinic areas and in emergency services. Nursing leadership reported FSP was fully staffed and had absorbed the staff from the closure of the Folsom Women's Facility. Nursing staff stated overall morale was good and they felt supported by the executive team. The nursing executive team reported they no longer mandated staff to work overtime.

Recommendations

- Nursing leadership should determine the challenges to nurses performing appropriate triage of sick calls, completing thorough face-to-face assessments, and co-consulting with providers when needed and should implement remedial measures as appropriate.

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***

FSP providers generally delivered good medical care. Compared with Cycle 6, providers improved across different aspects of care. Providers appropriately addressed patients' acute and chronic medical conditions. They made sound medical decisions and followed through on treatment plans. However, we identified instances in which providers did not always perform or document pertinent physical examinations. In addition, we identified a pattern of providers not appropriately managing their diabetic patients' blood sugar levels. Considering all aspects, the OIG rated this indicator ***adequate***.

Case Review Results

OIG clinicians reviewed 143 medical provider encounters and identified 30 deficiencies related to provider performance, 19 of which were significant.[39] In addition, our clinicians examined the quality of care in 25 comprehensive case reviews. Of these 25 cases, we rated 21 ***adequate*** and four ***inadequate***.[40]

Outpatient Assessment and Decision-Making

Providers usually made accurate assessments and appropriate decisions for their patients. They generally obtained adequate histories and explored different causes for their patients' complaints. However, OIG clinicians identified eight deficiencies related to poor assessments and decision-making.[41] The following are examples of poor decision-making:

- In case 9, the provider evaluated the patient, who complained of abdominal pain. The provider's examination showed right upper abdominal tenderness, which was concerning for acute cholecystitis.[42] The provider ordered laboratory

[39] Deficiencies occurred in cases 1, 3, 9–16, 19, 23, 26, and 28. Significant deficiencies occurred in cases 9–16, 19, 23, and 28.

[40] OIG clinicians rated cases 12–14 and 28 as ***inadequate***.

[41] Deficiencies in assessments and decision-making occurred in cases 9, 11–14, 16, and 28.

[42] Cholecystitis is inflammation of the gallbladder, which can be caused by stones or sludge leading to an infection. The gallbladder can become inflamed due to a blocked duct, requiring emergent intervention.

tests to be performed one day later and a medium-priority ultrasound to occur within 45 days. However, the provider should have ordered the laboratory tests and ultrasound to be completed sooner due to the increased risk for an acute and severe infection that would have required antibiotics or hospitalization.

- In case 14, the provider evaluated the patient at a chronic care appointment. The patient had a history of coronary artery disease but was not prescribed either a beta blocker or a cholesterol-lowering medication, both of which would reduce the risk for a heart attack or stroke.[43] The provider did not document a rationale for not prescribing these medications.

In four cases, OIG clinicians identified a pattern of providers poorly managing patients with uncontrolled diabetes. The following are examples:

- In case 11, the provider evaluated the patient for follow-up of extremely low blood sugar readings, which increased the risk for seizures. However, the provider did not consider ordering dextrose tablets in case of repeat episodes of low blood sugar.[44]

- In case 12, the provider evaluated the patient at a chronic care appointment and documented elevated blood sugar readings. However, the provider did not adjust the patient's diabetic medication regimen or order another hemoglobin A1c test to evaluate overall blood sugar control.[45] This increased the patient's risk for complications from uncontrolled diabetes.

Emergency Care

In the TTA, providers appropriately managed patients with urgent and emergent conditions. Providers were readily available for in-person consultations during business hours and via telephone during after-hours. OIG clinicians only identified one minor deficiency related to emergency care. We also discuss provider performance in emergent situations in the **Emergency Services** indicator.

Specialty Services

Providers usually referred patients for specialty consultations when needed. Providers often endorsed specialty consultative reports timely, addressed specialists' recommendations, and ordered appropriate follow-up appointments. We discuss provider performance further in the **Specialty Services** indicator.

[43] A beta-blocker is a medication used to treat high blood pressure and certain heart conditions by lowering the heart rate. Coronary artery disease is a heart condition with the presence of plaque within the heart arteries, leading to reduced blood flow and increased risk for a heart attack.

[44] Dextrose tablets are ingestible sugar tablets prescribed for patients for low blood sugar.

[45] Hemoglobin A1c is a blood test that measures the average plasma glucose over the previous 12 weeks.

Chronic Care

Providers performed well in managing their patients' chronic health conditions. However, in eight cases, we identified a pattern of providers not documenting pertinent physical examinations for patients' symptoms. The following are examples:

- In case 14, the provider evaluated the patient after a follow-up consultation with the ophthalmologist. However, the provider did not document an eye examination.

- In case 23, the provider evaluated the patient, who was recently hospitalized for a lower gastrointestinal bleed from hemorrhoids for which he underwent hemorrhoid surgery. The patient complained of rectal pain, but the provider did not document a rectal examination.

Outpatient Documentation Quality

Providers regularly documented their encounters, including co-consultations performed with nurses. Our clinicians did not find any significant deficiencies in documentation for outpatient encounters.

Outpatient Review of Records

Review of medical records is important to ensure patients' medical conditions are appropriately addressed. Providers usually documented their review of patients' medical records, including past diagnoses and test results. OIG clinicians did not identify any deficiencies with inadequate review of patients' records.

Patient Notification Letter

Providers usually sent test results notification letters to patients. However, OIG clinicians identified a pattern of letters not including all required elements per policy. We identified these deficiencies in 22 of the 25 detailed cases we reviewed. We also discuss this in the **Diagnostic Services** and **Health Information Management** indicators.

Outpatient Provider Continuity

Providers followed their patients without disruption, providing continuity for their patients. We found no cases in which multiple providers evaluated the same patient, which could result in a lack of continuity for the patient.

Clinician On-Site Inspection

OIG clinicians attended the clinic huddles, which included on-site providers. The patient care team (PCT) discussed new patients in addition to those patients who presented to the TTA or emergency room with emergent symptoms. The PCT also reviewed patients with expiring medications and those who returned from off-site specialty services. Staff stated PCTs provide continuous care to their patients, and many providers and nurses remain on the same team for several years.

OIG physicians met with the Chief Medical Executive (CME) and Chief Physician and Surgeon (CP&S). The CME and the CP&S reported no vacancies or providers on long-term leave. Medical leadership also reported no difficulty in either hiring or retaining providers, which they attributed to the location of the facility and stable staffing at FSP. The leadership mentioned they maintained provider continuity by ensuring providers who are on leave always have a covering partner. Leadership also stated they discussed difficult cases and health care policy changes in weekly provider meetings.

Providers reported good morale and expressed confidence in medical leadership. They felt comfortable bringing up challenging cases and unique situations at provider meetings or directly with medical leadership. Providers reported receiving laboratory tests and imaging studies timely. Furthermore, they obtained most specialty services without delay and had no problems coordinating care with the utilization management (UM) nurses for complex cases.

Recommendations

- Medical leadership should identify the root cause(s) for providers' poor diabetes management and should implement remedial measures as appropriate.

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* (69.8%)**

Case review found FSP performed satisfactorily with specialty services. Staff usually provided sufficient access to specialists. Providers generally endorsed specialty reports and followed specialists' recommendations. However, we identified a pattern of staff not timely scanning specialty reports into the EHRS. After reviewing all aspects, the OIG rated the case review component of this indicator ***adequate***.

Compliance testing showed a mixed performance in this indicator. Access to off-site specialists needed improvement. Preapproved specialty services for newly arrived patients only sometimes occurred within required time frames. In addition, performance in retrieving specialty reports and prompt provider endorsements varied. 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 97 events related to specialty services, which included 55 specialty consultations. We identified 31 deficiencies in this category, seven of which were significant.[46]

Access to Specialty Services

FSP had mixed performance in providing timely access to specialists. Compliance testing showed staff performed very well in timely providing medium-priority (MIT 14.004, 86.7%) and routine-priority (MIT 14.007, 86.7%) specialty appointments. Staff generally provided timely access to high-priority (MIT 14.001, 80.0%) specialty appointments. Compliance testing also showed staff usually provided timely subsequent follow-up medium-priority (MIT 14.006, 75.0%) and routine-priority (MIT 14.009, 83.3%) specialty appointments. However, they only sometimes provided timely subsequent follow-up specialty appointments for high-priority referrals (MIT 14.003, 57.1%). Additionally, staff needed improvement in ensuring specialty access for patients who transferred into the institution with a

[46] Deficiencies occurred in cases 1, 2, 11, 14, 15, 18, 20–23, and 27–29. Significant deficiencies occurred in cases 1, 2, 14, 18, 22, 23, and 29.

preapproved specialty request (MIT 14.010, 55.6%). OIG clinicians identified three deficiencies with specialty access, all of which were significant.[47] The following are examples:

- In case 1, the provider requested a high-priority consultation with the kidney specialist. However, the appointment occurred eight days late.

- In case 2, the patient submitted a sick call to see an optometrist for blurred vision and an inability to focus his left eye. The triage nurse ordered the appointment; however, another nurse cancelled this order, and the appointment occurred more than two months later.

Provider Performance

Providers usually ordered appropriate specialty consultations and followed specialists' recommendations. However, we identified two significant deficiencies after specialist consultations:

- In case 15, the provider evaluated the patient at a follow-up appointment after the endocrinology consultation. The specialist recommended to discontinue a medication used to help control the amount of sodium and fluids in the body. However, the provider did not address the specialist's recommendation to stop this medication and instead continued it. This increased the patient's risk for sodium abnormalities and fluid retention.

- In case 28, the oncologist evaluated the patient for recently diagnosed rectal cancer. This specialist recommended specialized imaging tests to guide therapeutic management and a follow-up appointment to occur within three weeks. However, the provider ordered these tests as medium- and routine-priority, and the tests were consequently not completed prior to the oncology follow-up appointment. This delayed the patient's plan of care for cancer treatment.

Nursing Performance

Overall, nurses performed good assessments, reviewed specialty reports for recommendations, and co-consulted with providers when appropriate. We reviewed 24 specialty events in eight cases and identified four deficiencies, one of which was significant.[48] However, these deficiencies did not significantly affect the overall care for the patients.

Health Information Management (HIM)

FSP performed variably with managing health information of specialty services. Compliance testing showed providers usually reviewed reports for high-priority (MIT 14.002, 80.0%) specialty services. However, providers needed improvement in reviewing reports for medium-priority (MIT 14.005, 66.7%) and routine-priority (MIT 14.008, 66.7%) specialty services. Compliance testing showed very good performance in retrieving specialty reports and in scanning specialty reports into the EHRS within required time frames (MIT 4.002, 86.7%). However, OIG clinicians identified a pattern in which HIM staff did not timely scan

[47] Deficiencies occurred in cases 1, 2, and 23.

[48] Deficiencies occurred in cases 1, 18, and 21. A significant deficiency occurred in case 1.

specialty documents into the EHRS. We identified 24 HIM deficiencies, 20 of which related to late receipt and scanning of specialty reports. Two deficiencies involved an untimely provider endorsement.[49] The following are examples:

- In case 18, FSP staff scanned a urology consultation report 37 days late.
- In case 29, the provider endorsed an oncology consultation report seven days late.

We discuss these issues further the **Health Information Management** indicator.

Clinician On-Site Inspection

OIG clinicians discussed the management of specialty services reports with the health records technician (HRT), specialty services supervising registered nurse (SRN), providers, and nurses. Upon a patient's return from an off-site specialty appointment, the TTA nurse would review the specialty information packet returning with the patient. These documents often included preliminary handwritten recommendations. The SRN stated they encountered some difficulties in obtaining final specialty reports due to lack of a timely response from the specialists' offices. This resulted in the late scanning of specialty reports into the chart.

The HRT supervisor reported the utilization management (UM) nurse and the specialty nurse forwarded the specialty reports to the HIM department. The HIM supervisor stated the specialty department coordinated with HIM to ensure staff timely received and scanned specialty reports into the EHRS.

The specialty services SRN reported no appointment backlogs with on-site specialty services, which included audiology, ophthalmology, optometry, and physical therapy. The UM staff and providers reported some difficulties with timely access to off-site specialty services, such as orthopedic surgery and urology. They attributed these difficulties to limited specialty availability. They also mentioned infrequent instances in which tertiary services were needed, which increased the risk for delayed care. The SRN stated schedulers at CCHCS headquarters coordinated telemedicine appointments.

[49] Deficiencies occurred in cases 1, 11, 14, 15, 18, 20, 22, 27, and 29. Case 14 included a specialty report that was scanned into EHRS but not forwarded to the provider for review. Case 27 included a provider endorsement of an MRI result for which a patient notification letter was not generated. Significant deficiencies occurred in cases 14, 18, 22, and 29.

Compliance Score Results

Table 16. Specialty Services

Compliance Questions	Scored Answer			
	Yes	No	N/A	Yes %
Did the patient receive the high-priority specialty service within 14 calendar days of the primary care provider order or the Physician Request for Service? (14.001)	12	3	0	80.0%
Did the institution receive and did the primary care provider review the high-priority specialty service consultant report within the required time frame? (14.002)	12	3	0	80.0%
Did the patient receive the subsequent follow-up to the high-priority specialty service appointment as ordered by the primary care provider? (14.003)	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)	13	2	0	86.7%
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	5	0	66.7%
Did the patient receive the subsequent follow-up to the medium-priority specialty service appointment as ordered by the primary care provider? (14.006)	3	1	11	75.0%
Did the patient receive the routine-priority specialty service within 90 calendar days of the primary care provider order or Physician Request for Service? (14.007)	13	2	0	86.7%
Did the institution receive and did the primary care provider review the routine-priority specialty service consultant report within the required time frame? (14.008)	10	5	0	66.7%
Did the patient receive the subsequent follow-up to the routine-priority specialty service appointment as ordered by the primary care provider? (14.009)	5	1	9	83.3%
For endorsed patients received from another CDCR institution: If the patient was approved for a specialty services appointment at the sending institution, was the appointment scheduled at the receiving institution within the required time frames? (14.010)	10	8	0	55.6%
Did the institution deny the primary care provider's request for specialty services within required time frames? (14.011)	0	2	0	0
Following the denial of a request for specialty services, was the patient informed of the denial within the required time frame? (14.012)	2	0	0	100%
			Overall percentage (MIT 14): **69.8%**	

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

Table 17. Other Tests Related to Specialty Services

	Scored Answer			
Compliance Questions	**Yes**	**No**	**N/A**	**Yes %**
Specialty service follow-up appointments: Did the clinician follow-up visits occur within required time frames? (1.008) *	40	5	0	88.9%
Are specialty documents scanned into the patient's electronic health record within five calendar days of the encounter date? (4.002)	26	4	15	86.7%

* 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

- Health care leadership should determine the root cause(s) of challenges to the timely provision of specialty appointments, including preapproved specialty appointments for transfer-in patients, and should implement remedial measures as appropriate.

- Health care leadership should determine the challenges to ensuring specialty reports are received, scanned, and endorsed in a timely manner 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 quality rating.

Ratings and Results Overview

Case Review Rating	Compliance Rating and Score
Not Applicable	***Adequate* (77.9%)**

FSP showed satisfactory performance in this indicator. While FSP scored well in some applicable tests, it needed improvement in several areas. The Emergency Medical Response Review Committee (EMRRC) intermittently completed required checklists. In addition, the institution conducted medical emergency response drills with incomplete or inconsistent documentation. Lastly, the nurse educator did not ensure all 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 ***adequate***.

Compliance Testing Results

Nonscored Results

At FSP, 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 that the preliminary mortality report had been completed. The reports were overdue at the time of the OIG's inspection (MIT 15.998).

Compliance Score Results

Table 18. 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)	4	3	0	57.1%
For institutions with licensed care facilities: Did the Local Governing Body (LGB) or its equivalent meet quarterly and discuss local operating procedures and any applicable policies? (15.004)	N/A	N/A	N/A	N/A
Did the institution conduct medical emergency response drills during each watch of the most recent quarter, and did health care and custody staff participate in those drills? (15.101)	0	3	0	0
Did the responses to medical grievances address all of the 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)	6	0	0	100%
Did nurse managers ensure the clinical competency of nurses who administer medications? (15.104)	9	1	0	90.0%
Did physician managers complete provider clinical performance appraisals timely? (15.105)	7	1	0	87.5%
Did the providers maintain valid state medical licenses? (15.106)	10	0	0	100%
Did the staff maintain valid Cardiopulmonary Resuscitation (CPR), Basic Life Support (BLS), and Advanced Cardiac Life Support (ACLS) certifications? (15.107)	2	0	1	100%
Did the nurses and the pharmacist-in-charge (PIC) maintain valid professional licenses and certifications, and did the pharmacy maintain a valid correctional pharmacy license? (15.108)	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)	1	0	0	100%
Did nurse managers ensure their newly hired nurses received the required onboarding and clinical competency training? (15.110)	0	1	0	0
Did the CCHCS Death Review Committee process death review reports timely? 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): **77.9%**

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

Recommendations

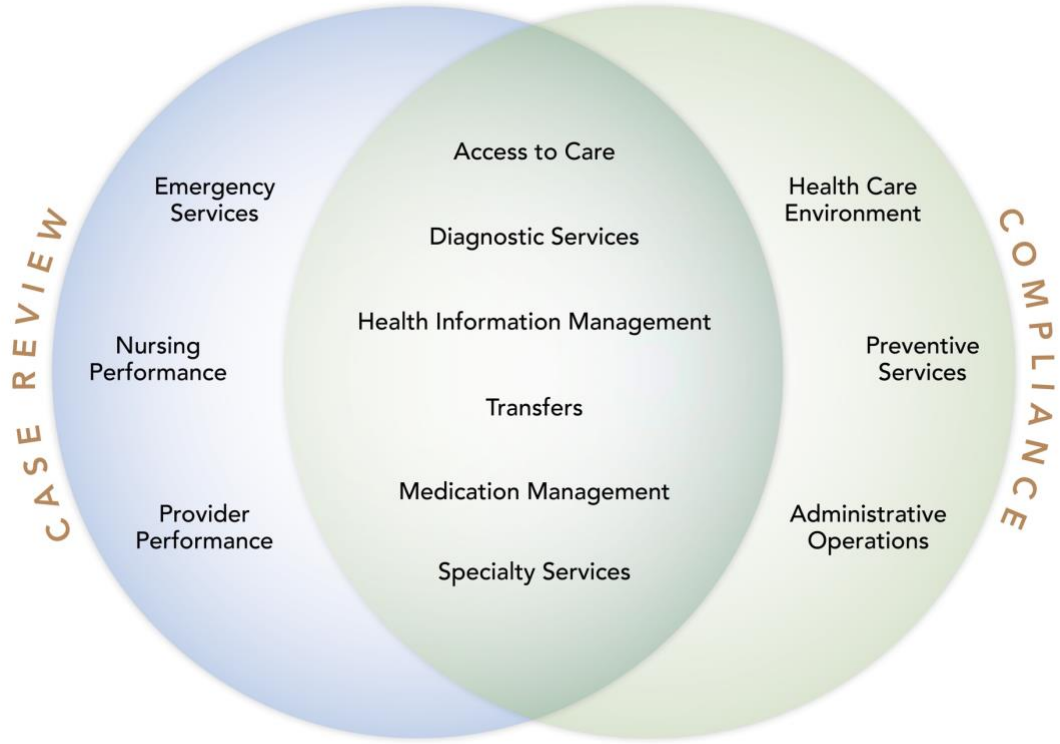
The OIG offers no recommendations for this indicator.

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 FSP



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

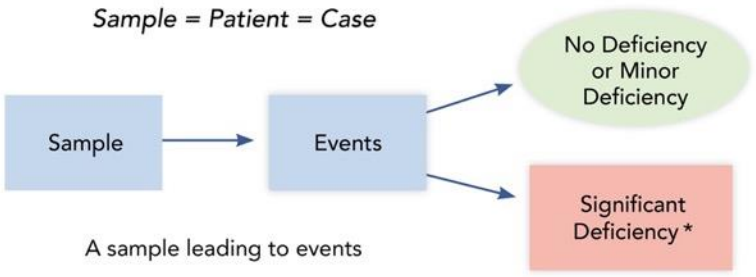
An OIG physician, a nurse consultant, or both review each case. As the clinicians review medical records, they record pertinent interactions between the patient and the health care system. We refer to these interactions as case review ***events***. Our clinicians also record medical errors, which we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

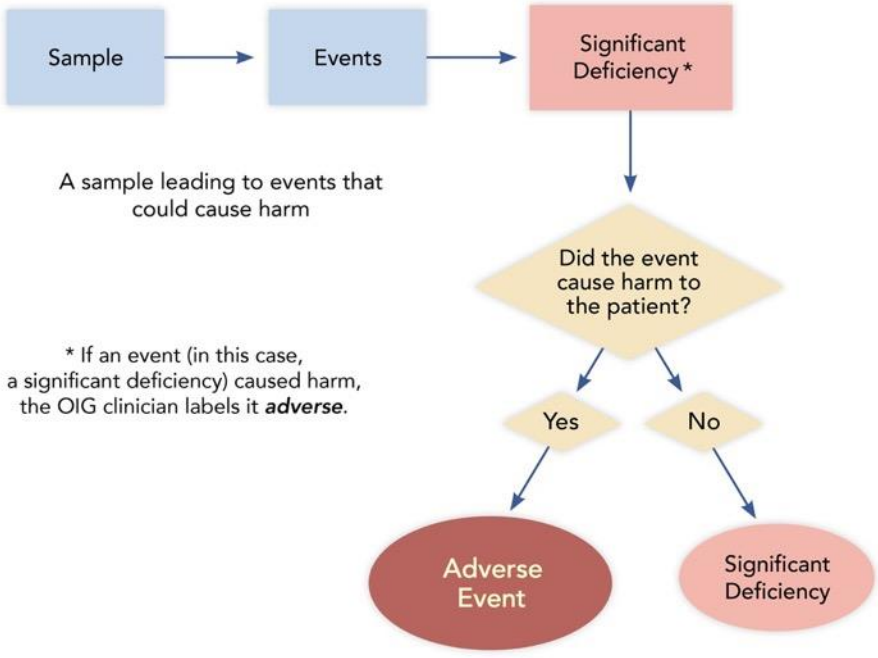
Figure A–2. Case Review Testing

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***.



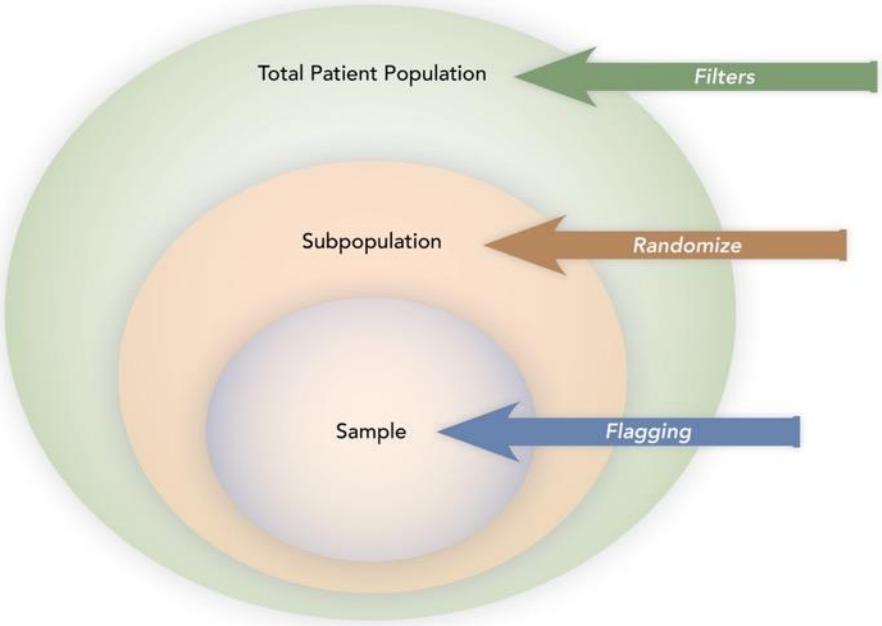
Source: The Office of the Inspector General medical inspection analysis.

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. FSP Case Review Sample Sets

Sample Set	Total
Death Review/Sentinel Events	3
Diabetes	6
Emergency Services – CPR	4
Emergency Services – Non-CPR	3
High Risk	5
Hospitalization	4
Intra-System Transfers In	3
Intra-System Transfers Out	3
RN Sick Call	28
Specialty Services	4
	63

Table B–2. FSP Case Review Chronic Care Diagnoses

Sample Set	Total
Anemia	1
Anticoagulation	1
Arthritis/Degenerative Joint Disease	6
Asthma	7
Cancer	6
Cardiovascular Disease	5
Chronic Kidney Disease	1
Chronic Pain	8
Cirrhosis/End-Stage Liver Disease	1
Coccidioidomycosis	1
COVID-19	1
Diabetes	14
Gastroesophageal Reflux Disease	11
Hepatitis C	14
Hyperlipidemia	20
Hypertension	22
Mental Health	12
Migraine Headaches	1
Rheumatological Disease	1
Seizure Disorder	2
Sickle Cell Anemia	1
Sleep Apnea	1
Substance Abuse	19
Thyroid Disease	2
	158

Table B–3. FSP Case Review Events by Program

Diagnosis	Total
Diagnostic Services	149
Emergency Care	45
Hospitalization	21
Intra-System Transfers In	6
Intra-System Transfers Out	6
Outpatient Care	444
Specialty Services	119
	790

Table B–4. FSP Case Review Sample Summary

Sample Set	Total
MD Reviews Detailed	25
MD Reviews Focused	0
RN Reviews Detailed	15
RN Reviews Focused	36
Total Reviews	76
Total Unique Cases	63
Overlapping Reviews (MD & RN)	13

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Appendix C: Compliance Sampling Methodology

Folsom State Prison

Quality Indicator	Sample Category	No. of Samples	Data Source	Filters
Access to Care				
MIT 1.001	Chronic Care Patients	25	Master Registry	• Chronic care conditions (at least one condition per patient—any risk level) • Randomize
MIT 1.002	Nursing Referrals	25	OIG Q: 6.001	• See Transfers
MITs 1.003–006	Nursing Sick Call (6 per clinic)	35	Clinic Appointment List	• Clinic (each clinic tested) • Appointment date (2–9 months) • Randomize
MIT 1.007	Returns From Community Hospital	11	OIG Q: 4.005	• See Health Information Management (Medical Records) (returns from community hospital)
MIT 1.008	Specialty Services Follow-Up	45	OIG Q: 14.001, 14.004 & 14.007	• See Specialty Services
MIT 1.101	Availability of Health Care Services Request Forms	6	OIG on-site review	• Randomly select one housing unit from each yard
Diagnostic Services				
MITs 2.001–003	Radiology	10	Radiology Logs	• Appointment date (90 days–9 months) • Randomize • Abnormal
MITs 2.004–006	Laboratory	10	Quest	• Appt. date (90 days–9 months) • Order name (CBC, BMP, or CMPs only) • Randomize • Abnormal
MITs 2.007–009	Laboratory STAT	6	Quest	• Appt. date (90 days–9 months) • Order name (CBC, BMP, 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	11	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	11	CADDIS off-site admissions	• Date (2–8 months) • Most recent 6 months provided (within date range) • Rx count • Discharge date • Randomize
Health Care Environment				
MITs 5.101–105 MITs 5.107–111	Clinical Areas	9	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	5	OIG inspector on-site review	• R&R IP transfers with medication

Quality Indicator	Sample Category	No. of Samples	Data Source	Filters
Pharmacy and Medication Management				
MIT 7.001	Chronic Care Medication	25	OIG Q: 1.001	• See Access to Care • At least one condition per patient—any risk level • Randomize
MIT 7.002	New Medication Orders	25	Master Registry	• Rx count • Randomize • Ensure no duplication of IPs tested in MIT 7.001
MIT 7.003	Returns From Community Hospital	11	OIG Q: 4.005	• See Health Information Management (Medical Records) (returns from community hospital)
MIT 7.004	RC Arrivals—Medication Orders	N/A at this institution	OIG Q: 12.001	• See Reception Center
MIT 7.005	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	4	SOMS	• Date of transfer (2–8 months) • Sending institution (another departmental facility) • Randomize • NA/DOT meds
MITs 7.101–103	Medication Storage Areas	Varies by test	OIG inspector on-site review	• Identify and inspect clinical & med line areas that store medications
MITs 7.104–107	Medication Preparation and Administration Areas	Varies by test	OIG inspector on-site review	• Identify and inspect on-site clinical areas that prepare and administer medications
MITs 7.108–111	Pharmacy	1	OIG inspector on-site review	• Identify & inspect all on-site pharmacies
MIT 7.112	Medication Error Reporting	1	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	0	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	22	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	N/A at this institution	CADDIS	• Admit date (2–8 months) • Type of stay (no MH beds) • Length of stay (minimum of 5 days) • Rx count • Randomize
MITs 13.101–102	Call Buttons	All	OIG inspector on-site review	• Specialized Health Care Housing • Review by location
Specialty Services				
MITs 14.001–003	High-Priority Initial and Follow-Up RFS	15	Specialty Services Appointments	• Approval date (3–9 months) • Remove consult to audiology, chemotherapy, dietary, Hep C, HIV, orthotics, gynecology, consult to public health/Specialty RN, dialysis, ECG 12-Lead (EKG), mammogram, occupational therapy, ophthalmology, optometry, oral surgery, physical therapy, physiatry, podiatry, radiology, follow-up wound care / addiction medication, narcotic treatment program, and transgender 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, radiology, follow-up wound care/addiction medication, narcotic treatment program, and transgender 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, radiology, follow-up wound care/addiction medication, narcotic treatment program, and transgender services • Randomize
MIT 14.010	Specialty Services Arrivals	18	Specialty Services Arrivals	• Arrived from (other departmental institution) • Date of transfer (3–9 months) • Randomize
MITs 14.011–012	Denials	2	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	7	EMRRC meeting minutes	• Monthly meeting minutes (6 months)
MIT 15.004	LGB	N/A at this institution	LGB meeting minutes	• Quarterly meeting minutes (12 months)
MIT 15.101	Medical Emergency Response Drills	3	On-site summary reports & documentation for ER drills	• Most recent full quarter • Each watch
MIT 15.102	Institutional Level Medical Grievances	10	On-site list of grievances/closed grievance files	• Medical grievances closed (6 months)

Quality Indicator	Sample Category	No. of Samples	Data Source	Filters
Administrative Operations (continued)				
MIT 15.103	Death Reports	6	Institution-list of deaths in prior 12 months	• Most recent 10 deaths Initial death reports
MIT 15.104	Nursing Staff Validations	10	On-site nursing education files	• On duty one or more years • Nurse administers medications • Randomize
MIT 15.105	Provider Annual Evaluation Packets	8	On-site provider evaluation files	• All required performance evaluation documents
MIT 15.106	Provider Licenses	10	Current provider listing (at start of inspection)	• Review all
MIT 15.107	Medical Emergency Response Certifications	All	On-site certification tracking logs	• All staff • Providers (ACLS) • Nursing (BLS/CPR) • Custody (CPR/BLS)
MIT 15.108	Nursing Staff and Pharmacist in Charge Professional Licenses and Certifications	All	On-site tracking system, logs, or employee files	• All required licenses and certifications
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	6	OIG summary log: deaths	• Between 35 business days & 12 months prior • California Correctional Health Care Services mortality reviews

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California Correctional Health Care Services' Response

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May 5, 2025

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 has reviewed the draft Medical Inspection Report for FSP conducted by the Office of the Inspector General from August 2023 to January 2024. Thank you for preparing the report.

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

Sincerely,

DocuSigned by:
DeAnna Gouldy
3B7F 6B95AC0A2D1...

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
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Cycle 7

Medical Inspection Report

for

Folsom State Prison

OFFICE *of the*
INSPECTOR GENERAL

Amarik K. Singh
Inspector General

Shaun Spillane
Chief Deputy Inspector General

STATE *of* CALIFORNIA
May 2025

OIG