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OIG | OFFICE *of the* INSPECTOR GENERAL

Independent Prison Oversight

July 2025

Cycle 7

Medical Inspection Report

Pelican Bay State Prison

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Contents

Illustrations

Tables

Figures

Photographs

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 that 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 Pelican Bay 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 November 2023 to April 2024.[4]

[4] Samples are obtained per case review methodology shared with stakeholders in prior cycles. The case reviews include death reviews between August 2023 and April 2024 and emergency services cardiopulmonary resuscitation reviews between June 2023 and April 2024.

Summary: Ratings and Scores

We completed the Cycle 7 inspection of PBSP in October 2024. OIG inspectors monitored the institution's delivery of medical care that occurred between November 2023 and April 2024.

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

The OIG rated the compliance component of the overall health care quality at PBSP ***adequate***.

OIG case review clinicians (a team of physicians and nurse consultants) reviewed 55 cases, which contained 645 patient-related events. They performed quality control reviews; their subsequent collective deliberations ensured consistency, accuracy, and thoroughness. Our OIG clinicians acknowledged institutional structures that catch and resolve mistakes that may occur throughout the delivery of care. After examining the medical records, our clinicians completed a follow-up on-site inspection in October 2024 to verify their initial findings. OIG physicians rated the quality of care for 20 comprehensive case reviews. Of these 20 cases, our physicians rated one ***proficient,*** 15 ***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 353 patient records and 1,086 data points, and used the data to answer 90 policy questions. In addition, we observed PBSP's processes during an on-site inspection in June 2024.

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

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

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

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

		Ratings: Proficient / Adequate / Inadequate		Scoring Ranges: 100%–85.0% / 84.9%–75.0% / 74.9%–0		
		Case Review		Compliance		
MIT Number	Health Care Indicators	Cycle 7	Change Since Cycle 6*	Cycle 7	Cycle 6	Change Since Cycle 6*
1	Access to Care	Proficient	↑	87.4%	79.7%	↑
2	Diagnostic Services	Adequate	=	75.6%	82.2%	=
3	Emergency Services	Adequate	=	N/A	N/A	N/A
4	Health Information Management	Proficient	↑	97.7%	64.2%	↑↑
5	Health Care Environment†	N/A	N/A	56.3%	67.9%	=
6	Transfers	Adequate	=	73.6%	77.1%	↓
7	Medication Management	Proficient	=	68.4%	64.4%	=
8	Prenatal and Postpartum Care	N/A	N/A	N/A	N/A	N/A
9	Preventive Services	N/A	N/A	87.9%	83.4%	↑
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	Adequate	=	73.3%	85.0%	↓↓
14	Specialty Services	Adequate	=	68.2%	54.2%	=
15	Administrative Operations†	N/A	N/A	66.0%	86.5%	↓↓

* The symbols in this column correspond to changes that occurred in indicator ratings between the medical inspections conducted during Cycle 6 and Cycle 7. The equals sign means there was no change in the rating. The single arrow means the rating rose or fell one level, and the double arrow means the rating rose or fell two levels (green, from *inadequate* to *proficient*; pink, from *proficient* to *inadequate*).

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

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

Medical Inspection Results

Deficiencies Identified During Case Review

Deficiencies are medical errors that increase the risk of patient harm. Deficiencies can be minor or significant, depending on the severity of the deficiency. An *adverse event* occurs when the deficiency caused harm to the patient. All major health care organizations identify and track adverse events. We identify deficiencies and adverse events to highlight concerns regarding the provision of care and for the benefit of the institution's quality improvement program to provide an impetus for improvement.[6]

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

Case Review Results

OIG case reviewers (a team of physicians and nurse consultants) assessed 10 of the 13 indicators applicable to PBSP. Of these 10 indicators, OIG clinicians rated three ***proficient***, seven ***adequate***, and none ***inadequate***. The OIG physicians also rated the overall adequacy of care for each of the 20 detailed case reviews they conducted. Of these 20 cases, 15 were ***adequate***, four were ***inadequate***, and one was ***proficient***. In the 645 events reviewed, we identified 103 deficiencies, 32 of which OIG clinicians considered to be of such magnitude that, if left unaddressed, would likely contribute to patient harm.

Our clinicians found the following strengths at PBSP:

- Staff provided excellent access to providers and nurses for patients after hospital encounters, after triage and treatment area (TTA) encounters, and upon transfer into the institution.
- Staff completed diagnostic tests for patients without any delays.
- Staff managed hospital, specialty, and TTA records for patients excellently.
- PBSP's medication management for patients was excellent with no significant administration lapses in new medications, hospital discharge medications, specialized medical housing (SMH) medications, and transfer medications.

Our clinicians found the following weaknesses at PBSP:

- Providers did not manage their patients with diabetes well.
- Staff needed to improve in completing patients' specialty appointments timely.
- Nurses needed to improve in performing complete assessments and interventions for patients during outpatient sick call encounters and in the specialized medical housing.

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

Compliance Testing Results

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

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

- Medical staff performed outstandingly in scanning and reviewing community hospital discharge reports and scanning requests for health care services into patients' electronic medical records within required time frames.
- Staff timely administered tuberculosis (TB) medications, offered influenza vaccinations, and provided colorectal cancer screenings to all sampled patients.
- Nursing staff processed sick call request forms, performed face-to-face evaluations, and completed nurse-to-provider referrals within required time frames. Moreover, staff provided provider appointments excellently to newly arrived patients and patients returning from hospitalizations.

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

- Nursing staff faltered in regularly inspecting emergency medical response bags (EMRBs).
- Health care staff did not consistently follow hand hygiene precautions before or after patient encounters.
- PBSP's medical clinics contained multiple expired medical supplies.
- Staff frequently failed to maintain medication continuity for chronic care patients, patients discharged from the hospital, and patients admitted to a specialized medical housing unit. In addition, PBSP maintained poor medication continuity for patients who had a temporary layover at PBSP.

Institution-Specific Metrics

Pelican Bay State Prison is located in the city of Crescent City in Del Norte County. The institution operates as a medium-security institution housing general population patients. CCHCS has designated PBSP as a *basic care institution*, providing outpatient health care services through its clinics, which handle nonurgent requests for medical services. Basic care institutions are located in rural areas, away from tertiary care centers and specialty care providers whose services would likely be used frequently by higher-risk patients. Basic care institutions can provide limited specialty medical services and consultations for a patient population that is generally healthy. PBSP health care staff treats patients needing urgent or emergent care in its triage and treatment area (TTA) and cares for patients requiring inpatient health services in its correctional treatment center (CTC).

As of January 22, 2025, the department reports on its public tracker that 66 percent of PBSP's incarcerated population is fully vaccinated for COVID-19 while 43 percent of PBSP's staff is fully vaccinated for COVID-19.[7]

In June 2024, the Health Care Services Master Registry showed that PBSP had a total population of 2,016. A breakdown of the medical risk level of the PBSP population as determined by the department is set forth in Table 2 below.[8]

Table 2. PBSP Master Registry Data as of June 2024

Medical Risk Level	Number of Patients	Percentage*
High 1	35	1.7%
High 2	152	7.5%
Medium	984	48.8%
Low	845	41.9%
Total	**2,016**	**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 6-10-24.

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

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

According to staffing data the OIG obtained from California Correctional Health Care Services (CCHCS), as identified in Table 3 below, PBSP had 2.0 vacant executive leadership positions, 2.0 primary care provider vacancies, 4.7 nursing supervisor vacancies, and 57.6 nursing staff vacancies.

Table 3. PBSP Health Care Staffing Resources as of June 2024

Positions	Executive Leadership*	Primary Care Providers	Nursing Supervisors	Nursing Staff †	Total
Authorized Positions	5.0	5.0	11.7	101.6	123.3
Filled by Civil Service	4.0	2.0	7.0	43.0	56.0
Vacant	2.0	2.0	4.7	57.6	66.3
Percentage Filled by Civil Service	80.0%	40.0%	59.8%	42.3%	45.4%
Filled by Telemedicine	0	3.2	0	0	3.2
Percentage Filled by Telemedicine	0	64.0%	0	0	2.6%
Filled by Registry	0	1.0	0	46.0	47.0
Percentage Filled by Registry	0	20.0%	0	45.3%	38.1%
Total Filled Positions	4.0	6.2	7.0	89.0	106.2
Total Percentage Filled	**80.0%**	**124.0%**	**59.8%**	**87.6%**	**86.1%**
Appointments in Last 12 Months	0	5.0	4.0	12.0	21.0
Redirected Staff	0	0	0	0	0
Staff on Extended Leave ‡	0	0	1.0	2.0	3.0
Adjusted Total: Filled Positions	**4.0**	**6.2**	**6.0**	**87.0**	**103.2**
Adjusted Total: Percentage Filled	**80.0%**	**124.0%**	**51.3%**	**85.6%**	**83.7%**

* 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 June 10, 2024, from California Correctional
Health Care Services.

Population-Based Metrics

In addition to our own compliance testing and case reviews, as noted above, the OIG presents selected measures from the Healthcare Effectiveness Data and Information Set (HEDIS) for comparison purposes. The HEDIS is a set of standardized quantitative performance measures designed by the National Committee for Quality Assurance to ensure the public has the data it needs to compare the performance of health care plans. Because the Veterans Administration no longer publishes its individual HEDIS scores, we removed them from our comparison for Cycle 7. Likewise, Kaiser (commercial plan) no longer publishes HEDIS scores. However, through the California Department of Health Care Services' *Medi-Cal Managed Care Technical Report,* the OIG obtained California Medi-Cal and Kaiser Medi-Cal HEDIS scores to use in conducting our analysis, and we present them here for comparison.

HEDIS Results

We considered PBSP'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)—PBSP'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. PBSP had a 43 percent influenza immunization rate for adults 18 to 64 years old and a 73 percent influenza immunization rate for adults 65 years of age and older.[9] The pneumococcal vaccination rate was 87 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)—PBSP's percentage of patients with colon cancer screening rate of 68 percent was lower than for California Kaiser NorCal and SoCal Medi-Cal but higher than for California Medi-Cal.

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[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. PBSP Results Compared With State HEDIS Scores

HEDIS Measure	PBSP Cycle 7 Results*	California Medi-Cal†	California Kaiser NorCal Medi-Cal†	California Kaiser SoCal Medi-Cal†
HbA1c Screening	100%	–	–	–
Poor HbA1c Control (> 9.0%) ‡,§	**11%**	33%	31%	22%
HbA1c Control (< 8.0%) ‡	82%	–	–	–
Blood Pressure Control (< 140/90) ‡	98%	–	–	–
Eye Examinations	44%	–	–	–
Influenza – Adults (18–64)	43%	–	–	–
Influenza – Adults (65+)	73%	–	–	–
Pneumococcal – Adults (65+)	87%	–	–	–
Colorectal Cancer Screening	68%	40%	**71%**	**71%**

Notes and Sources

* Unless otherwise stated, data were collected in June 2024 by reviewing medical records from a sample of PBSP'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 *Medi-Cal Managed Care Physical Health External Quality Review Technical Report*, dated July 1, 2023–June 30, 2024 (published April 2024; **https://www.dhcs.ca.gov/dataandstats/reports/Documents/CA2023-24-Medi-Cal-Managed-Care-Physical-Health-External-Quality-Review-Technical-Report-Vol1-F1.pdf**.

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

Diagnostic Services

- The department should develop and implement strategies, such as 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.

Emergency Services

- Leadership should develop strategies to ensure all staff immediately activate emergency medical services for emergent patients needing a higher level of care. Leadership should implement remedial measures as appropriate.

- Nursing leadership should analyze the challenges to nurses performing reassessments of emergent and urgent conditions and documenting accurate timelines of events. Leadership should implement remedial measures as appropriate.

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 remedial measures as appropriate.

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

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

Transfers

- Nursing leadership should develop strategies to ensure nursing staff completely answer and address required initial health screening questions. Leadership should implement remedial measures or education as appropriate.

Medication Management

- Medical and nursing leadership should determine the challenges to ensuring chronic care patients, hospital discharge patients, and patients admitted to specialized medical housing receive their medications timely and without interruption. Leadership should implement remedial measures as appropriate.

Nursing Performance

- Nursing leadership should determine the challenges to nurses performing detailed assessments as well as providing interventions during face-to-face patient evaluations 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

Specialized Medical Housing

- Nursing leadership should develop strategies to ensure nursing staff in the correctional treatment center (CTC) perform thorough patient assessments and should implement remedial measures as appropriate.

Specialty Services

- Health care leadership should determine the challenges to the timely provision of telemedicine specialty appointments 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
Proficient	***Proficient*** **(87.4%)**

Case review found PBSP provided excellent access to care. We did not find any deficiencies in provider access for patients with specialized medical housing care, after hospitalization care, after specialty services care, after TTA care, or upon transfer into the institution. PBSP also offered excellent clinic nursing access. Although we found a pattern of delayed appointments to telemedicine specialists within initial provider-ordered time frames, patients generally received acceptable access to specialists. Considering all aspects of care access, the OIG rated the case review component of this indicator ***proficient***.

Compliance testing showed PBSP performed very well in this indicator. Nurses always timely reviewed patient sick call requests and completed face-to-face encounters. Staff also always completed provider appointments for patients returning after hospitalizations and frequently timely completed provider appointments for newly transferred patients within required time frames. Staff further performed well in offering provider appointments for chronic care patients. Based on the overall **Access to Care** compliance score result, the OIG rated the compliance testing component of this indicator ***proficient***.

Case Review and Compliance Testing Results

OIG clinicians reviewed 344 provider, nursing, urgent or emergent care (TTA), specialty, and hospital events that required the institution to generate appointments. We identified eight deficiencies relating to **Access to Care**, four of which were significant.[11]

Access to Care Providers

PBSP ensured very good access to its providers. Compliance testing showed staff performed well in completing timely chronic care face-to-face follow-up appointments

[11] Access deficiencies occurred in cases 1, 14, 17, 18, 24, 25, 34, and 53. Significant access deficiencies occurred in cases 1, 24, 25, and 53.

(MIT 1.001, 84.0%) and acceptably in completing timely nurse-to-provider referral appointments (MIT 1.005, 80.0%).

OIG clinicians found providers evaluated patients timely when referred by nurses from their sick-call requests as well as when providers requested subsequent appointments. We identified three minor deficiencies related to provider access in the outpatient setting. The following are examples:

- In case 14, the provider evaluated the patient seven days late for the chronic care appointment.
- In case 18, the provider evaluated the patient five days late for a follow-up appointment.
- In case 34, the nurse documented a follow-up with a provider within 14 days but did not order the appointment, so the patient was not evaluated.

Access to Specialized Medical Housing Providers

PBSP performed excellently with access to specialized medical housing providers. OIG clinicians reviewed 65 CTC encounters and did not find any deficiencies related to provider access. Providers evaluated the patients in specialized medical housing with appropriate frequency, and the OIG found no delays in providers performing the initial admission history and physical examinations for patients.

Access to Clinic Nurses

PBSP provided outstanding access to clinic nurses. Compliance testing showed nurses always reviewed the patients' requests for service on the same day they were received (MIT 1.003, 100%), and all nurse face-to-face appointments occurred within one business day after the sick call requests were reviewed (MIT 1.004, 100%). OIG clinicians reviewed 136 nursing encounters within the institution and identified no nursing access deficiencies. Nurses timely triaged heath care requests, assessed patients, and scheduled follow-ups with providers when medically indicated.

Access to Specialty Services

Compliance testing showed mixed performance with specialty access. Although routine-priority specialty appointments frequently occurred timely (MIT 14.007, 86.7%), medium-priority specialty appointments only sporadically occurred timely (MIT 14.004, 33.3%), while high-priority specialty appointments inconsistently occurred timely (MIT 14.001, 73.3%).

During the last inspection cycle, OIG clinicians did not find any access deficiencies with specialists; however, in Cycle 7, we identified five access deficiencies. Of these five deficiencies, three were significant due to the duration of the delays from the original orders. The following is an example:

- In case 1, the patient with hearing loss requested service because his newly issued hearing aids were not working. The provider ordered a medium-priority audiology specialty appointment; however, the appointment occurred more than three months later, which was a two-month delay. On-site, the specialty

supervisor stated a new nurse was in charge of this area, which may have been the reason for the delay in scheduling.

Follow-Up After Specialty Services

Patients generally followed up with their providers after receiving high-priority specialty services. Compliance testing showed provider appointments after specialty services usually occurred within the required time frame (MIT 1.008, 76.7%). OIG clinicians did not identify any access deficiencies after specialty services.

Follow-Up After Hospitalization

Providers always evaluated their patients' hospitalizations within required time frames. Compliance testing showed providers always timely followed up with their patients after hospitalizations (MIT 1.007, 100%). OIG clinicians did not identify any access deficiencies with these follow-up appointments.

Follow-Up After Urgent or Emergent Care (TTA)

PBSP providers always evaluated their patients following triage and treatment area (TTA) encounters, as medically indicated. OIG clinicians reviewed 28 TTA events and identified no deficiencies with access to providers after TTA encounters.

Follow-Up After Transferring Into PBSP

PBSP consistently ensured providers timely evaluated their patients when they transferred into the institution. Intake appointments for newly arrived patients almost always occurred within the required timeframe (MIT 1.002, 96.0%). OIG clinicians did not find any access deficiencies with patients who transferred into the institution.

Clinician On-Site Inspection

OIG clinicians met with PBSP medical leadership, scheduling supervisors, nursing supervisors, and specialty nurses. The nursing supervisors agreed with the deficiencies discussed during the on-site inspection. The medical leadership reported the patient population had increased from 1,400 to 2,100 since the beginning of 2024, which represents a 50% increase in population. Additionally, most of these incoming patients had already been enrolled in the enhanced outpatient program (EOP), which resulted in increased utilization of resources.[12] Many of the incoming patients were also already out of compliance for their MAT appointments, so their arrivals instantly caused the Dashboard to reflect that status by turning red, giving the appearance that PBSP was significantly behind in scheduling these appointments.[13] Medical leadership also stated

[12] EOP is the mental health outpatient program for patients, which requires a separate patient care team, weekly patient group and individual therapy sessions, and regular psychiatry and medication monitoring.

[13] MAT is the Medication Assisted Treatment program for substance use disorder. CCHCS uses the Health Care Services (HCS) Dashboard as a tool to provide and monitor information such as patient access timeliness, disease management, patient outcomes, utilization of services, and cost. Organizational leaders and program managers use it to survey key performance indicators, identify opportunities for improvement, and trend performance over time.

CCHCS headquarters schedulers handled the telemedicine specialties, which caused delays and resulted in specialty appointment backlogs.

Compliance On-Site Inspection and Discussion

Three of six housing units randomly tested at the time of inspection had access to health care services request forms (CDCR Form 7362) (MIT 1.101, 50.0%). In three housing units, custody officers did not have a system in place for restocking the forms. According to custody officers, they relied on medical staff to replenish the forms in the housing units.

Compliance Score Results

Table 5. Access to Care

Compliance Questions	Scored Answer			
	Yes	No	N/A	Yes %
Chronic care follow-up appointments: Was the patient's most recent chronic care visit within the health care guideline's maximum allowable interval or within the ordered time frame, whichever is shorter? (1.001)	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)	24	1	0	96.0%
Clinical appointments: Did a registered nurse review the patient's request for service the same day it was received? (1.003)	40	0	0	100%
Clinical appointments: Did the registered nurse complete a face-to-face visit within one business day after the CDCR Form 7362 was reviewed? (1.004)	40	0	0	100%
Clinical appointments: If the registered nurse determined a referral to a primary care provider was necessary, was the patient seen within the maximum allowable time or the ordered time frame, whichever is the shorter? (1.005)	16	4	20	80.0%
Sick call follow-up appointments: If the primary care provider ordered a follow-up sick call appointment, did it take place within the time frame specified? (1.006)	1	0	39	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)	5	0	0	100%
Specialty service follow-up appointments: Did the clinician follow-up visits occur within required time frames? (1.008) *	23	7	15	76.7%
Clinical appointments: Do patients have a standardized process to obtain and submit health care services request forms? (1.101)	3	3	0	50.0%
				Overall percentage (MIT 1): **87.4%**

* 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)	8	2	0	80.0%
Did the patient receive the high-priority specialty service within 14 calendar days of the primary care provider order or the Physician Request for Service? (14.001)	11	4	0	73.3%
Did the patient receive the subsequent follow-up to the high-priority specialty service appointment as ordered by the primary care provider? (14.003)	5	3	7	62.5%
Did the patient receive the medium-priority specialty service within 15-45 calendar days of the primary care provider order or the Physician Request for Service? (14.004)	5	10	0	33.3%
Did the patient receive the subsequent follow-up to the medium-priority specialty service appointment as ordered by the primary care provider? (14.006)	6	3	6	66.7%
Did the patient receive the routine-priority specialty service within 90 calendar days of the primary care provider order or Physician Request for Service? (14.007)	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)	7	2	6	77.8%

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	***Adequate* (75.6%)**

Case review found PBSP performed very good diagnostic services, similar to its performance in Cycle 6. PBSP offered excellent access to and timely test completion of diagnostic studies. Staff also managed health information well as they usually retrieved and endorsed the laboratory, radiology, and pathology results and, with few exceptions, notified patients of their results timely. The OIG rated the case review component of this indicator ***adequate***.

In compliance testing, PBSP performed acceptably in this indicator. Staff performed excellently in completing radiology services, in retrieving and endorsing pathology reports, as well as in endorsing laboratory reports. In addition, providers satisfactorily reviewed and endorsed radiology reports. However, staff needed improvement in providing routine laboratory services and in generating complete patient test results notification letters with all required elements. Based on the overall **Diagnostic Services** compliance score result, the OIG rated the compliance testing component of this indicator ***adequate***.

Case Review and Compliance Testing Results

OIG clinicians reviewed 88 diagnostic events and identified 11 deficiencies, one of which was significant. Of these 11 deficiencies, all related to HIM and none to completing ordered diagnostic services.[14]

Test Completion

Compliance testing showed staff always completed radiology tests timely (MIT 2.001, 100%), but they needed improvement in completing laboratory tests within specified time frames (MIT 2.004, 70.0%). OIG clinicians found PBSP performed excellently with completing diagnostic tests, and we did not find any delays in provider-ordered laboratory or radiographic tests.

[14] Diagnostic deficiencies occurred in cases 11,15, 17, 18, 21, 22, 24, and 25. A significant deficiency occurred in case 11.

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

Health Information Management

PBSP performed variably with management of diagnostic test results. Compliance testing showed staff managed health information of radiologic studies sufficiently (MIT 2.002, 80.0%) and laboratory results excellently (MIT 2.005, 100%). Staff always retrieved (MIT 2.010, 100%) and reviewed (MIT 2.011, 100%) pathology results timely, but staff never notified patients of their results with complete test notification letters (MIT 2.012, zero). OIG clinicians identified minor deficiencies with one report retrieval delay, four endorsement delays, and five incomplete patient notifications. We found one significant deficiency as follows:

- In case 11, the diabetic patient had an elevated HbA1c blood test to monitor his sugar control.[15] No providers endorsed this result, and the patient did not receive a follow-up appointment during the review period.

Clinician On-Site Inspection

We spoke with the supervisor who oversaw the laboratory and radiology processes. The supervisor reported PBSP had only one senior radiologic technician working during the review period, and the unit was short-staffed with laboratory assistance until December 11, 2023. Staff offered x-ray service five days a week and CT, MRI, and ultrasound services one day a month.[16] Providers received the radiographic test results on the same day of service and generated patient notification letters after reviewing the results. The laboratory vendor interfaced with EHRS with the laboratory results, and providers had five days to review and send results letters to the patients.[17] At the time of the on-site inspection in October 2024, the radiology department had a backlog of 150 to 200 imaging orders, while the laboratory did not have any backlogs of laboratory test orders.

[15] Hemoglobin A1c (HbA1c) is a blood test that measures the average plasma glucose over the previous 12 weeks.

[16] 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.

[17] EHRS is the Electronic Health Records System. The department's electronic health record system is used for storing the patient's medical history and health care staff communication.

Compliance Score Results

Table 7. Diagnostic Services

	Scored Answer			
Compliance Questions	**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)	8	2	0	80.0%
Radiology: Did the ordering health care provider communicate the results of the radiology study to the patient within specified time frames? (2.003)	8	2	0	80.0%
Laboratory: Was the laboratory service provided within the time frame specified in the health care provider's order? (2.004)	7	3	0	70.0%
Laboratory: Did the health care provider review and endorse the laboratory report within specified time frames? (2.005)	10	0	0	100%
Laboratory: Did the health care provider communicate the results of the laboratory test to the patient within specified time frames? (2.006)	5	5	0	50.0%
Laboratory: Did the institution collect the STAT laboratory test and receive the results within the required time frames? (2.007)	N/A	N/A	N/A	N/A
Laboratory: Did the provider acknowledge the STAT results, OR did nursing staff notify the provider within the required time frames? (2.008)	N/A	N/A	N/A	N/A
Laboratory: Did the health care provider endorse the STAT laboratory results within the required time frames? (2.009)	N/A	N/A	N/A	N/A
Pathology: Did the institution receive the final pathology report within the required time frames? (2.010)	5	0	0	100%
Pathology: Did the health care provider review and endorse the pathology report within specified time frames? (2.011)	5	0	0	100%
Pathology: Did the health care provider communicate the results of the pathology study to the patient within specified time frames? (2.012)	0	5	0	0
				Overall percentage (MIT 2): **75.6%**

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

Recommendations

- The department should develop and implement strategies, such as 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.

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
Adequate	***Not Applicable***

Our clinicians found PBSP performed sufficiently in emergency care. Compared with Cycle 6, the institution demonstrated similar results. The nurses generally performed appropriate assessments and interventions, responded timely to emergency events, and initiated CPR without delay. In addition, medical leadership conducted clinical reviews on emergency events and generally identified training issues. However, we identified opportunities for improvement in immediately activating emergency medical services (EMS) and in nursing performance with reassessing and accurately documenting event time lines, all of which are discussed below. Taking these factors into consideration, the OIG rated this indicator ***adequate***.

Case Review Results

We reviewed 28 urgent or emergent events and found 19 emergency care deficiencies, four of which were significant.[18]

Emergency Medical Response

PBSP health care staff and custody staff responded promptly to emergencies throughout the institution and notified TTA staff timely. However, our clinicians identified two significant deficiencies related to a delay in contacting EMS. The following are examples:

- In case 7, staff activated a medical alarm for the patient, who was found unconscious due to a suspected drug overdose. Staff contacted EMS eight minutes after the alarm activation.
- In case 21, staff activated a medical alarm for a patient with a suspected seizure. While some documentation showed staff contacted EMS at the same time the medical alarm was activated, the TTA RN documented custody staff renotified the watch office to request an emergent ambulance due to a delay. Subsequently,

[18] Deficiencies occurred in cases 1, 4-7, 9, 17, and 20-22. Significant deficiencies occurred in cases 6, 7, and 21.

staff did not contact EMS until seven minutes after the activation of the emergency alarm.

Cardiopulmonary Resuscitation Quality

Our clinicians reviewed six cases in which staff initiated CPR.[19] Nursing and custody staff initiated CPR without delay. The nurses applied the automated external defibrillator (AED), administered Narcan timely, and notified emergency medical services from the scene. However, in one case we identified an opportunity for improvement:

- In case 6, staff activated a medical alarm in the B clinic for the patient, who became unconscious after reporting complaints of nausea with dizziness. The patient had no pulse and was not breathing. The RN initiated CPR, and the patient regained consciousness after one round of CPR. However, when discontinuing CPR, the RN did not reassess the patient's oxygenation saturation rate, mental status, or provide oxygen support for the patient despite an abnormally low respiratory rate. Staff did not apply the oxygen to the patient until five minutes after the discontinuation of CPR. In addition, medical leadership did not identify this deficiency in the clinical review.

Provider Performance

PBSP providers performed well in urgent and emergent situations, as well as in after-hours care. Providers either directly evaluated patients or were available to TTA staff by phone in 28 emergency events during the review period. Providers satisfactorily obtained patient histories, made appropriate triage decisions, developed supportable differential diagnoses, and sufficiently documented in the medical records. OIG clinicians did not find any provider deficiencies related to emergency care.

Nursing Performance

Nurses generally performed good nursing assessments and interventions. However, our clinicians identified a pattern of nurses not always reassessing vital signs when clinically indicated. The following are examples:

- In case 1, the RN evaluated the patient in the TTA for complaints of chest pain. Upon arrival, the patient complained of constant, left-sided, moderate to severe chest pain, described as pressure and sharp radiating pain to the left shoulder. The nurse administered nitroglycerin twice.[20] However, the nurse did not assess the patient's chest pain level after either nitroglycerin administration. In addition, nurses routinely obtained vital signs; however, they did not record the respiratory rate and effort from the time the patient arrived in the TTA to the time the patient transferred to the community hospital for 46 minutes. Similar deficiencies occurred in cases 6, 7, and 17.

[19] CPR events occurred in cases 3–8.

[20] Nitroglycerin is a medication that dilates blood vessels to increase blood flow to the heart.

Nursing Documentation

Nurses generally performed thorough documentation for emergency events. However, we identified seven documentation deficiencies and a pattern related to timeline discrepancies in the sequence of events.[21] The following is an example:

- In case 4, the staff activated an emergency alarm for the patient, who was found hanging in his cell and was unresponsive. Custody initiated CPR, but the patient ultimately died. In reviewing the timeline of events, we identified discrepancies in documenting the times when EMS was notified and when EMS arrived. Similar deficiencies occurred in cases 7, 9, 20 and 22.

Emergency Medical Response Review Committee

Our clinicians found medical leadership performed well with conducting clinical reviews for all patients who transferred to a higher level of care, including patient deaths. However, we found in six out of the 19 emergency cases reviewed, medical leadership did not identify the same opportunities for improvement as those our clinicians identified.[22] In relation, compliance testing revealed EMRRC event checklists were intermittently incomplete (MIT 15.003, 58.3%). We discuss this further in the **Administrative Operations** indicator.

Clinician On-Site Inspection

During the on-site inspection, our clinicians had the opportunity to interview the TTA staff. PBSP had two beds in the TTA and one emergency response vehicle (ERV). The staff reported the TTA was staffed with two RNs during the day and evening shifts and one RN during the night shift. One RN was designated as the rover, who was assigned to respond to all emergencies and, at times, would cover the receiving and release area (R&R) in the mornings when no RN was available to process patients who were paroling. The TTA had an assigned provider Monday through Friday and an on-call provider assigned for weekend coverage.

The TTA staff shared all clinic staff were required to respond until the TTA RN rover arrived on scene during an emergency alarm. This included the clinic RN, the licensed vocational nurse (LVN) coordinator, the clinic medical assistant, and the medication line LVN. Furthermore, the staff reported all clinic staff had assigned roles to perform during emergency events. In addition, the CDCR Fire Camp personnel were available to assist with emergency events as needed.[23]

The staff expressed having challenges with retaining staff because many staff were from the registry and had arrived to PBSP from different locations; thus, they were new to the

[21] Documentation deficiencies occurred in cases 4, 5, 7, 9, 20, 21 and 22.

[22] Clinical reviews conducted in cases 1, 3–9, 19–22, and 24. Deficiencies occurred in cases 1, 4–7, 9 and 20.

[23] The CDCR, in cooperation with the California Department of Forestry and Fire Protection (CAL FIRE) and the Los Angeles County Fire Department (LACFD), jointly operates 35 conservation camps, commonly known as fire camps, located in 25 counties across California. All camps are minimum-security facilities and staffed with correctional staff. Information was obtained from https://www.cdcr.ca.gov.

prison system. Nonetheless, staff expressed feeling supported by nursing leadership and having an excellent working relationship with custody.

Recommendations

- Leadership should develop strategies to ensure all staff immediately activate emergency medical services for emergent patients needing a higher level of care. Leadership should implement remedial measures as appropriate.

- Nursing leadership should analyze the challenges to nurses performing reassessments of emergent and urgent conditions and documenting accurate timelines of events. Leadership should implement remedial measures as appropriate.

Health Information Management

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

Ratings and Results Overview

Case Review Rating	Compliance Rating and Score
Proficient	***Proficient* (97.7%)**

Case review found PBSP performed excellently in managing health information. Staff retrieved, endorsed, and scanned records timely. In addition, they managed hospital, specialty, and urgent or emergent records very well. Staff also handled diagnostic information very well. As a result, the OIG rated the case review component of this indicator ***proficient***.

Compliance testing showed PBSP performed outstandingly in this indicator. Staff performed excellently in scanning patient sick call requests and specialty reports as well as scanning and reviewing hospital discharge reports timely. Staff also performed very well in properly scanning medical records into the correct patients' files. Based on the overall **Health Information Management** compliance score result, the OIG rated the compliance testing component of this indicator ***proficient***.

Case Review and Compliance Testing Results

We reviewed 645 events, including 148 hospital, diagnostic, and specialty reports, and identified 15 deficiencies related to health information management (HIM), one of which was significant.[24]

Hospital Discharge Reports

Compliance testing showed excellent performance with hospital discharge reports. PBSP staff retrieved and scanned all hospital discharge records timely (MIT 4.003, 100%). In addition, the hospital discharge reports included key elements, and providers reviewed the reports timely (MIT 4.005, 100%).

[24] HIM deficiencies occurred in cases 11, 15, 17, 18, 21, 22, 24, and 25. Significant deficiencies occurred in cases 11.

OIG clinicians reviewed 26 emergency department and hospital encounters. PBSP staff timely retrieved hospital records, scanned them into the EHRS, and reviewed them properly. We identified only one minor deficiency as follows:

- In case 24, the patient was discharged from the hospital, and the provider endorsed the report eight days after the receipt of the report.

Specialty Reports

Compliance testing showed PBSP staff performed variably with health information management of routine-priority, medium-priority, and high-priority specialty reports (MIT 14.008, 60.0%, MIT 14.005, 60.0%, and MIT 14.002, 80.0%). Nonetheless, staff almost always scanned specialty reports into the EHRS timely (MIT 4.002, 96.7%). OIG clinicians found staff performed well in retrieving, endorsing, and scanning specialty reports. We identified only three minor deficiencies: two minor delays in endorsement and one delayed echocardiogram report retrieval.[25]

Diagnostic Reports

Staff overall performed well with retrieving, endorsing, and scanning diagnostic records. Compliance testing showed PBSP staff performed excellently with reviewing pathology results (MIT 2.011, 100%) but poorly with test letter communication of these results (MIT 2.012, zero). OIG clinicians found staff usually retrieved, endorsed, and scanned diagnostic records timely. We reviewed two pathology reports, both of which staff handled appropriately. We also identified a total of 11 deficiencies: four with delayed endorsement of diagnostic reports, four without patient notification letters, two with incomplete patient notification letters, and one with delayed retrieval of the report. Only one of these deficiencies was significant and is discussed further in the **Diagnostic Services** indicator.

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

Urgent and Emergent Records

OIG clinicians reviewed 28 emergency care events and found PBSP nurses and providers documented these events well. Providers sufficiently documented their emergency care, specifically as a provider-on-call telephone consult or as a TTA in-person encounter. Providers sufficiently their emergency care, specifically as a provider-on-call telephone consult or as a TTA in-person encounter. OIG clinicians did not identify any deficiencies with health information management of urgent or emergent records. The **Emergency Services** indicator details additional information regarding emergency care.

Scanning Performance

PBSP's scanning performance was overall excellent. Compliance testing showed very good performance with scanning, labeling, and including medical records in the correct

[25] An echocardiogram is a procedure using an ultrasound to examine and image the heart.

patients' files (MIT 4.004, 91.7%). OIG clinicians did not find any mislabeled or misfiled medical documents.

Clinician On-Site Inspection

We discussed general medical records questions with HIM supervisors. They described how a specialty clinic office technician (OT) tracked all off-site scheduled encounters on a spreadsheet to ensure report retrieval. The utilization management (UM) RN tracked all hospitalizations and updated the patient care team. Once the specialty RN received the report, the RN sent the report to HIM staff, who scanned and forwarded a message through EHRS message center to the provider for review and signature. HIM staff stated the provider was responsible for the patient, and therefore, they did not track whether providers sent their patient notification letters. Health Record Technician I (HRT I) and Health Record Technician II (HRT II) staff had access to a local hospital's electronic medical records for printing to ensure timely record retrieval.

We discussed some of the deficiencies identified during our reviews with HIM staff. They explained newer policies assigned a high preference to scan hospital reports as they were retrieved, even if the records were incomplete. Staff scanned hospital radiology results, EKGs, and specialty consultations separately using specific document labels on the specific date these services were performed. The staff subsequently would also scan the full hospital record using the discharge date as the date of service. This activity increased their workload because they were required to review every hospital record and then separate diagnostic records from consultations and discharges. We did not identify any issues during the review period; however, this PBSP process may increase the risk for incorrectly scanned or duplicate reports.

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	20	100%
Are specialty documents scanned into the patient's electronic health record within five calendar days of the encounter date? (4.002)	29	1	15	96.7%
Are community hospital discharge documents scanned into the patient's electronic health record within three calendar days of hospital discharge? (4.003)	5	0	0	100%
During the inspection, were medical records properly scanned, labeled, and included in the correct patients' files? (4.004)	22	2	0	91.7%
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)	5	0	0	100%
				Overall percentage (MIT 4): **97.7%**

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)	8	2	0	80.0%
Laboratory: Did the health care provider review and endorse the laboratory report within specified time frames? (2.005)	10	0	0	100%
Laboratory: Did the provider acknowledge the STAT results, OR did nursing staff notify the provider within the required time frame? (2.008)	N/A	N/A	N/A	N/A
Pathology: Did the institution receive the final pathology report within the required time frames? (2.010)	5	0	0	100%
Pathology: Did the health care provider review and endorse the pathology report within specified time frames? (2.011)	5	0	0	100%
Pathology: Did the health care provider communicate the results of the pathology study to the patient within specified time frames? (2.012)	0	5	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)	9	6	0	60.0%
Did the institution receive and did the primary care provider review the routine-priority specialty service consultant report within the required time frame? (14.008)	9	6	0	60.0%

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

Recommendations

The OIG offers no recommendations for this indicator.

Health Care Environment

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

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

Ratings and Results Overview

Case Review Rating	Compliance Rating and Score
Not Applicable	***Inadequate* (56.3%)**

Overall, PBSP's performance in health care environment needed improvement. Medical supplies storage areas contained unidentified or inaccurately labeled medical supplies. In addition, we found expired or disorganized medical supplies. Several clinics did not meet the requirements for essential core medical equipment and supplies. Staff did not regularly sanitize their hands during patient encounters. Emergency medical response bags (EMRBs) contained compromised medical supply packaging and had not been properly inventoried. Based on the overall **Health Care Environment** compliance score result, the OIG rated this indicator ***inadequate***.

Compliance Testing Results

Patient Waiting Areas

We inspected outdoor patient waiting areas, which is used for restricted housing patients. Health care and custody staff reported existing waiting areas had sufficient seating capacity. The staff reported when the indoor waiting area was at capacity, patients waited in large outdoor areas (see Photo 1, right) or in partially covered individual modules (see Photo 2, next page).

We also inspected indoor waiting areas, which is used for patients housed in other areas (see Photo 3, next page). Health care and custody staff reported that existing indoor waiting areas contained sufficient seating capacity. During our inspection, we did not observe overcrowding.

Photo 1. Partially covered outdoor waiting modules (photographed on 6-18-24).

Photo 2. Partially covered outdoor waiting modules (detail) (photographed on 6-20-24).

Photo 3. Indoor waiting area (photographed on 6-18-24).

Clinic Environment

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

Eight of the 10 clinics we observed contained appropriate space, configuration, supplies, and equipment to allow clinicians to perform proper clinical examinations (MIT 5.110, 80.0%). In one clinic, the examination room had unsecured confidential medical records. In another clinic, the examination room lacked visual privacy for conducting clinical examinations.

Clinic Supplies

Only two of the 10 clinics followed adequate medical supply storage and management protocols (MIT 5.107, 20.0%). We found one or more of the following deficiencies in eight clinics: compromised sterile medical supply packaging; long-term storage of staff's food in the medical supply storage room (see Photo 4, right); expired medical supplies (see Photo 5, below); unorganized, unidentified, or inaccurately labeled medical supplies; medical supplies stored with medication (see Photo 6, below right); and cleaning materials stored with medical supplies.

Photo 4. Long-term storage of staff members' food in the medical supply room (photographed on 6-18-24).

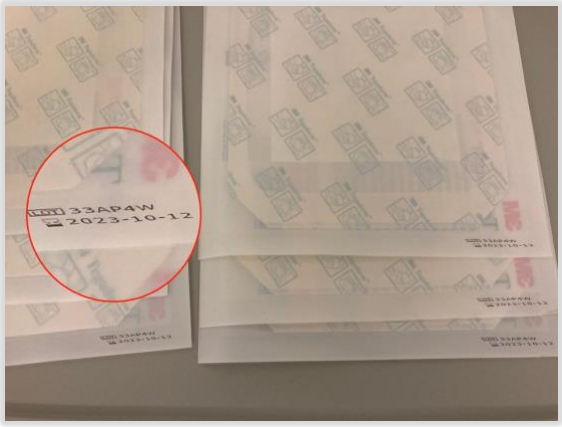

Photo 5. Expired medical supplies dated October 2023 (photographed on 6-20-24).

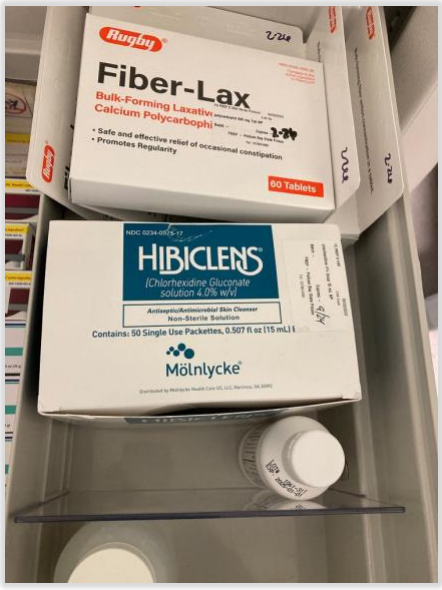

Photo 6. Medical supplies stored with medication (photographed on 6-20-24).

Six of the 10 clinics met requirements for essential core medical equipment and supplies (MIT 5.108, 40.0%). In four clinics we found one or more of the following deficiencies: missing disposable paper for the examination table; missing an established, identified Snellen chart distance line on the wall or the floor; a nonfunctional otoscope; and several inaccurate or incomplete clinic glucometer quality control logs. We also found staff did not consistently complete the defibrillator performance test log documentations within the last 30 days.

We examined EMRBs to determine whether they contained all essential items. We checked whether staff inspected the bags daily and inventoried them monthly. Only one of the nine applicable EMRBs passed our test (MIT 5.111, 11.1%). We found one or more of the following deficiencies with eight EMRBs: staff had not inventoried the EMRB when the seal tags were replaced; EMRB contained compromised medical supply packaging; and EMRB glucometer quality control logs were either inaccurate or incomplete.

Medical Supply Management

None of the medical supply storage areas located outside the medical clinics stored medical supplies adequately (MIT 5.106, zero). We found expired medical supplies in the medical warehouse (see Photo 7).

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

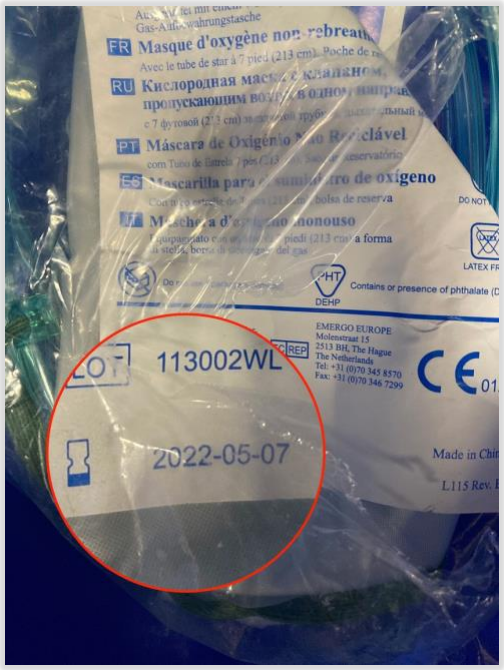

Photo 7. Expired medical supply dated May 2022 (phtotographed on 6-19-24).

Infection Control and Sanitation

Staff appropriately, cleaned, sanitized, and disinfected eight of 10 clinics (MIT 5.101, 80.0%). In one clinic, we found a damaged and unsanitary clinic floor, while in another clinic, we found an unsanitary cabinet under the clinic sink.

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

We found operating sinks and hand hygiene supplies in the examination rooms in six of 10 clinics (MIT 5.103, 60.0%). In four clinics, the patient restrooms lacked antiseptic soap or disposable hand towels.

We observed patient encounters in seven clinics. In five clinics, clinicians did not wash their hands before applying gloves or before each subsequent regloving (MIT 5.104, 28.6%).

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

Physical Infrastructure

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 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)	8	2	0	80.0%
Infection control: Do clinical health care areas ensure that reusable invasive and noninvasive medical equipment is properly sterilized or disinfected as warranted? (5.102)	10	0	0	100%
Infection control: Do clinical health care areas contain operable sinks and sufficient quantities of hygiene supplies? (5.103)	6	4	0	60.0%
Infection control: Does clinical health care staff adhere to universal hand hygiene precautions? (5.104)	2	5	3	28.6%
Infection control: Do clinical health care areas control exposure to blood-borne pathogens and contaminated waste? (5.105)	10	0	0	100%
Warehouse, conex, and other nonclinic storage areas: Does the medical supply management process adequately support the needs of the medical health care program? (5.106)	0	1	0	0
Clinical areas: Does each clinic follow adequate protocols for managing and storing bulk medical supplies? (5.107)	2	8	0	20.0%
Clinical areas: Do clinic common areas and exam rooms have essential core medical equipment and supplies? (5.108)	4	6	0	40.0%
Clinical areas: Are the environments in the common clinic areas conducive to providing medical services? (5.109)	10	0	0	100%
Clinical areas: Are the environments in the clinic exam rooms conducive to providing medical services? (5.110)	8	2	0	80.0%
Clinical areas: Are emergency medical response bags and emergency crash carts inspected and inventoried within required time frames, and do they contain essential items? (5.111)	1	8	1	11.1%
Does the institution's health care management believe that all clinical areas have physical plant infrastructures that are sufficient to provide adequate health care services? (5.999)	This is a nonscored test. Please see the indicator for discussion of this test.			
				Overall percentage (MIT 5): **56.3%**

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 remedial measures as appropriate.
- Health care leadership should determine the root cause(s) for staff not following equipment and medical supply management protocols and should implement remedial measures as appropriate.
- Nursing leadership should determine the root cause(s) for staff not ensuring the EMRBs are regularly inventoried, stocked, or sealed appropriately and should implement remedial measures as appropriate.

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 the performance of staff in communicating vital health transfer information, such as preexisting health conditions, pending appointments, tests, and specialty referrals; and inspectors confirmed whether staff sent complete medication transfer packages to 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* (73.6%)**

PBSP overall performed well in the transfer process. Compared with Cycle 6, the institution processed more events, but the number of deficiencies remained similar. The nurses completed the initial health screening form and scheduled provider appointments timely. Furthermore, the nurses performed excellently with providing medication continuity and ensuring medications were placed in the transfer packet for patients who transferred out. Although PBSP performed well in the transfer process, we found opportunities for improvement in nursing assessments when patients returned from an off-site hospitalization or emergency room. Considering all factors, the OIG rated the case review component of this indicator ***adequate***.

Compliance testing showed mixed results with the transfer process. The institution showed outstanding performance in ensuring transfer packets for departing patients included required documents and medications. PBSP performed satisfactorily in ensuring medication continuity for newly transferred patients. However, the institution faltered in completing initial health screening forms. Based on the overall **Transfers** compliance score result, the OIG rated the compliance testing component of this indicator ***inadequate***.

Case Review and Compliance Testing Results

We reviewed 51 events in 21 cases in which patients transferred into or out of the institution or returned from an off-site hospital or emergency room. We identified 10 deficiencies, one of which was significant.[26]

Transfers In

Our clinicians found PBSP's R&R nurses performed very well with evaluating the transfer-in patients and requested nurse and provider appointments within required time frames. We reviewed 15 transfer-in events and identified only two minor deficiencies related to documentation.[27]

Our clinicians found the nurses completed the initial health screening form and scheduled provider appointments timely. One RN was designated as the rover, who was assigned to respond to all emergencies and at times, would cover the receiving and release area (R&R) in the mornings when no RN was available to process patients who were paroling. In contrast, compliance testing revealed nurses rarely completed the initial health screening form within required time frames (MIT 6.001, 16.0%). However, compliance testing showed nurses performed excellently with completing the assessment and disposition section of the form (MIT 6.002, 100%).

Compliance testing showed PBSP performed excellently with ensuring new patient arrivals were evaluated by a provider within the required time frame (MIT 1.002, 96.0%). However, compliance testing revealed patients who had transferred in with pending specialty appointments were inconsistently seen within required time frames, and sometimes the appointments did not occur at all (MIT, 14.010, 42.9%).

Compliance testing showed PBSP showed satisfactory performance with ensuring medication continuity for new patient arrivals (MIT 6.003, 78.6%) and patients transferring within the facility most often received their medications without any interruptions (MIT 7.005, 84.0%). However, compliance testing also revealed the institution needed to improve with medication continuity for patient layovers (MIT 7.006, 33.3%). Specifically, in analyzing compliance data, we found only three applicable case samples, two of which were noncompliant with medications. In contrast, our clinicians found new patient arrivals received their medications timely.

Transfers Out

Our clinicians found PBSP performed well with the transfer-out process. We reviewed 10 transfer-out events and identified two minor deficiencies.[28] Nurses almost always completed the transfer information, administered medications prior to transfer, and ensured medications were placed in the transfer packet. Compliance testing showed PBSP performed excellently with ensuring transfer packets included the required medications and required transfer documents (MIT 6.101, 100%).

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[26] Deficiencies occurred in cases 1, 17, 21, 22, 24, 28, 31, and 53. Significant deficiencies occurred in case 24.

[27] Documentation deficiencies occurred in cases 17 and 28.

[28] Transfer-out deficiencies occurred in cases 31 and 53.

Hospitalizations

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

Compliance testing showed PBSP performed excellently in providing follow-up appointments within required time frames for patients returning from off-site hospitalizations (MIT 1.007, 100%) and revealed staff always scanned discharge documents into the patients' medical records within three calendar days of hospital discharge (MIT 4.003, 100%). Compliance testing also indicated providers always reviewed hospital reports within five calendar days (MIT 4.005, 100%). Our clinicians reached similar results.

Nursing generally performed appropriate nursing assessments and interventions. However, our clinicians identified three deficiencies related to incomplete nursing assessments upon the patient's hospital return.[29] The following is an example:

- In case 53, the nurse evaluated the patient upon returning from the hospital who complained of severe back pain with radiating pain down the left leg to the heel. However, the nurse did not obtain a full set of vital signs.

Compliance testing revealed PBSP performed poorly in medication continuity for patients who returned from off-site hospitalizations (MIT 7.003, 25.0%). The low score was mostly due to medications not being made available or administered to the patient by the ordering provider's administration date and time. Our clinicians did not find any medication-related deficiencies.

Clinician On-Site Inspection

Our clinicians toured the R&R and had the opportunity to interview the RN registry nurse, who was covering behind the regular R&R nurse. The staffing in R&R consisted of one RN each shift. The nurse shared they assessed a weekly average of 25 patients transferring in and five to 10 patients transferring out. The nurse explained how they reconciled medications for patient transfers and the process for communicating pending specialty appointments. The nurse expressed feeling supported by nursing leadership and having a cohesive relationship with custody staff.

Compliance On-Site Inspection and Discussion

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

[29] Incomplete nursing assessments occurred in cases 1, 22, and 53.

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)	11	3	11	78.6%
For patients transferred out of the facility: Do medication transfer packages include required medications along with the corresponding transfer packet required documents? (6.101)	9	0	1	100%
				Overall percentage (MIT 6): **73.6%**

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)	24	1	0	96.0%
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)	5	0	0	100%
Are community hospital discharge documents scanned into the patient's electronic health record within three calendar days of hospital discharge? (4.003)	5	0	0	100%
For patients discharged from a community hospital: Did the preliminary or final hospital discharge report include key elements and did a provider review the report within five calendar days of discharge? (4.005)	5	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)	1	3	1	25.0%
Upon the patient's transfer from one housing unit to another: Were medications continued without interruption? (7.005)	21	4	0	84.0%
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)	1	2	0	33.3%
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)	6	8	2	42.9%

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

Recommendations

- Nursing leadership should develop strategies to ensure nursing staff completely answer and address required initial health screening questions. Leadership should implement remedial measures or education 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
Proficient	***Inadequate* (68.4%)**

Our clinicians found PBSP performed excellently in medication management. Compared with Cycle 6, the institution had similar results. PBSP ensured patients almost always received their medications without interruption with new medication prescriptions, chronic care medications, hospital discharge medications, specialized medical housing medications. PBSP ensured patients almost always received their medications without interruption with new medication prescriptions, chronic care medications, hospital discharge medications, and specialized medical housing medications. Factoring in all the information, OIG rated the case review component of this indicator ***proficient***.

Compliance testing showed PBSP needed to improve in medication management. PBSP scored low in providing patients with chronic care medications, community hospital discharge medications, and ensuring medication continuity for patients laying over at PBSP. Based on the overall **Medication Management** compliance score result, the OIG rated the compliance testing component of this indicator ***inadequate***.

Case Review and Compliance Testing Results

We reviewed 126 events in 26 cases related to medications and found one medication deficiency, which was significant.[30]

New Medication Prescriptions

Compliance testing showed PBSP performed satisfactorily with ensuring new medications were made available and administered timely (MIT 7.002, 80.0%). In contrast, our clinicians found PBSP always ensured new medications were delivered and administered timely, and we did not identify any deficiencies related to new medication prescriptions.

[30] A significant deficiency occurred in case 15.

Chronic Medication Continuity

Compliance testing revealed PBSP needed to improve with ensuring chronic care medications were administered timely (MIT 7.001, 50.0%) In analyzing the compliance data, we found the low scores were due to the pharmacy having not filled and dispensed the medication timely, which included medications for blood pressure, cholesterol, and diabetes. In contrast, our clinicians found PBSP performed well with administering chronic care medications without interruption. We only identified one significant deficiency in one case wherein the patient did not receive his cardiac chronic care medication for the month of January 2024; however, the provider discontinued the medication the following month.[31] When we discussed this deficiency with the institution leadership, they agreed with the deficiency finding.

Hospital Discharge Medications

Compliance testing revealed the institution performed poorly in medication continuity for patients who returned from off-site hospitalizations (MIT 7.003, 25.0%). In contrast, our clinicians found PBSP performed excellently with timely administering hospital discharge medications. Please refer to the **Transfers** indicator for additional details.

Specialized Medical Housing Medications

Our clinicians found PBSP performed excellently with ensuring all medications were administered timely for patients admitted to the specialized medical housing unit. In contrast, compliance testing revealed staff needed to improve in medication continuity for new patient admissions (MIT 13.003, 33.3%). In analyzing the compliance data, the low score was mostly due to medications, which included those for seizures, chronic pain, and chest pain, not having been made available by the ordering provider's prescribed administration times.

Transfer Medications

Our clinicians found PBSP performed excellently with ensuring medications were administered without any interruptions for patient transfers into and out of the facility. Compliance testing showed satisfactory performance with medication continuity for new patient arrivals (MIT 6.003, 78.6%) and found patient transfers within the facility mostly received their medications without any interruptions (MIT 7.005, 84.0%). However, compliance testing showed the institution needed to improve with medication continuity for patient layovers at the institution (MIT 7.006, 33.3%). Please see the **Transfers** indicator for further details.

Both compliance testing and case review found PBSP performed perfectly in ensuring all patients who transferred out of the facility had a five-day supply of medications (MIT 6.101, 100%).

Medication Administration

Compliance testing showed staff performed excellently with ensuring TB medications were prescribed as ordered (MIT 9.001, 100%) and found staff appropriately monitored

[31] A significant deficiency for chronic care medication occurred in case 15.

most patients who were taking TB medications (MIT 9.002, 76.0%).

Clinician On-Site Inspection

During the on-site visit, our clinicians toured the medical clinic on the B Yard and interviewed the LVNs. The staff shared they were staffed with one LVN per shift and had an LVN who floated to assist when needed. The medication administration area was clean, spacious, and appeared well organized. The LVNs were knowledgeable about the medication KOP process and the medication transfer process. The LVNs expressed they were not always able to attend morning huddles due to conflicting times with medication lines. However, the medication LVN communicated any medications issues that needed to be addressed to the LVN coordinator to report during the huddle, and the medication LVN also sent a message to the provider. On the weekends, the medication LVN reported any medication concerns to the TTA RN rover and the on-call provider.

Nurses reported the staff worked well together as a team. They also expressed they felt supported by nursing leadership and had a good working relationship with custody staff.

Medication Practices and Storage Controls

The institution adequately stored and secured narcotic medications in seven of nine applicable clinic and medication line locations (MIT 7.101, 77.8%). In one location, nurses did not describe the appropriate narcotic medication discrepancy reporting process. In the other location, narcotic medications were not properly and securely stored as required by CCHCS policy.

PBSP appropriately stored and secured nonnarcotic medications in four of 10 applicable clinic and medication line locations (MIT 7.102, 40.0%). In six locations, we observed one or more of the following deficiencies: nurses did not follow the process in place to return medications with expired pharmacy labels to the pharmacy; the medication area lacked a clearly labeled designated area for medications that were to be returned to the pharmacy; nurses did not maintain unissued medication in its original labeled packaging; the medication storage cart was unsanitary; and medications were not properly and securely stored as required by CCHCS policy.

Staff kept medications protected from physical, chemical, and temperature contamination in six of the 10 applicable clinic and medication line locations (MIT 7.103, 60.0%). In three locations, staff did not consistently record room or refrigerator temperatures. In one location, the medication refrigerator was unsanitary.

Staff successfully stored valid, unexpired medications in eight of the 10 applicable medication line locations (MIT 7.104, 80.0%). In two locations, nurses did not label multiple-use medication as required by CCHCS policy.

Nurses exercised proper hand hygiene and contamination control protocols in two of six applicable locations (MIT 7.105, 33.3%). In four locations, nurses neglected to wash or sanitize their hands when required. These occurrences included before preparing and administering medications, or before each subsequent regloving.

Staff in five of six applicable medication preparation and administration areas demonstrated appropriate administrative controls and protocols (MIT 7.106, 83.3%). In

one location, medication nurses did not describe the process they followed when reconciling newly received medication and the medication administration record (MAR) against the corresponding physician's order.

Staff in one of six applicable medication areas used appropriate administrative controls and protocols when distributing medications to their patients (MIT 7.107, 16.7%). In five locations, we observed one or more of the following deficiencies: medication nurses did not always verify patient's identification using a secondary identifier; medication nurses did not reliably observe patients while they swallowed direct observation therapy medications; and some medication nurses did not properly disinfect the vial's port prior to withdrawing medication.

Pharmacy Protocols

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

The pharmacist-in-charge (PIC) always correctly accounted for narcotic medications stored in PBSP's pharmacy (MIT 7.111, 100%).

We examined 11 medication error reports and found the PIC also always 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 PBSP, the OIG did not find any applicable medication errors (MIT 7.998).

The OIG interviewed patients in restricted housing units to determine whether they had immediate access to their prescribed asthma rescue inhalers or nitroglycerin medications. Six of 10 applicable patients interviewed indicated they had access to their rescue medications. Four patients stated the rescue inhaler was taken away and placed in their property when they transferred to the restricted housing unit. We promptly notified the CEO of this concern, and health care management immediately issued replacement rescue inhalers to the patients (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)	10	10	5	50.0%
Did health care staff administer, make available, or deliver new order prescription medications to the patient within the required time frames? (7.002)	20	5	0	80.0%
Upon the patient's discharge from a community hospital: Were all ordered medications administered, made available, or delivered to the patient within required time frames? (7.003)	1	3	1	25.0%
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)	21	4	0	84.0%
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)	1	2	0	33.3%
All clinical and medication line storage areas for narcotic medications: Does the institution employ strong medication security controls over narcotic medications assigned to its storage areas? (7.101)	7	2	2	77.8%
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	6	1	40.0%
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)	6	4	1	60.0%
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	2	1	80.0%
Medication preparation and administration areas: Do nursing staff employ and follow hand hygiene contamination control protocols during medication preparation and medication administration processes? (7.105)	2	4	5	33.3%
Medication preparation and administration areas: Does the institution employ appropriate administrative controls and protocols when preparing medications for patients? (7.106)	5	1	5	83.3%
Medication preparation and administration areas: Does the institution employ appropriate administrative controls and protocols when administering medications to patients? (7.107)	1	5	5	16.7%
Pharmacy: Does the institution employ and follow general security, organization, and cleanliness management protocols in its main and remote pharmacies? (7.108)	1	0	0	100%
Pharmacy: Does the institution's pharmacy properly store nonrefrigerated medications? (7.109)	1	0	0	100%
Pharmacy: Does the institution's pharmacy properly store refrigerated or frozen medications? (7.110)	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)	11	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): **68.4%**

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)	11	3	11	78.6%
For patients transferred out of the facility: Do medication transfer packages include required medications along with the corresponding transfer-packet required documents? (6.101)	9	0	1	100%
Patients prescribed TB medication: Did the institution administer the medication to the patient as prescribed? (9.001)	25	0	0	100%
Patients prescribed TB medication: Did the institution monitor the patient per policy for the most recent three months he or she was on the medication? (9.002)	19	6	0	76.0%
Upon the patient's admission to specialized medical housing: Were all medications ordered, made available, and administered to the patient within required time frames? (13.003)	3	6	1	33.3%

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 admitted to specialized medical housing receive their medications timely and without interruption. Leadership 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*** **(87.9%)**

PBSP performed very well in preventive services. Staff performed excellently in administering TB medications to patients as prescribed, offering patients an influenza vaccination for the most recent influenza season, and offering colorectal cancer screening for patients from ages 45 through 75. Staff performed satisfactorily in monitoring patients on TB medications and in screening patients annually for TB. However, the institution needed improvement in offering required immunizations to chronic care patients. These findings are set forth in the table on the next page. Based on the overall **Preventive Services** 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)	25	0	0	100%
Patients prescribed TB medication: Did the institution monitor the patient per policy for the most recent three months he or she was on the medication? (9.002)	19	6	0	76.0%
Annual TB screening: Was the patient screened for TB within the last year? (9.003)	20	5	0	80.0%
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)	25	0	0	100%
Female patients from the age of 50 through the age of 74: Was the patient offered a mammogram in compliance with policy? (9.006)	N/A	N/A	N/A	N/A
Female patients from the age of 21 through the age of 65: Was patient offered a pap smear in compliance with policy? (9.007)	N/A	N/A	N/A	N/A
Are required immunizations being offered for chronic care patients? (9.008)	10	4	11	71.4%
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): **87.9%**

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***

Our clinicians found nursing performance was sufficient in this indicator. Compared with Cycle 6, the institution showed improvement with significantly fewer deficiencies. Nurses performed very well in the transfer process and in administering medications. Although nursing performance was satisfactory overall, our inspection continued to indicate opportunities for improvement in nursing assessments, interventions, and documentation, which we discuss below. Factoring in all the information, the OIG rated this indicator ***adequate.***

Case Review Results

We reviewed 164 nursing encounters in 50 cases. Of the nursing encounters we reviewed, 69 occurred in the outpatient setting and 55 were sick call requests. We identified 46 nursing performance deficiencies, five of which were significant.[32]

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. A comprehensive assessment allows nurses to gather essential information about their patients and develop appropriate interventions.

[32] Deficiencies occurred in cases 1, 2, 4-7, 9, 14, 15, 17, 20-22, 28, 31, 35-39, 45, 47, 53, and 55. Significant deficiencies occurred in cases 2, 6, 14, and 39.

Our clinicians identified 16 outpatient deficiencies, four of which were significant.[33] Nurses generally performed good assessments and interventions, triaged sick call requests appropriately, and evaluated patients timely. However, our clinicians found opportunities for improvement with incomplete nursing sick call assessments, initiating a co-consultation with the provider when conditions warranted, and initiating a provider follow-up appointment based on the plan of care findings. The following are examples:

- In case 14, on several occasions the diabetic patient had abnormal blood sugar readings. However, nurses did not inquire about signs and symptoms or notify the provider to report the critical blood sugar level results.

- In case 21, the nurse evaluated the diabetic patient for complaints of left-foot numbness radiating to all five toes. However, the nurse did not subjectively assess the time of symptom onset and did not schedule a provider follow-up appointment for further evaluation. Instead, the nurse advised the patient to return to the clinic if symptoms worsened.

- In case 47, the nurse evaluated the patient for complaints of head pain and a request for pain medication after the removal of a cyst on the forehead. However, the nurse did not assess the surgical wound to document signs and symptoms of infection, such as whether any redness, swelling, or drainage was present.

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. Nurses mostly documented care appropriately. Our clinicians identified three deficiencies related to incomplete nursing assessment documentation.[34] However, these deficiencies did not impact the overall care of the patients.

Emergency Services

We reviewed 28 urgent or emergent events. Nurses responded promptly to emergent events and generally performed appropriate assessments and interventions. However, we identified opportunities for improvement in nursing reassessments and in documenting event time lines, which we detail further in the **Emergency Services** indicator.

Hospital Returns

We reviewed 26 events involving returns from off-site hospitals or emergency room encounters. Nurses generally performed appropriate nursing assessments, which we detailed further in the **Transfers** indicator.

Transfers

We reviewed 25 cases involving transfer-in and transfer-out processes. PBSP nurses overall performed well in completing the initial health care screening, scheduling

[33] Outpatient deficiencies occurred in cases 1, 2, 14, 15, 21, 35, 36, 37, 38, 39, 45, and 47. Significant deficiencies occurred in cases 2, 14, and 39.

[34] Documentation deficiencies occurred in cases 15, 27, and 37.

provider follow-up appointments, and ensuring all transfer-out requirements were met. Please refer to the **Transfers** indicator for further details.

Specialized Medical Housing

We reviewed six cases with a total of 55 events. Nurses overall performed timely assessments, evaluated the patients frequently, and mostly documented patient care appropriately. Although the nurses overall performed good patient care, we found at times nursing assessments were incomplete. For more specific details, please refer to the **Specialized Medical Housing** indicator.

Specialty Services

We reviewed four cases in which patients returned from off-site specialty services appointments or consultations. Nursing overall performed well in this indicator. Our clinicians did not identify any deficiencies.

Medication Management

OIG clinicians reviewed 126 events involving medication management and found most nurses performed excellently in administering patient medications as prescribed. Our clinicians only identified one significant deficiency. Please refer to the **Medication Management** indicator for additional details.

Clinician On-Site Inspection

Our clinicians spoke with nursing supervisors and nurses in the TTA, CTC, R&R, outpatient clinics, and medication areas. We attended the morning huddle on the B Yard and found the huddle was well organized and demonstrated collaborative teamwork. Staff was familiar with their patient population, and addressed all patient concerns. The care team consisted of a telehealth primary care provider (PCP), a primary care RN, a medical assistant, and an LVN coordinator.

The B Clinic RN reported seeing an average of eight patients per day. At the time of our inspection, the nurse had three patients scheduled, and no backlog existed. Our clinicians interviewed the LVN coordinator, who shared her duties consisted of managing patient registries for annual screenings for various conditions, vaccinations, blood pressure checks, dressing changes, and issuing durable medical equipment.

Our clinicians had the opportunity to interview the chief nurse executive (CNE), who had significant experience working at PBSP. The CNE shared having two performance improvement projects in progress for specialty services and for urine toxicology laboratory drug screening for the medication-assisted treatment (MAT) program. The CNE reported the primary challenge was staffing retention, specifically in how it affected maintaining consistency with training and adherence to policies and procedures.

Recommendations

- Nursing leadership should determine the challenges to nurses performing detailed assessments as well as providing interventions during face-to-face patient evaluations 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***

PBSP providers delivered good care during this cycle. While COVID-19 affected provider performance in Cycle 6, it did not significantly affect provider care delivery during the review period in Cycle 7. We found providers performed well with assessment and decision-making, review of records, emergency care, specialty services, documentation quality, and provider care. They had room for improvement in chronic care, and 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 123 medical provider encounters and identified 24 deficiencies, 18 of which were significant.[35] In addition, we examined the quality of care in 20 comprehensive case reviews. Of these 20 cases, we found one ***proficient***, 15 ***adequate***, and four ***inadequate***.

Outpatient Assessment and Decision-Making

Providers generally made good assessments and sound decisions. They took pertinent histories, formed differential diagnoses, offered appropriate tests, provided proper workups for patients, and referred for specialty care when medically indicated. However, the OIG clinicians identified some deficiencies, the following of which are examples:

- In case 8, the patient requested to stop taking his MAT medication.[36] Based on evidence in the EHRS, OIG clinicians determined the provider appointment with the patient to discuss the MAT medication occurred. However, the provider did not document a progress note and did not follow up with the patient. This was

[35] Provider deficiencies occurred in cases 8, 9, 10, 11, 12, 13, 14, 15, 16, 18, 20, 21, 23, 24, and 25. Significant deficiencies occurred in cases 8, 10, 11, 12, 13, 14, 16, 18, 20, 21, 24, and 25.

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

important because this event was the only provider interaction in the review period before the patient died.

- In case 14, the patient complained of urinary hesitancy; however, the provider did not evaluate the patient's prostate as a cause.[37]

- In case 20, the nurse notified the provider about the patient having a persistent cough for two months. The provider should have ordered an in-person evaluation but did not. The patient was eventually seen by another provider more than a month later after the patient submitted another sick-call request for the cough.

Review of Records

Providers need to review several different types of records to properly deliver care. They review patient medical charts for medications, diagnostics, specialty appointments, emergency care, and hospitalizations. Providers generally reviewed medical records carefully. However, providers did not review vital signs appropriately in two encounters as detailed below:

- In case 14, the diabetic patient was admitted to the hospital with euglycemic diabetic ketoacidosis.[38] As part of the work-up, the patient underwent a CT scan of the abdomen and pelvis, which showed an adrenal nodule.[39] The patient also had elevation in GAD-65 autoantibodies.[40] Although the provider endorsed these results, the provider did not thoroughly address the findings.

- In case 21, the patient with diabetes and seizures did not have a chronic care appointment for more than a year. The provider evaluated the patient during episodic appointments and did not schedule a chronic care appointment to address the patient's chronic care conditions.

Emergency Care

Providers made appropriate triage decisions when patients arrived at the TTA for emergency treatment. Providers were available for consultation with TTA staff via telephone when outside normal office hours. They usually triaged patients appropriately and sent them for a higher level of care when needed. OIG clinicians did not identify any provider deficiencies related to emergency care.

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[37] Urinary hesitancy is a condition with difficulty starting or maintaining a urine stream. For a male patient, an enlarged prostate can cause urinary hesitancy.

[38] Euglycemic diabetic ketoacidosis is a serious complication of diabetes with normal to near-normal blood glucose levels, metabolic acidosis, and elevated ketone levels.

[39] An adrenal nodule is an abnormal growth in the adrenal gland. The adrenal gland is a small, triangular shaped gland located on the top of the kidneys. It produces hormones to regulate blood pressure, metabolism, and stress response.

[40] GAD-65 autoantibodies are detected in blood tests. An autoantibody is a substance made by the body that targets against the body's own cells, tissues, or organs. Elevated levels indicate autoimmune disease.

Chronic Care

While providers managed most chronic conditions well, they showed room for improvement with managing diabetes. OIG clinicians identified 12 deficiencies in the seven cases related to diabetes care. The following deficiencies are examples:

- In case 10, the provider evaluated the diabetic patient at a chronic care follow-up appointment. However, the provider did not consider ordering a moderate intensity statin for this patient with an elevated LDL cholesterol.[41]

- In case 11, the provider evaluated the patient who had diabetes, hypertension, and hyperlipidemia at a chronic care appointment. The provider cloned various parts of the provider's progress note and did not consider starting the patient on GLP-1 medication to control the patient's worsening blood sugar level.[42]

- In case 12, the provider evaluated the patient who had uncontrolled diabetes at a chronic care appointment. The patient had received his last insulin adjustment three months prior, and his blood sugars levels were worsening. Despite the patient feeling well at the time of the appointment and not wanting his insulin adjusted, the provider should have scheduled a follow-up earlier than 180 days later. In addition, a few days after the appointment, the patient's diabetic laboratory test showed his sugars had risen further, and the provider sent a letter noting a new appointment had been scheduled for him; however, this appointment did not occur.

- In case 13, the patient received a blood test showing his blood sugar levels were worsening, revealing the HbA1c count had increased from 7.2 percent to 12.9 percent.[43] The provider did not order a follow-up appointment with the patient to address the elevated blood test.

- In case 14, the patient had poorly controlled diabetes. The provider mismanaged the diabetes medication treatment by increasing empagliflozin and stopping a large dose of long-acting insulin.[44] This action would not be sufficient to control the diabetes. When the HbA1c result showed worsening control, the provider did not consider restarting the insulin or prescribing short-term fingerstick monitoring of sugars. The provider also did not ascertain whether the patient's dietary habits or physical activity level had been contributing to the worsening blood sugar levels and did not address the patient's low blood pressure during the appointment. Overall, the provider did not adjust any therapies or interact with the patient over a three-month period.

- In case 16, the provider evaluated the diabetic patient at a chronic care appointment and did not order an eye examination to evaluate for diabetic

[41] A statin is a cholesterol reducing medication. LDL cholesterol is a low-density lipoprotein and an elevated level is a risk factor for heart disease.

[42] Glucagon-like peptide 1 (GLP-1) is a medication used to reduce sugar levels.

[43] Hemoglobin A1c is a blood test that measures the average plasma glucose over the previous 12 weeks. For most patients with diabetes, the HbA1c goal is 7 percent or less. https://www.cdc.gov/diabetes/diabetes-testing/prediabetes-a1c-test.html

[44] Empagliflozin is a medication used to treat diabetes by blocking the reabsorption of sugar in the kidneys, resulting in more glucose excretion through urine and reduced blood sugar levels.

retinopathy or perform a monofilament test to evaluate for neuropathy.[45] Both of these were last performed over a year prior.

Specialized Medical Housing

Providers appropriately and timely completed admission history and physical examinations for patients. Providers evaluated patients at clinically appropriate intervals and delivered acceptable care.

Specialty Services

PBSP providers generally referred patients for specialty consultations when needed. OIG clinicians identified some provider performance deficiencies related to specialty services. The following are examples:

- In case 14, the diabetic patient complained of left-eye vision changes described as "black smoke."[46] The provider requested a routine-priority optometry appointment instead of an earlier appointment.

- In case 24, the neurologist evaluated the patient, who was on two antiseizure medications. The neurologist recommended the patient continue taking these medications, check the medication level with a laboratory test, and order an electroencephalogram.[47] However, the provider did not order the laboratory test to measure the medication level.

We also discuss provider specialty performance in the **Specialty Services** indicator.

Documentation Quality

Generally, providers documented progress notes appropriately. We identified a few errors in documentation as follows:

- In case 9, the provider evaluated the patient and reviewed the patient's urine toxicology test showing methamphetamines, marijuana, and fentanyl; however, the provider documented, "illicit substances were not found."

- In case 14, the provider documented the wrong date on the progress note.

- In case 15, the provider documented the patient was taking a different dose of suboxone than the dose the patient was actually taking.

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[45] Diabetic retinopathy is a complication of diabetes affecting the eyes resulting from damage to blood vessels in the retina. The retina is the layer of cells in back of the eye that senses light and sends signals to the brain. A monofilament test is a test using a small strand of nylon to check for loss of sensation in the foot.

[46] The visual complaints of "black smoke" may be indicative of a serious emergency medical condition such as retinal detachment where the eye retina pulls away from the back of the eye, resulting in blindness.

[47] An electroencephalogram test measures the electrical activity in the brain.

Provider Continuity

PBSP offered good provider continuity to the patients. OIG clinicians did not find any problems with provider continuity during the review period.

Clinician On-Site Inspection

At the on-site inspection, we received a report that PBSP was in a unique position; PBSP had neither a permanent chief medical executive (CME) as the CME had retired in February 2024, nor a permanent chief physician and surgeon (CP&S) as the CP&S had transferred to another institution. We spoke with the regional health executive (RHE) who was managing PBSP's providers in the interim. During our period of inspection, PBSP had one State physician, one advanced practitioner, and one registry provider on-site. The institution was also served by four telemedicine primary care providers remotely, along with two dual position providers.[48]

The RHE described the staffing and leadership shortages at the institution, which had been compounded by the prison population's increase of about 50 percent. The increased patient load consisted of predominantly Level 2 enhanced outpatient individuals, who used more medical and custodial resources. A large proportion of the new patients arrived with appointments already out of compliance, which created an instant provider appointment backlog that numbered more than 300 during the summer months.[49]

We spoke with the various providers who reported not having medical leadership was detrimental to their morale. According to providers, the loss of their long-time CME in February, reassignments to different yards a few months ago, and increased workloads due to new patients with more complaints made the process of caring for patients more difficult.

[48] Dual position providers worked at another institution for the access extra four hours per day.

[49] This occurred after the review period and before the OIG case review on-site inspection.

Recommendations

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

Specialized Medical Housing

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

Ratings and Results Overview

Case Review Rating	Compliance Rating and Score
Adequate	***Inadequate* (73.3%)**

Our clinicians found PBSP performed sufficiently in this indicator. Compared with Cycle 6, the institution showed improvement with significantly fewer deficiencies during Cycle 7. Providers delivered excellent care and made appropriate medical decisions. Nursing generally performed good assessments and interventions, completed admission assessments timely, co-consulted with the provider, and administered medications timely. Although nursing overall provided good care, we identified opportunities for improvement with completing thorough nursing assessments. Factoring in all the information, OIG rated this case review component of this indicator ***adequate***.

Compliance testing showed mixed performance in this indicator. Staff frequently completed admission assessments and history and physical (H&P) examinations timely. However, the institution needed significant improvement in ensuring medication continuity for patients admitted into the specialized medical housing unit. Based on the overall **Specialized Medical Housing** compliance score result, the OIG rated the compliance testing component of this indicator ***inadequate***.

Case Review and Compliance Testing Results

We reviewed 55 CTC events, including 26 provider events and 29 nursing events. Due to the frequency of nursing and provider contacts in the specialized medical housing, we bundle up to two weeks of patient care into a single event. We identified 12 deficiencies, none of which were significant.[50]

Provider Performance

Providers performed excellently in the specialized medical housing. We reviewed six CTC cases. Providers assessed patients and made good decisions, referred patients to specialists as needed, and reviewed other care events. They always completed their

[50] Deficiencies occurred in cases 2, 22, 24, 53, 54, and 55.

history and physical examinations timely upon admission into the CTC and performed their rounds for patients at appropriate intervals. OIG clinicians reviewed 26 provider encounters and did not find any deficiencies.

Compliance testing showed providers generally completed admission history and physical examinations timely (MIT 13.002, 80.0%).

Nursing Performance

Compliance testing showed nurses frequently completed an initial assessment of patients at the time of admission (MIT 13.001, 80.0%).

Our case review found nurses generally performed appropriate assessments and interventions. Nurses also completed the initial admission assessment within required time frames. However, we identified a pattern in three cases showing incomplete nursing assessments.[51] The following are examples:

- In case 2, during the period from of March 1, 2024, through April 19, 2024, the patient often complained of bilateral knee pain. However, the nurses did not always assess the pain scale level, the quality of pain, or follow-up with a corresponding pain assessment.

- In case 22, the patient with a peripherally inserted central catheter (PICC) line was admitted to the CTC for antibiotic therapy.[52] However, the nurses frequently did not assess the PICC line site or obtain external measurements to include arm circumference.

Medication Administration

Our clinicians found PBSP ensured all new patient admissions received their medications without interruption. In contrast, compliance testing revealed staff needed significant improvement in timely administering medication for new patient admissions (MIT 13.003, 33.3%). Please see the **Medication Management** indicator for further discussion.

Clinician On-Site Inspection

Our clinicians interviewed the CTC nursing supervisor and CTC staff. The CTC had 10 medical beds, 10 mental health crisis beds, one seclusion room, and two negative pressure rooms. The CTC staffing consists of two RNs on each shift as well as a psychiatric technician and an LVN during the day and the evening shifts. The CTC has an assigned provider Monday through Friday and an on-call provider assigned for weekend coverage. At the time of our on-site inspection, the patient census was 16.

The nursing supervisor shared the CTC held staff huddles each shift during which staff discussed patient care issues. Furthermore, the supervisor discussed the various nursing audits they had conducted to assess the quality of nursing care. Some of the challenges the CTC faced included staffing retention and the new enhanced outpatient program

[51] Patterns of incomplete nursing assessments occurred in cases 2, 22, and 53.

[52] A peripherally inserted central catheter provides intravenous access to administer fluids and medication.

(EOP) that had begun in February 2024, which had created an influx of new patients who had many health challenges.

The CTC staff reported they felt supported by nursing leadership and had an excellent working relationship with custody staff.

Compliance On-Site Inspection and Discussion

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

Compliance Score Results

Table 16. Specialized Medical Housing

	Scored Answer			
Compliance Questions	**Yes**	**No**	**N/A**	**Yes %**
For OHU, CTC, and SNF: Did the registered nurse complete an initial assessment of the patient on the day of admission? (13.001)	8	2	0	80.0%
Was a written history and physical examination completed within the required time frame? (13.002)	8	2	0	80.0%
Upon the patient's admission to specialized medical housing: Were all medications ordered, made available, and administered to the patient within required time frames? (13.003)	3	6	1	33.3%
For specialized health care housing (CTC, SNF, hospice, OHU): Do specialized health care housing maintain an operational call system? (13.101)	1	0	0	100%
For specialized health care housing (CTC, SNF, hospice, OHU): Do health care staff perform patient safety checks according to institution's local operating procedure or within the required time frames? (13.102)	0	0	1	N/A
			Overall percentage (MIT 13): **73.3%**	

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

Recommendations

- Nursing leadership should develop strategies to ensure nursing staff in the CTC perform thorough patient assessments and should implement remedial measures as appropriate.

Specialty Services

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

Ratings and Results Overview

Case Review Rating	Compliance Rating and Score
Adequate	***Inadequate* (68.2%)**

Case review found PBSP delivered very good specialty services for its patients. Providers referred patients when medically indicated and often endorsed specialty reports timely. Nurses always assessed patients who returned from off-site specialists and assisted with relaying recommendations during telemedicine specialty encounters. Medical records staff generally retrieved reports timely, sent reports to providers, and scanned them into the EHRS appropriately. However, we found access to specialists needed to improve; we identified delays in access to telemedicine specialists. 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' ranged from very good to needing significant improvement. Preapproved specialty services for newly arrived patients sporadically occurred within required time frames. In addition, performance in retrieving specialty reports and prompt provider endorsements varied. Based on the overall **Specialty Services** compliance score result, the OIG rated the compliance component of this indicator ***inadequate***.

Case Review and Compliance Testing Results

OIG clinicians reviewed 51 events related to specialty services: 34 specialty consultations and procedures, nine nursing encounters related to patient returns from outside or telemedicine specialty visits, and six provider encounters. We identified eight deficiencies in this category, four of which were significant.[53]

Access to Specialty Services

PBSP's performance was variable with access to specialty services. Compliance testing showed mixed performance with specialty access as routine-priority specialty appointments frequently occurred timely (MIT 14.007, 86.7%), high-priority specialty appointments inconsistently occurred timely (MIT 14.001, 73.3%), and medium-priority specialty appointments only sporadically occurred timely (MIT 14.004, 33.3%). Continuity of specialty services after transfer into the facility was poor (MIT 14.010, 42.9%). OIG

[53] Deficiencies occurred in cases 1, 17, 18, 24, 25, and 53. Significant deficiencies occurred in cases 1, 24, 25, and 53.

clinicians found acceptable access to specialty services. During the last inspection cycle, we did not find any access deficiencies with specialists; however, in this cycle, we found four access deficiencies, three of which were significant due to the delay duration from the original order. The following are two examples:

- In case 24, the patient had multiple abnormalities throughout both lungs showing on radiology imaging, suggesting sarcoidosis.[54] The provider ordered a medium-priority pulmonology specialty appointment; however, this appointment occurred with a two-month delay. On-site, the specialty supervisor stated the delays were due to CCHCS headquarters scheduling of telemedicine specialty appointments, along with the patient's multiple hospitalizations and CTC admissions causing the opening and closing of the patient's medical chart, which together resulted in the discontinuation of the appointment order.

- In case 53, the patient complained of intense back pain and had laboratory tests showing elevated markers of inflammation and anemia, all of which prompted the provider to be concerned about spinal cord infection. The provider ordered an urgent neurosurgery specialty referral, which should have occurred within two weeks; however, the referral was scheduled one month later and was then ultimately canceled and rescheduled several months later. On-site, the specialty supervisor stated the CCHCS headquarters schedulers were responsible for the timely arranging of telemedicine specialty appointments.

Provider Performance

Providers appropriately ordered specialty consults within the proper time frames. When specialists evaluated patients with high-priority referrals, the provider always followed up with the patients within five days of the referral. Additionally, the providers almost always reviewed specialty reports timely. We found only one provider performance deficiency related to inaccurate documentation as follows:

- In case 25, the provider evaluated the patient at a chronic care appointment and documented the patient had not seen the kidney specialist for over two years. However, the kidney specialist evaluated the patient two months prior and the provider had already endorsed the kidney specialist's report.

Compliance testing showed providers or nurses generally assessed patients timely after specialty services (MIT 1.008, 76.7%).

Nursing Performance

PBSP nurses performed excellently with specialty services. Nurses assessed patients returning from off-site appointments in the TTA and messaged providers as necessary. Nurses also supported telemedicine specialists and relayed recommendations to providers when orders were needed for medications or further appointments. OIG clinicians did not find any nursing deficiencies in specialty care.

[54] Sarcoidosis is an inflammatory condition affecting the lungs, skin, lymph nodes, and other parts of the body.

Health Information Management

PBSP medical records staff generally retrieved specialty reports timely and forwarded them to providers for endorsement. Compliance testing showed mixed performance with health information management of routine-, medium-, and high-priority specialty reports (MIT 14.008, 60.0%, MIT 14.005, 60.0%, and MIT 14.002, 80.0%). However, medical records staff almost always scanned specialty reports into the EHRS timely (MIT 4.002, 96.7%). OIG clinicians only found one delay in retrieving an echocardiogram. We found timely provider endorsements with two exceptions; however, both delays were two days or less.

Clinician On-Site Inspection

OIG clinicians spoke with PBSP medical leadership, specialty supervisors, and providers about specialty care. Medical leadership reported telemedicine specialties were handled by CCHCS headquarters schedulers, which caused delays and resulted in specialty appointment backlogs. Leadership was unsure if the delays were due to not having enough telemedicine specialty contractors to provide services or to the increased statewide specialty usage. Supervisors stated they had no on-site PBSP staffing shortages related to managing specialty services. They described retrieval of the reports for off-site specialty processes and how these reports were sent to providers for endorsements. We also spoke to the on-site nurse and the on-site optometrist. The optometrist stated the process was to document directly into the EHRS, so providers could view the report afterward. The optometrist notified the provider if and when providers needed to generate orders.

Compliance Score Results

Table 17. Specialty Services

Compliance Questions	Scored Answer			
	Yes	No	N/A	Yes %
Did the patient receive the high-priority specialty service within 14 calendar days of the primary care provider order or the Physician Request for Service? (14.001)	11	4	0	73.3%
Did the institution receive and did the primary care provider review the high-priority specialty service consultant report within the required time frame? (14.002)	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)	5	3	7	62.5%
Did the patient receive the medium-priority specialty service within 15-45 calendar days of the primary care provider order or Physician Request for Service? (14.004)	5	10	0	33.3%
Did the institution receive and did the primary care provider review the medium-priority specialty service consultant report within the required time frame? (14.005)	9	6	0	60.0%
Did the patient receive the subsequent follow-up to the medium-priority specialty service appointment as ordered by the primary care provider? (14.006)	6	3	6	66.7%
Did the patient receive the routine-priority specialty service within 90 calendar days of the primary care provider order or Physician Request for Service? (14.007)	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)	9	6	0	60.0%
Did the patient receive the subsequent follow-up to the routine-priority specialty service appointment as ordered by the primary care provider? (14.009)	7	2	6	77.8%
For endorsed patients received from another CDCR institution: If the patient was approved for a specialty services appointment at the sending institution, was the appointment scheduled at the receiving institution within the required time frames? (14.010)	6	8	2	42.9%
Did the institution deny the primary care provider's request for specialty services within required time frames? (14.011)	20	0	0	100%
Following the denial of a request for specialty services, was the patient informed of the denial within the required time frame? (14.012)	15	5	0	75.0%
			Overall percentage (MIT 14): **68.2%**	

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

Table 18. 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) *	23	7	15	76.7%
Are specialty documents scanned into the patient's electronic health record within five calendar days of the encounter date? (4.002)	29	1	15	96.7%

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

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

Recommendations

- Health care leadership should determine the challenges to the timely provision of telemedicine specialty appointments 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	***Inadequate* (66.0%)**

PBSP's performance was mixed in this indicator. While PBSP scored excellently in some applicable tests, it needed improvement in multiple areas. The Emergency Medical Response Review Committee (EMRRC) only sometimes completed the required checklists. Staff did not conduct a live medical emergency response drill or the drill was conducted with incomplete documentation and missing required emergency response drill forms. Staff also did not conduct two live emergency response drills for the most recent quarter. Physician managers did not complete annual performance appraisals timely, and they did not have a local process to monitor the providers' timely renewal of emergency response certifications prior to expiration. The nurse educator did not ensure all newly hired nurses received the required onboarding training and only intermittently ensured nurses who administer medications timely complete their annual competency testing. These findings are set forth in the table on the next page. Based on the overall **Administrative Operations** compliance score result, the OIG rated this indicator ***inadequate***.

Compliance Testing Results

Nonscored Results

At PBSP, 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 four patients, we found no evidence in the submitted documentation the preliminary mortality

reports had been completed. These reports were overdue at the time of OIG's inspection (MIT 15.998).

Compliance Score Results

Table 19. Administrative Operations

Compliance Questions	Scored Answer			
	Yes	No	N/A	Yes %
For health care incidents requiring root cause analysis (RCA): Did the institution meet RCA reporting requirements? (15.001)	This is a nonscored test. Please refer to the discussion in this indicator.			
Did the institution's Quality Management Committee (QMC) meet monthly? (15.002)	6	0	0	100%
For Emergency Medical Response Review Committee (EMRRC) reviewed cases: Did the EMRRC review the cases timely, and did the incident packages the committee reviewed include the required documents? (15.003)	7	5	0	58.3%
For institutions with licensed care facilities: Did the Local Governing Body (LGB) or its equivalent meet quarterly and discuss local operating procedures and any applicable policies? (15.004)	4	0	0	100%
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)	4	0	0	100%
Did nurse managers ensure the clinical competency of nurses who administer medications? (15.104)	5	5	0	50.0%
Did physician managers complete provider clinical performance appraisals timely? (15.105)	0	2	0	0
Did the providers maintain valid state medical licenses? (15.106)	16	0	0	100%
Did the staff maintain valid Cardiopulmonary Resuscitation (CPR), Basic Life Support (BLS), and Advanced Cardiac Life Support (ACLS) certifications? (15.107)	1	1	1	50.0%
Did the nurses and the pharmacist-in-charge (PIC) maintain valid professional licenses and certifications, and did the pharmacy maintain a valid correctional pharmacy license? (15.108)	6	0	1	100%
Did the pharmacy and the providers maintain valid Drug Enforcement Agency (DEA) registration certificates, 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): **66.0%**

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

Recommendations

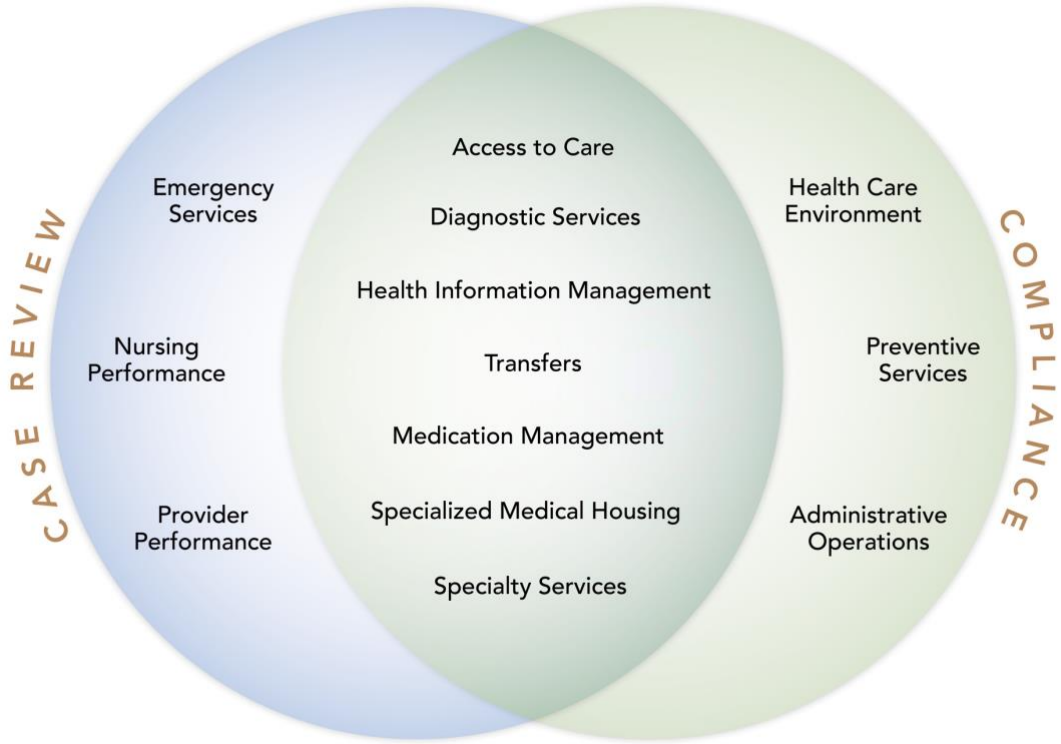
The OIG offers no recommendations for this indicator.

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 PBSP



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

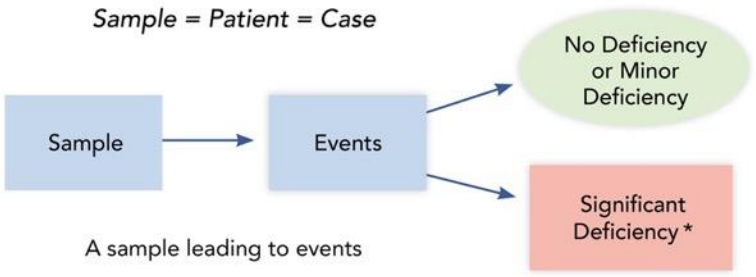
An OIG physician, a nurse consultant, or both review each case. As the clinicians review medical records, they record pertinent interactions between the patient and the health care system. We refer to these interactions as case review ***events***. Our clinicians also record medical errors, which we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

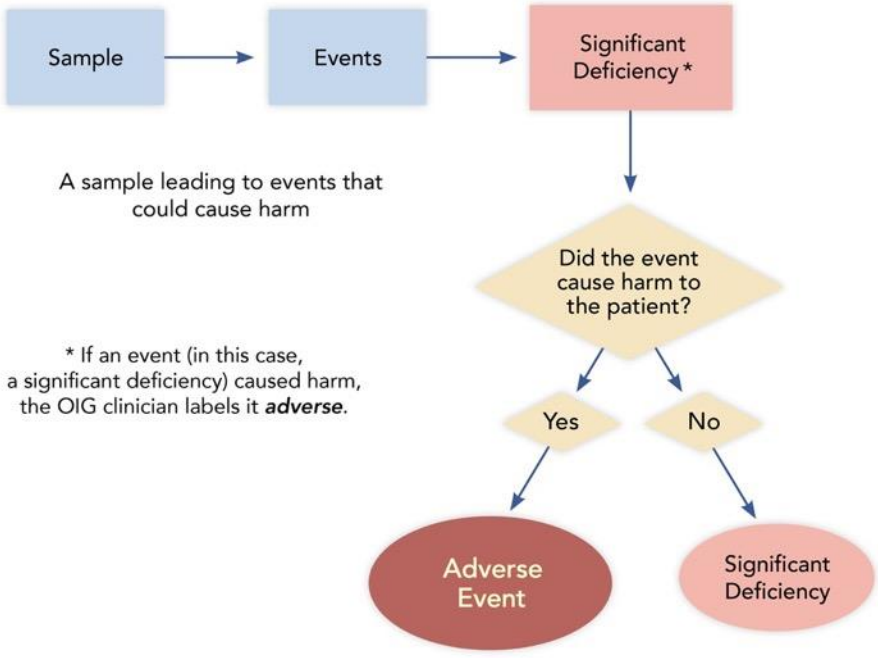
Figure A–2. Case Review Testing

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***.



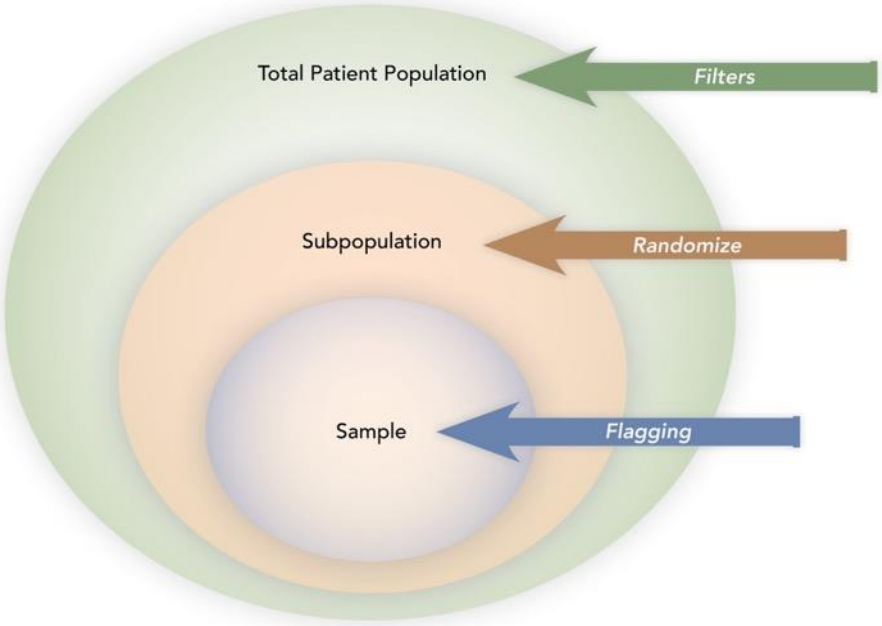
Source: The Office of the Inspector General medical inspection analysis.

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. PBSP Case Review Sample Sets

Sample Set	Total
CTC/OHU	3
Death Review/Sentinel Events	2
Diabetes	5
Emergency Services – CPR	5
Emergency Services – Non-CPR	2
High Risk	4
Hospitalization	4
Intrasystem Transfers In	3
Intrasystem Transfers Out	3
RN Sick Call	21
Specialty Services	3
	55

Table B–2. PBSP Case Review Chronic Care Diagnoses

Sample Set	Total
Anemia	2
Arthritis/Degenerative Joint Disease	7
Asthma	7
Cancer	1
Cardiovascular Disease	1
Chronic Kidney Disease	6
Chronic Pain	7
Cirrhosis/ End Stage Liver Disease	3
COPD	1
COVID-19	1
Diabetes	11
GERD	5
Hepatitis C	19
Hyperlipidemia	11
Hypertension	17
Mental Health	16
Rheumatological Disease	3
Seizure Disorder	3
Sleep Apnea	1
Substance Abuse	26
Thyroid Disease	1
	149

Table B–3. PBSP Case Review Events by Program

Diagnosis	Total
Diagnostic Services	94
Emergency Care	72
Hospitalization	29
Intrasystem Transfers In	15
Intrasystem Transfers Out	10
Outpatient Care	309
Specialized Medical Housing	65
Specialty Services	51
	645

Table B–4. PBSP Case Review Sample Summary

Sample Set	Total
MD Reviews Detailed	20
MD Reviews Focused	2
RN Reviews Detailed	13
RN Reviews Focused	42
Total Reviews	77
Total Unique Cases	55
Overlapping Reviews (MD & RN)	22

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Appendix C: Compliance Sampling Methodology

Pelican Bay 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)	40	Clinic Appointment List	• Clinic (each clinic tested) • Appointment date (2–9 months) • Randomize
MIT 1.007	Returns From Community Hospital	5	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	0	Quest	• Appt. date (90 days–9 months) • Order name (CBC, BMP, or CMPs only • Randomize • Abnormal
MITs 2.010–012	Pathology	5	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	40	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	5	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	5	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	10	OIG inspector on-site review	• Identify and inspect all on-site clinical areas
Transfers				
MITs 6.001–003	Intrasystem Transfers	25	SOMS	• Arrival date (3–9 months) • Arrived from (another departmental facility) • Rx count • Randomize
MIT 6.101	Transfers Out	10	OIG inspector on-site review	• R&R IP transfers with medication

Quality Indicator	Sample Category	No. of Samples	Data Source	Filters
Pharmacy and Medication Management				
MIT 7.001	Chronic Care Medication	25	OIG Q: 1.001	• See Access to Care • At least one condition per patient—any risk level • Randomize
MIT 7.002	New Medication Orders	25	Master Registry	• Rx count • Randomize • Ensure no duplication of IPs tested in MIT 7.001
MIT 7.003	Returns From Community Hospital	5	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	3	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	11	Medication error reports	• All medication error reports with Level 4 or higher • Select total of 25 medication error reports (recent 12 months)
MIT 7.999	Restricted Unit KOP Medications	10	On-site active medication listing	• KOP rescue inhalers & nitroglycerin medications for IPs housed in restricted units

Quality Indicator	Sample Category	No. of Samples	Data Source	Filters
Prenatal and Postpartum Care				
MITs 8.001–007	Recent Deliveries	N/A at this institution	OB Roster	• Delivery date (2–12 months) • Most recent deliveries (within date range)
	Pregnant Arrivals	N/A at this institution	OB Roster	• Arrival date (2–12 months) • Earliest arrivals (within date range)
Preventive Services				
MITs 9.001–002	TB Medications	25	Maxor	• Dispense date (past 9 months) • Time period on TB meds (3 months or 12 weeks) • Randomize
MIT 9.003	TB Evaluation, Annual Screening	25	SOMS	• Arrival date (at least 1 year prior to inspection) • Birth month • Randomize
MIT 9.004	Influenza Vaccinations	25	SOMS	• Arrival date (at least 1 year prior to inspection) • Randomize • Filter out IPs tested in MIT 9.008
MIT 9.005	Colorectal Cancer Screening	25	SOMS	• Arrival date (at least 1 year prior to inspection) • Date of birth (45 or older) • Randomize
MIT 9.006	Mammogram	N/A at this institution	SOMS	• Arrival date (at least 2 yrs. prior to inspection) • Date of birth (age 52–74) • Randomize
MIT 9.007	Pap Smear	N/A at this institution	SOMS	• Arrival date (at least three yrs. prior to inspection) • Date of birth (age 24–53) • Randomize
MIT 9.008	Chronic Care Vaccinations	25	OIG Q: 1.001	• Chronic care conditions (at least 1 condition per IP—any risk level) • Randomize • Condition must require vaccination(s)
MIT 9.009	Valley Fever	N/A at this institution	Cocci transfer status report	• Reports from past 2–8 months • Institution • Ineligibility date (60 days prior to inspection date) • All

Quality Indicator	Sample Category	No. of Samples	Data Source	Filters
Reception Center				
MITs 12.001–007	RC	N/A at this institution	SOMS	• Arrival date (2–8 months) • Arrived from (county jail, return from parole, etc.) • Randomize
Specialized Medical Housing				
MITs 13.001–003	Specialized Health Care Housing Unit	10	CADDIS	• Admit date (2–8 months) • Type of stay (no MH beds) • Length of stay (minimum of 5 days) • Rx count • Randomize
MITs 13.101–102	Call Buttons	All	OIG inspector on-site review	• Specialized Health Care Housing • Review by location
Specialty Services				
MITs 14.001–003	High-Priority Initial and Follow-Up RFS	15	Specialty Services Appointments	• Approval date (3–9 months) • Remove consult to audiology, chemotherapy, dietary, Hep C, HIV, orthotics, gynecology, consult to public health/Specialty RN, dialysis, ECG 12-Lead (EKG), mammogram, occupational therapy, ophthalmology, optometry, oral surgery, physical therapy, physiatry, podiatry, 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	16	Specialty Services Arrivals	• Arrived from (other departmental institution) • Date of transfer (3–9 months) • Randomize
MITs 14.011–012	Denials	20	InterQual	• Review date (3–9 months) • Randomize
		N/A	IUMC/MAR Meeting Minutes	• Meeting date (9 months) • Denial upheld • Randomize
Administrative Operations				
MIT 15.001	Adverse/sentinel events	0	Adverse/sentinel events report	• Adverse/Sentinel events (2–8 months)
MIT 15.002	QMC Meetings	6	Quality Management Committee meeting minutes	• Meeting minutes (12 months)
MIT 15.003	EMRRC	12	EMRRC meeting minutes	• Monthly meeting minutes (6 months)
MIT 15.004	LGB	4	LGB meeting minutes	• Quarterly meeting minutes (12 months)
MIT 15.101	Medical Emergency Response Drills	3	On-site summary reports & documentation for ER drills	• Most recent full quarter • Each watch
MIT 15.102	Institutional Level Medical Grievances	10	On-site list of grievances/closed grievance files	• Medical grievances closed (6 months)

Quality Indicator	Sample Category	No. of Samples	Data Source	Filters
Administrative Operations (continued)				
MIT 15.103	Death Reports	4	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	2	On-site provider evaluation files	• All required performance evaluation documents
MIT 15.106	Provider Licenses	16	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	4	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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July 8, 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 Pelican Bay State Prison conducted by the Office of the Inspector General from November 2023 to April 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
307F6B95AC0A4D1...

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

cc: Diana Toche, D.D.S., Undersecretary, Health Care Services, CDCR
Clark Kelso, Receiver
Jeff Macomber, Secretary, CDCR
Directors, CCHCS
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Chief Executive Officer, PBSP
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Cycle 7

Medical Inspection Report

for

Pelican Bay State Prison

OFFICE *of the*
INSPECTOR GENERAL

Amarik K. Singh
Inspector General

Shaun Spillane
Chief Deputy Inspector General

STATE *of* CALIFORNIA
July 2025

OIG