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OIG | OFFICE *of the* INSPECTOR GENERAL

Independent Prison Oversight

March 2026

Cycle 7

Medical Inspection Report

San Quentin Rehabilitation Center

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Introduction

Pursuant to California Penal Code section 6126 et seq., the Office of the Inspector General (the OIG) is responsible for periodically reviewing and reporting on the delivery of the ongoing medical care provided to incarcerated people[1] in the California Department of Corrections and Rehabilitation (the department).[2]

In Cycle 7, the OIG continues to apply the same assessment methodologies used in Cycle 6, including clinical case review and compliance testing. Together, these methods assess the institution's medical care on both individual and system levels by providing an accurate assessment of how the institution's health care systems function regarding patients with the highest medical risk, who tend to access services at the highest rate. Through these methods, the OIG evaluates the performance of the institution in providing sustainable, adequate care. We continue to review institutional care using 15 indicators as in prior cycles.[3]

Using each of these indicators, our compliance inspectors collect data in answer to compliance- and performance-related questions as established in the medical inspection tool (MIT). In addition, our clinicians complete document reviews of individual cases and also perform on-site inspections, which include interviews with staff. The OIG determines a total compliance score for each applicable indicator and considers the MIT scores in the overall conclusion of the institution's compliance performance.

In conducting in-depth quality-focused reviews of randomized cases, our case review clinicians examine whether health care staff used sound medical judgment in the course of caring for a patient. In the event we find errors, we determine whether such errors were clinically significant or led to a significantly increased risk of harm to the patient. At the same time, our clinicians consider whether institutional medical processes led to identifying and correcting individual or system errors, and we examine whether the institution's medical system mitigated the error. The OIG rates each applicable indicator ***proficient***, ***adequate***, or ***inadequate,*** and considers each rating in the overall conclusion of the institution's health care performance.

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

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

[2] The OIG's medical inspections are not designed to resolve questions about the constitutionality of care, and the OIG explicitly makes no determination regarding the constitutionality of care the department provides to its population.

[3] In addition to our own compliance testing and case reviews, the OIG continues to offer selected Healthcare Effectiveness Data and Information Set (HEDIS) measures for comparison purposes.

As we did during Cycle 6, our office continues to inspect both those institutions remaining under federal receivership and those delegated back to the department. There is no difference in the standards used for assessing a delegated institution versus an institution not yet delegated. At the time of the Cycle 7 inspection of San Quentin Rehabilitation Center (SQRC), 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 April 2024 to September 2024.[4]

[4] Samples are obtained per case review methodology shared with stakeholders in prior cycles. The case reviews include death reviews between February 2024 and September 2024.

Summary: Ratings and Scores

We completed the Cycle 7 inspection of SQRC in June 2025. OIG inspectors monitored the institution's delivery of medical care that occurred between April 2024 and September 2024.

The OIG rated the case review component of the overall health care quality at SQRC ***inadequate***.

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

OIG case review clinicians (a team of physicians and nurse consultants) reviewed 61 cases, which contained 1,013 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, which may occur throughout the delivery of care. After examining the medical records, our clinicians completed a follow-up on-site inspection in June 2025, to verify their initial findings. OIG physicians rated the quality of care for 25 comprehensive case reviews. Of these 25 cases, our physicians rated 21 ***adequate*** and four ***inadequate***.

To test the institution's policy compliance, our compliance inspectors (a team of registered nurses) monitored the institution's compliance with its medical policies by answering a standardized set of questions that measure specific elements of health care delivery. Our compliance inspectors examined 395 patient records and 1,194 data points and used the data to answer 93 policy questions. In addition, we observed SQRC's processes during an on-site inspection in December 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 SQRC.

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

Table 1. SQRC 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

MIT Number	Health Care Indicators	Case Review		Compliance		
		Cycle 7	Change Since Cycle 6*	Cycle 7	Cycle 6	Change Since Cycle 6*
1	Access to Care	Adequate	=	74.2%	76.0%	↓
2	Diagnostic Services	Adequate	↑	73.3%	54.2%	=
3	Emergency Services	Inadequate	=	N/A	N/A	N/A
4	Health Information Management	Adequate	=	90.0%	82.8%	↑
5	Health Care Environment†	N/A	N/A	51.6%	43.2%	=
6	Transfers	Adequate	↑	53.0%	63.0%	=
7	Medication Management	Inadequate	=	51.8%	39.6%	=
8	Prenatal and Postpartum Care	N/A	N/A	N/A	N/A	N/A
9	Preventive Services	N/A	N/A	85.7%	77.7%	↑
10	Nursing Performance	Inadequate	=	N/A	N/A	N/A
11	Provider Performance	Adequate	=	N/A	N/A	N/A
12	Reception Center	N/A	N/A	N/A	N/A	N/A
13	Specialized Medical Housing	Adequate	N/A	62.5%	82.5%	↓
14	Specialty Services	Adequate	↑	66.4%	60.1%	=
15	Administrative Operations†	N/A	N/A	66.2%	69.0%	=

* 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 SQRC 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 SQRC. Of these 10 indicators, OIG clinicians rated seven ***adequate*** and three ***inadequate***. OIG physicians also rated the overall adequacy of care for each of the 25 detailed case reviews they conducted. Of these 25 cases, 21 were ***adequate*** and four were ***inadequate***. In the 1,013 events reviewed, we identified 246 deficiencies, 77 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 SQRC:

- Patients received excellent access to providers and nurses.
- Staff completed all laboratory and radiology studies timely.
- Staff received and scanned hospital discharge reports timely.
- Providers delivered excellent care for patients with urgent or emergent conditions.
- SQRC's transfer-in screening nurses performed well.

Our clinicians found the following weaknesses at SQRC:

- Providers inconsistently sent complete test result notification letter to patients.
- Staff needed improvement in timely obtaining off-site specialty reports.
- Having only one specialty utilization management (UM) nurse responsible for specialty scheduling and specialty reports impacted access and report retrieval.

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

- Emergency nursing assessments were incomplete, performed inappropriately, and lacked pertinent information that led to poor emergency performance.

- Nurses showed a pattern of inappropriate assessments and documentation in specialized medical housing, transfer-out screenings, sick call appointments, and outpatient chronic care management appointments.

Compliance Testing Results

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

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

- Staff timely scanned non-dictated progress notes, initial health care screening forms, community hospital discharge reports, and requests for health care services into patients' electronic medical records.

- Staff performed well in offering immunizations and providing preventive services for their patients, such as influenza vaccination, annual testing for tuberculosis (TB), and colorectal cancer screenings. In addition, staff frequently administered TB medications to patients as prescribed and performed TB screenings.

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

- Staff often did not provide chronic care follow-up appointments within required time frames.

- SQRC did not perform well in ensuring specialty services were provided within specified time frames.

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

- Staff frequently did not maintain medication continuity for chronic care patients, patients discharged from the hospital, and patients with newly prescribed medications. In addition, the institution maintained poor medication continuity for patients who had a temporary layover at SQRC.

- Nurses did not regularly inspect emergency medical response bags.

Institution-Specific Metrics

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

As of July 31, 2025, the department reports on its public tracker 86 percent of SQRC's incarcerated population is fully vaccinated for COVID-19 while 70 percent of SQRC's staff is fully vaccinated for COVID-19.[7]

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

On November 25, 2024, the Health Care Services Master Registry showed SQRC had a total population of 3,043. A breakdown of the medical risk level of the SQRC population as determined by the department is set forth in Table 2 below.[8]

Table 2. SQRC Master Registry Data as of November 2024

Medical Risk Level	Number of Patients	Percentage*
High 1	437	14.4%
High 2	672	22.1%
Medium	1,078	35.4%
Low	856	28.1%
Total	**3,043**	**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 11-25-24.

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

According to staffing data the OIG obtained from California Correctional Health Care Services (CCHCS), as identified in Table 3 below, SQRC had no vacant executive leadership positions, no primary care provider vacancies, one nursing supervisor vacancy, and 44.1 nursing staff vacancies.

Table 3. SQRC Health Care Staffing Resources as of November 2024

Positions	Executive Leadership*	Primary Care Providers	Nursing Supervisors	Nursing Staff †	Total
Authorized Positions	7.0	13.0	21.0	221.9	262.9
Filled by Civil Service	7.0	13.0	20.0	177.8	217.8
Vacant	0	0	1.0	44.1	45.1
Percentage Filled by Civil Service	100%	100%	95.2%	80.1%	82.9%
Filled by Telemedicine	0	1.0	0	0	1.0
Percentage Filled by Telemedicine	0	7.7%	0	0	0.4%
Filled by Registry	0	1.0	0	26.0	27.0
Percentage Filled by Registry	0	7.7%	0	11.7%	10.3%
Total Filled Positions	6.0	13.0	20.0	203.8	242.8
Total Percentage Filled	**100%**	**100%**	**95.2%**	**91.8%**	**92.4%**
Appointments in Last 12 Months	1.0	1.0	3.0	43.6	48.6
Redirected Staff	0	0	0	1.0	1.0
Staff on Extended Leave‡	0	0	0	7.0	7.0
Adjusted Total: Filled Positions	**7.0**	**13.0**	**20.0**	**196.8**	**236.8**
Adjusted Total: Percentage Filled	**100%**	**100%**	**95.2%**	**88.7%**	**90.1%**

* Executive Leadership includes the Chief Physician and Surgeon.

† Nursing Staff includes the classifications of Senior Psychiatric Technician and Psychiatric Technician.

‡ In Authorized Positions.

Notes: The OIG does not independently validate staffing data received from the department. Positions are based on fractional time-base equivalents.

Source: Cycle 7 medical inspection preinspection questionnaire received on November 25, 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 SQRC'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 comparison: **poor HbA1c control**, which measures the percentage of diabetic patients who have poor blood sugar control, and **colorectal cancer screening rates** for patients ages 45 to 75. For poor HbA1c control and colorectal cancer screening, 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)—SQRC's percentage of patients with poor HbA1c control was significantly lower at four percent, 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. SQRC had a 52 percent influenza immunization rate for adults 18 to 64 years old and an 80 percent influenza immunization rate for adults 65 years of age and older.[9] The pneumococcal vaccination rate was 88 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)—SQRC's colorectal cancer screening rate of 95 percent was higher, indicating excellent performance on this measure.

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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. SQRC Results Compared With State HEDIS Scores

HEDIS Measure	SQRC Cycle 7 Results*	California Medi-Cal†	California Kaiser NorCal Medi-Cal†	California Kaiser SoCal Medi-Cal†
HbA1c Screening	100%	–	–	–
Poor HbA1c Control (> 9.0%) ‡,§	**4%**	33%	26%	19%
HbA1c Control (< 8.0%) ‡	89%	–	–	–
Blood Pressure Control (< 140/90) ‡	96%	–	–	–
Eye Examinations	72%	–	–	–
Influenza – Adults (18–64)	52%	–	–	–
Influenza – Adults (65+)	80%	–	–	–
Pneumococcal – Adults (65+)	88%	–	–	–
Colorectal Cancer Screening	**95%**	40%	71%	71%

Notes and Sources

* Unless otherwise stated, data were collected in November 2024 by reviewing medical records from a sample of SQRC's population of applicable patients. These random statistical sample sizes were based on a 95 percent confidence level with a 15 percent maximum margin of error.

† HEDIS Medi-Cal data were obtained from the California Department of Health Care Services publication *Medi-Cal Managed Care External Quality Review Technical Report*, dated July 1, 2023–June 30, 2024 (published April 2025); 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 SQRC 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 SQRC's performance, we offer the following recommendations to the department:

Access to Care

- Health care leadership should determine the root cause(s) of untimely chronic care provider appointments and should implement appropriate remedial measures.

Diagnostic Services

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

- Health care leadership should determine the root cause of challenges to the timely collection as well as notification and endorsement of STAT laboratory results and should implement remedial measures as appropriate.

Emergency Services

- Institutional leadership should determine the root cause(s) of delays in staff activating the 9-1-1 system immediately for emergent patients needing a higher level of care and should implement remedial measures as appropriate.

- Nursing leadership should analyze the challenges to nurses performing thorough assessments and interventions of emergent and urgent conditions. 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 emergency medical response bags (EMRBs) are regularly inventoried and sealed and should implement remedial measures as appropriate.

Transfers

- Nursing leadership should develop and implement strategies, such as internally auditing staff, to ensure complete and thorough screening of

patients transferring out of the institution, review pending specialty communications, and maintain patient hand-off communication to the receiving facility. Leadership should implement remedial measures as appropriate.

Medication Management

- Medical and nursing leadership should develop strategies to ensure medication continuity for chronic care medications, hospital discharge medications, newly prescribed medications, transfer-in and transfer-out medications, and medications for en-route patients. Leadership should implement remedial measures as appropriate.

- Nursing leadership should consider reminding nursing staff to document patient refusals in medical administration records, as described in CCHCS policy and procedures, and should implement remedial measures as appropriate.

Preventive Services

- Health care leadership should determine the root cause(s) for challenges to timely providing immunizations to chronic care patients and should implement appropriate remedial measures.

Nursing Performance

- Nursing leadership should analyze the challenges to nurses performing thorough assessments and interventions as well as thoroughly documenting during patient appointments and implement remedial measures as appropriate.

Specialized Medical Housing

- Nursing leadership should determine the root cause of challenges preventing specialized medical housing nurses from performing complete assessments and should implement remedial measures as appropriate.

- Nursing leadership should ensure initial admission assessments are completed within the time frames required by CCHCS policy and should implement remedial measures as appropriate.

Specialty Services

- Health care leadership should identify the root cause(s) related to untimely providing preapproved specialty appointments for newly arrived patients as well as initial and follow-up specialty service appointments and should implement remedial measures as appropriate.

- Health care leadership should develop and implement a solution, such as an upgraded specialty services tracking system, to allow multiple users to track and coordinate the timely scheduling of specialty appointments.

Access to Care

In this indicator, OIG inspectors evaluated the institution's performance in providing patients with timely clinical appointments. Our inspectors reviewed scheduling and appointment timeliness for newly arrived patients, sick calls, and nurse follow-up appointments. We examined referrals to primary care providers, provider follow-ups, and specialists. Furthermore, we evaluated the follow-up appointments for patients who received specialty care or returned from an off-site hospitalization.

Ratings and Results Overview

Case Review Rating	Compliance Rating and Score
Adequate	***Inadequate* (74.2%)**

In this cycle, case review found SQRC provided very good access to care. Access to providers in outpatient and specialized medical housing, clinic nurses, follow-up after hospitalizations, emergent care, specialty care, and care after transfer into the institution were excellent. However, we found poor access to specialty services. Considering all aspects of access to care, the OIG rated the case review component of this indicator ***adequate***.

Compliance testing showed SQRC performed variably in this indicator. Nursing staff always reviewed patient sick call requests the same day the requests were received. Providers often timely completed provider appointments for newly transferred patients, patients returning after specialty service appointments, and patients returning after hospitalizations. However, staff needed improvement in timely completing face-to-face triage appointments and 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 ***inadequate***.

Case Review and Compliance Testing Results

OIG clinicians reviewed 135 provider, nursing, urgent or emergent care, specialty, and hospital events requiring the institution to generate appointments. We identified eight deficiencies relating to access to care, six of which were significant.[11]

Access to Care Providers

SQRC performed variably with provider access. Compliance testing revealed poor access to chronic care follow-up appointments (MIT 1.001, 48.0%), but good nursing-to-provider sick call referrals (MIT 1.005, 85.7%). OIG clinicians found excellent access to providers. Providers timely evaluated patients when medically indicated. We identified no delays in patients receiving access to providers.

[11] Deficiencies occurred in cases 19, 20, 26, 30, 31, 50, and 55. Significant deficiencies occurred in cases 20, 26, 30, 31, and 50.

Access to Specialized Medical Housing Providers

SQRC has a correctional treatment center (CTC) that provides a higher level of care than the outpatient setting. Patients received excellent access to CTC providers. OIG clinicians found providers evaluated patients timely.

Access to Clinic Nurses

Compliance testing revealed SQRC's performance was mixed with access to clinic nurses. Nurses performed excellently in timely reviewing sick call requests (MIT 1.003, 100%) but needed improvement with completing face-to-face encounters within one business day after reviewing the sick call requests (MIT 1.004, 74.3%). OIG clinicians reviewed 39 nursing sick call events in 18 cases and identified two deficiencies related to clinic nurse access:

- In case 50, the nurse reviewed a sick call request for a symptomatic patient with diarrhea and sore throat. However, the nursed assessed the patient one day late.
- In case 55, the nurse assessed the patient one day late for a symptomatic sick call request for low back pain.

Access to Specialty Services

SQRC did not perform well with specialty services access. Compliance testing revealed staff needed improvement with timely completion of high-priority (MIT 14.001, 66.7%), medium-priority (MIT 14.004, 46.7%), and routine-priority (MIT 14.007, 73.3%) specialty appointments. Subsequent specialist follow-up appointments also occurred intermittently for high-priority (MIT 14.003, 60.0%), medium-priority (MIT 14.006, 60.0%), and routine-priority (MIT 14.009, 62.5%) services. OIG clinicians identified most access deficiencies related to specialty appointments. Scheduled specialty appointments often occurred beyond the deadlines requested by providers. The following are examples:

- In case 19, the pulmonary specialty appointment occurred six days late.
- In case 20, the neurosurgery specialty appointment occurred after a two-month delay.
- In case 26, the provider ordered a lung spirometry test.[12] However, this was scheduled six weeks late. Staff reported requesting the service at one facility only to find out that facility did not perform the procedure. Staff had to resubmit the appointment request to another facility, resulting in the delay.
- Also in case 26, the provider requested a medium-priority oncology specialty appointment, but this appointment did not occur.
- In case 30, the patient received a routine-priority oncology specialty appointment 13 days late.

[12] A lung spirometry test measures the airflow into and out of the lungs to evaluate how well the lungs are working.

- In case 31, the newly arrived patient received a follow-up HIV specialty appointment one month late.

We discuss these issues further in the **Specialty Services** indicator.

Follow-Up After Specialty Services

SQRC performed well in completing provider appointments after specialty encounters. Compliance testing showed most provider follow-up appointments occurred within required time frames (MIT 1.008, 80.0%). OIG clinicians found providers ensured patients received needed follow-up appointments. We did not find any delays with SQRC provider appointments after patients received specialty services.

Follow-Up After Hospitalization

After hospitalizations, patients may need medication changes, new requests for specialty care, or follow-up appointments. OIG clinicians did not find any deficiencies with access to providers after hospitalizations.

Follow-Up After Urgent or Emergent Care (TTA)

OIG clinicians found SQRC offered patients access to providers after emergency care when medically indicated. We did not find any delays with provider follow-up appointments.

Follow-Up After Transferring Into SQRC

Patients who recently transferred into the institution generally received timely access to care. Compliance testing showed good access to intake appointments for newly arrived patients (MIT 1.002, 84.0%). OIG clinicians found patients received intake appointments, and providers evaluated the patients timely after they transferred into SQRC.

Clinician On-Site Inspection

We spoke with providers, nurses, scheduling supervisors, the utilization management (UM) nurse, medical leadership, and nursing leadership. SQRC leadership reported no provider vacancies and no provider appointment backlogs, and nursing staffing was sufficient. While SQRC did not have morning provider meetings, we observed discussion of these events during the patient care team clinic huddles. The on-call provider would also send an email to the primary care team to summarize the overnight events.

Compliance Testing Results

Compliance On-Site Inspection and Discussion

Only one of the six housing units randomly tested at the time of inspection had access to health care services request forms (CDCR Form 7362) (MIT 1.101, 16.7%). In five housing units, custody officers did not have a system in place for restocking the forms. The custody officers reported reliance on medical staff to replenish the forms in the housing units or to print copies from their computers. In addition, one of the five housing units had no forms available at the time of our inspection.

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)	12	13	0	48.0%
For endorsed patients received from another CDCR institution: Based on the patient's clinical risk level during the initial health screening, was the patient seen by the clinician within the required time frame? (1.002)	21	4	0	84.0%
Clinical appointments: Did a registered nurse review the patient's request for service the same day it was received? (1.003)	35	0	0	100%
Clinical appointments: Did the registered nurse complete a face-to-face visit within one business day after the CDCR Form 7362 was reviewed? (1.004)	26	9	0	74.3%
Clinical appointments: If the registered nurse determined a referral to a primary care provider was necessary, was the patient seen within the maximum allowable time or the ordered time frame, whichever is the shorter? (1.005)	18	3	14	85.7%
Sick call follow-up appointments: If the primary care provider ordered a follow-up sick call appointment, did it take place within the time frame specified? (1.006)	5	1	29	83.3%
Upon the patient's discharge from the community hospital: Did the patient receive a follow-up appointment within the required time frame? (1.007)	22	1	1	95.7%
Specialty service follow-up appointments: Did the clinician follow-up visits occur within required time frames? (1.008) *	16	4	25	80.0%
Clinical appointments: Do patients have a standardized process to obtain and submit health care services request forms? (1.101)	1	5	0	16.7%
				Overall percentage (MIT 1): 74.2%

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

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

Table 6. Other Tests Related to Access to Care

	Scored Answer			
Compliance Questions	**Yes**	**No**	**N/A**	**Yes %**
For patients received from a county jail: If, during the assessment, the nurse referred the patient to a provider, was the patient seen within the required time frame? (12.003)	N/A	N/A	N/A	N/A
For patients received from a county jail: Did the patient receive a history and physical by a primary care provider within seven calendar days (prior to 07/2022) or five working days (effective 07/2022)? (12.004)	N/A	N/A	N/A	N/A
Was a written history and physical examination completed within the required time frame? (13.002)	2	0	0	100%
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)	10	5	0	66.7%
Did the patient receive the subsequent follow-up to the high-priority specialty service appointment as ordered by the primary care provider? (14.003)	6	4	5	60.0%
Did the patient receive the medium-priority specialty service within 15-45 calendar days of the primary care provider order or the Physician Request for Service? (14.004)	7	8	0	46.7%
Did the patient receive the subsequent follow-up to the medium-priority specialty service appointment as ordered by the primary care provider? (14.006)	6	4	5	60.0%
Did the patient receive the routine-priority specialty service within 90 calendar days of the primary care provider order or Physician Request for Service? (14.007)	11	4	0	73.3%
Did the patient receive the subsequent follow-up to the routine-priority specialty service appointment as ordered by the primary care provider? (14.009)	5	3	7	62.5%

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

Recommendations

- Health care leadership should determine the root cause(s) of untimely chronic care provider appointments and should implement appropriate remedial measures.

Diagnostic Services

In this indicator, OIG inspectors evaluated the institution's performance in timely completing radiology, laboratory, and pathology tests. Our inspectors determined whether the institution properly retrieved the resultant reports and whether providers reviewed the results correctly. In addition, in Cycle 7, we examined the institution's performance in timely completing and reviewing immediate (STAT) laboratory tests.

Ratings and Results Overview

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

In this cycle, case review found SQRC provided good diagnostic services, similar to the performance in Cycle 6. We found staff completed radiology and laboratory studies without delays. However, providers sometimes endorsed results late and only occasionally communicated test results to their patients with complete test result notification letters. Considering all aspects, the OIG rated the case review component of this indicator ***adequate***.

In compliance testing, SQRC performed variably in this indicator. Staff performed excellently in timely completing radiology services, laboratory services, and pathology services. Providers always endorsed and reviewed pathology results and frequently endorsed and reviewed radiology, laboratory, and STAT results within required time frames. However, staff needed significant improvement in timely completing STAT laboratory services, and providers needed improvement in generating complete patient test result 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 ***inadequate***.

Case Review and Compliance Testing Results

OIG clinicians reviewed 209 diagnostic events and identified 57 deficiencies, seven of which were significant.[13] All 57 deficiencies related to Health Information Management (HIM).

Test Completion

Completion of laboratory tests or radiologic studies is a crucial component of care delivery in institutions. In compliance testing, staff performed excellently in timely completing radiologic studies (MIT 2.001, 100%) and laboratory tests (MIT 2.004, 100%), but poorly for STAT laboratory tests (MIT 2.007, 30.0%). OIG clinicians did not identify any deficiencies with timely completing tests. Staff completed diagnostic tests within requested time frames and endorsed results timely.

[13] Diagnostic deficiencies occurred in cases 1, 7, 9, 10, 13–17, 19, 21, 23, and 25–28. Significant deficiencies occurred in cases 14, 17, 19, 23, and 27.

Health Information Management

Compliance testing showed providers performed very well in timely endorsing radiology (MIT 2.002, 90.0%) and laboratory tests (MIT 2.005, 90.0%), and providers performed excellently in timely reviewing pathology reports (MIT 2.011, 100%). Staff also performed excellently in retrieving pathology reports within required time frames (MIT 2.010, 100%). However, SQRC needed improvement in nurses timely notifying providers of STAT laboratory tests and providers timely acknowledging those tests (MIT 2.008, 70.0%). Providers also never communicated pathology results to patients with complete notification letters within specified time frames (MIT 2.012, zero).

OIG clinicians identified 57 deficiencies related to health information management of diagnostic results. We identified 13 instances of late endorsements and 44 deficiencies related to test result notification letters. Notification letters lacked one or more required elements, such as date of service, whether results were normal or abnormal, whether a follow-up appointment was needed, and the name of the provider reviewing the result. Occasionally, the providers did not send a letter to the patient or sent the letters late.

- In case 14, the provider endorsed the test result 190 days after the result was available and did not generate a patient notification letter when the patient's Hemoglobin A1c (HbA1c) was not at goal.[14]

- In case 17, on three separate instances, the patient had diagnostic tests performed, but the provider did not send the patient test results notification letters.

- In case 19, the patient had a urinalysis and urine culture result. The provider did not send a patient test results notification letter.

- In case 23, the patient had a urine study and an abnormal urine culture. The provider did not send a patient test results notification letter.

Clinician On-Site Inspection

We spoke with radiology staff, laboratory staff, and supervisors about diagnostic processes. They reported not having any backlogs or any difficulties completing the diagnostic orders. We discussed the deficiencies related to delayed endorsements and incomplete notification letters to patients.

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

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)	9	1	0	90.0%
Radiology: Did the ordering health care provider communicate the results of the radiology study to the patient within specified time frames? (2.003)	6	4	0	60.0%
Laboratory: Was the laboratory service provided within the time frame specified in the health care provider's order? (2.004)	10	0	0	100%
Laboratory: Did the health care provider review and endorse the laboratory report within specified time frames? (2.005)	9	1	0	90.0%
Laboratory: Did the health care provider communicate the results of the laboratory test to the patient within specified time frames? (2.006)	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)	3	7	0	30.0%
Laboratory: Did the provider acknowledge the STAT results, OR did nursing staff notify the provider within the required time frames? (2.008)	7	3	0	70.0%
Laboratory: Did the health care provider endorse the STAT laboratory results within the required time frames? (2.009)	9	1	0	90.0%
Pathology: Did the institution receive the final pathology report within the required time frames? (2.010)	10	0	0	100%
Pathology: Did the health care provider review and endorse the pathology report within specified time frames? (2.011)	10	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	10	0	0
				Overall percentage (MIT 2): 73.3%

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

Recommendations

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

- Health care leadership should determine the root cause of challenges to the timely collection as well as notification and endorsement of STAT laboratory results and should implement remedial measures as appropriate.

Emergency Services

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

Ratings and Results Overview

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

In this cycle, case review found SQRC's overall performance needed improvement in emergency services. First responders and nurses responded promptly to medical alarms, and nursing staff and medical leadership often performed good clinical reviews. However, we found delays in 9-1-1 activation, incomplete nursing assessments, and nurses not always providing appropriate interventions when clinically indicated. Factoring all the information, the OIG rated this indicator ***inadequate***.

Case Review Results

We reviewed 45 urgent and emergent events and found 47 emergency care deficiencies. Of these 47 deficiencies, 18 were significant.[15]

Emergency Medical Response

OIG clinicians found SQRC responded promptly to medical emergencies throughout the institution, and first responders and medical staff worked cohesively to provide emergency care. However, we found areas needing improvement. OIG clinicians reviewed four cases in which staff performed CPR and 12 cases in which medical response was provided.[16] OIG clinicians identified patterns with delays in activating emergency medical services (EMS), with nursing staff not applying cervical spine immobilization when warranted, with incomplete nursing assessments, and with inappropriate interventions.[17] The following are examples:

- In cases 1, 2, 5, 6, 9, and 24, staff delayed activating EMS from five minutes to 16 minutes.

[15] Deficiencies occurred in cases 1–7, 9, and 21–24. Significant deficiencies occurred in cases 1, 2, 4 –7, 9, and 21–24.

[16] CPR occurred in cases 4, 5, 6, and 9. A medical response occurred in cases 1-7, 9, and 21-24.

[17] Cervical spine immobilization is the process of stabilizing a patient's neck to prevent it from moving after an injury to reduce the risk of further injury, paralysis, or death.

- Also in case 1, staff activated a medical alarm for a patient with symptoms of severe chest pain, shortness of breath, and dizziness. At 8:14 a.m., the nurse obtained orders from the provider to transfer the patient emergently to the hospital. However, the nurse did not notify EMS until 16 minutes later at 8:30 a.m.

- In cases 2, 4, 5, and 9, nursing staff did not apply cervical spinal immobilization when warranted.

- Also in case 4, staff activated a medical alarm for a patient who was found hanging due to a suicide attempt. The patient was unresponsive and not breathing. First responders and nursing staff promptly initiated CPR and administered one dose of Naloxone.[18] The patient became responsive but not fully alert and had decreased respirations. Nursing staff discontinued oxygen and transported the patient to the triage and treatment area (TTA) using a wheelchair. However, nursing staff did not listen to lung sounds, assess breathing pattern, obtain vital sign measurements including oxygen saturation rate, apply cervical spinal immobilization to maintain posture of the neck and spine, or continue oxygen therapy until oxygen saturation rate was taken. In addition, nursing staff inappropriately transported the patient to the TTA using a wheelchair instead of transporting the patient on a gurney.

- In case 24, nursing staff responded to a medical alarm for a patient with chest pain. The nurse obtained vital signs and documented the patient was alert and the patient's skin was moist. The patient reported to the nurse he self-administered nitroglycerin medication for the chest pain.[19] However, the patient reported he continued to experience severe chest pain and feeling too weak to move or walk. The patient was transported to the TTA via gurney 12 minutes later. However, OIG clinicians identified a 12-minute delay in activating EMS for the patient with acute symptoms of chest pain.

Provider Performance

Providers performed well in urgent and emergent situations and in after-hours care. OIG clinicians reviewed 45 TTA events in which providers either directly evaluated patients or consulted with TTA nurses. Although we did not identify any provider care deficiencies in decision-making in those emergency events based on documentation, we did find clear instances in which providers did not have complete information to make better decisions. Based on these instances, OIG clinicians found opportunities for improvement in nursing and medical team collaboration, as these omissions may have increased risk of harm for patients. Below are two examples:

- In case 7, custody staff escorted the patient with symptoms of dizziness, weakness, and confusion to the TTA using a wheelchair. At the time of the

[18] Naloxone is a medication used for the emergency treatment of known or suspected opioid overdose. According to the manufacturer, nasal naloxone doses can be safely administered every two to three minutes. CCHCS emergency medical training allows nurses to administer five nasal naloxone doses when an opioid overdose is suspected.

[19] Nitroglycerin is a medication that dilates blood vessels to increase blood flow to the heart. Nitroglycerin is a medication used to relieve chest pain.

patient's arrival, the TTA RN documented the patient was lethargic, with dry pale skin. The nurse performed orthostatic vital signs, which showed abnormally low blood pressure with position changes 31 minutes after arriving to the TTA.[20] The nurse gave the patient water to drink, instead of identifying the patient recently had a cardiac procedure and would require further evaluation to rule out further complications. The nurse later called the provider and received orders to discharge the patient back to the housing unit. According to the provider's progress note, the provider was aware of initial vital signs taken upon arrival to the TTA and after fluid intake. However, the provider did not document being aware of the abnormal orthostatic blood pressure readings. Therefore, the record was unclear on whether the nurse and provider discussed the patient's full presentation prior to discharging the patient to the housing unit. Three days later, a second medical alarm was activated for this same patient with altered level of consciousness, shortness of breath, and back pain. Staff transferred the patient emergently to a higher level of care.

- In case 21, nurses responded to a medical alarm for the patient, who was confused, weak, and reported multiple episodes of nausea and vomiting for three days with upper abdominal pain. Staff transported the patient on a gurney to the TTA. The nurses obtained vital signs including abnormally elevated blood pressure readings with severe abdominal pain. The nurse notified the provider and received orders for State car transport to the hospital. Due to the patient's acute symptoms, medical personnel should have instead transferred the patient via ambulance, raising the concern the provider may not have had all the necessary information when ordering transport by State car.

Nursing Performance

SQRC's nursing performance in urgent and emergent events revealed opportunities for improvement in assessments and interventions. Of the 47 deficiencies we identified, 27 related to nursing performance, six of which were significant.[21] Nurses frequently performed incomplete assessments and delayed notification to the on-call providers when patients presented with urgent symptoms. The following are examples:

- In case 1, nursing staff provided urgent care for the patient, who presented with symptoms of chest pain, shortness of breath, dizziness, nausea, and vomiting. The RN did not perform a thorough examination to include listening to the patient's lung sounds.

- In case 2, the TTA RN responded to a medical alarm for a patient who had a witnessed seizure for one minute. Upon arrival to the patient's location, the RN noted the patient sustained a head injury after the seizure. The RN contacted the provider and received orders to provide continuous medical

[20] Orthostatic vitals mean the blood pressure and pulse measurements are recorded in three separate positions: laying down, sitting, and standing. Abnormal measurements indicate possible fluid loss.

[21] Nursing performance deficiencies occurred in case 1-7, 9, and 21-23. Significant deficiencies occurred in case 2, 4, 21, 22, and 23.

observation. The RN did not assess the patient's head for injuries or provide continuous monitoring to rule out any neurological deficits.

- In case 22, LVNs responded to a medical alarm for the patient who complained of shortness of breath. One of the LVNs gave the patient a rescue inhaler for shortness of breath and called 9-1-1. Two minutes later, the RN arrived and found the patient had an altered level of consciousness, dilated pupils, and sweaty skin. The RN obtained vital signs showing the patient had a critically low oxygen saturation rate. However, the nurses should have immediately administered Narcan for the patient presenting with symptoms of drug overdose, which led to a four-minute delay in administration of Naloxone.

Nursing Documentation

Nurses generally performed good documentation, and timelines were mostly thorough and accurate. The documentation deficiencies we identified did not affect overall patient care, and we did not identify any patterns of deficiencies.

Emergency Medical Response Review Committee

Compliance testing revealed the emergency medical response and unscheduled transport event checklists were frequently incomplete, and the institution did not review cases within required time frames (MIT 15.003, 16.7%). Similarly, OIG clinicians reviewed 11 emergency medical response and unscheduled transport event checklists or EMRRC meeting minutes in 10 cases and found seven deficiencies, two of which were significant.[22] However, OIG clinicians found leadership generally performed most clinical reviews and identified deficiencies. The following is an example of when leadership did not identify deficiencies:

- In case 5, nursing and medical leadership performed a clinical review for the patient, who was found unresponsive and not breathing. The patient had traumatic head injuries with a bleeding wound to the head. The clinical review did not identify the following deficiencies: first responders delayed initiating CPR, calling 9-1-1, and initiating bleeding control measures.

Clinician On-Site Inspection

OIG clinicians interviewed TTA RNs, TTA supervisors, providers, and executive nursing staff. OIG clinicians inspected the TTA, which had five rooms for patient care. Two rooms were equipped with emergency treatment carts. The TTA was staffed with two RNs each shift, and a medical provider was assigned on business days from 8:00 a.m. to 4:00 p.m. After-hours, weekends, and holidays, nursing staff responded to medical emergencies, performed assessments for all patients with urgent or emergent symptoms, and co-consulted with providers via telephone for patients who required consultation.

Nurses indicated two RNs would respond with custody staff if a medical alarm was activated for an unresponsive patient. Custody staff would drive the transportation vehicle when responding to a medical alarm. The nurses reported barriers to responding

[22] Deficiencies occurred in cases 1, 2, 4, 5, 9, and 23. Significant deficiencies occurred in cases 5 and 9.

to housing units. They reported each housing unit contained small hallways, which presented challenges to transporting patients who cannot walk to the emergency transport vehicle or golf cart. If a patient required transport to the emergency transport vehicle or golf cart, the patient could be transported with a stokes litter or stair chair. Staff previously used an institutional medical ambulance as well as personnel who would respond and help transport patients to the TTA. During our inspection the institutional medical ambulance had been out of service for six months. The staff utilized the golf cart to transport patients to the TTA.

Providers reported concerns with TTA nurses not providing verbal reports containing a detailed assessment to on-call providers. Specifically, during evening and overnight TTA events, TTA RNs did not always provide relevant patient information. Providers had to ask more questions to determine the situation, and the nurses routinely had to call back later to relay the answers. Other times, providers asked the nurses to take the phone to the patient's bedside so providers could ask the patient directly. Providers and medical leadership acknowledged this issue and had been providing in-service training, but at the time of our inspection, it remained an issue.

The nursing supervisor reported the RN new employee onboarding training had been reduced from 16 weeks to eight weeks for each area, which made it challenging to provide adequate training, especially in the TTA. At the time of inspection, the director of nursing (DON), acting on behalf of the chief nurse executive, was new to the institution. The DON acknowledged the OIG findings and explained they were working on emergency response and documentation.

Recommendations

- Institutional leadership should determine the root cause(s) of delays in staff activating the 9-1-1 system immediately for emergent patients needing a higher level of care and should implement remedial measures as appropriate.

- Nursing leadership should analyze the challenges to nurses performing thorough assessments and interventions of emergent and urgent conditions. 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
Adequate	***Proficient*** **(90.0%)**

Case review found SQRC performed satisfactorily in managing health information. Staff often timely retrieved and scanned hospital discharge records, diagnostic results, and specialty reports. They also performed well in scanning urgent and emergent records. Considering all factors, the OIG rated the case review component of this indicator ***adequate***.

Compliance testing showed SQRC performed very well in this indicator. Staff always scanned patient sick call requests and hospital discharge reports timely. Staff also showed satisfactory performance in scanning specialty reports within required time frames. However, staff needed improvement in properly scanning, labeling, and including medical records into the correct patient files. Based on the overall **Health Information Management** compliance score result, the OIG rated this indicator ***proficient.***

Case Review and Compliance Testing Results

OIG clinicians reviewed 1,013 events and identified 69 deficiencies related to health information management. Of these 69 deficiencies, nine were significant.[23]

Hospital Discharge Reports

In compliance testing, SQRC performed excellently with retrieving and scanning hospital discharge documents (MIT 4.003, 100%) as well as with reviewing and including key elements in the hospital discharge reports (MIT 4.005, 95.8%) within required time frames. OIG clinicians reviewed 18 off-site emergency department encounters and hospitalizations. SQRC staff retrieved, scanned, and reviewed these reports timely. OIG clinicians only identified one minor deficiency in which the provider endorsed an emergency department report six days after the report was made available.

[23] HIM deficiencies occurred in cases 1, 2, 7, 9, 10, 13–17, 19, 21, 23, and 25–28. Significant deficiencies occurred in cases 1, 10, 14, 17, 19, 23, and 27.

Specialty Reports

In compliance testing, SQRC handled specialty service reports variably. SQRC staff generally scanned specialty service reports (MIT 4.002, 83.3%) within five calendar days of the specialty service encounter date. Although SQRC staff usually received and reviewed routine-priority and high-priority specialty reports (MIT 14.002, 78.6% and MIT 14.008, 80.0%) timely, they needed improvement in receiving and reviewing medium-priority reports (MIT 14.005, 73.3%) within required time frames. OIG clinicians reviewed 106 specialty reports and identified six deficiencies related to health information management. Two deficiencies related to patient refusals not being sent to the provider. Two minor deficiencies related to delayed retrieval of specialty reports. Two further minor deficiencies related to delays in provider endorsement and scanning into EHRS.[24] We also discuss these findings in the **Specialty Services** indicator.

Diagnostic Reports

Compliance testing showed mixed performance with diagnostic reports. Staff frequently endorsed radiology and laboratory results (MIT 2.002, 90.0% and MIT 2.005, 90.0%) but only intermittently acknowledged or received STAT results (MIT 2.008, 70.0%) within required time frames. Staff always timely received and reviewed pathology reports (MIT 2.010, 100% and MIT 2.011, 100%), but never timely communicated those results with complete results notification letters to patients (MIT 2.012, zero). OIG clinicians reviewed 206 diagnostic reports and identified 57 diagnostic HIM deficiencies resulting from delays in provider endorsements or incomplete patient notification letters. Please refer to the **Diagnostic Services** indicator for further detailed discussion about diagnostics.

Urgent and Emergent Records

OIG clinicians reviewed 49 emergency care events and found providers and nurses recorded these events well. On-call providers also documented emergency care sufficiently. The **Emergency Services** indicator provides additional details. In one case, we found three deficiencies related to health information management of electrocardiograms (EKGs).[25] One example follows:

- In case 1, the nurse documented an EKG was performed and the provider documented the EKG findings. However, the EKG result was not scanned into the EHRS.

Scanning Performance

Compliance testing revealed inconsistent scanning, labeling, and filing of medical records into the correct patient files (MIT 4.004, 70.8%). However, OIG clinicians reviewed over 1,012 encounters and only identified the unscanned EKG from a TTA event mentioned above. We did not identify any mislabeled or misfiled records.

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[24] EHRS is the Electronic Health Records System. The department's electronic health record system is used for storing the patient's medical history. The health care staff use the system to communicate. This record stays with the patient throughout the patient's time in department's correctional system.

[25] The three deficiencies occurred in case 1. An EKG is an electrocardiogram. This non-invasive test measures and records the electrical impulses from the heart and is used to help diagnose heart problems.

Clinician On-Site Inspection

We discussed health information management processes with SQRC health information management supervisors, ancillary staff, diagnostic staff, nurses, and providers. The medical records supervisor reported having difficulty retrieving specialty records until the supervisor was notified of the issue and obtained access to off-site specialty services medical records systems. Since August 2024, SQRC staff have been able to log in and retrieve any reports not received timely, and the medical records supervisor stated retrieving specialty records was no longer a problem.

Compliance Score Results

Table 8. Health Information Management

Compliance Questions	Scored Answer			
	Yes	No	N/A	Yes %
Are health care service request forms scanned into the patient's electronic health record within three calendar days of the encounter date? (4.001)	20	0	15	100%
Are specialty documents scanned into the patient's electronic health record within five calendar days of the encounter date? (4.002)	25	5	15	83.3%
Are community hospital discharge documents scanned into the patient's electronic health record within three calendar days of hospital discharge? (4.003)	20	0	4	100%
During the inspection, were medical records properly scanned, labeled, and included in the correct patients' files? (4.004)	17	7	0	70.8%
For patients discharged from a community hospital: Did the preliminary or final hospital discharge report include key elements and did a provider review the report within five calendar days of discharge? (4.005)	23	1	0	95.8%
				Overall percentage (MIT 4): 90.0%

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

Table 9. Other Tests Related to Health Information Management

	Scored Answer			
Compliance Questions	**Yes**	**No**	**N/A**	**Yes %**
Radiology: Did the ordering health care provider review and endorse the radiology report within specified time frames? (2.002)	9	1	0	90.0%
Laboratory: Did the health care provider review and endorse the laboratory report within specified time frames? (2.005)	9	1	0	90.0%
Laboratory: Did the provider acknowledge the STAT results, OR did nursing staff notify the provider within the required time frame? (2.008)	7	3	0	70.0%
Pathology: Did the institution receive the final pathology report within the required time frames? (2.010)	10	0	0	100%
Pathology: Did the health care provider review and endorse the pathology report within specified time frames? (2.011)	10	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	10	0	0
Did the institution receive and did the primary care provider review the high-priority specialty service consultant report within the required time frame? (14.002)	11	3	1	78.6%
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)	11	4	0	73.3%
Did the institution receive and did the primary care provider review the routine-priority specialty service consultant report within the required time frame? (14.008)	12	3	0	80.0%

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* (51.6%)**

Overall, SQRC performed poorly with respect to its health care environment. Medical supply storage areas in the clinics contained unidentified, inaccurately labeled, or disorganized medical supplies. All applicable clinics tested did not meet the requirements for essential core medical equipment and supplies. In addition, staff did not regularly sanitize or wash their hands during patient encounters. Lastly, emergency medical response bags (EMRB) were missing staff verification or had not been properly inventoried when seal tags were changed. Based on the overall **Health Care Environment** compliance score result, the OIG rated this indicator ***inadequate***.

Compliance Testing Results

Waiting Areas

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

Photo 1. Patient waiting area (photographed on 12-18-24).

Clinic Environment

All 10 applicable clinic environments were sufficiently conducive for medical care; they provided reasonable auditory privacy, appropriate waiting areas, wheelchair accessibility, and nonexamination room workspace (MIT 5.109, 100%).

Of the 10 applicable clinics we observed, five contained appropriate space, configuration, supplies, and equipment to allow their clinicians to perform proper clinical examinations (MIT 5.110, 50.0%). The remaining five clinics had one or both of the following deficiencies: gurney had a torn and worn vinyl cover or examination rooms had unsecured confidential medical records.

Clinic Supplies

None of the 10 applicable clinics followed proper medical supply storage and management protocols (MIT 5.107, zero). We found one or more of the following deficiencies in all 10 clinics: unorganized, unidentified, or inaccurately labeled medical supplies; expired medical supplies (see Photo 2); compromised medical supply packaging; cleaning materials stored with medical supplies; medications stored with medical supplies; long-term storage of staff's food in the medical supply storage cabinet or drawer (see Photos 3 and 4, next page); and staff's personal items stored with medical supplies.

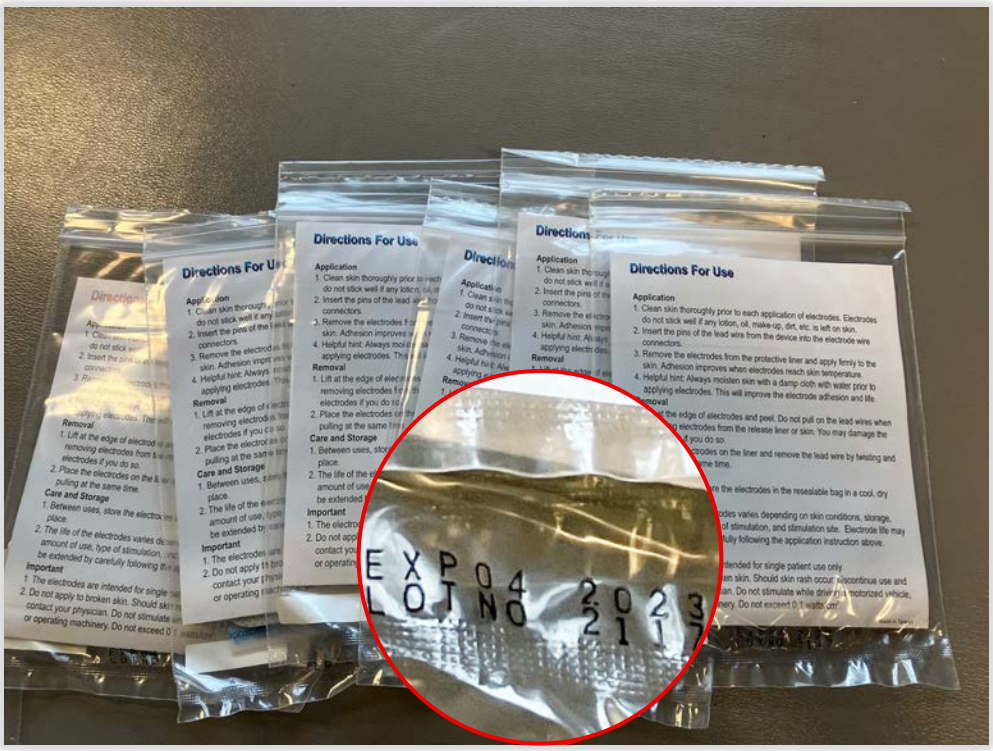

Photo 2. Expired medical supplies dated April 2023 (photographed on 12-17-24).

Photo 4. Long-term storage of staff's food in the medical supply storage drawer (photographed on 12-19-24).

Photo 3. Long-term storage of staff's food in the medical supply storage drawer (photographed on 12-17-24).

None of the 10 applicable clinics met requirements for essential core medical equipment and supplies (MIT 5.108, zero). We found one or more of the following deficiencies in all 10 clinics: clinics had missing or nonfunctional oto-ophthalmoscope, missing otoscope tips, or missing biohazard waste receptacle bin or red biohazard bag; staff had not properly calibrated a nebulizer; and a Snellen eye chart was missing an established distance line on the wall or floor. We found staff either did not consistently perform daily performance checks of the automated external defibrillator (AED) or did not properly document the defibrillator performance test log within the previous 30 days. Several clinic glucometer quality control logs were either incomplete, inaccurate, or not maintained at all.

We examined emergency medical response bags (EMRBs) to determine whether they contained all essential items. We checked whether staff inspected the bags daily and inventoried them monthly. Only three of the eight applicable EMRBs passed our test (MIT 5.111, 37.5%). We found one or more of the following deficiencies with five EMRBs: staff did not ensure the EMRB's compartments were sealed and intact; staff did not complete EMRB documentation; staff had not inventoried the EMRBs when the seal tags were replaced; and several EMRB daily glucometer quality control logs were either incomplete or inaccurate.

Medical Supply Management

None of the medical supply storage areas located outside the medical clinics stored medical supplies appropriately (MIT 5.106, zero). We found medical supplies stored directly on the floor (see Photo 5).

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

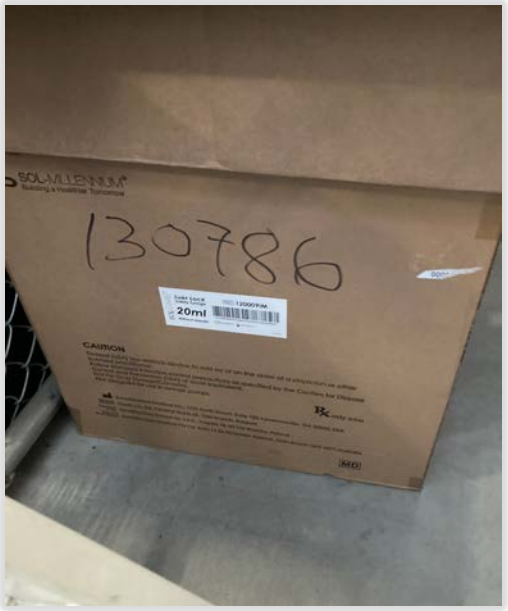

Photo 5. Medical supplies stored directly on the floor (photographed on 12-18-24).

Infection Control and Sanitation

Staff appropriately cleaned, sanitized, and disinfected six of 10 applicable clinics (MIT 5.101, 60.0%). In two clinics, biohazard waste was not emptied after each clinic day. In one clinic, the cleaning log was not maintained. In one other clinic, the health care area cabinet was unsanitary.

Staff in nine of 10 applicable clinics (MIT 5.102, 90.0%) properly sterilized or disinfected medical equipment. In one clinic, the examination table disposable paper was not removed and replaced in between patient encounters. In addition, staff did not mention disinfecting the examination table as part of their daily start-up protocol.

We found operational sinks and hand hygiene supplies in the examination rooms of all 10 applicable clinics (MIT 5.103, 100%).

We observed patient encounters in 10 clinics. In seven clinics, clinicians did not wash or sanitize their hands before applying gloves, before each subsequent regloving, or before and after performing an invasive procedure (MIT 5.104, 30.0%).

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

Physical Infrastructure

At the time of our medical inspection, the institution's administrative team reported no ongoing health care facility improvement program construction projects. The institution's health care management and plant operations manager reported all clinical area infrastructures were in good working order (MIT 5.999).

Compliance Score Results

Table 10. Health Care Environment

Compliance Questions	Scored Answer			
	Yes	**No**	**N/A**	**Yes %**
Infection control: Are clinical health care areas appropriately disinfected, cleaned, and sanitary? (5.101)	6	4	3	60.0%
Infection control: Do clinical health care areas ensure that reusable invasive and noninvasive medical equipment is properly sterilized or disinfected as warranted? (5.102)	9	1	3	90.0%
Infection control: Do clinical health care areas contain operable sinks and sufficient quantities of hygiene supplies? (5.103)	10	0	3	100%
Infection control: Does clinical health care staff adhere to universal hand hygiene precautions? (5.104)	3	7	3	30.0%
Infection control: Do clinical health care areas control exposure to blood-borne pathogens and contaminated waste? (5.105)	10	0	3	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)	0	10	3	0
Clinical areas: Do clinic common areas and exam rooms have essential core medical equipment and supplies? (5.108)	0	10	3	0
Clinical areas: Are the environments in the common clinic areas conducive to providing medical services? (5.109)	10	0	3	100%
Clinical areas: Are the environments in the clinic exam rooms conducive to providing medical services? (5.110)	5	5	3	50.0%
Clinical areas: Are emergency medical response bags and emergency crash carts inspected and inventoried within required time frames, and do they contain essential items? (5.111)	3	5	5	37.5%
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): 51.6%

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 emergency medical response bags (EMRBs) are regularly inventoried and sealed 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 staff performance in communicating vital health transfer information, such as preexisting health conditions, pending appointments, tests, and specialty referrals. Inspectors further confirmed whether staff sent complete medication transfer packages to receiving institutions. For patients who returned from off-site hospitals or emergency rooms, inspectors reviewed whether staff appropriately implemented recommended treatment plans, administered necessary medications, and scheduled appropriate follow-up appointments.

Ratings and Results Overview

Case Review Rating	Compliance Rating and Score
Adequate	***Inadequate* (53.0%)**

In Cycle 7, case review found SQRC performed sufficiently when patients transferred into the institution or returned from community hospitalization or emergency room encounters. In contrast, we identified opportunities for improvement in the transfer-out process, including notifying the receiving institution of pending specialty appointments and in medication continuity. Considering all factors, the OIG rated the case review component of this indicator ***adequate***.

Compliance testing showed SQRC performed poorly in this indicator. Although SQRC staff performed excellently in completing the assessment and disposition sections of the screening form, they performed poorly in timely completing initial health screening forms, in medication continuity for newly transferred patients, and in ensuring transfer packets for departing patients included all required documents and medications. 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

OIG clinicians reviewed 61 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 31 deficiencies, 10 of which were significant.[26]

[26] Deficiencies occurred in cases 1, 2, 7, 21, 22, 29, 30–34, 59, and 61. Significant deficiencies occurred in cases 2, 7, 22, 29, 30–34, 59, and 61.

Transfers In

SQRC's performance in the transfer-in process varied. Compliance testing showed nurses performed excellently in completing the assessment and disposition section on the initial health screening form (MIT 6.002, 100%). However, nurses performed poorly in completing the initial health screenings within required time frames (MIT 6.001, 32.0%). The reasons for the low score included instances of nursing staff completing the initial health screening after the patient moved to the housing unit, nurses documenting incomplete vital signs, and nurses not documenting an explanation for "yes" answers on the health screening form. OIG clinicians reviewed 18 events in four cases and identified four deficiencies, three of which were significant.[27] OIG clinicians did not identify any deficiencies with initial health screening assessments for transfer-in patients.

Both case review and compliance testing showed SQRC performed well with ensuring providers evaluated newly arrived patients within required time frames (MIT 1.002, 84.0%). OIG clinicians found most patients were seen by a provider within required time frames; however, in one case the R&R nurse did not place an order for a follow-up appointment as planned.[28]

Case review and compliance testing revealed SQRC performed poorly in scheduling approved specialty appointments for patients who transferred into the institution (MIT 14.010, 47.4%). For additional details please refer to the **Access to Care** indicator.

OIG clinicians and compliance testing also had mixed results for medication continuity for transfer-in patients. Compliance testing showed SQRC performed poorly with ensuring medication continuity for newly arrived patients (MIT 6.003, 46.7%). However, OIG clinicians only identified one deficiency, which was not significant.[29] Compliance testing showed SQRC also performed poorly in medication continuity for patient layovers (MIT 7.005, 48.0%). Analysis of the compliance data showed nurses did not document the reasons for refusals of medications. OIG clinicians did not review any events involving layovers.

Transfers Out

SQRC showed opportunities for improvement in the transfer-out process. OIG clinicians reviewed 25 events in eight cases and found 18 deficiencies, four of which were significant.[30] Nursing staff often performed appropriate screenings, completed vital signs assessments, and reviewed records for medical holds. However, OIG clinicians identified an RN who performed incomplete assessments outside required time frames.[31] Lastly, nursing staff did not always document communication of pending specialty appointments to the receiving facility.[32]

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[27] Deficiencies occurred in cases 4, and 29–31. Significant deficiencies occurred in cases 29, 30, and 31.

[28] Significant deficiency occurred in case 29.

[29] Deficiency occurred in case 29.

[30] Deficiencies occurred in cases 2, 32–34, 59, and 61. Significant deficiencies occurred in cases 2, 32, and 59.

[31] In cases 32 and 33, the same RN performed incomplete screenings more than 24 hours prior to the patients' departure.

[32] Nursing staff did not document communication of pending specialty appointments to the receiving institution in cases 32, 33, 59, and 61.

Compliance testing showed SQRC only sporadically ensured transfer packets included the required medications and transfer documents (MIT 6.101, 33.3%). OIG clinicians also found SQRC performed poorly with ensuring medication continuity for patients who transferred out of the institution. OIG clinicians identified nine deficiencies in five cases, two of which were significant.[33] Please refer to the **Medication Management** indicator for further details.

Hospitalizations

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

Compliance testing showed SQRC performed excellently in providing follow-up appointments within required time frames to patients returning from hospitalizations or emergency room encounters (MIT 1.007, 95.7%). In addition, SQRC also performed excellently in timely collecting and scanning community hospital discharge summaries (MIT 4.003, 100%).

OIG clinicians reviewed 13 events in 10 cases in which patients returned from hospitalization or emergency room evaluations and identified nine deficiencies, three of which were significant.[34] Of the three significant deficiencies, two related to medication continuity, and one related to nursing performance. Please refer to the **Medication Management** indicator for further details. Nurses generally performed appropriate assessments and interventions. Below is the significant deficiency for nursing performance:

- In case 7, the nurse assessed the patient, who returned from a cardiac procedure with stent placement. The nurse recorded vital signs reflecting a critically low blood pressure reading and a low pulse. The RN did not reassess the patient's pulse or blood pressure, assess the dressings sites located at the left side of the neck and right groin for any signs of excessive bleeding, listen to lung sounds, or perform either an abdominal assessment or skin assessment. In addition, the nurse documented the time the provider was notified of the patient's hospital recommendations prior to the time the patient was assessed. Therefore, the record was unclear on whether the provider was aware of the patient's condition.

Compliance testing revealed SQRC only sporadically ensured patients received medication within required time frames after discharge from a community hospital (MIT 7.003, 28.6%). In contrast, OIG clinicians found most patients received recommended hospital discharge medications timely.

[33] Deficiencies occurred in cases 2, 32, 34, 59, and 61. Significant deficiencies occurred in cases 32 and 59.

[34] Deficiencies occurred in cases 2, 7, 21, 22, and 59. Significant deficiencies occurred in cases 7, 22, and 59.

Clinician On-Site Inspection

At the receiving and release (R&R) area, OIG clinicians interviewed RNs working in the area and the R&R supervisor. The RN reported the R&R was staffed with an RN each shift Monday through Friday, excluding weekends and holidays. The nurses were knowledgeable about the transfer process and reported newly arrived patients received a vision test as part of the initial health screening.

Compliance On-Site Inspection and Discussion

R&R nursing staff ensured only one of the three applicable patients transferring out of the institution had the required medications, transfer documents, and assigned durable medical equipment (MIT 6.101, 33.3%). For two patients, the transfer packets did not have the required medications.

Compliance Score Results

Table 11. Transfers

	Scored Answer			
Compliance Questions	**Yes**	**No**	**N/A**	**Yes %**
For endorsed patients received from another CDCR institution: Did nursing staff complete the initial health screening and answer all screening questions within the required time frame? (6.001)	8	17	0	32.0%
For endorsed patients received from another CDCR institution: When required, did the RN complete the assessment and disposition section of the initial health screening form; refer the patient to the TTA if TB signs and symptoms were present; and sign and date the form on the same day staff completed the health screening? (6.002)	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)	7	8	10	46.7%
For patients transferred out of the facility: Do medication transfer packages include required medications along with the corresponding transfer packet required documents? (6.101)	1	2	1	33.3%
				Overall percentage (MIT 6): 53.0%

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)	21	4	0	84.0%
Upon the patient's discharge from the community hospital: Did the patient receive a follow-up appointment with a primary care provider within the required time frame? (1.007)	22	1	1	95.7%
Are community hospital discharge documents scanned into the patient's electronic health record within three calendar days of hospital discharge? (4.003)	20	0	4	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)	23	1	0	95.8%
Upon the patient's discharge from a community hospital: Were all ordered medications administered, made available, or delivered to the patient within required time frames? (7.003)	6	15	3	28.6%
Upon the patient's transfer from one housing unit to another: Were medications continued without interruption? (7.005)	12	13	0	48.0%
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)	7	3	0	70.0%
For endorsed patients received from another CDCR institution: If the patient was approved for a specialty services appointment at the sending institution, was the appointment scheduled at the receiving institution within the required time frames? (14.010)	9	10	1	47.4%

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

Recommendations

- Nursing leadership should develop and implement strategies, such as internally auditing staff, to ensure complete and thorough screening of patients transferring out of the institution, review pending specialty communications, and maintain patient hand-off communication to the receiving facility. Leadership should implement remedial measures as appropriate.

Medication Management

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

Ratings and Results Overview

Case Review Rating	Compliance Rating and Score
Inadequate	***Inadequate* (51.8%)**

In this cycle, case review found SQRC overall needed improvement in this indicator. SQRC performed sufficiently in medication continuity for patients on newly prescribed medications, transfer-in medications, and medications for patients returning from a hospitalization. However, we identified lapses in medication continuity throughout the institution, which led to multiple cases in which patients did not receive chronic care medications for 30 days. In addition, when patients returned from the hospital, transferred into the institution, or transferred out of the institution, we identified a pattern in which nurses did not ensure patients had rescue medications, such as rescue inhalers or nitroglycerin on person. Lastly, SQRC staff performed poorly in medication continuity for patients transferring out of the institution. Considering all factors, the OIG rated the case review component of this indicator ***inadequate***.

Compliance testing showed SQRC needed improvement in providing medication management services. SQRC performed poorly in providing patients with chronic care medications, newly prescribed medications, hospital discharge medications, transfer-in medications, transfer-out medications, and in ensuring medication continuity for patients transferring from yard to yard. SQRC also showed opportunities for improvement in ensuring medication continuity for patients laying over at SQRC. 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 35 cases related to medications and found 24 medication deficiencies, 11 of which were significant.[35]

New Medication Prescriptions

Compliance testing showed SQRC needed improvement in ensuring patients received newly prescribed medications (MIT 7.002, 52.0%). In contrast, OIG clinicians found most

[35] Deficiencies occurred in cases 2, 13, 15, 18, 19, 21, 22, 25–27, 29, 32, 34, 59, and 61. Significant deficiencies occurred in cases 13, 22, 25–27, 32, and 59.

newly prescribed medications were administered timely. OIG clinicians identified three deficiencies, two of which were significant.[36] Below is an example:

- In case 25, in May 2024, the patient received prednisone to treat inflammation of the arteries one day late due to the medication not being available.

Chronic Medication Continuity

During this review period, compliance found SQRC performed poorly in ensuring medication continuity for patients with chronic conditions (MIT 7.001, 45.5%). Compliance testing showed low scoring results occurred primarily due to pharmacy not timely filling and dispensing medication. Similarly, OIG clinicians found patients did not receive their chronic medications timely or did not receive them at all. OIG clinicians found eight deficiencies in eight cases, four of which were significant:[37]

- In case 13, during the month of May, the patient did not receive the monthly prescriptions for two blood pressure medications and aspirin. The nurses did not document the medication was administered in the medication administration record (MAR) or obtain a signed refusal from the patient.

- In case 18, during the month of July, the patient did not receive the monthly chronic medication prescription, Vitamin C, to treat skin pigment issues. The patient received the medication approximately one month late.

- In case 26, during the month of August, the patient did not receive the monthly prescription for his blood pressure medication. The patient received the medication one month late.

Hospital Discharge Medications

Compliance found SQRC only sporadically ensured medications were available, administered, and delivered to patients within required time frames (MIT 7.003, 28.6%). In contrast, OIG clinicians found only a few instances in which medication was not available to the patient within required time frames. OIG clinicians reviewed 13 events in 10 cases in which patients returned to the institution from the community hospital or emergency room encounter. We identified three deficiencies, two of which were significant, in which SQRC did not maintain medication continuity for patients upon return from the community hospital or emergency room.[38] Below are the significant deficiencies:

- In case 22, the patient was discharged from hospitalization with a discharge diagnosis of a heart attack, respiratory distress, and pneumonia. Upon return to the institution, the nurse obtained verbal orders for new prescriptions for aspirin and two blood pressure medications. However, staff administered all three medications one day late.

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[36] Deficiencies occurred in cases 21, 22, and 25. Significant deficiencies occurred in cases 22 and 25.

[37] Deficiencies occurred in cases 13, 15, 18, 19, 22, and 25–27. Significant deficiencies occurred in cases 13, 22, 25, and 27.

[38] Deficiencies occurred in cases 21, 22, and 59. Significant deficiencies occurred in cases 22 and 59.

- In case 59, the patient transferred from a different institution to the hospital. Upon hospital discharge, the patient transferred to SQRC. After transferring into SQRC, the patient missed 10 doses of medication prescribed for major depression. The institution reported the delay was caused due to SQRC health care staff incorrectly reconciling the patient's medications only from the sending institution's medication list in the patient's electronic health record instead of also reconciling the medications from the hospital discharge summary.

Specialized Medical Housing Medications

In two samples, compliance testing revealed both patients did not receive chronic care medications within required time frames in CTC (MIT 13.003, zero). Analysis of compliance data showed, for two samples, the patients did not receive the medication by the provider's ordered administration time, or the pharmacy did not deliver the medication timely. OIG clinicians reviewed six cases and found three deficiencies, two of which were significant.[39] Below is an example:

- In case 27, during the month of May, the provider ordered an antibiotic medication to treat an intestinal infection. Four days later, the medication was still not available. Therefore, the provider changed therapy to a different antibiotic, which led to a delay in treatment.

Transfer Medications

Compliance testing revealed SQRC performed poorly in administering medications without a lapse in continuity for newly arrived patients to the institution (MIT 6.003, 46.7%) and for those patients who transferred from yard to yard (MIT 7.005, 48.0%). In contrast, OIG clinicians found SQRC performed well in administering medication to newly arrived patients timely.

Compliance testing revealed patients who arrived to the institution for a temporary layover only intermittently received their medications without interruption (MIT 7.006, 70.0%). OIG clinicians did not review any events involving patients on a temporary layover at SQRC.

Compliance testing revealed SQRC performed poorly in ensuring all patients who transferred out of the institution received a five-day supply of medications (MIT 6.101, 33.3%). Similarly, OIG clinicians identified 10 deficiencies in six cases, two of which were significant.[40] Examples are below:

- In case 2, the patient transferred from SQRC on five separate occasions during the review period. However, the patient did not transfer with the prescribed patient-specific mental health medication every time he transferred.

- In case 32, the patient did not transfer with any of the prescribed chronic care medications, including medications prescribed for thyroid disorder,

[39] Deficiencies occurred in cases 27 and 59. Significant deficiencies occurred in case 27.

[40] Deficiencies occurred in cases 2, 32, 34, 59, and 61. Significant deficiencies occurred in cases 32 and 59.

elevated cholesterol, and hypertension. In addition, the nurse incorrectly sent a message to the receiving institution stating the patient did not have any active prescriptions.

- In case 59 and 61, nursing staff did not ensure the transfer-out patient had the prescribed rescue inhaler or the nitroglycerin on person for emergencies.

Medication Administration

Compliance testing showed nurses performed very well in administering TB medications as prescribed (MIT 9.001, 90.5%) and frequently monitored patients on TB medications (MIT 9.002, 85.7%).

Clinician On-Site Inspection

OIG clinicians interviewed the pharmacist-in-charge (PIC), nursing supervisors, and nursing leadership to discuss pharmacy and medication management questions.

OIG clinicians attended various clinic huddles and went to the medication administration areas. Medication nurses were very knowledgeable regarding the keep-on-person (KOP) process.[41] With nursing leadership and the pharmacist, OIG clinicians discussed patient-specific medications for which the record contained no documentation the patient had picked up the medication. The pharmacist provided supporting documentation in multiple cases demonstrating nursing staff received the medication, but the medication was not administered to the patient, and the nurse did not document the patient refused the medication.

The acting chief nursing executive (CNE (A)) reported, in the five months prior to the on-site inspection, the institution had implemented a medication workgroup to address scan overrides. Medication scan overrides occur when a nurse overrides the MAR alerts, which can potentially increase medication errors or poor patient outcomes. As a result of that workgroup, the CNE (A) reported override incidents had been reduced from 600 to 50 in the past year.

Medication Practices and Storage Controls

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

SQRC appropriately stored and secured nonnarcotic medications in five of 10 applicable clinic and medication-line locations (MIT 7.102, 50.0%). In five locations, we observed one or more of the following deficiencies: unsanitary medication carts; treatment cart logs were missing daily security check entries; the medication nurse did not follow the process in place to return medications with an expired pharmacy label that could potentially be restocked and reissued by the pharmacy; the medication area lacked a clearly labeled designated area for refrigerated medications that were to be returned to the pharmacy; and medications were not properly and securely stored as required by CCHCS policy.

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

Staff kept medications protected from physical, chemical, and temperature contamination in six of the 10 applicable clinic and medication-line locations (MIT 7.103, 40.0%). In nine locations, we found one or more of the following deficiencies: staff did not store internal and external medications separately; the medication refrigerator was unsanitary; staff stored medications with disinfectants; and staff did not consistently record the room or refrigerator temperatures.

Staff successfully stored valid, unexpired medications in eight of the 10 applicable medication-line locations (MIT 7.104, 80.0%). In one location, nurses did not label the multi-use medication as required by CCHCS policy. In another location, nurses stored a multi-use medication after the identified beyond use date.

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

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

In only one of seven applicable medication areas, staff used appropriate administrative controls and protocols when distributing medications to their patients (MIT 7.107, 14.3%). In six locations, we observed one or more of the following deficiencies: medication nurses did not distribute medication to patients within required time frames; medication nurses did not always verify a patient's identity using a secondary identifier; medication nurses did not reliably observe patients while they swallowed direct observation therapy medications; medication nurses did not follow the CCHCS care guide when administering Suboxone medication; some medication nurses did not properly disinfect the vial's port prior to withdrawing medication; and a medication nurse did not fully administer a crushed and float medication as ordered by the provider, specifically a portion of the crushed medication was poured on the counter and not into the patient's medication cup.

Pharmacy Protocols

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

The institution did not properly store refrigerated or frozen medications in the pharmacy (MIT 7.110, zero). Although room, refrigerator, and freezer temperatures were monitored by the pharmacy using a digital data logger, the pharmacy did not maintain a medication storage temperature log (CDCR 7217) for recording room temperature as required by CCHCS policy.

The PIC did not correctly review monthly inventories of controlled substances in the institution's clinic and medication storage areas. Specifically, the PIC did not sign a medication-area inspection checklist (CDCR Form 7477) (MIT 7.111, zero).

We examined 17 medication error reports. The PIC timely or correctly processed only four of these 17 reports. Of the other 13 reports, the PIC could not provide evidence of performing a pharmacy error follow-up review. (MIT 7.112, 23.5%).

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

Our compliance team interviewed patients in restricted housing units to determine whether they had immediate access to their prescribed asthma rescue inhalers or nitroglycerin medications. All six applicable patients indicated they had access to their rescue medications (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	12	3	45.5%
Did health care staff administer, make available, or deliver new order prescription medications to the patient within the required time frames? (7.002)	13	12	0	52.0%
Upon the patient's discharge from a community hospital: Were all ordered medications administered, made available, or delivered to the patient within required time frames? (7.003)	6	15	3	28.6%
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)	12	13	0	48.0%
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)	7	3	0	70.0%
All clinical and medication line storage areas for narcotic medications: Does the institution employ strong medication security controls over narcotic medications assigned to its storage areas? (7.101)	10	0	4	100%
All clinical and medication line storage areas for nonnarcotic medications: Does the institution properly secure and store nonnarcotic medications in the assigned storage areas? (7.102)	5	5	4	50.0%
All clinical and medication line storage areas for nonnarcotic medications: Does the institution keep nonnarcotic medication storage locations free of contamination in the assigned storage areas? (7.103)	4	6	4	40.0%
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	4	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	5	7	28.6%
Medication preparation and administration areas: Does the institution employ appropriate administrative controls and protocols when preparing medications for patients? (7.106)	7	0	7	100%
Medication preparation and administration areas: Does the institution employ appropriate administrative controls and protocols when administering medications to patients? (7.107)	1	6	7	14.3%
Pharmacy: Does the institution employ and follow general security, organization, and cleanliness management protocols in its main and remote pharmacies? (7.108)	1	0	0	100%
Pharmacy: Does the institution's pharmacy properly store nonrefrigerated medications? (7.109)	1	0	0	100%
Pharmacy: Does the institution's pharmacy properly store refrigerated or frozen medications? (7.110)	0	1	0	0
Pharmacy: Does the institution's pharmacy properly account for narcotic medications? (7.111)	0	1	0	0
Pharmacy: Does the institution follow key medication error reporting protocols? (7.112)	4	13	0	23.5%
Pharmacy: For Information Purposes Only: During compliance testing, did the OIG find that medication errors were properly identified and reported by the institution? (7.998)	This is a nonscored test. Please see the indicator for discussion of this test.			
Pharmacy: For Information Purposes Only: Do patients in restricted housing units have immediate access to their KOP prescribed rescue inhalers and nitroglycerin medications? (7.999)	This is a nonscored test. Please see the indicator for discussion of this test.			
				Overall percentage (MIT 7): 51.8%

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)	7	8	10	46.7%
For patients transferred out of the facility: Do medication transfer packages include required medications along with the corresponding transfer-packet required documents? (6.101)	1	2	1	33.3%
Patients prescribed TB medication: Did the institution administer the medication to the patient as prescribed? (9.001)	19	2	0	90.5%
Patients prescribed TB medication: Did the institution monitor the patient per policy for the most recent three months he or she was on the medication? (9.002)	18	3	0	85.7%
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)	0	2	0	0

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

Recommendations

- Medical and nursing leadership should develop strategies to ensure medication continuity for chronic care medications, hospital discharge medications, newly prescribed medications, transfer-in and transfer-out medications, and medications for en-route patients. Leadership should implement remedial measures as appropriate.

- Nursing leadership should consider reminding nursing staff to document patient refusals in medical administration records, as described in CCHCS policy and procedures, and should implement remedial measures as appropriate.

Preventive Services

In this indicator, OIG compliance inspectors tested whether the institution offered or provided cancer screenings, tuberculosis (TB) screenings, influenza vaccines, and other immunizations. If the department designated the institution as being at high risk for coccidioidomycosis (Valley Fever), we tested the institution's performance in transferring out patients quickly. The OIG rated this indicator solely according to the compliance score. Our case review clinicians do not rate this indicator.

Ratings and Results Overview

Case Review Rating	Compliance Rating and Score
Not Applicable	***Proficient*** **(85.7%)**

SQRC performed well in this indicator. Staff performed excellently in screening patients annually for tuberculosis (TB), offering patients an influenza vaccine for the most recent influenza season, and offering colorectal cancer screening for patients from ages 45 through 75. They also performed very well in administering TB medications to patients as prescribed and well in monitoring patients taking TB medications. However, staff needed significant 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

	Scored Answer			
Compliance Questions	**Yes**	**No**	**N/A**	**Yes %**
Patients prescribed TB medication: Did the institution administer the medication to the patient as prescribed? (9.001)	19	2	0	90.5%
Patients prescribed TB medication: Did the institution monitor the patient per policy for the most recent three months he or she was on the medication? (9.002)	18	3	0	85.7%
Annual TB screening: Was the patient screened for TB within the last year? (9.003)	24	1	0	96.0%
Were all patients offered an influenza vaccination for the most recent influenza season? (9.004)	24	1	0	96.0%
All patients from the age of 45 through the age of 75: Was the patient offered colorectal cancer screening? (9.005)	24	1	0	96.0%
Female patients from the age of 50 through the age of 74: Was the patient offered a mammogram in compliance with policy? (9.006)	N/A	N/A	N/A	N/A
Female patients from the age of 21 through the age of 65: Was patient offered a pap smear in compliance with policy? (9.007)	N/A	N/A	N/A	N/A
Are required immunizations being offered for chronic care patients? (9.008)	6	6	13	50.0%
Are patients at the highest risk of coccidioidomycosis (Valley Fever) infection transferred out of the facility in a timely manner? (9.009)	N/A	N/A	N/A	N/A
				Overall percentage (MIT 9): 85.7%

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

Recommendations

- Health care leadership should determine the root cause(s) for challenges to timely providing immunizations to chronic care patients and should implement appropriate remedial measures.

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
Inadequate	***Not Applicable***

Case review found SQRC's nursing staff assessed patients timely, correctly identified urgent sick call requests that required a same day nursing triage, and performed well in CPR events. However, we found nurses performed incomplete assessments in the outpatient clinic and specialized medical housing, with emergency care, and during the transfer-out process. In addition, we identified a trend in which nursing staff delayed or did not consult with a provider when clinically indicated. After taking all these factors into consideration, the OIG rated this indicator ***inadequate***.

Case Review Results

We reviewed 165 nursing encounters in 46 cases. Of the nursing encounters we reviewed, 80 were in the outpatient setting, and 37 were sick call requests. We identified 105 nursing performance deficiencies, 22 of which were significant.[42]

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.

[42] Deficiencies occurred in cases 1–9, 16–23, 29, 32, 33, 36–40, 44–50, 52–56, 58, 59, and 61. Significant deficiencies occurred in cases 2–4, 7, 20–23, 29, 32, 33, 45–47, 58, and 59.

OIG clinicians reviewed 37 sick call events and identified 26 deficiencies, seven of which were significant.[43] Generally, nurses evaluated patients timely. However, OIG clinicians identified nurses needed improvement in performing thorough nursing assessments and providing appropriate interventions. The following are examples:

- In case 7, the nurse's patient presented with swelling to the hand and foot for two days, shortness of breath, and fatigue. The nurse assessed the patient's lower extremity swelling. However, the nurse did not perform a thorough examination to include listening to lung sounds, performing an abdominal assessment, weighing the patient, or consulting with the provider of the patient's acute symptoms.

- In case 18, the nurse assessed the patient, who was referred from the provider to discuss radiology results of the lungs, inquire about recent infections, and notify the patient a repeat X-ray had been ordered. The patient had a history of coccidioidomycosis (Valley Fever) infection and was taking anti-fungal medication.[44] The RN did not perform a thorough Cocci screening assessment, listen to lung sounds, obtain the patient's weight, or perform a skin or cardiac assessment.

- In case 22, the TTA nurse triaged a sick call for the patient with complaints of breathing concerns and an increased use of the rescue inhaler, and the patient requested a nebulizer breathing treatment. The patient had multiple chronic conditions including asthma. The nurse assessed the patient with diminished lung sounds, and the patient had low peak flow measurements. The nurse administered a nebulizer treatment and discharged the patient to the housing unit. However, the nurse did not review medication compliance, reassess the patient's lung sounds after administering a breathing treatment to determine effectiveness, or consult with the provider to address urgent respiratory symptoms. Instead, the nurse initiated a one-day RN follow-up order that documented instructions for the clinic RN to co-consult with the provider.

- In case 45, the nurse reviewed a symptomatic request for a patient complaining of an extremely fast heartbeat and left arm pain. The nurse did not schedule a same day face-to-face assessment to rule out an urgent cardiac event.

- In case 47, the nurse assessed the patient for reports of heart rate fluctuations and anxiety after smelling fumes from nearby cells. However, the RN did not inquire about the duration of symptoms, assess the patient's respiratory rate or oxygen saturation rate, or inform the provider of the patient's symptoms.

[43] Sick call deficiencies occurred in cases 3, 7, 17, 18, 20, 22, 36–40, 44–47, 49, 53, 54, 56, and 58. Significant deficiencies occurred in cases 3, 7, 22, 45-47, and 58.

[44] Coccidioidomycosis (Valley Fever) infection is a lung infection caused by a fungus that lives in the soil.

Outpatient Nursing Documentation

Complete and accurate nursing documentation is an essential component of patient care. Without proper documentation, health care staff can overlook changes in patients' conditions. Nursing staff generally documented care provided appropriately.

Case Management

OIG clinicians reviewed 12 events in seven cases in which a nursing care manager or a care coordinator assessed the patient.[45] OIG clinicians identified five deficiencies relating to not thoroughly assessing the patient and incomplete documentation, none of which were significant.[46]

Wound Care

We reviewed 10 cases in which nurses provided wound care to patients and found 11 deficiencies, one of which were significant.[47] Overall, nurses performed appropriate wound care. However, we identified opportunities for improvement in documenting wound care thoroughly, but this did not affect overall patient care. The following is the significant deficiency we identified:

- In case 46, the patient was assessed by the RN for wound care to the left toe. The left toe assessment showed signs of infection. However, the nurse did not assess vital signs, pain level, and did not co-consult with the provider or request a follow-up with the wound care team for the abnormal wound assessment.

Emergency Services

Nurses responded promptly to emergency events. However, we identified a pattern of delays in activating emergency medical services, incomplete nursing assessments, and nurses not performing appropriate nursing interventions when warranted. Please refer to the **Emergency Services** indicator for further details.

Hospital Returns

We reviewed 13 events that involved returns from off-site hospitals or emergency rooms. Nurses performed sufficient nursing assessments and interventions. Please refer to the **Transfers** indictor for further details.

Transfers

OIG clinicians reviewed 11 cases involving transfer-in and transfer-out processes. We found nurses performed good assessments and often initiated provider appointments when patients arrived at the institution. In contrast, we identified opportunities for improvement in the transfer-out process with nursing staff not always documenting

[45] Nurse care manager or care coordinator events occurred in cases 1, 7, and 19–22.

[46] Care management nursing performance deficiencies occurred in cases 7, 19, 20, and 21.

[47] Wound care deficiencies occurred in cases 3, 8, 20, 46, and 59. A significant deficiency occurred in case 46.

notification of pending specialty appointments to the receiving institution for continuity of care. Please refer to the **Transfers** indictor for further details.

Specialized Medical Housing

We reviewed 22 nursing events and identified 12 deficiencies, one of which was significant.[48] OIG clinicians found nurses assessed patients in the CTC routinely. However, we identified nurses needed improvement in performing thorough nursing assessments. For more specific details, please refer to the **Specialized Medical Housing** indicator.

Specialty Services

We reviewed 23 events in nine cases in which patients returned from off-site specialty appointments and procedures. Overall, nurses performed good assessments when patients returned from off-site specialty appointments. OIG clinicians identified five nursing performance deficiencies, one of which was significant. Please refer to the **Specialty Services** indicator for further details.[49]

Medication Management

We reviewed 171 events in 35 cases and found 24 deficiencies, 11 of which were significant.[50] SQRC had challenges with chronic care medication and transfer-out medication continuity. Please refer to the **Medication Management** indicator for additional details.

Clinician On-Site Inspection

OIG clinicians interviewed nurses and nursing supervisors in the TTA, R&R, specialty services, outpatient clinics, medication areas, and the correctional treatment center (CTC). We attended organized huddles and population-management meetings. During huddles, staff reported no current backlogs for nursing appointments.

During our on-site inspection, we met with the director of nursing (DON) who was acting as the chief nurse executive CNE (A). She had been in the limited-term DON position for five months. Nursing leadership noted improvements, including better adherence to their dashboard measures of care provided, durable medical equipment compliance, and improvement in emergency response and documentation. However, the institution had challenges with staffing vacancies and replacing supplies. The CNE (A) reported challenges with hiring staff at the institution due to the increased cost of living in the area.

[48] Specialized Medical Housing nursing performance deficiencies occurred in cases 8, 59, and 61. A significant deficiency occurred in case 59.

[49] Specialty Services nursing performance deficiencies occurred in cases 7, 20, and 23. A significant deficiency occurred in case 20.

[50] Medication management deficiencies occurred in cases 2, 13, 15, 18, 19, 21, 22, 25–27, 29, 32, 34, 59, and 61. Significant deficiencies occurred in cases 13, 22, 25–27, 32, and 59.

Recommendations

- Nursing leadership should analyze the challenges to nurses performing thorough assessments and interventions as well as thoroughly documenting during patient appointments and 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***

Case review found SQRC providers delivered satisfactory care. They usually delivered good care for patients with chronic and emergency conditions as well as for patients housed in the CTC. Providers documented well and maintained good care continuity this cycle. Providers generally made appropriate assessments and decisions; however, they did not always thoroughly follow up with patients. Providers usually reviewed records with some occasional lapses. Lastly, providers inconsistently communicated tests results to their patients with complete notification letters. After considering all provider performance factors, the OIG rated this indicator ***adequate***.

Case Review Results

OIG clinicians reviewed 189 medical provider encounters and identified 23 deficiencies, 18 of which were significant.[51] In addition, we reviewed the quality of care in 25 comprehensive case reviews. Of these 25 cases, we rated 21 ***adequate*** and 4 ***inadequate***.

Outpatient Assessment and Decision-Making

Providers appropriately evaluated patients' conditions and made sound decisions. They generally asked pertinent questions and performed proper documentation of patient histories. Providers formulated reasonable differential diagnoses, ordered appropriate tests, and referred patients when medically indicated. However, they needed improvement in following through with their plans as shown in the following examples:

- In case 1, the provider documented the patient had an elevated PSA test result and planned to reorder this laboratory test in two months.[52] However, the provider did not order the test.

[51] Provider deficiencies occurred in cases 1, 3, 7, 11, 13, 15, 17, 19–24, 26, and 27. Significant provider deficiencies occurred in cases 11, 13, 15, 17, 19, 20, 22–24, 26, and 27.

[52] PSA is prostate specific antigen, a protein produced by the prostate gland. It is measured in the blood and is used to detect prostate cancer and other conditions.

- In case 20, the provider evaluated the patient with symptoms of dizziness multiple times but only ordered an EKG.[53] The provider did not consider arrythmia, situational syncope, or any other differential diagnoses as potential causes for the patient's symptoms.[54]

- In case 22, the patient completed a sleep study, which recommended a CPAP trial.[55] The provider reviewed the report a month later, and subsequently did not follow the recommendation until seven months later.

- In case 24, the provider reviewed laboratory results showing an abnormal kidney test result but did not closely follow up with monitoring. The patient had another abnormal kidney test during a hospital stay four months later.

Review of Records

Providers are responsible for reviewing the health record periodically, especially during preparation for a provider-patient encounter. Providers focused on any new laboratory results, encounters with specialists, hospitalization reconciliations, and medications that are new or needed renewing. Providers generally reviewed the patients' electronic health records appropriately; however, we identified some deficiencies as follows:

- In case 11, the patient with hemochromatosis had abnormally elevated iron and ferritin test levels.[56] The provider reviewed the elevated ferritin results but did not order another ferritin test or consider ordering a phlebotomy to reduce the ferritin levels.[57]

- In case 15, the patient complained of pain with urination. The point of care dipstick urine test showed evidence of a urinary tract infection. The provider ordered Bactrim, an antibiotic. The provider did not thoroughly review the record to be aware that a previous urine culture showed the bacteria was resistant to Bactrim.

- In case 20, the optometrist evaluated the patient. The optometrist documented the patient with an eyelid droop and also a discussion with the provider. However, the provider did not review the optometry report.

- In case 23, the patient was hospitalized with urosepsis.[58] The provider did not review the hospital records carefully to follow up on the possibility of

[53] An EKG is an electrocardiogram. This non-invasive test measures and records the electrical impulses from the heart and is used to help diagnose heart problems.

[54] Situational syncope occurs when a patient faints or passes out in response to a specific trigger or a specific situation.

[55] A CPAP (continuous positive airway pressure) device is a machine which delivers continuous flow of air through a face mask to treat sleep apnea.

[56] Hemochromatosis is a medical condition in which the body absorbs too much iron from the digestive tract, resulting in iron overload in some organs, possibly causing damage. The ferritin level is a measure of the store of iron in the body.

[57] Phlebotomy is a procedure of taking blood from a vein.

[58] Urosepsis is a life-threatening condition when the body is not able to properly respond to an infection arising from the urinary tract.

anaphylaxis, a severe allergic reaction from an antibiotic, ertapenem, and did not follow up on the results of the hepatitis tests.

- In case 27, the patient with history of coronary artery disease, which required aspirin indefinitely, had a lapsed prescription for aspirin.[59] The patient did not receive the aspirin for over one month as the provider did not reorder it.

- Also in case 27, the provider documented the patient had a pending endoscopic retrograde cholangiopancreatography (ERCP) report, but the provider had already reviewed and endorsed the report several days earlier.[60]

Emergency Care

SQRC providers generally appropriately triaged TTA patients who needed emergency treatment. On-call providers made correct decisions based on information they documented in the EHRS. Please refer to the **Emergency Services** indicator for more information.

Chronic Care

Providers appropriately managed most of their patients' chronic health conditions. OIG clinicians reviewed cases with three patients who took warfarin.[61] The anticoagulation clinic managed these patients well using blood test monitoring. Providers also accordingly managed high blood pressure, asthma, hepatitis C, and cardiovascular diseases. However, OIG clinicians identified a few deficiencies related to diabetes. The following are examples:

- In case 13, the provider reviewed the diabetic patient's laboratory test showing an elevated HbA1c but did not schedule a close interval follow-up encounter to review the plan for diabetes management.

- In case 15, the endocrinology specialist evaluated the patient.[62] The specialist recommended restarting glipizide 10 mg daily, but the provider started the medication at 5 mg daily and did not document a rationale for deviating from the specialist's recommendations.[63]

Specialized Medical Housing

Providers completed admission history and physicals thoroughly and timely. Providers rounded on patients at clinically appropriate intervals and made appropriate decisions. OIG clinicians did not find any problematic cloning of providers' progress notes.

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[59] Coronary artery disease, also known as coronary heart disease, is a condition in which the arteries supplying blood to the heart become narrowed or blocked, usually due to buildup of plaque. This constricts blood flue to the heart, potentially leading to chest pain, shortness of breath, or even a heart attack.

[60] ERCP is endoscopic retrograde cholangiopancreatography; a procedure using a camera and imaging to diagnose and treat conditions of the bile and pancreatic ducts.

[61] Warfarin is a blood thinning medication requiring laboratory testing to monitor its effectiveness.

[62] Endocrinology is a medical specialty involving the evaluation and management of glandular and hormonal conditions, including diabetes mellitus and thyroid diseases.

[63] Glipizide is a medication used to treat diabetes.

Specialty Services

SQRC providers mostly performed well with specialty services. They referred to the proper specialists within appropriate priorities and usually endorsed specialty reports timely. However, we identified instances of providers not following specialists' recommendations without documenting the medical rationale. The following is an example:

- In case 23, the patient saw the ENT specialist for hearing loss, and the specialist recommended a bone anchored hearing aid (BAHA) and possible eustachian tube dilation.[64] The provider delayed acting on this recommendation until two months later.

Please refer to the **Specialty Services** indicator for more information.

Documentation Quality

Providers documented encounters with patients and communication with nurses. OIG clinicians did not find any deficiencies with documentation.

Patient Notification Letters

Providers inconsistently sent test result notification letters to patients. When they did, the letters did not always contain all four elements required by policy: date of the test, reviewing provider's name, whether the results were within normal limits, and whether a provider follow-up appointment is required and will be scheduled. We discuss patient notification letters further in the **Diagnostic Services** and **Health Information Management** indicators

Provider Continuity

SQRC ensured good provider continuity. Providers assigned to the clinics developed rapport with their patients. OIG clinicians did not find any deficiencies related to a lack of provider continuity.

Clinician On-Site Inspection

OIG clinicians interviewed medical leadership and providers during the on-site inspection.

Most providers expressed high morale. They enjoyed their jobs and appreciated their medical leadership and their supervisors being available if they needed questions answered. A few providers felt morale could be improved if supervisors took a more proactive role by walking through clinics and making their presence known. Providers reported good relationships with custody staff and nurses. However, providers also stated

[64] An ENT specialist is an Ear Nose and Throat specialist. BAHA is a bone anchored hearing aid that helps a patient to hear by providing sound. The device is attached to the bone and amplifies sound, transmitting soundwaves into the inner ear. The eustachian tube is a canal that connects the middle ears to the back of throat. This tube helps drain fluid from the middle ear and balance pressure in the ears.

some nurses did not always relay the patient information needed for providers to make appropriate decisions during emergency events.

Medical leadership stated they had no vacancies and felt fortunate they had a great cadre of providers. They mentioned having very good providers and appreciated having two addiction medicine fellowship-trained providers.

Recommendations

The OIG offers no recommendations for this indicator.

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, SQRC's specialized medical housing consisted of a correctional treatment center (CTC).

Ratings and Results Overview

Case Review Rating	Compliance Rating and Score
Adequate	***Inadequate* (62.5%)**

Case review found SQRC performed satisfactorily in this indicator. CTC providers performed excellent care. Nursing staff performed appropriate assessments. However, nursing assessments were not always thorough. Considering all factors, the OIG rated the case review component of this indicator ***adequate.***

Compliance testing showed SQRC had mixed performance in specialized medical housing. Providers performed excellently in completing history and physical examinations. In contrast, nurses needed significant improvement in timely completing admission assessments and ensuring medication administration for newly admitted patients. Based on the overall **Specialized Medical Housing** compliance score result, the OIG rated this indicator ***inadequate***.

Case Review and Compliance Testing Results

We reviewed 56 events including 19 provider events and 22 nursing events. Due to the frequency of nursing and provider contacts in specialized medical housing, we bundled up to two weeks of patient care into a single event. We identified 15 deficiencies, three of which were significant.[65]

Provider Performance

Compliance testing showed providers always completed admission history and physicals timely (MIT 13.002, 100%). OIG clinicians found CTC providers delivered good care for patients. They performed thorough history and physical examinations, made sound medical decisions and plans, and reviewed test results and consultations timely. We reviewed 19 CTC events in six different cases and did not identify any deficiencies.

[65] Deficiencies occurred in cases 8, 27, 59, and 61. Significant deficiencies occurred in cases 27 and 59.

Nursing Performance

Compliance testing showed nurses intermittently provided timely admission assessments (MIT 13.001, 50.0%). Case review clinicians had one CTC case involving an admission assessment and did not identify any deficiencies with the admission.[66] Similarly, OIG clinicians found nurses assessed patients in the CTC routinely. However, we found nurses needed improvement in performing thorough nursing assessments. We identified 12 nursing performance deficiencies, one of which was significant.[67] The following are examples of nursing performance deficiencies:

- In cases 8, 59, and 61, nurses did not perform thorough wound care assessments.
- In case 59, the nurse assessed the patient with irregular lung sounds. The RN did not inquire whether the patient had respiratory symptoms, immediately obtain vital signs including the patient's respiratory rate and oxygen saturation level percentage, or notify the provider of the abnormal findings. The RN performed vital sign measurements three hours later, delaying potentially needed care.

Medication Administration

Compliance testing revealed patients admitted to SQRC's CTC did not receive their medications timely, or medications were not made available by the ordering provider's administration time (MIT 13.003, zero). In contrast, OIG clinicians found most patients received their medications timely. However, we identified three deficiencies, two of which were significant.[68] For further details please refer to the **Medication Management** indicator.

Clinician On-Site Inspection

The CTC had 24-hour nursing staff comprised of registered nurses (RNs), psychiatric technicians, and certified nursing assistants (CNAs). The CTC had a dedicated provider Monday through Friday from 8:00 a.m. to 4:00 p.m. During weekdays, the TTA provider covered CTC patients from 4:00 p.m. to 8:00 p.m. On weekends and holidays, the on-call provider was available for CTC patients. CTC staff were knowledgeable regarding the patient population and conducted organized morning huddles to discuss patient care.

Compliance On-site Inspection and Discussion

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

[66] CTC nursing initial assessment occurred in case 8.

[67] Deficiencies occurred in cases 8, 59, and 61. The significant deficiency occurred in case 59.

[68] Deficiencies occurred in cases 27, and 59. Significant deficiencies occurred in case 27.

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)	1	1	0	50.0%
Was a written history and physical examination completed within the required time frame? (13.002)	2	0	0	100%
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)	0	2	0	0
For specialized health care housing (CTC, SNF, hospice, OHU): Do specialized health care housing maintain an operational call system? (13.101)	1	0	0	100%
For specialized health care housing (CTC, SNF, hospice, OHU): Do health care staff perform patient safety checks according to institution's local operating procedure or within the required time frames? (13.102)	0	0	1	N/A
				Overall percentage (MIT 13): 62.5%

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

Recommendations

- Nursing leadership should determine the root cause of challenges preventing specialized medical housing nurses from performing complete assessments and should implement remedial measures as appropriate.

- Nursing leadership should ensure initial admission assessments are completed within the time frames required by CCHCS policy and should implement remedial measures as appropriate.

Specialty Services

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

Ratings and Results Overview

Case Review Rating	Compliance Rating and Score
Adequate	***Inadequate* (66.4%)**

Case review found SQRC performed satisfactorily with specialty services for its patients. Access to specialty services improved from Cycle 6 but still needed improvement. Providers usually ordered specialty referrals timely and appropriately but sometimes did not follow specialists' recommendations or document the medical rationale for not following the recommendations. Nurses generally assessed patients appropriately after off-site specialty appointments. Staff often managed specialty reports well, showing only minor deficiencies with late retrieval and late endorsements. Considering all factors, the OIG rated the case review component of this indicator ***adequate***.

Compliance testing showed SQRC needed improvement in this indicator. Staff usually retrieved and endorsed specialty reports timely. However, timely access to off-site specialty services was inconsistent and preapproved specialty services for newly arrived patients only occasionally occurred within required time frames. 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 145 events related to specialty services; 106 were specialty consultations and procedures. We identified 20 deficiencies in this category, nine of which were significant.[69]

Access to Specialty Services

In compliance testing, SQRC needed improvement in completing high-priority (MIT 14.001, 66.7%), medium-priority (MIT 14.004, 46.7%), and routine-priority (MIT 14.007, 73.3%) specialty appointments within required time frames. In addition, the institution only sporadically ensured specialty access for patients who transferred into the institution with preapproved specialty requests (MIT 14.010, 47.4%).

[69] Specialty deficiencies occurred in cases 7, 10, 13, 15, 16, 19, 20, 22, 23, and 26. Significant specialty deficiencies occurred in cases 10, 15, 20, 22, and 26.

OIG clinicians identified four deficiencies with delayed specialty appointments. The following are three examples:

- In case 20, the patient had a brain cyst.[70] The provider ordered a routine-priority neurosurgery referral. This appointment occurred with a two-month delay. The utilization management (UM) nurse documented this was a lapse.

- In case 26, the patient had lung disease due to a history of smoking. The pulmonary specialist requested a lung test to assess the patient's breathing capacity. The provider ordered this test; however, the test was completed about one and a half months late. The UM nurse had submitted the request to a facility that did not offer the procedure and had to resubmit to another facility.

- Also in case 26, the provider ordered a medium-priority oncology referral. The appointment did not occur. Eventually, the patient was seen by a different radiation oncologist two months after the compliance due date.

We discuss the specialty scheduling process further in the Clinician On-Site Inspection section below.

Provider Performance

Compliance testing showed SQRC providers frequently evaluated patients timely after high-priority specialty appointments (MIT 1.008, 80.0%). OIG clinicians found providers referred patients to specialists with appropriate priority time frames. However, providers inconsistently followed recommendations from the specialists and did not explain why they did not follow the recommendations. We identified five deficiencies in this area, four of which were significant.[71] The following are three examples:

- In case 15, the endocrinologist evaluated the patient and recommended restarting glipizide, a diabetes medication, at a specific dose. However, the provider restarted the medication at half the recommended dose without documenting the reason.

- In case 22, the patient had a sleep study that recommended a CPAP machine, which treats sleep apnea. However, the provider did not follow up on this recommendation until seven months later.

- In case 26, the patient's imaging tests showed lung nodules on two separate occasions. The pulmonologist requested to have the CT lung images be available to compare the nodule sizes and determine whether the patient needed further referral to a surgeon who specialized in chest surgeries for a biopsy. However, the patient's primary care provider did not document the medical rational for not following through with the pulmonologist's request.

[70] A cyst is a fluid filled sac.

[71] Deficiencies occurred in cases 12, 22, 23, and 26. Significant deficiencies occurred in cases 15, 22, and 26.

Nursing Performance

SQRC nurses performed sufficiently in assessing patients after they returned from off-site specialty appointments. However, we identified four deficiencies with incomplete assessments or problems in relaying pertinent information to the provider. Three of the deficiencies were minor, and the significant deficiency is described below:

- In case 20, the patient returned from an off-site brain MRI scan. While the patient initially refused vital signs and assessment, the nurse documented the patient reported dizziness from not drinking water but documented no follow-up was required. The nurse should have notified the provider of the patient's symptom of dizziness.

Health Information Management

Compliance testing of SQRC's health information management in specialty reports showed mixed performance. Staff received and providers reviewed routine- and high-priority specialty reports frequently (MIT 14.008, 80.0%, and MIT 14.002, 78.6%) but medium-priority specialty reports inconsistently (MIT 14.005, 73.3%) within required time frames. SQRC often timely scanned specialty reports into the EHRS (MIT 4.002, 83.3%).

OIG clinicians found SQRC staff generally retrieved specialty reports and sent them to providers timely. However, we identified six deficiencies in this area: three minor deficiencies related to staff not retrieving reports within required time frames;[72] two minor deficiencies related to refusal forms not being sent to the provider for endorsement;[73] and one minor deficiency related to a delayed specialty report endorsement.[74]

Clinician On-Site Inspection

We discussed specialty care with the off-site specialty UM nurse, medical records staff, providers, and nurses. The UM nurse stated some of the scheduling issues related to her self-developed tracking system, since no one else knew which specialty service requests were completed or in-progress. The UM nurse also stated she took responsibility to retrieve specialty reports, which also resulted in delays. When we discussed the last specialty service appointment deficiencies with the UM nurse, she admitted she had placed all the responsibility on herself and did not delegate any duties to anyone else. Because of this, some appointments were not scheduled timely. In Cycle 6, the OIG clinicians found the same nurse was responsible for the specialty services scheduling.

Health information managers stated, when the UM nurse asked for help in retrieving the specialty reports, they were able to assist and obtained electronic access to the outside medical records systems of the various specialty groups. The managers reported taking responsibility over specialty reports retrieval in August 2024, which was toward the end of the OIG case review period. The medical records staff reported not having any issues with retrieving reports once they gained access to outside systems' medical records. They

[72] The deficiencies occurred in cases 10, 15, and 16.

[73] The two deficiencies occurred in case 13.

[74] The deficiency occurred in case 10.

tracked when patients had seen specialists and were able to log in to retrieve specialty reports when necessary.

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)	10	5	0	66.7%
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)	11	3	1	78.6%
Did the patient receive the subsequent follow-up to the high-priority specialty service appointment as ordered by the primary care provider? (14.003)	6	4	5	60.0%
Did the patient receive the medium-priority specialty service within 15-45 calendar days of the primary care provider order or Physician Request for Service? (14.004)	7	8	0	46.7%
Did the institution receive and did the primary care provider review the medium-priority specialty service consultant report within the required time frame? (14.005)	11	4	0	73.3%
Did the patient receive the subsequent follow-up to the medium-priority specialty service appointment as ordered by the primary care provider? (14.006)	6	4	5	60.0%
Did the patient receive the routine-priority specialty service within 90 calendar days of the primary care provider order or Physician Request for Service? (14.007)	11	4	0	73.3%
Did the institution receive and did the primary care provider review the routine-priority specialty service consultant report within the required time frame? (14.008)	12	3	0	80.0%
Did the patient receive the subsequent follow-up to the routine-priority specialty service appointment as ordered by the primary care provider? (14.009)	5	3	7	62.5%
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)	9	10	1	47.4%
Did the institution deny the primary care provider's request for specialty services within required time frames? (14.011)	16	4	0	80.0%
Following the denial of a request for specialty services, was the patient informed of the denial within the required time frame? (14.012)	13	6	1	68.4%
				Overall percentage (MIT 14): 66.4%

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) *	16	4	25	80.0%
Are specialty documents scanned into the patient's electronic health record within five calendar days of the encounter date? (4.002)	25	5	15	83.3%

* 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 identify the root cause(s) related to untimely providing preapproved specialty appointments for newly arrived patients as well as initial and follow-up specialty service appointments and should implement remedial measures as appropriate.

- Health care leadership should develop and implement a solution, such as an upgraded specialty services tracking system, to allow multiple users to track and coordinate the timely scheduling of specialty appointments.

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* (66.2%)**

SQRC's performance was mixed in this indicator. While SQRC scored from satisfactorily to excellently in some applicable tests, it needed improvements in several areas. EMRRC only sporadically completed required checklists or reviewed cases within required time frames. In addition, staff did not provide documentation of completing the required medical emergency drill packets for the most recent quarter as required by CCHCS policy. Moreover, physician managers did not timely complete probationary or annual performance appraisals, and the nurse educator did not ensure all newly hired nurses received the required onboarding training. 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 SQRC, 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 10 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)	5	1	0	83.3%
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)	2	10	0	16.7%
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)	8	2	0	80.0%
Did nurse managers ensure the clinical competency of nurses who administer medications? (15.104)	8	2	0	80.0%
Did physician managers complete provider clinical performance appraisals timely? (15.105)	0	14	0	0
Did the providers maintain valid state medical licenses? (15.106)	18	0	0	100%
Did the staff maintain valid Cardiopulmonary Resuscitation (CPR), Basic Life Support (BLS), and Advanced Cardiac Life Support (ACLS) certifications? (15.107)	2	0	1	100%
Did the nurses and the pharmacist-in-charge (PIC) maintain valid professional licenses and certifications, and did the pharmacy maintain a valid correctional pharmacy license? (15.108)	6	0	1	100%
Did the pharmacy and the providers maintain valid Drug Enforcement Agency (DEA) registration certificates, and did the pharmacy maintain valid Automated Drug Delivery System (ADDS) licenses? (15.109)	1	0	0	100%
Did nurse managers ensure their newly hired nurses received the required onboarding and clinical competency training? (15.110)	0	1	0	0
Did the CCHCS Death Review Committee process death review reports timely? Effective 05/2022: Did the Headquarters Mortality Case Review process mortality review reports timely? (15.998)	This is a nonscored test. Please refer to the discussion in this indicator.			
What was the institution's health care staffing at the time of the OIG medical inspection? (15.999)	This is a nonscored test. Please refer to Table 3 for CCHCS-provided staffing information.			
				Overall percentage (MIT 15): 66.2%

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

Recommendations

The OIG offers no recommendations for this indicator.

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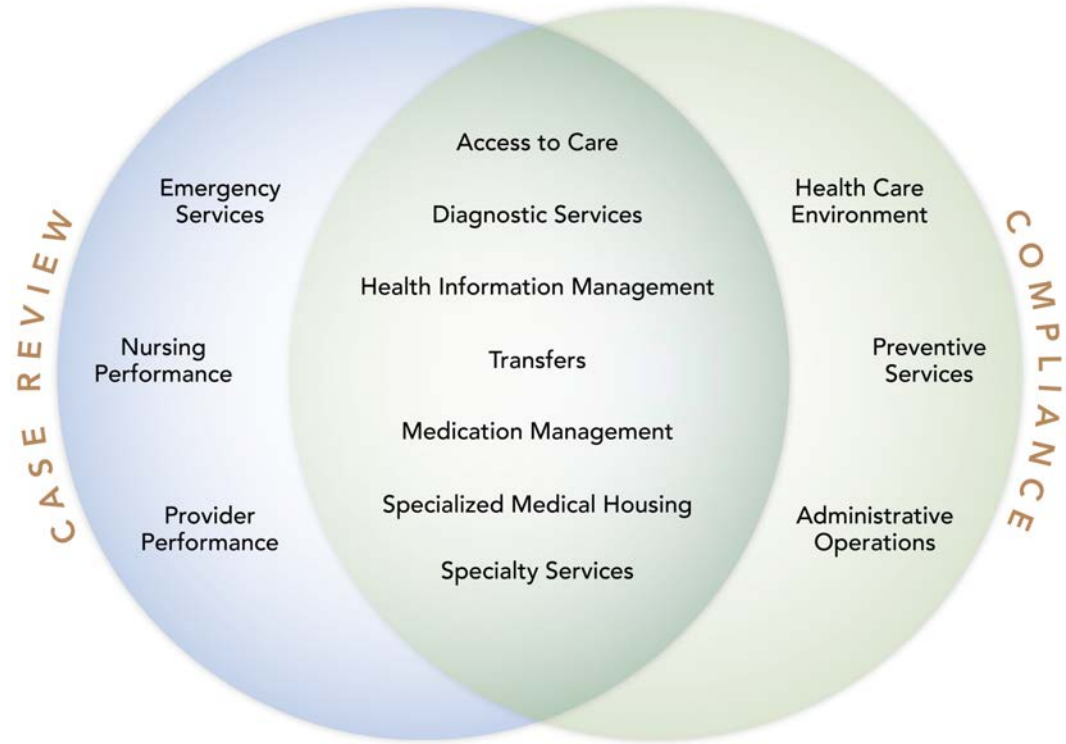
Appendix A: Methodology

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 SQRC



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

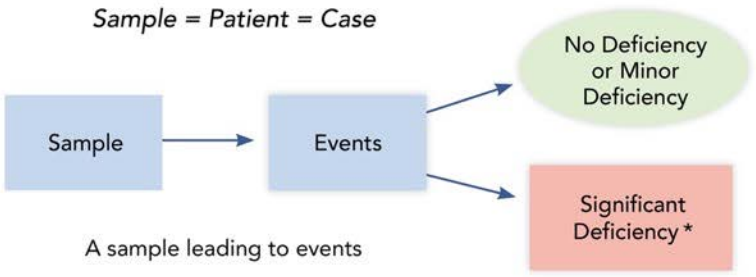
An OIG physician, a nurse consultant, or both review each case. As the clinicians review medical records, they record pertinent interactions between the patient and the health care system. We refer to these interactions as case review ***events***. Our clinicians also record medical errors, which we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

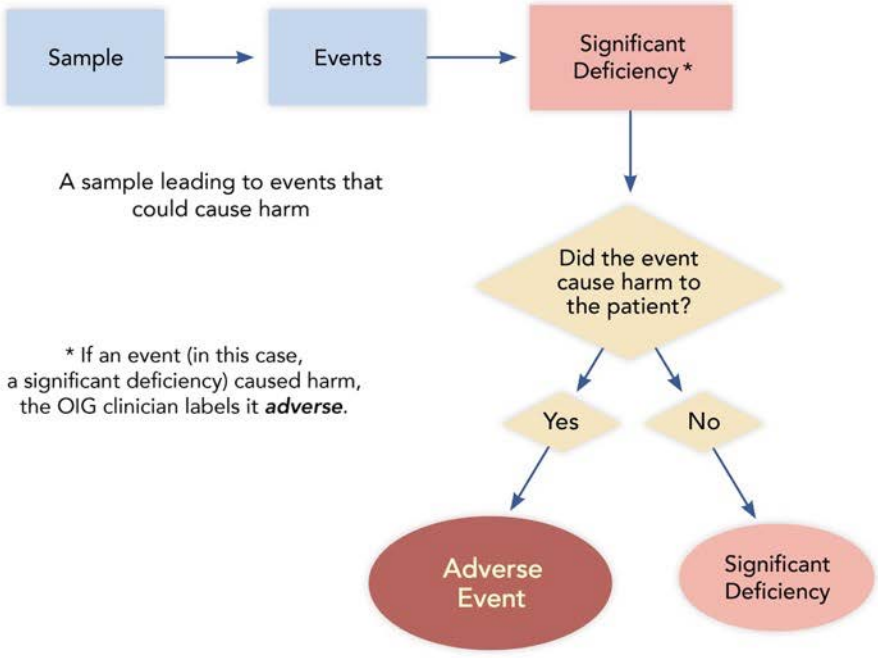
Figure A–2. Case Review Testing

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***.



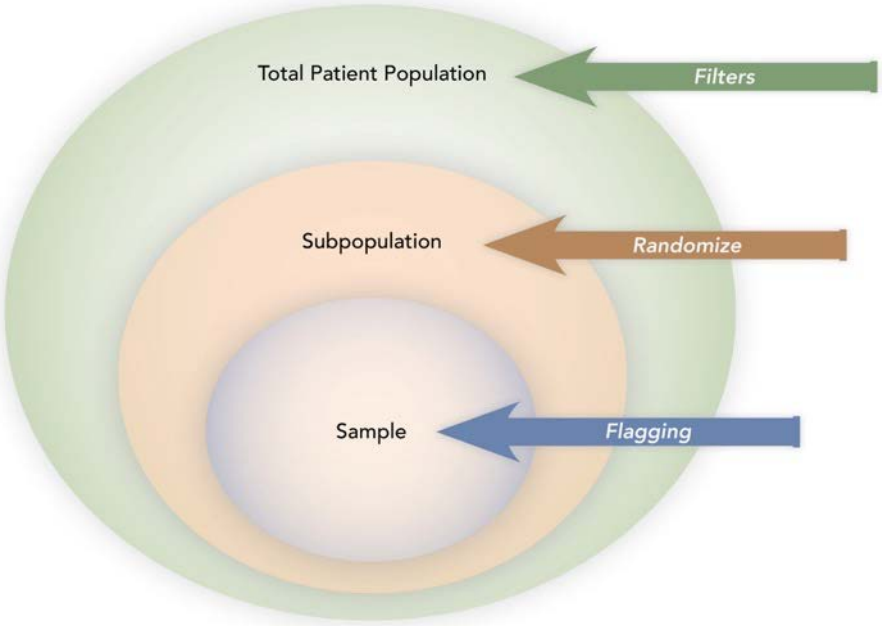
Source: The Office of the Inspector General medical inspection analysis.

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. SQRC Case Review Sample Sets

Sample Set	Total
Anticoagulation	3
CTC/OHU	3
Death Review/Sentinel Events	3
Diabetes	3
Emergency Services – CPR	3
Emergency Services – Non-CPR	3
High Risk	5
Hospitalization	4
Intrasystem Transfers In	3
Intrasystem Transfers Out	3
RN Sick Call	24
Specialty Services	4
	61

Table B–2. SQRC Case Review Chronic Care Diagnoses

Diagnosis	Total
Anemia	9
Anticoagulation	6
Arthritis/Degenerative Joint Disease	8
Asthma	13
Cancer	8
Cardiovascular Disease	11
Chronic Kidney Disease	7
Chronic Pain	11
Cirrhosis/End-State Liver Disease	3
Coccidioidomycosis (Valley Fever)	2
COPD	3
COVID-19	6
Deep Venous Thrombosis/Pulmonary Embolism	2
Diabetes	14
Gastroesophageal Reflux Disease (GERD)	14
Hepatitis C	10
HIV	3
Hyperlipidemia	26
Hypertension	22
Mental Health	16
Migraine Headaches	4
Rheumatological Disease	5
Seizure Disorder	3
Sleep Apnea	4
Substance Abuse	11
Thyroid Disease	5
	226

Table B–3. SQRC Case Review Events by Program

Program	Total
Diagnostic Services	209
Emergency Care	77
Hospitalization	30
Intrasystem Transfers In	19
Intrasystem Transfers Out	25
Outpatient Care	452
Specialized Medical Housing	56
Specialty Services	145
	1,013

Table B–4. SQRC Case Review Sample Summary

	Total
MD Reviews Detailed	25
MD Reviews Focused	3
RN Reviews Detailed	13
RN Reviews Focused	33
Total Reviews	74
Total Unique Cases	61
Overlapping Reviews (MD & RN)	13

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Appendix C: Compliance Sampling Methodology

San Quentin Rehabilitation Center

Quality Indicator	Sample Category	No. of Samples	Data Source	Filters
Access to Care				
MIT 1.001	Chronic Care Patients	25	Master Registry	• Chronic care conditions (at least one condition per patient—any risk level) • Randomize
MIT 1.002	Nursing Referrals	25	OIG Q: 6.001	• See Transfers
MITs 1.003–006	Nursing Sick Call (6 per clinic)	35	Clinic Appointment List	• Clinic (each clinic tested) • Appointment date (2–9 months) • Randomize
MIT 1.007	Returns From Community Hospital	24	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	10	Quest	• Appt. date (90 days–9 months) • Order name (CBC, BMP, or CMPs only) • Randomize • Abnormal
MITs 2.010–012	Pathology	10	InterQual	• Appt. date (90 days–9 months) • Service (pathology related) • Randomize

Quality Indicator	Sample Category	No. of Samples	Data Source	Filters
Health Information Management (Medical Records)				
MIT 4.001	Health Care Services Request Forms	35	OIG Qs: 1.004	• Nondictated documents • First 20 IPs for MIT 1.004
MIT 4.002	Specialty Documents	45	OIG Qs: 14.002, 14.005 & 14.008	• Specialty documents • First 10 IPs for each question
MIT 4.003	Hospital Discharge Documents	24	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	24	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	13	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	4	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	24	OIG Q: 4.005	• See Health Information Management (Medical Records) (returns from community hospital)
MIT 7.004	RC Arrivals—Medication Orders	N/A at this institution	OIG Q: 12.001	• See Reception Center
MIT 7.005	Intrafacility Moves	25	MAPIP transfer data	• Date of transfer (2–8 months) • To location/from location (yard to yard and to/from ASU) • Remove any to/from MHCB • NA/DOT meds (and risk level) • Randomize
MIT 7.006	En Route	10	SOMS	• Date of transfer (2–8 months) • Sending institution (another departmental facility) • Randomize • NA/DOT meds
MITs 7.101–103	Medication Storage Areas	Varies by test	OIG inspector on-site review	• Identify and inspect clinical & med line areas that store medications
MITs 7.104–107	Medication Preparation and Administration Areas	Varies by test	OIG inspector on-site review	• Identify and inspect on-site clinical areas that prepare and administer medications
MITs 7.108–111	Pharmacy	1	OIG inspector on-site review	• Identify & inspect all on-site pharmacies
MIT 7.112	Medication Error Reporting	17	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	6	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	21	Maxor	• Dispense date (past 9 months) • Time period on TB meds (3 months or 12 weeks) • Randomize
MIT 9.003	TB Evaluation, Annual Screening	21	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	2	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	20	Specialty Services Arrivals	• Arrived from (other departmental institution) • Date of transfer (3–9 months) • Randomize
MITs 14.011–012	Denials	20	InterQual	• Review date (3–9 months) • Randomize
		N/A	IUMC/MAR Meeting Minutes	• Meeting date (9 months) • Denial upheld • Randomize
Administrative Operations				
MIT 15.001	Adverse/sentinel events	0	Adverse/sentinel events report	• Adverse/Sentinel events (2–8 months)
MIT 15.002	QMC Meetings	6	Quality Management Committee meeting minutes	• Meeting minutes (12 months)
MIT 15.003	EMRRC	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	10	Institution-list of deaths in prior 12 months	• Most recent 10 deaths Initial death reports
MIT 15.104	Nursing Staff Validations	10	On-site nursing education files	• On duty one or more years • Nurse administers medications • Randomize
MIT 15.105	Provider Annual Evaluation Packets	14	On-site provider evaluation files	• All required performance evaluation documents
MIT 15.106	Provider Licenses	18	Current provider listing (at start of inspection)	• Review all
MIT 15.107	Medical Emergency Response Certifications	All	On-site certification tracking logs	• All staff • Providers (ACLS) • Nursing (BLS/CPR) • Custody (CPR/BLS)
MIT 15.108	Nursing Staff and Pharmacist in Charge Professional Licenses and Certifications	All	On-site tracking system, logs, or employee files	• All required licenses and certifications
MIT 15.109	Pharmacy and Providers' Drug Enforcement Agency (DEA) Registrations	All	On-site listing of provider DEA registration #s & pharmacy registration document	• All DEA registrations
MIT 15.110	Nursing Staff New Employee Orientations	All	Nursing staff training logs	• New employees (hired within last 12 months)
MIT 15.998	CCHCS Mortality Case Review	10	OIG summary log: deaths	• Between 35 business days & 12 months prior • California Correctional Health Care Services mortality reviews

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California Correctional Health Care Services' Response

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February 26, 2026

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 San Quentin Rehabilitation Center conducted by the Office of the Inspector General from April 2024 to September 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
3B7F6B95AC0A4D1...

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

cc: Diana Toche, D.D.S., Undersecretary, Health Care Services, CDCR
Clark Kelso, Receiver
Jeff Macomber, Secretary, CDCR
Directors, CCHCS
Sarah Hartmann, Chief Counsel, CCHCS Office of Legal Affairs
Renee Kanan, M.D., Deputy Director, Medical Services, CCHCS
Barbara Barney-Knox, R.N., Deputy Director, Nursing Services, CCHCS
Annette Lambert, Deputy Director, Quality Management, CCHCS
Rainbow Brockenborough, Deputy Director, Institution Operations, CCHCS
Robin Hart, Associate Director, Risk Management Branch, CCHCS
Regional Executives, Region I, CCHCS
Chief Executive Officer, SQRC
Heather Pool, Chief Assistant Inspector General, OIG
Doreen Pagaran, R.N., Nurse Consultant Program Review, OIG
Amanda Elhardt, Report Coordinator, OIG

CALIFORNIA CORRECTIONAL
HEALTH CARE SERVICES

P.O. Box 588500
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Cycle 7

Medical Inspection Report

for

San Quentin Rehabilitation Center

OFFICE *of the*
INSPECTOR GENERAL

Amarik K. Singh
Inspector General

Shaun Spillane
Chief Deputy Inspector General

STATE *of* CALIFORNIA
March 2026

OIG