***Roy W. Wesley**, Inspector General*

***Bryan B. Beyer**, Chief Deputy Inspector General*

OIG | OFFICE *of the* INSPECTOR GENERAL

Independent Prison Oversight

May 2021

Cycle 6
Medical Inspection Report

North Kern State Prison

Revised on 7-22-21; see next page for explanation.

Report revised and republished on 7-22-21:

On page 3, paragraph 2, the rating word was corrected and changed from ***inadequate*** *to* ***adequate****.*

Electronic copies of reports published by the Office of the Inspector General are available free in portable document format (PDF) on our website.

We also offer an online subscription service.
For information on how to subscribe,
visit **www.oig.ca.gov**.

For questions concerning the contents of this report,
please contact Shaun Spillane, Public Information Officer,
at 916-255-1131.

Contents

Illustrations

Tables

Figures

Photographs

Cover: Rod of Asclepius courtesy of Thomas Shafee

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 persons[1] in the California Department of Corrections and Rehabilitation (the department).[2]

In Cycle 6, the OIG continues to apply the same assessment methodologies used in Cycle 5, including clinical case review and compliance testing. These methods provide an accurate assessment of how the institution's health care systems function regarding patients with the highest medical risk who tend to access services at the highest rate. This information helps to assess the performance of the institution in providing sustainable, adequate care.[3]

We continue to review institutional care using 15 indicators, as in prior cycles. Using each of these indicators, our compliance inspectors collect data in answer to compliance- and performance-related questions as established in the *medical inspection tool* (MIT).[4] We determine a total compliance score for each applicable indicator and consider the MIT scores in the overall conclusion of the institution's performance. In addition, our clinicians complete document reviews of individual cases and also perform on-site inspections, which include interviews with staff.

In reviewing the cases, our clinicians examine whether providers used sound medical judgment in the course of caring for a patient. In the event we find errors, we determine whether such errors were clinically significant or led to a significantly increased risk of harm to the patient.[5] At the same time, our clinicians examine whether the institution's medical system mitigated the error. The OIG rates the indicators as ***proficient***, ***adequate***, or ***inadequate***.

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

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

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

4. The department regularly updates its policies. The OIG updates our policy-compliance testing to reflect the department's updates and changes.

5. If we learn of a patient needing immediate care, we notify the institution's chief executive officer.

The OIG has adjusted Cycle 6 reporting in two ways. First, commencing with this reporting period, we interpret compliance and case review results together, providing a more holistic assessment of the care; and, second, we consider whether institutional medical processes lead to identifying and correcting provider or system errors. The review assesses the institution's medical care on both system and provider levels.

As we did during Cycle 5, our office is continuing to inspect both those institutions remaining under federal receivership and those delegated back to the department. There is no difference in the standards used for assessing a delegated institution versus an institution not yet delegated. At the time of the Cycle 6 inspection of North Kern State Prison (NKSP), the receiver had not delegated this institution back to the department.

We completed our sixth inspection of NKSP, and this report presents our assessment of the health care provided at that institution during the inspection period between November 2019 and April 2020.[6]

North Kern State Prison (NKSP) is a medium-security prison located in Delano in Kern County. As a reception center, its mission is to process and classify incoming inmates received from county jails by evaluating their medical and mental health needs, evaluating their security levels and program requirements, and determining appropriate institutional placement prior to their transfer to other State facilities. NKSP operates multiple clinics in which staff members handle nonurgent requests for medical services. The institution also treats patients who need urgent or emergent care in its triage and treatment area (TTA), and provides inpatient care in its correctional treatment center (CTC). NKSP has been designated a *basic care institution* by California Correctional Health Care Services (CCHCS); basic facilities are typically located in rural areas, far away from tertiary care centers and specialty care providers whose services would likely be used frequently by patients with higher-risk medical patients. Due to the institution's remote location and its basic health care status, generally, healthier patients are placed in this institution.

6. Samples are obtained per case review methodology shared with stakeholders in prior cycles. The case reviews include diabetes reviews that occurred between November 2019 and May 2020, high-risk patient reviews between August 2019 and May 2020, cardiopulmonary resuscitation (CPR) reviews between June 2019 and April 2020, hospitalization reviews between September 2019 and April 2020, specialty services reviews between October 2019 and June 2020, registered nurse (RN) sick call reviews between February 2020 and July 2020, and correctional treatment center (CTC) reviews between August 2019 and January 2020.

Summary

We completed the Cycle 6 inspection of North Kern State Prison (NKSP) in August 2020. OIG inspectors monitored the institution's delivery of medical care that occurred between November 2019 and April 2020.

The OIG rated the overall quality of health care at NKSP as ***adequate*** (see note on inside cover). We list the individual indicators and ratings applicable for this institution in Table 1 below.

Table 1. NKSP Summary Table

Ratings

Proficient *Adequate* *Inadequate*

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

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

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

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

To test the institution's policy compliance, our compliance inspectors (a team of registered nurses) monitored the institution's compliance with its medical policies by answering a standardized set of questions that measure specific elements of health care delivery. Our compliance inspectors examined 442 patient records and 1,340 data points and used the data to answer 103 policy questions. In addition, we observed NKSP's processes during an on-site inspection in August 2020. Table 2 below lists NKSP's average scores from Cycles 4, 5, and 6.

The OIG clinicians (a team of physicians and nurse consultants) reviewed 54 detailed cases, which contained 799 patient-related events. After examining the medical records, our clinicians conducted a follow-up on-site inspection in August 2020 to verify their initial findings. The OIG physicians rated the quality of care for 20 comprehensive case reviews.

Table 2. NKSP Policy Compliance Scores

Scoring Ranges

100%–85.0% | 84.9%–75.0% | 74.9%–0

Medical Inspection Tool (MIT)	Policy Compliance Category	Average Score		
		Cycle 4	Cycle 5	Cycle 6
1	Access to Care	86.9%	67.9%	84.6%
2	Diagnostic Services	86.2%	84.4%	55.8%
4	Health Information Management	67.0%	74.1%	85.5%
5	Health Care Environment	57.1%	80.7%	56.9%
6	Transfers	82.9%	91.7%	60.7%
7	Medication Management	86.4%	79.1%	68.2%
8	Prenatal and Postpartum Care	N/A	N/A	N/A
9	Preventive Services	76.8%	79.1%	61.1%
12	Reception Center	74.5%	63.1%	34.0%
13	Specialized Medical Housing	100%	92.5%	85.0%
14	Specialty Services	83.3%	80.2%	82.1%
15	Administrative Operations	63.4%	80.4%	77.9%

* In Cycle 4, there were two secondary (administrative) indicators, and this score reflects the average of those two scores. In Cycle 5 and moving forward, the two indicators were merged into one, with only one score as the result.

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

Of these 20 cases, our physicians rated all 20 ***adequate***. Our physicians found no adverse events during this inspection.

The OIG then considered the results from both case review and compliance testing, and drew overall conclusions, which we report in the 14 health care indicators.[7] Multiple OIG physicians and nurses performed quality control reviews; their subsequent collective deliberations ensured consistency, accuracy, and thoroughness. Our clinicians acknowledged institutional structures that catch and resolve mistakes which may occur throughout the delivery of care. As noted above, we listed the individual indicators and ratings applicable for this institution in Table 1, the NKSP Summary Table.

In April 2020, the Health Care Services Master Registry showed that NKSP had a total population of 3,035. A breakdown of the medical risk level of the NKSP population as determined by the department is set forth in Table 3 below.[8]

Table 3. NKSP Master Registry Data as of April 2020

Medical Risk Level	Number of Patients	Percentage
High 1	25	0.8%
High 2	103	3.4%
Medium	918	30.2%
Low	1,989	65.5%
Total	**3,035**	**100%**

Source: Data for the population medical risk level were obtained from the CCHCS Master Registry dated 4-13-20.

7. The indicator for **Prenatal Care** did not apply to NKSP.
8. For a definition of ***medical risk***, see CCHCS HCDOM 1.2.14, Appendix 1.9.

Based on staffing data the OIG obtained from California Correctional Health Care Services (CCHCS), as identified in Table 4 below, NKSP did not have any vacant positions.

Table 4. NKSP Health Care Staffing Resources as of June 2020

Positions	Executive Leadership*	Primary Care Providers	Nursing Supervisors	Nursing Staff †	Total
Authorized Positions	5	9	13	108	135
Filled by Civil Service	5	9	13	108	135
Vacant	0	0	0	0	0
Percentage Filled by Civil Service	100.%	100%	100%	100%	100%
Filled by Telemedicine	N/A	0	0	0	0
Percentage Filled by Telemedicine	0	0	0	0	0
Filled by Registry	0	1	0	0	1
Percentage Filled by Registry	0	11.1%	0	0	1.0%
Total Filled Positions	5	9	13	108	135
Total Percentage Filled	100%	100%	100%	100%	100%
Appointments in Last 12 Months	2	0	4	8	14
Redirected Staff	0	0	0	0	0
Staff on Extended Leave‡	0	0	0	0	0
Adjusted Total: Filled Positions	**5**	**9**	**13**	**108**	**135**
Adjusted Total: Percentage Filled	**100%**	**100%**	**100%**	**100%**	**100%**

* Executive Leadership includes the Chief Physician and Surgeon.

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

‡ In Authorized Positions.

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

Source: Cycle 6 medical inspection preinspection questionnaire received June 2020, from California Correctional Health Care Services.

Medical Inspection Results

Deficiencies Identified During Case Review

Deficiencies are medical errors that increase the risk of patient harm. Deficiencies can be minor or significant, depending on the severity of the deficiency.

An *adverse event* occurs when the deficiency caused harm to the patient. All major health care organizations identify and track adverse events. We identify deficiencies and adverse events to highlight concerns regarding the provision of care and for the benefit of the institution's quality improvement program to provide an impetus for improvement.[9]

Our inspectors did not find any adverse events at NKSP during the Cycle 6 inspection.

Case Review Results

OIG case reviewers (a team of physicians and nurse consultants) assessed 14 of the 15 indicators applicable to NKSP. Of these 14 indicators, OIG clinicians rated two ***proficient***, seven ***adequate***, and five ***inadequate***. The OIG physicians also rated the overall adequacy of care for each of the 20 detailed case reviews they conducted. Of these 20 cases, all 20 were ***adequate***. In the 799 events reviewed, there were 105 deficiencies, 17 of which the OIG clinicians considered to be of such magnitude that, if left unaddressed, would likely contribute to patient harm.

Our clinicians found the following strengths at NKSP:

- The institution provided excellent access to care in most clinical areas, especially in provider appointments.
- The institution provided excellent health information management, as most hospital discharge records, diagnostic results, and specialty reports were retrieved and scanned timely.
- The institution provided appropriate nursing care, especially for patients returning from the hospital and specialty services.
- Institutional providers made appropriate assessments and decisions, managed chronic medical conditions effectively, reviewed medical records thoroughly, and addressed the specialists' recommendations adequately.

Our clinicians found NKSP could improve in the following areas:

- The institution performed poorly in collecting urgent (stat) laboratory tests and communicating the results within the required time frame.

9. For a further discussion of an adverse event, see Table A–1.

- The institution performed poorly in continuity of chronic care medications, hospital return medications, specialized medical housing medications, and transfer medications.

Compliance Testing Results

Our compliance inspectors assessed 11 of the 14 indicators applicable to NKSP. Of these 11 indicators, our compliance inspectors rated two ***proficient***, three ***adequate***, and six ***inadequate***. We tested only policy compliance in the **Health Care Environment**, **Preventive Services**, and **Administrative Operations** indicators as these indicators do not have a case review component.

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

- Medical records staff performed well in scanning health care service request forms, specialty service reports, and hospital discharge documents within the required time frames.
- Patients with chronic care conditions, returning from hospital admission and specialty service appointments, received timely follow-up appointments.
- Nursing staff received and reviewed health care service request forms and performed face-to-face triage evaluations within the required time frames. In addition, NKSP housing units maintained adequate supplies of health care service request forms.
- The institution provided high-priority, medium-priority, and routine-priority specialty services within specified time frames.

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

- Several clinics and the medical warehouse stored expired medical supplies. Furthermore, emergency response bags and crash carts were not regularly inspected and inventoried.
- Health care staff did not consistently follow universal hand hygiene precautions.
- There was poor medication continuity for patients transferring in from other institutions, for patients transferring within the institution, and for patients on layover.
- Patients with chronic care medications, returning from hospital admission, admitted to specialized medical housing, and transferring from county jail did not receive ordered medications within specified time frames.
- Providers did not appropriately complete patient diagnostic test result letters. Patients' letters were either missing the date of the

diagnostic test results, whether the results were within normal limits, or whether a follow-up appointment was needed.

Population-Based Metrics

In addition to our own compliance testing and case reviews, as noted above, the OIG presents selected measures from the Healthcare Effectiveness Data and Information Set (HEDIS) for comparison purposes. The HEDIS is a set of standardized quantitative performance measures designed by the National Committee for Quality Assurance to ensure that the public has the data it needs to compare the performance of health care plans. Because the Veterans Administration no longer publishes its individual HEDIS scores, we removed them from our comparison for Cycle 6. Likewise, Kaiser (commercial plan) no longer publishes HEDIS scores. However, through the California Department of Health Care Services' *Medi-Cal Managed Care Technical Report*, the OIG obtained Kaiser Medi-Cal HEDIS scores to use in conducting our analysis, and we present them here for comparison.

HEDIS Results

We considered NKSP's performance with population-based metrics to assess the macroscopic view of the institution's health care delivery. NKSP's results compared favorably with those found in State health plans for diabetic care measures. We list the five HEDIS measures in Table 5.

Comprehensive Diabetes Care

When compared with statewide Medi-Cal programs (California Medi-Cal, Kaiser Northern California (Medi-Cal), and Kaiser Southern California (Medi-Cal)), NKSP outperformed the other three health programs in all five diabetic measures. NKSP scored higher in HbA1c screening, had better HbA1c control and blood pressure controls, and a higher eye examination percentage than all community providers.

Immunizations

Statewide comparative data were not available for immunization measures; however, we include this data for informational purposes. NKSP had a 41 percent influenza immunization rate for adults 18 to 64 years old, and a 67 percent influenza immunization rate for adults 65 years of age and older.[10] The pneumococcal vaccine rate was 67 percent.[11]

10. The HEDIS sampling methodology requires a minimum sample of 10 patients to have a reportable result. The sample for older adults did not include a full sample.

11. The pneumococcal vaccines administered are the 13 valent pneumococcal vaccine (PCV13) or the 23 valent pneumococcal vaccine (PPSV23), depending on the patient's medical conditions. For the adult population, the influenza or pneumococcal vaccine may have been administered at a different institution other than the one in which the patient was currently housed during the inspection period.

Colorectal Cancer Screening

Statewide comparative data were not available for colorectal cancer screening; however, we include these data for informational purposes. NKSP had a 76 percent colorectal cancer screening rate.

Table 5. NKSP Results Compared With State HEDIS Scores

HEDIS Measure	NKSP Cycle 6 Results*	California Medi-Cal 2018†	California Kaiser NorCal Medi-Cal 2018†	California Kaiser SoCal Medi-Cal 2018†
HbA1c Screening	**100%**	88%	94%	95%
Poor HbA1c Control (>9.0%)‡,§	**16%**	34%	24%	20%
HbA1c Control (<8.0%)‡	**79%**	55%	62%	70%
Blood Pressure Control (<140/90)‡	**93%**	67%	75%	85%
Eye Examinations	**95%**	63%	77%	83%
Influenza–Adults (18–64)	41%	–	–	–
Influenza–Adults (65+)‖	67%	–	–	–
Pneumococcal–Adults (65+)‖	67%	–	–	–
Colorectal Cancer Screening	76%	–	–	–

Notes and Sources

* Unless otherwise stated, data were collected in July 2020 by reviewing medical records from a sample of NKSP's population of applicable patients. These random statistical sample sizes were based on a 95 percent confidence level with a 15 percent maximum margin of error.

† HEDIS Medi-Cal data were obtained from the California Department of Health Care Services publication titled, *Medi-Cal Managed Care External Quality Review Technical Report*, dated July 1, 2018–June 30, 2019 (published June 2020).

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

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

‖ For these measures the result was from a sample size fewer than 10. We believe the sample size was due to patient movement from transfers as NKSP is a reception center.

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 NKSP's performance, we offer the following recommendations to the department:

Diagnostic Services

- Laboratory and nursing leadership should ascertain the root causes of the lack of timeliness in collecting samples for stat laboratory tests and communicating the results of stat laboratory tests; leadership should implement remedial measures as appropriate.
- The department should consider developing and implementing a patient results letter template that autopopulates with all elements required by CCHCS policy.
- Medical leadership should identify the root causes of the untimely provision of pathology and diagnostic results letters to the institution's patients; leadership should implement remedial measures as appropriate.

Health Care Environment

- Nursing leadership should consider performing random spot checks to ensure staff follow management protocols for equipment and medical supply.
- Medical leadership should remind staff to follow universal hand hygiene precautions. Implementing random spot checks could improve compliance.
- Nursing leadership should direct each clinic nurse supervisor to review the monthly emergency medical response bag (EMRB) logs to ensure the EMRBs are regularly inventoried and sealed. We also recommend implementing random monthly inventory spot checks to ensure EMRBs have all medical supplies identified in the logs.
- Medical leadership should ensure that clinic common areas and examination rooms contain essential core medical equipment and supplies.

Transfers

- Health care leadership should identify why medication continuity was not maintained for patients newly arriving at the institution and for patients returning from hospitalizations or emergency rooms; leadership should implement remedial measures as appropriate.
- Nursing leadership should determine the root cause of challenges that prevent transfer-in nurses from accurately

documenting care; leadership should implement remedial measures as appropriate.

- The department should consider revising the electronic initial health screening powerform to include a prompt requiring further documentation when "yes" answers are selected and a prompt requiring completion when required fields are not completed.[12]

Medication Management

- Medical leadership should determine the causes of challenges related to medication continuity for patients who are chronic care, transfer-in, hospital discharge, and en-route patients; leadership should implement remedial measures as appropriate.

Preventive Services

- Medical leadership should remind nursing staff to perform weekly monitoring and address the symptoms of patients taking TB medications.
- Nursing leadership should monitor patients at the highest risk of coccidioidomycosis (valley fever) to assure they are transferred in a timely manner.

Nursing Performance

- Nursing leadership should determine the root causes of challenges that prevent outpatient nurses from performing complete assessments; leadership should implement remedial measures as appropriate.

Specialized Medical Housing

- Nursing leadership should remind correctional treatment center (CTC) nurses to ensure they complete documentation of wound care assessments, including assessments of the clinical appearance of the wound, surrounding tissue, and measurements.

Administrative Operations

- Medical leadership should ensure the timely completion of clinical performance appraisals.

12. A powerform refers to an electronic form in electronic medical record. Staff can enter data content and answer questions on the form.

Access to Care

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

Overall Rating ***Proficient***

Case Review Rating ***Proficient***

Compliance Score ***Adequate*** **(84.6%)**

Results Overview

NKSP provided excellent access to care in most clinical areas. The OIG clinicians found that most appointments were completed in a timely manner, including appointments with clinic providers, correctional treatment center (CTC) providers, nurses, and specialists. Compliance testing was consistent with the clinical review, as the overall access to care score was 85 percent. The OIG rated this indicator ***proficient***.

Case Review Results

Our clinicians reviewed 384 provider, nursing, specialty, and hospital events that required the institution to generate appointments. Of the 10 deficiencies we found related to access to care, six were significant.[13]

Access to Clinic Providers

Access to clinic providers is an integral part of patient care in health care delivery, and NKSP performed well in both compliance testing and case review in this indicator. Compliance testing found that 80.0 percent of chronic care follow-up appointments occurred on time (MIT 1.001), 100 percent of provider-ordered follow-up sick call appointments occurred within the time frame specified (MIT 1.006), and 42.9 percent of nurse-to-provider sick call referrals occurred as requested (MIT 1.005). OIG clinicians reviewed 91 clinic provider appointments and identified one significant deficiency:

- In case 8, the patient complained of back pain, and a provider requested a clinic provider appointment in seven days; however, the appointment occurred 17 days late.

Access to Specialized Medical Housing Providers

NKSP performed well in access to care in the CTC. When staff admitted the patients to the CTC, the providers examined the patients in a timely manner. The providers evaluated patients and documented their evaluations in progress notes within the appropriate time frames. Compliance testing found that 80.0 percent of the CTC admission

13. Deficiencies occurred twice in cases 2 and 25, and once in cases 8, 29, 30, 31, 40, and 55. Cases 8, 25, 30, 31, 40, and 55 had significant deficiencies.

history and physical examinations occurred within the required time frame (MIT 13.002). OIG clinicians assessed 14 CTC provider encounters and did not identify any deficiency related to late or missed admission history and physical examinations or follow-up appointments.

Access to Clinic Nurses

NKSP also performed well in access to nursing sick calls and provider-to-nurse referrals. Compliance testing found that all nurse sick call requests were reviewed on the day they were received (MIT 1.003, 100%). Moreover, nurses evaluated 90.0 percent of their patients within the required one business day (MIT 1.004). OIG clinicians identified only two deficiencies[14] related to clinic nurse access, one of which was significant:

- In case 40, the patient filled out a sick call request for abdominal pain, and the nurse assessed the patient two days late.

Access to Specialty Services

NKSP provided excellent specialty access. Compliance testing found that 85.7 percent of the high-priority specialty appointments occurred within the required time frame (MIT 14.001), 93.3 percent of the medium-priority specialty appointments occurred as requested (MIT 14.004), and 100 percent of the routine-priority specialty appointments occurred as requested (MIT 14.007).

NKSP also performed well in specialty follow-up appointments. Compliance testing found that most high-priority specialty follow-up appointments occurred timely (MIT 14.003, 90.9%), all medium-priority specialty follow-up appointment occurred as requested (MIT 14.006, 100%), and the majority of the routine-priority specialty follow-up appointments occurred as requested (MIT 14.009, 66.7%). The OIG clinicians reviewed 75 specialty events and identified only three minor delays in specialty appointments.[15]

Follow-Up After Specialty Service

NKSP performed well in ensuring patients saw their providers after specialty appointments. Compliance testing revealed that most provider appointments after specialty services occurred timely (MIT 1.008, 81.6%). OIG clinicians reviewed 75 specialty appointments and did not identify any missed or delayed provider follow-up appointment after specialty service.

Follow-Up After Hospitalization

NKSP ensured that patients saw their providers promptly after hospitalizations. Compliance testing found that most provider

14. Deficiencies occurred in cases 2 and 40.
15. Minor delays occurred in cases 2, 25, and 29.

appointments occurred within the required time frames (MIT 1.007, 88.0%). OIG clinicians reviewed 19 hospital returns and did not identify any missed or delayed provider appointments.

Follow-Up After Urgent or Emergent Care (TTA)

NKSP providers generally saw their patients following a triage and treatment area (TTA) event as requested. OIG clinicians assessed 29 TTA events and did not identify any delayed or missed appointments.

Follow-Up After Transferring Into the Institution

Compliance testing showed that NKSP providers saw transfer-in patients at timely follow-up appointments in 79.2 percent of the cases (MIT 1.002). OIG clinicians evaluated 15 transfer-in events, including 12 patients arriving at the reception center. We identified four significant deficiencies:

- In cases 25 and 55, the patients were new arrivals from another institution, and the receiving nurse requested provider appointments to occur in one month and seven days, respectively. The appointments were late, occurring in two months and 14 days, respectively.
- In cases 30 and 31, the patients were new arrivals at the reception center. The provider appointments requested to occur in seven days were late, occurring in 14 days and 15 days, respectively.

Clinician On-Site Inspection

NKSP has four main clinics, facilities A, B, C, and D. Each clinic had one primary provider and a secondary provider. Each clinic also had an office technician who attended the morning huddles and ensured provider appointments were met. Office technicians bundled provider appointments to maximize each appointment. Providers saw eight to 12 patients per day. The reception center processed about 140 patients per week and had one provider.

The scheduling supervisor explained that most of the delayed appointments resulted from the backlog of provider appointments due to COVID-19 and mumps outbreaks during the early months of 2020. At the time of the OIG on-site visit, there was no backlog of provider appointments in the main clinics or the reception center.

Recommendations

The OIG has no recommendations.

Compliance Testing Results

Table 6. Access to Care

Compliance Questions	Scored Answer Yes	No	N/A	Yes %
Chronic care follow-up appointments: Was the patient's most recent chronic care visit within the health care guideline's maximum allowable interval or within the ordered time frame, whichever is shorter? (1.001) *	20	5	0	80.0%
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) *	19	5	1	79.2%
Clinical appointments: Did a registered nurse review the patient's request for service the same day it was received? (1.003) *	30	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) *	27	3	0	90.0%
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) *	3	4	23	42.9%
Sick call follow-up appointments: If the primary care provider ordered a follow-up sick call appointment, did it take place within the time frame specified? (1.006) *	1	0	29	100%
Upon the patient's discharge from the community hospital: Did the patient receive a follow-up appointment within the required time frame? (1.007) *	22	3	0	88.0%
Specialty service follow-up appointments: Did the clinician follow-up visits occur within required time frames? (1.008) *,†	31	7	7	81.6%
Clinical appointments: Do patients have a standardized process to obtain and submit health care services request forms? (1.101)	5	0	1	100%
			Overall percentage (MIT 1): **84.6%**	

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

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

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

Table 7. Other Tests Related to Access to Care

Compliance Questions	Scored Answer			
	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) *	0	0	19	0
For patients received from a county jail: Did the patient receive a history and physical by a primary care provider within seven calendar days? (12.004) *	9	11	0	45.0%
For CTC and SNF only (effective 4/2019, include OHU): Was a written history and physical examination completed within the required time frame? (13.002) *	8	2	0	80.0%
For OHU, CTC, SNF, and Hospice (applicable only for samples prior to 4/2019): Did the primary care provider complete the Subjective, Objective, Assessment, and Plan notes on the patient at the minimum intervals required for the type of facility where the patient was treated? (13.003) *,†	N/A	N/A	N/A	N/A
Did the patient receive the high-priority specialty service within 14 calendar days of the primary care provider order or the Physician Request for Service? (14.001) *	12	2	1	85.7%
Did the patient receive the subsequent follow-up to the high-priority specialty service appointment as ordered by the primary care provider? (14.003) *	10	1	4	90.9%
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) *	14	1	0	93.3%
Did the patient receive the subsequent follow-up to the medium-priority specialty service appointment as ordered by the primary care provider? (14.006) *	7	0	8	100%
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) *	15	0	0	100%
Did the patient receive the subsequent follow-up to the routine-priority specialty service appointment as ordered by the primary care provider? (14.009) *	2	1	12	66.7%

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

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

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

Overall Rating
Inadequate

Case Review Rating
Adequate

Compliance Score
***Inadequate* (55.8%)**

Diagnostic Services

In this indicator, OIG inspectors evaluated the institution's ability to timely complete radiology, laboratory, and pathology tests. Our inspectors determined whether the institution properly retrieved the resultant reports and whether providers reviewed the results correctly. In addition, in Cycle 6, we examined the institution's ability to timely complete and review immediate (stat) laboratory tests.

Results Overview

In completing and retrieving diagnostic tests, NKSP performed adequately. However, the institution performed poorly in collecting stat laboratory samples and communicating test results within the required time frames. The provider did not always send letters to the patients informing them of the pathology results. The providers also did not include laboratory dates in the patient results letters. The OIG rated this indicator ***inadequate***.

Case Review Results

Our clinicians reviewed 135 diagnostic events and identified 21 deficiencies,[16] two of which were significant.[17]

Test Completion

Compliance testing showed NKSP completed most radiology tests within the required time frames (MIT 2.001, 90.0%). Our clinicians reviewed 35 radiology tests and did not identify any missed or delayed tests. All 15 electrocardiograms (EKGs) were also completed in a timely manner.

Compliance testing found that all laboratory tests were completed within required time frames (MIT 2.004, 100%). Our clinicians reviewed 81 laboratory tests and identified one minor delay[18] in a laboratory test completion and a significant deficiency related to a missed laboratory test:

- In case 21, a provider requested a sputum culture; however, the test was not completed.

Compliance testing found that the institution did not consistently collect stat laboratory samples or receive stat test results within the required time frames (MIT 2.007, 30.0%). The nursing staff also performed poorly in notifying the provider within 30 minutes of receiving stat laboratory test results (MIT 2.008, 10.0%).

16. Deficiencies occurred three times in cases 7, 10, 20, and 21, twice in cases 2, 11, and 32, and once in cases 3, 18, and 23.

17. Significant deficiencies occurred in cases 7 and 21.

18. A minor delay occurred in case 23.

Health Information Management

NKSP performed well in retrieving and endorsing diagnostic reports. Compliance testing showed providers endorsed most radiology reports timely (MIT 2.002, 80.0%), and endorsed most laboratory reports timely (MIT 2.005, 90.0%). The providers also endorsed the stat laboratory results within the required time frames (MIT 2.009, 90.0%). Our clinicians identified one significant deficiency related to a missing diagnostic test:

- In case 7, a nurse obtained an EKG; however, this test was not scanned into the medical record.

Compliance testing showed the providers did not thoroughly communicate the results of radiology studies or laboratory tests to the patients (MIT 2.003, zero, and MIT 2.006, zero, respectively). OIG clinicians identified 11 minor deficiencies[19] related to providers not documenting dates of the laboratory tests in letters to patients. Although required by policy, the missing dates were not clinically significant because the providers discussed the results with the patients during subsequent visits. The following case is one example:

- In case 2, the provider did not include the date of a laboratory test in the patient results letter.

NKSP generally retrieved and reviewed pathology reports in a timely manner. Compliance testing found that NKSP retrieved most pathology reports within the required time frames (MIT 2.010, 80.0%), and the providers endorsed all pathology reports (MIT 2.011, 100%). However, the providers did not send results letters to the patients within the required time frames (MIT 2.012, zero). Our clinicians found that all four pathology reports were retrieved in a timely manner. The providers endorsed timely result letters but did not send those result letters to the patients.[20] However, the providers discussed the results with their patients during the subsequent provider encounters.

Clinician On-Site Inspection

NKSP assigned a designated phlebotomist to each of the four main clinics to ensure that all laboratory tests are completed as ordered. NKSP also designated a member of their medical staff for tracking and retrieving all pathology reports. The laboratory vendor communicated stat laboratory results with TTA staff, who informed the provider immediately of the results.

19. Eleven minor deficiencies occurred twice in cases 2, 7, and 21, once in cases 3, 11, 18, 20, and 32.

20. Deficiencies occurred twice in case 10, and once in cases 21 and 32.

Recommendations

- Laboratory and nursing leadership should ascertain the root causes of the lack of timeliness in collecting samples for stat laboratory tests and communicating the results of stat laboratory tests; leadership should implement remedial measures as appropriate.
- The department should consider developing and implementing a patient results letter template that autopopulates with all elements required by CCHCS policy.
- Medical leadership should identify the root cause of the untimely provision of pathology and diagnostic results letters to their patients; leadership should implement remedial measures as appropriate.

Compliance Testing Results

Table 8. Diagnostic Services

Compliance Questions	Scored Answer			
	Yes	No	N/A	Yes %
Radiology: Was the radiology service provided within the time frame specified in the health care provider's order? (2.001) *	9	1	0	90.0%
Radiology: Did the ordering health care provider review and endorse the radiology report within specified time frames? (2.002) *	8	2	0	80.0%
Radiology: Did the ordering health care provider communicate the results of the radiology study to the patient within specified time frames? (2.003)	0	10	0	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)	0	10	0	0
Laboratory: Did the institution collect the STAT laboratory test and receive the results within the required time frames? (2.007) *	3	7	0	30.0%
Laboratory: Did the nursing staff notify the health care provider within one (1) hour from receiving the STAT laboratory results? (2.008) *	1	9	0	10.0%
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) *	8	2	0	80.0%
Pathology: Did the health care provider review and endorse the pathology report within specified time frames? (2.011) *	8	0	2	100%
Pathology: Did the health care provider communicate the results of the pathology study to the patient within specified time frames? (2.012)	0	8	2	0
			Overall percentage (MIT 2): **55.8%**	

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

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

Overall Rating
Adequate

Case Review Rating
Adequate

Compliance Score
(N/A)

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) ability to identify problems with its emergency services. The OIG assessed the institution's emergency services through case review only; we did not perform compliance testing for this indicator.

Results Overview

NKSP delivered acceptable emergency care that was slightly improved from Cycle 5. Providers delivered good care. Nursing staff responded promptly to emergent events and provided appropriate care. However, staff did not always notify EMS (emergency medical services) in a timely manner. Overall, the OIG rated this indicator ***adequate***.

Case Review Results

Our clinicians reviewed 29 urgent and emergent events and found 18 emergency care deficiencies, three of which were significant.[21]

Emergency Medical Response

NKSP responded promptly to emergencies throughout the institution. Staff initiated CPR and notified TTA staff timely. However, we identified delays in calling EMS in some cases. We found room for improvement in the following cases:

- In case 12, the patient complained of chest pain and the provider ordered an urgent transport to the hospital. However, the nurse called EMS an hour later. The patient's conditions remained stable while waiting for EMS.
- In case 14, the patient was involved in a physical altercation that resulted in multiple stab wounds to the back area. Two minutes later, the patient complained of severe back pain with shortness of breath. Although oxygen was administered, EMS was notified 15 minutes after the patient was found. This placed the patient at risk for delayed advanced treatment.

21. Deficiencies occurred five times in case 2, three times in cases 11 and 12, twice in cases 13 and 16, and once in cases 8 and 14. Significant deficiencies occurred in cases 2, 12, and 14.

Provider Performance

NKSP providers performed well in urgent and emergent situations. For patients who arrived at the TTA for emergency treatment, providers made appropriate decisions. On-call providers were available for consultation with the TTA staff and documented their telephone calls with the nurses. Our clinicians did not identify any deficiencies related to provider performance.

Nursing Performance

NKSP nurses generally provided appropriate nursing assessments and interventions. The nurses recognized opioid overdoses and implemented the nursing overdose protocol. We found room for improvement in the following cases:

- In case 12, the patient fell, hit his head, and complained of a headache. The nurse did not perform a complete neurological assessment.
- In case 16, the patient was unresponsive, and the nurse noted the patient's respirations were irregular and labored. However, the nurse did not listen to the patient's lung sounds.

Nursing Documentation

Nursing documentation was acceptable. Most nurses documented accurate timelines and assessments. However, we identified a pattern of deficiencies, in cases 2, 11, 13, and 16, in which nurses did not document the hand-off communication to EMS.

Emergency Medical Response Review Committee

The EMRRC met monthly and reviewed emergency response care within the required time frames. We found two deficiencies, in cases 13 and 16, related to the committee's failure to identify incomplete nursing assessments and documentation.

Clinician On-Site Inspection

The TTA maintained four beds, and the patient care area had sufficient space to provide emergency care. We discussed some of the case review findings with nursing leadership, who explained they planned to implement training for quality improvement.

Recommendations

The OIG has no specific recommendations for this indicator.

Overall Rating
Proficient

Case Review Rating
Proficient

Compliance Score
Proficient
(85.5%)

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.

Results Overview

In both compliance and case review, NKSP performed well in health information management. We found that medical staff retrieved and scanned most hospital discharge records, diagnostic results, and specialty reports in a timely manner; the OIG rated this indicator ***proficient***.

Case Review Results

Our clinicians reviewed 799 events and found nine deficiencies related to health information management, of which two were significant.[22]

Hospital-Discharge Reports

NKSP performed well in retrieving and scanning hospital records. Compliance testing found that NKSP staff retrieved and scanned hospital discharge records within the required time frame (MIT 4.003, 95.0%). Most discharge records included the important physician discharge summary, and providers endorsed the reports within five days (MIT 4.005, 100%). Our clinicians reviewed 19 hospital events and did not identify any lapse in retrieving and endorsing hospital records.

Specialty Reports

NKSP performed well retrieving and reviewing specialty reports. Compliance testing showed that 66.7 percent of specialty reports were scanned within the required time frame (MIT 4.002). NKSP providers generally reviewed the high-priority, medium-priority, and routine-priority specialty reports within the required time frame (MIT 14.002, 80.0%, MIT 14.005, 53.3%, and MIT 14.008, 57.1%).

Our clinicians reviewed 75 specialty reports and identified one significant deficiency related to a delay in retrieving a specialty report.[23] This deficiency is discussed in the **Specialty Services** indicator.

22. Deficiencies occurred five times in case 20, and once in cases 3, 7, 11, and 22. Significant deficiencies occurred in cases 7 and 20.

23. A significant deficiency occurred in case 20.

Diagnostic Reports

NKSP proficiently retrieved and endorsed diagnostic reports. Compliance testing showed providers endorsed radiology and laboratory reports within required time frames (MIT 2.002, 80.0%, and MIT 2.005, 90.0%). Our clinicians reviewed 135 diagnostic events and identified four deficiencies.[24] The one significant deficiency is discussed in the **Diagnostic Services** indicator.

Compliance testing found that staff retrieved most pathology reports within required time frames (MIT 2.010, 80.0%), and providers endorsed all pathology reports within specified time frames (MIT 2.011, 100%). Our clinicians found that all pathology reports were retrieved in a timely manner, and providers endorsed the reports and discussed the results with their patients during subsequent encounters.

Urgent and Emergent Records

Our clinicians reviewed 29 emergency care events and found that the nurses and providers recorded these events sufficiently. Our clinicians did not identify any deficiencies.

Scanning Performance

NKSP performed adequately with the scanning process. Compliance testing found most records were properly scanned and labeled without errors (MIT 4.004, 70.8%). Our clinicians identified three mislabeled documents.[25]

Clinician On-Site Inspection

Medical staff at NKSP's central medical record office scanned records as they received them. Most patients returning from a community hospital had their hospital records with them. TTA nurses were instructed to contact the hospital directly for any missing hospital records.

For on-site specialty reports, the on-site specialty nurses scanned the reports on the day the visit occurred. For off-site specialty reports, the medical record staff scanned the handwritten reports on the day the visit occurred and the formal specialty reports as they received them.

Recommendations

The OIG has no specific recommendations for this indicator.

24. Deficiencies occurred twice in case 20 and once in cases 7 and 11. A significant deficiency occurred in case 7.

25. Minor, mislabeled deficiencies occurred in cases 3, 20, and 22.

Compliance Testing Results

Table 9. Health Information Management

Compliance Questions	Scored Answer			
	Yes	No	N/A	Yes %
Are health care service request forms scanned into the patient's electronic health record within three calendar days of the encounter date? (4.001)	20	1	9	95.2%
Are specialty documents scanned into the patient's electronic health record within five calendar days of the encounter date? (4.002) *	20	10	15	66.7%
Are community hospital discharge documents scanned into the patient's electronic health record within three calendar days of hospital discharge? (4.003) *	19	1	5	95.0%
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) *	25	0	0	100%
Overall percentage (MIT 4): **85.5%**				

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

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

Table 10. Other Tests Related to Health Information Management

Compliance Questions	Scored Answer			
	Yes	No	N/A	Yes %
Radiology: Did the ordering health care provider review and endorse the radiology report within specified time frames? (2.002) *	8	2	0	80.0%
Laboratory: Did the health care provider review and endorse the laboratory report within specified time frames? (2.005) *	9	1	0	90.0%
Laboratory: Did the nursing staff notify the health care provider within one (1) hour from receiving the STAT laboratory results? (2.008) *	1	9	0	10.0%
Pathology: Did the institution receive the final pathology report within the required time frames? (2.010) *	8	2	0	80.0%
Pathology: Did the health care provider review and endorse the pathology report within specified time frames? (2.011) *	8	0	2	100%
Pathology: Did the health care provider communicate the results of the pathology study to the patient within specified time frames? (2.012)	0	8	2	0
Did the institution receive and did the primary care provider review the high-priority specialty service consultant report within the required time frame? (14.002) *	12	13	0	80.0%
Did the institution receive and did the primary care provider review the medium-priority specialty service consultant report within the required time frame? (14.005) *	8	7	0	53.3%
Did the institution receive and did the primary care provider review the routine-priority specialty service consultant report within the required time frame? (14.008) *	8	6	1	57.1%

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

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

Overall Rating
Inadequate

Case Review Rating
(N/A)

Compliance Score
Inadequate
(56.9%)

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' ability to maintain auditory and visual privacy for clinical encounters. Compliance inspectors asked the institution's health care administrators to comment on their facility's infrastructure and its ability to support health care operations. The OIG rated this indicator solely on the compliance score, using the same scoring thresholds as in the Cycle 4 and Cycle 5 medical inspections. Our case review clinicians do not rate this indicator.

Compliance Testing Results

For this indicator, NKSP's performance declined compared with its performance in Cycle 5. In the present cycle, multiple aspects of NKSP's health care environment needed improvement: examination rooms lacked adequate space; multiple clinics and the medical warehouse contained expired medical supplies; emergency medical response bag (EMRB) logs either were missing staff verification or inventory was not performed; and staff did not regularly sanitize their hands before or after examining patients. These factors resulted in an ***inadequate*** rating for this indicator.

Outdoor Waiting Areas

There were no waiting areas that required patients to be outdoors at the time of inspection.

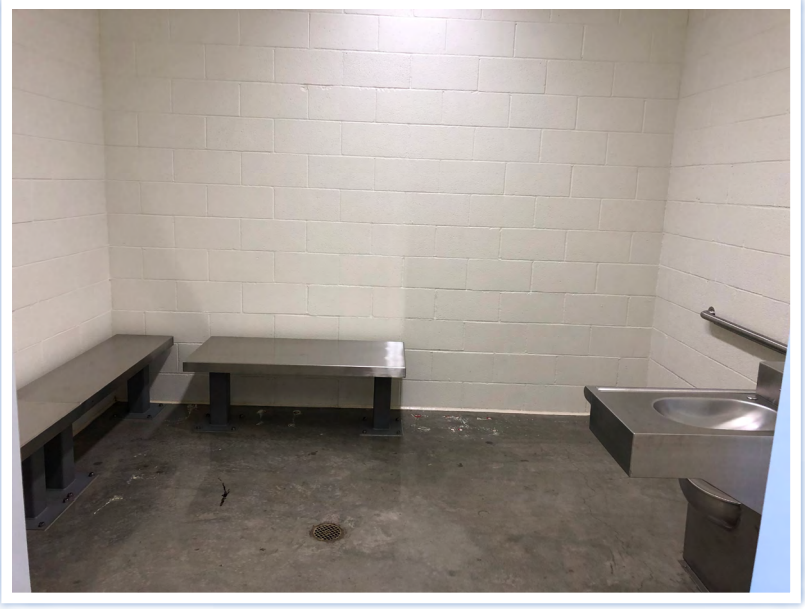


Photo 1. Indoor waiting area; in this photo, no social distancing demarcation was identified (photographed on July 16, 2020).

Indoor Waiting Areas

Inside the medical clinics, patients had adequate seating capacity while waiting for their appointments (see Photo 1, left). In addition, several clinics had multiple individual holding cells (see Photo 2, next page, top). These waiting areas had temperature control, running water, restrooms, and hand sanitation items. Custody and medical staff reported that patients are called to the clinic close to their appointment times to prevent overcrowding. During our inspection, we did not observe any overcrowding in the clinics' waiting areas.

Photo 2. Multiple indoor holding cells for patients (photographed on July 16, 2020).

Clinic Environment

Five of the nine clinic environments were sufficiently conducive to medical care: they provided reasonable auditory privacy, appropriate waiting areas, wheelchair accessibility, and adequate work space outside the examination room (MIT 5.109, 55.6%). In three clinics, the vital sign check station, triage station, or blood draw station configuration did not provide reasonable auditory privacy (see Photo 3, right).

Photo 3. Vital signs check station did not provide reasonable auditory privacy (photographed on July 16, 2020).

Photo 4. Examination room space could not accommodate a wheelchair-bound patient (photographed on July 14, 2020).

In the receiving and release (R&R) examination room, the space could not accommodate a wheelchair-bound patient (see Photo 4, above).

Of the nine clinics we observed, six contained appropriate space, configuration, supplies, and equipment to allow their clinicians to perform proper clinical examinations (MIT 5.110, 66.7%). The remaining three clinics had one or more of the following deficiencies: the examination room lacked visual and auditory privacy for conducting clinical examinations; rooms were unnecessarily cluttered and lacked adequate space (some rooms were smaller than the recommended 100 square feet); rooms' configurations did not allow sufficient space for clinical staff to perform clinical examinations (see Photo 5, next page); examination table covers were torn; and the examination table's placement impeded the clinicians' access to the patient.

Photo 5. Examination room configuration did not allow sufficient space for clinical staff to perform clinical examinations (photographed on July 14, 2020).

Clinic Supplies

Two of the nine clinics followed adequate medical supply storage and management protocols (MIT 5.107, 22.2%). We found one or more of the following deficiencies in seven clinics: expired medical supplies (see Photos 6 and 7, next page); medical supplies with missing or inaccurate labels; compromised sterile medical supply packaging; and cleaning supplies stored in the same area with medical supplies.

Three of the nine clinics met requirements for essential core medical equipment and supplies (MIT 5.108, 33.3%). The remaining six clinics lacked medical supplies or contained improperly calibrated or nonfunctional equipment. The missing items included an examination table, a nebulization unit, a Snellen reading chart, examination table disposable paper, tongue depressors, and a peak flow meter.

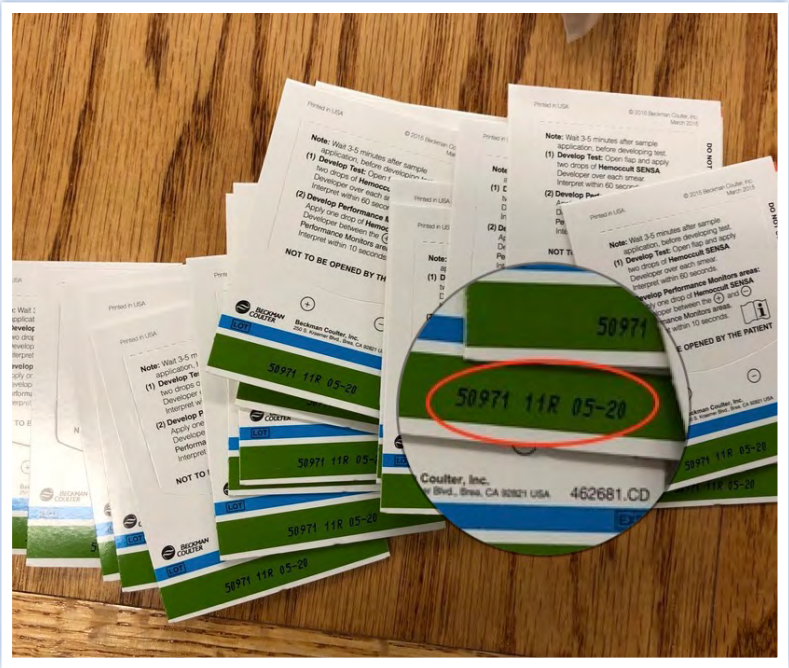


Photo 6. Expired medical supplies dated May 2020 (photographed on July 16, 2020).

The nebulization unit, examination table, an oto-ophthalmoscope, and a weight scale did not have the updated calibration stickers. We also found a nonfunctional oto-ophthalmoscope. Staff did not perform and record the automated external defibrillator (AED) performance test within the last 30 days.

We examined emergency medical response bags (EMRBs) to determine if they contained all essential items. We checked whether staff inspected the bags daily and inventoried them monthly. Only four of the eight EMRBs passed our test (MIT 5.111, 50.0%).

Photo 7. Expired medical supplies dated December 2019 and June 2020 (photographed on July 16, 2020).

We found one or more of the following deficiencies: staff failed to ensure the EMRBs' compartments were sealed and intact; staff either had not inventoried the EMRBs when seal tags were replaced or had not inventoried the EMRBs in the previous 30 days; and an EMRB lacked an extra-large blood pressure cuff. The crash cart in the TTA contained expired syringes and compromised sterile packaging.

Medical Supply Management

None of the medical supply storage areas located outside the medical clinics stored medical supplies adequately (MIT 5.106, zero). We found several medical supplies stored beyond manufacturer guidelines.

According to the chief executive officer (CEO), the institution's certified nursing assistants perform an inventory of medical supplies and submit orders on a weekly basis. Deliveries of medical supplies are scheduled every Wednesday and Thursday, in the same week the order is received. Health care managers expressed no concerns with the medical supply chain or with their communication process in the existing system.

Infection Control and Sanitation

Staff appropriately disinfected, cleaned, and sanitized eight of nine clinics (MIT 5.101, 88.9%). In one clinic, the examination room cabinet had accumulated dirt and grime. Staff in all clinics (MIT 5.102, 100%) properly sterilized or disinfected medical equipment.

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

We observed patient encounters in nine clinics. In four clinics, clinicians did not wash their hands before or after examining their patients or before donning gloves (MIT 5.104, 42.9%).

Health care staff in seven of nine clinics followed proper protocols to mitigate exposure to blood-borne pathogens and contaminated waste (MIT 5.105, 77.8%). In two clinics, we found one or more of the following deficiencies: staff were not able to locate the clinic's personal protective equipment (PPE); the examination room lacked a sharps container; the clinic's biohazardous waste was not properly secured in the designated storage location; the clinic lacked labeling to identify the biohazardous waste storage location; and nonbiohazardous waste or items were stored in the designated biohazard common room.

Physical Infrastructure

At the time of the compliance inspection, the institution was renovating and adding clinic space to three medical clinics (A Yard, specialty, and diagnostics). Renovation was also underway for the pharmacy and administrative offices. These projects began in late 2015 and early 2016. The institution did not provide estimated completion dates for these projects. The expansion and relocation of the institution's TTA was completed and functioning the week of our inspection. There is an additional project to expand and renovate the R&R clinic. However, there has been no groundbreaking on this project and no planned date for groundbreaking was provided. According to the CEO, the project completion delays are due to the following: a mumps outbreak, the COVID-19 pandemic, and fire marshal issues regarding fire retardant. The CEO stated that swing space is being used for the A Yard clinic and that the delays are not negatively impacting the patient care provided (MIT 5.999).

Recommendations

- Nursing leadership should consider performing random spot checks to ensure staff follow equipment and medical supply management protocols.
- Medical leadership should remind staff to follow universal hand hygiene precautions. Implementing random spot checks could improve compliance.
- Nursing leadership should direct each clinic nurse supervisor to review the monthly EMRB logs to ensure that EMRBs are regularly inventoried and sealed. We also recommend implementing random monthly inventory spot checks to ensure EMRBs have all medical supplies identified in the logs.
- Medical leadership should ensure that clinic common areas and examination rooms contain essential core medical equipment and supplies.

Compliance Testing Results

Table 11. Health Care Environment

Compliance Questions	Scored Answer			
	Yes	No	N/A	Yes %
Infection control: Are clinical health care areas appropriately disinfected, cleaned, and sanitary? (5.101)	8	1	1	88.9%
Infection control: Do clinical health care areas ensure that reusable invasive and noninvasive medical equipment is properly sterilized or disinfected as warranted? (5.102)	8	0	2	100%
Infection control: Do clinical health care areas contain operable sinks and sufficient quantities of hygiene supplies? (5.103)	8	1	1	88.9%
Infection control: Does clinical health care staff adhere to universal hand hygiene precautions? (5.104)	3	4	3	42.9%
Infection control: Do clinical health care areas control exposure to blood-borne pathogens and contaminated waste? (5.105)	7	2	1	77.8%
Warehouse, conex, and other nonclinic storage areas: Does the medical supply management process adequately support the needs of the medical health care program? (5.106)	0	1	0	0
Clinical areas: Does each clinic follow adequate protocols for managing and storing bulk medical supplies? (5.107)	2	7	1	22.2%
Clinical areas: Do clinic common areas and exam rooms have essential core medical equipment and supplies? (5.108)	3	6	1	33.3%
Clinical areas: Are the environments in the common clinic areas conducive to providing medical services? (5.109)	5	4	1	55.6%
Clinical areas: Are the environments in the clinic exam rooms conducive to providing medical services? (5.110)	6	3	1	66.7%
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)	4	4	2	50.0%
Does the institution's health care management believe that all clinical areas have physical plant infrastructures that are sufficient to provide adequate health care services? (5.999)	This is a nonscored test. Please see the indicator for discussion of this test.			
	Overall percentage (MIT 5): **56.9%**			

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

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

Overall Rating
Adequate

Case Review Rating
Adequate

Compliance Score
Inadequate
(60.7%)

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 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 if staff transferred patients with their medical equipment and gave correct medications before patients left. In addition, our inspectors evaluated the ability of staff to communicate vital health transfer information, such as preexisting health conditions, pending appointments, tests, and specialty referrals; and inspectors confirmed if staff sent complete medication transfer packages to the receiving institution. For patients who returned from off-site hospitals or emergency rooms, inspectors reviewed whether staff appropriately implemented the recommended treatment plans, administered necessary medications, and scheduled appropriate follow-up appointments.

Results Overview

Compared to Cycle 5, our clinicians reviewed fewer events and found fewer deficiencies, including significant deficiencies. We found incomplete initial nurse health screenings and a lack of medication continuity for patients transferring into the institution; however, the NKSP transfer-out process was excellent, as transferring-out patients had all their required documents and medications. For patients returning from an off-site hospital, we found that hospital records were retrieved and scanned within the required time frames, and the providers evaluated the patient in a timely manner; however, there was lack of medication continuity. Overall, the OIG rated this indicator ***adequate***.

Case Review Results

Our clinicians reviewed 37 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 11 deficiencies, three of which were significant.[26]

Transfers In

We found NKSP's transfer-in process to be inadequate. Compliance testing showed R&R nurses did not complete the initial health screening form thoroughly (MIT 6.001, zero). The nurses did not address the signs and symptoms of fatigue when screening for tuberculosis (TB) and did not follow up on health care screening questions that required

26. Deficiencies occurred in cases 2, 11, 12, 19, 22, 24, 25, 27, 53, and 55. Significant deficiencies occurred in cases 24, 25, and 55.

an explanation.[27] Compliance testing also showed poor medication continuity for newly arrived patients (MIT 6.003, 42.9%). Analysis of the compliance data showed four patients arrived without their medications, and their medications were delivered one to 14 days late. Some of these medications were necessary for patients to keep in their possession: these included a rescue inhaler for asthma and nitroglycerin for chest pain.

Our clinicians reviewed three transfer-in cases and found that the R&R nurses evaluated newly arrived patients within the required time frame and assessed them appropriately. We found one significant deficiency:

- In case 24, the transfer-in patient with a history of diabetes did not receive his diabetic medication at the next scheduled dosing because the medication was not available.

Compliance testing showed provider appointments for newly arrived patients occurred within the required time frames (MIT 1.002, 79.2%). Our clinicians found two delays in provider appointments; the delays are discussed in the **Access to Care** indicator. NKSP reported an outbreak of mumps, which contributed to one of the delays. In both of the delayed cases, however, the provider performed a chart review and ordered appropriate diagnostic tests and specialty follow-up appointments prior to the appointments.

When patients transferred into NKSP with preapproved specialty services, 75.0 percent of their specialty appointments were completed within required time frames (MIT 14.010). Our clinicians found a minor delay in an infectious disease preapproved follow-up appointment.[28]

Transfers Out

NKSP's transfer-out process was excellent. Compliance testing found all patients who transferred out had the required documents and medications (MIT 6.101, 100%).

Our clinicians reviewed six transfer-out cases and found nurses performed face-to-face evaluations and transferred patients with their medications and durable medical equipment. However, we identified minor documentation deficiencies.[29]

Hospitalizations

Patients returning from an off-site hospitalization or emergency room visit are at high risk for lapses in care. These patients have typically experienced severe illness or injury and require more care, placing strain on the institution's resources. Because these patients have complex medical issues, the successful transfer of health information is necessary

27. In April 2020, after our review, but before this report was published, CCHCS reported having added the symptom of *fatigue* into the EHRS for TB-symptom monitoring.

28. The minor deficiency occurred in case 25.

29. Deficiencies occurred in cases 11, 27, and 53.

for quality care. Any lapse in care can result in serious consequences for these patients.

Our clinicians reviewed 19 hospital or emergency room returns in 12 cases and identified four deficiencies.[30] All patients were assessed when they returned from the hospital. However, we found two deficiencies resulting from incomplete nursing assessments.

NKSP performed well in providing follow-up appointments within the required time frames to patients returning from the hospital and emergency room visits (MIT 1.007, 88.0%). All discharge documents were scanned into the patient's electronic health record within three calendar days of discharge (MIT 4.003, 95.0%). Compliance testing also found providers reviewed and endorsed documentation within required time frames (MIT 4.005, 100%). Case review identified one minor deficiency, resulting from a discharge summary mislabeled as an outpatient progress note.[31]

Compliance testing showed NKSP performed poorly in medication continuity, since ordered medications were administered, made available, or delivered to patients within the required time frame only 52.0 percent of the time (MIT 7.003). Our clinicians did not identify deficiencies related to medication continuity.

Clinician On-Site Inspection

Our clinicians interviewed the nurses, who were knowledgeable about their job duties and the transfer process. We met with nurse managers to discuss some of our clinical findings, and they indicated they would provide additional education and training to their staff.

Please see the **Reception Center** indicator for additional details.

Recommendations

- Health care leadership should identify why medication continuity was not maintained for patients newly arriving at the institution nor for patients returning from hospitalizations or emergency rooms; leadership should implement remedial measures as appropriate.
- Nursing leadership should determine the root causes of challenges that prevent transfer-in nurses from documenting care accurately; leadership should implement remedial measures as appropriate.
- The department should consider revising the electronic initial health screening powerform to include a prompt requiring further documentation when "yes" answers are selected and a prompt requiring completion when required fields are not completed.

30. Deficiencies occurred in cases 2, 12, 19, and 22.

31. A labeling deficiency occurred in case 22.

Compliance Testing Results

Table 12. Transfers

Compliance Questions	Scored Answer			
	Yes	No	N/A	Yes %
For endorsed patients received from another CDCR institution or COCF: Did nursing staff complete the initial health screening and answer all screening questions within the required time frame? (6.001) *	0	25	0	0
For endorsed patients received from another CDCR institution or COCF: When required, did the RN complete the assessment and disposition section of the initial health screening form; refer the patient to the TTA if TB signs and symptoms were present; and sign and date the form on the same day staff completed the health screening? (6.002)	23	0	2	100%
For endorsed patients received from another CDCR institution or COCF: If the patient had an existing medication order upon arrival, were medications administered or delivered without interruption? (6.003) *	6	8	11	42.9%
For patients transferred out of the facility: Do medication transfer packages include required medications along with the corresponding transfer packet required documents? (6.101) *	8	0	2	100%
Overall percentage (MIT 6): **60.7%**				

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

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

Table 13. Other Tests Related to Transfers

Compliance Questions	Scored Answer			
	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) *	19	5	1	79.2%
Upon the patient's discharge from the community hospital: Did the patient receive a follow-up appointment with a primary care provider within the required time frame? (1.007) *	22	3	0	88.0%
Are community hospital discharge documents scanned into the patient's electronic health record within three calendar days of hospital discharge? (4.003) *	19	1	5	95.0%
For patients discharged from a community hospital: Did the preliminary or final hospital discharge report include key elements and did a provider review the report within five calendar days of discharge? (4.005) *	25	0	0	100%
Upon the patient's discharge from a community hospital: Were all ordered medications administered, made available, or delivered to the patient within required time frames? (7.003) *	13	12	0	52.0%
Upon the patient's transfer from one housing unit to another: Were medications continued without interruption? (7.005) *	18	7	0	72.0%
For patients en route who lay over at the institution: If the temporarily housed patient had an existing medication order, were medications administered or delivered without interruption? (7.006) *	4	6	0	40.0%
For endorsed patients received from another CDCR institution: If the patient was approved for a specialty services appointment at the sending institution, was the appointment scheduled at the receiving institution within the required time frames? (14.010) *	3	1	0	75.0%

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

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

Medication Management

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

Overall Rating ***Inadequate***

Case Review Rating ***Adequate***

Compliance Score ***Inadequate*** **(68.2%)**

Results Overview

NKSP continued to perform poorly in medication management. Case review deficiencies decreased compared with case deficiencies in Cycle 5; however, compliance testing revealed room for improvement in the following medication processes: continuity of chronic care medications, hospital return medications, specialized medical housing medications, and transfer medications. Considering all these factors, the OIG rated this indicator ***inadequate***.

Case Review Results

Our clinicians reviewed 103 events related to medication management and found 15 deficiencies, three of which were significant.[32]

New Medication Prescriptions

Compliance testing showed most new medications were available and administered or delivered within required time frames (MIT 7.002, 80.0%). Our clinicians reported comparable findings.

Chronic Medication Continuity

Compliance testing found most patients did not receive their chronic care medications within the required time frames (MIT 7.001, 17.6%). Analysis of the compliance data showed patients received their hypertension, diabetes, and asthma medications late, from one to 37 days. In contrast, our clinicians found the majority of the patients in their case sample received their chronic care medications within the required time frame. However, there were two significant deficiencies in one case:

- In case 18, the patient did not receive his blood pressure medication and aspirin for one month. Then three months later, the patient received both his blood pressure medication and aspirin 12 days late. This placed the patient at risk for medical complications.

32. Deficiencies occurred twice in cases 8 and 9, five times in case 18, and once in cases 5, 19, 24, 32, and 54. Significant deficiencies occurred twice in case 18, and once in case 24.

Hospital Discharge Medications

Compliance testing found that about half of the patients returning from an off-site hospital or emergency room received their medications within the required time frame (MIT 7.003 52.0%). However, our case reviewers found that all patients in the review sample received their medications in a timely manner.

Specialized Medical Housing Medications

Our clinicians found the majority of CTC nurses administered patients' medications within required time frames. Compliance testing found medications were made available or administered within the required time frames in most cases (MIT 13.004, 70.0%). Further analysis showed each of the patients missed the medication by one day; however, the delays did not place the patients at risk of harm.

Transfer Medications

In compliance testing, NKSP did not perform well in continuity of medications for patients transferring into the institution (MIT 6.003, 42.9%). However, our clinicians found the majority of the patients sampled received their medications within the required time frame.

The OIG clinicians and compliance testing found that patients who transferred out of NKSP to another institution had all their transfer medications (MIT 6.101, 100%). However, patients transferring within the institution did not always receive their medication without interruption (MIT 7.005, 72.0%).

Medication Administration

Compliance testing showed nurses administered TB medications within required time frames when prescribed (MIT 9.001, 88.0%). Our clinicians found that nurses administered all medications properly. However, the institution did not thoroughly monitor patients taking TB medications, as required by policy (MIT 9.002, zero).

Clinician On-Site Inspection

Our clinicians interviewed medication nurses and found they were knowledgeable about the medication process. These medication nurses attended the clinic huddles via teleconference and notified the providers of expiring medications. We also met with the pharmacist and nurse managers to discuss some of our findings; they reported they were planning to use some of our findings as examples for quality improvement during their next meeting with the medication nurses.

Compliance Testing Results

Medication Practices and Storage Controls

The institution adequately stored and secured narcotic medications in six of nine clinic and medication line locations (MIT 7.101, 66.7%). In three locations, nurses could not describe the narcotic medication discrepancy reporting process.

NKSP appropriately stored and secured nonnarcotic medications in nine of 11 clinic and medication line locations (MIT 7.102, 81.8%). In one location, the medication storage was disorganized. In another location, the medication area lacked a clearly labeled designated area for medications that were to be returned to the pharmacy.

Staff kept medications protected from physical, chemical, and temperature contamination in nine of the 11 clinic and medication line locations (MIT 7.103, 81.8%). In one location, staff did not consistently record the refrigerator temperature. In another clinic, staff did not separate storage of oral and topical medications.

Staff successfully stored valid, unexpired medications in four of the 11 applicable medication line locations (MIT 7.104, 36.4%). In seven locations, one or both of the following deficiencies occurred: medication nurses failed to label the multiple-use medication as required by CCHCS policy, and an expired medication was found stored in the clinic.

Nurses exercised proper hand hygiene and contamination control protocols in five of seven locations (MIT 7.105, 71.4%). Some nurses neglected to wash or sanitize their hands before each subsequent regloving.

Staff in four of seven medication preparation and administration areas demonstrated appropriate administrative controls and protocols (MIT 7.106, 57.1%). In three locations, we observed the following deficiencies: when interviewed, the nurse did not describe the process he or she followed when reconciling newly received medication and the medication administration record (MAR) against the corresponding physician's order, and medication nurses did not maintain unissued medications in their original labeled packaging.

Staff in three of seven medication areas used appropriate administrative controls and protocols when distributing medications to their patients (MIT 7.107, 42.9%). In four locations, we observed one or more of the following deficiencies: the medication nurses did not reliably observe patients while those patients swallowed direct observation therapy medications; a nurse administered medication for one patient that did not match the patient's corresponding MAR; a medication nurse could not describe the medication error reporting process; and nurses did not follow insulin protocols properly.

Medication nurses did not consistently record the performed quality control check of the glucometer and did not record the repeat control value when the initial control check was out of range before checking patients' finger blood sugars on the diabetic line. During insulin administration, we observed that some medication nurses did not disinfect the vial's port prior to withdrawing medication. In addition, the diabetic line did not use a puncture-resistant container for collection and storage of used diabetic injections.

In addition to the above findings, our compliance inspectors observed the following issues with medication practices or storage during their on-site inspection:

- During a medication pass observation, the nurse and OIG inspector confirmed the patient's medication order, using the "Six Rights of Medication Administration" checklist prior to its administration. The medication nurse verbalized that she was administering 300 mg of Dilantin, along with other medications. When asked for reconfirmation, the medication nurse repeated that the patient would be receiving 300 mg of Dilantin. The OIG inspector then notified the medication nurse that the MAR was showing a contraindication of the Dilantin dosage order. The medication nurse continued to scan and prepare three Dilantin capsules, resulting in a generated warning by the electronic health record system (EHRS), stating a contraindicating dosage was detected. The nurse pressed "OK," and the warning window disappeared. As the medication nurse proceeded to administer 300 mg of Dilantin to the patient, the OIG inspector strongly advised researching the matter before administering the medication. Only at that time did the medication nurse pull the current order to find that a new order had been written on July 9, 2020, for a dosage change to 200 mg of Dilantin. The nurse then removed one capsule equivalent to 100 mg of Dilantin and proceeded to administer the rest of the medication. It was later found that the new bubble pack of medication for the patient, with new labeling and new dosage, was in the overflow area of a medication cart. The medication nurse was unaware of this medication change prior to the medication pass observation.

- Another observation from this incident was that potential medication errors can be bypassed through the EHRS. The medication nurse scanned three capsules and was prepared to give three capsules, demonstrating that the system only gives the contraindication detected message. Once the nurse selected "OK," the contraindication message disappeared, allowing the nurse to continue scanning and administering the wrong medication dosage.

In its pharmacy, NKSP followed general security, organization, and cleanliness-management protocols. The pharmacy also properly stored nonrefrigerated and refrigerated medications (MIT 7.108, MIT 7.109, and MIT 7.110, 100%).

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

We examined 18 medication error reports. The PIC timely or correctly processed only 10 of these 18 reports (MIT 7.112, 55.6%). In eight reports, we found one or more of the following deficiencies:

- The PIC did not complete the follow-up review within three business days from the error's reported date. It was completed between one and five days late.
- The PIC did not document pertinent data related to the medication error.
- The PIC did not document the notification or notify the patient or the prescribing physician of the medication error.

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

Due to COVID-19 pandemic precautions, we were unable to interview patients housed in administration segregation units and determine whether they had immediate access to their prescribed asthma rescue inhalers or nitroglycerin medications (MIT 7.999).

Recommendations

- Medical leadership should determine the cause of challenges related to medication continuity for patients who are chronic care, transfer-in, hospital discharge, and en-route patients; leadership should implement remedial measures as appropriate.

Table 14. Medication Management

Compliance Questions	Scored Answer Yes	No	N/A	Yes %
Did the patient receive all chronic care medications within the required time frames or did the institution follow departmental policy for refusals or no-shows? (7.001) *	3	14	8	17.6%
Did health care staff administer, make available, or deliver new order prescription medications to the patient within the required time frames? (7.002)	20	5	0	80.0%
Upon the patient's discharge from a community hospital: Were all ordered medications administered, made available, or delivered to the patient within required time frames? (7.003) *	13	12	0	52.0%
For patients received from a county jail: Were all medications ordered by the institution's reception center provider administered, made available, or delivered to the patient within the required time frames? (7.004) *	5	2	13	71.4%
Upon the patient's transfer from one housing unit to another: Were medications continued without interruption? (7.005) *	18	7	0	72.0%
For patients en route who lay over at the institution: If the temporarily housed patient had an existing medication order, were medications administered or delivered without interruption? (7.006) *	4	6	0	40.0%
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)	6	3	3	66.7%
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)	9	2	1	81.8%
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)	9	2	1	81.8%
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)	4	7	1	36.4%
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)	5	2	5	71.4%
Medication preparation and administration areas: Does the institution employ appropriate administrative controls and protocols when *preparing* medications for patients? (7.106)	4	3	5	57.1%
Medication preparation and administration areas: Does the institution employ appropriate administrative controls and protocols when *administering* medications to patients? (7.107)	3	4	5	42.9%
Pharmacy: Does the institution employ and follow general security, organization, and cleanliness management protocols in its main and remote pharmacies? (7.108)	1	0	0	100%
Pharmacy: Does the institution's pharmacy properly store nonrefrigerated medications? (7.109)	1	0	0	100%
Pharmacy: Does the institution's pharmacy properly store refrigerated or frozen medications? (7.110)	1	0	0	100%
Pharmacy: Does the institution's pharmacy properly account for narcotic medications? (7.111)	1	0	0	100%
Pharmacy: Does the institution follow key medication error reporting protocols? (7.112)	10	8	0	55.6%
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 isolation housing units have immediate access to their KOP prescribed rescue inhalers and nitroglycerin medications? (7.999)	This is a nonscored test. Please see the indicator for discussion of this test.			
				Overall percentage (MIT 7): **68.2%**

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

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

Table 15. Other Tests Related to Medication Management

Compliance Questions	Scored Answer			
	Yes	No	N/A	Yes %
For endorsed patients received from another CDCR institution or COCF: If the patient had an existing medication order upon arrival, were medications administered or delivered without interruption? (6.003) *	6	8	11	42.9%
For patients transferred out of the facility: Do medication transfer packages include required medications along with the corresponding transfer-packet required documents? (6.101) *	8	0	2	100%
Patients prescribed TB medication: Did the institution administer the medication to the patient as prescribed? (9.001) *	22	3	0	88.0%
Patients prescribed TB medication: Did the institution monitor the patient per policy for the most recent three months he or she was on the medication? (9.002) *	0	25	0	0
Upon the patient's admission to specialized medical housing: Were all medications ordered, made available, and administered to the patient within required time frames? (13.004) *	7	3	0	70.0%

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

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

Overall Rating
Inadequate

Case Review Rating
(N/A)

Compliance Score
Inadequate
(61.1%)

Preventive Services

In this indicator, OIG compliance inspectors tested whether the institution offered or provided cancer screenings, tuberculosis (TB) screenings, influenza vaccines, and other immunizations. If the department designated the institution as high risk for coccidioidomycosis (valley fever), we tested the institution's ability to transfer out patients quickly. The OIG rated this indicator solely based on the compliance score, using the same scoring thresholds as in the Cycle 4 and Cycle 5 medical inspections. Our case review clinicians do not rate this indicator.

Recommendations

- Medical leadership should remind nursing staff to perform weekly monitoring and address the symptoms of patients taking TB medications.
- Nursing leadership should monitor patients at the highest risk of coccidioidomycosis (valley fever) to ensure they are transferred in a timely manner.

Table 16. 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)	22	3	0	88.0%
Patients prescribed TB medication: Did the institution monitor the patient per policy for the most recent three months he or she was on the medication? (9.002) †	0	25	0	0
Annual TB screening: Was the patient screened for TB within the last year? (9.003)	0	25	0	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 50 through the age of 75: Was the patient offered colorectal cancer screening? (9.005)	21	4	0	84.0%
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)	14	2	9	87.5%
Are patients at the highest risk of coccidioidomycosis (valley fever) infection transferred out of the facility in a timely manner? (9.009)	18	7	0	72.0%
				Overall percentage (MIT 9): **61.1%**

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

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

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

Nursing Performance

Overall Rating ***Adequate***

Case Review Rating ***Adequate***

Compliance Score **(N/A)**

In this indicator, the OIG clinicians evaluated the quality of care delivered by the institution's nurses, including registered nurses (RNs), licensed vocational nurses (LVNs), psychiatric technicians (PTs), and certified nursing assistants (CNAs). Our clinicians evaluated nurses' ability to make timely and appropriate assessments and interventions. We also evaluated the institution's nurses' documentation for accuracy and thoroughness. Clinicians reviewed nursing performance in many clinical settings and processes, including sick call, outpatient care, care coordination and management, emergency services, specialized medical housing, hospitalizations, transfers, specialty services, and medication management. The OIG assessed nursing care through case review only and performed no compliance testing for this indicator.

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

Results Overview

Nurses at NKSP generally provided appropriate nursing care, especially for patients returning from the hospital and from specialty services. Compared with Cycle 5, NKSP had a decreased number of deficiencies in this indicator; however, we identified opportunities for improvement in several areas of the nursing process described in the subcategories below. Considering all these factors, the OIG rated this indicator ***adequate***.

Case Review Results

Our clinicians reviewed 193 nursing encounters in 54 cases. Of the nursing encounters we reviewed, 78 were in the outpatient setting. We identified 45 nursing performance deficiencies, three of which were significant.[33]

Nursing Assessment and Interventions

A critical component of nursing care is the quality of nursing assessment, which includes both subjective (patient interview) and objective (observation and examination) elements. Nurses at NKSP generally provided appropriate nursing assessments and interventions. However, the outpatient nursing assessments showed room for improvement.

33. Deficiencies occurred in cases 2, 7, 8, 10, 11, 12, 13, 16, 17, 18, 19, 20, 25, 27, 29, 30, 31, 37, 38, 40, 41, 45, 50, 52, 53, and 54. Significant deficiencies occurred twice in case 2, and once in case 8.

Nursing Documentation

Complete and accurate nursing documentation is an essential component of patient care. Without proper documentation, health care staff can overlook changes in a patient's condition. NKSP nurses generally documented their care appropriately. However, specialized medical housing and transfer-out nursing documentation showed room for improvement.

Nursing Sick Call

The staff reported that the clinic nurses saw on average eight patients per day, and they reported no nurse appointment backlog. Our clinicians reviewed 26 sick call requests. Most nurses performed triage appropriately on patient sick calls and performed timely evaluations for patients with symptoms. However, we found clinic nurses did not always perform thorough assessments. The following examples we found during our case review demonstrate room for improvement:

- In case 2, the patient complained of a sore throat, headache, and chest pain. The nurse did not assess the patient the same day but instead requested a follow-up appointment for the next day. Two days later, the patient was transported to the hospital for shortness of breath and chest pain.
- In case 19, the patient complained that his leg was swollen. The nurse did not assess skin temperature, document the steadiness of the patient's gait, or provide patient education.
- In case 38, the patient complained of knee pain and swelling. The nurse did not assess range of motion.

Emergency Services

We reviewed 16 urgent or emergent cases. The first medical responders responded promptly. Nurses in the TTA performed appropriate nursing assessments and interventions. However, we identified delays in calling emergency medical services (EMS), which is detailed further in the **Emergency Services** indicator.

Hospital Returns

We reviewed 12 cases that involved returns from off-site hospitals. The nurses provided good nursing assessments. Please refer to the **Transfers** indicator for further details.

Transfers

We reviewed nine cases that involved the transfer-in and transfer-out process. The nurses evaluated the patients within the required time frame but showed room for improvement in documentation. Please refer to the **Transfers** indicator for further details.

Specialized Medical Housing

We reviewed four CTC cases. The nurses provided satisfactory nursing assessments but showed room for improvement in documentation. Please refer to the **Specialized Medical Housing** indicator for further details.

Specialty Services

We reviewed 10 cases in which patients returned from off-site specialty appointments or telemedicine consultations. The nurses performed good assessments, reviewed the specialists' findings and recommendations, and communicated those results to the provider. The **Specialty Services** indicator provides further information.

Medication Management

We reviewed 32 cases and found that nurses administered patients' medications as prescribed. We did not find any nursing administration deficiencies.

Clinician On-Site Inspection

Our clinicians spoke with the nurses in the TTA, the CTC, R&R, specialty services, outpatient clinics, and medication areas. We attended organized clinic huddles. The clinic staff was knowledgeable and familiar with their patient population.

The chief nurse executive and the director of nursing were very knowledgeable about the nursing process and the medical operations of the institution. We met with the nurse managers to discuss some of our case review findings. The nurse managers acknowledged several opportunities for improvement and planned to implement training based on some of our findings.

Recommendations

- Nursing leadership should determine the root causes of challenges that prevent outpatient nurses from performing complete assessments; leadership should implement remedial measures as appropriate.

Overall Rating
Adequate

Case Review Rating
Adequate

Compliance Score
(N/A)

Provider Performance

In this indicator, OIG case review clinicians evaluated the quality of care the institution's providers (physicians, physician assistants, and nurse practitioners) delivered. Our clinicians assessed the institution's providers' ability to evaluate, diagnose, and manage 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. The OIG assessed provider care through case review only and performed no compliance testing for this indicator.

Results Overview

Providers at NKSP delivered good patient care. They generally made appropriate assessments and decisions, managed chronic medical conditions effectively, reviewed medical records thoroughly, and addressed the specialists' recommendations adequately. The OIG rated this indicator ***adequate***.

Case Review Results

Our clinicians reviewed provider performance in 20 comprehensive cases, and we found 18 minor deficiencies.[34]

Assessment and Decision-Making

NKSP providers generally made appropriate assessments and sound medical plans for their patients. They diagnosed medical conditions correctly, ordered appropriate tests, and referred their patients to proper specialists. Our clinicians identified one minor deficiency related to poor implementation of a medical plan:

- In case 20, the patient had an elevated blood pressure reading. The provider documented an order to check blood pressure three times per week but did not place the order.

Review of Records

For patients returned from hospitalizations, NKSP providers performed well in reviewing medical records and addressing the hospital recommendations. The providers also performed well in reviewing the MAR and reconciling the patient's medications.

34. Minor deficiencies occurred twice in cases 2, 7, 10, 18, 20, 21 and 32, and once in cases 3, 11, 12, and 33.

Emergency Care

NKSP providers made appropriate triage decisions when patients arrived in the TTA for emergency treatment. In addition, providers were available for consultation with TTA nursing staff. We did not identify any provider deficiencies in emergency care.

Chronic Care

NKSP providers performed well in managing chronic medical conditions such as hypertension, diabetes, asthma, hepatitis C infection, and cardiovascular disease. NKSP designated a provider to manage patients on anticoagulants. The provider appropriately monitored INR (a blood test for monitoring the effects of warfarin) levels and adjusted oral anticoagulants accordingly.

Specialty Services

NKSP providers appropriately referred and reviewed specialty reports in a timely manner, and providers adequately addressed the specialists' recommendations. We identified one minor deficiency, in which the provider did not address all of the specialist's recommendations:

- In case 18, the cardiologist made several recommendations including obtaining a sleep study. The provider addressed all the recommendations except obtaining a sleep study.

Documentation Quality

NKSP providers generally documented outpatient and TTA encounters on the day of the encounter. Our clinician identified 11 minor deficiencies related to providers not documenting the required dates of the laboratory tests in letters to patients. These deficiencies are discussed in the **Diagnostic Services** indicator.

Provider Continuity

NKSP assigned providers to specified clinics to ensure continuity of care. Our clinicians did not identify any issues related to provider continuity.

Clinician On-Site Inspection

OIG clinicians attended morning huddles at the two main clinics. The medical staff discussed events that occurred during the evening and overnight, such as specialty appointments, TTA events, and patients returning from hospital. The nurses also informed the provider of expiring medications.

NKSP had 10 full-time providers with no vacancy. Providers were enthusiastic about their work and generally satisfied with nursing, diagnostic, and specialty services. Providers screened patients for

possible opioid abuse and directed the patients to the substance use disorder treatment program.

The chief medical executive and the chief physician and surgeon (CP&S) were committed to patient care and quality improvement. The CP&S conducts population health management meetings twice a month, during which the providers identify patients with poorly controlled chronic medical conditions and strategize plans to improve clinical outcomes.

Recommendations

The OIG does not have any specific recommendations for this indicator.

Reception Center

Overall Rating
Inadequate

Case Review Rating
Adequate

Compliance Score
Inadequate **(34.0%)**

This indicator focuses on the management of medical needs and continuity of care for patients arriving from outside the department's system. The OIG review includes evaluation of the ability of the institution to provide and document initial health screenings, initial health assessments, continuity of medications, and completion of required screening tests; address and provide significant accommodations for disabilities and health care appliance needs; and identify health care conditions needing treatment and monitoring. The patients reviewed for reception center cases are those received from nondepartmental facilities, such as county jails.

Results Overview

The reception center at NKSP delivered insufficient care. Although our case reviewers found a small number of deficiencies in their sample cases, our compliance testing showed that the institution's performance was low in initial health screening, provider access, communication of test results, administration of TB testing, and the listing of missing medications upon the patient's arrival. Overall, the OIG rated this indicator ***inadequate***.

Case Review Results

Our clinicians reviewed 12 cases and identified six deficiencies, two of which were significant.[35]

Provider Access

Compliance testing found poor provider access. New patients from county jails were not seen by a provider within the required time frame (MIT 12.003, zero). However, there was only one applicable case in this sample: in that case, the provider visit occurred 14 days late. Compliance testing also showed that patients did not always receive a history and physical (H&P) examination by a provider within seven days, as required by policy (MIT 12.004, 45.0%). Analysis of the compliance data showed patients were seen by the provider for their H&P examination between two and 18 days late. There were six instances of the provider appointment for H&P examinations occurring more than 10 days late. In addition, intake screening tests were not always offered or completed within required time frames (MIT 12.005, 60.0%). Analysis of the compliance data showed these tests were between one and four days late.

Our case review clinicians found similar delays in provider access. In two instances, appointments with providers did not occur within appropriate time frames, and these significant deficiencies are discussed in the **Access to Care** indicator. However, in one case, the patient was seen

35. Deficiencies occurred twice in cases 30 and 31, and once in cases 20 and 30. Significant deficiencies occurred in cases 30 and 31.

14 days late due to appointment backlogs caused by COVID-19 isolation, and in another case, the patient was seen 15 days late due to a backlog stemming from an institutional mumps outbreak. In both cases, the provider reviewed the county medical records and ordered laboratory tests and an electrocardiogram (EKG) the same day.

Nursing Performance

We reviewed 12 cases that arrived from the reception center. The R&R nurses thoroughly completed the assessment screening the majority of the time (MIT 12.002, 92.3%). In contrast, the nurses did not complete the initial health screening forms thoroughly. The nurses did not address the signs and symptoms of fatigue when screening for TB and did not follow up on health care screening questions requiring an explanation.[36] In addition, upon the patient's arrival, the nurses did not list the medications that were missing (MIT 12.001, zero).

Our clinicians found that nurses appropriately assessed and referred patients to providers. However, there were minor deficiencies in three cases, in which the nurses did not provide patient education and inform patients of their rights.[37]

Clinician On-Site Inspection

Our clinicians interviewed the nurses, who were knowledgeable about their job duties and the transfer process. We met with the nurse managers to discuss some of our deficiency findings, and they indicated they would provide additional education and training to their staff.

Due to the COVID-19 pandemic, when patients transferred into the institution, they were quarantined for 14 days in their cells. The providers and nurses evaluated the patients in their cells for medical visits during that quarantine period.

Recommendations

Please see the **Transfers** and **Diagnostic Services** indicators for recommendations.

36. In April 2020, after our review but before this report was published, CCHCS reported adding the symptom of *fatigue* into the EHRS powerform for TB-symptom monitoring.

37. The deficiencies occurred in cases 29, 30, and 31.

Compliance Testing Results

Table 17. Reception Center

Compliance Questions	Scored Answer			
	Yes	No	N/A	Yes %
For patients received from a county jail: Prior to 4/2019: Did nursing staff complete the initial health screening and answer all screening questions on the same day the patient arrived at the institution? Effective 4/2019: Did nursing staff complete the initial health screening and answer all screening questions upon arrival of the patient at the reception center? (12.001) *	0	20	0	0
For patients received from a county jail: Prior to 4/2019: When required, did the RN complete the assessment and disposition section of the health screening form, and sign and date the form on the same day staff completed the health screening? Effective 4/2019: Did the RN complete the assessment and disposition section, and sign and date the completed health screening form upon patient's arrival at the reception center? (12.002) *	12	1	7	92.3%
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) *	0	1	19	0
For patients received from a county jail: Did the patient receive a history and physical by a primary care provider within seven calendar days? (12.004) *	9	11	0	45.0%
For patients received from a county jail: Were all required intake tests completed within specified timelines? (12.005) *	12	8	0	60.0%
For patients received from a county jail: Did the primary care provider review and communicate the intake test results to the patient within specified timelines? (12.006)	0	20	0	0
For patients received from a county jail: Was a tuberculin test both administered and read timely? (12.007)	2	18	0	10.0%
For patients received from a county jail: Was a Coccidioidomycosis (Valley Fever) skin test offered, administered, read, or refused timely? (12.008)	13	7	0	65.0%
				Overall percentage (MIT 12): **34.0%**

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

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

Table 18. Other Tests Related to Reception Center

Compliance Questions	Scored Answer			
	Yes	No	N/A	Yes %
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) *	5	2	13	71.4%

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

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

Specialized Medical Housing

Overall Rating ***Adequate***

Case Review Rating ***Adequate***

Compliance Score ***Proficient*** **(85.0%)**

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 considered 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, NKSP's only specialized medical housing unit was a correctional treatment center (CTC).

Results Overview

Compliance testing showed that NKSP scored well in this indicator. Our clinicians found that NKSP providers saw their patients in the CTC within recommended time frames and provided adequate care. The nurses performed timely admission assessments and generally provided acceptable care. Some of the nursing assessments were incomplete, however, and the nurses did not always document wound care thoroughly. Overall, the OIG rated this indicator ***adequate***.

Case Review Results

Our clinicians reviewed four CTC cases, which included 14 provider events and 15 nursing events. We identified seven deficiencies, none of which were significant.[38]

Provider Performance

NKSP providers delivered good care. The providers performed thorough evaluations, made sound medical plans, and reviewed test results and consultations within the required time frames. Compliance testing showed that the providers completed most admission history and physical (H&P) examinations without delay (MIT 13.002, 80.0%). OIG clinicians reviewed 14 provider events and did not identify any deficiencies related to provider performance.

Nursing Performance

CTC nurses performed timely admission assessments on the day of admission (MIT 13.001, 90.0%). Case review also showed that the nurses completed admission assessments on time. CTC nurses conducted regular rounds and generally provided satisfactory care. However, there were opportunities for improvement in nursing assessments and in the documentation of wound care:

38. Deficiencies occurred twice in cases 10, 52 and 54, and once in case 53.

- In case 52, the patient was admitted to the CTC for bilateral pneumothorax[39] and rib fractures. CTC nurses monitored the patient's use of the incentive spirometry only once instead of twice a day, as ordered by the provider.
- In case 53, the patient was receiving intravenous antibiotics for a wound infection. When the nurses performed wound care, they did not document a complete assessment of the wound care, including how the wound was cleansed and the appearance of the wound.

Medication Administration

OIG clinicians found that the majority of patients received their medications within the required time frame. Compliance testing showed 70.0 percent of newly admitted patients received their medications within required time frames (MIT 13.004).

Clinician On-Site Inspection

The institution's CTC had six medical beds, two of which were negative-pressure rooms. At the time of our inspection, four patients occupied the medical beds. Our compliance testing found that the call light system was functional and working. We attended a well-organized morning huddle. NKSP had a designated CTC provider who performed rounds with nursing staff. There were two RNs on the first watch and three RNs on both the second and the third watches.

Recommendations

- Nursing leadership should remind CTC nurses to ensure complete documentation of wound care assessments, including the clinical appearance of the wound, surrounding tissue, and measurements.

39. A pneumothorax is a lung puncture.

Compliance Testing Results

Table 19. Specialized Medical Housing

Compliance Questions	Scored Answer			
	Yes	No	N/A	Yes %
For OHU, CTC, and SNF: Prior to 4/2019: Did the registered nurse complete an initial assessment of the patient on the day of admission, or within eight hours of admission to CMF's Hospice? Effective 4/2019: Did the registered nurse complete an initial assessment of the patient at the time of admission? (13.001) *	9	1	0	90.0%
For CTC and SNF only (effective 4/2019, include OHU): Was a written history and physical examination completed within the required time frame? (13.002) *	8	2	0	80.0%
For OHU, CTC, SNF, and Hospice (applicable only for samples prior to 4/2019): Did the primary care provider complete the Subjective, Objective, Assessment, and Plan notes on the patient at the minimum intervals required for the type of facility where the patient was treated? (13.003) *,†	0	0	10	N/A
Upon the patient's admission to specialized medical housing: Were all medications ordered, made available, and administered to the patient within required time frames? (13.004) *	7	3	0	70.0%
For OHU and CTC only: Do inpatient areas either have properly working call systems in its OHU & CTC or are 30-minute patient welfare checks performed; and do medical staff have reasonably unimpeded access to enter patient's cells? (13.101) *	1	0	0	100%
For specialized health care housing (CTC, SNF, Hospice, OHU): Do health care staff perform patient safety checks according to institution's local operating procedure or within the required time frames? (13.102) *	0	0	1	N/A
				Overall percentage (MIT 13): **85.0%**

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

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

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

Overall Rating
Adequate

Case Review Rating
Adequate

Compliance Score
Adequate
(82.1%)

Specialty Services

In this indicator, OIG inspectors evaluated the quality of specialty services. The OIG clinicians focused on the institution's ability to provide 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.

Results Overview

NKSP provided satisfactory specialty services for its patients, scoring well in both case review and compliance testing. NKSP specialty staff performed well in coordinating specialty service appointments for their patients; most specialty appointments occurred within required time frames, and medical staff retrieved most specialty reports in a timely manner. The OIG rated this indicator ***adequate***.

Case Review Results

Our clinicians reviewed 103 events related to specialty services, including 75 specialty consultations and procedures, and found eight deficiencies, one of which was significant.[40]

Access to Specialty Services

Compliance testing showed that NKSP completed most high-priority specialty appointments (MIT 14.001, 85.7%), and completed medium-priority and routine-priority specialty appointments at a rate of 93.3 percent and 100 percent (MIT 14.004 and MIT 14.007). When patients transferred into NKSP with preapproved specialty services, 75.0 percent of their specialty appointments were completed within required time frames (MIT 14.010).

Our clinicians found excellent specialty access at NKSP. We reviewed 75 specialty appointments and found two minor delayed specialty appointments.[41] Our clinicians also assessed three transfer-in events and identified a minor deficiency: a delayed preapproved specialty appointment.[42]

Provider Performance

NKSP providers generally referred patients appropriately, reviewed specialty reports within recommended time frames, and addressed the specialists' recommendations. We identified one minor deficiency,

40. Deficiencies occurred in cases 2, 3, 10, 18, 20, 25, 29, and 30. A significant deficiency occurred in case 20.

41. Delays occurred in cases 2 and 29.

42. A delay occurred in case 25.

related to a provider who did not address all of the specialists' recommendations.[43]

Nursing Performance

Nurses at NKSP performed well. Specialty nurses reviewed requests for specialty services and appropriately arranged for specialty appointments. The nurses performed good nursing assessments when patients returned from their specialty appointments. They reviewed the specialists' findings and recommendations and communicated those results to the providers. The nurses also obtained orders and requested appropriate provider follow-up appointments. We reviewed 28 nursing encounters related to specialty services and identified only one deficiency.[44]

Health Information Management

NKSP performed adequately in retrieving and reviewing specialty reports. Compliance testing showed that medical staff retrieved and scanned most specialty reports within recommended time frames (MIT 4.002, 66.7%). Our clinicians identified three deficiencies related to the health information management, most of which were not clinically significant.[45] One was significant:

- In case 20, the interventional radiologist saw the patient, yet the consultation report was not scanned into the medical record until two weeks later.

Clinician On-Site Inspection

The institution employed multiple staff for on-site, off-site and telemedicine specialty services and had a tracking process to ensure all specialty appointments were completed within the requested time frames. Our clinicians attended a well-organized specialty services morning huddle. Some topics of discussion included the specialty messaging pool, whether there were any incorrect entry orders placed by the providers, and whether there were any specialty appointments out of compliance.

There were three office technicians assigned to the on-site, off-site and telemedicine specialty services, respectively. They tracked specialty reports and would contact the specialists if the reports were not available within 48 hours of the appointments.

Recommendations

The OIG has no specific recommendations for this indicator.

43. A minor deficiency occurred in case 18.
44. A deficiency occurred in case 10.
45. Deficiencies occurred in cases 3, 20, and 30.

Compliance Testing Results

Table 20. Specialty Services

Compliance Questions	Scored Answer Yes	No	N/A	Yes %
Did the patient receive the high-priority specialty service within 14 calendar days of the primary care provider order or the Physician Request for Service? (14.001) *	12	2	1	85.7%
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) *	12	3	0	80.0%
Did the patient receive the subsequent follow-up to the high-priority specialty service appointment as ordered by the primary care provider? (14.003) *	10	1	4	90.9%
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) *	14	1	0	93.3%
Did the institution receive and did the primary care provider review the medium-priority specialty service consultant report within the required time frame? (14.005) *	8	7	0	53.3%
Did the patient receive the subsequent follow-up to the medium-priority specialty service appointment as ordered by the primary care provider? (14.006) *	7	0	8	100%
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) *	15	0	0	100%
Did the institution receive and did the primary care provider review the routine-priority specialty service consultant report within the required time frame? (14.008) *	8	6	1	57.1%
Did the patient receive the subsequent follow-up to the routine-priority specialty service appointment as ordered by the primary care provider? (14.009) *	2	1	12	66.7%
For endorsed patients received from another CDCR institution: If the patient was approved for a specialty services appointment at the sending institution, was the appointment scheduled at the receiving institution within the required time frames? (14.010) *	3	1	0	75.0%
Did the institution deny the primary care provider's request for specialty services within required time frames? (14.011)	18	2	0	90.0%
Following the denial of a request for specialty services, was the patient informed of the denial within the required time frame? (14.012)	14	1	5	93.3%
			Overall percentage (MIT 14): **82.1%**	

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

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

Table 21. Other Tests Related to Specialty Services

Compliance Questions	Scored Answer			
	Yes	No	N/A	Yes %
Specialty service follow-up appointments: Did the clinician follow-up visits occur within required time frames? (1.008) *, †	31	7	7	81.6%
Are specialty documents scanned into the patient's electronic health record within five calendar days of the encounter date? (4.002) *	20	10	15	66.7%

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

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

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

Overall Rating
Adequate

Case Review Rating
(N/A)

Compliance Score
Adequate
(77.9%)

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 if the institution conducted the required emergency response drills. Inspectors also assessed whether the Quality Management Committee (QMC) met regularly and addressed program performance adequately. In addition, the inspectors examined if the institution provided training and job performance reviews for its employees. They checked whether staff possessed current, valid professional licenses, certifications, and credentials. The OIG rated this indicator solely based on the compliance score, using the same scoring thresholds as in the Cycle 4 and Cycle 5 medical inspections. Our case review clinicians do not rate this indicator.

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

Nonscored Results

We obtained CCHCS Death Review Committee (DRC) reporting data. Five unexpected (Level 1) deaths occurred during our review period. The DRC must complete its death review summary report within 60 calendar days of the death. Within seven days of completing the death review summary report, the DRC must submit the report to the institution's chief executive officer (CEO). In our inspection, we found the DRC did not complete any death review reports promptly: the DRC finished three reports late, two of them 16 and 131 days late, respectively; the DRC submitted those reports to the institution's CEO nine and 132 days after completion. The remaining report was overdue at the time of the OIG's inspection (MIT 15.998).

Recommendations

- Medical leadership should ensure the timely completion of clinical performance appraisals.

Table 22. Administrative Operations

Compliance Questions	Scored Answer			
	Yes	No	N/A	Yes %
For health care incidents requiring root cause analysis (RCA): Did the institution meet RCA reporting requirements? (15.001)	N/A	N/A	N/A	N/A
Did the institution's Quality Management Committee (QMC) meet monthly? (15.002)	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)	11	1	0	91.7%
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 inmates' grieved issues? (15.102)	10	0	0	100%
Did the medical staff review and submit initial inmate death reports to the CCHCS Death Review Unit on time? (15.103)	7	2	0	77.8%
Did nurse managers ensure the clinical competency of nurses who administer medications? (15.104)	10	0	0	100%
Did physician managers complete provider clinical performance appraisals timely? (15.105)	1	9	1	10.0%
Did the providers maintain valid state medical licenses? (15.106)	15	0	0	100%
Did the staff maintain valid Cardiopulmonary Resuscitation (CPR), Basic Life Support (BLS), and Advanced Cardiac Life Support (ACLS) certifications? (15.107)	1	1	1	50.0%
Did the nurses and the pharmacist-in-charge (PIC) maintain valid professional licenses and certifications, and did the pharmacy maintain a valid correctional pharmacy license? (15.108)	6	0	1	100%
Did the pharmacy and the providers maintain valid Drug Enforcement Agency (DEA) registration certificates? (15.109)	1	0	0	100%
Did nurse managers ensure their newly hired nurses received the required onboarding and clinical competency training? (15.110)	1	0	0	100%
Did the CCHCS Death Review Committee process death review reports timely? (15.998)	This is a nonscored test. Please refer to the discussion in this indicator.			
What was the institution's health care staffing at the time of the OIG medical inspection? (15.999)	This is a nonscored test. Please refer to Table 4 for CCHCS-provided staffing information.			
	Overall percentage (MIT 15): **77.9%**			

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

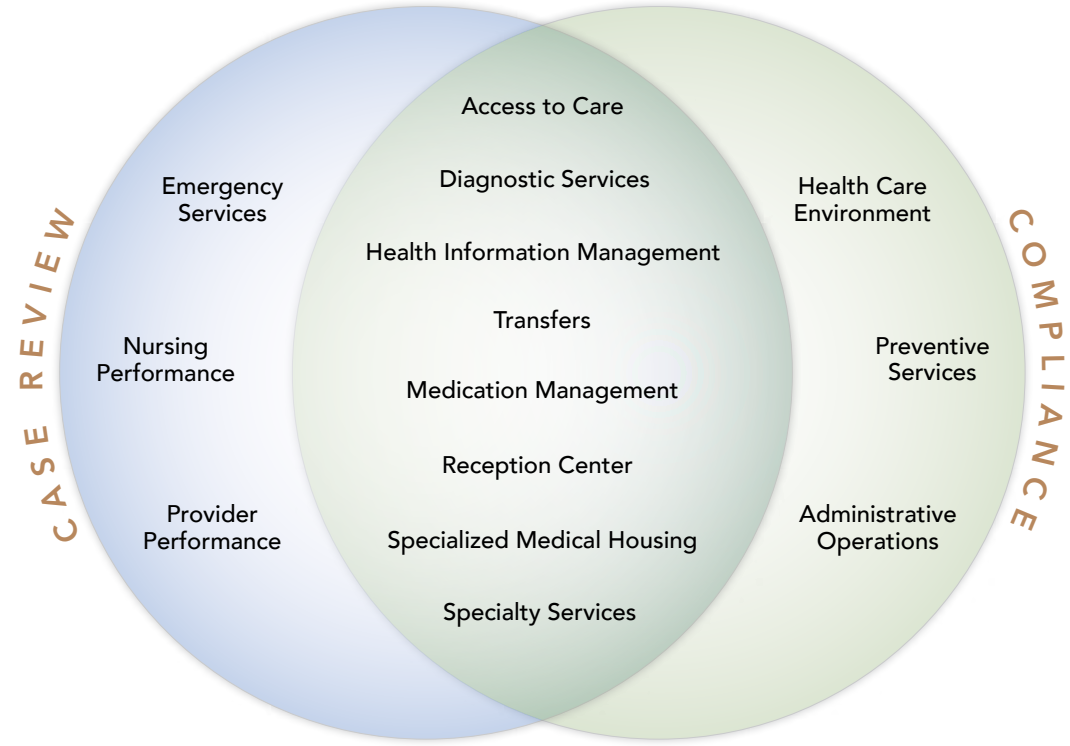
(This page left blank for reproduction purposes.)

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 NKSP



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

Case Reviews

The OIG added case reviews to the Cycle 4 medical inspections at the recommendation of its stakeholders, which continues in the Cycle 6 medical inspections. Below, Table A–1 provides important definitions that describe this process.

Table A–1. Case Review Definitions

Case, Sample, or Patient	The medical care provided to one patient over a specific period, which can comprise detailed or focused case reviews.
Comprehensive Case Review	A review that includes all aspects of one patient's medical care assessed over a six-month period. This review allows the OIG clinicians to examine many areas of health care delivery, such as access to care, diagnostic services, health information management, and specialty services.
Focused Case Review	A review that focuses on one specific aspect of medical care. This review tends to concentrate on a singular facet of patient care, such as the sick call process or the institution's emergency medical response.
Event	A direct or indirect interaction between the patient and the health care system. Examples of direct interactions include provider encounters and nurse encounters. An example of an indirect interaction includes a provider reviewing a diagnostic test and placing additional orders.
Case Review Deficiency	A medical error in procedure or in clinical judgment. Both procedural and clinical judgment errors can result in policy noncompliance, elevated risk of patient harm, or both.
Adverse Event	An event that caused harm to the patient.

The OIG eliminates case review selection bias by sampling using a rigid methodology. No case reviewer selects the samples he or she reviews. Because the case reviewers are excluded from sample selection, there is no possibility of selection bias. Instead, nonclinician 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 standardized protocol and select samples for clinicians to review. Samples are obtained per the case review methodology shared with stakeholders in prior cycles. Our physician and nurse reviewers test the samples by performing comprehensive or focused case reviews.

Case Review Testing Methodology

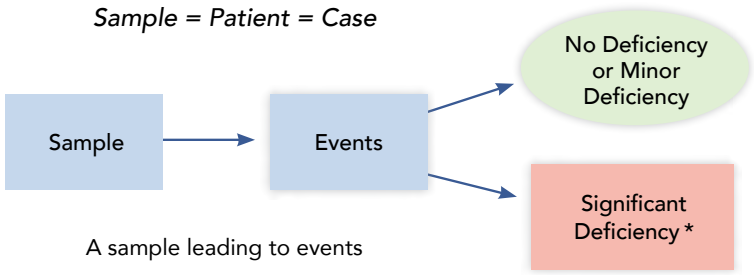
An OIG physician, a nurse consultant, or both review each case. As the clinicians review medical records, they record pertinent interactions between the patient and the health care system. We refer to these interactions as case review ***events***. Our clinicians also record medical errors, which we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

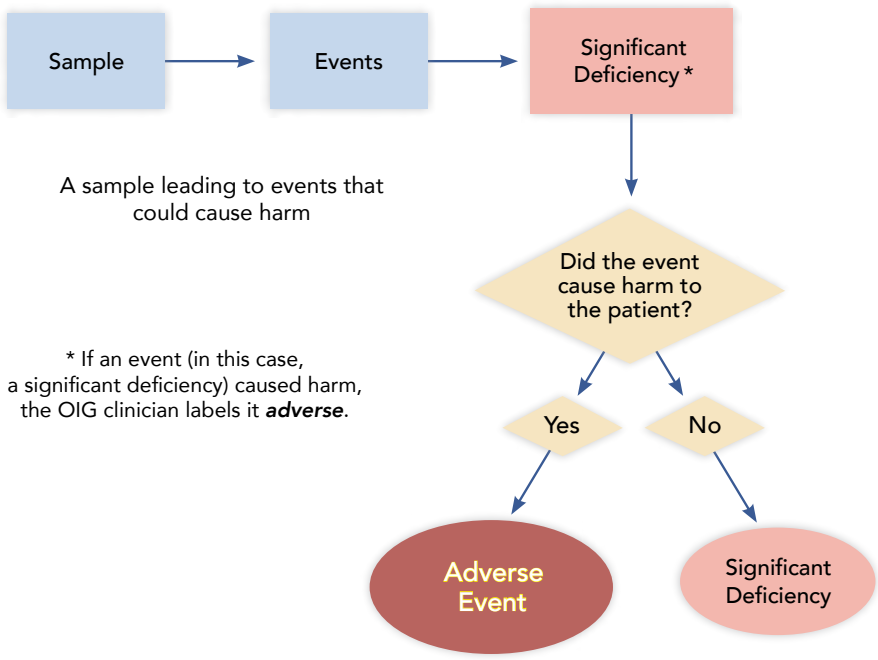
Figure A–2. Case Review Testing

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***.



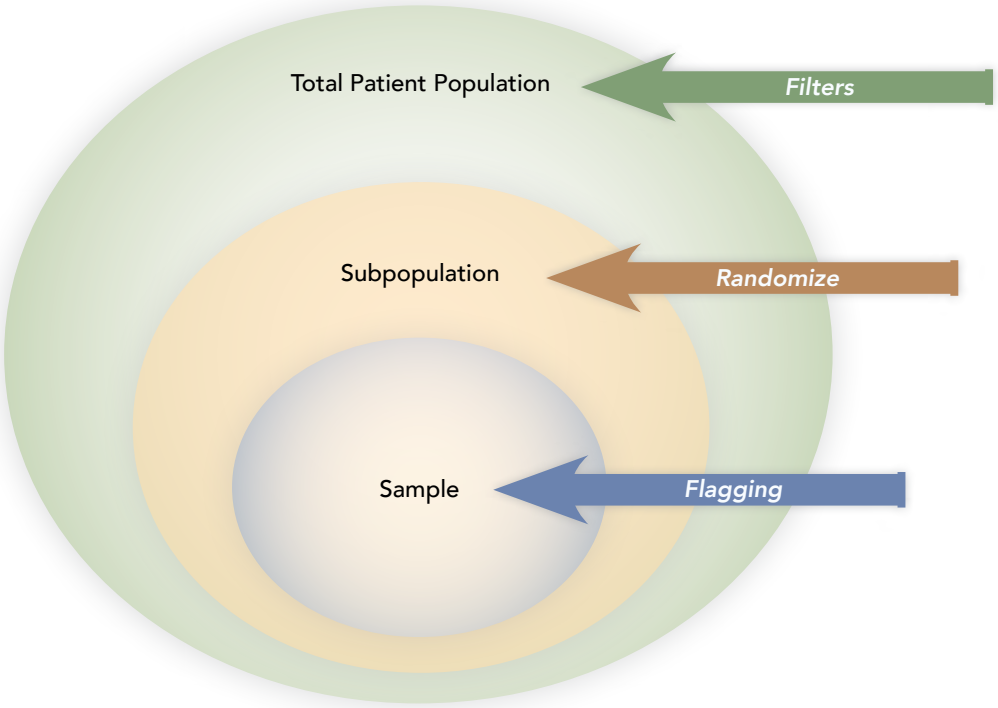
Source: The Office of the Inspector General medical inspection analysis.

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 also obtain information regarding plant infrastructure and local operating procedures.

Scoring Methodology

Our compliance team calculates the percentage of all ***Yes*** answers for each of the questions applicable to a particular indicator, then averages the scores. The OIG continues to rate these indicators based on the average compliance score using the following descriptors: ***proficient*** (85.0 percent or greater), ***adequate*** (between 84.9 percent and 75.0 percent), or ***inadequate*** (less than 75.0 percent).

Indicator Ratings and the Overall Medical Quality Rating

To reach an overall quality rating, our inspectors collaborate and examine all the inspection findings. We consider the case review and the compliance testing results for each indicator. After considering all the findings, our inspectors reach consensus on an overall rating for the institution.

Appendix B: Case Review Data

Table B–1. Case Review Sample Sets

Sample Set	Total
Anticoagulation	1
CTC/OHU	3
Death Review/Sentinel Events	2
Diabetes	3
Emergency Services – CPR	4
Emergency Services – Non-CPR	2
High Risk	4
Hospitalization	4
Intrasystem Transfers In	3
Intrasystem Transfers Out	3
RN Sick Call	18
Reception Center Transfers	3
Specialty Services	4
	54

Table B–2. Case Review Chronic Care Diagnoses

Diagnosis	Total
Anemia	4
Anticoagulation	2
Arthritis/Degenerative Joint Disease	4
Asthma	4
COPD	2
Cardiovascular Disease	3
Chronic Kidney Disease	1
Chronic Pain	10
Cirrhosis/End-Stage Liver Disease	4
Coccidioidomycosis	1
Deep Venous Thrombosis/Pulmonary Embolism	1
Diabetes	8
Gastroesophageal Reflux Disease	7
Hepatitis C	11
Hyperlipidemia	13
Hypertension	22
Mental Health	18
Migraine Headaches	0
Seizure Disorder	3
Sleep Apnea	**1**
Thyroid Disease	**0**
	123

Table B–3. Case Review Events by Program

Diagnosis	Total
Diagnostic Services	152
Emergency Care	35
Hospitalization	35
Intrasystem Transfers In	9
Intrasystem Transfers Out	9
Not Specified	0
Outpatient Care	337
Specialized Medical Housing	40
Specialty Services	146
	799

Table B–4. Case Review Sample Summary

MD Reviews Detailed	20
MD Reviews Focused	0
RN Reviews Detailed	13
RN Reviews Focused	28
Total Reviews	61
Total Unique Cases	54
Overlapping Reviews (MD & RN)	7

Appendix C: Compliance Sampling Methodology

North Kern State Prison

Quality Indicator	Sample Category	No. of Samples	Data Source	Filters
Access to Care				
MIT 1.001	Chronic Care Patients	25	Master Registry	• Chronic care conditions (at least one condition per patient—any risk level) • Randomize
MIT 1.002	Nursing Referrals	25	OIG Q: 6.001	• See Transfers
MITs 1.003–006	Nursing Sick Call (6 per clinic)	30	MedSATS	• Clinic (each clinic tested) • Appointment date (2–9 months) • Randomize
MIT 1.007	Returns From Community Hospital	25	OIG Q: 4.005	• See **Health Information Management** (Medical Records) (returns from community hospital)
MIT 1.008	Specialty Services Follow-Up	45	OIG Q: 14.001, 14.004 & 14.007	• See Specialty Services
MIT 1.101	Availability of Health Care Services Request Forms	6	OIG on-site review	• Randomly select one housing unit from each yard
Diagnostic Services				
MITs 2.001–003	Radiology	10	Radiology Logs	• Appointment date (90 days–9 months) • Randomize • Abnormal
MITs 2.004–006	Laboratory	10	Quest	• Appt. date (90 days–9 months) • Order name (CBC or CMPs only) • Randomize • Abnormal
MITs 2.007–009	Laboratory STAT	10	Quest	• Appt. date (90 days–9 months) • Order name (CBC or CMPs only) • Randomize • Abnormal
MITs 2.010–012	Pathology	10	InterQual	• Appt. date (90 days–9 months) • Service (pathology related) • Randomize

Quality Indicator	Sample Category	No. of Samples	Data Source	Filters
Health Information Management (Medical Records)				
MIT 4.001	Health Care Services Request Forms	30	OIG Qs: 1.004	• Nondictated documents • First 20 IPs for MIT 1.004
MIT 4.002	Specialty Documents	45	OIG Qs: 14.002, 14.005 & 14.008	• Specialty documents • First 10 IPs for each question
MIT 4.003	Hospital Discharge Documents	25	OIG Q: 4.005	• Community hospital discharge documents • First 20 IPs selected
MIT 4.004	Scanning Accuracy	24	Documents for any tested inmate	• Any misfiled or mislabeled document identified during OIG compliance review (24 or more = No)
MIT 4.005	Returns From Community Hospital	25	CADDIS off-site Admissions	• Date (2–8 months) • Most recent 6 months provided (within date range) • Rx count • Discharge date • Randomize
Health Care Environment				
MITs 5.101–105 MITs 5.107–111	Clinical Areas	11	OIG inspector on-site review	• Identify and inspect all on-site clinical areas.
Transfers				
MITs 6.001–003	Intrasystem Transfers	25	SOMS	• Arrival date (3–9 months) • Arrived from (another departmental facility) • Rx count • Randomize
MIT 6.101	Transfers Out	10	OIG inspector on-site review	• R&R IP transfers with medication

Quality Indicator	Sample Category	No. of Samples	Data Source	Filters
Pharmacy and Medication Management				
MIT 7.001	Chronic Care Medication	25	OIG Q: 1.001	See **Access to Care** • At least one condition per patient—any risk level • Randomize
MIT 7.002	New Medication Orders	25	Master Registry	• Rx count • Randomize • Ensure no duplication of IPs tested in MIT 7.001
MIT 7.003	Returns From Community Hospital	25	OIG Q: 4.005	• See **Health Information Management** (Medical Records) (returns from community hospital)
MIT 7.004	RC Arrivals—Medication Orders	N/A at this institution	OIG Q: 12.001	• See **Reception Center**
MIT 7.005	Intrafacility Moves	25	MAPIP transfer data	• Date of transfer (2–8 months) • To location/from location (yard to yard and to/from ASU) • Remove any to/from MHCB • NA/DOT meds (and risk level) • Randomize
MIT 7.006	En Route	10	SOMS	• Date of transfer (2–8 months) • Sending institution (another departmental facility) • Randomize • NA/DOT meds
MITs 7.101–103	Medication Storage Areas	Varies by test	OIG inspector on-site review	• Identify and inspect clinical & med line areas that store medications
MITs 7.104–107	Medication Preparation and Administration Areas	Varies by test	OIG inspector on-site review	• Identify and inspect on-site clinical areas that prepare and administer medications
MITs 7.108–111	Pharmacy	1	OIG inspector on-site review	• Identify & inspect all on-site pharmacies
MIT 7.112	Medication Error Reporting	18	Medication error reports	• All medication error reports with Level 4 or higher • Select total of 25 medication error reports (recent 12 months)
MIT 7.999	Isolation Unit KOP Medications	N/A at this institution	On-site active medication listing	• KOP rescue inhalers & nitroglycerin medications for IPs housed in isolation units

Quality Indicator	Sample Category	No. of Samples	Data Source	Filters
Prenatal and Postpartum Care				
MITs 8.001–007	Recent Deliveries	N/A at this institution	OB Roster	• Delivery date (2–12 months) • Most recent deliveries (within date range)
	Pregnant Arrivals	N/A at this institution	OB Roster	• Arrival date (2–12 months) • Earliest arrivals (within date range)
Preventive Services				
MITs 9.001–002	TB Medications	25	Maxor	• Dispense date (past 9 months) • Time period on TB meds (3 months or 12 weeks) • Randomize
MIT 9.003	TB Evaluation, Annual Screening	25	SOMS	• Arrival date (at least 1 year prior to inspection) • Birth month • Randomize
MIT 9.004	Influenza Vaccinations	25	SOMS	• Arrival date (at least 1 year prior to inspection) • Randomize • Filter out IPs tested in MIT 9.008
MIT 9.005	Colorectal Cancer Screening	25	SOMS	• Arrival date (at least 1 year prior to inspection) • Date of birth (51 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 (number will vary)	25	Cocci transfer status report	• Reports from past 2–8 months • Institution • Ineligibility date (60 days prior to inspection date) • All

Quality Indicator	Sample Category	No. of Samples	Data Source	Filters
Reception Center				
MITs 12.001–008	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 13.001–004	Specialized Health Care Housing Unit	10	CADDIS	• Admit date (2–8 months) • Type of stay (no MH beds) • Length of stay (minimum of 5 days) • Rx count • Randomize
MIT 13.101	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	MedSATS	• Approval date (3–9 months) • Remove consult to gynecology, consult to public health/Specialty RN, dialysis, ECG 12-Lead (EKG), mammogram, occupational therapy, ophthalmology, optometry, oral surgery, physical therapy, or podiatry • Randomize
MITs 14.004–006	Medium-Priority Initial and Follow-Up RFS	15	MedSATS	• Approval date (3–9 months) • Remove consult to gynecology, consult to public health/Specialty RN, dialysis, ECG 12-Lead (EKG), mammogram, occupational therapy, ophthalmology, optometry, oral surgery, physical therapy, or podiatry • Randomize
MITs 14.007–009	Routine-Priority Initial and Follow-Up RFS	15	MedSATS	• Approval date (3–9 months) • Remove consult to gynecology, consult to public health/Specialty RN, dialysis, ECG 12-Lead (EKG), mammogram, occupational therapy, ophthalmology, optometry, oral surgery, physical therapy, or podiatry • Randomize
MIT 14.010	Specialty Services Arrivals	4	MedSATS	• 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

Quality Indicator	Sample Category	No. of Samples	Data Source	Filters
Administrative Operations				
MIT 15.001	Adverse/sentinel events	N/A	Adverse/sentinel events (ASE) report	• Adverse/Sentinel events (2–8 months)
MIT 15.002	QMC Meetings	6	Quality Management Committee meeting minutes	• Meeting minutes (12 months)
MIT 15.003	EMRRC	12	EMRRC meeting minutes	• Monthly meeting minutes (6 months)
MIT 15.004	LGB	4	LGB meeting minutes	• Quarterly meeting minutes (12 months)
MIT 15.101	Medical Emergency Response Drills	3	On-site summary reports & documentation for ER drills	• Most recent full quarter • Each watch
MIT 15.102	Institutional Level Medical Grievances	10	On-site list of grievances/closed grievance files	• Medical grievances closed (6 months)
MIT 15.103	Death Reports	10	Institution-list of deaths in prior 12 months	• Most recent 10 deaths • Initial death reports
MIT 15.104	Nursing Staff Validations	10	On-site nursing education files	• On duty one or more years • Nurse administers medications • Randomize
MIT 15.105	Provider Annual Evaluation Packets	11	On-site provider evaluation files	• All required performance evaluation documents
MIT 15.106	Provider Licenses	15	Current provider listing (at start of inspection)	• Review all
MIT 15.107	Medical Emergency Response Certifications	All	On-site certification tracking logs	• All staff ◦ Providers (ACLS) ◦ Nursing (BLS/CPR) • Custody (CPR/BLS)
MIT 15.108	Nursing Staff and Pharmacist in Charge Professional Licenses and Certifications	All	On-site tracking system, logs, or employee files	• All required licenses and certifications

Quality Indicator	Sample Category	No. of Samples	Data Source	Filters
Administrative Operations				
MIT 15.109	Pharmacy and Providers' Drug Enforcement Agency (DEA) Registrations	All	On-site listing of provider DEA registration #s & pharmacy registration document	• All DEA registrations
MIT 15.110	Nursing Staff New Employee Orientations	All	Nursing staff training logs	• New employees (hired within last 12 months)
MIT 15.998	Death Review Committee	7	OIG summary log: deaths	• Between 35 business days & 12 months prior • Health Care Services death reviews

California Correctional Health Care Services' Response

April 13, 2021

Roy Wesley, Inspector General
Office of the Inspector General
10111 Old Placerville Road, Suite 110
Sacramento, CA 95827

Dear Mr. Wesley:

The Office of the Receiver has reviewed the draft report of the Office of the Inspector General (OIG) Medical Inspection Results for North Kern State Prison (NKSP) conducted from November 2019 to April 2020. California Correctional Health Care Services (CCHCS) acknowledges the OIG findings.

Thank you for preparing the report. Your efforts have advanced our mutual objective of ensuring transparency and accountability in CCHCS operations. If you have any questions or concerns, please contact me at (916) 691-3284.

Sincerely,

Amanda Oltean

Digitally signed by Amanda Oltean
Date: 2021.04.13 14:41:40 -07'00'

Amanda Oltean
Associate Director (A)
Risk Management Branch
California Correctional Health Care Services

cc: Clark Kelso, Receiver
Diana Toche, D.D.S., Undersecretary, Health Care Services, CDCR
Richard Kirkland, Chief Deputy Receiver
Katherine Tebrock, Chief Assistant Inspector General, OIG
Doreen Pagaran, R.N., Nurse Consultant Program Review, OIG
Directors, CCHCS
Roscoe Barrow, Chief Counsel, CCHCS Office of Legal Affairs
Jackie Clark, Deputy Director (A), Institution Operations, CCHCS
DeAnna Gouldy, Deputy Director (A), Policy and Risk Management Services, CCHCS
Renee Kanan, M.D., Deputy Director, Medical Services, CCHCS
Barbara Barney-Knox, R.N., Deputy Director (A), Nursing Services, CCHCS
Annette Lambert, Deputy Director, Quality Management, CCHCS
Regional Health Care Executive, Region III, CCHCS
Regional Deputy Medical Executive, Region III, CCHCS
Regional Nursing Executive, Region III, CCHCS
Chief Executive Officer, NKSP
Misty Polasik, Staff Services Manager I, OIG

CALIFORNIA CORRECTIONAL HEALTH CARE SERVICES

P.O. Box 588500
Elk Grove, CA 95758

(This page left blank for reproduction purposes.)

Cycle 6
Medical Inspection Report

for

North Kern State Prison

OFFICE *of the*
INSPECTOR GENERAL

Roy W. Wesley
Inspector General

Bryan B. Beyer
Chief Deputy Inspector General

STATE *of* CALIFORNIA
May 2021

OIG