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OIG | OFFICE *of the* INSPECTOR GENERAL

Independent Prison Oversight

June 2021

Cycle 6
Medical Inspection Report

Salinas Valley State Prison

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Introduction

Pursuant to California Penal Code section 6126 et seq., the Office of the Inspector General (the OIG) is responsible for periodically reviewing and reporting on the delivery of the ongoing medical care provided to incarcerated 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 Salinas Valley State Prison (SVSP), the receiver had not delegated this institution back to the department.

We completed our sixth inspection of SVSP, and this report presents our assessment of the health care provided at that institution during the inspection period between December 2019 and May 2020.[6] Our case reviews encompassed the treatment of patients during the COVID-19 pandemic. The inspection was otherwise completed with no further adjustments.

Located five miles north of Soledad, on a 300-acre site in Monterey County, Salinas Valley State Prison (SVSP) primarily houses Level 3 and Level 4 high-security patients. The institution ran clinics in which staff members handled nonurgent requests for medical care. Patients requiring urgent or emergent care were seen in the institution's triage and treatment area (TTA). SVSP also had a licensed correctional treatment center (CTC) for providing inpatient care. SVSP has been designated by California Correctional Health Care Services (CCHCS) as a ***basic care institution***. Basic facilities are typically located in rural areas, away from tertiary care centers and specialty care providers whose services would likely be used frequently by patients at higher medical risk.

6. Samples are obtained per case review methodology shared with stakeholders in prior cycles. The case reviews include emergency care non-CPR reviews that occurred between December 2019 and June 2020, death reviews that occurred between June 2019 and July 2020, diabetes reviews between November 2019 and June 2020, high-risk reviews between December 2019 and June 2020, hospitalizations between September 2019 and May 2020, specialty care reviews that occurred between November 2019 and May 2020, and registered nurse (RN) sick call reviews that occurred between November 2019 and June 2020.

Summary

We completed the Cycle 6 inspection of Salinas Valley State Prison (SVSP) in October 2020. OIG inspectors monitored the institution's delivery of medical care that occurred between December 2019 and May 2020.

The OIG rated the overall quality of health care at SVSP as ***inadequate***. We list the individual indicators and ratings applicable for this institution in Table 1 below.

Table 1. SVSP 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	N/A	N/A	N/A	N/A
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 359 patient records and 1,122 data points, and used the data to answer 90 policy questions. In addition, we observed SVSP's processes during an on-site inspection in September 2020. Table 2 below lists SVSP's average scores from Cycles 4, 5, and 6.

The OIG clinicians (a team of physicians and nurse consultants) reviewed 25 detailed cases, which contained 1,380 patient-related events. After examining the medical records, our clinicians conducted a follow-up on-site inspection in October 2020 to verify their initial findings. The OIG physicians rated the quality of care for 25 comprehensive

Table 2. SVSP 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	71.8%	66.1%	86.1%
2	Diagnostic Services	65.6%	67.8%	56.7%
4	Health Information Management	79.4%	71.0%	88.9%
5	Health Care Environment	50.6%	47.7%	61.9%
6	Transfers	77.3%	67.9%	66.1%
7	Medication Management	67.4%	69.2%	67.8%
8	Prenatal and Postpartum Care	N/A	N/A	N/A
9	Preventive Services	81.9%	95.8%	69.7%
12	Reception Center	N/A	N/A	N/A
13	Specialized Medical Housing	92.0%	72.5%	70.0%
14	Specialty Services	65.8%	74.5%	68.2%
15	Administrative Operations	57.6%*	82.1%	82.6%

* 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.

case reviews. Of these 25 cases, our physicians rated 23 ***adequate*** and two ***inadequate***. Although we did not find any adverse events, we did identify several patterns of widespread deficiencies, including 30 significant deficiencies, which contributed to the institution's overall ***inadequate*** rating.

The OIG then considered the results from both case review and compliance testing, and drew overall conclusions, which we report in the 13 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 SVSP Summary Table.

In June 2020, the Health Care Services Master Registry showed that SVSP had a total population of 2,909. A breakdown of the medical risk level of the SVSP population as determined by the department is set forth in Table 3 below.[8]

Table 3. SVSP Master Registry Data as of June 2020

Medical Risk Level	Number of Patients	Percentage
High 1	132	4.5%
High 2	268	9.2%
Medium	1,414	48.6%
Low	1,095	37.6%
Total	**2,909**	**100%**

Source: Data for the population medical risk level were obtained from the CCHCS Master Registry dated 6-29-20.

7. The indicators for **Reception Center** and **Prenatal Care** did not apply to SVSP.
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, SVSP had one executive leadership vacancy, 3.5 vacant primary care provider positions, 1.2 vacant nursing supervisor positions, and 3.8 vacant nursing staff positions.

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

Positions	Executive Leadership*	Primary Care Providers	Nursing Supervisors	Nursing Staff †	Total
Authorized Positions	5	10.5	14.2	114.8	144.5
Filled by Civil Service	4	7	13.2	114.8	138.8
Vacant	1	3.5	1.2	3.8	9.5
Percentage Filled by Civil Service	80.0%	67.0%	92.0%	97.0%	84.0%
Filled by Telemedicine	0	2.6	0	0	2.6
Percentage Filled by Telemedicine	0	25.0%	0	0	6.0%
Filled by Registry	0	1.6	0	26	27.6
Percentage Filled by Registry	0	15.0%	0	23.0%	9.0%
Total Filled Positions	4	11.2	13	140.8	165
Total Percentage Filled	80.0%	107%	92.0%	123%	100%
Appointments in Last 12 Months	1	3	3	30.6	37.6
Redirected Staff	0	0	0	0	0
Staff on Extended Leave‡	0	1	2	10	13
Adjusted Total: Filled Positions	**4**	**10.2**	**11**	**130.8**	**156**
Adjusted Total: Percentage Filled	**80.0%**	**97.0%**	**77.0%**	**114%**	**92.0%**

* 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 in 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 SVSP during the Cycle 6 inspection.

Case Review Results

OIG case reviewers (a team of physicians and nurse consultants) assessed 10 of the 15 indicators applicable to SVSP. Of these 10 indicators, OIG clinicians rated seven ***adequate*** and three ***inadequate***. The OIG physicians also rated the overall adequacy of care for each of the 25 detailed case reviews they conducted. Of these 25 cases, 22 were ***adequate,*** and three were ***inadequate***. In the 1,380 events reviewed, there were 325 deficiencies, 81 of which the OIG clinicians considered to be of such magnitude that, if left unaddressed, they would likely contribute to patient harm.

Our clinicians found the following strengths at SVSP:

- At the on-site inspection, the nurses reported high morale due to a new chief nursing executive (CNE).
- SVSP improved the completion of diagnostic tests.

Our clinicians found SVSP could improve in the following areas:

- SVSP performed poorly with specialty access and report retrieval.
- SVSP demonstrated a pattern of delayed emergency response and poor emergency nursing performance.
- The providers performed poorly in medical record review, assessments, decision-making, follow-through, and continuity of care.

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

Compliance Testing Results

Our compliance inspectors assessed 10 of the 13 indicators applicable to SVSP. Of these 10 indicators, our compliance inspectors rated two ***proficient***, one ***adequate***, and seven ***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.

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

- Nursing staff processed sick call request forms, performed face-to-face evaluations, and completed nurse-to-provider referrals within required time frames. In addition, SVSP housing units maintained an adequate supply of health care request forms.
- The institution's medical staff scanned health care services request forms and community hospital discharge reports into patients' electronic medical records within appropriate time frames.

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

- Patients did not always receive their chronic care medications within the required time frames. Medication continuity was poor for patients returning from hospitalizations, patients transferring into SVSP, and patients admitted to specialized medical housing.
- The medical warehouse and clinics had multiple medical supplies that were expired. In addition, medical clinics were missing properly calibrated medical equipment required to provide standard medical care.
- Clinicians did not follow hand hygiene precautions before or after patient encounters.
- Nursing staff did not regularly inspect emergency response bags.
- Providers performed poorly in communicating diagnostic test results to patients.

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 SVSP's performance with population-based metrics to assess the macroscopic view of the institution's health care delivery. SVSP'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)), SVSP performed better in three of the five diabetic measures and tied with California Kaiser Southern California on the fourth measure. SVSP scored lower than Kaiser Southern California and Kaiser Northern California in eye examinations.

Immunizations

Statewide comparative data were not available for immunization measures; however, we include this data for informational purposes. SVSP had a 31 percent influenza immunization rate for adults 18 to 64 years old, and a 77 percent influenza immunization rate for adults 65 years of age and older. The pneumococcal vaccine rate was 97 percent.[10]

Colorectal Cancer Screening

Statewide comparative data were not available for colorectal cancer screening; however, we include these data for informational purposes. SVSP had an 83 percent colorectal cancer screening rate.

10. 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 an institution other than the one in which the patient was currently housed during the inspection period.

Table 5. SVSP Results Compared With State HEDIS Scores

HEDIS Measure	SVSP 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%)‡	**76%**	55%	62%	70%
Blood Pressure Control (<140/90)‡	**85%**	67%	75%	**85%**
Eye Examinations	71.4%	63%	77%	**83%**
Influenza–Adults (18–64)	31%	–	–	–
Influenza–Adults (65+)	77%	–	–	–
Pneumococcal–Adults (65+)	97%	–	–	–
Colorectal Cancer Screening	83%	–	–	–

Notes and Sources

* Unless otherwise stated, data were collected in June 2020 by reviewing medical records from a sample of SVSP'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, 2017–June 30, 2018 (published June 2020).

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

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

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

Recommendations

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

Access to Care

- Nursing leadership should consider developing a checklist for the receiving and release (R&R) nurse to ensure that patients are timely scheduled with the primary care team for an assessment upon transfer into the institution.

Diagnostic Services

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

Emergency Services

- Nursing leadership should provide additional training to ensure nurses perform complete and appropriate assessments and interventions during emergencies.
- The Emergency Medical Response Review Committee (EMRRC) should more thoroughly review emergency response events and accurately detail findings.
- Nursing leadership should ensure nursing supervisors complete audits on all emergency events.

Health Information Management

- The triage and treatment area (TTA) nursing supervisors should audit stat laboratory draws to ensure providers are notified within required time frames.

Health Care Environment

- 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 emergency medical response bag (EMRB) logs to ensure the EMRBs are regularly inventoried and sealed.

Transfers

- Health care leadership should consider adjusting all EHRS screening forms to add the symptom of *fatigue* for TB-symptom monitoring.
- Health care leadership should determine the causes of challenges to the timely and uninterrupted delivery of medications for patients newly arriving to the institution and patients returning from hospitalizations or emergency rooms; then leadership should implement remedial measures as appropriate.

Medication Management

- Pharmacy leadership should consider reviewing the causes of the untimely delivery of prescribed medications.[11]
- Nursing leadership should ensure safe medication administration practices, including complete documentation, for all medications, and specifically for insulin and hypertensive medications.

Preventive Services

- Nursing leadership should remind nursing staff to fully document tuberculosis (TB) symptoms as part of the patient's TB-symptom monitoring.

Provider Performance

- CCHCS medical leadership should consider assigning dedicated and experienced providers to SVSP to help stabilize the provider workforce.

Specialized Medical Housing

- Medical leadership should ensure that admission history and physical examinations are completed within the time frame required by CCHCS policy.

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

- Nursing leadership should review the root causes of challenges to ensuring that patients admitted into Specialized Medical Housing receive their medications timely upon admission; nursing leadership should implement remedial measures as appropriate.

Specialty Services

- CCHCS headquarters should intervene on behalf of the institution to ensure that contracted specialists deliver reports within required time frames.
- Medical leadership should review the causes of the untimely provider review of specialty reports; medical leadership should implement remedial measures as appropriate.
- Medical leadership should ensure that patients receive specialty service appointments and specialty follow-up appointments within required time frames.
- Medical and nursing leadership should ensure that patients receive their previously scheduled specialty appointments within the required time frame when transferring between institutions.

Administrative Operations

- Medical leadership should ensure that the institution's Emergency Medical Response Review Committee (EMRRC) reviews cases within required time frames and includes all required documents.

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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 ***Adequate***

Case Review Rating ***Adequate***

Compliance Score ***Proficient*** **(86.1%)**

Results Overview

Our case review clinicians and our compliance testing staff produced different ratings in this indicator, respectively ***adequate*** and ***proficient***. Case reviewers observed that SVSP provided good access to providers and nurses, follow-up appointments after specialists, and follow-up appointments after hospital discharge, but had some difficulties with specialist access for patients after they transferred into the institution. Compliance scores were proficient at 86.1 percent. After reviewing the various aspects of our findings, we rated this indicator ***adequate***.

Case Review Results

We reviewed 374 provider, nursing, specialty, and hospital events that required the institution to generate appointments. We identified 24 deficiencies relating to this indicator, 12 of which were significant.[12]

Access to Clinic Providers

Failure to ensure provider appointment availability can cause lapses in care, but SVSP performed well in referrals to providers and requests for provider follow-up. We reviewed 264 outpatient provider encounters and identified three deficiencies, which occurred in cases 3, 9, and 28. Cases 3 and 9 contained minor deficiencies due to the sick-call nurse not appropriately ordering the provider follow-up appointment. The remaining deficiency was significant:

- In case 28, the provider requested a follow-up appointment with the patient. However, this appointment did not occur within the requested time frame. On site, the institution reported the appointment was scheduled, but that the patient was out to court. No one rescheduled another appointment for the patient.

Compliance testing also found that SVSP provided acceptable access to clinic providers. Chronic care follow-up appointments were timely 84.0 percent of the time (MIT 1.001). Nurse-to-provider sick call referrals occurred as requested at 77.8 percent of the time (MIT 1.005). Primary

12. Minor deficiencies occurred in cases 3, 9, 14, 21, 26. Significant deficiencies were identified in cases 1, 11, 16, 21, 24, 26, 28, 52, 56.

care provider (PCP) follow-up appointments also scored well (MIT 1.006, 100%).

Access to Specialized Medical Housing Providers

SVSP presented a mixed performance in this area. Case reviewers did not find any deficiencies related to access to specialized medical housing (SMH) providers. However, compliance testing found that the SMH providers did not perform admission history and physicals within the required time frame (MIT 13.002, 60.0%). We discuss this further in the **Specialized Medical Housing** indicator.

Access to Clinic Nurses

SVSP performed well the majority of the time in access for nursing sick calls and nurse-to-provider referrals. Compliance testing found that nursing sick call requests were reviewed on the day they were received (MIT 1.003, 100%), and nurses evaluated most of their symptomatic patients within the required time frame of one business day (MIT 1.004, 93.3%). OIG clinicians identified the following three cases in which there were delays in the face-to-face nursing assessments:

- In case 14, the patient submitted a sick call request for chronic pain. The triage nurse ordered a follow-up appointment the next day; however, the appointment did not occur within the requested time frame.
- In case 52, the patient submitted a sick call request for foot pain. The triage nurse ordered the patient to be seen within one business day, but the appointment never occurred. The patient submitted a second request three weeks later, and he was seen the next business day.
- In case 56, the patient submitted a sick call request for itchy, watery eyes. The triage nurse ordered the symptomatic patient to be seen within one business day, but the patient was not seen until six days later.

Our clinicians reviewed 221 nursing events that occurred in the outpatient clinics. Of the 221 events, 110 were symptomatic sick-call face-to-face assessments, eight events were nursing follow-up appointments, five were nurse wellness checks, and 31 events were additional nursing appointment types, including diabetic education, medication noncompliance, ear lavage, and nurses' wound assessments.[13]

The clinic care coordinator assessed patients in the clinic setting for 42 events, such as reviewing and performing blood pressure checks,

13. Sick call events occurred in cases 1, 3, 10, 11, 12, 14, 18, 19, 20, 21, 23, 24, 25, 26, 27, 29, 30, 37, 38, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, and 61. RN follow-up events occurred in cases 3, 9, 11, 23, 24, and 27. RN wellness checks occurred in cases 14, 19, 26, and 27. Additional RN appointments occurred in cases 11, 12, 13, 14, 15, 17, 21, 22, 24, 26, 30, and 37.

weight checks, and tuberculosis screening, providing durable medical equipment, completing electrocardiograms, addressing asymptomatic sick calls, and providing wound care and education on chronic illnesses (with the exception of diabetes).[14]

Additional events reviewed included interaction by the pill line licensed vocational nurses (LVN) and surveillance rounds that were shared by both registered nurses (RN) and LVNs.[15]

Access to Specialty Services

SVSP had problems with specialty access. It did not ensure that patients had appointments with their specialists as requested by the provider. One of the access deficiencies was due to incomplete paperwork. Other examples of poor specialty access include the following:

- In case 26, the provider ordered a routine follow-up appointment with the dermatologist because the patient developed a nonhealing wound after a biopsy. The patient was never evaluated by the dermatologist. The order was canceled more than three months later. However, at the time of the cancellation, the appointment was already out of compliance.
- In case 11, the provider requested an urgent ophthalmology appointment for glaucoma treatment. The ophthalmologist appointment did not occur. On-site, the institution's staff reported that the patient received optometrist care; however, this was not the requested appointment.
- In case 16, the provider requested a dietitian consultation within seven days. However, this appointment did not occur.
- In case 21, the provider requested a routine general surgery evaluation for transgender surgery. This appointment did not occur because the provider did not fill out the required packet for the referral.

Compliance testing resulted in borderline access for high-priority (MIT 14.001, 80.0%), medium-priority (MIT 14.004, 73.3%), and routine (MIT 14.007, 80.0%) appointments. Test results were poor for specialist follow-up appointments, with scores of 54.5% for high-priority (MIT 14.003), 62.5% for medium-priority (MIT 14.006), and 83.3% for routine appointments (MIT 14.009).

Follow-Up After Specialty Service

Access to providers after specialty services was good. Case reviewers only identified one minor deficiency: a nurse ordered a 14-day PCP follow-up appointment instead of a five-day follow-up. Fortunately, the scheduler

14. Care manager appointments occurred in cases 9, 12, 14, 15, 17, 22, 23, 24, 26, 27, and 30.

15. Surveillance rounds by nurses occurred in cases 19, 25, 27, 28, and 30. Interaction by pill line nurses occurred in cases 11, 14, and 16.

scheduled the appointment within five days. Compliance testing showed good access to PCPs after specialty services (MIT 1.008, 81.4%).

Follow-Up After Hospitalization

SVSP ensured that providers saw their patients after hospitalizations. Case reviewers did not find any provider follow-up deficiencies after hospitalization. However, compliance testing found borderline performance with PCP follow-up appointments after hospitalizations (MIT 1.007, 70.8%).

Follow-Up After Urgent or Emergent Care (TTA)

Case reviewers did not find any deficiencies in access to providers after urgent or emergent care. We reviewed cases to ensure that appointments with providers were scheduled within five days after a TTA visit. While patients frequently refused these follow-up appointments, these refusals were not access deficiencies.

Follow-Up After Transferring Into the Institution

In a significant number of cases, our case review clinicians identified that patients who transferred into SVSP were not scheduled to see the provider or the care manager within the required time frame. This corresponded with compliance testing (MIT 1.002, 68.0%). We discuss this in more detail in the **Transfers** indicator. Below is an example:

- In case 33, the receiving and release (R&R) nurse failed to order an initial PCP appointment within seven days for this high-risk patient with multiple co-morbidities. The patient was seen by the provider for a chronic care appointment more than five months later.

Clinician On-Site Inspection

During our on-site visit, our clinicians toured the clinics, attended huddles, and spoke with staff from different divisions. We were advised that the sick call boxes were located in each housing unit and that certified nursing assistants (CNAs) and medical assistants gathered the sick call slips each morning during the week for clinic RNs' review. On weekends and holidays, a float RN (a nurse not assigned to one location) gathered and reviewed the sick call requests. Staff assessed from 10 to 20 patients daily. When patients did not show up for appointments, the float RN looked for the patient at his housing unit and completed a refusal form. Patients in lockdown due to quarantine, if they were asymptomatic for COVID-19 symptoms, were masked and brought to the clinic at the end of the shift. For patients in isolation, nurses discussed the sick call requests with the chief physician and surgeon (CP&S) or chief medical executive (CME) for medical direction; RNs were directed to go to the side of the cells to assess patients, if needed. Patients who

needed specialty services or hospitalization were sent out. The nurses reported no backlog on any of the yards we toured.

Specialty access was a concern in this cycle as well in the last cycle. The supervisors reported that there was limited availability of face-to-face appointments with off-site specialists, who were located several hours to the north, east, or south of the institution. Local specialists refused to see the institution's patients due to the high rate of patient refusal, resulting in a low rate of specialist availability.

Recommendations

- Nursing leadership should consider developing a checklist for the receiving and release (R&R) nurse to ensure that patients are timely scheduled with the primary care team for an assessment upon transfer into the institution.

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) *	21	4	0	84.0%
For endorsed patients received from another CDCR institution: Based on the patient's clinical risk level during the initial health screening, was the patient seen by the clinician within the required time frame? (1.002) *	17	8	0	68.0%
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) *	28	2	0	93.3%
Clinical appointments: If the registered nurse determined a referral to a primary care provider was necessary, was the patient seen within the maximum allowable time or the ordered time frame, whichever is the shorter? (1.005) *	7	2	21	77.8%
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) *	17	7	1	70.8%
Specialty service follow-up appointments: Did the clinician follow-up visits occur within required time frames? (1.008) *,†	35	8	2	81.4%
Clinical appointments: Do patients have a standardized process to obtain and submit health care services request forms? (1.101)	6	0	0	100%
				Overall percentage (MIT 1): **86.1%**

* 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) *	N/A	N/A	N/A	N/A
For patients received from a county jail: Did the patient receive a history and physical by a primary care provider within seven calendar days? (12.004) *	N/A	N/A	N/A	N/A
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) *	6	4	0	60.0%
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	10	N/A
Did the patient receive the high-priority specialty service within 14 calendar days of the primary care provider order or the Physician Request for Service? (14.001) *	12	3	0	80.0%
Did the patient receive the subsequent follow-up to the high-priority specialty service appointment as ordered by the primary care provider? (14.003) *	6	5	11	54.5%
Did the patient receive the medium-priority specialty service within 15-45 calendar days of the primary care provider order or the Physician Request for Service? (14.004) *	11	4	0	73.3%
Did the patient receive the subsequent follow-up to the medium-priority specialty service appointment as ordered by the primary care provider? (14.006) *	5	3	7	62.5%
Did the patient receive the routine-priority specialty service within 90 calendar days of the primary care provider order or Physician Request for Service? (14.007) *	12	3	0	80.0%
Did the patient receive the subsequent follow-up to the routine-priority specialty service appointment as ordered by the primary care provider? (14.009) *	5	1	9	83.3%

* 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
(56.7%)

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 correctly reviewed the results. In addition, in Cycle 6, we examined the institution's ability to timely complete and review stat (immediate) laboratory tests.

Results Overview

In this indicator, the compliance testing showed SVSP performed inadequately, while the case review analysis showed an adequate performance. Compliance scores were low for stat laboratory test completion and reporting, as well as for provider communication of test results. Case reviewers found good test completion, but they also found some problems with timely endorsement and patient notification letters. Because compliance testing assesses a wider breadth of the diagnostics processes, we rated this indicator ***inadequate***.

Case Review Results

Our clinicians reviewed 202 diagnostic events and found 33 deficiencies, of which 10 were significant. Of those 33 deficiencies, we found seven related to health information management and four pertained to the completion of diagnostic tests.[16]

Test Completion

Compliance testing and case reviewers both found good performance in completing radiology services (MIT 2.001, 100%) and laboratory tests (MIT 2.004, 80.0%). However, we found the compliance rate for stat laboratory test completion was very poor (MIT 2.007, zero), yet our case reviewers did not find any deficiencies in stat laboratory services. Case reviewers found three minor delays in routine test completion.

Health Information Management

SVSP staff retrieved laboratory and diagnostic results promptly and sent them to providers for review. Compliance testing showed that providers endorsed both radiology (MIT 2.002, 100%) and laboratory (MIT 2.005, 100%) results timely. Pathology retrieval (MIT 2.010, 90.0%) and reviews (MIT 2.011, 90.0%) were very good.

Case reviewers found a minor pattern wherein providers did not endorse results: this occurred twice in case 11 and twice in case 16. In case 23, the laboratory test results were scanned into the electronic health record system (EHRS) 25 days after they were performed. We also found

16. Deficiencies occurred in cases 1, 3, 9, 11, 12, 13, 16, 20, 22, 23, 26, 27, 28, 29, and 37. Significant deficiencies occurred in cases 11, 13, 16, and 23.

that providers did not consistently send a patient results letter or did not include all elements in the results letter as required by CCHCS policy. We discuss this further in the **Provider Performance** indicator. Compliance testing results showed that scores for patient notification letters were poor (MIT 2.012, zero) as were scores for nurse-to-provider notifications of stat laboratory test results (MIT 2.008, zero).

Clinician On-Site Inspection

Radiology and laboratory staff reported no test backlogs. When studies are performed on-site, the radiology technician sends the images to the radiologist for the official reading. After the official reading is available, the images and report are uploaded to the radiology information system and patient archiving and communication system (RIS/PACS) and a copy of the report is uploaded into the electronic health record system (EHRS). This allowed providers to have two methods of accessing radiology reports: through either the EHRS or the RIS/PACS.

Recommendations

- Medical leadership should ensure that providers communicate diagnostic test results to their patients as required by CCHCS policy.
- The department should consider developing and implementing a template for patient results letters that autopopulates with all the elements required by CCHCS policy.
- Laboratory and nursing leadership should ascertain the root causes of the lack of timeliness in collecting samples for stat laboratory tests; 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) *	10	0	0	100%
Radiology: Did the ordering health care provider review and endorse the radiology report within specified time frames? (2.002) *	10	0	0	100%
Radiology: Did the ordering health care provider communicate the results of the radiology study to the patient within specified time frames? (2.003)	1	9	0	10.0%
Laboratory: Was the laboratory service provided within the time frame specified in the health care provider's order? (2.004) *	8	2	0	80.0%
Laboratory: Did the health care provider review and endorse the laboratory report within specified time frames? (2.005) *	10	0	0	100%
Laboratory: Did the health care provider communicate the results of the laboratory test to the patient within specified time frames? (2.006)	1	9	0	10.0%
Laboratory: Did the institution collect the STAT laboratory test and receive the results within the required time frames? (2.007) *	0	3	0	0
Laboratory: Did the nursing staff notify the health care provider within one (1) hour from receiving the STAT laboratory results? (2.008) *	0	3	0	0
Laboratory: Did the health care provider endorse the STAT laboratory results within the required time frames? (2.009)	3	0	0	100%
Pathology: Did the institution receive the final pathology report within the required time frames? (2.010) *	9	1	0	90.0%
Pathology: Did the health care provider review and endorse the pathology report within specified time frames? (2.011) *	9	1	0	90.0%
Pathology: Did the health care provider communicate the results of the pathology study to the patient within specified time frames? (2.012)	0	10	0	0
				Overall percentage (MIT 2): **56.7%**

* 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.

Emergency Services

Overall Rating ***Inadequate***

Case Review Rating ***Inadequate***

Compliance Score **(N/A)**

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

SVSP delivered poor emergency care, which was similar to the findings in Cycle 5. Our clinicians found serious deficiencies related to cardiopulmonary resuscitation (CPR). For patients who required CPR, there were delays in initiating CPR, delays in notifying emergency medical services (EMS), and inappropriate administration of oxygen. Furthermore, EMRRC did not always identify these training needs during their reviews. We placed greater value on the care provided during CPR because these emergency events require immediate and appropriate life-saving interventions. We found minor deficiencies in nursing documentation and noted providers had minor deficiencies. However, the poor CPR performance and lack of identification of problems during EMRRC are issues that need to be improved. Therefore, we rated this indicator ***inadequate***.

Case Review Results

Our clinicians reviewed 48 urgent and emergent events and found 50 deficiencies, of which 17 were significant.[17]

Emergency Medical Response

SVSP performed poorly in emergency medical response. Our clinicians reviewed 19 cases, of which nine cases had significant deficiencies. Various aspects of emergency care showed room for improvement. First medical responder assessments and interventions were problematic. Less serious deficiencies occurred in documentation. The findings were similar to SVSP's performance in this indicator in Cycle 5.

17. Deficiencies occurred in cases 1, 3, 4, 5, 6, 7, 8, 9, 11, 14, 19, 20, 23, 25, 26, 62, and 63. Significant deficiencies occurred in cases 1, 3, 4, 5, 6, 8, 11, 25, and 26.

Cardiopulmonary Resuscitation Quality

OIG clinicians reviewed seven CPR cases, of which four had significant deficiencies.[18] We identified delays in initiating CPR and inappropriate oxygen administration during emergencies. The following cases illustrate examples of first medical responder performance deficiencies:

- In case 1, the first medical responder noted upon arrival that CPR was in progress and the patient was breathing, but not sufficiently enough to adequately oxygenate. The first medical responder did not assess the respirations and inappropriately administered oxygen via a nasal canula.[19] This was inadequate because the patient required more complete assistance via an AmbuBag.[20]
- In case 5, the first medical responder did not assess for a pulse and inappropriately administered oxygen via a nonrebreather mask instead of providing an AmbuBag. The TTA nurse did not initiate CPR immediately after assessing a patient who had no pulse.
- In case 6, the nurse did not initiate high-flow oxygenation via an AmbuBag on a patient who was receiving CPR. Instead, the nurse administered low-flow oxygen via a nonrebreather mask.
- In case 8, there was a delay in initiating CPR and notifying EMS for a patient who was found unresponsive in his cell. In addition, the nurse did not respond to the emergency within the time frame required by policy.

Provider Performance

SVSP providers performed well in urgent and emergent situations, and in after-hours care. Providers made appropriate diagnoses and triage decisions. We reviewed 25 provider emergency events and identified two minor deficiencies. In cases 3 and 19, the TTA provider did not perform a focused and pertinent examination based on the patient's complaint.

Nursing Performance

SVSP nursing performance was poor for emergency care. Our clinicians reviewed 48 urgent and emergent events and found 28 deficiencies, of which seven were significant.[21] We identified delays, lack of interventions, and lack of patient monitoring. The following are examples:

18. CPR cases include cases 1, 4, 5, 6, 7, 8, and 9.

19. A nasal canula is a lightweight tube in which one end splits into two prongs, which are placed in the patient's nostrils to deliver oxygen.

20. An AmbuBag is a hand-held tool used to deliver positive-pressure ventilation for patients with insufficient or ineffective breaths.

21. Significant nursing performance deficiencies occurred in cases 1, 5, 6, 11, and 25.

- In case 11, the patient was evaluated in the TTA multiple times. In one TTA evaluation, the clinical health care staff arrived on scene 18 minutes after the medical alarm was activated for a patient with chest pain. This was beyond the time frame required by policy. Later, in another TTA event in which the patient had an altered level of consciousness, there was a delay in calling EMS and transporting the patient to the TTA. The patient was breathing rapidly, had a low blood pressure, a fast heart rate, and low oxygenation. The nurse did not monitor and perform frequent vital signs on this unstable patient.
- In case 25, the patient had chest pain, but the first responder did not assess the patient's vital signs until 23 minutes after the alarm was activated. Furthermore, after obtaining vital signs and an EKG, the TTA nurse did not immediately initiate the chest pain protocol, which would have provided the patient aspirin and nitroglycerin.

Nursing Documentation

SVSP nursing documentation was mostly adequate. However, we did identify minor documentation deficiencies. Examples include lack of documentation of pain levels, inadequate documentation in hand-off reports and provider orders, and poor documentation of the administration of emergency medications.[22]

Emergency Medical Response Review Committee

The EMRRC reviewed 15 emergency response cases within the required time frames, with the exception of case 4.[23] The EMRRC is required to audit all emergency events to evaluate staff performance, documentation, and policy adherence, and to identify training issues. Supervisors did not always audit emergency events.[24]

The EMRRC did not always identify deficiencies in emergency care. Our clinicians found deficiencies in cases 1, 5, 6, 8, 9, 11, and 25. Significant deficiencies that the EMRRC did not identify include the following: first medical responder not assessing for a pulse, inappropriate method of oxygen administration, delay in CPR initiation and EMS notification, delay in transporting patient to the TTA, and a lack of frequent documentation of vital signs for an unstable patient.

Deficiencies of less severity that were not identified include the following: a lack of documentation for both medication administered on the medication administration record (MAR) and real-time documentation of assessments, vital signs, and pain levels.

22. Documentation deficiencies occurred in cases 1, 3, 4, 5, 7, 11, 19, 23, 26, 62, and 63.

23. Emergency response events occurred in cases 1, 3, 4, 5, 6, 7, 8, 9, 11, 13, 19, 23, 25, 27, and 37.

24. Emergency events were not audited and reviewed in cases 11, 19, 23, and 25.

Case review and compliance finding were similar (MIT 15.003, 33.3%). Compliance results showed that in eight of 12 cases, the EMRRC did not review the cases within the required time frame or the EMRRC event checklist was incomplete.

Clinician On-Site Inspection

The TTA has three beds and is staffed with two registered nurses on each shift. A health care provider is assigned to the TTA from Monday through Friday during regular weekday hours, and an on-call provider is available after regular weekday hours and on weekends and holidays. The TTA is well-equipped with required emergency equipment and one emergency response vehicle. Custody staff, LVNs, and psychiatric technicians (PT) respond to medical emergencies throughout the facility. The institution's fire crew also responds to emergencies when the TTA staff is busy. Nursing staff reported they have a good rapport with custody staff.

Recommendations

- Nursing leadership should provide additional training to ensure nurses perform complete and appropriate assessments and interventions during emergencies.
- The EMRRC should more thoroughly review emergency response events and accurately detail findings.
- Nursing leadership should ensure nursing supervisors complete audits on all emergency events.

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. We also tested whether clinicians adequately reviewed and endorsed those reports. In addition, our inspectors checked whether staff correctly labeled and organized documents in the medical record.

Overall Rating
Adequate

Case Review Rating
Adequate

Compliance Score
Proficient **(88.9%)**

Results Overview

Compared to its performance in Cycle 5, SVSP improved in the timely retrieval and scanning of hospital discharge records, diagnostic results, and urgent and emergent reports, but the institution had difficulty retrieving specialty reports within required time frames. In this indicator, our compliance testing showed a proficient rating, while our case review analysis found an adequate rating. After reviewing all aspects, we rated this indicator ***adequate***.

Case Review Results

We reviewed 1,375 events and found 40 deficiencies related to health information management. Of these 40 deficiencies, ten were significant.[25]

Hospital Discharge Reports

We reviewed 23 off-site emergency department and hospital visits and found that SVSP staff timely retrieved, scanned, and reviewed hospital records properly. Case reviewers only identified one deficiency: a duplicate scan of an emergency department report scanned on the wrong date. Compliance testing also showed almost perfect performance in the retrieval and scanning of hospital discharge records (MIT 4.003, 95.0%). SVSP also ensured that hospital discharge reports included discharge summaries and that providers reviewed those hospital discharge reports within policy time frames (MIT 4.005, 92.0%).

Specialty Reports

SVSP did not perform well in information management of specialty reports. In nine cases, the institution had difficulty retrieving specialty reports within required time frames.[26] Three examples follow:

- In case 11, the institution did not retrieve the optometrist report until 12 days after the consultation. This was a

25. Deficiencies occurred in 3, 9, 11, 12, 13, 14, 15, 16, 18, 19, 23, 24, 26, 27, 30, and 37. Significant deficiencies were found in cases 3, 11, 14, 16, 23, 26, 37.

26. Deficiencies retrieving specialty reports within required time frames occurred in cases 3, 11, 13, 14, 26, 20, and 37.

significant delay because the provider did not receive the report within the appropriate time frame to refer the patient to the ophthalmologist specialist immediately, as the optometrist requested.

- In case 14, the patient had imaging of the heart to evaluate heart function, but the institution did not scan the report until eight months later.
- In case 37, the institution did not retrieve the ear, nose, and throat specialist's consultation report.

Compliance testing showed mixed results. SVSP scanned consultation reports in a timely manner (MIT 4.002, 86.7%). The data showed decreased performance in retrievals and endorsements of reports as the priority decreased, with high-priority reports at 86.7 percent (MIT 14.002), medium-priority at 73.3 percent (MIT 14.005), and routine at 53.3 percent (MIT 14.008). We also discuss these findings in the **Specialty Services** indicator.

Diagnostic Reports

SVSP performed well in diagnostic reports. Radiology and laboratory reports were retrieved timely. Case reviewers identified six deficiencies, wherein the provider did not endorse laboratory test results. Compliance testing results showed poor notification of stat laboratory test results to the provider (MIT 2.008, zero) and poor communication of pathology results to the patient (MIT 2.012, zero). However, providers did review the pathology reports at the high rate of 90.0 percent (MIT 2.011). Refer to the **Diagnostic Services** indicator for further detailed discussion.

Urgent and Emergent Records

OIG clinicians reviewed 48 emergency care events and found that SVSP nurses recorded these events well. Providers also recorded their emergency care sufficiently, including the off-site telephone encounters. We found one deficiency, in which the institution retrieved the emergency department (ED) report outside required time frames (case 26). Refer to the **Emergency Services** indicator for additional information regarding emergency care documentation.

Scanning Performance

SVSP performed poorly in the scanning process. The compliance testing score was 70.8 percent (MIT 4.004), revealing missing hospital and specialty reports and a mislabeled document. Case reviewers also found deficiencies in twelve missing refusal forms in two cases. We also identified five duplicated documents and one mislabeled document.

Clinician On-Site Inspection

On-site, we discussed deficiencies with SVSP health information management supervisors, ancillary staff, diagnostic staff, nurses, and providers. Providers described good performance in information management. Records were generally available for them to review. Supervisors explained that there was one off-site hospital that did not have reports available within required time frames; they have elevated this concern to headquarters.

Recommendations

- The triage and treatment area (TTA) nursing supervisors should audit stat laboratory draws to ensure providers are notified within required time frames.

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	0	10	100%
Are specialty documents scanned into the patient's electronic health record within five calendar days of the encounter date? (4.002) *	26	4	15	86.7%
Are community hospital discharge documents scanned into the patient's electronic health record within three calendar days of hospital discharge? (4.003) *	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) *	23	2	0	92.0%
Overall percentage (MIT 4): **88.9%**				

* 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.

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) *	10	0	0	100%
Laboratory: Did the health care provider review and endorse the laboratory report within specified time frames? (2.005) *	10	0	0	100%
Laboratory: Did the nursing staff notify the health care provider within one (1) hour from receiving the STAT laboratory results? (2.008) *	0	3	0	0
Pathology: Did the institution receive the final pathology report within the required time frames? (2.010) *	9	1	0	90.0%
Pathology: Did the health care provider review and endorse the pathology report within specified time frames? (2.011) *	9	1	0	90.0%
Pathology: Did the health care provider communicate the results of the pathology study to the patient within specified time frames? (2.012)	0	10	0	0
Did the institution receive and did the primary care provider review the high-priority specialty service consultant report within the required time frame? (14.002) *	13	2	0	86.7%
Did the institution receive and did the primary care provider review the medium-priority specialty service consultant report within the required time frame? (14.005) *	11	4	0	73.3%
Did the institution receive and did the primary care provider review the routine-priority specialty service consultant report within the required time frame? (14.008) *	8	7	0	53.3%

* 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
(61.9%)

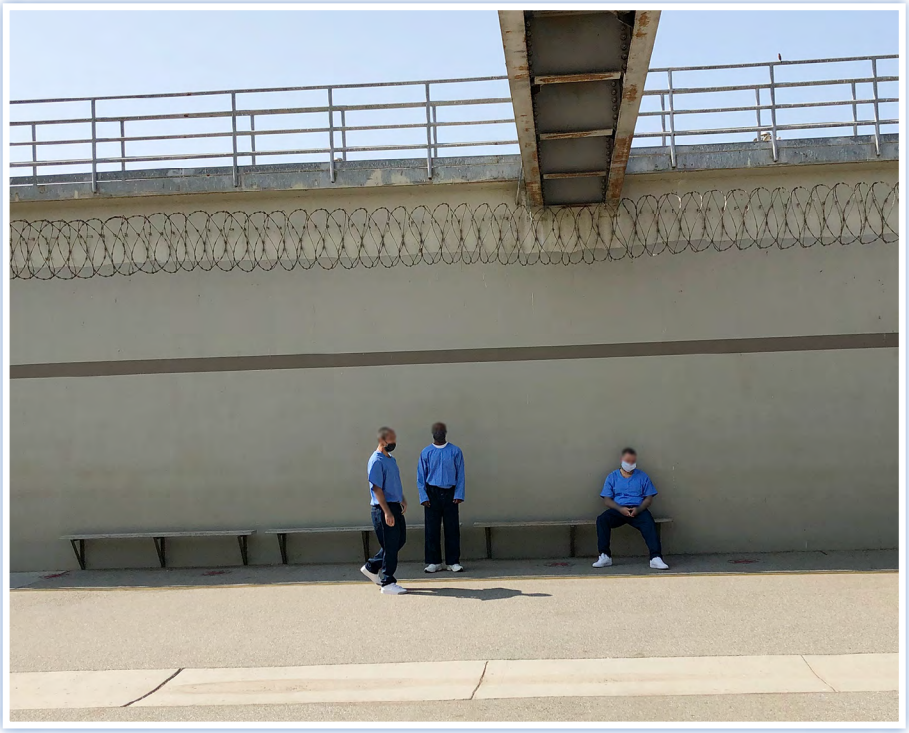
Health Care Environment

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.

Results Overview

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

Compliance Testing Results



Outdoor Waiting Areas

We inspected the outdoor patient waiting areas at SVSP. Patients had ample seating to wait for their appointments (see Photo 1, left.)

Photo 1. Outdoor waiting area (photographed on September 16, 2020).

We interviewed custody and medical staff, who reported the outdoor patient waiting areas are only used as a secondary waiting area to practice social distancing when the indoor waiting area is at capacity.

Indoor Waiting Areas

Inside the medical clinics, patients had sufficient seating capacity while waiting for their appointments (see Photo 2, below).

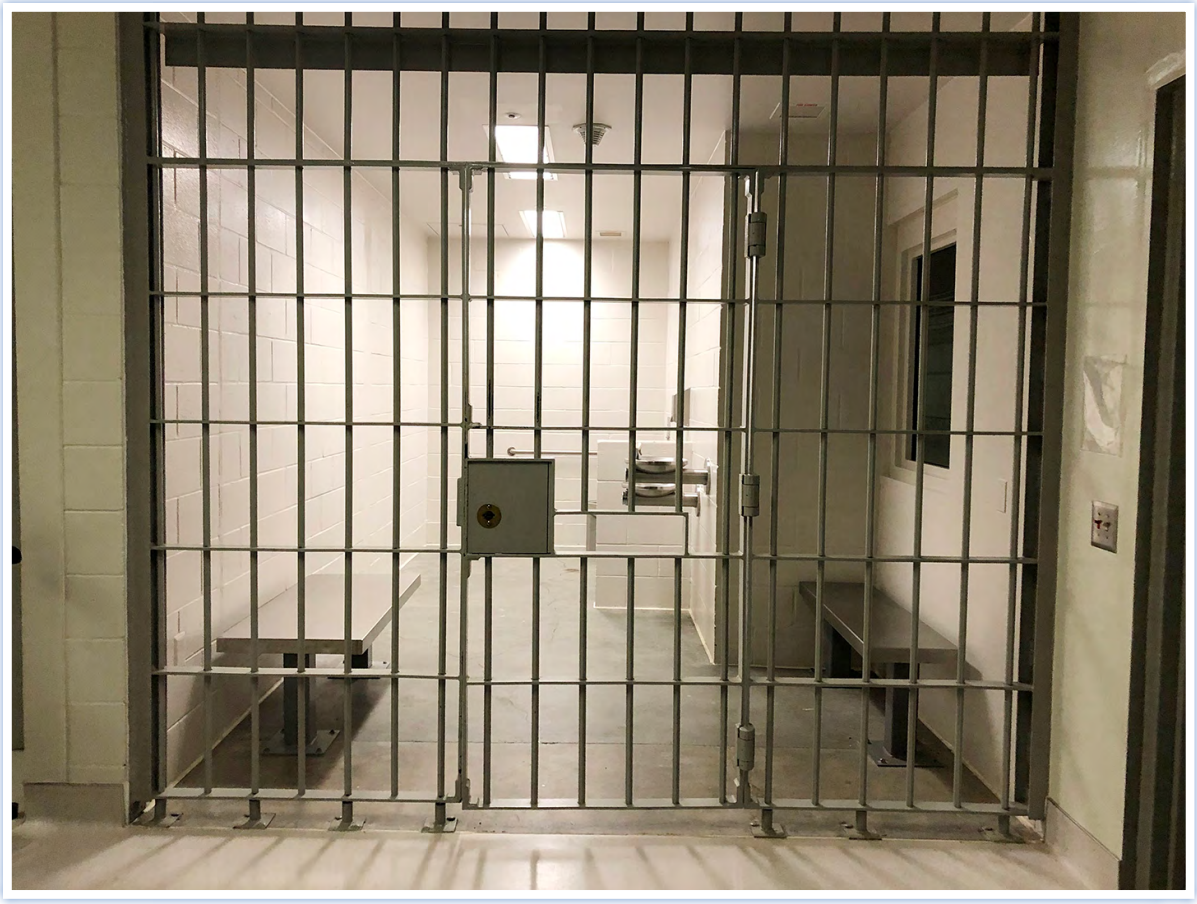


Photo 2. Indoor waiting area (photographed on September 17, 2020).

Depending on the population, patients were either placed in the clinic waiting area or held in individual modules (see Photo 3, following page). These holding areas included temperature control, running water, toilets, and hand sanitation items. Custody and medical staff reported that patient waiting areas were never filled to capacity.

Photo 3. Individual waiting module (photographed on September 16, 2020).

Clinic Environment

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

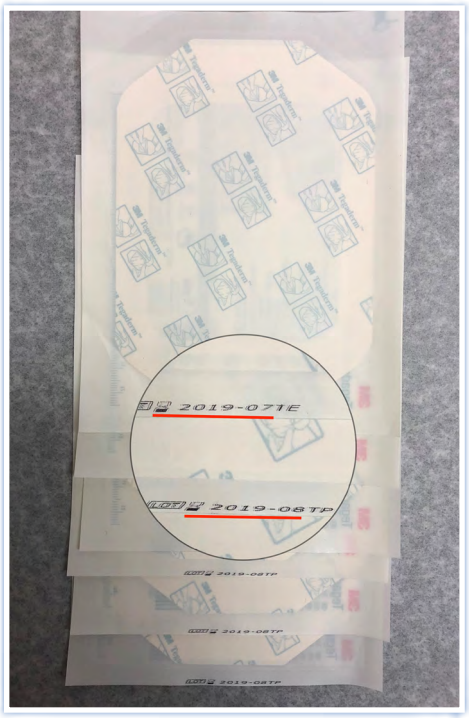
Of the 10 clinics we observed, eight contained appropriate space, configuration, supplies, and equipment to allow clinicians to perform proper clinical examinations (MIT 5.110, 80.0%). In one clinic, the examination room lacked adequate space (fewer than 100 square feet). The remaining clinic's examination room table had a torn cover.

In addition to the above findings, our compliance inspectors observed some notable findings in clinics during their on-site inspection. One clinic's ceiling showed residual water damage (see Photo 4, right); staff provided us with copies of work orders and a submitted repair request to address the damage. According to the nursing administrative staff, the plant manager received the repair order, which is pending completion. The plant manager reported safety and equipment issues are prioritized.

Photo 4. Residual water damage (photographed on September 17, 2020).

Clinic Supplies

Five of the eleven clinics followed adequate medical supply storage and management protocols (MIT 5.107, 45.5%). We found one or more of the following deficiencies in six clinics: expired medical supplies (see Photo 5, below), unidentified medical supplies, a disorganized medical supply drawer, and cleaning materials stored with medical supplies (see Photo 6, following page).



Two of the eleven clinics met requirements for essential core medical equipment and supplies (MIT 5.108, 18.2%). The remaining nine clinics lacked medical supplies or contained improperly calibrated or nonfunctional equipment. The missing items included an examination table, a nebulizer, and hemoccult cards or a fecal immunochemical test kit. OIG compliance inspectors found equipment without current calibration stickers, including vital sign machines, nebulizers, weight scales, and an automated external defibrillator (AED).

Photo 5. Expired medical supplies, dated July and August 2019 (photographed on September 17, 2020).

Photo 6. Germicidal wipes stored in the same area with medical supplies (photographed on September 17, 2020).

We found a Snellen chart without an identified distance line on the floor or wall and found several nonfunctional oto-ophthalmoscopes. We also noted staff failed to log results of the AED performance test within the preceding 30 days.

We examined emergency medical response bags (EMRBs) to determine whether they contained all essential items. We checked whether staff inspected the bags daily and inventoried them monthly. Only six of the nine EMRBs passed our test (MIT 5.111, 66.7%). For three EMRBs, staff failed to ensure the EMRBs' compartments were sealed and intact.

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 multiple expired medical supplies (see Photos 7 and 8, following page).

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

Infection control and sanitation staff appropriately disinfected, cleaned, and sanitized 10 of 11 clinics (MIT 5.101, 90.9%). In one clinic, we found a dead insect in one of the examination room's medical supply drawers (see Photo 9, page 40).

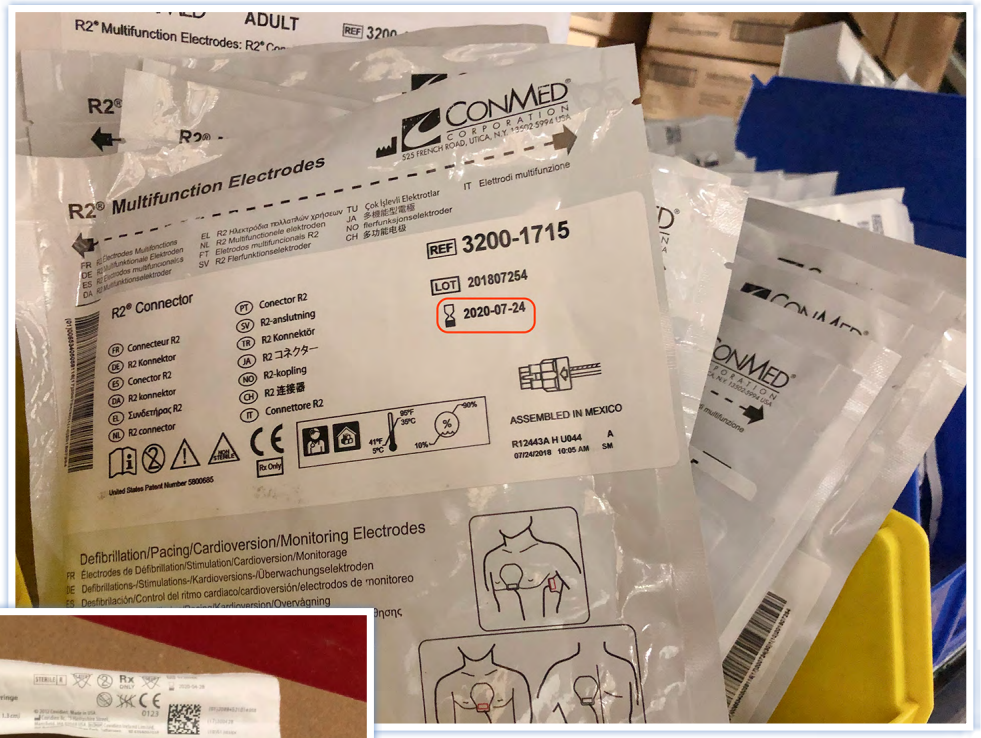


Photo 7. Expired medical supplies, dated July 24, 2020 (photographed on September 16, 2020).

Photo 8. Expired medical supplies, dated April 28, 2020 (photographed on September 16, 2020).

Staff in eight of 10 clinics (MIT 5.102, 80.0%) properly sterilized or disinfected medical equipment. In two clinics, staff relied on inmate porters or did not mention disinfecting the examination table as part of their daily start-up protocol.

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

In the seven clinics where we observed patient encounters, clinicians did not wash their hands before or after examining their patients, before applying gloves, or before performing blood draws (MIT 5.104, zero).

Photo 9. Dead insect found inside the examination room medical supply cabinet (photographed September 17, 2020).

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

Physical Infrastructure

SVSP's health care management and plant operations manager reported all clinical area infrastructures were in good working order and did not hinder health care services.

At the time of our medical inspection, the institution had no ongoing health care facility improvement program (HCFIP) construction projects (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 emergency medical response bag (EMRB) logs to ensure the EMRBs are regularly inventoried and sealed.

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)	10	1	0	90.9%
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	2	1	80.0%
Infection control: Do clinical health care areas contain operable sinks and sufficient quantities of hygiene supplies? (5.103)	11	0	0	100%
Infection control: Does clinical health care staff adhere to universal hand hygiene precautions? (5.104)	0	7	4	0
Infection control: Do clinical health care areas control exposure to blood-borne pathogens and contaminated waste? (5.105)	11	0	0	100%
Warehouse, conex, and other nonclinic storage areas: Does the medical supply management process adequately support the needs of the medical health care program? (5.106)	0	1	0	0
Clinical areas: Does each clinic follow adequate protocols for managing and storing bulk medical supplies? (5.107)	5	6	0	45.5%
Clinical areas: Do clinic common areas and exam rooms have essential core medical equipment and supplies? (5.108)	2	9	0	18.2%
Clinical areas: Are the environments in the common clinic areas conducive to providing medical services? (5.109)	9	0	2	100%
Clinical areas: Are the environments in the clinic exam rooms conducive to providing medical services? (5.110)	8	2	1	80.0%
Clinical areas: Are emergency medical response bags and emergency crash carts inspected and inventoried within required time frames, and do they contain essential items? (5.111)	6	3	2	66.7%
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): **61.9%**			

* 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
(66.1%)

Transfers

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

Results Overview

In this cycle, case reviewers and compliance testing yielded different ratings, adequate and inadequate, respectively. Compared to its performance in Cycle 5, SVSP's performance improved. Significant case review deficiencies decreased from 28 in Cycle 5 to only three in Cycle 6. SVSP had good performance with patients transferring out and returning from hospitalization. Compliance scores improved for six of the 11 MITs; three of the remaining MITs scored near or the same as in Cycle 5. However, compliance testing also identified that nurses sometimes did not perform complete assessments and did not order primary care provider follow-up appointments for high-risk patients transferring into the institution. Compliance testing further showed poor initial health- and TB-screening within the required time frame and poor medication continuity for patients transferring in. After considering case review and compliance ratings, we rated this indicator ***adequate***.

Case Review Results

We reviewed 65 events that occurred in 25 cases in which patients transferred into or out of the institution or returned from an off-site hospital or emergency room. We identified 27 deficiencies, three of which were significant.[27]

27. Deficiencies occurred in cases 9, 11, 14, 19, 23, 25, 26, 31, 32, 33, 34, 35, 36, 37, 64, and 65. Significant deficiencies were identified in cases 32, 33, and 37.

Transfers In

For patients who transferred into SVSP, compliance testing showed nursing staff did not complete initial health screenings or answer all screening questions within the required time frames (MIT 6.001, zero). Nursing staff did not address the signs and symptom of fatigue when screening for TB and did not follow up on health care screening questions that required an explanation.[28]

Our case review of 20 events that occurred in seven cases found that newly arrived patients were evaluated within required time frames and received adequate assessments. We identified only one incomplete assessment, as described below:

- In case 31, the newly arrived transfer-in patient was not screened for COVID-19, and the R&R nurse failed to document additional information for prior history of suicide attempt.

For patients who were endorsed from another departmental institution, compliance testing noted SVSP scored poorly in delivery of medication administration or delivery without interruption (MIT 6.003, 64.3%). Compliance testing found in two cases that nursing staff did not document on the medication administration record (MAR) the reason the patient refused his medication. Case review, on the other hand, cited no deficiencies in continuity of medication administration.

Both case review and compliance testing identified deficiencies in provider access for patients after their arrival to SVSP. Compliance testing noted that in a significant number of cases, providers did not see patients within the time frame required by their clinical risk level (MIT 1.002, 68.0%). The appointments for these delayed cases occurred 12 to 35 days late; in one case, there was no evidence the patient was ever seen by the provider. Case review identified two significant deficiencies in this area. An example follows:

- In case 32, the patient had a history of asthma, but the R&R nurse did not order a care manager appointment within 30 days or a provider appointment within seven days for this high-risk patient; the patient saw the provider almost three months later for a primary care appointment. In the interim between his arrival and his initial appointment, the patient was sent to the off-site emergency department for shortness of breath and chest pain. If the provider had seen the patient within seven days, this transfer might have been avoided.

However, compliance testing and case review agree that SVSP provided acceptable high-priority specialty service within 14 calendar days of the primary care provider order (MIT 14.001, 80.0%).

28. 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.

Transfers Out

SVSP's transfer out process was adequate. Compliance testing found no deficiencies when reviewing patients who transferred out: all had the required documents and medications (MIT 6.101, 100%).

Case review, however, identified two instances in which patients did not transfer with a five-day supply of medication.[29] In four cases, there was no notification to the receiving institution of pending appointments.[30] In three cases, there was no informed refusal forms completed for patients' refusals of vital signs.[31] While these were not significant deficiencies, they offer opportunities for improvement.

Hospitalizations

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

Our clinicians reviewed 34 hospital or emergency room returns in 18 cases.[32] We identified 15 deficiencies, one of which was significant.[33] While we found the overall care provided to patients who returned from off-site hospitalization or emergency room visits to be adequate, we did identify some areas that offered room for improvement.

Although patients were assessed upon their return to the facility, the assessments were often incomplete, as described in the examples below:

- In case 19, the patient returned after a hospitalization for chest pain with a cardiac angiogram[34] and stent placement. The hospital return nurse noted the catheter surgical site, but did not assess the location or condition of site. The same patient was later hospitalized again for chest pain and underwent another angiogram. When the patient returned to SVSP, the nurse obtained vital signs and a pain level, but did not perform any additional assessments.

29. The patient did not transfer with a five-day supply of medication in cases 14 and 34.

30. There was no notification of pending appointments for cases 14, 36, 64 and 65.

31. Refusal forms were not completed for refusal of preboarding vital signs in cases 34, 35, and 36.

32. Hospital or emergency room returns occurred in cases 1, 3, 9, 10, 11, 12, 13, 19, 23, 24, 25, 26, 27, 37, 62, 63, 64, and 65.

33. Deficiencies in hospital or emergency room returns were identified in cases 9, 11, 19, 23, 25, 26, and 37. The significant deficiency was identified in case 37.

34. A cardiac angiogram is a diagnostic test that uses X-rays to image the heart blood vessels using a catheter that is inserted into the body. Contrast dye is injected to show the blood vessels.

- In case 11, the insulin-dependent diabetic patient returned to the facility after a 14-day hospitalization. The nurse did not measure the patient's weight or pain level, nor obtain a finger stick blood-sugar level.

One area that did not test as well as in Cycle 5 was in providing follow-up appointments within the required time frame after a patient returned from a hospitalization or ER visit (MIT 1.007, 70.8%). Two of the cases that did not meet the required time frame for provider follow-up appointments occurred after implementation of COVID-19 Interim Guidance.[35]

Compliance testing showed that hospital discharge documents were scanned into the patient's electronic health record within three calendar days of discharge the majority of the time (MIT 4.003, 95.0%) and that providers generally reviewed and signed documents within five calendar days of discharge (MIT 4.005, 92.0%).

Our case reviewers did not identify medication continuity as problematic, citing a deficiency in only one case, in which an antibiotic was administrated five hours late. However, compliance testing identified that SVSP provided poor medication continuity (MIT 7.003, 60.0%). Half of these compliance samples were related to critical medications prescribed to treat hypertension, diabetes, asthma, angina, and elevated cholesterol. In addition, reconciliation of discharge recommendations is another area of concern and is discussed in the **Provider Performance** indicator.

The only significant case review deficiency in hospitalizations was related to an incorrect order for COVID-19 surveillance rounds for the patient who returned from the hospital. Although the patient had no adverse events, the following example did not follow the COVID-19 Interim Guidance:

- In case 37, the patient returned from a hospitalization and the nurse did not place an appropriate order for COVID-19 surveillance rounds. The order specified surveillance rounds "weekly on Wednesdays for two weeks" instead of "twice daily for 14 days."

Clinician On-Site Inspection

During the on-site visit at SVSP, we were able to tour the R&R area and interview staff. The R&R nurse is responsible for initial health screening and also prepares transfer packets for patients transferring to other institutions. We were advised that prior to the COVID-19 pandemic, an average of 15 to 20 patients transferred into the facility daily, but since

35. The purpose of the department's COVID-19 Interim Guidance is to provide an integrated approach to preventing, monitoring, and containing outbreaks of acute respiratory infection caused by SARS-CoV-2 (the virus that causes COVID-19), Influenza A and B, and other respiratory pathogens of public health significance (**https://cchcs.ca.gov/covid-19-interim-guidance/**).

the emergence of COVID-19 and the slowdown of patient movement, the number has decreased to approximately five patients per day. The institution had a similar pattern with patients transferring out. We were advised that for patients with urgent pending appointments, the receiving facility is either called or messaged, and patients with nonurgent appointments are placed on a medical hold. For patients who transfer in, the R&R nurse messages the provider on the yard where the patient is to be housed for reconciliation of orders. We received confirmation that a large percentage of the general population patients refuse vitals when transferring out of SVSP.

Recommendations

- Health care leadership should consider adjusting all EHRS screening forms to add the symptom of fatigue for TB-symptom monitoring.[36]
- Health care leadership should determine the causes of challenges to the timely and uninterrupted delivery of medications for patients newly arriving to the institution and patients returning from hospitalizations or emergency rooms; then leadership should implement remedial measures as appropriate.

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

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)	25	0	0	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) *	9	5	11	64.3%
For patients transferred out of the facility: Do medication transfer packages include required medications along with the corresponding transfer packet required documents? (6.101) *	3	0	1	100%
				Overall percentage (MIT 6): **66.1%**

* 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 13. Other Tests Related to Transfers

	Scored Answer			
Compliance Questions	**Yes**	**No**	**N/A**	**Yes %**
For endorsed patients received from another CDCR institution: Based on the patient's clinical risk level during the initial health screening, was the patient seen by the clinician within the required time frame? (1.002) *	17	8	0	68.0%
Upon the patient's discharge from the community hospital: Did the patient receive a follow-up appointment with a primary care provider within the required time frame? (1.007) *	17	7	1	70.8%
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) *	23	2	0	92.0%
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) *	15	10	0	60.0%
Upon the patient's transfer from one housing unit to another: Were medications continued without interruption? (7.005) *	21	4	0	84.0%
For patients en route who lay over at the institution: If the temporarily housed patient had an existing medication order, were medications administered or delivered without interruption? (7.006) *	N/A	N/A	N/A	N/A
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) *	7	13	0	35.0%

* 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

Overall Rating ***Inadequate***

Case Review Rating ***Adequate***

Compliance Score ***Inadequate*** **(67.8%)**

In this indicator, OIG inspectors evaluated the institution's ability to administer prescription medications on time and without interruption. We 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.

Results Overview

SVSP presented a mixed performance in this indicator. While the institution's performance in medication management has improved since its evaluation in Cycle 5, there were still problems. Compliance testing showed poor chronic care medication continuity; the institution did not ensure hospital discharge medications were given or that newly admitted specialized medical housing patients received their medication; medications for patients transferring from one housing unit to another were sometimes interrupted; and SVSP did not always monitor administration of tuberculosis (TB) medications.

Case review found better performance in medication management. Newly prescribed medications, TB medications, hospital discharge medications, and transfer-in medications were given to patients mostly within required time frames. However, we found problems with continuity of chronic medications in about a quarter of cases reviewed, and half of all newly arrived correctional treatment center (CTC) patients received their medications late. In this indicator, we assigned more weight to compliance testing because it tested more areas of medication management. Considering all these factors, we rated this indicator ***inadequate***.

Case Review Results

We reviewed 149 events in 29 cases related to medications; we identified 23 medication deficiencies, four of which were significant.[37] This was a significant improvement from the institution's performance in the Cycle 5 review.

New Medication Prescriptions

SVSP administered new medications most of the time. This corresponds with compliance findings (MIT 7.002, 92.0%). Case review clinicians

37. Medication events were identified in cases 1, 3, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 37, 62, 63, 64, and 65. Deficiencies were identified in cases 3, 9, 11, 17, 22, 23, 24, 26, 30, 38, 62, 63, and 65. Significant deficiencies were isolated to cases 9 and 11.

identified isolated instances when two patients received new prescriptions that were both administered two days late. In another case, the clinic nurse did not document on the MAR a topical medication given to the patient.[38]

Chronic Medication Continuity

Our compliance testing and our case reviews showed mixed results. Compliance testing found SVSP rated poorly for patients receiving their chronic medications timely (MIT 7.001, 9.5 %). Some of the findings included lack of documentation for patients' reasons for refusing medications; lack of referrals to the provider when 50 percent of the medication was refused in one week, as required by policy; and keep-on-person (KOP) medication refills not available one business day prior to depletion of supply. Of 29 cases reviewed, our clinicians identified seven cases when patients received chronic care medication late.[39] All deficiencies identified were minor and did not adversely affect patient care.

Hospital Discharge Medications

SVSP ensured that patients received their medications most of the time when they returned from an off-site hospital or emergency room visit. While compliance showed a below-average score (MIT 7.003, 60.0%), our clinicians noted a much better performance and identified only one deficiency: in case 26, the patient received his antibiotic five hours later than prescribed.

Specialized Medical Housing Medications

SVSP performed poorly in providing medications for newly admitted patients. This was confirmed by compliance testing (MIT 13.004, 30.0%) and case reviews. In three of the six CTC cases reviewed, the patients received their admission medications late. Please refer to the **Specialized Medical Housing** indicator for additional information and examples.

Transfer Medications

SVSP showed mixed results in medication continuity for patients transferring into the institution. Our compliance testing noted poor performance (MIT 6.003, 64.3%), while the case reviewers did not find any deficiencies for patients who transferred into the facility. The poor compliance rate was primarily due to a lack of documentation in the MAR summary for refusals of medications and delays in the provision of rescue inhalers. Patients who transferred from one housing unit to

38. Patients received newly prescribed medications late in cases 3 and 22, and the clinic nurse failed to scan the stock medication given for case 38.

39. Deficiencies in chronic care medication continuity were identified in cases 3, 9, 11, 17, 23, 24, and 30.

another maintained medication continuity the majority of the time (MIT 7.005, 84.0%).

The institution's transfer-out process was acceptable. Compliance testing found that patients transferred out of SVSP with the required five-day supply of medications (MIT 6.101, 100%). However, our case review clinicians identified four cases with medication deficiencies for patients who transferred out: these cases included significant medications, such as a blood pressure medication and an asthma rescue inhaler.[40] Please see the **Transfers** indicator for details.

Medication Administration

Case reviewers noted that SVSP nurses did not always administer medications properly. We found seven such deficiencies in three cases. Below is one example:

- In Case 11, pill line nurses did not interpret the finger stick blood sugar readings correctly against the insulin sliding scale orders and administered less insulin than prescribed on six different dates.

OIG compliance testing examined how well SVSP administered and monitored patients taking TB medications. The nursing staff correctly administered TB medications as prescribed (MIT 9.001, 100%), but did not correctly monitor these patients: staff often omitted documentation of TB symptoms and weekly evaluations (MIT 9.002, 14.3%).

Clinician On-Site Inspection

During the on-site visit, our clinicians attended several meetings: the morning provider meeting, huddles in different clinics, and a population management meeting. Topics covered in the well-organized population management meeting included medication reconciliation, nonformulary medications, chronic care medications that were ordered from the central fill pharmacy, and patients who were noncompliant with medication.[41] We also toured the medication administration areas in multiple yards and interviewed pill line nurses and psychiatric technicians. We observed clean, well-organized workstations with no backlog of KOP medications. Staff were knowledgeable about medication administration processes. The pill line nursing staff explained they respond to emergencies and had all mandatory emergency equipment within reach. Staff noted concern about having to push heavy medication carts to individual buildings multiple times a day to administer medications, a process resulting from areas quarantined due to the COVID-19 pandemic.

40. Medication deficiencies for patients that were transferred out of SVSP were identified in cases 14, 34, 64, and 65.

41. The central fill pharmacy is the department's general pharmacy, located in Sacramento.

Compliance Testing Results

Medication Practices and Storage Controls

The institution adequately stored and secured narcotic medications in nine of ten clinic and medication line locations (MIT 7.101, 90.0%). In one location, nurses did not mention the appropriate process for reporting narcotic medication discrepancies.

SVSP appropriately stored and secured nonnarcotic medications in 11 of 12 clinic and medication line locations (MIT 7.102, 91.7%). In one location, the medication cabinet was disorganized.

Staff kept medications protected from physical, chemical, and temperature contamination in eight of the 12 clinic and medication line locations (MIT 7.103, 66.7%). In four locations, we found one or more of the following deficiencies: staff did not record or did not consistently record the room and refrigerator temperatures, and staff did not separate storage of oral and topical medications.

Staff successfully stored valid, unexpired medications in 10 of the 12 applicable medication line locations (MIT 7.104, 83.3%). In one location, medication nurses did not label the multi-use medication as required by CCHCS policy. In another location, a multi-dose medication was stored beyond the expiration date on the label.

Nurses exercised proper hand hygiene and contamination control protocols in three of eight locations (MIT 7.105, 37.5%). In five locations, some nurses neglected to wash or sanitize their hands before donning gloves or before each subsequent regloving.

In six of eight medication preparation and administration areas, staff demonstrated appropriate administrative controls and protocols (MIT 7.106, 75.0%). In two locations, nurses did not maintain unissued medication in its original labeled packaging.

In six of eight medication areas, staff used appropriate administrative controls and protocols when distributing medications to their patients (MIT 7.107, 75.0%). In two locations, we found one or both of the following deficiencies: medication nurses did not reliably observe patients while they swallowed direct observation therapy medications, and nurses could not describe the medication error reporting process.

Pharmacy Protocols

The SVSP pharmacy followed general security, organization, and cleanliness protocols and properly stored nonrefrigerated and refrigerated medications (MIT 7.108, 7.109, and MIT 7.110, 100%).

The pharmacist-in-charge (PIC) did not correctly review monthly inventories of controlled substances in the institution's clinic and medication storage locations. Specifically, the PIC did not correctly complete several medication-area inspection checklists and neglected to

record names, signatures, or dates on each inventory record. These errors resulted in a score of zero in this test.

We examined five medication error reports. The PIC timely or correctly processed only one of these five reports (MIT 7.112, 20.0%). The PIC at the institution did not complete four medication error follow-up reports. The PIC reported that when the headquarters pharmacy was asked whether a nonpharmacy-related medication error requires a medication error follow-up form to be completed, there was no response.

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 SVSP, we did not find any applicable medication errors (MIT 7.998).

We interviewed patients in isolation units to determine whether they had immediate access to their prescribed asthma rescue inhalers or nitroglycerin medications. Of 19 applicable patients we interviewed, 17 indicated they had access to their rescue medications; the remaining two patients reported they did not have the prescribed rescue inhaler. One patient reported he did not notify custody or medical staff when he finished his inhaler; the other patient reported that he notified his provider that he does not need the medication. We promptly notified the CEO of this concern, and health care management immediately reissued a replacement rescue inhaler to one patient and a new patient refusal was documented for the other patient (MIT 7.999).

Recommendations

- Pharmacy leadership should consider reviewing the causes of the untimely delivery of prescribed medications.
- Nursing leadership should ensure safe medication administration practices, including complete documentation, for all medications, and specifically for insulin and hypertensive medications.

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) *	2	19	4	9.5%
Did health care staff administer, make available, or deliver new order prescription medications to the patient within the required time frames? (7.002)	23	2	0	92.0%
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) *	15	10	0	60.0%
For patients received from a county jail: Were all medications ordered by the institution's reception center provider administered, made available, or delivered to the patient within the required time frames? (7.004) *	N/A	N/A	N/A	N/A
Upon the patient's transfer from one housing unit to another: Were medications continued without interruption? (7.005) *	21	4	0	84.0%
For patients en route who lay over at the institution: If the temporarily housed patient had an existing medication order, were medications administered or delivered without interruption? (7.006) *	N/A	N/A	N/A	N/A
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)	9	1	2	90.0%
All clinical and medication line storage areas for nonnarcotic medications: Does the institution properly secure and store nonnarcotic medications in the assigned storage areas? (7.102)	11	1	0	91.7%
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)	8	4	0	66.7%
All clinical and medication line storage areas for nonnarcotic medications: Does the institution safely store nonnarcotic medications that have yet to expire in the assigned storage areas? (7.104)	10	2	0	83.3%
Medication preparation and administration areas: Do nursing staff employ and follow hand hygiene contamination control protocols during medication preparation and medication administration processes? (7.105)	3	5	4	37.5%
Medication preparation and administration areas: Does the institution employ appropriate administrative controls and protocols when *preparing* medications for patients? (7.106)	6	2	4	75.0%
Medication preparation and administration areas: Does the institution employ appropriate administrative controls and protocols when *administering* medications to patients? (7.107)	6	2	4	75.0%
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)	0	1	0	0
Pharmacy: Does the institution follow key medication error reporting protocols? (7.112)	1	4	0	20.0%
Pharmacy: For Information Purposes Only: During compliance testing, did the OIG find that medication errors were properly identified and reported by the institution? (7.998)	This is a nonscored test. Please see the indicator for discussion of this test.			
Pharmacy: For Information Purposes Only: Do patients in 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): **67.8%**

* 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.

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) *	9	5	11	64.3%
For patients transferred out of the facility: Do medication transfer packages include required medications along with the corresponding transfer-packet required documents? (6.101) *	3	0	1	100%
Patients prescribed TB medication: Did the institution administer the medication to the patient as prescribed? (9.001) *	14	0	0	100%
Patients prescribed TB medication: Did the institution monitor the patient per policy for the most recent three months he or she was on the medication? (9.002) *	2	12	0	14.3%
Upon the patient's admission to specialized medical housing: Were all medications ordered, made available, and administered to the patient within required time frames? (13.004) *	3	7	0	30.0%

* 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
(69.7%)

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. 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.

Results Overview

SVSP staff had mixed performance in preventive services. Staff performed well in some areas, such as administering the medication as prescribed, offering patients an influenza vaccine for the most recent influenza season, offering colorectal cancer screening for all patients ages 50 through 75, and offering required immunizations to chronic care patients. However, they faltered in monitoring patients who were taking prescribed TB medication and in screening patients annually for tuberculosis (TB). These findings are set forth in the table below. We rated this indicator ***inadequate***.

Recommendations

- Nursing leadership should remind nursing staff to fully document tuberculosis (TB) symptoms as part of the patient's TB monitoring.

Table 16. Preventive Services

Compliance Questions	Scored Answer			
	Yes	No	N/A	Yes %
Patients prescribed TB medication: Did the institution administer the medication to the patient as prescribed? (9.001)	14	0	0	100%
Patients prescribed TB medication: Did the institution monitor the patient per policy for the most recent three months he or she was on the medication? (9.002) †	2	12	0	14.3%
Annual TB screening: Was the patient screened for TB within the last year? (9.003)	11	14	0	44.0%
Were all patients offered an influenza vaccination for the most recent influenza season? (9.004)	25	0	0	100%
All patients from the age of 50 through the age of 75: Was the patient offered colorectal cancer screening? (9.005)	20	5	0	80.0%
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)	12	3	10	80.0%
Are patients at the highest risk of coccidioidomycosis (valley fever) infection transferred out of the facility in a timely manner? (9.009)	N/A	N/A	N/A	N/A
				Overall percentage (MIT 9): **69.7%**

* 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.

Overall Rating
Adequate

Case Review Rating
Adequate

Compliance Score
(N/A)

Nursing Performance

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, including **Emergency Services**, **Specialty Services**, and **Specialized Medical Housing**.

Results Overview

SVSP provided acceptable nursing care overall. Nursing care was mostly appropriate and timely. Compared to Cycle 5, SVSP nursing care showed improvement. There was a notable decrease in the number of assessment deficiencies and an overall improvement in documentation. Additionally, clinic nurses triaged sick calls appropriately and evaluated patients timely. Nevertheless, there is room for improvement in nursing emergency care and transfer-in care. We rated this indicator ***adequate***.

Case Review Results

We reviewed 320 nursing encounters in 60 cases and found 131 deficiencies, 15 of which were significant.[42] Of the nursing encounters we reviewed, 221 were in the outpatient setting. We identified 74 outpatient nursing performance deficiencies, five of which were significant.[43]

Nursing Assessment and Interventions

Generally, SVSP nurses performed complete and appropriate assessments and interventions. Specialized medical housing nurses completed admission assessments timely and frequently performed good assessments throughout the patient's stay in the CTC. Nurses mostly performed thorough assessments in outpatient, R&R, and hospital

42. Deficiencies occurred in cases 1, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 17, 19, 20, 21, 23, 24, 25, 26, 27, 28, 30, 31, 32, 33, 34, 35, 36, 37, 42, 48, 50, 51, 52, 54, 55, 56, 58, 29, 61, 62, 63, 64, and 65. Significant deficiencies occurred in cases 1, 5, 6, 8, 11, 17, 20, 21, 25, 32, 33, 37, and 55.

43. Significant deficiencies occurred in cases 17, 20, 21, and 55.

returns. For emergency care, first responder evaluation of patients was an area that showed room for improvement. Additionally, first responder intervention was an area of concern for emergency care. Please refer to the **Emergency Services** indicator for further details.

Nursing Documentation

Overall, SVSP nurses documented adequately. Complete and accurate documentation is required to communicate patient needs and to provide appropriate patient care. TTA documentation was adequate, with lower-level deficiencies that did not affect the care provided to the patient. The CTC nurses completed thorough assessments and care plans; this was an improvement from performance in this area in Cycle 5. Outpatient nurses usually completed thorough documentation; however, there were lower-level deficiencies in the outpatient care area.[44]

Nursing Sick Call

Our clinicians reviewed 110 symptomatic sick call requests. SVSP nurses collected, triaged, and assessed patients as required. Case review results showed patients were almost always seen within required time frames and the nurses usually performed thorough assessments. During our on-site visit, nurses reported they evaluated an average of 15 to 20 patients daily, and they did not have a backlog for sick call appointments. Please refer to the **Access to Care** indicator for additional information.

Care Coordinator

Our case reviewers did not identify any deficiencies in care management. Please refer to the **Access to Care** indicator for further discussion.

Wound Care

SVSP nurses provided good wound care. We reviewed five cases in which wound care was provided to patients, and we did not identify any significant deficiencies.[45] Our case reviewers identified six minor deficiencies, including incomplete wound assessments, incomplete documentation, and the nurse not completing a refusal form for missed wound care appointments. During our on-site visit, staff reported that LVNs perform daily wound dressing changes and RNs assess wounds weekly, unless ordered otherwise by the provider. The float RN also performed wound care on patients. The CTC and clinics have a camera available to photograph wounds.

44. Documentation deficiencies occurred one time in cases 9, 20, 30, 37, 42, 48, and 52, two times in cases 25 and 26, and three times in case 24.

45. We reviewed the following cases for wound care: cases 12, 24, 26, 37, and 62.

Emergency Services

SVSP emergency care was problematic. Our clinicians reviewed 19 cases and found significant deficiencies in nine cases. Areas of concern include first responder assessments, interventions, and EMRRC reviews. Nurses caring for the patients in the TTA generally provided good care. Please refer to the **Emergency Services** indicator for further discussion.

Hospital Returns

Thorough nursing assessments of patients returning from the hospital are important to assist decision-making for appropriate housing and ensure patients' health care needs are met. SVSP performance in this indicator was adequate. We reviewed 34 events in 18 cases involving patients who returned from the hospital or emergency room; we identified 11 deficiencies, one of which was significant. The significant deficiency was an inappropriate order for COVID-19 quarantine surveillance rounds. Incomplete assessments occurred in case 11 and on two occasions each in cases 19 and 23. Please refer to the **Transfers** indicator for further discussion.

Transfers

Care provided to patients who arrived at SVSP from another institution showed a need for improvement. We reviewed seven cases and found four deficiencies, of which two were significant. In cases 32 and 33, the nurse did not schedule appointments with the provider or care manager for the high-risk patients.

SVSP provided adequate care for patients who transferred to another departmental institution. Our clinicians did not identify any significant deficiencies; this is similar to our findings from Cycle 5 in this indicator. In the seven cases we reviewed, we identified eight deficiencies. A pattern of deficiencies occurred in which the nurse did not document pending specialty appointments or referrals for patients transferring out: this happened once in cases 34, 36, 64, and 65, and twice in case 14.

Specialized Medical Housing

CTC nursing care was very good. The nurses completed assessments, intervened, and initiated care plans as required. We reviewed 31 nursing events in five cases.[46] Our case reviewers did not identify any significant deficiencies. We identified three minor deficiencies in case 63, which we discuss in the **Specialized Medical Housing** indicator. Please refer to this indicator for further information.

46. We reviewed the following CTC cases: 20, 62, 63, 64, and 65.

Specialty Services

Nursing performance in this indicator improved from Cycle 5. Our reviewers did not find any significant deficiencies in nursing performance; however, there were three minor deficiencies. Please refer to the **Specialty Services** indicator for details.

Medication Management

Overall, SVSP showed improvement with nursing performance in medication management. Medication administration was generally good. Our clinicians reviewed 149 events involving medication management and administration and identified 23 deficiencies, of which four were significant. Please see the **Medication Management** indicator for details.

Clinician On-Site Inspection

Our clinicians visited the TTA, CTC, outpatient clinics, administrative segregation, and medication rooms. We interviewed the nurse instructors, supervising registered nurses (SRNs), RNs, LVNs, and the chief nurse executive (CNE). Our clinicians attended morning clinic huddles and the CTC. Overall, the huddles started timely, were well-organized, and included required staff. The participants discussed necessary patient information. Clinic RN staff generally evaluated 15 to 20 patients per day. Due to infection precautions, patients in COVID-19 quarantine who had submitted sick call slips and who needed to be seen in person were evaluated in the clinic after the normal clinic schedule. Patients in COVID-19 isolation were evaluated at cell side by the nurse. In addition to their regular duties, the clinics' LVN staff perform patient care coordination. The medication LVN staff were familiar with their policies and responded to medical emergencies. The medication rooms were equipped with a green emergency bag, an AED, and a radio. For those patients in quarantine or isolation, the medication cart was pushed to the patient's housing and the LVNs medicated the patients in the buildings. Most nursing staff reported good relationships with their assigned providers, supervisors, and custody staff.

Nursing staff reported a mixed response for nursing morale. We interviewed the CNE, who was recently hired into the position. The CNE is reviewing staff vacancies, overtime, and processes to identify where improvements are needed.

Recommendations

The OIG offers no specific recommendations for this indicator.

Overall Rating
Inadequate

Case Review Rating
Inadequate

Compliance Score
(N/A)

Provider Performance

In this indicator, OIG case review clinicians evaluated the quality of care delivered by the institution's providers: physicians, physician assistants, and nurse practitioners. Our clinicians assessed institutional 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

SVSP provider performance needed improvement. Many factors affected the quality of care. SVSP patients tended to require mental health services, to be more behaviorally aggressive, to refuse appointments, and to be noncompliant with medical care. Recruitment and retention of providers also affected care delivery. The institution relied on registry and telemedicine providers to provide care. Most registry providers did not stay long, and telemedicine providers had variable durations of service. By the time providers became familiar with their patients, the providers were reassigned to another institution. This reduced provider continuity, which affected how knowledgeable providers were about their patients.

We found that providers superficially reviewed records, ignored medical conditions, and had poor follow-through. Due to a confluence of the specific inmate population, difficulty recruiting, poor provider continuity, reliance on registry or telemedicine providers, superficial reviews and poor follow-through, we rated this indicator ***inadequate***.

Case Review Results

In our inspection, we reviewed 263 medical provider encounters and found a total of 84 deficiencies. Of these, we found 30 were significant. In addition, we examined the care quality in 25 comprehensive case reviews. Of these 25 cases, we rated 23 adequate and two inadequate. Even the 23 adequate cases suffered from patterns of widespread deficiencies.

Assessment and Decision-Making

Some providers made good assessments and sound decisions; however, a few providers made some questionable decisions, as the following examples illustrate:

- In case 3, the provider determined that the patient needed to be sent to the hospital for a possible heart attack, but the provider did not order an EKG (a diagnostic test to look for evidence of an electrical abnormality of the heart), nor aspirin and nitroglycerin

(medications known to improve survivability and reduce chest pain, respectively).

- In case 12, recognizing that the patient had anemia, the provider had stopped iron supplements, but did not order iron laboratory tests to determine whether the patient needed more supplementation. In addition, the provider did not consider checking Hepatitis C laboratory test results when the patient admitted to intravenous drug use after completion of Hepatitis C therapy.
- In case 23, the provider examined the patient with bilateral lower leg swelling and only focused on heart-related causes, despite normal cardiac examinations, laboratory tests, and diagnostic tests. The provider did not consider noncardiac causes.
- In case 25, the patient was placed under quarantine for symptoms of a cough and shortness of breath during screening. However, the provider did not order a COVID-19 test, as policy required given the patient's symptoms. Later in this case, the patient refused his prostate biopsy. The provider evaluated the patient, but did not inquire why the patient refused the biopsy appointment. Instead, the provider ordered a repeat prostate-specific antigen test. This was significant because not only did the patient have an elevated prostate-specific antigen level and an abnormal prostate examination, but he was also very worried about cancer in general. The primary care provider did not explicitly document that the patient may have had prostate cancer; instead, the provider documented that patients sometimes had incontinence as a result of the procedure.

Providers demonstrated a pattern of superficial examinations. They did not perform pertinent physical exams in cases 18, 19, 20, 23, 27, and in the following example.

- In case 13, on several occasions, providers were asked to evaluate the patient for confusion. On one occasion, custody staff brought the patient to the primary care clinic because a Prison Law Office advocate who happened to be at the institution noticed the patient was confused in the yard. The medical staff did not perform a cognitive assessment at that time.

Review of Records

SVSP providers did not review medical records carefully.[47] This deficiency was particularly significant in this institution because there was less provider continuity, leaving providers unfamiliar with the patients they were seeing.[48] Providers did not review vital signs

47. Providers did not carefully review records in cases 12, 13, 14, 16, 17, 19, and 22.

48. Significant deficiencies occurred due to lack of provider continuity in cases 10 and 25.

in case 17 and did not sufficiently review medical records in the following examples:

- In case 9, the provider did not review the patient's vital signs when the patient refused an appointment. This was significant because the patient had a very low heart rate, 49 beats per minute, and his pacemaker tip had just been repositioned.[49] The low heart rate is an indication that the pacemaker electrode may need further adjustment.
- In case 13, the provider did not review and reconcile the cardiologist's recommendations to continue lisinopril (blood pressure medication with cardioprotective properties) and a higher dose of atorvastatin (cholesterol medication with cardioprotective properties). The patient was not prescribed lisinopril at that time and was prescribed a lower dose of atorvastatin. The provider also did not review the patient's history thoroughly to recognize that the patient had alpha thalassemia.[50] Consequently, the provider ordered further unnecessary testing.
- In case 14, the provider did not review the MAR to notice that the patient was noncompliant with his medications, including his oral anticoagulant. The patient had a mechanical heart valve, which placed him at risk of a stroke. By not reviewing the record and counseling the patient, the provider increased the patient's risk of a stroke.
- In case 22, the provider endorsed the abnormal laboratory test results: leukocyte esterase[51] in the urinalysis and abnormal parathyroid hormone. However, the provider did not follow through and take action.

Emergency Care

SVSP providers appropriately managed patients in the TTA with urgent and emergent conditions. They examined patients appropriately, made accurate diagnoses, and sent patients to the hospital when necessary. TTA nursing staff generally did not have any deficiencies when contacting on-call providers.

Chronic Care

SVSP has an effective Coumadin (blood thinning medication) clinic to manage patients on anticoagulants. A clinical pharmacist appropriately

49. A normal heart rate is between 60 and 100 beats per minute.

50. Alpha thalassemia is a blood disorder with a reduction in hemoglobin, a protein in red blood cells that carries oxygen in the blood.

51. Leukocyte esterase is an enzyme produced by white blood cells and is found in urine. Its presence in urine may indicate inflammation or infection.

monitored INR (a blood test for monitoring the effects of Coumadin) levels and adjusted oral anticoagulants.

In most instances, SVSP providers appropriately managed their patients' chronic health conditions. However, in the following two diabetic cases, we identified that the providers did not properly take care of diabetic patients:

- In case 16, the provider ordered an endocrinology specialty follow-up appointment, but did not ensure that the proper paperwork was in place. As a result, the patient did not see the specialist as intended. When the nurse messaged the provider that the patient's blood sugars were generally uncontrolled, the provider did not order a follow-up appointment to closely monitor the patient's condition; instead, the provider did not see the patient until the next regularly scheduled appointment, which was more than two months later.
- In multiple instances in case 22, the provider did not review the patient's finger stick blood sugar logs to identify that the patient had many days of hypoglycemia. This placed the patient at significant risk of seizure, coma, or even death.

Specialty Services

SVSP providers did not always refer patients for specialty consultation when needed. However, they generally reviewed reports within required time frames when the specialty reports were available, and they followed the specialists' recommendations, except in the following examples. We discuss specialty providers' performance further in the **Specialty Services** indicator.

- In case 19, the provider did not ensure that the patient had a follow-up appointment with the cardiologist as recommended by the hospitalist after his cardiac procedure (cardiac stents placed in coronary arteries). The provider did not completely address the patient's risk factors for heart disease.
- In case 30, the provider reviewed a hand X-ray that showed a first metacarpal fracture. The provider should have referred the patient to the orthopedic surgeon with a high-priority instead of a medium-priority referral.
- In case 11, the optometrist recommended an urgent referral to an ophthalmologist to begin treatment for glaucoma. The provider acted upon this recommendation three weeks later. The provider stated that he did not act in a timely manner because the report was unavailable until two weeks after the encounter. However, the nurse had documented the optometrist's recommendations in a message to the provider the same day the optometrist visit occurred.

- In case 13, the urologist recommended a cystoscopy (a procedure to place a camera into the bladder to look for abnormalities) for microscopic hematuria (bleeding in the urine that is not visible to the naked eye). The provider did not request this procedure and the patient never received an evaluation for this condition.

Incomplete Follow-Through

SVSP providers demonstrated a pattern of developing plans of care, but not a follow-through on those plans. Following through on care plans is essential to develop rapport with this unique patient population. It is difficult to expect patients to adhere to medical plans when the providers do not adhere to them. The following are examples of incomplete follow-through:

- In case 12, the provider documented orders for an orthopedic specialist per hospital recommendations. However, the provider did not follow through on this plan.
- In case 19, the on-call provider received a call from the hospitalist who was discharging the patient, informing the on-call provider of the need for a cardiology follow-up appointment. However, the on-call provider did not inform the primary provider nor arrange the patient follow-up appointment with the cardiologist.
- In multiple instances in case 14, the provider was supposed to follow up on the patient's transesophageal echocardiogram (diagnostic imaging of the heart to evaluate function and valves). The provider did not notify anyone to retrieve this report.
- In case 14, the provider planned to schedule an appointment with the patient due to medication nonadherence. However, the provider did not follow through on this plan.
- In case 22, the provider saw the patient for abnormal liver function tests and parathyroid hormone levels. The provider planned to monitor the patient, but did not follow through on this plan. Subsequently, other laboratory test results (TSH and calcium) were abnormal. The provider planned to monitor these and did not follow through on this plan, either.
- In case 26, the wound care team documented a discussion with the provider to have the patient follow up with the dermatologist, the infectious disease specialist, and the rheumatologist. The provider did not follow through on these recommendations and stated on-site that he felt the patient's wounds were self-inflicted. However, the wound care team continued to request these specialists.

Documentation Quality

SVSP providers did not always provide accurate documentation. Some providers did not assess patients completely nor document their encounters fully, while other providers cloned elements

of their notes without proofreading the contents, which led to inaccurate documentation. Examples of poor documentation follow:

- In case 3, on two separate occasions, the providers did not document a lower extremity examination when the patient complained of pain in his calf and swelling.
- In case 12, the provider did not document vital signs when evaluating the patient for an elbow infection. Previously, the patient's heart rate had been elevated when he had a skin infection.
- In case 13, the provider copied elements of his notes from previous progress notes where he discussed starting aspirin to reduce the risk of heart disease. This gave the false impression that he wanted to start aspirin in a patient who was already on an oral anticoagulant (blood thinner), which would have increased the patient's bleeding risk. Due to cloned elements from previous notes, the provider also noted in one area of the document that the blood pressure was borderline and in another area of the document that the blood pressure was normal. These documentation irregularities lead one to question the veracity of the progress notes.
- Some providers did not send patient notification letters with the required elements as required by CCHCS policy: date of service, whether there is a need for follow-up, and provider signature. This occurred 25 times in the 25 cases we reviewed.[52]

Provider Continuity

The institution offered little provider continuity. The providers and medical leadership explained that providers were assigned to specific clinics; however, they frequently were reassigned due to provider shortages. Medical leadership explained that they must rely on registry and telemedicine providers to provide care. However, provider continuity was not consistent, as many registry providers did not stay beyond the training period and telemedicine providers had variable durations of service. This occurred in case 13 and in the following cases:

- In case 10, the patient had multiple sclerosis and needed medication intravenously every six months. However, the patient was seen by four different providers in six months. Due in part to the lack of care continuity, there was a delay in administration of this medication during the review period.
- In case 21, a nurse appropriately messaged the patient's primary provider to change the administration of the patient's

52. Cases 15, 21, 23, and 27 had results that did not have patient notification sent to the patient. Cases 9, 11, 12, 15, 17, 19, 21, 22, 23, 27, 29, and 30 had patient notification letters that did not contain all elements required per CCHCS policy.

medications. The provider responded that the next assigned provider would address this; however, the provider did not relay this information to the next assigned provider.

Clinician On-Site Inspection

Our case review clinicians observed a morning provider meeting and daily huddles. On-site huddle performance is discussed in the **Health Information Management** and **Nursing Performance** indicators.

We interviewed providers and medical leadership. The providers reported that working conditions and morale were much better than they were a few years ago, when the institution had only three providers.

In our case review, we found that more than a quarter of the provider deficiencies were caused by missing or incomplete patient notification letters. When we discussed this with providers, they described inconsistent requirements due to differences in training.

Medical leadership reported that provider vacancies continued to be problematic as they had just lost four providers—a registry provider and telemedicine providers—in the preceding week. Two of their State providers were transferring into positions as full-time medication-assisted treatment (MAT) clinicians and would no longer serve the rest of the SVSP population. SVSP interviewed many providers, but had difficulty finding providers who could care for the inmates. Multiple registry providers made it through the training period, but rarely stayed after a few days of patient care. Telemedicine providers were available for a few months before they were reassigned to another institution.

Medical leadership also voiced concern over the substance abuse disorder treatment program. CCHCS implemented a new multidisciplinary program to treat substance abuse this past year. However, due to the COVID-19 pandemic, the behavioral therapy component was paused, while CCHCS moved forward with the pharmacologic therapy. Because the pharmacologic therapy in this program has prison barter value, the CME expressed concern due to the volume of patients who requested pharmacologic treatment numbering in the thousands while she had the capacity to treat only a few hundred patients. She informed us that patients who are not in the treatment program have suboxone[53] in their urine toxicology screen results, which demonstrated diversion from patients in the program to others outside of the program. She informed the OIG inspectors she had contacted headquarters regarding the implementation of the program.

Recommendations

- CCHCS medical leadership should consider assigning dedicated and experienced providers to SVSP to help stabilize the provider work force.

53. Suboxone is a medication used to treat opioid addiction and dependence.

Specialized Medical Housing

Overall Rating
Inadequate

Case Review Rating
Adequate

Compliance Score
Inadequate **(70.0%)**

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, SVSP's specialized medical housing was a correctional treatment center (CTC).

Results Overview

In this indicator, the compliance testing and case reviews yielded different ratings, inadequate and adequate, respectively. Compliance scores were poor for timely provider history and physical examinations as well as for timely medication administration. Case reviewers found that nursing performance was good, but medication administration needed improvement. Considering compliance testing and case reviews, on balance, we rated this indicator ***inadequate***.

Case Review Results

We reviewed six CTC cases, which included 47 provider events and 31 nursing events. Because of the care volume that occurs in specialized medical housing units, each provider and nursing event represents up to one month of provider care and one week of nursing care. We identified 11 deficiencies, two of which were significant.[54]

Provider Performance

Performance in the CTC was mixed. Compliance testing showed poor completion of admission history and physicals at 60.0 percent (MIT 13.002). Clinicians reviewed six cases and found four deficiencies in one case. All deficiencies were due to superficial review and documentation. This resulted in misdiagnosing alpha thalassemia as anemia, failure to follow through with plans, incomplete assessment, and cloned notes.[55]

Nursing Performance

CTC nurses provided very good patient care. They performed accurate patient assessments, intervened timely, and implemented provider orders as required. Our compliance testing showed CTC nurses frequently completed thorough initial patient assessments within the required time frame (MIT 13.001, 90.0%). In addition, the nurses initiated

54. Deficiencies occurred in cases 13, 62, 63, and 64. Case 13 had two significant deficiencies.
55. Alpha thalassemia is an inherited blood disorder.

interdisciplinary care plans upon admission as required and educated the patients on the CTC routines, including the nurse call system. Our compliance team found the CTC maintained their operational call system and scored 100 percent (MIT 13.101). Our case reviewers did not identify any significant deficiencies or patterns of deficiencies related to nursing performance in the CTC. In comparison to Cycle 5, CTC nursing performance showed improvement in provider notification of patient condition changes and initiation of applicable care plans.

Medication Administration

This area showed room for improvement. We reviewed six CTC cases and found deficiencies in three cases. Patients did not receive admission medications as ordered because medications were not available, as identified in the following cases:

- In case 62, the patient did not receive the ordered prostate medication and glaucoma eye drops.
- In case 63, the patient did not receive his blood pressure and asthma medications.
- In case 65, the patient did not receive his liver medication as ordered.

Compliance scores were similar at 30.0 percent (MIT 13.004). In Cycle 5, the case reviewers did not identify any medication administration deficiencies.

Clinician On-Site Inspection

The CTC had a 22-bed capacity. Twelve beds were designated for medical patients, and 10 were designated for mental health patients. The CTC had one negative-pressure room. The average daily census was 20 to 22 patients. The CTC had a designated provider during the day, Monday through Friday. An on-call provider was available on weekends, evenings, and holidays. Each shift had an RN assigned as a shift lead, one medical RN, one mental health RN, and an LVN. The second watch also had a psychiatric technician assigned to the CTC. CNA assignments varied from two to four per shift, depending on the patient census. The SRN had recently been hired at SVSP and was assigned to the CTC in October 2020. Nursing staff reported good morale among CTC staff and that their SRN was available and supportive. They also reported good rapport with their custody staff.

We observed the CTC huddle, where the care team reviewed every patient and discussed overnight events. They discussed patients' refusals of medications, patient care, off-site reports, and the upcoming plans for the patient. The provider and the nursing staff demonstrated knowledge about the patients' conditions.

Recommendations

- Medical leadership should ensure that admission history and physical examinations are completed within the time frame required by CCHCS policy.
- Nursing leadership should review the root causes of challenges to ensuring patients who are admitted into Specialized Medical Housing receive their medications timely upon admission; nursing leadership should implement remedial measures as appropriate.

Compliance Testing Results

Table 17. 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 SVSP'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) *	6	4	0	60.0%
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	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) *	3	7	0	30.0%
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): **70.0%**

* 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.

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.

Overall Rating
Inadequate

Case Review Rating
Inadequate

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

Results Overview

SVSP provided poor specialty services for their patients. Compliance scores were low for patients who transferred in with previously approved specialty appointments and endorsement of routine specialty reports. Case reviewers found patterns in which patients did not receive access to specialists and did not receive timely follow-up appointments. Also, SVSP did not retrieve specialty reports within required time frames. Poor access to specialists and information management delays were also identified in Cycle 5. Upon consideration of the areas that need to improve, we rated this indicator ***inadequate***.

Case Review Results

We reviewed 120 events related to Specialty Services; 79 were specialty consultations and procedures. We found 22 deficiencies in this category, nine of which were significant.[56]

Access to Specialty Services

SVSP did not provide good access to specialty services. Compliance testing scores were mixed: specifically, for referrals, 80.0% for routine (MIT 14.007), 73.3% for medium-priority (MIT 14.004), and 80.0% for high-priority (MIT 14.001), and 35% for continuity of access for newly transferred patients with approved specialty consultations (MIT 14.010).

Case reviewers identified four significant deficiencies in this area. This was also discussed in the **Access to Care** indicator.

- In case 26, the provider ordered a routine follow-up appointment with the dermatologist because the patient developed a nonhealing wound after a punch biopsy. He was never seen by the dermatologist. The order was canceled over three months later due to the shelter-in-place order. At the time of the cancellation, the appointment was already out of compliance.
- In case 11, the provider requested an urgent ophthalmology appointment for glaucoma treatment. The appointment did

56. We found significant deficiencies in cases 10, 11, 14, 16, 21, 25, 26, and 37. We found minor deficiencies in 3, 9, 11, 13, 26, 30, 37, and 62.

not occur. The institution indicated that the patient received ophthalmology care from an optometrist.

- In case 16, the provider requested a dietitian consultation within seven days. However, this appointment did not occur.
- In case 21, the provider requested a routine general surgery evaluation for transgender surgery. This appointment did not occur because the provider did not fill out a required packet to seek approval.

Provider Performance

Generally, providers requested the correct specialist consultations within the proper time frames. However, we identified several deficiencies. Poor continuity of care contributed to the following deficiencies:

- In case 10, the provider requested a drug infusion for multiple sclerosis (a neurological disorder wherein the body destroys the lining of nerves) after the patient should have already received a dose. This delay occurred because the patient was seen by four different providers in a six-month period and those providers did not order the medication infusion.
- In case 11, the optometrist recommended an immediate ophthalmologist appointment to start glaucoma treatment. The TTA nurse, who assessed the patient upon return from the optometrist, immediately forwarded to the provider a message with the hand-written recommendations. However, the provider did not address the recommendation until three weeks later.

Compliance testing results showed that provider follow-up appointments after specialty appointments occurred within required time frames, with a score of 81.4% (MIT 1.008).

Nursing Performance

Nurses frequently performed thorough assessments, intervened, and completed documentation when they evaluated patients who returned from specialty appointments. We reviewed 18 events in nine cases for which patients returned from off-site specialty consultations or procedures.[57] We did not identify any significant deficiencies. However, we identified minor deficiencies in cases 26 and 32. Two were related to incomplete assessments and in one deficiency, the nurse did not call the specialty provider to obtain specialty documents.

57. Specialty nursing encounters occurred in cases 9, 11, 14, 16, 20, 21, 25, 26, and 62.

Health Information Management

SVSP did not perform well in information management of specialty reports. We identified a pattern of delayed retrieval of specialty reports in nine of the 25 cases we reviewed. The staff informed us that one of the contracted facilities that provides specialty services rarely complete their reports within required time frames. Examples of delayed report retrieval follow:

- In case 11, the patient did not retrieve the optometrist report until 12 days after the consultation. This was a significant delay because the specialist wanted the patient to be seen by the eye surgeon immediately.
- In case 14, the patient had undergone imaging of the heart to evaluate the heart function, but the institution did not scan the report until eight months later.
- In case 37, the institution did not retrieve the ear, nose, and throat specialist's consultation report.

Compliance testing showed mixed results. Although SVSP staff scanned consultation reports timely (MIT 4.002, 86.7%), their performance in retrievals and endorsements of reports was variable: they scored highest with high-priority reports (MIT 14.002, 86.7%), performed less adequately with medium-priority reports (MIT 14.005, 73.3%), and were inadequate with routine reports (MIT 14.008, 53.3%).

Clinician On-Site Inspection

We discussed specialty service performance with SVSP managers, supervisors, providers, and utilization management nursing staff.[58] Management explained that due to the institution's location, they must refer patients to facilities several hours away. In addition, because of the high number of patient refusals, many specialists did not want to see the institution's patients: they book their clinic with the patients only to have the patient refuse to show up. Management also explained that one facility did not return consultation reports timely, which led to some health information deficiencies. SVSP has elevated this issue to headquarters to address the problem. Institutional staff have had varied successes in obtaining the services of local specialists who are closer to the facility.

58. A utilization management nurse assists in ensuring the appropriate use of limited health care resources including, but not limited to, medical procedures, consultations with specialists, diagnostic studies, inpatient beds, and outpatient beds allocated for health program use to promote the best possible patient outcomes, eliminate unnecessary cost, and maintain consistency in the delivery of health care services' consistent with the stated goals of HCDOM section 1.2.15 Utilization Management Program.

Recommendations

- CCHCS headquarters should intervene on behalf of the institution to ensure that contracted specialists deliver reports within required time frames.
- Medical leadership should review the causes of the untimely provider review of specialty reports; medical leadership should implement remedial measures as appropriate.
- Medical leadership should ensure that patients receive specialty service appointments and specialty follow-up appointments within required time frames.
- Medical and nursing leadership should ensure that patients receive their previously scheduled specialty appointments within the required time frame when transferring between institutions.

Compliance Testing Results

Table 18. Specialty Services

Compliance Questions	Scored Answer			
	Yes	No	N/A	Yes %
Did the patient receive the high-priority specialty service within 14 calendar days of the primary care provider order or the Physician Request for Service? (14.001) *	12	3	0	80.0%
Did the institution receive and did the primary care provider review the high-priority specialty service consultant report within the required time frame? (14.002) *	13	2	0	86.7%
Did the patient receive the subsequent follow-up to the high-priority specialty service appointment as ordered by the primary care provider? (14.003) *	6	5	4	54.5%
Did the patient receive the medium-priority specialty service within 15-45 calendar days of the primary care provider order or Physician Request for Service? (14.004) *	11	4	0	73.3%
Did the institution receive and did the primary care provider review the medium-priority specialty service consultant report within the required time frame? (14.005) *	11	4	0	73.3%
Did the patient receive the subsequent follow-up to the medium-priority specialty service appointment as ordered by the primary care provider? (14.006) *	5	3	7	62.5%
Did the patient receive the routine-priority specialty service within 90 calendar days of the primary care provider order or Physician Request for Service? (14.007) *	12	3	0	80.0%
Did the institution receive and did the primary care provider review the routine-priority specialty service consultant report within the required time frame? (14.008) *	8	7	0	53.3%
Did the patient receive the subsequent follow-up to the routine-priority specialty service appointment as ordered by the primary care provider? (14.009) *	5	1	9	83.3%
For endorsed patients received from another CDCR institution: If the patient was approved for a specialty services appointment at the sending institution, was the appointment scheduled at the receiving institution within the required time frames? (14.010) *	7	13	0	35.0%
Did the institution deny the primary care provider's request for specialty services within required time frames? (14.011)	N/A	N/A	N/A	N/A
Following the denial of a request for specialty services, was the patient informed of the denial within the required time frame? (14.012)	N/A	N/A	N/A	N/A
				Overall percentage (MIT 14): **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 19. 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) *, †	35	8	2	81.4%
Are specialty documents scanned into the patient's electronic health record within five calendar days of the encounter date? (4.002) *	26	4	15	86.7%

* 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.

Administrative Operations

Overall Rating
Adequate

Case Review Rating
(N/A)

Compliance Score
Adequate
(82.6%)

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. We 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.

Results Overview

SVSP staff scored 100 percent in most applicable testing areas, with the exception of the Emergency Medical Response Review Committee's (EMRRC) reviewing cases within required time frames and the incident packages including the required documents, and excepting the institutions' performance in conducting medical emergency response drills during each watch of the quarter and in the health care and custody staff's participation in those drills. The physician managers only sometimes completed the annual performance appraisals in a timely manner. These findings are set forth in the table on page 81. We rated this indicator ***adequate***.

Nonscored Results

We reviewed SVSP's root cause analysis of reported incidents. During our testing period, SVSP submitted two reports to the CCHCS Health Care Incident Review Committee (HCIRC). We found that both root cause analysis reports were pending to be approved by the HCIRC and did not meet reporting requirements per CCHCS policy (MIT 15.001).

We obtained CCHCS Death Review Committee (DRC) reporting data. Nine 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. When the DRC completes the death review summary report, it must submit the report to the institution's CEO within seven

calendar days of completion. In our inspection, we found the DRC did not complete any death review reports promptly; the DRC finished six reports 65 to 114 days late and submitted them to the institution's CEO 11 to 54 days after that. The remaining three reports had not been completed at the time of OIG's inspection (MIT 15.998).

Recommendations

- Medical leadership should ensure the institution's Emergency Medical Response Review Committee (EMRRC) reviews cases within required time frames and includes all required documents.

Table 20. 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)	6	0	0	100%
For Emergency Medical Response Review Committee (EMRRC) reviewed cases: Did the EMRRC review the cases timely, and did the incident packages the committee reviewed include the required documents? (15.003)	4	8	0	33.3%
For institutions with licensed care facilities: Did the Local Governing Body (LGB) or its equivalent, meet quarterly and discuss local operating procedures and any applicable policies? (15.004)	4	0	0	100%
Did the institution conduct medical emergency response drills during each watch of the most recent quarter, and did health care and custody staff participate in those drills? (15.101)	3	0	0	100%
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)	9	1	0	90.0%
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)	3	3	1	50.0%
Did the providers maintain valid state medical licenses? (15.106)	13	0	0	100%
Did the staff maintain valid Cardiopulmonary Resuscitation (CPR), Basic Life Support (BLS), and Advanced Cardiac Life Support (ACLS) certifications? (15.107)	2	0	1	100%
Did the nurses and the pharmacist-in-charge (PIC) maintain valid professional licenses and certifications, and did the pharmacy maintain a valid correctional pharmacy license? (15.108)	6	0	1	100%
Did the pharmacy and the providers maintain valid Drug Enforcement Agency (DEA) registration certificates? (15.109)	1	0	0	100%
Did nurse managers ensure their newly hired nurses received the required onboarding and clinical competency training? (15.110)	0	1	0	0
Did the CCHCS Death Review Committee process death review reports timely? (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): **82.6%**			

* Effective March 2021, this test was for informational purposes only.

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

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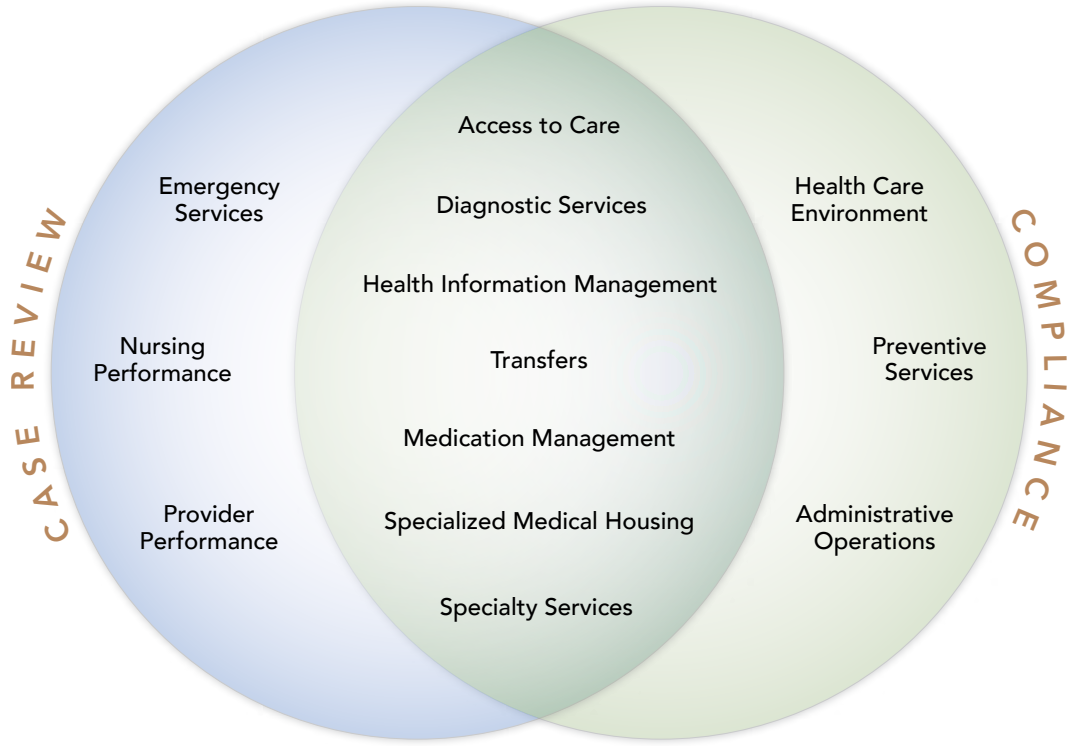
Appendix A: Methodology

In designing the medical inspection program, the OIG met with stakeholders to review CCHCS policies and procedures, relevant court orders, and guidance developed by the American Correctional Association. We also reviewed professional literature on correctional medical care; reviewed standardized performance measures used by the health care industry; consulted with clinical experts; and met with stakeholders from the court, the receiver's office, the department, the Office of the Attorney General, and the Prison Law Office to discuss the nature and scope of our inspection program. With input from these stakeholders, the OIG developed a medical inspection program that evaluates the delivery of medical care by combining clinical case reviews of patient files, objective tests of compliance with policies and procedures, and an analysis of outcomes for certain population-based metrics.

We rate each of the quality indicators applicable to the institution under inspection based on case reviews conducted by our clinicians or compliance tests conducted by our registered nurses. Figure A–1 below depicts the intersection of case review and compliance.

Figure A–1. Inspection Indicator Review Distribution for SVSP



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

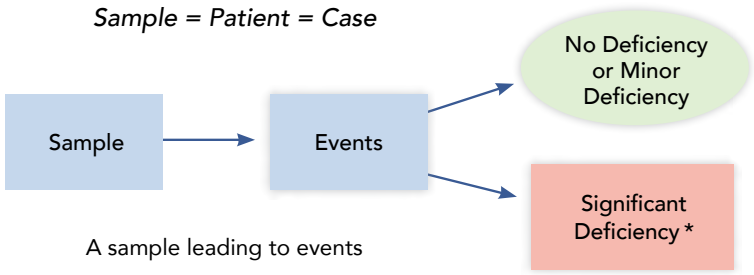
An OIG physician, a nurse consultant, or both review each case. As the clinicians review medical records, they record pertinent interactions between the patient and the health care system. We refer to these interactions as case review ***events***. Our clinicians also record medical errors, which we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

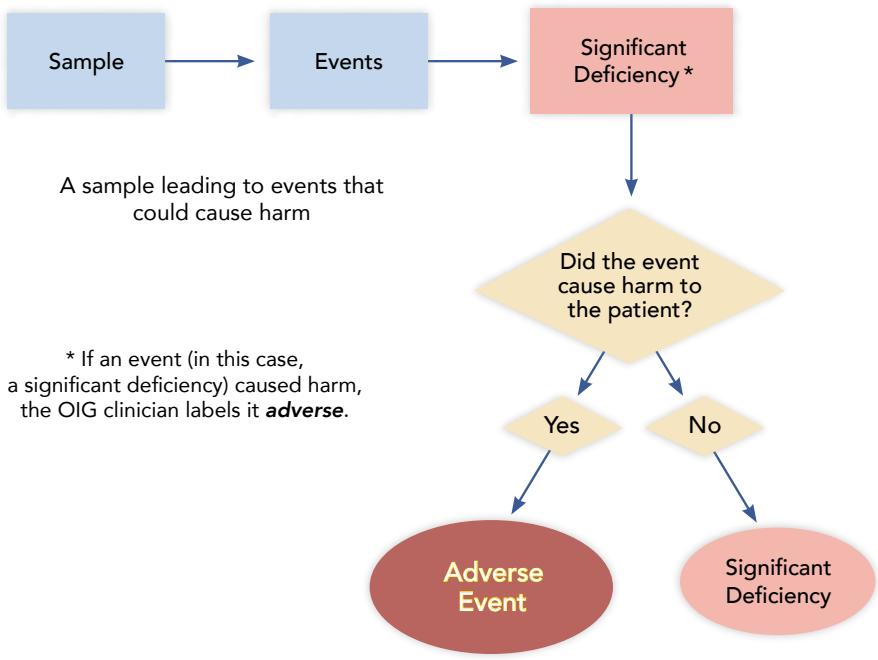
Figure A–2. Case Review Testing

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***.



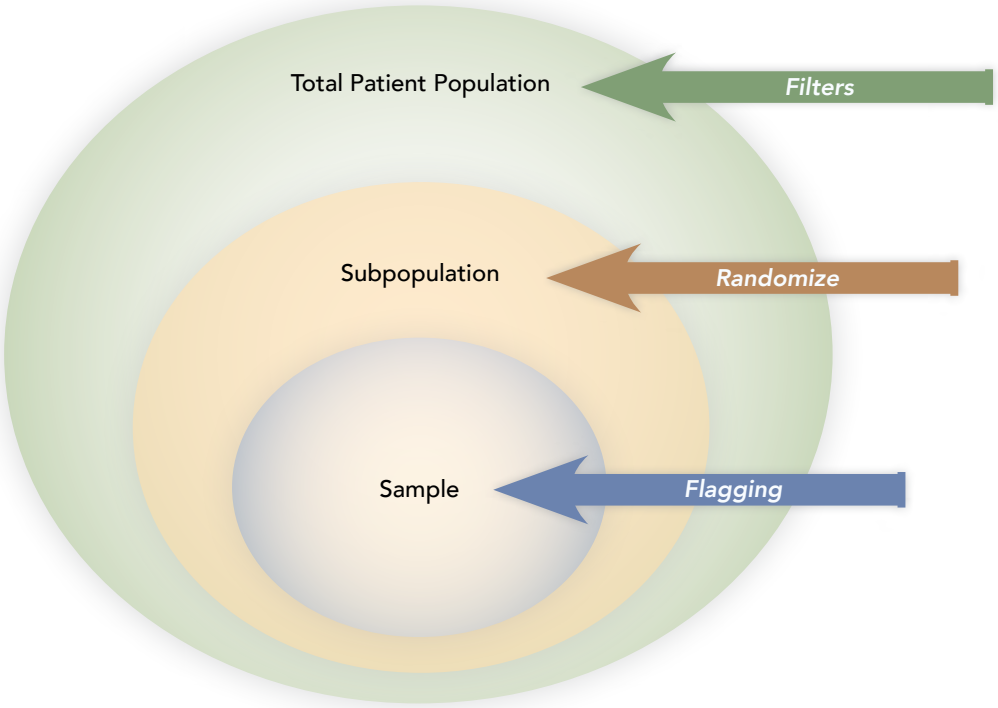
Source: The Office of the Inspector General medical inspection analysis.

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	3
CTC/OHU	4
Death Review/Sentinel Events	3
Diabetes	3
Emergency Services – CPR	5
Emergency Services – Non-CPR	3
High Risk	5
Hospitalization	4
Intrasystem Transfers In	3
Intrasystem Transfers Out	3
RN Sick Call	24
Specialty Services	4
	64

Table B–2. Case Review Chronic Care Diagnoses

Diagnosis	Total
Anemia	5
Anticoagulation	4
Arthritis/Degenerative Joint Disease	5
Asthma	11
COPD	3
Cancer	3
Cardiovascular Disease	3
Chronic Kidney Disease	19
Chronic Pain	6
Cirrhosis/End-Stage Liver Disease	1
Diabetes	7
Gastroesophageal Reflux Disease	9
Hepatitis C	22
Hyperlipidemia	11
Hypertension	19
Mental Health	26
Migraine Headaches	1
Seizure Disorder	6
Sleep Apnea	4
Thyroid Disease	**2**
	167

Table B–3. Case Review Events by Program

Diagnosis	Total
Diagnostic Services	232
Emergency Care	81
Hospitalization	58
Intrasystem Transfers In	20
Intrasystem Transfers Out	11
Not Specified	1
Outpatient Care	689
Specialized Medical Housing	127
Specialty Services	161
	1,380

Table B–4. Case Review Sample Summary

MD Reviews Detailed	25
MD Reviews Focused	0
RN Reviews Detailed	18
RN Reviews Focused	35
Total Reviews	78
Total Unique Cases	64
Overlapping Reviews (MD & RN)	14

Appendix C: Compliance Sampling Methodology

Salinas Valley 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	3	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	4	OIG inspector on-site review	• R&R IP transfers with medication

Quality Indicator	Sample Category	No. of Samples	Data Source	Filters
Pharmacy and Medication Management				
MIT 7.001	Chronic Care Medication	25	OIG Q: 1.001	See **Access to Care** • At least one condition per patient—any risk level • Randomize
MIT 7.002	New Medication Orders	25	Master Registry	• Rx count • Randomize • Ensure no duplication of IPs tested in MIT 7.001
MIT 7.003	Returns From Community Hospital	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	N/A at this institution	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	5	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	19	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	14	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)	N/A at this institution	Cocci transfer status report	• Reports from past 2–8 months • Institution • Ineligibility date (60 days prior to inspection date) • All

Quality Indicator	Sample Category	No. of Samples	Data Source	Filters
Reception Center				
MITs 12.001–008	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	20	MedSATS	• Arrived from (other departmental institution) • Date of transfer (3–9 months) • Randomize
MITs 14.011–012	Denials	N/A	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	2	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	7	On-site provider evaluation files	• All required performance evaluation documents
MIT 15.106	Provider Licenses	13	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	9	OIG summary log: deaths	• Between 35 business days & 12 months prior • Health Care Services death reviews

California Correctional Health Care Services' Response

June 10, 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 Salinas Valley State Prison (SVSP) conducted from December 2019 to May 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) 691-9452.

Sincerely,

Amanda Oltean Digitally signed by Amanda Oltean
Date: 2021.06.10 15:14:28 -07'00'

(for Terra Adams)
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
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Annette Lambert, Deputy Director, Quality Management, CCHCS
Regional Health Care Executive, Region II, CCHCS
Regional Deputy Medical Executive, Region II, CCHCS
Regional Nursing Executive, Region II, CCHCS
Chief Executive Officer, SVSP
Misty Polasik, Staff Services Manager I, OIG

CALIFORNIA CORRECTIONAL HEALTH CARE SERVICES

P.O. Box 588500
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Cycle 6
Medical Inspection Report

for

Salinas Valley State Prison

OFFICE *of the*
INSPECTOR GENERAL

Roy W. Wesley
Inspector General

Bryan B. Beyer
Chief Deputy Inspector General

STATE *of* CALIFORNIA
June 2021

OIG