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

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

OIG | OFFICE *of the* INSPECTOR GENERAL

Independent Prison Oversight

July 2021

Cycle 6
Medical Inspection Report

Richard J. Donovan Correctional Facility

Revised on 9-7-21; see next page for explanation.

Report revised and republished on 9-7-21:

Corrected months from June to July (Illustrations, Tables 3 and 4, page iv*).*

Adjusted percentage labeling and corrected data for Table 2 (legend and MIT 15, page 4).

Adjusted lead-in sentence and added bullet point (reference to adverse event, page 7).

Revised language from that which appeared in the original report (Tables 8, 10, 14, and 20, pages 28, 30, 54, and 74).

Corrected data (reference to MIT 14.005, page 27).

Corrected data for Tables 13 and 19 (pages 47 and 72).

Corrected data and revised language (Appendix C, pages 84 through 90).

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

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

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

Contents

Illustrations

Tables

Figures

Photographs

Cover: Rod of Asclepius courtesy of Thomas Shafee

(This page left blank for reproduction purposes.)

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 Richard J. Donovan Correctional Facility (RJD), the receiver had not delegated this institution back to the department.

We completed our sixth inspection of RJD, and this report presents our assessment of the health care provided at that institution during the inspection period between January 2020 and June 2020.[6] While the data we obtained for RJD predate the novel coronavirus disease pandemic (COVID-19), the on-site inspections occurred during the pandemic.

Richard J. Donovan Correctional Facility (RJD) is located in unincorporated San Diego County, near San Diego, and is approximately one and a half miles from the Mexico–United States border. The institution, which opened in July 1987, provides housing for general population and Level I, II, III, and IV incarcerated persons. The department designated RJD for incarcerated persons with severe mental illness as well as incarcerated persons with developmental disabilities. RJD has multiple clinics in which medical staff members respond to nonurgent requests for medical services and a triage and treatment area (TTA) to provide urgent and emergent care. The facility has a licensed correctional treatment center (CTC) to provide health care to patients who need supervised health care beyond what is normally provided on an outpatient basis. The department has also designated RJD as an intermediate care institution. Intermediate institutions are located in predominantly urban areas, close to tertiary care centers and specialty care providers, for the most cost-effective care.

6. Samples are obtained per case review methodology shared with stakeholders in prior cycles. The case reviews include cardiopulmonary resuscitation (CPR) reviews between April 2019 and March 2020, death reviews between June 2019 and March 2020, anticoagulation reviews between January 2020 and September 2020, hospitalization reviews between December 2019 and August 2020, RN sick call reviews between November 2019 and July 2020, and correctional treatment center (CTC) reviews between July 2019 and December 2019.

Summary

We completed the Cycle 6 inspection of Richard J. Donovan Correctional Facility (RJD) in December 2020. OIG inspectors monitored the institution's delivery of medical care that occurred between January 2020 and June 2020.

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

Table 1. RJD 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 444 patient records and 1,261 data points, and used the data to answer 92 policy questions. In addition, we observed RJD's processes during an on-site inspection in October 2020. Table 2 below lists RJD's average scores from Cycles 4, 5, and 6.

The OIG clinicians (a team of physicians and nurse consultants) reviewed 72 detailed cases, which contained 1,004 patient-related events. After examining the medical records, our clinicians conducted a follow-up on-site inspection in December 2020 to verify their initial findings. The OIG physicians rated the quality of care for 25 comprehensive case

Table 2. RJD 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	89.5%	85.9%	84.3%
2	Diagnostic Services	88.4%	70.0%	66.9%
4	Health Information Management	58.6%	62.4%	91.8%†
5	Health Care Environment	82.6%	62.6%	63.3%
6	Transfers	81.4%	78.0%	60.3%
7	Medication Management	70.4%	67.7%	49.0%
8	Prenatal and Postpartum Care	N/A	N/A	N/A
9	Preventive Services	60.4%	69.7%	59.3%
12	Reception Center	N/A	N/A	N/A
13	Specialized Medical Housing	92.0%	85.0%	72.5%
14	Specialty Services	80.7%	79.5%	67.5%
15	Administrative Operations	62.9%*‡	92.3%	71.4%

* 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.

† Score changed from 95.2 percent to 91.8 percent.

‡ Score changed from 58.3 percent to 62.9 percent.

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

reviews. Of these 25 cases, our physicians rated 23 ***adequate*** and two ***inadequate***. Our physicians found one adverse event during this inspection.

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

In July 2020, the Health Care Services Master Registry showed that RJD had a total population of 3,786. A breakdown of the medical risk level of the RJD population as determined by the department is set forth in Table 3 below.[8]

Table 3. RJD Master Registry Data as of July 2020

Medical Risk Level	Number of Patients	Percentage
High 1	668	17.6%
High 2	745	19.7%
Medium	1,606	42.4%
Low	767	20.3%
Total	**3,786**	**100%**

Source: Data for the population medical risk level were obtained from the CCHCS Master Registry dated 7-17-20.

7. The indicators for **Reception Center** and **Prenatal Care** did not apply to RJD.
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, RJD had one vacant executive leadership position, half of a position vacant among primary care providers, vacancies of 1.2 positions among nursing supervisors, and 10.2 vacant nursing staff positions.

Table 4. RJD Health Care Staffing Resources as of July 2020

Positions	Executive Leadership*	Primary Care Providers	Nursing Supervisors	Nursing Staff †	Total
Authorized Positions	10	16.5	25.7	218.8	271
Filled by Civil Service	9	16	24.5	208.6	258.1
Vacant	1	0.5	1.2	10.2	12.9
Percentage Filled by Civil Service	90.0%	97.0%	95.3%	95.3%	95.2%
Filled by Telemedicine	0	0	0	0	0
Percentage Filled by Telemedicine	0	0	0	0	0
Filled by Registry	0	0	0	9.6	9.6
Percentage Filled by Registry	0	0	0	4.4%	3.5%
Total Filled Positions	9	16	24.5	218.2	267.7
Total Percentage Filled	90.0%	97.0%	95.0%	99.7%	98.8%
Appointments in Last 12 Months	1	2	5	37	45
Redirected Staff	0	0	0	0	0
Staff on Extended Leave‡	0	0	1	3	4
Adjusted Total: Filled Positions	**9**	**16**	**23.5**	**215.2**	**263.7**
Adjusted Total: Percentage Filled	**90.0%**	**97.0%**	**91.4%**	**98.4%**	**97.3%**

* 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 July 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 found an adverse event in the case review at RJD during the Cycle 6 inspection:

- In case 20, the ophthalmologist diagnosed the patient with glaucoma and recommended starting the patient on a topical eye medication to lower the intraocular pressure and having the patient return for a follow-up appointment in three months. However, the provider did not address the recommendations, placing the patient at risk of untreated glaucoma and vision loss. The patient did not receive the recommended eye drops for eight months. [Adjusted lead-in sentence and added bullet point.]

Case Review Results

OIG case reviewers (a team of physicians and nurse consultants) assessed 10 of the 13 indicators applicable to RJD. Of these 10 indicators, OIG clinicians rated one ***proficient***, seven ***adequate***, and two ***inadequate***. The OIG physicians also rated the overall adequacy of care for each of the 25 detailed case reviews they conducted. Of these 25 cases, 23 were ***adequate*** and two were ***inadequate***. In the 1,004 events reviewed, there were 172 deficiencies, 35 of which the OIG clinicians considered to be of such magnitude that, if left unaddressed, would likely contribute to patient harm.

Our clinicians found the following strengths at RJD:

- The institution provided excellent health information management, as most hospital discharge records, diagnostic results, and specialty reports were retrieved and scanned within required time frames.
- RJD delivered good emergency care, comparable to that delivered in Cycle 5. Nursing staff responded promptly to emergent events, recognized opioid overdoses, and implemented the nursing overdose protocol within the required time frame.

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

- Providers performed well in urgent and emergent situations and were readily available for consultation with the TTA staff.
- RJD staff performed well in the specialized medical housing units. Compared to staff's performance in Cycle 5, our clinicians found fewer significant and overall deficiencies. Nurses performed appropriate admission assessments and rounds; providers saw their patients within the recommended time frames and provided adequate care.

Our clinicians found RJD could improve in the following areas:

- RJD continued to perform poorly in medication management. There were lapses in managing new medications, chronic care medications, hospital return medications, specialized medical housing medications, and transfer medications.
- RJD performed poorly in collecting laboratory samples and communicating stat laboratory results within the required time frame.
- RJD performed poorly in scheduling preapproved specialty appointments for patients transferred into the institution.

Compliance Testing Results

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

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

- Medical staff performed well in scanning initial health care screening forms, community hospital discharge reports, and requests for health care services into patients' electronic medical records within required time frames.
- Nursing staff at RJD reviewed health care services request forms and conducted face-to-face encounters within required time frames. In addition, RJD housing units contained adequate supplies of health care request forms.
- Providers saw patients returning from outside community hospitals within required time frames. Moreover, patients were referred within required time frames to their providers upon arrival at the institution.

RJD 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. There was poor medication continuity for patients returning from hospitalizations, for patients admitted to specialized medical housing, for patients transferring within RJD, and for patients laying over at RJD.
- RJD did not perform well in ensuring that approved specialty services were provided within specified time frames.
- RJD did poorly managing patients on tuberculosis (TB) medications. Patients were not receiving their TB medications timely. The institution did not complete monitoring at all required intervals. In addition, the nursing staff did not appropriately conduct TB screening timely.

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 RJD's performance with population-based metrics to assess the macroscopic view of the institution's health care delivery. RJD'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)), RJD performed better in four of the five diabetic measures: HbA1c screening, Poor HbA1c control, HbA1c control, and blood pressure control. RJD scored lower than Kaiser Southern California, Kaiser Northern California, and Medi-Cal for the diabetic eye examinations.

Table 5. RJD Results Compared With State HEDIS Scores

HEDIS Measure	RJD 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%)‡,§	**10%**	34%	24%	20%
HbA1c Control (<8.0%)‡	**79%**	55%	62%	70%
Blood Pressure Control (<140/90)‡	**87%**	67%	75%	85%
Eye Examinations	51%	63%	77%	**83%**
Influenza–Adults (18–64)	41%	–	–	–
Influenza–Adults (65+)‖	66%	–	–	–
Pneumococcal–Adults (65+)‖	82%	–	–	–
Colorectal Cancer Screening	74%	–	–	–

Notes and Sources

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

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

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

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

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

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

Immunizations

Statewide comparative data were not available for immunization measures; however, we include this data for informational purposes. RJD had a 41.0 percent influenza immunization rate for adults 18 to 64 years old, and a 66.0 percent influenza immunization rate for adults 65 years of age and older.[10] The pneumococcal vaccine rate was 82.0 percent.[11]

Colorectal Cancer Screening

Statewide comparative data were not available for colorectal cancer screening; however, we include these data for informational purposes. RJD had a 74.0 percent colorectal cancer screening rate.

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

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

Recommendations

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

Access to Care

- Medical leadership should continue to train medical staff in accurately placing provider and nurse appointments; leadership should implement remedial measures as appropriate.
- Medical leadership should ensure that appointments are completed within the required time frames for patients with chronic care conditions, for provider follow-up sick calls, and for follow-up after off-site specialty services.

Diagnostic Services

- Laboratory and nursing leadership should ascertain the root causes of the lack of timeliness in collecting samples for stat laboratory tests and communicating the results of stat laboratory tests; leadership should implement remedial measures as appropriate.
- The department should consider developing and implementing a letter template for patient results that autopopulates with all the elements required per CCHCS policy.
- Medical leadership should remind providers to send patient notification letters with appropriate key elements per CCHCS policy for diagnostic services.

Emergency Services

- RJD's EMRRC reports and logs were very thorough and well-organized. CCHCS should consider using RJD's reports as an example for best practice.

Transfers

- Health care leadership should identify the challenges to medication continuity for patients returning from hospitalizations or emergency rooms and for patients en route who lay over at the institution; leadership should implement remedial measures as appropriate.
- Nursing leadership should remind nursing staff to fully document tuberculosis (TB) symptoms as part of the patient's initial health assessment.
- Nursing leadership should educate nursing staff to thoroughly complete the initial health screening, including answering all

questions and documenting an explanation for each "yes" answer.

- Medical leadership should ensure that preapproved specialty services are scheduled and provided to the patient within specified time frames.
- Nursing leadership should remind nursing staff of documentation requirements in the patient's medical administration record.

Medication Management

- Medical leadership should determine the causes of untimely medication continuity for chronic care, transfer-in, hospital discharge, and en-route patients; leadership should implement remedial measures as appropriate.
- Medical and nursing leadership should ensure that chronic care, transfer-in, hospital discharge, and en-route patients receive their medications timely and without interruption; leadership should implement remedial measures as appropriate.
- Nursing leadership should remind nursing staff of documentation requirements in the patient's medical administration record and on the TB monitoring form.

Preventive Services

- Nursing leadership and a public health nurse should educate their nursing staff in accurately monitoring patients on TB medications.
- Nursing leadership should educate nursing staff to fully document TB symptoms as part of the patient's TB monitoring.

Specialized Medical Housing

- Nursing leadership should ensure that patients admitted to the correctional treatment center (CTC) timely receive their medications upon admission.
- Nursing leadership should ensure that initial assessments are completed within the time frame required by CCHCS policy.

Specialty Services

- Medical leadership should identify why preapproved specialty appointments were missed for transfer-in patients; leadership should implement remedial measures as appropriate.

- Medical leadership should identify the root causes for the untimely provision of ordered specialty services; leadership should implement remedial measures as appropriate.
- Medical leadership should ensure that specialty services consultant reports are timely retrieved and reviewed by the institution's providers.
- Medical leadership should ensure that when specialty services requests are denied, providers inform their patients of these denials within appropriate time frames.

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 ***Adequate*** **(84.3%)**

Results Overview

RJD provided adequate access to care in most clinical areas. Our clinicians found that most appointments were completed in a timely manner, including appointments with clinic providers, correctional treatment center (CTC) providers, nurses, and specialists. Compliance testing was consistent with clinical review, as the overall score for access to care was 84.3 percent. The OIG rated this indicator ***adequate***.

Case Review Results

We reviewed 506 provider, nursing, urgent or emergent care (TTA), specialty, and hospital events that required the institution to generate appointments. We identified 23 deficiencies related to access to care, of which 12 were significant.[12]

Access to Clinic Providers

Access to clinic providers is an integral part of patient care in health care delivery. RJD performed inadequately in both compliance testing and case review. Compliance testing found that 60.0 percent of chronic care follow-up appointments occurred on time (MIT 1.001), 66.7 percent of provider-ordered follow-up sick call appointments occurred within the time frame specified (MIT 1.006), and 77.8 percent of nurse-to-provider sick call referrals occurred as requested (MIT 1.005). Our clinicians reviewed 139 clinic provider appointments and identified six deficiencies,[13] including the examples below:

- In case 1, the patient underwent a surgical procedure on his great toe, and a provider requested a clinic provider appointment in 14 days; however, the appointment occurred more than one month later.
- In case 53, the patient had knee pain and requested to see his provider, and a nurse requested a clinic provider appointment within 14 days; however, the appointment did not occur. One

12. Deficiencies occurred four times in case 24, three times in case 25, twice in case 31, and once in cases 1, 3, 10, 12, 18, 20, 22, 27, 29, 38, 40, 53, 57, and 61. Cases 1, 18, 20, 24, 25, 27, 29, 31, 40, and 53 had significant deficiencies.

13. Deficiencies occurred in cases 1, 12, 38, 53, 57, and 61.

month later, the patient submitted another request to see his provider for knee pain, and the provider saw the patient then.

Access to Specialized Medical Housing Providers

RJD performed well in access to care in the CTC. When staff admitted patients to the CTC, providers evaluated the patients and documented progress notes within the appropriate time frames. Compliance testing found that 100 percent of the CTC admission history and physical examinations occurred within the required time frame (MIT 13.002). Our clinicians assessed 19 CTC provider encounters and did not identify any deficiency related to late or missed admission histories, physical examinations, or follow-up appointments.

Access to Clinic Nurses

RJD also performed well with access for nurse sick calls and provider-to-nurse referrals. Compliance testing found that all nurse sick call requests were reviewed on the day they were received (MIT 1.003, 100%). Moreover, nurses evaluated 95.0 percent of their patients within one business day, as required (MIT 1.004). OIG clinicians identified four deficiencies related to clinic nurse access, two of which were significant:[14]

- In case 24, the patient filled out a sick call request for muscle cramps and joint pain; however, the sick call appointment with a nurse did not occur.
- In case 40, the patient filled out a sick call request to be seen for an allergy issue; however, the sick call appointment with a nurse did not occur.

Access to Specialty Services

RJD provided inadequate specialty access. Compliance testing found that 73.3 percent of the high-priority specialty appointments occurred within the required time frame (MIT 14.001), medium-priority specialty appointments occurred as requested 60.0 percent of the time (MIT 14.004), and routine specialty appointments occurred as requested 86.7 percent of the time (MIT 14.007). Our clinicians reviewed 83 specialty events and identified four deficiencies, three of which were significant.[15] We discuss these deficiencies in the **Specialty Services** indicator.

14. Deficiencies occurred twice in case 25 and once in cases 24 and 40.

15. Deficiencies occurred twice in case 31 and once in cases 20 and 24. Significant deficiencies occurred twice in case 31 and once in case 20.

Follow-Up After Specialty Service

RJD performed well in ensuring patients saw their providers after specialty appointments. Compliance testing revealed that most provider appointments after specialty services occurred within required time frames (MIT 1.008, 78.9%). Our clinicians reviewed 83 specialty appointments and identified one missed provider follow-up appointment after specialty service:

- In case 29, the gastroenterologist saw the patient and recommended a capsule endoscopy; however, the required provider follow-up appointment did not occur.[16] Thus, the recommendation was not addressed.

Follow-Up After Hospitalization

RJD ensured that patients saw their providers promptly after hospitalizations. Compliance testing found that most provider appointments occurred within the required time frames (MIT 1.007, 92.0%). Our clinicians reviewed 25 hospital returns and identified one missed provider appointment:

- In case 25, the patient returned from the hospital with a diagnosis of bradycardia (an abnormally slow heart rate); the provider follow-up appointment required to occur within five days did not occur.

Follow-Up After Urgent or Emergent Care (TTA)

RJD providers generally saw their patients after an event in the triage and treatment area (TTA) as requested. Our clinicians assessed 33 TTA events and identified one delayed provider follow-up appointment:

- In case 25, TTA staff evaluated and treated the patient for right ear pain and requested a provider follow-up appointment within five days; however, the appointment occurred almost one month later.

Follow-Up After Transferring Into the Institution

Compliance testing showed that RJD providers saw 88.0 percent of the transfer-in patients within the required time frames (MIT 1.002). Our clinicians evaluated four transfer-in events and identified one delayed provider appointment:

- In case 3, a nurse performed the initial health screening examination for a patient who transferred into RJD and requested a provider appointment within seven days for this high-risk patient. However, the appointment occurred 15 days later.

16. A capsule endoscopy is a procedure that involves swallowing a small capsule, which is the size of a large pill. Inside the capsule is a tiny wireless camera that takes pictures as it passes through the small intestine.

Clinician On-Site Inspection

RJD has five main clinics, facilities A, B, C, D and E. Each clinic had one primary provider. Each clinic also had an office technician who attended the morning huddles and ensured that provider appointments were scheduled. The providers saw about six to eight patients per day.

The scheduling supervisor explained that most delayed or missed appointments were due to two provider vacancies and the COVID-19 schedule guidelines from CCHCS, which instructed that all nonurgent provider and nursing appointments should be rescheduled. In April 2020, RJD had a backlog of 1,292 provider appointments. However, by the time of our on-site visit, the backlog had already been reduced to 145 provider appointments in the main clinics. The supervisor reported the improvement in provider access because all the provider positions had been filled and the providers were able to return to their normal schedule.

The scheduling supervisor also reported that some of the missed appointments were also due to human errors, as the medical staff did not appropriately place the appointments. The scheduling supervisor explained the ongoing training to the medical staff was provided to correct this error.

Recommendations

- Medical leadership should continue to train medical staff in accurately placing provider and nurse appointments; leadership should implement remedial measures as appropriate.
- Medical leadership should ensure that appointments are completed within the required time frames for patients with chronic care conditions, for provider follow-up sick calls, and for follow-up off-site specialty services.

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) *	15	10	0	60.0%
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) *	22	3	0	88.0%
Clinical appointments: Did a registered nurse review the patient's request for service the same day it was received? (1.003) *	40	0	0	100%
Clinical appointments: Did the registered nurse complete a face-to-face visit within one business day after the CDCR Form 7362 was reviewed? (1.004) *	38	2	0	95.0%
Clinical appointments: If the registered nurse determined a referral to a primary care provider was necessary, was the patient seen within the maximum allowable time or the ordered time frame, whichever is the shorter? (1.005) *	14	4	22	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) *	2	1	37	66.7%
Upon the patient's discharge from the community hospital: Did the patient receive a follow-up appointment within the required time frame? (1.007) *	23	2	0	92.0%
Specialty service follow-up appointments: Did the clinician follow-up visits occur within required time frames? (1.008) *,†	30	8	7	78.9%
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): **84.3%**

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

† CCHCS changed its 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) *	10	0	0	100%
For OHU, CTC, SNF, and Hospice (applicable only for samples prior to 4/2019): Did the primary care provider complete the Subjective, Objective, Assessment, and Plan notes on the patient at the minimum intervals required for the type of facility where the patient was treated? (13.003) *,†	0	0	10	N/A
Did the patient receive the high-priority specialty service within 14 calendar days of the primary care provider order or the Physician Request for Service? (14.001) *	11	4	0	73.3%
Did the patient receive the subsequent follow-up to the high-priority specialty service appointment as ordered by the primary care provider? (14.003) *	1	5	9	16.7%
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) *	9	6	0	60.0%
Did the patient receive the subsequent follow-up to the medium-priority specialty service appointment as ordered by the primary care provider? (14.006) *	10	1	4	90.9%
Did the patient receive the routine-priority specialty service within 90 calendar days of the primary care provider order or Physician Request for Service? (14.007) *	13	2	0	86.7%
Did the patient receive the subsequent follow-up to the routine-priority specialty service appointment as ordered by the primary care provider? (14.009) *	2	4	9	33.3%

* 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.

Diagnostic Services

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

Overall Rating ***Inadequate***

Case Review Rating ***Adequate***

Compliance Score ***Inadequate*** **(66.9%)**

Results Overview

RJD showed mixed result in this indicator. The institution performed well in completing and retrieving radiology tests but performed poorly in collecting laboratory samples and communicating stat laboratory results within the required time frame. Our inspection yielded mixed results: although the case review rating was adequate, the compliance score was low, at 66.9 percent. Overall, the OIG rated this indicator ***inadequate***.

Case Review Results

We reviewed 220 diagnostic events and identified 17 deficiencies,[17] three of which were significant.[18]

Test Completion

Compliance testing showed the institution completed most radiology tests within the required time frames (MIT 2.001, 80.0%). Our clinicians reviewed 30 radiology tests and identified one incomplete radiology test:

- In case 11, a provider requested a chest X-ray to be done in 11 days; however, the X-ray was not performed.

Compliance testing found that 50.0 percent of laboratory tests were completed within the requested time frames (MIT 2.004). Our clinicians reviewed 169 laboratory tests and identified seven delays[19] in laboratory test completion, two of which were significant:

- In case 14, the patient was taking the blood thinner warfarin, and a provider requested the INR to be performed in seven days; however, the test was not done until three weeks later.[20]
- In case 22, the patient had muscle cramps, and a provider requested a complete metabolic panel laboratory test to be performed on the following day to assess for possible electrolyte imbalances; however, the test was performed three days later.

17. Deficiencies occurred four times in case 10, twice in cases 14 and 22, and once in cases 1, 11, 13, 16, 18, 23, 27, 30, and 57.
18. Significant deficiencies occurred in cases 11, 14, and 22.
19. Delays in laboratory completion occurred twice in cases 14 and 22, and once in cases 10, 23, and 27.
20. The INR is a laboratory test to assist in adjusting the warfarin level.

Compliance testing found that the institution did not consistently collect stat laboratory samples or receive stat test results within the required time frames (MIT 2.007, 50.0%). The nursing staff also performed poorly in notifying the provider within 30 minutes of receiving stat laboratory test results (MIT 2.008, 10.0%). Our clinicians reviewed one stat laboratory test and found the test was completed in a timely manner. Eighteen electrocardiograms (EKG) were also completed as requested.

Health Information Management

RJD performed well in retrieving, scanning, and endorsing diagnostic reports. Compliance testing showed providers endorsed all radiology and laboratory reports within specified time frames (MIT 2.002, 100% and MIT 2.005, 100%). Providers also endorsed stat laboratory results within the required time frames (MIT 2.009, 90.0%). Our clinicians identified only one minor delay[21] in scanning a laboratory test, and two minor delays[22] in endorsing laboratory tests.

Compliance testing showed providers did not thoroughly communicate the results of radiology studies or laboratory tests to the patients (MIT 2.003, 70.0%, and MIT 2.006, 20.0%). Our clinicians found that on one occasion, a provider did not send a laboratory result letter,[23] and on three occasions the providers did not include the dates of laboratory tests as required by policy[24]; the missing dates were not clinically significant, however, because the providers discussed the results with the patients during subsequent provider encounters.

Compliance testing showed that RJD retrieved 50.0 percent of pathology reports within the required time frames (MIT 2.010). Providers endorsed all pathology reports (MIT 2.011, 100%), and mostly sent results letters to the patients within the required time frames (MIT 2.012, 83.3%). Our clinicians found that all three pathology reports were retrieved and reviewed in a timely manner. On one occasion, however, a provider did not send a pathology results letter.[25]

Clinician On-Site Inspection

RJD assigned four full-time phlebotomists to the main clinics, TTA, and CTC to ensure that all laboratory tests were completed as ordered. RJD also employed medical staff for tracking and retrieving all pathology reports. The laboratory vendor communicated stat laboratory results with the TTA staff, who informed the provider of the results.

The diagnostic services supervisor informed OIG clinicians that the missed chest X-ray in case 11 above occurred because an X-ray machine

21. A minor delay occurred in case 10.
22. Minor delays occurred in cases 13 and 30.
23. A patient's laboratory results letter was missing in case 1.
24. Missing laboratory dates occurred in cases 10, 16, and 18.
25. The patient's pathology results letter was missing in case 10.

was temporarily not operational; however, the order was not canceled, nor was the patient sent to an off-site radiology services.

Recommendations

- Laboratory and nursing leadership should ascertain the root causes of the lack of timeliness in collecting samples for stat laboratory tests and communicating the results of stat laboratory tests; leadership should implement remedial measures as appropriate.
- The department should consider developing and implementing a letter template for patient results that autopopulates with all the elements required per CCHCS policy.
- Medical leadership should remind providers to send patient notification letters with appropriate key elements per CCHCS policy for diagnostic services.

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) *	8	2	0	80.0%
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)	7	3	0	70.0%
Laboratory: Was the laboratory service provided within the time frame specified in the health care provider's order? (2.004) *	5	5	0	50.0%
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)	2	8	0	20.0%
Laboratory: Did the institution collect the STAT laboratory test and receive the results within the required time frames? (2.007) *	5	5	0	50.0%
Laboratory: Did the provider acknowledge the STAT results, OR did nursing staff notify the provider within the required time frames (2.008) *,†	1	9	0	10.0%
Laboratory: Did the health care provider endorse the STAT laboratory results within the required time frames? (2.009)	9	1	0	90.0%
Pathology: Did the institution receive the final pathology report within the required time frames? (2.010) *	5	5	0	50.0%
Pathology: Did the health care provider review and endorse the pathology report within specified time frames? (2.011) *	7	0	3	100%
Pathology: Did the health care provider communicate the results of the pathology study to the patient within specified time frames? (2.012)	5	1	4	83.3%
				Overall percentage (MIT 2): **66.9%**

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

† This question was revised from that published in the original report.

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

Emergency Services

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

Overall Rating ***Adequate***

Case Review Rating ***Adequate***

Compliance Score **(N/A)**

Results Overview

RJD delivered good emergency care, comparable to the care we evaluated for our Cycle 5 assessment. Providers delivered good care. Nursing staff responded promptly to emergent events and performed good nursing assessments. However, nursing documentation showed room for improvement. Overall, the OIG rated this indicator ***adequate***.

Case Review Results

Our clinicians reviewed 33 urgent and emergent events and found 17 emergency care deficiencies, two of which were significant.[26]

Emergency Medical Response

RJD responded promptly to emergencies throughout the institution. In most cases, staff initiated CPR and activated emergency medical services (EMS) promptly. However, we found room for improvement in the following case:

- In case 3, the patient had stroke symptoms. The first medical responder and the TTA nurse did not activate EMS timely. Although the patient suffered no adverse events, this fell below nursing standards.

Provider Performance

RJD providers performed well in urgent and emergent situations. Providers made appropriate decisions for patients who arrived at the TTA for emergency treatment. On-call providers were available for consultation with the TTA staff and documented their telephone calls with nurses. Our clinicians identified two minor deficiencies related to

26. Deficiencies occurred three times in case 25, twice in cases 1, 5, 24, and 26, and once in cases 2, 3, 4, 6, 9, and 23. Significant deficiencies occurred in cases 4 and 25.

provider performance.[27] We discuss these deficiencies in the **Provider Performance** indicator.

Nursing Performance

RJD nurses generally provided good nursing assessments and interventions. Nurses recognized opioid overdose and implemented the nursing overdose protocol. There was room for improvement, however, as the following case demonstrates:

- In case 9, the patient complained of chest pain and the nurse administered pain medication. However, the nurse did not reassess the patient's pain level to determine if the medication was effective.

Nursing Documentation

Nursing documentation also showed room for improvement. Our clinicians identified seven deficiencies related to missing or inadequate documentation.[28] For example, pertinent documentation was missing, such as automated external defibrillator (AED) analyses and documentation of shocks delivered; there were timeline discrepancies related to the sequence of emergency events; and nurses did not always document the delivered medication on the medication administration record (MAR).

Emergency Medical Response Review Committee

Our clinicians found that the EMRRC met monthly to review emergency response care. We found the committee's reports and logs very well-organized and noted that the committee identified their staff's deficiencies and provided training accordingly.

Clinician On-Site Inspection

The TTA maintained four beds, and the patient care area had sufficient space to provide emergency care. Four RNs and a provider staffed the unit, and there was a provider available for phone consultation after hours. The nurses reported having a good rapport and collaborative working relationship with custody staff. We discussed some of the case review findings with nursing leadership, who explained additional training would be provided for quality improvement.

Recommendations

- RJD's EMRCC reports and logs were very thorough and well-organized. CCHCS should consider using RJD's reports as an example for best practice.

27. Deficiencies occurred in cases 6 and 24.

28. Deficiencies occurred twice in case 1 and once in cases 4, 5, 23, 24, and 26.

Health Information Management

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

Overall Rating ***Proficient***

Case Review Rating ***Proficient***

Compliance Score ***Proficient*** **(91.8%)**

Results Overview

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

Case Review Results

The OIG clinicians reviewed 1,004 events and found 11 deficiencies related to health information management, of which one was significant.[29]

Hospital Discharge Reports

RJD performed well in retrieving and scanning hospital records. Compliance testing found that RJD staff retrieved and scanned hospital discharge records within the required time frames (MIT 4.003, 100%). Most discharge records included the important physician discharge summary, and providers endorsed the reports within five days (MIT 4.005, 80.0%). Our clinicians reviewed 25 hospital events and identified one significant delay in retrieving a hospital record:

- In case 9, the patient returned from a hospitalization, and the hospital discharge record was not retrieved and scanned until six weeks later.

Specialty Reports

RJD performed well retrieving and reviewing the specialty reports. Compliance testing showed that 100 percent of specialty reports were scanned within the required time frame (MIT 4.002). RJD providers generally reviewed the high-priority, medium-priority, and routine specialty reports within the required time frames (MIT 14.002, 73.3%; MIT 14.005, 78.6%; and MIT 14.008, 93.3%). [MIT 14.005: changed from 78.5% to 78.6%.]

29. Deficiencies occurred three times in case 10 and once in cases 1, 9, 13, 16, 18, 30, 57, and 71. A significant deficiency occurred in case 9.

Our clinicians reviewed 82 specialty reports and identified one delay in retrieving a specialty report.[30] This deficiency is discussed in the **Specialty Services** indicator.

Diagnostic Reports

RJD proficiently retrieved and endorsed diagnostic reports. Compliance testing showed providers endorsed radiology and laboratory reports within the required time frames (MIT 2.002, 100%, and MIT 2.005, 100%). Our clinicians reviewed 220 diagnostic events and identified six minor deficiencies.[31] These deficiencies are discussed in the **Diagnostic Services** indicator.

Compliance testing found that staff did not retrieve all pathology reports within the required time frames (MIT 2.010, 50.0%); however, the providers endorsed all pathology reports within the specified time frames (MIT 2.011, 100%). Our clinicians found that all three pathology reports were retrieved in a timely manner, and the providers endorsed the reports and discussed the results with their patients during subsequent encounters. However, in one case the provider did not send the required patient result letter.[32]

Urgent and Emergent Records

Our clinicians reviewed 33 emergency care events and found that the nurses and providers performed well in recording these events. Our clinicians did not identify any deficiencies.

Scanning Performance

Compliance testing showed that RJD performed the scanning process adequately (MIT 4.004, 79.2%). Our clinicians did not identify any mislabeled documents.

Clinician On-Site Inspection

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

The laboratory vendor directly autopopulated laboratory results into the electronic health records system (EHRS).

For on-site specialty reports, the on-site specialty nurses scanned the reports on the same day the visit occurred. For off-site specialty reports,

30. The deficiency occurred in case 71.

31. Minor deficiencies occurred in cases 1, 10, 13, 16, 18, and 30.

32. The required patient letter was missing in case 10.

the medical record staff scanned the hand-written reports on the day the visit occurred and scanned the formal specialty reports as they received them.

Recommendations

We offer no specific recommendations for this indicator.

Compliance Testing Results

Table 9. Health Information Management

	Scored Answer			
Compliance Questions	**Yes**	**No**	**N/A**	**Yes %**
Are health care service request forms scanned into the patient's electronic health record within three calendar days of the encounter date? (4.001)	20	0	20	100%
Are specialty documents scanned into the patient's electronic health record within five calendar days of the encounter date? (4.002) *	30	0	15	100%
Are community hospital discharge documents scanned into the patient's electronic health record within three calendar days of hospital discharge? (4.003) *	20	0	5	100%
During the inspection, were medical records properly scanned, labeled, and included in the correct patients' files? (4.004) *	19	5	0	79.2%
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) *	20	5	0	80.0%
Overall percentage (MIT 4): **91.8%**				

* 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 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 provider acknowledge the STAT results, OR did nursing staff notify the provider within the required time frames? (2.008) *,†	1	9	0	10.0%
Pathology: Did the institution receive the final pathology report within the required time frames? (2.010) *	5	5	0	50.0%
Pathology: Did the health care provider review and endorse the pathology report within specified time frames? (2.011) *	7	0	3	100%
Pathology: Did the health care provider communicate the results of the pathology study to the patient within specified time frames? (2.012)	5	1	4	83.3%
Did the institution receive and did the primary care provider review the high-priority specialty service consultant report within the required time frame? (14.002) *	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	3	1	78.6%
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) *	14	1	0	93.3%

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

† This question was revised from that published in the original report.

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

Health Care Environment

In this indicator, OIG compliance inspectors tested clinics' waiting areas, infection control, sanitation procedures, medical supplies, equipment management, and examination rooms. Inspectors also tested clinics' 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.

Overall Rating
Inadequate

Case Review Rating
(N/A)

Compliance Score
Inadequate
(63.3%)

Results Overview

For this indicator, multiple aspects of RJD's health care environment needed improvement: multiple clinics and the medical warehouse contained expired medical supplies, emergency medical response bag (EMRB) logs either were missing staff verification or inventory was not performed, and staff did not regularly sanitize their hands before or after examining patients. The OIG rated this indicator ***inadequate***.

Compliance Testing Results

Outdoor Waiting Areas

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

We examined outdoor patient waiting areas (see Photo 1, left). Health care and custody staff reported that existing waiting areas had sufficient seating capacity and are only used to practice social distancing when the indoor waiting areas are at capacity. The staff reported that they only call patients close to their appointment time during inclement weather.

Indoor Waiting Areas

We inspected indoor waiting areas (see Photo 2, below). Health care custody staff reported that existing waiting areas contained sufficient seating capacity. During our inspection, we did not observe overcrowding or noncompliance to social distancing requirements in any of the clinics' indoor waiting areas. In addition, we observed custody officers routinely instructing patients to practice social distancing while seated in the waiting areas.

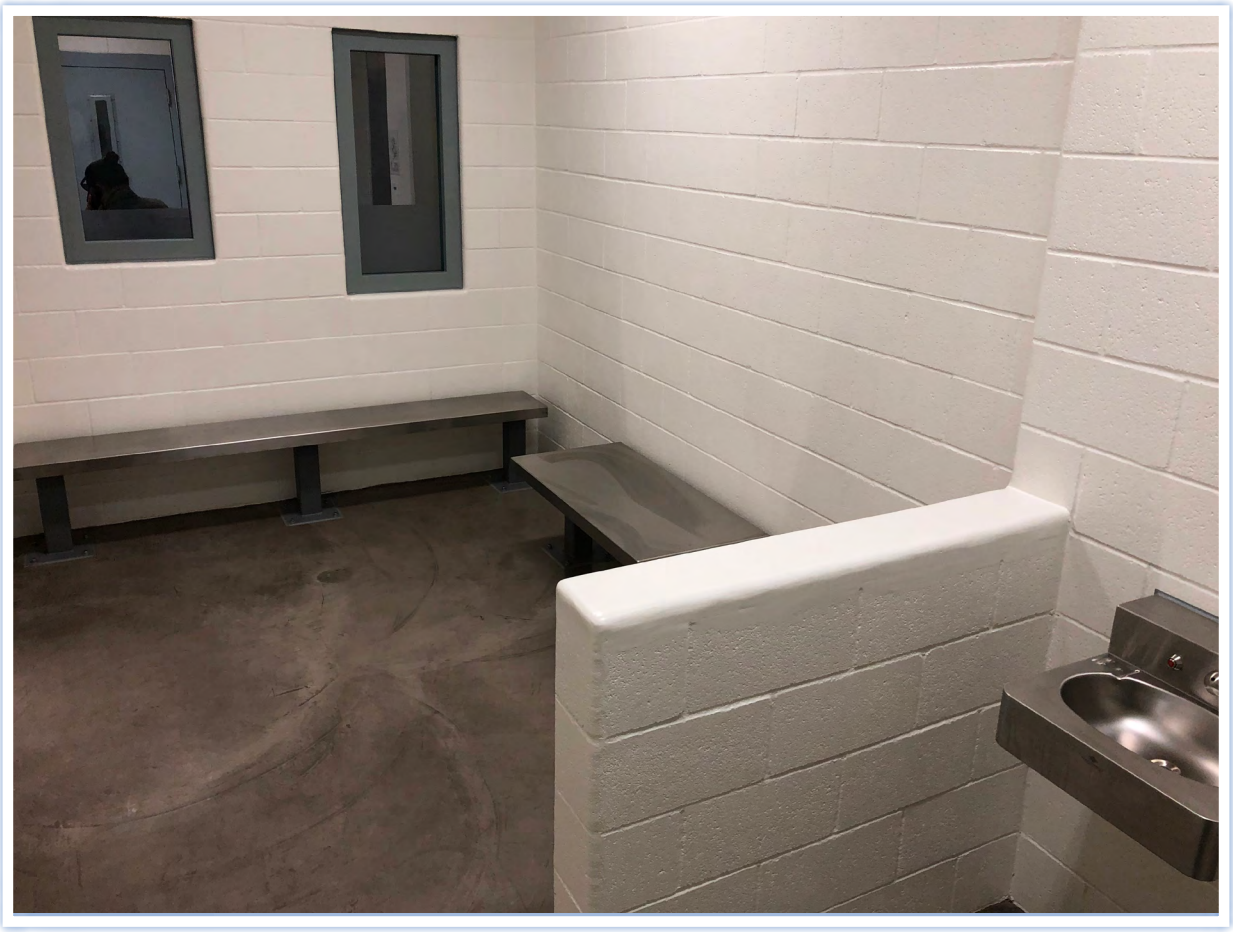
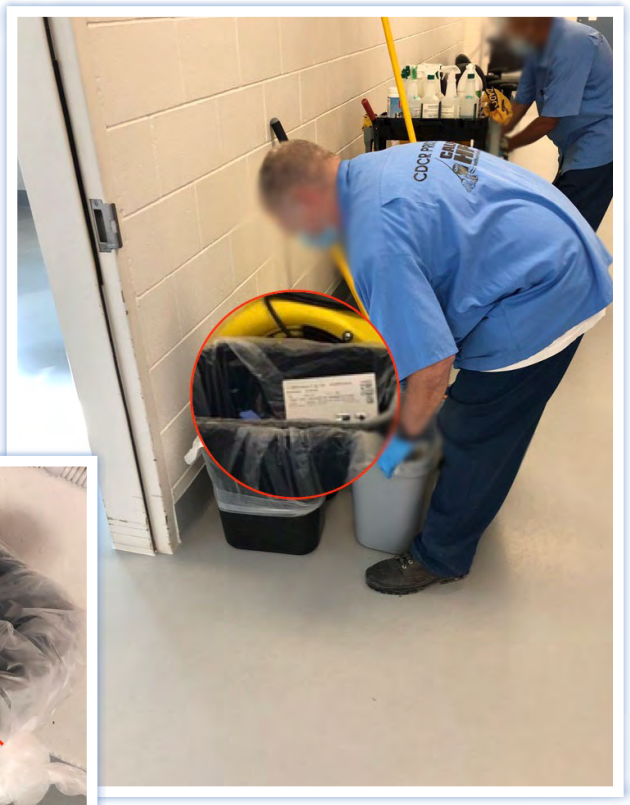
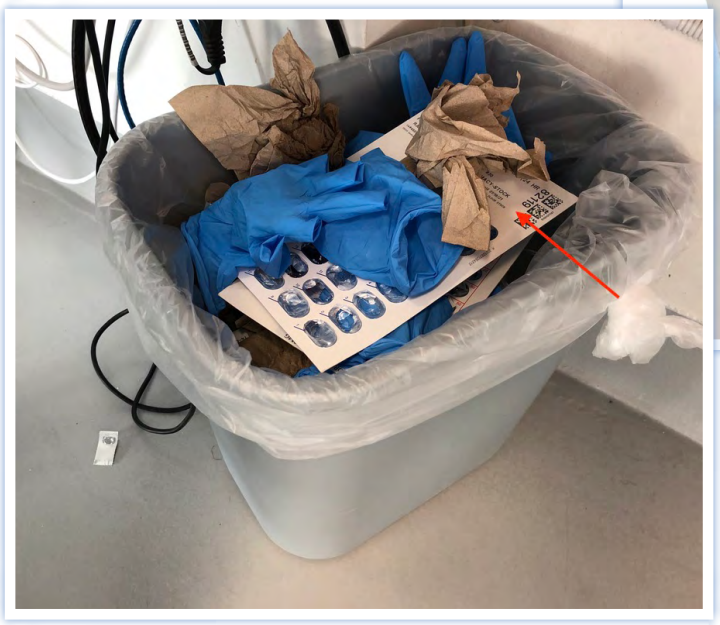


Photo 2. Indoor waiting area (photographed on October 16, 2020).

Clinic Environment

Eleven of 12 clinic environments were sufficiently conducive for medical care. They provided reasonable auditory privacy, appropriate waiting areas, wheelchair accessibility, and nonexamination room workspace (MIT 5.109, 91.7%). In one clinic, the configuration of the vital sign check stations did not provide auditory privacy.





Photos 3, above and 4, left. Confidential patient records were accessible to unauthorized individuals (photographed on October 15, 2020).

Of the 12 clinics we observed, ten contained appropriate space, configuration, supplies, and equipment to allow their clinicians to perform proper clinical examinations (MIT 5.110, 83.3%). One clinic had examination rooms that lacked visual privacy for conducting patient examinations and had confidential medical records that were accessible to unauthorized individuals (see Photos 3 and 4, this page). In another clinic, we found torn examination table covers.

In addition to the above findings, our compliance inspectors observed the following notable concerns in the clinic during their on-site inspection:

- The staff restroom and medication room in administrative segregation, Housing Unit 6, were not being properly cleaned. The staff reported the Prison Industry Authority (PIA) Healthcare Facilities Maintenance (HFM) program cleaned as a courtesy once per week. However, there had been no additional cleaning beyond that done for the courtesy visit. As a result, we noted that the medication room floor and staff restroom vents were in an unsanitary state with accumulated grime.

Clinic Supplies

Eight of the 12 clinics followed adequate medical supply storage and management protocols (MIT 5.107, 66.7%). We found one or more of the following deficiencies in four clinics: expired medical supplies (see Photo 5, below), compromised sterile medical supply packaging, staff not following manufacturers' guidelines in utilization of a solution, unidentified medical supplies, and food stored with medical supplies in the examination room (see Photo 6, next page).

Seven of the 12 clinics met requirements for essential core medical equipment and supplies (MIT 5.108, 58.3%). The remaining five clinics contained improperly calibrated equipment, including an oto-ophthalmoscope, automated vital sign and blood pressure

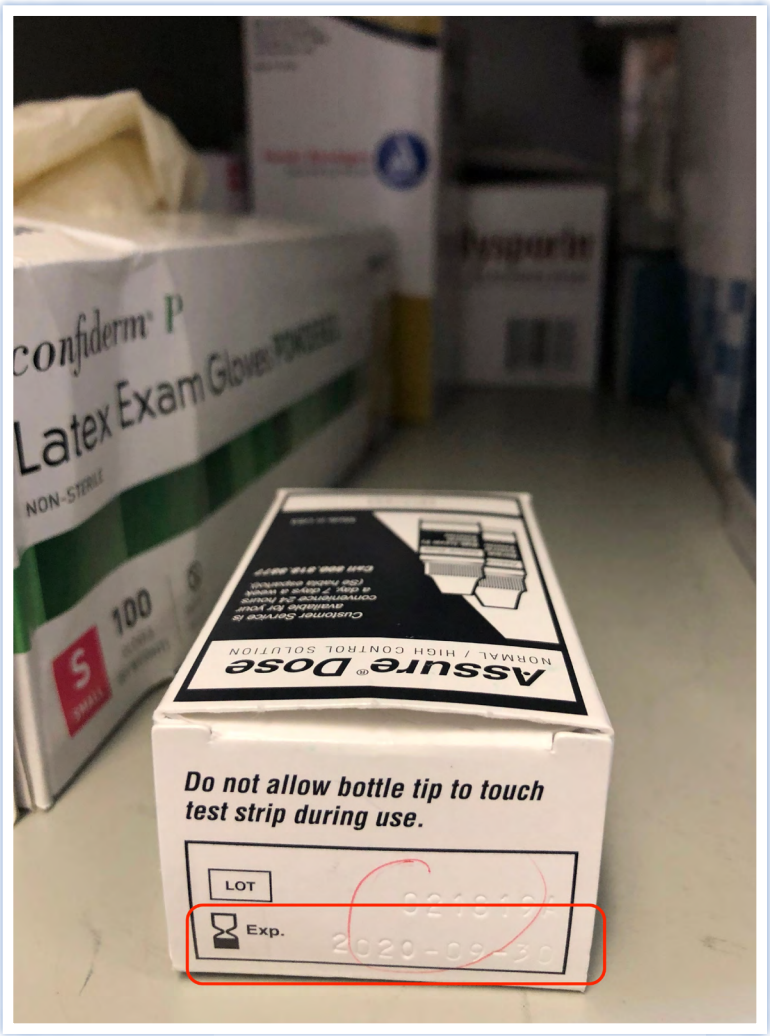


Photo 5. Expired medical supply, dated September 30, 2020 (photographed on October 15, 2020).

Photo 6. Staff's personal food items stored with medical supplies (photographed on October 15, 2020).

equipment, and a weight scale. RJD staff did not properly log or did not entirely log the results of the of the defibrillator performance test or the automated external defibrillator (AED) checklist within the preceding 30 days. An examination table had a torn vinyl cover (see Photo 7, below). We examined emergency medical response bags (EMRBs) to determine whether they contained all essential items and whether staff inspected the bags daily and inventoried them monthly. Only three of the 10 EMRBs passed our test (MIT 5.111, 30.0%). We found one of the following deficiencies with seven EMRBs: staff failed to ensure the EMRBs' compartments were sealed and intact or staff had not inventoried the ERMBs when seal tags were replaced.

In addition to the above findings, our compliance inspectors observed the following in the clinics or examination rooms when they conducted their on-site inspection:

- During an urgent encounter with a patient who had an actively

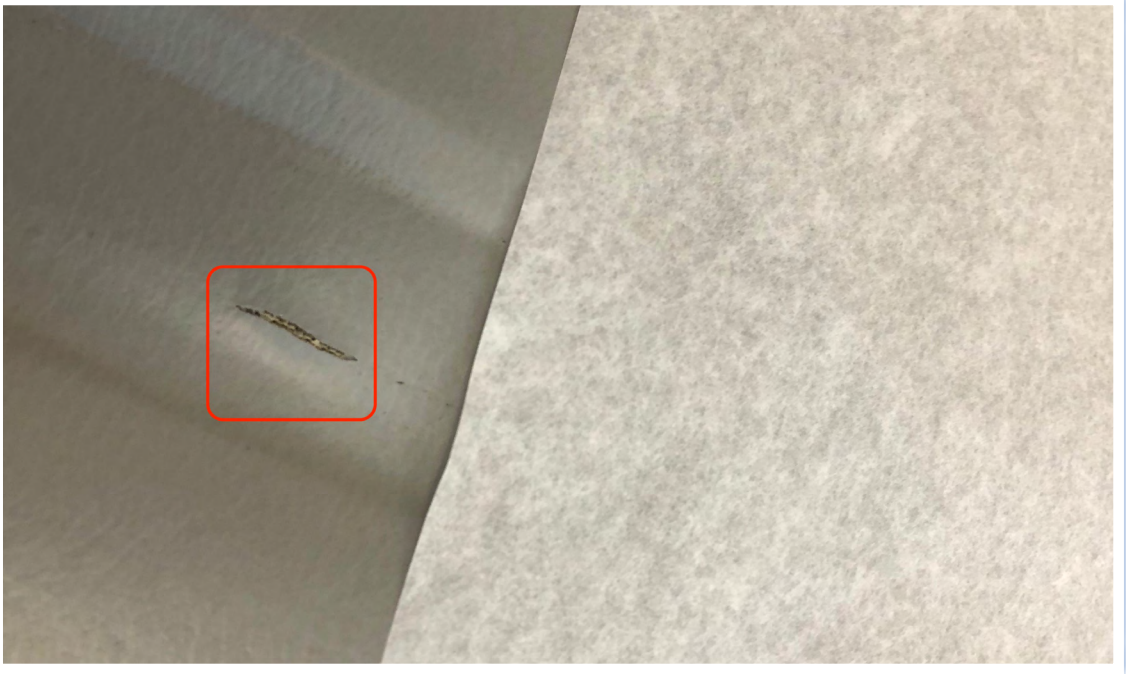


Photo 7. Torn examination table cover (photographed on October 15, 2020).

bleeding head wound, we observed that the physician came to the bedside and was not wearing PPE properly. The protective gown was loosely draped, exposing the physician's own clothing, while simultaneously sweeping across multiple body areas of the patient during assessment. In the same clinic and in other various clinics, we noted intravenous and feeding pumps with either no indication of calibration or with expired calibrations.

- Staff did not always check the functionality of the check-listed item. In one clinic, we noted an emergency medical response bag had a nonfunctional pen light. The interviewed staff were unable to verbalize when the last time the pen light was physically checked for functionality. Staff explained that the process was to check off the listed items if those items were present but rarely did staff physically inspect the item for integrity or functionality. In another clinic, although all the items were present in the EMRB, the medical staff was unable to identify the items for inspection. The medical staff could not identify a nasal cannula, nonrebreather mask, oral airways (oropharyngeal airway), nor a pocket mask. When asked for each of these above items, the medical staff would either show another medical supply item in its place or respond that the bag was missing the item.

Medical Supply Management

None of the medical supply storage areas located outside the medical clinics stored medical supplies adequately (MIT 5.106, zero). At the time of our inspection, the warehouse manager reported the temperature control unit was nonoperational. We found multiple temperature-sensitive supplies stored in these areas. We also found compromised sterile medical supply packaging stored in the warehouse (see Photos 8 and 9, next page).

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

In addition to the above findings, we observed the following in the medical warehouse during our on-site inspection:

- The RJD medical warehouse did not have an effective system for maintaining control of sharps (needles used to administer medications) in the warehouse; it did not account for its inventory of sharps; it did not track the sharps that were removed from the warehouse. Specifically, the clinic's health care manager reported that nursing staff can walk directly to the sharps supplies in the warehouse, remove any number of needles from any boxes, sign for the needles in the warehouse logbook, and leave. Warehouse staff did not consistently dispense needles to health care staff; staff could help themselves.

Photo 8. Temperature-sensitive medical supply product stored in the warehouse, which did not have a working temperature control (photographed on October 14, 2020).

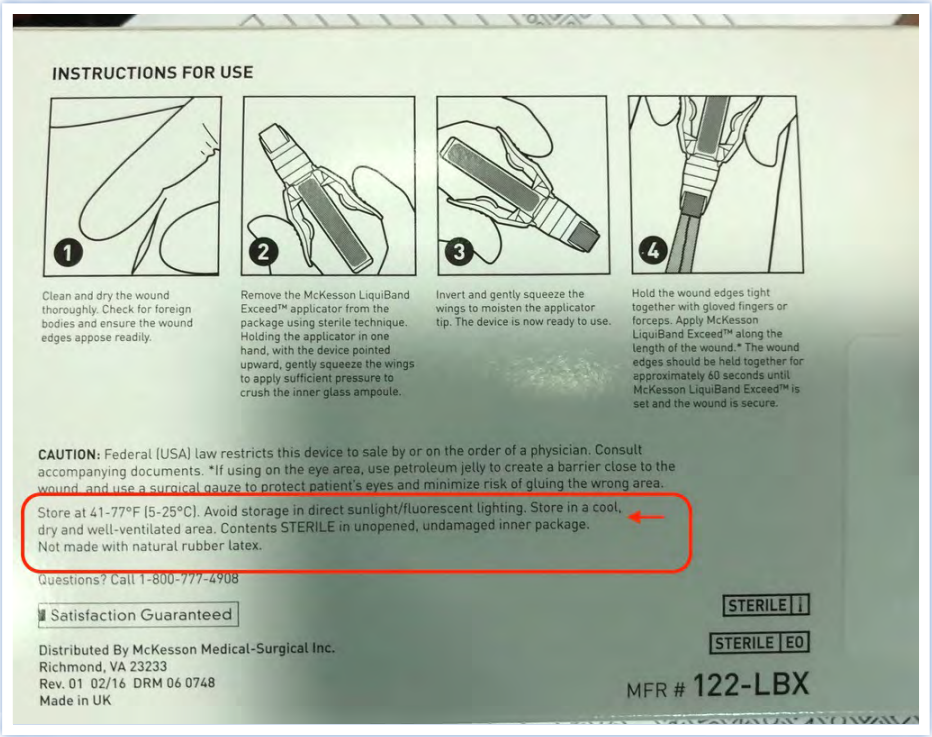


Photo 9. Temperature-sensitive medical supply product stored in the warehouse, which did not have a working temperature control (photographed on October 14, 2020).

Moreover, the warehouse did not track its own inventory of needles. We saw multiple open boxes of needles of various types and sizes; health care staff could take needles from any box without regard to the expiration date of the box or the availability of an already opened box, and staff had been withdrawing needles from boxes seemingly at random. The warehouse did not track the stock levels of its sharps supply, such as how many needles in a 100-count box were left and how many boxes of that size and type remained.

The warehouse also did not document the clinic at which dispensed needles were to be used. Health care staff could leave the warehouse with any number of different types and sizes of needles—intradermal needles, subcutaneous needles, intramuscular needles, intravenous needles, in various sizes—and the warehouse had no consistent means of accounting for each needle that left its possession. When interviewed, the warehouse manager did not know how many needles were left in each box on the shelf and exactly who took the needles that were missing.

However, when visiting the clinics, we found that boxes of sharps were carefully accounted for during each shift with accountability forms. The accountability form called for each needle to be logged with the date, time, patient name, departmental number, type of needle, and nurse's signature. In contrast, we found the E Yard's remote pharmacy to have expired sharps that had not been accounted for in the medication inventory. When we interviewed pharmacy staff about these sharps, we found no one was aware that the sharps were in the pharmacy.

When we inspected the medical warehouse, the staff reported water damage to the ceiling (see Photos 10 and 11, next page). Neither area that we observed with water damage had been reported to plant operations through a work order.

We also found that medical warehouse staff were using an institutional medication refrigerator to store their personal food items. On the side of the medication refrigerator was an approved document titled "Request to Retain and Utilize Personal Property on Institutional Grounds," which did not match either the make or the model of the refrigerator that was originally approved.

Infection Control and Sanitation

Staff appropriately cleaned, sanitized, and disinfected six of 12 clinics (MIT 5.101, 50.0%). In six clinics, we found one or more of the following deficiencies: cleaning logs were not maintained, cleaning logs were signed ahead of time, or the PIA healthcare facilities maintenance supervisor or incarcerated person porter was unable to verbalize the correct mixing ratio of the Cell Block 64 chemical intended for disinfection in the clinic environment.

Staff in 10 of 12 clinics (MIT 5.102, 83.3%) properly sterilized or disinfected medical equipment. In one clinic, staff did not discuss disinfecting the examination table prior to the start of their shift. In another clinic, staff did not remove and replace examination table paper after a patient encounter.

We found operating sinks and hand hygiene supplies in the examination rooms in eight of 12 clinics (MIT 5.103, 66.7%). The staff or the patient restrooms (or both) in four clinics lacked either antiseptic soap or disposable hand towels.

We observed patient encounters in twelve clinics. In four clinics, clinicians did not wash their hands before or after examining their

patients or before applying gloves (MIT 5.104, 66.7%). Health care staff in all clinics followed proper protocols to mitigate exposure to blood-borne pathogens and contaminated waste (MIT 5.105, 100%).

In addition to the above findings, we made the following notable observations in the clinic during our on-site inspection:

- Inside B Yard, administrative segregation, the staff restroom and medication room were not being properly cleaned. The staff reported that PIA-HFM workers clean the area as a courtesy once per week. However, we found the medication room floor and staff restroom vents were unsanitary or had accumulated grime (see Photo 12, next page).

Photo 10. Medical warehouse reported water damage to the ceiling (photographed on October 14, 2020).

Photo 11. Medical warehouse reported water damage to the ceiling (photographed on October 14, 2020).

Physical Infrastructure

The institution's health care management and plant operations manager noted that the infrastructure in all clinical areas were in good, working order. There was no medical clinic construction at RJD hindering adequate health care services.

At the time of our medical inspection, the institution's administrative team reported the Health Care Facility Improvement Program (HCFIP) projects had been completed. Although there were plans for additional medication spaces and other health care clinic spaces, there were no scheduled beginning construction dates for any of these future projects.

Photo 12. Staff restroom vents had accumulated dirt (photographed on October 16, 2020).

Recommendations

We offer no specific recommendations for this indicator.

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)	6	6	0	50.0%
Infection control: Do clinical health care areas ensure that reusable invasive and noninvasive medical equipment is properly sterilized or disinfected as warranted? (5.102)	10	2	0	83.3%
Infection control: Do clinical health care areas contain operable sinks and sufficient quantities of hygiene supplies? (5.103)	8	4	0	66.7%
Infection control: Does clinical health care staff adhere to universal hand hygiene precautions? (5.104)	8	4	0	66.7%
Infection control: Do clinical health care areas control exposure to blood-borne pathogens and contaminated waste? (5.105)	12	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)	8	4	0	66.7%
Clinical areas: Do clinic common areas and exam rooms have essential core medical equipment and supplies? (5.108)	7	5	0	58.3%
Clinical areas: Are the environments in the common clinic areas conducive to providing medical services? (5.109)	11	1	0	91.7%
Clinical areas: Are the environments in the clinic exam rooms conducive to providing medical services? (5.110)	10	2	0	83.3%
Clinical areas: Are emergency medical response bags and emergency crash carts inspected and inventoried within required time frames, and do they contain essential items? (5.111)	3	7	2	30.0%
Does the institution's health care management believe that all clinical areas have physical plant infrastructures that are sufficient to provide adequate health care services? (5.999)	This is a nonscored test. Please see the indicator for discussion of this test.			
				Overall percentage (MIT 5): **63.3%**

* 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
Adequate

Case Review Rating
Adequate

Compliance Score
Inadequate
(60.3%)

Transfers

In this indicator, OIG inspectors examined the transfer process for those patients who transferred into the institution, as well as for those who transferred to other institutions. For newly arrived patients, our inspectors assessed the quality of health screenings and the continuity of provider appointments, specialist referrals, diagnostic tests, and medications. For patients who transferred out of the institution, inspectors checked whether staff reviewed patient medical records and determined the patient's need for medical holds. They also assessed if staff transferred patients with their medical equipment and gave correct medications before patients left. In addition, our inspectors evaluated the ability of staff to communicate vital health transfer information, such as preexisting health conditions, pending appointments, tests, and specialty referrals; and inspectors confirmed if staff sent complete medication transfer packages to the receiving institution. For patients who returned from off-site hospitals or emergency rooms, inspectors reviewed whether staff appropriately implemented the recommended treatment plans, administered necessary medications, and scheduled appropriate follow-up appointments.

Results Overview

Compliance testing had an overall score of 60.3 percent, mainly due to a poor score on one measure in which the receiving and release (R&R) nurses did not thoroughly complete the initial health screening form. For patients transferring into RJD, our clinicians found deficiencies in both continuity of medications and continuation of specialty appointments. RJD's transfer-out process was sufficient, with only minor nursing documentation deficiencies. For patients returning from an off-site hospital, we found interruptions in medication continuity and opportunities for improvement in nursing assessment and interventions. Most of the deficiencies were minor and often related to medication continuity. Overall, the OIG rated this indicator ***adequate***.

Case Review Results

Our clinicians reviewed 48 events in 23 cases in which patients transferred into or out of the institution or returned from an off-site hospital or emergency room. We identified 17 deficiencies, five of which were significant.[33]

Transfers In

We found RJD's transfer-in process to be sufficient. However, compliance testing showed that R&R nurses did not complete the initial health screening form thoroughly (MIT 6.001, zero). On the other hand,

33. Deficiencies occurred three times in case 25, twice in cases 31, 33, and 71, and once in cases 3, 9, 10, 23, 24, 32, 35, and 36. Significant deficiencies occurred twice in case 31 and once in cases 9, 10, and 25.

the nurses performed well in addressing signs and symptoms when screening for tuberculosis (TB) and followed up on health care screening questions that required an explanation (MIT 6.002, 100%). OIG clinicians reviewed four transfer-in cases and found that the R&R nurses evaluated newly arrived patients and requested provider appointments within the appropriate time frames.

The compliance team found medication continuity at the time of transfer was good (MIT 6.003, 81.0%). Our clinicians found two deficiencies[34] related to medication continuity.

Compliance testing showed provider appointments for newly arrived patients occurred within the required time frames (MIT 1.002, 88.0%). Our clinicians found one delay[35] in a provider appointment, and this deficiency is discussed in the **Access to Care** indicator.

When patients transferred into RJD with preapproved specialty services, compliance testing found that 35.0 percent of their specialty appointments were completed within the required time frames (MIT 14.010). Our clinicians found similar results, as the following example demonstrates:

- In case 31, the patient had three pending specialist appointments upon arrival to RJD. Two of the appointments were never reconciled and did not occur; the other appointment occurred 75 days late.

Transfers Out

RJD's transfer-out process was satisfactory. Our clinicians reviewed four transfer-out cases and found that nurses completed face-to-face evaluations and transferred patients with their medications and durable medical equipment. However, we identified two minor deficiencies[36] related to incomplete intrafacility transfer forms. One example follows:

- In case 36, a nurse filled out an intra-facility transfer form but did not include the pending ear, nose, and throat specialist appointment.

Hospitalizations

Patients returning from an off-site hospitalization or emergency room are at high risk for lapses in care. These patients have typically experienced severe illnesses or injuries and require more care. Because these patients have complex medical issues, the successful transfer of health information is necessary for quality care. Any lapse in care can result in serious consequences for these patients. Our clinicians reviewed

34. Minor deficiencies occurred in cases 32 and 33.
35. A delayed provider appointment occurred in case 3.
36. Minor deficiencies occurred in cases 35 and 36.

25 hospital or emergency room returns in 17 cases and identified nine deficiencies, three of which were significant.[37]

RJD performed well in retrieving and scanning hospital records. Our clinicians identified one significant delay[38] in retrieving a hospital record, and this delay is discussed in the **Health Information Management** indicator.

RJD performed well in providing follow-up appointments within the required time frame to patients returning from the hospital and from emergency room visits (MIT 1.007, 92.0%). Our clinicians identified one significant deficiency related to a missed provider appointment,[39] which is discussed in the **Access to Care** indicator.

Compliance testing showed that RJD performed poorly in medication continuity (MIT 7.003, 16.0%). Our clinicians identified four deficiencies related to medication continuity,[40] one of which was significant. This significant deficiency is discussed in the **Medication Management** indicator.

Clinician On-Site Inspection

Our clinicians interviewed the R&R nurses, who were knowledgeable about their job duties and the transfer process. We were informed that all patients who transferred in or returned from an off-site hospitalization were placed on COVID-19 surveillance for 14 days prior to returning to the general population; this practice followed movement matrix guidelines.

RJD reported that patients returning from a higher level of care had a greater risk of missed medical care, and medical leadership had targeted this area for quality improvement. Within one day of returning from a higher level of care, patients were scheduled with an RN who ensured that the patients received their medications, their durable medical equipment, and patient education.

Recommendations

- Health care leadership should identify the challenges to medication continuity for patients returning from hospitalizations or emergency rooms and for patients en route who lay over at the institution; leadership should implement remedial measures as appropriate.
- Nursing leadership should remind nursing staff to fully document TB symptoms as part of the patient's initial health assessment.

37. Deficiencies occurred three times in case 25, twice in case 71, and once in cases 9, 10, 23, and 24. Significant deficiencies occurred in cases 9, 10, and 25.

38. A significant delay in retrieving a hospital record occurred in case 9.

39. A missed provider appointment occurred in case 25.

40. Deficiencies occurred in cases 10, 23, 25, and 71.

- Nursing leadership should educate nursing staff to thoroughly complete the initial health screening, including answering all questions and documenting an explanation for each "yes" answer.
- Medical leadership should ensure that preapproved specialty services are scheduled and provided to the patient within specified time frames.
- Nursing leadership should remind nursing staff of documentation requirements in the patient's medical administration record.

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)	24	0	1	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) *	17	4	4	81.0%
For patients transferred out of the facility: Do medication transfer packages include required medications along with the corresponding transfer packet required documents? (6.101) *	N/A	N/A	N/A	N/A
				Overall percentage (MIT 6): **60.3%**

* 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.

Table 13. Other Tests Related to Transfers

Compliance Questions	Scored Answer			
	Yes	No	N/A	Yes %
For endorsed patients received from another CDCR institution: Based on the patient's clinical risk level during the initial health screening, was the patient seen by the clinician within the required time frame? (1.002) *	22	3	0	88.0%
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) *	23	2	0	92.0%
Are community hospital discharge documents scanned into the patient's electronic health record within three calendar days of hospital discharge? (4.003) *	20	0	5†	100%
For patients discharged from a community hospital: Did the preliminary or final hospital discharge report include key elements and did a provider review the report within five calendar days of discharge? (4.005) *	20	5	0	80.0%
Upon the patient's discharge from a community hospital: Were all ordered medications administered, made available, or delivered to the patient within required time frames? (7.003) *	4	21	0	16.0%
Upon the patient's transfer from one housing unit to another: Were medications continued without interruption? (7.005) *	17	8	0	68.0%
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) *	2	8	0	20.0%
For endorsed patients received from another CDCR institution: If the patient was approved for a specialty services appointment at the sending institution, was the appointment scheduled at the receiving institution within the required time frames? (14.010) *	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.

† Changed from zero to 5.

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

Overall Rating
Inadequate

Case Review Rating
Inadequate

Compliance Score
Inadequate
(49.0%)

Medication Management

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

Results Overview

RJD continued to perform poorly in medication management. Compliance testing showed an overall score of 49.0 percent, which represents a significant decrease from the Cycle 5 score of 69.6 percent. Our clinicians also found more deficiencies in this cycle than we found in Cycle 5. There were lapses in continuity and delivery in most medication-related categories. The OIG rated this indicator ***inadequate***.

Case Review Results

We reviewed 126 events related to medication management and found 41 deficiencies, four of which were significant.[41]

New Medication Prescriptions

Compliance testing found that new medications were available and administered at a rate of 72.0 percent (MIT 7.002). Analysis of the compliance data showed some patients missed one to six doses of their essential medications, such as antibiotics. The OIG clinicians found a pattern of administering newly ordered medications late. Two examples follow:

- In case 22, the provider increased the patient's blood pressure medication dose, which was to start on the same day. However, the patient did not receive the new medication dose until three days later.
- In case 41, the patient complained of back pain. The provider ordered pain medication to start on the same day. However, the patient did not receive the pain medication until three days later.

41. Deficiencies occurred seven times in cases 21 and 22, three times in case 1, twice in cases 9, 15, 19, 25, and 71, and once in cases 2, 10, 11, 23, 24, 32, 33, 39, 41, 49, 62, 64, 70, and 72. Significant deficiencies occurred in cases 9, 10, 11, and 22.

Chronic Medication Continuity

Compliance testing found low scores for chronic care medication continuity (MIT 7.001, zero). Further analysis showed that in most cases, nursing staff did not properly document when patients refused or did not show up for their medications. In addition, patients did not receive their medication refills one day prior to the prescription's exhaustion. One patient never received his asthma inhaler or steroid cream. Our clinicians found that most patients received their chronic care medication within the required time frames. Most of the deficiencies were minor and did not place the patient at risk of harm.

Hospital Discharge Medications

Compliance testing showed that when patients returned from an off-site hospital or emergency room, they did not receive their medications within the required time frame (MIT 7.003, 16.0%). Our clinicians evaluated 27 hospital returns and identified one significant medication deficiency:

- In case 10, the patient returned from the hospital with an infection, and a provider prescribed an oral antibiotic to start on the following day. However, the patient didn't receive the antibiotic until two days later.

Specialized Medical Housing Medications

Compliance testing found that when patients were admitted to the Correctional Treatment Center (CTC), medications were rarely available or administered within the required time frames (MIT 13.004, 20.0%). Our clinicians found three medication continuity deficiencies among five CTC admissions examined.[42] Two of the deficiencies follow:

- In case 70, the patient was admitted to the CTC and did not receive three of his chronic care medications within the required time frames.
- In case 72, the patient did not receive a dose of his anti-seizure medication.

Transfer Medications

Compliance testing showed that RJD performed well in continuity of medications for patients transferring into the institution (MIT 6.003, 81.0%). However, the same did not apply when patients moved within the facility (MIT 7.005, 68.0%) or when patients had layovers at RJD (MIT 7.006 20.0%). Our clinicians reviewed four transfer-in cases and found two deficiencies[43] related to medication continuity. One example follows:

42. Deficiencies occurred in cases 70, 71, and 72.

43. Deficiencies occurred in cases 32 and 33.

- In case 32, the transfer-in patient did not receive his bedtime psychiatric medication within the required time frame.

Medication Administration

Compliance testing showed that nurses administered prescribed tuberculosis (TB) medications at a rate of 50.0 percent (MIT 9.001). Our clinicians found that the nurses administered all medications properly, with an exception in the following case:

- In case 11, the nurse administered the Hepatitis B and Zoster vaccines to the wrong patient.[44]

Clinician On-Site Inspection

Our clinicians interviewed medication nurses and found they were knowledgeable about the medication process, attended the clinic huddles, and notified the providers of expiring medications. We also met with pharmacist and nurse managers to discuss some of our findings. In response, they reported that they plan to provide training for quality improvement.

Compliance Testing Results

Medication Practices and Storage Controls

The institution adequately stored and secured narcotic medications in 10 of 11 clinic and medication line locations (MIT 7.101, 90.9%). In one location, the medication nurse transported narcotic, on-person medications unsecured. In addition, we observed that a nurse misplaced narcotic medications and did not follow the discrepancy reporting process.

RJD appropriately stored and secured nonnarcotic medications in eight of twelve clinic and medication line locations (MIT 7.102, 66.7%). In four locations, we observed one or more of the following deficiencies: staff did not have an effective inventory process to account for medications stored in the Omnicell, and the medication cart drawers were either dusty and unsanitary or disorganized (see Photos 13 and 14, next page).[45]

Staff kept medications protected from physical, chemical, and temperature contamination in six of the 12 clinic and medication line locations (MIT 7.103, 50.0%). In six locations, we found one or more of the following deficiencies: staff did not store oral and topical medications separately, staff did not consistently record the room and refrigerator temperatures, logs indicated medications were not stored within the acceptable temperature range, and staff stored medications directly on

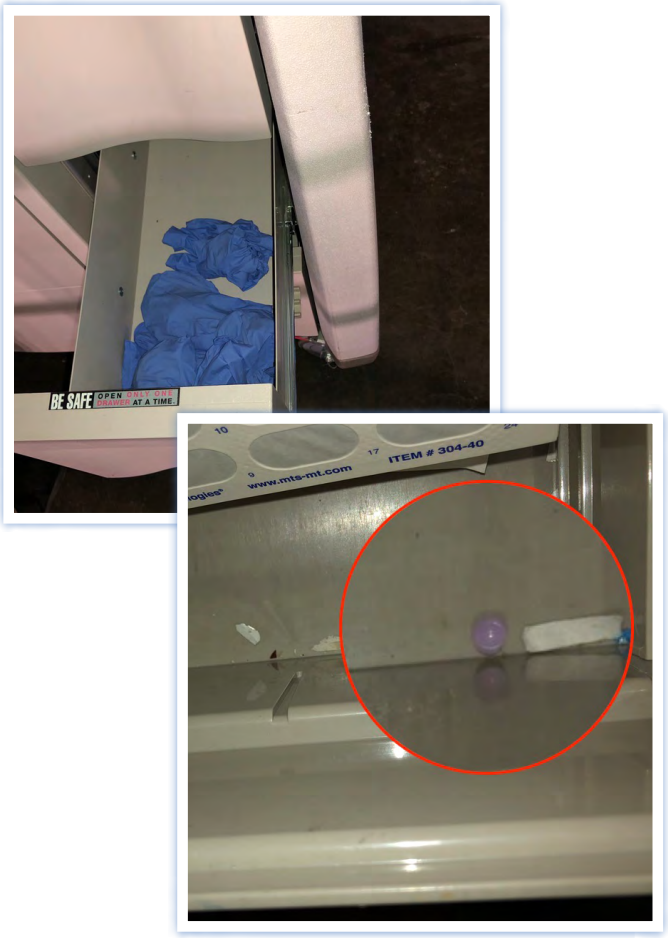
44. The Zoster vaccine reduces the incidence of shingles.

45. An Omnicell is an automated medication dispensing cabinet system.

the floor (see Photo 15, next page). Staff successfully stored valid, unexpired medications in ten of the 12 applicable medication line locations (MIT 7.104, 83.3%). In one location, the medication nurse did not label and initial the multiple-use medication. In another clinic, a normal saline syringe was not stored according to the manufacturer's guidelines.

Nurses exercised proper hand hygiene and contamination control protocols in four of eight locations (MIT 7.105, 50.0%). In four locations, some nurses neglected to wash or sanitize their hands before each subsequent regloving.

Staff in four of eight medication preparation and administration areas demonstrated appropriate administrative controls and protocols (MIT 7.106, 50.0%). In four locations, medication nurses did not maintain unissued medication in its original labeled packaging.



Photos 13 and 14, above. A medication cart drawer was found to be unsanitary; and a medication nurse used a medication cart drawer as a trash bin for soiled, contaminated gloves; (both images photographed on October 15, 2020).

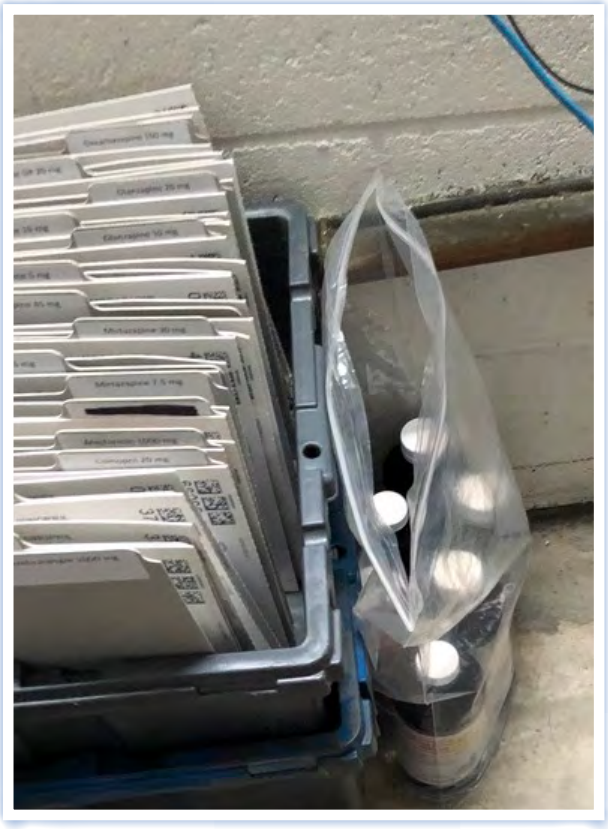


Photo 15. Staff stored medications directly on the floor (photographed on October 16, 2020).

Staff in four of eight medication areas used appropriate administrative controls and protocols when distributing medications to their patients (MIT 7.107, 50.0%). In four locations, we observed one or more of the following deficiencies: medication nurses did not reliably observe patients while they swallowed direct observation therapy medications; medication nurses did not perform secondary verbal patient verification when administering medications at the fronts of cells where the (inside) cell lights remained off; and nurses did not follow insulin protocols properly: more specifically, medication nurses did not disinfect the tops of previously opened insulin vials prior to withdrawing and administering the medication, nurses did not verify and accurately document patients' blood sugar

levels prior to administering insulin, and medication nurses did not verify and document patients' insulin injection sites upon patient self-administration.

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

- In one clinic medication administration area, a bottle of Cell Block 64 disinfectant was placed on the medication window counter. Medication nurses reported that the Cell Block 64 disinfectant was used to clean various surfaces and counter areas that are used for medication preparation.

Pharmacy Protocols

Pharmacy staff followed general security, organization, and cleanliness management protocols in the institution's main and remote pharmacies (MIT 7.108, 100%).

In both of the institution's pharmacies, staff did not properly store nonrefrigerated medications. We found expired medications stored in the pharmacy and noted that staff did not consistently record the room temperatures for nonrefrigerated medications. As a result, RJD scored zero for this test (MIT 7.109).

The institution properly stored refrigerated or frozen medications in one of two pharmacies (MIT 7.110, 50.0%). In the main pharmacy, staff did not consistently record the refrigerator and freezer temperatures.

In both of the institutions' pharmacies, 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 (CDCR Form 7477), or the PIC did not perform monthly physical inventories of controlled substance in several medication administration areas, or both. These errors resulted in a score of zero in this test (MIT 7.111).

We examined 24 medication error reports. The PIC timely or correctly processed only sixteen of these 24 reports (MIT 7.112, 66.7%). In eight reports, the PIC's documentation contained one or more of the following deficiencies: the PIC did not complete the follow-up review within three business days of the error's reported date, did not document the pertinent data related to the error, did not notify the patient or the prescribing physician of the medication error, did not document the medication error determinations or findings, or did not document the recommended changes to correct the medication error.

Nonscored Tests

In addition to testing the institution's self-reported medication errors, our inspectors also followed up on any significant medication errors

found during compliance testing. We did not score this test; we provide these results for informational purposes only. At RJD, the OIG did not find any applicable medication errors (MIT 7.998).

The OIG interviewed patients in isolation units to determine whether they had immediate access to their prescribed asthma rescue inhalers or nitroglycerin medications. Fifteen of 18 applicable patients interviewed indicated they had access to their rescue medications. We were not able to verify possession of medication for one patient as the patient was out to court at the time of inspection. For one patient, medical staff reported that the medication orders were changed to nurse-administered due to patient self-reporting inhaler abuse. Another patient reported he threw away his medication and did not notify any staff or request a replacement. We promptly notified the CEO of this concern, and health care management immediately reissued the rescue inhaler to the patient (MIT 7.999).

Recommendations

- Medical leadership should determine the cause of challenges related to untimely medication continuity for chronic care, transfer-in, hospital discharge, and en-route patients; leadership should implement remedial measures as appropriate.
- Medical and nursing leadership should ensure that chronic care, transfers-in, hospital discharge, and en-route patients receive their medications timely and without interruption; leadership should implement remedial measures as appropriate.
- Nursing leadership should remind nursing staff of documentation requirements in the patient's medical administration record and on the TB monitoring form.

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) *	0	21	4	0
Did health care staff administer, make available, or deliver new order prescription medications to the patient within the required time frames? (7.002)	18	7	0	72.0%
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) *	4	21	0	16.0%
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) *	17	8	0	68.0%
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) *	2	8	0	20.0%
All clinical and medication line storage areas for narcotic medications: Does the institution employ strong medication security controls over narcotic medications assigned to its storage areas? (7.101)	10	1	1	90.9%
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)	8	4	0	66.7%
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)	6	6	0	50.0%
All clinical and medication line storage areas for nonnarcotic medications: Does the institution safely store nonnarcotic medications that have yet to expire in the assigned storage areas? (7.104)	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)	4	4	4	50.0%
Medication preparation and administration areas: Does the institution employ appropriate administrative controls and protocols when *preparing* medications for patients? (7.106)	4	4	4	50.0%
Medication preparation and administration areas: Does the institution employ appropriate administrative controls and protocols when *administering* medications to patients? (7.107)	4	4	4	50.0%
Pharmacy: Does the institution employ and follow general security, organization, and cleanliness management protocols in its main and remote pharmacies? (7.108)	2	0	0	100%
Pharmacy: Does the institution's pharmacy properly store nonrefrigerated medications? (7.109)	0	2	0	0%
Pharmacy: Does the institution's pharmacy properly store refrigerated or frozen medications? (7.110)	1	1	0	50.0%
Pharmacy: Does the institution's pharmacy properly account for narcotic medications? (7.111)	0	2	0	0
Pharmacy: Does the institution follow key medication error reporting protocols? (7.112)	16	8	0	66.7%
Pharmacy: For Information Purposes Only: During compliance testing, did the OIG find that medication errors were properly identified and reported by the institution? (7.998)	This is a nonscored test. Please see the indicator for discussion of this test.			
Pharmacy: For Information Purposes Only: Do patients in restricted housing units have immediate access to their KOP prescribed rescue inhalers and nitroglycerin medications? (7.999) †	This is a nonscored test. Please see the indicator for discussion of this test.			
				Overall percentage (MIT 7): **49.0%**

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

† This question was revised from that published in the original report.

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) *	17	4	4	81.0%
For patients transferred out of the facility: Do medication transfer packages include required medications along with the corresponding transfer-packet required documents? (6.101) *	N/A	N/A	N/A	N/A
Patients prescribed TB medication: Did the institution administer the medication to the patient as prescribed? (9.001) *	3	3	0	50.0%
Patients prescribed TB medication: Did the institution monitor the patient per policy for the most recent three months he or she was on the medication? (9.002) *	1	5	0	16.7%
Upon the patient's admission to specialized medical housing: Were all medications ordered, made available, and administered to the patient within required time frames? (13.004) *	2	8	0	20.0%

* 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
(59.3%)

Preventive Services

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

Results Overview

RJD staff had a mixed performance in preventive services. Staff performed well in 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 administering TB medication as prescribed, monitoring patients who were taking prescribed TB medication, and screening patients annually for TB. These findings are set forth in the table on the next page. We rated this indicator ***inadequate***.

Recommendations

- Nursing leadership and a public health nurse should educate their nursing staff in accurately monitoring patients on TB medications.
- Nursing leadership should educate nursing staff to fully document 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)	3	3	0	50.0%
Patients prescribed TB medication: Did the institution monitor the patient per policy for the most recent three months he or she was on the medication? (9.002) †	1	5	0	16.7%
Annual TB screening: Was the patient screened for TB within the last year? (9.003)	5	20	0	20.0%
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)	16	2	7	88.9%
Are patients at the highest risk of coccidioidomycosis (valley fever) infection transferred out of the facility in a timely manner? (9.009)	N/A	N/A	N/A	N/A
			Overall percentage (MIT 9): **59.3%**	

* 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, such as **Emergency Services**, **Specialty Services**, and **Specialized Medical Housing**.

Results Overview

Nurses at RJD generally provided appropriate nursing care. The nurses performed excellent nursing assessments for patients returning from the hospital and from specialty services. The number of deficiencies we found in this indicator were comparable to those we found in Cycle 5, with an increase in significant deficiencies. We identified opportunities for improvement in several areas of the nursing process described in the subcategories below. Considering all these factors, the OIG rated this indicator adequate.

Case Review Results

We reviewed 234 nursing encounters in 69 cases. Of the nursing encounters we reviewed, 138 were in the outpatient setting. We identified 64 nursing performance deficiencies, nine of which were significant.[46]

Nursing Assessment and Intervention

A critical component of nursing care is the quality of nursing assessment, which includes both subjective (patient interview) and objective (observation and examination) elements. RJD nurses generally provided appropriate nursing assessments and interventions. However, outpatient nursing assessments showed room for improvement. The following are examples:

- In case 1, the patient had a wound on his toe. The provider

46. Deficiencies occurred in cases 1, 2, 3, 4, 5, 9, 10, 11, 18, 20, 22, 23, 24, 25, 26, 33, 35, 36, 37, 41, 42, 47, 55, 59, 60, 63, 64, 65, 66, 70, and 72. Significant deficiencies occurred three times in case 26, twice in case 24, and once in cases 1, 4, 22, and 55.

ordered daily wound care with antibiotic ointment for 14 days. However, the nurses did not consistently perform daily wound care as ordered and often did not apply the antibiotic ointment as directed.

- In case 26, the patient had elevated blood sugar levels from finger sticks intermittently for three months. The nurses did not inquire about signs and symptoms of hyperglycemia (elevated blood sugar levels) and did not notify the provider.

Nursing Documentation

Complete and accurate nursing documentation is an essential component of patient care. Without proper documentation, health care staff can overlook changes in patients' conditions. RJD nurses generally documented their care appropriately. However, emergency services and transfer-out nursing documentation showed room for improvement, which we discuss in the **Emergency Services** and **Transfers** indicators. The following deficiencies are examples we identified in the outpatient setting:

- In case 10, the patient complained of liver pain on three different occasions, yet the sick call nurse did not document whether the patient's abdomen was flat or distended.
- In case 11, the nurse administered a vaccine to the patient and did not document pertinent information, such as the name of the manufacturer, the lot number, or the expiration date. This information is important in the event the medication is recalled.

Nursing Sick Call

Our clinicians reviewed 39 sick call requests. The clinic saw an average of eight patients per day, and staff reported no nurse appointment backlog. Most nurses triaged patient sick calls appropriately and performed timely evaluations for patients with symptoms. However, we found clinic nurses did not always perform thorough assessments. The following examples demonstrated room for improvement:

- In cases 23 and 24, the patient complained of joint pain, yet the sick call nurse did not assess range of motion.
- In case 24, the patient complained of chills and a fever. The sick call nurse requested an appointment in one day. However, the patient should have been seen the same day and screened for COVID-19.
- In case 55, the patient with a history of bowel resection complained of abdominal cramps. The sick call nurse did not assess bowel sounds or abdominal tenderness, did not indicate whether the patient's abdomen was flat or distended, and did not weigh the patient. Although the patient had no adverse events, this assessment fell below nursing standards.

Emergency Services

We reviewed 19 urgent or emergent cases. The nurses responded promptly to emergent events and performed good nursing assessments. However, their documentation showed room for improvement, which we detail further in the **Emergency Services** indicator.

Hospital Returns

We reviewed 17 cases that involved returns from off-site hospitals. The nurses performed excellent nursing assessments, which we detailed further in the **Transfers** indicator.

Transfers

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

Specialized Medical Housing

We reviewed five CTC cases. The nurses provided satisfactory nursing care, which we detail further in the **Specialized Medical Housing** indicator.

Specialty Services

We reviewed 11 cases in which patients returned from off-site specialty appointments. The nurses performed excellent assessments, reviewed the specialists' findings and recommendations, and communicated those results to the provider. The **Specialty Services** indicator provides further information.

Medication Management

We reviewed 46 cases and found that nurses administered patients' medications as prescribed in all cases, with one exception. Please refer to the **Medication Management** indicator for additional details.

Clinician On-Site Inspection

Our clinicians spoke with the nurses and nurse managers in the TTA, CTC, R&R, specialty services, outpatient clinics, and medication areas. The clinic staff was familiar with their patient population, and the nursing staff reported that nursing morale was generally good.

We attended organized clinic huddles in person and attended the Health Care Quality Management Committee meeting via teleconference.

Some topics of discussion included access to care, health care incident reporting, and issues that significantly impacted operations, such as COVID-19.

We met with the nursing leadership to discuss some of our case review findings; they acknowledged several opportunities for quality improvement. The nursing leadership was knowledgeable about the nursing process and worked collaboratively with the multidisciplinary teams.

Recommendations

We offer no specific recommendations for this indicator.

Overall Rating
Adequate

Case Review Rating
Adequate

Compliance Score
(N/A)

Provider Performance

In this indicator, OIG case review clinicians evaluated the quality of care delivered by the institution's providers: physicians, physician assistants, and nurse practitioners. Our clinicians assessed the institution's providers' ability to evaluate, diagnose, and manage their patients properly. We examined provider performance across several clinical settings and programs, including sick call, emergency services, outpatient care, chronic care, specialty services, intake, transfers, hospitalizations, and specialized medical housing. We assessed provider care through case review only and performed no compliance testing for this indicator.

Results Overview

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

Case Review Results

During our inspection, we found a total of 27 deficiencies, four of which were significant.[47] Our physicians also rated the overall adequacy of care in each of the 25 detailed cases. Of these 25 cases, 23 were adequate and two were inadequate.

Assessment and Decision-Making

RJD providers generally made appropriate assessments and sound medical plans for their patients. They diagnosed medical conditions correctly, ordered appropriate tests, and referred their patients to proper specialists. Our clinicians identified one significant deficiency related to poor medical planning:

- In case 15, the patient had a critically high blood glucose level; however, the provider did not order an urgent follow-up appointment with the patient.

Review of Records

For patients returning from hospitalizations, RJD providers performed well in reviewing medical records and addressing the hospital recommendations. The providers also performed well in reviewing the medication administration record and reconciling the patients'

47. Deficiencies occurred six times in case 20, four times in case 24, three times in case 15, twice in cases 1, 10, and 18, and once in cases 6, 16, 19, 29, 62, 63, and 72. Significant deficiencies occurred twice in cases 15 and 20.

medications. However, our clinicians identified one significant deficiency related to poor management of a chronic medication:

- In case 20, the patient had been taking an antiarrhythmic drug, amiodarone,[48] for over two years; however, the provider did not perform the recommended monitoring for pulmonary toxicity, thyroid toxicity, and electrolyte imbalances.

Emergency Care

RJD providers made appropriate triage decisions when patients arrived at the triage and treatment area (TTA) for emergency treatment. In addition, providers were available for consultation with the TTA nursing staff. We identified one deficiency related to emergency care:

- In case 24, the TTA provider evaluated a patient for a fall and tailbone pain; however, the provider did not perform a physical examination of the tailbone.

Chronic Care

RJD providers performed well in managing chronic medical conditions such as hypertension, diabetes, asthma, hepatitis C infection, and cardiovascular disease. RJD designated a provider to manage patients on blood thinner medications. The provider appropriately monitored INR levels and adjusted oral blood thinner medications accordingly. Our clinicians identified one significant deficiency related to poor diabetic management:

- In case 15, a provider reviewed a laboratory test showing an elevated hemoglobin A1c and sent a patient result letter informing the patient of a follow-up visit to discuss the poorly controlled diabetes. However, during the follow-up visit, the provider did not did discuss the elevated hemoglobin A1c or the poorly controlled diabetes.

Specialty Services

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

- In case 18, the ophthalmologist diagnosed the patient with glaucoma and recommended to start the patient on a glaucoma medication and to have the patient follow-up in three months. A provider reviewed the specialist's report but did not address the recommendations.

48. An antiarrythmic medication regulates an abnormal heart rhythm.

Documentation Quality

RJD providers generally documented outpatient and TTA encounters on the same day of the encounter. Our clinicians identified five minor deficiencies[49] related to inadequate or missing provider documentation; one example follows:

- In case 24, a provider prescribed an antibiotic but did not document the reason.

Provider Continuity

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

Clinician On-Site Inspection

During the COVID-19 pandemic, RJD providers conducted their daily provider meeting and morning huddles via teleconference. Our clinicians attended two clinic huddles, during which the providers and medical staff discussed events that occurred during the evening and overnight, such as patients returning from hospital or specialty appointment and TTA events. The nurses also informed the providers of expiring medications and new patients to the clinic.

Medical leadership reported 16 full-time providers and no vacancies. Providers were enthusiastic about their work and generally satisfied with nursing, diagnostic, and specialty services. RJD assigned one provider to the substance use disorder treatment program; that provider monitored patients with opioid addiction and prescribed medications to treat addiction.

The chief medical executive and the chief physician and surgeon (CP&S) were committed to patient care and quality improvement. The CP&S conducted population health management meetings monthly for each main clinic, where the providers identified patients with poorly controlled chronic medical conditions and devised plans to improve clinical outcomes.

Recommendations

We offer no specific recommendations for this indicator.

49. Deficiencies occurred in cases 6, 10, 16, 18, and 24.

Specialized Medical Housing

Overall Rating ***Adequate***

Case Review Rating ***Adequate***

Compliance Score ***Inadequate*** **(72.5%)**

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

Results Overview

RJD had an overall compliance core of 72.5 percent, mainly due to poor medication management in the CTC. However, the institution performed well in three compliance measures: the nursing initial assessment completion, the provider history and physical examination completion, and the provision of an operational call system in the specialized medical housing. Compared to Cycle 5 inspection results, we found fewer and less significant deficiencies overall. Nurses performed appropriate admission assessment and rounds, and providers saw their patients within the recommended time frames and provided adequate care. Overall, the OIG rated this indicator ***adequate***.

Case Review Results

Our clinicians reviewed five CTC cases, which included 19 provider events and 14 nursing events. We identified seven minor deficiencies, none of which were significant.[50]

Provider Performance

RJD providers delivered good care. Compliance testing showed that providers completed all admission history and physical examinations without delay (MIT 13.002, 100%). Our clinicians found that providers performed thorough evaluations, made sound medical plans, and reviewed test results and consultations within the required time frames. We did not identify any deficiencies related to provider performance.

Nursing Performance

Compliance testing showed CTC nurses completed 70.0 percent of the initial admission assessments within the required time frames (MIT 13.001). Our clinicians found that CTC nurses performed timely

50. Deficiencies occurred three times in cases 70 and 72 and once in case 71.

admission assessments on the day of admission. The CTC nurses also conducted regular rounds and generally provided satisfactory care. Our clinicians identified four minor deficiencies related to nursing care.[51] Two examples follow:

- In case 70, the patient had an abnormally low heart rate; however, the nurse did not reassess the heart rate.
- In case 72, the patient had a visual impairment after eye surgery and was admitted to the CTC for assistance in performing activities of daily living; however, the CTC nurse did not initiate a care plan for the patient's visual impairment.

Medication Administration

RJD performed poorly in medication administration in the CTC. Compliance testing showed only 20.0 percent of newly admitted patients received their medications within the required time frames (MIT 13.004). Our clinicians identified three deficiencies related to medication management;[52] we discuss these in the **Medication Management** indicator.

Clinician On-Site Inspection

The institution's CTC had 14 medical beds, two of which were negative-pressure rooms. At the time of our visit, all medical beds were occupied. Our compliance testing found that the call light system was functional (MIT 13.101, 100%). RJD had a designated CTC provider who made rounds with nursing staff and conducted daily morning huddles. RJD staffed its CTC with registered nurses, licensed vocational nurses, psychiatric technicians, and certified nursing assistants.

RJD reported that it performed its own internal audit for quality improvement with a goal to ensure all CTC admission documentation was completed within the required time frame.

Recommendations

- Nursing leadership should ensure that patients admitted to the CTC timely receive their medications upon admission.
- Nursing leadership should ensure that initial assessments are completed within the time frame required by CCHCS policy.

51. Minor deficiencies occurred twice in cases 70 and 72.
52. Deficiencies occurred in cases 70, 71, and 72.

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 CMF's Hospice? Effective 4/2019: Did the registered nurse complete an initial assessment of the patient at the time of admission? (13.001) *	7	3	0	70.0%
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) *	10	0	0	100%
For OHU, CTC, SNF, and Hospice (applicable only for samples prior to 4/2019): Did the primary care provider complete the Subjective, Objective, Assessment, and Plan notes on the patient at the minimum intervals required for the type of facility where the patient was treated? (13.003) *,†	0	0	10	N/A
Upon the patient's admission to specialized medical housing: Were all medications ordered, made available, and administered to the patient within required time frames? (13.004) *	2	8	0	20.0%
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): **72.5%**

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

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

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

Overall Rating
Inadequate

Case Review Rating
Inadequate

Compliance Score
Inadequate
(67.5%)

Specialty Services

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

Results Overview

RJD received an overall compliance score of 67.5 percent, which was a decline from its Cycle 5 score of 79.5 percent. The institution performed poorly in coordinating high-priority specialty appointments and in scheduling preapproved specialty appointments for patients transferring into the institution. However, medical staff retrieved most specialty reports in a timely manner. The OIG rated this indicator ***inadequate***.

Case Review Results

Our clinicians reviewed 101 events related to specialty services, including 83 specialty consultations and procedures, and found nine deficiencies, four of which were significant.[53]

Access to Specialty Services

Compliance testing showed that RJD completed high-priority, medium-priority, and routine specialty appointments at a rate of 73.3 percent, 60.0 percent, and 86.7 percent, respectively (MIT 14.001, MIT 14.004, and MIT 14.007). However, only 16.7 percent of follow-up to the high-priority specialty appointments occurred within the requested time frames (MIT 14.003), and only 33.3 percent of follow-up to the routine specialty appointments occurred in a timely manner (MIT 14.009).

Our clinicians reviewed 83 specialty appointments and found three deficiencies,[54] two of which were significant:

- In case 20, a provider requested a cardiac angiogram, yet the procedure did not occur.
- In case 31, a provider requested an urgent wound care consultation; however, the consultation did not occur until three months later.

When patients transferred into RJD with preapproved specialty services, 35.0 percent of their specialty appointments were completed within the required time frames (MIT 14.010). Our clinicians assessed four transfer-in events and identified two missed preapproved specialty appointments:

53. Deficiencies occurred twice in cases 20, 24, 31, and 72 and once in case 71. Significant deficiencies occurred twice in cases 20 and 31.

54. Deficiencies occurred in cases 20, 24, and 31.

- In case 31, the patient had scheduled physical therapy and orthopedic appointments prior to his transfer to RJD; however, these appointments did not occur.

Provider Performance

RJD providers generally referred patients appropriately, reviewed specialty reports within the recommended time frames, and addressed the specialists' recommendations. We identified one significant deficiency related to a provider who did not address the specialist's recommendations.[55] This deficiency is discussed in the **Provider Performance** indicator.

Nursing Performance

Nurses at RJD performed well. Specialty nurses reviewed requests for specialty services and appropriately arranged for specialty appointments. Nurses performed good nursing assessments when patients returned from specialty appointments; nurses reviewed the specialists' findings and recommendations and communicated those results to the providers. Nurses also obtained orders and requested provider follow-up appointments. We reviewed 18 nursing encounters related to specialty services and identified two minor deficiencies related to incomplete nursing assessments.[56]

Health Information Management

Compliance testing showed that medical staff retrieved and reviewed high-priority, medium-priority, and routine specialty reports within the required time frames (MIT 14.002, 73.3%; MIT 14.005, 78.6%; and MIT 14.008, 93.3%). Our clinicians identified one delay in scanning a specialty report:

- In case 71, a dictated specialty report was not scanned into the medical record until 12 days after the appointment.

Clinician On-Site Inspection

The institution employed multiple staff for on-site, off-site and telemedicine specialty services and had a tracking process to ensure all specialty appointments were completed within the requested time frames. Three office technicians, one technician dedicated to each type of specialty service, retrieved the reports from on-site, off-site, and telemedicine specialty services. They tracked specialty reports and would contact the specialists if the reports were not available within 48 hours of the appointments.

55. A deficiency occurred in case 20.

56. Minor deficiencies occurred in cases 24 and 72.

The specialty services supervisor discussed the challenges of scheduling specialty appointments during the COVID-19 pandemic. Off-site specialty appointments were limited, as the specialty clinics adhered to their COVID-19 guidelines, and elective surgeries and procedures were postponed. Specialty nurses informed providers of the delays, so the providers either acknowledged the delays or explored other options to complete the appointments.

RJD had an e-consultation system, wherein the providers consulted the specialists via online messaging. The specialists usually responded to the providers' consultations within 24 hours.

Recommendations

- Medical leadership should identify why preapproved specialty appointments were missed for transfer-in patients; leadership should implement remedial measures as appropriate.
- Medical leadership should identify the root causes for the untimely provision of ordered specialty services; leadership should implement remedial measures as appropriate.
- Medical leadership should ensure that specialty services consultant reports are timely retrieved and reviewed by the institution's providers.
- Medical leadership should ensure that when specialty services requests are denied, providers inform their patients of these denials within appropriate time frames.

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) *	11	4	0	73.3%
Did the institution receive and did the primary care provider review the high-priority specialty service consultant report within the required time frame? (14.002) *	11	4	0	73.3%
Did the patient receive the subsequent follow-up to the high-priority specialty service appointment as ordered by the primary care provider? (14.003) *	1	5	9	16.7%
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) *	9	6	0	60.0%
Did the institution receive and did the primary care provider review the medium-priority specialty service consultant report within the required time frame? (14.005) *	11	3	1	78.6%
Did the patient receive the subsequent follow-up to the medium-priority specialty service appointment as ordered by the primary care provider? (14.006) *	10	1	4	90.9%
Did the patient receive the routine-priority specialty service within 90 calendar days of the primary care provider order or Physician Request for Service? (14.007) *	13	2	0	86.7%
Did the institution receive and did the primary care provider review the routine-priority specialty service consultant report within the required time frame? (14.008) *	14	1	0	93.3%
Did the patient receive the subsequent follow-up to the routine-priority specialty service appointment as ordered by the primary care provider? (14.009) *	2	4	9	33.3%
For endorsed patients received from another CDCR institution: If the patient was approved for a specialty services appointment at the sending institution, was the appointment scheduled at the receiving institution within the required time frames? (14.010) *	7	13	0	35.0%
Did the institution deny the primary care provider's request for specialty services within required time frames? (14.011)	20	0	0	100%
Following the denial of a request for specialty services, was the patient informed of the denial within the required time frame? (14.012)	13	6	1	68.4%
				Overall percentage (MIT 14): **67.5%**

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

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

Table 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) *, †	30	8	7	78.9%
Are specialty documents scanned into the patient's electronic health record within five calendar days of the encounter date? (4.002) *	30	0	15‡	100%

* 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.

‡ Changed from zero to 15.

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

Administrative Operations

Overall Rating
Inadequate

Case Review Rating
(N/A)

Compliance Score
Inadequate
(71.4%)

In this indicator, OIG compliance inspectors evaluated health care administrative processes. Our inspectors examined the timeliness of the medical grievance process and checked whether the institution followed reporting requirements for adverse or sentinel events and patient deaths. Inspectors checked whether the Emergency Medical Response Review Committee (EMRRC) met and reviewed incident packages. We investigated and determined whether the institution conducted the required emergency response drills. Inspectors also assessed whether the Quality Management Committee (QMC) met regularly and addressed program performance adequately. In addition, the inspectors examined if the institution provided training and job performance reviews for its employees. They checked whether staff possessed current, valid professional licenses, certifications, and credentials. The OIG rated this indicator solely based on the compliance score, using the same scoring thresholds as in the Cycle 4 and Cycle 5 medical inspections. Our case review clinicians do not rate this indicator.

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

Results Overview

RJD's performance was mixed in this indicator. The institution scored well in some applicable tests; however, the Emergency Medical Response Review Committee (EMRRC) often did not review cases within required time frames, using incident packages that included the required documents. In addition, the institution conducted medical emergency response drills with incomplete documentation. The nurse and physician managers did not always complete the annual performance appraisals in a timely manner. These findings are set forth in the table below. We rated this indicator ***inadequate***.

Nonscored Results

We obtained CCHCS Death Review Committee (DRC) reporting data. Three unexpected (Level 1) deaths occurred during our review period. The DRC must complete its death review summary report within 60 calendar days of a death. When the DRC completes the death review summary report, it must submit the death to the institution's CEO within seven calendar days of completion. In our inspection, we found the DRC did not complete five death review reports promptly; the DRC finished three reports 56 to 116 days late, respectively, and submitted them to the institution's CEO 19 to 79 days after that. The remaining five reports were overdue at the time of OIG's inspection (MIT 15.998).

Recommendations

We offer no specific recommendations for this indicator.

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)	1	11	0	8.3%
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)	3	1	0	75.0%
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)	1	2	0	33.3%
Did the responses to medical grievances address all of the inmates' appealed 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)	6	4	0	60.0%
Did physician managers complete provider clinical performance appraisals timely? (15.105)	11	7	0	61.1%
Did the providers maintain valid state medical licenses? (15.106)	20	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)	2	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): **71.4%**			

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

† This question was revised from that published in the original report.

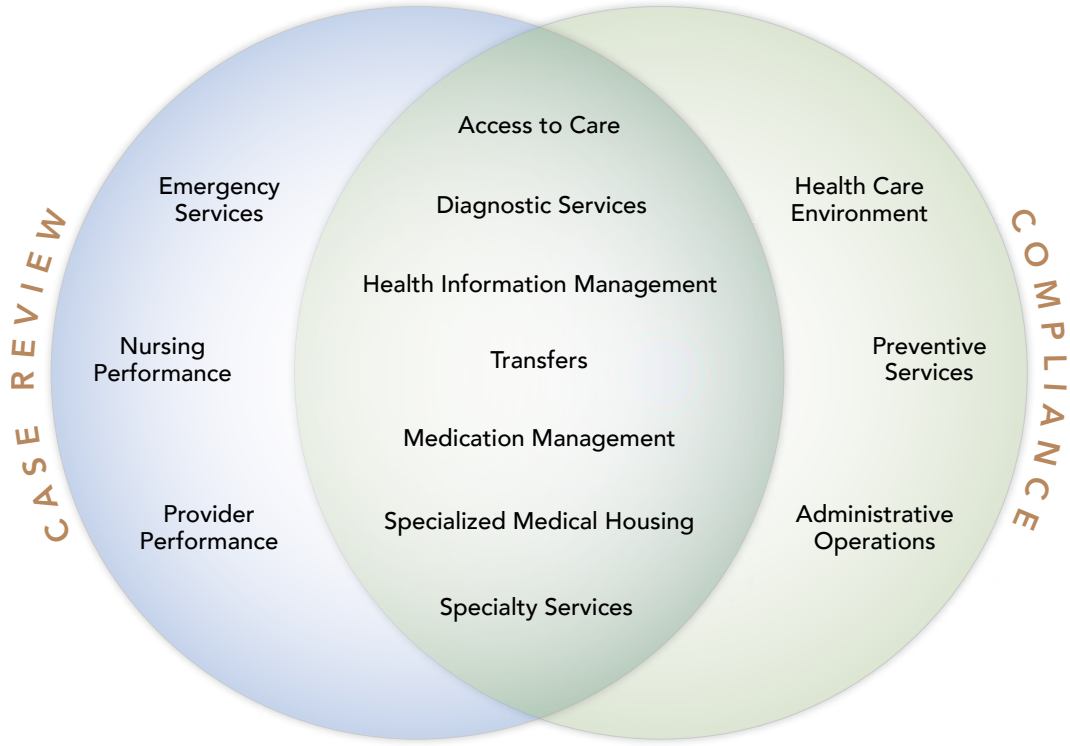
Source: The Office of the Inspector General medical inspection results.

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 RJD



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

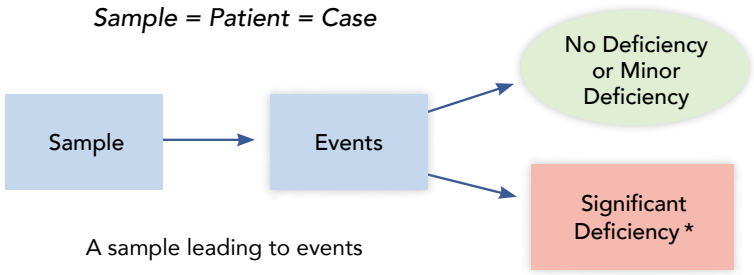
An OIG physician, a nurse consultant, or both review each case. As the clinicians review medical records, they record pertinent interactions between the patient and the health care system. We refer to these interactions as case review ***events***. Our clinicians also record medical errors, which we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

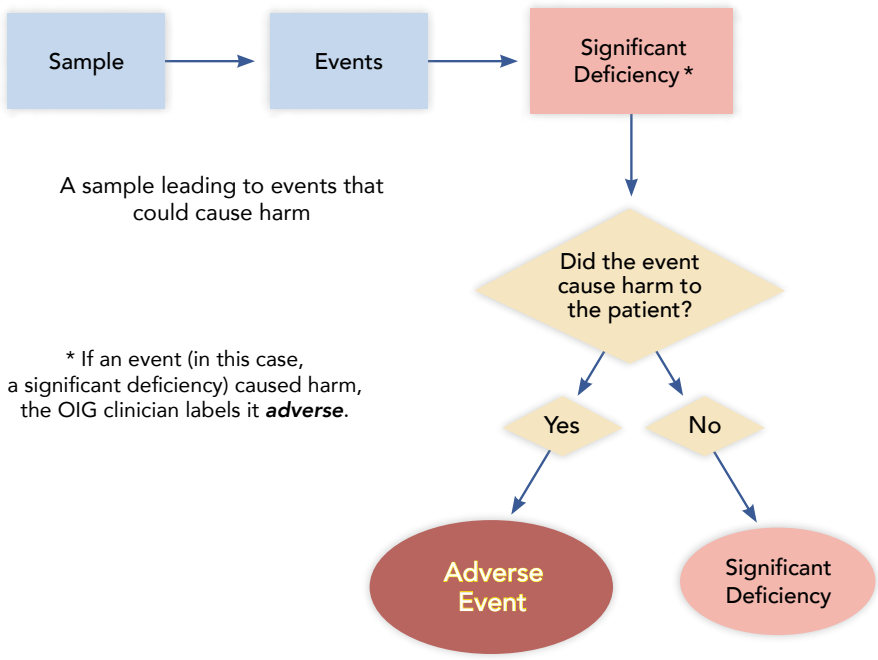
Figure A–2. Case Review Testing

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***.



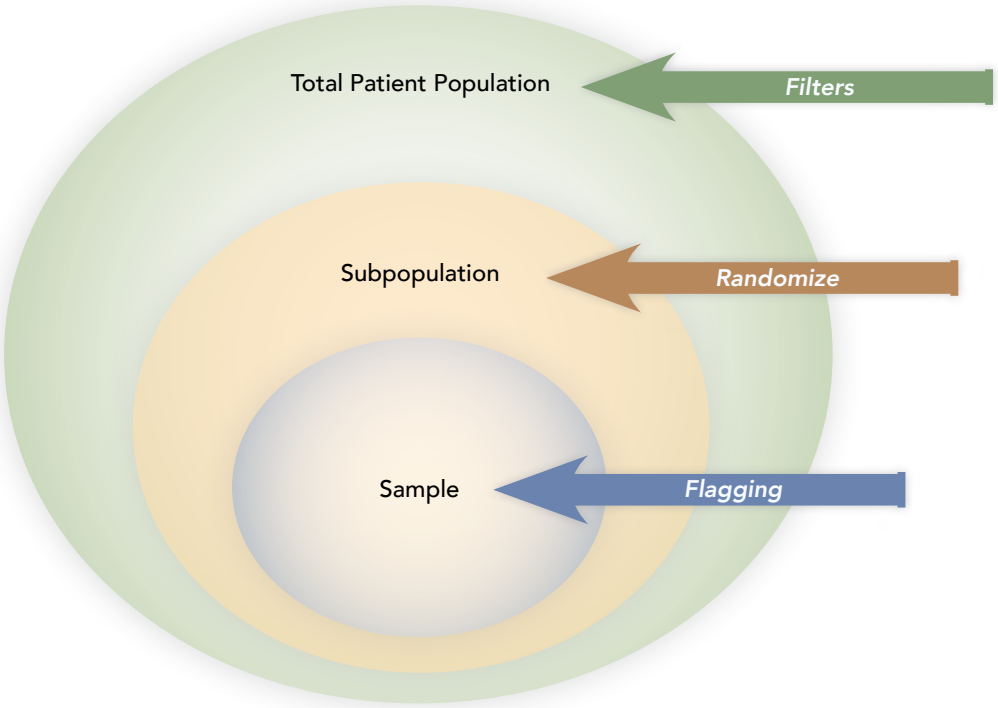
Source: The Office of the Inspector General medical inspection analysis.

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	32
Specialty Services	4
	72

Table B–2. Case Review Chronic Care Diagnoses

Diagnosis	Total
Anemia	6
Anticoagulation	3
Arthritis/Degenerative Joint Disease	14
Asthma	10
COPD	10
Cancer	3
Cardiovascular Disease	10
Chronic Kidney Disease	2
Chronic Pain	26
Cirrhosis/End-Stage Liver Disease	9
Deep Venous Thrombosis/Pulmonary Embolism	2
Diabetes	11
Gastroesophageal Reflux Disease	14
Gastrointestinal Bleed	1
HIV	3
Hepatitis C	22
Hyperlipidemia	28
Hypertension	33
Mental Health	37
Migraine Headaches	2
Seizure Disorder	5
Sleep Apnea	2
Substance Abuse	3
Thyroid Disease	6
	262

Table B–3. Case Review Events by Program

Diagnosis	Total
Diagnostic Services	238
Emergency Care	42
Hospitalization	49
Intrasystem Transfers In	15
Intrasystem Transfers Out	6
Outpatient Care	477
Specialized Medical Housing	44
Specialty Services	133
	1,004

Table B–4. Case Review Sample Summary

MD Reviews Detailed	25
MD Reviews Focused	0
RN Reviews Detailed	16
RN Reviews Focused	45
Total Reviews	86
Total Unique Cases	72
Overlapping Reviews (MD & RN)	14

Appendix C: Compliance Sampling Methodology

Richard J. Donovan Correctional Facility

Quality Indicator	Sample Category	No. of Samples	Data Source	Filters
Access to Care				
MIT 1.001	Chronic Care Patients	25	Master Registry	• Chronic care conditions (at least one condition per patient—any risk level) • Randomize
MIT 1.002	Nursing Referrals	25	OIG Q: 6.001	• See Transfers
MITs 1.003–006	Nursing Sick Call (6 per clinic)	40*	Clinic Appointment List†	• Clinic (each clinic tested) • Appointment date (2–9 months) • Randomize
MIT 1.007	Returns From Community Hospital	25	OIG Q: 4.005	• See **Health Information Management** (Medical Records) (returns from community hospital)
MIT 1.008	Specialty Services Follow-Up	45	OIG Q: 14.001, 14.004 & 14.007	• See Specialty Services
MIT 1.101	Availability of Health Care Services Request Forms	6	OIG on-site review	• Randomly select one housing unit from each yard
Diagnostic Services				
MITs 2.001–003	Radiology	10	Radiology Logs	• Appointment date (90 days–9 months) • Randomize • Abnormal
MITs 2.004–006	Laboratory	10	Quest	• Appt. date (90 days–9 months) • Order name (CBC or CMPs only) • Randomize • Abnormal
MITs 2.007–009	Laboratory STAT	10‡	Quest	• Appt. date (90 days–9 months) • Order name (CBC or CMPs only) • Randomize • Abnormal
MITs 2.010–012	Pathology	10	InterQual	• Appt. date (90 days–9 months) • Service (pathology related) • Randomize

* Changed from 30 to 40.

† Language revised from that published in the original report.

‡ Changed from 3 to 10.

Quality Indicator	Sample Category	No. of Samples	Data Source	Filters
Health Information Management (Medical Records)				
MIT 4.001	Health Care Services Request Forms	40*	OIG Qs: 1.004	• Nondictated documents • First 20 IPs for MIT 1.004
MIT 4.002	Specialty Documents	45	OIG Qs: 14.002, 14.005 & 14.008	• Specialty documents • First 10 IPs for each question
MIT 4.003	Hospital Discharge Documents	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	12†	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	0‡	OIG inspector on-site review	• R&R IP transfers with medication

* Changed from 30 to 40.

† Changed from 11 to12.

‡ Changed from 4 to zero.

Quality Indicator	Sample Category	No. of Samples	Data Source	Filters
Pharmacy and Medication Management				
MIT 7.001	Chronic Care Medication	25	OIG Q: 1.001	See **Access to Care** • At least one condition per patient—any risk level • Randomize
MIT 7.002	New Medication Orders	25	Master Registry	• Rx count • Randomize • Ensure no duplication of IPs tested in MIT 7.001
MIT 7.003	Returns From Community Hospital	25	OIG Q: 4.005	• See **Health Information Management** (Medical Records) (returns from community hospital)
MIT 7.004	RC Arrivals—Medication Orders	N/A at this institution	OIG Q: 12.001	• See **Reception Center**
MIT 7.005	Intrafacility Moves	25	MAPIP transfer data	• Date of transfer (2–8 months) • To location/from location (yard to yard and to/from ASU) • Remove any to/from MHCB • NA/DOT meds (and risk level) • Randomize
MIT 7.006	En Route	10*	SOMS	• Date of transfer (2–8 months) • Sending institution (another departmental facility) • Randomize • NA/DOT meds
MITs 7.101–103	Medication Storage Areas	Varies by test	OIG inspector on-site review	• Identify and inspect clinical & med line areas that store medications
MITs 7.104–107	Medication Preparation and Administration Areas	Varies by test	OIG inspector on-site review	• Identify and inspect on-site clinical areas that prepare and administer medications
MITs 7.108–111	Pharmacy	2†	OIG inspector on-site review	• Identify & inspect all on-site pharmacies
MIT 7.112	Medication Error Reporting	24‡	Medication error reports	• All medication error reports with Level 4 or higher • Select total of 25 medication error reports (recent 12 months)
MIT 7.999	Restricted Unit KOP Medications‖	18§	On-site active medication listing	• KOP rescue inhalers & nitroglycerin medications for IPs housed in restricted units‖

* Changed from N/A to 10.

† Changed from 1 to 2.

‡ Changed from 5 to 24.

§ Changed from 19 to 18.

‖ Language revised from that published in the original report.

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	6*	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

* Changed from 14 to 6.

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 13.101–102	Call Buttons	All	OIG inspector on-site review	• Specialized Health Care Housing • Review by location
Specialty Services				
MITs 14.001–003	High-Priority Initial and Follow-Up RFS	15	Specialty Service Appointments*	• Approval date (3–9 months) • Remove consult to audiology, chemotherapy, dietary, Hep C, HIV, orthotics, gynecology, consult to public health/Specialty RN, dialysis, ECG 12-Lead (EKG), mammogram, occupational therapy, ophthalmology, optometry, oral surgery, physical therapy, physiatry, podiatry, and radiology services* • Randomize
MITs 14.004–006	Medium-Priority Initial and Follow-Up RFS	15	Specialty Service Appointments*	• Approval date (3–9 months) • Remove consult to audiology, chemotherapy, dietary, Hep C, HIV, orthotics, gynecology, consult to public health/Specialty RN, dialysis, ECG 12-Lead (EKG), mammogram, occupational therapy, ophthalmology, optometry, oral surgery, physical therapy, physiatry, podiatry, and radiology services* • Randomize
MITs 14.007–009	Routine-Priority Initial and Follow-Up RFS	15	Specialty Service Appointments*	• Approval date (3–9 months) • Remove consult to audiology, chemotherapy, dietary, HepC, HIV, orthotics, gynecology, consult to public health/Specialty RN, dialysis, ECG 12-Lead (EKG), mammogram, occupational therapy, ophthalmology, optometry, oral surgery, physical therapy, physiatry, podiatry, and radiology services* • Randomize

* Language revised from that published in the original report.

Quality Indicator	Sample Category	No. of Samples	Data Source	Filters
Administrative Operations				
MIT 14.010	Specialty Services Arrivals	20	Specialty Services Arrivals*	• Arrived from (other departmental institution) • Date of transfer (3–9 months) • Randomize
MITs 14.011–012	Denials	20†	InterQual	• Review date (3–9 months) • Randomize
		N/A	IUMC/MAR Meeting Minutes	• Meeting date (9 months) • Denial upheld • Randomize
Administrative Operations				
MIT 15.001	Adverse/sentinel events	0‡	Adverse/sentinel events (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	18§	On-site provider evaluation files	• All required performance evaluation documents
MIT 15.106	Provider Licenses	20‖	Current provider listing (at start of inspection)	• Review all

* Language revised from that published in the original report.

† Changed from N/A to 20.

‡ Changed from 2 to zero.

§ Changed from 7 to 18.

‖ Changed from 13 to 20.

Quality Indicator	Sample Category	No. of Samples	Data Source	Filters
Administrative Operations				
MIT 15.107	Medical Emergency Response Certifications	All	On-site certification tracking logs	• All staff ◦ Providers (ACLS) ◦ Nursing (BLS/CPR) • Custody (CPR/BLS)
MIT 15.108	Nursing Staff and Pharmacist in Charge Professional Licenses and Certifications	All	On-site tracking system, logs, or employee files	• All required licenses and certifications
MIT 15.109	Pharmacy and Providers' Drug Enforcement Agency (DEA) Registrations	All	On-site listing of provider DEA registration #s & pharmacy registration document	• All DEA registrations
MIT 15.110	Nursing Staff New Employee Orientations	All	Nursing staff training logs	• New employees (hired within last 12 months)
MIT 15.998	Death Review Committee	10*	OIG summary log: deaths	• Between 35 business days & 12 months prior • Health Care Services death reviews

* Changed from 9 to 10.

California Correctional Health Care Services' Response

June 24, 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 Richard J. Donovan Correctional Facility (RJD) conducted from January to June 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,

DocuSigned by:
Terra Adams
7A82CF31BF79422...

Terra Adams
Associate Director (A)
Risk Management Branch
California Correctional Health Care Services

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

CALIFORNIA CORRECTIONAL HEALTH CARE SERVICES

P.O. Box 588500
Elk Grove, CA 95758

(This page left blank for reproduction purposes.)

Cycle 6
Medical Inspection Report

for

Richard J. Donovan Correctional Facility

OFFICE *of the*
INSPECTOR GENERAL

Roy W. Wesley
Inspector General

Bryan B. Beyer
Chief Deputy Inspector General

STATE *of* CALIFORNIA
July 2021

OIG