Roy W. Wesley, *Inspector General*

Bryan B. Beyer, *Chief Deputy Inspector General*

OIG | OFFICE *of the* INSPECTOR GENERAL

Independent Prison Oversight

November 2021

Cycle 6
Medical Inspection Report

Folsom State Prison

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

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

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

Contents

Illustrations

Tables

Figures

Photographs

Cover: Rod of Asclepius courtesy of Thomas Shafee

Introduction

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

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

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

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

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

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

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

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

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

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

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

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

Located in the city of Folsom, in Sacramento County, Folsom State Prison is California's second-oldest prison. The institution primarily houses medium-security general population Level II male patients. In addition, the institution houses minimum-security Level I male patients within a minimum--security facility located adjacent to the main security perimeter. FSP offers rehabilitative programs in academic courses and career technical education, as well as volunteer-run rehabilitative programs. FSP is the state's only prison with a mixed population of men and women. FSP includes a 523-bed stand-alone facility that provides housing, rehabilitative and reentry programming, substance abuse treatment, and job training to its minimum- and medium-security female population. Together, Folsom State Prison and Folsom Women's Facility (FWP) operate medical clinics where staff members handle nonurgent requests for medical services. FSP also treats patients requiring urgent or emergent care in its triage and treatment areas (TTAs). The institution has been designated as an ***intermediate care prison***; these institutions are predominantly located in urban areas close to tertiary care centers and specialty care providers likely to be necessary for a population with moderately high medical needs.

6. Samples are obtained per case review methodology shared with stakeholders in prior cycles. The case reviews include death reviews that occurred between April 2020 and October 2020, an emergency CPR review that occurred in March 2020, anticoagulation reviews that occurred between April 2020 and October 2020, hospitalization reviews that occurred between March 2020 and November 2020, specialty services reviews between March 2020 and October 2020, transfer-in reviews between February 2020 and June 2020, and RN sick call reviews between March 2020 and October 2020.

Summary

We completed the Cycle 6 inspection of Folsom State Prison (FSP) in February 2021. OIG inspectors monitored the institution's delivery of medical care that occurred between April 2020 and September 2020.

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

Table 1. FSP 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	N/A	N/A	N/A	N/A
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 384 patient records and 1,077 data points and used the data to answer 89 policy questions. In addition, we observed FSP processes during an on-site inspection in December 2020. Table 2 below lists FSP average scores from Cycles 4, 5, and 6.

Table 2. FSP 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	87.8%	91.3%	82.3%
2	Diagnostic Services	73.8%	70.0%	56.7%
4	Health Information Management	62.6%	95.2%	77.3%
5	Health Care Environment	70.6%	61.6%	59.6%
6	Transfers	87.3%	72.6%	63.9%
7	Medication Management	89.3%	71.9%	69.6%
8	Prenatal and Postpartum Care	N/A	N/A	N/A
9	Preventive Services	91.0%	89.2%	74.8%
12	Reception Center	N/A	N/A	N/A
13	Specialized Medical Housing	N/A	N/A	N/A
14	Specialty Services	91.4%	81.9%	72.1%
15	Administrative Operations	68.7%*	80.9%	67.8%

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

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

OIG case reviewers (a team of physicians and nurse consultants) reviewed 67 cases, which contained 877 patient-related events. After examining the medical records, our clinicians conducted a follow-up on-site inspection in February 2021 to verify their initial findings. The OIG physicians rated the quality of care for 24 comprehensive cases. Of these 24 cases, our physicians rated six ***inadequate*** and 18 ***adequate***. Our physicians found no adverse events during this inspection.

The OIG then considered the results from both case review and compliance testing, and drew overall conclusions, which we report in the 12 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 FSP Summary Table.

In November 2020, the Health Care Services Master Registry showed that FSP had a total population of 2,238. A breakdown of the medical risk level of the FSP population as determined by the department is set forth in Table 3 below.[8]

Table 3. FSP Master Registry Data as of November 2020

Medical Risk Level	Number of Patients	Percentage
High 1	70	3.1%
High 2	235	10.5%
Medium	665	29.7%
Low	1,268	56.7%
Total	**2,238**	**100%**

Source: Data for the population medical risk level were obtained from the CCHCS Master Registry dated 11-16-20.

7. The indicators for **Prenatal and Postpartum Care**, **Reception Center,** and **Specialized Medical Housing** did not apply to FSP.

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, FSP had one executive leadership vacancy, zero vacant primary care provider positions, 0.2 vacant nursing supervisor positions, and 16 vacant nursing staff positions.

Table 4. FSP Health Care Staffing Resources as of November 2020

Positions	Executive Leadership*	Primary Care Providers	Nursing Supervisors	Nursing Staff †	Total
Authorized Positions	7	9	16.2	99	131.2
Filled by Civil Service	6	9	16	83	114
Vacant	1	0	0.2	16	17.2
Percentage Filled by Civil Service	85.7%	100%	98.8%	83.8%	86.9%
Filled by Telemedicine	0	0	0	0	0
Percentage Filled by Telemedicine	0	0	0	0	0
Filled by Registry	0	0	0	2	2
Percentage Filled by Registry	0	0	0	2.0%	1.5%
Total Filled Positions	6	9	16	85	116
Total Percentage Filled	100%	100%	98.8%	85.9%	83.8%
Appointments in Last 12 Months	3	1	3	19	26
Redirected Staff	0	0	0	1	1
Staff on Extended Leave‡	0	0	0	2	2
Adjusted Total: Filled Positions	**6**	**9**	**16**	**85**	**113**
Adjusted Total: Percentage Filled	**57.1%**	**88.9%**	**80.3%**	**63.6%**	**61.7%**

* Executive Leadership includes the Chief Physician and Surgeon.

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

‡ In Authorized Positions.

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

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

Medical Inspection Results

Deficiencies Identified During Case Review

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

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

Our inspectors did not find any adverse events at FSP in the cases reviewed during the Cycle 6 inspection.

Case Review Results

OIG case reviewers (a team of physicians and nurse consultants) assessed nine of the 12 indicators applicable to FSP. Of these nine indicators, OIG clinicians rated none ***proficient,*** seven ***adequate***, and two ***inadequate***. The OIG physicians also rated the overall adequacy of care for each of the 24 detailed case reviews they conducted. Of these 24 cases, 18 were adequate and six were inadequate. In the 877 events reviewed, there were 376 deficiencies, 79 of which the OIG clinicians considered to be of such magnitude that, if left unaddressed, they would likely contribute to patient harm.

Our clinicians found the following strengths at FSP:

- Nursing quality and commitment to patient care were good, despite the additional COVID-19 pandemic workload. Nursing continued to see patients during the pandemic.
- The staff performed well in emergency cases.
- Ancillary services such as radiology and laboratory performed well, despite the challenges of the pandemic.

Our clinicians found FSP could make the following improvements:

- Increase the thoroughness of provider care and medical oversight of patients with complex medical conditions.
- Ensure providers submit specialty follow-up orders at the time of consultation review or patient follow-up visit.

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

- Correctly close appointments to accurately reflect which patient was seen by a provider versus which patient received a chart review.
- Ensure the providers document all medically necessary components in their progress notes, clarify when progress notes are required, and document their medical reasoning for not following specialist recommendations.

Compliance Testing Results

Our compliance inspectors assessed nine of the 12 indicators applicable to FSP. Of these nine indicators, our compliance inspectors rated two ***adequate*** and seven ***inadequate***. We tested only policy compliance in the **Health Care Environment**, **Preventive Services**, and **Administrative Operations** indicators, as these do not have a case review component.

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

- Nursing staff processed health care services request forms, performed face-to-face evaluations, and completed nurse-to-provider referrals within required time frames.
- Housing units in FSP had an adequate supply of health care request forms.
- The institution's staff timely scanned into patients' electronic medical records specialty service reports, community hospital discharge reports, and requests for health care services.

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

- FSP staff failed to maintain medication continuity for chronic care patients, patients discharged from the hospital, and patients who had a temporary layover.
- Medical staff did not follow proper hand hygiene practices before or after patient encounters. Also, medication nurses did not maintain proper hand hygiene while distributing medications to patients.
- FSP did not perform well in ensuring that approved specialty services were provided timely.
- Providers did not often communicate results of diagnostic services timely. Most patient letters communicating these results were missing the date of diagnostic service and information about whether the results were within normal limits.

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 FSP's performance with population-based metrics to assess the macroscopic view of the institution's health care delivery. FSP's results compared favorably with those found in State health plans for diabetic care measures. We list the 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)—FSP performed as well or better in three of the five diabetic measures. The institution scored higher than Kaiser Southern California in HbA1c screening, HbA1c control and blood pressure control. Statewide comparative data were unavailable for poor HbA1c control and eye examinations, but the FSP data are presented for informational purposes.

Immunizations

Statewide comparative data were also not available for immunization measures; however, we include this data for informational purposes. FSP had a 71 percent influenza immunization rate for adults 18 to 64 years old and 73 percent immunization rate for adults 65 years of age and older. The pneumococcal vaccine rate was 67 percent.[10]

Cancer Screening

Statewide comparative data were not available for colorectal cancer screening; however, we include these data for informational purposes.

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

FSP had an 83 percent colorectal screening rate. For cervical cancer screenings, FSP outperformed the other three State plans with a screening rate of 100 percent. In breast cancer screenings, FSP only outperformed California Medi-Cal.

Table 5. FSP Results Compared With State HEDIS Scores

HEDIS Measure	FSP Cycle 6 Results*	California Medi-Cal 2018†	California Kaiser NorCal Medi-Cal 2018†	California Kaiser SoCal Medi-Cal 2018†
HbA1c Screening	**97%**	90%	94%	96%
Poor HbA1c Control (>9.0%)‡,§	**10%**	34%	25%	18%
HbA1c Control (<8.0%)‡	78%	–	–	–
Blood Pressure Control (<140/90)‡	**85%**	65%	78%	84%
Eye Examinations	24%	–	–	–
Influenza–Adults (18–64)	71%	–	–	–
Influenza–Adults (65+)	73%	–	–	–
Pneumococcal–Adults (65+)	67%	–	–	–
Breast Cancer Screening	80%	62%	82%	**84%**
Cervical Cancer Screening	**100%**	65%	87%	83%
Colorectal Cancer Screening	83%	–	–	–

Notes and Sources

* Unless otherwise stated, data were collected in December 2020 by reviewing medical records from a sample of FSP'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, 2019–June 30, 2020 (published April 2021).

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

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

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

Recommendations

As a result of our assessment of FSP's performance, we offer the following recommendations to the department. Where we recommend an internal review of the root causes of identified problems, we further recommend that the institution consider all remedial measures to address challenges, including both systemic adjustments and individual accountability.

Access to Care

- The department should provide clear policy guidance to institutions regarding how to manage care during a pandemic, including how to manage care for chronic care patients whose appointments might be canceled or delayed, how to prioritize patient movement to ensure provider appointments occur, how to properly close an appointment for patients who receive only a medical chart review, and how to balance the workload to ensure equitable distribution of patient care among nursing and providers.
- Medical leadership should ensure that providers see the medium- and high-risk patients whose provider appointments were replaced with chart review during the COVID-19 pandemic.

Diagnostic Services

- The department should consider developing and implementing a patient results letter template that autopopulates with all elements required by California Correctional Health Care Services (CCHCS) policy.
- The department should consider developing and implementing an electronic solution to ensure that urine culture results from the laboratory portal autopopulate into the electronic health record system (EHRS).
- Medical leadership should educate providers to access the laboratory portal when laboratory results are missing in the EHRS.
- Medical leadership should consider implementing a system to track outside diagnostic reports, such as pathology reports, to ensure they are received and scanned timely.

Emergency Services

- Nursing leadership should ensure that the Emergency Medical Response Review Committee (EMRRC) thoroughly audits emergency events, identifies all deficiencies, and provides staff training in a timely manner.

- Leadership should ensure that all staff are reminded to activate the 9-1-1 system immediately for emergent patients needing a higher level of care.

Health Information Management

- Medical leadership should determine the root cause of challenges to the retrieval and timely provider review of urine culture and pathology results; leadership should implement remedial measures as appropriate.
- Medical leadership should ensure that signed informed refusal forms are obtained for specialty and clinic visits or procedures and are scanned into EHRS.
- The department should consider adjusting the default drop-down menu on the results letter in EHRS so that the menu defaults to *patient letter* instead of *DDP-Scan;* the department should train providers to generate the results letters appropriately.

Health Care Environment

- Medical leadership should remind staff to follow universal hand hygiene precautions. Implementing random spot checks could improve compliance.
- Nursing leadership should direct each clinic nurse supervisor to review the monthly emergency medical response bag (EMRB) logs to ensure the EMRBs are regularly inventoried and sealed. In addition, nursing leadership should implement random monthly inventory spot checks to ensure EMRBs and crash carts contain all the medical supplies identified in the logs.
- Nursing leadership should consider performing random spot checks to ensure that staff follow equipment and medical supply management protocols.

Transfers

- The department should consider developing and implementing an electronic alert to ensure that receiving and release (R&R) nurses properly complete initial health screening questions and follow up as needed.
- Medical leadership should ensure providers see transfer patients in the time frame required by the patients' clinical risk levels and that previously approved specialty appointments are scheduled within the required time frame.

Medication Management

- Pharmacy and nursing leadership should consider reviewing the causes of the untimely delivery of newly prescribed, chronic, and hospital discharge medications; leadership should implement remedial measures as appropriate.

Preventive Services

- Nursing leadership and the public health nurse should educate nursing staff to fully document tuberculosis (TB) symptoms as part of the patient's TB medication monitoring.
- Nursing leadership should educate nursing staff to timely perform and properly document yearly TB screenings.
- Medical leadership should ensure that providers offer required immunizations to patients with chronic care conditions, as required by policy.

Nursing Performance

- Nursing leadership should ensure that thorough assessments are completed for all face-to-face encounters.
- Nursing leadership should continue to provide guidance to staff during the monthly nursing all-staff meeting regarding documentation and intervention.

Provider Performance

- The department should define a nurse-to-provider co-consultation and should provide clear guidance to the providers on when provider progress notes are required for TTA and emergency phone calls, co-consultations, provider orders, and appointments.
- The department should provide clear policy guidance to institutions regarding how to manage care during a pandemic, including how to manage care for chronic care patients whose appointments might be canceled or delayed, how to prioritize patient movement to ensure that provider appointments occur, how to properly close an appointment for patients who only receive a medical chart review, and how to balance the workload to ensure equitable distribution of patient care among nurses and providers.
- Medical leadership should examine the causes of poor provider care for clinically complex patients and should implement remedial measures as appropriate.

Specialty Services

- Medical leadership should provide clear policies and procedures regarding who is responsible for ordering specialty follow-up visits and laboratory tests.
- Medical leadership should ensure that patients timely receive initial and follow-up specialty visits.
- Medical leadership should review the causes of the untimely retrieval of specialty reports and the untimely provider review of specialty reports; medical leadership should implement remedial measures as appropriate.

Administrative Operations

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

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
Inadequate

Compliance Score
Adequate
(82.3%)

Results Overview

FSP provided adequate access to care overall. This indicator would have been rated as inadequate but for the exceptional nursing performance and availability of ancillary services. Compliance testing rated access to care adequate as FSP scored high for nurse access, but revealed the need for improvement in provider chronic care and hospital follow-up appointment access. When a nurse referred a patient to the provider, the patient was usually seen in the ordered time frames. Nurses reviewed patient requests and saw patients timely. OIG clinicians found that nurses delivered good access during the COVID-19 pandemic. During the pandemic, FSP providers were allowed to work at home as telework providers, and they completed chart reviews. OIG clinicians noted in-person provider appointments were available for patients, but the providers frequently did not see patients, instead performing chart reviews. We found that providers deferred some appointments and documented them as having been completed in the EHRS even though the patients were not seen face-to-face with the provider.[11] After reviewing all aspects, the OIG rated this indicator ***adequate***.

Case Review and Compliance Testing Results

OIG clinicians reviewed 146 provider, nursing, specialty, and hospital events that required the institution to generate appointments. We identified 14 deficiencies relating to access to care, four of which were significant.[12]

Access to Clinic Providers

Access to clinic providers is an integral part of patient care in health care delivery. Early in the COVID-19 pandemic, CCHCS headquarters advised the institutions to see only urgent or emergent appointments; however, the guidance did not specify which urgent appointments should be seen or how many times an appointment could be deferred. FSP did not experience any novel coronavirus disease (COVID -19) cases until

11. A completed appointment occurs when the provider closes the appointment EHRS, which indicates an appointment such as a face-to-face interaction had occurred between the provider and patient.

12. Deficiencies occurred in cases 7, 9, 14, 17, 19, 27, 28, 29, 31, 43, and 47. Significant deficiencies occurred in cases 17, 19, and 31.

July 2020, and a significant outbreak did not occur until August through October 2020. At the time of our inspection, FSP continued to use headquarters' guidance to see only urgent or emergent patients, despite available appointments.

Compliance found that the providers performed with mixed results: providers saw patients referred by the nurses 91.7 percent of the time (MIT 1.005) and saw patients referred by their primary care provider for follow-up sick call appointments 100 percent of the time, (MIT 1.006); however, providers only saw chronic care patients within guidelines 54.2 percent of the time (MIT 1.001). Providers often deferred appointments with documentation that the patients could not be seen due to the COVID-19 pandemic, but there were often no documented reasons, such as movement restrictions or quarantine. We found that the providers marked some chronic care, specialty, and hospital follow-up visits as completed, rather than canceled or rescheduled, even though the patients were not seen by the provider. OIG clinicians noted that some providers would defer assessments to nursing or perform chart reviews instead of face-to-face encounters. Two examples follow:

- In case 9, the provider did not see the patient with uncontrolled diabetes after an endocrinology consultation and rescheduled the provider follow-up appointment for 60 days later. The provider documented the initial appointment as completed even though the provider did not see the patient. The patient was evaluated for a diabetic emergency TTA visit later that day, which might have been prevented if the provider had seen the patient. In addition, when the patient was scheduled for a chronic care appointment approximately one month later, the provider again deferred the appointment, even though the patient's diabetes was uncontrolled and his last chronic care visit had been over seven months earlier. Again, the provider documented the appointment as completed, but the provider did not see the patient in-person nor call the patient.

- In case 20, the provider ordered steroid medication for this patient with a potentially infected swollen elbow without seeing the patient. The provider relied upon nursing assessments of the patient's condition for medical decision-making. The patient was later seen by the specialist for an infected elbow and required hospital admission for intravenous antibiotics. By not seeing the patient, at which time the provider would have performed an evaluation, the provider placed the patient at an increased risk of harm. Upon release from the hospital, the patient was scheduled to see the provider for follow-up. On two separate scheduled appointments, the provider did not perform either a face-to-face or telephone appointment with the patient, yet documented these scheduled appointments as completed in the medical record. The hospital follow-up appointment with the provider was delayed, occurring 27 days after the hospital discharge.

As these cases were related to provider care and specialty performance, we discuss them further in the **Provider Performance** and **Specialty Services** indicators.

Access to Clinic Nurses

FSP provided excellent access to nurses. This is supported by compliance testing results for nursing triage of the patient's request for service (MIT 1.003, 100%) and timely registered nurse (RN) face-to-face assessments (MIT 1.004, 94.3%). Case reviewers reviewed 79 sick call encounters and identified three deficiencies.[13] The only significant deficiency was identified in the following case:

- In case 19, the patient submitted a sick call request for right lower extremity pain. The RN triaged the sick call and ordered a routine nurse follow-up appointment within 14 days. The appointment was discontinued when the patient was admitted to an off-site hospital for abdominal pain. Subsequently, the patient was never assessed for his right lower extremity pain.

The nurses performed well with care manager and RN follow-up appointments, with no identified deficiencies.

Access to Specialty Services

Compliance testing found that 73.3 percent of all high-priority specialty services, 93.3 percent of all medium-priority specialty appointments, and 53.3 percent of all routine-priority specialty appointments were performed within policy guidelines (MIT 14.001, 14.004, 14.007).

Compliance testing found that patients received high-priority follow-up specialty care 72.7 percent of the time, medium-priority follow-up specialty 100 percent of the time, and routine-priority specialty follow-up care 87.5 percent of the time (MIT 14.003, 14.006, and 14.009). The OIG clinicians found, however, that in 23 of 26 specialty visits, the providers did not order the specialty requested follow-up or laboratory work at the time of the provider follow-up visit.[14] In addition, providers did not document the reasons why they did not follow the specialty recommendations. Specialty nursing frequently messaged the providers for the orders. This is discussed further in the **Provider Performance** and **Specialty Services** indicators.

Follow-Up After Specialty Service

Compliance testing revealed that 65.1 percent of provider appointments after specialty services occurred within the required time frames (MIT 1.008). Of the 16 appointments that did not occur from April through September 2020, five were documented as not seen due to the COVID-19 pandemic. There were no COVID-19 cases at FSP prior to July 2020.

13. Deficiencies for RN sick call requests were identified in cases 19, 43, and 47.
14. These deficiencies occurred in cases 7, 9, 11, 12, 19, 20, 26, 27, 28, 30, and 31.

The OIG clinicians also noted providers often performed chart review rather than meeting with the patient. One instance was noted where the provider performed a phone appointment. [15]

Follow-Up After Hospitalization

FSP performed fair for follow up after hospitalization. Compliance testing found provider appointments occurred 71.4 percent of the time after a hospitalization (MIT 1.007). The OIG clinicians reviewed nine hospital returns and identified one significant deficiency:

- In case 20, the provider documented two hospital follow up appointments as completed, although the patient was not seen by the provider. The provider did not see a patient for 27 days after hospitalization for an infected elbow. Although the nurses assessed the patient, the provider should have evaluated the patient's infected elbow soon after a hospitalization requiring intravenous antibiotics. This fell below the standard of medical care.

Follow-Up After Urgent or Emergent Care (TTA)

FSP providers generally saw their patients following a triage and treatment area (TTA) event as ordered. OIG clinicians reviewed 23 triage and treatment area (TTA) events and found no deficiencies.

Follow-Up After Transferring into the Institution

Providers saw newly transferred patients at rate of 63.6 percent in compliance testing (MIT 1.002). The OIG clinicians evaluated six transfer-in events and identified one case in which follow-up was not ordered and one case in which outstanding specialty orders were not transferred:

- In case 16, the nurse did not order a provider follow up appointment within seven days and a nurse follow up appointment within 30 days as required by policy.
- In case 17, the patient transferred with an outstanding cardiology referral. The cardiology referral was not ordered, and the appointment did not occur.

Clinician On-Site Inspection

The OIG clinicians had discussions with medical and nursing leadership, most of the providers, specialty schedulers, clinic schedulers, specialty nurses, and TTA staff. Leadership and staff reported on the challenges experienced as a result of the COVID-19 pandemic, including patient movement to the medical clinics. Two COVID-19 cases occurred in

15. In case 31, the provider contacted the patient by phone to conduct specialty follow-up.

early July 2020, with significant outbreaks in August through early October. FSP arranged isolation tent housing to accommodate the ill patients, prior to the outbreaks. FSP recruited two additional providers to assist with rounds for patients in isolation during the outbreaks. Medical and nursing leadership reported excellent communication with custody. Leadership reported that providers had full personal protective equipment (PPE) available, and there were no PPE shortages during our review period.

Medical and nursing leadership reported that nurses continued to see patients on-site. Although two of the providers were at high risk for medical complications if they were to contract COVID-19, all providers were given accommodations to work from home. The provider clinic schedules were modified for part-time on-site and part-time remote work throughout the review period. FSP care manager and RN follow-up appointments had no backlogs.

Custody and medical leadership reported that patients, even those in quarantine and isolation, were allowed access to the canteen, to the showers, and to the yards in cohorts. During our on-site inspection, we observed masked patients moving freely between the units.

Several providers reported that COVID-19 movement restrictions reduced clinic space availability and that providers were unable to access the patients. We did not see significant impact in the clinical review, but the providers stated this made seeing patients difficult.

We asked the providers why they were documenting patient face-to-face appointments as complete when a patient was not seen or spoken to. The providers reported that they had been told by medical leadership that they could perform chart reviews on patients rather than see the patients. The providers reported that they if they reviewed the chart, they could mark the appointments as completed rather than cancel and reschedule, which would have reflected accurately that the patients were not seen face-to-face. We did not receive a formal local operating procedure about this practice.

Recommendations

- The department should provide clear policy guidance to institutions regarding how to manage care during the pandemic, including how to manage care for chronic care patients whose appointments might be canceled or delayed, how to prioritize patient movement to ensure provider appointments occur, how to properly close an appointment for patients who only receive a medical chart review, and how to balance the workload to ensure equitable distribution of patient care among nursing and providers.
- Medical leadership should ensure that providers see the medium- and high-risk patients whose provider appointments were replaced with chart review during the COVID-19 pandemic.

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) *	13	11	1	54.2%
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) *	14	8	3	63.6%
Clinical appointments: Did a registered nurse review the patient's request for service the same day it was received? (1.003) *	35	0	0	100%
Clinical appointments: Did the registered nurse complete a face-to-face visit within one business day after the CDCR Form 7362 was reviewed? (1.004) *	33	2	0	94.3%
Clinical appointments: If the registered nurse determined a referral to a primary care provider was necessary, was the patient seen within the maximum allowable time or the ordered time frame, whichever is the shorter? (1.005) *	11	1	23	91.7%
Sick call follow-up appointments: If the primary care provider ordered a follow-up sick call appointment, did it take place within the time frame specified? (1.006) *	2	0	33	100%
Upon the patient's discharge from the community hospital: Did the patient receive a follow-up appointment within the required time frame? (1.007) *	15	6	0	71.4%
Specialty service follow-up appointments: Did the clinician follow-up visits occur within required time frames? (1.008) *,†	28	15	2	65.1%
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): **82.3%**

* 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) *	N/A	N/A	N/A	N/A
For OHU, CTC, SNF, and Hospice (applicable only for samples prior to 4/2019): Did the primary care provider complete the Subjective, Objective, Assessment, and Plan notes on the patient at the minimum intervals required for the type of facility where the patient was treated? (13.003) *,†	N/A	N/A	N/A	N/A
Did the patient receive the high-priority specialty service within 14 calendar days of the primary care provider order or the Physician Request for Service? (14.001) *	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) *	8	3	4	72.7%
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) *	14	1	0	93.3%
Did the patient receive the subsequent follow-up to the medium-priority specialty service appointment as ordered by the primary care provider? (14.006) *	8	0	7	100%
Did the patient receive the routine-priority specialty service within 90 calendar days of the primary care provider order or Physician Request for Service? (14.007) *	8	7	0	53.3%
Did the patient receive the subsequent follow-up to the routine-priority specialty service appointment as ordered by the primary care provider? (14.009) *	7	1	7	87.5%

* 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 had state-mandated rounding intervals. OIG case reviewers continued to test the clinical appropriateness of provider follow-ups within specialized medical housing units through case reviews.

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

Overall Rating
Adequate

Case Review Rating
Adequate

Compliance Score
Inadequate
(56.7%)

Diagnostic Services

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

Results Overview

FSP performed fair for this indicator. FSP performed well in performing radiology and laboratory tests in requested time frames. The providers generally endorsed pathology, laboratory and radiology results timely. In compliance testing, providers did not communicate diagnostic results to the patients or send complete patient result letters. In addition, compliance testing found that stat laboratory test results were not reported to the providers within required time frames. Factoring together both case review and compliance testing, we rated this indicator ***adequate***.

Case Review and Compliance Testing Results

We reviewed 307 diagnostic events and found 111 deficiencies, of which three were significant. Eighty-eight deficiencies were related to health information management, and eight deficiencies pertained to the completion of diagnostic tests.[16] For health information management, we considered test reports that were never retrieved or reviewed to be a deficiency as severe as tests that were not performed. Sixteen deficiencies were related to missing patient results letters and three were for abnormal laboratory tests not addressed by the provider; we address these deficiencies in **Provider Performance** indicator.

Test Completion

FSP radiology and laboratory staff performed well in timely test completion. In case reviews, our clinicians found that only one laboratory test was not performed and that seven were late; all were minor deficiencies.[17] Compliance testing found that 100 percent of all radiology services and 80.0 percent of all laboratory tests were completed within requested time frames (MIT 2.001, 2.004), but only 33.3 percent of stat laboratory tests were completed within required time frames (MIT 2.007). In case review, we did not identify any significant stat laboratory test deficiencies.

16. Deficiencies occurred in cases 1, 2, 3, 5, 6, 7, 9, 10, 11, 12, 14, 19, 20, 21, 26, 27, 28, 29, 30, 31, and 66. Cases 19 and 30 had significant deficiencies.

17. Deficiencies occurred in cases 3, 5, 9, and 14; deficiencies occurred twice in cases 7 and 28.

Health Information Management

OIG clinicians did not cite significant deficiencies for FSP staff not sending COVID-19 patient results letters because medical leadership reported that the institution's mass communication systems were used to educate the population. The patients were notified of positive results when transferred to a dedicated isolation housing unit.

Compliance testing found that pathology reports were received 66.7 percent of the time (MIT 2.010) and that providers timely endorsed the reports they received 100 percent of the time (MIT 2.011).

Compliance testing also found that providers endorsed radiology results 70.0 percent of the time (MIT 2.002) and endorsed laboratory and pathology results 100 percent of the time (MIT 2.005 and 2.011). OIG clinicians identified 88 health information management deficiencies related to diagnostics; these deficiencies were predominantly missing patient letter components and unendorsed laboratory test results. We found that 28 of 289 laboratory test results were not endorsed by the provider and that 24 of the unendorsed results were COVID-19 tests. We considered the missing COVID-19 endorsements as not a significant deficiency since alternative mechanisms for notifying the patients of results were in place. Seven test results were endorsed late, which we also considered minor deficiencies.[18]

Overall, FSP providers performed poorly in communicating results to the patients. Compliance testing showed that providers communicated radiology, laboratory, and pathology results at percentage rates of 10.0, 20.0, and zero, respectively (MITs 2.003, 2.006, and 2.012). OIG clinicians identified 45 patient results letters that were missing required components and 16 patient results letters that were not sent.[19] In most cases, providers addressed abnormal laboratory test results they reviewed.

In compliance testing, nurses did not notify the provider of stat laboratory test results (MIT 2.008, zero), but providers reviewed stat laboratory test results timely 100 percent of the time (MIT 2.009).

Case review identified two significant diagnostic deficiencies related to health information management in the following cases:

- In case 19, a cancer-positive prostate biopsy was located and scanned into the medical record 55 days after the biopsy, which delayed follow-up care with the specialist. The provider did not timely advise the patient of the biopsy result; therefore, the patient was not aware of the cancer diagnosis when he refused a specialty appointment to follow up on the biopsy result and discuss potential treatment options.

18. Deficiencies occurred in cases 11, 26, 30, 31, and 66.

19. Deficiencies with results letters missing required components occurred in cases 1, 2, 6, 7, 9, 10, 12, 13, 14, 20, 21, 26, 27, 28, 29, 30, and 31. Deficiencies in which results letters were not sent occurred in cases 3, 6, 7, 10, 20, 22, 27, 30, and 31.

- In case 30, the positive urine culture results were available in the laboratory portal, but the results were not scanned into the electronic health record system (EHRS).

Clinician On-Site Inspection

During the on-site inspection, we interviewed leadership, supervisors, and staff to discuss work flow and deficiencies. We toured the laboratory and radiology areas. Leadership and staff reported challenges in completing routine laboratory and radiology tests, and challenges in both mass testing during the COVID-19 outbreak and testing patients in quarantine and isolation. The laboratory, radiology, and nursing staff reported working diligently to complete patient laboratory and radiology test appointments despite the significant challenges. Medical and nursing leadership stated that COVID-19 laboratory test results were not sent to the patients because they employed institutional communication via television and posters.

Many of the providers stated they were not aware that the patient results letters required four specific components, including the date of the test. They explained that they use a standard patient letter template in EHRS to notify patients; however, the test date is not contained in this template.

OIG clinicians identified cases in which urine culture results were not scanned into the EHRS. During our on-site inspection, we interviewed providers, nursing staff, and laboratory staff concerning the tracking and retrieval of urine culture results, all of whom stated that the urine culture results should have autopopulated into the EHRS. In our case reviews, however, we noted this did not occur.

Recommendations

- The department should consider developing and implementing a patient results letter template that autopopulates with all elements required by California Correctional Health Care Services (CCHCS) policy.
- The department should consider developing and implementing an electronic solution to ensure that urine culture results from the laboratory portal autopopulate into the electronic health record system (EHRS).
- Medical leadership should educate providers to access the laboratory portal when laboratory results are missing in the EHRS.
- Medical leadership should consider implementing a system to track outside diagnostic reports, such as pathology reports, to ensure they are received and scanned timely.

Compliance Testing Results

Table 8. Diagnostic Services

Compliance Questions	Scored Answer			
	Yes	No	N/A	Yes %
Radiology: Was the radiology service provided within the time frame specified in the health care provider's order? (2.001) *	10	0	0	100%
Radiology: Did the ordering health care provider review and endorse the radiology report within specified time frames? (2.002) *	7	3	0	70.0%
Radiology: Did the ordering health care provider communicate the results of the radiology study to the patient within specified time frames? (2.003)	1	9	0	10.0%
Laboratory: Was the laboratory service provided within the time frame specified in the health care provider's order? (2.004) *	8	2	0	80.0%
Laboratory: Did the health care provider review and endorse the laboratory report within specified time frames? (2.005) *	10	0	0	100%
Laboratory: Did the health care provider communicate the results of the laboratory test to the patient within specified time frames? (2.006)	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) *	1	2	0	33.3%
Laboratory: Did the provider acknowledge the STAT results, OR did nursing staff notify the provider within the required time frames? (2.008) *	0	3	0	0
Laboratory: Did the health care provider endorse the STAT laboratory results within the required time frames? (2.009)	3	0	0	100%
Pathology: Did the institution receive the final pathology report within the required time frames? (2.010) *	4	2	0	66.7%
Pathology: Did the health care provider review and endorse the pathology report within specified time frames? (2.011) *	6	0	0	100%
Pathology: Did the health care provider communicate the results of the pathology study to the patient within specified time frames? (2.012)	0	6	0	0
Overall percentage (MIT 2): **56.7%**				

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

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

Overall Rating
Adequate

Case Review Rating
Adequate

Compliance Score
(N/A)

Emergency Services

In this indicator, OIG clinicians evaluated the quality of emergency medical care. Our clinicians reviewed emergency medical services by examining the timeliness and appropriateness of clinical decisions made during medical emergencies. Our evaluation included examining the emergency medical response, cardiopulmonary resuscitation (CPR) quality, triage and treatment area (TTA) care, provider performance, and nursing performance. Our clinicians also evaluated the Emergency Medical Response Review Committee's (EMRRC) ability to identify problems with its emergency services. The OIG assessed the institution's emergency services through case review only; no compliance testing was performed for this indicator.

Results Overview

The OIG clinicians noted that the emergency care provided for Cycle 6 was comparable to the care provided in Cycle 5. FSP had slightly fewer deficiencies in Cycle 6, but the number of significant deficiencies remained the same. Custody and health care staff worked cohesively to respond to emergencies, provide appropriate care, and transfer patients to a higher level of care when necessary. While we did identify some cases that had deficiencies, these were isolated with no discernible patterns. For these reasons, we rated this indicator ***adequate***.

Case Review Results

We reviewed 23 urgent and emergent events identified within 10 cases and found 21 emergency care deficiencies, six of which were significant.[20]

Emergency Medical Response

FSP performed well in their emergency medical response most of the time. Medical first responders often responded promptly to emergencies throughout the institution, appropriately notified TTA, and activated 9-1-1 timely. There was a significant delay in requesting EMS response in one case, as described below:[21]

- In case 2, a medical alarm was activated for the patient found with multiple stab wounds to the chest, abdomen, back, and extremities. Medical staff responded, applied chest seal bandages to the penetrating injuries around the lungs, and transported the patient to the TTA. Instead of requesting EMS response immediately, the staff waited 18 minutes after alarm activation to call 9-1-1.

20. Emergency events occurred in cases 1, 2, 3, 4, 9, 10, 13, 19, 20, 21, 22, 27, 29, and 31. Deficiencies occurred in cases 2, 3, 4, 13, 19, 21, 22, 26, 27, and 31. Significant deficiencies were identified in cases 2, 21, 22, 26, 27, and 31.

21. EMS is the abbreviation for Emergency Medical Services.

We reviewed emergency responses and noted patients were often placed on oxygen but were occasionally not placed at the correct oxygen flow rate settings. For patients with altered levels of consciousness, we noted the staff used Narcan, an opioid reversal medication, but occasionally failed to check the patient's blood sugar to rule out hypoglycemia, as required by protocol. The OIG clinicians identified a few instances when staff documented incorrect Glascow Coma Scale (GCS) results.[22] These were isolated instances that did not affect the patients' outcomes.

Cardiopulmonary Resuscitation Quality

During the review period, we reviewed only one case in which cardiopulmonary resuscitation (CPR) was initiated. Custody and medical staff worked cohesively to provide care, move the patient to the TTA for additional interventions, and transfer the patient to a higher level of care. Staff activated the 911 system from the scene; Emergency Medical Services (EMS) arrived and assumed care of the patient within twelve minutes of alarm activation. We did identify some deficiencies, as discussed below, but these did not cause harm to the patient.

- In case 4, when custody staff found the patient hanging, they activated the medical alarm and initiated CPR. The nursing staff arrived and assumed care. The nursing staff did not apply the automated external defibrillator (AED), and a cervical collar was not placed on the patient until the patient's arrival in the TTA.

Provider Performance

FSP providers often delivered good care during emergency events. During the COVID-19 pandemic, providers were available to answer patient care questions via phone or telemedicine, and if needed, providers would come in to see the patient. Of the six emergency care deficiencies, three involved the providers. Of these three deficiencies, one was minor and two were significant.[23] The significant deficiencies included the following:

- In case 22, a patient with cirrhosis and low platelets was prescribed a systemic nonsteroidal anti-inflammatory pain medication for localized pain; the medication was contraindicated.[24]

- In case 26, the patient with very low oxygen levels was assessed by a provider, but orders to transfer to a higher level of care were

22. The Glasgow Coma Scale is a clinical scale used to reliably measure a person's level of consciousness and is based on ability to perform eye movements, speak, and move the body. GCS is a vital assessment tool used internationally and significantly affects the level of care needed for the patient.

23. A minor deficiency was cited in case 13. Significant deficiencies were noted in cases 22 and 26.

24. Liver cirrhosis is a medical condition involving scarred liver tissue and reduced liver function.

not placed until three hours later. The patient should have been transferred to a higher level of care immediately.

Nursing Performance

The FSP nursing staff usually performed well during emergency events. Although there were no delays from first medical responders, we noted they performed incomplete vital signs in two of the emergency events and did not assess blood sugar for the patient with an altered level of consciousness in three events.

Nursing assessments of patient complaints were generally thorough and complete. Appropriate and timely interventions were completed most of the time. Patients were generally closely monitored, with vital signs repeated at timely intervals, as required by policy. The nurses communicated critical clinical findings with the providers and obtained orders, with one noted exception, as described in the event below:

- In case 27, the patient in isolation who was positive for COVID-19 was assessed by the RN, who noted the patient had a low oxygen saturation level and a fever that decreased with Tylenol. The provider ordered a transfer to a higher level of care, and the patient was moved to the TTA to await transfer. EMS was called but did not arrive until three and a half hours later. During this time, the RN did not contact the ambulance service to determine the cause of this EMS delay and did not communicate this delay to the provider.

Nursing Documentation

Mostly, the nurses documented emergency and urgent events appropriately. We identified missing times and time line discrepancies in a few emergency responses. For one patient, the nurse did not document discharge instructions. There was an incomplete documentation of intravenous (IV) placement in three events.[25]

The TTA nurse did not document adequately in the following example:

- In case 31, the patient presented to the clinic nurse with a complaint of swollen tongue from hereditary angioedema.[26] The provider ordered a steroid medication injection, and the patient was taken to the TTA for medication and monitoring. The TTA nurse documented the medication but did not document the patient's response to the medication, the length of time the patient was monitored, the patient's repeat vital signs, or the patient's condition upon discharge.

25. The incomplete documentation occurred in case 2.

26. Hereditary angioedema is a disorder that results in recurrent attacks of swelling, including swelling of the arms, legs, face, intestinal tract, and airways.

Emergency Medical Response Review Committee

During our review period, we reviewed fourteen events that occurred in ten cases requiring transfer to a higher level of care.[27] For every transfer out, the supervisors reviewed the emergency response and care provided. The audits were reviewed within 30 days at the EMRRC meeting, with the exception of the following:

- In case 21, the patient who was positive for COVID-19 developed low oxygen saturation levels and a rapid heart rate, requiring emergency transfer to a higher level of care. The EMRRC review occurred over 30 days after the emergency event.

EMRRC audits were completed for the fourteen emergency transfers. In four cases, we identified deficiencies that the EMRRC had not recognized.[28]

Clinician On-Site Inspection

We toured the TTA and noted there were four rooms used for patient care. One room was used for urgent and emergent care, and the other two rooms were standard rooms for additional patients. There was a separate observation room with a closed door where patients who were infectious or potentially infectious were treated. The observation room could also be used as an overflow area. The crash cart was located in the urgent care room, and all areas in that room were clean and well-stocked. The TTA had an emergency response bag and also contained three multicasualty incident (MCI) bags: one bag was stocked with airway equipment; a second bag contained different types of bandages; and a third bag contained personal protective equipment (PPE).

The TTA nurses reported the TTA had two RNs on each shift and if there were additional emergencies, staff were pulled from the clinics. The nursing staff noted the average number of patients treated was one to ten patients daily. Although there was a dedicated TTA provider who was available by telephone and telemedicine, he had not been on-site for the preceding eight months due to the COVID-19 pandemic. This absence of the TTA provider was a major concern for the nursing staff.

TTA nurses felt they were generally supported by supervisors and management. We were advised that the director of nursing performs a staff debriefing meeting after any serious emergency response.

27. Patients required transfer to a higher level of care in cases 1, 2, 3, 4, 19, 20, 21, 22, 27, and 29.

28. EMRRC audits did not identify deficiencies in cases 2, 4, 21, and 27.

Recommendations

- Nursing leadership should ensure that the Emergency Medical Response Review Committee (EMRRC) thoroughly audits emergency events, identifies all deficiencies, and provides staff training in a timely manner.
- Leadership should ensure that all staff are reminded to activate the 9-1-1 system immediately for emergent patients needing a higher level of care.

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
Adequate

Case Review Rating
Adequate

Compliance Score
Adequate
(77.3%)

Results Overview

FSP performed satisfactorily in this indicator. Since our Cycle 5 review, the institution has continued to perform well in scanning health care service request forms, high-priority specialty reports, and hospital discharge documents. However, the institution performed poorly in properly generating and labeling patient letters. Both compliance testing and case review found that providers frequently did not communicate results to patients and that patient results letters were often incomplete. Overall, the OIG rated this indicator as ***adequate***.

Case Review and Compliance Testing Results

The OIG clinicians reviewed 877 events and found 90 deficiencies. We identified five significant deficiencies.[29]

Hospital Discharge Reports

FSP managed hospital discharge reports well. Compliance testing revealed that 100 percent of community hospital discharge documents were scanned into patients' medical records within three calendar days of discharge (MIT 4.003), and providers reviewed 100 percent of hospital discharge reports within five calendar days of discharge (MIT 4.005).

OIG clinicians reviewed 14 off-site emergency department and hospital visits. We found no deficiencies in the retrieval of emergency department physician reports and hospital discharge summaries.

Specialty Reports

Compliance testing showed FSP retrieved and scanned 86.7 percent of high-priority, medium-priority and routine-priority specialty reports (MIT 4.002). OIG clinicians reviewed 29 specialty visits and found only one minor deficiency: a missing provider endorsement.

While the institution performed well in the retrieval and scanning of specialty notes, compliance testing found that FSP providers did not

29. Significant deficiencies were identified in cases 19, 30, 31, and 60.

review all of these reports timely. Providers reviewed 92.9 percent of the high-priority specialty reports, 73.3 percent of the medium-priority specialty reports and only 57.1 percent of the routine-priority reports within the required time frames (MIT 14.002, 14.005, and 14.008). We discuss these findings in more detail in the **Specialty Services** indicator.

Diagnostic Reports

FSP had mixed results in managing diagnostic reports. FSP performed well in provider endorsement of diagnostic reports; however, providers performed poorly in communicating results to patients and writing complete patient results letters.[30] OIG clinicians reviewed 307 diagnostic events and identified 47 minor deficiencies in which the patient results letters did not contain all CCHCS-required components. In 16 deficiencies, the providers did not send patient results letters. Providers did not endorse twenty-four diagnostic tests, and they endorsed seven tests late. Compliance testing found providers reviewed pathology reports, receiving a score 100 percent, but scored zero in communicating results to patients (MITs 2.011 and 2.012). In addition, compliance testing found that nursing did not notify providers of stat laboratory test results (MIT 2.008, zero).

We noted two significant diagnostic deficiencies regarding health information management:

- In case 19, a prostate biopsy test result, positive for cancer, was not scanned into the EHRS for nearly two months after the biopsy was performed, significantly delaying follow-up evaluation.
- In case 30, a positive urine culture result was not scanned into the medical record or endorsed. The patient did not receive treatment indicated by this positive urine culture.

We discuss these findings in more detail in the **Diagnostics Services** indicator.

Urgent and Emergent Records

The OIG clinicians reviewed 23 emergency care events and found providers generally recorded these events sufficiently. We identified one minor deficiency, which we discuss in the **Emergency Services** indicator.

Scanning Performance

FSP performed poorly in the scanning process. Compliance testing found that zero medical records requiring scanning were properly scanned, labeled, and included in the correct patient's medical records without errors (MIT 4.004). In these compliance samples, we found that patient letters were generated incorrectly and saved as a *DDP -Scan* instead of

30. Deficiencies occurred in cases 1, 2, 6, 7, 9, 10, 12, 13, 14, 20, 21, 26, 27, 28, 29, 30, and 31.

as a *patient letter*.[31] OIG clinicians identified two mislabeled documents and found that patient informed refusal forms for specialty visits were missing: these deficiencies occurred in cases 2, 19, 29, and 31. These deficiencies were not clinically significant.

Clinician On-Site Inspection

We discussed health information management processes with health information management supervisors, ancillary staff, diagnostic staff, nurses, and providers. Supervisors stated they were fully staffed during the review period. Supervisors also reported that with the implementation of the electronic medical record, the laboratory vendor autopopulated laboratory test results directly into the medical record, so missing laboratory results were rare; however, our inspection revealed that urine culture and pathology reports may not always be retrieved timely or at all. We did not receive a clear response regarding who was responsible for ensuring pathology reports were retrieved in a timely manner. Designated specialty nurses tracked and retrieved specialty reports, ensured that handwritten reports with recommendations were done on the same day of the consultation, and communicated directly with the providers to discuss the specialty recommendations. Staff reported that they did not have electronic access to the local hospital records where the patients received care, so they manually tracked and retrieve those records.

Recommendations

- Medical leadership should determine the root cause of challenges to the retrieval and timely provider review of urine culture and pathology results; leadership should implement remedial measures as appropriate.
- Medical leadership should ensure that signed informed refusal forms are obtained for specialty and clinic visits or procedures and are scanned into the EHRS.
- The department should consider adjusting the default drop-down menu on the results letter in the EHRS so that the menu defaults to *patient letter* instead of *DDP-Scan*; the department should train providers to generate the results letters appropriately.

31. DDP is the abbreviation for the Developmental Disability Program.

Compliance Testing Results

Table 9. Health Information Management

Compliance Questions	Scored Answer			
	Yes	No	N/A	Yes %
Are health care service request forms scanned into the patient's electronic health record within three calendar days of the encounter date? (4.001)	20	0	15	100%
Are specialty documents scanned into the patient's electronic health record within five calendar days of the encounter date? (4.002) *	26	4	15	86.7%
Are community hospital discharge documents scanned into the patient's electronic health record within three calendar days of hospital discharge? (4.003) *	20	0	1	100%
During the inspection, were medical records properly scanned, labeled, and included in the correct patients' files? (4.004) *	0	24	0	0
For patients discharged from a community hospital: Did the preliminary or final hospital discharge report include key elements and did a provider review the report within five calendar days of discharge? (4.005) *	21	0	0	100%
Overall percentage (MIT 4): **77.3%**				

* 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 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) *	7	3	0	70.0%
Laboratory: Did the health care provider review and endorse the laboratory report within specified time frames? (2.005) *	10	0	0	100%
Laboratory: Did the provider acknowledge the STAT results, OR did nursing staff notify the provider within the required time frame? (2.008) *	0	3	0	0
Pathology: Did the institution receive the final pathology report within the required time frames? (2.010) *	4	2	0	66.7%
Pathology: Did the health care provider review and endorse the pathology report within specified time frames? (2.011) *	6	0	0	100%
Pathology: Did the health care provider communicate the results of the pathology study to the patient within specified time frames? (2.012)	0	6	0	0
Did the institution receive and did the primary care provider review the high-priority specialty service consultant report within the required time frame? (14.002) *	13	1	1	92.9%
Did the institution receive and did the primary care provider review the medium-priority specialty service consultant report within the required time frame? (14.005) *	11	4	0	73.3%
Did the institution receive and did the primary care provider review the routine-priority specialty service consultant report within the required time frame? (14.008) *	8	6	1	57.1%

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

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

Overall Rating
Inadequate

Case Review Rating
(N/A)

Compliance Score
Inadequate
(59.6%)

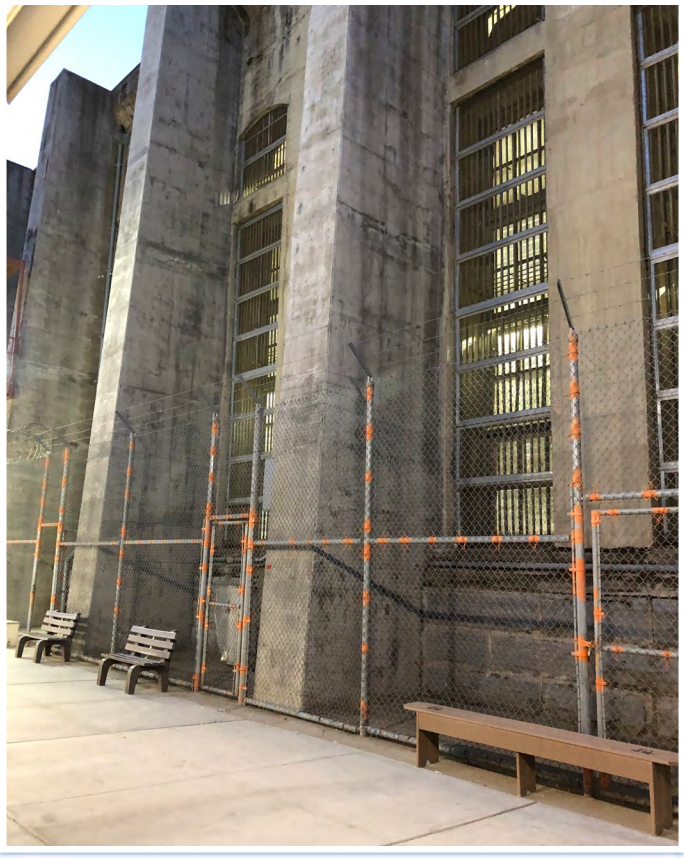
Health Care Environment

In this indicator, OIG compliance inspectors tested clinics' waiting areas, infection control, sanitation procedures, medical supplies, equipment management, and examination rooms. Inspectors also tested clinics' ability to maintain auditory and visual privacy for clinical encounters. Compliance inspectors asked the institution's health care administrators to comment on their facility's infrastructure and its ability to support health care operations. The OIG rated this indicator solely on the compliance score, using the same scoring thresholds as in the Cycle 4 and Cycle 5 medical inspections. Our case review clinicians do not rate this indicator.

Results Overview

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

Compliance Testing Results



Outdoor Waiting Areas

FSP has constructed indoor patient waiting areas within the newly constructed Health Care Facility Improvement Program (HCFIP) clinics. However, two clinic locations had outdoor waiting areas for overflow (see Photo 1, left). In both locations, the overflow outdoor waiting areas did not have an overhang to protect patients during inclement weather. Custody staff reported that the overflow areas were rarely used and will not be used during inclement weather. During our inspection, we did not observe any patients waiting outside for clinic appointments.

Photo 1. Outdoor overflow waiting area (photographed on December 9, 2020).

Indoor Waiting Areas

We inspected FSP indoor patient waiting areas. All clinics had indoor waiting areas. Health care and custody staff reported the existing indoor waiting areas contained sufficient seating capacity that provided patients protection from inclement weather (see Photo 2, right). Custody staff reported they brought in a few patients at a time, to prevent overcrowding the indoor waiting areas and to maintain safe social distances during the period of pandemic restrictions. Most patients sat while waiting for appointments. Although several patients were standing in the waiting area, the patients explained they preferred standing while waiting for appointments. We observed patients not wearing their masks properly (see Photo 3, below right) and custody staff only educating those patients after we brought this matter to their attention.

Photo 2. Indoor waiting area (photographed on December 9, 2020).

Photo 3. Patients not wearing masks properly (photographed on December 7, 2020).

Clinic Environment

All clinic environments were sufficiently conducive to medical care: they provided reasonable auditory privacy, appropriate waiting areas, wheelchair accessibility, and nonexamination room work space (MIT 5.109, 100%). All clinic environments contained appropriate space, configuration, supplies, and equipment to allow clinicians to perform proper clinical examinations (MIT 5.110, 100%).

Clinic Supplies

Four of the 12 clinics followed adequate medical supply storage and management protocols (MIT 5.107, 33.3%). We found one or more of the following deficiencies in eight clinics: expired medical supplies (see Photo 4, below), unidentified medical supplies, an unsanitary medical supply storage bin, and disinfectant stored with medical supplies (see Photo 5, below).

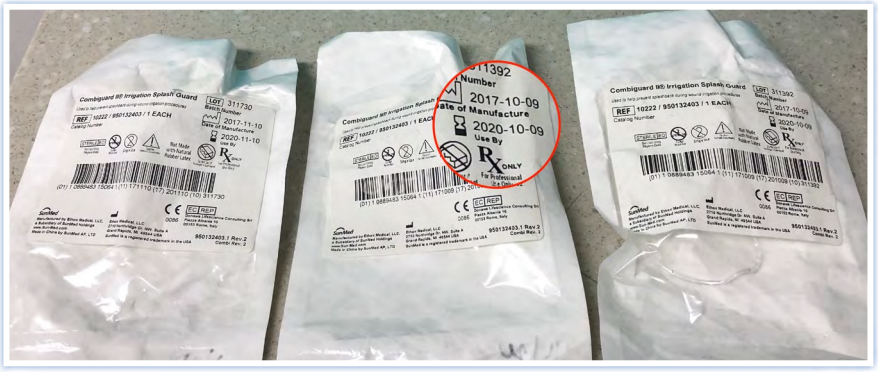


Photo 4. Expired medical supplies dated October 9, 2020 (photographed on December 7, 2020).

Photo 5. Disinfectant stored with medical supplies (photographed December 7, 2020).

Only one of the 12 clinics met requirements for essential core medical equipment and supplies (MIT 5.108, 8.3%). The remaining 11 clinics lacked medical supplies or contained improperly calibrated or nonfunctional equipment. The missing items included a nebulizer, examination table disposable paper, a biohazard receptacle bin, a weight scale, an examination table with stirrups, hemoccult cards, lubricating jelly, a tongue depressor, an oto-ophthalmoscope, and otoscope tips. The improperly calibrated equipment included a vital sign machine, a weight scale, an oto-ophthalmoscope, an automatic external defibrillator (AED), and a nebulization unit. We found that the Snellen chart did not have an identified distance line on the floor or wall.

We examined emergency medical response bags (EMRBs) to determine whether they contained all essential items. We checked whether staff inspected the bags daily and inventoried them monthly: only two of the nine EMRBs passed our test (MIT 5.111, 22.2%). We found one or more of the following deficiencies with seven EMRBs: staff did not ensure the EMRB's compartments were sealed and intact; staff did not seal all compartments when not in active use; and the EMRBs contained expired medical items (see Photo 6, below). The crash carts in the triage and treatment area (TTA) did not meet the minimum inventory level. Also, the crash cart daily check sheet (CDCR form 7544) did not include documentation showing that reasonable supply substitutions were made. In addition, staff did not place a yellow tag on the cart, indicating it was missing an item.

Photo 6. Expired nasal cannula dated June 2019 (photographed December 7, 2020).

Medical Supply Management

None of the medical supply storage areas located outside the medical clinics stored medical supplies adequately (MIT 5.106, zero). We found expired medical supplies (see Photo 7, below), medical supplies stored directly on the floor (see Photo 8, next page), and compromised sterile medical supply packaging.

According to the Chief Executive Officer (CEO), the institution did not have any concerns about the medical supply process. Health care and warehouse managers expressed no concerns about the medical supply chain or about their communication process with the existing system. Facility administrative staff stated they had been sent an overabundance of PPE and COVID-19 testing supplies when they had a COVID-19 outbreak and that they have had to find spaces to store the additional supplies.

Photo 7. Expired medical supply dated January 3, 2020 (photographed on December 7, 2020).

Photo 8. Medical supplies stored directly on the floor (photographed on December 7, 2020).

Infection Control and Sanitation

Staff appropriately disinfected, cleaned, and sanitized nine of 12 clinics (MIT 5.101, 75.0%). In three clinics, we found one or both of the following deficiencies: cleaning logs were not maintained, and biohazardous waste was not emptied after each clinic day.

Staff in nine of 12 clinics properly sterilized or disinfected medical equipment (MIT 5.102, 75.0%). In two clinics, staff did not mention disinfecting the examination table as part of their daily start-up protocol; they relied on inmate-porters to perform the cleaning. In one clinic, we observed the nurse use the examination table without disposable paper during a patient encounter. In addition, the nurse did not disinfect the examination table before or after the patient encounter.

We found operating sinks and hand hygiene supplies in the examination rooms in 11 of 12 clinics (MIT 5.103, 91.7%). The patient restroom in one clinic lacked antiseptic soap.

We observed patient encounters in eight clinics. In four clinics, staff did not wash their hands before or after examining their patients, nor before applying gloves (MIT 5.104, 50.0%).

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

Physical Infrastructure

We gathered information to determine whether the institution's physical infrastructure was maintained in a manner that supported health care management's ability to provide timely and adequate health care. When we interviewed health care managers, we found they did not have concerns about the facility's infrastructure or its effect on the staff's ability to provide adequate health care. At the time of inspection, the institution had three infrastructure projects underway that management felt would improve the delivery of care at FSP:[32]

- Project A: Roof replacement at FWF. This began in October 2020 and is expected to be completed by April 2021.
- Project B: Inmate ward labor conversion to Unit 2 & 3 medication distribution rooms. This is a conversion of an old clinical space to become medication distribution rooms for Buildings 2 and 3; the conversion began in August 2019. The health care managers did not have an expected completion date at the time of inspection due to the COVID-19 pandemic.
- Project C: A new health services building. All construction, which began in 2015, was completed at the time of the inspection, except for the radiology area, which was awaiting countertops to be delivered to the institution.

Despite the conversion delay of Project B described above, the CEO did not believe this delay negatively affected the institution's current ability to provide good patient care (MIT 5.999).

Recommendations

- Medical leadership should remind staff to follow universal hand hygiene precautions. Implementing random spot checks could improve compliance.
- Nursing leadership should direct each clinic nurse supervisor to review the monthly emergency medical response bag (EMRB) logs to ensure the EMRBs are regularly inventoried and sealed. In addition, nursing leadership should implement random monthly inventory spot checks to ensure EMRBs and crash carts contain all the medical supplies identified in the logs.
- Nursing leadership should consider performing random spot checks to ensure that staff follow equipment and medical supply management protocols.

32. This report is published after the expected completion dates of the projects; however, we cannot confirm their completion.

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)	9	3	0	75.0%
Infection control: Do clinical health care areas ensure that reusable invasive and noninvasive medical equipment is properly sterilized or disinfected as warranted? (5.102)	9	3	0	75.0%
Infection control: Do clinical health care areas contain operable sinks and sufficient quantities of hygiene supplies? (5.103)	11	1	0	91.7%
Infection control: Does clinical health care staff adhere to universal hand hygiene precautions? (5.104)	4	4	4	50.0%
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)	4	8	0	33.3%
Clinical areas: Do clinic common areas and exam rooms have essential core medical equipment and supplies? (5.108)	1	11	0	8.3%
Clinical areas: Are the environments in the common clinic areas conducive to providing medical services? (5.109)	9	0	3	100%
Clinical areas: Are the environments in the clinic exam rooms conducive to providing medical services? (5.110)	12	0	0	100%
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)	2	7	3	22.2%
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): **59.6%**			

* 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
(63.9%)

Transfers

In this indicator, OIG inspectors examined the transfer process for patients who transferred into the institution, as well as for those who transferred to other institutions. For newly arrived patients, our inspectors assessed the quality of health screenings and the continuity of provider appointments, specialist referrals, diagnostic tests, and medications. For patients who transferred out of the institution, inspectors checked whether staff reviewed patient medical records and determined the patient's need for medical holds. 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

FSP's performance in the **Transfer** indicator was mixed. In Cycle 6, case review findings showed that when patients arrived at FSP, nurses thoroughly completed the initial health screening, patients received their medications without interruption, and provider follow-up appointments as well as specialty appointments occurred within the required time frames. FSP also ensured that hospital discharge reports were timely retrieved, scanned, and reviewed by providers. However, compliance testing found that nurses did not always thoroughly document pertinent health information on the initial health screening forms for transfer-in patients. Compliance scores for provider follow-up appointments and scheduled specialty appointments were low. In the transfer-out process, our clinicians reviewed three cases and identified two significant deficiencies. FSP's performance for hospitalizations was adequate. The OIG considered COVID-19 pandemic movement restrictions for the low compliance scores for scheduled specialty appointments, for provider follow-up appointment for new arrivals, and for hospital returns. Considering all factors, we rated this indicator ***adequate***.

Case Review and Compliance Testing Results

In 18 cases we reviewed, we examined 28 events in which patients transferred into or out of the institution or returned from an off-site hospital or emergency room.[33] We identified 11 deficiencies, six of which were significant.[34]

33. We reviewed cases 1, 2, 3, 5, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, and 29.

34. We identified deficiencies in cases 3, 16, 17, 18, 19, 21, 22, 23, and 24. Significant deficiencies occurred in cases 3, 4, 21, 22, 23, and 24.

Transfers In

FSP's performance for patients transferring into the institution was adequate. OIG clinicians reviewed 11 events in six cases and found four deficiencies, of which one was significant.[35]

The receiving and release (R&R) nursing performance was mixed for transfers into the institution. Case review only identified one case in which the R&R nurse did not weigh the patient.[36] The R&R nurses completed the initial health screening within the required time frame. However, they did not always thoroughly document pertinent health-related questions, document the patient's weight, and address the symptom of *fatigue* in the TB screening (MIT 6.001, zero).[37]

Patients who transferred into FSP received their medications without interruption. Both case review and compliance testing had similar findings. Case review did not identify any deficiencies, and compliance testing results showed 91.7 percent compliance (MIT 6.003). FSP also ensured medications continued without interruption when patients transferred from one housing unit to another (MIT 7.005, 100%).

Compliance testing showed that providers did not always evaluate new patient arrivals to the facility within the required time frame (MIT 1.002, 63.6%). Due to COVID-19 movement restrictions, providers only sometimes performed face-to-face evaluations within the required time frames. Instead, providers performed chart reviews and rescheduled patient appointments. Our case reviewers identified a deficiency in case 16, in which the new arriving patient was not seen by a provider within seven days, as required by policy.

FSP's performance was adequate for specialty services appointments. When patients transferred into the prison, compliance testing showed 73.3 percent (MIT 14.001) of the specialty appointments occurred within the required time frame. Appointments were delayed due to COVID-19 movement restrictions. Our case reviewers identified only one significant deficiency in specialty appointments for new arrivals:

- In case 17, the patient transferred into FSP with a pending cardiology referral. FSP staff did not order the cardiology follow-up appointment, and the follow-up appointment did not occur.

35. We reviewed the following transfer-in cases: 5,16, 17, 18, 22, and 28. Deficiencies occurred in cases 16, 17, 18, and 22. A significant deficiency occurred in case 17.

36. The nurse did not obtain the patient's weight in case 18.

37. In April 2020, CCHCS added the symptom of *fatigue* for TB-symptom monitoring into some of the EHRS forms.

Transfers Out

FSP's transfer-out process showed room for improvement. We reviewed three cases and identified two deficiencies, both of which were significant:[38]

- In case 23, the patient transferred out of FSP to another institution, and the nurse did not communicate to the receiving institution pending referrals for an ophthalmology appointment and nerve tests.
- In case 24, prior to the patient transferring out of FSP, the nurse did not perform the interfacility transfer process, including screening the health record for contraindications to transfer; did not communicate with the pharmacy for transfer medications; did not prepare a transfer envelope; did not perform a face-to-face assessment within 24 hours of the transfer; did not provide transfer medications; did not ensure the patient possessed all durable medical equipment; and did not identify pending health care appointments.

Compliance testing did not have any applicable samples of patients transferring out of the institution (MIT 6.101) at the time of inspection.

Hospitalizations

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

FSP performed poorly with hospital returns. We reviewed 14 events in 10 cases in which patients were discharged from a hospitalization or returned from an emergency room visit.[39] We identified five deficiencies, of which three were significant. One example follows:[40]

- In case 22, the nurse did not notify the provider when the patient returned from a hospitalization for a right-leg skin infection and did not perform an assessment of the right leg.

Face-to-face provider follow-up appointments after hospitalizations or emergency room visits did not always occur within the required time frame. Compliance findings showed a score of 71.4 percent (MIT 1.007). Due to COVID-19 movement restrictions, providers did not always perform face-to-face evaluations. They performed timely chart

38. We reviewed the following transfer-out cases: 23, 24, and 25. Deficiencies occurred in cases 23 and 24; both deficiencies were significant.

39. We reviewed the following hospitalization cases: 1, 2, 3, 19, 20, 21, 22, 26, 27, and 29.

40. Hospitalization deficiencies occurred in cases 3, 19, 21, and 22. Significant hospitalization deficiencies occurred in cases 3, 21, and 22.

reviews and rescheduled patient appointments. For the rescheduled appointments, providers evaluated the patients either face-to-face or via telemedicine. Our case reviewers identified two deficiencies, one of which was significant in the following case:[41]

- In case 3, the patient returned from a hospitalization for vision loss and a new abnormal heart rhythm. The patient was not evaluated by a provider within five business days per policy, and instead, was seen eight days late.

FSP performed poorly in continuity of hospital recommended medications (MIT 7.003, 50.0%). Cycle 5 had shown similar findings, with a score of 64.2 percent. Medications were given late, from one dose late to six days late: these included medications to treat cholesterol, diabetes, inflammation, urinary tract issues, and topical creams for skin conditions. OIG clinicians identified one significant deficiency in case 21:

- The patient with a diagnosis of COVID-19 infection with acute respiratory failure did not receive steroid and diuretic medications on the day he returned from the hospital. The nurse documented the medications were not available.

FSP ensured that community hospital discharge documents were scanned into the patient's electronic health record within three days of discharge (MIT 4.003, 100%), that the documents included key elements, and that they were reviewed by the provider within five calendar days MIT (4.005, 100%). Similarly, case review did not identify any deficiencies.

Clinician On-Site Inspection

The R&R nurses in both FSP and FWF were very knowledgeable about the transfer process and stated they were sufficiently staffed.

Due to the COVID-19 pandemic, the number of patients transferring in and out of the institution has decreased. Currently, five to seven patients transfer in and out of FSP daily. At the time of the inspection, FWF was not receiving any patients. FSP has a process in place for COVID-19 quarantine and testing. When patients transferred to another institution and required a COVID-19 vaccination, the R&R nurses contacted the receiving institution to ensure that the appropriate vaccination was available. When patients paroled, the nurses provided them with information on where to obtain the COVID-19 vaccine. If the patient had received one dose of the vaccine and required the second dose, the R&R nurse ensured the patient had the vaccine information explaining where he or she could obtain the second dose.

The staff reported the challenge of having additional duties due to the pandemic. The nurses found their administrative staff to be supportive,

41. Provider follow-up deficiencies occurred in cases 3 and 19.

and they reported they had a good rapport with custody staff. Overall, the nurses stated morale was good, and staff turnover was low.

Recommendations

- The department should consider developing and implementing an electronic alert to ensure that receiving and release (R&R) nurses properly complete initial health screening questions and follow up as needed.
- Medical leadership should ensure that providers see transfer patients in the time frame required by the patients' clinical risk levels and that previously approved specialty appointments are scheduled within the required time frame.

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)	22	0	3	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) *	11	1	13	91.7%
For patients transferred out of the facility: Do medication transfer packages include required medications along with the corresponding transfer packet required documents? (6.101) *	0	0	1	N/A
				Overall percentage (MIT 6): **63.9%**

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

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

Table 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) *	14	8	3	63.6%
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) *	15	6	0	71.4%
Are community hospital discharge documents scanned into the patient's electronic health record within three calendar days of hospital discharge? (4.003) *	20	0	1	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) *	21	0	0	100%
Upon the patient's discharge from a community hospital: Were all ordered medications administered, made available, or delivered to the patient within required time frames? (7.003) *	10	10	1	50.0%
Upon the patient's transfer from one housing unit to another: Were medications continued without interruption? (7.005) *	25	0	0	100%
For patients en route who lay over at the institution: If the temporarily housed patient had an existing medication order, were medications administered or delivered without interruption? (7.006) *	1	1	0	50.0%
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) *	1	8	0	11.1%

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

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

Medication Management

Overall Rating ***Inadequate***

Case Review Rating ***Adequate***

Compliance Score ***Inadequate*** **(69.6%)**

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

FSP performed poorly in this indicator. Compliance scores were low for new medication prescriptions, chronic care medication continuity, hospital discharge medications, and layover medication continuity. Compliance scores for medication transfers were better. In case review, most of the deficiencies were related to chronic medication continuity. Considering all factors, we rated the **Medication Management** indicator ***inadequate***.

Case Review Results

We reviewed 24 cases related to medications and found 17 medication deficiencies, four of which were significant.[42] Most of the deficiencies were related to chronic medication continuity.

New Medication Prescriptions

FSP had a mixed performance in new medication prescriptions. In case review, FSP performed well in new medication prescriptions. Our clinicians identified only two minor deficiencies, occurring in cases 32 and 37.[43] However, compliance results showed that patients did not receive their newly prescribed medications timely (MIT 7.002, 60.0%). Most of the late medications were noncritical and one day late; however, in three samples, antibiotics and critical medications for blood pressure were administered up to two days late.

Chronic Medication Continuity

FSP did not ensure medication continuity for patients with chronic conditions. Compliance testing revealed patients did not receive their chronic medications timely (MIT 7.001, zero). All 18 patients tested

42. We reviewed the following cases for medication management: 1, 2, 3, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 19, 20, 21, 22, 26, 27, 28, 29, 30, and 31. Deficiencies occurred in cases 5, 6, 8, 12, 19, 26, 27, 28, 29, 30, 32, and 37. Significant deficiencies occurred in cases 6, 26, and 30.

43. The medications in cases 32 and 37 were not critical. They include throat lozenges and Naproxen.

received their medications one to eight days late. Patients did not receive their keep on person (KOP) medications one business day prior to the exhaustion of their supplies. On three occasions, patients did not receive their monthly medications at all. The undistributed medications included medications for cholesterol and high blood pressure. Case review showed similar findings. Of 17 deficiencies identified, 12 were related to chronic medication continuity.[44] The following cases are examples:

- In case 6, the patient did not receive his blood pressure medication, Lisinopril, for the month of September. The medication should have been filled automatically, but the medication administration record (MAR) showed that it was not given because the patient did not request it.
- In case 26, the patient did not receive his diuretic, Furosemide, for one month. The MAR documentation stated, "med not available." The patient did not receive the medication until approximately a month later.
- In case 30, the patient did not receive the automatic refill of his diabetes medication, Metformin, for the month of May 2020 and did not receive the automatic refill of his blood-pressure medication, Metoprolol, for the month of October 2020.

Hospital Discharge Medications

FSP had poor performance in hospital discharge medications. FSP scored low for patients receiving their discharge medications upon return from an off-site hospitalization or an emergency room visit (MIT 7.003, 50.0%). Compliance testing revealed 10 of 20 patients did not receive medications within the required time frame. Our OIG clinicians reviewed 10 cases and identified a deficiency in case 21. Please refer to the **Transfers** indicator for details.

Transfer Medications

FSP performed well in transfer medications. Compliance scores and case review showed similar findings. Compliance testing showed FSP maintained medication continuity when patients transferred into the institution (MIT 6.003, 91.7%) as well as when patients transferred from one housing unit to another (MIT 7.005, 100%). Compared with Cycle 5, FSP's performance in these two areas improved. In reviewing six cases in which patients arrived at FSP from other facilities, OIG clinicians did not identify any deficiencies. For patients who transferred out of FSP, we reviewed three cases and identified one deficiency, in which the patient transferred to another institution without his medications.[45] FSP

44. Deficiencies for chronic medication continuity occurred in cases 5, 6, 8, 19, 26, 27, 28, and 30. Significant deficiencies occurred in cases 6, 26, and 30.

45. Medications were not transferred with the patient when he transferred out of FSP in case 24.

did not always ensure patients en route to another facility received their medications without interruption (MIT 7.006, 50%).

Medication Administration

Case review and compliance findings showed FSP nurses frequently administered medications within required time frames. OIG clinicians reviewed 24 cases and found four medication administration deficiencies.[46] Nurses correctly administered TB medications as prescribed (MIT 9.001, 91.7%). However, the nurses often did not adequately monitor these patients by documenting and addressing TB symptoms as required (MIT 9.002, 16.7%).

Clinician On-Site Inspection

The main pharmacy is located at FSP, and a satellite pharmacy is located at FWF. The medication nurses were familiar with processes related to emergency response, patient transfers, hospital returns, and medication noncompliance. The nurses reported having a process in place for the distribution of KOP medications. While on-site, we observed the medication carts did not have a backlog of KOP medications.

The medication nurses reported administering medications at cell side for patients in quarantine or isolation for COVID-19; they did not have any issues with pharmacy or medication delivery. Overall, the medication nurses reported having a good rapport with custody staff as well as support from nursing leadership and supervisors.

Compliance Testing Results

Medication Practices and Storage Controls

The institution adequately stored and secured narcotic medications in six of eight clinic and medication line locations (MIT 7.101, 75.0%). In one location, nursing staff did not update the narcotics logbook: it was missing the name and strength of the medication, the time it was administered, and the quantity remaining in stock. In another location, nurses could not describe the narcotic medication discrepancy reporting process.

FSP appropriately stored and secured nonnarcotic medications in nine of 10 clinic and medication line locations (MIT 7.102, 90.0%). In one location, the medication refrigerator did not have a designated area for refrigerated medications to be returned to the pharmacy.

Staff kept medications protected from physical, chemical, and temperature contamination in eight of the 10 clinic and medication line locations (MIT 7.103, 80.0%). In one location, staff did not consistently

46. Medication administration deficiencies occurred in cases 5, 19, 27, and 28.

record the refrigerator temperatures. In another location, staff did not store oral and topical medication separately.

Staff successfully stored valid, unexpired medications in all of the applicable medication line locations (MIT 7.104, 100%).

Nurses exercised proper hand hygiene and contamination control protocols in only two of six locations (MIT 7.105, 33.3%). In four locations, nurses neglected to wash or sanitize their hands before each subsequent re-gloving.

Staff in all medication preparation and administration areas demonstrated appropriate administrative controls and protocols (MIT 7.106, 100%).

In four of six medication areas, staff used appropriate administrative controls and protocols when distributing medications to their patients (MIT 7.107, 66.7%). In one location, the supervising nurse did not verbalize reporting a medication error to the chief nurse executive (CNE) when interviewed. In another location, the medication nurses did not disinfect the top of a previously opened insulin vial prior to withdrawing and administering the medication.

Pharmacy Protocols

FSP followed general security, organization, and cleanliness management protocols in its main and remote pharmacies (MIT 7.108, 100%).

In its pharmacies, FSP properly stored nonrefrigerated medication (MIT 7.109, 100%).

The institution properly stored refrigerated or frozen medications in one of two pharmacies (MIT 7.110, 50.0%). In the remote pharmacy, we found an unsanitary refrigerator medication storage bin.

The pharmacist-in-charge (PIC) did not inspect medication storage areas as required by CCHCS HCDOM in one of two pharmacies (MIT 7.111, 50.0%). However, we acknowledge that the department sent a memorandum to the field on April 15, 2020, allowing a temporary change to the medication storage area inspections during the declared COVID-19 state of emergency. Because the OIG tests to the HCDOM policy, the institution scored 50 percent. Therefore, the score should be understood with the informal policy change in mind.

We examined 18 medication error reports. The PIC timely or correctly processed 14 of these 18 reports (MIT 7.112, 77.8%). In four reports, the PIC did not provide documentation of recommended changes to correct the errors from occurring in the future.

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

We interviewed patients in isolation units to determine whether they had immediate access to their prescribed asthma rescue inhalers or nitroglycerin medications. All six applicable patients interviewed indicated they had access to their rescue medications (MIT 7.999).

Recommendations

- Pharmacy and nursing leadership should consider reviewing the causes of the untimely delivery of newly prescribed, chronic, and hospital discharge medications; leadership should implement remedial measures as appropriate.

Table 14. Medication Management

Compliance Questions	Scored Answer Yes	No	N/A	Yes %
Did the patient receive all chronic care medications within the required time frames or did the institution follow departmental policy for refusals or no-shows? (7.001) *	0	18	7	0
Did health care staff administer, make available, or deliver new order prescription medications to the patient within the required time frames? (7.002)	15	10	0	60.0%
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) *	10	10	1	50.0%
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) *	25	0	0	100%
For patients en route who lay over at the institution: If the temporarily housed patient had an existing medication order, were medications administered or delivered without interruption? (7.006) *	1	1	0	50.0%
All clinical and medication line storage areas for narcotic medications: Does the institution employ strong medication security controls over narcotic medications assigned to its storage areas? (7.101)	6	2	4	75.0%
All clinical and medication line storage areas for nonnarcotic medications: Does the institution properly secure and store nonnarcotic medications in the assigned storage areas? (7.102)	9	1	2	90.0%
All clinical and medication line storage areas for nonnarcotic medications: Does the institution keep nonnarcotic medication storage locations free of contamination in the assigned storage areas? (7.103)	8	2	2	80.0%
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	0	2	100%
Medication preparation and administration areas: Do nursing staff employ and follow hand hygiene contamination control protocols during medication preparation and medication administration processes? (7.105)	2	4	6	33.3%
Medication preparation and administration areas: Does the institution employ appropriate administrative controls and protocols when *preparing* medications for patients? (7.106)	6	0	6	100%
Medication preparation and administration areas: Does the institution employ appropriate administrative controls and protocols when *administering* medications to patients? (7.107)	4	2	6	66.7%
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)	2	0	0	100%
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)	1	1	0	50.0%
Pharmacy: Does the institution follow key medication error reporting protocols? (7.112)	14	4	0	77.8%
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): **69.6%**

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

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

Table 15. Other Tests Related to Medication Management

Compliance Questions	Scored Answer			
	Yes	No	N/A	Yes %
For endorsed patients received from another CDCR institution or COCF: If the patient had an existing medication order upon arrival, were medications administered or delivered without interruption? (6.003) *	11	1	13	91.7%
For patients transferred out of the facility: Do medication transfer packages include required medications along with the corresponding transfer-packet required documents? (6.101) *	0	0	1	N/A
Patients prescribed TB medication: Did the institution administer the medication to the patient as prescribed? (9.001) *	11	1	0	91.7%
Patients prescribed TB medication: Did the institution monitor the patient per policy for the most recent three months he or she was on the medication? (9.002) *	2	10	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) *	N/A	N/A	N/A	N/A

* 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
(74.8%)

Preventive Services

In this indicator, OIG compliance inspectors tested whether the institution offered or provided cancer screenings, tuberculosis (TB) screenings, influenza vaccines, and other immunizations. The OIG rated this indicator solely based on the compliance score, using the same scoring thresholds as in the Cycle 4 and Cycle 5 medical inspections. Our case review clinicians do not rate this indicator.

Results Overview

FSP staff had a mixed performance in preventive services. Staff performed well in administering prescribed TB medication to patients, in offering patients an influenza vaccine for the most recent influenza season, in offering colorectal cancer screening for all patients from age 50 through 75, in offering mammograms for female patients from the age of 50 through the age of 74, and in offering pap smears for female patients from the age of 21 through the age of 65. However, FSP faltered in monitoring patients who were taking prescribed TB medication, in screening patients annually for TB, and in offering required immunizations to chronic care patients. These findings are set forth in the table on the next page. We rated this indicator ***inadequate***.

Compliance Testing Results

Recommendations

- Nursing leadership and the public health nurse should educate nursing staff to fully document tuberculosis (TB) symptoms as part of the patient's TB medication monitoring.
- Nursing leadership should educate nursing staff to timely perform and properly document yearly TB screenings.
- Medical leadership should ensure that providers offer required immunizations to patients with chronic care conditions, as required by policy.

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)	11	1	0	91.7%
Patients prescribed TB medication: Did the institution monitor the patient per policy for the most recent three months he or she was on the medication? (9.002) †	2	10	0	16.7%
Annual TB screening: Was the patient screened for TB within the last year? (9.003)	15	10	0	60.0%
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)	5	0	0	100%
Female patients from the age of 21 through the age of 65: Was patient offered a pap smear in compliance with policy? (9.007)	2	0	0	100%
Are required immunizations being offered for chronic care patients? (9.008)	5	5	15	50.0%
Are patients at the highest risk of coccidioidomycosis (valley fever) infection transferred out of the facility in a timely manner? (9.009)	N/A	N/A	N/A	N/A
				Overall percentage (MIT 9): **74.8%**

* 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** and **Specialty Services**.

Results Overview

Similar to their performance in Cycle 5, FSP nurses frequently delivered appropriate and timely care during Cycle 6. Generally, the nurses assessed and monitored patients timely, despite the added workload from the COVID-19 pandemic. While the providers were advised to prioritize only urgent and emergent cases, the nursing staff continued to provide daily care, even assessing the patients at cell side. Taking all of this information into account, the OIG rated the **Nursing Performance** indicator ***adequate.***

Case Review Results

We reviewed 268 nursing encounters in 67 cases. Of the nursing encounters we reviewed, 222 were in the outpatient setting. Of those 222 outpatient encounters, 66 events were related to either COVID-19 quarantine or isolation rounds that occurred up to twice daily for a two-week review period. Twice-daily rounds for two weeks means that one event could potentially include 28 nursing encounters and that the nurses actually performed several hundred additional patient contacts. We identified 116 nursing performance deficiencies, 22 of which were significant.[47]

47. Deficiencies were identified in cases 1, 2, 3, 4, 7, 9, 11, 12, 13, 14, 15, 16, 18, 19, 20, 21, 22, 23, 24, 26, 27, 28, 29, 31, 35, 37, 38, 40, 42, 44, 45, 46, 47, 48, 49, 52, 53, 54, 55, 56, 57, 58, 59, and 67. Significant deficiencies were identified in cases 2, 3, 9, 14, 19, 21, 22, 23, 24, 26, 27, 31, 35, 40, 47, and 52.

Nursing Assessment and Interventions

The nursing staff at FSP performed adequate assessments most of the time. However, we identified cases showing incomplete assessments, including in the following examples:

- In case 40, the patient submitted a sick call request for a swollen scrotum. On the sick call request, the patient wrote that he had experienced the same symptom in 2013, and that it had required surgical intervention. The clinic nurse did not assess the patient's scrotum, did not obtain records of the prior hospitalization, and did not consult with the provider.
- In case 31, the patient was sent to the TTA for a steroid medication injection for hereditary angioedema.[48] The TTA RN did not assess the patient, obtain repeat vital signs, monitor the patient, or document the patient's status before the patient returned to his housing.
- In case 26, nursing staff completed isolation rounds on the patient who was positive for COVID-19. The nurse noted a low oxygen saturation but did not notify the provider, as required by protocol.

We also identified instances in which the nurses documented follow-up appointments to be scheduled but did not place the orders. Occasionally, when the nurses identified unusual patient assessments or findings, they did not communicate with the providers.

Nursing Documentation

FSP nursing documentation is an area that offers opportunity for improvement. Of the 116 total deficiencies identified with nursing performance, 39 were related to poor or incomplete documentation.[49] Some of the deficiencies included incomplete vitals, the absence of documented intravenous fluid administration and medication administration in the Medication Administration Record (MAR), missing interventions, and a lack of communication with providers. We also identified several instances when patients refused vital signs or assessments, yet no informed patient refusal forms were obtained. Documentation deficiencies are usually considered minor due to their causing no harm to patient care; however, missing documentation of interventions and of communication with the providers in the following case caused concern about whether the patient received adequate care:

- In case 9, the diabetic patient was seen by the pill line nurses for finger stick blood sugar checks and to receive insulin. On seven

48. Hereditary angioedema is a disorder that results in recurrent attacks of swelling, including swelling of the arms, legs, face, intestinal tract, and airways.

49. Documentation deficiencies were identified in cases 1, 2, 3, 4, 7, 9, 12, 15, 19, 20, 21, 22, 26, 27, 28, 29, 31, 35, 37, 40, 53, 54, 58, and 67.

occasions, the nursing staff documented very low blood sugar levels but did not document interventions or notify the provider.

Nursing Sick Call

The OIG clinicians reviewed 79 sick call requests and identified 38 deficiencies, five of which were significant.[50] While we identified that the nurses triaged the requests and evaluated the patients timely, we also found a few cases in which the nurses incorrectly triaged the sick call requests that led to a delay in a face-to-face assessment and placed the patients at risk of harm. The following cases are significant examples:

- In case 35, the patient submitted a sick call request with multiple complaints, including shortness of breath. The nurse ordered an RN face-to-face appointment within one business day instead of assessing the patient the same day.
- In case 52, the patient submitted a sick call request for left neck and shoulder blade pain with indigestion. These symptoms are common manifestations of cardiac events. The nurse should have triaged the patient to be evaluated the same day the sick call was triaged. Instead, the patient was evaluated the following day.

Most of the deficiencies were minor and related to incomplete assessments, such as not weighing the patient or missing a portion of the vital signs, and not documenting discharge instructions.

Care Coordinator

We reviewed five events in which patients received care management appointments; we identified two minor deficiencies, in cases 22 and 27.

Wound Care

During our review period, OIG clinicians reviewed three nursing events that required wound care and identified no deficiencies.

Emergency Services

FSP performed adequately in the emergency services indicator. OIG clinicians reviewed 23 events in 14 cases and identified 12 deficiencies, nine of which resulted from the quality of nursing care provided.[51] The nursing staff responded quickly to emergency events, assessed the patients, provided additional interventions, and transferred the patients to a higher level of care when necessary most of the time. We identified

50. Deficiencies in the sick call process were identified in cases 11,12, 13, 14, 15, 22, 26, 29, 35, 37, 38, 40, 42, 44, 45, 46, 47, 48, 49, 52, 53, 54, 55, 56, 57, 58, 59, and 67. Significant deficiencies occurred in cases 19, 35, 40, 47, and 52.

51. In cases involving emergency care, we identified deficiencies related to the quality of nursing care in cases 2, 3, 4, 13, 21, and 27. We noted significant deficiencies in cases 2 and 27.

some areas for performance improvement, which we discuss further in the **Emergency Services** indicator.

Hospital Returns

We reviewed 14 events in which patients returned from a hospitalization or emergency room visit; we identified three deficiencies related to the quality of nursing performance.[52] The deficiencies included an incomplete assessment, a failure to administer medications, and a failure to place a follow-up order for a provider appointment. While these deficiencies were significant, we identified no discernible patterns. Please see the **Transfers** indicator for additional information.

Transfers

OIG clinicians reviewed 14 events that involved the transfer-in or transfer-out processes at FSP. Case reviewers identified three minor deficiencies in the transfer-in process and two significant deficiencies in the transfer-out process that were directly related to the quality of nursing care.[53] The significant deficiencies occurred during the COVID-19 surge at FSP, and leadership advised us that the transfers were unscheduled but recommended by headquarters to protect the highest-risk patients. These cases are further discussed in the **Transfers** indicator.

Specialty Services

We reviewed 65 events in 15 cases in which patients were seen for specialty appointments or interventional testing.[54] The OIG clinicians identified 38 deficiencies, with six related to the quality of nursing care.[55] While the specialty nurses were proficient in organizing schedules and communicating specialty appointment findings to the providers, the specialists did not always receive the information needed to make appropriate medical decisions.

- In case 9, the nurse did not provide the telemedicine endocrinologist with a complete list of the patient's current medications and the patient's recent low sugar readings for two appointments.
- In cases 9 and 28, the nurse did not provide the oncologist with the MRI results, which should have been available prior to the scheduled appointments.

52. In cases of patients returning from hospitals, we identified deficiencies related to the quality of nursing care in cases 2, 21, and 22.

53. We identified deficiencies in the transfer-in process in cases 16, 18, and 22. We identified deficiencies in the transfer-out process in cases 23 and 24.

54. We reviewed specialty services in cases 2, 6, 7, 9, 11, 12, 15, 19, 20, 26, 27, 28, 29, 30, and 31.

55. We identified deficiencies in specialty services in cases 2, 7, 9, 26, 27, 28, 30, and 31. We noted deficiencies in specialty services related to the quality of nursing care in cases 9, 19, 26, and 28.

Most of the time, the specialty RNs obtained vital signs and performed focused assessments to assist the specialty telemedicine providers. We identified a significant deficiency directly related to the quality of nursing care: In case 26, the telemedicine RN obtained vital signs and documented a very low blood pressure reading. The nurse did not recheck the vitals or notify the primary care physician.

Medication Management

Overall, the nursing staff obtained, provided, and documented medication administration well. There were 23 deficiencies related to medication management, but only six were due to the quality of nursing care and only one was significant.[56]

- In case 21, the patient returned from the hospital after hours. However, the nurse did not obtain the patient's medication from the Omnicell after hours. This case is further discussed in the **Medication Management** indicator.
- The five additional deficiencies related to medication administration were minor and related directly to documentation.

Clinician On-Site Inspection

During the on-site visit, we toured the primary care clinics, the TTA, the receiving and release area, pill lines, specialty clinics, telemedicine areas, the minimum yard, and FWF. We interviewed nursing staff and nursing leadership. We were advised that the clinic nurses average eight to twelve appointments per day and that there were no backlogs in the clinics we toured. The staff reported that they work cohesively, with little turnover. In addition, they verbalized contentment with the work environment, co-workers and leadership, and said they had good rapport and support from custody.

We were able to observe multiple morning huddles via conference call. The meetings were organized, well-scripted and thorough, and covered topics required by CCHCS policy. We were also present for the monthly nursing all-staff meeting when updates and current data were relayed to the nursing staff. The nurse instructor provided training on interventions and documentation as well as guidance on where to document information in electronic health records system.

The care manager position at FSP is a dual role performed by the clinic RNs. They are responsible for seeing newly arrived patients and performing timely chronic care appointments to monitor vital signs, laboratory results, and medication compliance, to perform additional assessments according to the chronic care diagnosis, and to provide education to the patients. The providers relied on the assessments performed by the care managers during our case review when the

56. We identified deficiencies in medication management that were result of the quality of nursing in cases 3, 19, 20, 21, 27, and 28. The significant deficiency occurred in case 21.

institution had an outbreak of COVID-19. This placed a heavy burden on the nursing staff. The nursing staff advised that there were no current separate care manager positions and that the SRN IIs and additional clinic nurses were seeing patients for care manager appointments due to the increased workload.[57] A shared request from several employees was that the care manager positions be implemented in order to provide more comprehensive care for patients with chronic care diagnoses. On-site, the chief nurse executive reported that FSP had upcoming interviews for care manager positions.

The specialty nurses were responsible for tracking postspecialty follow-up visits and laboratory testing, scheduling the visits, and then notifying the providers when orders should be placed and what those orders should be.

At the on-site inspection, we also met with the leadership team that managed the COVID-19 outbreak at FSP. The team reported immediately recognizing that the housing infrastructure at Folsom was a challenge for managing patients infected with COVID-19, as the majority of the buildings either have open bar cell doors or are dormitories. Due to the volume of patients positive for COVID-19, the management team converted multiple areas into quarantine and isolation housing, including the areas normally used for visiting, the tents, the FWF dorm, and the administration segregation unit.

The public health nurse reported that over the course of the outbreak, FSP had over 1000 patients who tested positive for COVID-19 and that the patient population had been mass- tested weekly since August 2020. Prior to our on-site visit, the nursing staff initiated vaccinating the patient population. The day prior to the inspection, 130 patients were vaccinated in one clinic alone.

The COVID-19 outbreak at FSP also impacted staff members. During the individual interviews, we were told that several of the staff, who were also tested weekly, had contracted the virus.

In response to COVID-19, CCHCS established health care team positions at each institution. At FSP, the employee health care team consisted of two RNs, two LVNs, one medical assistant, and one occupational therapist. An RN is available seven days per week from 6 a.m. to 4 p.m. The RNs attend weekly statewide meetings and report on staff who are positive for COVID-19, vaccination percentages, and additional information as requested.

Nursing leadership provided documentation to support critical staffing levels during the month of August and on some dates in September. Quarantine rounds were modified to once daily until the arrival of registry staff at the end of August, when rounds resumed the normal schedule of twice daily. Both state and registry staff at different times made both quarantine and isolation rounds. Nursing leadership stated that during the COVID-19 outbreak, nurses conferred twice daily with

57. An SRN II is a Supervising Registered Nurse level II.

leadership, nursing, and providers to report abnormal findings. These conference calls were usually conducted shortly after completion of the twice-daily rounds.

Recommendations

- Nursing leadership should ensure that thorough assessments are completed for all face-to-face encounters.
- Nursing leadership should continue to provide guidance to staff during the monthly nursing all-staff meeting regarding documentation and intervention.

Provider Performance

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

Overall Rating ***Inadequate***

Case Review Rating ***Inadequate***

Compliance Score **(N/A)**

Results Overview

FSP providers delivered poor patient care. OIG clinicians identified questionable decision-making regarding medical treatment, in deferring appointments, and in sending patients to higher levels of care. Providers in most instances did not order specialty follow-up appointments or testing recommended by the specialists, and they deferred management of specialty follow-up care to the specialty nurses. There were other deficiencies: providers did not follow up on abnormal laboratory test results, did not order clinic or laboratory follow-up tests, and did not provide adequate documentation. In light of these findings, OIG rated this indicator ***inadequate***.

Case Review Results

The OIG clinicians examined the quality of care in 24 comprehensive case reviews. Of these 24 cases, none were rated proficient, 18 were adequate and six were inadequate.[58] These cases included 109 provider encounters and 69 provider order events. Of the 127 deficiencies, 43 were significant.

Assessment and Decision-Making

Of the 24 comprehensive cases reviewed, six were inadequate.[59] Poor medical decision-making played a significant role in the deficiencies of these cases. Regarding patients returning from the hospital, providers made poor decisions by reviewing nursing assessments rather than conducting their own in-person patient assessments. Examples of significant deficiencies include the following:

- In case 27, the provider ordered an optometry examination for blurred vision in the patient with glaucoma, diabetes, and other chronic medical conditions, but did not document a history of

58. Deficiencies occurred in cases 1, 3, 5, 6, 7, 9, 10, 11, 12, 13, 14, 19, 20, 21, 22, 26, 27, 28, 29, 30, 31, 38, 52, 53, 61, 62, and 63. Significant deficiencies were found in cases 1, 9, 20, 22, 26, 27, 28, 29, 30, and 31.

59. Inadequate cases were 9, 27, 28, 29, 30, and 31.

eye complaints or perform an eye examination or vision test. This same patient was overdue for an ophthalmology glaucoma follow-up examination, but instead, the provider ordered the optometry examination to occur in 57 days, rather than urgently. Also, on multiple occasions, providers saw the patient for COVID-19 infection but did not discontinue the patient's three immunosuppressant medications.[60] The patient's condition worsened, and he was sent to the hospital, where he later died from complications related to COVID-19 infection.

- In case 28, the provider prescribed opiates for the patient with a substance abuse history and a history of cheeking opiates.[61] The provider did not perform an appropriate physical examination or offer a trial of nonnarcotic pain medications. A few days later, the provider did not see the patient yet increased the patient's opiates without assessing the patient and without any documentation of medical necessity.

- In case 31, the providers delivered poor care for the patient with a history of hereditary angioedema affecting his ability to breathe and a prior tracheostomy.[62] When the patient presented with a swollen tongue, and presented later with throat swelling, he was not sent to the hospital but was instead offered the same ineffective treatments. The providers prescribed medications that were not appropriate for this condition. One provider referred the patient to the specialist; however, this referral was denied by management, who recommended a trial of other inappropriate treatments. The patient requested a prior treatment that had worked, but that treatment was not provided during this review period. Also, when the patient was diagnosed with a COVID-19 infection, his immune-suppressant medications were not discontinued. When he did not improve and his condition worsened, a provider, rather than discontinue the immunosuppressants, started the patient on antibiotics without seeing the patient or performing a physical examination.

60. Immunosuppressant medications reduce the body's ability to fight or recover from infection.

61. *Cheeking medications* is a colloquial term for concealing a medication in the mouth, i.e., between the teeth and the cheek, in order to avoid swallowing it. See **https://medical-dictionary.thefreedictionary.com/cheeking**.

62. Hereditary angioedema is a disorder characterized by recurrent episodes of severe swelling (angioedema). The most common areas of the body to develop swelling are the limbs, face, intestinal tract, and airway. Minor trauma or stress may trigger an attack, but swelling often occurs without a known trigger. Episodes involving the intestinal tract cause severe abdominal pain, nausea, and vomiting. Swelling in the airway can restrict breathing and lead to life-threatening obstruction of the airway. About one-third of people with this condition develop a nonitchy rash called erythema marginatum during an attack. See **https://medlineplus.gov/genetics/condition/hereditary-angioedema/**. Tracheostomy is a hole that surgeons make through the front of the neck and into the windpipe (trachea). A tracheostomy tube is placed into the hole to keep it open for breathing. See **https://www.mayoclinic.org/tests-procedures/tracheostomy/about/pac-20384673**.

Review of Records

Providers reviewed hospital records in a timely manner but did not always follow up with the patients upon their return from the hospital. Diagnostic reports were usually reviewed timely but abnormal laboratory test results were not always addressed. The providers did not follow up on missing urine culture or pathology reports. This is discussed further in the **Health Information Management** indicator.

Emergency Care

Providers performed well in the 23 emergency events noted. Although the providers supported the TTA remotely during the COVID-19 pandemic, TTA staff advised that providers were available for consultation. Only four deficiencies were noted, one significant: a provider prescribed a contraindicated medication for a patient with a history of liver cirrhosis.[63]

Chronic Care

As we noted in the **Access to Care** indicator, providers frequently did not see patients face-to-face for chronic care appointments, instead performing chart review; the appointments were made, but the patients were not seen. However, providers documented these appointments as completed.[64]

Among the 109 provider encounters we reviewed, 19 chronic care appointments occurred. Of those, only seven included all medically necessary components in the progress notes, including an appropriate review of systems, a physical examination, preventive care, and an assessment and plan. In only one visit did the provider address all medically necessary components. Providers did not perform diabetic foot examinations and frequently did not perform diabetic eye examinations.[65] Providers performed adequately in routine chronic care issues on noncomplex patients with simple hypertension and well-controlled diabetes; however, with more clinically complex patients having less common diseases, multiple conditions, or less well-controlled common conditions, providers performed poorly.

Specialty Services

The OIG clinicians reviewed a total of 15 cases with specialty events, nine of which had performance deficiencies. As noted in the **Specialty**

63. Minor deficiencies were cited in cases 13, 22, and 31. One significant deficiency was noted in case 22. Liver cirrhosis is a condition involving scarred liver tissue and reduced liver function.

64. A completed appointment occurs when the provider closes the appointment EHRS, which indicates an appointment such as a face-to-face interaction had occurred between the provider and patient.

65. Chronic care visits occurred in cases 2, 3, 6, 10, 12, 13, 14, 19, 20, 22, 26, 28, 30, and 31. A complete chronic care visit in which the provider performed preventive care services occurred only in case 2.

Services indicator, FSP providers used initial specialty services appropriately but did not order specialty follow-up timely. Examples include not following specialist recommendations, not documenting the reasons for not following specialist recommendations, and not contacting the specialist when medically necessary.[66] The following cases provide examples of these deficiencies:

- In case 26, the provider saw the patient after a follow-up rheumatology consultation. The provider did not follow the specialist's request that the provider order a rheumatology follow-up appointment, laboratory tests, and a pulmonology referral. Three weeks later, the specialty nurse reminded the provider to place the missing orders, at which time the provider only ordered the specialty follow-up appointment and the requested laboratory tests. The pulmonology consultation was not ordered. The provider did not document the reasons for the untimely order delays and for not following the specialist's recommendations.

- In case 30, the cardiologist evaluated the patient with a history of atrial fibrillation and stroke who was already prescribed aspirin.[67] The cardiologist recommended that the patient be started on a blood-thinning medication rather than continue taking aspirin.[68] However, the provider did not start the blood-thinning medication until three months later, stating that the delay occurred because the cardiologist did not document the dose. The provider did not contact the cardiologist directly to obtain clarification on the dose. Furthermore, when the medication was started, the patient's aspirin was not stopped.

- In case 9, throughout the review period, the provider did not always follow the endocrinologist's recommendations and therefore treated the patient as having type 2 diabetes, instead following the endocrinologist's diagnosis of type 1 diabetes. The provider ordered oral diabetic medication in contrast to the recommendations of the endocrinologist and did not follow the endocrinologist's recommendations for insulin medication adjustments. As a consequence, the patient experienced several episodes of low sugar and uncontrolled diabetes.

- Headquarters telemedicine specialty clinics, such as Hepatitis C and addiction medicine, were not available at FSP due to the COVID-19 pandemic-related delays.

66. Specialty services events occurred in cases 2, 6, 9, 11, 12, 15, 19, 20, 26, 27, 28, 29, 30, and 31. Significant deficiencies in the quality of provider care related to specialty services occurred in cases 9, 26, 27, 30, and 31.

67. Atrial fibrillation is an irregular heart rhythm that can increase the risk of stroke and heart disease.

68. The blood-thinning medication reduces the risk of stroke more than aspirin does.

Documentation Quality

Provider documentation quality was variable. The most common deficiencies were providers not writing progress notes and not writing complete notes related to nurse co-consultations and phone calls. Nineteen deficiencies were related to providers not documenting their medical decision-making. This places patients at risk because care plans are not clear to other caregivers. In at least two of these instances, there were negative outcomes for the patient. Examples include the following:[69]

- In case 20, the provider ordered an urgent rheumatology specialist referral and steroid medication with a 27-day tapering off period, but the provider did not document the reason for the referral or for the steroid. The provider did not order a timely clinic follow-up appointment to ensure the patient's condition did not worsen. The patient had a rheumatology appointment over two weeks later. Unfortunately, by then the patient had a serious infection that required hospitalization.

- In case 27, the provider prescribed antibiotics to an immunocompromised patient with COVID-19 infection without documenting medical reasoning. A day later, the RN contacted the provider because the patient's condition had worsened. The patient was not sent to a higher level of care and the provider did not document why. Two days later, an RN contacted the provider regarding a decrease in the patient's oxygen levels. The provider saw the patient and placed an order for fluids; the provider did not immediately send the patient to the hospital and did not document any medical reasoning. The provider's medical decision-making was not clear in any of these events. Unfortunately, this patient later died from complications related to COVID-19.

Regarding provider progress notes, OIG clinicians often noted a pattern of incomplete physical examinations, histories, assessments, and plans. Two providers used language such as "exam was unchanged" and, at times, used that phrasing in sequential notes, without referring the reader to the examination that was unchanged. Physical examinations were often not well-documented and were missing components. Cloned notes were used. Examples include the following:

- In case 30, the provider used cloned notes to document having counseled the patient, who had refused specialty cancer care. Since a cloned note was used, it is not clear whether the provider had a meaningful interaction with the patient or whether the patient truly understood the risks at that time.

- In case 15, the provider ordered a head CT scan for a patient complaining of headaches and scalp swelling but did not

69. Deficiencies were found in cases 7, 13, 20, 22, 27, 30, 31, 38, 52, 53, 61, 62, and 63. Significant deficiencies were noted in cases 20, 22, 27, and 31.

document an appropriate history of illness, a review of systems, or a physical examination.

- In case 31, the provider saw the patient for specialty follow-up care. The provider's documented physical examination report stated "unchanged examination. Bilateral hands with improved swelling"; however, the provider did not indicate to which "unchanged examination" this note referred. In fact, the report of the prior examination stated the patient was normal except for minimally swollen lips. In addition, pertinent details, such as the amount of swelling, redness, and warmth, as well as any effect on range of motion, were not documented.

Provider Continuity

Provider continuity was generally good, with most providers attending to patients to on one yard for long periods of time, and in some cases, for years. With the exception of the periods when patients were in COVID-19 isolation, patients were usually seen by their primary care provider.

Clinician On-Site Inspection

OIG clinicians interviewed medical and nursing leadership, custody leadership, specialty staff, and most of the providers. Leadership reported that two registry providers were recruited to help during the COVID-19 outbreak. Those providers were not available for interview. We observed daily morning huddles remotely via telephone as requested due to the COVID-19 pandemic.

We noted good communication between the providers and leadership. The physician meetings were a forum for providing leadership guidance, referral review, peer review of cases, and an opportunity to express concerns. A new chief medical executive (CME) was in place and providers felt he was an excellent, approachable, and effective leader. Providers also expressed satisfaction with the long-standing chief physician and surgeon (CP&S), good cooperation among their staff, and overall job satisfaction, but they noted that the COVID-19 pandemic was a stressor because it placed them at risk, even with the part-time remote work they were offered.

Leadership reported that during the COVID-19 surge, there were no shortages of personal protective equipment (PPE).

Regarding provider appointment access, CCHCS headquarters issued guidelines stating that only urgent or emergent appointments were to be seen and left it to the providers to determine which appointments were urgent or emergent. Medical leadership, the providers, and nursing reported that from the beginning of the pandemic, all medical providers were given work accommodations, although only two providers were identified as at high risk for COVID-19 infection. These accommodations included working part-time from home and part-time on-site. Beginning

early in the pandemic, the high-risk providers used existing telemedicine equipment, including telemedicine carts, to see patients remotely. In July and August 2020, the CME obtained six additional telemedicine carts so that other providers could also see patients remotely. Providers and medical leadership reported that while working from home, providers performed chart review, but when we asked for detailed clinic schedules, the requested schedules were not provided.

We asked questions about the quality of care, and the providers replied that patients were not seen or patient care responsibilities were not carried out due to the COVID-19 pandemic. One provider mentioned it was necessary to share a clinic room with clinicians from other disciplines, which reduced clinic space availability. Some providers reported difficulty in getting patients to the clinic due to movement restrictions related to COVID-19. Providers reported that during the outbreaks from August to September, they performed rounds on isolation patients, which was time-consuming and prevented them from attending to clinic patients.

Some providers expressed discomfort at seeing patients who were positive for COVID-19. When such patients were housed in tented, climate-controlled isolation units in August and September 2020, these providers chose to see the patients in optional outdoor clinic areas while wearing full PPE in temperatures that could reach over 100 degrees.

Although we had been advised that provider clinic visits were restricted due to the COVID-19 pandemic, we observed during our on-site inspection that most incarcerated persons were out of their cells and in the walkways, wearing masks and moving freely. Custody, medical staff, and leadership advised that all incarcerated persons throughout the review period were allowed to attend the canteen, the yard, and the showers in cohorts, regardless of isolation or quarantine status.

In interviews with providers, OIG clinicians asked why the providers were documenting as completed in the medical records visits that were not completed. The providers explained that medical leadership advised providers to document a visit as completed if they reviewed the chart, rather than cancel or reschedule the appointment. No formal policy was provided. Of note, many of the providers felt that the replacement of LVN clinic assistants with medical assistants increased their administrative work.

When we discussed missing and incomplete provider notes, providers reported they felt that writing notes was left to their own discretion regarding co-consultations or nursing phone calls regarding patient care. Medical leadership stated that provider notes are required within one day for nurse co-consultations, but that otherwise, writing notes is at the discretion of the provider. The providers also expressed confusion about what qualified as a nurse co-consultation.

Nursing reported that they felt the providers were largely absent during the COVID-19 pandemic and that the nursing staff carried the weight

of patient care by providing most face-to-face appointments while the providers worked remotely.

Recommendations

- The department should define a nurse-to-provider co-consultation and should provide specific guidance to the providers on when provider progress notes are required for TTA and emergency phone calls, co-consultations, provider orders, and appointments.
- The department should provide clear policy guidance to institutions regarding how to manage care during the pandemic, including how to manage care for chronic care patients whose appointments might be canceled or delayed, how to prioritize patient movement to ensure that provider appointments occur, how to properly document an appointment for patients who only receive a medical chart review, and how to balance the workload to ensure the equitable distribution of patient care among nursing and providers.
- Medical leadership should examine the causes of poor provider care for clinically complex patients and should implement remedial measures as appropriate.

Specialty Services

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

Overall Rating ***Adequate***

Case Review Rating ***Adequate***

Compliance Score ***Inadequate*** **(72.1%)**

Results Overview

FSP provided satisfactory specialty services for its patients. Of note, as FSP followed CCHCS headquarters COVID-19 guidelines, only emergent and urgent specialty care was provided during the review period. Compliance review found that high- and medium-priority specialty appointments occurred timely; however, routine-priority appointments did not. OIG clinicians noted delays in off-site specialty care due to the unavailability of specialty clinics and due to appointments canceled because of COVID-19 pandemic quarantine and isolation. In addition, patients frequently refused care because they feared contracting COVID-19 and did not want to be placed in quarantine when they returned to FSP from an off-site specialty appointment. Providers often did not order follow-up specialty services timely, deferred responsibility for those orders to nursing, did not follow the specialist's instructions, and did not document their medical reasoning. Even with the delays in care and the deficiencies in provider care, however, patients overall were provided with specialty access, specialty reports were scanned and reviewed timely, and nursing performed well in managing specialty clinics. Overall, we rated this indicator ***adequate***.

Case Review and Compliance Testing Results

We reviewed 65 specialty services events, including 29 specialty services encounters. The specialty services encounters included 26 specialty consultations, two on-site addiction medicine consultations, and one procedure.[70] We identified 47 deficiencies in this category, 18 of which were significant.[71] We discuss these further in the **Provider Performance** indicator.

Access to Specialty Services

Compliance testing found that medium-priority specialty appointments occurred 93.3 percent of the time (MIT 14.004) and high-priority appointments occurred 73.3 percent of the time (MIT 14.005), but routine-priority specialty appointments occurred only 53.3 percent of the time (MIT 14.007). We attribute the low rate of routine priority appointments to the prioritization of urgent and emergent referrals and

70. In case 28, the patient underwent an ultrasound to facilitate a biopsy.

71. Deficiencies occurred in cases 2, 7, 9, 19, 26, 27, 28, 30, and 31. Significant deficiencies occurred in cases 9, 26, 27, 30, and 31.

to the limited availability of specialists in the community during the COVID-19 pandemic.

As noted in the **Access to Care** indicator, compliance testing found that FSP performed well in scheduling follow-up specialty care appointments. However, OIG case reviewers found a pattern in delayed ordering of specialty follow-up appointments and laboratory tests.[72] Generally, at most CCHCS institutions, the providers place orders upon review of the specialty report or at the follow-up appointment with the patient. This ensures that the specialists' follow-up appointments and laboratory tests will occur within appropriate time frames. At FSP, appointments and laboratory tests were ordered much later, and only after specialty RNs instructed providers to place these orders. Of the 29 specialty events reviewed by OIG case reviewers, 12 occurred more than 30 days past the specialist's requested follow-up date; these ranged from 30 to 99 days late.[73] Examples include the following:

- In case 26, the provider saw the patient for a rheumatology follow-up visit. At this provider visit, the rheumatologist's recommendations for laboratory tests and an appointment were not placed. No explanation for the delay in placing orders was documented in the EHRS. Three weeks later, the provider was notified by the specialty RN to place these orders. Later in the case, the patient again saw the rheumatologist, who requested several important laboratory tests and a follow-up appointment for close monitoring. The provider again saw the patient after his rheumatology appointment, and again, the provider did not follow through with the specialist's recommendations. When the patient died three months later, the specialty follow-up appointment and requested laboratory tests had still not been ordered.

- In case 27, the provider saw the patient for an endocrinology follow-up appointment. The provider did not order the endocrinology follow-up appointment until almost one month later, delaying specialty care to the patient. The provider also saw the patient for rheumatology follow-up, but similarly, did not place the order for the rheumatology follow-up appointment for over 30 days. Later, the patient was again seen by the provider for endocrinology and rheumatology follow-up. The provider again did not order the specialty follow-up appointments for almost two weeks. The provider did not document the reasons for the delays in ordering the specialty follow-up appointments.

- In case 31, the provider saw the patient for hematology follow-up. The provider did not order the hematology follow-up appointment within three to four weeks, as the specialist had requested. The provider did not order this appointment until 100 days later. The provider also saw the patient for a

72. Deficiencies related to provider orders occurred in cases 26, 27, 30, and 31. Significant deficiencies occurred in cases 9, 26, 27, 30, and 31.

73. Delays of greater than 30 days occurred in cases 12, 20, 27, 30, and 31.

rheumatology follow-up but did not order the rheumatology follow-up appointment or order the requested laboratory tests until over one month later, when the specialty RN advised the provider that the orders were needed. After that rheumatology visit occurred, the provider saw the patient for follow-up care and again did not order the rheumatology follow-up appointment or request laboratory tests, this time until two months later, when the specialty RN advised the provider that the orders were needed. This delayed rheumatology care twice in a patient being actively monitored under new rheumatology treatment. The provider did not document the reasons for not timely ordering the specialists' recommendations.

We also discuss these deficiencies in the **Access to Care** and **Provider Performance** indicators.

FSP performed poorly in ensuring that newly arrived patients with approved specialty appointments from another institution received follow-up appointments within the scheduled time frames (MIT 14.010, 11.1%). The low compliance score reflects specialty visits that were canceled without documentation of medical reasoning and appointments that were not ordered upon transfer or that did not occur timely.

Provider Performance

Providers performed poorly in this specialty indicator. Compliance testing found that providers saw or spoke to patients for specialty service follow-up visits within the required time frames only 65.1 percent of the time (MIT 1.008). Case reviewers found that the providers usually saw the patients timely for specialty follow-up care.

Generally, FSP providers used initial specialty services appropriately. The OIG clinicians reviewed a total of 15 cases with specialty events. Nine had deficiencies in the quality of provider performance. These deficiencies included not following specialist recommendations or delays in following specialist recommendations without appropriate documentation, and not contacting the specialist when medically necessary. Examples include the following:

- In case 27, the patient was regularly seen by an endocrinologist for diabetes management. The endocrinologist recommended laboratory tests and a return visit in three to four weeks for further medication adjustment. The provider did not order these until eleven weeks later and did not document why the orders were delayed.

- In case 30, the provider did not order critical blood-thinning medications as recommended by the specialist for more than three months. Although the provider had a question about the medication dose, the provider did not contact the specialist directly to clarify.

- In case 31, the rheumatologist requested to see the patient in four weeks with laboratory test results. The provider ordered only some of the tests, and even those were ordered more than two months later. This delayed the specialist's ability to thoroughly assess the patient's liver condition. The provider did not document the reasons these orders were delayed or not done.

Due to the COVID-19 pandemic, the OIG considered provider phone visits, during which all pertinent specialty visit details could be addressed, equivalent to face-to-face visits. Phone visits by the FSP providers were rare, with the providers electing to perform chart reviews rather than see patients by phone.

We discussed these further in the **Provider Performance** indicator.

Nursing Performance

In case review, the specialty RNs performed well in organizing the clinic schedules and communicating the specialty visit findings to the providers, despite the providers delegating the task of managing all specialty recommendations to those RNs. We found that specialty visit summary notes were completed in a timely manner.

Due to COVID-19 pandemic restrictions, there were only two specialty off-site return visits, both occurring in case 30. On one return visit, the RN did not perform an adequate assessment.

Of the 26 specialty visits our clinicians reviewed, eight RN messages were noted in the chart, advising the providers to order specialists' recommended follow-up appointments and laboratory tests. There were also several provider orders without associated documentation. Examples include the following:

- In case 26, one month after the specialist visit occurred, the RN messaged the provider to obtain specialty follow-up visit orders. The provider did not place the specialty orders as requested and the patient was not seen by a specialist in a follow-up visit as recommended by the specialist.
- In case 27, six weeks after the specialist visit occurred, the RN messaged the provider to obtain specialty follow-up visit orders, which had not been placed.
- In case 31, one month after the specialist visit occurred, the specialty RN messaged the provider to obtain specialty follow-up visit and laboratory test orders, which had not been placed.

The OIG clinicians found that the specialty RNs did not always submit appropriate patient medical information to the specialists. Two examples follow:

- In case 9, on two separate occasions, the RN did not provide the correct medication list and blood sugar readings to the specialist.

- In cases 19 and 28, the RN did not provide the requested images to the specialists.

Health Information Management

Compliance testing found FSP timely received and providers timely reviewed specialty reports for high-priority specialty referrals, (MIT 14.002, 92.9%), performed adequately in reviewing reports for medium-priority specialty referrals (MIT 14.005, 73.3%) and performed inadequately in reviewing reports for routine-priority specialty referrals (MIT 14.008, 57.1%).

Once the specialty reports were obtained, staff scanned the documents into the electronic health record 86.7 percent of the time (MIT 4.002). This is consistent with the case review findings.

Clinician On-Site Inspection

We discussed specialty care management with medical and nursing leadership, providers, specialty RNs, and schedulers. Leadership reported that the COVID-19 pandemic presented many challenges to specialty care, including loss of on-site specialty services, such as optometry and opthalmology. Custody, medical leadership, and health care staff stated that off-site and on-site telemedicine specialty visits were delayed due to quarantine and isolation; however, quarantine and isolation patients were allowed out of cell to go in cohorts to the canteen, the showers, and the yard.

Due to the COVID-19 pandemic, elective consultations were placed on hold per CCHCS headquarters policy, and only patients with urgent or emergent specialty consultations were seen. Some patients refused critical specialty care for fear of contracting COVID-19 or of being quarantined upon their return. In our discussions with custody staff and providers, we learned that both felt they had done everything possible to encourage the patients to follow through with specialty care that had been ordered, but frequently without success.

In our case review, we noted a pattern of providers not placing specialty orders in a timely manner. During our on-site visit, we asked several providers why they do not write the recommended specialty follow-up orders at the time of their follow-up visit with the patient or when they review the specialty report. The providers reported they defer ordering specialty care follow-up appointments until instructed to do so by the specialty RNs. We were advised that specialty RNs requested the providers to place the orders to correspond with the appointment once it is scheduled. The providers stated that as a group, they determined that specialty follow-up should be an RN responsibility, delegated the duty to the RNs, and did not write specialty follow-up orders until advised by nursing. The RNs reported that they track and email the providers about ordering specialty follow-up because the provider will not order follow-up care otherwise. The specialty RNs track postspecialty follow-up visits and laboratory testing, schedule the visits, then contact the providers

regarding when orders should be placed and for what date, rather than the providers initiating those orders on the provider specialty visit follow-up. The providers confirmed they did not track when the follow-up visits and laboratory requests should occur or whether they have yet to be ordered. Both the specialty RNs and the providers stated there was no official policy.

Providers were able to use eConsult to communicate with a specialist.[74] Limitations of eConsult were that the specialists could not see the patient in-person and that not all specialists were available. Leadership reported that early in the COVID-19 pandemic, eConsult was partially implemented to assist the off-site specialists. Guidelines on scanning eConsult documents or how to best use eConsult were not defined. The providers felt that eConsult would be effective for brief, direct questions, but was not helpful in complex cases. At the time of the on-site inspection, the system was not yet fully implemented, and automatic porting of eConsult to the CCHCS medical record had not yet occurred.

Leadership reported that health information management staff did not have electronic access to the medical records of its patients at contracted facilities, which required staff to obtain outside medical reports manually.

Recommendations

- Medical leadership should provide clear policies and procedures regarding who is responsible for ordering specialty follow-up visits and laboratory tests.
- Medical leadership should ensure that patients timely receive initial and follow-up specialty visits.
- Medical leadership should review the causes of the untimely retrieval of specialty reports and the untimely provider review of specialty reports; medical leadership should implement remedial measures as appropriate.

74. eConsult is an online consultation system by which providers can communicate with specialists for patient care advice and recommendations. See **https://www.econsultcdcr.com/**.

Compliance Testing Results

Table 17. Specialty Services

Compliance Questions	Scored Answer			
	Yes	No	N/A	Yes %
Did the patient receive the high-priority specialty service within 14 calendar days of the primary care provider order or the Physician Request for Service? (14.001) *	11	4	0	73.3%
Did the institution receive and did the primary care provider review the high-priority specialty service consultant report within the required time frame? (14.002) *	13	1	1	92.9%
Did the patient receive the subsequent follow-up to the high-priority specialty service appointment as ordered by the primary care provider? (14.003) *	8	3	4	72.7%
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) *	14	1	0	93.3%
Did the institution receive and did the primary care provider review the medium-priority specialty service consultant report within the required time frame? (14.005) *	11	4	0	73.3%
Did the patient receive the subsequent follow-up to the medium-priority specialty service appointment as ordered by the primary care provider? (14.006) *	8	0	7	100%
Did the patient receive the routine-priority specialty service within 90 calendar days of the primary care provider order or Physician Request for Service? (14.007) *	8	7	0	53.3%
Did the institution receive and did the primary care provider review the routine-priority specialty service consultant report within the required time frame? (14.008) *	8	6	1	57.1%
Did the patient receive the subsequent follow-up to the routine-priority specialty service appointment as ordered by the primary care provider? (14.009) *	7	1	7	87.5%
For endorsed patients received from another CDCR institution: If the patient was approved for a specialty services appointment at the sending institution, was the appointment scheduled at the receiving institution within the required time frames? (14.010) *	1	8	0	11.1%
Did the institution deny the primary care provider's request for specialty services within required time frames? (14.011)	9	1	0	90.0%
Following the denial of a request for specialty services, was the patient informed of the denial within the required time frame? (14.012)	6	4	0	60.0%
				Overall percentage (MIT 14): **72.1%**

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

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

Table 18. 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) *, †	28	15	2	65.1%
Are specialty documents scanned into the patient's electronic health record within five calendar days of the encounter date? (4.002) *	26	4	15	86.7%

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

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

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

Administrative Operations

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

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

Overall Rating
Inadequate

Case Review Rating
(N/A)

Compliance Score
Inadequate
(67.8%)

Results Overview

FSP'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, nor use incident packages that included the required documents. In addition, the institution conducted medical emergency response drills with incomplete documentation. The 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. Two unexpected (Level 1) deaths occurred during our review period. The DRC must complete its death review summary report within 60 calendar days of the death. When the DRC completes the death review summary report, it must submit the report to the institution's CEO within seven calendar days. In our inspection, we found the DRC completed one death review report promptly; the DRC finished one other report nine days late and submitted it to the institution's CEO two days late (MIT 15.998).

Recommendations

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

Compliance Testing Results

Table 19. Administrative Operations

Compliance Questions	Scored Answer			
	Yes	No	N/A	Yes %
For health care incidents requiring root cause analysis (RCA): Did the institution meet RCA reporting requirements? (15.001) *	N/A	N/A	N/A	N/A
Did the institution's Quality Management Committee (QMC) meet monthly? (15.002)	5	1	0	83.3%
For Emergency Medical Response Review Committee (EMRRC) reviewed cases: Did the EMRRC review the cases timely, and did the incident packages the committee reviewed include the required documents? (15.003)	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)	N/A	N/A	N/A	N/A
Did the institution conduct medical emergency response drills during each watch of the most recent quarter, and did health care and custody staff participate in those drills? (15.101)	0	3	0	0
Did the responses to medical grievances address all of the inmates' 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)	1	1	0	50.0%
Did nurse managers ensure the clinical competency of nurses who administer medications? (15.104)	10	0	0	100%
Did physician managers complete provider clinical performance appraisals timely? (15.105)	2	7	0	22.2%
Did the providers maintain valid state medical licenses? (15.106)	11	0	0	100%
Did the staff maintain valid Cardiopulmonary Resuscitation (CPR), Basic Life Support (BLS), and Advanced Cardiac Life Support (ACLS) certifications? (15.107)	1	1	1	50.0%
Did the nurses and the pharmacist-in-charge (PIC) maintain valid professional licenses and certifications, and did the pharmacy maintain a valid correctional pharmacy license? (15.108)	6	0	1	100%
Did the pharmacy and the providers maintain valid Drug Enforcement Agency (DEA) registration certificates? (15.109)	1	0	0	100%
Did nurse managers ensure their newly hired nurses received the required onboarding and clinical competency training? (15.110)	1	0	0	100%
Did the CCHCS Death Review Committee process death review reports timely? (15.998)	This is a nonscored test. Please refer to the discussion in this indicator.			
What was the institution's health care staffing at the time of the OIG medical inspection? (15.999)	This is a nonscored test. Please refer to Table 4 for CCHCS-provided staffing information.			
	Overall percentage (MIT 15): **67.8%**			

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

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

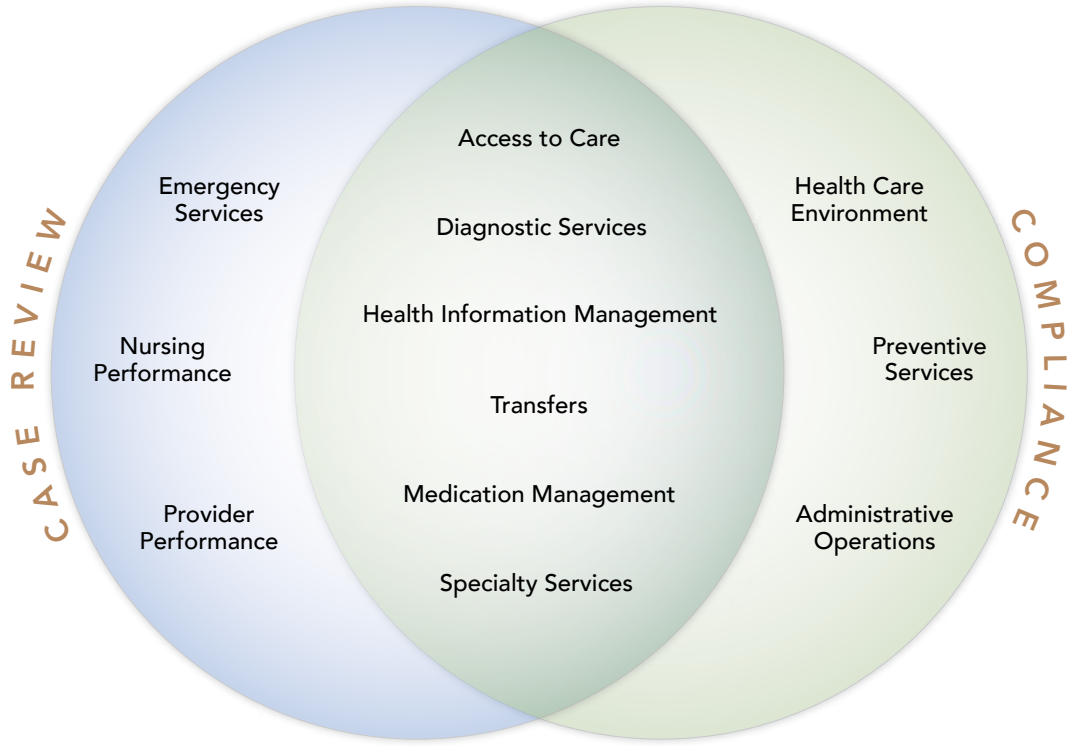
(This page left blank for reproduction purposes.)

Appendix A: Methodology

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

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

Figure A–1. Inspection Indicator Review Distribution for FSP



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

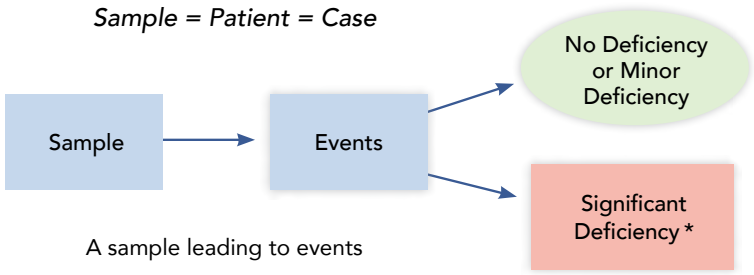
An OIG physician, a nurse consultant, or both review each case. As the clinicians review medical records, they record pertinent interactions between the patient and the health care system. We refer to these interactions as case review ***events***. Our clinicians also record medical errors, which we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

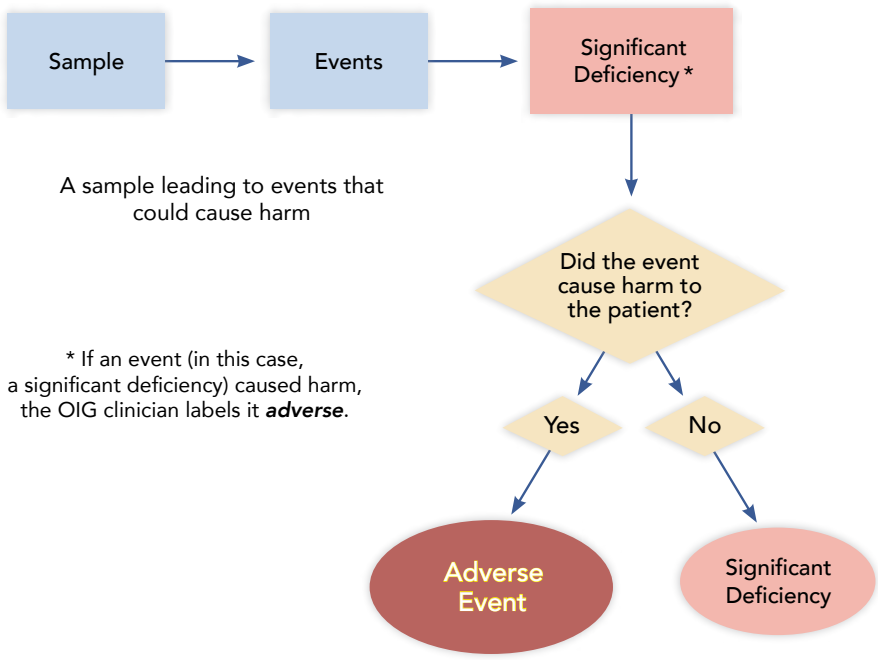
Figure A–2. Case Review Testing

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***.



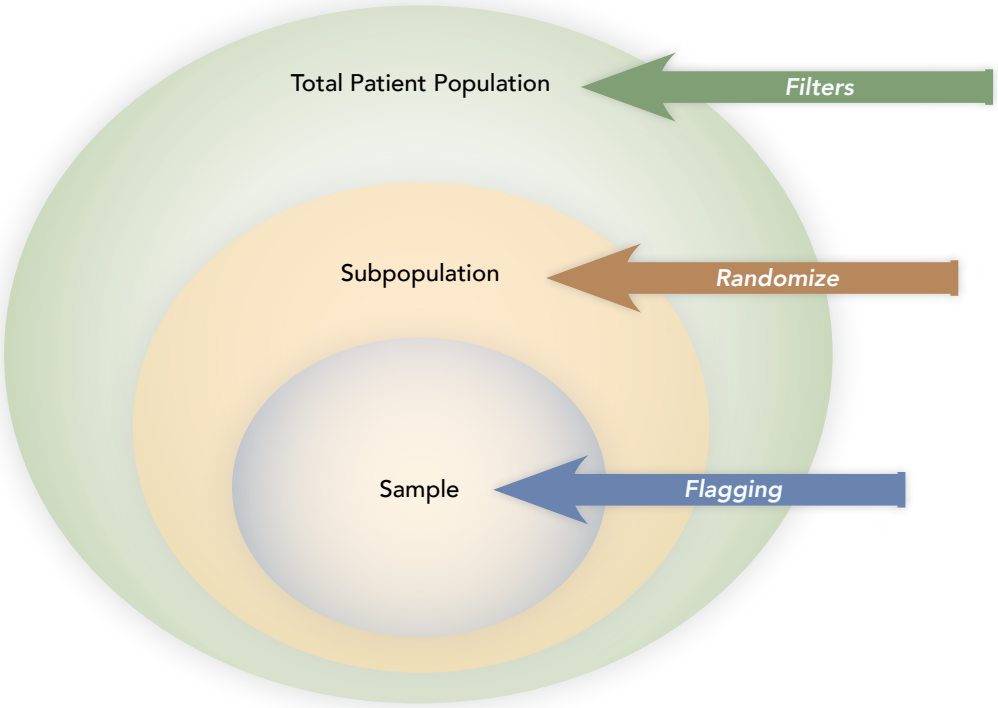
Source: The Office of the Inspector General medical inspection analysis.

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. FSP Case Review Sample Sets

Sample Set	Total
Anticoagulation	3
Death Review/Sentinel Events	2
Diabetes	3
Emergency Services – CPR	1
Emergency Services – Non-CPR	3
High Risk	5
Hospitalization	4
Intrasystem Transfers In	3
Intrasystem Transfers Out	3
RN Sick Call	36
Specialty Services	4
	67

Table B–2. FSP Case Review Chronic Care Diagnoses

Diagnosis	Total
Anemia	1
Anticoagulation	4
Asthma	6
COPD	3
COVID-19	20
Cancer	4
Cardiovascular Disease	3
Chronic Kidney Disease	1
Chronic Pain	5
Cirrhosis/End-Stage Liver Disease	4
Coccidioidomycosis	1
Deep Venous Thrombosis/Pulmonary Embolism	1
Diabetes	14
Gastroesophageal Reflux Disease	6
Hepatitis C	15
HIV	1
Hyperlipidemia	15
Hypertension	25
Mental Health	11
Migraine Headaches	3
Rheumatological Disease	4
Seizure Disorder	2
Sleep Apnea	1
Substance Abuse	10
Thyroid Disease	**3**
	163

Table B–3. FSP Case Review Events by Program

Diagnosis	Total
Diagnostic Services	201
Emergency Care	40
Hospitalization	23
Intrasystem Transfers In	11
Intrasystem Transfers Out	3
Not Specified	2
Outpatient Care	533
Specialty Services	64
	877

Table B–4. FSP Case Review Sample Summary

MD Reviews Detailed	24
MD Reviews Focused	0
RN Reviews Detailed	13
RN Reviews Focused	43
Total Reviews	80
Total Unique Cases	67
Overlapping Reviews (MD & RN)	13

Appendix C: Compliance Sampling Methodology

Folsom State Prison

Quality Indicator	Sample Category	No. of Samples	Data Source	Filters
Access to Care				
MIT 1.001	Chronic Care Patients	25	Master Registry	• Chronic care conditions (at least one condition per patient—any risk level) • Randomize
MIT 1.002	Nursing Referrals	25	OIG Q: 6.001	• See Transfers
MITs 1.003–006	Nursing Sick Call (6 per clinic)	35	Clinic Appointment List	• Clinic (each clinic tested) • Appointment date (2–9 months) • Randomize
MIT 1.007	Returns From Community Hospital	21	OIG Q: 4.005	• See **Health Information Management** (Medical Records) (returns from community hospital)
MIT 1.008	Specialty Services Follow-Up	45	OIG Q: 14.001, 14.004 & 14.007	• See Specialty Services
MIT 1.101	Availability of Health Care Services Request Forms	6	OIG on-site review	• Randomly select one housing unit from each yard
Diagnostic Services				
MITs 2.001–003	Radiology	10	Radiology Logs	• Appointment date (90 days–9 months) • Randomize • Abnormal
MITs 2.004–006	Laboratory	10	Quest	• Appt. date (90 days–9 months) • Order name (CBC or CMPs only) • Randomize • Abnormal
MITs 2.007–009	Laboratory STAT	3	Quest	• Appt. date (90 days–9 months) • Order name (CBC or CMPs only) • Randomize • Abnormal
MITs 2.010–012	Pathology	6	InterQual	• Appt. date (90 days–9 months) • Service (pathology related) • Randomize

Quality Indicator	Sample Category	No. of Samples	Data Source	Filters
Health Information Management (Medical Records)				
MIT 4.001	Health Care Services Request Forms	35	OIG Qs: 1.004	• Nondictated documents • First 20 IPs for MIT 1.004
MIT 4.002	Specialty Documents	45	OIG Qs: 14.002, 14.005 & 14.008	• Specialty documents • First 10 IPs for each question
MIT 4.003	Hospital Discharge Documents	21	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	21	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	1	OIG inspector on-site review	• R&R IP transfers with medication

Quality Indicator	Sample Category	No. of Samples	Data Source	Filters
Pharmacy and Medication Management				
MIT 7.001	Chronic Care Medication	25	OIG Q: 1.001	See **Access to Care** • At least one condition per patient—any risk level • Randomize
MIT 7.002	New Medication Orders	25	Master Registry	• Rx count • Randomize • Ensure no duplication of IPs tested in MIT 7.001
MIT 7.003	Returns From Community Hospital	21	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	2	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	18	Medication error reports	• All medication error reports with Level 4 or higher • Select total of 25 medication error reports (recent 12 months)
MIT 7.999	Restricted Unit KOP Medications	6	On-site active medication listing	• KOP rescue inhalers & nitroglycerin medications for IPs housed in restricted units

Quality Indicator	Sample Category	No. of Samples	Data Source	Filters
Prenatal and Postpartum Care				
MITs 8.001–007	Recent Deliveries	N/A at this institution	OB Roster	• Delivery date (2–12 months) • Most recent deliveries (within date range)
	Pregnant Arrivals	N/A at this institution	OB Roster	• Arrival date (2–12 months) • Earliest arrivals (within date range)
Preventive Services				
MITs 9.001–002	TB Medications	12	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	5	SOMS	• Arrival date (at least 2 yrs. prior to inspection) • Date of birth (age 52–74) • Randomize
MIT 9.007	Pap Smear	2	SOMS	• Arrival date (at least three yrs. prior to inspection) • Date of birth (age 24–53) • Randomize
MIT 9.008	Chronic Care Vaccinations	25	OIG Q: 1.001	• Chronic care conditions (at least 1 condition per IP—any risk level) • Randomize • Condition must require vaccination(s)
MIT 9.009	Valley Fever (number will vary)	N/A at this institution	Cocci transfer status report	• Reports from past 2–8 months • Institution • Ineligibility date (60 days prior to inspection date) • All

Quality Indicator	Sample Category	No. of Samples	Data Source	Filters
Reception Center				
MITs 12.001–008	RC	N/A at this institution	SOMS	• Arrival date (2–8 months) • Arrived from (county jail, return from parole, etc.) • Randomize
Specialized Medical Housing				
MITs 13.001–004	Specialized Health Care Housing Unit	N/A at this institution	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	N/A at this institution	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, 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

Quality Indicator	Sample Category	No. of Samples	Data Source	Filters
MIT 14.010	Specialty Services Arrivals	9	Specialty Services Arrivals	• Arrived from (other departmental institution) • Date of transfer (3–9 months) • Randomize
MITs 14.011–012	Denials	10	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 (ASE)	N/A	Adverse/sentinel events report	• Adverse/Sentinel events (2–8 months)
MIT 15.002	QMC Meetings	6	Quality Management Committee meeting minutes	• Meeting minutes (12 months)
MIT 15.003	EMRRC	12	EMRRC meeting minutes	• Monthly meeting minutes (6 months)
MIT 15.004	LGB	N/A	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	2	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	9	On-site provider evaluation files	• All required performance evaluation documents
MIT 15.106	Provider Licenses	11	Current provider listing (at start of inspection)	• Review all
MIT 15.107	Medical Emergency Response Certifications	All	On-site certification tracking logs	• All staff ◦ Providers (ACLS) ◦ Nursing (BLS/CPR) • Custody (CPR/BLS)
MIT 15.108	Nursing Staff and Pharmacist in Charge Professional Licenses and Certifications	All	On-site tracking system, logs, or employee files	• All required licenses and certifications

Quality Indicator	Sample Category	No. of Samples	Data Source	Filters
Administrative Operations				
MIT 15.109	Pharmacy and Providers' Drug Enforcement Agency (DEA) Registrations	All	On-site listing of provider DEA registration #s & pharmacy registration document	• All DEA registrations
MIT 15.110	Nursing Staff New Employee Orientations	All	Nursing staff training logs	• New employees (hired within last 12 months)
MIT 15.998	Death Review Committee	2	OIG summary log: deaths	• Between 35 business days & 12 months prior • California Correctional Health Care Services death reviews

California Correctional Health Care Services' Response

November 8, 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 Folsom State Prison (FSP) conducted from April to September 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) 621-9709.

Sincerely,

Erin Hoppin Digitally signed by Erin Hoppin Date: 2021.11.08 09:46:18 -08'00'

Erin Hoppin
Associate Director
Risk Management Branch
California Correctional Health Care Services

cc: Diana Toche, D.D.S., Undersecretary, Health Care Services, CDCR
Clark Kelso, Receiver
Richard Kirkland, Chief Deputy Receiver
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 I, CCHCS
Regional Deputy Medical Executive, Region I, CCHCS
Regional Nursing Executive, Region I, CCHCS
Chief Executive Officer, FSP
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

Folsom State Prison

OFFICE *of the*
INSPECTOR GENERAL

Roy W. Wesley
Inspector General

Bryan B. Beyer
Chief Deputy Inspector General

STATE *of* CALIFORNIA
November 2021

OIG