Amarik K. Singh, *Inspector General*

OIG | OFFICE *of the* INSPECTOR GENERAL

Independent Prison Oversight

March 2022

Cycle 6

Medical Inspection Report

Pelican Bay State Prison

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Introduction

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

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

We continue to review institutional care using 15 indicators, as in prior cycles. Using each of these indicators, our compliance inspectors collect data in answer to compliance- and performance-related questions as established in the *medical inspection tool* (MIT).[4] We determine a total compliance score for each applicable indicator and consider the MIT scores in the overall conclusion of the institution's performance. In addition, our clinicians complete document reviews of individual cases and 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 in Cycle 5, our office continues to inspect both those institutions remaining under federal receivership and those delegated back to the department. There is no difference in the standards used for assessing a delegated institution versus an institution not yet delegated. At the time of the Cycle 6 inspection of Pelican Bay State Prison (PBSP), the receiver had delegated this institution back to the department.

We completed our sixth inspection of PBSP, and this report presents our assessment of the health care provided at that institution during the inspection period between November 2020 and April 2021.[6] The data obtained for PBSP and the on-site inspections occurred during the COVID-19 pandemic.[7]

PBSP is located in Crescent City in Del Norte County. PBSP has one Level I minimum-security yard, one facility housing Level II patients, and two Level IV yards housing maximum-security patients in a general population setting. In addition, PBSP has a security housing unit (SHU) facility, which was designed for individuals who present serious management concerns, including prison gang members and violent maximum-security patients. The institution operates multiple clinics where medical staff handle nonurgent requests for medical services. It also provides inpatient care at its correctional treatment center (CTC) and treats patients needing urgent or emergent care in its triage and treatment area (TTA). PBSP has been designated by CDCR as a *basic care prison*, secondary to its location in a rural area away from tertiary care centers and specialty care providers whose services would likely be frequently used by higher-risk patients.

[6] Samples are obtained per case review methodology shared with stakeholders in prior cycles. The case reviews include cardiopulmonary resuscitation (CPR) reviews between August 2020 and February 2021, death reviews between January 2020 and March 2021, and RN sick call reviews between August 2020 and April 2020.

[7] As of October 5, 2021, the department reports on its public tracker that 78% of the incarcerated population at PBSP is fully vaccinated while 42% of PBSP staff are fully vaccinated: https://www.cdcr.ca.gov/covid19/population-status-tracking/

Summary

We completed the Cycle 6 inspection of PBSP in September 2021. OIG inspectors monitored the institution's medical care that occurred between November 2020 and April 2021.

The OIG rated the overall quality of health care at PBSP as ***adequate.*** We list the individual indicators and ratings applicable to this institution in the *PBSP Executive Summary Table* below.

Table 1. PBSP Summary Table

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

* 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 315 patient records and 874 data points and used the data to answer 87 policy questions. In addition, we observed PBSP's processes during an on-site inspection in June 2021. Table 2 below lists PBSP's average scores from Cycles 4, 5, and 6.

Table 2. PBSP Policy Compliance Scores

Scoring Ranges

100%–85.0%	84.9%–75.0%	74.9%–0

Medical Inspection Tool (MIT)	Policy Compliance Category	Cycle 4 Average Score	Cycle 5 Average Score	Cycle 6 Average Score
1	Access to Care	89.4%	86.5%	79.7%
2	Diagnostic Services	89.8%	75.2%	82.2%
4	Health Information Management	44.3%	83.1%	64.2%
5	Health Care Environment	85.0%	71.5%	67.9%
6	Transfers	93.8%	56.0%	77.1%
7	Medication Management	87.7%	72.2%	64.4%
8	Prenatal and Postpartum Care	N/A	N/A	N/A
9	Preventive Services	76.4%	95.5%	83.4%
12	Reception Center	N/A	N/A	N/A
13	Specialized Medical Housing	98.0%	95.0%	85.0%
14	Specialty Services	83.3%	91.0%	54.2%
15	Administrative Operations	74.4%*	84.3%	86.5%

* 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.

The OIG clinicians (a team of physicians and nurse consultants) reviewed 47 cases, which contained 950 patient-related events. After examining the medical records, our clinicians conducted a follow-up on-site inspection to verify their initial findings. The OIG physicians rated the quality of care for 20 comprehensive case reviews. Of these 20 cases, our physicians rated 18 ***adequate*** and 2 ***inadequate***. Our physicians did not identify any 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 13 health care indicators. 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 PBSP Summary Table.

In May 2021, the Health Care Services Master Registry showed that PBSP had a total population of 2,085. A breakdown of the medical risk level of the PBSP population as determined by the department is set forth in Table 3 below.[8]

Table 3. PBSP Master Registry Data as of May 14, 2021

Medical Risk Level	Number of Patients	Percentage
High 1	17	0.8%
High 2	93	4.5%
Medium	489	23.5%
Low	1,486	71.3%
Total	**2,085**	**100.0%**

Source: Data for the population medical risk level were obtained from the CCHCS Master Registry dated 5-14-21.

[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, Pelican Bay State Prison had zero vacant executive leadership positions, two vacant primary care provider positions, 1.7 vacant nursing supervisor positions, and 31.6 vacant nursing staff positions.

Table 4. PBSP Health Care Staffing Resources as of May 2021

Positions	Executive Leadership*	Primary Care Providers	Nursing Supervisors	Nursing Staff†	Total
Authorized Positions	6.0	5.0	10.7	86.6	108.3
Filled by Civil Service	6.0	4.0	9.0	55.0	74.0
Vacant	0	2.0	1.7	31.6	35.3
Percentage Filled by Civil Service	100.0%	80.0%	84.1%	63.5%	68.3%
Filled by Telemedicine	0	0	0	0	0
Percentage Filled by Telemedicine	0%	0%	0%	0%	0%
Filled by Registry	0	1	0	20	21.0
Percentage Filled by Registry	0%	20.0%	0%	23.1%	19.4%
Total Filled Positions	6.0	5.0	9.0	75.0	95.0
Total Percentage Filled	**100.0%**	**100.0%**	**84.1%**	**86.6%**	**87.7%**
Appointments in Last 12 Months	0	2	1	17	20
Redirected Staff	0	0	0	0	0
Staff on Extended Leave‡	0	0	0	6	6
Adjusted Total: Filled Positions	**6**	**5**	**9**	**69**	**89**
Adjusted Total: Percentage Filled	**100%**	**100%**	**84.1%**	**79.7%**	**82.2%**

* Executive Leadership includes the Chief Physician and Surgeon.

† Nursing Staff includes 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 May 2021, 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. An adverse event occurs when the deficiency caused harm to the patient, highlighting the serious consequences, and providing an impetus for improvement.[9] All major health care organizations identify and track adverse events. The OIG identifies deficiencies and adverse events for the benefit of the institution's quality improvement program.

The OIG did not find any adverse deficiencies at PBSP during the Cycle 6 inspection period.

Case Review Results

OIG case reviewers assessed 10 of the 13 indicators applicable to PBSP. Of these 10 indicators, OIG clinicians rated one ***proficient***, nine ***adequate*** and zero ***inadequate***. The OIG physicians also rated the overall adequacy of care for each of the 20 detailed case reviews they conducted. Of these 20 cases, none were ***proficient***, 18 were ***adequate***, and two were ***inadequate***. In the 950 events reviewed, there were 129 deficiencies, 30 of which the OIG clinicians considered to be of such magnitude that, if left unaddressed, would likely contribute to patient harm.

Our clinicians found the following strengths at PBSP:

- Correctional treatment center staff provided good quality medical care.
- Staff utilized built-in messaging to communicate patient care issues quickly and to ensure timely care. On several occasions specialty nurses messaged providers to ensure timely follow-up appointments and orders.
- Providers made good decisions during emergent or urgent situations.

Our clinicians found PBSP could improve in the following areas:

- During the Covid-19 pandemic, providers should more carefully consider whether a patient encounter could be postponed safely.

[9]For a definition of an event, see Table A–1, page 73.

Compliance Testing Results

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

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

- Providers performed well in completing history and physical examinations within the required time frames.
- Because the institution's specialized medical housing unit had working call buttons, medical staff were able to enter patient rooms in a timely manner during emergent events.
- Providers performed exceptionally well in endorsing and communicating diagnostic services results according to CCHCS policy.
- Nursing staff received and reviewed health care services request forms and conducted face-to-face encounters within policy time frames.

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

- The institution did not perform well in providing specialty services to patients with approved high-priority, medium-priority, and routine-priority orders.
- Providers often did not review specialty services reports within the required time frames.
- Patients did not timely receive their ordered chronic care medications and hospital discharge medications; patients with a temporary layover at PBSP also did not receive their medications timely.

Population-Based Metrics

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

HEDIS Results

We considered PBSP's performance with population-based metrics to assess the macroscopic view of the institution's health care delivery. PBSP's results compared favorably with those found in State health plans for diabetic care measures. We list the nine 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), PBSP performed better in all three diabetic measures that have statewide comparative data: HbA1c screening, Poor HbA1c control, and blood pressure control.

Immunizations

Statewide comparative data were not available for immunization measures; however, we include this data for informational purposes. PBSP had a 55 percent influenza immunization rate for adults 18 to 64 years old, and a 63 percent influenza immunization rate for adults 65 years of age and older.[10] The pneumococcal vaccine rate was 70 percent.[11]

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

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

Colorectal Cancer Screening

Statewide comparative data were not available for colorectal cancer screening; however, we include these data for informational purposes. PBSP had an 81 percent colorectal cancer screening rate.

Table 5. PBSP Results Compared with State HEDIS Scores

HEDIS Measure	PBSP Cycle 6 Results*	California Medi-Cal 2018†	California Kaiser NorCal Medi-Cal 2018†	California Kaiser SoCal Medi-Cal 2018†
HbA1c Screening	**100%**	90%	94%	96%
Poor HbA1c Control (> 9.0%) ‡, §	**19%**	34%	25%	18%
HbA1c Control (< 8.0%) ‡	69%	–	–	–
Blood Pressure Control (< 140/90) ‡	**86%**	65%	78%	84%
Eye Examinations	80%	–	–	–
Influenza – Adults (18–64)	55%	–	–	–
Influenza – Adults (65+)	63%	–	–	–
Pneumococcal – Adults (65+)	70%	–	–	–
Colorectal Cancer Screening	81%	–	–	–

Notes and Sources

* Unless otherwise stated, data were collected in June 2021 by reviewing medical records from a sample of PBSP'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). www.dhcs.ca.gov/documents/MCQMD/CA2019-20-EQR-Technical-Report-Vol3-F2.pdf

‡ For this indicator, the entire applicable PBSP 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 PBSP's performance, we offer the following recommendations to the department:

Access to Care

- Medical leadership should determine the root cause(s) of challenges in the timely provision of chronic care follow-up appointments with providers, nurse-to-provider referrals and implement remedial measures as appropriate.

- 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 cancelled 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.

Emergency Services

- Nursing leadership should provide additional training to staff for complete documentation of emergency medical events to include all appropriate times, interventions provided, report to EMS personnel, patient reassessments, and communication with the providers.

- The Emergency Medical Response Review Committee (EMRRC) should more thoroughly review emergency response events and accurately detail findings.

Health Information Management

- 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.

Health Care Environment

- Nursing leadership should consider performing random spot checks to ensure staff follow medical supply management protocols.

- Nursing leadership should direct each clinic nurse supervisor to review the monthly emergency medical response bag (EMRB)

and treatment cart logs to ensure the EMRBs and treatment carts are regularly inventoried, sealed, and meet the minimum par level.

Transfers

- Nursing leadership should develop and implement internal auditing of staff to ensure complete and thorough assessments for patients returning from hospitalizations.

- Healthcare leadership should consider adjusting the initial health screening form to add the symptom of fatigue for tuberculosis (TB) symptom monitoring and screening.

Medication Management

- Medical and nursing leadership should ensure that chronic care, hospital discharge, and en route patients receive their medications timely and without interruption.

Nursing Performance

- Nursing leadership should determine the root cause of challenges that prevent outpatient nurses from performing complete assessments and implement remedial measures as appropriate, including training of staff.

- Nursing leadership should determine the causes that prevent PBSP correctional treatment center (CTC) nurses from performing complete assessments and proper wound care, and implement remedial measures as appropriate, including training of staff.

Provider Performance

- Medical leadership should consider reminding providers to carefully review charts before rescheduling appointments due to COVID-19 Interim Guidelines.[12]

- Medical leadership should remind providers to document their rationale for not following specialists' recommendations.

Specialized Medical Housing

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

[12] https://cchcs.ca.gov/covid-19-interim-guidance/

- Nursing leadership should provide additional training on complete assessments including CCHCS policy on abnormal vital signs.

- PBSP leadership should formulate a plan to ensure handwritten documents are collected and scanned into the patient's chart in a timely manner.

- Nursing leadership should ensure that the initial assessments are completed within the required timeframe as stated in CCHCS policy.

Specialty Services

- Medical leadership should ensure that the institution timely receive and review the specialty reports.

- Medical leadership should determine the root cause(s) of challenges in the timely provision of specialty appointments and implement remedial measures as appropriate.

Access to Care

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

Overall Rating
Adequate

Case Review Rating
Adequate

Compliance Score
Adequate
(79.7%)

Results Overview

PBSP provided good access to care in the context of the COVID-19 pandemic. The comparison of PBSP's performance in Cycle 6 with its performance during Cycle 5 presented a unique challenge with respect to the COVID-19 pandemic and its repercussions throughout the correctional health care system. We considered specific concerns affecting PBSP during the review period such as reducing unnecessary appointments to minimize spread. However, it is imperative not to reschedule or cancel appointments when patients clinically need to be seen. The OIG case reviewers evaluated each case with the understanding that these circumstances may have impacted patient care. We did not consider postponed appointments to be deficiencies insofar as the provider's assessments met standards of care. However, in some instances, providers postponed or canceled appointments when patients should have been seen. This is discussed in the *Provider Performance* indicator.

Access to providers was mixed in the outpatient setting and in specialty services. PBSP provided excellent access to follow-up care after hospitalizations and after TTA encounters, and provided excellent access to CTC providers. PBSP provided good access to nurses and acceptable access to care following specialty appointments. After reviewing the case review and compliance results, we considered the context of the pandemic, the ongoing outbreak during the review period, and the clinical background of the cases. Ultimately, we rated this indicator as ***adequate***.

Case Review and Compliance Testing Results

We reviewed 140 provider, nursing, specialty, and hospital events that required the institution to generate appointments. We identified eight deficiencies relating to *Access to Care*, four of which were significant.[13]

Access to Clinic Providers

PBSP had mixed performance providing access to provider-ordered follow-up appointments. Case review clinicians found no deficiencies in the scheduling of provider appointments, while compliance testing showed poor access to chronic care follow-up appointments (MIT 1.001, 58.3%) and nursing to primary care provider sick call referrals (MIT 1.005, 72.7%). The differing results found by case review compared to compliance testing is attributed to case review clinicians taking into account that appointments were rescheduled due to the interim COVID-19 guidelines.[14] While in some instances the provider should have seen the patient, it was appropriate for other appointments to be rescheduled during the pandemic to minimize COVID-19 transmission. The instances in which we felt the patient should have been seen are discussed in the Provider Performance indicator, as it was the provider's decision to reschedule the patient.

Access to Specialized Medical Housing Providers

PBSP provided excellent access to specialized medical housing providers. Providers performed admission histories and physicals timely (MIT 13.002 90.0%). Case review clinicians did not find any deficiencies in access to providers in the correctional treatment center (CTC). The providers saw patients according to policy guidelines.

Access to Clinic Nurses

PBSP provided good access to RN sick call most of the time. Both case review and compliance inspectors noted that nursing staff triaged sick call requests the same day they were received (MIT 1.003, 100%). Compliance inspectors identified that patients had a face-to-face assessment within one business day of the sick call triage most of the time (MIT 1.004, 93.3%). However, OIG clinicians reviewed several sick calls that were canceled or rescheduled due to COVID-19 guidelines and believe the patients should have been seen. Examples are described in the cases below:

[13] Access to Care deficiencies were found in cases 1, 6, 11, 12, 18, and 20. Significant deficiencies occurred in cases 1, 18, and 20.

[14] https://cchcs.ca.gov/covid-19-interim-guidance/

- In case 18, a patient submitted a sick call request with complaints of severe skin pain, red bumps on his back, clear yellow drainage from under his arms, and creases on his arms and behind his legs for three days. Even though the patient documented he had yellow drainage, which could be a sign of infection, the nurse who reviewed the sick call determined a visit was not necessary. This was the third time within the past month an appointment was deferred. Appointments for this patient continued to be canceled and the patient was eventually hospitalized with sepsis, cellulitis, and dehydration.

- In case 1, a patient without a history of migraines or headaches submitted a sick call request with a complaint of severe headaches due to sunlight and bright lights. The nurse reviewed the appointment, and deemed the request nonessential. Two and a half months later, the patient submitted another sick call request with complaint of numbness to the right arm and the nurse requested an appointment within one business day instead of the same day. Before the patient could appear for the face-to-face appointment, he was sent to the hospital with slurred speech, asymmetrical gait, drooping to right side of the face, and right extremity weakness. He was diagnosed with a hemorrhagic stroke.

We reviewed events in which patients had provider-to-nurse referrals, care manager referrals, and care coordinator referrals. These appointments occurred as scheduled and we did not identify any delays or deficiencies.

Access to Specialty Services

PBSP had mixed performance with access to specialty services as case review clinicians did not assign deficiencies in cases where off-site specialists canceled appointments or appointments were canceled due to quarantine. Compliance testing revealed poor access to high-priority specialty consults (MIT 14.001, 25.0%), medium-priority consults (MIT 14.004, 20.0%), and routine-priority consults (MIT 14.007, 66.7%). Specialty follow-up appointment access after high-priority specialty visits was also poor (MIT 14.003, 50.0%); however, provider follow-up appointment access after medium and routine priority specialty visits was acceptable (MIT 14.006, 85.7% and MIT 14.009, 80.0%).

Follow-Up After Specialty Services

PBSP providers followed up with patients after specialty appointments (MIT 1.008, 87.5%). Case reviewers identified that in several cases,

specialty nurses appropriately messaged providers to ensure patients received follow-up that the specialists recommended.

Follow-up After Hospitalization

PBSP provided excellent provider follow-ups after hospitalization; neither case review nor compliance testing identified any deficiencies. (MIT 1.007, 100%). Communication between nurses and providers helped ensure that all recommendations regarding patient care were followed.

Follow-Up After Urgent or Emergent Care (TTA)

PBSP followed up with patients after urgent or emergent care in the TTA. Case review clinicians did not find any follow up access to care deficiencies for patients who were evaluated in the TTA.

Follow-Up for Patients Transferring Into the Institution

PBSP had mixed performance providing follow-up appointments for patients transferring into the institution. A fair percentage of newly arrived patients were seen timely (MIT 1.002, 76.0%).

Clinician On-Site Inspection

Most deficiencies identified by case review clinicians were due to face-to-face nursing appointments which were either rescheduled or did not occur, related to COVID-19 guidelines. PBSP managers explained that the deficiencies were due to interim COVID-19 guidelines to minimize movement and reserve face-to-face encounters for urgent and emergent care only. PBSP leadership assigned the supervising registered nurse (SRN) II the role of reviewing all nursing appointment orders and postponing any they deem nonessential. OIG clinicians evaluated deficiencies in light of the challenges imposed by the COVID-19 pandemic and considered the remaining deficiencies to be instances in which a patient with a postponed appointment needed to be seen much sooner.

During our on-site visit, we were unable to tour facility A and B clinics, as all quarantine and isolation patients were housed in these areas, and facility B clinic was being utilized to monitor and treat COVID-19 positive patients. On the first day of the on-site visit, no clinic lines were being run because the entire institution was undergoing mass COVID testing. On the second day of the on-site visit, we were able to tour the facility C and D clinics where patients were being seen. One nurse advised they normally receive approximately nine sick call requests per day and perform an average of five to six face-to-face

assessments daily. Due to nursing staffing shortages, clinic RNs were redirected to assist in other areas of the institution. Staff reported that facility C clinic typically had no backlog of patient visits. However, on the day of our visit, they reported that they had backlog of patient visits, which they attributed to a COVID-19 outbreak in the community and in the institution.

On both days of our on-site visit, OIG clinicians remotely attended the daily all-staff meetings, which were led by the CEO. After the roll call noting that all clinical areas were present, staff were advised of pertinent information such as areas in quarantine or isolation, any patients on hunger strike, suspension of patient lines due to mass testing, and suspension of the incoming transfer bus. The meetings were short but very informative. We were also able to attend the provider huddle led by the chief medical executive (CME). This meeting covered information concerning COVID-positive patients, treatment regimens, emergent transfers to a higher level of care, hospital returns, and specialty appointments. On the second day, we monitored the C yard huddle, which was extremely thorough and included information regarding all aspects of the huddle script. There appeared to be good communication from leadership and clinical staff concerning patient care.

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) *	14	10	1	58.3%
For endorsed patients received from another CDCR institution: Based on the patient's clinical risk level during the initial health screening, was the patient seen by the clinician within the required time frame? (1.002) *	19	6	0	76.0%
Clinical appointments: Did a registered nurse review the patient's request for service the same day it was received? (1.003) *	30	0	0	100%
Clinical appointments: Did the registered nurse complete a face-to-face visit within one business day after the CDCR Form 7362 was reviewed? (1.004) *	28	2	0	93.3%
Clinical appointments: If the registered nurse determined a referral to a primary care provider was necessary, was the patient seen within the maximum allowable time or the ordered time frame, whichever is the shorter? (1.005) *	8	3	19	72.7%
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) *	0	0	30	NA
Upon the patient's discharge from the community hospital: Did the patient receive a follow-up appointment within the required time frame? (1.007) *	2	0	0	100%
Specialty service follow-up appointments: Did the clinician follow-up visits occur within required time frames? (1.008) *, †	7	1	26	87.5%
Clinical appointments: Do patients have a standardized process to obtain and submit health care services request forms? (1.101)	3	3	0	50.0%
Overall percentage (MIT 1): **79.7%**				

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

† CCHCS changed its 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) *	NA	NA	NA	NA
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) *	NA	NA	NA	NA
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) *	9	1	0	90.0%
For OHU, CTC, SNF, and Hospice (applicable only for samples prior to 4/2019): Did the primary care provider complete the Subjective, Objective, Assessment, and Plan notes on the patient at the minimum intervals required for the type of facility where the patient was treated? (13.003) *	0	0	10	NA
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) *	1	3	0	25.0%
Did the patient receive the subsequent follow-up to the high-priority specialty service appointment as ordered by the primary care provider? (14.003) *	1	1	2	50.0%
Did the patient receive the medium-priority specialty service within 15–45 calendar days of the primary care provider order or the Physician Request for Service? (14.004) *	3	12	0	20.0%
Did the patient receive the subsequent follow-up to the medium-priority specialty service appointment as ordered by the primary care provider? (14.006) *	6	1	8	85.7%
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) *	10	5	0	66.7%
Did the patient receive the subsequent follow-up to the routine-priority specialty service appointment as ordered by the primary care provider? (14.009) *	4	1	10	80.0%

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

† CCHCS changed its policies and removed mandatory minimum rounding intervals for patients located in specialized medical housing. After April 2, 2019, MIT 13.003 only applied to CTCs that still 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.

Recommendations

- Medical leadership should determine the root cause(s) of challenges in the timely provision of chronic care follow-up appointments with providers, nurse-to-provider referrals and implement remedial measures as appropriate.

- 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 cancelled 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.

Diagnostic Services

Overall Rating **Adequate**

Case Review Rating ***Adequate***

Compliance Score ***Adequate* (82.2%)**

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

During this review period, PBSP performed well in completing and retrieving diagnostic tests. Due to COVID-19 testing, PBSP conducted four times the number of diagnostic tests it conducted in Cycle 5. Case reviewers found good test completion and management of diagnostic reports. Compliance testing showed untimely management of pathology information and incomplete patient notification letters. After considering the various aspects of diagnostic services, the OIG rated this indicator ***adequate***.

Case Review and Compliance Testing Results

We reviewed 391 diagnostic events and found six deficiencies, one of which was significant. Of those six deficiencies, we found four related to health information management and one pertained to the completion of diagnostic tests.[15]

For health information management, we consider test reports that were never retrieved or reviewed to be a problem as severe as tests that were never performed.

Test Completion

PBSP's performance in completing diagnostic tests was mixed. Compliance testing found excellent radiology test completion (MIT 2.001, 100%) and poor laboratory test completion (MIT 2.004, 50.0%). Case review clinicians found only one deficiency related to delayed completion of a laboratory test.

Health Information Management

Management of diagnostic services is critical, as therapy and decision-making rely on accurate and timely information. PBSP providers had excellent performance reviewing radiology studies (MIT 2.002, 100%), laboratory studies (MIT 2.005, 100%), and pathology reports (MIT 2.011,

[15] Diagnostic deficiencies were found in cases 16, 17, 22, 45, and 47.

100%). However, the institution needed improvement with retrieval of pathology reports (MIT 2.010, 33.3%) and communication of pathology results with patients (MIT 2.012, 66.7%). Case review clinicians identified four deficiencies; two were related to delayed endorsements and the other two were due to the provider not sending notification letters to the patients.

Clinician On-Site Inspection

Case review clinicians interviewed leadership, supervisors, and providers about diagnostic workflows and deficiencies. Diagnostic supervisors indicated they have increased their oversight to ensure diagnostic results are sent to providers for their endorsements.

The providers reported they had no issues with laboratory services or radiology services, as diagnostic tests occurred timely, and providers had access to the results. The providers were also aware they were required to send notification letters to patients to inform them of the diagnostic results.

Compliance Testing Results

Table 8. Diagnostic Services

Compliance Questions	Scored Answer Yes	No	N/A	Yes %
Radiology: Was the radiology service provided within the time frame specified in the health care provider's order? (2.001) *	10	0	0	100%
Radiology: Did the ordering health care provider review and endorse the radiology report within specified time frames? (2.002) *	10	0	0	100%
Radiology: Did the ordering health care provider communicate the results of the radiology study to the patient within specified time frames? (2.003)	9	1	0	90.0%
Laboratory: Was the laboratory service provided within the time frame specified in the health care provider's order? (2.004) *	5	5	0	50.0%
Laboratory: Did the health care provider review and endorse the laboratory report within specified time frames? (2.005) *	10	0	0	100%
Laboratory: Did the health care provider communicate the results of the laboratory test to the patient within specified time frames? (2.006)	10	0	0	100%
Laboratory: Did the institution collect the STAT laboratory test and receive the results within the required time frames? (2.007) *	NA	NA	NA	NA
Laboratory: Did the provider acknowledge the STAT results, OR did nursing staff notify the provider within the required time frames (2.008) *	NA	NA	NA	NA
Laboratory: Did the health care provider endorse the STAT laboratory results within the required time frames? (2.009)	NA	NA	NA	NA
Pathology: Did the institution receive the final pathology report within the required time frames? (2.010) *	1	2	0	33.3%
Pathology: Did the health care provider review and endorse the pathology report within specified time frames? (2.011) *	3	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)	2	1	0	66.7%
			Overall percentage (MIT 2):	**82.2%**

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

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

Recommendations

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

Emergency Services

Overall Rating
Adequate

Case Review Rating
Adequate

Compliance Score
(N/A)

In this indicator, OIG clinicians evaluated the quality of emergency medical care. Our clinicians reviewed emergency medical services by examining the timeliness and appropriateness of clinical decisions made during medical emergencies. Our evaluation included examining the emergency medical response, cardiopulmonary resuscitation (CPR) quality, triage and treatment area (TTA) care, provider performance, and nursing performance. Our clinicians also evaluated the Emergency Medical Response Review Committee's (EMRRC) ability to identify problems with its emergency services. The OIG assessed the institution's emergency services through case review only; we did not perform compliance testing for this indicator.

Results Overview

PBSP generally delivered good emergency care. Compared to Cycle 5, OIG clinicians reviewed slightly fewer events but identified more deficiencies. The prior cycle identified five significant deficiencies while in Cycle 6, we only identified one significant deficiency. Providers performed very well in providing emergency care. Staff provided timely and appropriate care most of the time, but did not always document accordingly. One area of concern was review of the emergency medical response (EMR) audits when transferring patients to a higher level of care. While the audits were completed timely, they did not identify areas of performance improvement in approximately half of the cases. More thorough audits would assist management in identifying additional training opportunities for staff. Taking all aspects into account, the OIG rated this indicator as ***adequate***.

Case Review Results

We reviewed 20 urgent or emergent events and identified 16 emergency care deficiencies, only one of which was considered significant.[16]

Emergency Medical Response

PBSP staff responded promptly to emergencies throughout the institution. Medical and custody staff worked cohesively to initiate care, activate EMS, and transfer patients to a higher level of care when applicable. OIG clinicians did not identify any significant deficiencies in PBSP's emergency response.

[16] Deficiencies in emergency services were identified in cases 1, 2, 3, 6, 16, 17, 18, and 20. The only significant deficiency was identified in case 17.

Cardiopulmonary Resuscitation Quality

PBSP performed well in this subindicator. The OIG clinicians reviewed four cases that required cardiopulmonary resuscitation (CPR).[17] Medical personnel initiated CPR in three of the cases. Custody staff initiated CPR when medical staff arrived on scene for the other case. The patients were assessed, and appropriate interventions were initiated. Staff utilized the automated external defibrillator (AED), assisted ventilations, provided narcotic reversal medications, checked blood sugar levels, and requested 9-1-1 without delay. The following case is an example of appropriate emergency response and interventions:

- In case 3, a patient had a seizure, which was witnessed by staff, and fell to the ground. Five medical staff responded and provided care. When the patient became pulseless, CPR was initiated, and the AED was utilized. The patient received electrical shocks and four doses of narcotic reversal medication. Emergency medical services (EMS) arrived, received report, and continued care. The patient's pulse returned and the patient ultimately survived a cardiac arrest.

Provider Performance

PBSP providers performed excellently in urgent, emergent, and after-hours care. In the cases we reviewed, providers considered diagnoses appropriately and sent patients to the hospital when necessary. They documented contact by the TTA nurses and urgent co-consults. We did not identify any provider deficiencies in emergent or urgent care.

Nursing Performance

PBSP nurses performed well most of the time for emergency events. Patients housed in COVID-19 quarantine were seen in the B yard clinic to prevent possible spread of the COVID-19 virus. Nursing staff evaluated patients and obtained initial vital signs, which were relayed to providers. Patients were usually monitored appropriately with the exception of the case described below:

- In case 17, a medical alarm was activated for a patient complaining of abdominal pain with nausea and rectal bleeding. Nursing staff responded and transported the patient to the clinic. The patient presented with a rapid heart rate. A nurse did not obtain orthostatic vital signs, nor did the nurse recheck the vital signs during the entire two hours the patient was at the clinic. The patient was seen by a provider, who

[17] CPR was performed on patients in cases 3, 4, 5, and 6.

consulted with the chief physician and surgeon, and ordered that the patient transfer to a higher level of care.

Nursing Documentation

While nurses responded quickly and provided appropriate interventions most of the time, nursing documentation was an area in need of improvement. Frequently, PBSP nurses failed to document times for emergent transfers to a higher level of care as required by policy, did not document handoff reports to EMS or the off-site ER, and failed to document patients' conditions prior to transfer. We identified a lack of documentation of medications provided during emergency events in the medication administration record (MAR). Although documentation deficiencies were the most commonly identified during urgent and emergent events, these documentation deficiencies are considered minor and did not significantly increase the risk of harm to patients.

Emergency Medical Response Review Committee

While the EMRRC met monthly and discussed pertinent findings obtained from the EMR audits, in seven of the 14 audits we reviewed, we identified missing or conflicting times and information, and poor identification of deficiencies by supervisory staff.[18] The OIG compliance team found incomplete checklists, missing entries, and missing time documentation (MIT 15.003, 25.0%).

Clinician On-Site Inspection

OIG clinicians toured the triage and treatment area (TTA) during our on-site visit. The TTA has two bays. We were advised one bay is used for emergent or urgent patients and the other is shared by the off-site return nurse and specialty clinics. Staffing for the TTA includes an RN rover who responds to all emergencies on the yards and an additional TTA RN for all shifts. The nurses are notified via radio and respond to emergency situations with a van equipped with a Stryker stretcher and emergency response equipment. At PBSP, the pill line staff are first responders. When the institution has simultaneous calls, additional staff is pulled from the correctional treatment center (CTC) or specialty clinic.

During normal business hours, PBSP has a designated provider for the TTA and the provider-on-call is utilized after hours, on weekends, and on holidays. TTA staff advised that there was never a problem reaching

[18] Deficiencies in EMR audits were identified in cases 1, 2, 3, 6, 17, and 20.

the CME or the CP&S. Nursing staff acknowledged that the director of nursing (DON) was a great resource.

Recommendations

- Nursing leadership should provide additional training to staff for complete documentation of emergency medical events to include all appropriate times, interventions provided, report to EMS personnel, patient reassessments, and communication with the providers.

- The Emergency Medical Response Review Committee (EMRRC) should more thoroughly review emergency response events and accurately detail findings.

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 ***Proficient***

Compliance Score ***Inadequate*** **(64.2%)**

Results Overview

PBSP had a mixed performance in this indicator. Case review clinicians identified excellent hospital discharge report performance and good diagnostic, emergency, and specialty report performance. However, compliance scores showed poor performance handling specialty reports and scanning. Factoring the proficient case review score and the poor compliance score, the OIG rated this indicator as ***adequate***.

Case Review and Compliance Testing Results

Our case review team reviewed 950 events and found 9 deficiencies related to health information management. Of these 9 deficiencies, one was significant.[19]

Hospital Discharge Reports

We reviewed 12 off-site emergency department and hospital visits. PBSP staff timely retrieved hospital records, scanned them into the medical record, and reviewed them properly. Case review clinicians did not identify any deficiencies related to hospital discharge reports. While compliance testing showed excellent performance with retrieval and scanning of hospital discharge reports (MIT 4.003, 100%), it also showed the institution did not include a discharge summary in one of the samples (MIT 4.005, 50.0%).

Specialty Reports

PBSP had poor compliance scores for handling specialty reports. PBSP did not always scan specialty reports timely (MIT 4.002, 70.8%), and had late retrieval of high-priority specialty reports (MIT 14.002, 50.0%), late retrieval of medium priority specialty reports (MIT 14.005, 46.7%), and

[19] Health information management deficiencies were identified in cases 10, 16, 17, 18, 21, 22, 45, and 47. A significant deficiency was found in case 18.

late retrieval and endorsement by the provider of routine-priority specialty reports (MIT 14.008, 26.7%). We also discuss these findings in the **Specialty Services** indicator. Case reviewers did not encounter many specialty consultations and there were only a few deficiencies. The following is an example:

- In case 18, a dermatology report was not sent to the provider for review. As a result, the subsequent dermatology follow-up was beyond the time frame the specialist recommended. During our on-site inspection, health information management supervisors acknowledged that a staff member should have sent the report to the provider.

Diagnostic Reports

PBSP performed well in managing diagnostic reports. Compliance testing showed excellent performance in timely reviewing pathology reports (MIT 2.011, 100%), but poor communication of pathology results (MIT 2.012, 66.7%). Case review found that providers generally reviewed and endorsed diagnostic reports and sent notification letters to inform patients timely. However, of the 396 events, we identified three instances in which providers did not endorse the diagnostic results within policy time frames. Please refer to the **Diagnostic Services** indicator for further discussion.

Urgent and Emergent Records

OIG clinicians reviewed 43 emergency care events and found that PBSP nurses performed well in recording these events. Providers recorded their emergency care excellently in the TTA as well as during their role as the provider-on-call. We did not identify any deficiencies pertaining to urgent and emergent records. The **Emergency Services** indicator provides additional details.

Scanning Performance

PBSP had mixed performance in this subindicator. Case review clinicians found good scanning performance. However, compliance testing was poor due to the mislabeling of patient letters as *DDP-Scan* (MIT 4.004, zero); every sample was mislabeled.[20]

Clinician On-Site Inspection

We discussed health information management processes with PBSP health information management supervisors, nurses, and providers.

[20] DDP is Developmental Disability Program.

Providers expressed that diagnostic and specialty reports were available timely. Nursing documentation issues were due to paper charting during EHRS downtime.

Compliance Testing Results

Table 9. Health Information Management

	Scored Answer			
Compliance Questions	**Yes**	**No**	**N/A**	**Yes %**
Are health care service request forms scanned into the patient's electronic health record within three calendar days of the encounter date? (4.001)	20	0	10	100%
Are specialty documents scanned into the patient's electronic health record within five calendar days of the encounter date? (4.002) *	17	7	10	70.8%
Are community hospital discharge documents scanned into the patient's electronic health record within three calendar days of hospital discharge? (4.003) *	1	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) *	1	1	0	50.0%
				Overall percentage (MIT 4): **64.2%**

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

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

Table 10. Other Tests Related to Health Information Management

	Scored Answer			
Compliance Questions	**Yes**	**No**	**N/A**	**Yes %**
Radiology: Did the ordering health care provider review and endorse the radiology report within specified time frames? (2.002) *	10	0	0	100%
Laboratory: Did the health care provider review and endorse the laboratory report within specified time frames? (2.005) *	10	0	0	100%
Laboratory: Did the provider acknowledge the STAT results, OR did nursing staff notify the provider within the required time frames? (2.008) *	NA	NA	NA	NA
Pathology: Did the institution receive the final pathology report within the required time frames? (2.010) *	1	2	0	33.3%
Pathology: Did the health care provider review and endorse the pathology report within specified time frames? (2.011) *	3	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)	2	1	0	66.7%
Did the institution receive and did the primary care provider review the high-priority specialty service consultant report within the required time frame? (14.002) *	2	2	0	50.0%
Did the institution receive and did the primary care provider review the medium-priority specialty service consultant report within the required time frame? (14.005) *	7	8	0	46.7%
Did the institution receive and did the primary care provider review the routine-priority specialty service consultant report within the required time frame? (14.008) *	4	11	0	26.7%

* 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.

Recommendations

- 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.

Health Care Environment

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

Overall Rating
Inadequate

Case Review Rating
(N/A)

Compliance Score
Inadequate
(67.9%)

Results Overview

PBSP's health care environment performance decreased when compared to its Cycle 5 inspection. Various PBSP aspects of the institution's health care environment still needed improvement: multiple clinics contained expired medical supplies, inventories were not performed for emergency medical response bags (EMRBs), and EMRB logs were missing staff verification. These factors resulted in an ***inadequate*** rating for this indicator.

Compliance Testing Results

Outdoor Waiting Areas

We examined outdoor patient waiting areas (see Photo 1). Health care and custody staff reported existing waiting areas had sufficient seating capacity. Staff reported the outdoor waiting area is only utilized when the indoor waiting area is at capacity. Staff also reported they only call patients close to their appointment time during inclement weather.

Photo 1: B clinic outdoor waiting area (photographed June 8, 2021)

Indoor Waiting Areas

We inspected indoor waiting areas (see Photo 2). Health care and custody staff reported existing waiting areas contained sufficient seating capacity. During our inspection, we did not observe overcrowding or noncompliance with social distancing requirements in any of the clinics' indoor waiting areas.

Photo 2: B Clinic indoor waiting area (photographed June 8, 2021)

Clinic Environment

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

Of the 10 clinics we observed, seven contained appropriate space, configuration, supplies, and equipment to allow their clinicians to perform proper clinical examinations (MIT 5.110, 70.0%). In two clinics, the examination room table had torn covers and one of the two clinics also had a torn pillow cover used for physical therapy services (see Photos 3 and 4). The remaining clinic did not allow patients to lie fully extended on the examination table without obstruction (see Photo 5).

Photo 3: Torn examination room table cover (photographed June 8, 2021)

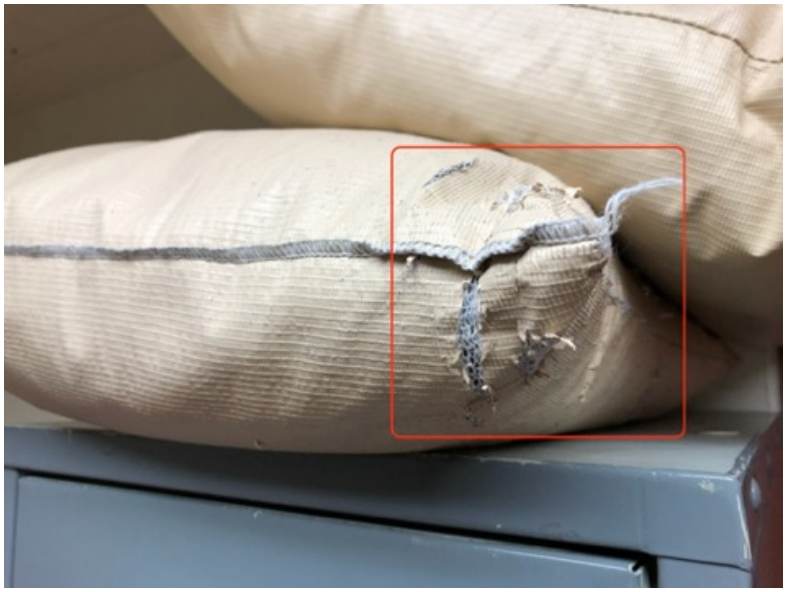


Photo 4: Torn pillow cover used for Physical Therapy services (photographed June 8, 2021)

Photo 5: Examination room configuration did not allow patients to lie fully extended without obstruction (photographed June 10, 2021)

Clinic Supplies

Five of the 10 clinics followed adequate medical supply storage and management protocols (MIT 5.107, 50.0%). We found one or more of the following deficiencies in five clinics: expired medical supplies (see Photo 6), unlabeled medical supplies (see Photo 7), staff members' personal food stored with medical supplies, and compromised sterile medical supply packaging.

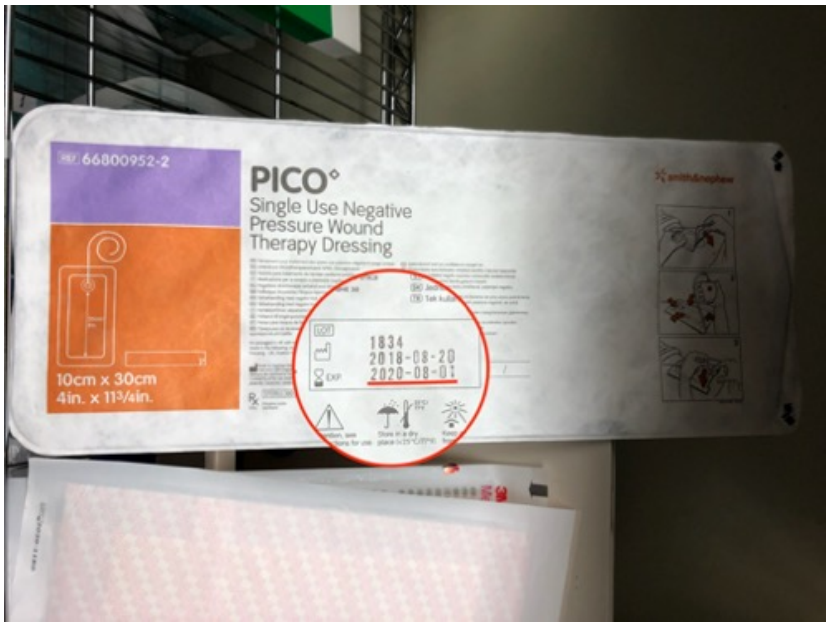


Photo 6: Expired medical supply dated August 1, 2020 (photographed June 8, 2021)

Photo 7: Unlabeled medical supplies (photographed June 9, 2021)

Nine of the eleven clinics met the requirements for essential core medical equipment and supplies (MIT 5.108, 81.8%). The correctional treatment center (CTC) lacked a Snellen chart. CTC staff reported patients are sent to the triage and treatment area (TTA) for eye examinations. In another clinic, we found a nonfunctional oto-opthalmoscope.

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. None of the nine EMRBs passed our test (MIT 5.111, zero). We found one or both of the following deficiencies with all EMRBs: staff failed to ensure EMRB compartments were sealed and intact, and staff had not inventoried the EMRBs when seal tags were replaced. In addition, the treatment carts in the TTA and CTC did not meet the minimum inventory level and lacked documentation indicating reasonable substitutions were made.

Medical Supply Management

All the medical supply storage areas located outside the medical clinics stored medical supplies adequately. However, we found staff's personal food items stored in the pharmacy's designated refrigerator and freezer located in the receiving warehouse. In addition, staff did not record the refrigerator and freezer temperatures. These deficiencies resulted in a score of zero for this test (MIT 5.106).

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

Infection Control and Sanitation

Staff appropriately disinfected, cleaned, and sanitized eight of 11 clinics (MIT 5.101, 72.7%). In one clinic, cleaning logs were not maintained. In two clinics, we found that either the stretcher was unsanitary or the exhaust under the clinic sink had accumulated dust (see Photo 8).

Photo 8: Exhaust under the clinic sink had accumulated dust (photographed June 8, 2021)

Staff in nine of 10 clinics (MIT 5.102, 90.0%) properly sterilized or disinfected medical equipment. In one clinic, staff did not date stamp and initial the packaging of sterilized medical equipment. We found operating sinks and hand hygiene supplies in the examination rooms in nine of 11 clinics (MIT 5.103, 81.8%). The patient restrooms in two clinics lacked antiseptic soap, disposable hand towels, or both antiseptic soap and disposable hand towels.

We observed patient encounters in five clinics. Health care staff in all clinics adhered to universal hand hygiene precautions (MIT 5.104, 100%). Health care staff in all clinics followed proper protocols to mitigate exposure to bloodborne pathogens and contaminated waste (MIT 5.105, 100%).

Physical Infrastructure

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

At the time of our medical inspection, the institution reported the Health Care Facility Improvement Program (HCFIP) project was in progress and included the renovation of Facility C primary clinic that started April 26, 2021. The institution estimated the project would be completed by April 2022. In addition, the renovation of the Clinic D medication distribution room was still in the planning phase (MIT 5.999).

Table 11. Health Care Environment

Compliance Questions	Scored Answer			
	Yes	No	N/A	Yes %
Infection control: Are clinical health care areas appropriately disinfected, cleaned, and sanitary? (5.101)	8	3	0	72.7%
Infection control: Do clinical health care areas ensure that reusable invasive and noninvasive medical equipment is properly sterilized or disinfected as warranted? (5.102)	9	1	1	90.0%
Infection control: Do clinical health care areas contain operable sinks and sufficient quantities of hygiene supplies? (5.103)	9	2	0	81.8%
Infection control: Does clinical health care staff adhere to universal hand hygiene precautions? (5.104)	5	0	6	100%
Infection control: Do clinical health care areas control exposure to blood-borne pathogens and contaminated waste? (5.105)	10	0	1	100%
Warehouse, conex, and other nonclinic storage areas: Does the medical supply management process adequately support the needs of the medical health care program? (5.106)	0	1	0	0
Clinical areas: Does each clinic follow adequate protocols for managing and storing bulk medical supplies? (5.107)	5	5	1	50.0%
Clinical areas: Do clinic common areas and exam rooms have essential core medical equipment and supplies? (5.108)	9	2	0	81.8%
Clinical areas: Are the environments in the common clinic areas conducive to providing medical services? (5.109)	11	0	0	100%
Clinical areas: Are the environments in the clinic exam rooms conducive to providing medical services? (5.110)	7	3	1	70.0%
Clinical areas: Are emergency medical response bags and emergency crash carts inspected and inventoried within required time frames, and do they contain essential items? (5.111)	0	9	2	0
Does the institution's health care management believe that all clinical areas have physical plant infrastructures that are sufficient to provide adequate health care services? (5.999)	This is a nonscored test. Please see the indicator for discussion of this test.			
				Overall percentage (MIT 5): **67.9%**

* 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

Recommendations

- Nursing leadership should consider performing random spot checks to ensure staff follow medical supply management protocols.

- Nursing leadership should direct each clinic nurse supervisor to review the monthly emergency medical response bag (EMRB) and treatment cart logs to ensure the EMRBs and treatment carts are regularly inventoried, sealed, and met the minimum par level.

Transfers

Overall Rating
Adequate

Case Review
Adequate

Compliance Score
Adequate
(77.1%)

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

Results Overview

PBSP performed well in this indicator. Compared to Cycle 5, OIG clinicians reviewed more events and identified almost twice as many deficiencies, although none were significant. While PBSP performed proficiently for the transfer-out process, there was room for improvement in the transfer-in and hospitalization-return processes. Both case review and compliance testing had similar results, and the overall rating was ***adequate***.

Case Review and Compliance Testing Results

We reviewed 35 events in 13 cases in which patients transferred into or out of the institution or returned from an off-site hospital or emergency room. We identified seven deficiencies, none of which were significant.[21]

Transfers In

PBSP's transfer-in process had mixed performance. OIG clinicians reviewed nine events in four cases in which patients transferred into

[21] Deficiencies were identified in cases 5, 17, 18, 20, 23, and 47.

the facility from other institutions. We identified only two minor deficiencies:[22]

- In case 5, an R&R nurse did not recognize a patient was a diabetic and did not check the patient's blood sugar.
- In case 23, a patient arrived to PBSP with his medication but did not receive his evening dose.

Our cases reviewers found nurses generally performed complete initial assessments. However, the case review findings differed from the compliance rating (MIT 6.001, 24.0%). The low compliance score was almost entirely due to staff's failure to ask patients during tuberculosis screenings whether they experienced fatigue.

Similarly, our case reviewers PBSP staff usually ensured medication continuity. This medication continuity findings were also reflected in compliance testing for patients who arrived at the institution (MIT 6.003, 84.2%).

Case review did not identify problems with provider assess or access to high-priority specialty services ordered by the provider upon patients' arrival to PBSP. In compliance findings, although patients were generally seen by the clinician within the required time frame (MIT 1.002, 76.0%), the patients often did not receive specialty services that were ordered by the provider within 14 days (MIT 14.001, 25.0%).

Transfers Out

R&R nurses performed very well in managing medications for patients who transferred out of the institution. There were no identifiable case review deficiencies, which mirrors the Cycle 5 findings. In the cases we reviewed, we found that proper screenings, which include vitals and COVID-19 testing, were conducted. Additionally, we found that patients were transferred out with all durable medical equipment and medications. This correlates with compliance testing in that all patients were transferred with their required medications and documents (MIT 6.101, 100%).

Hospitalizations

Patients returning from an off-site hospitalization or emergency room are at high-risk for lapses in care quality. These patients typically experienced severe illness or injury. They require more care and place strain on the institution's resources. Also, because these patients have

[22] Transfer-in events occurred in cases 5, 18, 23, and 24. Deficiencies were identified in cases 5 and 23.

complex medical issues, the successful transfer of health information is necessary for good quality care. Any lapses can result in serious consequences for these patients.

OIG clinicians reviewed 24 events in nine cases in which patients returned from an off-site hospitalization or emergency room visit. We identified five deficiencies, none of which were significant.[23] While PBSP provided good care, there is opportunity for improvement in this area. Most of the deficiencies we identified related to incomplete assessments and nurses' failure to identify and recheck abnormal vital signs when patients returned to the institution. This can be problematic, as providers rely on information gleaned from nursing staff to make decisions regarding orders and housing. We did not identify any deficiencies with primary care provider follow-up appointments, a finding that coincided with compliance findings (MIT 1.007, 100%). Neither case review nor compliance testing revealed any deficiencies pertaining to the availability of hospital or emergency room summary reports (MIT 4.003, 100%). However, compliance testing noted providers did not always review reports within five calendar days of a patient's discharge (MIT 4.005, 50.0%). Compliance testing also identified that the continuity of hospital recommended medications was inconsistent (MIT 7.003, 50.0%). Case reviewers, however, did not find any clinically relevant medication issues after a patient's hospital discharge, or any issues in the timeliness of providers' review of hospital records.

Clinician On-Site Inspection

During the on-site inspection, OIG clinicians toured the clean and well-organized receiving and release (R&R) area. There were three interview rooms; one of those rooms was equipped as an exam room, and patient scales were placed in the hallway outside the rooms. The RN assigned to the R&R advised us this area had recently been updated. Pertinent policy information, including abnormal vital signs, was displayed in plastic covers for reference. The R&R nurse advised us the facility had recently hired an RN for third watch. Before the addition to the third watch post, a nurse would arrive early to prepare patients for transferring out and would stay late to process patients transferring into the facility. OIG clinicians were advised that licensed correctional clinic (LCC) automated drug delivery system medications were recently made available in the R&R. Before implementation of the LCC medications, the rover RN was notified when patients needed medications and would obtain them from the pharmacy or Omnicell.

[23] Hospitalization or emergency room returns were reviewed in cases 1, 2, 5, 16, 17, 18, 19, 20, and 47. Deficiencies were identified in cases 17, 18, 20, and 47.

When patients arrived at the facility during regular weekday hours, a designated provider reconciled charts and placed orders, and after hours the RN utilized the provider-on-call (POC). The RN we interviewed appeared proficient in the transfer-in and transfer-out processes and was able to answer questions concerning policy and local operating procedures with ease.

During the on-site visit, medical leadership reported that there was a COVID-19 outbreak in the community with a significant number of hospital admissions, and that the bus that was to arrive with patients transferring into the institution had been placed on hold.

Compliance Testing Results

Table 12. Transfers

Compliance Questions	Scored Answers			
	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) *	6	19	0	24.0%
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)	17	0	8	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) *	16	3	6	84.2%
For patients transferred out of the facility: Do medication transfer packages include required medications along with the corresponding transfer packet required documents? (6.101) *	6	0	0	100%
Overall percentage (MIT 6): 77.1%				

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

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

Table 13. Other Tests Related to Transfers

Compliance Questions	Scored Answer			
	Yes	No	N/A	Yes %
For endorsed patients received from another CDCR institution: Based on the patient's clinical risk level during the initial health screening, was the patient seen by the clinician within the required time frame? (1.002) *	19	6	0	76.0%
Upon the patient's discharge from the community hospital: Did the patient receive a follow-up appointment with a primary care provider within the required time frame? (1.007) *	2	0	0	100%
Are community hospital discharge documents scanned into the patient's electronic health record within three calendar days of hospital discharge? (4.003) *	1	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) *	1	1	0	50.0%
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) *	1	1	0	50.0%
Upon the patient's transfer from one housing unit to another: Were medications continued without interruption? (7.005) *	19	6	0	76.0%
For patients en route who lay over at the institution: If the temporarily housed patient had an existing medication order, were medications administered or delivered without interruption? (7.006) *	1	3	0	25.0%
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) *	2	0	0	100%

* 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.

Recommendations

- Nursing leadership should develop and implement internal auditing of staff to ensure complete and thorough assessments for patients returning from hospitalizations.
- Healthcare leadership should consider adjusting the initial health screening form to add the symptom of fatigue for TB symptom monitoring and screening.

Medication Management

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

Overall Rating
Inadequate

Case Review Rating
Proficient

Compliance Score
Inadequate
(64.4%)

Results Overview

PBSP had mixed performance in this indicator. Although case review clinicians did not find many deficiencies in medication management, compliance testing showed PBSP had difficulty distributing chronic care medications, hospital discharge medications, and transfer medications timely. Most of the deficiencies were due to delays in medication administration. Factoring both case review and compliance results, we rated the **Medication Management** indicator ***inadequate***.

Case Review and Compliance Testing Results

We reviewed 125 events in 26 cases related to medication management and found five deficiencies, none of which were significant.[24]

New Medication Prescriptions

Both compliance and case review found PBSP performed well in delivering new medication prescriptions most of the time. This correlates with compliance testing (MIT 7.002, 92.0%). Case review identified a minor deficiency in the following case:

- In case 18, a patient did not receive his ordered medication, prednisone timely. Prednisone was prescribed and filled on three separate occasions. However, the prednisone was administered one and two days late.

Chronic Medication Continuity

PBSP had mixed results in chronic medication continuity. Case review clinicians identified only two minor deficiencies in patients receiving their chronic care medications without interruption. Compliance testing, however, found that PBSP performed poorly and identified that

[24] Deficiencies in medication management were identified in cases 8, 15, and 18.

patients usually received their chronic care medications one to two days late (MIT 7.001, 5.9%). CCHCS policy states keep-on-person medications must be available to patients one business day prior to exhaustion.

Hospital Discharge Medications

Case review and compliance testing again showed different results. Case review did not identify any medication management deficiencies when patients returned from a hospitalization or emergency room visit. However, the compliance team identified that half of the patients who returned from a hospitalization did not receive their needed medications within the required time frames (MIT 7.003, 50.0%). While the institution performed better than in Cycle 5 for this test, the results were still poor and showed room for improvement.

Specialized Medical Housing Medications

Both case review and compliance testing found PBSP performed well most of the time in ensuring patients received their needed medications upon admission to the correctional treatment center. This correlates with compliance findings (MIT 13.004, 80.0%). OIG clinicians did not identify any deficiencies when reviewing cases in which patients were admitted to specialized medical housing.

Transfer Medications

PBSP performed well in ensuring patients who transferred into the institution (MIT 6.003, 84.2%) and those who transferred from yard to yard (MIT 7.005, 76.0%) received their medication timely.We found a documentation discrepancy in one compliance sample. Specifically, we found a nurse who documented medications that were not dispensed due to patients' refusal; however, in the comments section of the medication administration record (MAR), this nurse documented there was no time to dispense medication to a patient. This incongruent documentation presents a serious question regarding medication continuity.[25]

PBSP had mixed performance managing medications for patients who were temporarily housed at the facility and had existing medication orders. Compliance testing found that most patients sampled did not receive their medications without interruption (MIT 7.006, 25.0%). However, case review clinicians identified only one deficiency: a patient

[25] Sample number 25, MIT 7.005.

transferred into the institution with his medications and did not receive his evening dose.

Both case review and compliance testing found PBSP performed proficiently in ensuring all patients who transferred out of the institution received a five-day supply of medications (MIT 6.101, 100%). Additional information is discussed in the **Transfers** indicator.

Medication Administration

Case review and compliance evaluated the institution's performance in administering medications and monitoring patients taking medications, specifically tuberculosis (TB) medications. In the 47 cases the clinicians reviewed, we did not identify any patient receiving TB medications.

PBSP did not have testable compliance samples for MITs 9.001 and 9.002.

Clinician On-Site Inspection

During the on-site visit, OIG clinicians met with the pharmacist and toured the pill lines. The C yard pill line room was small, but clean and well-organized. There were no keep-on-person (KOP) medications pending delivery, and we were advised the pharmacy had yet to deliver the medications for the day. The pill line staff advised that because no patients housed in administrative segregation were classified with mental health status, all of those patients were allowed to have KOP medications in their cells. Staff reported that due to employee shortages, there were a lot of mandates for nursing overtime. We were also advised staff were redirected up to several times per shift.

In the receiving and release area, we observed where the licensed correctional clinic (LCC) automated drug delivery system medications were placed. As discussed in the **Transfers** indicator, these medications had been made available the week before our visit and assisted the nursing staff in providing continuity of medication administration for patients who transferred in and out of the institution.

The OIG team monitored several huddles during the on-site visit and identified there was good communication among each team regarding medication management. Some issues discussed were medication compliance, medications expiring within three days, parole medications, suboxone, specialty medication for COVID-19 patients, and upcoming expiring medication orders.

Medication Practices and Storage Controls

The institution adequately stored and secured narcotic medications in six of nine clinic and medication line locations (MIT 7.101, 66.7%). In three locations, nurses could not describe the narcotic medication discrepancy reporting process. In addition, in one of the three locations, we observed the medication nurse remove narcotic medication from the tackle box in a manner that does not allow spontaneous count.

PBSP appropriately stored and secured nonnarcotic medications in all clinic and medication line locations (MIT 7.102, 100%).

Staff kept medications protected from physical, chemical, and temperature contamination in seven of the 11 clinic and medication line locations (MIT 7.103, 63.6%). In three locations, staff did not separate the storage of oral and topical medications. In one location, nurses stored return-to-pharmacy medications directly on the floor.

Staff successfully stored valid, unexpired medications in eight of the 11 applicable medication line locations (MIT 7.104, 72.7%). In three locations, nurses did not label the multi-use medication as required by CCHCS policy.

Nurses exercised proper hand hygiene and contamination control protocols in four of seven locations (MIT 7.105, 57.1%). In three locations, nurses neglected to wash or sanitize their hands before each subsequent regloving.

Staff in five of seven medication preparation and administration areas demonstrated appropriate administrative controls and protocols (MIT 7.106, 71.4%). In two locations, nurses did not maintain unissued medication in its original, labeled packaging.

Staff in one of seven medication areas used appropriate administrative controls and protocols when distributing medications to their patients (MIT 7.107, 14.3%). In six clinics, medication nurses did not reliably observe patients while they swallowed direct observation therapy medications. In addition, in one of the six clinics, we observed a medication nurse did not follow the CCHCS care guide when administering Suboxone medication.

Pharmacy Protocols

PBSP followed general security, organization, and cleanliness management protocols for nonrefrigerated and refrigerated medications stored in its pharmacy (MIT 7.108, 7.109, and 7.110, 100%).

The pharmacist-in-charge (PIC) did not thoroughly review monthly inventories of controlled substances in the institution's clinic and medication storage locations. Specifically, the nurses present at the time of the medication area inspection did not correctly complete several medication area inspection checklists (CDCR form 7477). These errors resulted in a score of zero for this test (MIT 7.111).

We examined eight medication error reports. The pharmacist-in-charge timely and correctly processed all reports (MIT 7.112, 100%).

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

The OIG interviewed patients in restricted housing units to determine whether they had immediate access to their prescribed asthma rescue inhalers or nitroglycerin medications. Fourteen of 16 applicable patients interviewed indicated they had access to their rescue medications. Two patients reported they did not have their prescribed rescue inhaler. One patient stated he does not need the inhaler, while the other patient stated the medication was taken away and placed in the patient's property when he transferred to the restricted housing unit. We promptly notified the CEO of this concern, and health care management obtained new refusal documentation for one patient, and immediately issued a replacement rescue inhaler to the other patient (MIT 7.999).

Compliance Testing Results

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) *	1	16	8	5.9%
Did health care staff administer, make available, or deliver new order prescription medications to the patient within the required time frames? (7.002)	23	2	0	92.0%
Upon the patient's discharge from a community hospital: Were all ordered medications administered, made available, or delivered to the patient within required time frames? (7.003) *	1	1	0	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) *	NA	NA	NA	NA
Upon the patient's transfer from one housing unit to another: Were medications continued without interruption? (7.005) *	19	6	0	76.0%
For patients en route who lay over at the institution: If the temporarily housed patient had an existing medication order, were medications administered or delivered without interruption? (7.006) *	1	3	0	25.0%
All clinical and medication line storage areas for narcotic medications: Does the institution employ strong medication security controls over narcotic medications assigned to its storage areas? (7.101)	6	3	2	66.7%
All clinical and medication line storage areas for nonnarcotic medications: Does the institution properly secure and store nonnarcotic medications in the assigned storage areas? (7.102)	11	0	0	100%
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)	7	4	0	63.6%
All clinical and medication line storage areas for nonnarcotic medications: Does the institution safely store nonnarcotic medications that have yet to expire in the assigned storage areas? (7.104)	8	3	0	72.7%
Medication preparation and administration areas: Do nursing staff employ and follow hand hygiene contamination control protocols during medication preparation and medication administration processes? (7.105)	4	3	4	57.1%
Medication preparation and administration areas: Does the institution employ appropriate administrative controls and protocols when *preparing* medications for patients? (7.106)	5	2	4	71.4%
Medication preparation and administration areas: Does the institution employ appropriate administrative controls and protocols when *administering* medications to patients? (7.107)	1	6	4	14.3%
Pharmacy: Does the institution employ and follow general security, organization, and cleanliness management protocols in its main and remote pharmacies? (7.108)	1	0	0	100%
Pharmacy: Does the institution's pharmacy properly store nonrefrigerated medications? (7.109)	1	0	0	100%
Pharmacy: Does the institution's pharmacy properly store refrigerated or frozen medications? (7.110)	1	0	0	100%
Pharmacy: Does the institution's pharmacy properly account for narcotic medications? (7.111)	0	1	0	0
Pharmacy: Does the institution follow key medication error reporting protocols? (7.112)	8	0	0	100%
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): **64.4%**			

* 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) *	16	3	6	84.2%
For patients transferred out of the facility: Do medication transfer packages include required medications along with the corresponding transfer-packet required documents? (6.101) *	6	0	0	100%
Patients prescribed TB medication: Did the institution administer the medication to the patient as prescribed? (9.001) *	NA	NA	NA	NA
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) *	NA	NA	NA	NA
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) *	8	2	0	80.0%

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

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

Recommendations

- Medical and Nursing leadership should ensure that chronic care, hospital discharge, and en route patients receive their medications timely without interruption.

Preventive Services

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

Overall Rating
Adequate

Case Review Rating
(N/A)

Compliance Score
Adequate
(83.4%)

Results Overview

PBSP staff performed well in offering patients an influenza vaccine for the most recent influenza season, as it offered colorectal cancer screening for all patients ages 50 through 75, and required immunizations to chronic care patients. However, they faltered in screening patients annually for TB. These findings are set forth in the table on the next page. We rated this indicator ***Adequate***.

Compliance Testing Results

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)	NA	NA	NA	NA
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) †	NA	NA	NA	NA
Annual TB screening: Was the patient screened for TB within the last year? (9.003)	12	13	0	48.0%
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)	25	0	0	100%
Female patients from the age of 50 through the age of 74: Was the patient offered a mammogram in compliance with policy? (9.006)	NA	NA	NA	NA
Female patients from the age of 21 through the age of 65: Was patient offered a pap smear in compliance with policy? (9.007)	NA	NA	NA	NA
Are required immunizations being offered for chronic care patients? (9.008)	12	2	11	85.7%
Are patients at the highest risk of coccidioidomycosis (valley fever) infection transferred out of the facility in a timely manner? (9.009)	NA	NA	NA	NA
			Overall percentage (MIT 9):	**83.4%**

* 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 EHRS PowerForm for tuberculosis symptom monitoring.

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

Recommendations

The OIG offers no specific recommendations for this indicator.

Nursing Performance

Overall Rating
Adequate

Case Review Rating
Adequate

Compliance Score
(N/A)

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

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

Results Overview

PBSP generally delivered acceptable nursing care. Nursing staff performed well in care management, emergency services, transfer services, and specialty services. However, compared to Cycle 5, OIG clinicians identified significantly more deficiencies with a notable number related to COVID-19 nurse rounding and supervisory audits. We identified challenges with registry staff's performance of quarantine and isolation rounds. Our clinicians identified opportunities for improvement in several areas including documentation and assessments. We rated PBSP **Nursing Performance** indicator as ***adequate.***

Case Review Results

We reviewed 182 nursing encounters in 41 cases. Of the nursing encounters we reviewed, 102 were in the outpatient setting. We identified 83 nursing performance deficiencies, 11 of which were significant.[26]

[26] Deficiencies in the quality of nursing care were identified in cases 1, 2, 3, 5, 6, 11, 12, 13, 15, 16, 17, 18, 19, 20, 23, 28, 29, 30, 31, 32, 35, 36, 37, 38, 39, 40, 41, 42, 45, 46, and 47. Significant deficiencies were identified in cases 1, 6, 16, 17, 18, 36, 38, 41, and 47.

Nursing Assessment and Interventions

Most deficiencies related to the quality of nursing care provided at PBSP were due to incomplete or inadequate nursing assessments. During case review, OIG clinicians identified several emergency response events in which nursing staff did not reassess or recheck vital signs for patients who were sent to a higher level of care. We also identified that nurses in both the inpatient and outpatient settings did not follow CCHCS protocol for abnormal vitals and did not recheck vital signs or notify the provider when patients had low heart rates, high heart rates, or elevated blood pressures.[27] Clinic nurses often did not weigh patients during face-to-face assessments and, in several cases, they did not thoroughly document when performing focused assessments for specific complaints as described in the cases below.

- In case 17, a patient submitted a sick call request stating he was recently diagnosed with colitis and that, while he had been taking antibiotics, the symptoms returned. He had abdominal pain with bloody, tarry stool, weakness, and chills. The patient was not evaluated the same day the sick call request was triaged. When the patient was seen, the nurse did not fully document an abdominal assessment.

- In case 41, a patient submitted a sick call request with complaints of having fatigue, dizziness, and chest tightness for one week. The patient reported symptoms were intermittent and began three weeks prior. While he had no symptoms at the time of the evaluation, he was concerned about whether "his heart was okay." The nurse did not subjectively assess the frequency, severity, and duration of the intermittent chest pain and whether it occurred when the patient was active or at rest. The nurse also did not subjectively assess the frequency and duration of the patient's dizziness and did not consider the patient's risk factors of high blood pressure, high cholesterol, obesity, and recent COVID-19 infection.

While case review did not identify a pattern of deficiencies related to interventions, the deficiencies we *did* identify were significant in the following cases:

- In case 1, a patient submitted a sick call request for a burning sensation in the left calf. A nurse performed a face-to-face evaluation and utilized nursing protocols to provide acetaminophen from the OTC stock medications, even though the patient's electronic health record indicated the patient was

[27] Abnormal vital signs were not rechecked and the provider was not notified in cases 6, 16, 17, 45, and 47.

allergic to acetaminophen.[28] Staff's failure to review medication allergies placed the patient at risk of harm.

- In case 17, a patient complained of abdominal pain, weight loss and bloody diarrhea. A clinic nurse evaluated the patient and noted the patient had a fast heart rate. The nurse did not weigh the patient or check the patient's orthostatic vital signs. The next day an emergency response was activated for the patient due to abdominal pain and rectal bleeding. The first responder noted the patient had a rapid heart rate. Again, a nurse did not check orthostatic vital signs or weigh the patient. Nursing staff did not recheck vital signs for over two hours before the patient was sent to a higher level of care.

Nursing Documentation

In almost every area we reviewed, nursing documentation showed room for improvement. Nurses frequently failed to document all times during emergency responses, failed to document giving report to emergency medical staff or to the emergency room, and often did not document medication given in the medication administration record (MAR). We identified deficiencies in face-to-face assessments, including inconsistent documentation in the *Infectious Disease* section of the assessment form that did not correlate with patient's complaints. We also found that the clinic nurses sometimes did not document exact area or location of pain or injury. When performing quarantine and isolation rounds, nursing staff often did not completely document vital signs, complaints, or both vital signs and complaints. In the inpatient correctional treatment center (CTC), nursing staff often failed to document peripherally inserted central catheters (PICC) or wound care, did not consistently document the percentage of meals patients consumed, and intermittently failed to document the effectiveness of PRN pain medication. While documentation deficiencies do not affect patient care and are considered minor, this is an area in which PBSP could improve.

Nursing Sick Call

Our clinicians reviewed 43 sick call requests and identified 24 deficiencies, seven of which were significant.[29] Some of the significant deficiencies were related to inadequate assessments and failure to perform timely evaluations. Even when taking into consideration that, due to COVID-19 guidelines, only urgent and emergent complaints

[28] OTC means over the counter.

[29] Deficiencies in face-to-face assessments for sick call requests were identified in cases 1, 5, 6, 17, 18, 20, 28, 29, 30, 31, 32, 35, 36, 37, 39, 40, 41, and 42. Significant deficiencies were identified in cases 1, 6, 17, 18, 36, and 41.

were scheduled to be evaluated in person, we identified several situations that warranted immediate attention. This is discussed further and examples are cited in the **Access to Care** indicator.

Care Management

OIG clinicians reviewed four cases in which patients were evaluated by a care manager.[30] We were advised clinic RNs act as care managers and clinic LVNs perform care coordinator duties, which include monthly and yearly TB screenings, vital sign checks, and distribution of DME and diabetic supplies. Case review did not identify any deficiencies in scheduling or evaluating patients for care management appointments.

Wound Care

We reviewed two cases involving wound care orders. Both patients were housed in the CTC.[31] During case review, OIG clinicians identified several days on which wound care was not provided or documented. We also identified lack of documentation of PICC line care and dressing changes.[32] There are further discussed in the **Specialized Medical Housing** indicator.

Emergency Services

PBSP performed well when responding to urgent and emergent patients. While nurses initiated prompt and appropriate interventions, their documentation was often incomplete, lacking timelines and assessment information. Another area with room for improvement was the accuracy of emergency response reviews completed as part of the EMRRC audits. This is further discussed in the **Emergency Services** indicator.

Hospital Returns

We reviewed 24 events in nine cases in which patients returned from an off-site hospitalization or emergency room visit. We identified five deficiencies, all related to nursing performance. All deficiencies were due to either missing documentation or incomplete assessments; all deficiencies were deemed minor, as they did not significantly affect patient care. Please see the **Transfers** indicator for additional information.

[30] Patients were evaluated by the care manager in cases 5, 16, 23, and 24.

[31] Wound care was ordered for cases 46 and 47.

[32] PICC is a peripherally inserted central catheter.

Transfers

Most of the time, PBSP performed well in transferring patients in and out of the institution. However, for patients who returned from hospitalizations or emergency room visits, assessments were often incomplete. We also identified that when patients presented with abnormal vital signs, nurses did not recheck vitals or notify the provider as CCHCS policy requires. Please refer to the **Transfers** indicator for additional information.

Specialized Medical Housing

OIG clinicians examined 95 events that occurred within nine cases in which patients were admitted to the correctional treatment center.[33] Nurses provided adequate care, but we identified several incomplete assessments, missing documentation, and failure to perform wound care. This area offers opportunity for performance improvement and is discussed in more detail in the **Specialized Medical Housing** indicator.

Specialty Services

We reviewed 28 events in 13 cases in which patients received specialty services. In four cases, patients returned from a specialty procedure or consultation. Nursing staff performed complete assessments, reviewed discharge recommendations, and notified the provider. We only identified one minor deficiency related to nursing performance.

Medication Management

OIG clinicians examined 125 events involving medication management and identified five medication deficiencies, none of which were significant. Nursing staff generally administered medications appropriately, but we identified some instances in which nursing staff did not properly document patient care in the medication administration record (MAR). The **Medication Management** indicator provides further information.

Clinician On-Site Inspection

Just before the OIG on-site visit, we were advised there was a COVID-19 outbreak in the community and at the institution. On the first day of our visit, during the all-staff meeting, we were advised all clinic lines were interrupted, and nursing staff were redirected to assist with testing the entire patient population for the virus. We were also advised that the housing units on A and B yards were utilized for quarantine

[33] Due to frequency of nursing contacts in the specialized medical housing, we bundle up to two weeks of patient care into a single event.

and isolation. This hampered the OIG's ability to interview clinic staff. We were, however, able to interview nursing educators, the utilization manager, the employee health nurse, the public health nurse, and nursing staff in the TTA and CTC.

On the second day of the on-site visit, we were able to tour two of the clinics. Staff informed us of multiple mandates and redirections due to nursing shortages. OIG staff were advised nursing morale was low and nursing staff were "tired." During the compliance team's on-site visit, we were advised PBSP had a nursing shortage of about 60 percent. During the case review on-site visit, we learned that about one and a half to two years prior, PBSP lost six registered nurses (RN) and had not recovered since. This was a drastic change from Cycle 5, when PBSP only had a 17 percent nursing shortage. At the time of the on-site visit, the institution had 14 positions filled with registry RNs and seven positions filled with contract and registry LVNs. On the first day of the visit, another experienced nurse was working a last shift before retiring. The on-site response to the low staffing levels included the use of registry staff to fill vacancies, and recruitments for civil service candidates were continuous. We were also advised that PBSP evaluates patient care activities daily and directs staffing resources to meet workload demands.

The institution was also affected by the COVID-19 outbreak. During our interview with the employee health nurse, the OIG team was advised there were 57 active cases among staff and only 30 percent of staff were vaccinated. On the first day of the OIG on-site visit, the public health nurse advised the facility had 25 positive cases within the incarcerated population, with 1,800 test results pending. During the compliance visit, we were advised that 66 percent of the patient population was vaccinated.

OIG clinicians were also able to meet with nursing instructors who advised training was continuous given staff turnover, new nursing registry, and mandatory trainings. The instructors reported difficulty scheduling staff for all the required trainings due to nursing shortages and the need to redirect staff. They also reported the annual skills training consisted of only one to two hours of training and some of the subjects covered included IVs, infectious disease, and hand hygiene. The annual CTC training covered information on chronic care conditions, IVs, chronic pain, and wound care. We were also advised that some area supervisors also provide specific on-the-job training to their staff, such as PICC line care for patients housed in the correctional treatment center.

Recommendations

- Nursing leadership should determine the root cause of challenges that prevent outpatient nurses from performing complete assessments and implement remedial measures as appropriate, including training of staff.

- Nursing leadership should determine the causes that prevent PBSP CTC nurses from performing complete assessments and proper wound care, and implement remedial measures as appropriate, including training of staff.

Provider Performance

Overall Rating
Adequate

Case Review Rating
Adequate

Compliance Score
(N/A)

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

Results Overview

PBSP providers delivered satisfactory care to patients. However, some providers rescheduled patients due to interim COVID-19 guidelines. In certain situations, this increased the risk of patient harm. There were also a few cases in which providers did not follow specialists' recommendations and did not document the reasons. The COVID-19 pandemic provided context for our evaluation of providers' care during the review period. After extensive deliberation, we rated this indicator as ***adequate***.

Case Review Results

OIG clinicians reviewed 112 medical provider encounters and identified 21 deficiencies, 12 of which were significant.[34] In addition, OIG clinicians examined the quality of care in 20 comprehensive case reviews. Of these 20 cases, 18 were rated adequate, and two were inadequate.

Assessment and Decision-Making

PBSP providers appropriately assessed patients' conditions and made sound decisions. They generally asked concise questions and performed proper documentation of patient histories. Providers formulated reasonable differential diagnoses, ordered appropriate tests, and referred patients when necessary. We found 11 deficiencies related to providers' decision-making.[35]

[34] Provider performance deficiencies were found in cases 1, 7, 8, 9, 10, 11, 13, 16, 17, 18, 21, and 46. Significant deficiencies were identified in cases 8, 10, 16, 17, 18, 21, and 46.

[35] Decision-making deficiencies were found in cases 1, 7, 8, 9, 10, 11, 16, 17, and 18. Significant deficiencies were found in cases 8, 16, 17, and 18.

We identified that certain providers tended to reschedule patients due to COVID-19 interim guidelines. While this was acceptable for certain episodic or chronic conditions, it was detrimental for others. The following are examples:

- In case 16, a provider canceled a chronic care appointment for a patient with a history of high blood pressure and protein in his urine. Protein in urine is an indication of kidney damage. It was important to follow the patient as the blood pressure can cause further kidney damage. The patient was eventually seen three months later by a different provider.

- In case 18, a provider canceled appointments and cited COVID-19 as the reason for the appointment cancellation even though a nurse repeatedly requested follow-up with the patient due to the patient's weeping eczema. The nurses eventually consulted with another provider and the patient was admitted to the hospital.

Review of Records

Generally, PBSP providers reviewed medical records carefully. We found one deficiency in which a provider did not review the medication record to identify that a patient had not taken his asthma medication for months, and another deficiency in which a provider did not review vital signs in a patient with a history of elevated blood pressure.

Emergency Care

PBSP providers managed patients with urgent and emergent conditions exceptionally well in the TTA. On-site providers examined, diagnosed, and triaged patients appropriately. We did not identify any problems in providers' communication with TTA RNs.

Chronic Care

During the review period, in most instances, PBSP providers appropriately managed patients' chronic health conditions; however, we found two deficiencies related to blood pressure control and two related to diabetes control. Several patients began Hepatitis C treatment. We did not review any patients on anticoagulation.

Specialty Services

PBSP providers appropriately referred patients for specialty consultation when needed. However, when specialists made recommendations, providers did not always follow them and did not document any reasons why. We found this in three of the cases we

reviewed. We discuss providers' specialty performance further in the **Specialty Services** indicator.

- In case 46, a provider did not follow an infectious disease (ID) specialist's recommendation to change antibiotics, order laboratory tests, and schedule further ID follow-up. The provider did not document any reason why the recommendations were not followed.

- In case 16, a provider did not follow a cardiologist's recommendations for a nephrology consultation, to keep the blood pressure below specific values, and to order a sleep study.

Documentation Quality

PBSP providers accurately documented encounters with patients and communication with nurses. The chief medical executive even documented when she had to contact a patient's family for end-of-life discussions. However, there were a few instances in which providers did not accurately document information. In one case, a CTC discharge summary did not include complete information. Another instance is described below.

- In case 11, a provider incorrectly documented that a patient, who had a high blood pressure, had normal blood pressure on the day of his visit.

Provider Continuity

Generally, PBSP offered good provider continuity. Providers were assigned to specified clinics. When patients were moved into isolation, placed in quarantine, or moved to the CTC, they were assigned a new provider.

Clinician On-Site Inspection

At the time of our inspection, PBSP had an active COVID-19 outbreak. In response, they conducted mass testing on the first day of our inspection. Medical leadership also discussed how to improve vaccination rates for their staff.

We attended daily provider huddles as well as team-based huddles. The team huddles were well-run and included pertinent information and discussion.

The providers we interviewed expressed they had full trust in the executive and medical leadership team. One provider stated patients at PBSP had better provider access than private sector patients. Medical

leadership was always available to listen and help with any concerns. The providers stated that, due to the remoteness of the institution, they sometimes approached care in a unique way. They had good working relationships with nursing as well as custody staff. Providers mentioned that nursing staff faced challenges due to staffing shortages. The providers noted that nurses whom they worked with were very diligent despite the staffing shortages.

Medical leadership stated they had a great group of providers, including several advanced practitioners. They explained that a prior CEO was an advanced practitioner who helped spearhead the use of advanced practitioners in prison health care. Leadership utilized two telemedicine providers and planned on utilizing more. They had no problems with any of their providers. The CME helped contact families when necessary. The CP&S helped approve patients to transfer out of the isolation setting. Both the CME and CP&S were very involved with day-to-day operations.

Recommendations

- Medical leadership should consider reminding providers to carefully review charts before rescheduling appointments due to COVID-19 Interim Guidelines.[36]

- Medical leadership should remind providers to document their rationale for not following specialists' recommendations.

[36] https://cchcs.ca.gov/covid-19-interim-guidance/

Specialized Medical Housing

Overall Rating
Adequate

Case Review Rating
Adequate

Compliance Score
Proficient (85.0%)

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

Results Overview

PBSP provided acceptable care for patients housed in the CTC. In Cycle 5, case review clinicians identified only two deficiencies, none of which were significant, which resulted in a proficient rating. However, in Cycle 6, OIG clinicians identified 25 deficiencies, three of which were significant. We discuss these significant deficiencies in the subindicators below. After considering case review results and compliance testing, we rated the **Specialized Medical Housing** indicator as ***adequate***.

Case Review and Compliance Testing Results

We reviewed nine CTC cases that included 28 provider events and 38 nursing events. Due to the volume of care that occurs in specialized medical housing units, each provider and nursing event represents up to one month of provider care and one week of nursing care, respectively. We identified 25 deficiencies, three of which were significant.[37]

Provider Performance

PBSP providers generally provided good care in the CTC. Case review clinicians found that providers always performed admission histories and physicals timely and rounded on patients in clinically appropriate intervals. Compliance testing also showed that providers performed admission histories and physicals timely (MIT 13.002, 90.0%). The

[37] Specialized medical housing deficiencies were identified in cases 1, 17, 19, 45, 46, and 47. Significant deficiencies were identified in cases 46 and 47.

compliance team did not test for clinically appropriate intervals, as MIT 13.003 was not applicable.

In general, providers made sound decisions and documented communication with patients and other staff. However, the following are exceptions.

- In case 46, a CTC provider saw a patient following an infectious disease specialist consultation. The provider did not follow through on the specialist's recommendations to change antibiotics or order laboratory tests, nor did the provider order follow-up with the specialist.

- In case 46, a CTC provider did not thoroughly document a discharge summary. The provider did not relay that a patient had a specialty consultation and was waiting for transesophageal echocardiogram (TEE) results. By happenstance, the patient did not have any adverse outcomes.[38]

Nursing Performance

Both case review and compliance testing concluded that patients admitted to the CTC received timely initial health assessments most of the time (MIT 13.001, 70.0%). We noted patients were assessed by nursing staff every shift, but the assessments were often incomplete. OIG clinicians concluded that of the 25 deficiencies identified in the specialized medical housing cases, 21 were directly related to quality of nursing care. Prominent areas of concern were incomplete assessments, lack of documentation that wound care was provided, failure to recheck abnormal vital signs, missing data, and failure to provide pertinent interventions. An example is described below.

- In case 47, a patient was admitted to the CTC for serratia bacteremia, presumed endocarditis, epidural abscess, and cervical disc fusion. Orders were written for IV antibiotics for six weeks, wound care, and as-needed pain medication. During our review of nursing care from December 11, 2020, through December 31, 2020, nurses did not document assessing or completing wound care from December 13, 2020, through December 23, 2020, and did not provide pain intervention or pain medication for moderate or severe pain for three different assessments. This falls below clinical nursing standards.

However, the compliance team noted the CTC maintains an operational call system to ensure patients have access to care (MIT 13.101, 100%).

[38] The transesophageal echocardiogram test uses soundwaves to image the heart lining, muscle, valves, and pumping function.

Medication Administration

Compliance testing found that patients admitted to the CTC received their medications timely most of the time (MIT 13.004, 80.0%). Case review did not find any issues in medication administration during our review period for Cycle 6.

Clinician On-Site Inspection

The CTC has 20 beds, 10 designated for medical patients and 10 designated for mental health patients; all 20 beds have functional call lights. They have two negative pressure rooms with ante rooms for respiratory isolation. At the time of our on-site inspection, we were advised only a few beds were available. The CTC was equipped with a standard scale to weigh patients upon admission and as ordered, but we were advised there was no wheelchair-accessible scale at the institution.

During our on-site visit, we interviewed CTC nursing staff. Two registered nurses and a psychiatric technician were on duty. One of the RNs had been redirected to work in the CTC due to mass COVID-19 testing throughout the institution. The second RN was a registry RN who had been working at the institution for only a few months. We were advised there is usually a designated primary care provider for the CTC during weekdays, and that staff contact the physician-on-call after hours, on weekends, and on holidays. We met with the CTC provider, who expressed great working relationships with nursing staff and custody staff in the CTC.

OIG clinicians remotely attended the well-organized CTC daily huddle. In attendance were medical providers such as the chief physician and surgeon, and mental health providers such as the psychiatrist, the psychologist, nursing staff, and the pharmacist. The director of nursing (DON) was also in attendance as the supervising registered nurse II was not on duty that day. Discussion included admissions, discharges, emergencies, medication renewals, specialty appointments, and treatments. The meeting started promptly and was both thorough and concise.

When OIG clinicians met with nursing leadership to review on-site questions concerning documentation missing from CTC cases, we were advised the institution had no connectivity to the EHRS during a specific time frame and that documentation was handwritten and scanned into the chart. The missing documents were not provided to the OIG.

Compliance Testing Results

Table 17. Specialized Medical Housing

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

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

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

Source: The Office of the Inspector General medical inspection results

Recommendations

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

- Nursing leadership should provide additional training on complete assessments including CCHCS policy on abnormal vital signs.

- Leadership should formulate a plan to ensure handwritten documents are collected and scanned into the patient's chart in a timely manner.

- Nursing leadership should ensure that the initial assessments are completed within the required timeframe as stated in CCHCS policy.

Specialty Services

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

Overall Rating

Inadequate

Case Review **Rating Adequate**

Compliance Score ***Inadequate* (54.2%)**

Results Overview

PBSP provided poor specialty services. Although providers and nursing staff performed competently, compliance testing for specialty access scored low. Case reviewers found that some providers did not always follow specialists' recommendations. Health information management in this indicator is another area where case review found good performance; however, compliance testing showed very poor retrieval of health information. Because compliance testing showed uniformly poor performance in specialty health information management, we rated PBSP as ***inadequate*** for this indicator.

Case Review and Compliance Testing Results

We reviewed 28 events related to specialty services; 24 were specialty consultations and procedures. We found seven deficiencies in this category, four of which were significant.[39]

Access to Specialty Services

PBSP's performance in this subindicator was mixed. Case review clinicians did not find any deficiencies related to access to specialty services. When providers requested specialty services, the appointments occurred within the requested time frames. When delays were due to cancellations by outside specialists, or when clinically stable patients were rescheduled due to COVID-19 interim guidelines, we did not assign deficiencies. However, compliance testing found untimely appointments and poor access to specialty services with routine priority (MIT 14.007, 66.7%) medium priority (MIT 14.004, 20.0%), and high priority (MIT 14.001, 25.0%) referrals. PBSP performed excellently in managing previously approved specialty appointments for newly transferred patients (MIT 14.010,100%).

[39] Specialty services deficiencies occurred in cases 6, 16, 18, 21, and 46. Significant deficiencies were found in cases 16, 18, 21, and 46.

Provider Performance

PBSP providers requested specialty consults correctly when they were initially needed. However, providers did not always follow through with specialists' recommendations even though they were aware of them, as evidenced by their endorsement of the reports. Compliance testing showed that the institution followed up with patients in a timely manner after specialty services (MIT 1.008, 87.5%).

Nursing Performance

Nurses at PBSP performed well in assessing patients who returned to the facility from off-site specialty appointments. While nursing staff appropriately obtained vital signs, assessed patients, and relayed off-site recommendations to providers, we identified one minor deficiency in which a patient had an abnormally low heart rate and a nurse did not recheck the patient's pulse or document notification to the provider.

Health Information Management

PBSP's performance in managing specialty services health information was mixed. Compliance testing showed poor retrieval and significant difficulty obtaining provider review of routine-priority (MIT 14.008, 26.7%) medium-priority (MIT 14.005, 46.7%) and high-priority specialty reports (MIT 14.002, 50.0%). Testing also showed untimely scanning of specialty reports into the EHRS (MIT 4.002, 70.8%). Although case review found fewer problems, there were still issues processing specialty reports. The following is an example.

- In case 18, a dermatology consultation was not sent to a provider for review and, as a result, the subsequent dermatology follow-up was delayed. On-site, the health information management supervisor acknowledged the report was not sent to the provider and stated the staff member will be assigned training.

Clinician On-Site Inspection

We discussed specialty services with the specialty services supervisors. They explained that due to COVID-19, they had a policy in which providers or medical leadership would review pending appointments and determine whether patients needed to be seen by the specialist as originally ordered, or whether the appointment could be postponed. During the review period, PBSP also experienced issues with

specialists' availability in the community. eConsult was available to the providers, and we observed one case in which it was utilized.[40]

OIG staff interviewed the utilization management (UM) RN who advised that PBSP generates approximately 20 to 30 medical referrals weekly. The UM RN reviews the chart and enters information into InterQual.[41] If a referral does not meet criteria, the UM RN discusses it at the weekly provider meeting. The UM RN reiterated there was a backlog of some specialty appointments due to the lack of specialist appointment availability in the community. On-site specialty services included optometry and physical therapy that did not require approval. Orthotics and audiology, which *do* require referrals, were also available on-site. In addition, CT scans, MRIs, ultrasounds, and FibroScans were offered at the facility monthly, and appointments were scheduled by the radiology staff.[42] Due to the location of the institution and lack of close off-site facilities for specialized procedures, the UM nurse advised there had been instances of delays in transportation.

[40] eConsult is a web-based application that allows providers to consult with specialists for advice and recommendations about patients' medical conditions.

[41] InterQual is an evidenced-based clinical support tool used to assist in determining whether proposed services are clinically indicated and provided in the appropriate level, or whether further evaluation is required.

[42] A FibroScan is an imaging diagnostic test that evaluates for liver scarring and fatty changes from liver disease.

Compliance Testing Results

Table 18. Specialty Services

Compliance Questions	Scored Answer Yes	No	N/A	Yes %
Did the patient receive the high-priority specialty service within 14 calendar days of the primary care provider order or the Physician Request for Service? (14.001) *	1	3	0	25.0%
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) *	2	2	0	50.0%
Did the patient receive the subsequent follow-up to the high-priority specialty service appointment as ordered by the primary care provider? (14.003) *	1	1	2	50.0%
Did the patient receive the medium-priority specialty service within 15-45 calendar days of the primary care provider order or Physician Request for Service? (14.004) *	3	12	0	20.0%
Did the institution receive and did the primary care provider review the medium-priority specialty service consultant report within the required time frame? (14.005) *	7	8	0	46.7%
Did the patient receive the subsequent follow-up to the medium-priority specialty service appointment as ordered by the primary care provider? (14.006) *	6	1	8	85.7%
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) *	10	5	0	66.7%
Did the institution receive and did the primary care provider review the routine-priority specialty service consultant report within the required time frame? (14.008) *	4	11	0	26.7%
Did the patient receive the subsequent follow-up to the routine-priority specialty service appointment as ordered by the primary care provider? (14.009) *	4	1	10	80.0%
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) *	2	0	0	100%
Did the institution deny the primary care provider's request for specialty services within required time frames? (14.011)	2	2	0	50.0%
Following the denial of a request for specialty services, was the patient informed of the denial within the required time frame? (14.012)	2	2	0	50.0%
Overall percentage (MIT 14): 54.2%				

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

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

Table 19. Other Tests Related to Specialty Services

Compliance Questions	Scored Answer Yes	No	N/A	Yes %
Specialty service follow-up appointments: Did the clinician follow-up visits occur within required time frames? (1.008) *,†	7	1	26	87.5%
Are specialty documents scanned into the patient's electronic health record within five calendar days of the encounter date? (4.002) *	17	7	10	70.8%

* 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.

Recommendations

- Medical leadership should ensure that the institution timely receive and review the specialty reports.
- Medical leadership should determine the root cause(s) of challenges in the timely provision of specialty appointments and implement remedial measures as appropriate.

Administrative Operations

Overall Rating
Proficient

Case Review Rating
(N/A)

Compliance Score
Proficient
(86.5 %)

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

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

Results Overview

PBSP performed well in this indicator. It scored high in most applicable tests; however, a few areas had room for improvement. The EMMRC had incomplete checklists and forms. In addition, PBSP did not properly complete required forms during emergency medical response drills. These findings are set forth in the table below. We rated this indicator ***proficient***.

Nonscored Results

We obtained CCHCS Death Review Committee (DRC) reporting data. Three unexpected (Level 1) deaths occurred during our review period. The DRC must complete its death review summary report within 60 calendar days of a death. When the DRC completes the death review summary report, it must submit the report to the institution's CEO within seven calendar days of completion. In our inspection, we found the DRC timely completed one death summary report and submitted the report to the institution's CEO timely. However, DRC did not complete two death review reports promptly; the DRC finished these

two reports 45 and 104 days late, respectively, and submitted them to the institution's CEO 38 and 100 days after that (MIT 15.998).

Compliance Testing Results

Table 20. Administrative Operations

Compliance Questions	Scored Answer Yes	No	N/A	Yes %
For health care incidents requiring root cause analysis (RCA): Did the institution meet RCA reporting requirements? (15.001)	NA	NA	NA	NA
Did the institution's Quality Management Committee (QMC) meet monthly? (15.002)	6	0	0	100%
For Emergency Medical Response Review Committee (EMRRC) reviewed cases: Did the EMRRC review the cases timely, and did the incident packages the committee reviewed include the required documents? (15.003)	3	9	0	25.0%
For institutions with licensed care facilities: Did the Local Governing Body (LGB) or its equivalent meet quarterly and discuss local operating procedures and any applicable policies? (15.004)	4	0	0	100%
Did the institution conduct medical emergency response drills during each watch of the most recent quarter, and did health care and custody staff participate in those drills? (15.101)	0	3	0	0
Did the responses to medical grievances address all of the inmates' 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)	3	0	0	100%
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)	4	0	5	100%
Did the providers maintain valid state medical licenses? (15.106)	10	0	0	100%
Did the staff maintain valid Cardiopulmonary Resuscitation (CPR), Basic Life Support (BLS), and Advanced Cardiac Life Support (ACLS) certifications? (15.107)	2	0	1	100%
Did the nurses and the pharmacist-in-charge (PIC) maintain valid professional licenses and certifications, and did the pharmacy maintain a valid correctional pharmacy license? (15.108)	6	0	1	100%
Did the pharmacy and the providers maintain valid Drug Enforcement Agency (DEA) registration certificates? (15.109)	1	0	0	100%
Did nurse managers ensure their newly hired nurses received the required onboarding and clinical competency training? (15.110)	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): **86.5%**				

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

Recommendations

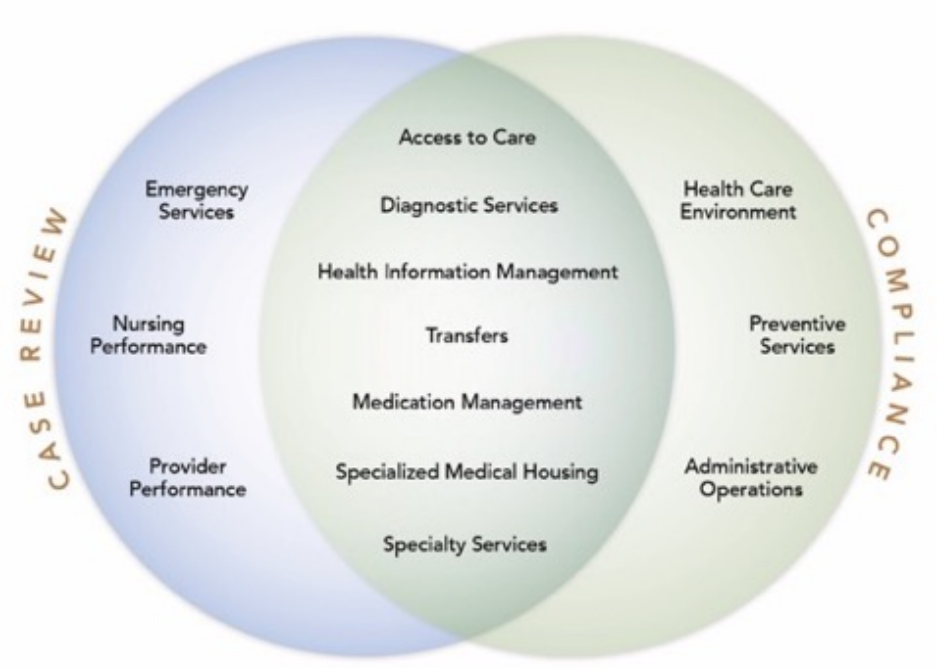
The OIG offers no specific recommendations for this indicator.

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 PBSP



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, nonclinical analysts use a standardized sampling methodology to select most of the case review samples. A randomizer is used when applicable.

For most basic institutions, the OIG samples 20 comprehensive physician review cases. For institutions with larger high-risk populations, 25 cases are sampled. For the California Health Care Facility, 30 cases are sampled.

Case Review Sampling Methodology

We obtain a substantial amount of health care data from the inspected institution and from CCHCS. Our analysts then apply filters to identify clinically complex patients with the highest need for medical services. These filters include patients classified by CCHCS with high medical risk, patients requiring hospitalization or emergency medical services, patients arriving from a county jail, patients transferring to and from other departmental institutions, patients with uncontrolled diabetes or uncontrolled anticoagulation levels, patients requiring specialty services or who died or experienced a sentinel event (unexpected occurrences resulting in high risk of, or actual, death or serious injury), patients requiring specialized medical housing placement, patients requesting medical care through the sick call process, and patients requiring prenatal or postpartum care.

After applying filters, analysts follow a predetermined protocol and select samples for clinicians to review. Our physician and nurse reviewers test the samples by performing comprehensive or focused case reviews.

Case Review Testing Methodology

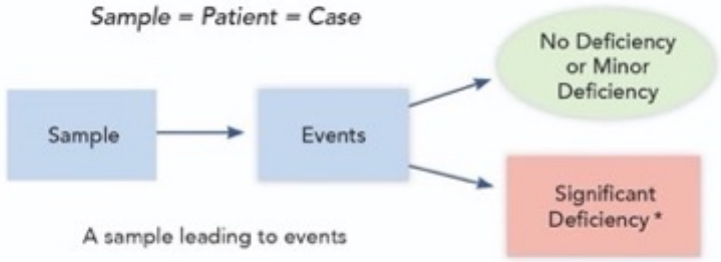
An OIG physician, a nurse consultant, or both review each case. As the clinicians review medical records, they record pertinent interactions between the patient and the health care system. We refer to these interactions as case review ***events***. Our clinicians also record medical errors, which we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

Deficiencies can be minor or significant, depending on the severity of the deficiency. If a deficiency caused serious patient harm, we classify the error as an ***adverse event***. On the next page, Figure A–2 depicts the possibilities that can lead to these different events.

After the clinician inspectors review all the cases, they analyze the deficiencies, then summarize their findings in one or more of the health care indicators in this report.

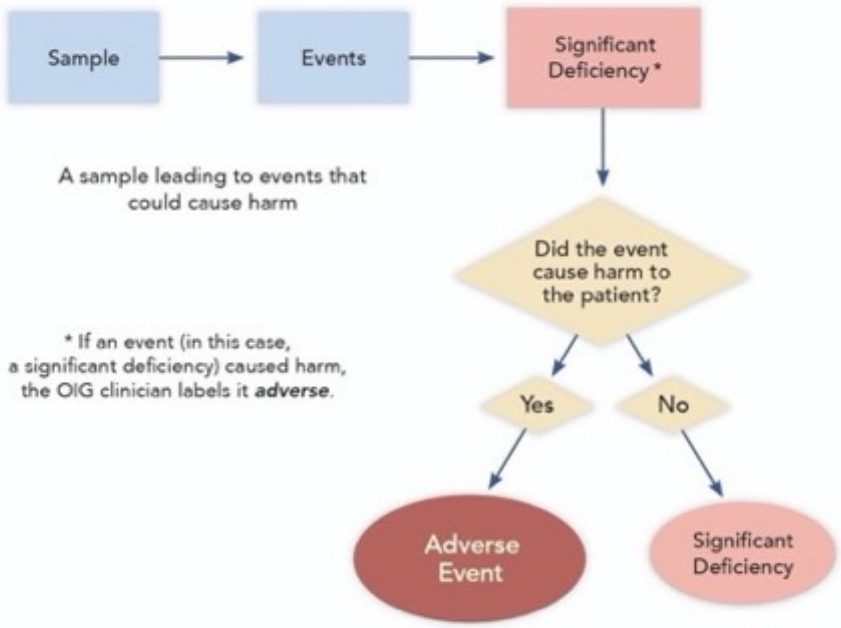
Figure A–2. Case Review Testing

The OIG clinicians examine the chosen samples, performing either a ***comprehensive case review*** or a ***focused case review***, to determine the events that occurred.



Deficiencies

Not all events lead to deficiencies (medical errors); however, if errors did occur, then the OIG clinicians determine whether any were ***adverse***.



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

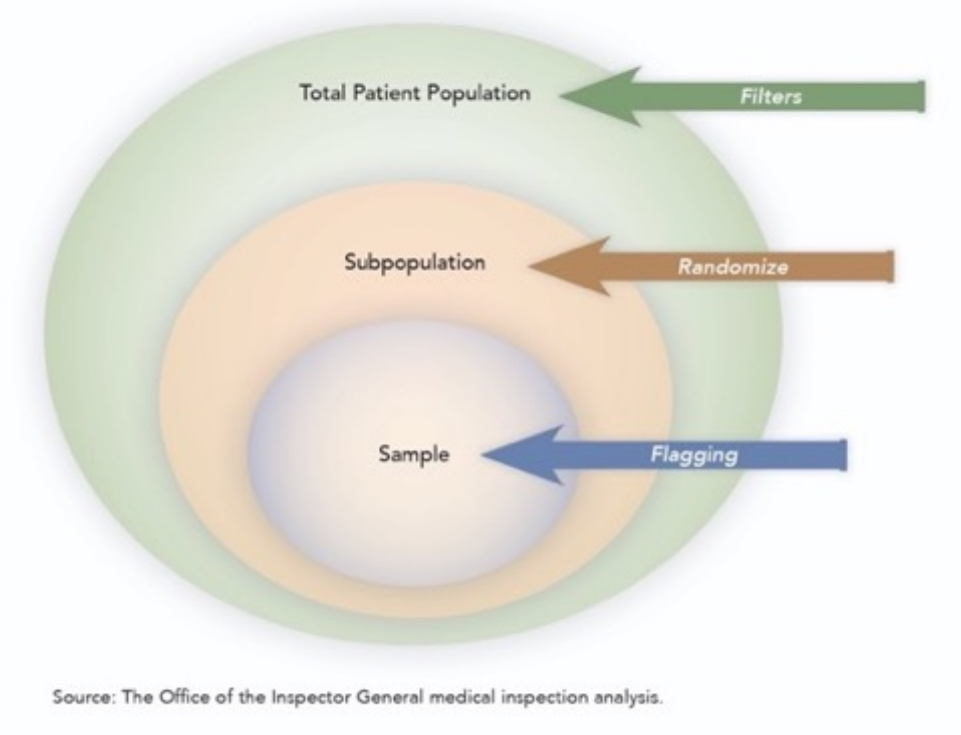
Compliance Testing

Compliance Sampling Methodology

Our analysts identify samples for both our case review inspectors and compliance inspectors. Analysts follow a detailed selection methodology. For most compliance questions, we use sample sizes of approximately 25 to 30. Figure A–3 below depicts the relationships and activities of this process.

Figure A–3. Compliance Sampling Methodology

Compliance Testing Methodology



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

Our inspectors answer a set of predefined medical inspection tool (MIT) questions to determine the institution's compliance with CCHCS policies and procedures. Our nurse inspectors assign a ***Yes*** or a ***No*** answer to each scored question.

OIG headquarters nurse inspectors review medical records to obtain information, allowing them to answer most of the MIT questions. Our regional nurses visit and inspect each institution. They interview health care staff, observe medical processes, test the facilities and clinics, review employee records, logs, medical grievances, death reports, and other documents, and obtain information regarding plant infrastructure and local operating procedures.

Scoring Methodology

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

Indicator Ratings and the Overall Medical Quality Rating

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. PBSP Case Review Sample Sets

Sample Set	Total
CTC/OHU	3
Death Review/Sentinel Events	2
Diabetes	4
Emergency Services – CPR	2
Emergency Services – Non-CPR	2
High Risk	5
Hospitalization	5
Intra-system Transfers In	2
Intra-system Transfers Out	2
RN Sick Call	18
Specialty Services	2
Total	**47**

Table B–2. PBSP Case Review Chronic Care Diagnoses

Diagnosis	Total
Anemia	3
Arthritis/Degenerative Joint Disease	2
Asthma	4
COPD	1
COVID-19	11
Cardiovascular Disease	1
Chronic Kidney Disease	2
Chronic Pain	7
Cirrhosis/End-Stage Liver Disease	1
Deep Venous Thrombosis/Pulmonary Embolism	1
Diabetes	7
Gastroesophageal Reflux Disease	3
Hepatitis C	9
Hyperlipidemia	9
Hypertension	15
Mental Health	4
Seizure Disorder	2
Sleep Apnea	9
Total	**91**

Table B–3. PBSP Case Review Events by Program

Diagnosis	Total
Diagnostic Services	392
Emergency Care	43
Hospitalization	24
Intra-system Transfers-In	9
Intra-system Transfers-Out	2
Outpatient Care	351
Specialized Medical Housing	95
Specialty Services	34
Total	**950**

Table B–4. PBSP Case Review Sample Summary

MD Reviews Detailed	20
MD Reviews Focused	3
RN Reviews Detailed	15
RN Reviews Focused	24
Total Reviews	62
Total Unique Cases	47
Overlapping Reviews (MD & RN)	15

Appendix C. Compliance Sampling Methodology

Pelican Bay State Prison

Quality Indicator	Sample Category	No. of Samples	Data Source	Filters
Access to Care				
MIT 1.001	Chronic Care Patients	25	Master Registry	• Chronic care conditions (at least one condition per patient—any risk level) • Randomize
MIT 1.002	Nursing Referrals	25	OIG Q: 6.001	• See Transfers
MITs 1.003–006	Nursing Sick Call (6 per clinic)	30	Clinic Appointment List	• Clinic (each clinic tested) • Appointment date (2–9 months) • Randomize
MIT 1.007	Returns From Community Hospital	2	OIG Q: 4.005	• See Health Information Management (Medical Records) (returns from community hospital)
MIT 1.008	Specialty Services Follow-Up	34	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	0	Quest	• Appt. date (90 days–9 months) • Order name (CBC or CMPs only) • Randomize • Abnormal
MITs 2.010–012	Pathology	3	InterQual	• Appt. date (90 days–9 months) • Service (pathology related) • Randomize

Quality Indicator	Sample Category	No. of Samples	Data Source	Filters
Health Information Management (Medical Records)				
MIT 4.001	Health Care Services Request Forms	30	OIG Qs: 1.004	• Nondictated documents • First 20 IPs for MIT 1.004
MIT 4.002	Specialty Documents	34	OIG Qs: 14.002, 14.005 & 14.008	• Specialty documents • First 10 IPs for each question
MIT 4.003	Hospital Discharge Documents	2	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	2	CADDIS Off-site Admissions	• Date (2–8 months) • Most recent 6 months provided (within date range) • Rx count • Discharge date • Randomize
Health Care Environment				
MITs 5.101–105 MITs 5.107–111	Clinical Areas	11	OIG inspector on-site review	• Identify and inspect all on-site clinical areas.
Transfers				
MITs 6.001–003	Intrasystem Transfers	25	SOMS	• Arrival date (3–9 months) • Arrived from (another departmental facility) • Rx count • Randomize
MIT 6.101	Transfers Out	6	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	2	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	4	SOMS	• Date of transfer (2–8 months) • Sending institution (another departmental facility) • Randomize • NA/DOT meds
MITs 7.101–103	Medication Storage Areas	Varies by test	OIG inspector on-site review	• Identify and inspect clinical & med line areas that store medications
MITs 7.104–107	Medication Preparation and Administration Areas	Varies by test	OIG inspector on-site review	• Identify and inspect on-site clinical areas that prepare and administer medications
MITs 7.108–111	Pharmacy	1	OIG inspector on-site review	• Identify & inspect all on-site pharmacies
MIT 7.112	Medication Error Reporting	8	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	16	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	0	Maxor	• Dispense date (past 9 months) • Time period on TB meds (3 months or 12 weeks) • Randomize
MIT 9.003	TB Evaluation, Annual Screening	25	SOMS	• Arrival date (at least 1 year prior to inspection) • Birth month • Randomize
MIT 9.004	Influenza Vaccinations	25	SOMS	• Arrival date (at least 1 year prior to inspection) • Randomize • Filter out IPs tested in MIT 9.008
MIT 9.005	Colorectal Cancer Screening	25	SOMS	• Arrival date (at least 1 year prior to inspection) • Date of birth (51 or older) • Randomize
MIT 9.006	Mammogram	N/A at this institution	SOMS	• Arrival date (at least 2 yrs. prior to inspection) • Date of birth (age 52–74) • Randomize
MIT 9.007	Pap Smear	N/A at this institution	SOMS	• Arrival date (at least three yrs. prior to inspection) • Date of birth (age 24–53) • Randomize
MIT 9.008	Chronic Care Vaccinations	25	OIG Q: 1.001	• Chronic care conditions (at least 1 condition per IP—any risk level) • Randomize • Condition must require vaccination(s)
MIT 9.009	Valley Fever	0	Cocci transfer status report	• Reports from past 2–8 months • Institution • Ineligibility date (60 days prior to inspection date) • All

Quality Indicator	Sample Category	No. of Samples	Data Source	Filters
Reception Center				
MITs 12.001–008	RC	N/A at this institution	SOMS	• Arrival date (2–8 months) • Arrived from (county jail, return from parole, etc.) • Randomize
Specialized Medical Housing				
MITs 13.001–004	Specialized Health Care Housing Unit	10	CADDIS	• Admit date (2–8 months) • Type of stay (no MH beds) • Length of stay (minimum of 5 days) • Rx count • Randomize
MITs 13.101–102	Call Buttons	All	OIG inspector on-site review	• Specialized Health Care Housing • Review by location
Specialty Services				
MITs 14.001–003	High-Priority Initial and Follow-Up RFS	4	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

MIT 14.010	Specialty Services Arrivals	2	Specialty Service Arrivals	• Arrived from (other departmental institution) • Date of transfer (3–9 months) • Randomize
MITs 14.011–012	Denials	4	InterQual	• Review date (3–9 months) • Randomize
		N/A	IUMC/MAR Meeting Minutes	• Meeting date (9 months) • Denial upheld • Randomize

Quality Indicator	Sample Category	No. of Samples	Data Source	Filters
Administrative Operations				
MIT 15.001	Adverse/sentinel events (ASE)	0	Adverse/sentinel events report	• Adverse/Sentinel events (2–8 months)
MIT 15.002	QMC Meetings	6	Quality Management Committee meeting minutes	• Meeting minutes (12 months)
MIT 15.003	EMRRC	12	EMRRC meeting minutes	• Monthly meeting minutes (6 months)
MIT 15.004	LGB	4	LGB meeting minutes	• Quarterly meeting minutes (12 months)
MIT 15.101	Medical Emergency Response Drills	3	On-site summary reports & documentation for ER drills	• Most recent full quarter • Each watch
MIT 15.102	Institutional Level Medical Grievances	10	On-site list of grievances/closed grievance files	• Medical grievances closed (6 months)
MIT 15.103	Death Reports	3	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	4	On-site provider evaluation files	• All required performance evaluation documents
MIT 15.106	Provider Licenses	10	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	3	OIG summary log: deaths	• Between 35 business days & 12 months prior • California Correctional Health Care Services death reviews

California Correctional Health Care Services' Response

February 28, 2022

Amarik Singh, Inspector General
Office of the Inspector General
10111 Old Placerville Road, Suite 110
Sacramento, CA 95827

Dear Ms. Singh:

The Office of the Receiver has reviewed the draft Medical Inspection Report for Pelican Bay State Prison (PBSP) conducted by the Office of the Inspector General (OIG) from November 2020 to April 2021. California Correctional Health Care Services (CCHCS) acknowledges the OIG findings.

Thank you for preparing the report. Your efforts have advanced our mutual objective of ensuring transparency and accountability in CCHCS operations. If you have any questions or concerns, please contact me at (916) 691-3747.

Sincerely,

DocuSigned by:
DeAnna Gouldy
3B7F6B95AC0A4D1...

DeAnna Gouldy
Deputy Director
Risk Management Branch
California Correctional Health Care Services

cc: Clark Kelso, Receiver
Diana Toche, D.D.S., Undersecretary, Health Care Services, CDCR
Directors, CCHCS
Roscoe Barrow, Chief Counsel, CCHCS Office of Legal Affairs
Jackie Clark, Deputy Director, Institution Operations, 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, PBSP
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

Cycle 6

Medical Inspection Report

for

Pelican Bay State Prison

OFFICE *of the*
INSPECTOR GENERAL

Amarik K. Singh
Inspector General

STATE *of* CALIFORNIA
March 2022

OIG