Amarik K. Singh, *Inspector General*

Neil Robertson, *Chief Deputy Inspector General*

OIG | OFFICE *of the* INSPECTOR GENERAL

Independent Prison Oversight

August 2022

Cycle 6

Medical Inspection Report

Calipatria State Prison

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

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

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

Contents

Illustrations

Tables

Figures

Photographs

Cover: Rod of Asclepius courtesy of Thomas Shafee

Introduction

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

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

We continue to review institutional care using 15 indicators, as in prior cycles. Using each of these indicators, our compliance inspectors collect data in answer to compliance- and performance-related questions as established in the *medical inspection tool* (MIT).[4] We determine a total compliance score for each applicable indicator and consider the MIT scores in our overall assessment 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 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 that the department provides to its population.

[3] In addition to our own compliance testing and case reviews, we continue to offer selected Healthcare Effectiveness Data and Information Set (HEDIS) measures for comparison purposes.

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

[5] If we learn a patient needs 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. Our review assesses the institution's medical care on both system and provider levels.

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

We completed our sixth inspection of CAL, and this report presents our assessment of the health care provided at this institution during the inspection period between April 2021 and September 2021.[6] We completed our on-site inspections during the coronavirus (COVID-19) pandemic and also obtained the data used for our analysis during the period of the pandemic.[7]

Calipatria State Prison (CAL) is located in the city of Calipatria, in Imperial County. The institution opened in 1992. The institution runs four main medical clinics and treats patients needing urgent or emergent care in its triage and treatment area (TTA). CAL also treats patients who require assistance with the activities of daily living, but do not require a higher level of inpatient care: those patients are treated in the institution's outpatient housing unit (OHU).

CAL has been designated by CCHCS as a *basic care institution*. Basic institutions are located in rural areas, away from tertiary care centers and specialty care providers whose services would likely be used frequently by higher-risk patients. Basic institutions have the capability to provide only limited specialty medical services and consultations for a generally healthy patient population.

[6] Samples are obtained per case review methodology shared with stakeholders in prior cycles. The case reviews include death reviews between July 2020 and June 2021, emergency noncardiopulmonary resuscitation (non-CPR) reviews between April 2021 and October 2021, CPR reviews between December 2020 and January 2021, diabetes reviews between March 2021 and September 2021, anticoagulation reviews between April 2021 and November 2021, high risk reviews between April 2021 and October 2021, hospitalization reviews between April 2021 and November 2021, specialty reviews between April 2021 and October 2021, transfer reviews between March 2021 and July 2021, and RN sick call reviews between March 2021 and August 2021.

[7] As of May 13, 2022, the department reports on its public tracker that 82% of its incarcerated population at CAL is fully vaccinated while 79% of CAL staff are fully vaccinated: www.cdcr.ca.gov/covid19/population-status-tracking/.

Summary

The OIG completed the Cycle 6 inspection of CAL in February 2022. Our inspectors monitored the institution's delivery of medical care that occurred between April 2021 and September 2021.

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

Table 1. CAL 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	*Indequate*	*Inadequate*	*Inadequate*	↓
Emergency Services	*Adequate*	*N/A*	*Adequate*	=
Health Information Management	*Adequate*	*Inadequate*	*Adequate*	↓
Health Care Environment	*N/A*	*Inadequate*	*Inadequate*	=
Transfers	*Adequate*	*Inadequate*	*Inadequate*	=
Medication Management	*Adequate*	*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	*Inadequate*	*Adequate*	*Inadequate*	↓
Specialty Services	*Adequate*	*Adequate*	*Adequate*	↓
Administrative Operations†	*N/A*	*Inadequate*	*Inadequate*	↓

* 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 346 patient records and 1,013 data points and used the data to answer 89 policy questions. In addition, we observed CAL processes during an on-site inspection in November 2021. Table 2 below lists CAL average scores from Cycles 4, 5, and 6.

Table 2. CAL Policy Compliance Scores

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	88.7%	73.6%	78.8%
2	Diagnostic Services	85.6%	78.1%	56.2%
4	Health Information Management	81.6%	89.6%	74.8%
5	Health Care Environment	80.9%	57.8%	48.5%
6	Transfers	80.7%	72.8%	70.6%
7	Medication Management	71.4%	58.4%	65.3%
8	Prenatal and Postpartum Care	N/A	N/A	N/A
9	Preventive Services	63.2%	86.5%	80.9%
12	Reception Center	N/A	N/A	N/A
13	Specialized Medical Housing	98.0%	93.3%	75.0%
14	Specialty Services	85.6%	89.1%	79.6%
15	Administrative Operations*	81.3%	84.8%	74.3%

* 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 890 patient-related events. After examining the medical records, our clinicians conducted a follow-up on-site inspection in February 2022 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 19 ***adequate*** and one ***inadequate***. Our physicians found one adverse event during this inspection.

The OIG then considered the results from both case review and compliance testing, and drew overall conclusions, which we report in the 13 health care indicators.[8] Multiple OIG physicians and nurses performed quality control reviews; their subsequent collective deliberations ensured consistency, accuracy, and thoroughness. Our OIG clinicians acknowledged institutional structures that catch and resolve mistakes which may occur throughout the delivery of care. As noted above, we listed the individual indicators and ratings applicable for this institution in the CAL Summary Table.

In October 2021, the Health Care Services Master Registry showed that CAL had a total population of 2,945. A breakdown of the medical risk level of the CAL population as determined by the department is set forth in Table 3 below.[9]

Table 3. CAL Master Registry Data as of October 2021

Medical Risk Level	Number of Patients	Percentage
High 1	8	0.3%
High 2	40	1.4%
Medium	426	14.5%
Low	2,471	83.9%
Total	**2,945**	100.0%

Source: Data for the population medical risk level were obtained from the CCHCS Master Registry dated 10-22-21.

[8] The indicators for **Reception Center** and **Prenatal Care** did not apply to CAL.

[9] 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 shown in Table 4 below, CAL had zero executive leadership vacancies, 0.5 primary care provider vacancies, 2.7 nursing supervisor vacancies, and 1.2 nursing staff vacancies.

Table 4. CAL Health Care Staffing Resources as of April 2021

Positions	Executive Leadership*	Primary Care Providers	Nursing Supervisors	Nursing Staff†	Total
Authorized Positions	5.0	6.0	11.7	62.1	84.8
Filled by Civil Service	5.0	5.5	9.0	62.1	81.6
Vacant	0	0.5	2.7	1.2	4.4
Percentage Filled by Civil Service	100.0%	91.7%	76.9%	100.0%	96.2%
Filled by Telemedicine	0	0	0	0	0
Percentage Filled by Telemedicine	0%	0%	0%	0%	0%
Filled by Registry	0	1	0	8	9
Percentage Filled by Registry	0%	16.7%	0%	12.9%	10.6%
Total Filled Positions	5.0	6.5	9.0	70.1	90.6
Total Percentage Filled	100.0%	108.3%	76.9%	112.9%	106.8%
Appointments in Last 12 Months	1	0	1.0	14.0	16.0
Redirected Staff	0	0	0	0	7.0
Staff on Extended Leave‡	0	0	3.0	1.0	4.0
Adjusted Total: Filled Positions	5.0	6.5	6.0	69.1	86.6
Adjusted Total: Percentage Filled	100%	108.3%	51.3%	111.3%	102.1%

* 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 April 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. Deficiencies can be minor or significant, depending on the severity of the deficiency.

An adverse event occurs when the deficiency caused harm to the patient. All major health care organizations identify and track adverse events. We identify deficiencies and adverse events to highlight concerns regarding the provision of care and for the benefit of the institution's quality improvement program to provide an impetus for improvement.[10]

The OIG identified one adverse event at CAL during the Cycle 6 inspection:

- In case 11, a provider reviewed a laboratory result of a hemoglobin A1c level of 12.6 percent, consistent with the diagnosis of new onset diabetes requiring timely treatment. The provider did not schedule a follow-up visit, as the new onset diabetes was not addressed until almost three months later. The delay placed the patient at risk for diabetic complications, such as diabetic ketoacidosis.[11]

Case Review Results

OIG case reviewers (a team of physicians and nurse consultants) assessed 10 of the 13 indicators applicable to CAL. Of these 10 indicators, OIG clinicians rated eight ***adequate*** and two ***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, 19 were ***adequate***, and one was ***inadequate***. In the 890 events reviewed, there were 139 deficiencies, 24 of which our clinicians considered to be of such magnitude that, if left unaddressed, would likely contribute to patient harm.

Our clinicians found the following strengths at CAL:

- The staff performed well with providing appointments with nurses and specialized medical housing providers.
- The staff provided excellent specialty services for their patients. The institution performed well in ensuring specialty appointments occurred within the required time frames.

[10] For a further discussion of an adverse event, see Table A-1.

[11] Diabetic ketoacidosis is a diabetic complication in which the patient's body produces excess blood acids called *ketones*. This condition can be life-threatening and requires the patient to be hospitalized for treatment.

- The nurses delivered excellent care for patients returning from the community hospital and from specialty services, as they provided excellent assessments, interventions, and documentation.

Our clinicians found the following weaknesses at CAL:

- Staff performed poorly in completing and communicating laboratory test results to their patients. The institution did not always retrieve pathology reports.

- Specialized medical housing nurses did not always provide good assessments or interventions for their patients. Specialized medical staff also performed poorly in administering medications.

Compliance Testing Results

Our compliance inspectors assessed 10 of the 13 indicators applicable to CAL. Of these 10 indicators, we rated four ***adequate*** and six ***inadequate***. We tested only policy compliance in the **Health Care Environment**, **Preventive Services**, and **Administrative Operations** indicators, as these indicators do not have a case review component.

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

- The institution performed well in offering immunizations to their patients and providing preventive services, such as influenza vaccinations, annual screenings for tuberculosis (TB), and colorectal cancer screenings.

- CAL did well in providing and administering TB medications to patients.

- Nursing staff at CAL reviewed health care services request forms and conducted face-to-face encounters within the required time frames.

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

- Providers frequently did not communicate results of diagnostic services timely. Most patient letters communicating these results were missing the date of the diagnostic service, the date of the results, and an indication of whether the results were within normal limits.

- CAL staff frequently failed to maintain medication continuity for chronic care patients, for patients discharged from the hospital, and for patients admitted to a specialized medical housing unit. There was also poor medication continuity for patients who transferred into the institution and for patients who had a temporary layover at CAL.

- The institution did not always ensure approved specialty services were provided timely to patients upon their arrival at CAL.
- Clinical staff did not consistently follow universal hand hygiene precautions before or after patient encounters.
- Nursing staff did not regularly inspect and replenish medical supplies, emergency response bags, and treatment carts.

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 CAL's performance with population-based metrics to assess the macroscopic view of the institution's health care delivery. CAL's results compared favorably with those found in State health plans for diabetic care measures. We list the applicable 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)—CAL performed better in two of the three diabetic measures that have statewide comparative data: HbA1c screening and poor HbA1c control. Kaiser SoCal outperformed CAL in blood pressure control.

Immunizations

Statewide comparative data were also not available for immunization measures; however, we include this data for informational purposes. CAL had a 54 percent influenza immunization rate for adults 18 to 64 years old.[12]

Cancer Screening

Statewide comparative data were not available for colorectal cancer screening; however, we include these data for informational purposes. CAL had a 72 percent colorectal cancer screening rate.

[12] The HEDIS sampling methodology requires a minimum sample of 10 patients to have a reportable result.

Table 5. CAL Results Compared With State HEDIS Scores

HEDIS Measure	CAL Cycle 6 Results*	California Medi-Cal 2018†	California Kaiser NorCal Medi-Cal 2018†	California Kaiser SoCal Medi-Cal 2018†
HbA1c Screening	**97%**	90%	94%	96%
Poor HbA1c Control (> 9.0%) ‡, §	**8%**	34%	25%	18%
HbA1c Control (< 8.0%) ‡	77%	–	–	–
Blood Pressure Control (< 140/90) ‡	82%	65%	78%	**84%**
Eye Examinations	70%	–	–	–
Influenza – Adults (18–64)	54%	–	–	–
Influenza – Adults (65+)[l]	N/A	–	–	–
Pneumococcal – Adults (65+)[l]	N/A	–	–	–
Colorectal Cancer Screening	72%	–	–	–

Notes and Sources

* Unless otherwise stated, data were collected in November 2021 by reviewing medical records from a sample of CAL'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 CAL population was tested.

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

[l] For this indicator, the scoring was nonapplicable due to the sample yielding a total population of less than 10 patients.

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

Diagnostic Services

- Medical leadership should ensure time-sensitive laboratory tests are completed within the specified time frames.
- The department should consider developing an electronic solution to ensure providers create patient letters at the time of endorsement and the patient results letter automatically populates accurately with all elements required by CCHCS policy.

Emergency Services

- Nursing leadership should consider providing additional training to staff to ensure thorough documentation of emergent events includes all appropriate times.
- Nursing leadership should ensure supervising registered nurses (SRNs) complete thorough audits of emergent events in which patients transfer to a higher level of care.

Health Information Management

- Medical leadership should ensure pathology results are retrieved within the required time frames.
- Medical leadership should remind staff to properly scan and file medical records.

Health Care Environment

- Medical leadership should remind staff to follow universal hand hygiene precautions. Implementing random spot checks could improve compliance.
- Executive and nursing leadership should consider performing random spot checks to ensure medical supplies are adequately stored in medical supply storage areas located in and outside the clinic.
- Nursing leadership should consider directing each clinic nurse supervisor to review the monthly emergency medical response bag (EMRB) logs to ensure the EMRBs are regularly inventoried and sealed.

Transfers

- Nursing leadership should consider reminding nursing staff to thoroughly complete the initial health screening, including answering all questions and documenting an explanation for each "yes" answer.

- Nursing leadership should ensure nursing staff administer medications to patients without interruption.

Medication Management

- Medical and nursing leadership should ensure that patients with chronic care conditions, patients returning from hospital admission, and layover patients receive their medications timely and without interruption.

Preventive Services

- Nursing leadership and the public health nurse should consider educating their nursing staff in accurately monitoring patients taking TB medications.

Nursing Performance

- Nursing leadership should ensure nurses perform more detailed assessments and interventions during outpatient encounters and should consider implementing audits.

Specialized Medical Housing

- Nursing leadership should ensure nurses initiate and document care plans in the electronic health record system (EHRS).

- Nursing leadership should remind outpatient housing unit (OHU) nurses to adhere to PICC line local operating procedures.[13]

- Nursing leadership should remind nurses to complete the OHU admission assessment within the required time frame, as stated in CCHCS policy.

- Nursing leadership should ensure that patients admitted to the OHU receive their medications upon admission timely and without interruption.

[13] A PICC is a peripherally inserted central catheter, which is used to provide intravenous access and administer fluids and medication.

Specialty Services

- Medical leadership should ascertain the challenges to providers' receiving specialty reports within the required time frames, as well as challenges to providers' timely reviewing those reports, and leadership should implement remedial measures as appropriate.

- Medical leadership should ensure patients receive preapproved specialty services within the specified time frames.

Access to Care

Overall Rating
Adequate

Case Review Rating
Adequate

Compliance Score
Adequate
(78.8%)

In this indicator, OIG inspectors evaluated the institution's performance in providing patients with timely clinical appointments. Our inspectors reviewed the scheduling and appointment timeliness for newly arrived patients, sick call, 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.

Results Overview

CAL provided good access to care. The OIG clinicians found that the institution performed adequately in clinic provider appointments, and most other appointments were also completed in a timely manner, including nursing appointments, specialized medical housing provider appointments, and specialist appointments. Compliance testing showed similar results. CAL's performances in both compliance testing and case review rating contributed to the OIG's rating this indicator ***adequate***.

Case Review and Compliance Testing Results

Our clinicians reviewed 403 provider, nursing, urgent or emergent care (TTA), specialty, and hospital events that required the institution to generate appointments. We found seven deficiencies related to access to care; two were significant.[14]

Access to Clinic Providers

CAL performed adequately in ensuring provider appointments occurred within the required time frames. Although compliance testing found poor completion of chronic care follow-up appointments (MIT 1.001, 48.0%), the institution performed well in both nurse-to-provider referred appointments and provider-ordered sick call follow-up appointments (MIT 1.005, 84.6%; MIT 1.006, 100%). The OIG clinicians reviewed 81 clinic provider appointments and identified two deficiencies.[15] An example follows:

- In case 6, a nurse evaluated the patient for headache and vomiting, and documented that the patient would follow up with a provider appointment in 14 days. However, the nurse did not initiate the appointment.

[14] Deficiencies occurred once in cases 3, 6, 17, 19, and 30, and twice in case 18. Cases 6 and 18 had significant deficiencies.

[15] Deficiencies occurred in cases 6 and 18.

Access to Specialized Medical Housing Providers

CAL performed well in access to care in its specialized medical housing, the outpatient housing unit (OHU). When staff admitted patients to the OHU, providers examined patients in a timely manner. Providers evaluated patients and completed progress notes within the appropriate time frames. Compliance testing found that 80.0 percent of the OHU admission history and physical examinations occurred within the required time frame (MIT 13.002). The OIG clinicians assessed 25 provider encounters and did not identify any deficiency related to a late or missed admission history and physical examinations or follow-up appointments.

Access to Clinic Nurses

CAL performed well with access to nurse sick calls and provider-to-nurse referrals. Compliance testing found that almost all nurse sick call requests were reviewed on the day they were received (MIT 1.003, 96.7%). Moreover, the nurses evaluated 96.6 percent of their patients within the required one business day (MIT 1.004). OIG clinicians identified four deficiencies related to clinic nurse access.[16] One example follows:

- In case 18, the patient complained of pain from an infection; however, the sick call nurse did not evaluate the patient until 13 days later.

Access to Specialty Services

OIG compliance testing found that 86.7 percent of the initial high-priority specialty appointments (MIT 14.001), 80.0 percent of the initial medium-priority specialty appointments (MIT 14.004), and 100 percent of the initial routine specialty appointments (MIT 14.007) occurred within the required time frames. The institution also performed well in follow-up specialty appointments (MIT 14.003, 100%; MIT 14.006, 88.9%; and MIT 14.009, 100%). OIG clinicians reviewed 68 specialty events and did not identify any deficiencies.

Follow-up After Specialty Service

CAL performed adequately in ensuring patients saw their providers after specialty appointments. Compliance testing revealed that 82.4 percent of provider appointments after specialty services occurred within the required time frames (MIT 1.008). The OIG clinicians did not identify missed or delayed provider appointments.

[16] Deficiencies occurred in cases 3, 18, 19, and 30.

Follow-up After Hospitalization

CAL performed well in ensuring that patients see their providers within the required time frames after hospitalizations. Compliance testing found that 83.3 percent of provider appointments occurred within the required time frames (MIT 1.007). OIG clinicians reviewed 13 hospital returns and did not identify missed or delayed provider appointments.

Follow-up After Urgent or Emergent Care (TTA)

CAL providers generally saw their patients following a triage and treatment area (TTA) event as requested. The OIG clinicians assessed 29 TTA events and identified one deficiency related to a missed provider appointment after a TTA event:

- In case 17, the TTA nurse provided emergency care for the patient with inflammatory bowel disease and consulted a provider; however, the nurse did not enter the order for the follow-up provider appointment as recommended by the provider.

Follow-up After Transferring Into the Institution

Compliance testing found that 68.0 percent of provider appointments for newly arrived patients occurred within the required time frames (MIT 1.002). Our clinicians evaluated seven transfer-in events and did not identify any missed or delayed provider appointments.

Clinician On-Site Inspection

CAL has four main clinics: Clinics A, B, C and D. Each clinic had an assigned provider and an office technician who attended the morning huddles and ensured that provider appointments were met. Each provider saw about 10 to 15 patients per day. At the time of the clinician on-site inspection, there were five appointments in the backlog for the four provider clinics. Our clinicians discussed the missed provider or nursing appointments with the scheduler supervisor and the chief nursing executive (CNE). They explained that the missed appointments were due to human errors, as the nurses did not enter the order for the appointments; the medical leadership would provide further training.

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) *	12	13	0	48.0%
For endorsed patients received from another CDCR institution: Based on the patient's clinical risk level during the initial health screening, was the patient seen by the clinician within the required time frame? (1.002) *	17	8	0	68.0%
Clinical appointments: Did a registered nurse review the patient's request for service the same day it was received? (1.003) *	29	1	0	96.7%
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	1	1	96.6%
Clinical appointments: If the registered nurse determined a referral to a primary care provider was necessary, was the patient seen within the maximum allowable time or the ordered time frame, whichever is the shorter? (1.005) *	11	2	17	84.6%
Sick call follow-up appointments: If the primary care provider ordered a follow-up sick call appointment, did it take place within the time frame specified? (1.006) *	1	0	29	100%
Upon the patient's discharge from the community hospital: Did the patient receive a follow-up appointment within the required time frame? (1.007) *	5	1	2	83.3%
Specialty service follow-up appointments: Did the clinician follow-up visits occur within required time frames? (1.008) *,†	14	3	28	82.4%
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): **78.8%**	

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

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

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

Table 7. Other Tests Related to Access to Care

Compliance Questions	Scored Answer			
	Yes	No	N/A	Yes %
For patients received from a county jail: If, during the assessment, the nurse referred the patient to a provider, was the patient seen within the required time frame? (12.003) *	N/A	N/A	N/A	N/A
For patients received from a county jail: Did the patient receive a history and physical by a primary care provider within seven calendar days? (12.004) *	N/A	N/A	N/A	N/A
For CTC and SNF only (effective 4/2019, include OHU): Was a written history and physical examination completed within the required time frame? (13.002) *	8	2	0	80.0%
For or OHU, CTC, SNF, and Hospice (applicable only for samples prior to 4/2019): Did the primary care provider complete the Subjective, Objective, Assessment, and Plan notes on the patient at the minimum intervals required for the type of facility where the patient was treated? (13.003)* †	0	0	10	N/A
Did the patient receive the high-priority specialty service within 14 calendar days of the primary care provider order or the Physician Request for Service? (14.001) *	13	2	0	86.7%
Did the patient receive the subsequent follow-up to the high-priority specialty service appointment as ordered by the primary care provider? (14.003) *	11	0	4	100%
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) *	12	3	0	80.0%
Did the patient receive the subsequent follow-up to the medium-priority specialty service appointment as ordered by the primary care provider? (14.006) *	8	1	6	88.9%
Did the patient receive the routine-priority specialty service within 90 calendar days of the primary care provider order or Physician Request for Service? (14.007) *	15	0	0	100%
Did the patient receive the subsequent follow-up to the routine-priority specialty service appointment as ordered by the primary care provider? (14.009) *	8	0	7	100%

* 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

The OIG offers no recommendations for this indicator.

Diagnostic Services

Overall Rating ***Inadequate***

Case Review Rating ***Inadequate***

Compliance Score ***Inadequate*** **(56.2%)**

In this indicator, OIG inspectors evaluated the institution's performance in timely completing 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 performance in timely completing and reviewing immediate (STAT) laboratory tests.

Results Overview

CAL delivered a poor performance in diagnostic services. Although CAL performed well in completing radiology tests, the institution needed improvement in completing laboratory tests and in communicating test results to patients. Furthermore, the institution did not always retrieve pathology reports or communicate the pathology results to patients. Considering the inadequate case review rating and the low overall compliance score, the OIG rated this indicator ***inadequate.***

Case Review and Compliance Testing Results

Our clinicians reviewed 241 diagnostic events and identified 23 deficiencies, four of which were significant.[17] The deficiencies were related to laboratory tests not completed timely, a pathology report not retrieved, and poor communication of test results to the patients.

Test Completion

CAL performed very well in completing radiology tests. Compliance testing showed the institution completed 100 percent of radiology tests within the required time frames (MIT 2.001). The OIG clinicians reviewed 22 radiology tests and found all tests completed as requested.

However, CAL performed poorly in completing laboratory tests. Compliance testing showed 50.0 percent of laboratory tests were completed within the requested time frames (MIT 2.004). Our clinicians reviewed 206 laboratory tests and identified five deficiencies related to late laboratory completion, one of which was significant:[18]

- In case 8, a provider ordered a urine toxicology to be completed on the same day; however, the test was not done until three weeks later.

[17] Deficiencies occurred once in cases 9, 13, 16, 17, 19, and 20; twice in cases 6, 15, and 21; three times in case 7; and four times in cases 8 and 14. Significant deficiencies occurred in cases 8, 14, 15, and 19.

[18] Deficiencies occurred once in cases 9, 13, and 14, and twice in case 8. A significant deficiency occurred in case 8.

The OIG did not review any STAT laboratory tests during the review period.

Health Information Management

Compliance testing showed providers endorsed most radiology and laboratory reports timely (MIT 2.002, 100%, and MIT 2.005, 90.0%). Our clinicians identified two deficiencies related to late endorsement of a diagnostic test.[19]

Compliance testing also showed providers did not thoroughly communicate the results of radiology studies or laboratory tests to the patients (MIT 2.003, 30.0%, and MIT 2.006, 10.0%). Our clinicians found on 11 occasions, providers did not thoroughly communicate the radiology or laboratory results to their patients, and on one occasion, the provider did not communicate a radiology result to the patient.[20] Examples follow:

- In case 6, the provider did not send a results letter informing the patient of the ultrasound result.

- In case 14, the provider sent a laboratory results letter but did not include all the required elements, such as the test date.

Compliance testing revealed that CAL retrieved 40.0 percent of pathology reports within the required time frames (MIT 2.010). Providers endorsed the pathology reports within the required time frames (MIT 2.011, 85.7%); however, the providers did not send pathology results letters to their patients within the required time frames (MIT 2.012, zero) Our clinicians reviewed two events associated with pathology reports and found two deficiencies:

- In case 14, the patient had a gastric biopsy, but the institution did not retrieve the pathology report.

- In case 21, the provider did not send a letter informing the patient of a pathology result.

Clinician On-Site Inspection

During the time of our on-site inspection, CAL had one part-time and two full-time phlebotomists. The OIG clinicians discussed the delays in completing laboratory tests. The supervisor attributed the delays to being short of staff during the OIG review period.

During business hours, CAL had on-site radiology technicians to perform X-ray examinations; after hours, on weekends, and on holidays, the institution transferred patients to a community hospital for urgent imaging tests. The

[19] Deficiencies occurred in cases 8 and 15.

[20] Deficiencies occurred once in cases 8, 15, 17, 20, and 21; twice in cases 6 and 14; and three times in case 7.

institution also had a mobile imaging vendor who performed on-site CT scans, MRIs, and ultrasound studies during business hours.

Our clinicians discussed the lack of thorough communication of test results to patients with the chief physician and surgeon (CP&S). The CP&S attributed to human error the providers' not including all the required elements in the patients' letters and said would notify providers of the error.

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)	3	7	0	30.0%
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) *	9	1	0	90.0%
Laboratory: Did the health care provider communicate the results of the laboratory test to the patient within specified time frames? (2.006)	1	9	0	10.0%
Laboratory: Did the institution collect the STAT laboratory test and receive the results within the required time frames? (2.007) *	N/A	N/A	N/A	N/A
Laboratory: Did the provider acknowledge the STAT results, OR did nursing staff notify the provider within the required time frames? (2.008) *	N/A	N/A	N/A	N/A
Laboratory: Did the health care provider endorse the STAT laboratory results within the required time frames? (2.009)	N/A	N/A	N/A	N/A
Pathology: Did the institution receive the final pathology report within the required time frames? (2.010) *	4	6	0	40.0%
Pathology: Did the health care provider review and endorse the pathology report within specified time frames? (2.011) *	6	1	3	85.7%
Pathology: Did the health care provider communicate the results of the pathology study to the patient within specified time frames? (2.012)	0	7	3	0
				Overall percentage (MIT 2): **56.2%**

* 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

- Medical leadership should ensure time-sensitive laboratory tests are completed within the specified time frames.

- The department should consider developing an electronic solution to ensure providers create patient letters at the time of endorsement and the patient results letter automatically populates accurately with all elements required by CCHCS policy.

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, cardio-pulmonary 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) performance in identifying problems with its emergency services. The OIG assessed the institution's emergency services mainly through case review.

Results Overview

CAL delivered adequate emergency care. We reviewed approximately the same number of events we reviewed in Cycle 5, and we identified fewer deficiencies. Providers performed well in urgent and emergent situations. Nursing staff provided timely and appropriate care but did not always document thoroughly. We identified a pattern of deficiencies in the documenting assessment timelines and intervention timelines. We identified another area for improvement in the emergency medical response (EMR) audits related to transferring patients to a higher level of care. Although audits were completed timely, the auditing committee did not identify areas of performance improvement in approximately half of the reviewed cases. Taking into account all aspects of emergency services, we rated this indicator ***adequate***.

Case Review Results

We reviewed 29 urgent or emergent events in 15 cases.[21] We identified 15 emergency care deficiencies, of which none were significant.[22]

Emergency Medical Response

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

[21] We reviewed emergency events in cases 1–8, 13, and 15–20.

[22] Deficiencies occurred twice in cases 3, 18, and 19, and three times in cases 5, 15, and 17.

Cardiopulmonary Resuscitation Quality

During the review period, we reviewed two cases in which cardiopulmonary resuscitation (CPR) was initiated.[23] We found that staff initiated CPR timely, activated the 9-1-1 system appropriately, and promptly transferred the patient to the TTA for further interventions.

Provider Performance

Providers performed well in urgent and emergent events. Providers were available to the TTA staff for consultation. The providers generally made appropriate decisions, ordered transfers to a higher level of care when necessary, and documented these events thoroughly.

Nursing Performance

Nurses performed well in emergency events. The nurses responded promptly to emergency events and provided appropriate assessments and interventions. Patients were monitored appropriately. We identified no patterns of deficiencies in assessments and interventions.

Nursing Documentation

Nursing documentation was adequate. Nurses generally documented the timelines of the emergency events appropriately. However, we identified a pattern of timeline discrepancies related to the sequence of events when patients are transferred to the community hospital.[24] Although documentation deficiencies were commonly identified during urgent and emergent events, these deficiencies are considered minor and did not significantly increase the risk of harm to patients. Examples follow:

- In cases 3 and 5, there were timeline documentation discrepancies in nursing assessments after the patients departed to the community hospital.
- In case 18, there was a timeline discrepancy in documenting nursing intervention, as the TTA nurse documented that the patient received medication and intravenous (IV) fluid after the patient had already departed the TTA to a community hospital. Furthermore, the nurse did not document the size of the IV needle.
- In case 19, there was a timeline discrepancy in documenting an emergent event, as the TTA nurse documented administering IV fluid prior to the patient's arrival at the TTA. Furthermore, the nurse

[23] We reviewed CPR in cases 2 and 5.

[24] Documentation deficiencies occurred once in cases 3, 5, 17, and 19, and twice in cases 15 and 18.

documented that the EKG was completed, but did not document the EKG result.

Emergency Medical Response Review Committee

Emergency Medical Response Review Committee (EMRRC) meetings occurred monthly, during which the committee discussed pertinent findings obtained from the EMR audits. Our compliance team found one incomplete checklist and identified that one checklist was missing, supervisory documentation of the committee's clinical review was missing, and entries were missing (MIT 15.003, 25.0%). In case review, we found documentation deficiencies were not identified in the EMRRC or in the supervisory clinical review.[25]

Clinician On-Site Inspection

Our clinicians toured the TTA, which had three bays to provide emergency care. Staffing for the TTA included two RNs for all shifts. During normal business hours, CAL had a designated provider for the TTA. After hours, on weekends, and on holidays, CAL used on-call providers.

The new EMR training was implemented January 2021. In emergency events, the TTA staff respond to the emergency with the medical emergency response vehicle (MERV).

The TTA supervising registered nurse (SRN) reported that audits are performed by spot-checking the documentation and assessment of all care provided in the TTA. The yard SRN is responsible for completing the EMR checklist if an emergency response occurs in the SRN's assigned yard. The TTA SRN reported that the yard SRN would address any documentation or assessment issues at the time of the review, when possible.

The TTA staff morale at the time of our visit was low; the staff were often overworked due to a staff shortage resulting from COVID-19 exposure. Staff reported that the TTA SRN was very supportive of the TTA staff and assisted them as needed.

[25] Deficiencies in EMR audits were identified in cases 3, 5, 15, 17, and 19.

Recommendations

- Nursing leadership should consider providing additional training to staff to ensure thorough documentation of emergent events includes all appropriate times.
- Nursing leadership should ensure supervising registered nurses (SRNs) complete thorough audits of emergent events in which patients transfer to a higher level of care.

Health Information Management

Overall Rating
Adequate

Case Review Rating
Adequate

Compliance Score
Inadequate **(74.8%)**

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

Results Overview

CAL had a mixed performance in this indicator. CAL performed well in retrieving and scanning hospital records, specialty reports, and diagnostic tests. Nurses and providers recorded urgent and emergent events thoroughly. However, the institution did not always retrieve pathology reports within the required time frames. After considering all factors of health information management, the OIG rated this indicator ***adequate***.

Case Review and Compliance Results

During the review period, our clinicians found 24 deficiencies related to health information management, five of which were significant.[26]

Hospital Discharge Reports

CAL performed very well in retrieving and scanning hospital records. Compliance testing found that CAL staff retrieved and scanned all hospital discharge records within the required time frames (MIT 4.003, 100%). Most discharge records included the important physician discharge summary, and providers endorsed the reports within five days (MIT 4.005, 87.5%). Our clinicians reviewed 13 hospital events and did not identify any deficiencies.

Specialty Reports

CAL performed well in retrieving and reviewing specialty reports. Compliance testing showed that 86.7 percent of specialty reports were scanned within the required time frame (MIT 4.002). Staff received or reviewed most high-priority, medium-priority, and routine specialty reports within the required time frames (MIT 14.002, 78.6%; MIT 14.005, 80.0%; and MIT 14.008, 66.7%).

[26] Deficiencies occurred once in cases 3 and 16; twice in cases 6, 17, 19, and 21; and three times in cases 7, 14, 15, and 20. Significant deficiencies occurred in cases 3, 14, 15, 19, and 20.

Our clinicians reviewed 67 specialty reports and identified two specialty reports received late and three specialty reports reviewed late.[27] These deficiencies are discussed in the **Specialty Services** indicator.

Diagnostic Reports

CAL proficiently retrieved and endorsed diagnostic reports. Compliance testing showed providers endorsed radiology and laboratory reports within the required time frames (MIT 2.002, 100%, and MIT 2.005, 90.0%).

However, CAL performed poorly in retrieving pathology reports, as compliance testing found staff retrieved 40.0 percent of pathology reports within the required time frames (MIT 2.010). Providers often endorsed the pathology reports within the specified time frames (MIT 2.011, 85.7%). Our clinicians found that one of two pathology reports was not retrieved; the missing pathology report is discussed in the **Diagnostic Services** indicator.[28]

Urgent and Emergent Records

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

Scanning Performance

Compliance testing found CAL performed poorly with the scanning process: the institution did not scan, label, or name medical files accurately (MIT 4.004, zero). Our clinicians identified one mislabeled document:

- In case 16, an EKG was mislabeled as a parole medication receipt.

Clinician On-Site Inspection

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

For on-site specialty reports, the on-site specialty nurses reported that they scanned the reports on the same day the visit occurred. For off-site specialty reports, the medical record staff scanned the hand-written reports on the day the visit occurred and scanned the formal specialty reports as they received them. The specialty nurses also contacted the specialists directly for any missing specialty reports.

---

[27] Two specialty reports were retrieved late occurred in case 20. Three specialty reports were reviewed late occurred in cases 3, 15, and 17.

[28] The missing pathology report occurred in case 14.

Table 9. Health Information Management

Compliance Questions	Scored Answer			
	Yes	No	N/A	Yes %
Are health care service request forms scanned into the patient's electronic health record within three calendar days of the encounter date? (4.001)	20	0	10	100%
Are specialty documents scanned into the patient's electronic health record within five calendar days of the encounter date? (4.002) *	26	4	15	86.7%
Are community hospital discharge documents scanned into the patient's electronic health record within three calendar days of hospital discharge? (4.003) *	8	0	0	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) *	7	1	0	87.5%
				Overall percentage (MIT 4): **74.8%**

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

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

Table 10. Other Tests Related to Health Information Management

	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) *	9	1	0	90.0%
Laboratory: Did the provider acknowledge the STAT results, OR did nursing staff notify the provider within the required time frame? (2.008) *	N/A	N/A	N/A	N/A
Pathology: Did the institution receive the final pathology report within the required time frames? (2.010) *	4	6	0	40.0%
Pathology: Did the health care provider review and endorse the pathology report within specified time frames? (2.011) *	6	1	3	85.7%
Pathology: Did the health care provider communicate the results of the pathology study to the patient within specified time frames? (2.012)	0	7	3	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) *	11	3	1	78.6%
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) *	12	3	0	80.0%
Did the institution receive and did the primary care provider review the routine-priority specialty service consultant report within the required time frame? (14.008) *	10	5	0	66.7%

* 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

- Medical leadership should ensure pathology results are retrieved within the required time frames.
- Medical leadership should remind staff to properly scan and file medical records.

Health Care Environment

Overall Rating
Inadequate

Case Review Rating
(N/A)

Compliance Score
Inadequate
(48.5%)

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' performance in maintaining 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 used in the Cycle 4 and Cycle 5 medical inspections. Our case review clinicians do not rate this indicator.

Results Overview

Multiple aspects of CAL's health care environment needed improvement: multiple clinics and the medical warehouse contained expired medical supplies; multiple clinics contained noncalibrated or nonfunctional equipment; Emergency Medical Response Bags (EMRB) had nonfunctional oxygen tanks or a defective oxygen pressure gauge; EMRB logs were missing staff verification, or EMRB inventory was not performed; and staff did not regularly sanitize their hands before or after examining patients. These factors resulted in an ***inadequate*** rating for this indicator.

Compliance Testing Results

Outdoor Waiting Areas

The institution had no waiting areas that required patients to be outdoors.

Indoor Waiting Areas

We inspected indoor waiting areas. Health care and custody staff reported existing waiting areas contained sufficient seating capacity. However, during our inspection, we observed overcrowding or noncompliance with social distancing requirements in a majority of the clinics' indoor waiting areas. For example, custody staff reported the indoor holding area for A Clinic had a maximum capacity of eight patients at a time, but we observed the holding area did not have enough space to comply with the social distancing requirement once it reach its maximum capacity. In addition, custody staff in B Clinic, which was located in a temporary location, reported they avoided overcrowding by only calling patients to the clinic close to the patient's appointment time, but we observed overcrowding and noncompliance with social distancing requirements (see Photo 1, next page).

Photo 1. Indoor waiting area in B Clinic showed overcrowding and noncompliance with social distancing requirement (photographed on November 16, 2021).

Clinic Environment

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

Of the nine clinics we observed, three contained appropriate space, configuration, supplies, and equipment to allow their clinicians to perform proper clinical examinations (MIT 5.110, 33.3%). The remaining six clinics had one or more of the following deficiencies: examination rooms lacked visual or auditory privacy (see Photo 2); examination rooms lacked adequate space (less than 100 square feet); there was a torn clinician chair vinyl cover; and examination table placement prevented patients from fully lying down.

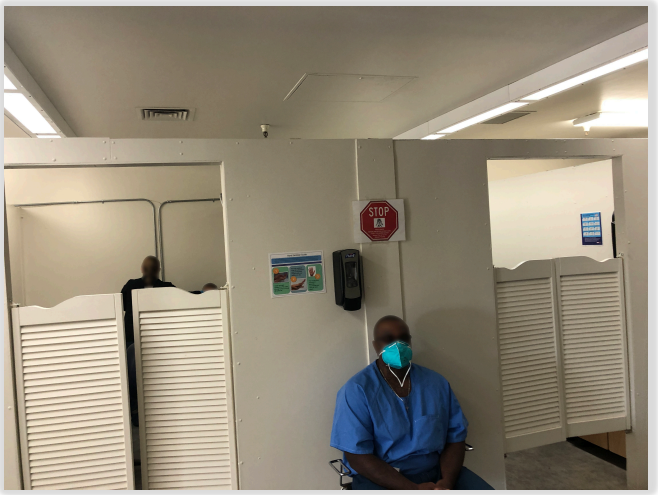


Photo 2. Patient seen sitting B Clinic's examination room doorway; patient encounter did not provide a reasonable level of auditory privacy (photographed on November 16, 2021).

Clinic Supplies

Three of the 10 clinics followed adequate medical supply storage and management protocols (MIT 5.107, 30.0%). We found one or more of the following deficiencies in six clinics: expired medical supplies (see Photo 3, next page); unidentified or inaccurately labeled medical supplies; compromised original medical supply

Photo 3. Expired medical supplies dated June 25, 2020 (photographed on November 16, 2021).

packaging; medical supplies stored directly on the floor; staff members' personal food items stored in the medical supply storage room location; and cleaning materials stored with medical supplies.

Four of the 10 clinics met requirements for essential core medical equipment and supplies (MIT 5.108, 40.0%). The remaining six clinics lacked medical supplies or contained improperly calibrated or nonfunctional equipment. The missing items included examination table disposable paper and a Snellen chart. The staff had not properly calibrated a nebulizer and vital sign equipment. We found a nonfunctional oto-ophthalmoscope and expired automated external defibrillator (AED) pads (see Photo 4, below).

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 eight EMRBs passed our test (MIT 5.111, zero). We found one or more of the following deficiencies with all the EMRBs: staff failed to ensure that EMRB compartments were sealed and intact; staff had not inventoried the EMRBs when seal tags were replaced or had not inventoried the EMRBs in the previous 30 days; several EMRBs lacked medium- or large-sized gloves; EMRBs contained compromised nonrebreather mask or Ambu bag packaging; and EMRBs had nonfunctional oxygen gauges. In addition, we found that the treatment carts in the TTA did not meet the minimum inventory level.

Photo 4. Expired automated external defibrillator (AED) in the OHU dated December 14, 2018 (photographed on November 16, 2021).

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

- We observed B clinic staff respond to housing unit B-3 for an emergency. Staff reported they were unable to use the EMRB's oxygen due to the installed nonfunctional oxygen gauge. Staff reported they needed to wait for the institution's emergency medical response vehicle (EMRV) to arrive at the housing unit to use the oxygen tank and administer oxygen to the patient.

Medical Supply Management

None of the medical supply storage areas located outside the medical clinics stored medical supplies adequately (MIT 5.106, zero). We found expired medical supplies and medical supplies stored directly on the floor (see Photos 5 and 6). The warehouse manager reported that he and his staff do not monitor and maintain a temperature log where medical supplies were stored.

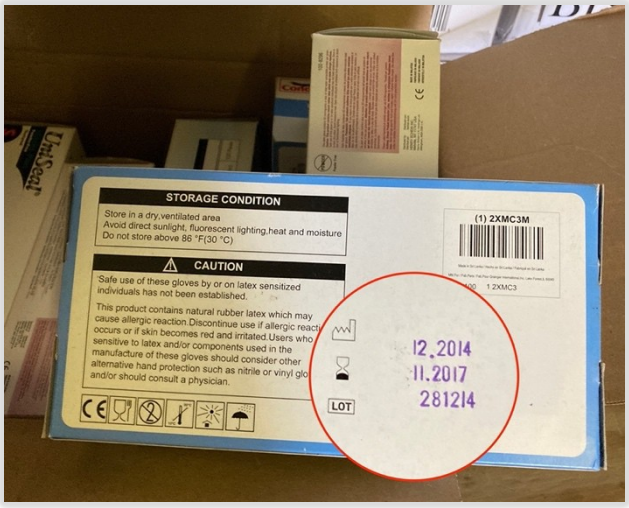


Photo 5. Expired medical supply dated November 2017 (photographed on November 18, 2021).

Photo 6. Medical supplies stored directly on the floor (photographed on November 18, 2021).

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

In addition to the above findings, our compliance inspectors observed the following in the medical warehouse or Conex box when they conducted their on-site inspection:

- The medical warehouse stored reusable medical equipment without date stamps that specified when the equipment was processed in the autoclave and without the nurse's initials (see Photo 7).

Photo 7. Previously sterilized reusable invasive medical equipment was missing a date stamp and nurse's initials (photographed on November 18, 2021).

Infection Control and Sanitation

Staff appropriately disinfected, cleaned, and sanitized eight of 10 clinics (MIT 5.101, 80.0%). In one clinic, cleaning logs were not maintained, and the cabinet under the sink was unsanitary. In another clinic, biohazardous waste was not emptied after each clinic day.

Staff in six of 10 clinics (MIT 5.102, 60.0%) properly sterilized or disinfected medical equipment. In four clinics, we found one or more of the following deficiencies: staff did not mention disinfecting the examination table as part of their daily start-up protocol; staff did not remove and replace the examination table disposable paper after each patient encounter; and staff stored previously sterilized medical equipment beyond the documented shelf life.

We found operating sinks and hand hygiene supplies in the examination rooms in eight of 10 clinics (MIT 5.103, 80.0%). In one clinic, the patient restroom lacked antiseptic soap. In another clinic, the patient restroom lacked disposable hand towels, and the clinic examination room lacked an alcohol-based hand sanitizer or antiseptic soap and disposable hand towels.

We observed patient encounters in five clinics. In four clinics, clinicians did not wash their hands before or after examining their patients, before regloving, or after performing physical therapy services (MIT 5.104, 20.0%).

Health care staff in nine of 10 clinics followed proper protocols to mitigate exposure to bloodborne pathogens and contaminated waste (MIT 5.105, 90.0%). One clinic lacked medical gowns as part of their personal protective equipment (PPE).

Physical Infrastructure

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

At the time of our medical inspection, the institution reported several health care facility improvement program (HCFIP) projects were started between July 2018 and June 2021, including renovating Clinics B, C, D, and the central health facility's primary clinics. The construction slowed and halted due to the COVID-19 pandemic. The institution estimated the projects would be restarted on February 2022 and be completed between March 2022 and August 2023 (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	2	0	80.0%
Infection control: Do clinical health care areas ensure that reusable invasive and noninvasive medical equipment is properly sterilized or disinfected as warranted? (5.102)	6	4	0	60.0%
Infection control: Do clinical health care areas contain operable sinks and sufficient quantities of hygiene supplies? (5.103)	8	2	0	80.0%
Infection control: Does clinical health care staff adhere to universal hand hygiene precautions? (5.104)	1	4	5	20.0%
Infection control: Do clinical health care areas control exposure to blood-borne pathogens and contaminated waste? (5.105)	9	1	0	90.0%
Warehouse, conex, and other nonclinic storage areas: Does the medical supply management process adequately supports 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)	3	7	0	30.0%
Clinical areas: Do clinic common areas and exam rooms have essential core medical equipment and supplies? (5.108)	4	6	0	40.0%
Clinical areas: Are the environments in the common clinic areas conducive to providing medical services? (5.109)	10	0	0	100%
Clinical areas: Are the environments in the clinic exam rooms conducive to providing medical services? (5.110)	3	6	1	33.3%
Clinical areas: Are emergency medical response bags and emergency crash carts inspected and inventoried within required time frames, and do they contain essential items? (5.111)	0	8	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): **48.5%**			

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

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

Recommendations

- Medical leadership should remind staff to follow universal hand hygiene precautions. Implementing random spot checks could improve compliance.
- Executive and nursing leadership should consider performing random spot checks to ensure medical supplies are adequately stored in medical supply storage areas located in and outside the clinic.
- Nursing leadership should consider directing each clinic nurse supervisor to review the monthly emergency medical response bag (EMRB) logs to ensure the EMRBs are regularly inventoried and sealed.

Transfers

Overall Rating
Inadequate

Case Review Rating
Adequate

Compliance Score
Inadequate **(70.6%)**

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 institutions, inspectors checked whether staff reviewed patient medical records and determined the patient's need for medical holds. They also assessed whether staff transferred patients with their medical equipment and gave correct medications before patients left. In addition, our inspectors evaluated the performance of staff in communicating vital health transfer information, such as preexisting health conditions, pending appointments, tests, and specialty referrals; and inspectors confirmed whether 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

CAL delivered a mixed performance in this indicator. Our clinicians reviewed a similar number of events for inter- and intrasystem transfers as we did in in Cycle 5. However, in this cycle, the clinicians identified multiple deficiencies related to medication continuity for patients returning from the hospital. Our compliance team also found delays in medication continuity for patients returning to the institution from the hospital as well as for patients transferring into CAL from another institution. In addition, the compliance team found nurses performed poorly in completing the initial health screening when the patients transferred into the institution. Considering both case review and compliance results, the OIG rated this indicator ***inadequate***.

Case Review and Compliance Testing Results

We reviewed 36 events in 20 cases in which patients transferred into or out of the institution or returned from an off-site hospital or emergency room. We identified nine deficiencies, three of which were significant.[29]

Transfers In

CAL's performance in transferring patients into the institution was poor. The receiving and release (R&R) nurses did not complete the initial health screening form thoroughly (MIT 6.001, 28.0%). Analysis of the compliance data showed that the nurses did not complete the initial health screening within the required time frames, address the symptom of fatigue in the TB screening, or obtain the

[29] Deficiencies occurred in cases 4, 15, 17, 22, 25, 26, and 46. Significant deficiencies occurred in case 4, 15, and 17.

patient's weight. In addition, the nursing staff did not document an explanation to the "Yes" answers to questions regarding medical appointments, mental illness treatment, and cocci risk factors.

OIG clinicians reviewed 14 events in seven cases in which patients transferred into the facility from other institutions. We identified three deficiencies, none of which were significant.[30] Examples follow:

- In case 4, the nurse assessed the newly arrived patient with a history of hypertension. The nurse obtained an elevated blood pressure reading but did not auscultate heart sounds, assess for leg edema, reassess the blood pressure, or inquire about compliance with blood pressure medications. In addition, the nurse documented an RN follow-up in 30 days but did not order the RN follow-up appointment on the arrival day. Instead, a nurse ordered the appointment 28 days later.

- In case 22, a patient arrived at CAL, but the nurse did not obtain vital signs and weight. In addition, daily COVID-19 quarantine rounds were not consistently conducted, as ordered.

The compliance team found that medication continuity for newly arrived patients was poor (MIT 6.003, 54.6%). The compliance team found that keep-on-person (KOP) medications were not provided timely. However, CAL performed well in medication continuity for patients who transferred within the institution (MIT 7.005, 92.0%). Our case reviewers did not find deficiencies related to medication continuity for patients arriving to the institution.

Compliance testing found that patients endorsed from another institution were seen by the clinician within the required time frame; however, the RN did not address the patient's chronic care conditions, such as asthma, hypertension, and pain (MIT 1.002, 68.0%). Our clinicians did not identify any missed or delayed clinician appointments.

Compliance testing found that 25.0 percent of the preapproved specialty appointments occurred timely for patients transferring into CAL (MIT 14.010). Our clinicians did not identify any missed or delayed preapproved specialty appointments.

Transfers Out

Compliance testing found that patients who transferred out of the institution consistently had their medications and required documents (MIT 6.101, 100%). Our clinicians reviewed three transfer-out cases and identified two deficiencies

[30] We reviewed the following transfer-in cases 4, 8, 20, 22, 23, 24, and 26. Deficiencies occurred in cases 4, 22, and 46.

related to incomplete interfacility transfer forms and one deficiency related to a lapse in medication continuity.[31] An example is listed below:

- In case 26, the nurse did not complete the interfacility transfer information, such as the medical clearance, history and physical exam, and patient's medical summary. Furthermore, the patient did not receive a five-day supply of aspirin.

Hospitalizations

Compliance testing showed that CAL performed poorly in medication continuity for patients who returned to the institution after discharge from the hospital (MIT 7.003, 50.0%). Our clinicians identified three deficiencies related to medication continuity; all three were considered significant:

- In case 4, the patient returned from a community hospital with a diagnosis of a stroke, and the patient received his blood pressure medications and aspirin two days late.

- In case 15, the patient with history of diabetes returned from the hospital, and the patient received his diabetic medication two days late and his chest pain medication 14 days late.

- In case 17, the patient returned from the hospital with a diagnosis of an acute inflammatory bowel disease, and the patient did not receive his morning doses of antibiotic, blood pressure medication, and nonsteroidal anti-inflammatory medications.

CAL performed well in ensuring that provider follow-up appointments occurred within the required time frame for patients returning from the hospital or emergency room visits (MIT 1.007, 83.3%). Our clinicians did not identify missed or delayed provider appointments.

Compliance testing found that staff retrieved and scanned all hospital discharge records within the required time frames (MIT 4.003, 100%). Most discharge records included the important physician discharge summary, and the providers endorsed the reports within five days (MIT 4.005, 87.5%). Our clinicians did not identify any deficiency related to hospital discharge records.

Clinician On-Site Inspection

The R&R staff were knowledgeable about the transfer process, including medication availability, provider appointment timelines, completion of screening questions, and specialty appointment continuity. For patients transferring into the institution, the R&R nurses reviewed the patients' charts to identify any special needs to ensure the transfer is appropriate for the institution. The R&R nurses also use Omnicell (the automated medication dispensing machine) in the

[31] Deficiencies occurred once in case 25 and twice in case 26.

TTA to obtain medications for newly arrived patients without their chronic care medications.

For patients transferring out of the institution, the R&R nurses prescreened the chart and messaged the provider for clearance. The nurses also performed either a COVID-19 polymerase chain reaction (PCR) or a rapid antigen test, verified the patient's possession of durable medical equipment and KOP medications, and obtained a five-day supply of medications. The resource RN coordinated all the care for patients on Suboxone upon arrival and discharge.[32] Paroling patients received a 30-day supply of Suboxone and information from the resource RN regarding where they would follow up in the community for further care.

[32] *Suboxone* is a medication used to treat opioid dependence and addiction.

Table 12. Transfers

Compliance Questions	Scored Answer			
	Yes	No	N/A	Yes %
For endorsed patients received from another CDCR institution or COCF: Did nursing staff complete the initial health screening and answer all screening questions within the required time frame? (6.001) *	7	18	0	28.0%
For endorsed patients received from another CDCR institution or COCF: When required, did the RN complete the assessment and disposition section of the initial health screening form; refer the patient to the TTA if TB signs and symptoms were present; and sign and date the form on the same day staff completed the health screening? (6.002)	25	0	0	100%
For endorsed patients received from another CDCR institution or COCF: If the patient had an existing medication order upon arrival, were medications administered or delivered without interruption? (6.003) *	6	5	14	54.6%
For patients transferred out of the facility: Do medication transfer packages include required medications along with the corresponding transfer packet required documents? (6.101) *	2	0	0	100%
Overall percentage (MIT 6): **70.6%**				

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

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

Table 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) *	17	8	0	68.0%
Upon the patient's discharge from the community hospital: Did the patient receive a follow-up appointment with a primary care provider within the required time frame? (1.007) *	5	1	2	83.3%
Are community hospital discharge documents scanned into the patient's electronic health record within three calendar days of hospital discharge? (4.003) *	8	0	0	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) *	7	1	0	87.5%
Upon the patient's discharge from a community hospital: Were all ordered medications administered, made available, or delivered to the patient within required time frames? (7.003) *	4	4	0	50.0%
Upon the patient's transfer from one housing unit to another: Were medications continued without interruption? (7.005) *	23	2	0	92.0%
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) *	3	2	0	60.0%
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) *	5	15	0	25.0%

* 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

- Nursing leadership should consider reminding nursing staff to thoroughly complete the initial health screening, including answering all questions and documenting an explanation for each "yes" answer.

- Nursing leadership should ensure nursing staff administer medications to patients without interruption.

Medication Management

Overall Rating
Inadequate

Case Review Rating
Adequate

Compliance Score
Inadequate
(65.3%)

In this indicator, OIG inspectors evaluated the institution's performance in administering 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 particularly considered the compliance test results, which tested medication processes to a much greater degree than case review testing. In addition to examining medication administration, our compliance inspectors also tested many other processes, including medication handling, storage, error reporting, and other pharmacy processes.

Results Overview

CAL performed variably in this indicator. In Cycle 5, both case review and compliance testing demonstrated that the institution administered medications without interruption. However, in this cycle, both case review and compliance testing showed delays in medication continuity with chronic care, hospital discharge, specialized medical housing, and transfer medications. Our compliance team found a pattern of patients' not receiving their 30-day supply of chronic care KOP medications within the required time frames. Our case review clinicians found significant deficiencies related to delays in medication continuity for patients returning from the hospital and for patients admitted to the specialized medical housing unit. Considering both case review and compliance testing results, we rated this indicator ***inadequate***.

Case Review and Compliance Testing Results

We reviewed 113 events in 26 cases related to medication management and found 21 medication deficiencies, six of which were significant.[33]

New Medication Prescriptions

CAL performed well in delivering newly prescribed medications. Compliance testing showed that most newly prescribed medication deliveries were completed within the required time frames (MIT 7.002, 92.0%), and case review also showed most patients received their newly prescribed medications timely. We identified five delays in patients' receiving newly prescribed medications.[34] An example follows:

- In case 28, the patient received newly prescribed pain-relieving medication one day late.

[33] Deficiencies occurred once in cases 1, 4, 12–14, 18, 26, 28, and 47; twice in cases 7 and 46; and four times in cases 15 and 17. Significant deficiencies occurred in cases 4, 7, 13, 15, 17, and 46.

[34] Delayed receiving of newly prescribed medication occurred in cases 1, 7, 15, 18, and 28.

Chronic Medication Continuity

Compliance testing found most patients did not receive their chronic care medications within the required time frames (MIT 7.001, 13.3%). Analysis of the compliance data further showed KOP medications were not made available one business day prior to supply exhaustion or were refused by patients, and when medication was refused, the reason for the refusal was not documented. In contrast, our clinicians found most patients received their chronic care medications within the required time frames; however, there were two significant deficiencies related to chronic medication continuity:

- In case 7, the patient received his blood thinner medication four days late.
- In case 13, the patient received his blood pressure medication one month late.

Hospital Discharge Medications

CAL frequently did not ensure patients received their medications when they returned from an off-site hospital or emergency room. The compliance team found that 50.0 percent of patients did not receive their medications within the required time frame (MIT 7.003). Our clinicians reviewed 13 hospital returns and identified three medication management deficiencies, all of which were significant.[35] These deficiencies are discussed further in the **Transfers** indicator.

Specialized Medical Housing Medications

Medication management in the specialized medical housing was poor. In compliance testing, patients who were admitted to the outpatient housing unit (OHU) were not always given their medications timely (MIT 13.004, 70.0%). Our case review clinicians identified five deficiencies related to medication management; one was considered significant.[36] These deficiencies are discussed further in the **Specialized Medical Housing** indicator.

Transfer Medications

In compliance testing, CAL frequently did not ensure that patients who transferred into the institution received their medication timely (MIT 6.003, 54.6%). Patients who were temporarily housed at the facility generally did not receive their medications within the required time frames (MIT 7.006, 60.0%). However, compliance testing found proficient medication continuity for patients transferring from yard to yard (MIT 7.005, 92.0%). Our case review clinicians did

[35] Significant deficiencies in medication management for patients returning from the hospital occurred in cases 4, 15, and 17.

[36] Medication management deficiencies in specialized medical housing occurred once in cases 7, 18, and 47, and twice in case 46. A significant deficiency occurred in case 46.

not find any deficiencies related to medication continuity for patients who transferred into the institution.

Both case review and compliance testing found that CAL performed well in ensuring patients who transferred out of the institution received their five-day supply of medications (MIT 6.101, 100%). Our clinicians found one deficiency related to medication management for a patient transferring out of the institution.[37] Additional information is discussed in the **Transfers** indicator.

Medication Administration

Compliance testing showed nurses administered tuberculosis (TB) medications within the required time frames (MIT 9.001, 88.2%). However, the institution did not thoroughly monitor patients taking TB medications, as required by policy (MIT 9.002, 29.4%). Our case review clinicians did not identify any deficiencies related to TB medications.

Clinician On-Site Inspection

Our clinicians attended huddles in the OHU, in A Clinic, and in C Clinic. During the huddles, care teams discussed medication compliance, including medication nonadherence, and discussed medication continuity for patients transferring into the institution, arriving from another yard, or returning from the hospital.

Our clinicians interviewed the medication nurses and found them to be knowledgeable about the medication administration process. The medication nurses attended clinic huddles and notified providers of expiring medications. Medication rooms were clean and organized, and there were no backlogs of KOP medications.

Our clinicians met with the pharmacist and with nursing leadership to review the on-site questions concerning delays in medication continuity for patients returning from the hospital. Nursing leadership recognized there should be more oversight of the medication reconciliation process. The chief medical executive (CME) also agreed the existing medication reconciliation process was not followed in one reviewed case that we discussed.[38]

The pharmacist-in-charge (PIC) had recently joined CAL and acknowledged that more training would be provided to his pharmacy technicians, in reviewing orders and scanning medications, to prevent delays in medication continuity. Nursing leadership confirmed that most of the medications can be obtained from the Omnicell in the TTA if the nurses need the medication for delivery.[39]

---

[37] A deficiency in medication management for patients transferring out of the institution occurred once in case 26.

[38] We discussed case 4.

[39] An Omnicell is an automated medication dispensing machine.

Compliance Testing Results

The institution adequately stored and secured narcotic medications in seven of eight clinic and medication line locations (MIT 7.101, 87.5%). In one location, nurses did not describe the appropriate narcotic medication discrepancy reporting process.

CAL 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 four of the 10 clinic and medication line locations (MIT 7.103, 40.0%). In six locations, we found one or more of the following deficiencies: staff did not consistently record room and refrigerator temperatures, and staff did not store oral and topical medications separately.

Staff successfully stored valid, unexpired medications in nine of the 10 applicable medication line locations (MIT 7.104, 90.0%). In one location, nurses did not label the multiuse medication, as required by CCHCS policy.

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

Staff in three of six medication preparation and administration areas demonstrated appropriate administrative controls and protocols (MIT 7.106, 50.0%). In three locations, we observed one or both of the following deficiencies: medication nurses did not maintain unissued medication in its original labeled packaging, or medication nurses did not describe the process they followed when reconciling newly received medication and the medication administration record (MAR) against the corresponding physician's order.

Staff in two of six medication areas used appropriate administrative controls and protocols when distributing medications to their patients (MIT 7.107, 33.3%). In four locations, we observed one or more of the following deficiencies: medication nurses did not distribute medications to patients within the time frame of one hour before or one hour after the normal distribution time; medication nurses did not consistently verify patients' identification prior to administering medications; medication nurses did not reliably observe patients while they swallowed direct observation therapy medications; and nurses did not follow insulin protocols properly. We observed during insulin administration that some medication nurses did not properly disinfect the vial's port prior to withdrawing medication.

Pharmacy Protocols

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

The pharmacist-in-charge (PIC) did not correctly review monthly inventories of controlled substances in the institution's clinic and medication storage locations. Specifically, the pharmacists and 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 in this test (MIT 7.111).

We examined 25 medication error reports. The PIC timely or correctly processed only 13 of these 25 reports (MIT 7.112, 52.0%). In 11 reports, the PIC did not document one or more of the following: an explanation for not notifying the provider and/or patient, the contributing cause of the error, where in the error occurred within the pharmacy process, and recommended changes to correct the medication error. For the remaining one report, the prior PIC completed a Medication Error Follow-up form that was not free of discrepancy. Specifically, the form was completed prior to the notification date of the error sent to the previous PIC.

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

We interviewed patients in restricted housing units to determine whether they had immediate access to their prescribed asthma rescue inhalers or nitroglycerin medications. Six of eight applicable patients interviewed indicated they had access to their rescue medications. Two patients reported they did not have their prescribed rescue inhalers: one patient stated he does not need the inhaler, while the other patient stated the medication just run out at the time of our inspection. 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).

Table 14. Medication Management

Compliance Questions	Scored Answer Yes	No	N/A	Yes %
Did the patient receive all chronic care medications within the required time frames or did the institution follow departmental policy for refusals or no-shows? (7.001) *	2	13	10	13.3%
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) *	4	4	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) *	N/A	N/A	N/A	N/A
Upon the patient's transfer from one housing unit to another: Were medications continued without interruption? (7.005) *	23	2	0	92.0%
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) *	3	2	0	60.0%
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)	7	1	2	87.5%
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)	10	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)	4	6	0	40.0%
All clinical and medication line storage areas for nonnarcotic medications: Does the institution safely store nonnarcotic medications that have yet to expire in the assigned storage areas? (7.104)	9	1	0	90.0%
Medication preparation and administration areas: Do nursing staff employ and follow hand hygiene contamination control protocols during medication preparation and medication administration processes? (7.105)	3	3	4	50.0%
Medication preparation and administration areas: Does the institution employ appropriate administrative controls and protocols when preparing medications for patients? (7.106)	3	3	4	50.0%
Medication preparation and administration areas: Does the institution employ appropriate administrative controls and protocols when administering medications to patients? (7.107)	2	4	4	33.3%
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)	13	12	0	52.0%
Pharmacy: For Information Purposes Only: During compliance testing, did the OIG find that medication errors were properly identified and reported by the institution? (7.998)	This is a nonscored test. Please see the indicator for discussion of this test.			
Pharmacy: For Information Purposes Only: Do patients in 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): **65.3%**

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

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

Table 15. Other Tests Related to Medication Management

Compliance Questions	Scored Answer			
	Yes	No	N/A	Yes %
For endorsed patients received from another CDCR institution or COCF: If the patient had an existing medication order upon arrival, were medications administered or delivered without interruption? (6.003) *	6	5	14	54.6%
For patients transferred out of the facility: Do medication transfer packages include required medications along with the corresponding transfer-packet required documents? (6.101) *	2	0	0	100%
Patients prescribed TB medication: Did the institution administer the medication to the patient as prescribed? (9.001) *	15	2	0	88.2%
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) *	5	12	0	29.4%
Upon the patient's admission to specialized medical housing: Were all medications ordered, made available, and administered to the patient within required time frames? (13.004) *	7	3	0	70.0%

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

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

Recommendations

- Medical and nursing leadership should ensure that patients with chronic care conditions, patients returning from hospital admission, and layover patients receive their medications timely and without interruption.

Preventive Services

Overall Rating
Adequate

Case Review Rating
(N/A)

Compliance Score
Adequate
(80.9%)

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 performance in transferring out patients quickly. The OIG rated this indicator solely according to the compliance score, using the same scoring thresholds used in the Cycle 4 and Cycle 5 medical inspections. Our case review clinicians do not rate this indicator.

Results Overview

CAL staff performed well in administering TB medications as prescribed, screening patients annually for TB, offering patients an influenza vaccine for the most recent influenza season, offering colorectal cancer screening for all patients ages 45 through 75, and offering required immunizations to chronic care patients. The institution faltered in monitoring patients who were taking prescribed TB medications. These findings are set forth in the table on the next page. Overall, we rated this indicator ***adequate***.

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)	15	2	0	88.2%
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) †	5	12	0	29.4%
Annual TB screening: Was the patient screened for TB within the last year? (9.003)	25	0	0	100%
Were all patients offered an influenza vaccination for the most recent influenza season? (9.004)	21	4	0	84.0%
All patients from the age of 45 through the age of 75: Was the patient offered colorectal cancer screening? (9.005)	24	1	0	96.0%
Female patients from the age of 50 through the age of 74: Was the patient offered a mammogram in compliance with policy? (9.006)	N/A	N/A	N/A	N/A
Female patients from the age of 21 through the age of 65: Was patient offered a pap smear in compliance with policy? (9.007)	N/A	N/A	N/A	N/A
Are required immunizations being offered for chronic care patients? (9.008)	14	2	9	87.5%
Are patients at the highest risk of coccidioidomycosis (valley fever) infection transferred out of the facility in a timely manner? (9.009)	N/A	N/A	N/A	N/A
				Overall percentage (MIT 9): **80.9%**

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

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

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

Recommendations

- Nursing leadership and the public health nurse should consider educating their nursing staff in accurately monitoring patients taking TB medications.

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' performance in making timely and appropriate assessments and interventions. We also evaluated the institution's nurses' performance in many clinical settings and processes, including sick call, outpatient care, care coordinating 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

CAL generally delivered acceptable nursing care. Compared to their performance in Cycle 5, CAL nurses improved in assessment, intervention, and documentation in outpatient clinics, care management, emergency services, hospital returns, and specialty services. In this cycle, CAL nursing performance was very good in hospitalizations and in specialty services. However, nurses had opportunities for improvement in assessments, documentation, and interventions, especially in the OHU and in interfacility transfers. We rated this indicator ***adequate***.

Case Review Results

Our clinicians reviewed 184 nursing encounters in 46 cases, of which 97 were outpatient nursing encounters. We identified 66 deficiencies, seven of which were significant.[40] Of the 97 outpatient nursing encounters, we identified 37 deficiencies, two of which were significant.[41]

Nursing Assessment and Intervention

A critical component of nursing care is the quality of nursing assessment, which includes both subjective (patient interview) and objective (observation and examination) elements. CAL nurses generally provided adequate nursing assessments and interventions. Most deficiencies related to the quality of nursing care were due to incomplete or inadequate nursing assessments. We identified a pattern of incomplete COVID-19 isolation or quarantine rounds, incomplete vital

[40] Nursing performance deficiencies occurred in cases 1–7, 12-13, 15-19, 22, 25, 26, 30, 31, 33, 34, 36, 39, 40, and 42–47. Significant deficiencies occurred in cases 6, 18, 33, and 46.

[41] Outpatient nursing performance deficiencies occurred in cases 1–4, 6, 12–19, 30, 31, 33, 34, 36, 39, 40, and 42–45. Significant deficiencies occurred in cases 6 and 33.

signs, especially the weight, and incomplete assessments of medication compliance.

- In cases 1, 2, 15, 16, 17, 18, 19, and 22, nurses did not perform COVID-19 quarantine rounds, as ordered.
- In cases 7, 13, 15, 17, 18, 22, 33, 42, 46, and 47, nurses either did not fully complete vital signs or did not complete vital signs at all.
- In cases 15, 33, and 39, nurses did not assess medication compliance.
- In case 2, nurses completed COVID-19 isolation rounds twice a day. However, nurses did not consistently obtain a full set of vital signs that included the respiratory rate.
- In case 6, the LVN consulted with the RN for a patient who reported symptoms of vomiting, fever, and the inability to hold down water. However, the RN instructed the LVN to advise the patient to submit a sick call request instead of evaluating the patient the same day for possible COVID-19 symptoms and dehydration.
- In case 15, the diabetic patient complained of lightheadedness, dizziness, and vomiting blood. The patient was transported to the hospital. The nurse did not obtain orthostatic vital signs or a blood sugar level, document the times EMS arrived and departed from the TTA, nor assess the patient's condition upon transfer.

Nursing Documentation

Complete and accurate nursing documentation is an essential component of patient care. Without proper documentation, health care staff can overlook changes in patients' conditions. Some examples of incomplete documentation include timeline discrepancies in emergency events, missing documentation on the medication administration record, missing discharge documentation from patients discharged from the OHU, missing refusals forms, and missing documentation of communication for pending specialty appointments for patients transferring out of the institution. However, CAL nurses performed well in documentation for outpatient clinics, specialty services, transfers, and hospitalizations.

Nursing Sick Call

The nursing sick call process involves reviewing each sick call request and determining whether the patient's medical symptoms warrant an urgent or routine evaluation. Our clinicians reviewed 49 nursing sick call requests and identified 21 deficiencies, one of which was significant.[42] CAL nurses reviewed

[42] Deficiencies in face-to-face assessments for sick call requests occurred in cases 3, 13, 15, 17, 18, 30, 31, 33, 36, 39, 40, 42, 43, 44, and 45. One significant deficiency occurred in case 33.

symptomatic sick call requests appropriately and generally saw patients timely. The examples below demonstrate room for improvement:

- In case 3, the sick call nurse evaluated the patient for leg swelling after starting a new blood pressure medication. However, the nurse did not weigh the patient. In addition, instead of consulting with the provider that day for a further plan of care, the nurse referred the patient for a provider appointment in 14 days.

- In case 15, the patient complained of not being able to keep food down and reported daily vomiting. The sick call nurse did not obtain a weight nor assess abdominal tenderness, flatness, or distention.

- In case 33, the patient with a history of asthma complained of food allergies, difficulty breathing, diarrhea, and drug withdrawal symptoms. The sick call nurse did not assess lung sounds, bowel sounds, or abdominal tenderness; did not indicate whether the abdomen was flat, distended, or rounded; did not assess medication compliance since the patient was prescribed an inhaler; and did not obtain a weight.

- In case 44, the patient was evaluated for hearing loss and tenderness to the right ear. However, the sick call nurse did not inspect the inside of the right ear. In addition, the nurse documented on the ear drop medication order that the medication was to be placed in the wrong ear.

Care Management

OIG clinicians reviewed seven cases in which patients were evaluated by a care manager or coordinator.[43] Our clinicians found nurses generally performed appropriate assessments and interventions for patients with chronic conditions. The RNs evaluated the patients' need for chronic care appointments upon their transfer into the institution and for follow-up visits ordered by the provider. The LVNs serve as care coordinators in addition to their other duties, such as performing TB screening, blood pressure checks, blood glucose checks, wound care, patient education, COVID-19 testing, vaccinations, and EKGs, as well as distributing durable medical equipment.

Wound Care

We reviewed one case in which wound care was provided.[44] We identified no deficiencies for wound care.

[43] Patients were evaluated by the care manager in cases 2, 4, 9, 11, 13, 15, and 16.

[44] Wound care was performed in case 16.

Emergency Services

Staff performed well when responding to urgent and emergent patients. Nurses generally provided appropriate assessments, interventions, and documentation. However, we identified a pattern of inconsistent timelines related to the sequence of events for patients transferring to the community hospital.[45] We also found room for improvement in the accuracy of the emergency response reviews completed as part of the EMRRC audits.[46] We discuss this further in the **Emergency Services** indicator.

Hospital Returns

We reviewed 11 events in eight cases involving patients who returned from a community hospital or emergency room.[47] Nurses performed well in providing complete assessments, interventions, and documentation. However, we did identify deficiencies related to medication continuity. We discuss this further in the **Transfers** indicator.

Transfers

We reviewed 10 cases that involved transfer-in or transfer-out processes at CAL.[48] Nurses generally performed well in the transfer-in process. However, there was room for improvement in the transfer-out process, due to incomplete screenings and missing documentation or communication of pending specialty appointments. Please refer to the **Transfers** indicator for further details.

Specialized Medical Housing

We reviewed five cases with a total of 22 nursing events, and we identified 16 deficiencies, five of which were significant.[49] Nursing assessment, documentation, and care plans had room for improvement in the outpatient housing unit (OHU). We discuss this further in the **Specialized Medical Housing** indicator.

---

[45] Emergency services documentation deficiencies occurred in cases 3, 5, 15, 17, 18, and 19.

[46] Deficiencies in EMR audits were occurred in cases 3, 5, 15, 17, and 19.

[47] Patients returning from an off-site hospitalization or emergency room visit occurred in cases 3, 4, 7, 15, 16, 17, 18, and 19.

[48] Transfer cases included cases 4, 8, 20, 22, 23, 24, 25, 26, 27, and 46.

[49] SMH nursing deficiencies occurred in cases 7, 18, 46, and 47. Significant deficiencies occurred twice in case 18 and three times in case 46.

Specialty Services

We reviewed 68 events in 16 cases in which patients received specialty services; there were no nursing performance deficiencies.[50] When patients returned to the institution from a specialty appointment, CAL nurses performed very well. Nurses appropriately assessed patients, reviewed off-site documents for recommendations, and communicated information to providers.

Medication Management

Our clinicians examined 113 events in 26 cases related to medications. We found 21 medication deficiencies, six of which were significant.[51] Both compliance inspectors and case reviewers identified lapses in medication continuity. In addition, we found incomplete medication reconciliation for patients returning from the hospital and lapses in medication administration in the OHU. Please refer to the **Medication Management** indicator for further details.

Clinician On-Site Inspection

Our clinicians interviewed nurses and nurse managers in the triage and treatment area (TTA), the outpatient housing unit, and the receiving and release (R&R) area, as well as in the specialty services clinics, public health clinics, outpatient clinics, and medication areas. Clinics B, C, and D were under construction, so the staff was working out of temporary facilities. Clinic A construction was completed six months prior to our on-site visit. We attended two outpatient clinic huddles and one OHU huddle. The huddles were well attended by the care teams, and pertinent information was discussed. Nursing staff were familiar with the patient population.

Clinic staff reported no backlog for the RN line at the time of our visit. The RN clinic line ranged from 15 to 23 patients per day, and the LVN care coordinator line ranged from 20 to 30 patients per day. The LVN staff served as care coordinators, and their duties consisted of performing blood pressure checks, performing TB screenings, offering vaccines, patient education, and dispensing durable medical equipment. The two outpatient clinics we visited were short-staffed, and the LVN care coordinators were out due to illness.

We also met with the chief executive officer (CEO), the chief medical executive (CME), chief nursing executive (CNE), the supervising registered nurse III (SRN III), the chief physician and surgeon (CP&S), the public health nurse (PHN), and the infection control nurse, and were told that the institution was on a modified program due to the COVID-19 outbreak at the institution. At the time of our visit, the team reported that 81 percent of patients were COVID-19 vaccinated and 77 percent of staff were COVID-19 vaccinated.

---

[50] Specialty services occurred in cases 3, 4, 7, 9, 10, 11, 12, 13, 14, 15, 17, 18, 20, 21, 46, and 47.

[51] Deficiencies in medication management occurred once in cases 1, 4, 12, 13, 14, 18, 26, 28, and 47; twice in cases 7 and 46; and four times in cases 15 and 17. Significant deficiencies occurred in cases 4, 7, 13, 15, 17, and 46.

The CEO reported the goal was to offer the patients the COVID-19 booster vaccines by March 2022.

At our on-site visit, the leadership informed us that they had 30 patients who had tested positive for COVID-19 and approximately 70 staff who either tested positive for COVID-19 or were in isolation or quarantine due to COVID-19 exposure. Five buildings were under COVID-19 quarantine. Patients in the quarantined buildings were released in cohorts, according to their building, for medications and appointments. The patients in COVID-19 isolation were medicated at the cell front, and if they had any medical concerns, they were evaluated in the building, which had a clinic space with adequate vital sign equipment. In addition, we were informed the CME had written standing orders for cough drops, Pedialyte, and Tylenol to limit patient movement for patients with COVID-19 symptoms.

The leadership addressed our findings and acknowledged several opportunities for quality improvement. Nursing leadership expressed its belief that the team had experienced challenges with staffing due to a 66-percent vacancy rate along with multiple staff who had been out sick due to COVID-19, but acknowledged the great work the team had performed in providing patient care, despite the current staffing constraints.

Recommendations

- Nursing leadership should ensure nurses perform more detailed assessments and interventions during outpatient patient encounters and should consider implementing audits.

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' performance in evaluating, diagnosing, and managing 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

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

Case Review Results

In our inspection, we found a total of nine deficiencies, of which two were considered significant.[52] OIG physicians also rated the overall adequacy of care for each of the 20 detailed case reviews they conducted. Of these 20 cases, 19 were ***adequate*** and one was ***inadequate***.

Assessment and Decision-Making

CAL providers generally made appropriate assessments and sound medical plans for their patients. They diagnosed medical conditions correctly, ordered appropriate tests, and coordinated effective treatment plans for their patients. Our clinicians identified four deficiencies related to poor medical decisions.[53] An example follows:

- In case 46, the patient complained of an ingrown toenail. The provider noted that the patient had an ingrown toenail on the left foot, but did not document which toe or assess for signs of infection that may have required treatment and an antibiotic.

[52] Deficiencies occurred in cases 5, 6, 8, 9, 11, 15, 16, 17, and 48. Significant deficiencies occurred in cases 6 and 11.

[53] Deficiencies occurred in cases 8, 16, 17, and 46.

Review of Records

For patients who returned from hospitalizations, CAL providers performed well in reviewing medical records and addressing the hospitalists' recommendations. Providers also performed well in reviewing the medication administration record (MAR) and reconciling the patient's medications.

Emergency Care

CAL providers made appropriate triage decisions when the patients arrived at the triage and treatment area (TTA) for emergency treatment. In addition, providers were available for consultation with the TTA nursing staff. We did not identify any deficiencies related to emergency care.

Chronic Care

CAL providers delivered good care in managing chronic medical conditions such as hypertension, diabetes, asthma, hepatitis C infection, and cardiovascular disease. For patient with diabetes, the providers regularly monitored the patients' blood glucose levels and adjusted diabetic medications as needed. However, our clinicians identified two deficiencies related to diabetic care, of which one was considered significant.[54] An example follows:

- In case 11, the provider reviewed an elevated hemoglobin A1c consistent with the diagnosis of new onset diabetes.[55] However, the provider did not address the new onset diabetes until almost three months later.

For patients requiring anticoagulation, providers prescribed appropriate doses of oral anticoagulants and monitored INR levels when indicated.[56] However, there was one significant deficiency related to poor anticoagulation management:

- In case 6, the patient had an acute deep vein thrombosis, and the provider prescribed an oral anticoagulant at half of the recommended dose to treat an acute deep vein thrombosis.

[54] Deficiencies occurred in cases 9 and 11. A significant deficiency occurred in case 11.

[55] Hemoglobin A1c is a blood test that measures the average plasma glucose over the previous 12 weeks.

[56] The INR is a lab test to measure the body's blood clotting. This test is used to monitor the effectiveness of blood thinning medications such as warfarin.

Specialty Services

CAL providers appropriately referred patients to specialists and reviewed specialty reports in a timely manner; providers also adequately addressed specialists' recommendations. Our clinicians did not identify any provider deficiencies related to specialty services.

Documentation Quality

CAL providers generally documented outpatient and TTA encounters on the day of the encounter. Our clinicians identified two deficiencies related to a provider's lack of documentation.[57] An example follows:

- In case 5, the patient presented to the TTA without a pulse, and a provider was notified; however, the provider did not document a progress note for this TTA event.

Provider Continuity

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

Clinician On-Site Inspection

Medical leadership reported that CAL had 6.5 provider positions and no vacancies. Providers were enthusiastic about their work and generally satisfied with nursing, diagnostic, and specialty services. Provider meetings occur every Wednesday, and population health management meetings occur one to two times per months for each main clinic. Our clinicians attended morning huddles, where the clinic team discussed patients returning from hospitalization or specialty appointments with recommendations. The nurses informed the providers of the scheduled appointments, expiring medications, and new arrivals from other institutions.

CAL providers routinely screened patients for possible opioid abuse and referred them to the substance use disorder treatment program. Our clinicians discussed with the chief physician and surgeon (CP&S) and chief medical executive (CME) possible Suboxone diversion.[58] Our clinicians discussed a case where the patient stated that he injected Suboxone under his clavicle, and subsequently the patient developed soft tissue infection and osteomyelitis.[59] The CME acknowledged the possible Suboxone diversion and stated that the institution followed the CCHCS guidelines for Suboxone administration. The CME also consulted with CCHCS

[57] Deficiencies occurred cases 5 and 15.

[58] Suboxone is a medication containing buprenorphine and naloxone. Suboxone is used to treat opioid dependence and addiction.

[59] Osteomyelitis is an infection of the bone.

medical leadership, who instructed the institution to continue with the use of Suboxone, as the benefits outweigh the risks of harm.

Recommendations

The OIG offers no recommendations for this indicator.

Specialized Medical Housing

Overall Rating
Inadequate

Case Review Rating
Inadequate

Compliance Score
Adequate **(75.0%)**

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 we 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, CAL's specialized medical housing consisted of an outpatient housing unit (OHU).

Results Overview

Overall, CAL delivered poor care in the OHU. We found poor nursing assessments and interventions. We also found problems with medication continuity. However, provider performance was adequate. After considering case review results and compliance testing, we rated this indicator ***inadequate***.

Case Review and Compliance Testing Results

We reviewed five OHU cases, which included 25 provider events and 22 nursing events.[60] Because of the care volume that occurred in the specialized medical housing unit, each provider event represented up to one month of provider care, and each nursing event represented up to two weeks of nursing care. We identified 22 deficiencies, six of which were significant.[61]

Provider Performance

The providers generally delivered good care in the OHU. Compliance inspectors found that providers generally performed timely admission history and physical exams (MIT 13.002, 80.0%). Our clinicians reported similar findings: providers performed rounds on their patients within appropriate intervals and completed thorough discharge summaries. Our clinicians found one provider deficiency; this deficiency is discussed in the **Provider Performance** indicator.[62]

[60] OHU events occurred in cases 7, 8, 18, 46, and 47.

[61] OHU deficiencies occurred three times in case 47, four times in case 7, six times in case 18, and nine times in case 46. Significant deficiencies occurred twice in case 18 and four times in case 46.

[62] The deficiency occurred in case 46.

Nursing Performance

Compliance testing found that patients admitted into the OHU frequently did not receive a timely initial nursing health assessment (MIT 13.001, 50.0%). Our clinicians did not identify any missed or delayed initial nursing health assessments. However, we found incomplete nursing assessments, missed care plans, and poor documentation. Our clinicians concluded that of the 22 deficiencies in specialized medical housing, 16 were directly related to quality of nursing care, five of which were significant. Examples of deficiencies follow:

- In cases 7, 18, 46, and 47, the nurses did not establish appropriate patient care plans.

- In cases 7 and 18, the nurses did not consistently assess the PICC line site at least daily for the patients requiring intravenous (IV) antibiotic therapy.[63] Furthermore, in these two cases, the nurses did not consistently obtain vital signs twice a day, as ordered.

- In case 18, on several occasions, the certified nursing assistant (CNA) obtained vital signs showing low pulses but did not notify the RN for further evaluation. In addition, an RN did not obtain an antibiotic trough level, as ordered.[64]

- In case 46, the patient with end stage liver disease was admitted to the OHU, but the admitting nurse did not assess lung and bowel sounds, did not palpate the abdomen for tenderness, and did not assess abdominal appearance. The nurse also did not obtain an admission weight. In addition, on a few occasions the patient's oxygen saturation was low while the patient was on room air; however, the nurses did not assess lung sounds, respiratory rate, skin color, or reassess the oxygen saturation timely.

- In case 47, the patient returned from a hospitalization for a joint infection and was readmitted to the OHU. The nurse did not obtain the patient's weight upon his readmission and did not establish a care plan to address the infection. In addition, the nurses did not consistently complete a full set of vital signs to include temperature, respiration rate, pulse, blood pressure, and oxygen saturation at least daily for a patient with an infection requiring antibiotic therapy.

[63] A PICC is a peripherally inserted central catheter, which is used to provide intravenous access and administer fluids and medication.

[64] The trough is the lowest level of the drug while in the therapeutic range. Trough levels are used in medication monitoring.

Medication Administration

OHU staff performed poorly in medication administration. Compliance testing showed 70.0 percent of patients newly admitted to the OHU received their medications within the required time frames (MIT 13.004). Our clinicians identified five deficiencies related to medication management; one was considered significant.[65] The following are examples:

- In case 18, the patient received the newly prescribed antibiotic one day late.
- In case 46, the patient was transferred to CAL and admitted to the OHU; however, the patient did not receive four doses of his blood pressure medication.
- In case 47, the patient received the newly prescribed blood pressure medication four days late.

Clinician On-Site Inspection

Our clinicians interviewed the OHU RN and the provider, who reported having a good working relationship with medical leadership and nursing staff. The OHU nurse reported the TTA or R&R RN provided care to the patient after hours, and that care could include admissions, discharges, emergencies, or changes of condition. When asked whether care plans were initiated in OHU, the OHU nurse reported that OHU nurses do not create care plans, and if there were an order to "Review Care Plans," that order meant they were to review the chart, not the actual care plan. The OHU nurse reported that sick call requests were collected and addressed the same day.

Our clinicians attended the well-organized OHU morning huddle, which was conducted daily. The provider, the RN, the utilization management nurse, the office technician, the infection control nurse, the supervising RN, and custody staff were present. The discussion included admissions, discharges, emergencies, medication renewals and refusals, specialty appointments, and patients on antibiotics through the PICC line.

The institution's OHU had 18 beds, including two negative-pressure rooms for respiratory isolation. At the time of our on-site inspection, 13 beds were occupied, and two were vacant due to alarm issues and a water leak. Nursing staff reported that patients who were at risk of falling were provided portable call lights in addition to their room call lights to help prevent injury.

Nurses provided 24-hour care, with an RN and CNA in the morning and one LVN on the evening and graveyard shifts. When there was no RN on duty in the OHU,

[65] Deficiencies occurred once in case 7, 18, and 47, and twice in case 46. A significant deficiency occurred once in case 46.

the LVNs were instructed to notify the treatment and triage area (TTA) RN if they had any patient concerns. The supervising RN was recently assigned to the OHU, approximately one month prior to our on-site visit, and was still learning the responsibilities in the OHU.

In the OHU, the provider generally saw the patient once a month, or more frequently as needed. The nurse reported rounds were performed on every shift and documented in a communication book. These rounds consisted of making sure the patient was stable and addressing any patient concerns. If a patient reported any changes of conditions or had any abnormal findings, the LVN or CNA notifies the RN for further evaluation and documents the conditions or findings, as well as the RN notification, in the electronic health record. The OHU RN generally performed rounds on the patient daily.

When our clinicians met with nursing leadership to review on-site questions regarding poor assessments or documentation, the nursing leadership reported that in the future more oversight would be implemented. Nursing leadership reported they had a PICC line group that created the PICC local operating procedures. The CNE reported the PICC line group will help monitor staff compliance and charting, to ensure that antibiotics were administered and the PICC policy was followed. Nursing leadership was not aware that OHU nurses were not initiating care plans but confirmed that OHU nurses should be initiating care plans for patients in OHU, and that training would be provided.

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) *	5	5	0	50.0%
For CTC and SNF only (effective 4/2019, include OHU): Was a written history and physical examination completed within the required time frame? (13.002) *	8	2	0	80.0%
For OHU, CTC, SNF, and Hospice (applicable only for samples prior to 4/2019): Did the primary care provider complete the Subjective, Objective, Assessment, and Plan notes on the patient at the minimum intervals required for the type of facility where the patient was treated? (13.003) *,†	0	0	10	N/A
Upon the patient's admission to specialized medical housing: Were all medications ordered, made available, and administered to the patient within required time frames? (13.004) *	7	3	0	70.0%
For OHU and CTC only: Do inpatient areas either have properly working call systems in its OHU & CTC or are 30-minute patient welfare checks performed; and do medical staff have reasonably unimpeded access to enter patient's cells? (13.101) *	1	0	0	100%
For specialized health care housing (CTC, SNF, Hospice, OHU): Do health care staff perform patient safety checks according to institution's local operating procedure or within the required time frames? (13.102) *	0	0	1	N/A
	Overall percentage (MIT 13): **75.0%**			

* 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 ensure nurses initiate and document care plans in the electronic health record system (EHRS).
- Nursing leadership should remind outpatient housing unit (OHU) nurses to adhere to PICC line local operating procedures.
- Nursing leadership should remind nurses to complete the OHU admission assessment within the required time frame, as stated in CCHCS policy.
- Nursing leadership should ensure that patients admitted to the OHU receive their medications upon admission timely and without interruption.

Specialty Services

Overall Rating
Adequate

Case Review Rating
Adequate

Compliance Score
Adequate
(79.6%)

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

Results Overview

CAL provided good specialty services for their patients. The institution performed well in ensuring that specialty appointments occurred within the required time frames. However, the institution did not always ensure that preapproved specialty appointments occurred timely for patients transferred into the institution. Medical staff generally retrieved specialty reports timely. Nurses appropriately assessed patients' returns from specialty appointments and informed the providers about any specialists' urgent recommendations. We rated this indicator ***adequate***.

Case Review and Compliance Testing Results

Our clinicians reviewed 81 events related to specialty services, including 68 specialty consultations and procedures, and found six deficiencies, two of which were significant.[66] The institution performed well in completing specialty appointments and scanning specialty reports. However, two specialty reports were not retrieved timely, and three reports were not endorsed within the required time frames.

Access to Specialty Services

Compliance testing showed that CAL completed the initial high-priority, medium-priority, and routine specialty appointments within the required time frames (MIT 14.001, 86.7%; MIT 14.004; 80.0%, and MIT 14.007, 100%). The institution also performed well in completing high-priority, medium-priority, and routine follow-up specialty appointments (MIT 14.003, 100%; MIT 14.006, 88.9%; and MIT 14.009, 100%). Our clinicians did not identify any missed or delayed specialty appointments.

For patients transferring into CAL, preapproved specialty appointments often occurred untimely (MIT 14.010, 25.0%). Our clinicians reviewed seven transfer-in events and did not identify any missed or delayed preapproved specialty appointments.

[66] Deficiencies occurred once in cases 15 and 17, and twice in cases 3 and 20. Significant deficiencies occurred in cases 3 and 20.

Provider Performance

Providers generally referred patients appropriately, reviewed specialty reports within the recommended time frames, and addressed the specialists' recommendations. We did not identify any deficiencies related to provider performance.

Nursing Performance

Specialty nurses reviewed requests for specialty services and appropriately arranged for specialty appointments. The nurses performed excellent nursing assessments when patient returned from their specialty appointments. They reviewed the specialists' findings and recommendations and communicated those results to the providers. The nurses also obtained orders and requested provider follow-up appointments. We reviewed 13 nursing encounters related to specialty services and did not identify any deficiencies.

Health Information Management

Compliance testing showed that 86.7 percent of specialty reports were scanned within the required time frames (MIT 4.002). However, the institution did not always receive or review the high-priority, medium-priority, and routine specialty reports within the required time frames (MIT 14.002, 78.6%; MIT 14.005, 80.0%; and MIT 14.008, 66.7%). Our clinicians identified two specialty reports retrieved late.[67] One example follows:

- In case 20, the orthopedic surgeon evaluated the patient; however, the report was not retrieved until 20 days after this encounter.

Our clinicians also identified one specialty report not endorsed by a provider and two reports endorsed late.[68]

Patient Care Environment

The telemedicine staff generally maintained the video, audio, and remote medical equipment, such as the stethoscope and the otoscope, so specialists could effectively assess their patients. However, there was a deficiency related to remoted medical equipment that was not available or broken:

- In case 3, the telemedicine cardiologist saw the patient twice, and in each appointment, the remote stethoscope was either not available or broken.

[67] Late retrieval of a specialty reports occurred twice case 20.

[68] An unendorsed specialty report occurred in case 17, and two late endorsed reports occurred in cases 3 and 15.

Clinician On-Site Inspection

The institution employed multiple nurses for on-site, off-site, and telemedicine specialty services. The nurses reviewed specialty requests, contacted the specialist for available appointments, and scheduled the appointments. The specialty nurses also assembled the diagnostic tests requested by the specialists and forwarded these tests to the specialists on the days of their appointments. CAL medical record staff acknowledged the missing specialty reports and had informed the program specialist. CAL medical records staff also informed our clinicians that the specialists occasionally did not forward their reports to CAL within the required time frames.

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) *	13	2	0	86.7%
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) *	11	3	1	78.6%
Did the patient receive the subsequent follow-up to the high-priority specialty service appointment as ordered by the primary care provider? (14.003) *	11	0	4	100%
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) *	12	3	0	80.0%
Did the institution receive and did the primary care provider review the medium-priority specialty service consultant report within the required time frame? (14.005) *	12	3	0	80.0%
Did the patient receive the subsequent follow-up to the medium-priority specialty service appointment as ordered by the primary care provider? (14.006) *	8	1	6	88.9%
Did the patient receive the routine-priority specialty service within 90 calendar days of the primary care provider order or Physician Request for Service? (14.007) *	15	0	0	100%
Did the institution receive and did the primary care provider review the routine-priority specialty service consultant report within the required time frame? (14.008) *	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) *	8	0	7	100%
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) *	5	15	0	25.0%
Did the institution deny the primary care provider's request for specialty services within required time frames? (14.011)	1	1	1	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)	3	0	0	100%
	Overall percentage (MIT 14): **79.6%**			

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

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

Table 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) *,†	14	3	28	82.4%
Are specialty documents scanned into the patient's electronic health record within five calendar days of the encounter date? (4.002) *	26	4	15	86.7%

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

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

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

Recommendations

- Medical leadership should ascertain the challenges to provider's receiving specialty reports within the required time frames, as well as challenges to providers' timely reviewing those reports, and leadership should implement remedial measures as appropriate.

- Medical leadership should ensure patients receive preapproved specialty services within the specified time frames.

Administrative Operations

Overall Rating
Inadequate

Case Review Rating
(N/A)

Compliance Score
Inadequate
(74.3%)

In this indicator, OIG compliance inspectors evaluated health care administrative processes. Our inspectors examined the timeliness of the medical grievance process and checked whether the institution followed reporting requirements for adverse or sentinel events and patient deaths. Inspectors checked whether the Emergency Medical Response Review Committee (EMRRC) met and reviewed incident packages. We investigated and determined whether the institution conducted the required emergency response drills. Inspectors also assessed whether the Quality Management Committee (QMC) met regularly and addressed program performance adequately. In addition, our inspectors determined whether the institution provided training and job performance reviews for its employees. We checked whether staff possessed current, valid professional licenses, certifications, and credentials. The OIG rated this indicator solely according to the compliance score, using the same scoring thresholds used 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), we did not consider this indicator's rating when determining the institution's overall quality rating.

Results Overview

CAL's performance was mixed in this indicator, as the institution scored well in some applicable tests but faltered in others. The Emergency Medical Response Review Committee (EMRRC) did not always complete the required checklists. In addition, the institution conducted medical emergency response drills with incomplete documentation. Physician managers did not always complete annual performance appraisals in a timely manner. These findings are set forth in the table on the next page. Overall, we rated this indicator ***inadequate***.

Nonscored Results

At CAL, the OIG did not have any applicable adverse sentinel events requiring root cause analysis during our inspection period (MIT 15.001).

We obtained CCHCS Death Review Committee (DRC) reporting data. Two unexpected (Level 1) deaths and one expected (Level 2) death occurred during our review period. In our inspection, we found the DRC did not complete any death review reports promptly. The DRC finished all three reports 43 to 99 days late and submitted the reports to the institution's CEO 36 to 92 days late (MIT 15.998).

Table 20. Administrative Operations

Compliance Questions	Scored Answer			
	Yes	No	N/A	Yes %
For health care incidents requiring root cause analysis (RCA): Did the institution meet RCA reporting requirements? (15.001) *	N/A	N/A	N/A	N/A
Did the institution's Quality Management Committee (QMC) meet monthly? (15.002)	6	0	0	100%
For Emergency Medical Response Review Committee (EMRRC) reviewed cases: Did the EMRRC review the cases timely, and did the incident packages the committee reviewed include the required documents? (15.003)	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)	N/A	N/A	N/A	N/A
Did the institution conduct medical emergency response drills during each watch of the most recent quarter, and did health care and custody staff participate in those drills? (15.101)	0	3	0	0
Did the responses to medical grievances address all of the inmates' appealed issues? (15.102)	10	0	0	100%
Did the medical staff review and submit initial inmate death reports to the CCHCS Death Review Unit on time? (15.103)	2	1	0	66.7%
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)	0	6	0	0
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): **74.3%**			

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

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

Recommendations

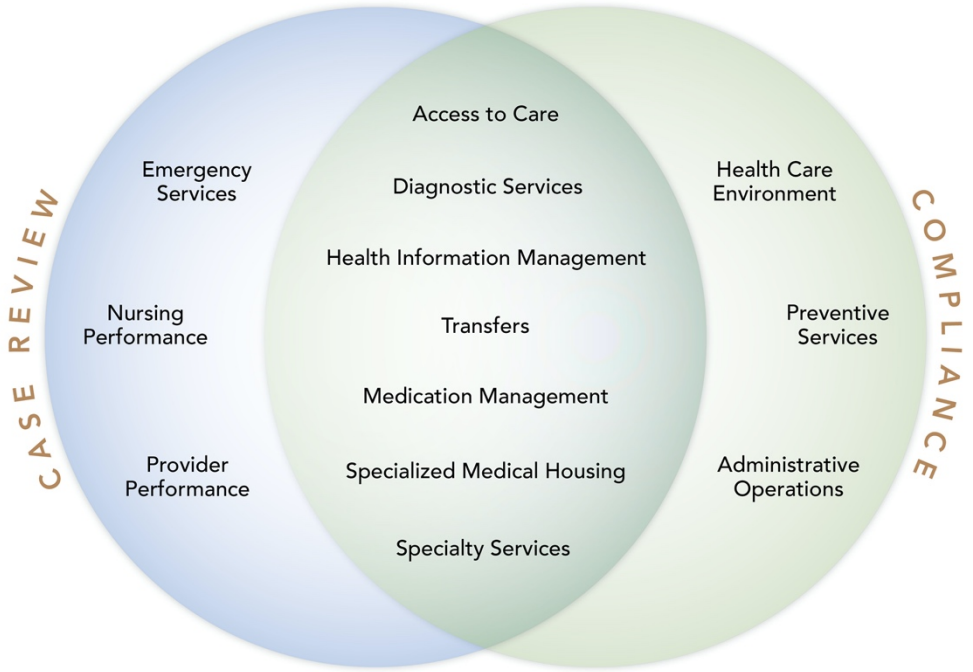
The OIG offers no recommendations for this indicator.

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 CAL



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

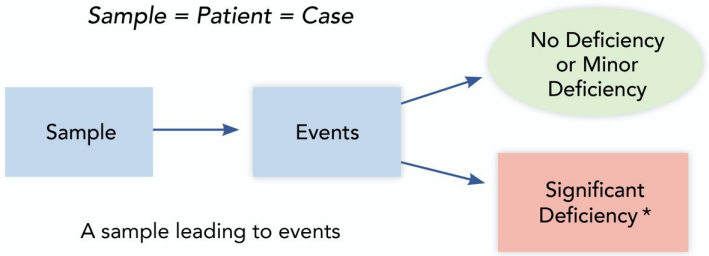
An OIG physician, a nurse consultant, or both review each case. As the clinicians review medical records, they record pertinent interactions between the patient and the health care system. We refer to these interactions as case review ***events***. Our clinicians also record medical errors, which we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

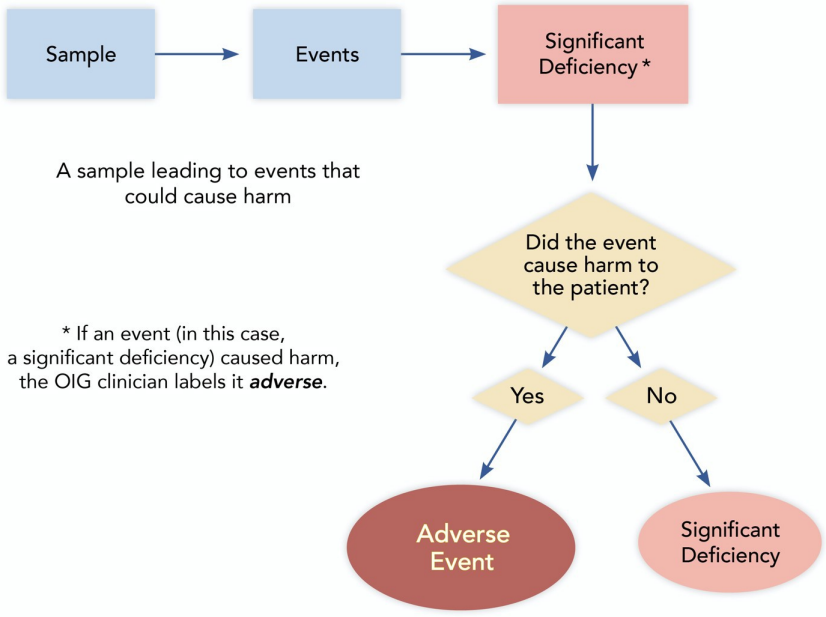
Figure A–2. Case Review Testing

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***.



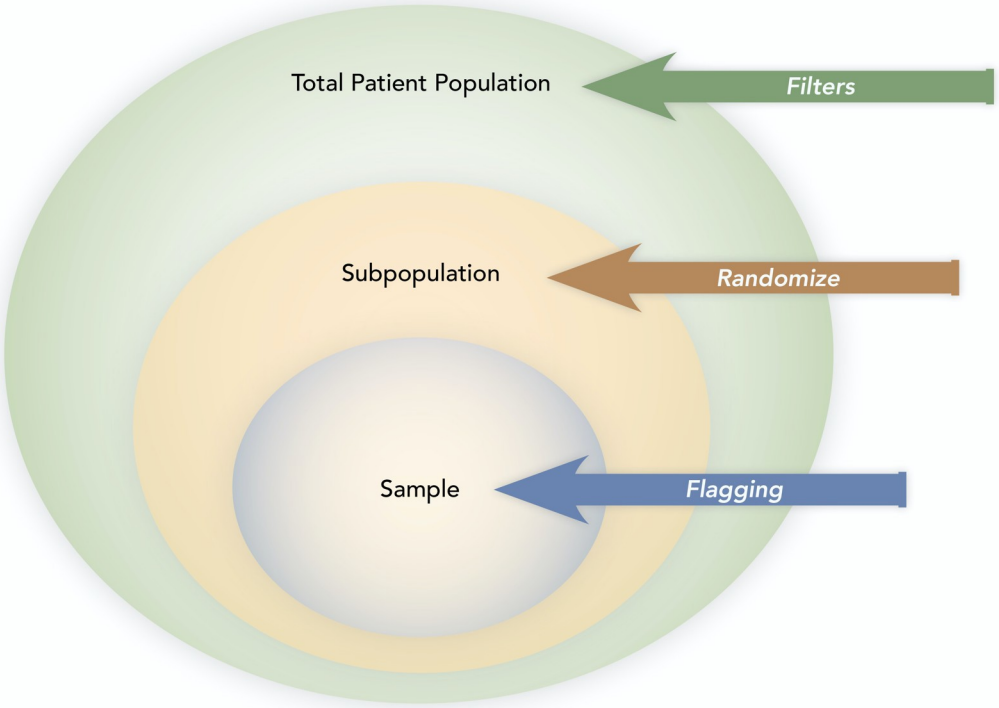
Source: The Office of the Inspector General medical inspection analysis.

Compliance Testing

Compliance Sampling Methodology

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

Figure A–3. Compliance Sampling Methodology



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

Compliance Testing Methodology

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

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

Sample Set	Total
Anticoagulation	3
CTC/OHU	2
Death Review/Sentinel Events	2
Diabetes	3
Emergency Services – CPR	1
Emergency Services – Non-CPR	2
High Risk	4
Hospitalization	4
Intrasystem Transfers In	3
Intrasystem Transfers Out	3
RN Sick Call	18
Specialty Services	2
Total	**47**

Table B–2. CAL Case Review Chronic Care Diagnoses

Diagnosis	Total
Anemia	5
Anticoagulation	3
Arthritis/Degenerative Joint Disease	3
Asthma	5
COPD	1
COVID-19	4
Cancer	1
Cardiovascular Disease	2
Chronic Pain	13
Cirrhosis/End-Stage Liver Disease	3
Coccidioidomycosis	1
Deep Venous Thrombosis / Pulmonary Embolism	3
Diabetes	7
Gastroesophageal Reflux Disease	5
Gastrointestinal Bleed	1
Hepatitis C	15
Hyperlipidemia	10
Hypertension	14
Mental Health	5
Migraine Headaches	1
Seizure Disorder	1
Sleep Apnea	1
Substance Abuse	18
Total	122

Table B–3. CAL Case Review Events by Program

Diagnosis	Total
Diagnostic Services	251
Emergency Care	45
Hospitalization	28
Intra-system Transfers In	14
Intra-system Transfers Out	3
Outpatient Care	340
Specialized Medical Housing	75
Specialty Services	134
Total	**890**

Table B–4. CAL Case Review Sample Summary

	Total
MD Reviews Detailed	20
MD Reviews Focused	0
RN Reviews Detailed	12
RN Reviews Focused	27
Total Reviews	59
Total Unique Cases	47
Overlapping Reviews (MD & RN)	12

Appendix C. Compliance Sampling Methodology

Calipatria 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	8	OIG Q: 4.005	• See Health Information Management (Medical Records) (returns from community hospital)
MIT 1.008	Specialty Services Follow-Up	45	OIG Q: 14.001, 14.004 & 14.007	• See Specialty Services
MIT 1.101	Availability of Health Care Services Request Forms	6	OIG on-site review	• Randomly select one housing unit from each yard
Diagnostic Services				
MITs 2.001–003	Radiology	10	Radiology Logs	• Appointment date (90 days–9 months) • Randomize • Abnormal
MITs 2.004–006	Laboratory	10	Quest	• Appt. date (90 days–9 months) • Order name (CBC or CMPs only) • Randomize • Abnormal
MITs 2.007–009	Laboratory STAT	0	Quest	• Appt. date (90 days–9 months) • Order name (CBC or CMPs only) • Randomize • Abnormal
MITs 2.010–012	Pathology	10	InterQual	• Appt. date (90 days–9 months) • Service (pathology related) • Randomize

Quality Indicator	Sample Category	No. of Samples	Data Source	Filters
Health Information Management (Medical Records)				
MIT 4.001	Health Care Services Request Forms	30	OIG Qs: 1.004	• Nondictated documents • First 20 Ips for MIT 1.004
MIT 4.002	Specialty Documents	45	OIG Qs: 14.002, 14.005 & 14.008	• Specialty documents • First 10 Ips for each question
MIT 4.003	Hospital Discharge Documents	8	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	8	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	10	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	2	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	8	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	5	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	25	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	8	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	17	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 (45 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	N/A at this institution	Cocci transfer status report	• Reports from past 2–8 months • Institution • Ineligibility date (60 days prior to inspection date) • All

Quality Indicator	Sample Category	No. of Samples	Data Source	Filters
Reception Center				
MITs 12.001–008	Reception Center	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	15	Specialty Services 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 Services 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 Services 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	20	Specialty Services Arrivals	• Arrived from (other departmental institution) • Date of transfer (3–9 months) • Randomize
MITs 14.011–012	Denials	3	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	N/A at this institution	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	6	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

July 29, 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 Calipatria State Prison (CAL) conducted by the Office of the Inspector General (OIG) from April to September 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) 896-6780.

Sincerely,

Robin Hart
Associate Director
Risk Management Branch
California Correctional Health Care Services

cc: Diana Toche, D.D.S., Undersecretary, Health Care Services, CDCR
Clark Kelso, Receiver
Directors, CCHCS
Roscoe Barrow, Chief Counsel, CCHCS Office of Legal Affairs
Jackie Clark, Deputy Director, Institution Operations, CCHCS
DeAnna Gouldy, Deputy Director, Policy and Risk Management Services, CCHCS
Renee Kanan, M.D., Deputy Director, Medical Services, CCHCS
Barbara Barney-Knox, R.N., Deputy Director, Nursing Services, CCHCS
Annette Lambert, Deputy Director, Quality Management, CCHCS
Regional Health Care Executive, Region IV, CCHCS
Regional Deputy Medical Executive, Region IV, CCHCS
Regional Nursing Executive, Region IV, CCHCS
Chief Executive Officer, CAL
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

Calipatria State Prison

OFFICE *of the*
INSPECTOR GENERAL

Amarik K. Singh
Inspector General

Neil Robertson
Chief Deputy Inspector General

STATE *of* CALIFORNIA
August 2022

OIG