***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

High Desert State Prison

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Introduction

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

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

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

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

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

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

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

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

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

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

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

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

High Desert State Prison (HDSP) is located approximately eight miles east of the town of Susanville, in Lassen County. The institution's primary mission is to provide housing and programming of general population and sensitive needs high-security (Level IV) and sensitive needs medium-security (Level III) patients. The institution operates several medical clinics in which health care staff members handle routine requests for medical services. In addition, HDSP operates a triage and treatment area (TTA) for urgent and emergent patient care, a receiving and release (R&R) clinic for the assessment of arriving and departing patients, and a specialty clinic. The institution also provides inpatient health care in its correctional treatment center (CTC) for those patients who require a higher level of service. CCHCS has designated HDSP as a *basic* health care institution, an institution located in a rural area away from tertiary care centers and specialty care providers whose services would likely be used frequently by higher-risk patients. Because of HDSP's remote location and its basic health care status, the department houses healthier patients at this institution.

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

[7] As of May 31, 2022, the department reports on its public tracker that 77% of the incarcerated population at HDSP is fully vaccinated while 50% of HDSP staff are fully vaccinated: see **https://www.cdcr.ca.gov/covid19/population-status-tracking/**.

Summary

We completed the Cycle 6 inspection of HDSP in October 2021. OIG inspectors monitored the institution's medical care that occurred between December 2020 and May 2021.

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

Table 1. HDSP 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	*Inadequate*	*Adequate*	*Inadequate*	=
Diagnostic Services	*Inadequate*	*Inadequate*	*Inadequate*	↓
Emergency Services	*Inadequate*	*N/A*	*Inadequate*	↓
Health Information Management	*Adequate*	*Proficient*	*Adequate*	=
Health Care Environment	*N/A*	*Inadequate*	*Inadequate*	↓
Transfers	*Inadequate*	*Inadequate*	*Inadequate*	↓
Medication Management	*Inadequate*	*Inadequate*	*Inadequate*	=
Prenatal and Postpartum Care	*N/A*	*N/A*	*N/A*	*N/A*
Preventive Services	*N/A*	*Inadequate*	*Inadequate*	↓
Nursing Performance	*Inadequate*	*N/A*	*Inadequate*	↓
Provider Performance	*Inadequate*	*N/A*	*Inadequate*	↓
Reception Center	*N/A*	*N/A*	*N/A*	*N/A*
Specialized Medical Housing	*Inadequate*	*Adequate*	*Inadequate*	↓
Specialty Services	*Adequate*	*Inadequate*	*Inadequate*	↓
Administrative Operations†	*N/A*	*Adequate*	*Adequate*	↑

* 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 355 patient records and 1,059 data points and used the data to answer 92 policy questions. In addition, we observed HDSP processes during an on-site inspection in August 2021. Table 2 below lists HDSP average scores from Cycles 4, 5, and 6.

Table 2. HDSP Policy Compliance Scores

Scoring Ranges

		100%–85.0%	84.9%–75.0%	74.9%–0
Medical Inspection Tool (MIT)	**Policy Compliance Category**	**Cycle 4 Average Score**	**Cycle 5 Average Score**	**Cycle 6 Average Score**
1	Access to Care	79.0%	75.5%	77.6%
2	Diagnostic Services	65.6%	58.9%	49.2%
4	Health Information Management	70.3%	66.0%	91.4%
5	Health Care Environment	44.4%	76.6%	59.1%
6	Transfers	87.0%	70.3%	67.1%
7	Medication Management	57.0%	68.8%	51.9%
8	Prenatal and Postpartum Care	N/A	N/A	N/A
9	Preventive Services	67.1%	81.3%	63.6%
12	Reception Center	N/A	N/A	N/A
13	Specialized Medical Housing	82.0%	77.5%	80.0%
14	Specialty Services	73.3%	72.6%	67.1%
15	Administrative Operations	53.2%*	62.0%	75.0%

* 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 55 cases, which contained 1,036 patient-related events. After examining the medical records, our clinicians conducted a follow-up on-site inspection to verify their initial findings. The OIG physicians rated the quality of care for 20 comprehensive case reviews. Of these 20 cases, our physicians rated 12 ***adequate*** and eight ***inadequate***. Our physicians did not identify any adverse events during this inspection.

The OIG then considered the results from both case review and compliance testing, and drew overall conclusions, which we report in the 13 health care indicators. Multiple OIG physicians and nurses performed quality control reviews; their subsequent collective deliberations ensured consistency, accuracy, and thoroughness. Our clinicians acknowledged institutional structures that catch and resolve mistakes that may occur throughout the delivery of care. As noted above, we listed the individual indicators and ratings applicable for this institution in Table 1, the HDSP Summary Table.

In July 2021, the Health Care Services Master Registry showed that HDSP had a total population of 3,264. A breakdown of the medical risk level of the HDSP population as determined by the department is set forth in Table 3 below.[8]

Table 3. HDSP Master Registry Data as of July 23, 2021

Medical Risk Level	Number of Patients	Percentage
High 1	46	1.4%
High 2	100	3.1%
Medium	1,333	40.8%
Low	1,785	54.7%
Total	**3,264**	**100.0%**

Source: Data for the population medical risk level were obtained from the CCHCS Master Registry dated 7-23-21.

[8] For a definition of *medical risk*, see CCHCS HCDOM 1.2.14, Appendix 1.9.

Based on staffing data the OIG obtained from California Correctional Health Care Services (CCHCS), as identified in Table 4 below, HDSP had zero executive leadership positions, 3.5 primary care provider vacancies, 3.2 nursing supervisor vacancies, and 17.8 nursing staff vacancies.

Table 4. HDSP Health Care Staffing Resources as of July 2021

Positions	Executive Leadership*	Primary Care Providers	Nursing Supervisors	Nursing Staff†	Total
Authorized Positions	5.0	7.5	11.2	109.4	133.1
Filled by Civil Service	5.0	4.0	8.0	91.6	108.6
Vacant	0	3.5	3.2	17.8	24.5
Percentage Filled by Civil Service	100.0%	53.3%	71.4%	83.7%	81.6%
Filled by Telemedicine	0	3.0	0	0	3.0
Percentage Filled by Telemedicine	0%	40.0%	0%	0%	2.3%
Filled by Registry	0	1	0	12.0	13.0
Percentage Filled by Registry	0%	13.3%	0%	11.0%	9.8%
Total Filled Positions	5.0	8.0	8.0	103.6	124.6
Total Percentage Filled	**100.0%**	**106.7%**	**71.4%**	**94.7%**	**93.6%**
Appointments in Last 12 Months	1.0	0	5.0	28.0	34.0
Redirected Staff	0	0	0	0	7.0
Staff on Extended Leave‡	0	0	1.0	13.0	14.0
Adjusted Total: Filled Positions	**5.0**	**8.0**	**7.0**	**83.6**	**103.6**
Adjusted Total: Percentage Filled	**100%**	**106.7%**	**62.5%**	**76.4%**	**77.8%**

* 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 July 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.[9]

The OIG did not find any adverse events at HDSP during the Cycle 6 inspection.

Case Review Results

OIG case reviewers (a team of physicians and nurse consultants) assessed 10 of the 13 indicators applicable to HDSP. Of these 10 indicators, OIG clinicians rated two ***adequate*** and eight ***inadequate***. The OIG physicians also rated the overall adequacy of care for each of the 20 detailed case reviews they conducted. Of these 20 cases, none were ***proficient***, 12 were ***adequate***, and 8 were ***inadequate***. In the 1,036 events reviewed, there were 430 deficiencies, 124 of which the OIG clinicians considered to be of such magnitude that, if left unaddressed, would likely contribute to patient harm.

Our clinicians found the following strengths at HDSP:

- The TTA and CTC providers delivered very good care. Provider to nursing and provider to hospital hand-offs were performed well.[10]
- Radiology services performed well in scheduling and obtaining studies.
- Medical and custody staff performed well in responding to and implementing appropriate interventions for patients with traumatic injuries requiring CPR.[11]
- Nursing staff delivered good care for diabetic patients. The medication licensed vocational nurses (LVNs) and PTs (psychiatry technicians) frequently monitored diabetic patients who had fingerstick blood sugar readings that were in the abnormal range and provided appropriate interventions while the patient was in the housing units. Rather than sending patients to the TTA for

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

[10] TTA is the triage and treatment area. CTC is the correctional treatment center.

[11] CPR is cardiopulmonary resuscitation.

observation, the LVNs went above the call of duty and monitored the patients in place.

- Health information services' staff usually scanned documents into the medical record accurately and timely.

Our clinicians found the following weaknesses at HDSP:

- Severe chronic staffing shortages affected various levels of medical operation, which was worsened by the COVID-19 pandemic. Chronic care follow-up appointments often did not occur as ordered and were frequently deferred.

- Nursing care oversight was not done during our review period; therefore, nursing management was unable to identify whether deficiencies in nursing performance had occurred.

- Some providers often made poor medical decisions regarding patient care and deferred patient appointments that should have occurred. Providers often did not document medical decision making.

- Several laboratory deficiencies were identified including STAT laboratory requests that frequently were not performed as ordered. In addition, pathology reports were usually not relayed to the patients.

- The institution's Emergency Medical Response Review Committee (EMRRC) committee frequently neither identified nursing deficiencies nor discussed cases that had significant deficiencies during the monthly review of unscheduled patient transfers to a higher level of care.

Compliance Testing Results

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

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

- Medical staff performed well in scanning requests for health care services and community hospital discharge reports into patients' electronic medical records within required time frames. Also, patient records were accurately scanned into appropriate patient files.

- Providers completed history and physical evaluations withing 24 hours of a patient's admission to the specialized medical housing.

- Nursing staff reviewed health care services request forms and performed face-to-face encounters timely.

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

- Providers did not often 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 whether the results were within normal limits.

- Medical staff frequently failed to maintain medication continuity for chronic care patients, patients discharged from the hospital, and patients transferring within and laying over at HDSP.

- HDSP did poorly in managing patients on tuberculosis (TB) medications. The institution did not complete monitoring at all the required intervals. In addition, the nursing staff did not appropriately conduct timely TB screenings.

- Health care staff did not consistently follow universal hand hygiene precautions during patient encounters.

- Nursing staff did not regularly inspect and maintain inventory levels for all emergency response bags and crash 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 HDSP's performance with population-based metrics to assess the macroscopic view of the institution's health care delivery. HDSP'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)—HDSP performed better in two of the three diabetic measures that have statewide comparative data: HbA1c screening and poor HbA1c control. Kaiser NorCal and Kaiser SoCal outperformed HDSP in blood pressure control.

Immunizations

Statewide comparative data were also not available for immunization measures; however, we include this data for informational purposes. HDSP had a 47 percent influenza immunization rate for adults 18 to 64 years old and a 73 percent influenza immunization rate for adults 65 years of age and older.[12] The pneumococcal vaccine rate was 80 percent.[13]

Cancer Screening

Statewide comparative data were not available for colorectal cancer screening; however, we include these data for informational purposes. HDSP had a 65 percent colorectal cancer screening rate.

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

[13] The pneumococcal vaccines administered are the 13 valent pneumococcal vaccine (PCV13), 15 valent pneumococcal vaccine (PCV15), 20 valent pneumococcal vaccine (PCV20), or 23 valent pneumococcal vaccine (PPSV23), depending on the patient's medical conditions. For the adult population, the influenza or pneumococcal vaccine may have been administered at an institution other than the one in which the patient was housed during the inspection period.

Table 5. HDSP Results Compared with State HEDIS Scores

HEDIS Measure	HDSP Cycle 6 Results*	California Medi-Cal 2018†	California Kaiser NorCal Medi-Cal 2018†	California Kaiser SoCal Medi-Cal 2018†
HbA1c Screening	**100%**	90%	94%	96%
Poor HbA1c Control (> 9.0%) ‡, §	**13%**	34%	25%	18%
HbA1c Control (< 8.0%) ‡	76%	–	–	–
Blood Pressure Control (< 140/90) ‡	73%	65%	78%	**84%**
Eye Examinations	10%	–	–	–
Influenza – Adults (18–64)	47%	–	–	–
Influenza – Adults (65+)	73%	–	–	–
Pneumococcal – Adults (65+)	80%	–	–	–
Colorectal Cancer Screening	65%	–	–	–

Notes and Sources

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

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

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

Recommendations

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

Access to Care

- The department should consider strategies to improve the number of staff, particularly with the implementation of new programs such as the Integrated Substance Use Disorder Treatment program (ISUDT).
- The department should consider tracking the medical complications from the Suboxone diversion.[14]

Diagnostic Services

- The department should consider how to improve HDSP's poor staffing levels.
- Medical leadership and diagnostic services' leadership should consider improving the STAT laboratory process to ensure testing is completed as ordered and results are related to providers timely.

Emergency Services

- Nursing leadership should consider ensuring nursing staff receive remedial training on assessments and reassessments of emergent and urgent conditions.
- Nursing leadership should consider resuming random audits to ensure nursing documentation is complete and thorough.
- The EMRRC committee should ensure all unscheduled transports to off-site hospitals are reviewed for deficiencies in the quality of nursing performance, policy, procedures, and form completion.

Health Care Environment

- Medical leadership should remind staff to follow universal hand hygiene precautions. Implementing random spot checks could improve compliance.
- Nursing leadership should consider performing random spot checks to ensure staff follow equipment and medical supply management protocols.

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

- Nursing leadership should direct each clinic nurse supervisor to review monthly emergency medical response bag (EMRB) logs to ensure the EMRBs are regularly inventoried and sealed.

Transfers

- Nursing leadership should consider requiring that all patients scheduled to transfer out have the preboarding screening completed within 24 hours to ensure medical holds are reviewed and to determine whether patients have all prescribed keep-on-person medication (KOP).

- Nursing leadership should ensure TTA nurses perform complete focused assessments on patients returning from the emergency room and inpatient hospitalizations.

- Nursing leadership should remind R&R nurses to communicate pertinent patient information to the receiving institution via the EHRS message center instead of using Microsoft Outlook email.[15]

- Medical and nursing leadership should consider developing a process between nursing and providers to ensure all hospital discharge recommendations are reviewed and orders are placed timely.

Medication Management

- Medical and nursing leadership should identify challenges to medication continuity for new medications, chronic care, hospital discharge, and specialized medical housing patients, implementing remedial measures as appropriate.

- The department should implement a monitoring system in the EHRS to identify reasons for patient safety concerns to prevent duplicate administration of medications, especially high-risk medications, within a 24-hour period for medications that are discontinued and reordered, and medications that are reconciled from a licensed medical bed to a general population housing unit.

- Nursing leadership should consider resuming audits for accurate documentation in the medication administration record (MAR) for refusals of KOP medications. Nurses documented that patients did not request refills in the MAR when, instead, patients refused KOP medications.

[15] EHRS is the electronic health record system.

Preventive Services

- Nursing leadership should consider developing and implementing measures to ensure that nursing staff timely screen patients for TB and that nursing staff completely address TB signs and symptoms in their TB screening.

- The institution should consider developing strategies to ensure preventive colorectal screenings and required vaccinations for chronic care patients.

Nursing Performance

- The department and nursing leadership should consider resuming random audits to ensure nursing staff perform complete assessments including vital signs and appropriate assessments in the outpatient and inpatient settings.

- Nursing leadership should consider providing remedial training for assessment and documentation of patients presenting with COVID-19 symptoms

Provider Performance

- The department should consider strategies to improve the number of providers, particularly with the implementation of new programs such as ISUDT.

- Medical and nursing leadership should ensure that medical providers have clinic assistance available during all clinic appointments.

Specialized Medical Housing

- The department and nursing leadership should ensure licensed medical beds are staffed with a sufficient level of RNs to perform patient assessments and interventions specific to registered nursing licensure.

- Nursing leadership should consider resuming nursing audits to monitor appropriate assessments and documentation of admission assessments, to provide continuity of care for patients in the CTC, and to ensure nurses initiate and update patients' care plans based on patients' medical conditions.

- Nursing leadership should consider providing training for an RN-to-RN documented hand-off communication.

Specialty Services

- The department should consider how to recruit and retain a sufficient level of nursing staff to avoid redirecting specialty RNs.
- Medical leadership should consider ways to improve access to specialty care, particularly eye care.
- Medical leadership should ensure that transfer-in patients receive their previously scheduled specialty appointments within the required time frame and that providers timely review all specialty reports.

Access to Care

Overall Rating **Inadequate**

Case Review Rating ***Inadequate***

Compliance Score ***Adequate*** **(77.6%)**

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

HDSP provided poor access to care, which was similar to that provided in Cycle 5. In this indicator, the OIG case review and compliance tests yielded different results. The poor performance in provider-ordered follow-up appointments, nurse-requested follow-ups, and chronic care visits all significantly affected the quality of care provided. Given the clinical importance of the deficiencies identified, the OIG determined an overall rating of ***inadequate***.

Case Review and Compliance Testing Results

We reviewed 125 provider, nursing, specialty, and hospital events that required the institution to generate appointments. We identified 31 deficiencies relating to this indicator, 16 of which were significant.[16]

Access to Clinic Providers

HDSP performed poorly with access to clinic providers.

Compliance testing found that chronic care visits occurred timely only 52.0 percent of the time (MIT 1.001). RN-to-provider follow ups occurred 27.3 percent of the time (MIT 1.005). PCP follow-up occurred 100 percent of the time, however, the sample size of three was very small (MIT 1.006).

Case review evaluated 88 outpatient provider encounters and 33 required follow-up provider visits, with 11 deficiencies identified, six of which were significant.[17] Examples of significant deficiencies include the following:

- In case 12, a provider saw an uncontrolled diabetic patient for a chronic care visit 91 days late. The patient should have been seen sooner.

[16] Deficiencies occurred in cases 1, 2, 11–18, 20 through 24, 26, 27, 35, 36, and 51. Significant deficiencies occurred in cases 12–17, 20–23, 26, 27, 36, and 51.

[17] Deficiencies occurred in cases 2, 11, 12, 13, 14, 15, 21, 24, 26, 27, and 51 with significant deficiencies in cases 12, 13, 14, 26, 27, and 51.

- In case 13, the uncontrolled diabetic patient's chronic care visit was delayed 102 days. A provider did not see the patient to address the need for diabetes care during this time. The patient should have been seen sooner.

- In case 14, the provider deferred a scheduled visit for an uncontrolled insulin-dependent diabetic for six months. The patient should have been seen sooner.

Access to Specialized Medical Housing Providers

HDSP performed well in providing patient access to specialized medical housing providers. Compliance testing found that providers performed admission history and physical appointments in accordance with guidelines (MIT 13.002, 80.0%). Case review found no specialized medical housing admission history and physical delays, and patients had access to the providers.

Access to Clinic Nurses

HDSP performed well in access to clinic nurses. Compliance testing found that nurses reviewed patient requests for health care services 86.7 percent of the time (MIT 1.003) and nurses saw the patients within one business day for symptomatic requests 90.0 percent of the time (MIT 1.004). Case review found only five deficiencies related to nursing access, with one being significant:[18]

- In case 20, the patient with a significant medical history was referred to nursing by custody for dark rings around the eyes and weight loss; however, the nurses did not see the patient until the next day, resulting in a delay of care to this very ill patient. The patient should have been seen emergently.

Access to Specialty Services

OIG compliance testing found that access to specialty services was mixed. While HDSP performed well in providing routine specialty appointments (MIT 14.007, 80.0%), its staff performed poorly in providing high- and medium-priority appointments (MIT 14.001, 73.3%, and MIT 14.004, 60.0%). While compliance testing found that high- and medium-priority specialty follow-up appointments were done timely (MIT 14.003, 100% and MIT 14.006, 100%), routine follow-up specialty appointments occurred within appropriate time frames only 40.0 percent of the time (MIT 14.009).

Case reviewers identified seven deficiencies in access to specialty services, and three were significant.[19] The three significant deficiencies were the following:

[18] Deficiencies occurred in cases 1, 18, 20, and 35.

[19] Deficiencies occurred in 15, 16, 17, 21, and 23.

- In case 16, a patient with blindness in the left eye and elevated eye pressure in the right eye required close monitoring due to elevated eye pressure that could have progressed to glaucoma, which could have resulted in vision loss in the patient's only seeing eye. The patient did not have any specialty follow-ups for nearly a year.

- In case 17, the eye specialist recommended a three-month follow-up for a patient with suspected glaucoma. However, by the end of the review period, the visit had still not occurred.

- In case 23, a provider requested an urgent hematology consultation to evaluate the cause and treatment for the patient's abnormal recurrent blood clotting. This appointment should have occurred within 14 days, but instead occurred 37 days late, placing the patient at an increased risk of harm.

Follow-up After Specialty Service

Compliance testing found that of the 43 samples tested, only 69.8 percent or 30 visits were seen within ordered time frames (MIT 1.008). Case review did not identify any access deficiencies in provider follow-up appointments after specialty services.

Follow-up After Hospitalization

Both case review and compliance teams found that HDSP usually saw patients returning from the hospital within ordered time frames (MIT 1.007, 88.9%). Case review found only one minor deficiency.[20]

Follow-up After Urgent or Emergent Care (TTA)

HDSP performed well in ensuring patients were seen for TTA follow-up within required time lines.

Follow-up After Transferring Into the Institution

HDSP is not a reception center, therefore, the institution receives new patients through intrafacility transfers from other State institutions. Compliance testing found that, usually, transfer patients were seen timely (MIT 1.002, 84.0%). Case reviewers evaluated four intrafacility transfer cases that included nine nursing and provider encounters, and there were two significant deficiencies for delay of provider evaluation cited:

- In case 26, the provider saw the high-risk patient for a new arrival history and physical examination four days late.

[20] A deficiency occurred in case 3.

- In case 27, the provider saw another high risk, complex medical patient for a new arrival history and physical examination 21 days late.

Clinician On-Site Inspection

OIG clinicians met with medical and nursing leadership, scheduling staff, custody, nursing staff, and providers to discuss processes and challenges with access to care. We were advised that HDSP had a large, chronic backlog due to significant provider and nursing shortages that worsened with the COVID-19 pandemic. During the institution's COVID-19 outbreak in late 2020 and early 2021, medical staffing and custody staffing levels were greatly impacted. All specialty services access was also reduced. Scheduling patient clinics was difficult due to COVID-19 patient-movement restrictions, the need to transport patients by cohort, and the refusal of patients to move to isolation and quarantine. In addition, patient areas and transport vehicles required disinfection between visits, which delayed patient care.

CCHCS implemented the Integrated Substance Use Disorder Treatment (ISUDT) program at HDSP. HDSP leadership and staff reported that ISUDT is a medical and custody staff-resource-intensive program. It requires medication administration, close monitoring, frequent follow-up visits, and laboratory testing which require custody, nursing, and ancillary staff participation to complete. At the time of the on-site inspection, the HDSP pharmacy confirmed over 800 Suboxone prescriptions were being distributed daily. Staff in all areas, except Health Information Management, had raised concerns about staff allocation for the ISUDT program, stating this implementation negatively affected access and their ability to provide care to patients.

HDSP providers reported that they saw many critically ill patients in clinic and TTA due to Suboxone misuse. Due to the Suboxone misuse epidemic at the institution, patients who before had presented with benign symptoms, now required workups for conditions such as skin infections, spinal abscesses, heart infections, and bone infections. Upon diagnosis or hospital return, these patients were frequently housed in the TTA for long periods, requiring complicated care and treatment, which increased CTC and TTA provider workloads and reduced available beds.

Compliance Testing Results

Table 6. Access to Care

Compliance Questions	Scored Answer Yes	No	N/A	Yes %
Chronic care follow-up appointments: Was the patient's most recent chronic care visit within the health care guideline's maximum allowable interval or within the ordered time frame, whichever is shorter? (1.001) *	13	12	0	52.0%
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) *	21	4	0	84.0%
Clinical appointments: Did a registered nurse review the patient's request for service the same day it was received? (1.003) *	26	4	0	86.7%
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) *	27	3	0	90.0%
Clinical appointments: If the registered nurse determined a referral to a primary care provider was necessary, was the patient seen within the maximum allowable time or the ordered time frame, whichever is the shorter? (1.005) *	3	8	19	27.3%
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) *	3	0	27	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) *	8	1	0	88.9%
Specialty service follow-up appointments: Did the clinician follow-up visits occur within required time frames? (1.008) *, †	30	13	2	69.8%
Clinical appointments: Do patients have a standardized process to obtain and submit health care services request forms? (1.101)	6	0	0	100%
			Overall percentage (MIT 1): **77.6%**	

* 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 OHU, CTC, SNF, and Hospice (applicable only for samples prior to 4/2019): Did the primary care provider complete the Subjective, Objective, Assessment, and Plan notes on the patient at the minimum intervals required for the type of facility where the patient was treated? (13.003) *	N/A	N/A	10	N/A
Did the patient receive the high-priority specialty service within? 14 calendar days of the primary care provider order or the Physician Request for Service? (14.001) *	11	4	0	73.3%
Did the patient receive the subsequent follow-up to the high-priority specialty service appointment as ordered by the primary care provider? (14.003) *	8	0	7	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) *	9	6	0	60.0%
Did the patient receive the subsequent follow-up to the medium-priority specialty service appointment as ordered by the primary care provider? (14.006) *	4	0	11	100%
Did the patient receive the routine-priority specialty service within 90 calendar days of the primary care provider order or Physician Request for Service? (14.007) *	12	3	0	80.0%
Did the patient receive the subsequent follow-up to the routine-priority specialty service appointment as ordered by the primary care provider? (14.009) *	2	3	10	40.0%

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

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

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

Recommendations

- The department should consider strategies to improve the number of staff, particularly with the implementation of new programs such as ISUDT.

- The department should consider tracking the medical complications from the Suboxone diversion.

Diagnostic Services

Overall Rating **Inadequate**

Case Review Rating ***Inadequate***

Compliance Score ***Inadequate*** **(49.2%)**

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

HDSP performed poorly in diagnostics primarily due to untimely completion of routine and STAT laboratory tests. In addition, pathology reports were not retrieved timely, and the providers usually did not communicate the pathology results to the patients. Providers usually endorsed radiology and laboratory results timely, but did not communicate the results to patients in accordance with CCHCS policies. Considering compliance and case reviews, we rated this indicator as ***inadequate***.

Case Review and Compliance Testing Results

Case reviewers examined 227 diagnostic events, including 40 refusals of care, 81 laboratory-completed events, 14 radiology events, and 102 nursing point-of-care events. Of the 62 deficiencies that were cited, 10 were significant. Of those 10 deficiencies, we found five related to record retrieval and scanning, and five were for delayed or incomplete diagnostic tests.[21]

For health information management, we considered test reports that were never retrieved or reviewed as severe a problem as tests that were not performed.

Test Completion

Case review found that of 187 diagnostic events, 81 were completed by the laboratory staff, 14 were imaging, 92 were nursing-collected COVID-19 events, and 10 were nurse-performed EKGs.[22] In 81 laboratory-collected tests, 75 percent were primarily blood samples and 25 percent were urine toxicology tests performed for the ISUDT program.

Laboratory studies, including STAT labs, were rarely done by the order date (MIT 2.004, 30.0% and MIT 2.007, zero). This is consistent with case review findings. In two cases, important STAT labs were not completed timely.[23] Both case review

[21] Deficiencies occurred in cases 1, 2, 9, 10, 12, 15, 16, 17–25, and 36. Significant deficiencies occurred cases 1, 2, 15, 17, 20, 21, 22, 23, and 24.

[22] Due to large number of tests, the individual COVID-19 tests were bundled monthly. For this reason, the number of COVID-19 tests events are fewer than the number of tests.

[23] Significant deficiencies regarding STAT laboratory completion occurred in cases 17 and 23.

and compliance testing found that HDSP performed very well in completing radiology services within ordered time frames (MIT 2.001, 80.0%).

Health Information Management

HDSP performed well in provider review of laboratory and imaging studies, however, it performed poorly in writing complete patient letters, processing STAT labs, and retrieving pathology reports.

Both case review and compliance testing found that HDSP providers reviewed X-rays and laboratory results within the required time frames (MIT 2.002, 100% and MIT 2.005, 100%). We also found that providers usually sent patient results' letters for imaging and laboratory studies; however, most did not contain all the necessary CCHCS-policy required components (MIT 2.003, 40.0%; MIT 2.006, 20.0%). Case review found most point-of-care (POC) tests were not endorsed by a provider.[24]

Case reviewers cited 50 deficiencies in this area with five being significant.[25] Most deficiencies were minor and related to incomplete patient results' letters. In the case review events, 10 EKGs were completed, however, two had significant scanning deficiencies as follows:

- In case 1, the patient had an EKG done, suggesting atrial fibrillation; however, the EKG was not scanned into the medical record or endorsed by a provider for two months.[26]

- In case 24, the patient's EKG was not scanned into the medical record for over five weeks. When a record was not scanned, it was not available for the provider's review and use in medical decision making.

Compliance testing found that STAT laboratory results were not relayed to the providers by nursing or acknowledged by the provider (MIT 2.008, zero). Compliance testing also found that pathology reports were not retrieved timely (MIT 2.010, 33.3%), and providers usually did not communicate the results to the patients (MIT 2.012, 12.5%). Case review had only two pathology reports in its events, and one was not retrieved timely, resulting in a significant deficiency in case 2.

Clinician On-Site Inspection

OIG case reviewers recognized the dedication of the leadership and most staff. We discussed the significant challenges they faced during the review period with medical leadership and radiology, laboratory, and health information

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[24] At the on-site inspection, the leadership informed that the POC COVID-19 tests were to have been endorsed by the providers.

[25] Significant deficiencies occurred in cases 1, 2, 15, 20, and 24.

[26] Atrial fibrillation is a medical condition in which the heart chamber contracts abnormally, which can be life threatening and require treatment.

management supervisors. As with other HDSP areas, the laboratory reported it was understaffed. At one point during the review period, the laboratory had only one staff member. The managers and the laboratory supervisor reported that it is very difficult to recruit and retain quality staff. They advised that several factors contributed to the chronic staff shortages including a rural location, CCHCS headquarters' recent directive that all current vacant positions be hired as "limited term," poor compensation packages, and the pending closure of CCC with the potential for more senior CCC staff to bump HDSP to lower-level positions.[27] Also, the staff shortages create a difficult work environment, worsening the ability to retain quality staff. Short-term and registry staff are frequently used.

The COVID-19 pandemic and frequent urine drug testing for the new ISUDT program significantly increased the laboratory staff workload. Staff reported that with staff shortages, this resulted in a backlog of over 1,100 tests for the past year. For example, medical leadership advised that approximately 50 percent of HDSP's incarcerated population was enrolled, or was pending evaluation, for ISUDT, and at least 800 Suboxone prescriptions were administered daily. Each of these patients required frequent monitoring with urine testing and evaluations. Laboratory and radiology staff reported that the initiation of the ISUDT program and subsequent patient misuse of Suboxone resulted in significant medical complications that often required urgent imaging and laboratory workup. The radiology staff advised this has greatly increased their X-ray usage and nearly doubled their MRI/CT (magnetic resonance imaging/computerized tomography) imaging utilization.

With the current workload and staff shortages, combined with the laboratory backlog, medical leadership and staff expressed they did not feel that this situation was sustainable in the long term and would impact patient care.

[27] *Limited term* means the position is for a predefined period, and the appointments do not confer civil service employment rights beyond the specified time period.

Compliance Testing Results

Table 8. Diagnostic Services

Compliance Questions	Scored Answer Yes	No	N/A	Yes %
Radiology: Was the radiology service provided within the time frame specified in the health care provider's order? (2.001) *	8	2	0	80.0%
Radiology: Did the ordering health care provider review and endorse the radiology report within specified time frames? (2.002) *	10	0	0	100%
Radiology: Did the ordering health care provider communicate the results of the radiology study to the patient within specified time frames? (2.003)	4	6	0	40.0%
Laboratory: Was the laboratory service provided within the time frame specified in the health care provider's order? (2.004) *	3	7	0	30.0%
Laboratory: Did the health care provider review and endorse the laboratory report within specified time frames? (2.005) *	10	0	0	100%
Laboratory: Did the health care provider communicate the results of the laboratory test to the patient within specified time frames? (2.006)	2	8	0	20.0%
Laboratory: Did the institution collect the STAT laboratory test and receive the results within the required time frames? (2.007) *	0	2	0	0
Laboratory: Did the provider acknowledge the STAT results, OR did nursing staff notify the provider within the required time frames (2.008) *	0	2	0	0
Laboratory: Did the health care provider endorse the STAT laboratory results within the required time frames? (2.009)	2	0	0	100%
Pathology: Did the institution receive the final pathology report within the required time frames? (2.010) *	3	6	0	33.3%
Pathology: Did the health care provider review and endorse the pathology report within specified time frames? (2.011) *	6	2	1	75.0%
Pathology: Did the health care provider communicate the results of the pathology study to the patient within specified time frames? (2.012)	1	7	1	12.5%
			Overall percentage (MIT 2): **49.2%**	

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

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

Recommendations

- The department should consider how to improve HDSP's poor staffing levels.

- The medical leadership and diagnostics leadership should consider improving the STAT laboratory process to ensure testing is completed as ordered and results related to the providers timely.

Emergency Services

Overall Rating
Inadequate

Case Review Rating
Inadequate

Compliance Score
(N/A)

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

Results Overview

HDSP delivered poor emergency care. Similar to Cycle 5, HDSP continued to struggle with incomplete nursing assessments, timely nursing interventions, and reassessments of the patients' conditions prior to discharge. Often, the documentation of assessments and care provided was inconsistent or incomplete. In addition, the institution's EMRRC committee often did not identify many nursing deficiencies or did not discuss cases with significant deficiencies during the monthly review of unscheduled patient transports to the hospital. However, since Cycle 5, nurses have significantly improved the first medical responder documentation. HDSP staff also performed well in responding and implementing appropriate interventions for patients with traumatic injuries requiring CPR. Factoring all aspects of emergency care, we rated this indicator ***inadequate.***

Case Review Results

Our clinicians reviewed 29 urgent or emergent events. We identified 48 emergency care deficiencies in 16 cases, of which 17 were significant.[28]

Emergency Medical Response

Overall, HDSP provided appropriate medical responses. First responders mostly evaluated the patient, notified clinical health care staff within the required time frame, and most of the time, notified emergency medical services (EMS) without delay. Our clinicians reviewed 29 events that involved a first medical responder and identified 23 deficiencies, four of which were significant.[29] The following is an example.

- In case 10, the TTA nursing staff did not respond to the clinic immediately when notified of a patient with right-sided facial and

[28] We reviewed emergency care in cases 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 17, 19, 20, 21, 22, 23, 24, and 53. Deficiencies occurred in cases 1–10, 17, 19, 20, 21, 22, and 24. Significant deficiencies occurred in cases 1, 2, 8, 10, 19, 20, 21, and 22.

[29] Deficiencies occurred in cases 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 17, 19, 20, 21, 22, and 24. Significant deficiencies occurred in cases 10, 19, and 22.

arm numbness. The response delay was greater than an hour. The TTA nurse assessed the patient and did not activate EMS for these symptoms.

Provider Performance

HDSP providers performed satisfactorily with urgent and emergent situations, and after-hours care. Providers considered diagnoses, but did not always intervene appropriately. We identified three significant deficiencies in which the necessary interventions were not ordered.

- In case 1, the TTA provider did not order IV fluids for a patient with positive orthostatic vitals for a patient who complained of nausea, vomiting, and abdominal pain.[30]

- In case 2, the on-call TTA provider did not order any medications to reduce the patient's abnormally elevated heart rate and pulse while the patient was waiting for transport to a higher level of care.

- In case 21, the provider discontinued antibiotics three days early, for the treatment of cellulitis, after the patient developed a rash. The provider did not order a different antibiotic. Subsequently, the patient was later sent to the community hospital, where a different antibiotic was administered.

Nursing Performance

HDSP nurses frequently responded promptly to emergent events. However, on several occasions, nurses did not perform well with complete assessments, timely interventions, reassessments, and timely provider notifications. Initial assessments were often incomplete, and reassessments of the patient's condition were not often completed prior to discharge to housing or transfer to the community hospital for a higher level of care.

- In case 1, a patient received emergency care for palpitations with a new onset of an irregular heart rhythm and abnormally elevated potassium level. TTA nurses did not listen to heart sounds or reassess the patient after medication was administered to lower the patient's heart rate. Although the patient was in the TTA for over seven hours, besides the vital signs, the nurses did not document the clinical reassessments.

- In case 19, TTA nurses did not listen to lung sounds, assess the respiratory effort for a patient who was observed in the TTA for two hours with shortness of breath, headache, fever, and fatigue with an abnormally low oxygen saturation. On a subsequent date, the patient

[30] Orthostatic vitals means the blood pressure and pulse measurements are recorded in three separate positions: laying down, sitting, and standing. Positive orthostatic is when these measurements are abnormal, indicating possible fluid loss.

was seen again for an abnormally low oxygen saturation rate with a fever. TTA nurses did not perform a complete respiratory assessment, including listening to lung sounds, and did not take the patient's temperature.

- In case 21, TTA nurses did not perform a complete abdominal assessment for a patient who presented with nausea and vomiting.

- In case 24, the TTA nurse did not perform a complete heart assessment for a patient who was seen for a syncopal episode with dizziness.[31] The patient was in the TTA for two and a half hours, and the nurses did not listen to heart sounds or reassess the patient's condition prior to transport to a higher level of care.

Nursing Documentation

Complete and accurate documentation illustrates the quality and timeliness of emergency care. HDSP nurses continued to have difficulty documenting the proper sequence of events and pertinent information, such as care provided during an emergency. We found opportunities for improvement in all 43 deficiencies. The following deficiencies are examples.

- In case 9, the TTA nurse responded to a patient who was confused and who had cold, clammy skin. The nurse's documentation of the assessment of the oxygen saturation was inconsistent. On one form in the EHRS, the nurse documented an oxygen saturation was not obtained due to the patient's involuntary hand shaking. However, in another area of the EHRS, the nurse documented the oxygen saturation rate was at an abnormally low level. In addition, the nurse did not document that the normal saline solution was administered on the patient's medication record.

- In case 19, the TTA nurse evaluated a patient for shortness of breath, headache, dizziness, fever, and fatigue. The nurse did not document the amount of oxygen given to the patient. In addition, the nurse documented two sets of vital signs after the patient had already left the institution to the hospital.

- In case 22, the TTA nurse evaluated the patient for severe abdominal pain, nausea, and vomiting. The TTA nurse did not document the pain level when the vital signs were taken. In addition, the nurse documented that intravenous pain medication was administered 15 minutes before intravenous access was obtained.

[31] Syncope is a transient loss of consciousness, which can be caused by insufficient blood flow to the brain.

Emergency Medical Response Review Committee

OIG clinicians reviewed 12 events that were discussed in the EMRRC.[32] We identified six deficiencies, and two were significant. In addition, there were four events that were not reviewed by the EMRRC, and we identified four significant deficiencies in these four events. At times, HDSP staff did not complete clinical reviews of unscheduled emergency transports.

EMRRC meetings were held monthly to review unscheduled transports. The committee determined which cases required committee review and documented those for which an open review did not occur. Our clinicians identified many cases with significant nursing deficiencies that were not identified by the SRN II review of the chart, as well as during the EMRRC meeting.[33]

At the beginning of the inspection, we requested information regarding the EMRRC. The institution self-identified deficiencies and planned to correct the error though the EMRRC review process, as noted in a memorandum sent to the OIG after the request was made to submit EMRRC documents for our review process. The HDSP warden and the chief executive officer (CEO) submitted the memorandum self-identifying missing times, the number of Narcan doses, the boxes that were not checked, and the protocols that were not addressed. The committee met and developed a plan to eliminate errors in the future. Event checklists submitted to the OIG were corrected prior to submission with corrections.

Patient Care Environment

HDSP nursing staff, medical providers, and custody staff generally collaborated well together in providing care for patients. However, collaboration was problematic in the following case:

- In case 22, the patient was seen for severe abdominal pain, nausea, and vomiting. The patient was evaluated in the TTA with unrelieved abdominal pain for over six hours before being transferred to a higher level of care. The nurses documented their assessment and notification to the provider of abnormal findings. However, the on-call provider reported during our on-site inspection that the verbal report given by the TTA nurse indicated the abdominal examination was benign and that the provider did not receive a report of symptoms of severe abdominal pain and tenderness.

Clinician On-Site Inspection

At HDSP, the TTA had two treatment rooms equipped with two gurneys each. The primary observation room was equipped with an emergency cart, external defibrillator, and an EKG machine. The TTA was staffed with two RNs, the TTA

[32] Events occurred in cases 1, 2, 3, 4, 5, 7, 8, 9,10, and 19. Significant deficiencies occurred in cases 1 and 19.

[33] Significant deficiencies occurred in cases 1, 6, 20, and 22.

RN, and a roving TTA RN (Rover). The TTA Rover was responsible for responding to all medical emergencies, delivering new medication orders to the yard medication clinics, and responding to COVID-19 pandemic quarantine and isolation patients with abnormal screening symptoms and vital signs.

Recommendations

- Nursing leadership should consider ensuring nursing staff receive remedial training on assessments and reassessments of emergent and urgent conditions.

- Nursing leadership should consider resuming random audits to ensure nursing documentation is complete and thorough.

- The EMRRC committee should ensure all unscheduled transports to off-site hospitals are reviewed for deficiencies in the quality of nursing performance, policy, procedures, and form completion.

Health Information Management

Overall Rating ***Adequate***

Case Review Rating ***Adequate***

Compliance Score ***Proficient*** **(91.4%)**

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

As in Cycle 5, HDSP performed adequately in all areas of health information management including scanning health care services requests, specialty consult notes, and hospital discharge summaries. Overall, the OIG rated this indicator ***adequate***.

Case Review and Compliance Results

The OIG case review team evaluated 1,036 events and found 60 deficiencies related to health information management. Of these 60 deficiencies, seven were significant.[34]

Hospital Discharge Reports

OIG case reviewers reviewed 18 off-site emergency department and hospital visits and found no significant deficiencies in this area.[35] Compliance testing found that HDSP staff timely retrieved hospital records, scanned them into the medical record, and reviewed them properly. (MIT 4.003, 88.9% and MIT 4.005, 100%)

Specialty Reports

Overall, HDSP performed poorly regarding specialty reports. Compliance testing found HDSP performed sufficient in scanning specialty consult notes once they were received (MIT 4.002, 76.7%); however, the institution did not receive high, medium or routine-priority specialty reports timely nor did the providers review the reports within the required time frames (MIT 14.002, 42.9%, MIT 14.005, 73.3% and MIT 14.008, 46.7%).

[34] Deficiencies occurred in cases 1,2, 4, 5, 9, 10, 12, 15–25 and 36. Significant deficiencies occurred in cases 1, 2, 15, 20, 22, and 24.

[35] Hospital and/or ER events occurred in cases 1, 2, 8, 9, 10, 15, 17, and 19–24.

In contrast, we identified four deficiencies in case review, two of which were significant.[36] Many of the specialty reports were completed by CCHCS telemedicine specialty providers for medication-assisted treatment, wound care, and, occasionally, hepatitis C treatment initiation. These specialists entered their notes directly into the EHRS, eliminating the need for specialty note retrieval and scanning.

OIG clinicians also found that eConsult notes were not fully scanned into the medical record, which could have caused a loss of critical consultation information.

We also discuss these findings further in the **Specialty Services** indicator.

Diagnostic Reports

Compliance testing and case review found that HDSP performed well in providers reviewing imaging and regularly scheduled laboratory reports; however, STAT labs were not acknowledged by the provider within compliance time frames, pathology reports were usually not retrieved timely, and the patients were rarely advised of the pathology results. Refer to the **Diagnostic Services** indicator for further detailed discussion.

Urgent and Emergent Records

OIG clinicians reviewed 29 emergency care events and found that HDSP nurses and providers recorded these events adequately. The providers also recorded their emergency care sufficiently, including on-call telephone encounters. Refer to the **Emergency Services** indicator for additional information regarding emergency care documentation.

Scanning Performance

Both case review and compliance testing found that HDSP performed well with the scanning process (MIT 4.004, 91.7%). Case review found that if the documents were received by health information management, they were scanned correctly and timely. Case review found only one minor deficiency in case 1. Deficiencies were identified on two other EKGs; however, these were not sent to staff for scanning. These are discussed further under the **Diagnostic Services** indicator.

Clinician On-Site Inspection

We discussed health information management processes with HDSP medical leadership, health information management supervisors, office technicians, ancillary staff, diagnostic staff, nurses, and providers. Staffing was a significant problem, partially due to the COVID-19 pandemic, but also due to chronic difficulty in hiring and retaining quality staff. At times, it was necessary to

[36] Deficiencies occurred in cases 2, 20, 22, and 24. The two significant deficiencies occurred in cases 20 and 22.

borrow staff from other areas of the institution. Both management and staff reported working extended hours for long durations to keep up with the workload. OIG case reviewers saw dedication in the staff; however, staff expressed significant fatigue and frustration with the chronic staffing shortages.

We were advised that local hospitals and specialty offices had similar staffing challenges, which delayed their ability to respond to HDSP requests. Health information management advised that just prior to our review period, they had received online access to one local hospital's records and another other recently as well, which should expedite the process of getting hospital documents in the future.

EKGs were not always sent correctly by nursing to the health information management area. Staff reported that there had been a significant turnover of nursing staff, which may have contributed to this problem. This is discussed further in the **Nursing Performance** indicator.

Compliance Testing Results

Table 9. Health Information Management

Compliance Questions	Scored Answer Yes	No	N/A	Yes %
Are health care service request forms scanned into the patient's electronic health record within three calendar days of the encounter date? (4.001)	20	0	10	100%
Are specialty documents scanned into the patient's electronic health record within five calendar days of the encounter date? (4.002) *	23	7	15	76.7%
Are community hospital discharge documents scanned into the patient's electronic health record within three calendar days of hospital discharge? (4.003) *	8	1	0	88.9%
During the inspection, were medical records properly scanned, labeled, and included in the correct patients' files? (4.004) *	22	2	0	91.7%
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) *	9	0	0	100%
Overall percentage (MIT 4): **91.4%**				

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

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

Table 10. Other Tests Related to Health Information Management

Compliance Questions	Scored Answer Yes	No	N/A	Yes %
Radiology: Did the ordering health care provider review and endorse the radiology report within specified time frames? (2.002) *	10	0	0	100%
Laboratory: Did the health care provider review and endorse the laboratory report within specified time frames? (2.005) *	10	0	0	100%
Laboratory: Did the provider acknowledge the STAT results, OR did nursing staff notify the provider within the required time frames? (2.008) *	0	2	0	0
Pathology: Did the institution receive the final pathology report within the required time frames? (2.010) *	3	6	0	33.3%
Pathology: Did the health care provider review and endorse the pathology report within specified time frames? (2.011) *	6	2	1	75.0%
Pathology: Did the health care provider communicate the results of the pathology study to the patient within specified time frames? (2.012)	1	7	1	12.5%
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) *	6	8	1	42.9%
Did the institution receive and did the primary care provider review the medium-priority specialty service consultant report within the required time frame? (14.005) *	11	4	0	73.3%
Did the institution receive and did the primary care provider review the routine-priority specialty service consultant report within the required time frame? (14.008) *	7	8	0	46.7%

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

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

Recommendations

The OIG offers no recommendations for this indicator.

Health Care Environment

Overall Rating
Inadequate

Case Review Rating
(N/A)

Compliance Score
Inadequate
(59.1%)

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

For this indicator, HDSP's performance declined compared with its performance in Cycle 5. In the present cycle, multiple aspects of HDSP's health care environment needed improvement: multiple clinics contained expired medical supplies; multiple clinics lacked medical supplies or contained improperly calibrated or nonfunctional equipment; emergency medical response bag (EMRB) logs were either missing staff verification or inventory was not performed; and staff did not regularly sanitize their hands before, after examining patients, or before and after blood draw. These factors resulted in an ***inadequate*** rating for this indicator.

Outdoor Waiting Areas

We examined outdoor patient waiting areas (see Photo 1). Health care and custody staff reported existing waiting areas had sufficient seating capacity. The staff reported that they only call patients from their respective housing units at the time of their appointments during inclement weather.

Photo 1. A clinic outdoor waiting area (photographed on October 7, 2021).

Indoor Waiting Areas

We inspected indoor waiting areas (see Photo 2). Healthcare and custody staff reported existing waiting areas contained sufficient seating capacity. During our inspection, we did not observe overcrowding or noncompliance to social distancing requirements in any of the clinics' indoor waiting areas. However, C Facility custody sergeants reported that there were no protocol or instructions given on where to place patients waiting for their clinic visit during inclement weather, since the facility's indoor waiting area was under construction.

Photo 2. E Clinic indoor waiting area (photographed on October 5, 2021).

Clinic Environment

Of 11 clinic environments, 10 were sufficiently conducive to medical care; they provided reasonable auditory privacy, appropriate waiting areas, wheelchair accessibility, and nonexamination room workspace (MIT 5.109, 90.9%). In one clinic, the triage station did not provide reasonable auditory privacy.

Of the 11 clinics we observed, nine contained appropriate space, configuration, supplies, and equipment to allow their clinicians to perform proper clinical examinations (MIT 5.110, 81.8%). The remaining two clinics had one or more of the following deficiencies: the examination room chair had torn cover, the room lacked sufficient space (fewer than 100 square feet), or rooms had unsecured confidential medical records.

Clinic Supplies

Six of the 11 clinics followed appropriate medical supply storage and management protocols (MIT 5.107, 54.6%). We found one or more of the following deficiencies in five clinics: expired medical supplies (see Photos 3 and 4, this page), unidentified medical supplies, cleaning materials stored with medical supplies (Photo 5, next page), or staff members' personal items and food stored long term in the medical supply storage room (Photo 6, next page).

Photo 3. Expired medical supply dated February 20, 2021 (photographed on October 6, 2021).

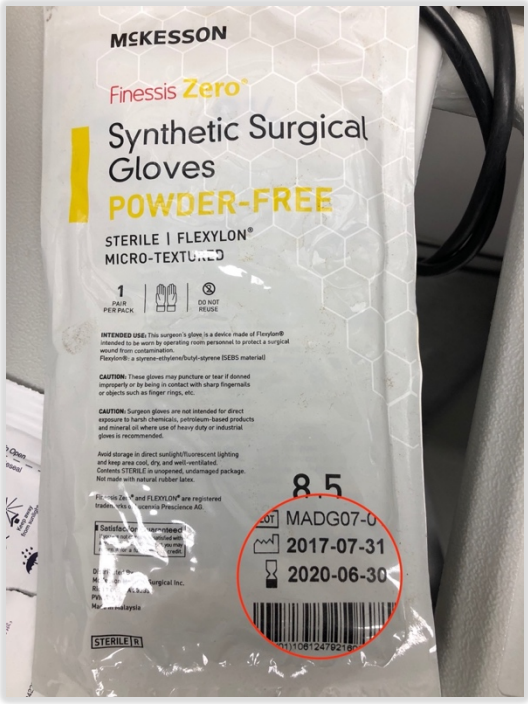

Photo 4. Expired medical supply dated June 30, 2020 (photographed on October 6, 2021).

Photo 5. Medical supplies stored with cleaning materials (photographed on October 6, 2021).

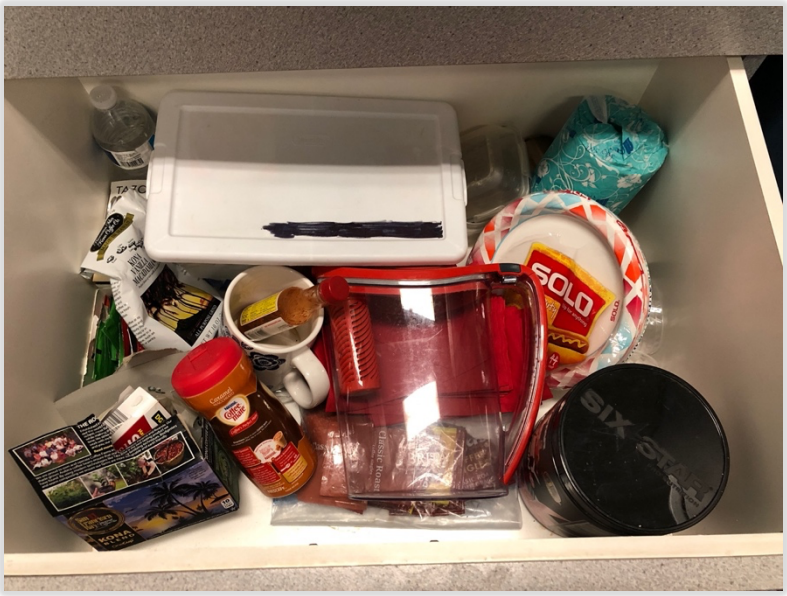

Photo 6. Staff members' personal items and food stored long term in the medical supply storage room (photographed on October 7, 2021).

Six of the 11 clinics met the requirements for essential core medical equipment and supplies (MIT 5.108, 54.6%). The remaining five clinics lacked medical supplies or contained improperly calibrated or nonfunctional equipment. The missing item was examination table disposable paper. The staff had not properly calibrated a vital signs equipment and weight scale. We found the Snellen eye chart did not have an identified distance line marked on the floor or wall and there was a nonfunctional oto-ophthalmoscope. HDSP staff did not properly log the results of the automated external defibrillator (AED) checklist within the last 30 days.

We examined EMRBs to determine whether they contained all essential items and if staff had inspected the bags daily and inventoried them monthly. None of the eight EMRBs passed our tests (MIT 5.111, zero). We found one or more of the following deficiencies with all EMRBs: staff failed to ensure the EMRB's compartments were sealed and intact, staff had not inventoried the EMRBs when the seal tags were replaced or inventoried the EMRBs which were not opened in the previous 30 days, EMRBs contained compromised sterile medical supply packaging (see Photo 7 and 8), and staff failed to log EMRB daily glucometer control results. The treatment carts in the TTA and CTC did not meet the minimum inventory level, and staff did not document that reasonable substitutions were made.

Photo 7. Compromised medical supply found in the EMRB (photographed on October 5, 2021).

Photo 8. Compromised medical supply found in the EMRB (photographed on October 7, 2021).

Medical Supply Management

None of the medical supply storage areas located outside the medical clinics stored medical supplies adequately (MIT 5.106, zero). We found expired medical supplies (see Photos 9, 10, and 11) and medical supplies stored directly on the floor (see Photo 12). In addition, the medical warehouse was found unclean and not free of dust build-up (see Photos 13 and 14).

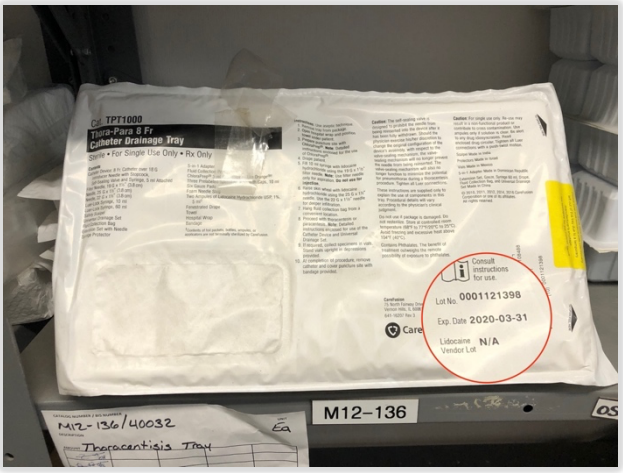

Photo 9. Expired medical supply dated March 31, 2020 (photographed on October 5, 2021).

Photo 10. Expired medical supply dated March 2020 (photographed on October 5, 2021).

Photo 11. Expired medical supply dated July 31, 2020 (photographed on October 5, 2021).

Photo 12. Medical supplies stored directly on the floor (photographed on October 5, 2021).

Photo13. Medical warehouse found unclean and not free of dust build-up (photographed on October 5, 2021).

Photo 14. Medical warehouse found unclean and not free of dust build-up (photographed on October 5, 2021).

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

Infection Control and Sanitation

Staff appropriately cleaned, sanitized, and disinfected eight of 11 clinics (MIT 5.101, 72.7%). In two clinics, biohazardous waste was not emptied the previous day. The remaining clinic's examination room floor and table were not free of grime, dirt, or stains (see Photo 15).

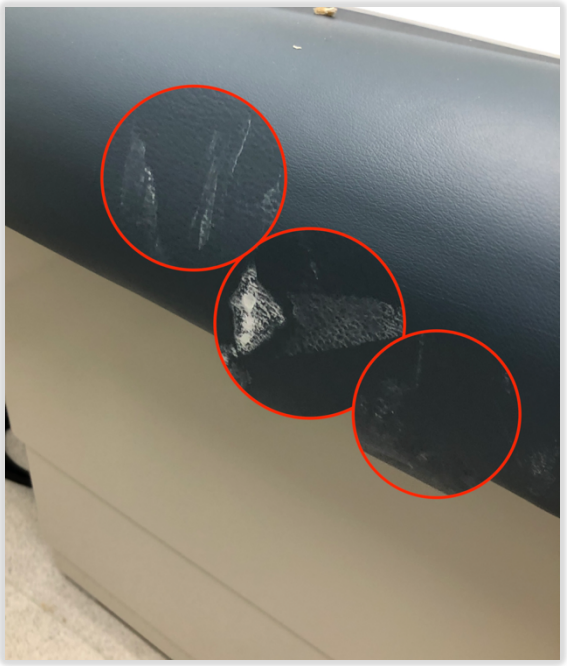

Photo 15. Stain on the examination table (photographed on October 6, 2021).

Staff in nine of 11 clinics (MIT 5.102, 81.8%) properly sterilized or disinfected medical equipment. In two clinics, staff did not mention disinfecting the examination table as part of their daily start-up protocol.

We found operating sinks and hand hygiene supplies in the examination rooms in eight of 11 clinics (MIT 5.103, 72.7%). In one clinic, the patient restroom had a nonfunctional sink (see Photo 16). In another clinic, the provider reported challenges in receiving sufficient supplies of antiseptic soap for the examination room within the past six months. The remaining clinic's blood draw station lacked an operational sink.

Photo 16. Patient restroom sink leaking from the side (photographed on October 7, 2021).

We observed patient encounters in six clinics. In three clinics, clinicians did not wash their hands before or after examining their patients, before applying gloves, or after performing blood draws (MIT 5.104, 50.0%).

Health care staff in 10 of 11 clinics followed proper protocols to mitigate exposure to blood-borne pathogens and contaminated waste (MIT 5.105, 90.9%). In one clinic, the examination room lacked a sharps container.

Physical Infrastructure

At the time of our medical inspection, the institution's administrative team reported six concurrent, ongoing, active health care facility improvement program (HCFIP) construction projects. Some projects had already broken ground or were nearing project completion. All six projects were either renovations or additions of clinic spaces designed to provide improvements in the quality of patient care. The institution reported the projects were expected to be completed between the first and third quarters of 2022 (MIT 5.999).

Compliance Testing Results

Table 11. Health Care Environment

Compliance Questions	Scored Answer Yes	No	N/A	Yes %
Infection control: Are clinical health care areas appropriately disinfected, cleaned, and sanitary? (5.101)	8	3	0	72.7%
Infection control: Do clinical health care areas ensure that reusable invasive and noninvasive medical equipment is properly sterilized or disinfected as warranted? (5.102)	9	2	0	81.8%
Infection control: Do clinical health care areas contain operable sinks and sufficient quantities of hygiene supplies? (5.103)	8	3	0	72.7%
Infection control: Does clinical health care staff adhere to universal hand hygiene precautions? (5.104)	3	3	5	50.0%
Infection control: Do clinical health care areas control exposure to blood-borne pathogens and contaminated waste? (5.105)	10	1	0	90.9%
Warehouse, conex, and other nonclinic storage areas: Does the medical supply management process adequately support the needs of the medical health care program? (5.106)	0	1	0	0
Clinical areas: Does each clinic follow adequate protocols for managing and storing bulk medical supplies? (5.107)	6	5	0	54.6%
Clinical areas: Do clinic common areas and exam rooms have essential core medical equipment and supplies? (5.108)	6	5	0	54.6%
Clinical areas: Are the environments in the common clinic areas conducive to providing medical services? (5.109)	10	1	0	90.9%
Clinical areas: Are the environments in the clinic exam rooms conducive to providing medical services? (5.110)	9	2	0	81.8%
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	3	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): **59.1%**

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

Source: The Office of the Inspector General medical inspection results

Recommendations

- Medical leadership should remind staff to follow universal hand hygiene precautions. Implementing random spot checks could improve compliance.

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

- Nursing leadership should direct each clinic nurse supervisor to review the monthly emergency medical response bag (EMRB) logs to ensure the EMRBs are regularly inventoried and sealed.

Transfers

Overall Rating
Inadequate

Case Review Rating
Inadequate

Compliance Score
Inadequate
(67.1%)

In this indicator, OIG inspectors examined the transfer process for those patients who transferred into the institution as well as for those who transferred to other institutions. For newly arrived patients, our inspectors assessed the quality of health screenings and the continuity of provider appointments, specialist referrals, diagnostic tests, and medications. For patients who transferred out of the 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

Overall, HDSP performed poorly in patient care for the transfer process. Compared with Cycle 5, HDSP nurses continued to adequately perform good nursing assessments for patients transferring into or out of the institution. However, for the hospital return process, there was a lapse in the continuity of hospital recommendations, including delayed medication reconciliation, incomplete nursing assessments, and delays in provider follow-ups after hospitalizations. Considering all aspects of the transfer process, we rated this indicator ***inadequate***.

Case Review and Compliance Testing Results

In case review, our clinicians reviewed 20 cases in which patients transferred into or out of the institution or returned from an off-site hospital or emergency room. We identified 21 deficiencies, nine of which were significant.[37]

Transfers In

Our case reviewers reviewed four cases in which patients transferred into HDSP from other institutions and identified two deficiencies; both deficiencies were significant.[38]

Compliance testing showed that R&R nurses did not complete the initial health screening form thoroughly (MIT 6.001, 28.0%). The most common reasons for the

[37] Deficiencies occurred in cases 1, 2, 10,15, 19, 21, 23, 26, 27, 29, 30, and 31. Significant deficiencies occurred in cases 2, 29, 30, and 31.

[38] Deficiencies occurred in cases 26 and 27. Significant deficiencies occurred in cases 27 and 28.

low score was the failure to address the health screening question inquiring treatment for mental illness and the fatigue symptoms for tuberculosis (TB) screening. On the other hand, the nurses performed well in timely completing the assessment and disposition section of the health screening form (MIT 6.002, 100%). OIG clinicians reviewed four transfer-in cases and found that the R&R nurses evaluated newly arrived patients and ordered provider appointments within appropriate time frames.

Compliance testing found HDSP performed poorly in providing medication continuity for patients who arrived from another departmental institution (MIT 6.003, 73.3%). Case review did not identify any deficiencies related to medication continuity of patients newly arriving to the institution. Compliance testing also showed HDSP did not perform well in administering medication without interruption to patients who laid over at the institution (MIT 7.006, 66.7%). Our clinicians did not review any cases with a layover.

Compliance testing showed provider appointments for newly arrived patients occurred within required time frames (MIT 1.002, 84.0%). However, our clinicians identified two significant deficiencies when the provider's new arrival visit was delayed for high-risk patients.[39]

When patients transferred into HDSP with preapproved specialty appointments, compliance testing found that 73.3 percent of their specialty appointments were completed within the required time frames (MIT 14.001). Our clinicians did not identify any deficiencies during case review.

Transfers Out

HDSP's transfer-out process was satisfactory. Our clinicians reviewed three transfer-out cases and found that nurses completed face-to-face evaluations on the day of transfer. However, one deficiency was identified for a preboarding screening not completed within 24 hours of transfer. We also found that the R&R nurse did not inform the receiving facility of pending specialty appointments in three cases.[40] Compliance testing did not test for patients transferring out of the institution with the required documentation and medication as there were no transfer outs during the week of the compliance inspection (MIT 6.101, N/A). Our clinicians found most patients were screened appropriately prior to transfer. However, one patient did not receive preboarding screenings on two separate occasions prior to transfer.

- In case 2, the patient was scheduled for transfer on two separate occasions. Prior to the first transfer, R&R nurses did not perform a preboarding screening as required prior to transfer within 24 hours. When the patient reported to the R&R, the patient had abnormally elevated vital signs and was transported to the community emergency room for further evaluation. The patient was scheduled for transfer six days later. Once again, the preboarding screening was

[39] Significant deficiencies occurred in cases 26 and 27.

[40] Deficiencies occurred in cases in 29, 30, and 21.

not completed within 24 hours, and the patient was not considered for a medical hold because the patient had not seen the provider for follow-up after the emergency room visit.

Hospitalizations

Patients returning from an off-site hospitalization or emergency room were at high-risk for lapses in care quality. These patients typically experienced severe illness or injury. They required more care and placed a strain on the institution's resources. Also, because the patients had complex medical issues, successful health information transfer was necessary for good quality care. Any transfer lapse could have resulted in serious consequences for these patients.

Our clinicians reviewed 15 hospital or emergency room returns in 10 cases. We identified 13 deficiencies, seven of which were significant.[41]

HDSP TTA nurses saw the patients returning from the hospital and timely notified the provider of hospital recommendations. However, nurses frequently did not perform complete assessments and documentation. Our clinicians identified five deficiencies, three of which were significant.[42] The following are two examples.

- In case 15, upon return from a community hospitalization, the patient complained of severe, intermittent abdominal pain. Although the nurse completed vital signs, the nurse did not perform a complete abdominal assessment.

- In case 19, the patient returned from a hospital admission for respiratory failure on oxygen and severe malnutrition. The nurse did not assess breath sounds or weigh the patient.

HDSP performed well in retrieving and scanning hospital records. Our clinicians identified one minor deficiency with an incorrect scanning date for a PICC line placement.[43]

Compliance testing showed that HDSP performed well in providing follow-up appointments within the required time frame to patients returning from the hospital and from emergency room visits (MIT 1.007, 88.9%). Our clinicians identified one minor deficiency related to delayed provider appointments. See the example below:

- In case 2, the nurse ordered a provider follow-up when the patient returned from an emergency room visit for an abnormally elevated blood pressure. Three days later, the provider canceled the order and

[41] Deficiencies occurred in cases 1, 2, 10, 15, 19, 21, and 23. Significant deficiencies occurred in cases 6 and 7.

[42] Deficiencies occurred in cases 1, 15, 19, 21, and 23. Significant deficiencies occurred in cases 1, 19, and 21.

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

placed a new order, which extended the compliance date four additional days. The provider follow-up occurred four days late from the initial order date.

In most cases, hospital discharge documents were scanned into the patients' electronic health record within three calendar days of hospital discharge (MIT 4.003, 88.9%). Compliance testing also found providers routinely reviewed and endorsed documents in a timely manner (MIT 4.005, 100%).

Compliance showed HDSP had opportunities for improvement in medication continuity for patients discharged from a community hospital (MIT 7.003, 60.0%). Analysis of the compliance data showed in one case that the provider did not reconcile hospital return medication within the required time frame. In another case, the provider-ordered antibiotic was administered one day late. Likewise, case review also found there were lapses in the continuity of medication for patients who returned from the hospital, as seen in the examples below:

- In case 15, the patient was readmitted to the CTC after returning from a community hospitalization. The patient's cholesterol medication was not reconciled until 24 days later. The patient's seizure medication was not reconciled until 25 days later when the patient was found on the ground with a possible seizure. The patient's migraine medication was not reconciled for over a month until the patient reported symptoms of a migraine.

- In case 19, the patient returned from a community hospitalization for respiratory failure secondary to COVID-19 pneumonia. The patient missed the first dose of the antibiotic because the medication was not available.

- In case 21, the patient returned from the emergency room after being treated for an allergic reaction. Before release from the hospital, the patient received a steroid injection. The hospital recommended further steroid medication for five days to start the following morning. However, the TTA nurse obtained a phone order for a reduced dose of steroid and on the same day, administered it to the patient when he returned to the institution.

Clinician On-Site Inspection

OIG clinicians met with the R&R nurse who evaluated patients arriving and transferring from the institution. During our inspection, the R&R nurse reviewed the transportation list along with the patient's medical record for medical risk level, chronic care conditions, durable medical equipment (DME), COVID-19 POC results, and COVID-19 vaccination status. At the time of our inspection, nonvaccinated new patient arrivals were placed in quarantine. The R&R nurse reported communication to other institutions and care teams is usually done using Microsoft Outlook email rather than through the EHRS messaging system.

Transfer-out patients were evaluated by the R&R RN on the day of transfer. For transfer-out patients, the R&R nurse reported the medications, specialty appointments, and medical holds were reviewed, and the receiving institution was notified via Outlook email.

The TTA RN Rover evaluated patients returning from the emergency room and hospital admissions. The TTA nurses reported that during business hours, the TTA provider reviewed the hospital discharge packet and reconciled all orders. After hours, the TTA nurse would contact on-call providers to receive verbal orders for medication. The provider reconciled all additional orders during normal business hours.

Compliance Testing Results

Table 12. Transfers

Compliance Questions	Scored Answers			
	Yes	No	N/A	Yes %
For endorsed patients received from another CDCR institution or COCF: Did nursing staff complete the initial health screening and answer all screening questions within the required time frame? (6.001) *	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)	24	0	1	100%
For endorsed patients received from another CDCR institution or COCF: If the patient had an existing medication order upon arrival, were medications administered or delivered without interruption? (6.003) *	11	4	10	73.3%
For patients transferred out of the facility: Do medication transfer packages include required medications along with the corresponding transfer packet required documents? (6.101) *	N/A	N/A	N/A	N/A
Overall percentage (MIT 6): 67.1%				

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

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

Table 13. Other Tests Related to Transfers

Compliance Questions	Scored Answer			
	Yes	No	N/A	Yes %
For endorsed patients received from another CDCR institution: Based on the patient's clinical risk level during the initial health screening, was the patient seen by the clinician within the required time frame? (1.002) *	21	4	0	84.0%
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) *	8	1	0	88.9%
Are community hospital discharge documents scanned into the patient's electronic health record within three calendar days of hospital discharge? (4.003) *	8	1	0	88.9%
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) *	9	0	0	100%
Upon the patient's discharge from a community hospital: Were all ordered medications administered, made available, or delivered to the patient within required time frames? (7.003) *	3	2	4	60.0%
Upon the patient's transfer from one housing unit to another: Were medications continued without interruption? (7.005) *	18	7	0	72.0%
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) *	6	3	0	66.7%
For endorsed patients received from another CDCR institution: If the patient was approved for a specialty services appointment at the sending institution, was the appointment scheduled at the receiving institution within the required time frames? (14.010) *	2	6	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 requiring that all patients scheduled to transfer out have the preboarding screening completed within 24 hours to ensure medical holds are reviewed and to determine whether patients have all prescribed keep-on-person medication (KOP).

- Nursing leadership should ensure TTA nurses perform complete, focused assessments on patients returning from the emergency room and inpatient hospitalizations.

- Nursing leadership should remind R&R nurses to communicate pertinent patient information to the receiving institution via the EHRS message center instead of using Microsoft Outlook email.

- Medical and nursing leadership should consider developing a process between nursing and providers to ensure all hospital discharge recommendations are reviewed and orders are placed timely.

Medication Management

Overall Rating
Inadequate

Case Review Rating
Inadequate

Compliance Score
Inadequate
(51.9%)

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 strongly considered the compliance test results, which tested medication processes to a much greater degree than case review testing. In addition to examining medication administration, our compliance inspectors also tested many other processes, including medication handling, storage, error reporting, and other pharmacy processes.

Results Overview

HDSP performed poorly in medication management. Areas for improvement included new medication prescriptions, chronic care medication continuity, hospital discharge medications, and transfer medications. In addition, nurses did not always administer KOP medications timely or document clearly if the patient refused the KOP medication. One bright spot was with good medication continuity in patient admissions to the CTC. Both compliance and case review rated this indicator ***inadequate.***

Case Review and Compliance Testing Results

Our clinicians reviewed 142 medication events in 31 cases related to medications and found 44 medication deficiencies, 15 of which were significant.[44]

New Medication Prescriptions

Compliance testing found that new medications were available and administered at a rate of 44.0 percent (MIT 7.002). Analysis of the compliance data showed some patients missed one dose to four days late of essential medications such as antibiotics, hypertension medication, and diabetic medication. In contrast, OIG clinicians found most new medications were administered timely. Five new medications were administered one day late in two cases.[45]

Chronic Medication Continuity

Compliance testing found low scores for chronic care medication continuity (MIT 7.001, zero). Further analysis showed that in most cases, nursing staff did not properly document when patients refused or did not show up for medications. Instead of documenting that patients refused medication, the nurses documented the refill was not requested on chronic care medications

[44] Deficiencies occurred in cases 1, 2,10, 12, 13, 14, 15, 17–24, and 49. Significant deficiencies occurred in cases 1, 10, 12, 14, 15, 17, 20, 23, and 24.

[45] Deficiencies occurred in cases 16 and 19.

which were ordered as automatic refills. In addition, patients did not receive their medication refills one day prior to the prescription's exhaustion. Similarly, our clinicians also found a lapse in continuity of chronic care medication. During our on-site inspection, nursing supervisors reported nurses documenting a refill was not requested on KOP medication when patients refused to pick up the medication, instead of documenting that patients refused, did not show up, or had no barriers to picking up the medication, as in the following examples:

- In case 1, nursing staff incorrectly documented the patient's blood pressure medication as "refill not requested." However, the patient's medication was delivered by the pharmacy to the nursing medication room and returned to the pharmacy when the patient refused to pick up medication.

- In case 14, the patient did not receive chronic care medication for hypertension, diabetes, and high cholesterol for a month. Two months later, the patient received the hypertension medication.

Hospital Discharge Medications

Compliance testing showed that when patients returned from an off-site, hospitalization or emergency room visit, they did not receive their medications within the required time frame (MIT 7.003, 60.0%). Analysis of the compliance data showed there were only five applicable samples. Our clinicians found most patients received their hospital discharge medication within the required time frames. Three deficiencies were found in two cases and all three deficiencies were significant.[46]

- In case 15, the patient's seizure medication was not reconciled until the patient was found on the floor and reported having a seizure. The patient missed 50 doses of medication. In addition, the patient's medication for high cholesterol was not reconciled until 24 days later, and the patient's migraine headache medication not reconciled until the patient reported a migraine headache, almost 30 days later.

- In case 19, the patient missed one dose of antibiotic after discharge from the community hospital for COVID-19 pneumonia.

Specialized Medical Housing Medications

Compliance testing found that when patients were admitted to the correctional treatment center (CTC), they received their medications within the required time frame. (MIT 13.004, 80.0%). Our clinicians found patients mostly received their medications in the CTC without interruption. We found six deficiencies, including three significant deficiencies.[47]

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[46] Deficiencies occurred in cases 15 and 19. Significant deficiencies occurred in cases 15 and 19.

[47] Deficiencies occurred in cases 10, 15, 20, and 24. Significant deficiencies occurred in cases 10, 20, and 24.

- In case 24, the patient's blood thinning medication was not renewed timely. Subsequently, the patient missed six doses before the medication was renewed. Also in case 24, the patient did not receive two doses of a prescribed antibiotic. On another date, the patient's nitroglycerin was not reconciled and reordered when the patient was admitted to the CTC.

Transfer Medications

Compliance testing showed that HDSP did not perform well for patients transferring into the institution (MIT 6.003, 73.3%). Analysis of the compliance data for patients transferring into the institution showed 10 samples were not applicable. Of the four samples in which medication was not administered timely, three of them were due to documentation deficiencies. In contrast, our clinicians did not identify any deficiencies with transfer-in medications.

- In case 2, the patient transferred from CTC to ASU and did not receive the evening dose of three chronic care medications.[48]

Compliance testing found medication continuity was interrupted when patients transferred between housing units (MIT 7.005, 72.0%) and when patients were at the institution for a temporary layover (MIT 7.006, 66.7%).

Medication Administration

Compliance testing showed that nurses were ***proficient*** in administering prescribed tuberculosis (TB) medications at a rate of 90.0 percent (MIT 9.001). Our clinicians found nurses administered most medications timely with an exception in two cases:

- In case 15, the patient was incorrectly given cholesterol medication twice on the day the patient was transferred from CTC to the housing unit. The medication was ordered for once a day.

- In case 23, the patient received a medication injection to prevent blood clotting twice within twenty minutes. This placed the patient at an increased risk for severe bleeding.

Clinician On-Site Inspection

Our clinicians discussed medication management issues with the pharmacist-in-charge (PIC), nursing supervisors, nursing leadership, medical leadership, and providers. We toured medication lines and interviewed nurses who administered medications. Rooms with medication lines were clean and organized. Medical staff responded to emergencies as first responders, and emergency response equipment was readily available. Nurses were familiar with the medication process and policies. Nurses explained a medication list for available KOPs for

[48] ASU is the administrative segregation unit.

pick-up was created and attached to the medication window. Also, medication lists were sent to the housing buildings.

At HDSP, nursing staff reported many patients refused their KOP medication and patients who refused were not required to sign a refusal form. Nursing staff informed housing unit custody staff that KOPs were not picked up. Custody staff notify the patients and let the nursing staff know which patients had stated they did not want their KOP medication. Nursing staff kept the KOP medications in the medication room for five days before returning them to the pharmacy if the medication had not been picked up.

The LVN care coordinators complete 7219 forms, help distribute KOPs, order overdue laboratory work from the medical registry tools, and administer vaccines.[49] In addition, a group of patient care teams were available to efficiently administer COVID-19 vaccines to reduce medication waste.

Nursing leadership reported the administration of Suboxone has required an increase usage of nursing staff in medication lines by 100 percent. HDSP provided updated policies related to Suboxone medication administration process. Medication nurses reported the administration of Suboxone required additional time for administration.[50]

Compliance Testing Results

Medication Practices and Storage Controls

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 could not describe the narcotic medication discrepancy reporting process.

HDSP appropriately stored and secured nonnarcotic medications in seven of nine clinic and medication line locations (MIT 7.102, 77.8%). In two locations, we found medication carts were left unlocked when not in active use. In addition, one of the two locations did not have a designated area for refrigerated medications to be returned to the pharmacy.

Staff kept medications protected from physical, chemical, and temperature contamination in three of the nine clinic and medication line locations (MIT 7.103, 33.3%). In six locations, we found one or more of the following deficiencies: staff did not maintain a temperature log for medications stored in the examination room, staff did not consistently record refrigerator temperatures, or staff did not store oral and topical medications separately.

[49] The 7219 is a medical report form for injuries or unusual occurrences.

[50] Medication nurses reported two patient identifiers were used for identification. The patients were told to take off their jackets to reduce diversion. The medication was obtained from the Omnicell for each prescribed dose. The patient has to show water to the nurse before they drink in a paper medicine cup and once administered the nurse will observe the patient for a few seconds. However, the nurses did not perform mouth checks.

Staff successfully stored valid, unexpired medications in eight of the nine applicable medication line locations (MIT 7.104, 88.9%). In one location, we found an unopened medication stored beyond manufacturer guidelines.

Nurses exercised proper hand hygiene and contamination control protocols in three of seven locations (MIT 7.105, 42.9%). Some nurses neglected to wash or sanitize their hands when required. These occurrences included before each subsequent regloving or after touching a patient's skin.

Staff in five of seven medication preparation and administration areas demonstrated appropriate administrative controls and protocols (MIT 7.106, 71.4%). In one location, medication nurses did not maintain unissued medications in their originally labeled packaging. In another clinic, 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 one of seven medication areas used appropriate administrative controls and protocols when distributing medications to their patients (MIT 7.107, 14.3%). In six locations, we observed one or both of the following deficiencies: medication nurses did not reliably observe patients while they swallowed direct observation therapy medications or medication nurses could not describe the medication error reporting process.

Pharmacy Protocols

HDSP followed general security, organizational, and cleanliness management protocols in its main pharmacy (MIT 7.108, 100%).

In its main pharmacy, HDSP properly stored nonrefrigerated medication. (MIT 7.109, 100%).

The pharmacy did not maintain a temperature log for medications stored in the freezer. In addition, the pharmacy did not have an identifiably designated area for refrigerated medications that were returned to the pharmacy. As a result, HDSP scored zero in this test (MIT 7.110)

The PIC did not thoroughly review monthly inventories of controlled substances in the institution's clinic and medication storage locations. Specifically, the PIC did not correctly complete several medication area inspection checklists (CDCR Form 7477) and neglected to record the name, signature, or date on several inventory records. These errors resulted in a score of zero in this test (MIT 7.111).

We examined 22 medication error reports. The PIC timely or correctly processed only 5 of these 22 reports (MIT 7.112, 22.7%). For 16 medication error reports, we found one or more of the following deficiencies: the PIC did not document the date when the report was completed, the PIC did not document when the provider was notified of the error, or the PIC was unable to provide evidence that the pharmacy follow-up review was performed within the required period. For one medication error report, the report was not free of discrepancy. More specifically, the documented report completion was before the date when the

error occurred and reported through a CCHCS electronic health care incident report (eHCIR).

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

The OIG interviewed patients in restricted housing to determine whether they had immediate access to their prescribed asthma rescue inhalers or nitroglycerin medications. Nine of 10 applicable patients interviewed indicated they had access to their rescue medications (MIT 7.999). One patient reported that he did not have possession of his rescue inhaler for 10 days and did not notify the medical staff. We promptly notified the CEO of this concern, and health care management immediately reissued a replacement rescue inhaler to the patient.

Table 14. Medication Management

Compliance Questions	Scored Answer Yes	No	N/A	Yes %
Did the patient receive all chronic care medications within the required time frames or did the institution follow departmental policy for refusals or no-shows? (7.001) *	0	15	10	0
Did health care staff administer, make available, or deliver new order prescription medications to the patient within the required time frames? (7.002)	11	14	0	44.0%
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) *	3	2	4	60.0%
For patients received from a county jail: Were all medications ordered by the institution's reception center provider administered, made available, or delivered to the patient within the required time frames? (7.004) *	N/A	N/A	N/A	N/A
Upon the patient's transfer from one housing unit to another: Were medications continued without interruption? (7.005) *	18	7	0	72.0%
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) *	6	3	0	66.7%
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	3	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)	7	2	2	77.8%
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)	3	6	2	33.3%
All clinical and medication line storage areas for nonnarcotic medications: Does the institution safely store nonnarcotic medications that have yet to expire in the assigned storage areas? (7.104)	8	1	2	88.9%
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	4	4	42.9%
Medication preparation and administration areas: Does the institution employ appropriate administrative controls and protocols when *preparing* medications for patients? (7.106)	5	2	4	71.4%
Medication preparation and administration areas: Does the institution employ appropriate administrative controls and protocols when *administering* medications to patients? (7.107)	1	6	4	14.3%
Pharmacy: Does the institution employ and follow general security, organization, and cleanliness management protocols in its main and remote pharmacies? (7.108)	1	0	0	100%
Pharmacy: Does the institution's pharmacy properly store nonrefrigerated medications? (7.109)	1	0	0	100%
Pharmacy: Does the institution's pharmacy properly store refrigerated or frozen medications? (7.110)	0	1	0	0
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)	5	17	0	22.7%
Pharmacy: For Information Purposes Only: During compliance testing, did the OIG find that medication errors were properly identified and reported by the institution? (7.998)	This is a nonscored test. Please see the indicator for discussion of this test.			
Pharmacy: For Information Purposes Only: Do patients in restricted housing units have immediate access to their KOP prescribed rescue inhalers and nitroglycerin medications? (7.999)	This is a nonscored test. Please see the indicator for discussion of this test.			
				Overall percentage (MIT 7): **51.9%**

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

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

Table 15. Other Tests Related to Medication Management

Compliance Questions	Scored Answer			
	Yes	No	N/A	Yes %
For endorsed patients received from another CDCR institution or COCF: If the patient had an existing medication order upon arrival, were medications administered or delivered without interruption? (6.003) *	11	4	10	73.3%
For patients transferred out of the facility: Do medication transfer packages include required medications along with the corresponding transfer-packet required documents? (6.101) *	N/A	N/A	N/A	N/A
Patients prescribed TB medication: Did the institution administer the medication to the patient as prescribed? (9.001) *	9	1	0	90.0%
Patients prescribed TB medication: Did the institution monitor the patient per policy for the most recent three months he or she was on the medication? (9.002) *	0	10	0	0
Upon the patient's admission to specialized medical housing: Were all medications ordered, made available, and administered to the patient within required time frames? (13.004) *	8	2	0	80.0%

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

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

Recommendations

- Medical and nursing leadership should identify challenges to medication continuity for new medications, chronic care, hospital discharge, and specialized medical housing patients, implementing remedial measures as appropriate

- The department should implement a monitoring system in the EHRS to identify reasons for patient safety concerns to prevent duplicate administration of medications, especially high-risk medications, within a 24-hour period for medications that are discontinued and reordered, and medications that are reconciled from a licensed medical bed to a general population housing unit.

- Nursing leadership should consider resuming audits for accurate documentation in the medication administration record (MAR) for refusals of KOP medications. Nurses documented that patients did not request refills in the MAR when, instead, patients refused KOP medications.

Preventive Services

Overall Rating
Inadequate

Case Review Rating
(N/A)

Compliance Score
Inadequate
(63.6%)

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

HDSP staff's performance was mixed in providing preventive services. Staff performed well in administering TB medication as prescribed and offering influenza vaccine for the most recent influenza season. The institution faltered in monitoring patients who were taking prescribed TB medication, screening patients annually for TB, in offering colorectal cancer screening for all patients from ages 45 through 75, and offering required immunizations to chronic care patients. These findings are set forth in the table on the next page. We rated this indicator ***inadequate***.

Compliance Testing Results

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)	9	1	0	90.0%
Patients prescribed TB medication: Did the institution monitor the patient per policy for the most recent three months he or she was on the medication? (9.002) †	0	10	0	0
Annual TB screening: Was the patient screened for TB within the last year? (9.003)	14	11	0	56.0%
Were all patients offered an influenza vaccination for the most recent influenza season? (9.004)	25	0	0	100%
All patients from the age of 45 through the age of 75: Was the patient offered colorectal cancer screening? (9.005)	18	7	0	72.0%
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)	7	4	14	63.6%
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):	**63.6%**

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

† In April 2020, after our review but before this report was published, CCHCS reported adding the symptom of *fatigue* into the EHRS PowerForm for tuberculosis symptom monitoring.

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

Recommendations

- Nursing leadership should consider developing and implementing measures to ensure that nursing staff timely screen patients for TB and that nursing staff completely address TB signs and symptoms in their TB screening.

- The institution should consider developing strategies to ensure preventive colorectal screenings and required vaccinations for chronic care patients.

Nursing Performance

Overall Rating ***Inadequate***

Case Review Rating ***Inadequate***

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

At HDSP, nursing care was poor. While nurses evaluated most patients timely, nurses frequently performed incomplete assessments and often did not take vital signs. In addition, nurses at times did not notify the provider of abnormal patient findings or urgent symptoms. Due the increased workload related to the COVID-19 pandemic, HDSP leadership stopped completing nursing performance audits. Despite the assistance of registry staff and CCHCS' implementation of strategies to better manage COVID-19 quarantine and isolation patients, the pandemic's increased staffing level put a significant strain on HDSP's nursing operations. Overall, we rated this indicator ***inadequate***.

Case Review Results

We reviewed 246 nursing encounters in 51 cases. Of the nursing encounters we reviewed, 166 were in the outpatient setting. Furthermore, of the 246 nursing encounters, 21 events were directly related to COVID-19 quarantine or isolation rounds.[51] Our clinicians identified 118 nursing performance deficiencies, 30 of which were significant.[52] Of the deficiencies we identified, 21 were related to COVID-19 nursing performance, including three significant deficiencies.[53]

[51] COVID-19 rounding is generally performed over the quarantine or isolation order period. Therefore, each event reviewed by the OIG case review team included single nursing rounds or could have included many nursing encounters.

[52] Deficiencies occurred in cases 1, 2, 9, 10, 11–26, 32, 34, 36, 37, 38, 41–45, 47, 48, and 51–55. Significant deficiencies occurred in cases 1, 2, 9, 12, 13, 14, 17, 19, 20, 21, 23, 24, 25, and 43.

[53] Deficiencies occurred in cases 1, 2, 14, 15, 16, 17, 19, 20, 21, 22, 25, and 26. Significant deficiencies occurred in cases 2, 19, and 21.

Nursing Assessment and Interventions

Nurses have a critical role in patient care which includes observing, managing, and collaborating with other disciplines to manage acute and chronic conditions as well as to proactively assess to prevent further illness in patients. Therefore, accurate assessments and timely interventions are essential in the proper care of patients.

At HDSP, most of the deficiencies occurred in the outpatient setting. Of the 51 cases reviewed, 36 cases had nursing deficiencies in assessments, interventions, and documentation. Frequently, the nurses did not take vital signs and performed incomplete assessments for symptomatic patients. The following are examples:

- In case 1, the nurse did not perform an ear, nose, and throat assessment or an abdominal assessment for a patient who complained of throbbing ear pain and vomiting. In addition, the nurse did not take vital signs including weight and did not notify the provider of the patient's urgent symptoms.

- In case 20, custody staff referred the patient for observations of dark rings under the patient's eyes and weight loss. The patient had an abnormally high heart rate, but the nurse did not perform a complete set of vital signs or perform a complete abdominal assessment. Six days later, custody again referred the patient for a change in skin color, weight loss, and severe back pain. The nursing supervisor assessed the patient at cell side. The patient's skin was pale, and the patient admitted to injecting a medication prescribed orally for substance abuse. The nursing supervisor did not take vital signs, perform an objective abdominal and lung assessment, refer the patient to TTA, or inform the provider of the abnormal findings and patient's admission of substance abuse. Instead, the nursing supervisor only told the patient of a scheduled upcoming provider appointment.

Our clinicians' review included cases in which patients were screened for COVID-19 symptoms and who were placed in quarantine or isolation. During our review period, the institution's leadership reported implementing a process whereby patients were quarantined in their housing units instead of dedicated areas for quarantine and isolation. We identified opportunities for improvement in quarantine and isolation rounds that were not completed as ordered. We found that symptomatic patients were not always assessed by the RN for COVID-19 symptoms, and nursing staff was not always available to perform vital signs. We also found similar nursing deficiencies when providers performed rounds on COVID-19 positive and high-risk patients.

- In case 2, the nurse assessed a patient with a headache, productive cough, and difficulty breathing at night. The nurse did not listen to the lungs or assess the onset dates for difficulty breathing and headache. The nurse messaged the provider in the EHRS instead of urgently calling the provider to inform of the symptoms.

- In case 19, the nurse assessed a patient with COVID-19 pneumonia. The patient had greatly diminished breath sounds, but the nurse did not immediately arrange for transport to the TTA or call a medical emergency.

Nursing Documentation

Complete and accurate documentation is an essential component of patient care. Without proper documentation, health care staff may overlook changes in patients' conditions and the ability to assess the quality of care can be challenging. HDSP continued to struggle with incomplete and inaccurate documentation. Of the 118 nursing performance deficiencies, 42 were related to incomplete or inaccurate documentation.

- In case 18, the nurse documented that the patient refused COVID-19 assessments during isolation rounds. However, the patient was not in isolation for COVID-19 or diagnosed with COVID-19. In addition, there was no signed refusal in the patient's chart.

- In case 19, the patient in the TTA was transferred to a higher level of care for fever, shortness of breath, and an abnormally low oxygen saturation rate. However, the TTA nurse did not document an assessment, patient communicate to EMS, or the patient's condition upon departure from the facility.[54]

Nursing Sick Call

Our clinicians reviewed 74 sick call requests and identified 54 deficiencies, including 15 significant deficiencies. Frequently, the nurses did not objectively assess the patients or take vital signs. When nurses assessed patients, nurses often performed incomplete assessments and did not notify the provider of abnormal findings.

- In case 2, the sick call nurse reviewed patient for headaches and dizziness. The nurse noted the patient was evaluated in the TTA and had orders for headache and symptoms of irritable bowel syndrome. The nurse did not assess vital signs, perform an abdominal assessment including pain level, or perform a skin assessment.

- In case 12, the sick call nurse assessed an uncontrolled diabetic patient for difficulty urinating with a pain level of 10. The nurse did not obtain vital signs, perform a genitourinary assessment, obtain a urine specimen, obtain an order to check the urine, consult the provider of urgent symptoms, and educate the patient.

- In case 22, sick call nurses did not perform a complete assessment for the patient who complained of a fever, night sweats, and abdominal pain. A patient with this presentation may have had

[54] EMS is the emergency medical services.

COVID-19 and for this reason, a lung assessment should have been completed.

Care Management

During our review period, we identified few chronic care visits from the RN lines due to the COVID-19 movement restrictions. The LVNs continued to provide some chronic care management. Our inspectors reviewed 30 events in which the LVNs performed annual TB screenings, administered vaccinations, and performed dressing changes.

Wound Care

We reviewed seven cases in which wound care was provided for the patients. HDSP nurses provided appropriate wound care to the patients. Our clinicians identified five deficiencies, including one significant deficiency. However, all deficiencies were related to one case.[55]

Emergency Services

HDSP nurses did not perform well in emergency care for patients in the TTA. Our clinicians reviewed 46 events in 19 cases and found 24 deficiencies related to nursing performance, four of which were significant.[56] This is detailed further in the **Emergency Services** indicator.

Hospital Returns

We reviewed 15 cases involving patients who returned from a community hospital or emergency room. Our clinicians identified five deficiencies, and three of the deficiencies were significant.[57] HDSP nurses promptly evaluated the patients and accurately documented their assessments. However, we found the assessments were often incomplete for patients who were symptomatic when they returned from the hospital or emergency room. This is discussed further in the **Transfers** indicator.

Transfers

The institution's nurses provided poor care for patients transferring into or out of HDSP. We reviewed nine events in seven cases that involved the transfer-in or transfer-out process and identified seven deficiencies. For the hospital return process, we found lapses in the continuity of hospital recommendations including delayed medication reconciliation, incomplete nursing assessments,

[55] These deficiencies occurred in case 10.

[56] Deficiencies occurred in cases 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 17, 19, 20, 21, 22, and 24. Significant deficiencies occurred in cases 10, 19, and 22.

[57] Deficiencies occurred in cases 1, 15, 19, 21, and 23. Significant deficiencies occurred in cases 1, 19, and 21.

and a delay in provider follow-ups after hospitalizations. This is detailed further in the **Transfers** indicator.

Specialized Medical Housing

HDSP had room for improvement in nursing performance in the CTC. The OIG clinicians reviewed 46 events in 10 cases and identified 45 deficiencies related to nursing performance; 12 were significant.[58] This is detailed further in the **Specialized Medical Housing** indicator.

Specialty Services

When patients returned to the institution from a specialty appointment, HDSP nurses appropriately assessed the patients, reviewed off-site documents for recommendations, and communicated information to the providers. OIG clinicians reviewed 11 events in eight cases and identified five deficiencies related to nursing performance, one of which was significant.[59] This is detailed further in the **Specialty Services** indicator.

Medication Management

OIG clinicians examined 142 events involving medication management and administration, and identified 43 deficiencies. Of these deficiencies, 13 were related to nursing.[60] The nurses generally administered medications properly. There were isolated cases which had opportunities for improvement in hospital medication reconciliation and administering KOPs timely. The **Medication Management** indicator provides further information.

Clinician On-Site Inspection

During our on-site inspection, we interviewed nursing leadership, supervisors, managers, and staff. Nursing executive leadership reported they had a high nursing staff vacancy rate due an inability to attract qualified candidates and the pending closure of a nearby institution, California Correctional Center (CCC). At the time of our inspection, HDSP had 24 RN vacancies, 22 LVN nursing vacancies, four supervising RN vacancies, and four medical assistant (MA) vacancies. In addition, at HDSP, clinic RNs functioned as both primary clinic nurses and care managers.

During the COVID-19 pandemic, nursing leadership followed a staffing matrix, which they were still following at the time of our inspection. Staff reported that in response to the COVID-19 pandemic, CCHCS deployed additional staff to HDSP to provide short-term training and support. The COVID-19 pandemic

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[58] Deficiencies occurred in cases 2, 10, 15, 17, 19, 20, 21, 22, 23, and 24. Significant deficiencies occurred in cases 10, 15, 17, 20, and 23.

[59] Deficiencies occurred in cases 2, 15, 20, 23, and 25. A significant deficiency occurred in case 20.

[60] Deficiencies occurred in cases 12, 14, 15, 22, and 23. Significant deficiencies occurred in cases 12, 14, 15, 23.

placed an additional strain on already limited resources. For example, one nurse was expected to complete COVID-19 assessments for 100 quarantined patients or 50 patients in isolation per day. Nurses did not have a mobile computer unit to enter patients' information into the EHRS, so nurses used paper lists and entered the information after completing patient rounding.

Recommendations

- The department and nursing leadership should consider resuming random audits to ensure nursing staff perform complete assessments including vital signs and appropriate assessments in the outpatient and inpatient settings.

- Nursing leadership should consider providing remedial training for assessment and documentation of patients presenting with COVID-19 symptoms.

Provider Performance

Overall Rating ***Inadequate***

Case Review Rating **Inadequate**

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

HDSP providers delivered a mixed performance. Providers were challenged during the period with COVID-19 pandemic, patients with Suboxone-related medical conditions, and severe staffing shortages. Two providers saw most of the patients and provided very good care; however, errors made by the other providers, despite their being involved in fewer cases, were considered significant. Even considering the good care rendered by the two providers, errors in medical judgement, missed opportunities in emergency care, and deferment of necessary chronic care visits contributed to the overall rating of ***inadequate***.

Case Review Results

In our inspection, case review clinicians examined the care quality in 20 comprehensive case reviews. Of these 20 cases, none were rated ***proficient***, 12 ***adequate***, and eight ***inadequate***. OIG clinicians found a total of 75 quality of provider care deficiencies; of these, 25 were significant.[61]

Assessment and Decision Making

OIG case review clinicians found that some HDSP providers demonstrated excellent assessment and decision making, while others did not. Of the 75 provider performance deficiencies, 32 were related to poor medical decision making and 20 of those were considered severe.[62] Two physicians completed most of the provider events and, fortunately, had the fewest number of severe deficiencies. The other three providers were responsible for most of the severe deficiencies, although they completed only a small portion of the provider events (38 of 167 events). The following are examples:

- In case 21, the patient presented with a right leg infection. After nursing contacted the provider with findings, the provider did not

[61] Deficiencies occurred in cases 1, 2, 9–17, 19–25, and 44. Significant deficiencies occurred in cases 1,2, 9, 11–15, 19–21, 23, and 24.

[62] Quality of provider assessment and decision-making deficiencies occurred in cases 1, 2, 9, 11, 12, 13, 14, 15, 17, 19, 20, 21, 23 and 24. Significant deficiencies occurred in cases 1, 2, 9, 11, 12, 13, 14, 15, 19, 20, 21, and 24.

see the patient, but instead prescribed antibiotics based on the nursing assessment and ordered a provider follow-up visit in five days. Two days later, when nursing advised the provider that the patient had worsened, the provider again did not see the patient and changed antibiotics without providing a thorough evaluation. Later that same day, the TTA provider saw the patient and sent the patient to the hospital where he remained for several days.

- In case 9, the nurse contacted the provider about a patient with history of heart valve replacement due to infection related to intravenous drug use who complained of leg swelling, four days of chills and fatigue, night sweats, and fever. These are all symptoms of possible recurrent infection or worsening heart condition. The provider advised the nurse to tell the patient to increase his fluid intake and that the patient would be seen by a cardiology specialist as he had been previously. In addition, the provider did not see the patient, did not order any follow-up, and did not document a note indicating the medical reasoning for these decisions. The patient later died of multiple causes, the most significant cause being a recurrent heart valve infection that could no longer be treated.

- In case 21, when the patient was diagnosed with influenza B, the provider did not order influenza isolation and did not notify public health. As a result, contact tracing was not performed; therefore, potential contacts were not given prophylactic influenza treatment. This could have led to an outbreak of influenza in the institution.

OIG clinicians found care in the CTC and daytime TTA coverage was excellent. Most errors in clinical assessment and decision making in the TTA, emergency services, and CTC were made by on-call providers.[63]

There were 11 instances of providers not ordering studies, medications, or follow-ups that were medically necessary; two were severe.[64]

Review of Records

At clinic visits, providers reviewed the patient records, which included vital signs. Frequently, the providers did not anyone taking vital signs and recording them in the patient's health record for their clinic visits. We were advised that the lack of vital signs was due to nursing shortages and disruptions in the provider's usual workflow due to the COVID-19 pandemic.[65]

HDSP had a local expectation that its providers endorsed all point-of-care tests. During our review, we found that providers did not endorse point-of-care tests and some COVID-19 test results, so it is unclear whether these results were reviewed; however, there were systems in place to notify patients if a patient

[64] Deficiencies occurred in cases 9, 11, 16, 19–21, 23, 24. Severe deficiencies occurred in cases 9 and 24.

[65] Vitals signs checks were missing in at least one clinician visit in cases 16, 19, 20, 21, and 23.

tested positive for COVID-19. This is discussed further in the **Health Information Management** indicator.

Only one severe deficiency was identified:

- In case 11, a provider increased a patient's blood thinning medication, but did not recognize that another provider had increased the same medication the day prior. This could have led to significant bleeding and patient harm.

Emergency Care

HDSP providers usually managed emergent patients in the TTA appropriately, however, severe deficiencies occurred. Providers were available for consultation with nursing staff. The daytime TTA provider performed excellently in ensuring patients were sent to the correct local hospital depending on need, and hand-offs to the receiving facility were documented clearly and occurred regularly. When the local hospitals were at capacity due to the COVID-19 pandemic, the on-site TTA provider was advised that some patients could not be accepted as usual and that a higher level of acuity would need to be kept at the institution. The TTA provider worked closely with hospital staff to decide the best on-site treatment plans, and the warning signs and symptoms for which a patient would be accepted. The daytime TTA provider often demonstrated excellent medical assessment and decision-making skills; however, five deficiencies were identified among all providers, with three being significant:[66]

- In case 1, a patient was evaluated in the TTA with nausea, vomiting, abdominal pain, and evidence of orthostatic hypotension (low blood pressure). The provider should have ordered intravenous fluids to treat the orthostatic hypotension.

- In case 2, the on-call provider did not treat a patient's critically high blood pressure or elevated heart rate.

- In case 21, the patient with a severe infection, who was on antibiotics, developed signs of a possible allergic reaction. The on-call provider discontinued the antibiotic, but did not order a replacement antibiotic, which could have led to a worsening infection.

There was a severe deficiency cited that involved emergency care in the TTA, which was described in the **Emergency Services** indicator. It is mentioned below due to its severity and risk to the patient; however, both the nurse and the on-call provider each had different histories of the events in the case, making it difficult to determine whether nursing, the provider, or both were responsible:

- In case 22, in a patient with several hours of severe abdominal pain, nausea, and vomiting, the on-call provider ordered medications that

[66] Deficiencies occurred in cases 1, 2, 19 and 21.

were not appropriate for the patient's condition and did not send the patient to a higher level of care. When the provider was called more than two hours later, the patient was in even more pain and was unable to tolerate the nurse's abdominal examination. The provider ordered further on-site testing and documented that the patient would be seen by the TTA provider upon arrival, which was over two hours later. The patient had a gangrenous gallbladder, a life-threatening medical condition, and should have been immediately sent to a higher level of care in both instances. At the on-site inspection, the provider stated that the nurses did not make him aware of the critical findings, which was consistent with the provider's notes. Nursing stated they gave the provider all the pertinent and critical details, which was also documented in their notes. It is not clear where the communication breakdowns occurred.

Chronic Care

HDSP providers performed poorly in completing chronic care assessments for their patients. When queried on-site, providers cited one of the reasons was reduced patient movement due to the COVID-19 pandemic. Very few chronic care visits occurred during our review period; of the 167 provider encounters over a six-month period, only 11 were for chronic care visits. We found a pattern of providers deferring necessary chronic care visits, especially for noncompliant diabetic patients for extended periods.[67] We also identified inappropriate deferral of nondiabetic chronic care visits. Examples include the following:

- In case 9, the patient with several months' history of symptoms of possible indolent infection, heart problems, and a previously abnormal heart imaging study had a chronic care visit scheduled. The provider deferred the visit for 90 days despite two prior nursing visits of concern and the abnormal heart study. The patient should have been seen and later died.

- In case 12, the provider deferred a diabetic patient's chronic care visit for three months due to COVID-19 "risks outweighing the benefit of seeing the patient" and instead, wrote a progress note. The provider copied his prior month's note and the patient's prior finger stick glucose readings into this note, did not document a current chart review despite recent changes to the patient's diabetes medications, or address two instances of low blood sugar readings, which occurred one and five days prior to the deferred visit. This patient who has a history of uncontrolled diabetes and fluctuating high and low blood sugars, should have been seen by the provider.

[67] Cases 12, 13, and 14 were inappropriately deferred.

Specialty Services

HDSP providers usually referred patients to specialists as needed. We identified only one minor deficiency. This was discussed further in the **Specialty Services** indicator.

Documentation Quality

HDSP providers often did not document on-call notes or failed to document complete clinic notes. Twelve notes were missing, and 17 were not complete.[68] When the patient received the appropriate medical care, the deficiencies were considered minor. However, when the patients did not receive appropriate medical care, the deficiencies were considered more severe.

Provider Continuity

HDSP generally provided good provider continuity to clinic and specialized medical housing patients. Only one deficiency was cited, in case 11, which was not severe.

Clinician On-Site Inspection

OIG clinicians met with HDSP medical leadership, providers, nursing, scheduling, and custody staff. Medical leadership, scheduling staff, and providers expressed concerns over a significant provider shortage. According to the CCHCS dashboard at the time of the inspection, HDSP was at 142 percent population capacity (greater than 3,000 inmates), but had a 49 percent provider vacancy rate. By December 2021, HDSP had only four on-site providers to manage the entire HDSP patient population. Since then, one provider retired and another resigned, stating disagreement with the Medication Assisted Treatment (MAT) program and COVID-19 policies.

Most of the providers held the CME and chief physician and surgeon in high regard; however, the provider's most frequent complaints other than a lack of providers were lack of nursing staff, the ISUDT program, and the long working hours. Providers advised that they worked especially long hours, including weekends and evenings, which worsened during the COVID-19 outbreak. COVID-19 patients could refuse housing, so they were scattered throughout the institution, making provider rounding more difficult than it would have been otherwise. The providers were seeing patients at cell side due to custody and nursing shortages, and patients' refusals to transfer to isolation and quarantine cells. Several providers stated they were seeing as many patients as possible each clinic day, going from cell to cell, often without nursing assistance or the taking of patients' vital signs, then returning to their offices to document notes from memory or cursory handwritten notes. Most providers showed dedication to quality patient care; however, they reported suffering from fatigue. Medical

[68] Deficiencies occurred in in cases 2, 9, 12, 16, 17, 19, 20, 21, 22, and 23. A significant deficiency occurred in case 9.

leadership expressed concern that operating with so few providers was not sustainable, and CCHCS leadership and headquarters recruiting had been made aware of this concern. HDSP had not yet received any substantial leads to help with shortages. As echoed by other staff, recruiting new providers was extremely difficult due to the rural location, CCHCS headquarters mandated limited-term hiring requirements, and potential job insecurity due to the pending closure of CCC.

All providers expressed concern over the ISUDT program and the prescribing of Suboxone to the patients. We were advised that inmates were diverting the Suboxone and modifying it to create an injectable form. The modified drug, however, is contaminated with mouth bacteria, which can cause severe infections that can lead to prolonged hospitalizations or death. As discussed in the **Access to Care** indicator, providers were seeing many critically ill patients due to Suboxone diversion and misuse. Providers advised that intravenous injection of diverted Suboxone was so common that if a patient presented with a simple complaint such as routine back pain, providers might have been required to send the patient to the hospital or do a resource intensive infection workup. Providers could not quantify the number of Suboxone-related infections that occurred, because there was no official tracking, but we were told "many," and given numbers of seven confirmed cases in the past few months to 20 total over the past year. Medical leadership and providers also expressed concern over CCHCS headquarters' ISUDT plans to transfer ISUDT care to the already understaffed provider team.

Recommendations

- The department should consider strategies to improve the number of providers, particularly with the implementation of new programs such as ISUDT.

- Medical and nursing leadership should ensure that medical providers have clinic assistance available during all clinic appointments.

Specialized Medical Housing

Overall Rating
Inadequate

Case Review Rating
Inadequate

Compliance Score
Adequate **(80.0%)**

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 inspections, HDSP's specialized medical housing consisted of a correctional treatment center (CTC).

Results Overview

HDSP had a mixed performance in CTC care. The nurses completed timely admission assessments. However, frequently the assessments were incomplete, and at times, admission assessments did not occur during the nursing shift when the patient was admitted. Daily nursing assessments were often done timely. Like admission assessments, the daily assessments were often incomplete, and sometimes the nursing assessment was completed by a licensed vocational nurse instead of a registered nurse. Considering both compliance testing and case review findings, we rated this indicator ***inadequate.***

Case Review and Compliance Testing Results

We reviewed 10 CTC cases, which included 61 provider events and 46 nursing events. Because of the care volume that occurs in specialized medical housing units, each nursing event represented up to two week of nursing care. We identified 60 deficiencies, 15 of which were significant.

Provider Performance

HDSP providers delivered good care. Compliance testing showed providers completed timely admission histories and physical examinations (MIT 13.002, 80.0%). Case review clinicians found 10 deficiencies in specialized medical housing; one was significant.[69]

- In case 15, the patient complained of burning with urination. The CTC provider ordered a laboratory urinalysis, but did not order a urine point-of-care test.[70] The laboratory reported that the urine sample was inadequate for testing and the urinalysis needed be redone. The provider did not order a urine point-of-care test. Instead,

[69] Deficiencies occurred in cases 16, 17, 20,21, 22, and 23. A significant deficiency occurred in case 15.

[70] The urine point of care test, such as a urine dipstick, is a clinic urine test performed at the time of clinic appointment to quickly determine if the patient's urine show signs of infection.

the provider, again, ordered a laboratory urinalysis, which caused a delay in providing diagnosis and care for the patient.

Nursing Performance

Nurses in the CTC frequently assessed patients daily, performed COVID-19 rounds on isolation patients, and reassessed patients for readiness for discharge. However, frequently, assessments were incomplete, and sometimes vital signs were not performed. Often, assessments for PICC lines were not assessed thoroughly with measurements to establish secure placement. Our clinicians found nursing assessment and intervention deficiencies in the following cases:

- In cases 10 and 20, the CTC nurse did not perform a thorough assessment of the PICC line on admission. The nurse did not measure the external catheter length and the patient's arm circumference. These measurements established a baseline for the location of catheter placement, which required frequent monitoring and assessment.

- In cases 15 and 17, the LVN instead of the RN performed a patient assessment. The role of the RN is to assess patients, intervene appropriately, and update individualized goal directed care plans. Patient assessments are required by a nurse with RN licensure.

Compliance testing showed CTC nurses performed poorly in timely admission assessments (MIT 13.001, 60.0%). Analysis of the compliance data showed delayed admission assessments were between one hour and 2.5 hours after the patient was admitted to CTC. Our clinicians also found deficiencies in admission assessments.

- In case 2, the patient was admitted to the CTC for a preprocedural bowel cleansing for a colonoscopy to evaluate for rectal bleeding. The CTC nurse did not palpate the patient's abdomen, listen to bowel sounds, or document the last date of the patient's bowel movement.

- In case 10, the CTC nurse measured the external catheter length and arm circumference on a patient with a PICC line. The external catheter length was extended four centimeters more since initial measurements were done. The nurse reinserted the external catheter back into the PICC line. The provider was not notified until the following morning, when the provider ordered discontinuing the PICC line. The reinsertion of the catheter and the delay in provider notification placed the patient at a greater risk for infection. The catheter tip was not cultured and sent to the laboratory to check for infection.

- In case 17, the patient was admitted to the CTC after an inpatient hospitalization for COVID-19 low oxygenation. The patient arrived in the CTC on supplemental nasal oxygen. The CTC nurse did not auscultate lungs.

- In case 23, the patient was admitted to the CTC. The admissions nurse did not perform an objective assessment upon admission. The patient was not assessed until the next shift RN came on duty.

Medication Administration

Compliance testing showed HDSP performed well in providing continuity of medication for patients newly admitted to the CTC (MIT 13.004, 80.0%). Our clinicians reviewed seven cases in which the patient was admitted to the CTC after hospitalization and found significant deficiencies in two cases.[71] This is discussed further in the **Transfer** Indicator.

HDSP nursing staff in the CTC frequently administered medication timely and reassessed patients after administering as-needed medication. However, our clinicians identified five deficiencies, two of which were significant.[72] During our on-site inspection, CTC nurses and supervisors reported the CTC RN on night shift performed a 24-hour chart review that included scanning the chart for missing tasks and expired medication. However, we identified the following deficiencies:

- In case 10, the patient missed seven doses of a blood thinner medication because the medication was not renewed timely when it expired.

- In case 20, the patient did not receive an intravenous antibiotic as ordered because the medication was not available. The patient missed two doses.

Clinician On-Site Inspection

HDSP's CTC had 20 medical beds, 10 negative pressure rooms, and two observation cells. At the time of our visit, all medical beds were occupied. The 10 negative pressure rooms were used for suspected or confirmed COVID-19 cases. Nursing staff assigned to treat COVID-19 patients were only assigned to those patients. Staff also reported at the time of inspection, patients on COVID-19 quarantine rounds were placed in the negative pressure rooms, and nursing staff charted in the patient's electronic health record every two hours. Nurses reported COVID-19 polymerase chain reaction (PCR) tests were done on patients who returned from off-site specialty appointments on the third and the tenth days.

The CTC had nursing staff 24 hours a day. HDSP had a designated CTC provider who made rounds with nursing staff and conducted daily morning huddles. The providers were on-site during business hours and available for consultation at other times. Nursing leadership reported that the CTC always had one RN, and LVNs were placed in the CTC during staffing shortages. During our on-site inspection, nurses stated that for admission and readmissions to CTC, nurses reconciled all medication, notified the provider, and providers reconciled the

[71] We reviewed cases 10, 15, 17, 19, 20, 21, and 22. Significant deficiencies occurred in cases 15 and 19.

[72] Deficiencies occurred in cases 10, 15, and 20.

remaining orders within the following business day. For after-hours reconciliation which required a medication that was not available, nurses documented that the medication was not available on the MAR, notified the pharmacy, and the pharmacy delivered medication to the CTC the following morning.

OIG clinicians observed a CTC huddle that was led by the CTC provider. The CTC provider was very knowledgeable regarding the patients in the CTC. The provider gave updates on medical patients and had collaborative discussions with team members on pending results. In addition to CTC team members, including mental health, specialty nurses and supervisors participated in the huddle. The CTC SRN II was very knowledgeable regarding the patients in the CTC and provided updates on pending diagnostics and status of the patients. However, the CTC RN did not have patient updates at the time of huddle.

During the time of our inspection, the institution recently had new admissions for symptomatic COVID-19 patients and stated there were frequent admissions in the CTC for infections related to Suboxone injections by the patients. Medical leadership reported due to multiple cases of infections secondary to injecting drugs, medical and nursing leadership trained nurses to be more aware, assess, and consult the providers for patients with high risk for these infections.

Compliance Testing Results

Table 17. Specialized Medical Housing

Compliance Questions	Scored Answer Yes	No	N/A	Yes %
For OHU, CTC, and SNF: Prior to 4/2019: Did the registered nurse complete an initial assessment of the patient on the day of admission, or within eight hours of admission to CMF's Hospice? Effective 4/2019: Did the registered nurse complete an initial assessment of the patient at the time of admission? (13.001) *	6	4	0	60.0%
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) *,†	N/A	N/A	10	N/A
Upon the patient's admission to specialized medical housing: Were all medications ordered, made available, and administered to the patient within required time frames? (13.004) *	8	2	0	80.0%
For OHU and CTC only: Do inpatient areas either have properly working call systems in its OHU & CTC or are 30-minute patient welfare checks performed; and do medical staff have reasonably unimpeded access to enter patient's cells? (13.101) *	1	0	0	100%
For specialized health care housing (CTC, SNF, Hospice, OHU): Do health care staff perform patient safety checks according to institution's local operating procedure or within the required time frames? (13.102) *	0	0	1	N/A
			Overall percentage (MIT 13): **80.0%**	

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

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

- The department and nursing leadership should ensure licensed medical beds are staffed with a sufficient level of RNs to perform patient assessments and interventions specific to registered nursing licensure.

- Nursing leadership shall consider resuming nursing audits to monitor appropriate assessments and documentation of admission assessments, continuity of care for patients in the CTC, and to ensure nurses initiate and update the patient's care plans based on the patients' medical conditions.

- Nursing leadership should consider providing training for an RN-to-RN documented hand-off communication.

Specialty Services

Overall Rating
Inadequate

Case Review Rating
Adequate

Compliance Score
Inadequate **(67.1%)**

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

HDSP had a mixed performance for specialty services. In compliance testing, initial routine appointments were usually done within ordered time frames, but initial high- and medium-priority specialty appointments were often not completed timely. In contrast, follow-up high- and medium-priority visits were completed timely, but routine visits were not. Compliance testing also found that often specialty reports were not retrieved or endorsed by a provider as required by CCHCS policy. Patients transferring to HDSP from other facilities often did not receive pending specialty services as ordered. The providers usually ordered appropriate consultation for the appropriate time frames; however, the visits may not occur as ordered. Factoring compliance scoring and case reviews, the OIG rated this indicator as ***inadequate***.

Case Review and Compliance Testing Results

OIG case review evaluated 53 specialty services events, including 42 specialty consultations. Twenty-four events were off-site specialty visits, and 18 were CCHCS providers treating patients for substance abuse, wound care, and Hepatitis C treatment. We found 17 deficiencies in this category, six of which were significant.[73] The OIG compliance review team tests a larger number of specialty cases; therefore, their testing is weighted more heavily.

Access to Specialty Services

HDSP had mixed performance in high- and medium-risk specialty appointment access and continuity of specialty appointments for incoming transfer patients. Compliance testing found that 80.0 percent of all routine specialty appointments occurred within the required time frames, however, only 60.0 percent of medium-priority and 73.3 percent of high-priority specialty appointments occurred within required time frames (MITs 14.007, 14.004, and 14.001). Case review found seven access to care deficiencies in the 24 non-CCHCS specialty services, three of which were significant:[74]

[73] Deficiencies occurred in cases 2, 15, 16, 17, and 20–25. Significant deficiencies occurred in cases 16, 17, 20, 22, and 23.

[74] Deficiencies occurred in cases 15–17, 21 and 23. Significant deficiencies occurred in cases 16, 17, and 23.

- In case 16, the patient had a history of severe trauma and infection in the left eye that resulted in significant vision impairment. Prior to the review period, the optometrist evaluated the patient and documented elevated eye pressure in the right eye. Staff at HDSP timely submitted requests for eye specialists; however, for the duration of the review period, the patient did not receive follow-up eye care to check the eye pressures. Elevated eye pressures could lead to blindness in this, the patient's only seeing eye, and it was imperative that this follow-up occur.

- In case 17, the optometrist evaluated the diabetic patient for possible glaucoma and recommended a three-month follow-up.[75] Fourteen months later, a follow-up with the specialist had not occurred to recheck the eye.

- In case 23, an urgent hematology consult for recurrent blood clotting occurred 47 days late, placing the patient at risk of harm and delayed treatment.

In addition, compliance testing found that only 25.0 percent of patients who transferred with specialty orders had the appointment scheduled through HDSP within the required time frames, causing a delay in patient care (MIT 14.010).

In Cycle 5, there was a delay in specialty services denial decisions. In Cycle 6, this situation has improved. Compliance testing found that 95.0 percent of all provider referral requests were decided within the required time frame (MIT 14.011); however, HDSP continued to perform poorly in advising patients of denials. Compliance testing found only 68.4 percent of patients were advised within required time frames that their specialty services requests were denied (MIT 14.012). Case review did not find delays related to specialty services denial decisions.

Provider Performance

CCHCS has changed provider specialty follow-up policies since Cycle 5. Currently, providers are only required to schedule follow-up visits for high-priority specialty consultations; follow-up on medium- and routine-priority consultations are ordered at provider discretion. This has reduced the number of provider specialty follow-up appointments. Compliance testing found that, even with the reduced number of visits required, when provider specialty follow-up orders were placed, the patients were not seen within the required time frames; only 69.8 percent of visits occurred within ordered time frames (MIT 1.008). As in Cycle 5, case review found that providers usually ordered correct specialty consultations for the proper time frames.

[75] Glaucoma can be a painless eye condition that leads to vision loss.

Nursing Performance

HDSP specialty nurses usually performed proper off-site return assessments, documented specialist recommendations, and reported abnormal findings to a provider. The OIG identified five opportunities for patient assessment improvement, including one significant deficiency.[76] Required specialty services refusal forms were not always obtained from the refusing patients.[77] Nursing performance in specialty services is discussed further in the **Nursing Performance** indicator.

Health Information Management

HDSP performed poorly in obtaining off-site specialty reports within required time frames and in delays with provider endorsement. Compliance testing found that HDSP received, and providers reviewed, routine specialty reports 46.7 percent of the time, medium-priority specialty reports 73.3 percent of the time and high-priority specialty reports only 42.9 percent of the time (MITs 14.008, 14.005, and 14.002). Most deficiencies were due to delayed document receipt, but we also found a delay in a provider review of the specialty notes. Case review identified two deficiencies in retrieving specialty consultation notes and both were considered significant:

- In case 24, the patient had a heart study performed, and the final report was never retrieved.

- In case 22, the patient was sent for a surgery postoperative follow-up and external drain removal that had been placed to prevent fluids from accumulating in the abdominal cavity. The drain was removed. The dictated surgery consult note was not retrieved.

OIG clinicians also found that a full eConsult note was not scanned into the medical record, which could have caused loss of critical consultation information:[78]

- In case 20, the provider communicated a detailed and thorough history via eConsult to an infectious disease specialist regarding the continued treatment plan for an infected spine. Only the eConsult response was documented in the patient's electronic health record. This omission would make it difficult for a subsequent provider to deliver appropriate continuity of medical care to the patient.

This is also discussed in the **Health Information Management** indicator.

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[76] Deficiencies occurred in cases 2, 15, 20, 23 and 25. Case 20 had a significant deficiency.

[77] Deficiencies occurred in cases 2, 15, 20, 22, 23 and 25. A significant deficiency occurred in case 20.

[78] eConsult is an electronic specialty consulting service whereby providers can inquire of specialists about medical questions and receive advice and recommendations for patient care.

Clinician On-Site Inspection

We discussed specialty referral management with HDSP medical leadership, supervisors, providers, and specialty nurse(s) and utilization management nurse(s). During our review period, specialty services was fully staffed; however, staff were frequently redirected to assist with COVID-19 pandemic-related issues or to fill temporary nursing vacancies in other clinics.

Staff advised during the COVID-19 pandemic, they only scheduled urgent or emergent specialty referrals, resulting in a large backlog of over 190 specialty visits. The highest number of backlogs were with sleep studies and optometry visits. Specialty services advised that the local hospital also had significant staffing shortages. The reduced transport custody access contributed to the specialty access problems.

In OIG's Cycle 5 review period, we reviewed 49 specialty services encounters. Each of these encounters were completed by off-site specialists such as cardiology, general surgery, and so forth. During the Cycle 6 review period, 38 total specialty visits occurred, and only 20 of these were completed by off-site specialists. The remaining 18 specialty visits were completed by CCHCS telemedicine primary care providers serving as specialists: 18 were for the MAT program for opioid use disorder, three were for wound care, and one for HCV treatment.

Staff advised that the implementation of the ISUDT program impacted the availability of clinic space, custody transport staff, and nursing staff. In addition, both medical leadership and staff advised the high number of patients on Suboxone, its diversion, and the high number of diversion-related serious medical complications had placed a significant burden on an already strained prison health care system.

Compliance Testing Results

Table 18. Specialty Services

Compliance Questions	Scored Answer			
	Yes	No	N/A	Yes %
Did the patient receive the high-priority specialty service within 14 calendar days of the primary care provider order or the Physician Request for Service? (14.001) *	11	4	0	73.3%
Did the institution receive and did the primary care provider review the high-priority specialty service consultant report within the required time frame? (14.002) *	6	8	1	42.9%
Did the patient receive the subsequent follow-up to the high-priority specialty service appointment as ordered by the primary care provider? (14.003) *	8	0	7	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) *	9	6	0	60.0%
Did the institution receive and did the primary care provider review the medium-priority specialty service consultant report within the required time frame? (14.005) *	11	4	0	73.3%
Did the patient receive the subsequent follow-up to the medium-priority specialty service appointment as ordered by the primary care provider? (14.006) *	4	0	11	100%
Did the patient receive the routine-priority specialty service within 90 calendar days of the primary care provider order or Physician Request for Service? (14.007) *	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) *	7	8	0	46.7%
Did the patient receive the subsequent follow-up to the routine-priority specialty service appointment as ordered by the primary care provider? (14.009) *	2	3	10	40.0%
For endorsed patients received from another CDCR institution: If the patient was approved for a specialty services appointment at the sending institution, was the appointment scheduled at the receiving institution within the required time frames? (14.010) *	2	6	0	25.0%
Did the institution deny the primary care provider's request for specialty services within required time frames? (14.011)	19	1	0	95.0%
Following the denial of a request for specialty services, was the patient informed of the denial within the required time frame? (14.012)	13	6	1	68.4%
Overall percentage (MIT 14): 67.1%				

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

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

Table 19. Other Tests Related to Specialty Services

Compliance Questions	Scored Answer			
	Yes	No	N/A	Yes %
Specialty service follow-up appointments: Did the clinician follow-up visits occur within required time frames? (1.008) *, †	30	13	2	69.8%
Are specialty documents scanned into the patient's electronic health record within five calendar days of the encounter date? (4.002) *	23	7	15	76.7%

* 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

- The department should consider how to recruit and retain a sufficient level of nursing staff to avoid redirecting specialty RNs.
- Medical leadership should consider ways to improve access to specialty care, particularly eye care.
- Medical leadership should ensure the transfer-in patients receive their previously scheduled specialty appointments within the required time frame and that providers review all specialty reports timely.

Administrative Operations

Overall Rating
Adequate

Case Review Rating
(N/A)

Compliance Score
Adequate
(75.0%)

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), the OIG did not consider this indicator's rating when determining the institution's overall quality rating.

Results Overview

HDSP performance was mixed in this indicator as the institution scored well in some applicable tests. However, the institution needed improvement in several areas. The institution conducted medical emergency response drills with incomplete documentation. Physician managers did not always complete annual performance appraisals in a timely manner. Nursing did not timely perform onboarding and competency training for newly hired nurses. These findings are set forth in the table on the next page. We rated this indicator ***adequate***.

Nonscored Results

At HDSP, 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. Nine unexpected (Level 1) and one expected (Level 2) deaths occurred during our review period. The DRC completed four death reports and submitted them to the institution's CEO timely. The other six death reports were completed 10 to 84 days late and were submitted to the institution's CEO 3 to 77 days after (MIT 15.998).

Compliance Testing Results

Table 20. Administrative Operations

Compliance Questions	Scored Answer Yes	No	N/A	Yes %
For health care incidents requiring root cause analysis (RCA): Did the institution meet RCA reporting requirements? (15.001)	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)	9	3	0	75.0%
For institutions with licensed care facilities: Did the Local Governing Body (LGB) or its equivalent meet quarterly and discuss local operating procedures and any applicable policies? (15.004)	4	0	0	100%
Did the institution conduct medical emergency response drills during each watch of the most recent quarter, and did health care and custody staff participate in those drills? (15.101)	0	3	0	0
Did the responses to medical grievances address all of the inmates' appealed issues? (15.102)	10	0	0	100%
Did the medical staff review and submit initial inmate death reports to the CCHCS Death Review Unit on time? (15.103)	9	1	0	90.0%
Did nurse managers ensure the clinical competency of nurses who administer medications? (15.104)	10	0	0	100%
Did physician managers complete provider clinical performance appraisals timely? (15.105)	3	2	0	60.0%
Did the providers maintain valid state medical licenses? (15.106)	6	0	0	100%
Did the staff maintain valid Cardiopulmonary Resuscitation (CPR), Basic Life Support (BLS), and Advanced Cardiac Life Support (ACLS) certifications? (15.107)	1	1	1	50.0%
Did the nurses and the pharmacist-in-charge (PIC) maintain valid professional licenses and certifications, and did the pharmacy maintain a valid correctional pharmacy license? (15.108)	6	0	1	100%
Did the pharmacy and the providers maintain valid Drug Enforcement Agency (DEA) registration certificates? (15.109)	1	0	0	100%
Did nurse managers ensure their newly hired nurses received the required onboarding and clinical competency training? (15.110)	0	1	0	0
Did the CCHCS Death Review Committee process death review reports timely? (15.998)	This is a nonscored test. Please refer to the discussion in this indicator.			
What was the institution's health care staffing at the time of the OIG medical inspection? (15.999)	This is a nonscored test. Please refer to Table 4 for CCHCS-provided staffing information.			
Overall percentage (MIT 15): 75.0%				

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

Recommendations

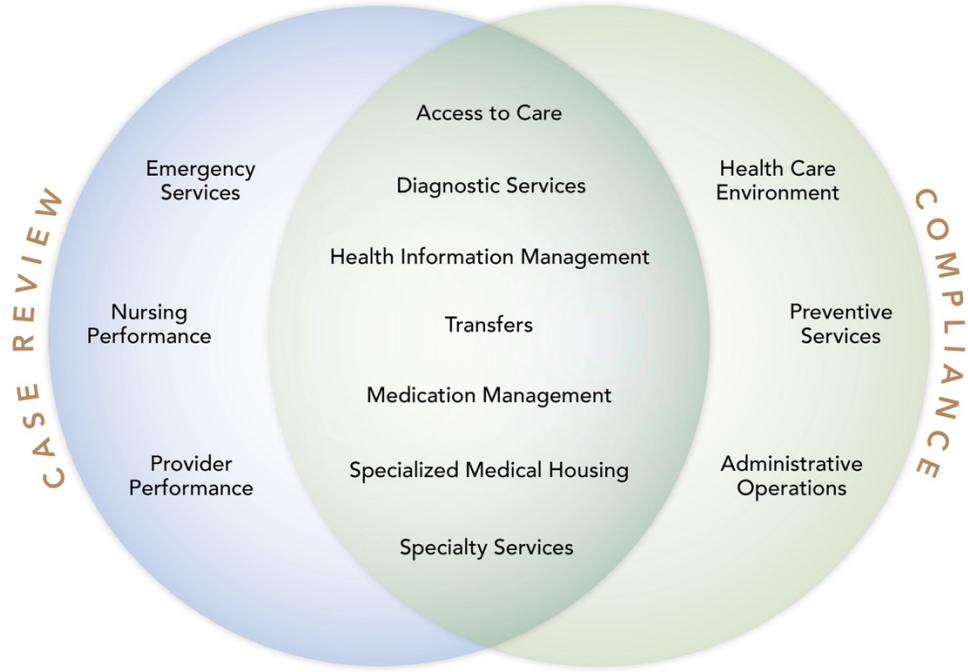
The OIG offers no specific recommendations for this indicator.

Appendix A: Methodology

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

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

Figure A-1. Inspection Indicator Review Distribution for HDSP



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

Case Reviews

The OIG added case reviews to the Cycle 4 medical inspections at the recommendation of its stakeholders, which continues in the Cycle 6 medical inspections. Below, Table A–1 provides important definitions that describe this process.

Table A–1. Case Review Definitions

Case, Sample, or Patient	The medical care provided to one patient over a specific period, which can comprise detailed or focused case reviews.
Comprehensive Case Review	A review that includes all aspects of one patient's medical care assessed over a six-month period. This review allows the OIG clinicians to examine many areas of health care delivery, such as access to care, diagnostic services, health information management, and specialty services.
Focused Case Review	A review that focuses on one specific aspect of medical care. This review tends to concentrate on a singular facet of patient care, such as the sick call process or the institution's emergency medical response.
Event	A direct or indirect interaction between the patient and the health care system. Examples of direct interactions include provider encounters and nurse encounters. An example of an indirect interaction includes a provider reviewing a diagnostic test and placing additional orders.
Case Review Deficiency	A medical error in procedure or in clinical judgment. Both procedural and clinical judgment errors can result in policy noncompliance, elevated risk of patient harm, or both.
Adverse Event	An event that caused harm to the patient.

The OIG eliminates case review selection bias by sampling using a rigid methodology. No case reviewer selects the samples he or she reviews. Because the case reviewers are excluded from sample selection, there is no possibility of selection bias. Instead, nonclinical analysts use a standardized sampling methodology to select most of the case review samples. A randomizer is used when applicable.

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

Case Review Sampling Methodology

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

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

Case Review Testing Methodology

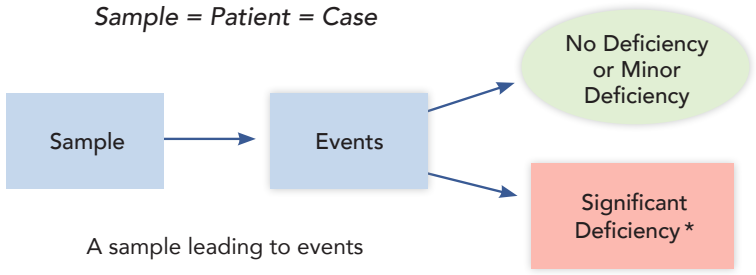
An OIG physician, a nurse consultant, or both review each case. As the clinicians review medical records, they record pertinent interactions between the patient and the health care system. We refer to these interactions as case review ***events***. Our clinicians also record medical errors, which we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

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

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

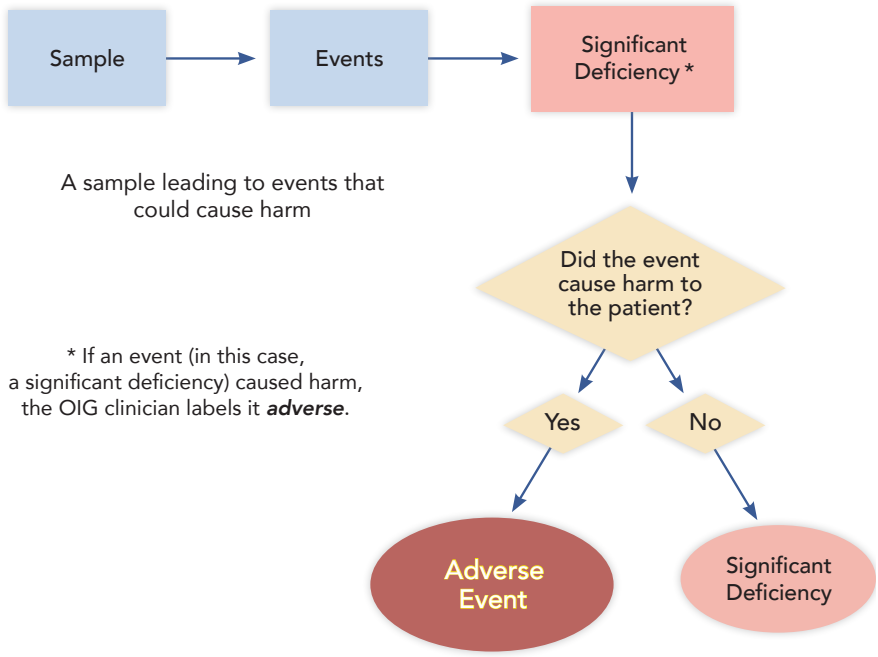
Figure A–2. Case Review Testing

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



Deficiencies

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



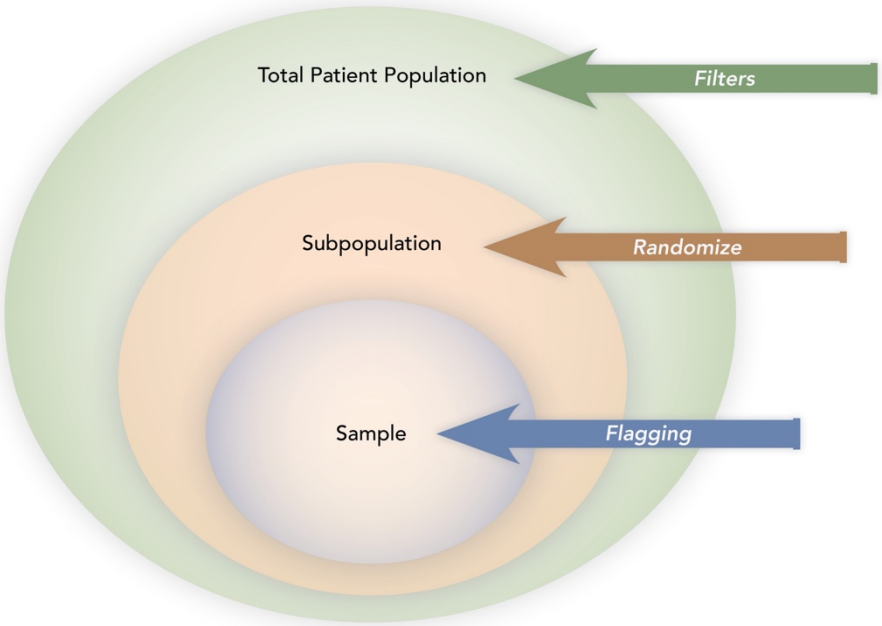
Source: The Office of the Inspector General medical inspection analysis.

Compliance Testing

Compliance Sampling Methodology

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

Figure A–3. Compliance Sampling Methodology



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. Case Review Sample Sets

Sample Set	Total
Anticoagulation	2
Death Review/Sentinel Events	2
Diabetes	3
Emergency Services – CPR	5
Emergency Services – Non-CPR	2
High Risk	4
Hospitalization	4
Intrasystem Transfers In	3
Intrasystem Transfers Out	3
RN Sick Call	24
Specialty Services	3
	55

Table B–2. Case Review Chronic Care Diagnoses

Diagnosis	Total
Anemia	2
Anticoagulation	3
Arthritis/Degenerative Joint Disease	1
Asthma	7
COPD	1
COVID-19	12
Cardiovascular Disease	1
Chronic Kidney Disease	1
Chronic Pain	10
Cirrhosis/End-Stage Liver Disease	4
Diabetes	6
Gastroesophageal Reflux Disease	4
Hepatitis C	20
Hyperlipidemia	10
Hypertension	13
Mental Health	19
Migraine Headaches	1
Rheumatological Disease	1
Seizure Disorder	2
Sleep Apnea	3
Substance Abuse	19
Thyroid Disease	3
Total	143

Table B–3. Case Review Events by Program

Diagnosis	Total
Diagnostic Services	227
Emergency Care	52
Hospitalization	26
Intrasystem Transfers In	9
Intrasystem Transfers Out	5
Outpatient Care	488
Specialized Medical Housing	149
Specialty Services	77
	1,033

Table B–4. Case Review Sample Summary

	Total
MD Reviews Detailed	20
MD Reviews Focused	0
RN Reviews Detailed	10
RN Reviews Focused	32
Total Reviews	62
Total Unique Cases	55
Overlapping Reviews (MD & RN)	7

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Appendix C. Compliance Sampling Methodology

High Desert 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	9	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	2	Quest	• Appt. date (90 days–9 months) • Order name (CBC or CMPs only) • Randomize • Abnormal
MITs 2.010–012	Pathology	9	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	9	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	9	CADDIS Off-site Admissions	• Date (2–8 months) • Most recent 6 months provided (within date range) • Rx count • Discharge date • Randomize
Health Care Environment				
MITs 5.101–105 MITs 5.107–111	Clinical Areas	11	OIG inspector on-site review	• Identify and inspect all on-site clinical areas.
Transfers				
MITs 6.001–003	Intrasystem Transfers	25	SOMS	• Arrival date (3–9 months) • Arrived from (another departmental facility) • Rx count • Randomize
MIT 6.101	Transfers Out	0	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	9	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	9	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	22	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	10	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	10	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	8	Specialty Services Arrivals	• Arrived from (other departmental institution) • Date of transfer (3–9 months) • Randomize
MITs 14.011–012	Denials	20	InterQual	• Review date (3–9 months) • Randomize
		N/A	IUMC/MAR Meeting Minutes	• Meeting date (9 months) • Denial upheld • Randomize

Quality Indicator	Sample Category	No. of Samples	Data Source	Filters
Administrative Operations				
MIT 15.001	Adverse/sentinel events (ASE)	0	Adverse/sentinel events report	• Adverse/Sentinel events (2–8 months)
MIT 15.002	QMC Meetings	6	Quality Management Committee meeting minutes	• Meeting minutes (12 months)
MIT 15.003	EMRRC	12	EMRRC meeting minutes	• Monthly meeting minutes (6 months)
MIT 15.004	LGB	4	LGB meeting minutes	• Quarterly meeting minutes (12 months)
MIT 15.101	Medical Emergency Response Drills	3	On-site summary reports & documentation for ER drills	• Most recent full quarter • Each watch
MIT 15.102	Institutional Level Medical Grievances	10	On-site list of grievances/closed grievance files	• Medical grievances closed (6 months)
MIT 15.103	Death Reports	10	Institution-list of deaths in prior 12 months	• Most recent 10 deaths • Initial death reports
MIT 15.104	Nursing Staff Validations	10	On-site nursing education files	• On duty one or more years • Nurse administers medications • Randomize
MIT 15.105	Provider Annual Evaluation Packets	5	On-site provider evaluation files	• All required performance evaluation documents
MIT 15.106	Provider Licenses	6	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	10	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 19, 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 High Desert State Prison (HDSP) conducted by the Office of the Inspector General (OIG) from December 2020 to May 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,

DocuSigned by:
Robin Hart
8052220F6D6A411...

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

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

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Cycle 6

Medical Inspection Report

for

High Desert
State Prison

OFFICE *of the*
INSPECTOR GENERAL

Amarik K. Singh
Inspector General

Neil Robertson
Chief Deputy Inspector General

STATE *of* CALIFORNIA
August 2022

OIG