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Office of the Inspector General

California State Prison, Sacramento
Medical Inspection Results
Cycle 5

November 2018

Fairness ◆ Integrity ◆ Respect ◆
Service ◆ Transparency

Office of the Inspector General

CALIFORNIA STATE PRISON, SACRAMENTO

Medical Inspection Results

Cycle 5

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FOREWORD

Pursuant to California Penal Code Section 6126 et seq., which assigns the Office of the Inspector General (OIG) responsibility for oversight of the California Department of Corrections and Rehabilitation (CDCR), the OIG conducts a comprehensive inspection program to evaluate the delivery of medical care at each of CDCR's 35 adult prisons. The OIG **explicitly** makes no determination regarding the constitutionality of care in the prison setting. That determination is left to the Receiver and the federal court. The assessment of care by the OIG is just one factor in the court's determination whether care in the prisons meets constitutional standards.

The OIG's inspections are mandated by the Penal Code and not aimed at specifically resolving the court's questions on constitutional care. To the degree that they provide another factor for the court to consider, the OIG is pleased to provide added value to the taxpayers of California.

In Cycle 5, for the first time, the OIG will be inspecting institutions delegated back to CDCR from the Receivership. There is no difference in the standards used for assessment of a delegated institution versus an institution not yet delegated. At the time of the Cycle 5 inspection of California State Prison, Sacramento, the Receiver had not delegated this institution back to CDCR.

This fifth cycle of inspections will continue evaluating the areas addressed in Cycle 4, which included clinical case review, compliance testing, and a population-based metric comparison of selected Healthcare Effectiveness Data Information Set (HEDIS) measures. In agreement with stakeholders, the OIG made changes to both the case review and compliance components. The OIG found that in every inspection in Cycle 4, larger samples were taken than were needed to assess the adequacy of medical care provided. As a result, the OIG reduced the number of case reviews and sample sizes for compliance testing. Also, in Cycle 4, compliance testing included two secondary (administrative) indicators (*Internal Monitoring, Quality Improvement, and Administrative Operations*; and *Job Performance, Training, Licensing, and Certifications*). For Cycle 5, these have been combined into one secondary indicator, *Administrative Operations*.

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EXECUTIVE SUMMARY

The OIG completed the Cycle 5 medical inspection of California State Prison, Sacramento (SAC), in September 2018. The vast majority of our inspection findings were based on SAC's health care delivery between January 2017 and September 2017. Our policy compliance inspectors performed an onsite inspection in September 2017. After reviewing the institution's health care delivery, our case review clinicians performed an onsite inspection in June 2018 to follow up on their findings.

OVERALL RATING:

Inadequate

Our clinician team, consisting of expert physicians and nurse consultants, reviewed cases (patient medical records) and interpreted our policy compliance results to determine the quality of health care the institution provided. Our compliance team, consisting of registered nurses, monitored the institution's compliance with its medical policies by answering a predetermined set of policy compliance questions.

Our clinician team reviewed 90 cases that contained 1,494 patient-related events. Our compliance team tested 88 policy questions by observing SAC's processes and examining 406 patient records and 1,279 data points. We distilled the results from both the case review and compliance testing into 13 health care indicators and have listed the individual indicators and ratings applicable for this institution in the *SAC Executive Summary Table* on the following page. Our experts made a considered and measured opinion that the overall quality of health care at SAC was ***inadequate.***

SAC Executive Summary Table

Inspection Indicators	Case Review Rating	Compliance Rating	Cycle 5 Overall Rating	Cycle 4 Overall Rating
1—Access to Care	*Adequate*	*Proficient*	***Adequate***	*Adequate*
2—Diagnostic Services	*Adequate*	*Adequate*	***Adequate***	*Inadequate*
3—Emergency Services	*Inadequate*	Not Applicable	***Inadequate***	*Inadequate*
4—Health Information Management	*Inadequate*	*Inadequate*	***Inadequate***	*Inadequate*
5—Health Care Environment	Not Applicable	*Adequate*	***Adequate***	*Inadequate*
6—Inter--and Intra-System Transfers	*Inadequate*	*Inadequate*	***Inadequate***	*Adequate*
7—Pharmacy and Medication Management	*Inadequate*	*Inadequate*	***Inadequate***	*Inadequate*
8—Prenatal and Post-Delivery Services	Not Applicable	Not Applicable	Not Applicable	Not Applicable
9—Preventive Services	Not Applicable	*Inadequate*	***Inadequate***	*Inadequate*
10—Quality of Nursing Performance	*Inadequate*	Not Applicable	***Inadequate***	*Inadequate*
11—Quality of Provider Performance	*Inadequate*	Not Applicable	***Inadequate***	*Inadequate*
12—Reception Center Arrivals	Not Applicable	Not Applicable	Not Applicable	Not Applicable
13—Specialized Medical Housing	*Inadequate*	*Proficient*	***Inadequate***	*Adequate*
14—Specialty Services	*Inadequate*	*Inadequate*	***Inadequate***	*Inadequate*
15—Administrative Operations (Secondary)	Not Applicable	*Proficient*	***Proficient***	*Inadequate**

* In Cycle 4, there were two secondary (administrative) indicators. This score reflects the average of those two scores.

Expert Clinician Case Review Results

Our expert clinicians reviewed cases of patients with many medical needs and included a review of 1,494 patient care events.[1] The vast majority of our case review covered the period between April 2017 and September 2017. As depicted on the *Executive Summary Table* on page *iv*, our experts rated 10 of the 13 indicators applicable to SAC. Of those ten applicable indicators, we rated two *adequate* and eight *inadequate.* When determining the overall adequacy of care, we paid particular attention to the clinical nursing and provider quality indicators, as adequate health care staff can sometimes overcome suboptimal compliance or performance with processes and programs. However, the opposite is not true; inadequate health care staff cannot provide adequate care, even though the established processes and programs may be adequate. We identified inadequate medical care based on the risk of significant harm to the patient, not the actual outcome.

Program Strengths — Clinical

- SAC providers reported feeling supported by their medical leadership. They believed that their leadership worked diligently to resolve issues that they reported.
- SAC nurses expressed excellent job satisfaction and felt equally supported by their immediate supervisors, the director of nursing (DON) and the chief nurse executive (CNE).

Program Weaknesses — Clinical

- Providers made superficial assessments, questionable medical decisions, and did not thoroughly review medical records. These errors led to many care deficiencies.
- Emergency medical staff often failed to respond to the scene of medical emergencies. Custody staff had patients walk to the triage and treatment area (TTA) unmonitored and unaccompanied by medical personnel, even when the patients were experiencing life-threatening symptoms.
- Providers often failed to document the care they provided in the TTA setting. This resulted in lapses in medical care during follow-up visits.
- TTA nurses often made incomplete assessments and did not document important aspects of care into patients' electronic medical records.
- The institution had serious problems with ensuring medication continuity and demonstrated inconsistent medication administration.

[1] Each OIG clinician team consists of a board-certified physician and a registered nurse consultant with experience in correctional and community medical settings.

Compliance Testing Results

Of the 13 health care indicators applicable to SAC, 10 were evaluated by compliance inspectors.[2] Three were *proficient*, two were *adequate*, and five were *inadequate*. The vast majority of our compliance testing was of medical care that occurred between January 2017 and September 2017. There were 88 individual compliance questions within those 10 indicators, generating 1,279 data points that tested SAC's compliance with California Correctional Health Care Services (CCHCS) policies and procedures.[3] Those 88 questions are detailed in *Appendix A — Compliance Test Results*.

Program Strengths — Compliance

The following are some of SAC's strengths based on its compliance scores on individual questions in the health care indicators:

- The institution's specialized medical housing did an excellent job completing the initial health assessment of patients admitted to the correctional treatment center (CTC). In addition, providers completed history and physical, and Subjective, Objective, Assessment, Plan, and Education (SOAPE) notes for patients admitted into the CTC within the required time frames.
- SAC's nursing staff received and reviewed patients' health care services request forms timely.
- Patients received their radiology, laboratory, and pathology services timely.
- Medical clinics at SAC followed proper protocols to mitigate exposure to blood-borne pathogens and contaminated waste. In addition, medical clinic environments were conducive to providing adequate medical services.
- The institution's medical warehouse met the supply management process and supported the needs of the medical health care program.

Program Weaknesses — Compliance

The following are some of the weaknesses identified by SAC's compliance scores on individual questions in the health care indicators:

- SAC providers did not timely receive and review specialty services reports.

[2] The OIG's compliance inspectors are trained registered nurses with expertise in CDCR policies regarding medical staff and processes.

[3] The OIG used its own clinicians to provide clinical expert guidance for testing compliance in certain areas where CCHCS policies and procedures did not specifically address an issue.

- SAC's health care management did not notify patients of their denied specialty services timely.
- Patients did not receive their ordered chronic care medications and hospital discharge medications within the specified time frames.
- SAC did poorly managing patients on tuberculosis (TB) medications. Patients were not receiving their TB medications timely. The institution did not complete monitoring at all required intervals. In addition, the nursing staff did not appropriately conducted TB screening timely.

Recommendations

The OIG recommends the following:

- The institution's chief executive officer (CEO) and CNE should coordinate with both custody staff and emergency response medical staff to provide education and training to ensure that first medical responders respond to patients with emergent symptoms, assess them, and transport them appropriately to receive medical care. We found multiple cases in which first medical responders failed to respond to emegencies and did not assess patients with life threatening symptoms. In these cases, custody staff required patients to walk, unaccompanied and unmonitored by medical staff, to the clinic or TTA for further care.
- The CEO should rectify the review process of the Emergency Medical Response Review Committee (EMRRC) because the committee failed to identify problems with SAC's emergency response as well as with the care provided by the TTA providers and nurses. The institution needs a properly functioning EMRRC to identify and correct its various lapses in emergency care.
- The CEO, CNE, and pharmacist in charge (PIC) should remedy the problems we identified with medication continuity, inconsistent medication administration, delays with dispensing medications, and failures to properly identify duplicate orders across most of the institution's health care areas. These poorly functioning processes were especially worrisome for patients returning from a community hospital and for patients transferring to other CDCR institutions.
- The CNE should audit the hospital return process because of the nurses' inability to properly review hospital discharge instructions and ensure medication continuity for these patients.
- The chief medical executive (CME) should assign a provider to the TTA to handle emergent and urgent situations. With a dedicated TTA provider, the clinic providers would have fewer conflicting responsibilities. Clinic providers could focus on their

regularly scheduled clinic patients and would not have to reschedule appointments whenever there was a medical emergency.

- The CEO should improve the scheduling process for newly-arrived patients and monitor these appointments to ensure patients receive their required appointments timely.
- The CME should instruct the providers to specify the appropriate clinical time frame for the ordered specialty service within the electronic health record system (EHRS) and eliminate their use of handwritten requests to expedite specialty services. The CNE should also direct the specialty department to follow the time frame specified in the EHRS order when scheduling services.
- CCHCS should eliminate time frames for both routine and urgent priority requests from its specialty access policies. Instead, CCHCS should monitor specialty access by measuring the ability of each institution to provide specialty services within the time frames specified in each order in the EHRS.
- The CME should identify providers who are not carefully reviewing their patients' specialty consultations, progress notes, medications, and appointments. The CME should provide additional EHRS training for those providers who claimed their errors were because of their inability to locate this information in the EHRS.
- The CME should ensure providers in the correctional treatment center (CTC) and outpatient housing unit (OHU) perform a thorough chart review before each patient encounter. Providers should also discuss the status of each of the patient's current conditions in their progress notes whenever they pass the care of the patient to another provider. The CME should monitor provider performance in the CTC and OHU regularly by reviewing the care of these patients.
- The CNE should develop and implement new strategies to appraise and improve nursing competency and quality across all areas of nursing care because of the poor overall nursing performance we identified in this inspection.
- The CNE should clarify and communicate specific duties and expectations to the nurse care managers. The CNE should then provide training and monitor the care managers to ensure they perform appropriate chronic care management for their patients.

Population-Based Metrics

In general, SAC performed comparably to other health plans as measured by population-based metrics. In comprehensive diabetes care, SAC outperformed all state and national health care plans in three diabetic measures. However, SAC scored lower than four health care plans for diabetic eye exams and lower than three plans for blood pressure control.

With regard to immunization measures, SAC scored higher than four other health care plans for influenza immunizations for younger adults. However, SAC had the lowest influenza immunization percentage for older adults compared to Medicare and the VA. The institution's score for pneumococcal immunizations was the second highest score. Colorectal cancer screening scores were mixed, with the institution scoring higher than two health plans and scoring lower than three other health plans.

SAC may improve its scores for colorectal cancer screenings by reducing patient refusals through educating patients on the benefits of these preventive services.

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INTRODUCTION

Pursuant to California Penal Code Section 6126 et seq., which assigns the Office of the Inspector General (OIG) responsibility for oversight of the California Department of Corrections and Rehabilitation (CDCR), and at the request of the federal Receiver, the OIG developed a comprehensive medical inspection program to evaluate the delivery of medical care at each of CDCR's 35 adult prisons. The OIG conducted a clinical case review and a compliance inspection, ensuring a thorough, end-to-end assessment of medical care within CDCR.

California State Prison, Sacramento (SAC), was the 26th medical inspection of Cycle 5. During the inspection process, the OIG assessed the delivery of medical care to patients using the primary clinical health care indicators applicable to the institution. The *Administrative Operations* indicator is secondary because it does not reflect the actual clinical care provided.

ABOUT THE INSTITUTION

California State Prison, Sacramento (SAC), is located in the city of Folsom, in Sacramento County. Originally named "New Folsom Prison", SAC opened in 1986 as an addition to Folsom State Prison and was administered by the same warden. In 1992, the institution's name was officially changed. SAC is now administered as a separate prison with its own warden. Sac's mission is to protect the public by housing maximum-security patients serving long sentences. SAC also houses patients requiring specialized mental health programming and patients with high-risk medical concerns.

SAC has three separate, self-contained facilities each comprised of eight housing blocks and a recreational yard. The institution operates multiple clinics where health care staff handle non-urgent requests for medical services. Patients requiring urgent or emergent care are treated in one of the institution's three TTAs. Screenings for patients upon their arrival are conducted in the receiving and release (R&R) clinic. There is also a clinic for onsite and telemedicine specialty services. SAC has a CTC for inpatient services. Patients who require assistance with daily living activities but who do not require a higher level of inpatient care are treated in the OHU.

CCHCS has designated SAC an "intermediate" health care institution for medical purposes; these institutions are predominantly located in urban areas, close to care centers and specialty care providers likely to be used by a patient population with higher medical needs for the most cost-effective care.

After an initial accreditation in April of 2012, the institution received re-accreditation from the Commission on Accreditation for Corrections in March of 2015. This accreditation program is a professional peer review process based on national standards set by the American Correctional Association.

Based on staffing data the OIG obtained from the institution as identified in the *SAC Health Care Staffing Resources as of September 2017* table, SAC's vacancy rate for providers was 30 percent; the rate for nursing supervisors was 24 percent; and the rate for nursing staff was 15 percent. All management positions were filled.

SAC Health Care Staffing Resources as of September 2017

	Management		Primary Care Providers		Nursing Supervisors		Nursing Staff	
Description	**Number**	**%**	**Number**	**%**	**Number**	**%**	**Number**	**%**
Filled Positions	5	100%	6	70%	13	76%	90.1	85%
Vacancies	0	0%	2.6	30%	4	24%	15.9	15%
Total Authorized Positions	5	100%	8.6	100%	17	100%	106	100%

SAC Health Care Filled Positions

		Management		Primary Care Providers		Nursing Supervisors		Nursing Staff	
Limited Productivity	*Recent Hires (within 12 months)*	0	0%	4	67%	4	31%	29	32%
	Staff Utilized from Registry	0	0%	1.1	18%	0	0%	1.2	1%
	Redirected Staff (to Non-Patient Care Areas)	0	0%	0	0%	0	0%	2	2%
	Staff on Extended Leave	0	0%	0	0%	0	0%	0	0%
Full Productivity		5	100%	.9	15%	9	69%	57.9	64%
Total Filled Positions		5	100%	6	100%	13	100%	90.1	100%

Note: SAC Health Care Staffing Resources and Filled Position data was not validated by the OIG.

As of September 25, 2017, the Master Registry for SAC showed that the institution had a total population of 2,206. Within that total population, 6.2 percent were designated as high medical risk, Priority 1 (High 1), and 16.5 percent were designated as high medical risk, Priority 2 (High 2). Patients' assigned risk levels are based on the complexity of their required medical care related to their specific diagnoses, the frequency of higher levels of care, age, and abnormal laboratory tests and procedures. High 1 has at least two high-risk conditions; High 2 has only one. Patients at high medical risk are more susceptible to poor health outcomes than those at medium or low medical risk. Patients at high medical risk also typically require more health care services than do patients with lower assigned risk levels. The following table illustrates the breakdown of the institution's medical risk levels at the start of the OIG medical inspection.

SAC Master Registry Data as of September 5, 2017

Medical Risk Level	Number of Patients	Percentage
High 1	136	6.2%
High 2	363	16.5%
Medium	1,063	48.2%
Low	644	29.2%
Total	**2,206**	**100.0%**

OBJECTIVES, SCOPE, AND METHODOLOGY

In designing the medical inspection program, the OIG reviewed CCHCS policies and procedures, relevant court orders, and guidance developed by the American Correctional Association. The OIG 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, CDCR, the Office of the Attorney General, and the Prison Law Office to discuss the nature and scope of the OIG's inspection program. With input from these stakeholders, the OIG developed a medical inspection program that evaluates medical care delivery 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.

To maintain a metric-oriented inspection program that evaluates medical care delivery consistently at each state prison, the OIG identified 15 indicators (14 primary (clinical) indicators and 1 secondary (administrative) indicator) of health care to measure. The primary quality indicators cover clinical categories directly relating to the health care provided to patients, whereas the secondary quality indicator addresses the administrative functions that support a health care delivery system. The *SAC Executive Summary Table* on page *iv* of this report identifies these 15 indicators.

The OIG rates each of the quality indicators applicable to the institution under inspection based on case reviews conducted by OIG clinicians and compliance tests conducted by OIG registered nurses. The case review results alone, the compliance test results alone, or a combination of both these information sources may influence an indicator's overall rating. For example, the OIG derives the ratings for the primary quality indicators *Quality of Nursing Performance* and *Quality of Provider Performance* entirely from the case review done by clinicians, while the ratings for the primary quality indicators *Health Care Environment* and *Preventive Services* are derived entirely from compliance testing done by registered nurse inspectors. As another example, primary quality indicators such as *Diagnostic Services* and *Specialty Services* receive ratings derived from both sources.

The OIG does not inspect for efficiency or cost-effectiveness of medical operations. Consistent with the OIG's agreement with the Receiver, this report only addresses the quality of CDCR's medical operations and its compliance with quality-related policies. Moreover, if the OIG learns of a patient needing immediate care, the OIG notifies the chief executive officer of health care services and requests a status report. Additionally, if the OIG learns of significant departures from community standards, it may report such departures to the institution's chief executive officer or to CCHCS. Because these matters involve confidential medical information protected by state and federal privacy laws, the OIG does not include specific identifying details related to any such cases in the public report.

In all areas, the OIG is alert for opportunities to make appropriate recommendations for improvement. Such opportunities may be present regardless of the score awarded to any particular quality indicator; therefore, recommendations for improvement are not necessarily indicative of deficient medical care delivery.

CASE REVIEWS

The OIG added case reviews to the Cycle 4 medical inspections at the recommendation of its stakeholders, which continues in the Cycle 5 medical inspections. The following exhibit provides definitions that describe this process.

Exhibit 1. Case Review Definitions

Case = Sample = Patient
An appraisal of the medical care provided to one patient over a specific period, which can comprise detailed or focused case reviews.

Detailed 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.

Case Review 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 non-compliance, elevated risk of patient harm, or both.

Adverse Deficiency
A medical error that increases the risk of, or results in, serious patient harm. Most health care organizations refer to these errors as *adverse events*.

The OIG's clinicians perform a retrospective case review of selected patient files to evaluate the care given by an institution's primary care providers and nurses. Retrospective case review is a well-established review process used by health care organizations that perform peer reviews and patient death reviews. Currently, CCHCS uses retrospective case review as part of its death review process and in its pattern-of-practice reviews. CCHCS also uses a more limited form of retrospective case review when performing appraisals of individual primary care providers.

Patient Selection for Retrospective Case Reviews

Because retrospective case review is time consuming and requires qualified health care professionals to perform it, the OIG must carefully select a sample of patient records for clinician review. Accordingly, the group of patients the OIG targeted for case review carried the highest clinical risk and utilized the majority of medical services. The majority of patients selected for retrospective case review were high-utilizing patients with chronic care illnesses who were classified as high or medium risk. The reason the OIG targeted these patients for review is twofold:

1. The goal of retrospective case review is to evaluate all aspects of the health care system. Statewide, high-utilization patients consume medical services at a disproportionate rate. Between October 2011 and March 2012, nine percent of the total statewide adult patient population was classified as high-risk and accounted for more than half of CCHCS's pharmaceutical, specialty, community hospital, and emergency costs.[4] This disproportionate utilization of health care resources was consistent with that observed in the general U.S. population. Based on the 2010 Medical Expenditure Panel Survey data, 5 percent of the U.S. population accounted for 50 percent of health care costs.[5] By May 2018, the proportion of high-risk patients increased to 13.6 percent of the statewide adult patient population.[6]

2. Selecting this target group for case review provides a significantly greater opportunity to evaluate all the various aspects of the health care delivery system at an institution.

Underlying the choice of high- and medium-risk patients for detailed case review, the OIG clinical experts made the following three assumptions:

1. If the institution is able to provide adequate clinical care to the most challenging patients with multiple complex and interdependent medical problems, it is more likely to provide

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[4] California Correctional Health Care Services (CCHCS) Quality Management Section, *High-Risk Patient Performance Report – Appropriate Placement in the CCHCS Primary Care Environment,* August 2012; **https://cchcs.ca.gov/wp-content/uploads/sites/60/2017/08/T21_20120915_Appendix6.pdf** (accessed 9-10-18).

[5] S.B. Cohen, *The Concentration and Persistence in the Level of Health Expenditures Over Time: Estimates for the U.S. Population, 2009–2010* (Rockville, MD: Agency for Healthcare Research and Quality, U.S. Department of Health and Human Services, 2012); **https://meps.ahrq.gov/data_files/publications/st392/stat392.shtml** (accessed 9-10-18).

[6] CCHCS Public Dashboard, Statewide, May 2018; **https://cchcs.ca.gov/wp-content/uploads/sites/60/2018/08/Public-Dashboard-2018-05.pdf** (accessed 9-10-18).

adequate care to patients with less complicated health care issues. Because clinical expertise is required to determine whether the institution has provided adequate clinical care, the OIG utilizes experienced correctional physicians and registered nurses to perform this analysis.

2. The health of less complex patients is more likely to be affected by processes such as timely appointment scheduling, medication management, routine health screening, and immunizations. To review these processes, the OIG simultaneously performs a broad compliance review.

3. Patient cases generated during death reviews, sentinel events (unexpected occurrences involving death or serious injury, or risk thereof), and hospitalizations are more likely to comprise high-risk patients.

Benefits and Limitations of Targeted Subpopulation Review

Because the patients selected utilize the broadest range of services offered by the health care system, the OIG's retrospective case review provides adequate data for a qualitative assessment of the most vital system processes (referred to as "primary quality indicators"). Retrospective case review provides an accurate qualitative assessment of the relevant primary quality indicators as applied to the targeted subpopulation of high-risk and high-utilization patients. While this targeted subpopulation does not represent the prison population as a whole, the institution's ability to *respond* with adequate medical care to this subpopulation is a crucial and vital indicator of how the institution provides health care to its whole patient population. Simply put, if the institution's medical system does not *respond* adequately for those patients needing the most care, then it is not fulfilling its obligations, even if it takes good care of patients with less complex medical needs.

Since the targeted subpopulation does not represent the institution's general prison population, the OIG cautions against inappropriate extrapolation of medical *conditions* or *outcomes* from the retrospective case reviews to the general population. For example, if the high-risk diabetic patients reviewed have poorly controlled diabetes, one cannot conclude that all the diabetics' conditions are poorly controlled. Similarly, if the high-risk diabetic patients under review have poor outcomes, one cannot conclude that the entire diabetic population is having similarly poor outcomes. The OIG does not extrapolate *conditions* or *outcomes*, but instead extrapolates the institution's *response* for those patients needing the most care because the *response* yields valuable system information.

In the above example, if the institution responds by providing appropriate diabetic monitoring, medication therapy, and specialty referrals for the high-risk patients reviewed, then it is reasonable to infer that the institution is also responding appropriately to all the diabetics in the prison. However, if these same high-risk patients needing monitoring, medications, and referrals

are not getting those needed services, it is likely that the institution is not providing appropriate diabetic services.

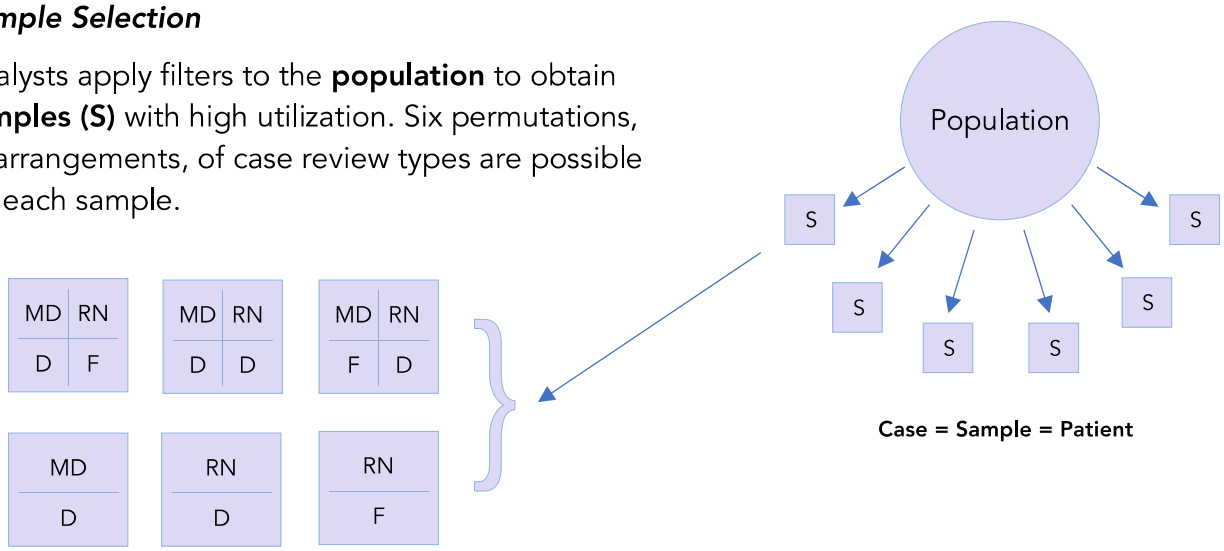
Case Review Sampling Methodology

Using a pre-defined case review sampling algorithm, OIG analysts apply various filters to each institution's patient population. The various filters include medical risk status, number of prescriptions, number of specialty appointments, number of clinic appointments, and other health-related data. The OIG uses these filters to narrow down the population to those patients with the highest utilization of medical resources (see Chart 1, next page). To prevent selection bias, the OIG ensures that the same clinicians who perform the case reviews do not participate in the sample selection process.

Chart 1. Case Review Sample Selection

Sample Selection

Analysts apply filters to the **population** to obtain **samples (S)** with high utilization. Six permutations, or arrangements, of case review types are possible for each sample.



MD = Provider
RN = Registered Nurse
D = Detailed Review
F = Focused Review

The OIG's case sample sizes matched those of other qualitative research. The empirical findings, supported by expert statistical consultants, showed adequate conclusions after 10 to 15 cases had undergone comprehensive, or detailed, clinician review. In qualitative statistics, this phenomenon is known as "saturation." The OIG found the Cycle 4 medical inspection sample size of 30 for detailed physician reviews far exceeded the saturation point necessary for an adequate qualitative review. At the end of Cycle 4 inspections, the OIG re-analyzed the case review results using half the number of cases; there were no significant differences in the ratings. To improve inspection efficiency while preserving the quality of the inspection, the OIG reduced the number of the samples for Cycle 5 medical inspections to the current levels. For most basic institutions, the OIG samples 20 cases for detailed physician review. For intermediate institutions and several basic institutions with larger high-risk populations, the OIG samples 25 cases. For California Health Care Facility, the OIG samples 30 cases for detailed physician review.

Breadth of Case Reviews

As indicated in *Appendix B, Table B-1: SAC Sample Sets*, the OIG clinicians evaluated medical records for 90 unique cases. *Appendix B, Table B-4: SAC Case Review Sample Summary* clarifies that both nurses and physicians reviewed 21 of those cases, for 111 case reviews in total. Physicians performed detailed reviews of 25 cases, and nurses performed detailed reviews of 15 cases, totaling 40 detailed case reviews. Physicians and nurses also performed a focused review

of an additional 71 cases. These reviews generated 1,494 case review events (*Appendix B, Table B-3: SAC Event – Program*).

While the sample method specifically pulled only 6 chronic care cases, i.e., 3 diabetes cases and 3 anticoagulation cases (*Appendix B, Table B-1: SAC Sample Sets*), the 90 unique cases sampled included 314 chronic care diagnoses, including 14 additional cases with diabetes (for a total of 17) and 1 additional anticoagulation case (for a total of 4) (*Appendix B, Table B-2: SAC Chronic Care Diagnoses*). The OIG's sample selection tool allowed evaluation of many chronic care programs because the complex and high-risk patients selected from the different categories often had multiple medical problems. While the OIG did not evaluate every chronic disease or health care staff member, the OIG did assess for adequacy the overall operation of the institution's system and staff.

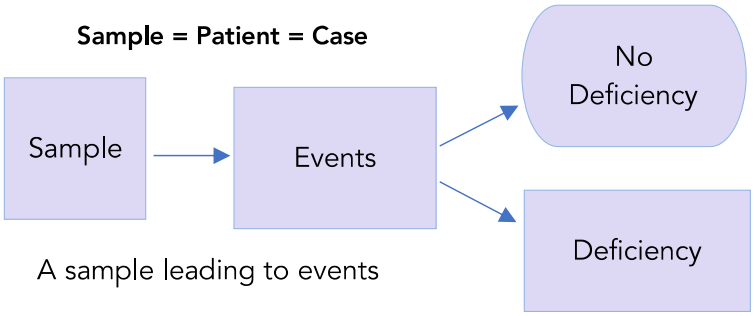
Case Review Testing Methodology

A physician, a nurse consultant, or both clinician inspectors review each case. The OIG clinician inspector can perform one of two different types of case review: detailed or focused (see Exhibit 1, page 5, and Chart 1, page 9). As the OIG clinician inspector reviews the medical record for each sample, the inspector records pertinent interactions between the patient and the health care system. These interactions are also known as case review *events*. When an OIG clinician inspector identifies a medical error, the inspector also records these errors as case review *deficiencies.* If a deficiency is of such magnitude that it caused, or had the potential to cause, serious patient harm, then the OIG clinician records it as an *adverse deficiency* (see Chart 2, next page).

Chart 2. Case Review Testing and Deficiencies

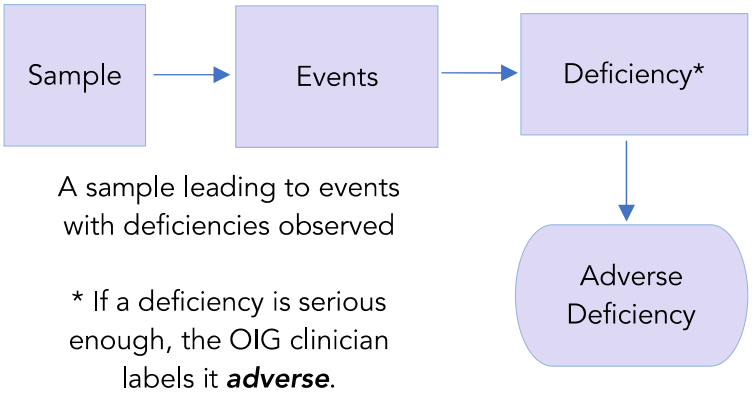
Case Review Testing

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



Deficiencies

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



When the OIG clinician inspectors have reviewed all cases, they analyze the deficiencies. OIG inspectors search for similar types of deficiencies to determine if a repeating pattern of errors existed. When the same type of error occurs multiple times, the OIG inspectors identify those errors as findings. When the error is frequent, the likelihood is high that the error is regularly recurring at the institution. The OIG categorizes and summarizes these deficiencies in one or more health care quality indicators in this report to help the institution focus on areas for improvement.

Additionally, the OIG physicians also rate each of the detailed physician cases for adequacy based on whether the institution met the patient's medical needs and if it placed the patient at significant risk of harm. The cumulative analysis of these cases gives the OIG clinicians additional perspective to help determine whether the institution is providing adequate medical services or not.[7]

Based on the collective results of clinicians' case reviews, the OIG clinicians rated each quality indicator *proficient* (excellent), *adequate* (passing), or *inadequate* (failing). A separate confidential *SAC Supplemental Medical Inspection Results: Individual Case Review Summaries* report details the case reviews the OIG clinicians conducted and is available to specific stakeholders. For further details regarding the sampling methodologies and counts, see *Appendix B — Clinical Data, Table B-1; Table B-2; Table B-3;* and *Table B-4*.

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[7] Regarding individual provider performance, the OIG did not design the medical inspection to be a focused search for poorly performing providers; rather, the inspection assesses each institution's systemic health care processes. Nonetheless, while the OIG does not purposefully sample cases to review each provider at the institution, the cases usually involve most of the institutions' providers. Providers should only escape OIG case review if institutional managers assigned poorly performing providers the care of low-utilizing and low-risk patients, or if the institution had a relatively high number of providers.

COMPLIANCE TESTING

Sampling Methods for Conducting Compliance Testing

Our registered nurse inspectors attained answers to 88 objective medical inspection test (MIT) questions designed to assess the institution's compliance with critical policies and procedures applicable to the delivery of medical care. To conduct most tests, inspectors randomly selected samples of patients for whom the testing objectives were applicable and reviewed their electronic medical records. In some cases, inspectors used the same samples to conduct more than one test. In total, inspectors reviewed medical records for 406 individual patients and analyzed specific transactions within their records for evidence that critical events occurred. Inspectors also reviewed management reports and meeting minutes to assess certain administrative operations. In addition, during the week of September 18, 2017, registered nurse field inspectors conducted a detailed onsite inspection of SAC's medical facilities and clinics; interviewed key institutional employees; and reviewed employee records, logs, medical appeals, death reports, and other documents. This generated 1,279 scored data points to assess care.

In addition to the scored questions, the OIG obtained information from the institution that it did not score. This included, for example, information about SAC's plant infrastructure, protocols for tracking medical appeals and local operating procedures, and staffing resources.

For details of the compliance results, see *Appendix A — Compliance Test Results*. For details of the OIG's compliance sampling methodology, see *Appendix C — Compliance Sampling Methodology*.

Scoring of Compliance Testing Results

After compiling the answers to the 88 questions for the 10 applicable indicators, the OIG derived a score for each quality indicator by calculating the percentage score of all *Yes* answers for each of the questions applicable to a particular indicator, then averaging those scores. Based on those results, the OIG assigned a rating to each quality indicator of *proficient* (greater than 85.0 percent), *adequate* (between 75.0 percent and 85.0 percent), or *inadequate* (less than 75.0 percent).

OVERALL QUALITY INDICATOR RATING FOR CASE REVIEWS AND COMPLIANCE TESTING

The OIG derived the final rating for each quality indicator by combining the ratings from the case reviews and from the compliance testing, as applicable. When combining these ratings, the case review evaluations and the compliance testing results usually agreed, but there were instances when the rating differed for a particular quality indicator. In those instances, the

inspection team assessed the quality indicator based on the collective ratings from both components. Specifically, the OIG clinicians and registered nurse inspectors discussed the nature of individual exceptions found within that indicator category and considered the overall effect on the ability of patients to receive adequate medical care.

To derive an overall assessment rating of the institution's medical inspection, the OIG evaluated the various rating categories assigned to each of the quality indicators applicable to the institution, giving more weight to the rating results of the primary quality indicators, which directly relate to the health care provided to patients. Based on that analysis, OIG experts made a considered and measured overall opinion about the quality of health care observed.

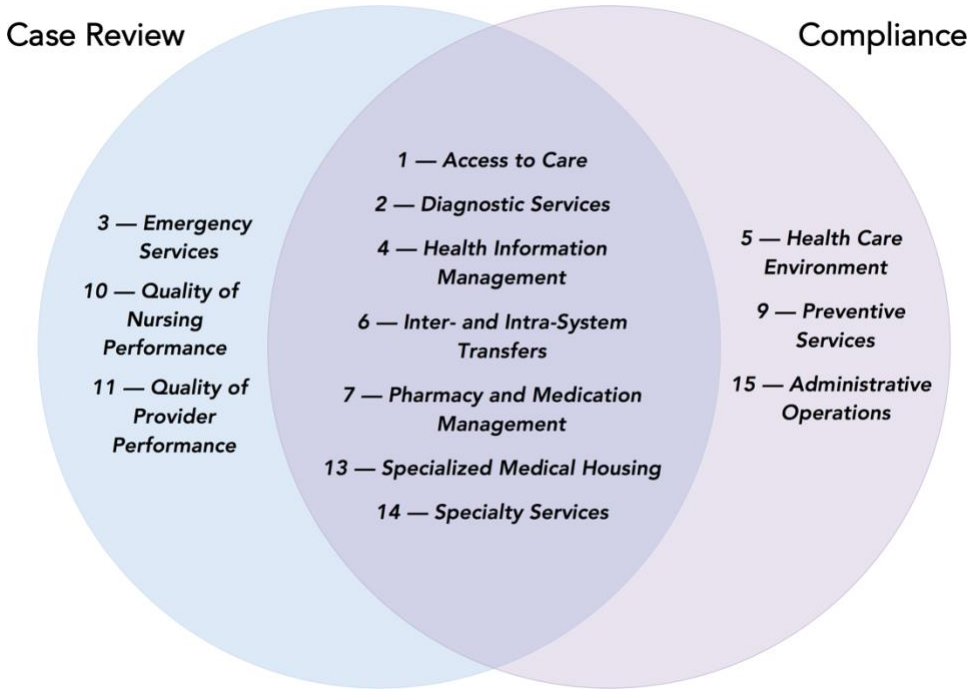
POPULATION-BASED METRICS

The OIG identified a subset of Healthcare Effectiveness Data Information Set (HEDIS) measures applicable to the CDCR patient population. To identify outcomes for SAC, the OIG reviewed some of the compliance testing results, randomly sampled additional patients' records, and obtained SAC data from the CCHCS Master Registry. The OIG compared those results to HEDIS metrics reported by other statewide and national health care organization.

MEDICAL INSPECTION RESULTS

The OIG's case review and clinician teams use quality indicators to assess the clinical aspects of health care. The SAC *Executive Summary Table* on page *iv* of this report identifies the 13 indicators applicable to this institution. The following chart depicts their union and intersection:

Chart 3. Inspection Indicator Review Distribution



The *Administrative Operations* indicator is a secondary indicator; therefore, the OIG did not rely upon this indicator when determining the institution's overall score. Based on the analysis and results in all the primary indicators, the OIG experts made a considered and measured opinion that the quality of health care at SAC was ***inadequate***.

Summary of Case Review Results: The clinical case review component assessed 10 of the 13 indicators applicable to SAC. Of these ten indicators, OIG clinicians rated two *adequate* and eight *inadequate*.

The OIG physicians rated the overall adequacy of care for each of the 25 detailed case reviews they conducted. Of these 25 cases, 15 were *adequate,* and 10 were *inadequate*. In the 1,494 events reviewed, there were 484 deficiencies, 164 of which were considered to be of such magnitude that, if left unaddressed, they would likely contribute to patient harm.

Adverse Deficiencies Identified During Case Review: Adverse deficiencies are medical errors that markedly increased the risk of, or resulted in, serious patient harm. Medical care is a complex and dynamic process with many moving parts, subject to human error even within the best health care organizations. All major health care organizations typically identify and track adverse deficiencies for the purpose of quality improvement. Adverse deficiencies are not typically representative of medical care delivered by the organization. The OIG normally identifies adverse deficiencies for the dual purposes of quality improvement and the illustration of problematic patterns of practice found during the inspection. Because of the anecdotal nature of these deficiencies, the OIG cautions against drawing inappropriate conclusions regarding the institution based solely on adverse deficiencies. The OIG identified seven adverse deficiencies in the case reviews at SAC:

- In case 1, the nurse failed to transfer the patient with chest pain safely. Instead of using a wheelchair or gurney, the patient walked from the OHU to the TTA for treatment. The provider saw the patient in the TTA for chest pain and failed to evaluate the patient for a heart attack. The provider ill-advisedly discharged the patient back to regular housing. We also discuss this case in the *Emergency Services* indicator.

- In case 10, the patient developed dizziness, slurred speech, and confusion; these symptoms were suggestive of a stroke. No first medical responder assessed the patient. Instead, a custody officer walked the patient to the clinic, unaccompanied by medical staff and unmonitored. We also discuss this case in the *Emergency Services* indicator.

- In case 11, the patient arrived at the TTA with blood in his urine, flank pain, an abnormally fast heart rate, and abnormally low blood pressure. The provider did not urgently transfer the patient to the outside emergency department (ED). This error resulted in a severe delay in care. When the patient eventually went to the ED, he required admission to the intensive care unit. We also discuss this case in the *Emergency Services* indicator.

- In case 22, nurses repeatedly failed to dispense the patient's essential medications, which included blood pressure medications and treatment for his degenerative eye condition. The patient did not receive his blood pressure medications for nearly a month, and his recommended eye drops for four months. These errors increased the patient's risk of heart disease, blindness, and other complications. We also discuss this case in the *Pharmacy and Medication Management* indicator.

- In case 24, the patient saw the TTA nurse because he was vomiting blood. The nurse found the patient had low blood pressure. The nurse gave the patient intravenous fluids and started him on oxygen. Even though the patient was unstable, the nurse discharged the patient back to housing without notifying the provider. The patient returned to the TTA five minutes later and required hospitalization. We also discuss this case in the *Quality of Nursing Performance* indicator.

- In case 25, the patient developed symptoms suggestive of a heart attack. No first medical responder assessed the patient. Instead, custody staff required the patient to walk to the TTA, unaccompanied and unmonitored by medical staff. We also discuss this case in the *Emergency Services* indicator.

- In case 90, multiple provider errors resulted in a severe delay in the diagnosis and treatment of the patient's liver cancer. One provider repeatedly failed to review the patient's medical records and did not follow up on abnormal tests. Another provider failed to communicate with the specialist, who suggested that the patient did not need a biopsy to be treated for liver cancer. The institution did not schedule a computed tomography (CT) scan promptly, creating further delays. When a surgeon recommended referring the patient to a subspecialist, a provider ignored the recommendation and ordered a different test. When the institution finally sent the patient to the subspecialist, it did not send the CT images with the patient. As a result, SAC did not treat the patient's liver cancer until ten months after it providers first discovered it. We also discuss this case in the *Access to Care*, *Specialized Medical Housing*, and the *Specialty Services* indicators.

Summary of Compliance Testing Results: The compliance component assessed 10 of the 13 indicators applicable to SAC. Of these ten indicators, OIG inspectors rated three *proficient*, two *adequate*, and five *inadequate*. Each section of this report summarizes the results of those assessments, whereas *Appendix A* provides the details of the test questions used to assess compliance for each indicator.

1 — *ACCESS TO CARE*

This indicator evaluates the institution's ability to provide patients with timely clinical appointments. Compliance and case review teams review areas specific to patients' access to care, such as initial assessments of newly arriving patients, acute and chronic care follow-ups, face-to-face nurse appointments when patients request to be seen, provider referrals from nursing lines, and follow-ups after hospitalization or specialty care. Compliance testing for this indicator also evaluates whether patients have Health Care Services Request forms (CDCR Form 7362) available in their housing units.

Case Review Rating:
Adequate
Compliance Score:
Proficient
(87.0%)
Overall Rating:
Adequate

For this indicator, the case review and compliance review processes yielded different results, with the case reviewers assigning an *adequate* rating and the compliance testing resulting in a *proficient* score. Our case reviewers rating found that SAC did not always provide consistent registered nurse (RN) follow-up appointments or timely appointments to patients who transferred into the institution. Also, SAC did not schedule some patients who had onsite radiology services for provider follow-up appointments. Because the institution had room for improvement in these areas, we determined that the overall rating for this indicator was *adequate*.

Case Review Results

We reviewed 387 provider, nurse, specialty, and hospital events that required a follow-up appointment and identified 40 deficiencies relating to access to care. Of the 40 deficiencies, 29 were significant. The case review rating for this indicator was *adequate*.

Provider-to-Provider Follow-up Appointments

SAC performed well with provider-ordered follow-up appointments. These are among the most important aspects of the *Access to Care* indicator. Failure to accommodate these appointments can often result in serious lapses in care. The OIG clinicians reviewed 129 provider-ordered follow-up appointments and found only two significant deficiencies.

- In case 22, on several occasions, the provider scheduled the patient for a follow-up appointment to occur on the following day. For one of these appointments, the follow-up appointment did not occur for seven days.
- In case 66, the provider saw the patient for rectal bleeding and ordered a follow-up appointment to occur in seven days. The provider follow-up appointment was delayed for 41 days.

RN Sick Call Access

SAC appropriately scheduled patients for RN sick call appointments. However, sick call nurses struggled to recognize potentially urgent medical conditions and to perform timely nursing evaluations. We discuss sick call nursing performance further in the *Quality of Nursing Performance* indicator.

RN-to-Provider Referrals

SAC performed well with RN-to-provider referrals. We did not identify any deficiencies in this area.

RN Follow-up Appointments

As we observed during the Cycle 4 inspection, SAC continued to have difficulty providing patients with appropriate RN follow-up appointments. Appointments did not occur in cases 10, 11, 21, and the following cases:

- In case 2, the provider examined and appropriately arranged a close monitoring for the patient who had left-sided weakness, facial droop, and headache. The provider ordered an RN follow-up appointment to occur the following day; however, the appointment did not occur for three days.

- In case 18, the provider ordered daily dressing changes for the patient who had an open wound on his leg. The scheduler erroneously arranged for the patient to have only one dressing change which resulted in the patient not receiving wound care for seven days. This error could have compromised the healing process and placed the patient at unnecessary risk of developing wound complications.

- In case 26, the patient refused a nursing assessment of his swollen legs. Although the nurse documented the patient would be rescheduled, the appointment did not occur. Because of this lapse in medical care, the patient's legs became infected and required treatment with additional antibiotics.

Provider Follow-up After Specialty Services

SAC satisfactorily scheduled provider follow-up appointments after specialty consultations. We reviewed 113 specialty services requiring follow-up appointments and found only five deficiencies. We found minor delays in provider follow-up appointments in cases 11, 26, 88, and the following cases:

- In case 19, the patient saw a dermatologist for an urgent consultation. Because of the urgency of the consultation, the nurse should have scheduled the patient for a three-day follow-up appointment with his primary provider. Instead, the nurse erroneously ordered a routine provider follow-up appointment, resulting in a delay of ten days.

- In case 90, the scheduler did not arrange a provider follow-up appointment for the patient after he returned from a radiology scan to evaluate his liver and pancreas. This error placed the patient at risk for a lapse in care.

Intra-System Transfers

SAC did not ensure patients transferring into the institution received timely provider appointments. We reviewed eight transfer-in events and found several provider appointments were late (cases 25, 31, and 33).

Follow-up After Hospitalization

The institution did well ensuring providers followed up with patients after they returned from an outside hospital or emergency department. We reviewed 26 hospitalizations and identified only one significant deficiency:

- In case 3, the patient returned from the emergency department where he was seen for chest pain. Staff scheduled the patient for a five-day follow-up appointment but the provider ordered the appointment rescheduled. Staff failed to reschedule the appointment, and as a result, the patient did not receive follow up for the chest pain.

Follow-up After Urgent/Emergent Care

Generally, SAC appropriately scheduled provider follow-up appointments for patients who visisted the TTA for urgent medical services. The OIG reviewed 19 events and identified only one follow-up appointment that SAC did not schedule properly:

- In case 1, the patient went to the TTA for chest pain and the provider started him on blood pressure medication. After staff sent the patient back to housing, they did not schedule him for a provider follow-up appointment.

Specialized Medical Housing

The institution performed well with provider access during and after admission to the CTC or OHU. The OIG clinicians reviewed two patient admissions and 141 visits with providers. We found four delays in provider evaluation (cases 86, 88, and 90). Two of these delays were significant:

- In case 88, the provider requested a two-day follow-up appointment but did not see the patient until five days later.

- In case 90, the provider did not see the patient following an offsite imaging procedure.

Specialty Access and Follow-up

SAC performed satisfactorily with specialty access and follow-up. We discuss this performance further in the *Specialty Services* indicator.

Diagnostic Results Follow-up

The institution generally did well with scheduling and completing provider follow-up appointments after providers reviewed diagnostic tests. Medical staff scheduled appointments appropriately, except for two cases in which follow-up appointments were missed:

- In case 23, the institution did not schedule a follow-up appointment for the provider to review an ultrasound. The provider was not aware of this diagnostic result. The error placed the patient at risk for a lapse in care.
- In case 89, the institution did not schedule a follow-up appointment after the patient underwent an abdominal CT scan. SAC did not schedule the patient until the provider attempted to see the patient 24 days after the imaging study.

Clinician Onsite Inspection

The scheduling supervisor explained that some of the nursing follow-up errors occurred because the nurses overly relied on verbal communication and failed to schedule the appointments in the EHRS. The institution agreed with our identification of this issue and initiated a performance improvement work plan to rectify this problem. The supervisor also claimed that lapses in wound care occurred because orders for wound care did not transfer correctly into the EHRS.

The scheduling supervisor reported no significant provider or nursing backlogs. The supervisor worked closely with medical and nursing staff to monitor access to care. They relied heavily on the CCHCS dashboard to closely track their performance. Medical leadership was very involved in making sure appointments were scheduled timely. However, the providers reported they repeatedly rescheduled appointments because they did not have enough time to see all the patients that were scheduled. Providers complained of excessive responsibilities due to caring for regular patients in the clinic as well as handling emergent cases because SAC lacked a dedicated TTA provider.

Case Review Conclusion

In comparison to the previous inspection, SAC improved its RN sick call access. Generally, SAC patients saw their providers and nurses timely. Patients had good access to emergency services and to the hospital when needed. After seeing outside specialty services, patients had follow-up appointments with their providers. However, the institution continued to have errors in RN follow-up appointments. Also, patients who transferred into SAC did not always receive timely appointments. The institution failed to schedule some patients for provider follow-up

appointments following onsite radiology services. Nonetheless, SAC performed sufficiently with regards to *Access to Care*, and we rated this indicator *adequate*.

Compliance Testing Results

The institution performed in the *proficient* range with a compliance score of 87.0 percent in the *Access to Care* indicator. Four tests earned scores in the *proficient* range:

- Inspectors sampled 60 health care service request forms submitted by patients across all facility clinics. Nursing staff reviewed all service request forms on the same day they were received (MIT 1.003).
- For 58 of the 60 patients sampled (96.7 percent) who submitted health care services request forms, nursing staff completed a face-to-face encounter with the patient within one business day after reviewing the form. A nurse conducted one patient's visit five days late. For one other patient, the nursing staff failed to document if the patient received or refused a face-to-face encounter (MIT 1.004).
- Of the eight patients sampled whom nursing staff referred to a provider and for whom the provider subsequently ordered a follow-up appointment, all eight received their follow-up appointments timely (MIT 1.006).
- Patients had access to health care services request forms at all six housing units the OIG inspected (MIT 1.101).

Three tests received scores in the *adequate* range:

- We sampled 25 patients with chronic care conditions and found that 21 (84.0 percent) received timely provider follow-up appointments. Three patients' follow-up appointments were one to eight days late. One patient's follow-up appointment was 59 days late (MIT 1.001).
- OIG inspectors tested 25 patients discharged from a community hospital to determine whether they received a provider follow-up appointment at SAC within five calendar days of their return to the institution. Twenty-one patients (84.0 percent) received a timely provider follow-up appointment. Two patients received their follow-up appointments 10 and 15 days late. For the remaining two patients, a follow-up appointment did not occur at all (MIT 1.007).
- Twenty of 24 sampled patients (83.3 percent) who received a high-priority or routine specialty service also received a timely follow-up appointment with a SAC provider. Four patients' follow-up appointments were 7 to 17 days late (MIT 1.008).

We found room for improvement in the following two areas:

- Among 24 applicable patients sampled who transferred into SAC from other institutions and whom nurses referred to a provider based on their initial health care screening, 16 were seen timely (66.7 percent). Seven patients received their provider appointments from 2 to 23 days late. One other patient did not receive a provider visit at all (MIT 1.002).

- Among 19 health care services request forms (CDCR Form 7362) sampled on which nursing staff referred the patient for a provider appointment, only 13 patients (68.4 percent) received timely appointments. Four patients received their appointments from 1 to 31 days late. Two other patients did not receive a provider visit at all (MIT 1.005).

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2 — *DIAGNOSTIC SERVICES*

Case Review Rating:
Adequate
Compliance Score:
Adequate
(81.1%)

Overall Rating:
Adequate

This indicator addresses several types of diagnostic services. Specifically, it addresses whether radiology and laboratory services were timely provided to patients, whether primary care providers timely reviewed results, and whether providers communicated results to the patient within required time frames. In addition, for pathology services, the OIG determines whether the institution received a final pathology report and whether the provider timely reviewed and communicated the pathology results to the patient. The case reviews also factor in the appropriateness, accuracy, and quality of the diagnostic test(s) ordered and the clinical response to the results.

Case Review Results

We reviewed 246 diagnostic events and found 12 deficiencies, 4 of which were significant. Of the 12 deficiencies, 11 were related to health information management and 1 was related to the completion of ordered tests. For health information management, test reports never being retrieved or reviewed is as severe of a problem as tests not being performed. The case review rating for this indicator was *adequate*.

Test Completion

SAC performed extremely well with performing diagnostic tests timely. We found only one significant deficiency:

- In case 92, the provider ordered several laboratory tests; however, the laboratory did not complete all of the tests.

Health Information Management

SAC performed well with retrieving laboratory and radiology reports. However, we found a pattern of delays in which providers reviewed laboratory and diagnostic reports late. We identified this pattern in cases 1, 11, 21, 88, 90, and the following cases:

- In case 86, after the tests were completed, the provider failed to review the laboratory results for almost two months.
- In case 92, the provider reviewed the laboratory result one month after the test was completed.

Clinician Onsite Inspection

SAC providers stated that diagnostic services were good. They did not report any delays in obtaining diagnostic reports from either the laboratory or radiology departments. The institution

also demonstrated an effective tracking process to ensure the timely completion of diagnostic procedures.

Case Review Conclusion

SAC improved in performing diagnostic tests compared to the last cycle. SAC performed nearly all of the diagnostic tests timely. The institution also improved availability of onsite x-ray services. The onsite radiologic technologist was available more often to perform diagnostic scans compared to the last cycle. However, one area of improvement for the institution is for the providers to review diagnostic tests promptly. Considering these factors, we rated the *Diagnostic Services* indicator *adequate*.

Compliance Testing Results

The institution earned an *adequate* compliance score of 81.1 percent in the *Diagnostic Services* indicator, which encompasses radiology, laboratory, and pathology services. For clarity, we discuss each type of diagnostic service separately:

Radiology Services

- Radiology services were timely performed for all ten patients sampled (MIT 2.001). SAC providers then timely reviewed and signed the corresponding diagnostic reports for only two of the ten patients (20.0 percent); for eight patients, inspectors found no evidence the providers signed their reports (MIT 2.002). Providers timely communicated test results to nine of the ten patients sampled (90.0 percent); one patient's result was communicated five days late (MIT 2.003).

Laboratory Services

- Nine of the ten sampled patients (90.0 percent) received their provider-ordered laboratory services timely. One patient received his laboratory service eight days late (MIT 2.004). The institution's providers reviewed all ten resulting laboratory service reports within required time frames (MIT 2.005). Finally, providers timely communicated report results to nine of the ten patients (90.0 percent). One patient never received his results (MIT 2.006).

Pathology Services

- SAC clinicians timely received final pathology reports for nine of the ten patients sampled (90.0 percent); however, one patient's pathology report was received five days late (MIT 2.007). Providers timely reviewed and signed final pathology reports for nine of the ten patients (90.0 percent). For one patient, the provider reviewed the final pathology report 27 days late (MIT 2.008). Providers timely communicated final pathology results to six of the ten sampled patients (60.0 percent). For two patients, the

provider communicated pathology results 7 and 13 days late. Two additional patients never received any provider communication concerning their results (MIT 2.009).

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3 — *EMERGENCY SERVICES*

Case Review Rating:
Inadequate
Compliance Score:
Not applicable
Overall Rating:
Inadequate

An emergency medical response system is essential to providing effective and timely emergency medical response, assessment, treatment, and transportation 24 hours per day. Provision of urgent/emergent care is based on a patient's emergency situation, clinical condition, and need for a higher level of care. The OIG reviews emergency response services including first aid, basic life support (BLS), and advanced cardiac life support (ACLS) consistent with the American Heart Association guidelines for cardiopulmonary resuscitation (CPR) and emergency cardiovascular care, and the provision of services by knowledgeable staff appropriate to each individual's training, certification, and authorized scope of practice.

The OIG evaluates this quality indicator entirely through clinicians' reviews of case files and conducts no separate compliance testing element.

Case Review Results

We reviewed 42 urgent and emergent events and identified 50 deficiencies in various aspects of emergency care. The OIG clinicians considered six of these deficiencies significant. The case review rating for this indicator was *inadequate*.

Emergency Medical Response

We identified several SAC emergency response problems that posed a serious risk of harming patients. SAC staff did not treat some emergencies with appropriate urgency, and in some cases, no first medical responder responded to the scene of the emergency:

- In case 1, the nurse failed to transport the patient who was experiencing chest pain safely. Instead of using a wheelchair or gurney, the patient walked from the outpatient OHU to the TTA for treatment.
- In case 10, the patient developed dizziness, slurred speech, and confusion; these symptoms suggested a stroke. No first medical responder assessed the patient. Instead, a custody officer walked the patient to the clinic, unaccompanied and unmonitored by medical staff.
- In case 25, the patient developed symptoms suggestive of a heart attack. No first medical responder assessed the patient. Instead, custody staff walked the patient to the TTA, unaccompanied and unmonitored by medical staff.

Provider Performance

Although SAC providers usually demonstrated appropriate assessments and treatment plans in the TTA, we found the following exceptions:

- In case 1, the patient had risk factors for heart disease. The provider saw the patient in the TTA for chest pain. The provider performed only a superficial physical examination and failed to evaluate the patient for a heart attack. The provider did not properly diagnose the reason for the patient's chest pain. The provider ill-advisedly discharged the patient back to regular housing.

- In case 11, the patient arrived at the TTA with blood in his urine, flank pain, an abnormally fast heart rate, and abnormally low blood pressure. The provider should have urgently transferred the patient to the outside emergency department but did not. This error resulted in a severe delay in care. When the patient eventually went to the ED, he required admission to the intensive care unit.

- SAC providers consistently failed to document their TTA assessments and decision-making. Providers often failed to record a proper TTA evaluation for patients who were potentially unstable. We identified missing TTA progress notes in cases 2, 11, 21, and 24.

Nursing Performance

The institution's nurses had difficulty performing correct emergency assessments and interventions. Nurses failed to perform relevant examinations and monitor their patients' conditions appropriately. Furthermore, nurses did not reevaluate the medical status of patients after administering treatments or before discharging patients from the TTA (cases 2, 6, 7, 9, 11, 18, 20, 21, 70, and 88).

Also, SAC nurses did not always follow through with provider-ordered interventions or interventions that nurses could perform independently. Nurses also failed to consult with the provider or provide patient education when needed. We identified these deficiencies in cases 2, 9, 20, and in the following case:

- In case 24, the nurse failed to immediately contact and report to the provider that the patient was vomiting blood and had low blood pressure. Instead, the nurse erroneously discharged the patient back to regular housing. The patient continued to vomit blood and required hospitalization later the same day. This delay in transferring the patient to the hospital increased his risk of developing a cardiopulmonary arrest and death.

Nursing Documentation

SAC nurses' poor emergency documentation resulted in critical gaps in patients' electronic medical records. Documentation often lacked details of nursing care provided in the TTA or aid

given by a first medical responder. Examples of poor nursing documentation included nurses failing to document when and how patients arrived at the TTA, when the nurse contacted a provider or dialed 9-1-1, when an ambulance arrived, and when a patient left the institution (cases 1, 2, 3, 6, 9, 10, 11, 20, 21, 24, 26, and 70).

Emergency Medical Response Review Committee

We reviewed six emergency medical response cases, also reviewed by the EMRRC. In four cases, the EMRRC failed to identify incomplete assessments, incomplete nursing documentation and failed to recommend training. SAC's ineffective EMRRC review makes it more difficult for the institution to implement quality improvement in this area.

Clinician Onsite Inspection

At the time of our visit, SAC still utilized a separate area in each of the main clinics for medical emergencies. During regular business hours, the clinic nurses and providers attended to medical emergencies in addition to their own regularly scheduled clinic patients. After hours, the TTA nurse notified the on-call provider for any patient care issues.

In June 2018, SAC opened a building that houses a new TTA and two new clinics to meet patient demand for medical services. The new TTA has five beds for urgent and emergent care.

Case Review Conclusion

SAC staff demonstrated poor emergency services. Often, first medical responders failed to respond to the scene of the emergency. Instead, staff required patients, some with potentially life-threatening symptoms, to walk to the TTA unmonitored and unaccompanied by any medical staff. Provider performance in the TTA was at times problematic and included a pattern of missing TTA documentation. The nurses failed to document nursing care and timelines properly, and often did not properly assess patients. The EMRRC did not identify incomplete nursing assessments and nursing documentation. We, therefore, rated SAC's *Emergency Services* indicator *inadequate*.

4 — *HEALTH INFORMATION MANAGEMENT*

Case Review Rating:
Inadequate
Compliance Score:
Inadequate
(64.1%)
Overall Rating:
Inadequate

Health information management is a crucial link in the delivery of medical care. Medical personnel require accurate information in order to make sound judgments and decisions. This indicator examines whether the institution adequately manages its health care information. This includes determining whether the information is correctly labeled and organized and available in the electronic medical record; whether the various medical records (internal and external, e.g., hospital and specialty reports and progress notes) are obtained and scanned timely into the patient's electronic medical record; whether records routed to clinicians include legible signatures or stamps; and whether hospital discharge reports include key elements and are timely reviewed by providers.

SAC had converted to the new electronic health record system (EHRS) in May 2017, after the testing period began; therefore, most testing occurred in the EHRS, with a smaller portion of the testing occurring in the electronic unit health record (eUHR).

Case Review Results

We reviewed 1,494 events and found 70 deficiencies related to health information management, 11 of which were significant. The case review rating for this indicator was *inadequate*.

Inter-Departmental Transmission

There were frequent failures by various medical departments to communicate vital information. Schedulers, pharmacy staff, and medication nurses did not properly send or receive important orders. These errors were more common when the staff used fax machines and in the first month of the EHRS transition:

- In case 1, the provider changed the administration route of several of the patient's medications from nurse-administered to self-administered. However, the patient never received his medications because the pharmacy never received the order.
- In case 10, the nurse intended to schedule a follow-up appointment for a patient who had an allergic reaction to an antibiotic. However, the schedulers did not make the appointment because they never received the order.
- In case 18, just before the institution transitioned to the EHRS, the provider ordered daily wound care for four days. This order did not correctly transfer to the EHRS, and the dressing changes were incorrectly ordered as twice weekly for a month. Later in the month, the nurse again ordered daily dressing changes. However, the nurse incorrectly entered the order, and the scheduler misinterpreted the order as a one-time-only order.

- In case 26, the provider ordered an antibiotic for a skin infection on a Friday afternoon. The nurse faxed the order that same afternoon to the pharmacy and the medication nurse. However, the patient did not receive the antibiotic. This error placed the patient at risk of worsening infection.

Hospital Records

SAC continued to perform well with the retrieval of emergency department physician and hospital discharge summaries, as it did in the last cycle. We reviewed 28 hospitalization and emergency department visits and found only one case in which the provider did not sign the hospital records.

Specialty Services

SAC managed specialists' reports poorly. As in the last cycle, staff scanned most specialty reports into the electronic unit health record (eUHR) before providers reviewed them. We discuss these findings in detail in the *Specialty Services* indicator.

Diagnostic Reports

SAC has room for improvement with diagnostic report processing. The providers signed diagnostic reports late in cases 1, 3, 11, 21, 86, 88, 90, and 92. We discuss these findings in detail in the *Diagnostic Services* indicator.

Urgent/Emergent Records

As in the previous cycle, SAC providers continued to perform inconsistenly when documenting TTA visits. Problems in this area occurred during regular work hours and after hours. We discuss these findings in the *Emergency Services* indicator.

Scanning Performance

We continued to find many mislabeled or misfiled documents, as in the last cycle. There were mislabeled documents in cases 1, 2, 5, 8, 9, 10, 11, 19, 20, 21, 22, 85, 86, 88, and 92. We identified misfiled documents in cases 20, 86 and the following cases:

- In case 25, staff misfiled the patient's emergency department report into a different patient's medical record. This error could have resulted in a significant lapse in medical care. If left uncorrected, this error could have led to additional mistakes.

- In case 26, staff misfiled part of the patient's emergency department report into a different patient's medical record.

We also identified missing records in cases 18, 19, 23, 27, 86, 88, 89, 90, and 92. The absence of important information from patients' medical records could have led to additional errors.

Legibility

Most staff dictated or typed their progress notes. Legibility at SAC was usually good, except for a few providers and nurses who had illegible handwriting.

Clinician Onsite Inspection

We observed clinical information transmission during the institution's morning huddles. SAC care teams used a standard huddle report agenda to distribute and discuss important after-hours clinical information during their morning huddles. Each care team displayed in-depth knowledge of their patients and their specific issues. Also, SAC conducted a separate provider quality improvement meeting to review patients transferred to the outside hospital and to determine if those transfers were appropriate.

Case Review Conclusion

SAC's performance in *Health Information Management* was variable. Compared to the previous cycle, the institution performed well with the retrieval of outside ED reports and hospital discharge summaries. The medical records department demonstrated timely but inaccurate scanning. Patients' electronic medical records frequently were missing important documents. Often, staff misfiled or mislabeled documents in the electronic medical records. Providers often failed to sign laboratory results and specialty reports. The providers also did not consistently document their TTA encounters or on-call encounters. Overall, SAC performed poorly in several important areas of the *Health Information Management* indicator. We rated this indicator as *inadequat*e.

Compliance Testing Results

The institution scored in the *inadequate* range with a compliance score of 64.1 percent in the *Health Information Management* indicator. The following tests received *inadequate* scores:

- Fourteen of 20 specialty service consultant reports sampled (70.0 percent), were scanned into the patients' electronic health records within five calendar days. Four documents were scanned from 1 to 12 days late. Two documents were scanned 21 and 67 days late (MIT 4.003).

- SAC received a score of zero on labeling and filing of documents scanned into patients' electronic health records. For this test, once the OIG identifies 24 mislabeled or misfiled documents, we deduct the maximum points, resulting in a zero for this test (MIT 4.006).

- Among 25 sampled patients admitted to a community hospital and then returned to the institution, SAC's providers timely reviewed 16 corresponding hospital discharge reports within three calendar days of the patient's discharge (64.0 percent). For six patients, providers reviewed their hospital discharge reports one to four days late. For two patients, the institution did not attempt to obtain missing key information on the

hospital discharge reports. For one remaining patient, the provider did not review his hospital discharge report (MIT 4.007).

Two tests received *proficient* scores:

- The institution timely scanned 11 of 12 sampled non-dictated health care documents into patients' electronic medical records (91.7 percent). One health care services request form was scanned six days late (MIT 4.001).
- The institution's medical records staff timely scanned patients' discharge records into 19 of the 20 sampled patients' electronic medical records (95.0 percent); staff scanned one record one day late (MIT 4.004).

5 — *HEALTH CARE ENVIRONMENT*

This indicator addresses the general operational aspects of the institution's clinics, including certain elements of infection control and sanitation, medical supplies and equipment management, the availability of both auditory and visual privacy for patient visits, and the sufficiency of facility infrastructure to conduct comprehensive medical examinations. The OIG rates this component entirely on the compliance testing results from the visual observations inspectors make at the institution during their onsite visit. There is no case review portion.

Case Review Rating:
Not Applicable
Compliance Score:
Adequate
(80.1%)
Overall Rating:
Adequate

Compliance Testing Results

The institution received an *adequate* compliance score of 80.1 percent in the Health Care Environment indicator, with several tests scoring in the *proficient* range:

- Staff appropriately cleaned, disinfected, and sanitized 19 of 21 clinics (90.5 percent). In one clinic, inspectors found accumulated grime on the exam floor. In another clinic, we found dust build-up on the surface of the medical gurney (MIT 5.101).
- Clinical health care staff at 19 of the 21 applicable clinics (90.5 percent) ensured that reusable invasive and non-invasive medical equipment was properly sterilized or disinfected. One clinic did not have appropriate sterilization safeguards for invasive medical equipment. In another clinic, when describing their daily protocol, staff did not include disinfecting the examination table prior to their shift (MIT 5.102).
- Nineteen of the 21 clinic locations inspected (90.5 percent) had operable sinks and sufficient quantities of hand hygiene supplies in the exam areas. In two clinics, the patient restroom did not have sufficient quantities of antiseptic soap (MIT 5.103).
- Health care staff at all 21 clinics followed proper protocols to mitigate exposure to blood-borne pathogens and contaminated waste (MIT 5.105).
- The non-clinic bulk medical supply storage areas met the supply management needs of the medical health care program; SAC earned a score of 100.0 percent on this test (MIT 5.106).
- Twenty of the 21 clinics (95.2 percent) followed appropriate medical supply storage and management protocols. In one clinic, the inventory replenishment system did not ensure the clinic was stocked or restocked on a regular basis, and several medical supplies were expired. (MIT 5.107).

- Clinic common areas had an environment conducive to providing medical services in 19 of the 21 clinics (90.5 percent). Two clinics did not have wheelchair access (MIT 5.109).

One test received an *adequate* score:

- We examined emergency medical response bags (EMRBs) to determine if the institution's staff inspected the bags daily, inventoried them monthly, and whether the bags contained all essential items. EMRBs were compliant in 11 of the 13 applicable clinical locations (84.6 percent). In one location, the bag's log was missing an entry to verify compartments were sealed and intact. In another location, the crash cart did not have the minimum levels of medical supplies required (MIT 5.111).

Three tests received *inadequate* scores:

- Clinicians followed proper hand hygiene practices in 12 of the 21 clinics observed (57.1 percent). At nine clinic locations, clinicians failed to wash their hands before or after patient contact or before applying gloves (MIT 5.104).

- Only 12 of 21 clinic locations (57.1 percent) met compliance requirements for essential core medical equipment and supplies. The remaining nine clinics were missing one or more functional pieces of properly calibrated core equipment or other medical supplies necessary to conduct a comprehensive exam. The missing items included a medication refrigerator and hemoccult developers. The expired items included defibrillator pads (MIT 5.108) (*Figure 1*).

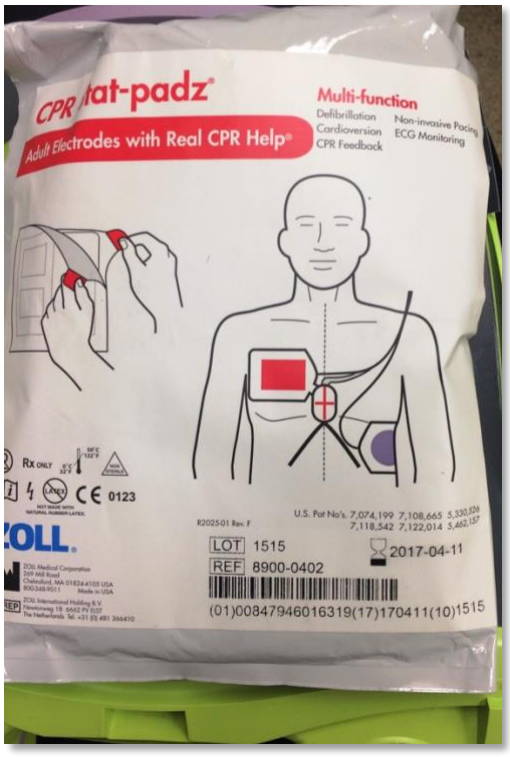

Figure 1: Expired defibrillator pads.

- Only 5 of the 20 clinic exam rooms (25.0 percent) had appropriate space, configuration, supplies, and equipment to allow clinicians to perform a proper clinical examination. In 15 clinics, inspectors identified one or more deficiencies: patients were unable to lie fully extended on the exam table due to physical obstructions; exam tables had torn vinyl covers; exam rooms did not provide auditory privacy; and confidential medical records were not shredded on a daily basis (MIT 5.110).

Non-Scored Results

The OIG gathered information to determine if the institution's physical infrastructure was maintained in a manner that supported health care management's ability to provide timely or adequate health care. We do not score this question. When we interviewed health care managers, they did not have concerns about the facility's infrastructure or its effect on the staff's ability to provide adequate health care. However, as noted below, the institution had three infrastructure projects underway, which management staff felt would improve the delivery of care at SAC. The following projects started in the summer of 2015, and the institution estimated that they would be complete by the end of summer 2018 (MIT 5.999):

- Project A: Construction of a new Psychiatric Segregation Unit – Administrative Segregation Unit (PSU-ASU) primary care clinic.
- Project B: Renovation of existing general population primary care building.
- Project C: Construction of a new central health services building.

6 — *INTER- AND INTRA-SYSTEM TRANSFERS*

Case Review Rating:
Inadequate
Compliance Score:
Inadequate
(59.9%)

Overall Rating:
Inadequate

This indicator focuses on the management of patients' medical needs and continuity of patient care during the inter- and intra-facility transfer process. The patients reviewed for this indicator include those received from, as well as those transferring out to, other CDCR institutions. The OIG review includes evaluation of the institution's ability to provide and document health screening assessments, initiation of relevant referrals based on patient needs, and the continuity of medication delivery to patients arriving from another institution. For those patients, the OIG clinicians also review the timely completion of pending health appointments, tests, and requests for specialty services. For patients who transfer out of the institution, the OIG evaluates the ability of the institution to document transfer information that includes pre-existing health conditions, pending appointments, tests and requests for specialty services, medication transfer packages, and medication administration prior to transfer. The OIG clinicians also evaluate the care provided to patients returning to the institution from an outside hospital and check to ensure the appropriate implementation of the hospital assessment and treatment plans.

Case Review Results

We reviewed 63 inter- and intra-system transfer events. These included 26 hospitalizations and outside emergency room visits, 23 of which resulted in a transfer back to the institution. We identified 32 deficiencies, 16 of which were significant. The case review rating for this indicator was *inadequate*.

Transfers In

We reviewed eight cases in which patients transferred to SAC from another institution. Compared to the previous cycle, nurses performed better with the transfer-in process; nurses assessed newly-arrived patients appropriately and intervened correctly. Nonetheless, SAC continued to have problems ensuring these patients saw a nurse or a provider timely:

- In case 25, the patient had high blood pressure and recurrent chest pain. The receiving and release clinic (R&R) nurse requested a next-day follow-up appointment with another nurse and a seven-day appointment with a provider for the newly-arrived patient. The nurse follow-up appointment did not occur. The provider follow-up appointment was not scheduled until yet another nurse noticed there was no provider follow-up scheduled.

- In case 33, the nurse requested a provider appointment for the new patient, who had multiple chronic conditions. The patient should have been seen within two weeks but the provider did not see him until two months after arrival.

Transfers Out

We reviewed five cases in which patients transferred to another CDCR institution. SAC did not properly prepare patients for transfer:

- In cases 23 and 25, SAC transferred two patients without essential medications.
- In case 36, the R&R nurses did not record the patient's medical equipment. SAC nurses should have informed the receiving institution about the medical equipment to ensure the patient's safety and to promote continuity of medical care.

Hospitalizations

Patients returning from hospitalizations are some of the highest-risk encounters due to two factors. First, these patients usually require hospitalization for a severe illness or injury. Second, they are at risk due to potential lapses in continuity of care that can occur during any transfer.

We reviewed 26 cases, yielding 39 events in which patients returned from a hospital or outside emergency department. We identified 23 deficiencies, 12 of which were significant. SAC nurses performed poorly evaluating patients who were returning from the hospital or emergency room. We found a strong pattern of substandard nursing performance in these cases. Nurses failed to notify providers of important hospital recommendations that required immediate provider attention, such as changes to the patient's regular medications. Also, nurses failed to review patients' records thoroughly and did not identify their patients' healthcare needs:

- In case 1, the nurse did not inform the provider of the hospital's recommendation that the patient receive an ophthalmology follow-up appointment within two days. Fortunately, a provider reviewed the hospital's recommendation the following day, mitigating the nurse's error.
- In case 11, the nurse did not thoroughly review the hospital discharge orders when the patient returned to the institution. As a result, the nurse did not inform the provider of the recommended discharge medications and the on-call provider did not order them.
- In case 21, the nurse did not inform the provider of the hospital's recommendation to decrease the patient's insulin dose. As a result, the patient's insulin dose was not adjusted for two months. This resulted in the patient experiencing unnecessary episodes of hypoglycemia (low blood sugar level) and increased the patient's risk of falling and having a seizure.
- In case 25, the nurse entered a telephone order for ranolazine (a medication for chest pain) but did not recognize there was already an active order. The patient received multiple doses of the same medication for several days.

- In case 92, the patient had a stroke which caused weakness in half of his body. The utilization management nurse failed to anticipate the patient's rehabilitation needs and did not arrange for physical, speech, or occupational therapy when the patient returned from the hospital.

The nurses also failed to assess their patients' conditions in the following cases:

- In case 11, the patient had a craniotomy (a surgical opening of the skull). The nurse failed to examine the surgical site or evaluate the patient's mental status.
- In case 20, the patient had deep vein thrombosis (a blood clot in a deep vein) in his lower extremity. The nurse failed to assess the patient's affected leg.
- In case 25, the patient returned from the emergency department for bleeding at his incision site from his spinal surgery. The nurse failed to check his surgical site.
- In case 86, staff sent the patient to an emergency department for altered mental status. When he returned, the nurse failed to reassess the patient's mental status.

As in the previous cycle, SAC continued to have problems ensuring medication continuity for patients returning from an outside hospital.

- In case 11, the patient had a craniotomy at an outside hospital. He returned to the institution with hospital recommendations for critical medications to decrease the brain swelling and to prevent other side effects. However, the nurse failed to obtain any of these medications from the after-hours medication cabinet to ensure timely administration to the patient.
- In case 20, the patient returned from the hospital with recommendations for a blood thinning medication to treat a blood clot in his leg. The nurse ordered the medication correctly, but staff failed to administer the medication to the patient the following day. This break in medication continuity increased the patient's risk of developing a pulmonary embolism (a potentially fatal blood clot in the lung) and other complications from the blood clot.
- In case 26, the patient returned from the hospital with recommendations for an antibiotic medication to treat his cellulitis (a skin infection). The nurse did not obtain the medication from the after-hours medication cabinet and failed to contact the on-call pharmacist. The institution did not administer the medication until three days later, increasing the patient's risk of a worsening infection and other complications.

Case Review Conclusion

SAC had difficulty providing timely access for newly-arrived patients. Also, the institution sent patients to other institutions without the correct medications. The nurses performed extremely poorly assessing their patients who returned from the hospital. Also, nurses did not accurately follow hospital recommendations or ensure medication continuity. These errors increased SAC patients' risk of harm, and we rated this indicator *inadequate.*

Compliance Testing Results

The institution scored in the *inadequate* range for this indicator, with a compliance score of 59.9 percent. The following three tests earned scores in the *inadequate* range:

- Of the 25 sampled patients who transferred into SAC, 21 had existing medication orders that required nursing staff to issue or administer medications upon their arrival. Eleven of these 21 patients (52.4 percent) received their medications without interruption. Ten patients incurred medication interruptions of one or more dosing periods upon arrival (MIT 6.003).

- We sampled 20 patients who transferred out of SAC to another CDCR institution to determine whether SAC identified scheduled specialty service appointments on the patients' health care transfer forms. Nursing staff correctly listed pending specialty service appointments for 11 of the 20 patients (55.0 percent). Staff failed to list six patients' pending specialty services, and for three patients, no transfer form was found (MIT 6.004).

- We inspected the transfer packages of six applicable patients who transferred out of SAC during the onsite inspection to determine whether they included required medications and related documentation. All transfer packages were missing medication administration records, resulting in a score of zero for this test (MIT 6.101).

Two tests received scores in the *proficient* range:

- We tested 25 patients who transferred into SAC from other CDCR institutions to determine whether nursing staff completed an Initial Health Screening form (CDCR Form 7277) on the same day patients arrived. Although nursing staff timely prepared the screening forms, they neglected to answer all applicable questions for two patients, resulting in a score of 92.0 percent for this test (MIT 6.001).

- Nursing staff timely completed the assessment and disposition sections of the screening forms for all 24 applicable patients who transferred into SAC (MIT 6.002).

7 — *PHARMACY AND MEDICATION MANAGEMENT*

Case Review Rating:
Inadequate
Compliance Score:
Inadequate
(66.2%)

Overall Rating:
Inadequate

This indicator is an evaluation of the institution's ability to provide appropriate pharmaceutical administration and security management, encompassing the process from the written prescription to the administration of the medication. By combining both a quantitative compliance test with case review analysis, this assessment identifies issues in various stages of the medication management process, including ordering and prescribing, transcribing and verifying, dispensing and delivering, administering, and documenting and reporting. Because numerous entities across various departments affect medication management, this assessment considers internal review and approval processes, pharmacy, nursing, health information systems, custody processes, and actions taken by the prescriber, staff, and patient.

Case Review Results

We evaluated 122 events related to medications and found 60 deficiencies, 36 of which were significant. Significant deficiencies occurred in cases 1, 3, 10, 11, 14, 18, 19, 20, 21, 22, 23, 25, 26, 29, 35, 88, and 89. We identified gaps in medication continuity, nursing delays in medication delivery, and pharmacy dispensing errors. The case review rating for this indicator was *inadequate.*

Medication Continuity

Medication continuity at SAC was extensively problematic because of lapses in communication between the pharmacists, nurses, and providers. As a result, patients did not consistently receive their monthly chronic care medications. We also identified a pattern of delayed medication dispensing:

- In case 1, the patient's glaucoma medication had expired over the weekend. The medication nurse sent a message to the on-call provider to renew this medication. However, the provider did not review this message timely and did not renew the medication until three days later.
- In case 20, the pharmacy rejected a provider order for eplerenone (a blood pressure medication) because of a drug interaction with spironolactone (another blood pressure medication). However, the pharmacist was in error because the patient was never prescribed spironolactone. Furthermore, the pharmacist never notified the provider that eplerenone was rejected.
- In case 22, the patient submitted four separate requests to renew his Tylenol in one month. SAC did not deliver the patient's Tylenol until early the following month, almost a month after the patient's initial request.

- Also in case 22, the nurse failed to dispense the patient's monthly supply of aspirin and two blood pressure medications for 25 days. Consequently, the patient went without his essential medications for nearly one month, which increased his risk of heart disease and other complications.

- Again in case 22, the patient was prescribed vitamins as a treatment for degenerative eye disease and to preserve his vision. The nurses dispensed the patient's prescription 20 days late.

Medication continuity was also a significant problem for patients transferring out of SAC to other institutions:

- In case 23, the transfer nurse failed to send the patient's rescue inhaler to the receiving institution. Without this inhaler, the patient would be unable to treat an asthma attack.

Medication Administration

We also found frequent errors with nursing medication administration. The nurses often continued to administer medications after the provider either discontinued or ordered nurses to hold the medication. Also, the nurses failed to complete refusal forms when patients refused their nurse-administered medications. We identified these deficiencies in cases 18, 20, 24, 26, 85, and the following cases**:**

- In case 1, the medication nurse did not administer the full dose of the patient's glaucoma medication and failed to document why this error occurred.

- Also in case 1, the provider stopped the patient's glaucoma medication, but the medication nurse continued to administer the medication.

- Again in case 1, the provider gave two separate orders to hold the patient's aspirin after he had eye surgery. Despite these orders, the nurse continued to give the patient his medication for two days after he returned to the institution. This medication error increased the patient's risk of developing surgical complications, such as bleeding.

- In case 3, the nurse failed to dispense the patient's medication for prostate enlargement for an entire month.

- Also in case 3, the nurse failed to administer the full dose of the patient's nortriptyline (a neuropathic pain medication) and failed to document why this error occurred.

- Again in case 3, the nurse recorded administering the patient's cancer medication but also recorded that the patient refused the same medication. Further investigation showed that the medication was not available during that time. This nursing error created an inaccurate medical record that could have led to additional complications.

- In case 10, the nurse erroneously provided the patient with a month's supply of propranolol (a medication for liver disease) to take himself. Unfortunately, the nurse did not recognize that the patient already had a duplicate prescription which the medication line nurses were administering. Consequently, the patient began to take twice the prescribed dosage of the medication, which significantly increased his risk of developing severe hypotension (an abnormally low blood pressure) and bradycardia (an abnormally slow heart rate).

We also found that in addition to erroneously administering medications, nurses also often failed to give medications when they should have:

- In case 12, the medication nurse failed to administer the patient's Lovenox (a blood thinner) for two days. This failure significantly increased the patient's risk of developing blood clot complications, such as a stroke, a pulmonary embolism (a blood clot in the lung), or cardiac arrest.

- In case 14, the nurses did not give the patient his warfarin (another blood thinner) on two separate occasions. This failure significantly increased the patient's risk of developing blood clot complications.

- In case 26, the provider ordered an antibiotic to treat a skin infection on the patient's leg. Staff faxed the order to both the pharmacy and the medication nurse. However, the nurses did not administer the antibiotic immediately and missed 11 doses of the medication.

- In case 49, the provider ordered a medication for the patient's hip pain to start the following day. The patient received the medication three days after the intended start date.

Pharmacy Errors

SAC's pharmacy delivery system contributed to gaps in treatment, errors in medication administration, failures to consistently identify duplicate orders, over-administration of medications, and potential overdose:

- In case 1, the pharmacist misread the provider's order and discontinued the aspirin prescription instead of renewing the medication.

- In case 18, the pharmacy was unprepared to supply the patient's medication to treat multiple sclerosis (a disease of the central nervous system). The institution was unable to dispense the medication promptly.

- In case 21, the pharmacist informed the OIG clinicians that the SAC pharmacy dispensed a topical antibiotic medication, even though the medication was out of stock. The patient did not receive the medication for seven days.

- In case 25, the pharmacy erroneously dispensed hydroxyzine (an antihistamine) instead of the hydralazine (a blood pressure medication) the provider prescribed.

- Also in case 25, the pharmacy dispensed the patient's atorvastatin (a cholesterol medication), carvedilol (a heart medication), hydrochlorothiazide and diltiazem (blood pressure medications) twice in the same month. The duplicate delivery of these medications increased the patient's risk of overdose.

- Again in case 25, the pharmacy failed to recognize an order for Ranexa (a medication for chest pain) as a duplicate order. Consequently, the patient received double the amount of this medication for more than ten days.

Clinician Onsite Inspection

The institution's staff said most deficiencies occurred because many of the medication orders were faxed to the pharmacy and lost before SAC transitioned to the EHRS in May of 2017. The pharmacist explained that when staff sent multiple orders to the pharmacy at the same time, some of the orders were not received. The transition to the EHRS also complicated the pharmacy processes and contributed to pharmacy errors. According to the SAC's supervisors, some of the deficiencies that occurred after the EHRS implementation were due to the medication nurses not clearing their tasks from the EHRS correctly. When this occurred, the EHRS may have prompted nurses to administer medications another nurse had already administered, resulting in duplicate medication administration. The supervisors also claimed if staff did not clear tasks correctly in the EHRS, the error could also prevent the EHRS from prompting the nurses to administer medications at the patient's next scheduled dosing. The SAC supervisors said they were aware of these issues with the EHRS before our onsite inspection and already implemented training to reduce these preventable errors.

Case Review Conclusion

SAC had significant problems with medication continuity, inconsistent medication administration, delays with dispensing medications, and failures to properly identify duplicate orders resulting in the excessive administration of medications. Overall, SAC performed poorly in the *Pharmacy and Medication Management* indicator. We rated this indicator as *inadequate*.

Compliance Testing Results

The institution received an *inadequate* compliance score of 66.2 percent in the *Pharmacy and Medication Management* indicator. For discussion purposes, we divide this indicator into three sub-indicators: medication administration, observed medication practices, and storage controls, and pharmacy protocols.

Medication Administration

For this sub-indicator, the institution received an *inadequate* compliance score of 52.7 percent. The following three tests earned *inadequate* scores:

- SAC administered chronic care medications timely to 11 of the 21 applicable patients sampled (52.4 percent). Five patients did not receive appropriate counseling for missed doses. For three patients, the nursing staff did not provide their ordered keep-on-person (KOP) medications for 30 or more days. Nursing staff did not refill another patient's KOP medication prior to exhaustion. For one remaining patient, nursing staff administered a medication that was not scheduled to be given (MIT 7.001).

- SAC timely provided hospital discharge medications to 8 of 25 patients sampled (32.0 percent). Nine patients received their medications from one to seven days late. For eight remaining patients, there was no evidence that they received or refused their medications (MIT 7.003).

- Nursing staff administered medications without interruption to only one of the nine patients (11.1 percent) who were on the way from one institution to another and had a temporary layover at SAC. For the other eight patients, there was no evidence that nursing staff administered the patients' medications (MIT 7.006).

Two tests earned scores in the *adequate* range:

- SAC timely administered or delivered newly prescribed medication to 21 of the 25 patients sampled (84.0 percent). Two patients received their medications one and eight days late. There was no evidence that two other patients received or refused their medications (MIT 7.002).

- SAC ensured that 21 of the 25 sampled patients who transferred from one housing unit to another (84.0 percent) received their prescribed medications without interruption. Four patients did not receive one or more doses of their medications at the next dosing interval after the transfer occurred (MIT 7.005).

Observed Medication Practices and Storage Controls

The institution received an *inadequate* compliance score of 74.6 percent in this sub-indicator, with the following two tests scoring in the *inadequate* range:

- We observed the medication preparation and administration processes at eight applicable medication line locations. The nursing staff was compliant with proper hand hygiene and contamination control protocols at five locations (62.5 percent). At three other locations, not all nursing staff washed or sanitized their hands before reapplying gloves (MIT 7.104).

- Only two of eight inspected medication preparation and administration areas demonstrated appropriate administrative controls and protocols (25.0 percent). At six other locations, one or more of the following deficiencies occurred: the medication nurse did not always ensure that patients swallowed directly observed therapy (DOT) medications; the medication nurse did not always verify patients' identities through a picture form of identification; the medication nurse could not verbalize the appropriate process for reporting medication errors; and the medication nurse did not appropriately administer medication as ordered by the provider (MIT 7.106).

One test received an *adequate* score:

- SAC safely stored non-refrigerated, non-narcotic medications in 15 of the 19 applicable clinics and medication line storage locations (79.0 percent). In three locations, oral and topical medications were not properly separated when stored. In one other location, multi-use medication was not labeled with the date it was opened (MIT 7.102).

Three tests received *proficient* scores:

- SAC had strong security controls over narcotic medications in each of the 13 applicable clinics and medication line storage locations. As a result, the institution scored 100.0 percent on this test (MIT 7.101).

- SAC safely stored refrigerated, non-narcotic medications in 15 of 16 applicable clinics and medication line storage locations (93.8 percent). In one location, although there was a bin designated for refrigerated return-to-pharmacy medications, there was no process in place to return refrigerated medications to the pharmacy (MIT 7.103).

- Nursing staff at seven of eight inspected medication line locations (87.5 percent) employed proper administrative controls and protocols during medication preparation. In one location, there was no system to verify the accuracy of newly received medications through reconciling medications with the physician's orders (MIT 7.105).

Pharmacy Protocols

SAC scored in the *inadequate* range with a compliance score of 69.6 percent in this sub-indicator. The following two tests scored in the *inadequate* range:

- The institution's pharmacist in charge (PIC) did not properly account for narcotic medications stored in SAC's pharmacy or review monthly inventories of controlled substances in the institution's clinics and medication line storage locations. Also, the pharmacy staff responsible for inspecting medication areas did not record their findings on the Medication Area Inspection Checklist (CDCR Form 7477). As a result, SAC received a score of zero on this test (MIT 7.110).

- The institution's PIC followed required protocols for 12 of the 25 medication error reports and monthly statistical reports reviewed (48.0 percent). Monthly medication error statistical reports for January 2017 and March 2017 were submitted to the chief of pharmacy services one and four business days late, accounting for ten of the untimely reports. In addition, for two of these ten untimely reports, the PIC completed the medication error follow-up forms 1 and 25 business days late. For three other reports, the PIC completed the medication error follow-up forms 2 to 51 business days late (MIT 7.111).

The following three tests earned *proficient* scores:

- SAC's main pharmacy followed general security, organization, and cleanliness management protocols. In addition, the institution properly stored both non-refrigerated and refrigerated medications (MIT 7.107, 7.108, 7.109).

Non-Scored Tests

- In addition to our testing of reported medication errors, we follow up on any significant medication errors found during compliance testing to determine whether SAC properly identified and reported the errors. We provide those results for information purposes only. We did not find any applicable medication errors at SAC (MIT 7.998).

- We interviewed patients housed in isolation units to determine if they had immediate access to their prescribed rescue inhalers and nitroglycerin medications. Fifteen of the 17 applicable patients reported they had access to their rescue medications. Two patients reported they had exhausted their inhalers but did not inform clinical staff. The OIG inspectors notified the CEO and SAC took timely action to replace the inhaler for one patient. The other patient's rescue inhaler was changed to DOT medication for safety concerns (MIT 7.999).

8 — *PRENATAL AND POST-DELIVERY SERVICES*

This indicator evaluates the institution's capacity to provide timely and appropriate prenatal, delivery, and postnatal services to pregnant patients. This includes the ordering and monitoring of indicated screening tests, follow-up visits, referrals to higher levels of care, e.g., high-risk obstetrics clinic, when necessary, and postnatal follow-up.

As SAC does not have female patients, this indicator does not apply.

Case Review Rating:
Not Applicable
Compliance Score:
Not Applicable
Overall Rating:
Not Applicable

9 — *PREVENTIVE SERVICES*

This indicator assesses whether the institution offered or provided various preventive medical services to patients. These include cancer screenings, tuberculosis screenings, and influenza and chronic care immunizations. This indicator also assesses whether certain institutions take preventive actions to relocate patients identified as being at higher risk for contracting coccidioidomycosis (valley fever).

Case Review Rating:
Not Applicable
Compliance Score:
Inadequate
(65.5%)
Overall Rating:
Inadequate

The OIG rates this indicator entirely through the compliance testing component; the case review process does not include a separate qualitative analysis for this indicator.

Compliance Testing Results

The institution scored in the *inadequate* range for this indicator at 65.5 percent. The following four tests were in the *inadequate* range:

- We examined the health care records of all seven patients who were on tuberculosis (TB) medications during the inspection period. Only three of the seven patients received all their required doses of TB medications (42.9 percent). SAC failed to provide the required doses of TB medications to four patients. These four patients missed one or more scheduled doses and did not receive timely provider counseling for missed doses (MIT 9.001).

- SAC scored poorly in monitoring patients on TB medications. Only two of the seven patients receiving TB medication were properly monitored (28.6 percent). For five other patients, SAC either failed to complete monitoring at all required intervals, to document weight monitoring, or to scan monitoring forms into the patient's electronic medical record timely (MIT 9.002).

- We sampled 30 patients at SAC to determine whether they received a TB screening within the last year and during the month of their birth. SAC timely screened 18 of the 30 sampled patients (60.0 percent). Although the remaining 12 patients did receive TB screenings within the last year, their screenings did not occur during their birth month (MIT 9.003).

- We tested whether the institution offered vaccinations for influenza, pneumonia, and hepatitis to patients who suffered from chronic care conditions; 11 of the 15 sampled patients (73.3 percent) received the required vaccinations. For four patients, there was no evidence they received or refused the pneumococcal immunization within the last five years (MIT 9.008).

Two tests received *proficient* scores:

- SAC offered annual influenza vaccinations to 24 of the 25 sampled patients (96.0 percent) subject to the annual screening requirement. For one patient, there was no evidence the patient received or refused the vaccination within the most recent influenza season (MIT 9.004).
- SAC offered colorectal cancer screenings to 23 of the 25 sampled patients subject to the annual screening requirement (92.0 percent). Two patients did not have normal colonoscopies within the last ten years and were not offered colorectal cancer screenings within the previous 12 months (MIT 9.005).

10 — *QUALITY OF NURSING PERFORMANCE*

Case Review Rating:
Inadequate
Compliance Score:
Not Applicable

Overall Rating:
Inadequate

The *Quality of Nursing Performance* indicator is a qualitative evaluation of the institution's nursing services. The evaluation is completed entirely by OIG nursing clinicians within the case review process and does not have a score under the OIG compliance testing component. Case reviews include face-to-face encounters and indirect activities performed by nursing staff on behalf of the patient. Review of nursing performance includes all nursing services performed onsite, such as outpatient, inpatient, urgent/emergent, patient transfers, care coordination, and medication management. The key focus areas for evaluation of nursing care include appropriateness and timeliness of patient triage and assessment, identification and prioritization of health care needs, use of the nursing process to implement interventions, and accurate, thorough, and legible documentation. Although the OIG reports nursing services provided in specialized medical housing units in the *Specialized Medical Housing* indicator, and those provided in TTA or related to emergency medical responses in the *Emergency Services* indicator, this *Quality of Nursing Performance* indicator summarizes all areas of nursing services.

Case Review Results

We reviewed 444 nursing encounters, 225 of which were in the outpatient setting. Most outpatient nursing encounters were for sick call requests, walk-in visits, and RN follow-up visits. In all, we found 183 deficiencies related to nursing care performance, 39 of which were significant. Compared to the previous cycle, SAC improved in some nursing areas, but some patterns of deficiencies continued in the current cycle. The case review rating for this indicator was *inadequate*.

Nursing Assessment

Nurses base their assessment on the information they collect through the interview, medical record review, and physical examination as it pertains to the patient's symptoms. Inaccurate or incomplete data collection or examination can lead to an incorrect diagnosis or inappropriate treatment. SAC nurses performed inadequate assessments across various areas of nursing services. They failed to perform assessments based on the patient's presenting problems. Some nurses failed to recheck abnormal vital signs, including elevated blood pressure and heart rate, or to reevaluate the patient's condition after providing treatment. We listed several of these cases in the *Emergency Services, Inter- and Intra-System Transfers,* and *Specialized Medical Housing* indicators. The following are additional examples of nursing assessment deficiencies:

- In case 20, the patient had leg swelling and shortness of breath. The nurse did not listen to the patient's lungs, assess the patient's leg swelling, or measure the patient's pulse rate, blood pressure, or weight. After the patient received Lasix (a diuretic), the nurse

failed to reassess the patient to determine if the medication had the desired effect. On another occasion, the LVN reported the patient's complaints of nausea, chills, and diarrhea to the clinic RN. The RN did not assess the patient and ignored the complaints.

- In case 56, the patient had a headache. The nurse did not ask the patient about important symptoms such as frequency, severity, and location of the headache. Also, the nurse did not check for critically related symptoms such as nausea or light sensitivity or inquire about precipitating factors that triggered the headache.

- In case 66, the patient reported passing blood in his stool. The nurse did not obtain vital signs or ask basic questions such as how frequent the symptoms were or how much bleeding the patient was having.

- In case 73, the patient complained of constant aching pain in his lungs and joints. The nurse did not check the patient's chest wall for tenderness, evaluate the patient's joints, or ask if his lung pain worsened with breathing.

Nursing Intervention

SAC nurses struggled with recognizing the need for appropriate and timely intervention. The nurses frequently failed to inform the provider regarding their patient's medical condition, request appropriate provider follow-up appointments, communicate instructions from the specialist or hospital, or implement orders correctly. We described details regarding these deficiency patterns in the *Inter- and Intra-System Transfers, Specialty Services, Emergency Services*, and *Specialized Medical Housing* indicators. The following are additional examples of inadequate nursing intervention:

- In case 3, the nurse discovered the patient's provider follow-up appointment did not occur after he returned from the outside emergency department. The nurse still failed to schedule an earlier appointment for the patient, causing a further delay in his medical care.

- In case 11, the nurse palpated a mass in the patient's abdomen but did not report this important clinical finding to the provider.

- In case 25, the provider ordered the nurse to monitor the patient's blood pressure twice a week. However, the nurse failed to perform the monitoring.

- In case 57, the patient reported headaches and a "racing heart" following a change in his medication. The nurse failed to inform the provider of the patient's complaints.

Nursing Documentation

The nurses' incomplete documentation created gaps in patients' medical records, while erroneous, inaccurate documentation increased the risk of medical errors. SAC nurses had

difficulty recording essential information such as their clinical findings, what nursing care they provided, and accurate emergency response timelines. These deficiencies were common in the outpatient clinics, specialized medical housing units, and the TTA. We cited some of these deficiencies in the *Emergency Services* and *Specialized Medical Housing* indicators.

The nurses recorded erroneous information in patients' medical records. We identified inaccurate nurse findings in cases 2, 3, 9, 21, 26, 37, 56, 69, 70, 73, 75, 76, 86, 89, and 92. Nurses also did not always complete the required form when patients refused medical care or appointments; this occurred in cases 2, 11, 18, 25, 26, 49, and 90.

Wound Care

We reviewed six cases in which providers ordered wound care (cases 11, 18, 19, 21, 25, and 26). The nurses did not perform thorough assessments and failed to change wound dressings as frequently as the provider ordered. We found these deficiencies in all the cases reviewed. Also, when nurses performed wound care, they often failed to record their care in the patient's medical record.

- In case 18, the patient's wound was still open and draining when the wound care order expired. The nurse did not notify or ask the provider to extend the wound care order.
- In case 25, the patient's surgical wound reopened and required hospitalization for treatment. When the patient returned to the institution, the nurse failed to contact the provider for a wound care order. Fortunately, the provider examined the patient the following day and wrote an order for daily dressing changes and mitigated the nurse's error.

Nursing Sick Call

We reviewed 142 sick call requests. SAC nurses had no difficulty reviewing sick call requests on the same day and scheduling RN sick call appointments. However, the nurses had problems recognizing patients with urgent, potentially dangerous symptoms that required an evaluation on the same day; nurses either failed to intervene properly or did not assess the patients at all. We found these deficiencies in cases 2, 14, 20, 22, 44, 76, 90, and in the following cases:

- In case 21, the patient had severe pain in his chest and rib areas and had fallen in the shower ten days before. The nurse did not assess the patient who may have sustained a significant injury. On another occasion, the same patient complained of shortness of breath, severe vomiting, and swelling in his lower extremities. The nurse did not assess the patient on the same day.
- In case 50, the patient had abdominal pain, nausea, weakness, and dark urine. The patient also complained of leg and back pain. The patient's symptoms could have signs

of a serious medical condition requiring urgent intervention. The nurse should have seen the patient on the same day but did not assess the patient until three days later.

- In case 65, the patient reported back and leg injury after he fell in the shower. The patient could have sustained a serious injury. The nurse should have evaluated the patient on the same day, but instead saw the patient three days later.

The nursing staff also performed unsatisfactory assessments during sick call encounters. We identified these errors in cases 21, 26, 39, 54, 60, 62, 67, 79, 80, and in the following cases:

- In case 1, the patient asked for a walking stick because of his poor vision. The nurse did not determine the patient's risk of falling or assess his ability to walk safely.

- In case 45, the diabetic patient reported lower extremity pain and swelling. The nurse did not examine the patient's legs for swelling or check the patient's feet for tingling, numbness, skin changes, or poor circulation.

- In case 56, the patient complained of headaches. The nurse did not ask for essential information such as frequency, characteristics and severity of the pain, accompanying symptoms, and current medications.

Care Management

The primary care nurses also served as RN care managers and were responsible for both episodic illnesses and care management. However, their actual responsibilities were limited to providing education before procedures, provision of durable medical equipment, and provider-ordered nurse follow-up appointments. While each main clinic had an RN care coordinator, only one nurse interacted with patients to provide education. In all the cases we reviewed, only one case had a true RN care management visit for chronic care management. We found scant evidence of effective RN care management, which should include a substantive review of the patient records, patient discussion, and care planning.

Urgent/Emergent Care

Compared to the previous cycle, SAC's nurses improved their emergency response times but continued to make inappropriate assessments and interventions. The institution's nurses also failed to record critical details of the emergency events such as event timelines or care provided to the patient. We discuss their performance further in the *Emergency Services* indicator.

Specialized Medical Housing

Nursing performance in the CTC and OHU has not improved since the previous medical inspection. In fact, we found additional patterns of deficiencies. New deficiency patterns include nurses' failures to inform providers when their patients refuse treatment or developed a change in

condition, and inappropriate nursing interventions. We describe these findings in the *Specialized Medical Housing* indicator.

Transfers and Hospital Returns

SAC nurses delivered poor care to patients that returned from the hospital. The nurses failed to review discharge instructions properly and did not notify the provider of recommended changes to patients' medications. Poor nursing care resulted in erroneous medication orders and missed medications. We discuss these findings further in the *Inter- and Intra- System Transfers* indicator.

Specialty Services

While the nurses sometimes provided sufficient care for patients returning from offsite specialty appointments, we identified several significant nursing deficiencies. We describe these findings in the *Specialty Services* indicator.

Medication Administration

We reviewed 121 nursing events related to medication and identified 43 deficiencies of nursing performance. As in the previous cycle, the institution continued to have problems with medication continuity and administration during this inspection. We discuss these findings further in the *Pharmacy and Medication Management* indicator.

Clinician Onsite Inspection

We observed the clinic huddles, which were organized and thorough. SAC transitioned to the EHRS in May of 2017. The nurses expressed satisfaction with the EHRS because it was easier than the old system and seemed to decrease medication errors. The CNE and DON were accessible and visible to their nursing staff. The nurses had good relationships with their immediate supervisors and praised their CNE and DON as effective leaders, committed to improving nursing performance.

We discussed some cases with the CNE, who provided in-depth responses to our questions. We asked for work improvement plans implemented since the previous medical inspection. The CNE described the changes and highlighted some of the ongoing nursing improvement projects. Nursing managers discussed cases in weekly nursing education sessions to improve nursing care and documentation issues. The nursing supervisors regularly audited nursing performance to check the quality of care in their areas. The CNE also initiated working groups to monitor medication and scheduling issues.

Case Review Conclusion

The nursing staff continued to perform poorly in nursing assessment, intervention, and documentation. While we saw some improvement in nursing performance in emergency response times and for patients newly-arrived at the institution, we did not see improvement in

most other nursing areas. Chronic care management was virtually nonexistent and was ineffective. We believe that the strong patterns of SAC nursing deficiencies placed patients at increased risk of harm. We rated this indicator as *inadequate*.

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11 — *QUALITY OF PROVIDER PERFORMANCE*

In this indicator, the OIG physicians provide a qualitative evaluation of the adequacy of provider care at the institution. The case review clinicians review the provider care regarding appropriate evaluation, diagnosis, and management plans for programs including, but not limited to, nursing sick call, chronic care programs, TTA, specialized medical housing, and specialty services.

OIG physicians alone assess provider care. There is no compliance testing component associated with this quality indicator.

Case Review Rating:
Inadequate
Compliance Score:
Not Applicable
Overall Rating:
Inadequate

Case Review Results

We reviewed 383 medical provider encounters and identified 120 deficiencies related to provider performance, 47 of which were significant. Overall, provider performance at SAC was poor. The case review rating for this indicator was *inadequate.*

Assessment and Decision-Making

The SAC providers consistently failed to make sound assessments or accurate diagnoses. Poor assessments and misdiagnoses frequently occurred throughout the cases we reviewed. Many providers made questionable decisions regarding patient care. We identified deficiencies in cases 1, 12, 17, 18, 19, 20, 26, 90, 92, and in the following cases:

- In case 10, the provider inappropriately discontinued a blood pressure medication that was also prescribed to prevent bleeding in a patient with liver cirrhosis (chronic liver damage).
- In case 20, the nurse sent a message informing the provider of the patient's weight gain, which was caused by fluid retention from his liver failure. The provider failed to evaluate the patient. The patient required hospitalization 11 days later because of his worsening fluid retention.
- In case 27, the provider ordered a positron emission tomography–computed tomography (PET/CT) scan for the patient who had multiple lung nodules, weight loss, and rib pain. The provider ordered the scan with routine priority (up to 90 days) but should have ordered the scan with urgent priority due to the concern for malignancy.

Review of Records

SAC providers did not sufficiently review patients' medical records. The providers performed a superficial review of medical records in cases 11, 16, 21, 25, 29, and the following cases:

- In case 12, the patient's blood thinner medication was about to expire. The provider mistakenly prescribed an increased dose of the medication to begin the very same day the prior prescription expired. On that day, the patient received both the expiring medication dose as well as the new medication dose. This error increased the patient's risk of developing a bleeding complication.

- In case 16, the provider failed to review the patient's laboratory results carefully. Therefore, he failed to recognize the patient had chronic kidney disease.

- In case 21, the provider failed to carefully review the hospital discharge recommendation to decrease the patient's insulin dose. The provider's error contributed to the patient developing several episodes of low blood sugar before the provider finally reduced his insulin dose. This error resulted in a significant lapse in the patient's medical care; the patient's low blood sugar levels could have caused a seizure or loss of consciousness.

- In case 29, the provider failed to prescribe the correct glaucoma medication to the patient on several occasions. The provider prescribed the incorrect medication for three months.

Unintentional Errors

The SAC providers frequently made unintentional errors. While the providers usually documented a plan of action, they often failed to implement the plan of action. We identified these errors in cases 24, 28, and the following cases:

- In case 17, the provider noted the patient had uncontrolled diabetes and planned to increase the dose of his metformin (diabetes medication) and to add a new medication. However, the provider never prescribed the new medication regimen. Furthermore, the provider saw the patient several weeks later in a follow-up appointment and erroneously documented the patient's metformin dose had been increased when in fact, the patient was still taking the same ineffective regimen that he had been on previously.

- In case 25, the provider discontinued the aspirin medication as recommended by the specialist. Later that same day, the provider erroneously renewed the prescription for aspirin despite having just stopped it a few hours before.

- In case 86, the provider documented a plan to order specific laboratory tests to evaluate the patient's bloody urine. However, the provider never actually ordered any of the tests.

Chronic Care

The SAC providers consistently failed to review their patients' chronic conditions thoroughly. We found problems in diabetes care in cases 1, 12, 15, 27, and the following cases:

- In case 17, the provider inexplicably stopped the patient's diabetic medication when his diabetes came under control. Without his medication, the patient's diabetes predictably went out of control again.

- Also in case 17, the provider failed to prescribe the recommended dose of the patient's cholesterol medication and failed to treat the patient's abnormally elevated blood pressure. These provider errors increased the patient's risk of developing cardiovascular complications such as a heart attack or stroke.

SAC utilized nurses to help monitor the anticoagulation levels in patients that were on warfarin (a blood-thinning medication). Anticoagulation management was effective except in the following case:

- In case 12, the patient had life-threatening blood clots in his leg and his lungs. When the patient continued to have low levels of warfarin (a blood thinner), the providers should have protected against blood clot complications by starting the patient on enoxaparin (a fast-acting blood thinner) when the patient continued to have low levels of warfarin (a slow-acting blood thinner). Failing to protect the patient with enoxaparin increased the patient's risk for developing potentially fatal blood clot complications.

The providers also failed to address chronic medical conditions during appointments designated for chronic care:

- In case 20, the provider saw the patient for a chronic care appointment. The provider failed to address the patient's chronic care issues, which included his liver cirrhosis.

- In case 28, the provider saw the patient for a chronic care appointment. The provider failed to address the patient's chronic care issues, which included hepatitis C (a chronic liver infection) and his chronic lung disease.

Specialty Services

The SAC providers appropriately referred patients to specialty services, but at times did not thoroughly review the specialists' recommendations. Please refer to the *Specialty Services* indicator for further details.

Emergency Care

SAC did not designate a TTA provider. Instead, each primary clinic provider was responsible for emergency patient care in each of the respectively designated clinics in addition to their regular clinic responsibilities. The provider care was sometimes problematic due to missing TTA documentation. Please refer to the *Emergency Services* indicator for further details.

Clinician Onsite Inspection

Our onsite interviews with the providers yielded little information about the rationale for their poor medical decisions because many of those providers had left their jobs before the onsite inspection. At the onsite inspection, five new providers had recently joined the institution; however, this review period did not sufficiently cover the care given by the new providers.

The providers present at the time of our inspection described their medical leaders as fair, consistent, and approachable. Some of the providers expressed concern that medical leadership was intentionally overbooking their schedules without considering the time needed for urgent patient walk-ins or medical emergencies. The providers claimed overbooking sometimes resulted in the rescheduling of patients. We identified a pattern where providers rescheduled their patients in cases 3, 22, and 28.

Case Review Conclusion

Overall, provider performance at SAC was poor. We found strong patterns of deficiencies in assessment and decision-making, superficial care, neglect of chronic conditions even during chronic care appointments, insufficient documentation of emergent and urgent patients, and cursory review of medical records. The SAC providers also did not ensure medication continuity as they failed to review each patient's medications and conditions thoroughly. Because of this poor performance, we rated this indicator *inadequate*.

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12 — *RECEPTION CENTER ARRIVALS*

Case Review Rating:
Not Applicable
Compliance Score:
Not Applicable
Overall Rating:
Not Applicable

This indicator focuses on the management of medical needs and continuity of care for patients arriving from outside the CDCR system. The OIG review includes evaluation of the ability of the institution to provide and document initial health screenings, initial health assessments, continuity of medications, and completion of required screening tests; address and provide significant accommodations for disabilities and health care appliance needs; and identify health care conditions needing treatment and monitoring. The patients reviewed for reception center cases are those received from non-CDCR facilities, such as county jails.

SAC does not have a reception center; therefore, this indicator does not apply.

13 — *SPECIALIZED MEDICAL HOUSING*

This indicator addresses whether the institution follows appropriate policies and procedures when admitting patients to onsite inpatient facilities, including completion of timely nursing and provider assessments. The chart review assesses all aspects of medical care related to these housing units, including quality of provider and nursing care. SAC's specialized medical housing units are the CTC and OHU.

Case Review Rating:
Inadequate
Compliance Score:
Proficient (100.0%)
Overall Rating:
Inadequate

For this indicator, the case review and compliance review processes yielded different results, with the case reviewers assigning an *inadequate* rating and the compliance testing resulting in a *proficient* score. The main reason for the *inadequate* case review rating was that the OHU and CTC providers and nurses demonstrated poor quality care that increased their patients' risk of harm. Furthermore, there were only four compliance tests which only minimally represented the quality of patient care. We determined that the overall rating for this indicator was *inadequate*.

Case Review Results

SAC's specialized medical housing unit had a 26-bed CTC, 2 of which were medical beds. The institution also had a 20-bed OHU. We reviewed seven CTC and OHU patients, which yielded 140 provider and 88 nursing events. We identified 95 deficiencies, 18 of which were significant. The case review rating for this indicator was *inadequate*.

Provider Performance

Provider care was poor in the specialized medical housing units. In two cases, the providers evaluated the patients late. Provider care was at times superficial and incomplete, even though patients housed in this area usually required in-depth medical care. The providers also failed to review patient charts thoroughly. As a result, providers were often unaware of patients' pending diagnostic studies, laboratory results, and current medications.

- In case 1, the provider failed to thoroughly review the patient's medication list and therefore, ordered a duplicate prescription for aspirin.
- In case 86, the provider did not sufficiently review the medical record and thus failed to treat the patient's irregular heart rhythm.
- In case 88, the provider failed to review the specialist's consultation and recommendations to remove a mass near the jaw. As a result, the patient's care lapsed.
- In case 90, the provider did not review the surgeon's recommendation to consult a subspecialist surgeon to evaluate the patient for liver cancer. This error resulted in a

delay of more than three weeks before a provider ordered the consultation with the subspecialist surgeon.

- Also in case 90, the provider did not review a magnetic resonance imaging (MRI) test for the patient's liver cancer. As a result, the provider further delayed the surgery to remove cancer.

- In case 92, the provider recorded on four separate occasions that the patient was taking a blood pressure medication the patient had not been prescribed.

SAC providers demonstrated poor decision-making in the following cases:

- In case 86, the provider ignored the oncologist's recommendations for a special liver CT scan with a short interval follow-up appointment. Instead, the provider ordered a laboratory test which had low sensitivity for detecting liver cancer. This inappropriate decision could have delayed the patient's cancer diagnosis and treatment.

- In case 90, the provider inappropriately ordered an urgent CT-guided biopsy of a mass that was suspicious for liver cancer. Liver cancers are often not biopsied due to the risk of the biopsy procedure spreading cancer and making the condition worse.

The providers also made errors unintentionally by not ordering planned tests as documented. These errors occurred in case 86 and 92.

The providers' documentation quality was poor. Providers cloned many notes, making it impossible to determine if patients had received medical care. We identified cloned notes in cases 1, 86, 88, and 92.

Nursing Performance

Nurses in the CTC and OHU performed poorly compared to the last inspection. The insufficient assessment was common and identified in cases 85, 86, 88, 89, and 90. This pattern included performing inadequate physical examinations and failing to ask patients about accompanying symptoms and severity of pain.

Also, the institution's nurses failed to inform the provider when the patient refused treatment or medication or had a change in condition. The nurses did not always follow provider orders or initiate nursing interventions when necessary. We identified these types of deficiencies in cases 89, 90, 92, and in the following cases:

- In case 1, the nurse failed to inform the physician of the patient's elevated pulse and blood pressure and low oxygen level.

- In case 85, the patient reported difficulty swallowing and tightness in his neck and throat, but the nurse failed to inform the provider of these symptoms.

- In case 86, the patient had a red and swollen eye, possibly the result of an unwitnessed fall. The nurse failed to notify the provider.

- In case 88, the nurse observed the patient holding onto the wall for support when he walked. The patient also reported increased weakness. The nurse failed to obtain a mobility device such as a walker to help the patient safely walk and prevent dangerous falls. The nurse also failed to inform the physician when the patient refused his insulin and blood sugar checks for more than two weeks. When the patient gained more than eight pounds in a week, the nurse did not notify the provider, even though the physician had given instructions to be notified. On another occasion, the provider ordered the nurse to monitor and report any increase in the patient's heart rate or worsening of his left knee pain or swelling. The nurse did not recheck the patient's heart rate or reevaluate his left knee.

Nursing documentation was sometimes incorrect or incomplete. We found incomplete or erroneous documentation in cases 85, 86, 89, 92, and the following case:

- In case 88, the provider ordered the nurse to check orthostatic vital signs (pulse and blood pressure while the patient is in the supine and standing position) daily for one week and to notify a provider if the patient's orthostatic vital signs were abnormal. When the nurses checked these vital signs, they did not always record the numerical values of the patient's pulse rate and blood pressure readings. As a result, the provider would be unable to identify any abnormal trends in the patient's vital signs. Furthermore, the provider would not be able to properly compare any abnormal vital signs based on the incomplete information that was available.

Clinician Onsite Inspection

During the onsite inspection, the 2 CTC medical beds and 18 of the OHU beds were filled. In the OHU, an RN was on duty during the day shift and licensed vocational nurses (LVNs) covered the evening and overnight shifts. A certified nurse assistant (CNA) assisted with medical care during each shift. In the CTC, at least one RN, LVN or psychiatric technician for medication passes, and a nursing assistant was present during each shift. Nursing staff in each specialized medical housing area had immediate access to the patients.

Case Review Conclusion

We found evidence of superficial provider care with poor provider documentation and the providers' use of cloned notes. Furthermore, the providers failed to review patient records thoroughly and were often unaware of their patients' medical conditions or pending diagnostic studies. The nurses did not assess medical conditions appropriately. Also, nurses failed to inform providers when there was a change in the patient's condition. Nurses did not consistently follow through with provider orders or nursing interventions. Nursing documentation was often

incomplete or incorrect. Because of the poor nursing performance and provider care, we rated the *Specialized Medical Housing* indicator *inadequate*.

Compliance Testing Results

The institution received a proficient compliance score of 100.0 percent in this indicator. Four tests earned scores of 100 percent:

- For the two patients sampled, nursing staff timely completed an initial health assessment the same day they admitted the patient to the CTC (MIT 13.001).
- Providers evaluated the two sampled patients within 24 hours of admission to the CTC and completed the required history and physical exam (MIT 13.002).
- When we tested whether providers completed their Subjective, Objective, Assessment, Plan, and Education (SOAPE) notes at required 14-day intervals, we found that providers completed timely SOAPE notes at required intervals for the two sampled patients in the CTC (MIT 13.003).
- When inspectors observed the working order of sampled call buttons in two CTC units and the OHU, inspectors found all working properly. In the OHU, staff conducted 30-minute welfare checks in the absence of a call light system. In addition, according to staff members interviewed, custody officers and clinicians were able to access patients' locked rooms when emergent events occurred expeditiously (MIT 13.101).

14 — *SPECIALTY SERVICES*

Case Review Rating:
Inadequate
Compliance Score:
Inadequate
(72.8%)
Overall Rating:
Inadequate

This indicator focuses on specialist care from the time a physician completes a request for services or a physician's order for specialist care to the time of receipt of related recommendations from specialists. This indicator also evaluates the providers' timely review of specialist records and documentation reflecting the patients' care plans, including the course of care when specialist recommendations were not ordered, and whether the results of specialists' reports are communicated to the patients. For specialty services denied by the institution, the OIG determines whether the denials are timely and appropriate and whether the provider updates the patient on the plan of care.

Case Review Results

We reviewed 166 events related to specialty services, the majority of which were specialty consultations and procedures. We identified 52 deficiencies, 17 of which were significant. The case review rating for this indicator was *inadequate*.

Access to Specialty Services

SAC did not perform well with access to specialty services. We found delays in specialty scheduling in case 2 and the following cases:

- In case 1, the patient had severe glaucoma (increased pressure within the eye) which could lead to blindness. The provider requested an optometry appointment within three days to evaluate the patient's eye pressures, but the appointment never occurred. Fortunately, the patient was eventually seen by an eye surgeon.

- In case 28, the patient had cataract surgery, and the provider requested a follow-up appointment with an ophthalmologist (an eye doctor) in seven days. The patient saw the ophthalmologist 18 days after the surgery, which could have severely delayed his care if there had been any complications.

- In case 88, the patient had a serious bleeding disorder. At the time of his hospital discharge, the hospital physician recommended a follow-up appointment with the hematologist. Although a SAC provider ordered the hematology referral, the appointment never occurred.

- In case 90, the patient had a liver mass that was suspicious for cancer. The provider ordered an urgent abdominal CT scan within three weeks. The institution did not perform the test until seven weeks later. This scheduling error contributed to a significant delay in medical care. The patient's cancer was not removed until ten months after providers initially discovered it.

Nursing Performance

The nurses had difficulty in properly evaluating patients returning from offsite specialty appointments and reviewing specialty recommendations. Often nurses performed incomplete assessments, which included the failure to check vital signs or to describe the appearance of a patient's wound. When patients refused to have vital signs assessed or to go to specialty appointments, the nurses often did not complete a refusal form. We found problems with specialty nursing care in cases 18, 26, and the following cases:

- In case 1, the patient underwent a surgical operation to decrease his eye pressure. The ophthalmologist recommended the patient stop taking aspirin and start taking new eyedrop medications. The nurse erroneously entered an order to hold the patient's aspirin for one day only and did not give the patient the new medications that the provider prescribed to start the same day. These errors placed the patient at unnecessary risk of surgical complications.

- In case 29, the ophthalmologist recommended a combination of two medications to treat the patient's eye pressure and to administer the medications to both of his eyes. When the patient returned to the institution, the nurse did not thoroughly review the recommendations and entered only one of the two medications the patient needed.

- In case 90, the specialist saw the patient for a consultation. The specialist required an imaging report to determine the best intervention to treat the patient's liver cancer. Unfortunately, the specialty nurse failed to send the imaging report to the specialist, resulting in delayed care. On a separate occasion, the nurse failed to assess a patient that returned from an offsite appointment.

Provider Performance

The institution's providers did not consistently order specialty referrals with the correct priority and did not consistently review specialists' recommendations timely. Even when providers did review the recommendations, they did not always properly implement them.

- In case 26, when the patient's biopsy results returned showing invasive prostate cancer, the provider did not order an urgent priority specialty referral. During our inspection, the provider explained that the medical leadership discouraged the providers from ordering urgent priority referrals to perform well on their CCHCS healthcare dashboard metrics. Because the provider did not order the referral with the correct priority, the staff did not expedite the consultation, and the patient experienced a delay in cancer care.

- In case 90, a surgeon described the patient's liver mass as "highly suspicious for malignancy." After reviewing the surgeon's report, the provider did not immediately order an urgent follow-up appointment with the recommended subspecialist. Instead, the

provider waited two weeks before ordering an evaluation, resulting in a delay in cancer care.

Health Information Management

Medical records staff retrieved and scanned the majority of the specialty reports timely, except one report. However, we found scanning errors in cases 1, 3, 10, 11, 22, 27, and 85. The providers either did not sign or date their review of specialty reports in cases 11 and 90. We also identified a pattern in which the providers in the specialized medical housing units failed to sign specialty reports. We also discuss these problems in the *Health Information Management* indicator.

Clinician Onsite Inspection

To improve their CCHCS healthcare dashboard scores, the institution's chief medical executive (CME) and chief physician and surgeon (CP&S) encouraged providers to order specialty services with routine priority (90 days) and discouraged providers from ordering urgent priority (14 days) services. SAC's medical leaders asked the providers to submit a handwritten request for any patient who required a specialty appointment sooner than 90 days. The CME then reviewed these handwritten requests, which were not reflected in the CCHCS dashboard. We do not agree with SAC's practice of encouraging providers to order all specialty services with routine priority. When a provider orders a specialty service, the provider should consider the patient's clinical condition and specify the appropriate period in which the specialty service should occur. They should not arbitrarily specify a 90-day window for all services. Providers now have the ability to specify exact time frames for these services within the EHRS. CCHCS should change their specialty access policies and monitor each institution's ability to provide specialty access based on the provider's order rather than "routine" or "urgent" time frames that may not be clinically correct.

Case Review Conclusion

SAC did not perform well with access to specialty services. We identified significant lapses in specialty follow-up care. Provider performance was poor because providers failed to review specialty service reports thoroughly. Superficial reviews of specialty recommendations often led to lapses in medical care. Nursing services were often problematic because of mistakes made by the nurses who processed patients returning from offsite medical care. Based on the issues identified during this inspection, we rated this indicator *inadequate*.

Compliance Testing Results

The institution received an *inadequate* compliance score of 72.8 percent in this indicator, with the following three tests scoring in the *inadequate* range:

- Providers both received and reviewed specialists' reports timely following routine specialty service appointments in only 5 of the 14 cases reviewed (35.7 percent). For two patients, providers received the reports 6 and 26 days late. For six patients, providers reviewed the reports 7 to 25 days late. For one final patient, the institution did not obtain the specialist's report (MIT 14.004).

- When one institution approves and schedules a patient for specialty services and the patient transfers to another institution, CCHCS policy requires the receiving institution to reschedule and provide the appointment timely. Only 11 of the 20 applicable patients sampled who transferred to SAC with an approved specialty service received their appointment within the required time frame (55.0 percent). For four patients, the appointments were 12 to 22 days late. For one other patient, the appointment was 55 days late. For four other patients, there was no evidence the appointments ever occurred (MIT 14.005).

- For 20 patients sampled who had a specialty service denied by SAC's health care management, 12 (60.0 percent) received timely notification of the denied service, including having a provider meet with them within 30 days to discuss alternate treatment strategies. For eight patients, there was no evidence the institution ever communicated the denial (MIT 14.007).

One test received a score in the *adequate* range:

- Providers timely received and reviewed specialists' reports for 11 of 14 sampled patients (78.6 percent). For one patient, SAC received the specialist's report five days late, and the provider failed to review the report. For two other patients, there was no evidence SAC either received or reviewed their reports (MIT 14.002).

Three tests earned *proficient* scores:

- For 13 of 15 patients sampled (86.7 percent), high-priority specialty services appointments occurred within 14 calendar days of the provider's order. Two patients received their specialty services appointments 16 to 17 days late (MIT 14.001).

- SAC provided routine specialty service appointments to 14 of 15 patients sampled within the required time frame (93.3 percent). For one patient, the routine specialty service appointment was 32 days late (MIT 14.003).

- SAC timely denied providers' specialty service requests for all 20 patients sampled (MIT 14.006).

15 — *ADMINISTRATIVE OPERATIONS (SECONDARY)*

Case Review Rating:
Not Applicable
Compliance Score:
Proficient
(91.6%)
Overall Rating:
Proficient

This indicator focuses on the institution's administrative health care oversight functions. The OIG evaluates whether the institution promptly processes patient medical appeals and addresses all appealed issues. Inspectors also verify that the institution follows reporting requirements for adverse/sentinel events and patient deaths. The OIG verifies that the Emergency Medical Response Review Committee (EMRRC) performs required reviews and that staff perform required emergency response drills. Inspectors also assess whether the Quality Management Committee (QMC) meets regularly and adequately addresses program performance. For those institutions with licensed facilities, inspectors also verify that required committee meetings are held. In addition, the OIG examines whether the institution adequately manages its health care staffing resources by evaluating whether job performance reviews are completed as required; specified staff possess current, valid credentials and professional licenses or certifications; nursing staff receive new employee orientation training and annual competency testing; and clinical and custody staff have current emergency medical response certifications. The *Administrative Operations* indicator is a secondary indicator; therefore, it was not relied on for the institution's overall score.

Compliance Testing Results

The institution received a *proficient* compliance score of 91.6 percent in this indicator, with several tests scoring in the *proficient* range:

- SAC's Quality Management Committee (QMC) met monthly, evaluated program performance, and acted when management identified areas for improvement opportunities (MIT 15.003).
- SAC took adequate steps to ensure the accuracy of its Dashboard data reporting (MIT 15.004).
- During the last 12 months, SAC's local governing body (LGB) met at least quarterly and exercised responsibility for the quality management of patient care each quarter, as documented in the meeting minutes (MIT 15.006).
- All drill packages, for three medical emergency response drills conducted in the prior quarter, contained required summary reports, and related documentation. Furthermore, the drills included participation by both health care and custody staff (MIT 15.101).
- Based on a sample of ten second-level medical appeals, the institution's responses addressed all the patients' appealed issues (MIT 15.102).

- Ten patient deaths occurred at SAC during the OIG's testing period. The institution did not timely notify CCHCS's Death Review Unit of one death case. The notification requirement was noon, the next business day following the death. SAC notification was 7 hours and 53 minutes late, resulting in a score of 90.0 percent for this test (MIT 15.103).

- We examined nursing reviews completed by five different nursing supervisors for their subordinate nurses; in all instances, the reviews were sufficiently completed (MIT 15.104).

- All ten nurses sampled who administered medications possessed current clinical competency validations. All nursing staff hired within the last year timely received new employee orientation training (MIT 15.105, 15.111).

- All providers at the institution were current with their professional licenses. Similarly, all nursing staff and the pharmacist in charge were current with their professional licenses and certification requirements (MIT 15.107, 15.109).

- All active duty providers and nurses were current with their emergency response certifications (MIT 15.108).

- All pharmacy staff and providers who prescribed controlled substances had current Drug Enforcement Agency registrations (MIT 15.110).

Two tests earned *adequate* scores:

- Of the 12 sampled incident packages for emergency medical responses the institution's Emergency Medical Response Review Committee (EMRRC) reviewed during the prior 12-month period, 10 packages (83.3 percent) complied with CCHCS policy. One incident package did not include the required EMRRC checklist. One other incident package had an incomplete EMRRC checklist (MIT 15.005).

- Supervisors completed a proper clinical performance appraisal for five of the six SAC providers (83.3 percent). For one provider, the supervising physician did not complete a performance appraisal (MIT 15.106).

On one test, SAC showed room for improvement:

- We reviewed data received from the institution (which was not validated by the OIG) to determine whether SAC timely processed at least 95 percent of its monthly patient medical appeals during the most recent 12-month period. SAC was compliant with only one of the 12 months' appeals (8.3 percent) (MIT 15.001).

Non-Scored Results

- We gathered non-scored data regarding the completion of the death review reports by CCHCS's Death Review Committee (DRC). Ten deaths occurred during our review period, eight unexpected (Level 1) deaths and two expected (Level 2) deaths. CCHCS policy requires the DRC to complete its death review summary report within 60 calendar days from the date of death for the Level 1 deaths and within 30 calendar days from the date of death for the Level 2 deaths; the reports should then be submitted to the institution's CEO within seven calendar days after that. None of the death reviews at SAC met CCHCS's reporting guidelines. For five of the Level 1 deaths, the DRC completed its reports 15, 15, 37, 79, and 203 days late (75, 75, 97, 139, and 263 days after death) and submitted them to SAC's CEO 31, 38, 59, 85, and 212 days late. For one other Level 1 death, the DRC completed its report timely but submitted it to the CEO 12 days late. For the final two Level 1 deaths, there was no evidence at the time of our inspection that the DRC had completed its reports. For the two Level 2 deaths, the DRC completed its report 51 and 92 days late (81 and 122 days after death) and submitted it to the CEO 60 and 148 days late (MIT 15.998).
- We discuss the institution's health care staffing resources in the *About the Institution* section of this report (MIT 15.999).

RECOMMENDATIONS

The OIG recommends the following:

- The institution's chief executive officer (CEO) and CNE should coordinate with both custody staff and emergency response medical staff to provide education and training to ensure that first medical responders respond to patients with emergent symptoms, assess them, and transport them appropriately to receive medical care. We found multiple cases in which first medical responders failed to respond to emegencies and did not assess patients with life threatening symptoms. In these cases, custody staff required patients to walk, unaccompanied and unmonitored by medical staff, to the clinic or TTA for further care.

- The CEO should rectify the review process of the Emergency Medical Response Review Committee (EMRRC) because the committee failed to identify problems with SAC's emergency response as well as with the care provided by the TTA providers and nurses. The institution needs a properly functioning EMRRC to identify and correct its various lapses in emergency care.

- The CEO, CNE, and pharmacist in charge (PIC) should remedy the problems we identified with medication continuity, inconsistent medication administration, delays with dispensing medications, and failures to properly identify duplicate orders across most of the institution's health care areas. These poorly functioning processes were especially worrisome for patients returning from a community hospital and for patients transferring to other CDCR institutions.

- The CNE should audit the hospital return process because of the nurses' inability to properly review hospital discharge instructions and ensure medication continuity for these patients.

- The chief medical executive (CME) should assign a provider to the TTA to handle emergent and urgent situations. With a dedicated TTA provider, the clinic providers would have fewer conflicting responsibilities. Clinic providers could focus on their regularly scheduled clinic patients and would not have to reschedule appointments whenever there was a medical emergency.

- The CEO should improve the scheduling process for newly-arrived patients and monitor these appointments to ensure patients receive their required appointments timely.

- The CME should instruct the providers to specify the appropriate clinical time frame for the ordered specialty service within the electronic health record system (EHRS) and eliminate their use of handwritten requests to expedite specialty services. The CNE

should also direct the specialty department to follow the time frame specified in the EHRS order when scheduling services.

- CCHCS should eliminate time frames for both routine and urgent priority requests from its specialty access policies. Instead, CCHCS should monitor specialty access by measuring the ability of each institution to provide specialty services within the time frames specified in each order in the EHRS.

- The CME should identify providers who are not carefully reviewing their patients' specialty consultations, progress notes, medications, and appointments. The CME should provide additional EHRS training for those providers who claimed their errors were because of their inability to locate this information in the EHRS.

- The CME should ensure providers in the correctional treatment center (CTC) and outpatient housing unit (OHU) perform a thorough chart review before each patient encounter. Providers should also discuss the status of each of the patient's current conditions in their progress notes whenever they pass the care of the patient to another provider. The CME should monitor provider performance in the CTC and OHU regularly by reviewing the care of these patients.

- The CNE should develop and implement new strategies to appraise and improve nursing competency and quality across all areas of nursing care because of the poor overall nursing performance we identified in this inspection.

- The CNE should clarify and communicate specific duties and expectations to the nurse care managers. The CNE should then provide training and monitor the care managers to ensure they perform appropriate chronic care management for their patients.

POPULATION-BASED METRICS

The compliance testing and the case reviews give an accurate assessment of how the institution's health care systems are functioning with regard to the patients with the highest risk and utilization. This information is vital to assess the capacity of the institution to provide sustainable, adequate care. However, one significant limitation of the case review methodology is that it does not give a clear assessment of how the institution performs for the entire population. For better insight into this performance, the OIG has turned to population-based metrics. For comparative purposes, the OIG has selected several Healthcare Effectiveness Data and Information Set (HEDIS) measures for disease management to gauge the institution's effectiveness in outpatient health care, especially chronic disease management.

The Healthcare Effectiveness Data and Information Set is a set of standardized performance measures developed by the National Committee for Quality Assurance with input from over 300 organizations representing every sector of the nation's health care industry. It is used by over 90 percent of the nation's health plans as well as many leading employers and regulators. HEDIS was designed to ensure that the public (including employers, the Centers for Medicare and Medicaid Services, and researchers) has the information it needs to accurately compare the performance of health care plans. Healthcare Effectiveness Data and Information Set data is often used to produce health plan report cards, analyze quality improvement activities, and create performance benchmarks.

Methodology

For population-based metrics, we used a subset of HEDIS measures applicable to the CDCR patient population. Selection of the measures was based on the availability, reliability, and feasibility of the data required for performing the measurement. We collected data utilizing various information sources, including the electronic medical record, the Master Registry (maintained by CCHCS), as well as a random sample of patient records analyzed and abstracted by trained personnel. We did not independently validate the data obtained from the CCHCS Master Registry and Diabetic Registry, and we presume it to be accurate. For some measures, we used the entire population rather than statistically random samples. While the OIG is not a certified HEDIS compliance auditor, we use similar methods to ensure that measures are comparable to those published by other organizations.

Comparison of Population-Based Metrics

For the California State Prison, Sacramento, nine HEDIS measures were selected and are listed in the following *SAC Results Compared to State and National HEDIS Scores* table. Multiple health plans publish their HEDIS performance measures at the state and national levels. The OIG has provided selected results for several health plans in both categories for comparative purposes.

Results of Population-Based Metric Comparison

Comprehensive Diabetes Care

For chronic care management, the OIG chose measures related to the management of diabetes. Diabetes is the most complex common chronic disease requiring a high level of intervention on the part of the health care system in order to produce optimal results. SAC performed well with its management of diabetes.

When compared statewide, SAC outperformed Medi-Cal in all five diabetic measures and outperformed Kaiser in three of the five diabetic measures. The institution scored lower in blood pressure monitoring than Kaiser (North and South).

When compared nationally, SAC outperformed Medicaid, commercial plans, and Medicare in four of the five diabetic measures. The institution scored lower than Medicare in diabetic eye exams. The institution outperformed the United States Department of Veterans Affairs (VA) in two of the four applicable measures, with SAC scoring lower in blood pressure control and diabetic eye exams.

Immunizations

Comparative data for immunizations was only fully available for the VA and partially available for Kaiser, commercial plans, Medicaid, and Medicare. With respect to administering influenza vaccinations to younger adults, SAC outperformed all healthcare plans and matched Kaiser South. With respect to administering influenza vaccinations to older adults, SAC scored lower than all healthcare plans. With regard to administering pneumococcal vaccines to older adults, SAC scored higher than Medicare, but lower than the VA.

Cancer Screening

With respect to colorectal cancer screening, SAC outperformed commercial plans and Medicare, but scored lower than Kaiser (North and South) and the VA.

Summary

SAC's population-based metrics performance reflected a well-functioning chronic care program, compared to the other state and national health care entities reviewed. The institution may improve its scores for immunizations and colorectal cancer screenings by reducing patient refusals through patient education.

SAC Results Compared to State and National HEDIS Score

Clinical Measures	California				National			
	SAC Cycle 5 Results[1]	HEDIS Medi-Cal 2017[2]	HEDIS Kaiser (No. CA) 2016[3]	HEDIS Kaiser (So. CA) 2016[3]	HEDIS Medicaid 2017[4]	HEDIS Com-mercial 2017[4]	HEDIS Medicare 2017[4]	VA Average 2016[5]
Comprehensive Diabetes Care								
HbA1c Testing (Monitoring)	**100%**	87%	94%	94%	87%	91%	94%	99%
Poor HbA1c Control (>9.0%)[6, 7]	**12%**	38%	20%	23%	43%	33%	26%	18%
HbA1c Control (<8.0%)[6]	**81%**	52%	70%	63%	47%	56%	63%	-
Blood Pressure Control (<140/90)	**71%**	63%	83%	83%	60%	62%	64%	76%
Eye Exams	**65%**	57%	68%	81%	55%	54%	70%	89%
Immunizations								
Influenza Shots - Adults (18–64)	**57%**	-	56%	57%	39%	48%	-	52%
Influenza Shots - Adults (65+)[6]	**60%**	-	-	-	-	-	71%	72%
Immunizations: Pneumococcal[6]	**77%**	-	-	-	-	-	74%	93%
Cancer Screening								
Colorectal Cancer Screening	**74%**	-	79%	82%	-	63%	67%	82%

1. Unless otherwise stated, data was collected in September 2017 by reviewing medical records from a sample of SAC's population of applicable inmate-patients. These random statistical sample sizes were based on a 95 percent confidence level with a 15 percent maximum margin of error.

2. HEDIS Medi-Cal data was obtained from the California Department of Health Care Services *Medi-Cal Managed Care External Quality Review Technical Report (July 1, 2016 - June 30, 2017)*.

3. Data was obtained from Kaiser Permanente November 2016 reports for the Northern and Southern California regions.

4. National HEDIS data for Medicaid, commercial plans, and Medicare was obtained from the 2017 *State of Health Care Quality Report*, available on the NCQA website: www.ncqa.org. The results for commercial plans were based on data received from various health maintenance organizations.

. The Department of Veterans Affairs (VA) data was obtained from the VA's website, www.va.gov.For the Immunizations: Pneumococcal measure only, the data was obtained from the *VHA Facility Quality and Safety Report - Fiscal Year 2012 Data*.

6. For this indicator, the entire applicable SAC population was tested.

7. For this measure only, a lower score is better. For Kaiser, the OIG derived the Poor HbA1c Control indicator using the reported data for the <9.0% HbA1c control indicator.

APPENDIX A — COMPLIANCE TEST RESULTS

California State Prison-Sacramento Range of Summary Scores: 59.9% – 100.0%	
Indicator	**Compliance Score (Yes %)**
1–***Access to Care***	87.0%
2–***Diagnostic Services***	81.1%
3–***Emergency Services***	Not Applicable
4–***Health Information Management (Medical Records)***	64.1%
5–***Health Care Environment***	80.1%
6–***Inter- and Intra-System Transfers***	59.9%
7–***Pharmacy and Medication Management***	66.2%
8–***Prenatal and Post-Delivery Services***	Not Applicable
9–***Preventive Services***	65.5%
10–***Quality of Nursing Performance***	Not Applicable
11–***Quality of Provider Performance***	Not Applicable
12–***Reception Center Arrivals***	Not Applicable
13–***Specialized Medical Housing (OHU, CTC, SNF, Hospice)***	100.0%
14–***Specialty Services***	72.8%
15–***Administrative Operations***	91.6%

Reference Number	1–*Access to Care*	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
1.001	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?	21	4	25	84.0%	0
1.002	For endorsed patients received from another CDCR institution: If the nurse referred the patient to a provider during the initial health screening, was the patient seen within the required time frame?	16	8	24	66.7%	1
1.003	Clinical appointments: Did a registered nurse review the patient's request for service the same day it was received?	60	0	60	100.0%	0
1.004	Clinical appointments: Did the registered nurse complete a face-to-face visit within one business day after the CDCR Form 7362 was reviewed?	58	2	60	96.7%	0
1.005	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?	13	6	19	68.4%	41
1.006	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?	8	0	8	100.0%	52
1.007	Upon the patient's discharge from the community hospital: Did the patient receive a follow-up appointment within the required time frame?	21	4	25	84.0%	0
1.008	Specialty service follow-up appointments: Do specialty service primary care physician follow-up visits occur within required time frames?	20	4	24	83.3%	6
1.101	Clinical appointments: Do patients have a standardized process to obtain and submit health care services request forms?	6	0	6	100.0%	0
Overall percentage:					**87.0%**	

Reference Number	2–*Diagnostic Services*	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
2.001	Radiology: Was the radiology service provided within the time frame specified in the provider's order?	10	0	10	100.0%	0
2.002	Radiology: Did the primary care provider review and initial the diagnostic report within specified time frames?	2	8	10	20.0%	0
2.003	Radiology: Did the primary care provider communicate the results of the diagnostic study to the patient within specified time frames?	9	1	10	90.0%	0
2.004	Laboratory: Was the laboratory service provided within the time frame specified in the provider's order?	9	1	10	90.0%	0
2.005	Laboratory: Did the primary care provider review and initial the diagnostic report within specified time frames?	10	0	10	100.0%	0
2.006	Laboratory: Did the primary care provider communicate the results of the diagnostic study to the patient within specified time frames?	9	1	10	90.0%	0
2.007	Pathology: Did the institution receive the final diagnostic report within the required time frames?	9	1	10	90.0%	0
2.008	Pathology: Did the primary care provider review and initial the diagnostic report within specified time frames?	9	1	10	90.0%	0
2.009	Pathology: Did the primary care provider communicate the results of the diagnostic study to the patient within specified time frames?	6	4	10	60.0%	0
Overall percentage:					**81.1%**	

3–*Emergency Services*

This indicator is evaluated only by case review clinicians. There is no compliance testing component.

Reference Number	4–*Health Information Management*	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
4.001	Are non-dictated healthcare documents (provider progress notes) scanned within 3 calendar days of the patient encounter date?	11	1	12	91.7%	0
4.002	Are dictated/transcribed documents scanned into the patient's electronic health record within five calendar days of the encounter date?	Not Applicable				
4.003	Are High-Priority specialty notes (either a Form 7243 or other scanned consulting report) scanned within the required time frame?	14	6	20	70.0%	0
4.004	Are community hospital discharge documents scanned into the patient's electronic health record within three calendar days of hospital discharge?	19	1	20	95.0%	0
4.005	Are medication administration records (MARs) scanned into the patient's electronic health record within the required time frames?	Not Applicable				
4.006	During the inspection, were medical records properly scanned, labeled, and included in the correct patients' files?	0	24	24	0.0%	0
4.007	For patients discharged from a community hospital: Did the preliminary hospital discharge report include key elements and did a primary care provider review the report within three calendar days of discharge?	16	9	25	64.0%	0
Overall percentage:					**64.1%**	

Reference Number	5–*Health Care Environment*	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
5.101	Are clinical health care areas appropriately disinfected, cleaned, and sanitary?	19	2	21	90.5%	0
5.102	Do clinical health care areas ensure that reusable invasive and non-invasive medical equipment is properly sterilized or disinfected as warranted?	19	2	21	90.5%	0
5.103	Do clinical health care areas contain operable sinks and sufficient quantities of hygiene supplies?	19	2	21	90.5%	0
5.104	Does clinical health care staff adhere to universal hand hygiene precautions?	12	9	21	57.1%	0
5.105	Do clinical health care areas control exposure to blood-borne pathogens and contaminated waste?	21	0	0	100.0%	0
5.106	Warehouse, Conex and other non-clinic storage areas: Does the medical supply management process adequately support the needs of the medical health care program?	1	0	0	100.0%	0
5.107	Does each clinic follow adequate protocols for managing and storing bulk medical supplies?	20	1	21	95.2%	0
5.108	Do clinic common areas and exam rooms have essential core medical equipment and supplies?	12	9	21	57.1%	0
5.109	Do clinic common areas have an adequate environment conducive to providing medical services?	19	2	21	90.5%	0
5.110	Do clinic exam rooms have an adequate environment conducive to providing medical services?	5	15	20	25.0%	1
5.111	Emergency response bags: Are TTA and clinic emergency medical response bags inspected daily and inventoried monthly, and do they contain essential items?	11	2	13	84.6%	8
Overall percentage:					**80.1%**	

Reference Number	6–*Inter- and Intra-System Transfers*	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
6.001	For endorsed patients received from another CDCR institution or COCF: Did nursing staff complete the initial health screening and answer all screening questions on the same day the patient arrived at the institution?	23	2	25	92.0%	0
6.002	For endorsed patients received from another CDCR institution or COCF: When required, did the RN complete the assessment and disposition section of the 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?	24	0	24	100.0%	1
6.003	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?	11	10	21	52.4%	4
6.004	For patients transferred out of the facility: Were scheduled specialty service appointments identified on the patient's health care transfer information form?	11	9	20	55.0%	0
6.101	For patients transferred out of the facility: Do medication transfer packages include required medications along with the corresponding transfer packet required documents?	0	6	6	0.0%	0
Overall percentage:					**59.9%**	

Reference Number	*7–Pharmacy and Medication Management*	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
7.001	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?	11	10	21	52.4%	4
7.002	Did health care staff administer, make available, or deliver new order prescription medications to the patient within the required time frames?	21	4	25	84.0%	0
7.003	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?	8	17	25	32.0%	0
7.004	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?	Not Applicable				
7.005	Upon the patient's transfer from one housing unit to another: Were medications continued without interruption?	21	4	25	84.0%	0
7.006	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?	1	8	9	11.1%	0
7.101	All clinical and medication line storage areas for narcotic medications: Does the Institution employ strong medication security over narcotic medications assigned to its clinical areas?	13	0	13	100.0%	8
7.102	All clinical and medication line storage areas for non-narcotic medications: Does the Institution properly store non-narcotic medications that do not require refrigeration in assigned clinical areas?	15	4	19	79.0%	2
7.103	All clinical and medication line storage areas for non-narcotic medications: Does the institution properly store non-narcotic medications that require refrigeration in assigned clinical areas?	15	1	16	93.8%	5
7.104	Medication preparation and administration areas: Do nursing staff employ and follow hand hygiene contamination control protocols during medication preparation and medication administration processes?	5	3	8	62.5%	13
7.105	Medication preparation and administration areas: Does the institution employ appropriate administrative controls and protocols when preparing medications for patients?	7	1	8	87.5%	13
7.106	Medication preparation and administration areas: Does the Institution employ appropriate administrative controls and protocols when distributing medications to patients?	2	6	8	25.0%	13

Reference Number	7–*Pharmacy and Medication Management*	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
7.107	Pharmacy: Does the institution employ and follow general security, organization, and cleanliness management protocols in its main and satellite pharmacies?	1	0	1	100.0%	0
7.108	Pharmacy: Does the institution's pharmacy properly store non-refrigerated medications?	1	0	1	100.0%	0
7.109	Pharmacy: Does the institution's pharmacy properly store refrigerated or frozen medications?	1	0	1	100.0%	0
7.110	Pharmacy: Does the institution's pharmacy properly account for narcotic medications?	0	1	1	0.0%	0
7.111	Does the institution follow key medication error reporting protocols?	12	13	25	48.0%	0
Overall percentage:					**66.2%**	

8–*Prenatal and Post-Delivery Services*
The institution has no female patients, so this indicator is not applicable.

Reference Number	9–*Preventive Services*	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
9.001	Patients prescribed TB medication: Did the institution administer the medication to the patient as prescribed?	3	4	7	42.9%	0
9.002	Patients prescribed TB medication: Did the institution monitor the patient monthly for the most recent three months he or she was on the medication?	2	5	7	28.6%	0
9.003	Annual TB Screening: Was the patient screened for TB within the last year?	18	12	30	60.0%	0
9.004	Were all patients offered an influenza vaccination for the most recent influenza season?	24	1	25	96.0%	0
9.005	All patients from the age of 50 - 75: Was the patient offered colorectal cancer screening?	23	2	25	92.0%	0
9.006	Female patients from the age of 50 through the age of 74: Was the patient offered a mammogram in compliance with policy?	Not Applicable				
9.007	Female patients from the age of 21 through the age of 65: Was patient offered a pap smear in compliance with policy?	Not Applicable				
9.008	Are required immunizations being offered for chronic care patients?	11	4	15	73.3%	10
9.009	Are patients at the highest risk of coccidioidomycosis (valley fever) infection transferred out of the facility in a timely manner?	Not Applicable				
Overall percentage:					**65.5%**	

10–*Quality of Nursing Performance*

This indicator is evaluated only by case review clinicians. There is no compliance testing component.

11–*Quality of Provider Performance*

This indicator is evaluated only by case review clinicians. There is no compliance testing component.

12–*Reception Center Arrivals*

The institution has no reception center, so this indicator is not applicable.

Reference Number	13–*Specialized Medical Housing*	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
13.001	For OHU, CTC, and SNF: 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?	2	0	2	100.0%	0
13.002	For CTC and SNF only: Was a written history and physical examination completed within the required time frame?	2	0	2	100.0%	0
13.003	For OHU, CTC, SNF, and Hospice: Did the primary care provider complete the Subjective, Objective, Assessment, Plan, and Education (SOAPE) notes on the patient at the minimum intervals required for the type of facility where the patient was treated?	2	0	2	100.0%	0
13.101	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?	3	0	3	100.0%	0
Overall percentage:					**100.0%**	

Reference Number	14–*Specialty Services*	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
14.001	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?	13	2	15	86.7%	0
14.002	Did the primary care provider review the high priority specialty service consultant report within the required time frame?	11	3	14	78.6%	1
14.003	Did the patient receive the routine specialty service within 90 calendar days of the primary care provider order or Physician Request for Service?	14	1	15	93.3%	0
14.004	Did the primary care provider review the routine specialty service consultant report within the required time frame?	5	9	14	35.7%	1
14.005	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?	11	9	20	55.0%	0
14.006	Did the institution deny the primary care provider request for specialty services within required time frames?	20	0	20	100%	0
14.007	Following the denial of a request for specialty services, was the patient informed of the denial within the required time frame?	12	8	20	60.0%	0
Overall percentage:					**72.8%**	

Reference Number	15–*Administrative Operations*	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
15.001	Did the institution promptly process inmate medical appeals during the most recent 12 months?	1	11	12	8.3%	0
15.002	Does the institution follow adverse / sentinel event reporting requirements?	Not Applicable				
15.003	Did the institution Quality Management Committee (QMC) meet at least monthly to evaluate program performance, and did the QMC take action when improvement opportunities were identified?	6	0	6	100.0%	0
15.004	Did the institution's Quality Management Committee (QMC) or other forum take steps to ensure the accuracy of its Dashboard data reporting?	1	0	1	100.0%	0
15.005	Does the Emergency Medical Response Review Committee perform timely incident package reviews that include the use of required review documents?	10	2	12	83.3%	0
15.006	For institutions with licensed care facilities: Does the Local Governing Body (LGB), or its equivalent, meet quarterly and exercise its overall responsibilities for the quality management of patient health care?	4	0	4	100.0%	0
15.101	Did the institution complete a medical emergency response drill for each watch and include participation of health care and custody staff during the most recent full quarter?	3	0	3	100.0%	0
15.102	Did the institution's second level medical appeal response address all of the patient's appealed issues?	10	0	10	100.0%	0
15.103	Did the institution's medical staff review and submit the initial inmate death report to the Death Review Unit in a timely manner?	9	1	10	90.0%	0
15.104	Does the institution's Supervising Registered Nurse conduct periodic reviews of nursing staff?	5	0	5	100.0%	0
15.105	Are nursing staff who administer medications current on their clinical competency validation?	10	0	10	100.0%	0
15.106	Are structured clinical performance appraisals completed timely?	5	1	6	83.3%	2
15.107	Do all providers maintain a current medical license?	8	0	8	100.0%	0
15.108	Are staff current with required medical emergency response certifications?	2	0	2	100.0%	1

Reference Number	15–*Administrative Operations*	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
15.109	Are nursing staff and the Pharmacist-in-Charge current with their professional licenses and certifications, and is the pharmacy licensed as a correctional pharmacy by the California State Board of Pharmacy?	6	0	6	100.0%	1
15.110	Do the institution's pharmacy and authorized providers who prescribe controlled substances maintain current Drug Enforcement Agency (DEA) registrations?	1	0	1	100.0%	0
15.111	Are nursing staff current with required new employee orientation?	1	0	1	100.0%	0
Overall percentage:					**91.6%**	

APPENDIX B — CLINICAL DATA

Table B-1: SAC Sample Sets

Sample Set	Total
Anticoagulation	3
CTC/OHU	6
Death Review/Sentinel Events	3
Diabetes	3
Emergency Services – CPR	5
Emergency Services – Non-CPR	3
High Risk	5
Hospitalization	4
Intra-System Transfers In	3
Intra-System Transfers Out	3
RN Sick Call	48
Specialty Services	4
	90

Table B-2: SAC Chronic Care Diagnoses

Diagnosis	Total
Anemia	10
Anticoagulation	4
Arthritis/Degenerative Joint Disease	10
Asthma	18
COPD	5
Cancer	11
Cardiovascular Disease	13
Chronic Kidney Disease	5
Chronic Pain	33
Cirrhosis/End Stage Liver Disease	9
Coccidioidomycosis	3
DVT/PE	4
Deep Venous Thrombosis/Pulmonary Embolism	2
Diabetes	17
Diagnosis	1
Gastroesophageal Reflux Disease	12
Gastrointestinal Bleed	1
HIV	6
Hepatitis C	33
Hyperlipidemia	23
Hypertension	37
Mental Health	37
Migraine Headaches	2
Rheumatological Disease	1

Diagnosis	Total
Seizure Disorder	7
Sickle Cell Anemia	1
Sleep Apnea	1
Thyroid Disease	8
	314

Table B-3: SAC Event – Program

Diagnosis	Total
Diagnostic Services	258
Emergency Care	64
Hospitalization	39
Intra-system Transfers-In	8
Intra-system Transfers-Out	5
Not Specified	2
Outpatient Care	656
Specialized Medical Housing	271
Specialty Services	191
	1,494

Table B-4: SAC Review Sample Summary

	Total
MD Reviews Detailed	25
MD Reviews Focused	6
RN Reviews Detailed	15
RN Reviews Focused	65
Total Reviews	111
Total Unique Cases	90
Overlapping Reviews (MD & RN)	21

APPENDIX C — COMPLIANCE SAMPLING METHODOLOGY

California State Prison, Sacramento

Quality Indicator	Sample Category (number 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 ***Intra-system Transfers***
MITs 1.003–006	Nursing Sick Call (5 per clinic) (30)	MedSATS	• Clinic (each clinic tested) • Appointment date (2–9 months) • **Randomize**
MIT 1.007	Returns from Community Hospital (8)	OIG Q: 4.007	• See ***Health Information Management (Medical Records)*** (returns from community hospital)
MIT 1.008	Specialty Services Follow-up (30)	OIG Q: 14.001 & 14.003	• See ***Specialty Services***
MIT 1.101	Availability of Health Care Services Request Forms (6)	OIG onsite 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	Pathology (10)	InterQual	• Appt. date (90 days–9 months) • Service (pathology related) • **Randomize**

Quality Indicator	Sample Category (number of samples)	Data Source	Filters
Health Information Management (Medical Records)			
MIT 4.001	Timely Scanning (13)	OIG Qs: 1.001, 1.002, & 1.004	• Non-dictated documents • 1st 10 IPs MIT 1.001, 1st 5 IPs MITs 1.002, 1.004
MIT 4.002	(0)	OIG Q: 1.001	• Dictated documents • First 20 IPs selected
MIT 4.003	(20)	OIG Qs: 14.002 & 14.004	• Specialty documents • First 10 IPs for each question
MIT 4.004	(8)	OIG Q: 4.007	• Community hospital discharge documents • First 20 IPs selected
MIT 4.005	(0)	OIG Q: 7.001	• MARs • First 20 IPs selected
MIT 4.006	(10)	Documents for any tested inmate	• Any misfiled or mislabeled document identified during OIG compliance review (24 or more = No)
MIT 4.007	Returns From Community Hospital (8)	Inpatient claims data	• Date (2–8 months) • Most recent 6 months provided (within date range) • Rx count • Discharge date • **Randomize** (each month individually) • First 5 patients from each of the 6 months (if not 5 in a month, supplement from another, as needed)
Health Care Environment			
MIT 5.101–105 MIT 5.107–111	Clinical Areas (12)	OIG inspector onsite review	• Identify and inspect all onsite clinical areas.
Inter- and Intra-System Transfers			
MIT 6.001–003	Intra-System Transfers (25)	SOMS	• Arrival date (3–9 months) • Arrived from (another CDCR facility) • Rx count • **Randomize**
MIT 6.004	Specialty Services Send-Outs (20)	MedSATS	• Date of transfer (3–9 months) • **Randomize**
MIT 6.101	Transfers Out (9)	OIG inspector onsite review	• R&R IP transfers with medication

Quality Indicator	Sample Category (number of samples)	Data Source	Filters
Pharmacy and Medication Management			
MIT 7.001	Chronic Care Medication (25)	OIG Q: 1.001	*See **Access to Care*** • At least one condition per patient—any risk level • **Randomize**
MIT 7.002	New Medication Orders (25)	Master Registry	• Rx count • **Randomize** • Ensure no duplication of IPs tested in MIT 7.001
MIT 7.003	Returns from Community Hospital (8)	OIG Q: 4.007	• 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 Arrivals***
MIT 7.005	Intra-Facility 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 (0)	SOMS	• Date of transfer (2–8 months) • Sending institution (another CDCR facility) • **Randomize** • NA/DOT meds
MITs 7.101–103	Medication Storage Areas (varies by test)	OIG inspector onsite review	• Identify and inspect clinical & med line areas that store medications
MITs 7.104–106	Medication Preparation and Administration Areas (varies by test)	OIG inspector onsite review	• Identify and inspect onsite clinical areas that prepare and administer medications
MITs 7.107–110	Pharmacy (1)	OIG inspector onsite review	• Identify & inspect all onsite pharmacies
MIT 7.111	Medication Error Reporting (25)	Monthly medication error reports	• All monthly statistic reports with Level 4 or higher • Select a total of 5 months
MIT 7.999	Isolation Unit KOP Medications (10)	Onsite active medication listing	• KOP rescue inhalers & nitroglycerin medications for IPs housed in isolation units
Prenatal and Post-Delivery Services			
MIT 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)

Quality Indicator	Sample Category (number of samples)	Data Source	Filters
Preventive Services			
MITs 9.001–002	TB Medications (9)	Maxor	• Dispense date (past 9 months) • Time period on TB meds (3 months or 12 weeks) • **Randomize**
MIT 9.003	TB Evaluation, Annual Screening (30)	SOMS	• Arrival date (at least 1 year prior to inspection) • Birth Month • **Randomize**
MIT 9.004	Influenza Vaccinations (25)	SOMS	• Arrival date (at least 1 year prior to inspection) • **Randomize** • Filter out IPs tested in MIT 9.008
MIT 9.005	Colorectal Cancer Screening (25)	SOMS	• Arrival date (at least 1 year prior to inspection) • Date of birth (51 or older) • **Randomize**
MIT 9.006	Mammogram *(N/A at this institution)*	SOMS	• Arrival date (at least 2 yrs prior to inspection) • Date of birth (age 52–74) • **Randomize**
MIT 9.007	Pap Smear *(N/A at this institution)*	SOMS	• Arrival date (at least three yrs prior to inspection) • Date of birth (age 24–53) • **Randomize**
MIT 9.008	Chronic Care Vaccinations (25)	OIG Q: 1.001	• Chronic care conditions (at least 1 condition per IP—any risk level) • **Randomize** • Condition must require vaccination(s)
MIT 9.009	Valley Fever (number will vary) *(N/A at this institution)*	Cocci transfer status report	• Reports from past 2–8 months • Institution • Ineligibility date (60 days prior to inspection date) • **All**

Quality Indicator	Sample Category (number of samples)	Data Source	Filters
Reception Center Arrivals			
MITs 12.001–008	RC *(N/A at this institution)*	SOMS	• Arrival date (2–8 months) • Arrived from (county jail, return from parole, etc.) • **Randomize**
Specialized Medical Housing			
MITs 13.001–004	CTC (10)	CADDIS	• Admit date (1–6 months) • Type of stay (no MH beds) • Length of stay (minimum of 5 days) • **Randomize**
MIT 13.101	Call Buttons CTC (all)	OIG inspector onsite review	• Review by location
Specialty Services			
MITs 14.001–002	High-Priority (15)	MedSATS	• Approval date (3–9 months) • **Randomize**
MITs 14.003–004	Routine (15)	MedSATS	• Approval date (3–9 months) • Remove optometry, physical therapy, or podiatry • **Randomize**
MIT 14.005	Specialty Services Arrivals (20)	MedSATS	• Arrived from (other CDCR institution) • Date of transfer (3–9 months) • **Randomize**
MIT 14.006–007	Denials (16)	InterQual	• Review date (3–9 months) • **Randomize**
	(4)	IUMC/MAR Meeting Minutes	• Meeting date (9 months) • Denial upheld • **Randomize**

Quality Indicator	Sample Category (number of samples)	Data Source	Filters
Administrative Operations			
MIT 15.001	Medical Appeals (all)	Monthly medical appeals reports	• Medical appeals (12 months)
MIT 15.002	Adverse/Sentinel Events (0)	Adverse/sentinel events report	• Adverse/sentinel events (2–8 months)
MITs 15.003–004	QMC Meetings (6)	Quality Management Committee meeting minutes	• Meeting minutes (12 months)
MIT 15.005	EMRRC (12)	EMRRC meeting minutes	• Monthly meeting minutes (6 months)
MIT 15.006	LGB (4)	LGB meeting minutes	• Quarterly meeting minutes (12 months)
MIT 15.101	Medical Emergency Response Drills (3)	Onsite summary reports & documentation for ER drills	• Most recent full quarter • Each watch
MIT 15.102	2nd Level Medical Appeals (10)	Onsite list of appeals/closed appeals files	• Medical appeals denied (6 months)
MIT 15.103	Death Reports (4)	Institution-list of deaths in prior 12 months	• Most recent 10 deaths • Initial death reports
MIT 15.104	RN Review Evaluations (5)	Onsite supervisor periodic RN reviews	• RNs who worked in clinic or emergency setting six or more days in sampled month • **Randomize**
MIT 15.105	Nursing Staff Validations (10)	Onsite nursing education files	• On duty one or more years • Nurse administers medications • **Randomize**
MIT 15.106	Provider Annual Evaluation Packets (5)	Onsite provider evaluation files	• All required performance evaluation documents
MIT 15.107	Provider licenses (5)	Current provider listing (at start of inspection)	• Review all

MIT 15.108	Medical Emergency Response Certifications (all)	Onsite certification tracking logs	• All staff
			  ○ Providers (ACLS)
			  ○ Nursing (BLS/CPR)
			• Custody (CPR/BLS)

MIT 15.109	Nursing staff and Pharmacist in Charge Professional Licenses and Certifications (all)	Onsite tracking system, logs, or employee files	• All required licenses and certifications

Quality Indicator	Sample Category (number of samples)	Data Source	Filters
Administrative Operations			
MIT 15.110	Pharmacy and Providers' Drug Enforcement Agency (DEA) Registrations (all)	Onsite listing of provider DEA registration #s & pharmacy registration document	• All DEA registrations
MIT 15.111	Nursing Staff New Employee Orientations (all)	Nursing staff training logs	• New employees (hired within last 12 months)
MIT 15.998	Death Review Committee (4)	OIG summary log - deaths	• Between 35 business days & 12 months prior • CCHCS death reviews

CALIFORNIA CORRECTIONAL HEALTH CARE SERVICES' RESPONSE

November 7, 2018

Roy Wesley, Inspector General
Office of the Inspector General
10111 Old Placerville Road, Suite 110
Sacramento, CA 95827

Dear Mr. Wesley:

The Office of the Receiver has reviewed the draft report of the Office of the Inspector General (OIG) Medical Inspection Results for California State Prison, Sacramento (SAC) conducted from January to September 2017. California Correctional Health Care Services (CCHCS) acknowledges the OIG findings.

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

Sincerely,

DeANNA GOULDY
Associate Director
Risk Management Branch
California Correctional Health Care Services

cc: Clark Kelso, Receiver
Diana Toche, D.D.S., Undersecretary, Health Care Services, CDCR
Richard Kirkland, Chief Deputy Receiver
Stephen Tseng, M.D., Chief of Medical Inspections, OIG
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