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Inspector General

Office of the Inspector General

San Quentin State Prison
Medical Inspection Results
Cycle 4

July 2016

Fairness ◆ Integrity ◆ Respect ◆
Service ◆ Transparency

Office of the Inspector General
SAN QUENTIN STATE PRISON
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EXECUTIVE SUMMARY

Under the authority of California Penal Code Section 6126, 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 court may find that an institution the OIG found to be providing adequate care still did not meet constitutional standards, depending on the analysis of the underlying data provided by the OIG. Likewise, an institution that has been rated *inadequate* by the OIG could still be found to pass constitutional muster with the implementation of remedial measures if the underlying data were to reveal easily mitigated deficiencies.

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.

For this fourth cycle of inspections, the OIG added a clinical case review component and significantly enhanced the compliance portion of the inspection process from that used in prior cycles. In addition, the OIG added a population-based metric comparison of selected Healthcare Effectiveness Data Information Set (HEDIS) measures from other State and national health care organizations and compared that data to similar results for San Quentin State Prison (San Quentin).

The OIG performed its Cycle 4 medical inspection at San Quentin from January to March 2016. The inspection included in-depth reviews of 89 inmate-patient files conducted by clinicians, as well as reviews of documents from 421 inmate-patient files, covering 102 objectively scored tests of compliance with policies and procedures applicable to the delivery of medical care. The OIG assessed the case review and compliance results using 15 health care quality indicators applicable to the institution, made up of 13 primary clinical indicators and two secondary administrative indicators. To conduct clinical case reviews, the OIG employs a clinician team consisting of a physician and a registered nurse consultant, while compliance testing is done by a team of deputy inspectors general and registered nurses trained in monitoring medical compliance. Of the 13 primary indicators, eight were rated by both case review clinicians and compliance inspectors, three were rated by case review clinicians only, and two were rated by compliance inspectors only; both secondary indicators were rated by compliance inspectors only. See the Health Care Quality Indicators table on page ii. Based on that analysis, OIG experts made a considered and measured overall opinion that the quality of health care at San Quentin was ***adequate***.

Health Care Quality Indicators

Fourteen Primary Indicators (Clinical)	All Institutions–Applicability	San Quentin Applicability
1–Access to Care	All institutions	Both case review and compliance
2–Diagnostic Services	All institutions	Both case review and compliance
3–Emergency Services	All institutions	Case review only
4–Health Information Management (Medical Records)	All institutions	Both case review and compliance
5–Health Care Environment	All institutions	Compliance only
6–Inter- and Intra-System Transfers	All institutions	Both case review and compliance
7–Pharmacy and Medication Management	All institutions	Both case review and compliance
8–Prenatal and Post-Delivery Services	Female institutions only	Not applicable
9–Preventive Services	All institutions	Compliance only
10–Quality of Nursing Performance	All institutions	Case review only
11–Quality of Provider Performance	All institutions	Case review only
12–Reception Center Arrivals	Institutions with reception centers	Both case review and compliance
13–Specialized Medical Housing (OHU, CTC, SNF, Hospice)	All institutions with an OHU, CTC, SNF, or Hospice	Both case review and compliance
14–Specialty Services	All institutions	Both case review and compliance
Two Secondary Indicators (Administrative)	**All Institutions–Applicability**	**San Quentin Applicability**
15–Internal Monitoring, Quality Improvement, and Administrative Operations	All institutions	Compliance only
16–Job Performance, Training, Licensing, and Certifications	All institutions	Compliance only

Overall Assessment: Adequate

Overall Assessment Rating:

Adequate

Based on the clinical case reviews and compliance testing, the OIG's overall assessment rating for San Quentin was *adequate*. Of the 13 primary (clinical) quality indicators applicable to San Quentin, the OIG found one *proficient*, ten *adequate*, and two *inadequate*. Of the two secondary (administrative) quality indicators, the OIG found both *inadequate*. To determine the overall assessment, the OIG considered individual clinical ratings and individual compliance question scores within each of the indicator categories, putting emphasis on the primary indicators. Based on that analysis, OIG experts made a considered and measured overall opinion about the quality of health care observed at San Quentin.

Clinical Case Review and OIG Clinician Inspection Results

The clinicians' case reviews sampled patients with high medical needs and included a review of more than 1,883 patient care events.[1] Of the 13 primary indicators applicable to San Quentin, 11 were evaluated by clinician case review; one was *proficient*, nine were *adequate*, and one was *inadequate*. When determining the overall adequacy of care, the OIG paid particular attention to the clinical nursing and provider quality indicators, as adequate health care staff can sometimes overcome suboptimal processes and programs. However, the opposite is not true; inadequate health care staff cannot provide adequate care, even though the established processes and programs onsite may be adequate. The OIG clinicians identify inadequate medical care based on the risk of significant harm to the patient, not the actual outcome.

Program Strengths — Clinical

- Providers displayed proficient medical care. Providers performed very well managing complex medical patients. Providers usually made sound and accurate diagnoses, and treatment plans were appropriate and thorough. Providers reviewed medical records thoroughly. Emergency care and anticoagulation management were also good. Hepatitis C and diabetes management were typically excellent. Providers referred patients for specialty services appropriately, and the quality of their documentation was excellent. The institution had one designated provider who delivered coordinated specialty care and closely monitored hepatitis C patients. This provider demonstrated in-depth knowledge and understanding about the disease process.

- During the period of review, San Quentin provided good access to primary care services.

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

- The institution provided good diagnostic services, with diagnostic tests being performed in a timely manner.

- San Quentin was fully committed to a primary care home model with good provider continuity. The OIG clinicians' onsite inspection revealed well-functioning care teams. The institution's nurses demonstrated an equal commitment to this model. In most clinics, nurses carried out tasks beyond their routine duties, such as conducting daily sick call visits and performing informal checks on patients who required more attention. Providers and nurses frequently utilized email as a means to communicate, which was more effective than voicemail, so open lines of communication between providers and nurses was maintained.

- Health care leadership at San Quentin was excellent and provided good support, which allowed each primary care team to deliver effective health care to patients. Nursing staff felt equally supported by their supervisors and the chief nursing executive (CNE). At the onsite interviews, all of the providers expressed excellent job satisfaction as well as good morale. The majority of nurses interviewed were also enthusiastic about their positions, due in large part to the excellent leadership.

- At the time of the OIG onsite inspection, the offsite specialty services nurse and the utilization management (UM) nurse had an excellent process of transmitting offsite specialty reports to providers. Both nurses diligently obtained and, on the same day, emailed specialty and hospital reports to providers. This ensured providers had immediate access to all offsite medical information. Also, this process mitigated any lapses in the transmission of medical information to providers, thus preventing any lapses in patient care.

Program Weaknesses — Clinical

- The institution had problems with processing diagnostic and specialty reports. Staff often did not retrieve or scan the reports into the electronic unit health record. The OIG clinicians also found some delays in the retrieval of diagnostic and specialty reports.

- San Quentin had difficulty with processing provider and nursing progress notes. Numerous cases were identified where provider and nursing documents were missing from the eUHR.

- Staff also performed poorly with scanning times for providers' progress notes and diagnostic reports in the eUHR. However, most delays in scanning resulted from providers or onsite specialists failing to sign documents in a timely manner.

Compliance Testing Results

Of the 13 total health care indicators applicable to San Quentin, ten were evaluated by compliance inspectors.[2] There were 102 individual compliance questions within those ten indicators, generating 1,529 data points, testing San Quentin's compliance with California Correctional Health Care Services (CCHCS) policies and procedures.[3] Those 102 questions are detailed in *Appendix A — Compliance Test Results*. The institution's inspection scores in the 12 applicable indicators ranged from 60.2 percent to 87.0 percent, with the secondary (administrative) indicator *Internal Monitoring, Quality Improvement, and Administrative Operations* receiving the lowest score, and the primary indicator *Inter- and Intra-System Transfers* receiving the highest. Of the ten primary indicators applicable to compliance testing, the OIG rated one *proficient*, five *adequate*, and four *inadequate*. Of the two secondary indicators, which involve administrative health care functions, both were rated *inadequate*.

Program Strengths — Compliance

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

- Nursing staff timely reviewed patients' requests for health care services and timely completed face-to-face visits with patients.
- Patients received timely provider follow-up visits upon returning from specialty service appointments.
- Patients received their radiology, laboratory, and pathology diagnostic services within required time frames.
- Providers timely reviewed community hospital discharge reports when patients returned to the institution.
- Clinical areas were disinfected, cleaned, and sanitary; reusable invasive and non-invasive medical equipment was properly sterilized; and clinic common areas had an adequate environment conducive to providing medical services.
- For patients who transferred out of San Quentin, medication transfer packages included required medications, corresponding medication administration records (MARs), and medication reconciliation records.

[2] The OIG's compliance inspectors are trained deputy inspectors general and 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.

- Health care staff timely delivered newly ordered prescription medications. Patients discharged from community hospitals or received from county jails also received their medications within the required time frame.

- In its main pharmacy, San Quentin followed general security, organization, and cleanliness management protocols; properly stored and monitored non-narcotic medications; and properly accounted for narcotic medications.

- Patients timely received or were timely offered influenza vaccinations and colorectal cancer screenings.

- Nursing staff properly completed the Initial Health Screening form (CDCR Form 7277), and providers timely completed a history and physical examination for all inmates sampled whom San Quentin received from a county jail.

- Patients timely received high-priority specialty service appointments, and providers reviewed the reports within the required time frame.

The following are some of the strengths identified within the two secondary administrative indicators:

- The institution promptly processed inmate medical appeals during the most recent 12 months, and San Quentin addressed the patients' issues in all of the sampled second-level medical appeals.

- The Quality Management Committee met at least monthly to evaluate program performance and took action when improvement opportunities were identified.

- Medical staff reviewed and submitted all initial inmate death reports to the Death Review Unit in a timely manner.

- All providers and nurses and the pharmacist in charge were current with their professional licenses and certifications, and the pharmacy and authorized providers maintained current Drug Enforcement Agency registrations.

Program Weaknesses — Compliance

The institution received ratings of *inadequate*, scoring below 75 percent, in the following four primary indicators: *Diagnostic Services*, *Health Information Management (Medical Records)*, *Preventive Services*, and *Specialized Medical Housing (OHU, CTC, SNF, Hospice)*. The institution also received *inadequate* scores in both secondary indicators, *Internal Monitoring, Quality Improvement, and Administrative Operations* and *Job Performance, Training, Licensing, and Certifications*. The following are some of the weaknesses identified by San Quentin's compliance scores on individual questions in all the primary health care indicators:

- Providers did not conduct timely appointments with patients who required a PCP follow-up visit for chronic care conditions or those who were referred by a registered nurse for a provider sick call follow-up appointment.

- Primary care providers did not always review and initial radiology reports timely, and did not always communicate results from pathology reports to patients.

- Clinical health care staff did not always adhere to universal hand hygiene precautions.

- Clinics did not always follow protocols for managing and storing bulk medical supplies, and clinic common areas and exam rooms did not always have essential medical equipment and supplies.

- Clinical staff did not employ strong security controls over narcotic medications assigned to clinical areas and did not follow proper protocols for storing non-narcotic medications.

- The institution did not always properly store refrigerated and non-refrigerated medications.

- Nursing staff did not always utilize proper hand hygiene protocols during medication preparation, and did not always follow administrative protocols when administering medications.

- The institution did not always administer anti-tuberculosis medications to patients at proper dosing intervals, and the institution's monitoring of patients on anti-tuberculosis medications was poor. In addition, the institution did not properly conduct the annual tuberculosis screening test, primarily as a result of nursing staff failing to document the time the tuberculosis test was administered or read.

- For inmate-patients received from county jails, the tuberculosis and coccidioidomycosis tests were not timely or properly administered.

The following are some of the weaknesses identified within the two secondary administrative indicators:

- The local governing body responsible for the quality management of patient health care did not always document its meetings as required by policy.

- Emergency response drill packages lacked the required documentation.

- Medical supervisors did not complete performance appraisals of providers.

The *San Quentin Executive Summary Table* on the following page lists the quality indicators the OIG inspected and assessed during the clinical case reviews and objective compliance tests, and

provides the institution's rating in each area. The overall indicator ratings were based on a consensus decision by the OIG's clinicians and non-clinical inspectors.

San Quentin Executive Summary Table

Primary Indicators (Clinical)4	Case Review Rating	Compliance Rating	Overall Indicator Rating
Access to Care	*Adequate*	*Adequate*	*Adequate*
Diagnostic Services	*Adequate*	*Inadequate*	*Adequate*
Emergency Services	*Adequate*	Not Applicable	*Adequate*
Health Information Management (Medical Records)	*Inadequate*	*Inadequate*	*Inadequate*
Health Care Environment	Not Applicable	*Adequate*	*Adequate*
Inter- and Intra-System Transfers	*Adequate*	*Proficient*	*Adequate*
Pharmacy and Medication Management	*Adequate*	*Adequate*	*Adequate*
Preventive Services	Not Applicable	*Inadequate*	*Inadequate*
Quality of Nursing Performance	*Adequate*	Not Applicable	*Adequate*
Quality of Provider Performance	*Proficient*	Not Applicable	*Proficient*
Reception Center Arrivals	*Adequate*	*Adequate*	*Adequate*
Specialized Medical Housing (OHU, CTC, SNF, Hospice)	*Adequate*	*Inadequate*	*Adequate*
Specialty Services	*Adequate*	*Adequate*	*Adequate*

Note: The *Prenatal and Post-Delivery Services* indicator did not apply to this institution.

Secondary Indicators (Administrative)		Compliance Rating	Overall Indicator Rating
Internal Monitoring, Quality Improvement, and Administrative Operations	Not Applicable	*Inadequate*	*Inadequate*
Job Performance, Training, Licensing, and Certifications	Not Applicable	*Inadequate*	*Inadequate*

Compliance results for quality indicators are *proficient* (greater than 85.0 percent), *adequate* (75.0 percent to 85.0 percent), or *inadequate* (below 75.0 percent).

Population-Based Metrics

In general, San Quentin performed adequately as measured by population-based metrics. Statewide, the institution outperformed or equaled Medi-Cal and Kaiser (typically one of the highest scoring health organizations in California). Nationally, the institution outperformed Medicaid, Medicare, and commercial health plans in all five diabetic measures, and outperformed the United States Department of Veterans Affairs (VA) in three of four applicable measures, with the VA outperforming the institution in only diabetic eye exams.

With regard to immunization measures, San Quentin's scores were average, higher than commercial health plans and Medicare, but lower than Kaiser and the VA. For pneumococcal vaccinations, San Quentin outperformed Medicare, but underperformed in comparison to the VA. The institution scored well in colorectal cancer screening by outperforming all statewide and national health care organizations.

Overall, San Quentin's performance demonstrated by population-based metrics indicated that comprehensive diabetes care, immunizations, and colorectal cancer screening were adequate in comparison to statewide and national health care organizations.

INTRODUCTION

Under the authority of California Penal Code Section 6126, 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. For this fourth cycle of inspections, the OIG augmented the breadth and quality of its inspection program used in prior cycles, adding a clinical case review component and significantly enhancing the compliance component of the program.

San Quentin State Prison (San Quentin) was the 19th medical inspection of Cycle 4. During the inspection process, the OIG assessed the delivery of medical care to patients for 13 primary clinical health care indicators and two secondary administrative health care indicators applicable to the institution. It is important to note that while the primary quality indicators represent the clinical care being provided by the institution at the time of the inspection, the secondary quality indicators are purely administrative and are not reflective of the actual clinical care provided.

The OIG is committed to reporting on each institution's delivery of medical care to assist in identifying areas for improvement, but the federal court will ultimately determine whether any institution's medical care meets constitutional standards.

ABOUT THE INSTITUTION

San Quentin State Prison is California's oldest and best-known correctional institution, established on the site currently known as Point San Quentin in July 1852. The walled prison houses mostly medium-security (Level 2) and reception center inmates, and has four large cell blocks (west, south, north, and east), one maximum-security cell block (the adjustment center), a central health care service building, a medium-security dorm setting, and a minimum-security firehouse. The institution houses all of California's condemned male inmates on death row.

The institution runs eight medical clinics where staff members handle non-urgent requests for medical services, and it treats inmates needing urgent or emergency care in the triage and treatment area (TTA). San Quentin has a correctional treatment center (CTC) for inpatient services, which also includes a 40-bed psychiatric inpatient program. Inmates are seen in the receiving and release (R&R) clinic upon arrival at San Quentin, and there is specialty services clinic. It has been designated an intermediate (as opposed to basic) care prison; these institutions are predominately located in urban areas close to care centers and specialty care providers likely to be used by an inmate population with higher medical needs for the most cost-effective care.

On August 16, 2015, the institution received national accreditation from the Commission on Accreditation for Corrections. This accreditation program is a professional peer review process based on national standards set by the American Correctional Association.

Based on unaudited staffing data the OIG obtained from the institution, San Quentin's vacancy rate among medical managers, primary care providers (PCPs), supervisors, and rank-and-file nurses was 5 percent in January 2016, with the highest vacancy percentages among nursing staff at 6 percent. Lastly, the chief executive officer reported that in January 2016, there were five medical staff members recently under disciplinary review and working in clinical settings at the prison.

San Quentin Health Care Staffing Resources as of January 2016

	Management		Primary Care Providers		Nursing Supervisors		Nursing Staff		Totals	
Description	**Number**	**%**	**Number**	**%**	**Number**	**%**	**Number**	**%**	**Number**	**%**
Authorized Positions	5	3%	13	8%	12.5	7%	140.7	82%	171.2	100%
Filled Positions	5	100%	13	100%	12	96%	132.9	94%	162.9	95%
Vacancies	0	0%	0	0%	0.5	4%	7.8	6%	8.3	5%
Recent Hires (within 12 months)	0	0%	2	15%	1	8%	31	23%	34	21%
Staff Utilized from Registry	0	0%	0	0%	0	0%	0	0%	0	0%
Redirected Staff (to Non-Patient Care Areas)	0	0%	0	0%	0	0%	0	0%	0	0%
Staff on Long-term Medical Leave	0	0%	0	0%	1	8%	8	6%	9	6%

Note: San Quentin Health Care Staffing Resources data was not validated by the OIG.

As of January 4, 2016, the Master Registry for San Quentin showed that the institution had a total population of 3,733. Within that total population, 7.3 percent were designated as high medical risk, Priority 1 (High 1), and 14.5 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, frequency of higher levels of care, age, and abnormal labs 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 chart below illustrates the breakdown of the institution's medical risk levels at the start of the OIG medical inspection.

Master Registry Data as of January 4, 2016

Medical Risk Level	# of Inmate-Patients	Percentage
High 1	274	7.3%
High 2	541	14.5%
Medium	1,378	36.9%
Low	1,540	41.3%
Total	**3,733**	**100%**

Commonly Used Abbreviations

ACLS	Advanced Cardiovascular Life Support	**HIV**	Human Immunodeficiency Virus
AHA	American Heart Association	**HTN**	Hypertension
ASU	Administrative Segregation Unit	**INH**	Isoniazid (anti-tuberculosis medication)
BLS	Basic Life Support	**IV**	Intravenous
CBC	Complete Blood Count	**KOP**	Keep-on-Person (in taking medications)
CC	Chief Complaint	**LPT**	Licensed Psychiatric Technician
CCHCS	California Correctional Health Care Services	**LVN**	Licensed Vocational Nurse
CCP	Chronic Care Program	**MAR**	Medication Administration Record
CDCR	California Department of Corrections and Rehabilitation	**MRI**	Magnetic Resonance Imaging
CEO	Chief Executive Officer	**MD**	Medical Doctor
CHF	Congestive Heart Failure	**NA**	Nurse Administered (in taking medications)
CME	Chief Medical Executive	**N/A**	Not Applicable
CMP	Comprehensive Metabolic (Chemistry) Panel	**NP**	Nurse Practitioner
CNA	Certified Nursing Assistant	**OB**	Obstetrician
CNE	Chief Nurse Executive	**OHU**	Outpatient Housing Unit
C/O	Complains of	**OIG**	Office of the Inspector General
COPD	Chronic Obstructive Pulmonary Disease	**P&P**	Policies and Procedures (CCHCS)
CP&S	Chief Physician and Surgeon	**PA**	Physician Assistant
CPR	Cardio-Pulmonary Resuscitation	**PCP**	Primary Care Provider
CSE	Chief Support Executive	**POC**	Point of Contact
CT	Computerized Tomography	**PPD**	Purified Protein Derivative
CTC	Correctional Treatment Center	**PRN**	As Needed (in taking medications)
DM	Diabetes Mellitus	**RN**	Registered Nurse
DOT	Directly Observed Therapy (in taking medications)	**Rx**	Prescription
Dx	Diagnosis	**SNF**	Skilled Nursing Facility
EKG	Electrocardiogram	**SOAPE**	Subjective, Objective, Assessment, Plan, Education
ENT	Ear, Nose and Throat	**SOMS**	Strategic Offender Management System
ER	Emergency Room	**S/P**	Status Post
eUHR	electronic Unit Health Record	**TB**	Tuberculosis
FTF	Face-to-Face	**TTA**	Triage and Treatment Area
H&P	History and Physical (reception center examination)	**UA**	Urinalysis
HIM	Health Information Management	**UM**	Utilization Management

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 14 primary (clinical) and two secondary (administrative) quality indicators 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 indicators address the administrative functions that support a health care delivery system. The 14 primary quality indicators are *Access to Care*, *Diagnostic Services*, *Emergency Services*, *Health Information Management (Medical Records)*, *Health Care Environment*, *Inter- and Intra-System Transfers*, *Pharmacy and Medication Management*, *Prenatal and Post-Delivery Services*, *Preventive Services*, *Quality of Nursing Performance*, *Quality of Provider Performance*, *Reception Center Arrivals*, *Specialized Medical Housing (OHU, CTC, SNF, Hospice)*, and *Specialty Services*. The two secondary quality indicators are *Internal Monitoring, Quality Improvement, and Administrative Operations*; and *Job Performance, Training, Licensing, and Certifications*.

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 deputy inspectors general and registered nurses. The ratings may be derived from the case review results alone, the compliance test results alone, or a combination of both these information sources. For example, the ratings for the primary quality indicators *Quality of Nursing Performance* and *Quality of Provider Performance* are derived entirely from the case review results, while the ratings for the primary quality indicators *Health Care Environment* and *Preventive Services* are derived entirely from compliance test results. As another example, primary quality indicators such as *Diagnostic Services* and *Specialty Services* receive ratings derived from both sources. At San Quentin, 15 of the quality indicators were applicable, consisting of 13 primary clinical indicators and two secondary administrative indicators. Of the 13 primary indicators, eight were rated by both case review clinicians and compliance inspectors, three were rated by case review clinicians only, and two were rated by compliance inspectors only; both secondary indicators were rated by compliance inspectors only.

Consistent with the OIG's agreement with the Receiver, this report only addresses the conditions found related to medical care criteria. The OIG does not review for efficiency and economy of operations. Moreover, if the OIG learns of an inmate-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, specific identifying details related to any such cases are not included in the OIG's 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 should not necessarily be interpreted as indicative of deficient medical care delivery.

CASE REVIEWS

The OIG has added case reviews to the Cycle 4 medical inspections at the recommendation of its stakeholders. At the conclusion of Cycle 3, the federal Receiver and the Inspector General determined that the health care provided at the institutions was not fully evaluated by the compliance tool alone, and that the compliance tool was not designed to provide comprehensive qualitative assessments. Accordingly, the OIG added case reviews in which OIG physicians and nurses evaluate selected cases in detail to determine the overall quality of health care provided to the inmate-patients. The OIG's clinicians perform a retrospective chart review of selected patient files to evaluate the care given by an institution's primary care providers and nurses. Retrospective chart review is a well-established review process used by health care organizations that perform peer reviews and patient death reviews. Currently, CCHCS uses retrospective chart review as part of its death review process and in its pattern-of-practice reviews. CCHCS also uses a more limited form of retrospective chart review when performing appraisals of individual primary care providers.

PATIENT SELECTION FOR RETROSPECTIVE CASE REVIEWS

Because retrospective chart review is time consuming and requires qualified health care professionals to perform it, OIG clinicians must carefully sample patient records. Accordingly, the group of patients the OIG targeted for chart review carried the highest clinical risk and utilized the majority of medical services. A majority of the patients selected for retrospective chart review were classified by CCHCS as high-risk patients. The reason the OIG targeted these patients for review is twofold:

1. The goal of retrospective chart review is to evaluate all aspects of the health care system. Statewide, high-risk and high-utilization patients consume medical services at a disproportionate rate; 11 percent of the total patient population are considered high-risk and

account for more than half of the institution's pharmaceutical, specialty, community hospital, and emergency costs.

2. Selecting this target group for chart 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-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 will be providing 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 charts generated during death reviews, sentinel events (unexpected occurrences involving death or serious injury, or risk thereof), and hospitalizations are mostly of high-risk patients.

BENEFITS AND LIMITATIONS OF TARGETED SUBPOPULATION REVIEW

Because the selected patients utilize the broadest range of services offered by the health care system, the OIG's retrospective chart review provides adequate data for a qualitative assessment of the most vital system processes (referred to as "primary quality indicators"). Retrospective chart 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 ability of the institution to provide adequate 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 adequately care 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 conclusions from the retrospective chart reviews to the general population. For example, if the high-risk diabetic patients reviewed have poorly-controlled diabetes, one cannot conclude that the entire diabetic population is inadequately controlled. Similarly, if the high-risk diabetic patients under review have poor outcomes and require significant specialty interventions, one cannot conclude that the entire diabetic population is having similarly poor outcomes.

Nonetheless, the health care system's response to this subpopulation can be accurately evaluated and yields valuable systems information. In the above example, if the health care system is providing appropriate diabetic monitoring, medication therapy, and specialty referrals for the high-risk patients reviewed, then it can be reasonably inferred that the health care system is also providing appropriate diabetic services to the entire diabetic subpopulation. However, if these same high-risk patients needing monitoring, medications, and referrals are generally not getting those services, it is likely that the health care system is not providing appropriate diabetic services to the greater diabetic subpopulation.

CASE REVIEWS SAMPLED

As indicated in *Appendix B, Table B–1, San Quentin Sample Sets*, the OIG clinicians evaluated medical charts for 89 unique inmate-patients. *Appendix B, Table B–4, San Quentin Case Review Sample Summary*, clarifies that both nurses and physicians reviewed charts for 18 of those patients, for 107 reviews in total. Physicians performed detailed reviews of 30 charts, and nurses performed detailed reviews of 17 charts, totaling 47 detailed reviews. For detailed case reviews, physicians or nurses looked at all encounters occurring in approximately six months of medical care. Nurses also performed a limited or focused review of medical records for an additional 60 inmate-patients. These generated 1,883 clinical events for review (*Appendix B, Table B-3, San Quentin Event-Program*). The reporting format provides details on whether the encounter was adequate or had significant deficiencies, and identifies deficiencies by programs and processes to help the institution focus on improvement areas.

While the sample method specifically pulled only five chronic care patient records, i.e., two diabetes patients and three anticoagulation patients (*Appendix B, Table B–1, San Quentin Sample Sets*), the 89 unique inmate-patients sampled included patients with 333 chronic care diagnoses, including 29 additional patients with diabetes (for a total of 31) (*Appendix B, Table B–2, San Quentin Chronic Care Diagnoses*). The OIG's sample selection tool evaluated 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 overall operation of the institution's system and staff were assessed for adequacy. The OIG's case review methodology and sample size matched other qualitative research. The empirical findings, supported by expert statistical consultants, showed adequate conclusions after 10 to 15 charts had undergone full clinician review. In qualitative statistics, this phenomenon is known as "saturation." The sample size of over 30 detailed reviews certainly far exceeds the saturation point necessary for an adequate qualitative review. With regard to reviewing charts from different providers, the OIG's pilot inspections have shown that most providers have been adequately reviewed. The case review is not intended to be a focused search for poorly performing providers; rather, it is focused on how the system cares for those patients who need care the most. Providers would only escape OIG case review if institutional management successfully mitigated patient risk by having the more poorly performing PCPs care for the less complicated, low utilizing, and lower

risk patients. The OIG concluded that the case review sample size was more than adequate to assess the quality of services provided.

Based on the collective results of clinicians' case reviews, the OIG rated each quality indicator as either *proficient* (excellent), *adequate* (passing), *inadequate* (failing), or not applicable. A separate confidential *San Quentin Supplemental Medical Inspection Results: Individual Case Review Summaries* report details the case reviews 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.*

COMPLIANCE TESTING

SAMPLING METHODS FOR CONDUCTING COMPLIANCE TESTING

From January to March 2016, deputy inspectors general and registered nurses attained answers to 102 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 inmate-patients for whom the testing objectives were applicable and reviewed their electronic unit health records. In some cases, inspectors used the same samples to conduct more than one test. In total, inspectors reviewed health records for 421 individual inmate-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 January 18, 2016, field inspectors conducted a detailed onsite inspection of San Quentin's medical facilities and clinics; interviewed key institutional employees; and reviewed employee records, logs, medical appeals, death reports, and other documents. This generated 1,529 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 San Quentin'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

The OIG rated the institution in the following ten primary (clinical) and two secondary (administrative) quality indicators applicable to the institution for compliance testing:

- Primary indicators: *Access to Care, Diagnostic Services, Health Information Management (Medical Records), Health Care Environment, Inter- and Intra-System Transfers, Pharmacy*

and Medication Management, Preventive Services, Reception Center Arrivals, Specialized Medical Housing (OHU, CTC, SNF, Hospice), and *Specialty Services*.

- Secondary indicators: *Internal Monitoring, Quality Improvement, and Administrative Operations*; and *Job Performance, Training, Licensing, and Certifications*.

After compiling the answers to the 102 questions, the OIG derived a score for each primary and secondary quality indicator identified above 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 percent), *adequate* (between 75 percent and 85 percent), or *inadequate* (less than 75 percent).

DASHBOARD COMPARISONS

In the first ten medical inspection reports of Cycle 4, the OIG identified where similar metrics for some of the individual compliance questions were available within the CCHCS Dashboard, which is a monthly report that consolidates key health care performance measures statewide and by institution. However, there was not complete parity between the metrics due to differing time frames for data collecting and differences in sampling methods, rendering the metrics non-comparable. Some of the OIG's stakeholders suggested removing the Dashboard comparisons from future reports to eliminate confusion. Dashboard data is available on CCHCS's website, www.cphcs.ca.gov.

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, deputy inspectors general and registered nurses 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 inmate-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 inmate-patient population. To identify outcomes for San Quentin, the OIG reviewed some of the compliance testing results, randomly sampled additional inmate-patients' records, and obtained San Quentin data from the CCHCS Master Registry. The OIG compared those results to HEDIS metrics reported by other statewide and national health care organizations.

MEDICAL INSPECTION RESULTS

PRIMARY (CLINICAL) QUALITY INDICATORS OF HEALTH CARE

The primary quality indicators assess the clinical aspects of health care. As shown on the *Health Care Quality Indicators* table on page ii of this report, 13 of the OIG's primary indicators were applicable to San Quentin. Of those 13 indicators, eight were rated by both the case review and compliance components of the inspection, three were rated by the case review component alone, and two were rated by the compliance component alone.

The *San Quentin Executive Summary Table* on page ix shows the case review compliance ratings for each applicable indicator.

Summary of Case Review Results: The clinical case review component assessed 11 of the 13 primary (clinical) indicators applicable to San Quentin. Of these 11 indicators, the OIG clinicians rated one *proficient*, nine *adequate*, and one *inadequate*.

The OIG physicians rated the adequacy of care for each of the 30 detailed case reviews they conducted. Of these 30 cases, four were *proficient*, 22 were *adequate,* and four were *inadequate*. In the 1,883 events reviewed, there were 680 deficiencies, of which 67 were considered to be of such magnitude that, if left unaddressed, they would likely contribute to patient harm.

Adverse Events Identified During Case Review: Medical care is a complex dynamic process with many moving parts, subject to human error even within the best health care organizations. Adverse events are typically identified and tracked by all major health care organizations for the purpose of quality improvement. They are not generally representative of medical care delivered by the organization. The OIG identified adverse events for the dual purposes of quality improvement and the illustration of problematic patterns of practice found during the inspection. Because of the anecdotal description of these events, the OIG cautions against drawing inappropriate conclusions regarding the institution based solely on adverse events.

There were three adverse events identified in the case reviews at San Quentin. The cases were not reflective of the quality of care at San Quentin.

- In case 6, the provider failed to recognize a critically elevated blood pressure in a patient. However, the patient had previously been noncompliant with his blood pressure medications and had repeatedly refused to follow-up with his providers for management of his hypertension. This may be why the provider did not transfer the patient to a higher level of care such as the triage and treatment area (TTA). In addition, the provider may not have immediately treated the patient's blood pressure as he denied having chest pain and was asymptomatic at the time.

- In case 18, the provider incorrectly diagnosed the patient's lung abscess as a possible empyema (collection of pus in the chest cavity). The patient was not immediately transferred

to an outside hospital for treatment. However, the provider may have kept the patient in-house for a few additional days because he had recently been discharged from the hospital without a diagnosis of infection. However, the provider failed to recognize the patient's abnormally elevated heart rate as a sign of early sepsis (a life threatening infection). The provider did eventually decide to transfer the patient to a hospital. However, the untreated infection led to the patient's cardiopulmonary arrest (sudden loss of consciousness, breathing, and heart function) while he awaited transfer, and the patient died in the TTA.

- In case 43, the provider failed to do further workup for a patient with a recently discovered lung mass and prior non-Hodgkin lymphoma (cancer of the lymph gland); 42 days passed before the provider ordered a follow-up chest computerized tomography (CT) scan for the patient. Furthermore, the referral for the CT scan was inappropriately submitted as routine rather than urgent.

Summary of Compliance Results: The compliance component assessed 10 of the 13 primary (clinical) indicators applicable to San Quentin. Of these ten indicators, one was rated *proficient*, five *adequate*, and four *inadequate*. The results of those assessments are summarized within this section of the report. The test questions used to assess compliance for each indicator are detailed in *Appendix A*.

ACCESS TO CARE

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

Case Review Rating:
Adequate
Compliance Score:
Adequate
(77.9%)

Overall Rating:
Adequate

Case Review Results

The OIG clinicians reviewed 946 provider, nursing, specialty, and outside hospital encounters and identified 15 deficiencies relating to *Access to Care*. Although there were a low number of deficiencies, the deficiencies in 13 of the 15 cases were more likely than not to cause patient harm if allowed to persist and not rectified. Due to the qualitative severity of the deficiencies, San Quentin could not be granted the highest rating for *Access to Care* and was thus rated *adequate*.

Provider-to-Provider Follow-up Appointments

San Quentin performed marginally with provider-ordered follow-up appointments. These are among the most important aspects of the *Access to Care* indicator. Failure to accommodate provider-ordered appointments can result in lapses in care or even in patients being lost to follow-up. This deficiency was displayed in cases 9, 19, 22, 25, 27, 31, 38, and 43. The OIG clinicians reviewed 229 outpatient provider encounters and found only two major deficiencies, both of which resulted entirely from scheduling oversights. Although infrequent, errors such as these placed the patients at significant risk of harm.

- In case 6, the patient had a critically elevated blood pressure of 211/130. The provider ordered a two-day RN follow-up for a repeat blood pressure, but it did not occur.

- In case 39, the patient had an invasive type of tongue cancer being treated with radiation and chemotherapy. The patient lost significant weight due to his meal portions not being increased as his provider had ordered. His provider ordered a two-day follow-up, but it did not occur.

RN Sick Call Access

San Quentin performed very well with RN sick call assessments. Of the 91 sick call assessments reviewed, only one was not completed in a timely manner.

RN-to-Provider Referrals

- In case 27, the nurse requested a provider follow-up, but it never occurred.
- In case 80, the nurse requested a 14-day provider follow-up, but it did not occur until eight weeks later.

Provider Follow-up After Specialty Service

The institution consistently provided patients with a provider follow-up after specialty services. The OIG clinicians reviewed 160 diagnostic and consultative specialty services and found only five deficiencies where provider follow-ups were delayed.

- In case 24, the follow-up ordered by the nephrologist was 11 days late.
- In case 25, the provider saw the patient six days outside the three-month follow-up interval ordered by the podiatrist.
- In case 40, the provider saw the patient four days outside the one-month follow-up interval ordered by the telemedicine dermatologist.
- Also for case 40, a provider saw the patient 12 days outside the requested follow-up date by an urologist.
- In case 42, the patient was seen four days outside the two- to three-week week follow-up interval ordered by the vascular surgeon.

Intra-System Transfers

Patients who transferred into San Quentin, and whom an RN referred to the provider were generally seen timely. The OIG clinicians reviewed eight transfer-in patients, three of whom a provider did not see within the required time frame:

- In case 11, the referred patient was seen by a provider eight days later than ordered.
- In case 13, the initial provider visit occurred 12 days later than ordered.
- In case 44, the initial provider visit occurred one day later than ordered.

Reception Center

San Quentin performed well in providing initial provider visits for history and physical examinations. The majority of these exams were completed timely. Of the five patients reviewed, all but one (case 44) had a provider visit within seven days. In case 44, the initial provider visit occurred one day late due to a custody issue.

RN Case Management

The OIG clinicians reviewed case management RN encounters with two diabetic patients. San Quentin case management nurses met weekly with both of these patients.

Follow-up After Hospitalization

San Quentin had no difficulty ensuring that providers saw their patients after return from an outside hospital or an emergency department. The institution had 41 hospitalization and outside emergency events. There were no deficiencies with *Access to Care* in this area.

Urgent/Emergent Care

The institution had no difficulty ensuring that the PCP or the clinic RN evaluated patients in the triage and treatment area (TTA). The OIG clinicians reviewed 57 urgent/emergent encounters, of which 37 required a PCP or an RN follow-up. In six instances, either the PCP follow-up or the clinic RN follow-up from the TTA did not occur.

- In case 18, a provider saw the patient in the TTA for back pain. The follow-up ordered by the provider did not occur until five days after the requested time frame.

- In case 19, the patient with severe congestive heart failure was seen in the TTA after his implantable cardiac defibrillator activated and delivered an electrical shock to his heart. A next-day TTA follow-up with the PCP was ordered but did not occur.

- In case 22, the patient arrived at the TTA for respiratory distress, as documented by the RN. The RN also documented that the patient had wheezing during the exam. A provider ordered a next-day RN follow-up, but it did not occur.

- In case 25, the patient with progressive lung disease went to the TTA for cough and shortness of breath. The RN follow-up did not occur within the two-day interval ordered by the provider.

- In case 30, TTA staff evaluated the patient after accidentally ingesting cleaning fluid. The on-call physician ordered a TTA follow-up for later that day, but it did not occur.

- In case 32, the patient was seen in the TTA for a severe groin rash. The follow-up ordered by the provider did not occur until 13 days after the requested time frame.

Specialized Medical Housing

San Quentin performed poorly with provider access during and after admission to the correctional treatment center (CTC). Providers did not always see patients in the CTC within the appropriate time interval. The OIG clinicians reviewed seven CTC admissions with 135 CTC provider encounters. A pattern emerged during the case review wherein providers failed to follow up with CTC patients every 72 hours, as policy requires. In cases 10 and 27, this policy was violated numerous times.

Specialty Access

Access to specialty services is discussed in the *Specialty Services* indicator.

Clinician Onsite Inspection

The issue of CTC patients not being seen within the every 72-hour policy requirement was addressed during the onsite inspection. The OIG clinicians already knew of the waiver that allowed providers to follow up at least every seven days with those patients who were designated long-term care (LTC) patients. However, the OIG clinicians informed the medical staff that all the delays in CTC follow-ups had occurred prior to the waiver being granted on October 7, 2015. Furthermore, providers failed to designate patients as LTC prior to only seeing them every seven days. San Quentin medical staff admitted they had been unaware of the waiver being granted in October 2015 and initially thought the CTC follow-ups reviewed by the OIG clinicians fell under the time period covered by the waiver. Finally, one CTC provider did not know that CTC patients had to be first designated as LTC before they could be seen every seven days.

Clinician Summary

Only a few areas displayed problems, such as follow-up appointments after TTA visits, delays in scheduled provider follow-up appointments, rare scheduling errors, and inappropriate CTC follow-ups prior to obtaining the waiver. The OIG clinicians rated San Quentin *adequate* in this indicator.

Compliance Testing Results

The institution performed in the *adequate* range in the *Access to Care* indicator, with a compliance score of 77.9 percent. San Quentin scored in the *proficient* range in the following test areas:

- Inmates had access to Health Care Services Request forms (CDCR Form 7362) at all six housing units inspected (MIT 1.101).

- Inspectors sampled 40 Health Care Services Request forms (CDCR Form 7362) submitted by inmates across all facility clinics. Nursing staff reviewed 38 of the forms on the same day they were received (95 percent). Two nurses reviewed the request form one day late (MIT 1.003). In 39 of 40 samples of the CDCR Form 7362s, nursing staff completed a

face-to-face encounter with each patient within one business day of reviewing the service request form (98 percent). One patient was offered a face-to-face encounter three days late (MIT 1.004).

- Inspectors also sampled 28 patients who received a specialty service; 25 of them (89 percent) received a timely follow-up appointment with a PCP. Three patients receive their follow-up appointment from one to 15 days late (MIT 1.008).

The institution scored in the *adequate* range in the following two tests:

- Of the 28 patients sampled who transferred into San Quentin from other institutions and were referred to a PCP for a routine appointment based on nursing staff's initial health care screening, 22 were seen timely (79 percent). For six patients, appointments were held from 3 to 17 days late (MIT 1.002).

- Out of 30 sampled patients, 23 (77 percent) were offered a follow-up appointment with a PCP within five days of discharge from a community hospital. For seven patients, follow-up appointments were held between one and 17 days late (MIT 1.007).

The following test areas received scores in the *inadequate* range:

- When the OIG reviewed recent appointments for 40 inmate-patients with chronic care conditions, only 11 of the patients (28 percent) received timely routine appointments. For 21 patients, their chronic care follow-up appointment occurred from one day to nearly one year (354 days) late. Eight other patients never received their follow-up appointments at all (MIT 1.001).

- Among 20 sampled Health Care Services Request forms (CDCR Form 7362) on which nursing staff referred the patient for a PCP appointment, only 13 of the patients (65 percent) received a timely appointment. For seven patients, routine appointments were one to 68 days late (MIT 1.005).

- Inspectors tested a sample of 14 patients whom nursing staff referred for a PCP appointment and for whom the PCP subsequently ordered an additional follow-up appointment. Ten of the patients (71 percent) received their subsequent follow-up appointments timely; one patient never received his, and three patients received theirs between one and 34 days late (MIT 1.006).

Recommendations

No specific recommendations.

DIAGNOSTIC SERVICES

Case Review Rating:
Adequate
Compliance Score:
Inadequate
(71.6%)

Overall Rating:
Adequate

This indicator addresses several types of diagnostic services. Specifically, it addresses whether radiology and laboratory services were timely provided to inmate-patients, whether the primary care provider (PCP) timely reviewed the results, and whether the results were communicated to the inmate-patient within the required time frames. In addition, for pathology services, the OIG determines whether the institution received a final pathology report and whether the PCP 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.

In this indicator, the OIG's case review and compliance review processes yielded different results, with the case review giving an *adequate* rating and the compliance testing resulting in an *inadequate* score. The OIG's internal review process considered those factors that led to both results and ultimately rated this indicator *adequate*. Although the case review and compliance testing showed deficiencies in provider review of diagnostic reports, the case review process found that these delays did not affect patient care.

Case Review Results

San Quentin performed the majority of diagnostic services in a timely manner. However, failure to complete diagnostic tests is a serious deficiency that can potentially lead to significant delays or even lapses in medical care. Errors that involved tests that were not completed as ordered were uncommon, but were more likely to occur when tests had been ordered with longer processing time frames. The following examples are provided for quality improvement purposes only:

- In cases 5, 24, 31, 38, and 44, laboratory tests were ordered by the provider but not performed. The orders for these lab tests were never processed by the laboratory.
- In case 37, a provider ordered an x-ray for the patient that was never performed.
- Cases 43 and 44 had moderate delays in the collection of labs.
- In case 46, clinical staff collected routine labs for a reception center patient, and sent them to the laboratory services center contractor. The contractor received these labs the following day, but the results were not faxed to San Quentin until 28 days later. Furthermore, institution staff mislabeled these lab results in the electronic unit health record.

- In case 94, stat correctional treatment center labs (urgent lab tests performed and reported within hours) were ordered by the provider but drawn by the nurse the next day, and received by the laboratory services contractor two days after the order.

Health Information Management

Within the *Health Information Management* indicator, San Quentin displayed inadequacy in the following cases:

- San Quentin staff did not retrieve and scan laboratory reports into the eUHR in cases 22, 29, 32, and 37.

- Delayed scans of diagnostic reports into the eUHR were found in cases 22, 24, 38, 40, and 43. While these delays were moderate to significant, the majority were due to providers failing to consistently review test results in a timely manner. However, the quality of care was not significantly affected by these delays.

- Providers did not legibly sign or did not date laboratory reports in cases 32, 33, 38, and 43.

Clinician Onsite Inspection

During the onsite inspection, the OIG clinicians inquired about the low number but recurring instance of laboratory tests that were not completed. The laboratory supervisor explained that San Quentin had investigated several of the identified errors. The most common explanation was that orders were not received.

Clinician Summary

San Quentin generally did well in most aspects of the *Diagnostic Services* indicator. However, the low but recurring rate of laboratory tests that were ordered but not completed prevented San Quentin from attaining the highest rating in this category. In addition, the institution occasionally had difficulty in collecting and processing laboratory tests by the provider's order date. However, this was infrequent, and the majority of diagnostic services were completed in a timely manner. Therefore, the OIG clinicians rated this indicator *adequate.*

Compliance Testing Results

The institution received an *inadequate* compliance score of 71.6 percent in the *Diagnostic Services* indicator, which encompasses radiology, laboratory, and pathology services. For clarity, each type of diagnostic service is discussed separately below:

Radiology Services

- In all ten of the radiology services sampled, the services were timely performed (MIT 2.001); however, the provider only reviewed and signed three of the ten sampled

diagnostic reports timely (30 percent). For five samples, the TTA provider or CME, not the patient's provider as policy requires, reviewed the radiology results. A provider reviewed one sample 14 days late, and another sample was never reviewed (MIT 2.002). Lastly, providers only communicated the radiology results timely to six of the patients (60 percent). For the other four patients, providers communicated the results one to 14 days late (MIT 2.003).

Laboratory Services

- All ten of the laboratory services sampled were performed timely (MIT 2.004). However, only seven of the ten laboratory service orders sampled (70 percent) were timely reviewed by a provider. For two samples, the providers reviewed the reports three and four days late, and one other sample was never reviewed (MIT 2.005). Finally, providers timely communicated only seven of ten laboratory reports to the patient. Providers communicated results to three patients two to four days late (MIT 2.006).

Pathology Services

- The institution timely received the final pathology report for nine of ten patients sampled (90 percent). For one patient, San Quentin received the pathology report five days late (MIT 2.007). Providers documented sufficient evidence that they timely reviewed the final report results for eight of the ten patients (80 percent); for the other two patients, the PCP reviews were one and five days late (MIT 2.008). Providers timely communicated the final pathology test results to only four of the nine patients sampled (44 percent). Four patients received the provider communication of the pathology test results from one to 58 days late; for another patient, there was no evidence the provider communicated the test results to the patient at all (MIT 2.009).

Recommendations

No specific recommendations**.**

EMERGENCY SERVICES

Case Review Rating:
Adequate
Compliance Score:
Not Applicable

Overall Rating:
Adequate

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 the patient's emergency, clinical condition, and need for 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

The OIG clinicians reviewed 106 urgent or emergent events and found 52 deficiencies in a variety of areas, but the majority of deficiencies were minor and did not significantly impact patient care. In general, San Quentin performed adequately with basic life support (BLS) care and 9-1-1 call activation times. Overall, patients requiring urgent or emergent services received timely and adequate care in the majority of cases reviewed.

Provider Performance

The TTA providers generally saw patients timely and made adequate assessments. The providers made sound triage decisions and sent patients to higher levels of care appropriately. In one instance, a TTA provider failed to perform an adequate assessment, which had a negative impact for the patient. This incident is discussed further in the *Quality of Provider Performance* indicator.

Nursing Performance

The nursing care provided during emergency medical response incidents was generally adequate, with 21 deficiencies in the quality of nursing care. While most nursing deficiencies were minor, some TTA encounters displayed inadequate assessment and monitoring by the nurses. The following examples demonstrate these case review findings:

- In case 18, the TTA RN failed to adequately assess and monitor the patient. The patient was sent to the TTA in a wheelchair for shortness of breath. His medical history included chronic obstructive pulmonary disease (COPD), and he had been hospitalized recently for pneumonia. The RN did not assess the patient upon his arrival in the TTA other than to take vital signs. The RN failed to perform a thorough assessment or measure the peak flow

(measurement to determine breathing function). After placing oxygen on the patient, the RN did not monitor the patient's status until 80 minutes later, when the patient became unresponsive in his wheelchair. The physician was present in the TTA. Staff performed cardiopulmonary resuscitation (CPR) and administered rescue medications, but the patient could not be resuscitated.

- In case 27, the patient was brought to the TTA unable to urinate. The patient had prior surgeries to the urethra (a duct that drains urine from the bladder). The RN made three unsuccessful attempts to insert a catheter. At most, the RN should have made one very gentle attempt at catheterization. Subsequent attempts could (and did) result in damage to the urethra.

The following cases are for nursing quality improvement purposes:

- In case 3, the emergency response RN did not measure the blood glucose level in a non-breathing, insulin-dependent diabetic patient.

- In case 17, the TTA RN did not measure the blood glucose level in a diabetic patient until 35 minutes after the patient arrived.

- In case 21, the RN checked vital signs one time only when the patient arrived in the TTA. The patient received a pain medication injection 90 minutes later, and the RN released him to housing 20 minutes later. The RN should have checked vital signs prior to the release.

- In case 22, the patient presented to the TTA with fever, muscle aches, diarrhea, and confusion. The RN did not assess the patient for other symptoms of Legionnaire's Disease. This infectious disease had infected other patients at this prison during the time of this patient's encounter. The patient returned to the TTA the next morning for a follow-up visit with the RN. The patient complained of pain in his neck and a headache. The RN did not assess the new complaints of pain. Ultimately, this patient did not have Legionnaire's Disease, but medical staff should have initially tested him for this infection.

Clinician Onsite Inspection

The patient care environment in the TTA was staffed appropriately and contained necessary supplies and equipment for providing safe patient care. There were two nurses (one medical responder and one TTA RN) present in the TTA during the visit. The RN medical responder duties included going to the yard for any medical emergencies, while the TTA RN remained in the TTA for the duration of the shift. Two RNs were assigned during each watch for 24-hour coverage.

The TTA was located in the main medical building. Medical staff were required to carry emergency response equipment from the TTA and drive a transport vehicle to medical incidents. The TTA RNs frequently directed emergency medical services paramedics to respond directly to the scene when it was likely that the patient would require transfer to the hospital. Response times of the paramedics

ranged from 10 to 20 minutes from telephone call to arrival at the scene. Passing through security gates did not prolong the response time.

Specific examples of case review findings for patients returning through the TTA from hospital discharge medical return and other offsite appointments are discussed in the *Intra- and Inter-System Transfers* indicator. Case review findings for TTA documentation are discussed in the *Health Information Management* indicator.

Clinician Summary

San Quentin staff provided *adequate* emergency services to patients. While TTA providers made occasional questionable assessments, their triage decisions were largely appropriate. Nursing staff at San Quentin generally provided appropriate assessment, intervention, and monitoring during emergency medical responses.

Recommendations

No specific recommendations.

HEALTH INFORMATION MANAGEMENT (MEDICAL RECORDS)

Case Review Rating:
Inadequate
Compliance Score:
Inadequate
(64.6%)

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 unit health record (eUHR); whether the various medical records (internal and external, e.g., hospital and specialty reports and progress notes) are obtained and scanned timely into the inmate-patient's eUHR; whether records routed to clinicians include legible signatures or stamps; and whether hospital discharge reports include key elements and are timely reviewed by providers.

Case Review Results

Inter-Departmental Transmission

The institution made few transmission errors, the most significant of which was in case 88, when a critical lab result was not reported to the provider. Had the provider received the report, he may not have delayed the patient's transfer to the hospital.

Dictated Progress Notes

There were delays in transcribing provider progress notes in cases 2, 24, 27, 28, 30, 32, 39, 40, 42, and 43.

Hospital Records

San Quentin did very well with the retrieval of emergency department (ED) physician reports and hospital discharge summaries. The OIG clinicians reviewed nine ED events and 34 community hospital events. The institution retrieved and scanned all ED reports and discharge summaries in a timely manner, except in case 8.

Institution staff retrieved, reviewed, and scanned all hospital records into the eUHR, with the exception of case 40.

Most hospital records were appropriately reviewed and signed by a provider, except in cases 18 and 19 when the hospital discharge summaries lacked a provider signature to indicate that they were reviewed.

Most hospital records were dated by a provider to document when the report had been reviewed; cases 10 and 40 were exceptions.

Specialty Services

There were frequent problems in the retrieval and review of specialty reports. These findings are discussed in detail in the *Specialty Services* indicator.

There was one misfiled specialty document:

- In case 31, staff filed a specialty report in the wrong patient's chart.

Diagnostic Reports

San Quentin demonstrated poor performance in the retrieval and scanning of diagnostic reports, specifically laboratory reports. These findings are discussed in detail in the *Diagnostic Services* indicator.

Urgent/Emergent Records

Nurses sometimes did not properly document their urgent and emergent encounters. Cases 19, 24, 27, 30, and 31 had nursing documentation that was missing.

Scanning Performance

Mistakes were identified in the document scanning process as either mislabeled or misfiled documents. Mislabeled documents in the eUHR occurred in cases 5 and 42. Documents were misfiled (into the wrong patient's chart) more frequently; this error occurred in cases 9, 31 (discussed above), 38, 39, and 41.

San Quentin performed poorly regarding timeliness of scanning lab reports and providers' progress notes into the eUHR. Most delays in scanning were related to documents that providers or onsite specialists did not sign timely. This deficiency occurred in cases 9, 18, 21, 23, 24, 25, 27, 30, 31, 32, 37, 38, 40, 42, and 43. According to the medical records supervisor, a few providers had problems accessing the dictation service to electronically sign their progress notes.

The OIG clinicians also identified documents that were missing from the eUHR in cases 3, 7, 8, 10, 14, 18, 19, 22, 24, 26, 27, 29, 30, 31, 32, 38, 39, 40, 42, and 94. This deficiency occurred frequently and had a negative effect on the quality of medical care because relevant clinical information was not always available to providers.

Legibility

Since providers dictated the majority of progress notes, there were no concerns about legibility.

Clinician Onsite Inspection

Providers maintained open lines of communication with their local hospital and many of their local specialists, which likely mitigated any problems retrieving hospital records, including discharge summaries. Once these offsite specialty services and hospital records were retrieved, they were

immediately delivered to providers via email, often on the same day staff retrieved these records. The effectiveness of this same-day retrieval and delivery process mitigated lapses in medical care.

The OIG clinicians observed clinical information transmission during the daily morning huddles and interviewed various health care staff regarding how information, especially regarding after-hours and offsite medical care, was handled. The process staff used to communicate this important information was not consistent among care teams. While each clinic used a standard huddle agenda every morning, relevant discussion about patients who had required after-hours or offsite care was not discussed at every morning huddle. The discussion at one particular care team huddle was superficial and touched only upon whether or not these patients had follow-up appointments. There was no actual discussion or further assessment by this care team to determine if these patients required any additional intervention during the day.

Clinician Summary

San Quentin showed significant need for improvement in several *Health Information Management* areas. While the institution performed well in the retrieval of hospital and outside ED reports, the retrieval of progress notes by providers and nurses was poor. There were serious problems with the retrieval of diagnostic and specialty reports, discussed in further detail in their respective indicators. There were also significant delays in the scanning times of progress notes by providers, nurses, and onsite specialists. The transmission of important after-hours and offsite clinical information during morning huddles was not consistent. Due to the multitude of problems described above, the OIG clinicians rated this indicator *inadequate*.

Compliance Testing Results

San Quentin scored in the *inadequate* range in the *Health Information Management (Medical Records)* indicator, with a compliance score of 64.6 percent. The following three areas were *inadequate*:

- The institution scored just 8 percent in its labeling and filing of documents scanned into patients' electronic unit health records. Seven errors were mislabeled documents, including primary care progress notes labeled as specialist progress notes. One document was scanned under the wrong patient name, and another document was missing pages (MIT 4.006).

- The institution scored only 15 percent in the timely scanning of dictated or transcribed provider progress notes into patients' eUHR files. Progress notes were timely scanned within five calendar days for only 3 of the 20 sampled documents, while 17 sampled progress notes were scanned between one and 20 days late (MIT 4.002).

- When the OIG reviewed various medical documents (hospital discharge reports, initial health screening forms, certain medication records, and specialty services reports) to ensure that clinical staff legibly documented their names on the forms, 24 of 40 samples

(60 percent) were compliant. Sixteen of the samples did not include clinician name stamps or a legible signature (MIT 4.007).

The institution performed in the *adequate* range in the following two tests:

- Institution staff timely scanned eight of ten sampled initial health screening forms and health care service request forms into patients' eUHR file within three calendar days of the patient encounter (80 percent). Two documents were scanned one and four days late (MIT 4.001).

- San Quentin timely scanned community hospital discharge reports or treatment records into the patient's eUHR for 15 of the 20 sampled reports (75 percent); five reports were scanned one day late (MIT 4.004).

The institution scored in the *proficient* range in the following areas:

- Staff timely scanned 19 of the 20 sampled medication administration records (MARs) into patients' eUHRs (95 percent); one MAR was scanned three days late (MIT 4.005).

- Inspectors reviewed eUHR files for 30 patients sent or admitted to the hospital; hospital discharge reports or treatment records for 28 patients (93.3 percent) were complete and reviewed by providers within three calendar days of discharge. For two patients, providers reviewed the hospital discharge summary reports five and six days late (MIT 4.008).

- For 18 of 20 specialty service consultant reports sampled (90 percent), staff scanned the reports into the patient's eUHR file within five calendar days. Two documents were scanned 17 and 29 days late (MIT 4.003).

Recommendations

The OIG recommends that San Quentin require providers to directly sign laboratory reports and notes from onsite specialists to indicate their review and to avoid scanning delays.

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 inmate-patient visits, and the sufficiency of facility infrastructure to conduct comprehensive medical examinations. Rating of this component is based entirely on the compliance testing results from the visual observations inspectors make at the institution during their onsite visit.

Case Review Rating:
Not Applicable
Compliance Score:
Adequate
(75.4%)

Overall Rating:
Adequate

Compliance Testing Results

The institution received an *adequate* compliance score of 75.4 percent in the *Health Care Environment* indicator, with *proficient* scores in the following four areas:

- Health care staff at all 13 clinics ensured that non-invasive medical equipment was properly sterilized and disinfected (MIT 5.102).
- The institution's non-clinic bulk medical supply storage areas met the supply management process and support needs of the medical health care program (MIT 5.106).
- All 13 clinic areas had an environment conducive to providing medical services (MIT 5.109).
- Staff appropriately disinfected, cleaned, and sanitized 12 of its 13 clinics (92 percent). One clinic had incomplete cleaning logs (MIT 5.101).

The following two test areas received scores in the *adequate* range:

- Eleven of thirteen clinics had operable sinks and sufficient quantities of hand hygiene supplies in clinical areas (85 percent). Two clinic locations' inmate-patient restrooms did not have either soap or disposable towels (MIT 5.103).
- When inspecting for proper protocols to mitigate exposure to blood-borne pathogens and contaminated waste, the OIG inspectors found 11 of 13 clinics (85 percent) compliant. One clinic did not have a biohazard container, and another did not have a sharps container (MIT 5.105).

San Quentin scored in the *inadequate* range in the following five areas:

- The OIG inspected various exam rooms in each of San Quentin's 13 clinics, observing patient encounters and interviewing clinical staff, to determine if appropriate space, configuration, supplies, and equipment allowed clinicians to perform a proper clinical exam. The exam rooms or treatment spaces in only 5 of 13 clinics (38 percent) were sufficient. Eight clinics had exam areas where 25 percent or more of the exam area cabinets were not labeled for easy identification. Two of the eight clinics also did not provide visual privacy for patients (*Figure 1*) (MIT 5.110).

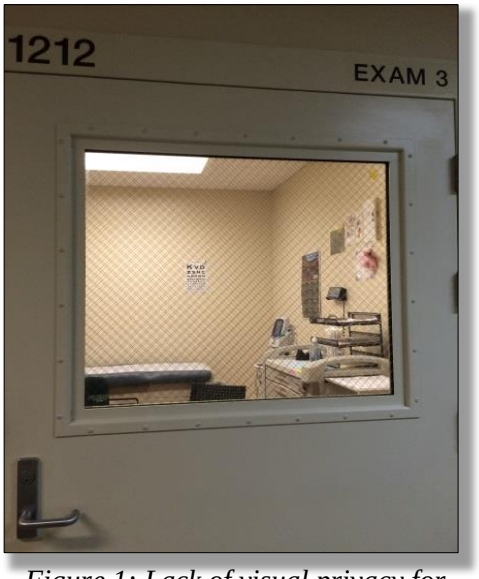

Figure 1: Lack of visual privacy for patients

- OIG inspectors observed clinicians' encounters with inmate-patients in 11 clinics. Clinicians followed good hand hygiene practices in only six clinics (55 percent). In two clinics, clinicians failed to wash their hands immediately after physical contact with a patient. At three clinic locations, clinicians did not wash or sanitize their hands prior to applying gloves and examining the patient (MIT 5.104).

- Only 7 of 13 clinics inspected followed adequate medical supply storage and management protocols in their clinical areas (54 percent). Medical supplies at six clinics were not orderly or clearly identifiable, and one of the six clinics out of compliance had personal food items stored in the same area as medical supplies (MIT 5.107).

- The institution furnished only 7 of 13 clinics and exam rooms with essential supplies and core equipment necessary to conduct a comprehensive exam (54 percent). Missing items in exam rooms included hemoccult cards and developer, lubricating jelly, and tongue depressors. Two clinics had an automated external defibrillator without evidence of current calibration (*Figure 2*), and another clinic had an otoscope without a working light (MIT 5.108).

Figure 2: AED without current calibration

- Inspectors examined emergency response bags to determine if the bags were inspected daily and inventoried monthly, and whether they contained all essential items. Emergency response bags were compliant in six of the nine sampled clinical locations where they were

stored (67 percent). In three locations, the logs showed the bags had not been inspected each watch for the five most recent days prior to the inspection (MIT 5.111).

Other Information Obtained from 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. This question was not scored. OIG inspectors interviewed health care management, who did not have concerns about the facility's ability to provide adequate health care. At the time of the OIG inspection, there were two projects underway to improve medication preparation and distribution. The existing medication room in North Block was 80 square feet, and construction was taking place to provide a new medication distribution facility with four windows. Construction had also begun to create two new medication rooms within the South Block housing facility. The construction included adding sinks and water faucets. According to management, the projects began in phases starting in July 2015 and were scheduled to be completed in mid-2016 (MIT 5.999).

Recommendation for CCHCS

The OIG recommends that CCHCS develop a statewide policy to identify required core equipment and supplies for each type of clinical setting, including primary care clinics, specialty clinics, TTAs, R&Rs, and inpatient units.

Recommendations for San Quentin

The OIG recommends the institution implement the following:

- Conduct periodic training and refresher courses on proper hand sanitation techniques and protocols that staff should follow when applying and removing protective gloves before, during, and subsequent to patient encounters.

- Improve patient privacy with portable privacy screens.

INTER- AND INTRA-SYSTEM TRANSFERS

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

Overall Rating:
Adequate

This indicator focuses on the management of inmate-patients' medical needs and continuity of patient care during the inter- and intra-facility transfer process. The patients reviewed for *Inter- and Intra-System Transfers* include inmates received from other CDCR facilities and inmates transferring out of San Quentin to another CDCR facility. 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 inmate-patients who transfer out of the facility, 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 appropriate implementation of the hospital assessment and treatment plans.

In this indicator, the OIG's case review and compliance review processes yielded different results, with the case review giving an *adequate* rating and the compliance testing resulting in a *proficient* score. The result variance is due to different testing approaches. For example, transfer documents may have been present in the medical record as required by policy, and the finding was positively reflected in the compliance rating. However, the clinical quality of those same documents may have been poor and negatively reflected in the case review rating. In this indicator, the case review found concerns related to hospital discharge patients, who were generally of higher risk than most. As a result, the overall rating for this indicator was *adequate*.

Case Review Results

The OIG clinicians reviewed 22 encounters related to inter- and intra-system transfers, including information from both the sending and receiving institutions. The OIG reviewed six encounters for inmates transferring out of San Quentin to other institutions, and 16 encounters for inmates transferring into San Quentin from other institutions. The OIG reviewed 36 events related to patients returning to San Quentin from a community hospitalization or emergency department.

Transfers In

There were a few minor deficiencies regarding inmates transferring into San Quentin from other CDCR institutions, primarily due to incomplete nursing documentation. However, one case (case 11) involved a lapse in continuity of an essential medication. Examples of the deficiencies included:

- In case 11, there was a lapse in medication continuity. The patient did not receive phenytoin, a medication to prevent seizures, until the third day after arrival. Phenytoin must be taken every day to maintain an adequate blood level.

- In cases 11 and 44, the initial provider visit occurred beyond the requested time frame.

- In case 13, lab tests ordered at the sending institution on the day before transfer were not performed. The sending institution did not scan the orders into the eUHR until two months after the transfer. A follow-up PCP visit, also ordered the day before transfer, occurred beyond the requested time frame. A review of the patients' eUHR file by clinical staff upon transfer to the institution would have identified these issues from the sending institution.

Transfers Out

Deficiencies with inmates transferring out of San Quentin were largely due to incomplete nursing documentation of significant medical information on the Health Care Transfer Information (CDCR Form 7371). Although in most cases the nurses attached a patient summary, information on the summary was not always accurate or complete. If a patient has a pending specialty appointment, the transfer nurse emailed the information to the PCP and to the receiving and release provider to determine if a medical hold was indicated.

- In case 14, the RN did not document that a spirometry test to assess the severity of lung disease was completed two days before transfer. Institution staff never scanned the test report into the eUHR. The RN also did not include two pending specialty referrals that San Quentin medical staff approved. The institution emailed one request for an ophthalmology consultation to the receiving institution one month after the transfer, and the consultation occurred timely. The second request, for a sleep study, was emailed by San Quentin to the wrong institution, which then emailed it to the receiving institution. The sleep study request was received two months after transfer to the new receiving institution, and the order was discontinued.

Hospitalizations

Patients returning from hospitalizations or from outside emergency departments (EDs) are some of the highest risk encounters due to two factors. These patients are of higher acuity since they had just been hospitalized for a severe illness in most cases. These patients are doubly at risk due to the potential lapses in care that can occur during the hand-off from the hospital to the institution. TTA nurses processed hospital discharged patients upon return to San Quentin. Most discharge

summaries were retrieved from community hospitals and scanned into the eUHR within acceptable time frames, but discharge summaries were often not signed off or dated by a provider (further discussed in *Health Information Management* and *Specialty Services).* In the majority of cases, registered nurses appropriately reviewed the discharge medications, plan of care, and obtained physician orders.

However, five cases illustrate how the lack of attention to detail can result in transfer errors or risk of harm for patients returning from the hospital. The OIG provided these cases for quality improvement purposes.

- In case 8, the RN noted the patient's gait was unsteady, but did not initiate an intervention such as providing a temporary walker to ensure the patient was safe from falls.

- In case 24, the RN did not contact the emergency department to obtain discharge information, including whether the emergency department gave the patient insulin before they discharged him.

- In case 27, there was a delay in the discharge report scanned into the eUHR by Medical Records. This resulted in the report not being available to the provider at the follow-up visit. In addition, on a different hospital discharge, the RN did not observe the dressing on the patient's newly placed suprapubic catheter (tube to drain urine from the bladder) and did not request orders for wound care from the provider on call.

- In case 40, medical records failed to obtain the results of biopsies of the patient's bladder tumor that the hospital completed. This was a significant lapse in medical care for the patient, especially given his history of bladder cancer.

- In case 41, medical records mistakenly scanned another patient's hospitalization report under this patient's file. This error occurred because the two patients shared the same last name. This was a significant error in scanning as it presented medical providers with the wrong patient information and could have led to subsequent provider errors in the patient's medical care.

Clinician Onsite Visit

The receiving and release (R&R) process occurred in the same clinic as the reception center. The LVN took vital signs. The RN reviewed the Health Care Transfer Information form (CDCR Form 7371), medication reconciliation form, medication administration records, patient summary, and any medical equipment or supplies that came with the patient. The RN met with the patient to complete the Initial Health Screening form (CDCR Form 7277) and to identify any special needs, such as a lower bunk. The nurse obtained medication orders from the R&R provider who reviewed the transfer information and ordered the initial PCP visit.

Systemwide Transfer Challenges

In reviewing *Inter- and Intra-System Transfers*, the OIG acknowledges system-wide challenges common to all institutions. Nurses are responsible for accurately communicating pertinent information, identifying health care conditions that need treatment and monitoring, and facilitating continuity of care during the transfer process. While this is sufficient for most CDCR patients, it has not been adequate for patients with complex medical conditions or patients referred for complex specialty care. Often, nurses not familiar with the patient's care or are not part of the primary care team initiate the CDCR Form 7371 transfer forms. In addition, providers are often left out of the transfer process altogether, and patients are transferred without the provider's knowledge. Without a sending and receiving provider, the risk for lapses in care increase significantly. The OIG understands CCHCS is currently working to revise the transfer policy with its Patient Management Care Coordination Initiative and looks forward to reviewing that new policy once finalized.

Compliance Testing Results

The institution performed in the *proficient* range and obtained a score of 87.0 percent in the *Inter- and Intra-System Transfers* indicator, scoring well in the two areas below:

- During onsite testing, transfer packages included the required medications and related documentation for all five applicable inmate-patients who transferred out of the institution (MIT 6.101).

- Nursing staff timely completed the assessment and disposition sections of the Initial Health Screening form (CDCR Form 7277) for 28 of the 30 (93 percent) applicable patients sampled. For two samples, nursing staff did not properly sign the form (MIT 6.002).

The institution scored within the *adequate* range in the remaining three tests:

- Inspectors sampled 30 patients who transferred into San Quentin from other institutions to ensure that each patient received a timely health screening assessment upon arrival at the institution. Nursing staff completed a CDCR Form 7277 on the same day for 24 of the arriving patients (80 percent). Nursing staff did not answer all required questions on the CDCR Form 7277 for six patients (MIT 6.001).

- Of 11 sampled patients who transferred into San Quentin with an existing medication order, nine of them (82 percent) received their medications without interruption upon arrival to the institution. Two patients received their medications one day late (MIT 6.003).

- The OIG tested 20 patients who transferred out of San Quentin to another CDCR institution to determine whether their scheduled specialty service appointments were listed on the Health Care Transfer Information form (CDCR Form 7371). Staff identified the scheduled appointments on the transfer forms of 16 of patients sampled (80 percent). Nursing staff did

not document the previously approved specialty service appointment for four patients (MIT 6.004).

Recommendations

No specific recommendations.

PHARMACY AND MEDICATION MANAGEMENT

Case Review Rating:
Adequate
Compliance Score:
Adequate
(77.8%)

Overall Rating:
Adequate

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 effective medication management is affected by numerous entities across various departments, this assessment considers internal review and approval processes, pharmacy, nursing, health information systems, custody processes, and actions taken by the PCP prescriber, staff, and patient.

Case Review Results

The OIG clinicians evaluate pharmacy and medication management as secondary processes as they relate to the quality of clinical care provided. Compliance testing is a more targeted approach and is heavily relied on for the overall rating for this indicator. Overall pharmacy and medication administration performance was rated *adequate*.

Nursing Medication Errors

During the onsite visit, OIG clinicians met with medical, nursing, and pharmacy representatives regarding case review findings. Nursing instruction and monitoring of staff knowledge, skills, and practice regarding medication administration was evident by current records maintained in the individual education and administrative nursing files. The nursing instructor and nursing administrators at San Quentin had implemented medication administration competency and physical assessment testing as part of the annual training for nursing staff.

OIG clinicians reviewed 44 medication management nursing events in the case reviews, of which the vast majority demonstrated that patients received medications timely and as prescribed. Medication errors revealed during case reviews were rare. However, the following deficiency can be used for education and quality improvement purposes:

- In case 43, the medication nurse did not notify the PCP that the patient refused three consecutive doses of a medication that prevents blood clots from forming in the veins. Fortunately, no harm came to the patient.

Pharmacy Errors

In case 44, the medication nurse failed to reconcile the medication administration record with the provider's order and gave the patient a supply of a new self-administer medication. There was no order for this medication in the eUHR. Later, when the patient learned it was cough medication, he stated he did not need the medication and returned it.

Medication Continuity

In the majority of cases, medication continuity was not a significant problem for patients transferring into the institution, returning from a community hospital, or receiving monthly chronic care medications.

- In case 11, there was a lapse in medication continuity for a patient transferring from another CDCR institution. The patient did not receive phenytoin (anticonvulsant) until the third day after his arrival. This medication must be taken every day to maintain an adequate blood level. This case is also discussed in the *Inter- and Intra-System Transfers indicator*.

- In case 23, a chronic care prescription for high blood pressure expired on June 16 and was last dispensed by the pharmacy on May 21. However, the patient picked up a supply of the keep-on-person medication on September 16, despite the fact a provider never renewed the medication for the patient.

Anticoagulant Medication

In case 43, the patient initially refused his warfarin (blood thinner medication that requires days to start working), but agreed to restart the medication after discussion with his provider. However, the provider failed to start the patient's Lovenox (another immediate acting blood thinner) at the time the provider restarted the patient's warfarin. The patient's Lovenox was delayed for nearly one week before being restarted. In addition, while the provider documented that the patient's warfarin would be restarted, the medication was not actually ordered until a week later.

Conclusion

The OIG rated the case review portion of *Pharmacy and Medication Management* performance *adequate.*

Compliance Testing Results

The institution performed in the *adequate* range and received a compliance score of 77.8 percent in the *Pharmacy and Medication Management* indicator. For discussion purposes below, this indicator is divided into three sub-indicators: medication administration, observed medication practices and storage controls, and pharmacy protocols.

Medication Administration

In this sub-indicator, the institution received a *proficient* score of 92.4 percent, performing well in the five areas below:

- Inspectors reviewed files of 20 sampled patients who recently arrived from a county jail and identified two patients who needed to be reissued medications upon their arrival. Both patients received their medications timely (MIT 7.004).

- Thirty-nine of the 40 patients sampled (98 percent) timely received their new medication orders. One patient received his medication 11 days late (MIT 7.002).

- San Quentin ensured that 28 of 30 patients sampled (93 percent) received their medications without interruption when they transferred from one housing unit to another. One patient did not receive his prescribed medication at the next dosing interval following the transfer; the corresponding MAR indicated an unexplained missed dose. Another patient refused the medication, but a signed refusal form could not be found in the eUHR (MIT 7.005).

- San Quentin timely provided hospital discharge medications to 26 of 30 patients sampled who had returned from a community hospital (87 percent). Nursing staff provided one of the patient's discharge medications one day late; for two other patients, there was no evidence that one or more medications ordered by the provider were administered at all. One patient received the ordered medication twice (MIT 7.003).

- Nursing staff timely dispensed long-term chronic care medications to 33 of the 39 inmate-patients sampled, scoring 85 percent on this test. Four patients received their KOP medication refills from 11 to 29 days late; a fifth patient did not receive a provider follow-up visit within one calendar day after the patient refused his prescribed critical medication. Finally, a nurse did not sign a medication administration record to evidence the medication was administered (MIT 7.001).

Observed Medication Practices and Storage Controls

For this sub-indicator, the institution received an *inadequate* score of 47.2 percent, showing room for improvement in the following areas:

- The OIG interviewed nursing staff and inspected narcotics storage areas at 11 applicable locations; four locations were in compliance (37 percent). Three locations did not have signatures for narcotics log books during December 2016 and January 2016, and three other locations did not have counter-signatures of two nurses to verify narcotics inventory at the end of a shift on several days in December 2015 and January 2016 (MIT 7.101).

- San Quentin properly stored non-narcotic medications that did not require refrigeration at 8 of 15 applicable clinics and medication line storage locations (53 percent). In six locations, there were no established systems in place for return-to-pharmacy medications. In four locations, internal (oral) and external (topical) medications were not stored separately (*Figure 3*). In another location, a single dose of open sterile water was not discarded within the manufacturer's guidelines (MIT 7.102).

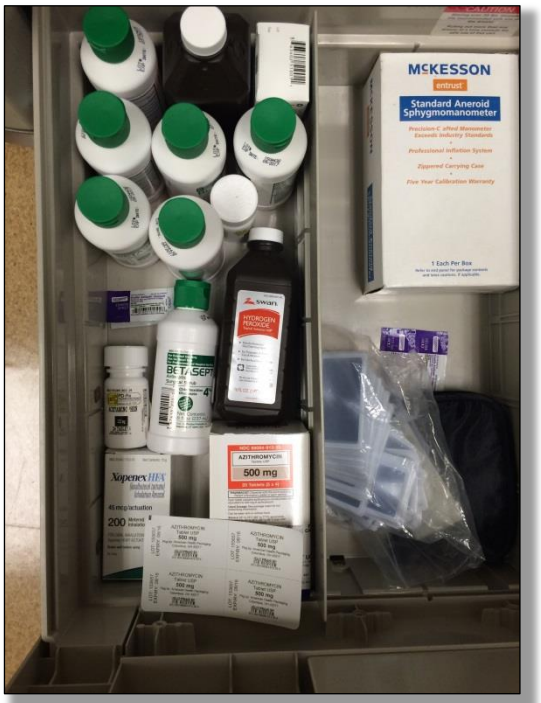

Figure 3: Oral and topical medications that should be stored separately

- Non-narcotic medications requiring refrigeration were properly stored at only one of 13 applicable clinic and medication line locations. At 11 locations, staff did not have a designated return-to- pharmacy area for refrigerated medications. Five of the inspected locations displayed errors in labeling opened medication to determine when it would expire. Three locations did not record all historical refrigerator temperature logs as required, and one location's historical temperature logs showed recorded refrigerator temperature readings that were out of range per CCHCS policy (MIT 7.103).

- Inspectors observed the medication preparation and administration processes at seven medication line locations. Nursing staff were compliant with proper hand hygiene contamination control protocols at only two of the seven (29 percent). At five locations, nurses failed to sanitize or wash their hands prior to initially putting on gloves or re-gloving during medication administration (MIT 7.104).

- At four of seven observed medication line locations, the medication distribution process was compliant with administrative controls and protocols (57 percent). Two medication line nurses did not follow instructions on how to properly administer medication by crushing and floating medication as ordered. One nurse did not observe whether the patient swallowed direct observation medications (MIT 7.106).

The institution scored 100 percent on the following test:

- Nursing staff at all seven of the medication and preparation administration locations employed appropriate administrative controls and protocols during medication preparation (MIT 7.105).

Pharmacy Protocols

San Quentin scored 100 percent in all five tests of this sub-indicator:

- In its main pharmacy, the institution followed general security, organization, and cleanliness management protocols; properly stored non-refrigerated, refrigerated, and frozen medications; properly accounted for narcotic medications; and followed key medication error reporting protocols (MIT 7.107, 7.108, 7.109, 7.110, 7.111).

Non-Scored Tests

In addition to testing reported medication errors, OIG inspectors follow-up on any significant medication errors found during the case reviews or compliance testing to determine whether the errors were properly identified and reported. These findings are not scored. At San Quentin, the OIG did not find any applicable medication errors subject to this test (MIT 7.998)

The OIG also tested inmate-patients housed in isolation units to determine if they had immediate access to prescribed KOP rescue inhalers and nitroglycerin medications. Inspectors interviewed ten applicable inmates, and nine had possession of their prescribed rescue medication. One inmate claimed his rescue inhaler was not forwarded to him when he returned from court. Following the OIG's notification, the San Quentin chief executive officer showed the OIG the patient received his inhaler within one hour after he claimed he did not have it (MIT 7.999).

Recommendations

No specific recommendations.

PREVENTIVE SERVICES

This indicator assesses whether various preventive medical services are offered or provided to inmate-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 inmate-patients identified as being at higher risk for contracting coccidioidomycosis (valley fever).

Case Review Rating:
Not Applicable
Compliance Score:
Inadequate
(61.5%)

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 performed in the *inadequate* range in the *Preventive Services* indicator, with a compliance score of 61.5 percent, showing need for improvement in the following four areas:

- The institution scored 33 percent for timely administering anti-tuberculosis medications to patients with tuberculosis. Of 30 patients sampled, only 10 received all required doses of their medication during the most recent three-month period. The other 20 patients missed one or more doses of their medication or did not receive counseling when they refused the medication (MIT 9.001). For the same 30 patients sampled, the institution did not properly document the monitoring of patients taking anti-tuberculosis medications. Only eight of the patients sampled (27 percent) had weekly scanned Tuberculosis Monthly Monitoring forms. Inspectors found that 22 patients did not receive their weekly or monthly monitoring, or the monitoring forms were not scanned on a weekly or monthly basis (MIT 9.002).

- Although the institution timely screened all 30 sampled patients for tuberculosis within the prior year, clinicians only properly screened 57 percent of those patients. Fifteen of the sampled patients were classified as Code 34 (subject only to an annual signs and symptoms check), and 15 sampled patients were classified as a Code 22 (requiring a tuberculosis skin test in addition to a signs and symptoms check). For Code 34 patients, 14 of 15 samples tested were properly screened, with one patient for whom the nurse did not properly complete the history and symptoms section. However, only 3 of the 15 patients classified as Code 22 were properly screened. Specifically, 12 of the sampled Code 22 patients received improper screenings: in two instances, an LVN or LPT, rather than a RN, public health nurse, or primary care provider, read the skin test results; and nursing staff did not document either the specific administered (start) or read (end) date and time to evidence the TB test was completed within the required 48-to-72-hour time frame (MIT 9.003).

- The OIG tested whether the institution offered vaccinations for influenza, pneumonia, and hepatitis to patients who suffered from a chronic care condition; only 15 of the 27 patients sampled (56 percent) received or were offered all recommended vaccinations at the required intervals. For nine patients, there was no evidence the patients either received or refused one or more of the three types of vaccinations within the last five years (MIT 9.008).

The institution did score in the *proficient* range in the following two tests:

- The institution was compliant in offering annual influenza vaccinations to all 30 patients sampled (MIT 9.004).

- The institution provided colorectal cancer screenings to 29 of 30 sampled patients subject to the annual screening requirement (97 percent). For one patient, there was no evidence the patient was offered or refused the screening within the previous 12 months (MIT 9.005).

Recommendations

No specific recommendations.

QUALITY OF NURSING PERFORMANCE

***Case Review Rating**:*
Adequate
***Compliance Score**:*
Not Applicable

Overall Rating:
Adequate

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, therefore, does not have a score under the compliance testing component. The OIG nurses conduct case reviews that include reviewing face-to-face encounters related to nursing sick call requests identified on the Health Care Services Request form (CDCR Form 7362), urgent walk-in visits, referrals for medical services by custody staff, registered nurse case management, registered nurse utilization management, clinical encounters by licensed vocational nurses (LVNs) and licensed psychiatric technicians (LPTs), and any other nursing service performed on an outpatient basis. The OIG case review also includes activities and processes performed by nursing staff that are not considered direct patient encounters, such as the initial receipt and review of CDCR Form 7362 service requests and follow-up with primary care providers and other staff on behalf of the patient. Key focus areas for evaluation of outpatient 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 including patient education and referrals, and documentation that is accurate, thorough, and legible. Nursing services provided in the correctional treatment center (CTC), or other inpatient units are reported under the *Specialized Medical Housing* indicator. Nursing services provided in the triage and treatment area (TTA) or related to emergency medical responses are reported under *Emergency Services*. OIG nursing clinicians rated the *Quality of Nursing Performance* at San Quentin *adequate*.

Case Review Results

The OIG evaluated 549 nursing encounters during the case review, of which 251 were outpatient nursing encounters. Of the 251 outpatient nursing encounters reviewed, approximately 170 were for sick call requests (CDCR form 7362) or primary care clinic nurse follow-up visits, 15 were for nursing care management, and five were for other outpatient nursing encounters such as public health and specialty care. In general, nursing performed well. In all, 68 deficiencies were found in outpatient nursing services, the majority of which were determined to be unlikely to contribute to patient harm. Nevertheless, these deficient areas are clearly established in CCHCS policy as requirements for nursing care and practice and, therefore, require quality improvement strategies. However, several cases (8, 20, 81, and 83) displayed deficiencies with the potential for adverse outcomes or unnecessary delays in needed health care services.

Nursing Sick Call

The majority of sick call RNs appropriately assessed complaints and symptoms, and provided necessary interventions for patients presenting with medical issues in the outpatient nurse clinics. The quality of nursing performance was affected by patterns of deficiencies that included poor

assessment, improper implementation of interventions based on assessment, and inadequate nursing documentation, such as in the following examples:

- In case 8, the patient reported on a sick call request that he had a sore throat and abdominal pain for a few months with increasing severity, and current vomiting. The patient also reported a poor appetite at times. At the RN visit, the patient stated that those symptoms had resolved and he now had cold symptoms with fatigue and muscle pain for three weeks. The RN assessed the patient's cold symptoms and provided the patient with cold medication. However, the RN failed to assess the patient's abdominal pain and vomiting, which worsened over several months. The RN also failed to refer the patient to the PCP for evaluation. The RN's failure delayed this patient's cancer diagnosis.

- In case 20, the sick call RN did not recognize the patient's acute illness had not improved after several days of antibiotics. The RN failed to notify the PCP of the patient's continuing symptoms before releasing the patient from the clinic. Three days later, the patient was hospitalized with sepsis (an infection in the bloodstream) and then died.

- In case 27, the patient submitted a sick call request for problems urinating. The RN reviewed the patient's history and determined the problem may have been a urethral blockage. The RN made an urgent referral to the PCP for the next day. The RN should have called the PCP before releasing the patient to return to his housing. Instead, the PCP visit occurred in two days. The patient was unable to urinate after the PCP visit and was sent to the hospital.

- In case 57, the patient had four sick call RN visits for symptoms of hemorrhoids. The RNs did not perform adequate assessments and did not give the patient hemorrhoid treatment available via the nursing protocol. At the fifth sick call request visit, the RN noted that a colonoscopy report recommended treatment for external hemorrhoids. The RN contacted the PCP and obtained an order for the same medication that was available via the nursing protocol.

- In case 68, the patient submitted a sick call request to speak to his PCP about surgery for a worsening hernia. The PCP's plan at the previous visit was to delay surgery until the patient was in better health. The RN did not consult with the PCP about whether to remove the patient's abdominal binder and inspect the hernia. Instead, the RN advised the patient that he had a PCP visit scheduled in seven to ten days. The institution sent the patient to the emergency department before the PCP visit after the hernia became more painful and could not be treated manually.

- In case 71, the RN failed for a week to make a referral to the PCP for a patient with a nosebleed. Although there was no bleeding during the sick call visit, the patient had an extensive medical history and was on medication to inhibit blood clotting.

- In case 81, the RN saw the patient for a sick call request for pain and a possible eye infection after surgery. The RN assessed the patient at his cell front, but did not assess vital signs, visual acuity, or pain level. The RN failed to contact the PCP regarding a possible recurrent infection.

- In case 83, the RN saw the patient on the same day the sick call request was received. The patient recently had neck surgery and was complaining of new neurological symptoms. The RN failed to refer the patient to the provider. This placed the patient at risk of harm. Fortunately, the patient saw the provider three days later and was referred to the TTA for further evaluation.

Other Outpatient Nursing Encounters

- In case 23, the patient frequently went to the TTA for non-emergency oxygen therapy for headache. The PCP ordered a specific rate and method of oxygen delivery. However, in the 30 encounters reviewed, the nurse either did not document the flow rate or method of oxygen administration, or provided oxygen at a rate or method different from what the PCP had ordered.

- In case 59, nurses did not perform dressing changes three times a week as ordered.

Medication Administration

Medication administration was generally timely and reliable. See the *Pharmacy and Medication Management* indicator for specific findings.

Emergency Care

See the *Emergency Services* indicator for specific findings.

Inter- and Intra-System Transfers

See the *Inter- and Intra-System Transfers* and *Diagnostic Services* indicators for specific findings.

Specialized Medical Housing

See the *Specialized Medical Housing* indicator for specific findings.

Clinician Onsite Visit

The nurses in outpatient clinic settings were active participants in the primary care team morning huddles. The huddles started and ended on time and were well attended by the providers, sick call nurses, medication line nurses, schedulers, and others. The PCP facilitated the morning report and discussions about currently hospitalized and newly discharged patients, TTA visits, on-call physician reports, mental health concerns, and any other issues related to current patient issues and the day's clinic. All staff members had the opportunity to participate in the team discussions.

During walking rounds, the RN and LVN staff verbalized having no major barriers with initiating communication with nursing supervisors, providers, and custody officers regarding patient care needs. The yard clinic nurses were knowledgeable about their patient panel and went beyond their daily sick call visits to check on patients they were concerned about. The receiving and release and reception center nurses demonstrated clear knowledge of processes established to assess the health care status of incoming inmates, and they provided necessary care while the patients remained in the clinic area. Utilization management, specialty nurses, and support staff developed communication systems and backup systems to ensure providers closely followed hospitalized patients, and that specialty consultations were completed on time. Nurses were enthusiastic about their assignments and working conditions. The nursing staff believed they provided quality nursing care to the patients and felt supported by the supervising RNs and chief nursing executive. Nurses in all areas reported good working relationships with providers. Nursing staff is to be commended for their knowledge about assigned patients, specific processes, procedures for their individual assignments, and the institution-wide nursing communication practices.

Recommendations

The OIG recommends that San Quentin do the following:

- Provide training to reinforce a focused subjective and objective nursing assessment for each medical complaint based on both the patient's current complaints and past health history.
- Provide training to remind nursing staff to document accurate, legible nursing notes according to subjective, objective, assessment, plan, and education (SOAPE) note format requirements, including a legible signature and the time of the encounter.
- Fully implement the nursing case manager position.

QUALITY OF PROVIDER PERFORMANCE

In this indicator, the OIG physicians provide a qualitative evaluation of the adequacy of provider care at the institution. Appropriate evaluation, diagnosis, and management plans are reviewed for programs including, but not limited to, nursing sick call, chronic care programs, TTA, specialized medical housing, and specialty services. The assessment of provider care is performed entirely by OIG physicians. There is no compliance testing component associated with this quality indicator.

Case Review Rating:
Proficient
Compliance Score:
Not Applicable

Overall Rating:
Proficient

Case Review Results

The OIG clinicians reviewed 438 medical provider encounters and identified 47 deficiencies related to provider performance. Of the 47 deficiencies, 16 were significant. The providers performed very well managing complex medical patients. Providers usually made sound and accurate diagnoses, and treatment plans were appropriate and thorough. Providers generally reviewed medical records with good depth. Emergency care and anticoagulation management were also good. Hepatitis C and diabetes management were excellent in most cases. Providers referred patients for specialty services appropriately, and the quality of their documentation was excellent. Providers ordered patient follow-ups within the appropriate time interval. Due to the excellent care provided, OIG clinicians rated this indicator *proficient*.

Assessment and Decision-Making

Poor assessment and misdiagnoses, although rare, did occur. OIG clinicians found errors with provider assessment in cases 9, 22, 42, 43, and the following two cases:

- In case 6, the patient had a critically elevated blood pressure of 211/130. The provider failed to recognize hypertensive urgency and did not transfer the patient to the TTA for closer monitoring. Furthermore, the provider did not give the patient appropriate medications to treat his abnormal blood pressure. This failure resulted in an emergency room send-out for this patient. If the provider had correctly diagnosed the patient and initiated prompt treatment, the emergency room transfer was potentially avoidable.

- In case 18, the patient had severe chronic obstructive lung disease that required oxygen supplementation 24 hours a day. However, the provider only ordered an oxygen concentrator for use as needed.

Despite the examples above, providers demonstrated excellent diagnostic skills in most of the cases:

- In case 29, the patient received dialysis for his end-stage renal disease. The patient also had multiple, chronic medical issues that required almost daily management by his providers. This case was further complicated by the patient's persistent noncompliance with his dialysis and his frequent refusals to have labs drawn to monitor his potassium levels. As a result, the patient's potassium level became critically high, prompting providers to transfer him to the local ER for urgent dialysis. Due to the diligence of providers, the patient never developed any potentially lethal cardiac arrhythmia as is usually associated with critically elevated potassium levels.

Review of Records

Providers generally performed thorough chart reviews, which greatly aided in their diagnostic assessments and their ability to provide comprehensive medical care for patients.

- In case 32, the provider was meticulous regarding chart review and expertly managed all of the patient's multiple medical conditions, such as chronic kidney disease, hypertension, and progressive lung disease. The provider closely monitored the patient's labs for anticoagulation levels. The provider also ordered appropriate tests for the patient's chronic medical issues and reviewed the results in a timely manner.

- In case 35, the providers diligently reviewed the patient's medical records and ordered appropriate laboratory tests for the patient's diabetes. Despite the patient's repeated refusals for care, his providers still scheduled follow-ups for the patient with the telemedicine endocrinologist and arranged a surveillance diabetic eye exam with the ophthalmologist.

The following cases demonstrated insufficient depth of review of medical records by providers:

- In case 7, the patient had a new finding of abnormally low red blood cells. The provider failed to address this due to an inadequate review of the patient's laboratory results.

- In case 17, the provider did not properly review the patient's medication profile, and the provider ordered a second blood pressure medication. This second medication added to the first medication could have potentially injured the patient's kidneys.

- In case 38, the provider unnecessarily repeated a laboratory test that the patient had previously completed. This was due to the provider's failure to carefully review the electronic unit health record.

Emergency Care

Emergency care provider performance was good. Only five deficiencies out of the 51 TTA encounters reviewed were attributable to providers, and only one of the deficiencies had a significant impact on medical care. In general, TTA and on-call providers made accurate assessments and triage decisions. Institution staff appropriately sent out patients requiring higher levels of care. The following case is for quality improvement purposes only:

- In case 18, the provider incorrectly diagnosed the patient with a possible empyema (collection of pus in the chest cavity) when the patient actually had a possible lung abscess (focal collection of pus in the lung itself). Despite the misdiagnosis, the provider should have immediately transferred the patient to an outside hospital for prompt treatment. Unfortunately, the provider also failed to recognize that the patient's abnormally elevated heart rate was a sign of early sepsis (a life-threatening infection). Even though the provider was aware of the patient's lung infection and abnormally elevated heart rate, the provider made the incorrect decision not to transfer the patient to the hospital. When the provider decided three days later to transfer the patient to a hospital, the patient died in the TTA. This case was discussed with the chief medical executive (CME) and the chief physician and surgeon during the onsite inspection. According to the CME, the provider involved in the case was not a regular physician at San Quentin, but a physician contractor. The CME also reported that this physician was infrequently employed by San Quentin.

Chronic Care

Chronic care performance was excellent. Providers demonstrated proficient skill and knowledge in caring for patients with complicated chronic medical issues. Providers properly monitored patients and made sound decisions when intervention was necessary. The following cases demonstrated *proficient* provider care:

- In case 19, the patient's automatic implantable cardioverter-defibrillator (AICD) for congestive heart failure activated several times, delivering electric shocks to the heart. In this case, the provider performed exceptionally well, arranging appropriate follow-ups to address the patient's AICD to ensure the device would function properly, diligently ordering and adjusting the patient's cardiac medications, and expertly coordinating the patient's care between several cardiologists and a cardiac electrophysiologist. In addition, the provider frequently took additional time to discuss this case with the patient's cardiac specialists to avoid any lapse in care.

- In case 32, the patient required anticoagulation medication due to his chronic irregular heartbeat. San Quentin providers expertly managed and coordinated the patient's care with the clinical pharmacist. The provider adjusted the patient's anticoagulation medication in a timely manner. Furthermore, the patient's other chronic medical issues were well managed by his providers with no lapses in his medical care.

- In case 39, the patient was being treated with radiation and chemotherapy for an invasive tongue cancer. The provider expertly coordinated the multiple follow-ups the patient had with the specialists, ensuring he received his radiation and chemotherapy treatments without any delays. Due to the diligence of the provider, the patient had appropriate and timely follow-ups with multiple specialists, including the otolaryngologist, radiation oncologist, medical oncologist, and offsite dentist. Furthermore, the patient's repeat magnetic resonance imaging scan of his head and neck and his gastrostomy tube were promptly done. When the patient began to lose weight from his chemotherapy and radiation treatments, the provider properly adjusted the portions of his modified diet.

One provider's management of hepatitis C was particularly excellent. In all cases reviewed, this provider demonstrated in-depth knowledge and excellent understanding of this disease process. The provider properly evaluated and treated patients regardless of the severity of hepatitis C. The provider closely monitored and had appropriate follow-ups with patients to ensure the stability of their condition.

Diabetic management was also good. Providers demonstrated good diabetic management skills, with one exception:

- In case 35, the patients' laboratory test indicated the patient's diabetes was poorly controlled. Instead of ordering an early follow-up for close monitoring, the provider chose to order a follow-up in three to four months, a time interval typically used for patients with good diabetes control.

The clinical pharmacist in the anticoagulation clinic typically managed anticoagulation management. However, both the clinical pharmacist and providers monitored anticoagulation levels of patients. The OIG clinicians did not identify any significant deficiencies with anticoagulation management by either the clinical pharmacist or providers. Pharmacy staff did make a few errors in anticoagulation management, which are discussed separately in the *Pharmacy and Medication Management* indicator.

Specialty Services

Providers appropriately referred patients for specialty services. Please refer to the *Specialty Services* indicator for further details.

Documentation Quality

Providers dictated the majority of their progress notes. The average progress note was extensive and included all relevant aspects of preventive health care. The average correctional treatment center discharge summary was also extensive, with all relevant discharge information included, such as pending follow-ups and discharge medications. Despite the use of a dictation service, OIG clinicians found only minor evidence of "cloned" progress notes, on which outdated medical information inappropriately carried forward to a current progress note. In addition, the majority of

telephone encounters from providers assigned to on-call duty were completed and scanned into the eUHR. Overall, San Quentin documentation quality was good.

Provider Continuity

Case review found excellent provider continuity in outpatient cases. The inpatient continuity in the CTC, however, was not as good due to different rotating providers being present when the regular correctional treatment center provider was not available.

Health Information Management

Providers generally documented patient encounters the day they occurred. However, there was a problem with dictated progress notes transcribed late, which caused a delay in notes being scanned into the eUHR. There were also delays in notes signed by certain providers and onsite specialists. Please refer to the *Health Information Management* indicator for further details.

Clinician Onsite Inspection

Morning huddles were staggered and scheduled at different times in the morning. The quality of morning huddles varied at each clinic. Please refer to the *Health Information Management* indicator for further details.

Overall, San Quentin providers performed well individually and as a group, with the institution fully committed to a primary care home model. All providers were satisfied with their primary care teams and reported that they found working as a team personally and professionally rewarding.

Onsite interviews with the provider staff revealed excellent job satisfaction and good provider morale. Providers felt that the CME was an excellent and approachable leader who provided the support providers needed to give quality care to the patients. At the time of the onsite inspection, the chief physician and surgeon (CP&S) position was being filled by a provider from San Quentin to ensure continuity and stability in the management of the provider group. The former CP&S had left San Quentin on good terms to pursue an opportunity for career advancement without causing any friction among the provider group.

Interviews with the CP&S and the CME confirmed that they closely monitored job performance. Provider performance was monitored in various ways, including annual clinical appraisals, CCHCS dashboard evaluations, and careful review of specialty referrals. At the time of the OIG clinician onsite visit, all provider annual performance appraisals were complete and current. No problems with provider retention or provider recruitment were identified.

Recommendations

No specific recommendations.

RECEPTION CENTER ARRIVALS

Case Review Rating:
Adequate
Compliance Score:
Adequate
(78.0%)

Overall Rating:
Adequate

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.

Case Review Results

San Quentin provided adequate care to inmate-patients arriving from county jails and other non-CDCR facilities. Nurses generally performed thorough assessments. A provider reviewed the Initial Health Screening forms (CDCR Form 7277) and clinical information from the sending facilities, and then ordered essential medications and required laboratory tests. The provider identified high-risk patients who were seen urgently. The OIG clinicians reviewed 37 reception center patient encounters from five cases and identified four deficiencies, one of which was considered significant:

- In case 47, the patient reported a seizure disorder, diarrhea several times a day for six months, and a dry cough. The RN did not assess these symptoms.

Clinician Onsite Inspection

Nursing and provider exam areas were adequate and well stocked. An LVN took vital signs, tested vision acuity, and, for diabetic patients, checked fingerstick blood sugar levels. The LVN performed TB tests, offered cocci testing, and administered flu vaccines. The RN interviewed each patient to complete the Initial Health Screening form (CDCR Form 7277). If necessary, the RN performed an assessment using CCHCS encounter forms and provided protocol medications. A provider reviewed the information and ordered medications and laboratory tests. The provider also triaged the patients and determined if they needed to be seen urgently by a provider, if they could be assigned to a telemedicine provider for the history and physical, or if an onsite provider was more appropriate. A lab technician went to the Reception Center to draw blood for lab tests. Medication orders sent to the pharmacy before 5:00 p.m. were dispensed directly to the Reception Center.

Conclusion

The OIG clinicians rated the *Reception Center Arrivals* indicator at San Quentin *adequate*.

Compliance Testing Results

The institution performed in the *adequate* range in the *Reception Center Arrivals* indicator, with a compliance score of 78.0 percent, but scored in the *proficient* range in the following test areas:

- Of the 20 sampled patients who arrived at the reception center, all 20 patients' screenings required that a RN complete an assessment and disposition of the results on the same day staff completed the health screening. Of the 20 applicable samples, nursing staff properly documented and timely completed all 20 of the screenings (MIT 12.002). In addition, based on the dispositions, intake nurses referred all 20 sampled patients to see a provider, and all of the patients received their provider appointments timely (MIT 12.003).

- Providers timely completed a written history and physical examination for all 20 sampled reception center patients within seven calendar days of their arrival (MIT 12.004).

- Inspectors sampled 20 reception center patients to ensure that each received a timely health screening upon his arrival at the institution. Nursing staff conducted timely and complete screenings for 18 (90 percent). In two of the patient screenings, nurses did not answer all of the required screening questions (MIT 12.001).

San Quentin scored in the *adequate* range in the following two tests:

- Sixteen of 20 sampled reception center patients received all required intake tests (80 percent). For one patient, the PCP did not order the required varicella (chickenpox) intake test, and OIG inspectors did not find laboratory results in the eUHR. For three patients, there was no evidence the gonorrhea/chlamydia test was completed for patients under 36 years of age (MIT 12.005).

- Providers timely reviewed and communicated intake test results for 16 of the 19 reception center patients who arrived at San Quentin during the sample period (84 percent). A provider communicated the test results to three patients one day late (MIT 12.006).

The following test areas received scores in the *inadequate* range:

- Although all of the 20 sampled patients received a timely tuberculosis test upon arrival at the reception center, only four patients' skin test results were properly conducted (20 percent). Specifically, one or more of the following errors occurred for those patients who did not receive a proper skin test: for 15 patients sampled, an LVN read the tuberculosis test, but policy requires a RN, public health nurse, or provider to read the test; nursing staff for one of these 15 patients did not document the administration time for the test, and inspectors were not able to verify that the 48-to-72-hour reading requirement was met. One additional patient properly received a chest x-ray, but the nurse did not complete the signs and symptoms portion of the CDCR Form 7331 (MIT 12.007).

- The institution timely administered a coccidioidomycosis (valley fever) skin test to only 10 of the 20 sampled reception center patients (50 percent). Four patients were administered the test between 6 and 48 days late, and three patients were offered the test from 20 to 28 days late. Two other patients consented to the test but did not receive it, and there was no evidence that one additional patient was offered or received the test (MIT 12.008).

Recommendations

No specific recommendations.

SPECIALIZED MEDICAL HOUSING (OHU, CTC, SNF, HOSPICE)

This indicator addresses whether the institution follows appropriate policies and procedures when admitting inmate-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. San Quentin's only specialized medical housing unit is the Correctional Treatment Center (CTC).

Case Review Rating:
Adequate
Compliance Score:
Inadequate
(71.4%)

Overall Rating:
Adequate

For this indicator, the OIG's case review and compliance review processes yielded different results, with the case review giving an *adequate* rating and the compliance testing resulting in an *inadequate* score. While each area's results are discussed in detail below, the result variance is due to the different testing approaches. Because the case review process contained a more detailed review, the OIG inspection team determined the final overall rating was *adequate*.

Case Review Results

San Quentin had a ten-bed CTC, of which two were negative pressure rooms (spaces designed to limit the spread of contagious diseases). The OIG reviewed 143 provider and 181 nursing encounters in 15 cases of patients admitted to the CTC for a higher level of supervised medical treatment and monitoring. The OIG clinicians identified deficient areas that needed improvement in both nursing and provider care as demonstrated by findings in the following case review examples.

Provider Performance

Provider performance in the CTC is discussed in the *Access to Care* and *Quality of Provider Performance* indicators.

Nursing Performance

The CTC nursing performance was adequate. The majority of nursing encounters reviewed demonstrated appropriate patient-specific nursing assessment, interventions, and documentation. The majority of the deficiencies involved inadequate assessment, intervention, and documentation by nursing staff. Of the 57 deficiencies in nursing services, one was significant, and it contributed to the patient's death.

Inadequate Nursing Assessment and Intervention

- In case 2, actions and omissions by the CTC nurses contributed to the patient's death. Medical staff sent the patient to the TTA from his housing unit for paranoia, delusions, and confusion. In the TTA, the patient stated he took methamphetamine drugs for the last three days. His heart rate was rapid at 123 beats a minute. The patient had prior suicide attempts,

but denied current suicidal thoughts. He admitted to auditory hallucinations. A mental health provider ordered the patient admitted to a mental health crisis bed (MHCB) on suicide precautions, and with staff checking the patient every 15 minutes. MHCBs were in a specific section of the CTC in rooms designed to safely house patients with psychiatric problems. When the patient arrived in the CTC, the RN placed the patient in a medical room with an electric cord. The RN failed to check vital signs, or notify the medical provider of the patient's rapid heart rate in the TTA. Staff found the patient strangled with the electric cord, and could not resuscitate him.

- In case 8, the patient returned from a hospitalization with a medication order for potassium chloride twice a day. The patient refused the medication, but the RNs did not notify the provider. Failure to take the potassium medication could have caused abnormal heart rhythms. Two days later, the provider became aware that the patient was not taking the medication when a lab test showed a low level of potassium. The patient ultimately was sent to an outside emergency department for evaluation and treatment.

- In case 10, the patient with chronic obstructive pulmonary disease (COPD) developed increased shortness of breath and a low level of oxygen in his blood. The patient's blood pressure and heart rate were elevated. The RN increased his oxygen and gave him a breathing treatment. The RN did not check the patient again until two hours later. At that time, his blood oxygen level was still low and his heart rate was still elevated. The RN monitored the patient throughout the rest of the morning, but did not notify the provider until four hours after the patient's condition had deteriorated.

Inadequate Nursing Documentation

Nurses did not document dressing changes as ordered in cases 7, 27, and 96, and did not always document an adequate description of wounds' appearance. This was not a particularly serious problem because these wounds were not complex.

Nurses did not monitor patients who left the unit for specialty appointments. Nurses did not check patients prior to departure, did not document the time of departure and time of return, nor evaluate patients upon their return (cases 8 and 96).

- In case 88, the patient left the unit with custody and was transported to a local hospital for a specialty procedure. The nurse did not check the patient when he departed. If the nurse had checked the patient prior to departure, custody could have been notified that the specialty appointment had been cancelled, and transportation to the hospital was not necessary. The next morning, the patient left the unit with a cane instead of a walker, even though there was an order for him to ambulate only with a walker.

Nursing care plans for the patient were not always individualized, and interventions and goals were not always specific. Nursing staff did not always update patient care plans when there was a change in condition or treatment plan (cases 88 and 94).

- In case 8, the care plan was not updated when the patient was placed on respiratory isolation, when he started to lose weight due to chemotherapy, or when his ambulatory status changed from independent to requiring a walker due to dizziness.

Clinician Onsite Inspection

Nurses working in the CTC communicated between shifts with walking rounds, similar to morning huddles in the clinics. Nurses used a "kardex" system. The kardex was a printout that listed information about each patient for that date, such as treatments to be performed, medical equipment used, activity level, lab tests due, type of diet, frequency of vital signs, dressing changes, etc. The physician conducted thorough rounds on Monday, Wednesday, and Friday mornings. Nurses stated they had access to a physician at all times. Nurses also reported that custody provided ready access to the patients.

Clinician Summary

San Quentin provided adequate CTC care to patients, although deficiencies were identified in the case reviews. Most nursing deficiencies did not place patients at risk of harm. In the case that resulted in the patient's death, executive staff responded to the problem quickly and efficiently, identified system and staff weaknesses, and took prompt and appropriate corrective actions.

Compliance Testing Results

The institution received an *inadequate* compliance score of 71.4 percent in the *Specialized Medical Housing* indicator, which focused on the institution's CTC, and showed need for improvement in the following two areas:

- All of the seven patients sampled had provider progress note gaps exceeding three days between provider visits and the completion of subjective, objective, assessment, plan, and education (SOAPE) notes as policy requires, earning the institution a zero on this test (MIT 13.004).

- Providers evaluated four of seven patients within 24 hours of admission (57 percent). For the other three patients, based on the available documentation, the providers either left the evaluation time blank, or completed the evaluation after 24 hours of admission (MIT 13.002).

The following three tests received *proficient* scores of 100 percent:

- For all seven patients sampled, nursing staff timely completed an initial assessment on the day the patient was admitted to the CTC (MIT 13.001).

- Providers completed a history and physical examination within 72 hours of admission for all seven patients sampled (MIT 13.003).

- When the OIG observed the working order of a sample of call buttons in CTC patient rooms, all were working properly. In addition, according to staff interviews, custody officers and clinicians were able to efficiently respond and access patients' rooms in approximately one minute and twenty seconds when an emergent event occurred (MIT 13.101).

Recommendations

- The OIG clinicians recommend CTC nurses continue to use San Quentin's pilot wound form, especially for complex, infected, or non-healing wounds.

- The OIG recommends that CTC nurses continue to use the *North American Nursing Diagnosis Association* as a resource when developing nursing care plans to ensure that the information is specific to that patient. The OIG further recommends that nursing care plans be updated at the time changes occur, not only on a monthly basis.

- The OIG clinicians recommend nurses document the exact time and the patient's condition when a patient leaves the unit to go to an offsite appointment, as well as any information sent from the offsite location with the patient when he returns to San Quentin.

SPECIALTY SERVICES

Case Review Rating:
Adequate
Compliance Score:
Adequate
(77.5%)

Overall Rating:
Adequate

This indicator focuses on specialist care from the time a request for services or physician's order for specialist care is completed 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 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 inmate-patient is updated on the plan of care.

Case Review Results

The OIG clinicians reviewed 339 events related to *Specialty Services,* the majority of which were specialty consultations. There were 67 deficiencies in this category.

Access to Specialty Services

Specialty services were generally provided within adequate time frames for both routine and urgent services. Most specialty referrals were completed within an acceptable time frame, except in cases 25, 40, 41, 42, and 43, in which there were delays in specialist follow-ups. The majority of these delays did not significantly affect patient care.

- In case 40, the urologist recommended a cystoscopy for a patient with a history of bladder cancer. However, the cystoscopy did not occur within the recommended two-week time frame. When the cystoscopy took place six weeks later, abnormal bladder tissue required a biopsy. By completing the cystoscopy later than recommended, the patient's subsequent medical intervention and treatment was also delayed.

Nursing Performance

Nurses performed adequate assessments for patients being prepared for or returning from specialty appointments. There were five minor documentation deficiencies in this area..

Provider Performance

Providers generally made appropriate referrals for specialty services. Case reviews identified only one deficiency in which a provider submitted a referral without proper priority:

- In case 43, the patient had a lung mass, but no further workup was done after the initial discovery for over five weeks, at which time a follow-up CT scan was completed.

Furthermore, the provider improperly ordered the referral for the CT scan as routine instead of urgent.

Health Information Management

There were problems with the processing of specialty reports. Providers frequently did not retrieve specialty reports and onsite specialty notes, resulting in providers not having relevant information available. Even if the ordering provider was notified and had reviewed the report, that information would not be readily available to any subsequent medical staff. Therefore, the absence of specialty reports creates a significant barrier for any provider or nurse to overcome to provide quality and continuity of care to patients. OIG clinicians identified this deficiency in cases 8, 14, 26, 30, 38, and 40. The following case illustrates the markedly high risk generated when an institution fails to scan specialty reports into the medical record.

- In case 40, the patient had a history of bladder cancer and underwent a follow-up cystoscopy, which identified abnormal tissue that required multiple biopsies. However, staff never retrieved and scanned the report into the electronic unit health record (eUHR). Therefore, the provider was not aware the abnormal tissue was a recurrent malignancy that required urgent workup and treatment.

When staff retrieved specialty reports, the reports often were not retrieved timely. Delays in retrieval of specialty reports significantly increased the risk of delays or lapses in care. This deficiency was identified in cases 10, 24, 30, 42, and 43. If available, providers appropriately reviewed the majority of specialty reports. However, specialty reports in cases 20, 24, 25, 39, 40, and 42 did not have a provider's signature or initials. Furthermore, cases 20, 27, 38, and 39 had specialty reports that had an illegible provider signature or lacked a date.

Utilization Management

The OIG clinicians did not identify any significant problems with the institution's utilization management program.

Onsite Inspection

The OIG clinicians discovered that the offsite specialty nurse and the utilization management (UM) nurse had an excellent process for forwarding offsite specialty and hospital reports to San Quentin providers. The offsite specialty and UM nurses diligently obtained all specialty and hospital reports and then emailed the reports on the same day to all providers. This process ensured providers had immediate access to all offsite medical information, thereby mitigating any lapses in the transmission of information between offsite locations and San Quentin.

Clinician Summary

Providers did a good job of identifying and referring patients appropriately when needed. Specialty access was generally good, despite some delays in specialist follow-ups. Specialty report handling was poor, however, with frequent failures as well as delays in the retrieval of specialty reports. Unfortunately, this deficiency resulted in several specialty reports that providers did not review. These failures were offset by the dedication of the offsite specialty and UM nurses, who ensured the transmission of offsite specialty reports to all providers. Despite the problems identified above, San Quentin provided patients with needed specialty care. The OIG clinicians thus rated this indictor *adequate*.

Compliance Testing Results

The institution received an *adequate* compliance score of 77.5 percent in the *Specialty Services* indicator, scoring within the *proficient* range in four of the seven test areas:

- For all 15 patients sampled, the high-priority specialty services appointment occurred within 14 calendar days of the provider's order (MIT 14.001). Providers also timely received and reviewed the specialists' reports for 13 of the 15 sampled patients (87 percent). A provider reviewed the specialty report one day late for one patient, and the institution never received another patients' specialty report (MIT 14.002).

- For 13 of the 15 patients sampled (87 percent), the routine specialty service appointment occurred within 90 calendar days of the provider's order. One patient received his routine service 37 days late, and another patient never received his specialty appointment (MIT 14.003).

- The OIG tested the timeliness of denials of provider specialty services requests for two patients; both denials occurred within the required time frame (MIT 14.006).

San Quentin scored in the in*adequate* range on the following three tests:

- When an institution approves or schedules a patient for specialty services appointments and then transfers the patient to another institution, policy requires that the receiving institution ensure the patient's appointment occurs timely. At San Quentin, only 10 of the 20 sampled patients (50 percent) received their specialty services appointment within the required time frame. Nine patients were seen from one to 136 days late, and one other patient did not receive his specialty service at all (MIT 14.005).

- Of the two patients sampled who had a specialty service denied, one (50 percent) received timely communication from a provider that the service was denied. A provider never notified the other patient that his specialty service was denied (MIT 14.007).

- Regarding routine specialty services, providers timely reviewed the specialists' reports for 9 of 13 patients sampled (69 percent). For three patients, there was no evidence the report was either received or reviewed by the provider, and a provider reviewed one other specialty report five days late (MIT 14.004).

Recommendations

No specific recommendations.

SECONDARY (ADMINISTRATIVE) QUALITY INDICATORS OF HEALTH CARE

The last two quality indicators (*Internal Monitoring, Quality Improvement, and Administrative Operations*; and *Job Performance, Training, Licensing, and Certifications*) involve health care administrative systems and processes. Testing in these areas applies only to the compliance component of the process. Therefore, there is no case review assessment associated with either of the two indicators. As part of the compliance component of the first of these two indicators, the OIG did not score several questions. Instead, the OIG presented the findings for informational purposes only. For example, the OIG described certain local processes in place at San Quentin.

To test both the scored and non-scored areas within these two secondary quality indicators, OIG inspectors interviewed key institutional employees and reviewed documents during the onsite visit to San Quentin in January 2016. They also reviewed documents obtained from the institution and from CCHCS prior to the start of the inspection. The test questions used to assess compliance for each indicator are detailed in *Appendix A.*

For comparative purposes, the *San Quentin Executive Summary Table* on page ix of this report shows the case review and compliance ratings for each applicable indicator.

INTERNAL MONITORING, QUALITY IMPROVEMENT, AND ADMINISTRATIVE OPERATIONS

Case Review Rating:
Not Applicable
Compliance Score:
Inadequate
(60.2%)

Overall Rating:
Inadequate

This indicator focuses on the institution's administrative health care oversight functions. The OIG evaluates whether the institution promptly processes inmate-patient medical appeals and addresses all appealed issues. Inspectors also verify that the institution follows reporting requirements for adverse/sentinel events and inmate deaths, and whether the institution is making progress toward its Performance Improvement Work Plan initiatives. In addition, 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.

Compliance Testing Results

The institution received an *inadequate* score of 60.2 percent in the *Internal Monitoring, Quality Improvement, and Administrative Operations* indicator, and scored in the *inadequate* range in the following five areas:

- The OIG reviewed the only adverse/sentinel event (ASE) that occurred at San Quentin during the prior six-month period, which required a root cause analysis. Inspectors found the institution did not complete the first monthly status report that was due in November 2015. As a result, the institution received a score of zero on this test (MIT 15.002).

- Based on information provided by the institution's chief executive officer, there was no documented information related to the methodologies used to train staff who collected Dashboard data to ensure its accuracy. As a result, San Quentin scored zero on this test (MIT 15.004).

- The local governing body (LGB) met during all four of the most recent quarters; however, the meeting minutes for only one quarter were properly approved and signed. For two of the quarters, the meeting minutes were not approved timely, and for another quarter, the meeting minutes were not properly signed. San Quentin scored 25 percent on this test (MIT 15.006).

- Inspectors reviewed the summary reports and related documentation for three medical emergency response drills conducted in the prior quarter. The institution performed a comprehensive drill for third watch, but did not complete a Cardiopulmonary Resuscitation Record (CDCR Form 7462) for the first watch drill, and did not complete a proper report

with all the required elements during the second watch drill. As a result, San Quentin scored 33 percent on this test (MIT 15.101).

- San Quentin improved or reached targeted performance objectives for only three of the five quality improvement initiatives identified in its 2014 Performance Improvement Work Plan, resulting in a score of 60 percent. For two of the five initiatives, San Quentin provided insufficient data to assess whether the institution made program improvement (MIT 15.005).

The institution performed in the *adequate* range on the test below:

- The OIG inspected documentation for 12 emergency medical response incidents reviewed by San Quentin's Emergency Medical Response Review Committee (EMRRC) during the prior six-month period, and ten of the sampled incident packages (83 percent) complied with policy. For one package, the institution used an outdated form, and for another, the institution did not use the required Medical Emergency Event Checklist (MIT 15.007).

The institution scored 100 percent on the four tests below:

- The institution promptly processed all inmate medical appeals in each of the most recent 12 months (MIT 15.001).

- San Quentin's QMC met monthly, evaluated program performance, and took action when improvement opportunities were identified (MIT 15.003).

- Based on a sample of ten second-level medical appeals, the institution's responses addressed all of the patients' appealed issues (MIT 15.102).

- Medical staff promptly submitted the Initial Inmate Death Report (CDCR Form 7229A) to CCHCS's Death Review Unit for the ten applicable deaths that occurred at San Quentin in the prior 12-month period (MIT 15.103).

Other Information Obtained from Non-Scored Areas

- The OIG gathered non-scored data regarding the completion of death review reports. During the time frame of the OIG's review, the CCHCS's Death Review Committee (DRC) was required to complete a death review summary within 30 business days of an inmate's death and to further communicate the results to the institution's chief executive officer within five additional business days. The DRC completed one of ten reports timely, but did not notify the chief executive officer timely; therefore, none of the ten sampled death reviews were completed properly. For eight of the inmate deaths reviewed, the DRC completed its death review summary between 2 and 236 days late (47 to 279 calendar days after the death). In addition, the institution's chief executive officer was not timely notified of the summary results for those aforementioned eight deaths. The chief executive officer was notified of the results from 7 to 249 days late (or 50 to 299 days after death). There were two inmate death

reviews that were not complete as of May 2, 2016, making the Death Review Summaries at least 260 to 343 days overdue. Consequently, the DRC did not provide timely results to the chief executive officer for any of the sampled death reviews (MIT 15.996).

- Inspectors met with San Quentin's chief executive officer (CEO) for health care services to inquire about protocols for tracking appeals. Management received monthly reports with updates on appeals, summarizing each inmate's appeal, from the health care appeals coordinator. The report included documentation on overdue and rejected appeals, comparing these appeals with those of the two most recent years, as well as the number of appeals filed for ADA issues and major complaints that impacted health care appeals overall. The appeals report also listed the subject area of each appeal, and the appeals were ranked based on the number of appeals filed for each subject. Management also used the reports to track trends or spikes in the number of appeals filed by inmates in specific categories, and to closely review and resolve any issues in those areas to decrease the appeals. San Quentin health care managers were assigned to resolve any issues in their respective areas of expertise when there was a spike in inmate medical appeals. In the six months preceding the OIG's inspection, management did not identify any critical problems through medical appeals (MIT 15.997).

- Non-scored data gathered regarding San Quentin's practices for implementing local operation procedures (LOPs) indicated that there was an effective process in place for developing LOPs. The institution had a health program specialist who was responsible for reviewing and analyzing all updated and revised statewide policies and procedures to determine if the revisions impacted the institution's LOPs. If an LOP needed to be revised, the chief support executive assigned a subject matter expert to make any revisions to the LOP, and submitted the revised LOP to the Patient Care Policy Committee for review. The Patient Care Policy Committee then forwarded the revised LOP to the local governing body for final approval. Once the revised LOP was approved, the LOP was posted on the institution's health care shared drive to allow staff to access and review the revised LOP, and supervisors and managers conducted training on revised LOPs as necessary. At the time of the OIG's inspections, San Quentin had implemented all 49 applicable LOPs that related to the core topical areas recommended by the clinical experts who helped develop the OIG's medical inspection compliance program (MIT 15.998).

- San Quentin's health care staffing resources are discussed in the *About the Institution* section on page 2 of this report (MIT 15.999).

Recommendations

No specific recommendations.

JOB PERFORMANCE, TRAINING, LICENSING, AND CERTIFICATIONS

In this indicator, 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 medical emergency response certifications.

Case Review Rating:
Not Applicable
Compliance Score:
Inadequate
(72.6%)

Overall Rating:
Inadequate

Compliance Testing Results

The institution received an *inadequate* compliance score of 72.6 percent in the *Job Performance, Training, Licensing, and Certifications* indicator. The institution has an opportunity to improve in the following three indicators:

- There was one registered nurse hired within the last year who did not timely receive the new employee orientation training. As a result, the institution scored zero on this test (MIT 16.107).

- The OIG reviewed performance evaluation packets for San Quentin's 14 Unit Health Record Clinical Appraisals (UCA) providers. The institution only completed performance appraisals for two providers (14 percent). For ten providers sampled, there was no evidence a supervisor discussed the Unit Health Record Clinical Appraisals results with the provider. Two other providers had overdue appraisals (MIT 16.103).

- The OIG tested provider, nursing, and custody staff records to determine if the institution ensured that those staff members had current emergency response certifications. The institution's provider and nursing staff were all compliant, but custody managers were not. While the California Penal Code exempts custody managers who primarily perform managerial duties from medical emergency response certification training, CCHCS policy does not allow for such an exemption. As a result, the institution received a score of 67 percent on this test (MIT 16.104).

The institution received a score of 100 percent on the following tests:

- All providers were current with their professional licenses, and nursing staff and the pharmacist in charge were current with their professional licenses and certification requirements (MIT 16.001, 16.105).

- Nursing supervisors completed the required number of nursing reviews for all five of the nurses sampled (MIT 16.101).

- All ten sampled nurses who administered medications possessed current clinical competency validations (MIT 16.102).

- The institution's pharmacy and providers who prescribed controlled substances were current with their Drug Enforcement Agency registrations (MIT 16.106).

Recommendations

No specific recommendations.

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

Comparison of Population-Based Metrics

For San Quentin, nine HEDIS measures were selected and are listed in the following *San Quentin 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. San Quentin performed very well with its management of diabetes.

When compared statewide, San Quentin outperformed Medi-Cal in all five measures, and outperformed or matched Kaiser scores in four of five diabetic measures selected. Kaiser South performed 4 percentage points higher than San Quentin for eye exams. When compared nationally, San Quentin outperformed Medicaid, Medicare, and commercial health plans (based on data obtained from health maintenance organizations) in all five diabetic measures. San Quentin outscored the U.S. Department of Veterans Affairs (VA) in three of the applicable measures, but scored 13 percentage points lower than the VA in diabetic eye exams.

Immunizations

Comparative data for immunizations was only fully available for the VA and partially available for Kaiser Permanente, commercial plans, and Medicare. With respect to administering influenza shots to adults aged 18 to 64, San Quentin's rate was higher than the average rates for commercial plans, but slightly lower than Kaiser and 13 percentage points lower than the VA. For administering influenza shots to adults aged 65 and older, the institution scored higher than Medicare and matched the VA. With regard to administering pneumococcal vaccines to older adults, San Quentin scored higher than Medicare but slightly lower than the VA. However, for all immunization measures, San Quentin routinely offered patients these preventive services, but many of them refused the offers; these refusals adversely affected the institution's scores.

Cancer Screening

With respect to colorectal cancer screening, San Quentin scored higher than all health care plans statewide and nationally. Patient refusals slightly impacted the institution's score for this measure; 7 percent of San Quentin patients sampled were timely offered the cancer screening but refused it.

Summary

San Quentin's population-based metrics performance reflects an adequate chronic care program, corroborated by the institutions *proficient* rating in *Quality of Provider Performance*, and *adequate* ratings in the *Access to Care* and *Quality of Nursing Performance* indicators. The institution has an opportunity for improvement in conducting dilated eye exams within the required time frame for patients. San Quentin can also take steps to improve immunization measures by making interventions to lower patient refusals.

San Quentin Results Compared to State and National HEDIS Scores

Clinical Measures	California				National			
	San Quentin Cycle 4 Results[1]	HEDIS Medi-Cal 2014[2]	HEDIS Kaiser (No. CA) 2015[3]	HEDIS Kaiser (So.CA) 2015[3]	HEDIS Medicaid 2015[4]	HEDIS Com-mercial 2015[4]	HEDIS Medicare 2015[4]	VA Average 2012[5]
Comprehensive Diabetes Care								
HbA1c Testing (Monitoring)	**100%**	83%	95%	94%	86%	91%	93%	99%
Poor HbA1c Control (>9.0%)[6, 7]	**14%**	44%	18%	24%	44%	31%	25%	19%
HbA1c Control (<8.0%)[6]	**74%**	47%	70%	62%	47%	58%	65%	-
Blood Pressure Control (<140/90)	**85%**	60%	84%	85%	62%	65%	65%	80%
Eye Exams	**77%**	51%	69%	81%	54%	56%	69%	90%
Immunizations								
Influenza Shots - Adults (18–64)[8]	**52%**	-	54%	55%	-	50%	-	65%
Influenza Shots - Adults (65+)	**76%**	-	-	-	-	-	72%	76%
Immunizations: Pneumococcal	**89%**	-	-	-	-	-	70%	93%
Cancer Screening								
Colorectal Cancer Screening	**83%**	-	80%	82%	-	64%	67%	82%

1. Unless otherwise stated, data was collected in January 2016 by reviewing medical records from a sample of San Quentin'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 2014 *HEDIS Aggregate Report for the Medi-Cal Managed Care Program*.

3. Data was obtained from Kaiser Permanente November 2015 reports for the Northern and Southern California regions.

4. National HEDIS data for Medicaid, commercial plans, and Medicare was obtained from the 2015 *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.

5. The Department of Veterans Affairs (VA) data was obtained from the *VHA Facility Quality and Safety Report - Fiscal Year 2012 Data*.

6. For this measure, the entire applicable San Quentin's 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.

8. The VA data is for the age range 50–64.

APPENDIX A — COMPLIANCE TEST RESULTS

San Quentin State Prison Range of Summary Scores: 60.17% - 87.70%	
Indicator	**Compliance Score (Yes %)**
Access to Care	77.88%
Diagnostic Services	71.60%
Emergency Services	Not Applicable
Health Information Management (Medical Records)	64.58%
Health Care Environment	75.35%
Inter- and Intra-System Transfers	87.03%
Pharmacy and Medication Management	77.83%
Prenatal and Post-delivery Services	Not Applicable
Preventive Services	61.48%
Quality of Nursing Performance	Not Applicable
Quality of Provider Performance	Not Applicable
Reception Center Arrivals	78.03%
Specialized Medical Housing (OHU, CTC, SNF, Hospice)	71.43%
Specialty Services	77.51%
Internal Monitoring, Quality Improvement, and Administrative Operations	60.17%
Job Performance, Training, Licensing, and Certifications	72.62%

Reference Number	*Access to Care*	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
1.001	**Chronic care follow-up appointments:** Was the inmate-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?	11	29	40	27.50%	0
1.002	**For endorsed inmate-patients received from another CDCR institution:** If the nurse referred the inmate-patient to a provider during the initial health screening, was the inmate-patient seen within the required time frame?	22	6	28	78.57%	2
1.003	**Clinical appointments:** Did a registered nurse review the inmate-patient's request for service the same day it was received?	38	2	40	95.00%	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?	39	1	40	97.50%	0
1.005	**Clinical appointments:** If the registered nurse determined a referral to a primary care provider was necessary, was the inmate-patient seen within the maximum allowable time or the ordered time frame, whichever is the shorter?	13	7	20	65.00%	20
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?	10	4	14	71.43%	26
1.007	**Upon the inmate-patient's discharge from the community hospital:** Did the inmate-patient receive a follow-up appointment within the required time frame?	23	7	30	76.67%	0
1.008	**Specialty service follow-up appointments:** Do specialty service primary care physician follow-up visits occur within required time frames?	25	3	28	89.29%	2
1.101	**Clinical appointments:** Do inmate-patients have a standardized process to obtain and submit health care services request forms?	6	0	6	100.00%	0
Overall Percentage:					**77.88%**	

Reference Number	*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	100.00%	0
2.002	**Radiology:** Did the primary care provider review and initial the diagnostic report within specified time frames?	3	7	10	30.00%	0
2.003	**Radiology:** Did the primary care provider communicate the results of the diagnostic study to the inmate-patient within specified time frames?	6	4	10	60.00%	0
2.004	**Laboratory:** Was the laboratory service provided within the time frame specified in the provider's order?	10	0	10	100.00%	0
2.005	**Laboratory:** Did the primary care provider review and initial the diagnostic report within specified time frames?	7	3	10	70.00%	0
2.006	**Laboratory:** Did the primary care provider communicate the results of the diagnostic study to the inmate-patient within specified time frames?	7	3	10	70.00%	0
2.007	**Pathology:** Did the institution receive the final diagnostic report within the required time frames?	9	1	10	90.00%	0
2.008	**Pathology:** Did the primary care provider review and initial the diagnostic report within specified time frames?	8	2	10	80.00%	0
2.009	**Pathology:** Did the primary care provider communicate the results of the diagnostic study to the inmate-patient within specified time frames?	4	5	9	44.44%	1
Overall Percentage:					**71.60%**	

Emergency Services	Scored Answers
Assesses reaction times and responses to emergency situations. The OIG RN clinicians will use detailed information obtained from the institution's incident packages to perform focused case reviews.	**Not Applicable**

Reference Number	*Health Information Management (Medical Records)*	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
4.001	Are non-dictated progress notes, initial health screening forms, and health care service request forms scanned into the eUHR within three calendar days of the inmate-patient encounter date?	8	2	10	80.00%	0
4.002	Are dictated / transcribed documents scanned into the eUHR within five calendar days of the inmate-patient encounter date?	3	17	20	15.00%	0
4.003	Are specialty documents scanned into the eUHR within the required time frame?	18	2	20	90.00%	0
4.004	Are community hospital discharge documents scanned into the eUHR within three calendar days of the inmate-patient date of hospital discharge?	15	5	20	75.00%	0
4.005	Are medication administration records (MARs) scanned into the eUHR within the required time frames?	19	1	20	95.00%	0
4.006	During the eUHR review, did the OIG find that documents were correctly labeled and included in the correct inmate-patient's file?	1	11	12	8.33%	0
4.007	Did clinical staff legibly sign health care records, when required?	24	16	40	60.00%	0
4.008	**For inmate-patients discharged from a community hospital:** Did the preliminary hospital discharge report include key elements and did a PCP review the report within three calendar days of discharge?	28	2	30	93.33%	0
Overall Percentage:					**64.58%**	

Reference Number	*Health Care Environment*	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
5.101	**Infection Control:** Are clinical health care areas appropriately disinfected, cleaned and sanitary?	12	1	13	92.31%	0
5.102	**Infection control:** Do clinical health care areas ensure that reusable invasive and non-invasive medical equipment is properly sterilized or disinfected as warranted?	13	0	13	100.00%	0
5.103	**Infection Control:** Do clinical health care areas contain operable sinks and sufficient quantities of hygiene supplies?	11	2	13	84.62%	0
5.104	**Infection control:** Does clinical health care staff adhere to universal hand hygiene precautions?	6	5	11	54.55%	2
5.105	**Infection control:** Do clinical health care areas control exposure to blood-borne pathogens and contaminated waste?	11	2	13	84.62%	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	1	100.00%	0
5.107	**Clinical areas:** Does each clinic follow adequate protocols for managing and storing bulk medical supplies?	7	6	13	53.85%	0
5.108	**Clinical areas:** Do clinic common areas and exam rooms have essential core medical equipment and supplies?	7	6	13	53.85%	0
5.109	**Clinical areas:** Do clinic common areas have an adequate environment conducive to providing medical services?	13	0	13	100.00%	0
5.110	**Clinical areas:** Do clinic exam rooms have an adequate environment conducive to providing medical services?	5	8	13	38.46%	0
5.111	**Emergency response bags:** Are TTA and clinic emergency medical response bags inspected daily and inventoried monthly, and do they contain essential items?	6	3	9	66.67%	4
5.999	**For Information Purposes Only:** Does the institution's health care management believe that all clinical areas have physical plant infrastructures sufficient to provide adequate health care services?	Information Only				
Overall Percentage:					**75.35%**	

Reference Number	*Inter- and Intra-System Transfers*	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
6.001	**For endorsed inmate-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 inmate-patient arrived at the institution?	24	6	30	80.00%	0
6.002	**For endorsed inmate-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 inmate-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?	28	2	30	93.33%	0
6.003	**For endorsed inmate-patients received from another CDCR institution or COCF:** If the inmate-patient had an existing medication order upon arrival, were medications administered or delivered without interruption?	9	2	11	81.82%	19
6.004	**For inmate-patients transferred out of the facility:** Were scheduled specialty service appointments identified on the Health Care Transfer Information Form 7371?	16	4	20	80.00%	0
6.101	**For inmate-patients transferred out of the facility:** Do medication transfer packages include required medications along with the corresponding Medical Administration Record (MAR) and Medication Reconciliation?	5	0	5	100.00%	5
Overall Percentage:					**87.03%**	

Reference Number	*Pharmacy and Medication Management*	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
7.001	Did the inmate-patient receive all chronic care medications within the required time frames or did the institution follow departmental policy for refusals or no-shows?	33	6	39	84.62%	1
7.002	Did health care staff administer or deliver new order prescription medications to the inmate-patient within the required time frames?	39	1	40	97.50%	0
7.003	**Upon the inmate-patient's discharge from a community hospital:** Were all medications ordered by the institution's primary care provider administered or delivered to the inmate-patient within one calendar day of return?	26	4	30	86.67%	0
7.004	**For inmate-patients received from a county jail:** Were all medications ordered by the institution's reception center provider administered or delivered to the inmate-patient within the required time frames?	2	0	2	100.00%	18
7.005	**Upon the inmate-patient's transfer from one housing unit to another:** Were medications continued without interruption?	28	2	30	93.33%	0
7.006	**For inmate-patients en route who lay over at the institution:** If the temporarily housed inmate-patient had an existing medication order, were medications administered or delivered without interruption?	Not Applicable				
7.101	**All clinical and medication line storage areas for narcotic medications:** Does the institution employ strong medication security controls over narcotic medications assigned to its clinical areas?	4	7	11	36.36%	9
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?	8	7	15	53.33%	5
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?	1	12	13	7.69%	7
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?	2	5	7	28.57%	13
7.105	**Medication preparation and administration areas:** Does the institution employ appropriate administrative controls and protocols when preparing medications for inmate-patients?	7	0	7	100.00%	13
7.106	**Medication preparation and administration areas:** Does the institution employ appropriate administrative controls and protocols when distributing medications to inmate-patients?	4	3	7	57.14%	13
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	100.00%	0

7.108	**Pharmacy:** Does the institution's pharmacy properly store non-refrigerated medications?	1	0	1	100.00%	0
7.109	**Pharmacy:** Does the institution's pharmacy properly store refrigerated or frozen medications?	1	0	1	100.00%	0
7.110	**Pharmacy:** Does the institution's pharmacy properly account for narcotic medications?	1	0	1	100.00%	0
7.111	**Pharmacy:** Does the institution follow key medication error reporting protocols?	30	0	30	100.00%	0
7.998	**For Information Purposes Only:** During eUHR compliance testing and case reviews, did the OIG find that medication errors were properly identified and reported by the institution?	Information Only				
7.999	**For Information Purposes Only:** Do inmate-patients in isolation housing units have immediate access to their KOP prescribed rescue inhalers and nitroglycerin medications?	Information Only				
Overall Percentage:					**77.83%**	

Prenatal and Post-Delivery Services	**Scored Answers**
This indicator is not applicable to this institution.	**Not Applicable**

Reference Number	*Preventive Services*	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
9.001	**Inmate-patients prescribed TB medications:** Did the institution administer the medication to the inmate-patient as prescribed?	10	20	30	33.33%	0
9.002	**Inmate-patients prescribed TB medications:** Did the institution monitor the inmate-patient monthly for the most recent three months he or she was on the medication?	8	22	30	26.67%	0
9.003	**Annual TB Screening:** Was the inmate-patient screened for TB within the last year?	17	13	30	56.67%	0
9.004	Were all inmate-patients offered an influenza vaccination for the most recent influenza season?	30	0	30	100.00%	0
9.005	**All inmate-patients from the age of 50 through the age of 75:** Was the inmate-patient offered colorectal cancer screening?	29	1	30	96.67%	0
9.006	**Female inmate-patients from the age of 50 through the age of 74:** Was the inmate-patient offered a mammogram in compliance with policy?	Not Applicable				
9.007	**Female inmate-patients from the age of 21 through the age of 65:** Was the inmate-patient offered a pap smear in compliance with policy?	Not Applicable				
9.008	Are required immunizations being offered for chronic care inmate-patients?	15	12	27	52.63%	13
9.009	Are inmate-patients at the highest risk of coccidioidomycosis (valley fever) infection transferred out of the facility in a timely manner?	Not Applicable				
Overall Percentage:					**61.48%**	

Quality of Nursing Performance	**Scored Answers**
The quality of nursing performance will be assessed during case reviews, conducted by OIG clinicians, and is not applicable for the compliance portion of the medical inspection. The methodologies OIG clinicians use to evaluate the quality of nursing performance are presented in a separate inspection document entitled OIG MIU Retrospective Case Review Methodology.	**Not Applicable**

Quality of Provider Performance	**Scored Answers**
The quality of provider performance will be assessed during case reviews, conducted by OIG clinicians, and is not applicable for the compliance portion of the medical inspection. The methodologies OIG clinicians use to evaluate the quality of provider performance are presented in a separate inspection document entitled OIG MIU Retrospective Case Review Methodology.	**Not Applicable**

Reference Number	*Reception Center Arrivals*	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
12.001	**For inmate-patients received from a county jail:** Did nursing staff complete the initial health screening and answer all screening questions on the same day the inmate-patient arrived at the institution?	18	2	20	90.00%	0
12.002	**For inmate-patients received from a county jail:** When required, did the RN complete the assessment and disposition section of the health screening form, and sign and date the form on the same day staff completed the health screening?	20	0	20	100.00%	0
12.003	**For inmate-patients received from a county jail:** If, during the assessment, the nurse referred the inmate-patient to a provider, was the inmate-patient seen within the required time frame?	20	0	20	100.00%	0
12.004	**For inmate-patients received from a county jail:** Did the inmate-patient receive a history and physical by a primary care provider within seven calendar days?	20	0	20	100.00%	0
12.005	**For inmate-patients received from a county jail:** Were all required intake tests completed within specified timelines?	16	4	20	80.00%	0
12.006	**For inmate-patients received from a county jail:** Did the primary care provider review and communicate the intake test results to the inmate-patient within specified timelines?	16	3	19	84.21%	1
12.007	**For inmate-patients received from a county jail:** Was a tuberculin test both administered and read timely?	4	16	20	20.00%	0
12.008	**For inmate-patients received from a county jail:** Was a Coccidioidomycosis (Valley Fever) skin test administered and read timely?	10	10	20	50.00%	0
Overall Percentage:					**78.03%**	

Reference Number	*Specialized Medical Housing (OHU, CTC, SNF, Hospice)*	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
13.001	**For all higher level care facilities:** Did the registered nurse complete an initial assessment of the inmate-patient on the day of admission, or within eight hours of admission to CMF's Hospice?	7	0	7	100.00%	0
13.002	**For OHU, CTC, & SNF only:** Did the primary care provider for OHU or attending physician for a CTC & SNF evaluate the inmate-patient within 24 hours of admission?	4	3	7	57.14%	0
13.003	**For OHU, CTC, & SNF only:** Was a written history and physical examination completed within 72 hours of admission?	7	0	7	100.00%	0
13.004	**For all higher level care facilities:** Did the primary care provider complete the Subjective, Objective, Assessment, Plan, and Education (SOAPE) notes on the inmate-patient at the minimum intervals required for the type of facility where the inmate-patient was treated?	0	7	7	0.00%	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 inmate-patient's cells?	1	0	1	100.00%	0
Overall Percentage:					**71.43%**	

Reference Number	*Specialty Services*	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
14.001	Did the inmate-patient receive the high-priority specialty service within 14 calendar days of the PCP order?	15	0	15	100.00%	0
14.002	Did the PCP review the high priority specialty service consultant report within the required time frame?	13	2	15	86.67%	0
14.003	Did the inmate-patient receive the routine specialty service within 90 calendar days of the PCP order?	13	2	15	86.67%	0
14.004	Did the PCP review the routine specialty service consultant report within the required time frame?	9	4	13	69.23%	2
14.005	**For endorsed inmate-patients received from another CDCR institution:** If the inmate-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?	10	10	20	50.00%	0
14.006	Did the institution deny the primary care provider request for specialty services within required time frames?	2	0	2	100.00%	0
14.007	Following the denial of a request for specialty services, was the inmate-patient informed of the denial within the required time frame?	1	1	2	50.00%	0
Overall Percentage:					**77.51%**	

Reference Number	*Internal Monitoring, Quality Improvement, and 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?	12	0	12	100.00%	0
15.002	Does the institution follow adverse/sentinel event reporting requirements?	0	1	1	0.00%	0
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	100.00%	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?	0	1	1	0.00%	0
15.005	For each initiative in the Performance Improvement Work Plan (PIWP), has the institution performance improved or reached the targeted performance objective(s)?	3	2	5	60.00%	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?	1	3	4	25.00%	0
15.007	Does the Emergency Medical Response Review Committee perform timely incident package reviews that include the use of required review documents?	10	2	12	83.33%	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?	1	2	3	33.33%	0
15.102	Did the institution's second level medical appeal response address all of the inmate-patient's appealed issues?	10	0	10	100.00%	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?	10	0	10	100.00%	0
15.996	**For Information Purposes Only:** Did the CCHCS Death Review Committee submit its inmate death review summary to the institution timely?	Information Only				
15.997	**For Information Purposes Only:** Identify the institution's protocols for tracking medical appeals.	Information Only				
15.998	**For Information Purposes Only:** Identify the institution's protocols for implementing health care local operating procedures.	Information Only				
15.999	**For Information Purposes Only:** Identify the institution's health care staffing resources.	Information Only				
Overall Percentage:					**60.17%**	

Reference Number	*Job Performance, Training, Licensing, and Certifications*	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
16.001	Do all providers maintain a current medical license?	16	0	16	100.00%	0
16.101	Does the institution's Supervising Registered Nurse conduct periodic reviews of nursing staff?	5	0	5	100.00%	0
16.102	Are nursing staff who administer medications current on their clinical competency validation?	10	0	10	100.00%	0
16.103	Are structured clinical performance appraisals completed timely?	2	12	14	14.29%	0
16.104	Are staff current with required medical emergency response certifications?	2	1	3	66.67%	0
16.105	Are nursing staff and the Pharmacist-in-Charge current with their professional licenses and certifications?	5	0	5	100.00%	1
16.106	Do the institution's pharmacy and authorized providers who prescribe controlled substances maintain current Drug Enforcement Agency (DEA) registrations?	1	0	1	100.00%	0
16.107	Are nursing staff current with required new employee orientation?	0	1	1	0.00%	0
Overall Percentage:					**72.62%**	

APPENDIX B — CLINICAL DATA

Table B-1 San Quentin Sample Sets	
Sample Set	**Total**
Anticoagulation	3
CTC/OHU	5
Death Review/Sentinel Events	5
Diabetes	2
Emergency Services – CPR	5
Emergency Services – Non-CPR	5
High Risk	5
Hospitalization	5
Intra-System Transfers In	3
Intra-System Transfers Out	3
RN Sick Call	38
Reception Center Transfers	5
Specialty Services	5
	89

Table B-2 San Quentin Chronic Care Diagnoses	
Diagnosis	**Total**
Anemia	8
Anticoagulation	3
Arthritis/Degenerative Joint Disease	4
Asthma	13
COPD	17
Cancer	7
Cardiovascular Disease	18
Chronic Kidney Disease	15
Chronic Pain	26
Cirrhosis/End-Stage Liver Disease	4
DVT/PE	2
Diabetes	31
Gastroesophageal Reflux Disease	25
Gastrointestinal Bleed	2
HIV	10
Hepatitis C	27
Hyperlipidemia	30
Hypertension	60
Mental Health	15
Migraine Headaches	1
Seizure Disorder	5
Sleep Apnea	5
Thyroid Disease	5
	333

Table B-3 San Quentin Event — Program	
Program	**Total**
Diagnostic Services	312
Emergency Care	122
Hospitalization	70
Intra- System Transfers In	20
Intra-System Transfers Out	5
Not Specified	1
Outpatient Care	568
Reception Center Care	29
Specialized Medical Housing	423
Specialty Services	333
	1,883

Table B-4 San Quentin Case Review Sample Summary	
	Total
MD Reviews Detailed	30
MD Reviews Focused	0
RN Reviews Detailed	17
RN Reviews Focused	60
Total Reviews	107
Total Unique Cases	89
Overlapping Reviews (MD & RN)	18

APPENDIX C — COMPLIANCE SAMPLING METHODOLOGY

SAN QUENTIN STATE PRISON			
Quality Indicator	**Sample Category (number of samples)**	**Data Source**	**Filters**
Access to Care			
MIT 1.001	Chronic care patients (40)	Master Registry	• Chronic care conditions (at least one condition per inmate-patient—any risk level) • **Randomize**
MIT 1.002	Nursing Referrals (30)	OIG Q: 6.001	• See ***Intra-system Transfers***
MITs 1.003-006	Nursing sick call (5 per clinic) 40	MedSATS	• Clinic (each clinic tested) • Appointment date (2–9 months) • **Randomize**
MIT 1.007	Returns from community hospital (30)	OIG Q: 4.008	• 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***
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**
Health Information Management (Medical Records)			
MIT 4.001	Timely scanning (10)	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	(20)	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	(20)	OIG Q: 4.008	• Community hospital discharge documents • First 20 IPs selected
MIT 4.005	(20)	OIG Q: 7.001	• MARs • First 20 IPs selected
MIT 4.006	(12)	Documents for any tested inmate	• Any misfiled or mislabeled document identified during OIG compliance review (12 or more = No)
MIT 4.007	Legible signatures & review (40)	OIG Qs: 4.008, 6.001, 6.002, 7.001, 12.001, 12.002 & 14.002	• First 8 IPs sampled • One source document per IP

Quality Indicator	Sample Category (number of samples)	Data Source	Filters
Health Information Management (Medical Records) (continued)			
MIT 4.008	Returns from community hospital (30)	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 inmate-patients from each of the 6 months (if not 5 in a month, supplement from another, as needed)
Health Care Environment			
MIT 5.101-111	Clinical areas (13)	OIG inspector onsite review	• Identify and inspect all onsite clinical areas.
Inter- and Intra-System Transfers			
MIT 6.001-003	Intra-system transfers (30)	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 (5)	OIG inspector onsite review	• R&R IP transfers with medication
Pharmacy and Medication Management			
MIT 7.001	Chronic care medication (40)	OIG Q: 1.001	*See **Access to Care*** • At least one condition per inmate-patient—any risk level • **Randomize**
MIT 7.002	New Medication Orders (40)	Master Registry	• Rx count • **Randomize** • Ensure no duplication of IPs tested in MIT 7.001
MIT 7.003	Returns from Community Hospital (30)	OIG Q: 4.008	• See ***Health Information Management (Medical Records)*** *(returns from community hospital)*
MIT 7.004	RC arrivals – medication orders (20)	OIG Q: 12.001	• See ***Reception Center Arrivals***
MIT 7.005	Intra-facility moves (30)	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 *N/A at this institution*	SOMS	• Date of transfer (2–8 months) • Sending institution (another CDCR facility) • **Randomize** • NA/DOT meds

Quality Indicator	Sample Category (number of patients)	Data Source	Filters
Pharmacy and Medication Management (continued)			
MITs 7.101-103	Medication storage areas (15)	OIG inspector onsite review	• Identify and inspect clinical & med line areas that store medications
MITs 7.104–106	Medication Preparation and Administration Areas (7)	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 (30)	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)
Preventive Services			
MITs 9.001–002	TB medications (30)	Maxor	• Dispense date (past 9 months) • Time period on TB meds (3 months or 12 weeks) • **Randomize**
MIT 9.003	TB Code 22, annual TST (30)	SOMS	• Arrival date (at least 1 year prior to inspection) • TB Code (22) • **Randomize**
	TB Code 34, annual screening (30)	SOMS	• Arrival date (at least 1 year prior to inspection) • TB Code (34) • **Randomize**
MIT 9.004	Influenza vaccinations (30)	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 (30)	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 (40)	OIG Q: 1.001	• Chronic care conditions (at least 1 condition per IP—any risk level) • **Randomize** • Condition must require vaccination(s)

Quality Indicator	Sample Category (number of patients)	Data Source	Filters
Preventive Services (continued)			
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**
Reception Center Arrivals			
MITs 12.001–008	RC (20)	SOMS	• Arrival date (2–8 months) • Arrived from (county jail, return from parole, etc.) • **Randomize**
Specialized Medical Housing			
MITs 13.001–004	CTC (7)	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 Access			
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 (2)	InterQual	• Review date (3–9 months) • **Randomize**
	(2)	IUMC/MAR Meeting Minutes	• Meeting date (9 months) • Denial upheld • **Randomize**
Internal Monitoring, Quality Improvement, & Administrative Operations			
MIT 15.001	Medical appeals (all)	Monthly medical appeals reports	• Medical appeals (12 months)
MIT 15.002	Adverse/sentinel events (1)	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	Performance improvement work plans (PIWP) (5)	Institution PIWP	• PIWP with updates (12 months) • Medical initiatives

Quality Indicator	Sample Category (number of samples)	Data Source	Filters
Internal Monitoring, Quality Improvement, & Administrative Operations (continued)			
MIT 15.006	LGB (4)	LGB meeting minutes	• Quarterly meeting minutes (12 months)
MIT 15.007	EMRRC (12)	EMRRC meeting minutes	• Monthly meeting minutes (6 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 (10)	Institution-list of deaths in prior 12 months	• Most recent 10 deaths • Initial death reports
MIT 15.996	Death Review Committee (10)	OIG summary log - deaths	• Between 35 business days & 12 months prior • CCHCS death reviews
MIT 15.998	Local operating procedures (LOPs) (all)	Institution LOPs	• All LOPs
Job Performance, Training, Licensing, and Certifications			
MIT 16.001	Provider licenses (16)	Current provider listing (at start of inspection)	• Review all
MIT 16.101	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 16.102	Nursing Staff Validations (10)	Onsite nursing education files	• On duty one or more years • Nurse administers medications • **Randomize**
MIT 16.103	Provider Annual Evaluation Packets (all)	OIG Q:16.001	• All required performance evaluation documents

MIT 16.104	Medical Emergency Response Certifications (all)	Onsite certification tracking logs	• All staff
			  ○ Providers (ACLS)
			  ○ Nursing (BLS/CPR)
			  ○ Custody (CPR/BLS)

MIT 16.105	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
Job Performance, Training, Licensing, and Certifications (continued)			
MIT 16.106	Pharmacy and Providers' Drug Enforcement Agency (DEA) Registrations (all)	Onsite listing of provider DEA registration #s & pharmacy registration document	• All DEA registrations
MIT 16.107	Nursing Staff New Employee Orientations (all)	Nursing staff training logs	• New employees (hired within last 12 months)

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