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OIG | OFFICE *of the* INSPECTOR GENERAL

Independent Prison Oversight

June 2024

Cycle 7

Medical Inspection Report

California State Prison Solano

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Introduction

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

In Cycle 7, the OIG continues to apply the same assessment methodologies used in Cycle 6, including clinical case review and compliance testing. Together, these methods assess the institution's medical care on both individual and system levels by providing an accurate assessment of how the institution's health care systems function regarding patients with the highest medical risk, who tend to access services at the highest rate. Through these methods, the OIG evaluates the performance of the institution in providing sustainable, adequate care. We continue to review institutional care using 15 indicators as in prior cycles.[3]

Using each of these indicators, our compliance inspectors collect data in answer to compliance- and performance-related questions as established in the medical inspection tool (MIT). In addition, our clinicians complete document reviews of individual cases and also perform on-site inspections, which include interviews with staff. The OIG determines a total compliance score for each applicable indicator and considers the MIT scores in the overall conclusion of the institution's compliance performance.

In conducting in-depth quality-focused reviews of randomized cases, our case review clinicians examine whether health care staff used sound medical judgment in the course of caring for a patient. In the event we find errors, we determine whether such errors were clinically significant or led to a significantly increased risk of harm to the patient. At the same time, our clinicians consider whether institutional medical processes led to identifying and correcting individual or system errors, and we examine whether the institution's medical system mitigated the error. The OIG rates each applicable indicator ***proficient***, ***adequate***, or ***inadequate,*** and considers each rating in the overall conclusion of the institution's health care performance.

In contrast to Cycle 6, the OIG will provide individual clinical case review ratings and compliance testing scores in Cycle 7, rather than aggregate all findings into a single overall institution rating. This change will clarify the distinctions between these differing quality measures and the results of each assessment.

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

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

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

As we did during Cycle 6, our office continues to inspect both those institutions remaining under federal receivership and those delegated back to the department. There is no difference in the standards used for assessing a delegated institution versus an institution not yet delegated. At the time of the Cycle 7 inspection of California State Prison, Solano, the institution had not been delegated back to the department by the receiver.

We completed our seventh inspection of the institution, and this report presents our assessment of the health care provided at this institution during the inspection period from July 2022 to December 2022.[4]

[4] Samples are obtained per case review methodology shared with stakeholders in prior cycles. The case reviews include death reviews between September 2021 and August 2022, emergency noncardiopulmonary (CPR) reviews between August 2022 and January 2023, hospitalization reviews between July 2022 and January 2023, and transfer reviews between May 2022 and December 2022.

Summary: Ratings and Scores

We completed the Cycle 7 inspection of SOL in June 2023. OIG inspectors monitored the institution's delivery of medical care that occurred between July 2022 and December 2022.

The OIG rated the case review component of the overall health care quality at SOL ***adequate***.

The OIG rated the compliance component of the overall health care quality at SOL ***inadequate***.

The OIG clinicians (a team of physicians and nurse consultants) reviewed 69 cases, which contained 922 patient-related events. They performed quality control reviews; their subsequent collective deliberations ensured consistency, accuracy, and thoroughness. Our OIG clinicians acknowledged institutional structures that catch and resolve mistakes that may occur throughout the delivery of care. After examining the medical records, our clinicians completed a follow-up on-site inspection in June 2023 to verify their initial findings. The OIG physicians rated the quality of care for 25 comprehensive case reviews. Of these 25 cases, our physicians rated 18 ***adequate*** and seven ***inadequate***. Our physicians found no adverse deficiencies during this inspection.

To test the institution's policy compliance, our compliance inspectors (a team of registered nurses) monitored the institution's compliance with its medical policies by answering a standardized set of questions that measure specific elements of health care delivery. Our compliance inspectors examined 382 patient records and 1,129 data points and used the data to answer 90 policy questions. In addition, we observed SOL's processes during an on-site inspection in March 2023.

The OIG then considered the results from both case review and compliance testing and drew overall conclusions, which we report in 13 health care indicators.[5]

[5] The indicators for **Reception Center** and **Prenatal and Postpartum Care** did not apply to SOL.

We list the individual indicators and ratings applicable for this institution in Table 1 below.

Table 1. SOL Summary Table: Case Review Ratings and and Policy Compliance Scores

		Ratings		*Scoring Ranges*		
		Proficient *Adequate* *Inadequate*		100%–85.0% 84.9%–75.0% 74.9%–0		
		Case Review		**Compliance**		
MIT Number	**Health Care Indicators**	**Cycle 7**	**Change Since Cycle 6***	**Cycle 7**	**Cycle 6**	**Change Since Cycle 6***
1	Access to Care	*Adequate*	=	82.7%	92.0%	↓
2	Diagnostic Services	*Adequate*	=	59.8%	56.0%	=
3	Emergency Services	*Adequate*	=	*N/A*	*N/A*	*N/A*
4	Health Information Management	*Adequate*	↓	87.1%	76.0%	↑
5	Health Care Environment†	*N/A*	*N/A*	54.3%	76.0%	↓
6	Transfers	*Adequate*	↑	86.0%	67.0%	↑↑
7	Medication Management	*Adequate*	↑	76.7%	79.0%	=
8	Prenatal and Postpartum Care	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*
9	Preventive Services	*N/A*	*N/A*	68.2%	70.0%	=
10	Nursing Performance	*Adequate*	=	*N/A*	*N/A*	*N/A*
11	Provider Performance	*Adequate*	=	*N/A*	*N/A*	*N/A*
12	Reception Center	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*
13	Specialized Medical Housing	*Adequate*	↓	85.7%	82.0%	↑
14	Specialty Services	*Inadequate*	↓	52.7%	84.0%	↓
15	Administrative Operations†	*N/A*	*N/A*	74.4%	71.0%	=

* The symbols in this column correspond to changes that occurred in indicator ratings between the medical inspections conducted during Cycle 6 and Cycle 7. The equals sign means there was no change in the rating. The single arrow means the rating rose or fell one level, and the double arrow means the rating rose or fell two levels (green, from *inadequate* to *proficient*; pink, from *proficient* to *inadequate*).

† **Health Care Environment** and **Administrative Operations** are secondary indicators and are not considered when rating the institution's overall medical quality.

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

Medical Inspection Results

Deficiencies Identified During Case Review

Deficiencies are medical errors that increase the risk of patient harm. Deficiencies can be minor or significant, depending on the severity of the deficiency. An *adverse event* occurs when the deficiency caused harm to the patient. All major health care organizations identify and track adverse events. We identify deficiencies and adverse events to highlight concerns regarding the provision of care and for the benefit of the institution's quality improvement program to provide an impetus for improvement.[6]

The OIG did not find any adverse events at SOL during the Cycle 7 inspection.

Case Review Results

OIG case reviewers (a team of physicians and nurse consultants) assessed 10 of the 13 indicators applicable to SOL. Of these 10 indicators, OIG clinicians rated nine ***adequate*** and one ***inadequate***. OIG physicians also rated the overall adequacy of care for each of the 25 detailed case reviews they conducted. Of these 25 cases, 18 were ***adequate*** and seven were ***inadequate***. In 922 events reviewed, we identified 201 deficiencies, 38 of which our clinicians considered to be of such magnitude that, if left unaddressed, would likely contribute to patient harm.

Our clinicians found the following strengths at SOL:

- Staff provided excellent access to nursing, follow-up appointments after urgent or emergent care, and follow-up appointments after hospitalizations.
- Staff performed well in completing laboratory and radiology tests.
- Providers performed very well with urgent or emergent care in the TTA.
- Staff provided effective medication continuity for patients transferring between housing units, and for those transferring in from another institution.

Our clinicians found the following weaknesses at SOL:

- Providers did not consistently complete and send diagnostic test result letters to patients.
- Staff encountered difficulties obtaining timely specialty services.
- Staff did not always retrieve or scan specialty reports timely.

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

Compliance Testing Results

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

SOL showed a high rate of policy compliance in the following areas:

- Medical staff performed well in scanning requests for health care services and community hospital discharge reports into patients' electronic medical records.
- Nursing staff and providers did an excellent job completing assessments of patients admitted to the specialized medical housing unit within the required time frame. The institution had properly functioning call buttons, and medical staff were able to enter patient rooms during emergent events in a timely manner.
- Nursing staff reviewed health care services request forms and conducted face-to-face encounters within required time frames. In addition, the housing units contained adequate supplies of health care request forms.
- Patients with chronic care conditions and those returning from specialty services appointments saw their primary care providers within the specified time frames.

SOL showed a low rate of policy compliance in the following areas:

- Health care staff did not consistently follow universal hand hygiene precautions during patient encounters.
- Medical clinics did not meet requirements for essential core medical equipment and supplies. Almost all clinics that we tested were missing properly calibrated medical equipment and medical supplies required to provide standard medical care.
- Nursing staff did not regularly inspect emergency response bags and treatment carts.
- Staff frequently failed to maintain medication continuity for chronic care patients, patients discharged from the hospital, and patients admitted to specialized medical housing. In addition, medication continuity was poor for patients who had a temporary layover at SOL.
- Staff did not perform well in ensuring approved specialty services were provided within specified time frames. Furthermore, staff often did not ensure specialty services reports were timely received from specialty services providers. Providers often did not review these reports within required time frames.

Institution-Specific Metrics

California State Prison, Solano (SOL), is located in the city of Vacaville and operates as a medium-security institution housing general population incarcerated people. It is designated as an *intermediate care prison*, providing outpatient health care services through its nine clinics, which handle nonurgent requests for medical services. Patients needing urgent or emergent care are treated in its triage and treatment area (TTA) and patients requiring inpatient health services are cared for in its correctional treatment center (CTC). As of January 24, 2024, the department reports on its public tracker that 75% of SOL's incarcerated population is fully vaccinated while 60% of SOL's staff is fully vaccinated.[7]

In February 2023, the Health Care Services Master Registry showed that SOL had a total population of 3,406. A breakdown of the medical risk level of the SOL population as determined by the department is set forth in Table 2 below.[8]

Table 2. SOL Master Registry Data as of February 2023

Medical Risk Level	Number of Patients	Percentage*
High 1	345	10.1%
High 2	505	14.8%
Medium	907	26.6%
Low	1,649	48.4%
Total	**3,406**	**100.0%**

* Percentages may not total 100% due to rounding.

Source: Data for the population medical risk level were obtained from the CCHCS Master Registry dated 2-24-23.

[7] For more information, see the department's statistics on its website page titled Population COVID-19 Tracking.

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

According to staffing data the OIG obtained from California Correctional Health Care Services (CCHCS), as identified in Table 3 below, SOL had zero executive leadership vacancies, 4.5 vacant primary care provider positions, 0.2 vacant nursing supervisor positions, and 26 vacant nursing staff positions.

Table 3. SOL Health Care Staffing Resources as of February 2023

Positions	Executive Leadership*	Primary Care Providers	Nursing Supervisors	Nursing Staff †	Total
Authorized Positions	5.0	10.5	11.2	122.8	149.5
Filled by Civil Service	5.0	6.0	11.0	100.0	122.0
Vacant	0	4.5	0.2	26.0	30.7
Percentage Filled by Civil Service	100%	57.1%	98.2%	81.4%	81.6%
Filled by Telemedicine	0	2.0	0	0	2.0
Percentage Filled by Telemedicine	0	19.0%	0	0	1.3%
Filled by Registry	0	1.0	0	9.0	10.0
Percentage Filled by Registry	0	9.5%	0	7.3%	6.7%
Total Filled Positions	5.0	9.0	11.0	109.0	134.0
Total Percentage Filled	**100%**	**85.7%**	**98.2%**	**88.7%**	**89.6%**
Appointments in Last 12 Months	0	1.0	9.0	34.0	44.0
Redirected Staff	0	0	0	0	0
Staff on Extended Leave‡	0	1.0	0	4.0	5.0
Adjusted Total: Filled Positions	**5.0**	**8.0**	**11.0**	**105.0**	**129.0**
Adjusted Total: Percentage Filled	**100%**	**76.2%**	**98.2%**	**85.5%**	**86.3%**

* Executive Leadership includes the Chief Physician and Surgeon.

† Nursing Staff includes the classifications of Senior Psychiatric Technician and Psychiatric Technician.

‡ In Authorized Positions.

Notes: The OIG does not independently validate staffing data received from the department. Positions are based on fractional time-base equivalents.

Source: Cycle 7 medical inspection preinspection questionnaire received on February 24, 2023, from California Correctional Health Care Services.

Population-Based Metrics

In addition to our own compliance testing and case reviews, as noted above, the OIG presents selected measures from the Healthcare Effectiveness Data and Information Set (HEDIS) for comparison purposes. The HEDIS is a set of standardized quantitative performance measures designed by the National Committee for Quality Assurance to ensure that the public has the data it needs to compare the performance of health care plans. Because the Veterans Administration no longer publishes its individual HEDIS scores, we removed them from our comparison for Cycle 7. Likewise, Kaiser (commercial plan) no longer publishes HEDIS scores. However, through the California Department of Health Care Services' *Medi-Cal Managed Care Technical Report*, the OIG obtained California Medi-Cal and Kaiser Medi-Cal HEDIS scores to use in conducting our analysis, and we present them here for comparison.

HEDIS Results

We considered SOL's performance with population-based metrics to assess the macroscopic view of the institution's health care delivery. Currently, only one HEDIS measure is available for review: poor HbA1c control, which measures the percentage of diabetic patients who have poor blood sugar control. SOL's results compared favorably with those found in State health plans for this measure. We list the applicable HEDIS measures in Table 5.

Comprehensive Diabetes Care

When compared with statewide Medi-Cal programs—California Medi-Cal, Kaiser Northern California (Medi-Cal), and Kaiser Southern California (Medi-Cal)—SOL's percentage of patients with poor HbA1c control was significantly lower, indicating very good performance on this measure.

Immunizations

Statewide comparative data were not available for immunization measures; however, we include this data for informational purposes. SOL had a 35 percent influenza immunization rate for adults 18 to 64 years old and a 64 percent influenza immunization rate for adults 65 years of age and older. The pneumococcal vaccination rate was 87 percent.[9]

Colorectal Cancer Screening

Statewide comparative data were not available for colorectal cancer screening; however, we include this data for informational purposes. SOL had a 76 percent colorectal cancer screening rate.

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

Table 4. SOL Results Compared With State HEDIS Scores

HEDIS Measure	SOL Cycle 7 Results*	California Medi-Cal†	California Kaiser NorCal Medi-Cal†	California Kaiser SoCal Medi-Cal†
HbA1c Screening	100%	–	–	–
Poor HbA1c Control (>9.0%)‡,§	**9%**	38%	28%	20%
HbA1c Control (<8.0%)‡	80%	–	–	–
Blood Pressure Control (<140/90)‡	84%	–	–	–
Eye Examinations	87%	–	–	–
Influenza–Adults (18–64)	35%	–	–	–
Influenza–Adults (65+)	64%	–	–	–
Pneumococcal–Adults (65+)	87%	–	–	–
Colorectal Cancer Screening	76%	–	–	–

Notes and Sources

* Unless otherwise stated, data were collected in March 2023 by reviewing medical records from a sample of SOL's population of applicable patients. These random statistical sample sizes were based on a 95 percent confidence level with a 15 percent maximum margin of error.

† HEDIS Medi-Cal data were obtained from the California Department of Health Care Services publication titled *Medi-Cal Managed Care External Quality Review Technical Report*, dated July 1, 2021–June 30, 2022 (published April 2023); **https://www.dhcs.ca.gov/dataandstats/reports/Documents/CA2021-22-MCMC-EQR-TR-VOL1-F1.pdf**.

‡ For this indicator, the entire applicable SOL population was tested.

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

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

Recommendations

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

Diagnostic Services

- The department should consider solutions, such as potentially developing an electronic solution, to ensure providers create patient letters at the time of endorsement and the patient results letter automatically populates accurately with all required elements per CCHCS policy and take necessary remedial measures.

- Medical leadership should determine the cause of challenges preventing providers from generating patient notification letters for pathology results and take necessary remedial measures.

Health Information Management

- Medical leadership should ascertain the challenges in the timely retrieval of specialty reports and the timely provider review of these reports and implement remedial measures as appropriate.

Health Care Environment

- Medical leadership should determine the root cause for staff not following all required universal hand hygiene precautions and take necessary remedial measures.

- Executive leadership should determine the root cause for staff not ensuring medical supply storage areas, located outside the clinics, store medical supplies adequately, and take necessary remedial measures.

- Nursing leadership should determine the root cause for staff not ensuring clinic examination rooms contain calibrated functional essential core medical equipment and take necessary remedial measures.

- Nursing leadership should determine the root cause for staff not ensuring the emergency medical response bags (EMRBs) are regularly inventoried and sealed, or staff failing to properly complete the monthly logs, and take necessary remedial measures.

Transfers

- Nursing leadership should analyze the challenges preventing staff from properly documenting communication of pending specialty appointments to the receiving facility for transfer-out patients and take necessary remedial measures.

- Nursing leadership should analyze the challenges preventing staff from documenting and addressing required initial health screening questions and take necessary remedial measures.

Medication Management

- Medical and nursing leadership should analyze the challenges in ensuring that chronic care, hospital discharge, and en route patients receive their medications timely and without interruption and implement remedial leadership as appropriate.

Preventive Services

- Nursing leadership should analyze the challenges to ensuring nursing staff monitor patients receiving TB medications according to CCHCS guidelines and take necessary remedial measures.

- Medical leadership should analyze the challenges related to the untimely provision of preventive vaccines to chronic care patients and implement remedial measures as appropriate.

Nursing Performance

- Nursing leadership should analyze the challenges to nurses performing thorough assessments and interventions during patients' appointments and should take necessary remedial measures.

Provider Performance

- Medical leadership should analyze the challenges to providers performing focused examinations based on the patients' medical complaints and symptoms and take necessary remedial measures.

- Medical leadership should clarify for providers the criteria for approval of medium- and high-priority specialty referrals.

Specialty Services

- Medical leadership should determine causative factors related to the untimely provision or scheduling of patients' specialty service appointments and follow-up appointments and implement remedial measures as appropriate.

Access to Care

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

Ratings and Results Overview

Case Review Rating	Compliance Rating and Score
Adequate	***Adequate* (82.7%)**

Case Review found SOL provided sufficient access for patients during Cycle 7. The staff offered excellent access to nurses and appropriate follow-ups after TTA visits, after hospitalizations, and after transferring into the institution. In contrast, access to specialty services was poor. Overall, the OIG rated the case review component of this indicator ***adequate***.

Compliance testing found SOL performed excellently in reviewing patient sick call requests, completing nurse face-to-face encounters, and completing provider follow-ups appointments for patients transferring into the institution. SOL showed good performance in delivering provider follow-ups for patients returning from hospitalization and fair performance in delivering follow-ups for patients with chronic care condition. However, compliance testing resulted in low scores for provider follow-up appointments returning from specialty services and follow-up sick call appointments. Factoring in all the information, the OIG rated the compliance testing component of this indicator ***adequate***.

Case Review and Compliance Testing Results

OIG clinicians reviewed 363 provider, nursing, urgent or emergent care (TTA), specialty, and hospital events that required the institution to generate appointments.[10] We identified 16 deficiencies relating to **Access to Care**, seven of which were significant.[11]

Access to Care Providers

SOL offered satisfactory access to providers. Compliance testing found most chronic care face-to-face follow-up appointments (MIT 1.001, 76.0%) and most registered nurse to primary care provider (RN-to-PCP) appointments (MIT 1.005, 81.8%) occurred timely.

[10] SOL urgent and emergent care are provided at the triage and treatment area (TTA).

[11] Deficiencies occurred in cases 1, 19, 26, 37, 42, and 75–79. Significant deficiencies occurred in cases 42 and 75–79.

Similarly, case review found good access to clinic providers; however, we identified four deficiencies, with two examples below:

- In case 42, the provider ordered a provider follow-up within 182 days, but the appointment had not yet been scheduled by the end of the OIG's review period, which was one day after the last date on which the follow-up appointment could have timely occurred.

- In case 75, the patient was seen by the nurse for knee pain. The nurse generated a provider routine appointment order and closed it the same day. This appointment did not occur. During our on-site inspection, staff mentioned the process of generating and closing a provider's routine appointment was referred to as a "capture" of co-consultations, and is the process staff uses to document when a provider assessed the patient as part of an RN appointment. However, the physician did not document anything about this co-consultation assessment, and we found no other objective evidence the provider saw the patient.

Access to Specialized Medical Housing Providers

SOL provided good access to care in the correctional treatment center (CTC). The CTC housed six medical beds. At the time of the review and inspection, the primary care providers followed their patients and provided care when they were admitted to the CTC. Case review clinicians found one deficiency with CTC access to providers as described below:

- In case 79, the CTC provider did not see the patient, as dictated by policy intervals, between late October and early November.

Access to Clinic Nurses

SOL performed excellently with access to nurse sick calls and provider-to-nurse referrals. Compliance testing scores were excellent with both RN review of sick call (MIT 1.003, 97.5%) and RN face-to-face (MIT 1.004, 95.0%) appointments. Our clinicians assessed 66 nursing sick call requests in 41 cases. We similarly did not find any access deficiencies related to sick calls or provider-to-nurse referrals.

Access to Specialty Services

SOL needed, overall, to improve with access to specialty services. Compliance testing found a poor completion rate of high-priority appointments (MIT 14.001, 40.0%), and improvement needed in medium-priority appointments (MIT 14.004, 53.3%), and routine-priority appointments (MIT 14.007, 66.7%). Case review clinicians also found a pattern of delays with specialty consultations. We also identified two instances where PCP follow-ups did not occur after high-priority imaging scans. The following are three examples:

- In case 19, the patient's prostate biopsy was rescheduled twice due to SOL staff not properly preparing the patient for the procedure. They did not administer the patient the proper antibiotics or the proper bowel preparation, respectively.

- In case 77, the provider generated a medium-priority RFS for a CT scan of the abdomen with oral and intravenous (IV) contrast, but the test was not completed within the requested time frame.[12]

- In case 78, institution staff did not schedule the urology follow-up as requested by the specialist within the time frame specified.

Follow-Up After Specialty Services

SOL follow-up after specialty services was mixed. Compliance testing showed SOL needed improvement with completing provider appointments after specialty services within the required time frame (MIT 1.008, 62.5%). In contrast, case review clinicians found most appointments were completed timely. However, we found two deficiencies in the same case:

- In case 78, institution staff did not generate a provider follow-up appointment after a high-priority MRI and a high-priority CT scan.[13]

Follow-Up After Hospitalization

SOL provided excellent access to care for patients after hospitalization. Case review did not find any deficiencies with access to follow-up appointments after hospitalizations.

Follow-Up After Urgent or Emergent Care (TTA)

Providers almost always saw their patients following a TTA event as medically indicated. OIG clinicians assessed 39 TTA events and only identified one deficiency in a provider follow-up appointment, as described below:

- In case 42, the patient was seen in the TTA for a high blood sugar level. The patient was not seen by a provider after this TTA event.

Follow-Up After Transferring Into the Institution

Access to care for patients who had recently transferred into the institution was excellent (MIT 1.002, 100%). Case reviewers did not find any deficiencies in this area; however, we only reviewed three cases in which patients transferred from another institution.

Clinician On-Site Inspection

We observed several huddles over the two-day, on-site inspection. The yard clinic huddles were run well, and staff relayed important information to the pertinent members of the care team. However, in the CTC, the huddles occurred without any medical providers present as each patient may be assigned a different provider. The nursing staff stated they contact the provider with any patient issues. We suggested medical leadership

[12] The request for service (RFS) is a referral order for a specialty consultation. A CT scan is a computed, or computerized, tomography imaging scan.

[13] MRI is a magnetic resonance imaging test.

assign a TTA provider to participate in the CTC huddle to address any urgent medical issues that present during the huddle.

We discussed the deficiencies with scheduling supervisors. They voiced concern about a reduction of provider availability that contributed to some provider appointment backlogs. Providers commented frequent lockdowns, which prevented all movement during normal operating hours, also reduced available appointment times. Both medical and executive leadership were in ongoing talks with custody staff to resolve the issue and to allow medical appointments to occur as scheduled.

Providers and medical leadership had different perspectives concerning access to specialty services. Line staff felt some requests for specialty services were unfairly denied, whereas the medical leadership described emphasizing conservative medical and time management to reduce unnecessary work. The latter discussed implementing a system whereby a PCP appointment would be scheduled within two weeks after a denial of an RFS.

During the on-site inspection, staff explained nurses ordered a provider follow-up and then completed the order that same day to signify that the provider had been co-consulted. Medical leadership expected providers to document decision-making for all co-consults.

Compliance Testing Results

Compliance On-Site Inspection and Discussion

Five of six housing units randomly tested at the time of inspection had access to Health Care Services Request Forms (CDCR 7362) (MIT 1.101, 83.3%). In one housing unit, the custody officers reported they provided a scanned version of the CDCR 7362 form saved to the desktop computer and printed more copies when needed. The staff provided copies of the form rather than procuring original CDCR 7362 forms from the medical warehouse or custody program offices.

Compliance Testing Results

Table 5. Access to Care

Compliance Questions	Scored Answer			
	Yes	No	N/A	Yes %
Chronic care follow-up appointments: Was the patient's most recent chronic care visit within the health care guideline's maximum allowable interval or within the ordered time frame, whichever is shorter? (1.001)	19	6	0	76.0%
For endorsed patients received from another CDCR institution: Based on the patient's clinical risk level during the initial health screening, was the patient seen by the clinician within the required time frame? (1.002)	25	0	0	100%
Clinical appointments: Did a registered nurse review the patient's request for service the same day it was received? (1.003)	39	1	0	97.5%
Clinical appointments: Did the registered nurse complete a face-to-face visit within one business day after the CDCR Form 7362 was reviewed? (1.004)	38	2	0	95.0%
Clinical appointments: If the registered nurse determined a referral to a primary care provider was necessary, was the patient seen within the maximum allowable time or the ordered time frame, whichever is the shorter? (1.005)	18	4	18	81.8%
Sick call follow-up appointments: If the primary care provider ordered a follow-up sick call appointment, did it take place within the time frame specified? (1.006)	3	2	35	60.0%
Upon the patient's discharge from the community hospital: Did the patient receive a follow-up appointment within the required time frame? (1.007)	22	3	0	88.0%
Specialty service follow-up appointments: Did the clinician follow-up visits occur within required time frames? (1.008) *	20	12	13	62.5%
Clinical appointments: Do patients have a standardized process to obtain and submit health care services request forms? (1.101)	5	1	0	83.3%
			Overall percentage (MIT 1): **82.7%**	

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

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

Table 6. Other Tests Related to Access to Care

Compliance Questions	Scored Answer			
	Yes	No	N/A	Yes %
For patients received from a county jail: If, during the assessment, the nurse referred the patient to a provider, was the patient seen within the required time frame? (12.003)	N/A	N/A	N/A	N/A
For patients received from a county jail: Did the patient receive a history and physical by a primary care provider within seven calendar days (prior to 07/2022) or five working days (effective 07/2022)? (12.004)	N/A	N/A	N/A	N/A
Was a written history and physical examination completed within the required time frame? (13.002)	7	0	0	100%
Did the patient receive the high-priority specialty service within 14 calendar days of the primary care provider order or the Physician Request for Service? (14.001)	6	9	0	40.0%
Did the patient receive the subsequent follow-up to the high-priority specialty service appointment as ordered by the primary care provider? (14.003)	9	3	3	75.0%
Did the patient receive the medium-priority specialty service within 15-45 calendar days of the primary care provider order or the Physician Request for Service? (14.004)	8	7	0	53.3%
Did the patient receive the subsequent follow-up to the medium-priority specialty service appointment as ordered by the primary care provider? (14.006)	5	1	9	83.3%
Did the patient receive the routine-priority specialty service within 90 calendar days of the primary care provider order or Physician Request for Service? (14.007)	10	5	0	66.7%
Did the patient receive the subsequent follow-up to the routine-priority specialty service appointment as ordered by the primary care provider? (14.009)	4	3	8	57.1%

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

Recommendations

The OIG offers no recommendations for this indicator.

Diagnostic Services

In this indicator, OIG inspectors evaluated the institution's performance in timely completing radiology, laboratory, and pathology tests. Our inspectors determined whether the institution properly retrieved the resultant reports and whether providers reviewed the results correctly.

Ratings and Results Overview

Case Review Rating	Compliance Rating and Score
Adequate	***Inadequate* (59.8%)**

Case Review found SOL delivered overall good performance in this indicator. The institution performed excellently in its completion of radiology and laboratory tests. However, the institution did not ensure providers endorsed the reports timely and did not always send complete patient test result notification letters. On balance, timely completion of the tests is more important for the care of the patient; therefore, the OIG rated the case review component of this indicator ***adequate***.

Compliance testing found the institution needed to improve in retrieving, reviewing, and endorsing pathology reports. In addition, SOL performed poorly in generating patient test result letters with all required key elements. In contrast, the institution performed excellently in providing radiology and laboratory services and performed well in reviewing and endorsing results. On balance, the OIG rated the compliance testing component of this indicator ***inadequate***.

Case Review and Compliance Testing Results

We reviewed 230 diagnostic events and found 51 deficiencies, three of which were significant.[14] Of these 51 deficiencies, 48 related to health information management and three pertained to provider performance.

Test Completion

SOL performed perfectly in completing radiology tests. Compliance testing showed the institution completed all 10 radiology samples within the required time frames (MIT 2.001, 100%). Case reviewers similarly did not find any radiology study completion deficiencies.

SOL also performed perfectly in completing laboratory tests. Compliance testing showed that the institution completed all 10 laboratory samples within the required time frames (MIT 2.004, 100%). No compliance STAT laboratory samples were available during our testing period (MIT 2.007, N/A). Case reviewers similarly did not identify any laboratory test completion deficiencies.

[14] Deficiencies occurred in cases 1–3, 10, 18, 20, 22–26, 37, 41, and 75–78. Significant deficiencies occurred in cases 37, 41, and 78.

Health Information Management

Providers usually reviewed and endorsed reports within specific time frames for radiology (MIT 2.002, 80.0%) and laboratory tests (MIT 2.005, 90.0%). Staff only intermittently retrieved pathology reports within required time frames (MIT 2.010, 60.0%), but providers generally reviewed and endorsed reports in a timely manner (MIT 2.011, 77.8%). However, providers did not communicate the results of pathology studies to patients within specified time frames in any of the samples we reviewed (MIT 2.012, zero).

OIG clinicians identified 48 deficiencies in health information management.[15] Eight deficiencies involved delays in obtaining providers' endorsements of test results. The following case is an example:

- In case 37, the provider endorsed an INR test 11 days late.[16]

Case review clinicians found most of the health information deficiencies involved incomplete patient results notification letters (39 out of 48 deficiencies). The following cases were examples:

- In case 75, the provider endorsed a CT scan of the liver but did not generate a patient results notification letter.
- In case 78, the provider endorsed a pathology report but did not generate a patient results notification letter.

Incomplete Follow-Through

We identified a slight pattern where providers developed care plans but did not completely follow through on their stated plans when they reviewed test results. This is further discussed in the **Provider Performance** indicator.

Clinician On-Site Inspection

Case review clinicians interviewed medical leadership, diagnostic supervisors, and providers about diagnostic procedures. Laboratory supervisors and providers reported no issues with timely completion of laboratory tests. However, radiology recently had one vacancy, which resulted in a backlog of X-rays to be completed. This backlog occurred after our review period; we did not identify any issues with radiology study completion in case review or compliance.

[15] Deficiencies occurred in cases 1–3, 10, 18, 22–26, 37, 41, and 75–78.

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

Compliance Testing Results

Table 7. Diagnostic Services

Compliance Questions	Scored Answer			
	Yes	No	N/A	Yes %
Radiology: Was the radiology service provided within the time frame specified in the health care provider's order? (2.001)	10	0	0	100%
Radiology: Did the ordering health care provider review and endorse the radiology report within specified time frames? (2.002)	8	2	0	80.0%
Radiology: Did the ordering health care provider communicate the results of the radiology study to the patient within specified time frames? (2.003)	3	7	0	30.0%
Laboratory: Was the laboratory service provided within the time frame specified in the health care provider's order? (2.004)	10	0	0	100%
Laboratory: Did the health care provider review and endorse the laboratory report within specified time frames? (2.005)	9	1	0	90.0%
Laboratory: Did the health care provider communicate the results of the laboratory test to the patient within specified time frames? (2.006)	0	10	0	0
Laboratory: Did the institution collect the STAT laboratory test and receive the results within the required time frames? (2.007)	N/A	N/A	N/A	N/A
Laboratory: Did the provider acknowledge the STAT results, OR did nursing staff notify the provider within the required time frames? (2.008)	N/A	N/A	N/A	N/A
Laboratory: Did the health care provider endorse the STAT laboratory results within the required time frames? (2.009)	N/A	N/A	N/A	N/A
Pathology: Did the institution receive the final pathology report within the required time frames? (2.010)	6	4	0	60.0%
Pathology: Did the health care provider review and endorse the pathology report within specified time frames? (2.011)	7	2	1	77.8%
Pathology: Did the health care provider communicate the results of the pathology study to the patient within specified time frames? (2.012)	0	9	1	0
				Overall percentage (MIT 2): **59.8%**

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

Recommendations

- The department should consider solutions, such as potentially developing an electronic solution, to ensure providers create patient letters at the time of endorsement and the patient results letter automatically populates accurately with all required elements per CCHCS policy and take necessary remedial measures.

- Medical leadership should determine the cause of challenges preventing providers from generating patient notification letters for pathology results and take necessary remedial measures.

Emergency Services

In this indicator, OIG clinicians evaluated the quality of emergency medical care. Our clinicians reviewed emergency medical services by examining the timeliness and appropriateness of clinical decisions made during medical emergencies. Our evaluation included examining the emergency medical response, cardio-pulmonary resuscitation (CPR) quality, triage and treatment area (TTA) care, provider performance, and nursing performance. Our clinicians also evaluated the Emergency Medical Response Review Committee's (EMRRC) performance in identifying problems with its emergency services. The OIG assessed the institution's emergency services mainly through case review.

Ratings and Results Overview

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

SOL's performance in emergency services was acceptable. Providers made good decisions and nursing staff performed appropriate assessments and interventions. Although SOL showed some improvement in comparison to Cycle 6, staff still have further opportunities for improvement in nursing assessments and documentation. Overall, the OIG rated this indicator ***adequate***.

Case Review Results

We reviewed 36 urgent or emergent events and found 21 emergency care deficiencies. Of these 21 deficiencies, three were significant. [17]

Emergency Medical Response

SOL staff responded promptly to emergencies throughout the institution. Staff activated emergency medical services (EMS), notified TTA staff, and initiated cardiopulmonary resuscitation (CPR) appropriately. However, case review found nurses did not always promptly request EMS. The following are examples:

- In case 3, the patient complained of headaches and began having a seizure. The nurses did not request EMS for 26 minutes.
- In case 5, custody staff found the patient unresponsive and initiated CPR. Nurses responded to the patient and custody staff continued CPR. However, EMS was not requested for 11 minutes.

[17] Deficiencies occurred in cases, 1–3, 5, 7–9, 11, 42, and 76. Significant deficiencies occurred in cases, 3, 5, and 42.

Cardiopulmonary Resuscitation Quality

SOL's custody and healthcare staff performed well in initiating CPR promptly, and nursing intervened appropriately providing basic life support. Staff also administered medication appropriately when an opioid overdose was suspected.

Provider Performance

Providers performed excellently in urgent, emergent situations, and after-hours care. In all TTA encounters, providers assessed patients and made prompt treatment decisions. OIG clinicians identified only one documentation deficiency as follows:

- In case 3, the TTA RN notified the provider when the patient was in the TTA for a migraine headache during the day. The TTA provider did not document their decision-making regarding evaluating and treating the migraine headache.

After each urgent or emergent visit in the TTA, providers almost always followed up with patients, except in the following instance:

- In case 42, the patient was in the TTA for an elevated blood sugar level. The provider did not see the patient after this evaluation in the TTA.

Nursing Performance

Nurses generally performed appropriate nursing assessments and interventions during emergencies. However, our clinicians identified a pattern where nurses did not consistently perform complete assessments or reassess their patients prior to discharge from the TTA. The following are two examples:

- In case 2, the TTA nurse did not reassess the patient's chest pain severity after administering nitroglycerin.[18]

- In case 3, the TTA nurse evaluated the patient for altered level of consciousness after a seizure. However, the TTA nurse did not monitor the patient's vital signs every five minutes or reassess for abnormal neurological signs.

Nursing Documentation

Nurses generally appropriately documented emergent events. However, our clinicians identified a pattern of deficiencies with nursing documentation discrepancies. The following are two examples:

- In case 2, the nurse documented administering a medication after the patient had departed the TTA en route to a community hospital.

[18] Nitroglycerin is a medication to treat heart conditions. It helps relax and widen blood vessels allowing better blood flow to the heart.

- In case 7, the nurse inconsistently documented the patient's oxygen level as both high and very low at the same time.

Emergency Medical Response Review Committee

Our clinicians found that supervising RNs (SRN) completed postevent checklists for all patients who had transferred to a higher level of care, including patient deaths. Designated executive nursing and physician staff completed clinical reviews. However, we found these staff frequently did not identify opportunities for improvement. In addition, our compliance testing found SOL leadership did not review the emergency events within the required time frames and checklists were not completed thoroughly (MIT 15.003, 8.33%). This is discussed further in the **Administrative Operations** indicator.

Clinician On-Site Inspection

During the clinician inspection, we toured the TTA and interviewed two nurses. SOL TTA had four rooms to provide patient care. The staff reported they had three emergency response vehicles. Furthermore, the nurses commented the TTA was staffed with two RNs on each shift, with one RN as the designated first responder. In addition, they indicated one provider was assigned to the TTA Monday through Friday from 8 a.m. to 4 p.m. If the assigned provider was not available, the telemedicine provider covered.

Nursing staff indicated, when medical emergencies occurred, the TTA staff was notified by radio, and the first responder responded throughout the institution. The clinicians were also informed custody staff have positive pressure ventilation devices in every building with attached CO_2 detectors that contained both a bacterial and a viral filter. SOL staff members also stated they documented emergency medication administered by custody staff on the medical first responder form and on the primary and secondary survey.

Nurses expressed they felt supported by nursing leadership and had a positive working relationship with custody staff. However, they shared that nursing morale had declined due to many changes with nursing executive staff.

Nursing leadership reported having completed emergency response training in 2019. All new employees receive the training, and all staff receive the training annually and thereafter.

Recommendations

The OIG offers no recommendations for this indicator.

Health Information Management

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

Ratings and Results Overview

Case Review Rating	Compliance Rating and Score
Adequate	***Proficient*** **(87.1%)**

Case Review found SOL had good health information management. The institution performed well in retrieving and scanning hospital records and diagnostic results. However, staff had difficulty with the timely retrieval of specialty reports. The institution also had difficulty sending complete patient test result letters to the patients and performed poorly with the endorsement of reports. However, these lapses did not significantly affect the patients' care. Overall, the OIG rated the case review component of this indicator ***adequate***.

Compliance testing found SOL performed exceptionally well in scanning patient sick call requests, labeling, and scanning medical records into the correct patient files. The institution also performed well in retrieving, scanning, and endorsing hospital records. However, the institution needed to improve in scanning specialty documents. Taking all results into consideration, the OIG rated the compliance testing component of this indicator ***proficient***.

Case Review and Compliance Results

We reviewed 921 events and found 57 deficiencies related to health information management. Of these 57 deficiencies, four were significant.[19]

Hospital Discharge Reports

SOL staff performed well in retrieving and scanning hospital discharge documents into patients' electronic health records within required time frames (MIT 4.003, 85.0%). Most of the hospital discharge reports contained physician discharge summaries, and providers generally reviewed these reports timely (MIT 4.005, 84.0%). OIG clinicians

[19] Deficiencies occurred in cases 1–3, 10, 18, 20–26, 37, and 75–78. Significant deficiencies occurred in cases 37, 75–76, and 78.

reviewed 20 off-site emergency department and hospital encounters and identified three deficiencies.[20] The following is an example:

- In case 76, SOL staff did not route the scanned hospital discharge report to the provider for endorsement.

Specialty Reports

SOL performed poorly in managing specialty reports. Providers frequently did not review the high-priority, medium-priority, and routine-priority specialty reports within the required time frames (MIT 14.002, 26.7%; MIT 14.005, 66.7%; and MIT 14.008, 35.7%). In addition, SOL needs to improve in scanning the specialty reports, as compliance testing showed SOL staff often did not scan specialty reports within the required time frame (MIT 4.002, 66.7%). Our clinicians reviewed 60 specialty reports and identified six deficiencies.[21] The following are examples:

- In case 22, the patient had cataract surgery, but the report was retrieved 19 days after the procedure.
- In case 26, a provider endorsed a cardiothoracic surgery report 12 days after the report was available.

Diagnostic Reports

SOL had a mixed performance in managing diagnostic reports. Compliance testing showed providers endorsed most radiology and laboratory reports timely (MIT 2.002, 80.0%, and MIT 2.005, 90.0%). However, compliance testing showed providers sporadically communicated the results of radiology studies (MIT 2.003, 30.0%) and never communicated laboratory studies (MIT 2.006, zero) to their patients. Our clinicians found 13 delayed endorsements in seven of the 20 cases we reviewed. We also identified one deficiency related to a laboratory test lacking endorsement and 39 deficiencies related to not thoroughly completing patient test result letters.

SOL needed to improve in retrieving pathology reports (MIT 2.010, 60.0%). Providers sometimes did not endorse all pathology reports within the required time frames (MIT 2.011, 77.8%), and they never sent pathology results letters to their patients within required time frames (MIT 2.012, zero). Our clinicians reviewed nine events associated with pathology reports and found three deficiencies. These deficiencies are discussed in the **Diagnostic Services** indicator.

Urgent and Emergent Records

OIG clinicians reviewed 37 emergent care events and found that both nurses and providers generally recorded these events sufficiently. The **Emergency Services** indicator provides additional details.

[20] Deficiencies occurred in cases 1, 25, and 76.

[21] Deficiencies occurred in cases 22, 26, 75, and 78.

Scanning Performance

SOL staff performed well in the scanning process. Compliance testing showed staff always properly scanned medical files (MIT 4.004, 100%). Similarly, OIG clinicians found no deficiencies or mislabeled documents.

Clinician On-Site Inspection

At the on-site inspection, OIG clinicians interviewed medical managers, health information management supervisors, providers, nurses, and ancillary staff. Providers and staff reported no difficulties with off-site reports.

Compliance Testing Results

Table 8. Health Information Management

Compliance Questions	Scored Answer			
	Yes	No	N/A	Yes %
Are health care service request forms scanned into the patient's electronic health record within three calendar days of the encounter date? (4.001)	20	0	20	100%
Are specialty documents scanned into the patient's electronic health record within five calendar days of the encounter date? (4.002)	20	10	15	66.7%
Are community hospital discharge documents scanned into the patient's electronic health record within three calendar days of hospital discharge? (4.003)	17	3	5	85.0%
During the inspection, were medical records properly scanned, labeled, and included in the correct patients' files? (4.004)	24	0	0	100%
For patients discharged from a community hospital: Did the preliminary or final hospital discharge report include key elements and did a provider review the report within five calendar days of discharge? (4.005)	21	4	0	84.0%
Overall percentage (MIT 4): **87.1%**				

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

Table 9. Other Tests Related to Health Information Management

Compliance Questions	Scored Answer			
	Yes	No	N/A	Yes %
Radiology: Did the ordering health care provider review and endorse the radiology report within specified time frames? (2.002)	8	2	0	80.0%
Laboratory: Did the health care provider review and endorse the laboratory report within specified time frames? (2.005)	9	1	0	90.0%
Laboratory: Did the provider acknowledge the STAT results, OR did nursing staff notify the provider within the required time frame? (2.008)	N/A	N/A	N/A	N/A
Pathology: Did the institution receive the final pathology report within the required time frames? (2.010)	6	4	0	60.0%
Pathology: Did the health care provider review and endorse the pathology report within specified time frames? (2.011)	7	2	1	77.8%
Pathology: Did the health care provider communicate the results of the pathology study to the patient within specified time frames? (2.012)	0	9	1	0
Did the institution receive and did the primary care provider review the high-priority specialty service consultant report within the required time frame? (14.002)	4	11	0	26.7%
Did the institution receive and did the primary care provider review the medium-priority specialty service consultant report within the required time frame? (14.005)	10	5	0	66.7%
Did the institution receive and did the primary care provider review the routine-priority specialty service consultant report within the required time frame? (14.008)	5	9	1	35.7%

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

Recommendations

- Medical leadership should ascertain the challenges to timely retrieval of specialty reports and timely provider review of these reports and implement remedial measures as appropriate.

Health Care Environment

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

Ratings and Results Overview

Case Review Rating	Compliance Rating and Score
Not Applicable	***Inadequate* (54.3%)**

SOL performed poorly with health care environment. Medical supply storage areas outside the clinics were unsanitary. Emergency medical response bag (EMRB) logs were missing staff verification; staff did not ensure EMRBs' compartments were sealed and intact; staff did not perform the EMRB inventory check when seal tags were changed; and bags stored compromised medical supplies. Several clinics did not meet the requirements for essential core medical equipment and supplies. Finally, staff did not regularly sanitize their hands before and after examining patients. These factors resulted in an ***inadequate*** rating for this indicator.

Compliance Testing Results

Outdoor Waiting Areas

The institution had no outdoor waiting areas for patients waiting for clinic appointments.

Indoor Waiting Areas

We inspected indoor waiting areas. Health care and custody staff reported existing waiting areas contained sufficient seating capacity. Depending on the population, patients were either placed in clinic waiting areas or held in individual modules (see Photos 1 and 2, next page). During our inspection, we did not observe overcrowding in any of the clinics' indoor waiting areas.

Clinic Environment

Four of five applicable clinic environments were sufficiently conducive for medical care. They provided reasonable auditory privacy, appropriate waiting areas, wheelchair accessibility, and nonexamination room workspace (MIT 5.109, 80.0%). In one clinic, we observed laboratory staff providing services to multiple patients simultaneously at blood draw stations, which hindered auditory privacy.

Photo 1. Indoor clinic waiting area (photographed on 3-14-23).

Photo 2. Individual waiting module (photographed on 3-14-23).

Of the nine clinics we observed, eight contained appropriate space, configuration, supplies, and equipment to allow their clinicians to perform proper clinical examinations (MIT 5.110, 88.9%). In one clinic, the examination room lacked visual privacy for conducting clinical examinations.

Clinic Supplies

Four of the nine clinics followed adequate medical supply storage and management protocols (MIT 5.107, 44.4%). We found one or more of the following deficiencies in five clinics: unidentified or inaccurately labeled medical supplies, disorganized medical supply cabinet or drawer, medical supplies stored directly on the floor, or cleaning materials stored with medical supplies (see Photo 3).

Photo 3. Cleaning materials stored with medical supplies (photographed on 3-14-23).

Only two of the nine clinics met the requirements for essential core medical equipment and supplies (MIT 5.108, 22.2%). The remaining seven clinics lacked medical supplies or contained improperly calibrated or nonfunctional equipment. The missing medical supplies included examination table disposable paper and lubricating jelly. Staff had not properly calibrated the following medical equipment: a nebulization unit, an automated vital signs machine, an otoscope, and an ophthalmoscope. We found several nonfunctional ophthalmoscopes. SOL staff either did not always perform daily performance checks of the automated external defibrillator (AED) or did not always complete defibrillator performance test log documentation records within the past 30 days. In addition, several clinic daily glucometer quality control logs were inaccurate. Specifically, the glucometer quality control solution lot number did not match what was documented in the log at the time of our inspection.

We examined EMRBs to determine whether they contained all essential items. We checked if staff inspected the bags daily and inventoried them monthly. Only one of the seven applicable EMRBs passed our test (MIT 5.111, 14.3%). We found one or more of the following deficiencies with six EMRBs: staff did not ensure the EMRBs' compartments were sealed and intact (see Photo 4).

Photo 4. An EMRB's compartment's were not sealed (photographed on 3-16-23).

In addition, staff had not inventoried the EMRBs when seal tags were replaced, and EMRBs contained medical supplies with compromised sterile packaging (see Photo 5). In addition, the treatment cart in CTC did not meet the minimum inventory level, or staff did not document that reasonable inventory substitutions were made.

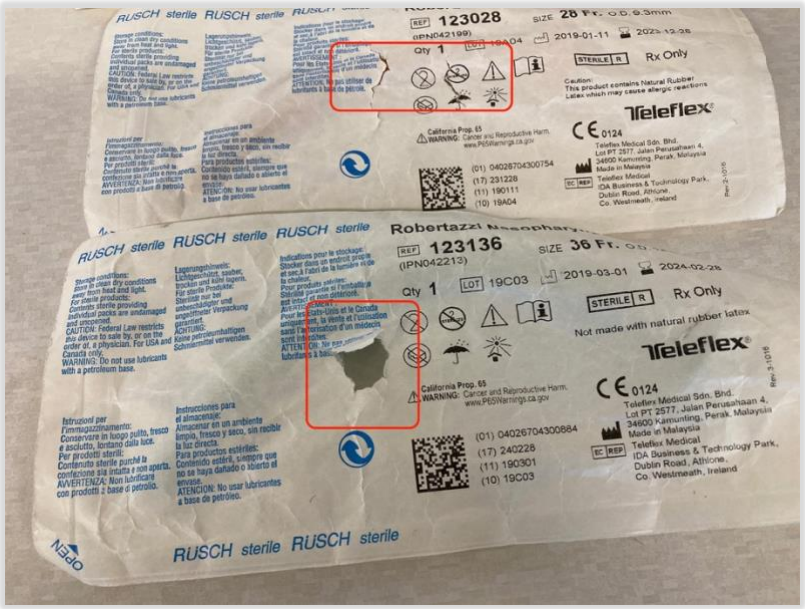

Photo 5. EMBR stored medical supplies with compromised sterile packaging (photographed on 3-15-23).

Medical Supply Management

None of the medical supply storage areas located outside the medical clinics stored medical supplies adequately (MIT 5.106, zero). We found unsanitary medical supplies and storage shelves (see Photos 6 and 7). In addition, the warehouse manager did not maintain a temperature log for solutions stored in the warehouse.

Photo 6. Unsanitary stored medical supplies (photographed on 3-15-23).

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

Photo 7. Unsanitary stored medical supplies (photographed on 3-14-23).

Infection Control and Sanitation

Staff appropriately cleaned, sanitized, and disinfected seven of nine clinics (MIT 5.101, 77.8%). In two clinics, cleaning logs were not maintained.

Staff in all eight applicable clinics properly sterilized or disinfected medical equipment (MIT 5.102, 100%).

We found operating sinks and hand hygiene supplies in examination rooms in six of nine clinics (MIT 5.103, 66.7%). In two clinics, patient restrooms lacked disposable hand towels. In one clinic, the examination room lacked disposable hand towels.

We observed patient encounters in seven applicable clinics. In six clinics, clinicians did not wash their hands before or after examining their patients, before regloving, or after performing wound care services (MIT 5.104, 14.3%).

Health care staff in eight of nine clinics followed proper protocols to mitigate exposure to bloodborne pathogens and contaminated waste (MIT 5.105, 88.9%). In one clinic, nursing staff did not describe the appropriate disinfection process for medical equipment after coming in contact with biohazardous waste.

Physical Infrastructure

We 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 and adequate health care. At the time of inspection, the institution had three infrastructure projects underway, which management staff felt would improve the delivery of care at SOL. Management reported on the following projects:

- Project SP 2.4: Relocation and renovation of the CTC pharmacy to add office spaces and patient holding cells began in August 2021. The project had been delayed due to several challenges, such as the COVID-19 pandemic, labor changes, and difficulty obtaining needed materials and supplies. At the time of inspection, the project was expected to have been completed by July 2023.

- Project SP 2: Renovation of the main corridor to provide code compliant access to the new CTC entrance began in December 2022. The project had been delayed due to a nonresponsive fire sprinkler contractor. At the time of inspection, the project was expected to be completed by April 2023.

- Renovation and expansion of the restricted housing unit medication preparation room in B Facility Housing Unit 10 began in December 2022. At the time of inspection, the project was progressing as planned and was expected to have been completed by the end of March 2023.

Despite the delay of both Projects SP 2.4 and SP 2 described above, when we interviewed health care managers, they did not have concerns about the institution's infrastructure or its effect on staff's ability to provide adequate health care (MIT 5.999).

Compliance Testing Results

Table 10. Health Care Environment

	Scored Answer			
Compliance Questions	**Yes**	**No**	**N/A**	**Yes %**
Infection control: Are clinical health care areas appropriately disinfected, cleaned, and sanitary? (5.101)	7	2	0	77.8%
Infection control: Do clinical health care areas ensure that reusable invasive and noninvasive medical equipment is properly sterilized or disinfected as warranted? (5.102)	8	0	1	100%
Infection control: Do clinical health care areas contain operable sinks and sufficient quantities of hygiene supplies? (5.103)	6	3	0	66.7%
Infection control: Does clinical health care staff adhere to universal hand hygiene precautions? (5.104)	1	6	2	14.3%
Infection control: Do clinical health care areas control exposure to blood-borne pathogens and contaminated waste? (5.105)	8	1	0	88.9%
Warehouse, conex, and other nonclinic storage areas: Does the medical supply management process adequately support the needs of the medical health care program? (5.106)	0	1	0	0
Clinical areas: Does each clinic follow adequate protocols for managing and storing bulk medical supplies? (5.107)	4	5	0	44.4%
Clinical areas: Do clinic common areas and exam rooms have essential core medical equipment and supplies? (5.108)	2	7	0	22.2%
Clinical areas: Are the environments in the common clinic areas conducive to providing medical services? (5.109)	4	1	4	80.0%
Clinical areas: Are the environments in the clinic exam rooms conducive to providing medical services? (5.110)	8	1	0	88.9%
Clinical areas: Are emergency medical response bags and emergency crash carts inspected and inventoried within required time frames, and do they contain essential items? (5.111)	1	6	2	14.3%
Does the institution's health care management believe that all clinical areas have physical plant infrastructures that are sufficient to provide adequate health care services? (5.999)	This is a nonscored test. Please see the indicator for discussion of this test.			
	Overall percentage (MIT 5): **54.3%**			

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

Recommendations

- Medical leadership should determine the root cause for staff not following all required universal hand hygiene precautions and take necessary remedial measures.

- Executive leadership should determine the root cause for staff not ensuring medical supply storage areas, located outside the clinics, store medical supplies adequately, and take necessary remedial measures.

- Nursing leadership should determine the root cause for staff not ensuring clinic examination rooms contain calibrated functional essential core medical equipment and take necessary remedial measures.

- Nursing leadership should determine the root cause for staff not ensuring the emergency medical response bags (EMRBs) are regularly inventoried and sealed, or staff failing to properly complete the monthly logs, and take necessary remedial measures.

Transfers

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

Ratings and Results Overview

Case Review Rating	Compliance Rating and Score
Adequate	***Proficient* (86.0%)**

Case review found SOL performed satisfactorily in this indicator. Compared with Cycle 6, SOL improved with initial assessments upon transfer in and medication continuity. When patients transferred in and out of SOL, including for hospital returns, nurses mostly performed well with completing assessments, and provider follow-up appointments occurred within required time frames. However, case reviewers identified opportunities for improvement with notifications to the receiving facility of pending specialty appointments and thorough assessments when patients returned from the hospital. After reviewing all aspects, the OIG rated the case review component of this indicator ***adequate.***

Compared with Cycle 6, SOL's compliance performance greatly improved for this indicator. Although SOL needed to improve in completing initial health screening forms, the institution performed excellently in completing the assessment and disposition section of the screening process and ensuring medication continuity for newly transferred patients. Consequently, the OIG rated the compliance testing component of this indicator ***proficient***.

Case Review and Compliance Testing Results

We reviewed 32 events in 17 cases in which patients transferred into or out of the institution or returned from an off-site hospital or emergency room. We identified 15 deficiencies, four of which were significant.[22]

Transfers In

The transfer-in process at SOL was satisfactory. Compliance testing found that receiving and releasing (R&R) nurses intermittently provided an explanation to questions that were answered "Yes" on the screening form and sometimes did not perform thorough assessments (MIT 6.001, 64.0%). However, compliance testing also showed nurses performed excellently in completing the assessment and disposition section of the form (MIT 6.002, 100%). Our clinicians reviewed six transfer-in cases and found one deficiency related to incomplete assessment and follow-up. However, we found nurse-initiated provider appointments occurred within required time frames.[23]

Compliance testing found patients who transferred into SOL often received their medications timely (MIT 6.003, 80.0%). Case review identified one deficiency related to medication continuity, which did not impact the overall care of the patient.[24]

Compliance testing found medication continuity was not always maintained for patient layovers at the institution (MIT 7.006, 70.0%). Analysis of the compliance data showed that patients refused their medications in three samples; however, nurses did not document the reason for refusal on the medication administration record. Compliance testing found patients transferring within the institution received their medications without any interruptions (MIT 7.005, 92.0%). Case review did not have any case samples related to patient transfers within the institution.

Both compliance testing and case review found SOL performed excellently with ensuring newly arrived patients were seen by a provider within necessary time frames (MIT 1.002, 100%). However, compliance testing found preapproved specialty appointments rarely occurred timely (MIT 14.010, 15.0%).

Transfers Out

Compliance testing had only one applicable case sample for a patient transferring out of SOL. In that sample, staff included the required medications and corresponding transfer documents (MIT 6.101, 100%). However, our clinicians found opportunities for improvement in that nurses only sometimes documented patients' pending specialist appointments and did not always ensure patients were screened and tested for COVID-19 prior to transfer. The following are two examples:

[22] Deficiencies occurred in cases, 1, 2, 23–25, 32, 33, 35, 36, 76, and 79. Significant deficiencies occurred in cases, 23, 24, 76, and 79.

[23] Transfer in events occurred in cases 31–33, and 79. Deficiencies occurred in cases 32 and 33.

[24] A transfer-in deficiency occurred in case 33 related to medication continuity.

- In case 36, the patient transferred to another institution. The nurse did not communicate and document the patient's pending dermatologist and optometrist appointments.

- In case 79, the patient transferred to another institution. The nurse did not document or communicate the patient's pending specialty appointment for a liver ultrasound. In addition, the nurse did not perform a COVID-19 screening or ensure COVID-19 testing was completed prior to the patient's transfer.

Case review did not have any deficiencies related to medication continuity for patients who transferred out of the institution.

Hospitalizations

Patients returning from an off-site hospitalization or emergency room are at high risk for lapses in care quality. These patients typically have experienced severe illness or injury. They require more care and place a strain on the institution's resources. In addition, because these patients have complex medical issues, a successful health information transfer is necessary for good quality care. Any transfer lapse can result in serious consequences for these patients.

Compliance testing showed staff performed very well in ensuring patients had timely follow-up appointments after hospitalizations or emergency room visits (MIT 1.007, 88.0%). Staff also performed well in retrieving and scanning hospital records (MIT 4.003 85.0%). Providers often reviewed the hospital records and reports within five calendar days of discharge (MIT 4.005 84.0%).

OIG clinicians reviewed 20 events in which patients returned from a hospitalization or emergency room evaluation and identified nine deficiencies.[25] Overall, SOL's hospital return process was sufficient; however, our clinicians identified opportunities for improvement discussed below.

On four occasions, nurses did not thoroughly evaluate patient complaints or perform thorough assessments.[26] The following is an example:

- In case 1, the patient returned to SOL and complained of abdominal pain; however, the nurse did not perform a complete abdominal assessment.

Compliance testing showed medication continuity was sporadically maintained when patients were discharged from a community hospital (MIT 7.003, 20.8%). Analysis of compliance data revealed patients received their keep-on-person (KOP) and chronic care medications one to three days late, and medications were not always made available by pharmacy. In contrast, case review found only one lapse in medication continuity. Please see the **Medication Management** indicator for further discussion.

[25] Deficiencies occurred in cases 1, 2, 23–25, and 76. Significant deficiencies occurred in cases 23, 24, and 76.

[26] Incomplete nursing assessment deficiencies occurred in cases 1, 2, and 76.

Clinician On-Site Inspection

Our clinicians toured the R&R unit and had the opportunity to interview the day shift R&R RN. The nurse was knowledgeable about the transfer process. The nurse stated 20 patients transferred into SOL each day and about five patients transferred out. The nurse indicated medication continuity had improved in the R&R clinic after adopting the Licensed Correction Clinic (LCC) model. The nurse indicated the LCC model allowed the clinic to have floor stock medications to utilize when the patient did not have their prescribed medications. In the event the R&R did not have a medication, the TTA automated drug delivery system was used.

The R&R nurses expressed that morale was positive, immediate nurse supervisors were supportive, and collaboration with custody staff was cohesive. We also learned the TTA nurses were tasked with assessing patients returning from a community hospital or emergency room. The nurses indicated they communicated with providers to reconcile any orders and follow-up appointments.

Compliance Testing Results

Table 11. Transfers

Compliance Questions	Scored Answer			
	Yes	No	N/A	Yes %
For endorsed patients received from another CDCR institution: Did nursing staff complete the initial health screening and answer all screening questions within the required time frame? (6.001)	16	9	0	64.0%
For endorsed patients received from another CDCR institution: When required, did the RN complete the assessment and disposition section of the initial health screening form; refer the patient to the TTA if TB signs and symptoms were present; and sign and date the form on the same day staff completed the health screening? (6.002)	23	0	2	100%
For endorsed patients received from another CDCR institution: If the patient had an existing medication order upon arrival, were medications administered or delivered without interruption? (6.003)	8	2	15	80.0%
For patients transferred out of the facility: Do medication transfer packages include required medications along with the corresponding transfer packet required documents? (6.101)	1	0	1	100%
	Overall percentage (MIT 6): **86.0%**			

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

Table 12. Other Tests Related to Transfers

Compliance Questions	Scored Answer			
	Yes	No	N/A	Yes %
For endorsed patients received from another CDCR institution: Based on the patient's clinical risk level during the initial health screening, was the patient seen by the clinician within the required time frame? (1.002)	25	0	0	100%
Upon the patient's discharge from the community hospital: Did the patient receive a follow-up appointment with a primary care provider within the required time frame? (1.007)	22	3	0	88.0%
Are community hospital discharge documents scanned into the patient's electronic health record within three calendar days of hospital discharge? (4.003)	17	3	5	85.0%
For patients discharged from a community hospital: Did the preliminary or final hospital discharge report include key elements and did a provider review the report within five calendar days of discharge? (4.005)	21	4	0	84.0%
Upon the patient's discharge from a community hospital: Were all ordered medications administered, made available, or delivered to the patient within required time frames? (7.003)	5	19	1	20.8%
Upon the patient's transfer from one housing unit to another: Were medications continued without interruption? (7.005)	23	2	0	92.0%
For patients en route who lay over at the institution: If the temporarily housed patient had an existing medication order, were medications administered or delivered without interruption? (7.006)	7	3	0	70.0%
For endorsed patients received from another CDCR institution: If the patient was approved for a specialty services appointment at the sending institution, was the appointment scheduled at the receiving institution within the required time frames? (14.010)	3	17	0	15.0%

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

Recommendations

- Nursing leadership should analyze the challenges preventing staff from properly documenting communication of pending specialty appointments to the receiving facility for transfer-out patients and take necessary remedial measures.

- Nursing leadership should analyze the challenges preventing staff from documenting and addressing required initial health screening questions and take necessary remedial measures.

Medication Management

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

Ratings and Results Overview

Case Review Rating	Compliance Rating and Score
Adequate	***Adequate* (76.7%)**

Case review found SOL overall performed well with this indicator. Compared with Cycle 6, the institution presented with similar results. SOL ensured medication continuity for chronic care, hospital discharge, specialized medical housing, and patients who transferred in and out of the facility. However, case review found three deficiencies related to newly prescribed medications. After reviewing all aspects, the OIG rated the case review component of this indicator ***adequate.***

Compliance testing found SOL had a mixed performance for this indicator. The institution's pharmacy performed exceptionally in employing general security and storing medications in its main pharmacy and performed well in medication continuity for patients transferring within the institution. Conversely, the institution still required significant improvement in timely providing chronic care medications, newly prescribed medication orders, hospital discharge medications, and medications for patients temporarily housed in SOL. On balance, the OIG rated the compliance testing component of this indicator ***adequate***.

Case Review and Compliance Testing Results

We reviewed 144 events related to medications and found 10 medication deficiencies, four of which were significant.[27]

New Medication Prescriptions

Compliance testing found that newly prescribed medications were frequently not available or not administered timely (MIT 7.002, 64.0%). Analysis of the compliance data showed that in seven of nine samples, the patients received their newly prescribed

[27] Deficiencies occurred in cases, 2, 3, 9, 18, 19, 23, 26, 33, and 76. Significant deficiencies occurred in cases 3, 19, 23, and 76.

medications between one and two days late. Our clinicians identified three significant deficiencies related to newly prescribed medications. The following is an example:

- In case 19, a provider ordered a three-day course of antibiotics to start prior to a scheduled procedure. However, the patient did not receive the medication prior to the procedure. Subsequently, the patient's procedure was canceled by the off-site specialist due to incomplete procedure preparation.

Chronic Medication Continuity

Compliance testing found patients rarely received their chronic care medications within the required time frames (MIT 7.001, 10.5 %). Analysis of the compliance data found most of the deficiencies occurred because the institution did not make the medications available one day prior to the prescriptions expiring, and the pharmacy was not timely in filling and dispensing the medications as ordered. In contrast, our clinicians found patients received their chronic care medications timely.

Hospital Discharge Medications

Compliance testing found patients returning from off-site hospitals or emergency room sporadically received their medication within the required time frames (MIT 7.003, 20.8%). Further analysis found most of the deficiencies were related to delays in issuing KOP medications. Our clinicians identified one significant deficiency where the patient did not receive their medication on hospital return.

Specialized Medical Housing Medications

Analysis of the compliance data indicated newly admitted patient medications were occasionally made available by pharmacy and administered within the ordered time frames (MIT 13.003, 42.9%). Our clinicians, on the other hand, did not identify any delays with medication administration for newly admitted patients.

Transfer Medications

Compliance testing showed satisfactory results in medication continuity for patients arriving from other institutions (MIT 6.003, 80.0%). When patients had layovers or were temporarily housed at SOL, nurses documented administering medications. However, when patients refused medications, nurses did not always document the reasons for the refusal (MIT 7.006, 70.0%). SOL performed very well in ensuring patients transferring from one housing unit to another received their medications timely (MIT 7.005, 92.0%). Our clinicians found one deficiency when a newly transferred patient missed one dose of medication. Compliance testing found SOL performed excellently in completing transfer packets (MIT 6.101, 100%). Please see the **Transfer** indicator for further details.

Medication Administration

Compliance testing found SOL performed sufficiently with administering tuberculosis (TB) medication to patients timely (MIT 9.001, 76.5%). However, the institution poorly monitored patients on TB medications (MIT 9.002, 25.0%). Analysis of the compliance data showed patient weekly monitoring often was not conducted. In addition, nursing

frequently did not include one or more symptoms on the TB monitoring form. Our clinicians did not identify any deficiencies related to TB medications.

Clinician On-Site Inspection

During the on-site inspection, our clinicians toured the medication clinics and interviewed the licensed vocational nurses (LVN) on Facility D. The medication administration areas are located on Yards A through D in a separate location from the central health clinics (CHCs). The medication administration areas were spacious, clean, and appeared well organized. The LVNs seemed knowledgeable in various processes to include the KOP medication process, emergency response, and transfers.

The medication nurses indicated they only attend huddles when time permits. However, the nurse indicated leadership expected at least one LVN to attend either in person or virtually. The attending LVN was tasked with addressing any medication concerns with the provider during the huddle, or through the message pool. The LVN also shared they provide custody staff a list of patients who had medications to pick up. In addition, the LVNs would initiate one last call to the buildings if medications were still not picked up on the fourth day before they are returned to the pharmacy.

The medication nurses shared they are not involved in the transfer process unless the patient had a specialty medication that needed to be sent to R&R for patient transfers. For patients who transferred yard to yard, the LVNs prepared the medications and placed them in an envelope for custody staff to transport to the receiving yard.

Compliance Testing Results

Medication Practices and Storage Controls

The institution adequately stored and secured narcotic medications in six of eight applicable clinic and medication line locations (MIT 7.101, 75.0%). In one location, nurses did not describe the narcotic medication discrepancy reporting process. In the remaining location, narcotic medications were not properly or securely stored as required by CCHCS policy.

SOL appropriately stored and secured nonnarcotic medications in four of eight applicable clinic and medication line locations (MIT 7.102, 50.0%). In two locations, staff did not always perform and log daily treatment cart security checks. In one location, nurses did not maintain unissued medications in their original labeled packaging. In the remaining location, medications were not properly or securely stored, as required by CCHCS policy.

Staff kept medications protected from physical, chemical, and temperature contamination in seven of the eight applicable clinic and medication line locations (MIT 7.103, 87.5%). In one location, staff did not consistently record room temperatures.

Staff successfully stored valid, unexpired medications in all eight applicable medication line locations (MIT 7.104, 100%).

Nurses exercised proper hand hygiene and contamination control protocols in only three of six applicable locations (MIT 7.105, 50.0%). In three locations, some nurses neglected

to wash or sanitize their hands before preparing and administering medications, or before each subsequent regloving.

Staff in five of six applicable medication preparation and administration areas showed appropriate administrative controls and protocols (MIT 7.106, 83.3%). In one location, medication nurses did not describe the process they followed when reconciling newly received medications and the medication administration record (MAR) against the corresponding physician's order.

Staff in all six applicable medication areas used appropriate administrative controls and protocols when distributing medications to their patients (MIT 7.107, 100%).

Pharmacy Protocols

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

The pharmacist in charge (PIC) correctly accounted for narcotic medications stored in SOL's pharmacy (MIT 7.111, 100%).

We examined 18 medication error reports. The PIC timely and correctly processed all reports (MIT 7.112, 100%).

Nonscored Tests

In addition to testing the institution's self-reported medication errors, our inspectors also followed up on any significant medication errors found during compliance testing. We did not score this test; we provide these results for informational purposes only. At SOL, the OIG did not find any applicable medication errors (MIT 7.998).

The OIG interviewed patients in restricted housing units to determine whether they had immediate access to their prescribed asthma rescue inhalers or nitroglycerin medications. Six of seven applicable patients interviewed indicated they had access to their rescue medications. One patient stated he was not aware an order was placed. We promptly notified the CEO of this concern, and health care management immediately issued a replacement rescue inhaler to the patient (MIT 7.999).

Compliance Testing Results

Table 13. Medication Management

Compliance Questions	Scored Answer			
	Yes	No	N/A	Yes %
Did the patient receive all chronic care medications within the required time frames or did the institution follow departmental policy for refusals or no-shows? (7.001)	2	17	6	10.5%
Did health care staff administer, make available, or deliver new order prescription medications to the patient within the required time frames? (7.002)	16	9	0	64.0%
Upon the patient's discharge from a community hospital: Were all ordered medications administered, made available, or delivered to the patient within required time frames? (7.003)	5	19	1	20.8%
For patients received from a county jail: Were all medications ordered by the institution's reception center provider administered, made available, or delivered to the patient within the required time frames? (7.004)	N/A	N/A	N/A	N/A
Upon the patient's transfer from one housing unit to another: Were medications continued without interruption? (7.005)	23	2	0	92.0%
For patients en route who lay over at the institution: If the temporarily housed patient had an existing medication order, were medications administered or delivered without interruption? (7.006)	7	3	0	70.0%
All clinical and medication line storage areas for narcotic medications: Does the institution employ strong medication security controls over narcotic medications assigned to its storage areas? (7.101)	6	2	2	75.0%
All clinical and medication line storage areas for nonnarcotic medications: Does the institution properly secure and store nonnarcotic medications in the assigned storage areas? (7.102)	4	4	2	50.0%
All clinical and medication line storage areas for nonnarcotic medications: Does the institution keep nonnarcotic medication storage locations free of contamination in the assigned storage areas? (7.103)	7	1	2	87.5%
All clinical and medication line storage areas for nonnarcotic medications: Does the institution safely store nonnarcotic medications that have yet to expire in the assigned storage areas? (7.104)	8	0	2	100%
Medication preparation and administration areas: Do nursing staff employ and follow hand hygiene contamination control protocols during medication preparation and medication administration processes? (7.105)	3	3	4	50.0%
Medication preparation and administration areas: Does the institution employ appropriate administrative controls and protocols when *preparing* medications for patients? (7.106)	5	1	4	83.3%
Medication preparation and administration areas: Does the institution employ appropriate administrative controls and protocols when *administering* medications to patients? (7.107)	6	0	4	100%
Pharmacy: Does the institution employ and follow general security, organization, and cleanliness management protocols in its main and remote pharmacies? (7.108)	1	0	0	100%
Pharmacy: Does the institution's pharmacy properly store nonrefrigerated medications? (7.109)	1	0	0	100%
Pharmacy: Does the institution's pharmacy properly store refrigerated or frozen medications? (7.110)	1	0	0	100%
Pharmacy: Does the institution's pharmacy properly account for narcotic medications? (7.111)	1	0	0	100%
Pharmacy: Does the institution follow key medication error reporting protocols? (7.112)	18	0	0	100%
Pharmacy: For Information Purposes Only: During compliance testing, did the OIG find that medication errors were properly identified and reported by the institution? (7.998)	This is a nonscored test. Please see the indicator for discussion of this test.			
Pharmacy: For Information Purposes Only: Do patients in restricted housing units have immediate access to their KOP prescribed rescue inhalers and nitroglycerin medications? (7.999)	This is a nonscored test. Please see the indicator for discussion of this test.			
	Overall percentage (MIT 7): **76.7%**			

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

Table 14. Other Tests Related to Medication Management

Compliance Questions	Scored Answer			
	Yes	No	N/A	Yes %
For endorsed patients received from another CDCR institution: If the patient had an existing medication order upon arrival, were medications administered or delivered without interruption? (6.003)	8	2	15	80.0%
For patients transferred out of the facility: Do medication transfer packages include required medications along with the corresponding transfer-packet required documents? (6.101)	1	0	1	100%
Patients prescribed TB medication: Did the institution administer the medication to the patient as prescribed? (9.001)	13	4	0	76.5%
Patients prescribed TB medication: Did the institution monitor the patient per policy for the most recent three months he or she was on the medication? (9.002)	4	12	1	25.0%
Upon the patient's admission to specialized medical housing: Were all medications ordered, made available, and administered to the patient within required time frames? (13.003)	3	4	0	42.9%

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

Recommendations

- Medical and nursing leadership should analyze the challenges in ensuring that chronic care, hospital discharge, and en route patients receive their medications timely and without interruption and implement remedial leadership as appropriate.

Preventive Services

In this indicator, OIG compliance inspectors tested whether the institution offered or provided cancer screenings, tuberculosis (TB) screenings, influenza vaccines, and other immunizations. If the department designated the institution as being at high risk for coccidioidomycosis (Valley Fever), we tested the institution's performance in transferring out patients quickly. The OIG rated this indicator solely according to the compliance score. Our case review clinicians do not rate this indicator.

Ratings and Results Overview

Case Review Rating	Compliance Rating and Score
Not Applicable	***Inadequate* (68.2%)**

SOL had a mixed performance in preventive services. Staff performed well in administering TB medications, screening patients annually for TB, offering patients an influenza vaccine for the most recent influenza season, and offering colorectal cancer screening for patients from ages 45 through 75. However, SOL only occasionally monitored patients taking prescribed TB medications and sporadically offered required immunizations to chronic care patients. The OIG rated this indicator ***inadequate***.

Compliance Testing Results

Table 15. Preventive Services

Compliance Questions	Scored Answer			
	Yes	No	N/A	Yes %
Patients prescribed TB medication: Did the institution administer the medication to the patient as prescribed? (9.001)	13	4	0	76.5%
Patients prescribed TB medication: Did the institution monitor the patient per policy for the most recent three months he or she was on the medication? (9.002)	4	12	1	25.0%
Annual TB screening: Was the patient screened for TB within the last year? (9.003)	25	0	0	100%
Were all patients offered an influenza vaccination for the most recent influenza season? (9.004)	25	0	0	100%
All patients from the age of 45 through the age of 75: Was the patient offered colorectal cancer screening? (9.005)	22	3	0	88.0%
Female patients from the age of 50 through the age of 74: Was the patient offered a mammogram in compliance with policy? (9.006)	N/A	N/A	N/A	N/A
Female patients from the age of 21 through the age of 65: Was patient offered a pap smear in compliance with policy? (9.007)	N/A	N/A	N/A	N/A
Are required immunizations being offered for chronic care patients? (9.008)	2	8	15	20.0%
Are patients at the highest risk of coccidioidomycosis (Valley Fever) infection transferred out of the facility in a timely manner? (9.009)	N/A	N/A	N/A	N/A
				Overall percentage (MIT 9): **68.2%**

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

Recommendations

- Nursing leadership should analyze the challenges to ensuring nursing staff monitor patients receiving TB medications according to CCHCS guidelines and implement remedial measures as appropriate.

- Medical leadership should analyze the challenges related to the untimely provision of preventive vaccines to chronic care patients and implement remedial measures as appropriate.

Nursing Performance

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

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

Ratings and Results Overview

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

SOL nurses provided sufficient nursing care. Overall nurses mostly performed appropriate nursing assessments and interventions. Compared with Cycle 6, SOL had fewer deficiencies in this cycle. However, we still identified room for improvement with nursing triage in the outpatient setting. Considering all factors, the OIG rated this indicator ***adequate***.

Case Review Results

We reviewed 210 nursing encounters in 63 cases. Of the nursing encounters we reviewed, 84 occurred in the outpatient setting, and 66 were sick call requests. We identified 69 nursing performance deficiencies of which seven were significant.[28]

Outpatient Nursing Assessment and Interventions

A critical component of nursing care is the quality of nursing assessment, which includes both subjective elements (patient interviews) and objective elements (observation and examination). Nurses generally provided appropriate nursing assessments and interventions, and they often identified when patient complaints warranted a same-day nurse evaluation. In addition, nurses usually consulted with a provider when clinically

[28] Deficiencies occurred in cases 1–3, 7–9, 11, 18, 22, 23, 26, 32, 33, 35, 36, 45, 46, 48–52, 54, 59, 60, 61, 66–69, 72–74, 76, 78, and 79. Significant deficiencies occurred in cases 1–3, 67, 73, and 79.

necessary. However, we identified opportunities for improvement in sick call triage. The following are two examples of outpatient deficiencies:

- In case 49, the nurse evaluated this high-risk patient who required self-catheterization to empty the bladder. The patient complained of painful urinary catheter insertion and occasional penile discharge. However, the nurse did not consult a provider and did not schedule a follow-up appointment.

- In case 67, the nurse triaged the patient's sick call complaint of drainage from a surgical site. However, the nurse did not evaluate the patient the same day to rule out potential infection. Instead, the nurse scheduled the patient to be seen the next business day.

Outpatient Nursing Documentation

Complete and accurate nursing documentation is an essential component of patient care. Without proper documentation, health care staff can overlook changes in patients' conditions. On most occasions, nursing staff documented appropriately. However, below is an example of an outpatient documentation deficiency:

- In case 18, the nurse documented that the patient had a facial scar but did not document the size and specific location of the scar.

Emergency Services

We reviewed 36 urgent or emergent events. Nurses responded promptly to emergent events and generally performed appropriate nursing assessments and interventions, which we detail further in the **Emergency Services** indicator.

Hospital Returns

We reviewed 20 events in which patients returned from a hospitalization or an emergency room. In the nurse evaluations, we identified opportunities for improvement in the areas of assessment and intervention. Please see the **Transfer** indicator for further details.

Transfers

We reviewed 11 cases involving transfer-in and transfer-out processes. Receiving nurses evaluated patients appropriately and requested provider appointments within the required time frames. Transfer-out nurses generally screened patients appropriately and mostly documented pertinent information. Please refer to the **Transfers** indicator for further details.

Specialized Medical Housing

We reviewed two cases with a total of 14 events. Nurses generally performed timely assessments and evaluated patients appropriately. Please see the **Specialized Medical Housing** indicator for further details.

Specialty Services

We reviewed 10 cases in which patients returned from off-site specialty appointments. Nurses frequently performed appropriate assessments and interventions. Please refer to the **Specialty Services** indicator for additional details.

Medication Management

OIG clinicians examined 144 events involving medication management and found most nurses administered patients' medications as prescribed. Please refer to the **Medication Management** indicator for additional details.

Clinician On-Site Inspection

Our clinicians spoke with nurses and nursing supervisors in the TTA, CTC, R&R, specialty clinics, outpatient clinics, medication areas, and scheduling unit. We attended two well-organized care team huddles. SOL had a total of eight care teams. Each team consisted of a provider, a primary care RN, and an LVN or medical assistant (MA) for provider support. The outpatient nurses indicated they saw an average of 10–12 patients per day and did not have any appointment backlog.

Our clinicians interviewed central health clinic nursing supervisors. Supervisors shared they conducted monthly sick call audits and had identified opportunities for improvement in their nurses' documentation and patient education.

A supervising registered nurse indicated they had a performance improvement project called the *Kanban Rollout*. The nursing supervisor indicated it was an electronic tracking system to ensure sufficient medical supplies were readily available. During our visit, Building 24 on D Yard was on COVID-19 quarantine due to recent exposure. We learned that LVNs were primarily responsible for conducting quarantine and isolation rounds. Nursing leadership stated they had a designated team hired specifically to complete both quarantine and isolation rounds.

Medication line nurses shared they did not respond to medical emergencies unless the emergency event occurred in clinic areas, or they were summoned by their supervisor to respond. Staff further stated the medical clinics currently did not have any radios, and the TTA RN was the designated primary first responder. However, nursing leadership shared medication line nurses would soon be responding to emergency alarms. They had recently received the radio chargers for the clinics, but were still awaiting the radios. In addition, they had a performance improvement workgroup in progress to implement this change.

Our clinicians interviewed the SRNs for on-site and off-site specialty, to include the utilization management (UM) RN. On-site specialty services consisted of ophthalmology, physical therapy (PT), virtual PT, orthotics, and various specialties through telemedicine. They had one telemedicine RN for on-site specialty and off-site specialty, and one RN designated for off-site specialty. LVNs and MAs were assigned to assist with provider support for on-site specialty. They had two nurses cross-trained for UM and two nurses for off-site specialty.

Headquarters scheduled appointments for telemedicine. We found no appointment backlogs in this area at the time of our visit. However, the radiology technician at SOL had left in March 2023, which resulted in a backlog of over 100 for radiology appointments. At the time of our inspection, the facility was working on a plan to mitigate this issue and was utilizing the radiology department at California Medical Facility (CMF), a nearby institution, to complete the appointments. The UM nurse expressed difficulties obtaining appointments within compliance for on-site urology, ENT, radiology, and gastroenterology.

The acting CNE reported she had been in the position since April 2023. She expressed experiencing challenges with hiring and retaining staff and stated the onboarding process is lengthy. The nurses expressed overall morale was good, and they felt supported by their supervisors.

Recommendations

- Nursing leadership should analyze the challenges to nurses performing more thorough assessments and interventions during patients' appointments and should implement remedial measures as indicated.

Provider Performance

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

Ratings and Results Overview

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

SOL providers delivered acceptable care. Providers reviewed records, managed urgent and emergent situations, documented appropriate actions, and had good care continuity. However, we found occurrences where a few providers did not perform the proper examination for specific complaints or properly monitor patients with anticoagulation issues or diabetes. Factoring in all the information, the OIG rated this indicator ***adequate***.

Case Review Results

OIG clinicians reviewed 131 medical provider encounters and identified 41 deficiencies, 15 of which were significant.[29] In addition, our clinicians examined the quality of care in 25 comprehensive case reviews. Of these 25 cases, we found 18 ***adequate*** and seven ***inadequate***.

Outpatient Assessment and Decision-Making

Most providers made good assessments and sound decisions. However, we identified a small pattern of providers not performing the proper examination based on patients' complaints.[30] This type of deficiency occurred four times, three of which were by telemedicine providers. In addition, we found other poor decision-making deficiencies. The following are examples of deficiencies we identified:

- In case 18, the patient complained of having back pain for about 30 days. The provider did not perform the proper examination that would have included the back, neurologic status, and gait evaluation. The provider also did not consider a physical therapy referral for a stated pain level of 10 on a scale of 10 out of 10, with 10 being the highest level of pain.

[29] Provider deficiencies occurred in cases 1–3, 9, 18–20, 22–24, 26, 37, 38, 40, 41, and 75–78. Significant deficiencies occurred in cases 18–20, 24, 26, 37, 38, 75, 77, and 78.

[30] Deficiencies occurred in cases 9, 18, 20, and 23.

- In case 26, the patient returned from the hospital after a heart procedure to improve blood flow to the heart blood vessels. The provider did not order a high dose statin.[31]

Outpatient Review of Records

Providers generally reviewed medical records carefully. OIG clinicians did not identify any provider review deficiencies pertaining to medication. We identified four provider review deficiencies out of 77 off-site specialty reports and hospital discharge reports.[32] The following is an example:

- In case 75, the provider saw the patient and did not review the laboratory test result that showed blood in the stool.

Emergency Care

Providers appropriately managed patients in 32 TTA encounters with urgent or emergent conditions. We identified one deficiency in the following case:

- In case 3, the provider did not document his decision-making regarding the patient's migraine.

Chronic Care

In most instances, providers appropriately managed the patient's chronic health conditions; however, the OIG found room for improvement. We identified two areas with deficiencies: anticoagulation and diabetes. In two anticoagulation cases, providers did not follow the patients appropriately to manage their risk of bleeding. In two diabetes cases, providers did not properly assess the patients' signs and control of diabetes.

- In case 18, the provider saw the patient, a diabetic and former smoker, for chronic care evaluation, but the provider did not thoroughly evaluate for symptoms or control of diabetes and did not consider lung cancer screening.

- In case 20, the patient was prescribed Entresto, a congestive heart failure medication. Per the MAR, the patient did not receive this medication in October 2022 because a refill request was not generated. The provider did not select "automatic refill" for this chronic heart failure medication.

- In case 37, the patient was prescribed warfarin, a blood thinning medication that requires frequent testing to reduce the risk of bleeding. The provider reviewed multiple instances of an elevated INR, which indicated an increased risk of bleeding, but did not evaluate or order a primary care team member to look for signs of bleeding. This omission placed the patient at risk of bleeding.

[31] A statin is a cholesterol reducing medication.

[32] Deficiencies occurred in cases 2, 22, 75, and 77.

- In case 38, the patient was prescribed warfarin, but the provider did not order the required test for several months. The laboratory tests needed to be performed at least monthly.

Specialty Services

Providers generally referred patients to specialists when needed. However, the OIG found a few instances in which providers did not place orders at the appropriate priority level. When specialists had recommendations, providers generally followed through with the recommendations. We identified a few delays. We discuss providers' specialty performance further in the **Specialty Services** indicator; however, the following are examples of some deficiencies:

- In case 19, the patient had a significantly elevated prostate specific antigen (PSA), suggesting prostate cancer. The patient eventually had a prostate biopsy about 14 months later, which revealed prostate cancer. This extreme delay of over a year related to the provider's decision to order a routine priority prostate biopsy as well as poor patient preparation on two occasions, which resulted in two rescheduled biopsies.

- In case 75, the provider did not review the ophthalmology consultation for cataract surgery within the required policy time frame.

- In case 78, the patient had a specialty procedure where a rectal nodule was found, and the specialist recommended further imaging (MRI of the rectum and CT of the chest, abdomen, and pelvis). The provider did not order the studies until over two weeks later.

Incomplete Follow-Through

Providers displayed a slight pattern of developing care plans but not completely following through on their stated plans. Following through on stated plans is essential to develop rapport with this patient population. Expecting patients to adhere to medical plans, when providers do not, creates difficulties in providing good care. This occurred in case 26 and in the following case:

- In case 41, on two occasions, the provider reviewed laboratory tests and documented that the patient would be scheduled for follow-up appointments. The appointments did not occur.

Documentation Quality

Providers documented accurately most of the time. We found two minor deficiencies in which the provider did not document the rationale for choosing a specific medication in case 1 and did not document an objective description of cellulitis in case 3. During the on-site inspection, staff explained that SOL documents co-consultations through the nurse generating a nurse-to-provider appointment that is completed the same day. Providers and nurses confirmed this.

Provider Continuity

SOL offered good provider continuity. Providers were assigned to specific clinics and followed their patients into the CTC to ensure continuity of care. With very few exceptions, patients were usually seen by their primary care providers.

Clinician On-Site Inspection

At the time of the on-site inspection, SOL had four on-site providers and four telemedicine providers. Medical leadership expressed recent concern with difficulties in recruiting even one sufficient interview candidate for their on-site provider positions. They recently sacrificed an on-site position to obtain a telemedicine provider because they had no applicants for the on-site position. SOL also experienced appointment backlogs due to shortage of providers. One provider retired, one provider transferred to another institution, and a few providers were on vacation.

We discussed patient care with providers, who brought up several issues. Unanimously, they felt the request process for specialty services was arduous; specifically, many requests were denied. They stated the denials created more unnecessary work and delays because they then had to see the patient again within 30 days and possibly resubmit the request. Providers expressed concern that this cycle creates more animosity from patients, and patients also generate more sick-call requests. In addition, providers unanimously complained about lockdowns, which occurred randomly but frequently. Because of custody drills, the central "quad" had to be closed to patient movement and patients could not be transported to the medical building. These occurred during normal operating hours and would last for hours. As a result, multiple patients arrived in the medical building right before the end of the day, which made seeing all scheduled patients impossible.

For deficiencies attributed to providers no longer working at the institution, we discussed those deficiencies with the chief medical executive (CME) and chief physician and surgeon (CP&S). We also discussed the issues that providers raised during our provider interviews. The CME stated he was very judicious with approving RFSs because he believed it saved providers time by not approving unnecessary consults that could result in more follow-up appointments. Generally, if the referral had InterQual criteria, the request must meet all aspects, except when he feels they are necessary.[33] Most denials were due to incomplete information. When he denied RFSs, he appropriately documented his reasons to allow the provider to follow up and determine the next steps.

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

Recommendations

- Medical leadership should analyze the challenges to providers performing focused examinations based on the patients' medical complaints and symptoms and implement remedial measures as indicated.

- Medical leadership should clarify for providers the criteria for approval of medium- and high-priority specialty referrals.

Specialized Medical Housing

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

Ratings and Results Overview

Case Review Rating	Compliance Rating and Score
Adequate	***Proficient* (85.7%)**

Case review found SOL performed satisfactorily in this indicator. Compared with Cycle 6, case reviewers found more significant deficiencies per case. However, OIG clinicians reviewed two CTC admissions and found nurses initiated thorough care plans. We also found nurses performed timely admission assessments, and we determined provider care in the CTC was acceptable. After reviewing all aspects, the OIG rated the case review component of this indicator ***adequate***.

Compared with Cycle 6, compliance testing found SOL had greatly improved in this indicator. SOL performed excellently in completing initial assessments as well as history and physical examinations within required time frames. In contrast, medication administration records showed poor medication continuity with patients newly admitted to specialized medical housing. Factoring in all the information, the OIG rated the compliance testing component of this indicator ***proficient***.

Case Review and Compliance Testing Results

We reviewed two CTC cases that included five provider events and nine nursing events. Due to the frequency of nursing and provider contacts in the specialized medical housing, we bundle up to two weeks of patient care into a single event. We identified six deficiencies, three of which were significant.[34]

Provider Performance

Providers delivered acceptable care in the CTC. Compliance testing showed providers performed excellently in timely completing admission history and physical examinations

[34] Deficiencies occurred in cases 26 and 79. Significant deficiencies occurred in cases 26 and 79.

(MIT 13.002, 100%). OIG clinicians reviewed two cases in the CTC and found provider deficiencies in one case and a rounding interval deficiency in the other case.

- In case 26, the patient returned from the hospital after having a coronary artery bypass graft. The provider did not order a high dose cholesterol medication for secondary prevention of coronary artery disease. The provider also did not reconcile the patient's event monitor for his heart rhythm disorder (atrial fibrillation).

- In case 79, the CTC provider did not see the patient within policy intervals during the months of October and November 2022.

Nursing Performance

Compliance testing showed nurses always performed timely initial admission assessments (MIT 13.001, 100%); case review testing reached similar findings. Case review also found nurses developed thorough patient care plans. Although we identified three deficiencies related to incomplete assessment during nursing patient care rounds, we found overall nursing care was good.[35] An example of an opportunity for improvement is shown below:

- In case 79, after transfer to SOL and admission to the CTC, nurses did not reassess the patient's high blood pressure reading until the following day and did not notify the provider of the abnormal reading.

Medication Administration

Compliance testing showed staff performed poorly in ensuring newly admitted patients received their medications within required time frames (MIT 13.003, 42.9%). Analysis of the compliance data showed most of the patients did not timely receive their medications due to the pharmacy not filling and dispensing the medications by the due date. Our case review did not identify any medication administration deficiencies.

Clinician On-Site Inspection

Our clinicians interviewed CTC nurses and learned the CTC had six medical beds, nine mental health beds, and one negative pressure room. The nurses indicated their average census was between 10 to 15 patients. Nursing leadership indicated their CTC was staffed with two to three registered nurses, a psychiatric technician (PT), and an additional registered nurse "shift lead." In addition, they sometimes staff the CTC with an LVN. RNs were assigned to both mental health and medical patients. Each patient had their own assigned provider, and the on-call provider covered after hours. The CTC had no designated provider. Nursing staff, mental health staff, and custody staff all participated in CTC rounds. Nurses contacted the patients' providers for notifications, medication renewals, and orders.

Staff reported nurses performed patient rounding at the beginning of each shift. Any further rounding depended on patient necessity. The CTC staff also shared, when patients were discharged from the CTC back to the yard, the provider would order all the

[35] Deficiencies were identified in cases 26 and 79.

medications, and the pharmacy would deliver any KOP medications before patients were discharged.

Nurses stated on-call pharmacists were previously available outside of business hours to address any medication-related issues. However, that changed, and pharmacists are now only available after hours intermittently.

CTC nurses shared some challenges with staffing retention. However, overall, they felt supported by their nurse supervisors.

Compliance Testing Results

At the time of the on-site inspection, the CTC had a functional call light communication system (MIT 13.101, 100%).

Compliance Testing Results

Table 16. Specialized Medical Housing

	Scored Answer			
Compliance Questions	**Yes**	**No**	**N/A**	**Yes %**
For OHU, CTC, and SNF: Did the registered nurse complete an initial assessment of the patient on the day of admission? (13.001)	7	0	0	100%
Was a written history and physical examination completed within the required time frame? (13.002)	7	0	0	100%
Upon the patient's admission to specialized medical housing: Were all medications ordered, made available, and administered to the patient within required time frames? (13.003)	3	4	0	42.9%
For specialized health care housing (CTC, SNF, hospice, OHU): Do specialized health care housing maintain an operational call system? (13.101)	1	0	0	100%
For specialized health care housing (CTC, SNF, hospice, OHU): Do health care staff perform patient safety checks according to institution's local operating procedure or within the required time frames? (13.102)	0	0	1	N/A
	Overall percentage (MIT 13): **85.7%**			

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

Recommendations

The OIG offers no recommendations for this indicator.

Specialty Services

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

Ratings and Results Overview

Case Review Rating	Compliance Rating and Score
Inadequate	***Inadequate* (52.7%)**

Case review clinicians found SOL provided poor specialty services for patients. Specifically, access to specialists was often untimely, and we found poor provider responses to patients' specialty needs and poor management of specialty health information. While nursing care related to specialty services was acceptable, on balance, the OIG rated the case review component of this indicator ***inadequate***.

Compared with Cycle 6, compliance testing found SOL overall performed poorly in this indicator. SOL's performance was satisfactory for providing subsequent follow-up appointments for high- and medium-priority specialty services. However, compliance testing resulted in low scores for providing approved specialty services, retrieving, and endorsing specialty reports, and communicating denied requests for specialty services. Factoring in all the information, the OIG rated the compliance testing component of this indicator ***inadequate***.

Case Review and Compliance Testing Results

We reviewed 172 events related to specialty services; 77 were specialty consultations or procedures. We found 28 deficiencies in this category, five of which were significant.[36]

Access to Specialty Services

SOL provided poor access to specialists. Compliance test scores showed poor performance across all priorities—routine-priority (MIT 14.007, 66.7%), medium-priority (MIT 14.004, 53.3%) and high-priority (MIT 14.001, 40.0%)—as well as transfer continuity of previously approved specialty referrals (MIT 14.010, 15.0%). Case review clinicians also identified seven deficiencies in this area, most of which were delays in obtaining specialty services. The following are three examples:

- In case 19, the patient was scheduled to have a prostate biopsy to check for prostate cancer because he had an extremely elevated PSA.[37] The institution

[36] Specialty deficiencies in case 2, 3, 19, 22, 26, and 75–78. Significant specialty deficiencies in cases 19 and 76–78.

[37] PSA is prostate specific antigen, a protein produced by the prostate gland that can be measured in the blood and is used to detect prostate cancer and other conditions.

did not ensure he received his preprocedural antibiotics, which caused the procedure to be canceled by the specialist. On the rescheduled date of the biopsy, the institution did not ensure the patient received the preprocedural enema and the biopsy had to be rescheduled again. Unfortunately, the two lapses in preprocedural preparation resulted in a seven-month delay in diagnosing prostate cancer.

- In case 76, the provider placed an order for orthopedic follow-up two weeks postoperatively for corrective osteotomy.[38] However, this appointment was never scheduled.

- In case 77, the provider requested a CT scan of the patient's abdomen and pelvis to evaluate for possible liver cancer. This study was not performed within the requested time frame.

Provider Performance

SOL had mixed results with provider performance for specialty services. Case review found providers generally ordered specialty appointments within proper time frames and followed up with patients after their appointments. However, we identified three deficiencies, two of which involved providers taking several weeks to order specialist-recommended follow-ups that resulted in delays. In addition, compliance testing indicated provider follow-up did not consistently occur after specialty consultations (MIT 1.008, 62.5%).

Nursing Performance

Nursing performance in specialty services was acceptable. We identified 10 deficiencies in this area; most were due to incomplete assessments upon patients' returns from off-site appointments or not ordering follow-up appointments. These deficiencies were all minor and did not significantly affect patient care.

- In case 2, the patient returned from a cardiology appointment. The nurse did not obtain a blood pressure reading or conduct a cardiac assessment to include symptoms or edema. The nurse also did not order a required Day 10 follow-up COVID-19 test.

Health Information Management

SOL's management of health information was mixed regarding specialty reports. Compliance testing revealed poor performance in retrieval and provider review of specialty service consultant reports within required time frames for routine-priority (MIT 14.008, 35.7%), medium-priority (MIT 14.005, 66.7%), and high-priority (MIT 14.002, 26.7%) reports, and untimely scanning of specialty documents into the Electronic Health Record System (EHRS) (MIT 4.002, 66.7%). Case review found seven deficiencies in this area, which included late endorsements and delayed scans into the EHRS.

[38] An osteotomy is a surgical procedure that involves cutting and reshaping a bone.

Clinician On-Site Inspection

We discussed specialty access with specialty supervisors, providers, and medical leadership. Staff again voiced concerns about the RFS process. They felt leadership denied a significant portion of their requests due to a strict adherence to InterQual criteria. We identified an example of this in case 19. The patient had a significantly elevated prostate specific antigen blood test, discovered in late 2021. Following two delays discussed above, when the provider eventually submitted an RFS, the provider ordered a routine-priority request instead of a high-priority request for this patient with possible cancer. Adherence to medical time frames and the lack of preprocedural preparation contributed to multiple delays for the patient.

Compliance Testing Results

Table 17. Specialty Services

Compliance Questions	Scored Answer			
	Yes	No	N/A	Yes %
Did the patient receive the high-priority specialty service within 14 calendar days of the primary care provider order or the Physician Request for Service? (14.001)	6	9	0	40.0%
Did the institution receive and did the primary care provider review the high-priority specialty service consultant report within the required time frame? (14.002)	4	11	0	26.7%
Did the patient receive the subsequent follow-up to the high-priority specialty service appointment as ordered by the primary care provider? (14.003)	9	3	3	75.0%
Did the patient receive the medium-priority specialty service within 15-45 calendar days of the primary care provider order or Physician Request for Service? (14.004)	8	7	0	53.3%
Did the institution receive and did the primary care provider review the medium-priority specialty service consultant report within the required time frame? (14.005)	10	5	0	66.7%
Did the patient receive the subsequent follow-up to the medium-priority specialty service appointment as ordered by the primary care provider? (14.006)	5	1	9	83.3%
Did the patient receive the routine-priority specialty service within 90 calendar days of the primary care provider order or Physician Request for Service? (14.007)	10	5	0	66.7%
Did the institution receive and did the primary care provider review the routine-priority specialty service consultant report within the required time frame? (14.008)	5	9	1	35.7%
Did the patient receive the subsequent follow-up to the routine-priority specialty service appointment as ordered by the primary care provider? (14.009)	4	3	8	57.1%
For endorsed patients received from another CDCR institution: If the patient was approved for a specialty services appointment at the sending institution, was the appointment scheduled at the receiving institution within the required time frames? (14.010)	3	17	0	15.0%
Did the institution deny the primary care provider's request for specialty services within required time frames? (14.011)	10	10	0	50.0%
Following the denial of a request for specialty services, was the patient informed of the denial within the required time frame? (14.012)	12	7	1	63.2%
			Overall percentage (MIT 14):	**52.7%**

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

Table 18. Other Tests Related to Specialty Services

Compliance Questions	Scored Answer			
	Yes	No	N/A	Yes %
Specialty service follow-up appointments: Did the clinician follow-up visits occur within required time frames? (1.008) *	20	12	13	62.5%
Are specialty documents scanned into the patient's electronic health record within five calendar days of the encounter date? (4.002)	20	10	15	66.7%

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

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

Recommendations

- Medical leadership should determine causative factors related to the untimely provision or scheduling of patients' specialty service appointments and follow-up appointments and implement remedial measures as appropriate.

Administrative Operations

In this indicator, OIG compliance inspectors evaluated health care administrative processes. Our inspectors examined the timeliness of the medical grievance process and checked whether the institution followed reporting requirements for adverse or sentinel events and patient deaths. Inspectors checked whether the Emergency Medical Response Review Committee (EMRRC) met and reviewed incident packages. We investigated and determined whether the institution conducted required emergency response drills. Inspectors also assessed whether the Quality Management Committee (QMC) met regularly and addressed program performance adequately. In addition, our inspectors determined whether the institution provided training and job performance reviews for its employees. We checked whether staff possessed current, valid professional licenses, certifications, and credentials. The OIG rated this indicator solely based on the compliance score. Our case review clinicians do not rate this indicator.

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

Ratings and Results Overview

Case Review Rating	Compliance Rating and Score
Not Applicable	***Inadequate* (74.4%)**

SOL's performance was mixed in this indicator. SOL performed well in processing institutional-level grievances and initial inmate death reports, providing annual nursing competencies, and training newly hired nursing staff. However, the institution needed improvement in several areas. The Emergency Medical Response Review Committee (EMRRC) did not complete the event checklists, or the review was not completed timely. In addition, the institution conducted medical emergency response drills with incomplete documentation. Physician managers never completed probationary and annual performance appraisals in a timely manner. These findings are set forth in the table below. We rated this indicator ***inadequate***.

Compliance Testing Results

Nonscored Results

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

In our review period, we examined mortality reports that occurred before the newly revised CCHCS morality review policy requirements. Prior to May 2022, we obtained CCHCS Death Review Committee (DRC) reporting data. Effective May 2022, we obtained CCHCS Mortality Case Review reporting data. Two unexpected (Level 1) deaths occurred during our review period. In our inspection, we found the DRC neither completed any death review reports nor communicated to the CEO within the required time frame. The DRC finished the reports 78 and 222 days late and submitted them to the institution's

CEO 71 and 215 days late. At the time of the OIG's inspection, we found no evidence in the submitted documentation of the preliminary mortality report being completed for four patients. These reports were overdue at the time of the OIG's inspection (MIT 15.998).

Compliance Testing Results

Table 19. Administrative Operations

Compliance Questions	Scored Answer			
	Yes	No	N/A	Yes %
For health care incidents requiring root cause analysis (RCA): Did the institution meet RCA reporting requirements? (15.001)	This is a nonscored test. Please refer to the discussion in this indicator.			
Did the institution's Quality Management Committee (QMC) meet monthly? (15.002)	6	0	0	100%
For Emergency Medical Response Review Committee (EMRRC) reviewed cases: Did the EMRRC review the cases timely, and did the incident packages the committee reviewed include the required documents? (15.003)	1	11	0	8.3%
For institutions with licensed care facilities: Did the Local Governing Body (LGB) or its equivalent meet quarterly and discuss local operating procedures and any applicable policies? (15.004)	3	1	0	75.0%
Did the institution conduct medical emergency response drills during each watch of the most recent quarter, and did health care and custody staff participate in those drills? (15.101)	0	3	0	0
Did the responses to medical grievances address all of the patients' appealed issues? (15.102)	10	0	0	100%
Did the medical staff review and submit initial patient death reports to the CCHCS Mortality Case Review Unit on time? (15.103)	5	1	0	83.3%
Did nurse managers ensure the clinical competency of nurses who administer medications? (15.104)	10	0	0	100%
Did physician managers complete provider clinical performance appraisals timely? (15.105)	0	5	0	0
Did the providers maintain valid state medical licenses? (15.106)	7	0	0	100%
Did the staff maintain valid Cardiopulmonary Resuscitation (CPR), Basic Life Support (BLS), and Advanced Cardiac Life Support (ACLS) certifications? (15.107)	2	0	1	100%
Did the nurses and the pharmacist-in-charge (PIC) maintain valid professional licenses and certifications, and did the pharmacy maintain a valid correctional pharmacy license? (15.108)	6	0	1	100%
Did the pharmacy and the providers maintain valid Drug Enforcement Agency (DEA) registration certificates, and did the pharmacy maintain valid Automated Drug Delivery System (ADDS) licenses? (15.109)	1	0	0	100%
Did nurse managers ensure their newly hired nurses received the required onboarding and clinical competency training? (15.110)	1	0	0	100%
Did the CCHCS Death Review Committee process death review reports timely? Effective 05/2022: Did the Headquarters Mortality Case Review process mortality review reports timely? (15.998)	This is a nonscored test. Please refer to the discussion in this indicator.			
What was the institution's health care staffing at the time of the OIG medical inspection? (15.999)	This is a nonscored test. Please refer to Table 3 for CCHCS-provided staffing information.			
	Overall percentage (MIT 15): **74.4%**			

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

Recommendations

The OIG offers no recommendations for this indicator.

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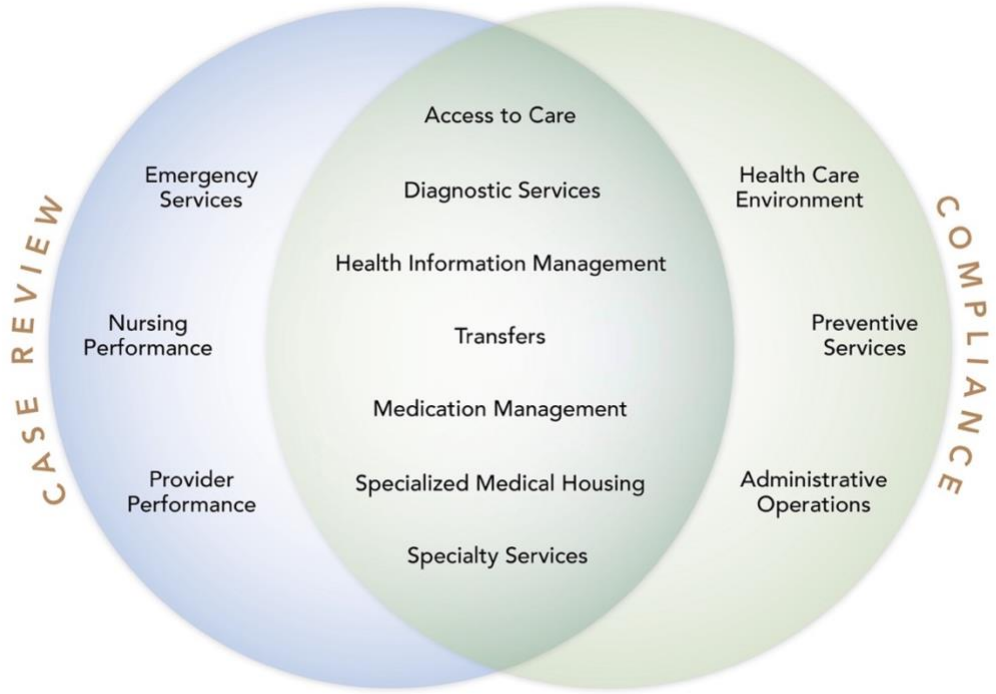
Appendix A: Methodology

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

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

Figure A–1. Inspection Indicator Review Distribution for SOL



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

Case Reviews

The OIG added case reviews to the Cycle 4 medical inspections at the recommendation of its stakeholders, which continues in the Cycle 7 medical inspections. Below, Table A–1 provides important definitions that describe this process.

Table A–1. Case Review Definitions

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

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

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

Case Review Sampling Methodology

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

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

Case Review Testing Methodology

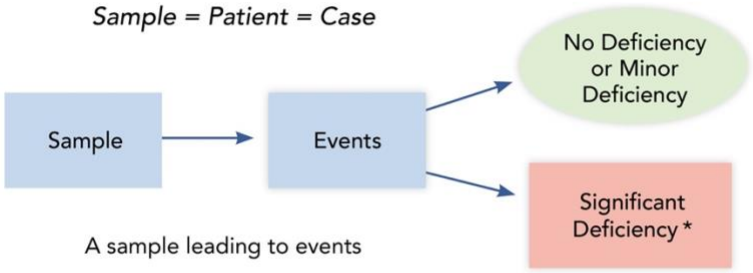
An OIG physician, a nurse consultant, or both review each case. As the clinicians review medical records, they record pertinent interactions between the patient and the health care system. We refer to these interactions as case review ***events***. Our clinicians also record medical errors, which we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

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

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

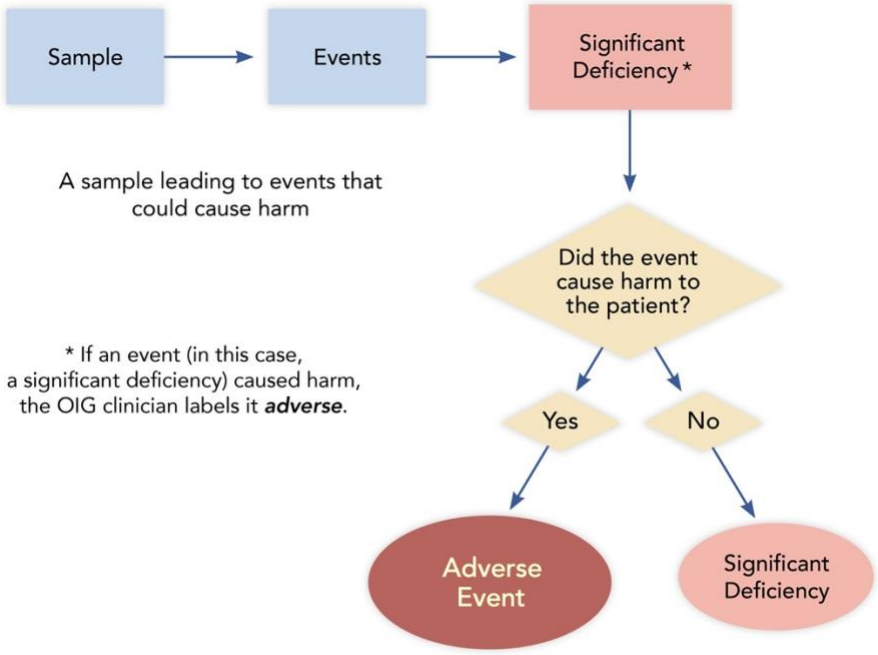
Figure A–2. Case Review Testing

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



Deficiencies

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



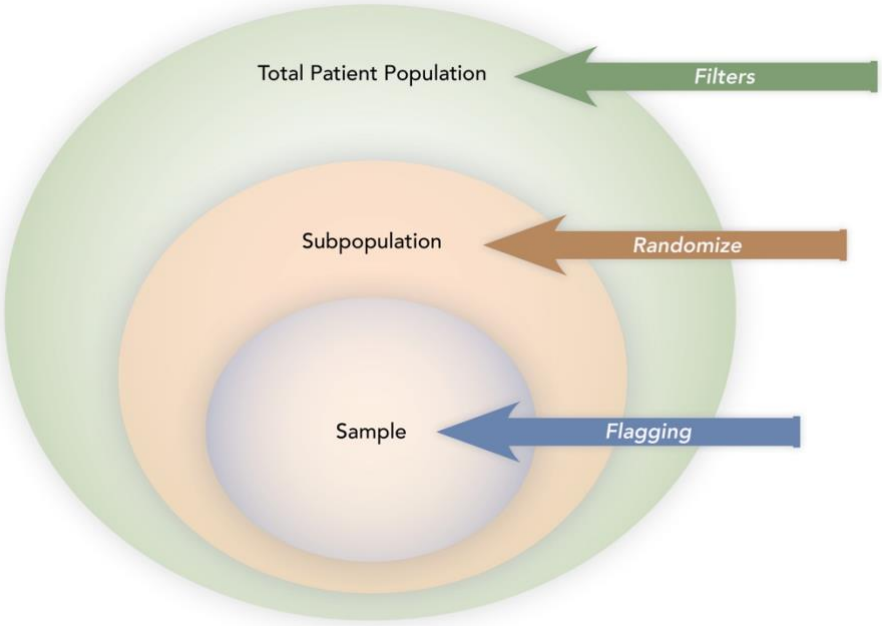
Source: The Office of the Inspector General medical inspection analysis.

Compliance Testing

Compliance Sampling Methodology

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

Figure A–3. Compliance Sampling Methodology



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

Compliance Testing Methodology

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

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

Scoring Methodology

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

Indicator Ratings and the Overall Medical Quality Rating

The OIG medical inspection unit individually examines all the case review and compliance inspection findings under each specific methodology. We analyze the case review and compliance testing results for each indicator and determine separate overall indicator ratings. After considering all the findings of each of the relevant indicators, our medical inspectors individually determine the institution's overall case review and compliance ratings.

Appendix B: Case Review Data

Table B–1. SOL Case Review Sample Sets

Sample Set	Total
Anticoagulation	3
CTC/OHU	1
Death Review/Sentinel Events	3
Diabetes	3
Emergency Services – CPR	5
Emergency Services – Non-CPR	3
High Risk	5
Hospitalization	4
Intrasystem Transfers In	3
Intrasystem Transfers Out	3
RN Sick Call	32
Specialty Services	4
	69

Table B–2. SOL Case Review Chronic Care Diagnoses

Diagnosis	Total
Anemia	9
Anticoagulation	6
Arthritis/Degenerative Joint Disease	5
Asthma	8
Cancer	4
Cardiovascular Disease	14
Chronic Kidney Disease	5
Chronic Pain	9
Cirrhosis/End-Stage Liver Disease	8
COVID-19	5
Deep Venous Thrombosis/Pulmonary Embolism	1
Diabetes	13
Gastroesophageal Reflux Disease	20
Gastrointestinal Bleed	1
Hepatitis C	12
HIV	1
Hyperlipidemia	21
Hypertension	34
Mental Health	16
Migraine Headaches	2
Rheumatological Disease	1
Seizure Disorder	3
Sleep Apnea	2
Substance Abuse	18
Thyroid Disease	4
	222

Table B–3. SOL Case Review Events by Program

Diagnosis	Total
Diagnostic Services	242
Emergency Care	68
Hospitalization	32
Intrasystem Transfers In	6
Intrasystem Transfers Out	6
Outpatient Care	376
Specialized Medical Housing	20
Specialty Services	172
	922

Table B–4. SOL Case Review Sample Summary

MD Reviews Detailed	25
MD Reviews Focused	0
RN Reviews Detailed	14
RN Reviews Focused	44
Total Reviews	83
Total Unique Cases	69
Overlapping Reviews (MD & RN)	14

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Appendix C: Compliance Sampling Methodology

California State Prison, Solano

Quality Indicator	Sample Category	No. of Samples	Data Source	Filters
Access to Care				
MIT 1.001	Chronic Care Patients	25	Master Registry	• Chronic care conditions (at least one condition per patient—any risk level) • Randomize
MIT 1.002	Nursing Referrals	25	OIG Q: 6.001	• See Transfers
MITs 1.003–006	Nursing Sick Call (6 per clinic)	40	Clinic Appointment List	• Clinic (each clinic tested) • Appointment date (2–9 months) • Randomize
MIT 1.007	Returns From Community Hospital	25	OIG Q: 4.005	• See **Health Information Management** (Medical Records) (returns from community hospital)
MIT 1.008	Specialty Services Follow-Up	45	OIG Q: 14.001, 14.004 & 14.007	• See Specialty Services
MIT 1.101	Availability of Health Care Services Request Forms	6	OIG on-site review	• Randomly select one housing unit from each yard
Diagnostic Services				
MITs 2.001–003	Radiology	10	Radiology Logs	• Appointment date (90 days–9 months) • Randomize • Abnormal
MITs 2.004–006	Laboratory	10	Quest	• Appt. date (90 days–9 months) • Order name (CBC or CMPs only) • Randomize • Abnormal
MITs 2.007–009	Laboratory STAT	0	Quest	• Appt. date (90 days–9 months) • Order name (CBC or CMPs only) • Randomize • Abnormal
MITs 2.010–012	Pathology	10	InterQual	• Appt. date (90 days–9 months) • Service (pathology related) • Randomize

Quality Indicator	Sample Category	No. of Samples	Data Source	Filters
Health Information Management (Medical Records)				
MIT 4.001	Health Care Services Request Forms	40	OIG Qs: 1.004	• Nondictated documents • First 20 IPs for MIT 1.004
MIT 4.002	Specialty Documents	45	OIG Qs: 14.002, 14.005 & 14.008	• Specialty documents • First 10 IPs for each question
MIT 4.003	Hospital Discharge Documents	25	OIG Q: 4.005	• Community hospital discharge documents • First 20 IPs selected
MIT 4.004	Scanning Accuracy	24	Documents for any tested incarcerated person	• Any misfiled or mislabeled document identified during OIG compliance review (24 or more = No)
MIT 4.005	Returns From Community Hospital	25	CADDIS off-site admissions	• Date (2–8 months) • Most recent 6 months provided (within date range) • Rx count • Discharge date • Randomize
Health Care Environment				
MITs 5.101–105 MITs 5.107–111	Clinical Areas	9	OIG inspector on-site review	• Identify and inspect all on-site clinical areas.
Transfers				
MITs 6.001–003	Intrasystem Transfers	25	SOMS	• Arrival date (3–9 months) • Arrived from (another departmental facility) • Rx count • Randomize
MIT 6.101	Transfers Out	2	OIG inspector on-site review	• R&R IP transfers with medication

Quality Indicator	Sample Category	No. of Samples	Data Source	Filters
Pharmacy and Medication Management				
MIT 7.001	Chronic Care Medication	25	OIG Q: 1.001	See **Access to Care** • At least one condition per patient—any risk level • Randomize
MIT 7.002	New Medication Orders	25	Master Registry	• Rx count • Randomize • Ensure no duplication of IPs tested in MIT 7.001
MIT 7.003	Returns From Community Hospital	25	OIG Q: 4.005	• See **Health Information Management** (Medical Records) (returns from community hospital)
MIT 7.004	RC Arrivals—Medication Orders	N/A at this institution	OIG Q: 12.001	• See **Reception Center**
MIT 7.005	Intrafacility Moves	25	MAPIP transfer data	• Date of transfer (2–8 months) • To location/from location (yard to yard and to/from ASU) • Remove any to/from MHCB • NA/DOT meds (and risk level) • Randomize
MIT 7.006	En Route	10	SOMS	• Date of transfer (2–8 months) • Sending institution (another departmental facility) • Randomize • NA/DOT meds
MITs 7.101–103	Medication Storage Areas	Varies by test	OIG inspector on-site review	• Identify and inspect clinical & med line areas that store medications
MITs 7.104–107	Medication Preparation and Administration Areas	Varies by test	OIG inspector on-site review	• Identify and inspect on-site clinical areas that prepare and administer medications
MITs 7.108–111	Pharmacy	1	OIG inspector on-site review	• Identify & inspect all on-site pharmacies
MIT 7.112	Medication Error Reporting	18	Medication error reports	• All medication error reports with Level 4 or higher • Select total of 25 medication error reports (recent 12 months)
MIT 7.999	Restricted Unit KOP Medications	7	On-site active medication listing	• KOP rescue inhalers & nitroglycerin medications for IPs housed in restricted units

Quality Indicator	Sample Category	No. of Samples	Data Source	Filters
Prenatal and Postpartum Care				
MITs 8.001–007	Recent Deliveries	N/A at this institution	OB Roster	• Delivery date (2–12 months) • Most recent deliveries (within date range)
	Pregnant Arrivals	N/A at this institution	OB Roster	• Arrival date (2–12 months) • Earliest arrivals (within date range)
Preventive Services				
MITs 9.001–002	TB Medications	17	Maxor	• Dispense date (past 9 months) • Time period on TB meds (3 months or 12 weeks) • Randomize
MIT 9.003	TB Evaluation, Annual Screening	25	SOMS	• Arrival date (at least 1 year prior to inspection) • Birth month • Randomize
MIT 9.004	Influenza Vaccinations	25	SOMS	• Arrival date (at least 1 year prior to inspection) • Randomize • Filter out IPs tested in MIT 9.008
MIT 9.005	Colorectal Cancer Screening	25	SOMS	• Arrival date (at least 1 year prior to inspection) • Date of birth (45 or older) • Randomize
MIT 9.006	Mammogram	N/A at this institution	SOMS	• Arrival date (at least 2 yrs. prior to inspection) • Date of birth (age 52–74) • Randomize
MIT 9.007	Pap Smear	N/A at this institution	SOMS	• Arrival date (at least three yrs. prior to inspection) • Date of birth (age 24–53) • Randomize
MIT 9.008	Chronic Care Vaccinations	25	OIG Q: 1.001	• Chronic care conditions (at least 1 condition per IP—any risk level) • Randomize • Condition must require vaccination(s)
MIT 9.009	Valley Fever	N/A at this institution	Cocci transfer status report	• Reports from past 2–8 months • Institution • Ineligibility date (60 days prior to inspection date) • All

Quality Indicator	Sample Category	No. of Samples	Data Source	Filters
Reception Center				
MITs 12.001–007	RC	N/A at this institution	SOMS	• Arrival date (2–8 months) • Arrived from (county jail, return from parole, etc.) • Randomize
Specialized Medical Housing				
MITs 13.001–003	Specialized Health Care Housing Unit	7	CADDIS	• Admit date (2–8 months) • Type of stay (no MH beds) • Length of stay (minimum of 5 days) • Rx count • Randomize
MITs 13.101–102	Call Buttons	All	OIG inspector on-site review	• Specialized Health Care Housing • Review by location
Specialty Services				
MITs 14.001–003	High-Priority Initial and Follow-Up RFS	15	Specialty Services Appointments	• Approval date (3–9 months) • Remove consult to audiology, chemotherapy, dietary, Hep C, HIV, orthotics, gynecology, consult to public health/Specialty RN, dialysis, ECG 12-Lead (EKG), mammogram, occupational therapy, ophthalmology, optometry, oral surgery, physical therapy, physiatry, podiatry, and radiology services • Randomize
MITs 14.004–006	Medium-Priority Initial and Follow-Up RFS	15	Specialty Services Appointments	• Approval date (3–9 months) • Remove consult to audiology, chemotherapy, dietary, Hep C, HIV, orthotics, gynecology, consult to public health/Specialty RN, dialysis, ECG 12-Lead (EKG), mammogram, occupational therapy, ophthalmology, optometry, oral surgery, physical therapy, physiatry, podiatry, and radiology services • Randomize
MITs 14.007–009	Routine-Priority Initial and Follow-Up RFS	15	Specialty Services Appointments	• Approval date (3–9 months) • Remove consult to audiology, chemotherapy, dietary, Hep C, HIV, orthotics, gynecology, consult to public health/Specialty RN, dialysis, ECG 12-Lead (EKG), mammogram, occupational therapy, ophthalmology, optometry, oral surgery, physical therapy, physiatry, podiatry, and radiology services • Randomize

Quality Indicator	Sample Category	No. of Samples	Data Source	Filters
Specialty Services (continued)				
MIT 14.010	Specialty Services Arrivals	20	Specialty Services Arrivals	• Arrived from (other departmental institution) • Date of transfer (3–9 months) • Randomize
MITs 14.011–012	Denials	20	InterQual	• Review date (3–9 months) • Randomize
		N/A	IUMC/MAR Meeting Minutes	• Meeting date (9 months) • Denial upheld • Randomize
Administrative Operations				
MIT 15.001	Adverse/sentinel events	0	Adverse/sentinel events report	• Adverse/Sentinel events (2–8 months)
MIT 15.002	QMC Meetings	6	Quality Management Committee meeting minutes	• Meeting minutes (12 months)
MIT 15.003	EMRRC	12	EMRRC meeting minutes	• Monthly meeting minutes (6 months)
MIT 15.004	LGB	4	LGB meeting minutes	• Quarterly meeting minutes (12 months)
MIT 15.101	Medical Emergency Response Drills	3	On-site summary reports & documentation for ER drills	• Most recent full quarter • Each watch
MIT 15.102	Institutional Level Medical Grievances	10	On-site list of grievances/closed grievance files	• Medical grievances closed (6 months)
MIT 15.103	Death Reports	6	Institution-list of deaths in prior 12 months	• Most recent 10 deaths • Initial death reports
MIT 15.104	Nursing Staff Validations	10	On-site nursing education files	• On duty one or more years • Nurse administers medications • Randomize
MIT 15.105	Provider Annual Evaluation Packets	5	On-site provider evaluation files	• All required performance evaluation documents
MIT 15.106	Provider Licenses	7	Current provider listing (at start of inspection)	• Review all
MIT 15.107	Medical Emergency Response Certifications	All	On-site certification tracking logs	• All staff • Providers (ACLS) • Nursing (BLS/CPR) • Custody (CPR/BLS)

Quality Indicator	Sample Category	No. of Samples	Data Source	Filters
Administrative Operations (continued)				
MIT 15.108	Nursing Staff and Pharmacist in Charge Professional Licenses and Certifications	All	On-site tracking system, logs, or employee files	• All required licenses and certifications
MIT 15.109	Pharmacy and Providers' Drug Enforcement Agency (DEA) Registrations	All	On-site listing of provider DEA registration #s & pharmacy registration document	• All DEA registrations
MIT 15.110	Nursing Staff New Employee Orientations	All	Nursing staff training logs	• New employees (hired within last 12 months)
MIT 15.998	CCHCS Mortality Case Review	6	OIG summary log: deaths	• Between 35 business days & 12 months prior • California Correctional Health Care Services mortality reviews

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California Correctional Health Care Services' Response

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May 30, 2024

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

Dear Ms. Singh:

California Correctional Health Care Services has reviewed the revised draft Medical Inspection Report for California State Prison, Solano (SOL) conducted by the Office of the Inspector General (OIG) from July 2022 to December 2022. Thank you for preparing the report.

If you have any questions or concerns, please contact me at (916) 691-3747.

Sincerely,

DocuSigned by:
DeAnna Gouldy
3B7166B95AC0A4D1...

DeAnna Gouldy
Deputy Director
Policy and Risk Management Services
California Correctional Health Care Services

cc: Clark Kelso, Receiver
Diana Toche, D.D.S., Undersecretary, Health Care Services, CDCR
Jeff Macomber, Secretary, CDCR
Directors, CCHCS
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Cycle 7

Medical Inspection Report

for

California State Prison, Solano

OFFICE *of the*
INSPECTOR GENERAL

Amarik K. Singh
Inspector General

Neil Robertson
Chief Deputy Inspector General

STATE *of* CALIFORNIA
June 2024

OIG